Houses of the Oireachtas

Joint Committee on Health and Children

Report on the Orthodontic Service in Ireland

February 2002
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- Mid-Western Health Board
- Southern Health Board
- Western Health Board
- South-Eastern Health Board
- Midland Health Board
- North Eastern Health Board
- Dental Council
- The Royal College of Surgeons in Ireland
- Dublin Dental Hospital
- Cork University Dental School
- The Orthodontic Society of Ireland
- The Irish Consultant Orthodontists Group
- Mr. Ian O'Dowling, Consultant Orthodontist
- Ms. Triona McNamara, Consultant Orthodontist
- Dr. Antonia Hewson, Principal Dental Surgeon
The Joint Committee on Health and Children was established in November 1997. As part of its work programme for 2001 and 2002, the Joint Committee decided to examine the issue of the orthodontic service in Ireland. This has included an examination of current policy and practices, educational and training requirements and public concerns about the severe delays in the provision of services.

During the period November 2001 to January 2002, the Committee held a series of public meetings and heard evidence from a number of invited groups, organisations and individuals. In January 2002, the Joint Committee appointed Mr. John Kissane to assist it in reviewing the written and oral presentations received and to assist in the preparation of a draft report. The draft report was considered by the Joint Committee at its meeting on 21st February 2002. The report, as amended, was agreed.

The Joint Committee has asked me to express its total dissatisfaction with the operations of the orthodontic service to date. The members are not satisfied that the various stakeholders involved are working to provide a service which meets public needs. The interests of children are paramount and must take precedence over all other interests.

It is the intention of the Joint Committee to consider this matter again if significant progress is not made in implementing the recommendations in this report immediately.

The Joint Committee is grateful to Mr. John Kissane for his efforts in assisting the Joint Committee. The Committee would also like to sincerely thank all those who came before the Committee to give evidence. In particular, the Committee would like to express its appreciation to the following individuals and organisations:

- Department of Health and Children
  - Mr. Tom Mooney
  - Dr. Gerard Gavin

- Eastern Regional Health Authority
  - Mr. Pat McLoughlin
  - Dr. Brian Burke

- North Western Health Board
  - Mr. Pat Gaughan

- Mid-Western Health Board
  - Mr. John O'Brien
  - Mr. Ted McNamara
Southern Health Board
- Mr. Tony McNamara

Western Health Board
- Dr. Mary Hynes

South-Eastern Health Board
- Mr. Richard Dooley

Midland Health Board
- Dr. Dan O'Meara
- Mr. David Hegarty

North Eastern Health Board
- Dr. Ambrose McLoughlin

The Dental Council
- Mr. Joe Le Masney, President
- Mr. Brian Murray, Vice President
- Professor Robert McConnell, Chair of Education Committee
- Mr. Tom Farren, Registrar

The Royal College of Surgeons in Ireland
- Dr. Peter Cowan, Dean, Faculty of Dentistry
- Dr. Denis Field, Consultant Orthodontist, Dental School, NUI, Cork.

Dublin Dental Hospital
- Mr. Brian Murray, Chief Executive
- Professor John Clarkson, Dean of Faculty
- Dr. Therese Garvey, Senior Lecturer/Consultant in Orthodontics
- Dr. Paul Dowling, Senior Lecturer/Consultant in Orthodontics

Cork University Dental School
- Professor Robert McConnell, Head of School
- Ms. Kathryn Neville, Hospital Manager

The Orthodontic Society of Ireland
- Dr. Therese Garvey, President
- Dr. Burga Healy, Specialist Orthodontist

The Irish Consultant Orthodontists Group
- Mr. Patrick McSherry, Chairman
- Mr. Niall McGuinness, Secretary
- Mr. Brian Jones
- Dr. Brian Burke
- Mr. David Hegarty
- Dr. Paul Dowling
- Dr. Marial Blake
Mr. Ian O’Dowling, Consultant Orthodontist

Ms. Triona McNamara, Consultant Orthodontist

Dr. Antonia Hewson, Principal Dental Surgeon

The Joint Committee requests that the issues raised in this report be the subject of a debate in both Houses of the Oireachtas.

Chairman

21 February 2002
Summary of Recommendations

The Joint Committee recommends that:

Relationships

1. In the continued absence of agreement from all Regional Consultants, the areas of dispute should be referred to an expert panel. This panel should consist of an expert nominated by the three consultant orthodontists in question, an expert nominated by the other parties in the dispute, and an independent Chairman to be agreed by the two other nominees. The findings of this panel should be binding on all parties.  

Orthodontic Service Strategy

2. An Orthodontic Action Plan should be prepared within the next six months by the Department of Health and Children in which the critical success factors, performance indicators including target timeframes for access to the service and possible corrective actions are clearly spelled out.

3. The proposed legislation for an independent Health Information and Quality Authority provides that the relevant Houses of the Oireachtas Committee may request it to review matters it considers appropriate, in a similar manner to the Public Accounts Committee’s access to the Controller and Auditor General.

Guidelines for prioritising Service

4. A mechanism is put in place to ensure that guidelines for prioritising the orthodontic service are not amended before they have been considered by an appropriate Committee of the Houses of the Oireachtas and that an agreed copy is laid before the Houses of the Oireachtas.

5. A reduction in the 1985 guidelines, if considered appropriate, should apply only to the next group of 12 year olds to be assessed and not to children on the existing waiting list for assessment or treatment.

Training

6. The primary Dental Degree course in Dublin and Cork be upgraded/amended to cover primary level orthodontics.

7. Dublin Dental Hospital and School receive State funding to upgrade their facilities for orthodontic postgraduate training with a view to catering for up to 18 trainees.
8. All specialist training places in Dublin and Cork be funded by the State and attached to health authorities until health authorities have a minimum of 50 specialists.

9. A second Consultant Orthodontist be appointed to each Health Board to speed up assessments and facilitate training of Dentists and trainee specialists.

10. The minimum number of trainee specialists in training be increased to 24 by 2004 at latest, with not less than 6 of these being trained in Cork.

11. Flexibility be shown to Dentists with considerable experience in Orthodontics so that they can avail of specialist training.

12. Health authorities encourage and with the Department facilitate dentists to apply for specialised courses in the U.K. and N.I.

13. That Health Boards be facilitated in developing links with U.K. and N.Ireland Dental Colleges to train specialists in view of the inadequate training facilities available at present.

14. Section 34 of the Dentists Act, 1985, which sets out the duties of the Dental Council in relation to education and training, be amended to require the Council to ensure that the number of people in training is adequate to meet public dental needs.

Manpower levels

15. Specialist manpower levels should be based on the 1985 guidelines and on a caseload of 250 completed cases each year per Specialist Orthodontist.

Recruitment

16. The qualifications for the grade of Specialist Orthodontist be directed by the Minister as a matter of urgency.

17. The number of permanent whole-time posts of Specialist Orthodontist in each Health Authority be decided as a matter of urgency and that the position of
existing qualified Specialists and trainees be sorted so that the remaining posts in Health Boards are clearly identified.

18. Planning should now commence involving the appropriate recruitment body, the Department and the Health Authorities to:
   • identify and target the recruitment of the 15 Irish postgraduate students mentioned in 7.5
   • identify countries and schools training prospective Specialists and identify appropriate times for focused targeting of personnel.
   • travel to interview applicants for Specialist posts in their country of residence, if necessary

19. The health authorities prepare an attractive information pack for circulation to prospective Specialist applicants.

20. Priority in the filling of permanent whole-time Specialist posts be given to health authorities with the greatest need e.g., Southern and Eastern authorities.

21. A recruitment campaign for permanent whole-time Specialist posts focusing on Scandinavia, Northern Europe and the U.S.A. be undertaken as soon as possible in view of the perceived overproduction of Specialists in these areas.

22. State funding be provided to train Consultant Orthodontists, to try to avoid a shortage at this level and to facilitate manpower planning.

23. Consideration be given to the provision of free accommodation or an accommodation allowance, for the first two years, to qualified applicants from abroad.

Delivery of Orthodontic Service:

24. Each Health Board initiate a review of its awaiting assessment lists immediately.

25. An Automated Appointment system be considered for use by each Health Board.

26. A Grant-in-Aid option be provided for persons over 16 years on the treatment waiting lists either by amending legislation or through the Social Welfare system.
27. Arrangements with the Dental Schools be negotiated to treat the maximum number of public service patients at the minimum fee.

28. Video conferencing links with Cork, Galway and other appropriate Orthodontic Units be the subject of public funding to facilitate more efficient training.

29. The Joint Committee consider that the Chief Dental Officer of the Department should be at least of equal status with Consultant Orthodontists.

30. Planning for the orderly provision of oral surgery in the Health Boards commence immediately.

31. An accurate system of outcome measurement and audit is put in place as a matter of urgency to verify completed cases, confirm quality and facilitate cost comparisons.
1. Introduction

1.1 This report draws on information contained in the various submissions received by the Joint Committee and on the Report on Orthodontic Services (Moran Report) submitted by a review group to Chief Executive officers of Health Board in October 1998.

Definitions of Orthodontics

1.2 (i) The dental specialty concerned with the cosmetic and functional state of the position of the teeth, and the relationship of the upper teeth to the lower (occlusion). Orthodontics takes advantage of the remarkable degree to which teeth positioning can be influenced by sustained pressure, and several different kind of appliances are used to apply such pressure. These include various types of braces, springs, wires and harnesses. Sometimes small metal appliances are cemented to the teeth so that force may be applied, and sometimes teeth are deliberately extracted to make room.

Pressure applied to a tooth causes absorption of socket bone on the side opposite to the pressure, and new bone production on the same side. The process is slow, but the effect on the position of the tooth is permanent.
(Source: Encyclopaedia of Family Health)

(ii) Orthodontics is that branch of dentistry concerned with growth of the face, development of the occlusion and the prevention and correction of occlusal anomalies. In simpler terms, orthodontics deals with the position of teeth, and the way they come together (bite).

The study of orthodontics includes factors such as variations in facial development and growth, in orofacial function, that may influence the occlusal development; the effects of occlusal variations on facial appearance and on the health and function of the masticatory system.
(Source: Moran Report 1998)

Reasons orthodontic treatment is undertaken.

1.3 Orthodontic treatment is undertaken for the following reasons:

- Dental Health
- Speech
- Appearance

Through improving facial appearance orthodontics can achieve a considerable degree of Social Gain for patients, particularly when more severe defects are corrected. Hence, psychosocial reasons are often cited as the main justification for funding a public health orthodontic service. There is less scientific evidence to show that orthodontics can lead to a significant degree of Health Gain.
Dental Health

The association between malocclusion and dysfunction and oral diseases is controversial and may be considered with regard to the following:

- the available evidence suggests that the disadvantages of malocclusion from a dental health and functional viewpoint are rather modest
- with regards to variations in tooth alignment it appears that only extreme variations such as deep overbites and gross displacement of individual teeth represent true risks to dental health
- a number of studies suggest that while dental malocclusions do have an effect on oral health, other factors such as personal oral hygiene skills and attitude of the patient can have a far greater effect.

In regard to chewing ability, adults with severe malocclusions often report difficulty in chewing, and after treatment say that their chewing ability is improved. It would seem reasonable that poorly-fitting teeth would be a handicap to function, but there is no good test for chewing ability and no objective way to measure the extent of any functional handicap.

Speech

Speech problems are reported by parents (more often than patients) to be related to the presence of a malocclusion. It would appear that only severe malocclusions actually cause certain speech sounds to become distorted, and it must be borne in mind that during the eruption of the adult incisors, a transient open bite will result in a lisp. It has been shown that a malocclusion is rarely the primary cause of a speech defect and conversely speech defects are rarely the cause of malocclusions.

Appearance

Studies in the field of social psychology indicate that an unattractive physical appearance may cause unfavourable social responses and unattractive children are more likely to be the victims of bullying. When nicknames and teasing are concerned, comments concerning the teeth appear to be more hurtful than those about other features.

Demand for orthodontic treatment

The position in relation to orthodontic waiting lists as of December 2001 is set out in table 1 with category A and B figures for awaiting treatment.
All the 12-year-old children, born in 1990 and around 55,000 in number, come up for orthodontic consideration in 2002, this year. Depending on the guidelines to be followed to prioritise needs a figure ranging from one fifth to one third of these could be added to the waiting lists. The implications of this for each Health Board is set out in table 2 below.

Table 2: Potential orthodontic patients in 2002 for each Health Board area.

<table>
<thead>
<tr>
<th>Health Area</th>
<th>No. of 12 year olds</th>
<th>One third</th>
<th>One Quarter</th>
<th>One Fifth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>19,059</td>
<td>6,353</td>
<td>4,765</td>
<td>3,812</td>
</tr>
<tr>
<td>Southern</td>
<td>8,259</td>
<td>2,753</td>
<td>2,065</td>
<td>1,652</td>
</tr>
<tr>
<td>Midwestern</td>
<td>4,804</td>
<td>1,621</td>
<td>1,216</td>
<td>973</td>
</tr>
<tr>
<td>North-western</td>
<td>3,277</td>
<td>1,092</td>
<td>819</td>
<td>655</td>
</tr>
<tr>
<td>Western</td>
<td>5,269</td>
<td>1,756</td>
<td>1,317</td>
<td>1,054</td>
</tr>
<tr>
<td>Midlands</td>
<td>3,370</td>
<td>1,123</td>
<td>843</td>
<td>674</td>
</tr>
<tr>
<td>South-eastern</td>
<td>6,171</td>
<td>2,057</td>
<td>1,543</td>
<td>1,234</td>
</tr>
<tr>
<td>North-eastern</td>
<td>4,924</td>
<td>1,641</td>
<td>1,231</td>
<td>985</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>55,193</strong></td>
<td><strong>18,396</strong></td>
<td><strong>13,790</strong></td>
<td><strong>11,039</strong></td>
</tr>
</tbody>
</table>

The potential orthodontic patients for each year from 2003 to 2012, based on registered birth statistics for each year 1991 to 2000, is set out in table 3.
Table 3: Potential Orthodontic Patients for each year 2003 to 2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>One third</th>
<th>One quarter</th>
<th>One fifth</th>
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<tbody>
<tr>
<td>2003</td>
<td>52,690</td>
<td>17,563</td>
<td>13,173</td>
<td>10,538</td>
</tr>
<tr>
<td>2004</td>
<td>51,684</td>
<td>17,195</td>
<td>12,896</td>
<td>10,317</td>
</tr>
<tr>
<td>2005</td>
<td>49,456</td>
<td>16,485</td>
<td>12,364</td>
<td>9,988</td>
</tr>
<tr>
<td>2006</td>
<td>47,929</td>
<td>15,976</td>
<td>11,982</td>
<td>9,546</td>
</tr>
<tr>
<td>2007</td>
<td>48,530</td>
<td>16,177</td>
<td>12,133</td>
<td>9,706</td>
</tr>
<tr>
<td>2008</td>
<td>50,190</td>
<td>16,797</td>
<td>12,598</td>
<td>10,078</td>
</tr>
<tr>
<td>2009</td>
<td>52,311</td>
<td>17,497</td>
<td>13,078</td>
<td>10,462</td>
</tr>
<tr>
<td>2010</td>
<td>53,551</td>
<td>17,850</td>
<td>13,388</td>
<td>10,710</td>
</tr>
<tr>
<td>2011</td>
<td>53,354</td>
<td>17,785</td>
<td>13,339</td>
<td>10,671</td>
</tr>
<tr>
<td>2012</td>
<td>54,239</td>
<td>18,080</td>
<td>13,558</td>
<td>10,848</td>
</tr>
</tbody>
</table>

Areas of general consensus

1.5 There would appear to be general consensus among those involved in the delivery of the service in the following areas:

- orthodontic problems, in varying degrees of severity affect 30 – 50% of the entire adolescent population which is a situation unparalleled compared to any other medical or surgical discipline
- the vast majority of orthodontic malocclusions have little dental or general health implications
- the majority of patients seek treatment for cosmetic and/or social reasons
- if no barriers to orthodontic treatment existed, up to something between 60% and 66% of the population would seek it.

Areas of debate

1.6 There are a number of areas of debate relating to provision of the service including:

- guidelines to prioritise for treatment (Chapter 4)
- training position (Chapter 5)
- manpower levels (Chapter 6)
- recruitment issues (Chapter 7)
- service provision (Chapter 8)

Relationships between key players

1.7 It became clear to the Joint Committee during its consideration of this matter that there were difficulties between the three longest serving Consultant orthodontists in the Health Board sector and other key players in the sector.

It is not within the present remit of the Joint Committee to give views on the rights or wrongs of these difficulties. However having regard to the magnitude of the problems facing the service the Joint Committee would appeal to all involved
to now give priority to the National interest in this area. The Joint Committee note
the recent appointment of a Director of Training by the Irish Committee for
Specialist training in Dentistry and would ask all key players to co operate with
him in the development of existing training programmes and establishing new
programmes.

Legislative Framework

1.8 The principal legislation governing the provision of services is the Health Act
1970 which sets out the entitlement to dental treatment, and particularly sections
66 and 67 relating to services for children.

The Dentists Act, 1985 deals with training and registration of the dental
profession and established the Dental Council.

The Act requires that training, recognition etc., conform with EU directives (e.g.

The 1994 Dental Treatment Services Scheme provided for free basic dental
services for over 1 million adult medical cardholders. Eligibility for public dental
services has been extended to all children under 16 years.
2. Development of Orthodontic Services in Ireland

2.1 In the 1950s the demand for orthodontic treatment in Ireland was low. Some simple treatments were carried out by both public and private dentists.

2.2 In the 1970s Health Boards engaged the services of orthodontists in private practice who treated patients with removable appliances on a capitation fee system. These fees covered removable appliance costs but did not cover the cost of fixed appliance treatment. Where fixed appliances were considered necessary, application was made to the Department of Health on a case-by-case basis. Very few patients received this treatment which was expensive and approved at private fee rates. There was no overall severity rating system and as the demand for orthodontics increased this placed an excessive burden on an extremely limited service.

2.3 In the late 1980s fixed orthodontic appliances became more readily available. Structured fees were established. This allowed some fixed appliances to be provided by private orthodontists. Health Board fees were lower than private fees and the level of funding available was limited. Consequently, there was considerable difficulty in meeting the growing demand of public patients.

2.4 The first appointment of a consultant orthodontist to a Health Board was made in 1985.

2.5 When the first appointment was made, a number of dentists with appropriate support staff were assigned to work in orthodontics under the direction, training and supervision of the consultant. Some dentists are attracted to providing orthodontist services under the supervision of a Consultant Orthodontist, and value the opportunity of being trained towards a recognised qualification. Using this combined-care approach, it has been possible to treat larger numbers of patients and while most of the work is done by non-orthodontists, the process and outcomes are monitored by the consultant and the standard of treatment where external evaluation has been carried out has proved to be satisfactory. This pattern of service provision was adopted as standard as further consultants were appointed.

2.6 The current strategy for developing the orthodontic service is set out in the Dental Health Action Plan 1994. The Action Plan provides for the development by each Health Board of a Consultant-led secondary care orthodontic service thus continuing the practice developed after the first consultant appointment in 1985.

2.7 In 1996, the Department wrote to the Chief Executive Officers of the Health Boards recommending that a group, representative of Health Board management and Consultant Orthodontists review the orthodontic service.
2.8 In 1997, the Dublin Dental School received approval for its specialist Dentist in Orthodontics training programme. That approval derived from an assessment by the Specialist Advisory Committee (SAC) of the Joint Committee for Specialist Training in Dentistry which is representative of the Royal Colleges of Surgeons in Ireland and Great Britain and was established to oversee acceptable standards of postgraduate training.

2.9 In 1998, the review group reported, the Moran Report, and the key recommendations was that appropriately trained, qualified and registered orthodontists be employed in Regional Orthodontic Units to ensure the provision of a timely and high quality service. This recommendation was accepted by the Department.

2.10 In 1999 the Dental Council established a Specialist Register with divisions of Orthodontics and oral Surgery with the consent of the Minister for Health and Children in exercise of its powers under the Dental Act, 1985. Following upon the establishment of the Register of Dental Specialists the Council appointed the Irish Committee for Specialist Training in Dentistry as the body within the State that it would recognise for the purpose of granting evidence of satisfactory completion of specialist training.

2.11 At present, the Eastern Regional Health Authority (ERHA) and the other seven boards have a consultant-led orthodontic service. Consultant Orthodontists, in addition to their clinical role, are also responsible for planning services and for training health board dentists within an appropriate framework.

Recent changes include the creation of the grade of specialist in orthodontics and the creation of a grade of auxiliary worker to work in the orthodontic area. Specialists are allowed operate their clinics unsupervised but the Consultants see all patients initially for assessment.
3. Orthodontic Services Strategy

3.1 A Government decision in 1994 to proceed with a Consultant-led strategy for developing orthodontic services led to the setting up of Regional Orthodontic Departments. This development was an essential component of the National Health Strategy, "Shaping a Healthier Future". The Health Strategy stressed the importance of focusing on the concept of equity, quality and accountability when evaluating existing services or making decisions to set up new services.

3.2 The current strategy for the orthodontic service is the Dental Health Action Plan dated 26 May 1994. The overall objectives of dental health policy as set out in the Dental Health Action Plan of 1994 were:

- to reduce the level of dental disease in children
- to improve the level of oral health in the population overall
- to provide adequate treatment services to children, Medical cardholders and persons over 70.

A main element of the plan was the provision of a new Dublin Dental Hospital and School. The plan also provided for the phased improvement of primary and secondary care orthodontic treatment for children as follows:

"The successful recruitment by most health boards of a consultant orthodontist has begun to improve the position. It is estimated, however, on the basis of the numbers who need treatment that a total of nine consultant orthodontists and 31 approximately trained dental support staff will be required to meet the service needs."

3.3 The Department of Health and Children Strategy Statement 1998 – 2001 provided for the following steps relevant to the orthodontic service to meet dental services objectives:

- Continue implementation of Dental Health Action Plan.
- Develop specialised dental services through the establishment of regional consultant services.

The statement acknowledged that this was but a first step towards development of more refined plans for the area and that the formulation of more detailed plans would be undertaken, which would include the:

(a) Identification of the critical success factors
(b) Setting of performance indicators and
(c) Indication of what corrective action might be taken in the event of objectives not being reached.
3.4 The recent Health Strategy "Quality and Fairness: A Health System for You" provides for the expansion of specialist dental services and indicates that:

(i) following review of the Dental Health Action Plan, new goals for oral health will be formulated
(ii) the objective of the orthodontic service is to provide timely treatment to patients most in need
(iii) patients with less severe needs will be treated as quickly as the availability of trained specialists allows
(iv) a new grade of Specialist in Orthodontics has been created and training programmes have been put in place so that dentists can reach specialist level
(v) a special needs-based approach will be taken to developing dental services over the next five to seven years as follows:

- a plan for the delivery of specialist dental services on a prioritised basis will be prepared and implemented
- areas of specialisation in dentistry will be approved and publicly funded specialist training programmes will be established in those areas
- the services of orthodontists in the private sector will be used on a more widespread basis. This, together with additional sessions by health board specialist staff, will enable the treatment of a further 3,500 patients annually.

3.5 The recent strategy also indicates that:

- new legislation to provide clear statutory provision on entitlements will be provided
- guidelines will be published concerning target timeframes for access to various services and
- an independent Health Information and Quality Authority will be established with responsibility for health information systems, quality assurance and reviewing and reporting on services.

Conclusion

3.6 The Joint Committee consider that the Dental Health Action Plan is and has been clearly inadequate to deal with the orthodontic situation and that there is an urgent need for a radically reviewed plan.

Recommendations:

3.7 The Joint Committee recommends that:

(i) an Orthodontic Action Plan should be prepared within the next six months by the Department of Health and Children in which the critical success
factors, performance indicators including target timeframes for access to the service and possible corrective actions are clearly spelled out.

(ii) a sessional orthodontic adviser be appointed by the Department to assist in the preparation of the Orthodontic Action Plan in view of the timescale involved.

(iii) the proposed legislation for an independent Health Information and Quality Authority provide that the relevant Houses of the Oireachtas Committee may request it to review matters it considers appropriate, in a similar manner to the Public Accounts Committee’s access to the Controller and Auditor General.
4. Guidelines for Prioritising Service

4.1 As indicated in Chapter 3.4 the recent Health strategy states that the objective of the orthodontic service is to provide timely treatment to patients most in need and that patients with less severe needs will be treated as quickly as the availability of trained specialists allows.

4.2 The Department issued guidelines in 1985 to Health Boards on the classification of cases awaiting treatment in descending order of severity. Children have been assessed for treatment by Health Boards in accordance with these guidelines and, where appropriate, placed on waiting lists. These guidelines relate to three categories of patients as follows:

- **Category A**: the most severe cases e.g. cleft lip and palate (less than 1%).
- **Category B**: cases with a functional handicap e.g. marked distortion between the upper and lower jaws (approximately 6%).
- **Category C**: non-handicapped cases but having a need for treatment (approximately 16%).

In relation to Category C, for planning purposes in the Dental Health Action Plan 1994, a lower figure of 9% was chosen as the realistic treatment need for the category when other factors were taken into consideration such as likely patient compliance and levels of oral hygiene.

In relevant tables in this report, e.g. table 2 – Chapter 1, one quarter has been used as the number of potential patients under the 1985 guidelines.

4.3 The report of the Health Board group (The Moran Report mentioned in Chapter 2.4) recommends the adoption of an internationally recognised index, the Index of Treatment Need (IOTN), for the assessment of orthodontic patients. Under this index cases are placed in categories I, no need for treatment, to 5, great need, in ascending order of “handicap”.

 Patients in Category 5 would include patients with cleft lip and palate, multiple missing teeth or a destructive malocclusion, which would damage the hard and soft tissues.

 Patients in Category 1 would include those with minor tooth displacements where there is little need for treatment.

The report recommended the provision of orthodontic treatment for Categories 4 and 5 of the I.O.T.N. Under these recommendations 50% of 12-year-old children would qualify for orthodontic treatment. The report recommends the service should provide for the treatment of one third of children. This is more than double
under the 1985 guidelines. In relevant tables in this report one third has been used as the number of potential patients under I.O.T.N. guidelines.

4.4 The guidelines for prioritising the service have been under review and presentations before the committee suggest that draft / revised guidelines circulated in June 2000 and October 2001 would reduce the number of potential patients to be treated to a figure below that proposed under the 1985 guidelines.

4.5 Potential patients for the years 2003 to 2012 under guidelines discussed at 4.2, 4.3, and 4.4 are set out in table 3.

4.6 The target number of patients to be treated each year at specialist level under the Dental Health Action Plan was 16,500 or Categories A, B and C of 1985 guidelines. This was to be achieved with 40 orthodontic teams with each team completing 250 cases each year. The committee has been informed that returns supplied by the health boards relating to cases completed in considerably lower than the target figure and consisted of Category A and B patients only. Factors seen as contributing to the poor figures are:

• the majority of support staff have been trainees
• trainers are restricted in number of cases they can deal with
• the high turnover of staff at specialist level
• no specialist grade in the service.

Until these factors are addressed it is unlikely that a caseload of 250 each year per team will be achieved. The short-term outlook, next 2 to 3 years, is not very promising without considerable private sector involvement.

4.7 In the present circumstances it is clear that as each years 12 year olds are added to the waiting list for treatment, with priority being given to Category A and B cases, existing Category C people in particular are likely to move down the list. This leads to many parents being upset and taking the matter up at Health Board level and with public representatives.

Recommendations

4.8 The Joint Committee recommends that:

(i) a mechanism is put in place to ensure that guidelines for prioritising the orthodontic service are not amended before they have been considered by an appropriate Committee of the Houses of the Oireachtas and that an agreed copy is laid before the Houses of the Oireachtas.

(ii) a reduction in the 1985 guidelines, if considered appropriate, should apply only to the next group of 12 year olds to be assessed and not to children on the existing waiting list for assessment or treatment.
5. Training

5.1 The current Health Strategy, as indicated in Chapter 3.4, provides for the delivery of specialist dental services and the provision of publicly funded specialist training programmes.

5.2 State funding was first provided to people to train as specialists in orthodontics in 1999. Eight trainees are being funded at present and are working for the following Health Boards:

<table>
<thead>
<tr>
<th>Health Authority/Board</th>
<th>No.</th>
<th>Due to qualify</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western</td>
<td>2</td>
<td>2002</td>
</tr>
<tr>
<td>Eastern</td>
<td>4</td>
<td>2004</td>
</tr>
<tr>
<td>South Eastern</td>
<td>1</td>
<td>2004</td>
</tr>
<tr>
<td>North Eastern</td>
<td>1</td>
<td>2004</td>
</tr>
</tbody>
</table>

5.3 Council Directive 78/687 sets out EU requirements for specialist training by Member States. Article 2(1) provides that:

“Member States shall ensure that the training leading to a diploma, certificate or other evidence of formal qualifications as a practitioner of specialised dentistry meets the following requirements at least:

(a) it shall entail the completion and validation of a five-year full-time course of theoretical and practical instruction within the framework of the training referred to in Article 1, or possession of the documents referred to in Article 7(1) of Directive 78/686/EEC.
(b) it shall comprise theoretical and practical instruction;
(c) it shall be a full-time course of a minimum of three years’ duration supervised by the competent authorities or bodies;
(d) it shall be in a university centre, in a treatment, teaching and research centre or, where appropriate, in a health establishment approved for this purpose by the competent authorities or bodies;
(e) it shall involve the personal participation of the dental practitioner training to be a specialist in the activity and in the responsibilities of the establishments concerned”.

Article 3 of that directive provides for part-time training when training on a full-time basis would not be practicable for well-founded reasons.

5.4 Article 2(3) of the Directive provided that Member States would designate the body to recognise evidence of satisfactory completion of specialist training. The Dental Council was designated for this purpose in the Dentist Act 1985, and as indicated in Chapter 2.10, it established a Specialist Register in Orthodontics in 1999, and appointed the Irish Committee for Specialist Training in Dentistry as the body to grant evidence of satisfactory completion of specialist training.
The recognised training bodies in Ireland for postgraduate training are the University of Dublin, University College Cork and the Royal College of Surgeons. The Dublin Dental School and Hospital commenced orthodontic postgraduate training in 1989. The Cork Dental School and Hospital has not been in a position to commence postgraduate training to date. The Royal College of Surgeons is unable to provide clinical training facilities on site. Therefore postgraduate training in Ireland to specialist orthodontic level is limited to Dublin and Cork Dental Schools and Hospitals.

Postgraduate Orthodontic training prior to 1999:

(i) Dublin Dental Hospital and School
In the period 1989 - 1999 the Dublin Dental School and Hospital was only able to graduate 10 orthodontic specialists and train 5 specialists to consultant level because of a shortage of consultant staff both in the Dental School and in the Health Boards.

(ii) Cork Dental Hospital and School
Cork Dental School has been unable to provide specialist training in orthodontics because it does not have a second orthodontic consultant in post.

(iii) Regional Orthodontic Units
It has been indicated to the Committee that the Regional Orthodontic Units produced 5 specialists in the period up to 1999.

The present position in relation to the number of Specialists, Consultants and Trainee specialists with the Health Board Service is set out in table 4.

<table>
<thead>
<tr>
<th>Health Board / Authority</th>
<th>Specialists</th>
<th>Consultants</th>
<th>Total</th>
<th>Trainee Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern - SWA</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>- NA</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>- EC</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Southern</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Midwest</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Northwest</td>
<td>3</td>
<td>1.5 (2/3rd)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Western</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Midlands</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Southeast</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Northeast</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>18</td>
<td>10</td>
<td>28</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 5 sets out the projected number of consultant/specialist orthodontists required in each health authority by 2008 under various case loads while still
operating under the 1985 classification guidelines. The population projections for each Health Board area used are taken from the Moran Report.

Table 5: Consultant/Specialist Numbers required by 2008 under 1985 guidelines

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern - SWA</td>
<td>9.0</td>
<td>11.2</td>
<td>18.0</td>
<td>22.4</td>
</tr>
<tr>
<td>- NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- EC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern</td>
<td>1.0</td>
<td>4.5</td>
<td>7.1</td>
<td>9.0</td>
</tr>
<tr>
<td>Midwestern</td>
<td>3.0</td>
<td>2.7</td>
<td>4.3</td>
<td>5.4</td>
</tr>
<tr>
<td>Northwestern</td>
<td>5.5</td>
<td>1.7</td>
<td>2.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Western</td>
<td>2.0</td>
<td>2.8</td>
<td>4.5</td>
<td>5.6</td>
</tr>
<tr>
<td>Midlands</td>
<td>1.0</td>
<td>1.8</td>
<td>2.9</td>
<td>3.6</td>
</tr>
<tr>
<td>Southeastern</td>
<td>4.0</td>
<td>3.3</td>
<td>5.2</td>
<td>6.8</td>
</tr>
<tr>
<td>Northeastern</td>
<td>4.0</td>
<td>2.6</td>
<td>4.2</td>
<td>5.2</td>
</tr>
<tr>
<td>Totals</td>
<td>27.5</td>
<td>30.6</td>
<td>49.0</td>
<td>61.2</td>
</tr>
</tbody>
</table>

* 2008 Requirement based on 400 completed cases per year. (Moran Report)
** 2008 Requirement based on 500 completed cases each 2 years.
*** 2008 Requirement based on 400 completed cases each 2 years.

A caseload of 400 completed cases each year is hard to substantiate based on evidence given to the Committee. A figure of 400 or 500 completed cases every two years is a more likely performance target with the higher figure perhaps only achievable with the assistance of orthodontic auxiliaries.

The Joint Committee also accepts that Consultant Orthodontists cannot be expected to carry a worthwhile caseload due to their involvement in all assessments and supervising trainee specialists and dentists carrying out orthodontic work.

The Joint Committee considers that immediate action is required to raise the number of specialist orthodontics from 18 at present to 49 as quickly as possible.

Training Capacity

5.9 (i) Dublin Dental School and Hospital

The Specialist Advisory Committee (SAC) of the Joint Committee for Higher Training in Dentistry of the Royal College of Surgeons, in a report published in 1999, permitted an increase in the number of trainees, from a maximum of 6 at any one time to a maximum of 10 or 12, depending on the involvement of the Regional Orthodontic Units. With improved facilities in Dublin it is understood that Dublin could raise its intake to provide 18 specialists in a three-year period.
iii) Cork Dental School and Hospital

In certain circumstances Cork has the capacity to commence a specialist training programme for 2 to 4 trainee and increase that number to 6 to 8.

There is therefore a possibility of catering for the training of a minimum of 24 Specialists at an early date. The Joint Committee considers that arrangements to achieve this should be fast tracked by all involved and that all of these posts should be funded by the State and attached to Health Boards.

In the event that Cork Dental School and Hospital is not in a position to contribute to specialist training needs by 2003 it is imperative that the Regional Orthodontic Units be facilitated in setting up a training programme to cover the shortfall involved.

Orthodontic Auxiliaries

5.10 Agreement has been reached on the setting up of a grade of Orthodontic Auxiliary. The Committee has been informed that this grade may be of more use in the private sector than in the public sector. It has been suggested that this grade, working on a one to one basis, can assist specialist and others to raise their completed caseload by perhaps 50 or more cases a year. On this basis the Joint Committee considers that the training of Orthodontic Auxiliaries should commence as soon as possible with a view to having an equivalent number of Auxiliaries to Specialists in the public service.

Training Outside Ireland

5.11 Prior to 1999 some specialist training took place where Regional Orthodontic Units were linked to Dental Schools outside the country with the trainees based here.

It is still open to Irish Dentists to train abroad if they are successful in getting a place in a training course outside the country but it appears all the practical elements of the course would have to be done outside the country. If Cork Dental School and Hospital is not able to provide specialist training in the immediate future this matter should be revisited.

Recommendations

5.12 The Joint Committee recommends that:

(i) the primary Dental Degree course in Dublin and Cork be upgraded / amended to cover primary level orthodontics

(ii) Dublin Dental Hospital and School receive State funding to upgrade their facilities for orthodontic postgraduate training with a view to catering for up to 18 trainees
(iii) all specialist training places in Dublin and Cork be funded by the State and attached to health authorities until health authorities have a minimum of 50 specialists.

(iv) a second Consultant Orthodontist be appointed to each Health Board to speed up assessments and facilitate training of Dentists and trainee specialists.

(v) the minimum number of trainee specialists in training be increased to 24 by 2004 at latest, with not less than 8 of these being trained in Cork.

(vi) flexibility be shown to Dentists with considerable experience in Orthodontics so that they can avail of specialist training.

(vii) Health authorities encourage and with the Department facilitate dentists to apply for specialised courses in the U.K. and N.I.

(viii) That Health Boards be facilitated in developing links with U.K. and N.Ireland Dental Colleges to train specialists in view of the inadequate training facilities available at present.

(ix) Section 34 of the Dentists Act, 1985, which sets out the duties of the Dental Council in relation to education and training, be amended to require the Council to ensure that the number of people in training is adequate to meet public dental needs.
6 Manpower Levels

Comparison with other EU States and U.S.A.

6.1 It appears there is no such concept as an average E.U. requirement per 1,000 population for orthodontists. The situation that has arisen in some EU States particularly those in Scandinavia and North Europe is that because of policy drift there was overproduction of specialists including orthodontists. This led to over provision of specialist care and escalation of health care costs. Some of these countries are now engaged in retrenchment and are reducing specialist care provision and specialist numbers.

The principle of subsidiarity allows for member states to determine their own priorities relating to health service provision including orthodontic care and associated manpower levels.

Information to hand in relation to the ratio of Orthodontists to 12-year-old population is set out in table 6.

Table 6: Ratio of Orthodontists to 12-year-old population:

<table>
<thead>
<tr>
<th>Country</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>1 : 251</td>
</tr>
<tr>
<td>Germany</td>
<td>1 : 278</td>
</tr>
<tr>
<td>Sweden</td>
<td>1 : 287</td>
</tr>
<tr>
<td>USA</td>
<td>1 : 312</td>
</tr>
<tr>
<td>Denmark</td>
<td>1 : 381</td>
</tr>
<tr>
<td>Finland</td>
<td>1 : 422</td>
</tr>
<tr>
<td>France</td>
<td>1 : 474</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1 : 680</td>
</tr>
<tr>
<td>Ireland</td>
<td>1 : 688</td>
</tr>
<tr>
<td>UK</td>
<td>1 : 873</td>
</tr>
<tr>
<td>Spain</td>
<td>1 : 952</td>
</tr>
<tr>
<td>Greece</td>
<td>1 : 970</td>
</tr>
<tr>
<td>Italy</td>
<td>1 : 1,687</td>
</tr>
<tr>
<td>Portugal</td>
<td>1 : 2,040</td>
</tr>
</tbody>
</table>

6.2 Figures supplied to the Committee would indicate an existing Consultant / Specialist manpower level of approximately 80 as set out in table 7.
Table 7: Existing Orthodontic Specialist Manpower

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>47</td>
</tr>
<tr>
<td>Public Sector</td>
<td>18</td>
</tr>
<tr>
<td>Regional Consultant</td>
<td>10</td>
</tr>
<tr>
<td>Academic Consultant</td>
<td>4</td>
</tr>
<tr>
<td>Tertiary Care Consultant</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
</tr>
</tbody>
</table>

In order for Ireland to have a ratio of 1:500 12-year-olds we would require a total of 106 specialist orthodontists and for a ratio of 1:400 a total of 133 specialist orthodontists.

There would seem little reason to provide full public funding for specialist training once a figure of approximately 130 Consultants / Specialists is reached, provided that roughly half of these are working in the public service.

Projected manpower needs in Public Sector

6.3

the manpower needs of the public sector is a factor of:

• the guidelines to be used to prioritise needs.
• the number of patients each year needing treatment following application of the guidelines.
• the maximum safe caseload for a specialist.
• the average length of treatment.

The guidelines to be used are a choice between the 1985 guidelines, the IOTN guidelines, reduced 1985 guidelines or increased 1985 guidelines. The maximum safe caseload suggested to the Committee has varied from 200 to 400 completed cases each year. There seems to be general agreement that the average length of treatment is 18 to 24 months.

The potential number of orthodontic patients from 2002 to 2012 under IOTN guidelines, 1985 guidelines and 1985 reduced guidelines is set out in table 8.
Table 8: Potential Orthodontic Patients for each year 2002 to 2012 under various Guidelines

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>IOTN</th>
<th>1985</th>
<th>Reduced 1985</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>55,193</td>
<td>18,396</td>
<td>13,799</td>
<td>11,039</td>
</tr>
<tr>
<td>2003</td>
<td>52,690</td>
<td>17,563</td>
<td>13,173</td>
<td>10,538</td>
</tr>
<tr>
<td>2004</td>
<td>51,584</td>
<td>17,195</td>
<td>12,896</td>
<td>10,317</td>
</tr>
<tr>
<td>2005</td>
<td>49,456</td>
<td>16,485</td>
<td>12,364</td>
<td>9,981</td>
</tr>
<tr>
<td>2006</td>
<td>47,929</td>
<td>15,976</td>
<td>11,982</td>
<td>9,548</td>
</tr>
<tr>
<td>2007</td>
<td>48,530</td>
<td>16,177</td>
<td>12,133</td>
<td>9,706</td>
</tr>
<tr>
<td>2008</td>
<td>50,390</td>
<td>16,797</td>
<td>12,598</td>
<td>10,078</td>
</tr>
<tr>
<td>2009</td>
<td>52,311</td>
<td>17,497</td>
<td>13,078</td>
<td>10,462</td>
</tr>
<tr>
<td>2010</td>
<td>53,551</td>
<td>17,850</td>
<td>13,308</td>
<td>10,710</td>
</tr>
<tr>
<td>2011</td>
<td>53,354</td>
<td>17,785</td>
<td>13,339</td>
<td>10,671</td>
</tr>
<tr>
<td>2012</td>
<td>54,239</td>
<td>18,080</td>
<td>13,558</td>
<td>10,848</td>
</tr>
</tbody>
</table>

The projected Specialist Orthodontist requirement in each health authority under I.O.T.N. guidelines is set out in table 9.

Table 9: Consultant / Specialist Numbers required under I.O.T.N. guidelines in 2008

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern - SWA - NA - EC</td>
<td>9.0</td>
<td>15.0</td>
<td>24.0</td>
<td>30.0</td>
</tr>
<tr>
<td>Southern</td>
<td>1.0</td>
<td>5.8</td>
<td>9.3</td>
<td>11.6</td>
</tr>
<tr>
<td>Midwestern</td>
<td>3.0</td>
<td>3.5</td>
<td>5.7</td>
<td>7.0</td>
</tr>
<tr>
<td>Northwestern</td>
<td>3.5</td>
<td>2.3</td>
<td>3.7</td>
<td>4.6</td>
</tr>
<tr>
<td>Western</td>
<td>2.0</td>
<td>2.7</td>
<td>6.0</td>
<td>7.4</td>
</tr>
<tr>
<td>Midlands</td>
<td>1.0</td>
<td>2.4</td>
<td>3.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Southeastern</td>
<td>4.0</td>
<td>4.4</td>
<td>7.0</td>
<td>8.8</td>
</tr>
<tr>
<td>Northeastern</td>
<td>4.0</td>
<td>7.5</td>
<td>5.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Totals</td>
<td>27.5</td>
<td>40.0</td>
<td>65.1</td>
<td>81.2</td>
</tr>
</tbody>
</table>

* 2008 Requirement per Moran report at 400 completed cases per year.
** 2008 Requirement based on 500 completed cases each 2 years.
*** 2008 Requirement based on 400 completed cases each 2 years.

Table 5, Chapter 5.8 shows the projected specialist manpower requirements at various caseloads under the 1985 guidelines. The comparison with the I.O.T.N. guidelines is as follows:
Recommendation

6.4 Having regard to recruitment and training problems the Joint Committee recommends that specialist manpower levels should be based on the 1985 guidelines and on a caseload of 250 completed cases each year.

(* Number of completed caseloads each year)
7. Recruitment

Consultant Orthodontist

7.1 There has always been a problem in recruiting Orthodontists at Consultant level. This is still the position today as evidenced by the fact that the North Western Health Board has not got a whole time, permanent Consultant. This problem affects the UK also. Five of the present consultants were appointed in the last 2 to 3 years. Since 1994 a decision exists to proceed with a consultant-led strategy for developing orthodontic services yet there is no consultant at present undergoing training in the Dublin Dental School and Hospital. The Joint Committee considers that the matter should receive the attention of all concerned as the availability of Consultants and the presence of at least one Consultant in each health authority is the cornerstone for a successful service.

Consultant posts are filled through the Local Appointments Commission (LAC).

Specialist Orthodontist

7.2 A key recommendation of the 1998 Review Group (Moran Report) was that appropriately trained, qualified and registered specialist orthodontists be employed in Regional Orthodontic Units. There are at present 18 Specialist Orthodontists and 9 trainees working in the Health Service. Trainees are paid a salary and have their fees paid and are required / contracted to spend 3 years working with a health authority after qualification.

A grade of Specialist Orthodontist has only recently been agreed. The Minister has not yet directed qualifications for this grade. No decision on the number of whole time permanent posts for each Health Authority has been made. The salary for the grade will be in the region of €98,000. The position therefore is that by 2002 the body, presumably the Local Appointments Commission, to recruit the Specialist Orthodontist grade is not yet in a position to recruit whole time permanent staff.

7.3 In the circumstances outlined the Joint Committee consider that there has been a marked lack of urgency among all concerned to implement government policy in the provision of an effective orthodontic service.

7.4 In order to operate a successful recruitment policy for specialist orthodontists the following factors are considered important:

* a decision on the number of whole time permanent posts appropriate to each Health Authority having regard to contract obligations of trainees
* the provision of attractive salary and conditions of service
* directing appropriate qualifications for the grade
* knowing the schools / institutions who produce the likely applicants and when they are going to come on stream
7.5 During consideration of this matter, the Joint Committee was made aware that there are currently 15 Irish postgraduate students training in the U.K./U.S.A. Planning should now commence so that every effort is made to recruit as many of these as possible to the Irish Orthodontic Service.

7.6 It would appear that there has only been limited success in recruiting trained Specialists. Countrywide only 10 Specialists have been recruited to salaried dental services, i.e., 1 Ireland, 4 U.K., 2 U.S., 1 Lebanon, 1 Sweden and 1 Denmark. Retention has been poor, with only one having taken up permanent employment with a Health Authority. There is reason to believe that the very recent agreement with the Health Service Employers Agency on responsibilities, duties, terms of office and conditions of service should facilitate improved recruitment and selection.

Recommendations

7.7 It is recommended that:

(i) the qualifications for the grade of Specialist Orthodontist be directed by the Minister as a matter of urgency

(ii) the number of permanent wholetime posts of Specialist Orthodontist in each Health Authority be decided as a matter of urgency and that the position of existing qualified Specialists and trainees be sorted so that the remaining posts in Health Boards are clearly identified

(iii) planning should now commence involving the appropriate recruitment body (L.A.C.?), the Department and the Health Authorities to:

- identify and target the recruitment of the 15 Irish postgraduate students mentioned in 7.3
- identify countries and schools training prospective Specialists and identify appropriate times for focused targeting of personnel.
- travel to interview applicants for Specialist posts in their country of residence, if necessary.

(iv) the health authorities prepare an attractive information pack for circulation to prospective Specialist applicants

(v) priority in the filling of permanent wholetime Specialist posts be given to health authorities with the greatest need e.g., Southern and Eastern Authorities

(vi) a recruitment campaign for permanent wholetime Specialist posts focusing on Scandinavia, Northern Europe and the U.S.A. be undertaken as soon as
possible in view of the perceived overproduction of Specialists in these areas

(vii) State funding be provided to train Consultant Orthodontists, to try to avoid a shortage at this level and to facilitate manpower planning

(viii) consideration be given to the provision of free accommodation or an accommodation allowance, for the first two years, to qualified applicants from abroad.
8. Delivery of Orthodontic Service

Existing Services

8.1 At present patients may be provided with a service by one or more of the following practitioners depending on the health authority:

- Consultant Orthodontists.
- Specialist Orthodontists unsupervised.
- Dental Officers (some with orthodontic qualifications) in the Orthodontic service under the direction and supervision of a consultant.
- Dental Officers in the Primary Dental Service under the direction of a consultant.
- Dental Officers in Primary Dental Service unsupervised.
- Private Orthodontists employed on a fee per item basis either in their own or in health authority surgeries.
- Consultant, Registrar, postgraduate or undergraduate level in the Dublin and Cork Dental Schools and Hospitals.
- Trainee specialist orthodontists in the orthodontic service under the supervision and direction of a Consultant.

Ideal Service

8.2 The Joint Committee consider that the ideal service should be provided as follows in each health authority:

- Consultant Orthodontists.
- Specialist Orthodontics working with Orthodontic Auxillaries.
- Trainee specialist orthodontists, as required, working under the direction and supervision of a Consultant.
- Non-specialised Dental Surgeons in the Orthodontic service under the direction and supervision of a consultant and providing future trainee specialist orthodontists.
- Private Orthodontists as approved by a Consultant in situations where target guidelines for access to orthodontic services are not being met.

Dealing with the existing awaiting treatment arrears

8.3 The current Health Strategy states that “the services of orthodontists in the private sector will be used on a more widespread basis. This, together with additional sessions by health board specialist staff, will enable the treatment of a further 3,500 patients annually.” This would indicate that each Health Board orthodontist is expected to deal with an extra 50 treatments and each private orthodontist to take on 50 treatments on average. It appears a high target to achieve.

The Joint Committee would support any mix of public / private staff and facilities that would lead to a continuous reduction in the arrears. It considers that the
Orthodontic Strategy Plan recommended at 3.7 should include the arrangements in place to deliver the 3,500 treatments targeted.

Dealing with existing waiting assessment arrears

The Joint Committee note with interest the initiative of the East Coast Area Health Board in dealing with its Category II assessment waiting list since 3 October 2001. Over 2,300 patients were contacted directly by letter asking whether or not they are still interested in orthodontic treatment. By 8 November 2001

- 1,300 (56.5%) replied positively.
- 250 (10%) replied negatively.
- 50 (2%) raised queries.
- 700 (30%) did not reply to the first letter and were sent a subsequent letter seeking a reply in 14 days.

The Joint Committee considered that each Health Authority should deal with its awaiting assessment arrears in a similar manner as soon as possible and in an overtime situation if necessary.

Effective Appointment Rostering

It would appear that a problem in maximising the use of scarce orthodontic personnel may exist due to non-attendance of patients at the appointed times. In order to counter this problem the Joint Committee considers that an Automated Appointment System similar to that in use by the National Car testing Service Ltd. should be investigated for use by each health authority.

Grant-in-Aid for eligible patients

The question of a Grant-in-Aid for eligible patients has been raised in contributions to the Committee. It is not allowed under the existing Health legislation. Full funding of private fees is allowed and an essential part of the orthodontic service. New legislation to provide clear statutory provisions on entitlements is proposed. The Joint Committee consider the provision of a grant-in-aid would help to reduce the backlog for treatment and advance the date of treatment for patients who are not in a position to avail of it.

The Joint Committee considers that an option of a grant-in-aid should exist for patients on the waiting list who reach 16 years of age on the following basis:

- Consultant to indicate the nature of the treatment required, maximum fee appropriate and a list of private orthodontists patient may or may not use.
- 50% of fee provided by Health Board.
- 50% of fee paid by individual (with a 20% or 42% tax refund still available to person paying income tax).
The grant-in-aid option should be provided for either in amended Health legislation or through the Social Welfare system.

**Treatment capacity of trainee specialists and use of Dental Hospitals**

8.7 The treatment capacity of trainee specialists is estimated at 100 - 120 completed cases in three years. Supervision will involve the loss of consultant / specialist treatment time. Therefore the probable net treatment gain from students may be 60 - 75 completed cases in three years.

The fees charged by the Dental Hospitals are lower than that of private consultants. In view of the increased commitment of public expenditure to specialised training the Joint Committee considers that arrangement with the Dental Schools should be negotiated to maximise the number of health authority patient treatments at the most favourable price available.

**Video conferencing link**

8.8 The 1999 Specialist Advisory Committee (SAC) report indicated that it believed that it would be of great value to establish a video conferencing link between the Dublin and Cork Schools and perhaps between Dublin and Galway. This would enable part of training to be provided by this link and avoid some round trips to Dublin.

In view of the proposal to concentrate short to medium term training of specialists on Health authority trainees the Joint Committee considers that public money should be provided to set up a video conferencing link to Galway and Cork and to other orthodontic units if of benefit.

**Status of Chief Dental Officer**

8.9 The Joint Committee consider that the Chief Dental Officer of the Department should be at least of equal status with Consultant Orthodontists.

**Demand for Oral Surgery**

8.10 As our orthodontic service improves there is likely to be significantly more demand for oral surgery. The Joint Committee considers that now is the time for the Department and Health authorities to start planning for the orderly provision of oral surgery. There are no specialists in oral Surgery in the public health sector at present. The matter should be addressed in an Orthodontic Action Plan.

**System of outcome measurement and audit**

8.11 In 1998 the Moran Report recommended the use of the Peer Assessment Review (PAR) system for outcome measurement and audit purposes. It would appear that no satisfactory system for outcome measurement is in place to date. The Joint Committee supports the Specialist Orthodontist / Orthodontist Auxiliary System as the basis that it will deliver an average of 250 completed cases for specialist each year. It considers a system of outcome measurement and audit is urgently required to verify outcome, confirm quality and facilitate cost comparisons.
Co-operation of Regional Consultants

8.12 The co-operation of all regional consultants is required if the arrears are to be decreased and an efficient service delivered. The recently appointed Director of Training is endeavouring to get the co-operation required. In the continued absence of agreement from all Regional Consultants, the areas of dispute should be referred to an expert panel. This panel should consist of an expert nominated by the three consultant orthodontists in question, an expert nominated by the other parties in the dispute, and an independent Chairman to be agreed by the two other nominees. The findings of this panel should be binding on all parties.

Recommendations

8.13 The Joint Committee recommends that:

(i) Each Health Board initiate a review of its awaiting assessment lists immediately.

(ii) An Automated Appointment system be considered for use by each Health Board.

(iii) A Grant-in-Aid option be provided for persons on the treatment waiting lists and over 16 years either by amending legislation or through the Social Welfare system.

(iv) Arrangements with the Dental Schools be negotiated to treat the maximum number of public service patients at the minimum fee.

(v) Video conferencing links with Cork, Galway and other appropriate Orthodontic Units be the subject of public funding to facilitate more efficient training.

(vi) The Joint Committee consider that the Chief Dental Officer of the Department should be at least of equal status with Consultant Orthodontists.

(vii) Planning for the orderly provision of oral surgery in the Health Boards commence immediately.

(viii) An accurate system of outcome measurement and audit is put in place as a matter of urgency to verify completed cases, confirm quality and facilitate cost comparisons.
(iii) In the continued absence of agreement from all Regional Consultants, the areas of dispute should be referred to an expert panel.
9. Orthodontic Fees

9.1 During the Joint Committees consideration of the Orthodontic service two issues regarding fees arose:
- cost effectiveness of public, health board, sector compared to the private sector,
- fees charged for orthodontic treatment in the South compared to Northern Ireland.

Schedule of fees approved by Department

9.2 The following is the schedule of fees approved by the Department from 1 April 2001:

<p>| | | |</p>
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<tbody>
<tr>
<td></td>
<td>Initial Examination Fee</td>
<td>€ 50.04</td>
</tr>
<tr>
<td>Treatment Fee</td>
<td>€ 267.08</td>
<td></td>
</tr>
<tr>
<td>Fixed Appliance Orthodontic Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both Archess</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Initial Examination</td>
<td>€ 50.04</td>
<td></td>
</tr>
<tr>
<td>(b) Active Treatment</td>
<td>€ 950.09</td>
<td></td>
</tr>
</tbody>
</table>
- (including construction, and fitting of appliances, maintenance, changing appliances in the course of treatment and debanding)
| (c) Retention period, where applicable | € 99.67 |
|                            | €1,099.80  |
| Single Arch               |            |            |
| (a) Initial Examination   | € 50.04    |
| (b) Active Treatment      | € 635.91   |
- (including construction, and fitting of appliances, maintenance, changing appliances in the course of treatment and debanding)
| (c) Retention Period, where applicable | € 99.67 |
|                            | € 785.62   |

The cost of appliances supplied may also be met.

Health Boards are expected to operate from this schedule of fees to a ceiling of €2,920 in September 2001, when contracting public orthodontist patients to private consultants.
Private Orthodontists fees

9.3 The private orthodontists contend that when all cost factors are taken into account in the setting up of regional units they would be more cost efficient. Taking a €2,920 scenario as the average cost of any orthodontic treatment in the private sector the cost can be broken down as follows:
- Cost of treatment over two years €2,920
- Average % expenses in Private practice, 51% €1,490
- Profit for Private Orthodontist €1,430
- Tax return on profit, 42% €600
- Cost to State per completed treatment €2,320

Public Sector costs

9.4 Having regard to the various material available to it the Joint Committee considers that it is reasonable to assume that activity data to support the exercise of reaching a cost per treatment basis in the Public Sector is not readily available. The Joint Committee expects that this matter will be rectified under Recommendation number 29. The Joint Committee notes that a review of orthodontic costs for one health board completed in 2001 put the cost per successful treatment for 1999 at €1,860 and for 2000 at €2,476 and suggested a benchmark of €1,850. The variation between 1999 and 2000 cost resulted from decreased activity.

Comparison with fees in Northern Ireland

9.5 A schedule of fees to do a comparison with Northern Ireland has not been located. Orthodontic treatments include:
- Single Fixed Appliance
- Upper and Lower Fixed Appliances
- Single Appliance Removable
- Upper and Lower Removable Appliances
- Functional Appliance
- Single Orthodontic Retainer Replacement
- Upper and Lower Orthodontic Retainer Replacement
- Single Essix Replacement Retainer
- Single Orthodontic Retainer Repair

There is a general agreement that fees in the South are higher than in N.I. for more complicated treatments. The loss of income tax to the State is some balancing factor here.

Orthodontists contacted in N.I. would require a precise treatment plan before quoting a price. Therefore in order to provide a worthwhile cost comparison it would be necessary to arrange a visit or visits to Orthodontics in the South, get a precise treatment plan and a price quoted and then get a price for this treatment plan from an Orthodontist in N.I.
The Joint Committee considers that the Department, through the Health Boards should carry out a limited survey for different treatments in the South and Northern Ireland and supply the Committee with the results as soon as possible.

9.6 Average cost of orthodontic care in all U.S. cities (average values). The following prices are estimated from data gathered by various American agencies:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Exam</td>
<td>Free</td>
<td>$250.00</td>
</tr>
<tr>
<td>Comprehensive Orthodontics – Youth</td>
<td>$3,876.00</td>
<td>$5,314.00</td>
</tr>
<tr>
<td>Comprehensive Orthodontics – Adolescent</td>
<td>$4,125.00</td>
<td>$5,826.00</td>
</tr>
<tr>
<td>Comprehensive Orthodontics – Adult</td>
<td>$4,638.00</td>
<td>$6,251.00</td>
</tr>
<tr>
<td>Replace Lost Retainer</td>
<td>$239.00</td>
<td>$373.00</td>
</tr>
</tbody>
</table>
Information on Dental Schools and Hospitals in U.K. and N.I.

Dental Schools

Currently there are 16 dental schools in the UK as follows:

- Belfast
- Glasgow
- Dundee
- Edinburgh
- Newcastle-on-Tyne
- Leeds
- Liverpool
- Manchester
- Birmingham
- Sheffield
- Bristol
- Cardiff
- Royal London
- King's College London
- Guy's Hospital
- Eastman

All offer postgraduate training in orthodontics which conforms to EU specialist directives.

Number of trained orthodontists likely to graduate each year

Each year 96 Career grade NHS Specialist registrars and 45 overseas (non-EU) trainees (approximate figure) start in England and Wales.

Total output every year is approximately 150, of which one-third are overseas and most of these will return to their countries of origin.

Salary of specialist orthodontics in UK and Ireland

- UK: Associate specialist salary: stg£30,000 - £52,000 pa (= €49 - €85,000)
- Staff grade salary: stg£27,000 - £44,000 pa (= €43 - €70,000)
- Senior Dental Officer: stg£40,000 - £50,000 pa (= €64 - €80,000)

Ireland: Proposed specialist salary: IR£77,000 (= €100,000)

Take tax into account: one-third of one's income goes in tax, superannuation and national insurance in the UK while 46% approximately goes on income in excess of €28,000 or €37,000, depending on status, in Ireland.
Appendices
APPENDIX 1

Members of the Joint Committee

Deputies: Bernard Allen (FG)
          Martin Brady (FF)
          Paul Connaughton (FG)
          John Derricke (FF)
          Beverley Cooper-Flynn (FF)
          John Gormley (GP)
          Cecilia Keaveney (FF)
          Brendan Kenneally (TF)
          Liz McManus (Lab)
          Gay Mitchell (FG)
          Dan Neville (FG)
          Batt O'Keeffe (FF) (Chairman)
          Michael Ring (FG)
          G.V. Wright (FF)

Senators: Dermot Fitzpatrick (FF)
          Camillus Glynn (FF)
          Mary Jackman (FG)
          Pat Moylan (FF)
          Kathleen O'Meara (Lab)

Notes:
  a. Senator Kathleen O'Meara was appointed in place of Senator Pat Gallagher on 4 November 1999
  b. Deputy Liz McManus was appointed in place of Deputy Rilain Shortall on 4 November 1999
  c. Deputy Gay Mitchell was appointed in place of Deputy Alan Shatter on 29 June 2000
  d. Deputy Michael Ring was appointed in place of Deputy Deirdre Cline on 29 June 2000
  e. Deputy Bernard Allen replaced Paul Bradford on the 29th March 2001
  f. Deputy Martin Brady replaced Deputy Michael Allen on 17th May 2001
Appendix 2

Orders of Reference

Dáil Éireann
13th November, 1997, (* 28th April, 1998), (** 14th February 2001),

Ordered:

(1)(a) That a Select Committee, which shall be called the Select Committee on Health and Children, consisting of 14 members of Dáil Éireann (of whom 4 shall constitute a quorum), be appointed to consider such—

(i) Bills the statute law in respect of which is dealt with by the Department of Health and Children, and

(ii) Estimates for Public Services within the aegis of that Department,

** (iii) Proposals contained in any motion, including any motion within the meaning of Standing Order 149(A) concerning the approval by the Dáil of international agreements involving a charge on public funds,

as shall be referred to it by Dáil Éireann from time to time.

(b) For the purpose of its consideration of Bills under paragraph (1)(a)(i), the Select Committee shall have the powers defined in Standing Order 78A(1), (2) and (3).

(c) For the avoidance of doubt, by virtue of his or her ex officio membership of the Select Committee in accordance with Standing Order 84(1), the Minister for Health and Children (or a Minister or Minister of State nominated in his or her stead) shall be entitled to vote.

(2)(a) The Select Committee shall be joined with a Select Committee to be appointed by Seanad Éireann to form the Joint Committee on Health and Children to consider

(i) such public affairs administered by the Department of Health and Children as it may select, including bodies under the aegis of that Department in respect of Government policy,
(ii) such matters of policy for which the Minister in charge of that Department is officially responsible as it may select,

(iii) the strategy statement laid before each House of the Oireachtas by the Minister in charge of that Department pursuant to section 5(2) of the Public Service Management Act, 1997, and shall be authorised for the purposes of section 10 of that Act, and

(iv) such Annual Reports or Annual Reports and Accounts, required by law and laid before either or both Houses of the Oireachtas, of bodies under the aegis of the Department(s) specified in paragraph 2(a)(i), and the overall operational results, statements of strategy and corporate plans of these bodies, as it may select.

Provided that the Joint Committee shall not, at any time, consider any matter relating to such a body which is, which has been, or which is, at that time, proposed to be considered by the Committee of Public Accounts pursuant to the Orders of Reference of that Committee and/or the Comptroller and Auditor General (Amendment) Act, 1993.

Provided further that the Joint Committee shall refrain from inquiring into in public session, or publishing confidential information regarding, any such matter if so requested either by the body or by the Minister in charge of that Department; and

(v) such other matters as may be jointly referred to it from time to time by both Houses of the Oireachtas,

and shall report thereon to both Houses of the Oireachtas.

(b) The quorum of the Joint Committee shall be 5, of whom at least 1 shall be a member of Dáil Éireann and 1 a member of Seanad Éireann.

(c) The Joint Committee shall have the powers defined in Standing Order 78A(1) to (9) inclusive.

(3) The Chairman of the Joint Committee, who shall be a member of Dáil Éireann, shall also be Chairman of the Select Committee.
Seanad Éireann
Ordered

(1) (a) That a Select Committee consisting of 5 members of Seanad Éireann shall be appointed to be joined with a Select Committee of Dáil Éireann to form the Joint Committee on Health and Children to consider—

(i) such public affairs administered by the Department of Health and Children as it may select, including bodies under the aegis of that Department in respect of Government policy,

(ii) such matters of policy for which the Minister in charge of that Department is officially responsible as it may select,

(iii) the strategy statement laid before each House of the Oireachtas by the Minister in charge of that Department pursuant to section 5 (2) of the Public Service Management Act, 1997, and shall be authorised for the purposes of section 10 of that Act, and

* (iv) such Annual Reports or Annual Reports and Accounts, required by law and laid before either or both Houses of the Oireachtas, of bodies under the aegis of the Department(s) specified in paragraph 2(a)(i), and the overall operational results, statements of strategy and corporate plans of those bodies, as it may select.

Provided that the Joint Committee shall not, at any time, consider any matter relating to such a body which is, which has been, or which is, at that time, proposed to be considered by the Committee of Public Accounts pursuant to the Orders of Reference of that Committee and/or the Comptroller and Auditor General (Amendment) Act, 1993.

Provided further that the Joint Committee shall refrain from inquiring into in public session, or publishing confidential information regarding, any such matter if so requested either by the body or by the Minister in charge of that Department; and

(v) such other matters as may be jointly referred to it from time to time by both Houses of the Oireachtas,

and shall report thereon to both Houses of the Oireachtas.
(b) The quorum of the Joint Committee shall be 5, of whom at least 1 shall be a member of Dáil Éireann and 1 a member of Seanad Éireann.

(c) The Joint Committee shall have the powers defined in Standing Order 62A(1) to (9) inclusive.

(2) The Chairman of the Joint Committee who shall be a member of Dáil Éireann.
Appendix 3
Proceedings of the Joint Committee

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAI

THE JOINT COMMITTEE ON HEALTH AND CHILDREN

Imnachtaí An Chomhchoiste
Proceedings of the Joint Committee

Dé Dithaisin, 21 Febhra 2002

1. The Joint Committee met at 9.30 a.m. in Committee Rooms 4, LH2000.

2. MEMBERS PRESENT.
The following members were present:

Deputies Batt O’Keeffe (in the chair), Bernard Allen, John Derrnchy, Cecilia Keevaney, Liz McManus, Gay Mitchell, Dan Neville and Michael Ring
Senators Mary Jackman and Pat Moylan.

3. DRAFT REPORT ON THE ORTHODONTIC SERVICE

The Chairman brought forward a draft report on the Orthodontic Service. The Report was read and amended. The Report, as amended, was agreed.

Ordered: To report accordingly.

4. ADJOURNMENT

The Committee adjourned at 10.35 a.m. sine die.
Appendix 4

Presentations to the Joint Committee
Statement of the Department of Health and Children
to the Joint Committee on Health and Children
8 November 2001

Introduction

I am grateful to the Chairman and members of the Committee for inviting us here today to discuss the orthodontic services. The extent of the waiting list and waiting time for orthodontic assessment and treatment is unacceptable and seriously concerns the Department. The prevailing situation is further compounded by the fact that the provision of orthodontic services is currently severely restricted due to the limited availability of trained specialist clinical staff to assess and treat patients. This shortage has resulted from the difficulties we have had in agreeing arrangements for training programmes and I will deal in some length with it presently.
Aims & Policy of the Service

The orthodontic services continue to be developed in accordance with the Dental Health Action Plan. The Action Plan provides for the development by each health board of a Consultant-led secondary care orthodontic service. At present, the Eastern Regional Health Authority (ERHA) and the other seven boards have a Consultant-led orthodontic service. Consultant Orthodontists, in addition to their clinical role, are also responsible for planning services and for training health board dentists within an appropriate framework.

The Moran Report

In 1996, I wrote to the Chief Executive Officers of the Health Boards recommending that a group, representative of health board management and Consultant Orthodontists, review the orthodontic services. The objective of this review was to ensure an adequate and equitable provision of orthodontic treatment throughout the health boards. One of
the key recommendations of this Review Group – known as the ‘Moran Report’ – was that appropriately trained, qualified and registered specialist orthodontists be employed in Regional Orthodontic Units to ensure the provision of a timely and high quality service.

This was against the background of a consultant-led service which developed in the mid 1980s. Within this service a number of dentists had worked in orthodontics under the direction and supervision of consultants with a view to achieving postgraduate qualifications in orthodontics.

This informal training framework was inconsistent with the modernisation of dentistry under governing EU Directives which led to the introduction of specialisation in dentistry in the 1990s.

Accordingly, with the consent of the Minister for Health & Children, the Dental Council established a Specialist Register with a division of Orthodontics in 1999.
Specialist Dentist in Orthodontics

Agreement has now been reached at the Health Service Employers Agency on the creation of the Specialist Dentist in Orthodontics grade in the Orthodontic Service. This agreement resulted from complex and time-consuming negotiations. The introduction of the Specialist grade will have a tremendous impact on the future delivery of orthodontics.

Training

It is considered essential that Specialist Dentist in Orthodontics training programmes meet internationally recognised standards. As I have already said the Dental Council has established and maintains a Specialist Register in exercise of its powers under the Dentist’s Act, 1985. In this context, it has recognised the Irish Committee for Specialist Training in Dentistry as a body within the State to advise it on the granting of evidence of satisfactory completion of specialist training. The Irish Committee for Specialist Training in Dentistry fulfils its role through its Specialist Advisory Committee in Orthodontics.
In 1997, the **Dublin Dental School** received approval for its Specialist Dentist in Orthodontics training programme. This approval derived from an assessment by the Specialist Advisory Committee of the **Joint Committee for Specialist Training in Dentistry**. That Joint committee is representative of the **Royal Colleges of Surgeons** in Ireland and Great Britain and was established to oversee acceptable standards of postgraduate training. Currently, the Irish Committee has taken over this role of the Joint committee in accordance with Irish and EU legislation.

The **Specialist Advisory Committee** conducted a visitation of the Regional Orthodontic Units in Galway and Cork in 1999. Following from its report, the Unit in Galway and the **Dublin Dental Hospital** are now co-operating in the provision of an approved Specialist Dentist in Orthodontics training programme for 2 dentists. Due to structural deficiencies in the region, approval was not given by the Specialist
Advisory Committee for a training programme in the Southern Health Board area.

As a consequence of the structural deficiencies identified, the Department has taken a number of initiatives. The recruitment and funding of a Professor in Orthodontics at Cork University Dental School was approved in order to facilitate the development of a Specialist training programme. In addition, capital funding of approximately £1m was provided for refurbishment of the Unit to an appropriate standard. The Department would welcome proposals for a Specialist training programme from this University and the Consultant Orthodontists of the Southern Health Board and neighbouring boards.

Current Developments

The Moran Report recommended that the current policy of having a Consultant-led service should continue and that Regional Orthodontic Units of the health boards be involved with the Dental Schools in the
training of specialists on a rotational basis. At present, six dentists from the Eastern Regional Health Authority, North Eastern Health Board and South Eastern Health Board commenced their training in October 2001 for Specialist Dentist in Orthodontics qualifications. Furthermore, three dentists from the Western Health Board and North Eastern Health Board are already in specialist training for orthodontics bringing the total number in such training to nine.

The general objective of these training programmes is to educate dentists to become Specialists in Orthodontics with a broad academic background and experience in different clinical treatment methods. They are made possible by cooperation between health boards, consultants and Dental teaching institutions. Discussions on providing an additional training course to commence in 2002 are also underway.

**Auxiliaries**

The Moran Report also recommended that auxiliaries be employed in the Regional Orthodontic Units. In order to enable the achievement of greater
caseloads, the Dental Council has been approached concerning the creation of a Scheme for the recognition of auxiliary dental workers in orthodontics. This grade will act as a support to the Consultant Orthodontist, Specialists and other dentists working in the orthodontic unit thus enabling a greater volume of treatment.

**Orthodontic Guidelines**

Orthodontic guidelines were issued by the Department in 1985 and are still in operation. Their purpose is to allow prioritisation of children for secondary care orthodontic treatment based on the severity of need.

It is important that health boards identify those patients in greatest need by the use of the 1985 orthodontic guidelines and commence timely treatment for them. The number of cases treated will depend on the level of resources available, in terms of qualified staff, in an area.
Patients assessed as Category A have severe malocclusions and should receive urgent orthodontic care; patients assessed as Category B have less severe problems and are placed on orthodontic treatment waiting lists.

The Moran Report recommended the use of an alternative index to determine need. This is known as the Index of Orthodontic Treatment Need (IOTN). The Chief Dental Officer has advised that this new index should not be implemented until its implications have been evaluated in a national survey of children's dental health that is currently underway. This survey will identify accurately the number of children that would benefit from orthodontic treatment and the resources, particularly manpower, needed to provide the corresponding level of care.

**Orthodontic Initiative**

However, cognizant that it may be some time before these structural changes impact significantly on the waiting times for treatment, health boards were asked to develop proposals to make an immediate significant
impact on their waiting lists. An additional investment of £5.3m (€6.729) has been approved for orthodontic services this year, of which £3.7m (€4.698m) is to fund an initiative on orthodontic waiting lists. This is enabling health boards to recruit additional staff and engage the services of private specialist orthodontic practitioners to treat patients. An additional six-surgery facility and five-surgery facility at the Loughlinstown Regional Orthodontic Unit and the St James’ Hospital Regional Orthodontic Unit respectively have also been developed under the initiative.

The Department is exploring with boards every possibility to expand the level of services in the short term such as the use of private specialist orthodontic practitioners and the treatment of patients in out-of-hours sessions by health board orthodontists.
Outside of this initiative, new Regional Orthodontic Units at Navan and Dundalk were funded and are now operational and a Consultant Orthodontist was recruited for the Midland Health Board.

Furthermore, the Department has funded the appointment of a director of Specialist Training for the Irish Committee for Specialist Training in Dentistry through the Post Graduate Medical and Dental Board. The director of Specialist Training will take up duty in January 2002. The Director will play a pivotal role in assisting the different agencies involved in dental specialist training programmes and will report to the Irish Committee for Specialist Training in Dentistry.

I understand from the Chief Executive Officers of the health boards that at the end of September last, there were 23,686 patients awaiting orthodontic assessment and 11,995 awaiting orthodontic treatment. In addition, approximately 16,100 patients are currently in orthodontic...
treatment and the objective of this Department is to increase this figure significantly. I am confident that in cooperation with the health boards, the Dental Council, Dental Hospitals, the Irish Committee for Higher Training in Dentistry of the Royal College of Surgeons in Ireland, and the Post-Graduate Medical and Dental Board, all these measures combined will ensure the achievement of this objective.

Again, I would like to thank the Chairman and Committee members for giving the Department this opportunity to outline developments in the orthodontic services.
Introduction

The Eastern Regional Health Authority (ERHA) was established on the 1st March 2000 and is the statutory body with responsibility to plan, arrange and oversee health and personal social services for the 1.5m people who live in Dublin, Wicklow and Kildare. Services are delivered by three Area Health Boards (the Northern, East Coast and South Western) and 36 voluntary providers.

The three Area Health Boards have taken over statutory responsibility in their own areas for services previously provided by the Eastern Health Board. This report deals with the situation at the introduction of the ERHA and the three Area Health Boards, the plan put in place by the Authority and the Boards and the implementation to date of the plan to deal with the needs of patients in the eastern region for orthodontic services.

Position at March 2000

In March 2000 the Regional Orthodontic Service had difficulties coping with the needs of patients in its region.

At that time the clinical staff available to the service was as follows:
- 1 Consultant Orthodontist
- 4 Specialist Orthodontists (M. Orth. qualified clinicians)
- 4 Senior Dental Surgeons

In May 2000 the Authority in conjunction with the three Area Health Boards devised a strategy to develop a service capable of catering for the orthodontic needs of children in the eastern region into the future.

In June 2000 approval was received from the Department of Health & Children for the proposals submitted and efforts to implement the necessary changes began immediately.
The approved plan including certain elements that had previously been approved was comprised of the following measures:

- The appointment of a locum Consultant Orthodontist.
- The recruitment of two additional permanent Consultant Orthodontists.
- The appointment of 6 Community Orthodontists from existing M. Orth. qualified staff.
- The recruitment of three managers at Grade VIII level to manage the orthodontic services in the Area Health Boards.
- Treatment of patients through private orthodontists in line with departmental conditions.
- Recruitment of three M. Orth. qualified clinicians to replace existing vacancies at Senior Dental Surgeon level.
- Recruitment of an additional three M. Orth. qualified clinicians.
- Recruitment of 12 nursing and 9 administrative support staff.
- The sourcing of a modern patient information management system for the orthodontic service.
- The equipping of an additional 5 surgeries at the Orthodontic Unit, St. James’s Hospital.
- The development of a 12 surgery orthodontic unit to serve the Northern Area Health Board area.

Arrangements for the staffing of the new orthodontic unit at St. Columcille’s Hospital, comprising six chairs, excluding the consultant post were additional to the plan.

It was clear from the outset of this planning process that the main limiting factor in the implementation of the plan would be the difficulty in recruiting qualified orthodontists at both specialist and consultant level. However, it was deemed essential that approval be sought for the necessary complement of staff at that time in order to ensure that no impediment would exist to the recruitment of any qualified staff that became available.

As anticipated it has proved extremely difficult to recruit the clinical staff provided for in the plan and throughout this period staff continued to leave the service exacerbating an already serious situation.

**Staffing Issues**

Appendix A details the key staff movements covering the period from March 2000 to October 2001. This indicates the considerable movement of clinical staff within the system during the period in question. The clinical staff complement at the end of October 2001 was as follows:

- 3 Consultant Orthodontists
- 2.6 Senior Dental Surgeons
- 6 M. Orth. qualified orthodontists (5.4 WTE)

When this complement is compared with the complement at March 2000 there is a net gain of two clinicians providing public orthodontic treatment in the region. This small net gain occurred despite a major ongoing effort by the Boards to recruit clinicians both at home and abroad. This recruitment difficulty remains the main problem facing the service.
Physical Infrastructure
The following developments have taken place in the physical infrastructure available within the eastern region since its establishment.

- In September 2001 the new orthodontic unit opened at St. Columcille’s Hospital (Loughlinstown) serving the East Coast Area Health Board providing an additional 6 chairs.

- Five additional surgeries opened at the orthodontic unit in St. James’s Hospital in the South Western Area Health Board bringing the total to 12 chairs.

- The Northern Area Health Board have a plan in place to provide a new orthodontic suite, comprising 12 chairs, as part of the capital development at James Connolly Memorial Hospital in Blanchardstown. The Northern Area Health Board is at present examining the possibility of establishing orthodontic clinics on a temporary basis pending the development of a new purpose built unit.

When this programme is completed the net increase in chairs will be 23 over and above the position at March 2000.

Training of Orthodontists

Having regard to the ongoing difficulties in recruitment a combined effort involving the Authority, the three Area Health Boards in the eastern region, the North Eastern Health Board, the South Eastern Health Board, the Department of Health & Children and the Dublin Dental Hospital & School has resulted in a significant new development in the training of orthodontists.

A revised joint training programme between the Boards and the Dublin Dental Hospital & School commenced in October 2001. As part of this programme four post graduate trainees selected by open competition began a three year Masters Degree in Orthodontics for the eastern region.

These trainees are employees of the Boards and will spend two days per week in the orthodontic units at St. James’s Hospital and St. Columcille’s Hospital as part of their training under the supervision of the Board’s Consultant Orthodontists. In addition, the Board’s Consultants will have a teaching commitment in the Dublin Dental Hospital & School.

On completion of the course the trainees will be eligible for the new position of Specialist Orthodontist within the health service and will be obliged to spend a minimum period of three years in the Board’s service in return for the financial commitment of the Boards during the training period.

These trainees will treat between 400 - 500 cases in total from the public treatment list during the training period.

The main benefit of the scheme will accrue in the period of public service commitment following completion of the course. For the first time the service will have a guaranteed flow of qualified orthodontists into the system.
IT System

Following extensive consultation a specification was agreed in August 2001 and was tendered for in August 2001. The approved system has now commenced in St. Columcille’s and will be implemented in each centre on a phased basis.

Management & Organisational Changes

The Authority and three Area Health Boards agreed that it was necessary to provide a manager for each of the Area Health Boards to drive the implementation of the plan. In January 2001 three posts of Manager of Orthodontic Services were advertised and in July / August 2001 the three Managers were appointed and devolution of the management of the service to the respective Area Health Boards commenced.

Statistics & Waiting Lists & Treatment

The orthodontic service experienced considerable disruption in the two years prior to March 2000. This led to a suspension of assessment work for new patients and the interruption of treatment being provided to patients already within the system.

The priority task in addressing the difficulties within the system was to restore all interrupted patients to active treatment in the first instance and then to devote any remaining resources to the Category I patients as these groups were a clinical priority.

The 884 patients whose treatment was interrupted have now had their treatment restored.

The following table reflects the success in addressing these clinical priorities while also showing the unavoidable increases in the Category II assessment waiting list over the period from September 2000 to October 2001.

<table>
<thead>
<tr>
<th></th>
<th>01/09/00</th>
<th>03/10/01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category I Assessment</td>
<td>236</td>
<td>0</td>
</tr>
<tr>
<td>Assessment Waiting List</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category II Assessment</td>
<td>9,929</td>
<td>11,781</td>
</tr>
<tr>
<td>Assessment Waiting List</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category I Treatment</td>
<td>47</td>
<td>67</td>
</tr>
<tr>
<td>Waiting List</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category II Treatment</td>
<td>926</td>
<td>803</td>
</tr>
<tr>
<td>Waiting List</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients in fixed</td>
<td>884</td>
<td>0</td>
</tr>
<tr>
<td>appliances (without</td>
<td></td>
<td></td>
</tr>
<tr>
<td>regular treatment)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Following the devolution of management responsibility for the service the above figures for October 3rd 2001 can be broken down as follows.

<table>
<thead>
<tr>
<th></th>
<th>SWAHB</th>
<th>NAHB</th>
<th>ECAHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category II Ass. Waiting List **</td>
<td>3736</td>
<td>5035</td>
<td>3010</td>
</tr>
<tr>
<td>Category II Treatment Waiting List</td>
<td>420</td>
<td>383</td>
<td>0</td>
</tr>
<tr>
<td>Category I Treatment Waiting List</td>
<td>47</td>
<td>40</td>
<td>0</td>
</tr>
</tbody>
</table>

** This figure is subject to minor revision subject to the finalisation of the division of patients from Dental areas that straddle the new Area Health Board boundaries.

The total number of patients in treatment in the region at October 3rd 2001 was 3338.
Following the devolution of responsibility for the service to the Area Health Boards each Board has now put in place its own strategy for dealing with the particular problems that face that Board.

Public/Private Service Mix Proposal

Because of the difficulties which the Northern Area Health Board experienced in trying to recruit consultant orthodontists and because of the time which it will take to bring on board the capital projects, the Board proposed to the Authority the operation of a pilot scheme. It was proposed that if a patient on assessment met the criteria laid down for non-urgent/routine treatment, that s/he be given the option of availing of treatment from a private practitioner. The scheme as proposed was to operate on the following basis:

a) When private treatment was chosen, the patient was taken off the treatment list and a replacement patient was called from the assessment list.

b) The Board would offer a grant of 50% of the cost of the overall treatment programme (health board estimated cost). The grant would be paid when evidence was produced (orthodontist certificate) by the parents/guardian that the patient had completed 50% of the programme. The parents/guardian would also be in a position to avail of tax credits on the balance of the cost thus ensuring that the net contribution from the family equates to approximately 25% of the overall cost.

c) Medical card patients would be paid 100% - the estimated cost - 50% at the halfway stage as above with the balance being paid on completion of the programme.

Based on a maximum of 1,000 people availing of the scheme, it was estimated that the funding required to bring this scheme on stream would amount to £0.5m. The Authority and the Department of Health & Children approved of the proposal in principle subject to a detailed consideration of the legal and financial issues involved. Regrettably it was found that this proposal did not comply with the existing legislative framework. The Northern Area Health Board are now utilising the resources provided by the Authority for this scheme for the engagement of two orthodontists from outside the eastern region to treat patients from the Northern Area Health Board region.

Present Position

An indication of the progress which can be made with the provision of dedicated local facilities which are staffed is evidenced by data available from the East Coast Area Health Board.

At the 3rd October 2001 there were 3,010 on the East Coast Area Health Board’s Category II assessment waiting list. Over 2,300 patients have been contacted directly by letter asking them whether or not they are still interested in orthodontic treatment. To date the East Coast Area Health Board’s has had 1,300 positive replies i.e. 56.5%, 250 (10%) negative replies and 50 queries which are currently being processed. Those 700 (30%) or so who did not reply to the first letter have been sent a subsequent letter asking them to reply within 14 days if interested.

The assessment waiting list has been sorted by year and month order and the assessments are starting from the replies in date order. Following this a further letter, has been sent to the parents/guardians of those on the validated assessment waiting list asking them to attend for treatment. The assessment process has begun in St. Columcille’s and since the 24th September 2001 (roughly) 400 people have been assessed. Approximately 12 patients are seen daily by each of

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Report to the Joint Oireachtas Committee on Health & Children

3 or 5
the orthodontists. It is anticipated that a further 200 patients will be assessed before the end of this year. This assessment process will continue during 2002.

Summary

The Authority and the Area Health Boards believe that we either have in place at this stage or are putting in place the necessary physical infrastructure to ensure local access to services in each of the Area Health Boards. The Authority and Boards believe that the provision of the training programme marks a major development in the provision of orthodontists for the future delivery of the service. We are continuing to make strenuous efforts to engage orthodontists to provide treatment. The Area Health Boards are prepared to work closely with private orthodontists to determine the extent to which they can provide treatment for patients in their area. The eastern region has traditionally lacked both the physical and manpower resources to deal with the numbers of patients who presented and the Authority believes that there is merit in considering schemes of the nature identified by the Northern Area Health Board as a vehicle for more rapidly dealing with the present waiting list.

P. McLoughlin,
Director of Planning & Commissioning.

Appendix A

July/August 2000:
- 1 M. Orth. departed on maternity leave.
- 2 Senior Dental Surgeons left the service.
- 1 Locum Consultant Orthodontist commenced service (this Consultant was subsequently successful in his application for a permanent appointment).
- Advertisements placed in both Ireland and the UK seeking applications from M. Orth. qualified orthodontists.

September 2000:
- 1 M. Orth. qualified Specialist Orthodontist commenced service.
- 1 Consultant Orthodontist off duty.

October 2000:
- Interviews held by the Local Appointments Commission for two permanent Consultant Orthodontist posts.
- One Successful candidate, previously appointed on a locum basis was assigned to the East Coast Area Health Board.
- The second post in the Northern Area Health Board was not filled.
- Subsequently, a second successful candidate was appointed to a new Consultant post in the South Western Area Health Board.

December 2000:
- 1 M. Orth. qualified orthodontist commenced duty.

February 2001:
- Consultant previously off duty returned on a part time basis.
- Recruitment of ancillary staff for St. Colmcille’s Unit commences.

April 2001:
- Consultant Orthodontist commences on a locum one day per week basis.

July/August 2001:
- Renewed attempts to fill the vacant position of Consultant Orthodontist with the Northern Area Health Board fail.
- Advertisements in both this country and the UK for M. Orth. qualified clinicians fail to attract any candidates.

September 2001:
- Additional Consultant Orthodontist commences duty with the South Western Area Health Board.
- 1 M. Orth. resigned.
- 1 M. Orth. qualified clinician commences duty.
October 2001:
- 4 post graduate students commence joint training programme in orthodontics.
Presentation to Joint Oireachtas Committee on Health

By Pat Gaughan – Assistant Chief Executive Officer

On

The Provision of Orthodontic Services for Children in the North Western Health Board

Thursday 8th November 2001
2.0 Current Status

2.1 Waiting Lists

**Table 1**

<table>
<thead>
<tr>
<th>Category</th>
<th>Dec-99</th>
<th>Dec-00</th>
<th>Mar-01</th>
<th>Jun-01</th>
<th>Sep-01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A - Priority</td>
<td>441</td>
<td>445</td>
<td>430</td>
<td>528</td>
<td>281</td>
</tr>
<tr>
<td>Category B - Urgent</td>
<td>1832</td>
<td>1844</td>
<td>1921</td>
<td>2075</td>
<td>1892</td>
</tr>
</tbody>
</table>

**Figure A**

**NWHE - Orthodontic Waiting List By Category**

Current Waiting List by Adults and Children as at end September 2001

**Table 2**

<table>
<thead>
<tr>
<th>Awaiting Assessment</th>
<th>Adults</th>
<th>Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A</td>
<td>140</td>
<td>141</td>
<td>281</td>
</tr>
<tr>
<td>Category B</td>
<td>956</td>
<td>942</td>
<td>1892</td>
</tr>
<tr>
<td>Total on Waiting List</td>
<td>1096</td>
<td>1083</td>
<td>2173</td>
</tr>
</tbody>
</table>

Persons Currently Being Treated

|                  | 1701   | 412      | 2119  |

Note: Table 2 above categorises children <14 yrs
There are a number of points to note in relation to waiting lists:

- (Figure A) highlights a gradual increase in the total numbers of patients waiting for treatment from 1999 to mid 2001. This trend is now redressed somewhat with the appointment of additional orthodontic staff...see (staffing below)

- There is a significant reduction from June to September 2001 noted in relation to Category A (priority) patients.

### 2.2 Orthodontic Treatments

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Dec-99</th>
<th>Dec-00</th>
<th>Mar-01</th>
<th>Jun-01</th>
<th>Sep-01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Receiving Treatment</td>
<td>1489</td>
<td>1293</td>
<td>2003</td>
<td>1978</td>
<td>2119</td>
</tr>
</tbody>
</table>

(Table 3) outlines activity in the Secondary Care Orthodontic service over the past 3 years. The increase in the number of patients currently receiving treatment and in one year is noteworthy.

### 2.3 Current staffing

**Secondary Care Orthodontic Services**

1. Consultant Orthodontist (currently working part time 0.5)
2. Orthodontic Specialists (2 of which took up post in mid 2001)
3. Hygienist
4. Dental Assistants
3 Administration Staff

Oral Surgery

A limited oral surgery service is available in Letterkenny General Hospital (on a sessional basis by a visiting Surgeon) for Donegal patients. Patients from Sligo/Leitrim are referred to Dublin on a limited basis.

3.0 Difficulties affecting the Orthodontic Service

The main difficulties in maintaining a service has been that of changes in staffing levels and associated staff recruitment problems.

3.1 Changes in Staffing levels

During 2001 one Orthodontic Specialist left the service to enter private practice. The existing Consultant Orthodontist has indicated for some time that he wishes to retire. A replacement post was advertised on 2 occasions by the Local Appointments Commission but have been unable to appoint. When last advertised, there were no applicants. In light of these difficulties, the existing Consultant agreed to continue on a part-time basis.
Both factors have clearly affected the capacity.

3.2 Difficulties in Staff Recruitment

The Board has made intensive efforts to recruit and retain Orthodontic Specialist staff. This included:

- A study of potential markets using information from the World Health Organisation (WHO).
- Extensive research, advertising and recruitment drives in UK, Sweden, Finland, Germany as well as a number of other countries.

This resulted in the recent appointment of two additional Orthodontic Specialists who took up post in mid 2001 and a strong prospect of a fourth post from January 2002.

4.0 Future Plans:

The NWHB would aim to work towards a standard whereby:

"Patients prioritised as "Category A" should have treatment commenced within 6 months of referral"

The following developments (both immediate and medium to long term) are critical to achieving this.
4.1 Immediate

- A 4th Orthodontic Specialist has recently been recruited and plans to take up duty in January 2002. It is expected that this will have a positive impact on the waiting list (particularly in relation to category A patients).

- The Board will continue to pursue the appointment of a Consultant Orthodontist through the Local Appointments Commission.

- Agreement has recently been finalised with an Orthodontic Practice in Northern Ireland to contract out a number of cases from the current waiting list. In addition, we hope to conclude similar agreements with recently established private practices within the region and possibly a number of other centres in Northern Ireland.

4.2 Medium to Long Term

- A second Orthodontic Consultant

- An additional Orthodontic Specialist bringing the total to 5 in the region.

- Continue to augment the service with private practitioners until the waiting list is addressed and targets achieved.
Orthodontics

Background

1. The Mid Western Health Board was the first board to appoint a Consultant Orthodontist in 1985 in line with national policy at that time. This was accompanied by the appointment of three Dental Surgeons and a training initiative to enable all Dental Surgeons in the region to undertake minor cases not requiring specialist input.

2. The Special Advisory Committee (SAC) of the 4 Royal Colleges of Surgeons in the U.K. formally approved a postgraduate Training Programme in 1987 for Dental Surgeons wishing to specialise in Orthodontics. This Training Programme was fully accredited by the SAC.

3. The Training Programme ceased suddenly in May 1999 when the Accrediting body i.e. SAC failed to undertake a routine accreditation visit to the Mid West region.

Context

1. There are increasing numbers on Waiting Lists for assessment and treatment and increased waiting times (1993: number awaiting treatment = nil, number awaiting assessment 1,280; 2000: number awaiting treatment = 1,488, number awaiting assessment = 2,752).

2. The capacity to respond is restricted due to:
   - Difficulty with availability of trained Orthodontists,
   - The cessation of training and the consequential availability of the trainee 'resource',
   - The cost of referring patients to the private sector,
   - The absence of transitional arrangements prior to the availability of the 'new' trainees in 2004.

   This is reflected in the activity statistics attached.

3. Increasing risks to patient health and safety due to the lack of timely intervention.

National Strategy

The national review of Orthodontics published in 1998 (Moran Report) provides a basis for service provision in future. The key recommendations in this report are;

1. Standardisation of severity indices, assessment and prioritisation protocols, costing models, and outcomes measurement

2. Appropriate organisation structures and referral procedures

3. The employment of Specialists in Orthodontics and other support staff
4. The role of the Dental Schools in the training of Specialists and in service provision as part of training

5. Post graduate and continuing education

6. Representation on the Dental Council

7. Information systems and technology

Key issues and actions

Long term

1. The appointment of appropriately qualified personnel to Chairs/Professorships in the Dental Schools in Dublin and Cork to implement training programmes. The contribution of other academic institutions external to this country should be explored.

2. The implementation of a training programme that takes account of the academic and practical requirements, both during training and post registration.

3. A system of staff retention so that there is an incentive to continue working in the public sector.


Short term

5. A co-ordinated recruitment drive to attract Orthodontists to work in the public sector. This may require a campaign overseas.

6. The reintroduction, on an interim basis of the training scheme that is in abeyance since 1999. This scheme should be reviewed concurrent with point 1 above. There should not be a difficulty with obtaining accreditation nor should there be a difficulty in adjusting the balance between practice and academia if necessary.

7. Continuation of public/private arrangements on a limited basis under the direction of the Consultant Orthodontist.

8. Full implementation of the low-cost/non-cost elements of the 'Moran' Report.

Conclusion

The current situation of ever-increasing waiting lists and waiting times and the consequences for patient care is likely to continue unless a co-ordinated approach among all the key stakeholders is adopted.

The 'Moran' Report provides an appropriate framework for the short and longer-term measures outlined above which represent a value for money approach in responding to patient needs and thus, avoiding exposure to risks.
## Orthodontic Services

### Orthodontic Waiting List

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting for Treatment</td>
<td>Nil</td>
<td>Nil</td>
<td>44</td>
<td>215</td>
<td>352</td>
<td>920</td>
<td>1,341</td>
<td>1,488</td>
<td>1,392</td>
</tr>
<tr>
<td>Waiting for Assessment</td>
<td>1,280</td>
<td>221</td>
<td>1,247</td>
<td>2,575</td>
<td>3,318</td>
<td>2,513</td>
<td>2,388</td>
<td>2,752</td>
<td>3,380</td>
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</table>

### Summary of Orthodontic Activity

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<tr>
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<tbody>
<tr>
<td>Completed Treatments</td>
<td>400</td>
<td>558</td>
<td>363</td>
<td>785</td>
<td>538</td>
<td>532</td>
<td>653</td>
<td>528</td>
<td></td>
</tr>
<tr>
<td>Cases Commenced</td>
<td>900</td>
<td>977</td>
<td>807</td>
<td>903</td>
<td>705</td>
<td>543</td>
<td>554</td>
<td>535</td>
<td></td>
</tr>
<tr>
<td>Active Treatments</td>
<td>2,000</td>
<td>1,821</td>
<td>2,245</td>
<td>1,959</td>
<td>2,343</td>
<td>2,508</td>
<td>2039</td>
<td>1,589</td>
<td></td>
</tr>
<tr>
<td>Cases being Monitored</td>
<td>1,300</td>
<td>1,616</td>
<td>1,500</td>
<td>1,400</td>
<td>1,323</td>
<td>1,470</td>
<td>1,758</td>
<td>2,044</td>
<td></td>
</tr>
</tbody>
</table>
Presentation to Joint Oireachtas Committee on Health and Children  
on behalf of the  
Southern Health Board  

Orthodontic Services for Children

Mr. Chairman, Deputies, Ladies and Gentlemen thank you for the invitation to attend before you today to discuss the subject of Orthodontic Services for Children. It is indeed a privilege to do so.

In the context of the very wide range of services provided by the Irish Health Service there are few which stimulate so much public comment and present so significant a challenge in terms of matching supply and demand as the Orthodontic service.

I would like to address a number of key issues from the perspective of the Southern Health Board which I hope will contribute to discussion and debate and perhaps provide an indication of the strategies which the health system as a whole might adopt to meet the challenges which this service pose.

I would like to structure this necessarily brief presentation under the following broad headings:

- Profile of Southern Health Board Orthodontic service
- Key issues for the service
- Strategies being adopted by the Southern Health Board to address the needs of the service

Profile of Orthodontic Service

The Southern Health Board - covering Counties Cork and Kerry with a population of approx. 560,000 - was one of the first Boards in this country to appoint a Consultant Orthodontist in 1990. It is the responsibility of the Consultant Orthodontist both to provide a clinical Orthodontic service for those children who qualify for treatment in accordance with Guidelines issued by the
Department of Health and Children and to advise the Board on the measures it might take towards the development of the service.

The Orthodontic service in the Southern Health Board is located centrally in St. Finbarr's Hospital in Cork city where the Consultant and his team of – presently 6 – dentists are based. These dentists were originally recruited from within the Board’s Community Care Dental service and are skilled in providing patient treatment under the overall supervision of the Consultant.

Regular outreach Orthodontic clinics are provided in Tralee, Mallow and Bantry at which the Consultant and/or his staff attend and treat patients as near as possible to their home.

The service is managed as part of the Acute Hospital programme and the Consultant Orthodontist reports directly to the General Manager of Cork University Hospital Group.

The annual budget for the service is £1,833,000 comprising pay £496,000 and non-pay £1,337,000.

In this year’s Letter of Determination an additional allocation of £813,000 was provided to the Board to put in place a range of measures to improve the service including the appointment of additional Consultant Orthodontic staff, additional dentists for the service and the provision of additional dental chairs and I would like to revert to this development programme later.

In addition to the service provided by the Southern Health Board the Cork Dental School and Hospital, which is managed by University College Cork, provides an academic undergraduate Orthodontic function and in fulfilling this function it treats a small number of patients. For the past number of years a position of Professor of Orthodontics has been vacant – despite having been advertised on a number of occasions – because of the difficulty in recruiting a Professor of the calibre required to oversee the academic programme. During that time the School has employed a Lecturer in Orthodontics who provides the academic and service component of the service provided by the School.

The Dental School, which was provided with additional funding of £100,000 for the Professorship in Orthodontics in 2000, has again in recent weeks advertised for the filling of this post.

Despite the best efforts of all Southern Health Board staff involved in the provision of the Orthodontic service there are substantial waiting lists for both assessment and treatment of approximately 5,500 and 4,500 children respectively at present. The reasons for waiting lists of this magnitude are multi-factorial but appear to centre on the matters of the number of Orthodontists working in the service and the National Guidelines under which the system is administered.
Key issues

Members of the Southern Health Board – and its' General Hospitals Committee - have discussed the Orthodontic service on many occasions. In summary the key issues for the service in Cork and Kerry are as follows:

- The number of Orthodontists working in the service and the need to increase manpower capacity through the development of approved recognised training programmes.
- The need for consistency in the interpretation of the National Guidelines
- The economic reality of the public service effectively competing with the private service which can offer opportunities for significantly increased income
- The need to provide specialist services as close as possible to the patient
- The need to manage the Orthodontic waiting list in a pro-active transparent and equitable manner

Staffing

This year the Southern Health Board got funding and approval from the Department of Health and Children for the appointment of 2 additional Consultant Orthodontists and support staff. It decided that as part of its' strategy to develop the service it would locate one Consultant and his / her team in both Cork and Kerry.

These posts were advertised in June by the Local Appointments Commission and resulted in only one candidate applying for the posts. This is indicative of the small numbers of Orthodontists being trained for the service and the practical difficulty in attracting Orthodontists to work in the public system when private practice can offer substantially higher income.

The Board is in the process of offering the post to the successful candidate who will be based in Cork and it is intended to re-advertise the second post in the coming months.

The Cork Dental School and Hospital is one of only 2 Dental Schools and it is essential that it puts in place the academic appointments necessary to enable it to begin training Orthodontists and that it does so in collaboration with the Southern Health Board and adjoining Boards in order that training and research compliment the service being provided.
At a National level the Health Service Employers Agency on behalf of the Department of Health and Children has just concluded agreement on the pay and conditions for a new post of Specialist Orthodontist to be recruited into the Irish health service. Specialist Orthodontists will be trained to function as independent practitioners and will be able to undertake a substantial range of treatments presently undertaken by Consultants. The Southern Health Board will shortly be advertising for a Specialist and it will take some time before it can be adjudged how successful this development will be in meeting the manpower demands of the service.

Again at a national level it is essential that future manpower requirements are evaluated as part of a national strategy and that numbers in training are matched to meet this need as in the case of other medical and surgical specialties.

**National Guidelines**

The National Guidelines are presently the basis for determining the eligibility for treatment and must be implemented on a consistent basis throughout the country in the interest of equity.

This implies that referring Health Board Community Dentists and Consultant Orthodontists should apply the same standards and must implement the Guidelines in similar fashion within Boards and within the health service as a whole.

Variations in the numbers of children being referred for assessment and subsequently accepted as being eligible for treatment between Health Boards suggests that differing interpretations are in place in respect of the National Guidelines and it is in everybody's interest that this is addressed.

**Strategies being adopted by Southern Health Board**

The following is a summary of the measures taken by the Southern Health Board to put in place the infrastructure to meet the demands of the service bearing in mind that there is no one single measure which in the short term will meet these demands:

1. The Board has advertised for 2 additional Consultant Orthodontists and is in the process of making one appointment with a view to re-advertising the second post again in the coming months.

2. Following agreement between the Health Services Employers Agency and the Irish Dental Association, the Southern Health Board will shortly be advertising for a Specialist Orthodontist who will be an independent practitioner and can carry his / her own workload but will function as part of the overall service.
3. The Board has made provision for additional dental chairs in its facility in St. Finbarr's Hospital which are now ready for occupation and will be advertising shortly for the staff necessary to commission these chairs.

4. The Board has appointed a Manager for the Orthodontic service to support the Consultant and his team in the management of the waiting lists.

5. The Board is in the process of computerising the Orthodontic waiting lists as a further measure to improve the management of the waiting lists.

6. The Board has written to private Orthodontists in Cork and Kerry seeking to contract out the treatment of Orthodontic patients with 5 responses to date and these responses are currently being evaluated.

7. The Board has also investigated the possibility of bringing Orthodontists to work in Cork from the UK and Northern Ireland without success.

8. The Board is anxious to see the development of a recognised training programme for Orthodontists and will work with the Dental School and Hospital towards this end.

9. The Board will work with the Dental School towards the filling of the Professor of Orthodontics post and is anxious to collaborate in any way that would make this post attractive to candidates.

**Summary**

The Southern Health Board is committed to putting in place a range of measures which will collectively serve to address the needs of the Orthodontic service but it is essential that issues of manpower planning, training and the interpretation of National Guidelines are addressed on a National basis.

Finally it is essential that, again on a national basis the economic reality of private practice being seen as a more attractive option than public practice be addressed in the interest of patient care.
Orthodontic Service for Children

Western Health Board Presentation to the Joint Oireachtas Committee on Health and Children

Dr. Mary Hynes
Regional Manager Acute Services
8 November 2001
Introduction
In simple terms, orthodontics deals with the position of the teeth and the way they come together (bite).

Orthodontic treatment is a long-term treatment and cannot be carried out in one visit. It takes 18 months to two years, involving 10-20 visits to the orthodontist, to complete a course of treatment, sometimes longer. This is followed by a further period of up to two years when the patient has to wear retainers. Only a limited number of patients can be treated by any clinician at any particular time. Attempting to increase this number risks compromising treatment and poor clinical outcomes.

In 1985 the Department of Health laid down guidelines in order to provide a standardised approach to the selection of patients and to ensure that children with the greatest clinical need were prioritised for orthodontic assessment and treatment.

Western Health Board Service
The orthodontic service in the Western Health Board was established in 1994, when the Department of Orthodontics opened at Merlin Park Regional Hospital. It is equipped with modern up to date facilities together with nursing and secretarial support.

The current staffing level is as follows:
- 1 Consultant orthodontist
- 4 Full time Orthodontic practitioners
- 3 Part time Orthodontic practitioners
- 7 Dental surgery assistants
- 2 Clerical support staff

Currently only the consultant and part-time practitioners have specialist training in orthodontics. The consultant orthodontist carries out all assessments in order to ensure that all patients who are placed on the orthodontic treatment waiting list are eligible according to the guidelines issued by the Department of Health. Approximately 15% of patients referred for assessment are found to be eligible, with a further 4% requiring immediate treatment for severe problems. Currently approximately 250 patients are added to the treatment waiting list annually.

Consultant clinics deal with complex problems such as impacted teeth, unerupted supernumeraries and dental anomalies. Patients with cleft lip and palate are provided with the service as part of a multidisciplinary team. Joint cleft clinics are held monthly in UCHG including the consultants in orthodontics, plastic surgery, and ENT surgery together with speech therapy.
Two Senior Clinical Dental Surgeons are currently undergoing training in collaboration with the Dublin Dental School in order to gain their specialist qualifications and are due to complete training in June 2002. When they achieve their specialist qualification, they will be in a position to take over responsibility for a larger number of patients and reduce the numbers waiting. It is hoped to provide one training place on an ongoing basis. Our aim is to develop the service so that it is consultant led and provided by trained specialists in orthodontics. It is essential that an attractive salary and career structure is provided for specialists so that they will be recruited and retained within the public service.

Other countries in the EU employ orthodontic auxiliaries (dental nurses or hygienists with additional training) to undertake treatment under the direction of the consultant and specialists but this grade of staff is not available in Ireland. Their addition to the staff complement would help to increase throughput.

Trends in expenditure in recent years are shown in Table 1.

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>1,376</td>
</tr>
<tr>
<td>2000</td>
<td>829</td>
</tr>
<tr>
<td>1999</td>
<td>628</td>
</tr>
<tr>
<td>1998</td>
<td>543</td>
</tr>
</tbody>
</table>

There are currently 1,417 patients under treatment in the Department.

Service pressures
The current service is dealing with a large backlog of patients. This arose as a result of staff losses in the period 1995-1999 when disruption in staffing was an almost constant feature. This is summarised in Table 2.

<table>
<thead>
<tr>
<th>Year</th>
<th>Consultant</th>
<th>Dental staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>1995</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>1996</td>
<td>1 (left mid-year)</td>
<td>3</td>
</tr>
<tr>
<td>1997</td>
<td>1 (from mid-Aug.)</td>
<td>2/3</td>
</tr>
<tr>
<td>1998</td>
<td>1</td>
<td>2/3</td>
</tr>
<tr>
<td>1999</td>
<td>1</td>
<td>3/4</td>
</tr>
</tbody>
</table>

Difficulties in attracting replacement staff and resulting delays in recruitment during this period created a backlog of unmet need that is now being actively addressed. When staff left, their caseload had to be absorbed by remaining staff, resulting in longer treatment times and seriously affecting our ability to take
patients off the waiting list. From mid-1996 to mid-1997 when there was no
consultant cover, almost no patients were taken off the waiting list for treatment
whilst patients were still being added to the list.

Waiting list
Table 3 shows trends in numbers waiting for treatment.

Table 3. Trends in numbers waiting

<table>
<thead>
<tr>
<th>Year</th>
<th>Assessment</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>1,023</td>
<td>865</td>
</tr>
<tr>
<td>1996</td>
<td>1,025</td>
<td>1,367</td>
</tr>
<tr>
<td>1997</td>
<td>607</td>
<td>3,036</td>
</tr>
<tr>
<td>1998</td>
<td>165</td>
<td>3,838</td>
</tr>
<tr>
<td>1999</td>
<td>357</td>
<td>2,171</td>
</tr>
<tr>
<td>2000</td>
<td>509</td>
<td>2,214</td>
</tr>
<tr>
<td>2001 (Sept)</td>
<td>719</td>
<td>1,479</td>
</tr>
</tbody>
</table>

The current waiting list is as follows:

**Assessment**
- Category A (urgent): None
- Category B (non-urgent): 719

The waiting time for assessment of non-urgent cases is 7 months

**Treatment**
- Category A (urgent): None
- Category B (non-urgent): 1479

Of the 1479 patients awaiting treatment, 283 have been waiting less than one
year, 581 have been waiting one to two years and 605 have been waiting two to
three and a half years.

In 2001, a sum of IRE420,000 was allocated to tackle the orthodontic waiting list.
Since the beginning of the year, the numbers awaiting treatment have fallen by
735. Currently 1,420 patients are receiving treatment in the region.

Waiting list initiative
Under a waiting list initiative that began in 2000, private practitioners in the region
were contracted to carry out treatments on a fee per service basis in their
practices, to treat patients who had been waiting longest for treatment. All four
fulltime private practitioners in Galway and the one practitioner in County Mayo
agreed to participate in the initiative. Four of the five already had busy practices
when contacted and therefore had limited capacity to take on extra patients.

Patients are examined initially by the WHB consultant orthodontist who
determines eligibility. Patients are then given a choice as to which private
orthodontist they wish to attend. The average fee paid is IRE2,500. By the end of
August this year 193 patients from the waiting list had been assigned to private practitioners and it is anticipated that this will reach 250 patients by the end of the year.

The second aspect of the strategy to address waiting lists is to build capacity within the Board to meet need. The Minister for Health and Children has now approved the creation of a grade of Specialist in Orthodontics. This post provides an improved career structure and remuneration for orthodontic practitioners. We have been successful in recruiting a Specialist who is due to start work at the end of this month. This new staff member will remove 300 additional patients from the waiting list within a relatively short period of time.

When the two practitioners who are currently in training complete their course in June 2002, they will be in a position to assume a full caseload, each removing 150 additional patients from the waiting list.

Public Concern

A report on Orthodontic Services in the Western Health Board area was presented to the last Meeting of the Board held on the 5th November.

Considerable discussion took place on the various aspects of the Report and many members identified Orthodontics as a primary cause of contact from their constituents. They spoke of the psychological distress of young people on the waiting list, their vulnerability to bullying and the potential for social gain if the problem is addressed. Arising from the debate, the following proposals were put forward and agreed by the Board as potential ways in which the issue of lengthy waiting times for Orthodontic treatment can be resolved:

1. That existing legislation be amended to allow for co-funding between the Health Board and the family of the child seeking orthodontic treatment.

2. Once-off additional funding be made available to address Orthodontic Waiting Lists. In the Western Health Board it would cost approximately £1.8million to deal in the private sector with those waiting for two years or more.

The future

Orthodontic services impinge on the lives of many young people and their families. The service in the Western Health Board was set up in 1994 but suffered from reduced staffing levels for many of the intervening years. This led to a backlog of unmet need. There is great potential for social gain in addressing this need.

While significant progress has been made this year in tackling the waiting list through a combination of our own in-house efforts and contracting out to private practitioners, the situation remains unsatisfactory, with many young people waiting unacceptable periods for treatment.
By June 2002, we will have three orthodontic specialists in addition to the consultant orthodontist. This will increase our capacity to meet the priority needs of the population. However, it will still take some time to reach a point when the waiting time for treatment is below 12 months.

Additional funding is needed to accelerate the progress that has been made to date. Such funding could be utilised in a number of ways:

• Recruiting additional specialists (if available) to further increase capacity immediately
• Commitment to train additional specialists on an ongoing basis to increase capacity in the medium term
• Further contracting of service to private practitioners based in the region as in the current initiative
• Payment of direct grant support to parents of eligible patients to source their own private practitioner, subject to safeguards about quality
• Amending legislation to allow co-payment by patients and Health Boards, as proposed by Western Health Board members.

All of the above have the potential to reduce waiting lists substantially. In addition consideration should be given to the introduction of an auxiliary grade to maximise the efficiency of the practitioners currently in the service.
PROVISION OF ORTHODONTIC SERVICES

SOUTH EASTERN HEALTH BOARD

PRESENTATION TO

JOINT OIREACHTAS COMMITTEE ON HEALTH AND CHILDREN

THURSDAY, 8TH NOVEMBER, 2001.
1. South Eastern Health Board.

   Population: 420,000

   Composition:
   Waterford
   Wexford
   Carlow/Kilkenny
   Tipperary South.

2. Orthodontic Service Organisation.

   • Staff

   1 Consultant Orthodontist, Waterford Regional Hospital.
   3 Specialists Orthodontists, Waterford Regional Hospital.
   4 Orthodontists (all with > 6 years full time experience.)
• Surgeries (per week)

<table>
<thead>
<tr>
<th>No.</th>
<th>Location</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>W.R.H.</td>
<td>4.5 Days</td>
</tr>
<tr>
<td>1</td>
<td>Kilkenny</td>
<td>5 Days</td>
</tr>
<tr>
<td>1</td>
<td>Clonmel</td>
<td>5 Days</td>
</tr>
<tr>
<td>1</td>
<td>Carlow</td>
<td>4 Days</td>
</tr>
<tr>
<td>1</td>
<td>Wexford</td>
<td>4 Days</td>
</tr>
<tr>
<td>1</td>
<td>Enniscorthy</td>
<td>3 Days</td>
</tr>
<tr>
<td>1</td>
<td>Gorey</td>
<td>1 Day</td>
</tr>
<tr>
<td>1</td>
<td>Dungarvan</td>
<td>1 Day</td>
</tr>
<tr>
<td>1</td>
<td>New Ross</td>
<td>1 Day</td>
</tr>
</tbody>
</table>

• Activity. (No. of patients in treatment.)

<table>
<thead>
<tr>
<th>Month</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec. 99</td>
<td>1,744</td>
</tr>
<tr>
<td>Dec. 00</td>
<td>1,699</td>
</tr>
<tr>
<td>Dec. 01 (Projected)</td>
<td>2,007</td>
</tr>
</tbody>
</table>

• Waiting Lists - Orthodontic Services.

<table>
<thead>
<tr>
<th>No. on List</th>
<th>September 1999</th>
<th>September 2000</th>
<th>October 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Time for Assessment (weeks)</td>
<td>20</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Waiting Time for Treatment (weeks)</td>
<td>88</td>
<td>64</td>
<td>48</td>
</tr>
</tbody>
</table>
- Assessment waiting time 4 – 8 weeks depending on area.
- All patients screened by Consultant Orthodontist prior to placing on list.
- Consultant Orthodontist has 4 – 5 assessment sessions per week and visits all counties.
- Parents must attend and are interviewed.
- All Orthodontic staff visit W.R.H. once per week to discuss cases and maintain contact.
- Close liaison with Community Care Dental Service essential.

3. Issues:
- Provision of orthodontic services is not for cosmetic purposes.
- Requirement for additional trained staff.
ORTHODONTICS IN THE MIDLAND HEALTH BOARD

Population 200,000
Serving counties of
Laois
Offaly
Longford
Westmeath

Consumer-Oriented Service
Informed Consent
- Patient/parent given all treatment options
- Queries addressed
- Respect and dignity
- Competent and qualified staff

ORTHODONTICS IN THE MIDLAND HEALTH BOARD
Presentation to Joint Oireactas Committee on Health and Children, November 8th 2001

Mr. David J. Hegarty
Consultant Orthodontist, Midland Health Board
Dr. Dan O’Moore
Principal Dental Surgeon, Longford/Westmeath Area

We wish to thank the committee for the opportunity to make this presentation.

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<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>New Starts</td>
<td>410</td>
<td>320</td>
<td>330</td>
<td>870</td>
</tr>
<tr>
<td>Completed</td>
<td>123</td>
<td>145</td>
<td>134</td>
<td>875</td>
</tr>
<tr>
<td>No. = active treatment</td>
<td>5480</td>
<td>2240</td>
<td>1300</td>
<td>5800</td>
</tr>
<tr>
<td>No. on waiting list</td>
<td>527</td>
<td>977</td>
<td>232</td>
<td>2</td>
</tr>
</tbody>
</table>

Consumer-Oriented Service
- Minimal treatment delay
- Comfortable setting
- Complaints answered
FUNCTIONAL APPLIANCE GROWTH MODIFICATION

Improved Facial Profile before and after growth modification treatment.

Dental improvement with Functional Appliance treatment.

More than half of our Midland Health Board patients benefit from this type of orthodontic treatment.
The duration of treatment is on average 2 years long.
SURGICAL ORTHODONTIC TREATMENT

Severe malocclusion beyond limits of conventional orthodontic treatment

Jaw Surgery

Outcome after 2 years of fixed orthodontic appliances and jaw surgery
Consultant-lead Service

**ADVANTAGES**
- Problem-oriented
- Clinical Motivation
- Low cost-per-case
- Specialist Training
- Multidisciplinary cases

**DISADVANTAGES**
- Integration with Management
- Service Development
- Clinical safeguards
- Hierarchical system
- Research

Eligibility and Need

The Department of Health Guidelines - 14 qualify

Horan Report (1997) recommends [CTN-1,3]

Qualify

Eligibility and Need

- A review of the guidelines should address the following questions:
  1. Are some patients with significant treatment need excluded under the existing guidelines?
  2. Where should the cut-off points be?
  3. Are guidelines evidence-based and in line with best practice?

Eligibility and Need

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ORTHODONTICS IN THE MIDLAND HEALTH BOARD

Presentation to Joint Oireachtas Committee on Health and Children

On 8th November 2001 by:

David J. Hegarty
Consultant Orthodontist
Midland Health Board

Dan O’Meara, Principal Dental Surgeon
Longford/Westmeath catchment area

Thank committee for opportunity to make presentation.
ORTHODONTICS IN THE MIDLAND HEALTH BOARD

Population 200,000

Serving counties of
Laois
Offaly
Longford
Westmeath
Estimates of projected Orthodontic activity in the Midland Health Board

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Starts</td>
<td>412</td>
<td>320</td>
<td>536</td>
<td>870</td>
</tr>
<tr>
<td>Completed</td>
<td>331</td>
<td>350</td>
<td>536</td>
<td>870</td>
</tr>
<tr>
<td>No. in active treatment</td>
<td>1480</td>
<td>1200</td>
<td>1900</td>
<td>3050</td>
</tr>
<tr>
<td>No. on waiting list</td>
<td>407</td>
<td>477</td>
<td>250</td>
<td>0</td>
</tr>
</tbody>
</table>

Primary aim is to provide a timely and efficient service to all within current guidelines. Once the service is fully expanded orthodontic treatment can be considered for a greater proportion of the population with less severe malocclusions if it is decided to widen guidelines. Emphasis is on waiting list but good work is being done!
Eligibility and need

The Department of Health Guidelines- $\frac{1}{4}$ children qualify for treatment

Moran Report (1997) recommends IOTN- $\frac{1}{3}$ children will qualify
Eligibility and need

DoH guidelines

A review of guidelines should address the following questions:

- Are some patients with significant treatment needs excluded under the existing guidelines?
- What should cut-off points be?
- Are guidelines evidence-based and in line with best practice?

Note on IOTN Guidelines (possible alternative)

Excluded patients have only minor malocclusions evidenced-based
Cut-offs sensible—risk/benefit analyses
Consumer-Oriented Service

Informed Consent

Patient/parent given all treatment options

Queries addressed

Respect and dignity

Competent and qualified staff
Consumer-Oriented Service

Minimal treatment delay

Comfortable setting

Complaints answered
Consultant-led Service

Consultant led service for 'public'
Patients – no different from standards in private Care
## Consultant-led Service

<table>
<thead>
<tr>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-orientated approach</td>
<td>Waiting lists</td>
</tr>
<tr>
<td>Clinical motivations</td>
<td>and the portrayal as a problem</td>
</tr>
<tr>
<td>integrated system</td>
<td></td>
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<tr>
<td>Multidisciplinary cases</td>
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<tr>
<td>Patient follow-up</td>
<td></td>
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<tr>
<td>Low cost-per-case</td>
<td></td>
</tr>
<tr>
<td>Logical Service Development</td>
<td></td>
</tr>
<tr>
<td>Clinical Safeguards</td>
<td></td>
</tr>
<tr>
<td>Specialist/Staff Training</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td></td>
</tr>
<tr>
<td>Continuing Education</td>
<td></td>
</tr>
<tr>
<td>Note also participation with all key decision</td>
<td></td>
</tr>
<tr>
<td>makers in the management committee</td>
<td></td>
</tr>
</tbody>
</table>
Audit

Clinical effectiveness improves overall standards

Provide accurate information necessary for costing and improvement of the service
Audit

Service is monitored through the analysis of:

Clinical activity

Waiting Lists

Treatment success - The PAR index
Keys to Ideal Orthodontic Service

Consultant Units - 1 per 200,000 population

Service tailored to population needs

Specialist and auxiliary training
Keys to Ideal Orthodontic Service

Critical analysis and evolution of service
Continuous Medical Education

Research to provide evidence base for clinical practice

IT network facilitates gathering information
To each member of:

The Committee of the Oireachtas on Health & Children

Re: Regional Orthodontic Services, North Eastern Health Board.

The overall objective of the Regional Orthodontic Service in the North Eastern Health Board is to provide an efficient, effective and quality-orientated orthodontic service for eligible patients.

In doing so, the Board has sought to provide high-quality, accessible treatment units and also has indicated its firm commitment to reducing waiting times for orthodontic treatment.

The Consultant led Orthodontic Service commenced in the North Eastern Health Board in late 1998 with the appointment of a Regional Consultant Orthodontist. Prior to this, the service was provided on a fee per item basis by a visiting Orthodontist - a service that was unsuitable to the growing needs of the Board.

Since the appointment of the Consultant Orthodontist, two regional units have been set up, one at Our Lady’s Hospital, Navan which opened in September, 2001 and one at Louth County Hospital, Dundalk, to serve the needs of people from the northern part of the region. In addition, facilities are used in Monaghan General Hospital and Cavan General Hospital where patients from the Cavan and Monaghan catchment areas are seen.

With almost 2,000 patients currently under treatment, it is anticipated that in the year 2002 there will be a further increase in the number of patients under treatment. Waiting lists have been reduced from in excess of 1,200 to approximately 600 over the past 12 months. (See Appendix A.) An additional Specialist Orthodontist is being recruited. If we are successful in recruiting the Specialist, then 500 more cases will be started in 2002.

The Board has a very strong commitment to the ongoing recruitment of orthodontic staff on a region-wide basis. The three Specialist Orthodontists now working in the Board are employed on a three-year contract and their contracts are due to be reviewed in September 2002. The Board has found it useful to use the British and Swedish Dental Journals for recruitment purposes. We are hoping to expand this into other parts of Europe where orthodontists qualify for inclusion on the Specialists Register in Dublin.
Journals for recruitment purposes. We are hoping to expand this into other parts of Europe where orthodontists qualify for inclusion on the Specialists Register in Dublin.

The current orthodontic staffing levels are set out as follows:

<table>
<thead>
<tr>
<th>4</th>
<th>Specialist Orthodontists</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Post-graduate trainees (1 morning per week in Navan, 2 days in Dundalk)</td>
</tr>
<tr>
<td>2</td>
<td>Dental Hygienists</td>
</tr>
<tr>
<td>10</td>
<td>Dental Surgery Assistants</td>
</tr>
<tr>
<td>3.5</td>
<td>Clerical Officer Grade III</td>
</tr>
</tbody>
</table>

The cost of funding the Orthodontic Service in the North Eastern Health Board for the year 2001 is £1.2m, with an additional £90,000 which was given as a once-off payment to fund additional activity.

The Board would be anxious to see the appointment of auxiliary personnel to the Orthodontic Service. The Board is hopeful that the Dental Council and the Dental Schools in Ireland will undertake to train and register such personnel. The Regional Orthodontic Units in both Navan and Dundalk have been designed for the provision of Orthodontic Services supported by auxiliary grades.

**Oral Surgery/Maxillofacial Surgery Services.**

Comhairle Na nOspideal is presently examining the position in relation to Maxillofacial Surgery. The Board has taken the view that it is desirable to have a Consultant Maxillofacial Surgeon appointed to serve the patients of the North Eastern region, based in the Louth/Meath Hospital Group.

The Board presently has a limited Oral Surgery service at Louth County Hospital provided by a visiting Oral Surgeon from Belfast. Presently, we refer patients to St. James Hospital in Dublin and the Dublin Dental Hospital. The waiting time for surgical assessment is at least one year. This is unacceptable as patients in the North East have to wait two years for their treatment. The Board is therefore anxious to develop its own Maxillofacial and Oral Surgery Services.

The Board is co-operating with our basic dental service and it is envisaged that a number of dental surgeons working in the community service will, under the supervision of orthodontic consultant personnel, work within the Regional Orthodontic Unit on a sessional basis. This will greatly improve the efficiency and effectiveness of our Orthodontic Services.
Links with Community Dental Service

The service has established vital links with the Community Dental Service particularly in the area of education.

Continuing Education.

The North Eastern Health Board has developed very close working relationships with the Dental School at Queens University, Belfast and the Dental School at Trinity College, Dublin. In addition to one Orthodontic trainee at Belfast, there is another trainee at Dublin. We are hopeful that we will be in a position to train additional personnel in the coming years.

The Regional Consultant Orthodontist in the North East holds a teaching appointment to the Dental School at Trinity College, Dublin.

Activity Levels:

We set out below details of the activity levels including the number of patients under treatment, number of patients on the waiting list by category, details of the waiting times for treatment. (See Appendix A)

The biggest dependency which the Board has in relation to the provision of Orthodontic Service is the recruitment and retention of appropriately trained clinical and specialist staff, especially Orthodontists.

The Board measures the performance of its Orthodontic Service on a quarterly basis and quarterly activity levels are collected and serve as performance indicators for all the units.

The Board has plans to expand its Orthodontic Services both at Cavan and Monaghan and it is envisaged two units will be established, one at Monaghan adjacent to the Dental Unit in the hospital and one in Cavan, adjacent to the Dental Unit at Cavan Hospital. They will be self-sufficient Orthodontic Units and will add significantly to the Board's capacity to provide orthodontic services.

Clearly, there is going to be an increasing demand for Orthodontic Services. It is the view of the Board's Management that priority should be given to those patients with urgent clinical need and those with functional problems which require orthodontic intervention.

Dr. Ambrose McLoughlin,
Deputy Chief Executive Officer,
North Eastern Health Board.
## Regional Orthodontic Services

### Activity Report

<table>
<thead>
<tr>
<th>Waiting List</th>
<th>31/3/2000</th>
<th>30/9/2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients Category A</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>No. of patients Category B</td>
<td>1,221</td>
<td>640</td>
</tr>
<tr>
<td>Average Waiting Time:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category A</td>
<td>6 – 8 weeks</td>
<td>6 – 8 weeks</td>
</tr>
<tr>
<td>Category B</td>
<td>24 – 30 months</td>
<td>20 – 24 months</td>
</tr>
<tr>
<td>Length of Time on Waiting List</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 12 months</td>
<td>552</td>
<td>263</td>
</tr>
<tr>
<td>&gt; 12 months</td>
<td>669</td>
<td>377</td>
</tr>
<tr>
<td>No. Currently Receiving Treatment</td>
<td>1,551</td>
<td>1,859</td>
</tr>
<tr>
<td>Completed Treatments</td>
<td>Year 2000</td>
<td>Year 1/1/01 – 30/9/01</td>
</tr>
<tr>
<td>No. of Completed Treatments</td>
<td>228</td>
<td>189</td>
</tr>
</tbody>
</table>
Mr Chairman and members of the Committee I would like to thank you for the invitation to make a presentation to you on the provision of orthodontic services in Ireland. It is fair to say that our orthodontic service is an area of dentistry that is the subject of much discussion and I hope that our contribution today will be of assistance to you in your deliberations.

The Dental Council:
The Dental Council was established under the provisions of the Dentists Act 1985 taking over from the Dental Board that had functioned since 1928. The general concern of the Council is to promote high standards of professional education and professional conduct among dentists and it is given particular duties under the Act in relation to registration, education and training, fitness to practise and auxiliary dental workers.

The Council has no specific remit in relation to the delivery of dental services in the State.
Orthodontic Services:

While education and training in orthodontics forms part of the undergraduate dental curriculum in our two dental schools, dentists on graduation would only be competent to provide a basic service in this discipline. As a result very little orthodontic care is delivered at general practitioner level in Ireland and it has become almost exclusively an area for specialist intervention.

Specialist registration:

In 1999 the Council, with the consent of the Minister for Health and Children, established a Register of Dental Specialists with divisions therein in respect of orthodontics and oral surgery.

Specialist training:

Prior to the establishment of the Register of Dental Specialists, specialist training here was overseen by the UK based Joint Committee for Specialist Training in Dentistry which committee includes representation from the Royal Surgical Colleges of the UK and Ireland. The Specialist Advisory Committees of the Joint
Committee approved courses, gave guidance on access, advised trainees and monitored the implementation of the training programmes. In relation to orthodontic specialist training the relevant SAC recognised the importance of joint involvement between the training institutions and the service providers but emphasised the primacy of training over service. A training programme that assigned the trainee to a teaching institution for 60% of the time and to a clinic/hospital providing services for 40% of the time was viewed as ideal.

Irish Committee for Specialist Training:
Following upon the establishment of the Register of Dental Specialists the Council appointed the Irish Committee for Specialist Training in Dentistry as the body within the State that it would recognise for the purpose of granting evidence of satisfactory completion of specialist training. This Committee through its imprimatur from the Dental Council will in future be the body responsible for the role previously carried out by the Joint Committee for Specialist Training in Dentistry and its Specialist Advisory Committee. The Council has instructed the Irish
Committee to approve programmes that meet with EU training requirements and future registration in the Register of Dental Specialists will be on the basis of evidence of satisfactory completion of specialist training granted by the Irish Committee.

The Irish Committee maintains its links with the Joint Committee thus ensuring that training in Ireland will be on par with training in the UK and the rest of Europe.

The Irish Committee for Specialist Training in Dentistry has recently appointed a Director of Specialist Training and it is expected that with this appointment the Committee will be in a position to give support to existing training programmes and act as the catalyst in having new programmes established.

**Orthodontic Auxiliaries:**

The modern approach to orthodontic treatment with fixed appliance therapy is for the specialist practitioner labour intensive and time consuming. The Council has identified a number of tasks within this treatment process that could be undertaken by trained assistants.
Following consideration of submissions made by the main interested bodies the Council will at its meeting early in December consider a recommendation from its Auxiliary Dental Workers Committee that a grade of Orthodontic Therapist be established. Members of this grade, operating under the direction and supervision of a specialist orthodontist, would undertake a number of routine but time-consuming tasks and free the orthodontist to concentrate on those aspects of treatment that only the specialist can perform.

**Summary:**

1. Orthodontic treatment in Ireland, in the public as well as the private sector, is carried out mainly by dentists who have satisfactorily completed specialist training.

2. Specialist training that heretofore was approved by the UK based Joint Committee for Specialist Training will in future, because of the establishment of the Register of Dental Specialists, be overseen by the Irish Committee for Specialist Training in Dentistry. This development will provide for a more focused and structured approach to training.
Presentation to Joint Oireachtas Committee on Health and Children by
the Faculty of Dentistry, Royal College of Surgeons in Ireland
November 22, 2001

Introduction:

Mr. Chairman, ladies and gentlemen,

I have been asked to attend today’s session as a representative of the Royal
College of Surgeons (RCSI) in my capacity as Dean of the Faculty of
Dentistry. I would like to begin by thanking you for giving me the
opportunity to address this Joint Committee on Health and Children.

The Faculty of Dentistry of the Royal College of Surgeons in Ireland was
established in 1963. The objectives of the Faculty were the same then as
they are now - that is to advance the science, art and practice of Dentistry
and to promote education, study and research in this field. The Faculty is
recognised not only in the UK by its sister Faculties in England, Edinburgh
and Glasgow but also throughout the world as a postgraduate centre of
excellence in Dentistry.

From the outset, the Faculty realised there was a need to develop the highest
standards of postgraduate training and education and the need to provide a
level that would in today’s terms be denoted as Specialist level. It was
therefore regarded as essential that Specialist Fellowship examinations in a
number of disciplines be established in the early days - a format which has
been gradually adopted by the UK Colleges - to allow trainees to be
independently assessed at the highest level. Although the Faculty is unable
at this time to provide clinical training facilities on site, it has the
opportunity to inspect, approve or recommend alterations to training
facilities in institutions which apply for recognition of their postgraduate
programmes for the purpose of gaining admission to the Faculty’s
Fellowship examination.
In addition, there is reciprocal recognition between the Faculty and its sister Faculties in the UK. In this way, a large number of training centres throughout Ireland, the UK, Australia, the Middle-East, the USA etc are recognised as having the requisite facilities and acceptable training programmes to allow their trainees to be eligible to sit the Faculty examinations.

The Faculty has a close working relationship with the Academic institutions in the University of Dublin, Trinity College and the National University of Ireland, Cork where the two Dental Schools are based. It is also in harmony with the Dental Council, the ultimate competent authority in Dentistry in Ireland.

Development of training and standards:

As already stated, training in postgraduate Dentistry takes place outside the RCS! In the early days, most of this occurred in the Dental Schools exclusively. Now, it is based both in the schools and also in other approved posts e.g. Health Boards. Up until recently, all postgraduate training programmes in Ireland were approved and overseen by Specialist Advisory Committees (SACs) of the Joint Committee for Specialist Training in Dentistry (JCSTD) in the UK. This provided an independent overview by a highly respected body and it paralleled the situation of our medical colleagues.

However, following the decision of the Dental Council with the approval of the Minister for Health and Children to introduce a Register of Dental Specialists with divisions in Oral Surgery and Orthodontics in the first instance, it was necessary for the Council to recognise another body within the State for the purpose of inspecting, approving and overseeing the conduct of specialist training programmes in dentistry in Ireland. This body has been reconstituted and is called the Irish Committee for Specialist Training in Dentistry (ICSTD).
The ICSTD is a standing committee of the Faculty of Dentistry but with a wide membership across the dental spectrum that includes the three recognised training bodies in the State (the two dental schools in Dublin and Cork and the RCSI), the Irish Dental Association, representatives of the relevant specialist and consultant groups in both Oral Surgery and Orthodontics, the Chief Dental Officer and the Chairman of the JCSTD. Each of the membership categories is required to decide upon its own nominee(s). It is important to note that within the specialist and consultant groups nominations, provision has been made to cover each of the relevant categories – i.e. one academic consultant, one regional consultant and one registered specialist and these are elected from within their own subgroups.

Within the ICSTD, two new Advisory Committees have been established to provide a similar role to that of the SACs of the Joint Committee. From now on, any training facilities which are to be established in Ireland in either Oral Surgery or Orthodontics, must be inspected by these Advisory Committees and obtain approval through the ICSTD. Postgraduate programmes which do not have the approval of the ICSTD will not be recognised and the dentists who participate in such programmes will not gain entitlement to have their names entered in Register of Dental Specialists.

The provision of recognised training will ensure not only that our graduates will be trained to the highest level but it will also allow our patients to receive the highest standards of care. This is, after all, what everyone would wish to achieve.

Orthodontics:

It is a requirement under the European Union Dental Directives that our specialists in Orthodontics are trained to at least the agreed minimum European standard. The European Union Advisory Committee on the training of Dental Practitioners has issued guidelines on specialist training and the Directive requires specialist training to be of a minimum of 3 years duration. The Dental Council has adopted the European model for specialist training in Ireland. Therefore, the curriculum for training and the regulations for examinations as laid down by the Council follow this format in this country.
Training:

1. The entry point into specialist training which has been agreed by the three training bodies is:

   1. 2 years general professional training post-qualification and possession of the Membership of the Faculty of Dentistry, RCSI diploma (MFDRCSI) or equivalent

   2. The course content broadly corresponds to the guidelines for the UK training programmes in Orthodontics for specialist registrars and other trainees' (April 1999) and fulfils the requirements of the relevant EU Directive

   3. The course location has also been agreed in that more than 60% of the training time must be spent in a Dental school under the direct supervision of the Consultant trainer.

   4. The training time will be 3 years after which an exit qualification will be taken at specialist level

   5. If trainees wish to continue to Consultant level, a further 2 years training is required following which the Intercollegiate Specialist Fellowship will be necessary. The requirements for consultant appointments have already been drawn up and agreed between the CDO at the Department of Health and Children and the Faculty

The training described above mirrors the situation as it stands at present in the UK. The Faculty considers these standards to be essential for the trainee who will be recognised as an equal among his/her European colleagues, for the patient who will receive the best treatment and for the profession which reflects the standard of healthcare in this country.
Mr. Chairman, I would conclude this short presentation by saying that the Faculty of Dentistry would see itself as having no direct role in issues relating to manpower in this country but rather as a postgraduate body involved in the maintenance of the highest standards in postgraduate training in Dentistry in Ireland along with the Dental Council and the Universities.

Dr. Peter Cowan
Dean, Faculty of Dentistry, RCSI
Submission by the Dublin Dental School & Hospital to the Joint Committee on Health & Children of the Oireachtas in relation to Orthodontics

Professor John Clarkson, Dean
Mr. Brian Murray, Chief Executive Officer
Dr. Therese Garvey, Senior Lecturer/Consultant in Orthodontics
Dr. Paul Dowling, Senior Lecturer/Consultant in Orthodontics

6th December 2001
Mission
The provision of an environment where quality education, research and service programmes are integrated in a balanced way, appropriate to the resources available and the needs of the Community.

Goals
Educate and train students to become highly competent, critically thinking, life long learning, ethical and socially responsible members of the dental team comprising dentists, dental hygienists, dental nurses and dental technicians.

Educate and train dentists in specialist and consultant postgraduate programmes to meet the needs of the community.

Provide continuing education opportunities for all members of the dental team.

Conduct research in education, basic and clinical sciences which builds on our strengths and individual talents at national and international level.

Provide clinical services at reasonable fees appropriate to the needs of the community in ways which ensure that the requirements of high quality teaching and research are met.

Provide a referral and consultation resource to healthcare providers and also provide appropriate clinical services at secondary care level focusing on multidisciplinary care and the development of centres of excellence.

Provide an environment that aids the retention and development of high quality staff.

The School and Hospital's mission and activities must operate in accordance with the Hospital's Establishment Order (S.I. 129 of 1963), be subject to the regulations of the Dental Council and international accreditation bodies and be carried out in collaboration with the University of Dublin, Trinity College.

The School and Hospital currently has 205 full time and 73 part time staff.

To achieve these objectives the School and Hospital carries out the following activities:

Teaching

Undergraduate Teaching

The undergraduate dental programme is a five year course leading to the award of a Bachelor in Dental Science (B.Dent.Sc.) degree of the University of Dublin. The teaching methodology is student self-directed learning (problem-based learning). Forty students are admitted to the course each year, of whom 8 are from outside the
European Union. The award of the degree permits, following registration, the carrying out of independent practice by dentists.

Postgraduate Teaching

The Hospital provides a range of graduate programmes and courses:

Higher/Consultant
The Hospital is the only training centre in the country capable of providing programmes across the full range of specialities at consultant level.

Specialist
The Hospital provides three-year full-time training in a range of specialities. All graduates of these programmes are eligible for a certificate of specialist training for use in member states of the EU and satisfy the criteria set out on behalf of the Dental Council by the Irish Committee for Specialist Training in Dentistry of the Royal College of Surgeons.

Pre-Fellowship and Pre-Membership
Those who require to undertake specialist and higher training are required to have work experience in a dental hospital for at least one year or to have undertaken a course in vocational training. The School and Hospital provides courses for staff preparing for these programmes.

Higher University Degrees
The School and Hospital provides the resource to accommodate graduates undertaking scientific Masters and Doctoral programmes.

Continuing Education for Dental Practitioners

The School and Hospital provides formal programmes to practitioners in the form of both lecture based and clinical practice programmes. In addition, staff provide lectures to regional centres where scientific meetings are held. Also, staff members present lectures throughout the country on a regular basis.

Lecture Programme: - A monthly evening continuing education lecture programme is organised for dentists from around the country.

Clinical Practice Programme: - A weekly continuing education clinical practice course is organised. Dentists undertake to complete 6 practice modules over a 3 year period.

Dental Auxiliaries

The School and Hospital provides formal training programmes in dental hygiene, dental nursing and dental technology.

Dental Hygiene: - A full time two year programme provides training for an intake of 8 students each year. The course meets the requirements of the Dental Council and includes training in infiltration local anaesthesia and dental radiography.

Dental Technology: - A full time three year programme provides training for an intake of up to 8 students each year.
Dental Nursing— A full time two year programme provides training for an intake of 20 each year. The course became a full time two year programme in 1999 in order to address perceived deficiencies in the clinical experience of those qualifying. The course is aimed at school leavers.

A part time (evening) two year programme is provided for those working in dental surgeries who have no formal qualifications. In cooperation with the Dental Council, the Hospital is anxious to expand the numbers in dental nurse training at a regional level in order to address a shortage of trained personnel.

Staff Development

The School and Hospital continues to train and develop all staff both clinical and non-clinical through a comprehensive training and development programme.

The School and Hospital provides support and encouragement for staff through the payment of fees and release for study leave to undertake courses leading to the award of Certificates, Diplomas, Degrees, Masters and Doctorates in a variety of disciplines.

The School and Hospital also provides support to staff through access to training in areas such as computer skills, manual handling, clinical skill development and management skills, etc.

External Academic Activity

As an academic unit within the University of Dublin and in the European and international context of dentistry the Hospital provides significant input including leadership roles in the following activities which are essential for a dental teaching school and hospital:

University membership of Academic Council, College Officers and the Faculty of Health Sciences, Trinity College
Royal Colleges of Surgeons in Dublin, Edinburgh, Glasgow and London
International Association for Dental Research
Irish Dental Association
Dental Council
EU Advisory Committee on the Training of Dental Practitioners
International Federation of Dental Education Associations
Postgraduate Medical and Dental Board
Association for Dental Education in Europe
16 international specialist associations
European Association of Dental Public Health
US National Institute for Dental and Cranio-Facial Research
Health Research Board

In addition, as an academic clinical unit the School and Hospital provides an independent and hopefully informed opinion in all matters of oral health, disease and their treatment in this society.
## Education and Training Programmes - numbers undergoing training

<table>
<thead>
<tr>
<th>Programme</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Undergraduates (full-time)</td>
<td>196</td>
<td>195</td>
<td>200</td>
</tr>
<tr>
<td>* 6 year programme until 1998</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher Training (full-time)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Restorative Dentistry</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dental Radiology</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Specialist Trainees: M Dent Ch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Periodontology</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Paediatric Dentistry</td>
<td>2</td>
<td>2</td>
<td>0</td>
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<tr>
<td>Periodontology/Restorative</td>
<td>3</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Oral Medicine</td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td>Pre-Fellowship and Pre-Membership Courses</td>
<td>12</td>
<td>13</td>
<td>11</td>
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<tr>
<td>Higher University Degrees</td>
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<tr>
<td>Ph.D.</td>
<td>5</td>
<td>4</td>
<td>7</td>
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<tr>
<td>M.Sc.</td>
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<td>2</td>
<td>7</td>
</tr>
<tr>
<td>MD</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Dental Auxiliary Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Nurse (full-time)</td>
<td>22</td>
<td>15</td>
<td>36</td>
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<tr>
<td>Dental Nurse (part-time)</td>
<td>38</td>
<td>70</td>
<td>66</td>
</tr>
<tr>
<td>Dental Hygiene (full-time)</td>
<td>16</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Dental Technology (full-time)</td>
<td>9</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Continuing Dental Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly Lecture Course</td>
<td>75</td>
<td>75</td>
<td>96</td>
</tr>
<tr>
<td>Weekly Hands-on Course</td>
<td>40</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Dental nurse courses</td>
<td>20</td>
<td>146</td>
<td>126</td>
</tr>
<tr>
<td>Dental hygienist courses</td>
<td>62</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>517</td>
<td>600</td>
<td>664</td>
</tr>
</tbody>
</table>
Research

High quality research has been identified as a major priority for the School of Dental Science and the Dublin Dental Hospital. There has been a very significant increase in the quality and quantity of research papers published by the School's staff in international peer-reviewed journals of good standing over the last decade. The development of the new Dental Hospital & School complex on the Trinity College campus has provided a fresh impetus for clinical and basic research and the majority of staff are committed to developing and enhancing the School's research output over the next five year period.

There are currently several main areas of research undertaken or under development within the School and Hospital.

Current research areas within the Dublin Dental Hospital & School

- Oral Fungal Diseases
- Periodontology
- Oral Diseases and Oral Medicine
- Dental Education
- Public Dental Health
- Saliva and Salivary Gland Research
- Oral Pathology
- Restorative Dentistry & Materials Science
- Oral Clinical Research

The research output is measured by reference to papers published in peer-review international journals, invited oral presentations from School & Hospital staff at prestigious international conferences and research grants. The overall research output of the School and Hospital compares favourably with similar institutions in the United Kingdom and in Europe.

The appointment of new key staff members during the last two years has allowed the expansion of the range of research activities undertaken in the School & Hospital to include community dental health research, salivary gland and saliva research and gene therapy. Furthermore, an important new area of research into the microbiological quality of water in dental chair units, biofilm formation and environmental risk factors associated with dental equipment and the potential for the transmission of disease has been developed. This research program is essential because of increased awareness of potential biohazards in the dental clinic and concern about increasing numbers of dental patients with diminished resistance to overt and opportunistic microbial pathogens.

The School continues to co-ordinate a major EU Socrates Thematic Network (DeniEd) to develop an EU system of quality assurance and application of best practice in dental education throughout Europe. All EU countries are represented by seventy different schools/institutions/national associations. This network is funded by DG XXII of the Commission.
Table 2. Research Activities

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Clinical Services

Introduction

The School and Hospital's oral services are broadly divided into three categories: emergency care, specialist services and general dental services carried out by students under supervision.

Emergency Services

The Hospital provides a walk-in service for people in pain from Monday to Friday, 9.00 a.m. - 5.00 p.m. Patients are primarily self-referred and in pain. General hospitals and general dental practitioners also refer patients in pain for whom they cannot provide a service.

In addition, the Hospital provides an out of hours emergency service for the public and general hospitals accessed by telephoning the Hospital switchboard. This service operates until 01.00 hours and includes all day Saturdays, Sundays and Bank Holidays. Hospital staff are present in the Hospital for 2 hours every evening and for 3 hours every Saturday and Sunday to deal with emergencies. A review is currently taking place of the after hours service to determine whether it is necessary to continue with an after hours on site service during week days.

Hospital consultants are also on call from 01.00 hours until 09.00 hours each night to deal with emergencies from general hospitals with which the Dental Hospital has a service arrangement.

Last year 9507 emergency treatments were provided.

General Dental Services

As a training centre the Hospital provides primary dental care to a cohort of patients who are treated by students under supervision, so that they can gain the requisite clinical experiences for the recognition of their courses. The students are required to gain experience across the full range of services provided by general practitioners in public and private practice.

Patients are sourced from a range of places including self-referral, the emergency service, referral from public and private practitioners who regard patients as being suitable for treatment in the Hospital, for social or economic reasons. Patients are assessed by staff as to their compatibility with student training needs and then assigned to student clinics.

Specialist Services

The Hospital acts as a national resource for health board and general practice dentists for the referral of patients who require specialist treatments which dentists cannot provide. The principal referral specialities are:

Oral Medicine, Oral Pathology and Oral Radiology where the Hospital is the only reference centre in the country.

Orthodontics. Last year 11,304 treatments were provided.
Oral Surgery, covering maxillo-facial trauma, intermediate surgery and minor oral surgery. Last year 7,197 treatments were provided.

Restorative Dentistry, where the major treatment disciplines are fixed prosthodontics, removable prosthodontics, endodontics, full dentures, crowns, implants, occlusion, periodontology and general restorative treatments. Last year 20,067 treatments were provided.

Paediatric Dentistry. Last year 4,896 treatments were provided.

X-Ray Services. Last year 21,578 x-rays were provided.

The Hospital's X-Ray department has 2.5 full time equivalent radiographers who provide services for the Hospital's patients and for patients referred from other hospitals and dental practitioners for x-rays.

Laboratory Services

The Hospital operates an Oral Mycology laboratory and provides services as follows:

- Consultant and clinical diagnostic microbiology service for infectious fungi and yeasts to the Hospital's Clinics, the Prison Service, the National Haemophilic Centre at St. James's Hospital, and for clinicians in general practice. The laboratory comprises the only such dedicated mycology laboratory in the country.

- Antifungal drug susceptibility testing service for oral yeast species.

- Sterility testing service for Dental Hospital, Prison Service and St. Mary's Hospital Dental Theatre autoclaves.

- International reference and referral centre for clinical isolates of the recently identified pathogenic yeast species Candida dubliniensis, which was discovered by Dental Hospital researchers in 1995. The laboratory now receives a large volume of isolates for investigation each year from clinical laboratories all over the world.

- The laboratory also provides a unique molecular epidemiological service for investigating recurrent oral fungal infections.

The Hospital's Oral Pathologist operates in both the School and Hospital and the Central Pathology Laboratory (CPL) in St. James's Hospital. All oral pathology specimens are processed through the CPL.

External Services

The School and Hospital has service agreements with a range of agencies to provide specialist care services. These services play an important role in specialist/consultant training programmes as well as delivering specialist care for patients.
Mater Hospital:

The School and Hospital provides a maxillo-facial surgery unit at the Mater for the management of acute facial trauma, orthognathic (including TMJ) surgery and minor oral surgery.

St Vincent’s Hospital:

The School and Hospital provides a consultant service for 2 sessions a week for inpatient consultations to the liver transplant, cardiac, haematology and respiration units of St. Vincent’s Hospital.

St Luke’s Hospital:

The School and Hospital provides oral care services for patients from St. Luke’s Hospital undergoing radiotherapy treatment.

St Mary’s Hospital:

The Hospital undertakes 5 theatre sessions each week for general anaesthetic and LA sedation cases in Oral Surgery.

St Columcille’s Hospital:

A weekly theatre session is scheduled for the treatment of disabled patients and to undertake dental implant surgery. Very few of the scheduled sessions can be held because of the unavailability of beds. Where possible patients have been treated as day surgery cases in the Dental Hospital.

Hume Street:

One consultant session each week is provided for a joint clinic in Hume Street for patients with skin and oral mucosal pathologies.

Tallaght Hospital:

Two consultant sessions per week are provided for the treatment of children with bleeding disorders in the National Paediatric Haemophilia Centre and for children who are candidates for bone marrow and heart/lung transplants.

St James’s Hospital:

A full dental service is provided by a consultant, house officer and dental nurse, for two sessions each week to the Haematology Department, which includes the Oncology and Bone Marrow Treatment Units and the National Haemophilia Centre.

One consultant session each week of Oral health care service is provided to the GUM clinic for care of patients with oral complications associated with HIV infection and sexually transmitted diseases.

Our Lady’s Hospital for Sick Children, Crumlin:

The Hospital shares a paediatric consultant with Crumlin, together with non consultant dentists and dental nurses.
Prison Service:

A full oral/dental trauma service to Mountjoy Gaol, St Patrick's Training Unit, Arbour Hill Prison and Wheatfield Prison. This service is funded by the Department of Justice, Equality and Law Reform and provides for 19 clinical sessions each week.

Voluntary Health Insurance Board:

For the past 10 years the Dental Hospital has provided an advisory service to the VHI in respect of oral/dental surgery claims. This has had a significant influence in directing benefits towards more efficacious treatments. When first introduced this process reversed an escalating increase in oral/dental claims, the containment of which has been maintained since with significant cost savings to the VHI.

BUPA

An advisory service, similar to that provided for VHI, is provided for BUPA.

Emergency Services:

A 24 hour, 7 day on-call service for emergencies involving pain, bleeding, trauma and serious oral/dental infections is provided to Mater, St. Vincent's, St. Lukes, St. Columbille's, Our Lady's Hospitals and to the Prison Service.
Specialist Orthodontic Teaching

Since the School & Hospital commenced orthodontic postgraduate training in 1989, we have graduated 14 specialist orthodontists and at the same time provided training for 7 orthodontists to consultant level.

There are currently 10 orthodontic postgraduate students in the School. This year we unsuccessfully advertised for the recruitment of a senior registrar to commence consultant training.

The Joint Committee should note that this is a high output of orthodontic specialists and consultants given the staff and resources available in comparison with Schools in other countries.

1989-1999

The School & Hospital commenced the training of specialist orthodontists in October 1989. We recognised the future need for specialists and the increasing pressure which was evident in demand for orthodontic treatment in the public service.

The Joint Committee will be aware that in 1989 the Dental Hospital was in a building which was condemned by the Dublin Fire Service and there was no prospect of a new building in sight. At the same time, the School had to ensure that whatever programmes it offered met with accepted international standards, particularly as graduates of the specialist orthodontic course would have an automatic right to register as specialists in other EU countries under European law. The European Erasmus guidelines provide for orthodontic specialists to be in full time training with an academic institution for at least three years. The recognised training bodies here are the University of Dublin, University College Cork and the Royal College of Surgeons.

The University requires that all courses are externally examined as part of its quality assurance and improvement programme. In addition, the School and Hospital sought approval of its course from the Specialist Advisory Committee of the Joint Committee for Higher Training in Dentistry of the Royal College of Surgeons.

The Specialist Advisory Committee (SAC) guidelines limited the number of orthodontic postgraduates who could be accommodated within the Dental School so as to ensure adequate and appropriate training.

Because of a shortage of consultant staff both in the Dental School and in the Health Boards during the period 1989-1999, the School & Hospital was only able to graduate 10 orthodontic specialists and train 5 specialists to consultant level.

1999-2004

In 1998 the Department of Health & Children, arising from the Moran Report and its consideration of the establishment of a specialist register in Orthodontics, requested the SAC to visit training facilities in the country. The SAC Report, published in 1999, permitted an increase in the number of trainees from a maximum of 6 at any one time to a maximum of 10 or 12 (depending on the involvement of the Regional Orthodontic Units).
At the time of the SAC visit in 1999 we had discussions with the Eastern and Western Health Boards to involve their regional consultant orthodontists in postgraduate training so as to widen the training base. Agreement was reached with the Western Health Board and two of their staff commenced our orthodontic postgraduate programme in October 1999. Two other students also commenced training that year.

When new consultants were appointed in the Eastern Regional Health Authority in 2000, it was possible to agree a training programme for 4 orthodontic postgraduates in the School working with Dr. Brian Bourke and Dr. Marielle Blake. In addition, working with Dr. Jane Davis in the South Eastern Health Board and Dr. Pat McSherry in the North Eastern Health Board, it was possible to accommodate a further 2 postgraduates.

There are currently 4 postgraduates in training who will graduate in 2002 and a further 6 who will graduate in 2004. For the next ten years, given the current training approval and resources, we anticipate being able to graduate a further 20-30 specialists.

Since the introduction of the Specialist Register in Orthodontics, the responsibility for recommending approval of specialist training programmes has shifted from the SAC to the Dental Council through the Irish Committee for Specialist Training in Dentistry. That Committee has just appointed a Director of Specialist Training and will be in a position to revisit training centres in the next couple of years. Although this may alter the approval for numbers in training, it is unlikely to move very far beyond the existing guidelines, which fall within international norms.

The Dental School & Hospital will co-operate fully with that Committee insofar as we have the staffing and resources.

Training Impediments

The Committee should be advised that training is critically dependent on the number of consultant staff in the Schools and in the regional units. I would like to pay tribute to all those involved in our postgraduate programme, particularly my colleagues present, Dr. Garvey and Dr. Dowling, and Drs B. Bourke, M. Blake, N. McGuinness, J. Davis and P. McSherry in the regional orthodontic units and also Professor Lagerstrom who continues to provide some teaching support. Our staff are, however, under pressure to maintain the standard and quality of the specialist postgraduate programmes whilst at the same time providing undergraduate teaching primarily to dental students and also to dental hygienists and dental nurses.

Members of the Committee will, I am sure, be aware that it is extremely difficult to recruit dental nurses in Dublin and virtually impossible to recruit radiographers. This places serious difficulties in the way of maintaining teaching and service and is affecting our ability to provide the range of training and care we would wish.

The present teaching and seminar space is inadequate for our existing postgraduate specialist trainees in the various disciplines and causes concern with respect to increasing numbers further. A request has been made to the Department of Health & Children recently to purchase adjoining buildings to accommodate and expand our postgraduates training facilities. (The Committee's support for this would be very welcome)
Future Training

Existing Resources

Given existing staffing and facilities and with the active involvement of the regional consultant orthodontists it will be possible for the School to train 10-12 specialists at any one time provided dental nursing staffing, radiographer staffing and physical facilities be improved.

In addition we are also very anxious to train additional consultants to meet present and future needs and we expect to have a number of applicants in 2002.

We are also keen to train the proposed dental auxiliary therapists proposed by the Dental Council at the request of the Minister for Health & Children.

We would like to take this opportunity to thank the Department of Health & Children, in particular Mr. Tom Mooney and Dr. Gerard Gavin for all their assistance.

Additional Resources

With additional resources, including a full time consultant orthodontist, dental nurses, radiographer, patient manager and space together with the vital involvement of our regional consultant colleagues, it would be possible to increase the number of postgraduates, consultants and therapists in training.

If we are to meet the level of demand for orthodontic services in the public sector, it will require the active participation of regional orthodontic units with both schools to make in roads on the projected manpower requirements.

As a School and Hospital, we continue to play our part in achieving that objective in so far as our resources permit, bearing in mind that orthodontics is one of the range of dental specialties for which we need to provide.
Presentation by the Cork Dental School and Hospital to the Joint Oireachtas Committee on Health and Children

6th December 2001

Thank you Chairman and members of the committee for your invitation to make a presentation to you on the provision of orthodontic services in Ireland. Our presentation today will clarify the role of the Cork Dental School and Hospital in dental education and training, at both undergraduate and postgraduate level, and I hope that it will be of assistance to you in your deliberations.

Status and Function of Cork Dental School and Hospital

The Cork University Dental School and Hospital evolved from the original dental hospital that had been established in 1913 by the North Charitable Infirmary. In 1968, University College Cork took over the administration and control of the dental hospital and a new Dental School and Hospital, built on a site adjacent to the Cork University Hospital in Wilton, was opened in 1982. The facility functions primarily as a teaching institution under the direction of University College Cork and it receives approximately 75 per cent of its funding from the Department of Education and Science. Teaching is delivered to students of dentistry, dental hygiene and dental nursing and approximately 150 students are enrolled at any one time.
Undergraduate Training

The Cork Dental School and Hospital provides undergraduate dental education and training leading to the award of the degree of Bachelor of Dental Surgery by the National University of Ireland. This is one of the two qualifications awarded in the State that confer entitlement to registration in the Register of Dentists and the subsequent right to practise dentistry here. The main function of the Dental School and Hospital is to provide education and training to students of dentistry so that on graduation they have the requisite knowledge and competence to provide treatment at primary care level and the diagnostic skills to refer patients for specialist treatment. In order to train undergraduates to this level, both primary and specialist dental care must be provided within the school and hospital and to this end staff and students provide a wide range of dental treatments for patients from the Southern, South Eastern and Mid Western Health Board areas.

Specialist Services currently provided to Health Boards

The senior staff of Cork Dental School and Hospital is comprised of specialists in paediatric dentistry, oral and maxillofacial surgery, oral surgery, restorative dentistry and orthodontics. These staff, in addition to their academic duties, provide an important consultant service within their areas of specialisation. An example of this service is the treatment of orthognathic surgical cases in the region. This means that all patients with orthodontic problems requiring surgical intervention, for example patients whose jaws need to be repositioned, can have their treatment provided by consultant staff of the Dental School and Hospital.
Specialist Training

A secondary, but very important, function of the Cork Dental School and Hospital is to provide post-graduate clinical training to specialist and consultant level. Prior to the development of the Health Board orthodontic services and laterally the setting up of the Register of Dental Specialists, postgraduate clinical training in orthodontics was provided largely on a demand basis. The bulk of orthodontic treatment was provided through private practices and dentists sought training with a view to setting up such practices.

Specialist training was overseen by the UK based Joint Committee for Specialist Training in Dentistry but this function is now the responsibility of the Irish Committee for Specialist Training in Dentistry.

One of the current requirements for specialist training programmes is that trainees are supervised and trained by at least two consultants. At present the Dental School and Hospital employs just one consultant in orthodontics and consequently cannot at this time apply for recognition of a training programme.

Senior academic consultant orthodontic staff are in short supply worldwide and a number of efforts by the School to recruit staff at this level in the recent past have unfortunately proved to be unsuccessful.

In 1998 the Dental School offered an appointment as a visiting professor of orthodontics to a orthodontist from New Zealand. However, due to personal reasons, he unfortunately could not take up the appointment and our proposals to commence a programme of specialist training in the discipline had to be abandoned.
In 1999 an application to the Department of Health and Children for assistance with the funding of a permanent Professorship in Orthodontics was approved and the post was advertised. There were two applicants but neither was deemed to suitable for appointment at this level. The post has again been advertised this year and interviews are scheduled to take place in mid February. From the number of inquiries made to date I am confident that the post will be filled in 2002 and we should be in a position to re-commence specialist training in orthodontics before the end of the year.

Facilities and Funding

Training to specialist or consultant level involves the acquisition of diagnostic and clinical skills as well as the gaining of experience in research and audit. It is important that future directors of the delivery of health care are not alone fully experienced in all aspects of their own specialty but also knowledgeable about related specialties. They must work closely with other specialties within dentistry and medicine, and such a facility is available in a multidisciplinary dental school sited next to a major general hospital. The Department of Health and Children acknowledged that other requirements, such as clinical and computing facilities were required for postgraduate learning and in 1999 provided the necessary funding to have these put in place.
Plans for 2002

The Cork Dental School and Hospital understands and accepts its remit to provide specialist training. The Dental School would welcome the opportunity of working closely with the local health board in the development of specialist training in orthodontics. The Dental School is currently unable to provide appropriate training in orthodontics because it does not have a second orthodontic consultant in post.

In 2002 the Cork Dental School and Hospital expects to:

- Employ a specialist orthodontist.
- Appoint a Professor of Orthodontics.
- Begin a specialist training programme for 2-4 orthodontic trainees.
- With co-operation from Regional Consultants, and with the approval of the ICSTD, the number of trainees could increase to perhaps 6-8 per annum commencing in 2003.
Presentation to Joint Oireachtas Committee on Health and Children regarding Public Health Orthodontics 24/1/02
Ian O’Dowling, Consultant Orthodontist.

Good morning

The National Orthodontic Service is disintegrating. The waiting lists for treatment are increasing, the waiting time for orthodontic treatment, that is the time from being placed on the list and receiving treatment has increased to such an extent that some patients now require surgery in order to achieve the same standard of result that could have been achieved if they were treated at an earlier age. We find ourselves in this position because of the incompetence of the Department of Health and Children and the greed of the Dental Schools of Cork and Dublin. There are four problems facing the service: -

2. Treatment of Patients.
3. Training.
4. The after effects of the SAC visit in 1999.

Determination of Eligibility for treatment
In 1985 the Department of Health issued guidelines based on the severity of a child’s problem. The guidelines are vague and the Moran Report, which looked at the future development of orthodontic services, recommended a specific index, the IOTN. This recommendation has not been implemented by the Department and in June 2000 and October 2001; two further sets of guidelines were issued by the Department. There is now such confusion, that as Consultant I do not know what guidelines are to be used when assessing children to determine their eligibility for treatment. The recent guidelines issued by the Department are so severe that I firmly believe Children will be damaged by exclusion from the service if I am forced to implement them.

Treatment of Patients
The only way we can significantly increase the number of patients under treatment, is to employ more staff: -

* Consultants
* Specialist Orthodontist
* Non-Specialist Dental Surgeons
* Private Orthodontists
* Axillaries
Due to the lack of trained personnel our ability to attract Consultants or Specialist Orthodontists to the service are extremely limited. The vast majority of treatment is provided by non-specialist Dental Surgeons trained by the Consultants. The Private Orthodontist's where I work are unwilling to accept patients from the boards existing waiting lists. Orthodontic Therapists will not reduce waiting lists.

Training
The future of the service depends on our ability to train our staff to become Specialists in orthodontics. In most Countries it is recognised that training programmes are organised through Dental Schools. We have two Schools in this State, one in Dublin, one in Cork. The school in Dublin is the only school within the state recognised for post-graduate training in Orthodontics. It has been particularly unhelpful in developing training programmes for those working within the public health system and contrary to statements made by John Clarkson, is specifically unwilling to accept trainees from Cork. The school in Cork lost its recognition in 1996 and despite the appointment of a new Dean has been unable to regain its recognition. The letter of 1999, whereby the Consultant Orthodontist within the school stated that they were ready willing and able to provide post-graduate training for my staff was particularly unacceptable. In 1999, fed up at the lack of support from the Dental Schools, the Regional Consultants set a post-graduate training programme of their own. This training programme was due to be assessed in 1999 by an SAC visitation from the Royal College of Surgeons in London. Recognition of a training programme is necessary if one is to be allowed sit the specialist examination of membership of Orthodontics of one of the Royal Colleges. At the request of the Department and through the interference of the Dental Schools the training programme was refused recognition and collapsed in May '99.

The after effects of the SAC visit in 1999
A. Effect on Staff.
- Resignation of Staff
- Dissatisfaction with status, job description etc.
- Reduction in numbers of new patients commencing treatment
B. The Attempted removal of certain Consultants.

Since 1999 the public orthodontic service has been very much under the control of the Dental Schools and the Department. You will have heard John Clarkson and Robert McConnell refer to three specific Consultants. It is almost as if the Dental Schools have targeted three particular Consultants as being in some way unsupportive of their actions. We know that Triona McNamara was harassed and bullied by management within the Eastern Health Board, and that she was prevented from doing her job properly. We know that complaints to senior management and indeed to the Minister were a waste of time. It is clear that an attempt was made to force the resignation of Triona McNamara as Consultant to the Eastern Health Board.

C. Appointment of Pro-Dental Hospital Consultants.

When the LAC interviewed for further Consultant posts in the Eastern Health Board, astonishingly Triona McNamara was not on the interview board. However both Consultants on the board represented the Dublin Dental School. Clearly the Dublin Dental School was now in a position to provide a strangle hold on Consultant appointments in the Eastern Health Board.

Solutions

1. Guidelines.

There is a simple solution to the problems regarding guidelines. If the Consultants working within the Service could meet with the Minister for Health and his officials in the Department then very quickly consensus can be agreed on what guidelines are to be used. This will mean that the same set of criteria interpreted in the same manner is used in all health boards. However, I do not believe that the presence of the Chief Dental Officer would not be conducive to getting agreement.

2. Training

The issue regarding training is more complex. However if the Minister uses the EU directives, then he can decide what training programmes are recognised, if for example this afternoon he writes to the CEO's of all the Health Boards advising them to contact teaching institutions in the U.K and Northern Ireland, then I believe that training programmes can be set up. In
the mean time the Dublin School can reassess its commitment towards training and the school in Cork need not be forced into appointing unacceptable candidates to the post of Professor of Orthodontics.

There are problems and there are solutions, but unless the Department change and discover the courage to support the Public Health Service in contrast to supporting two Dental Schools, then there will not be solutions to the problems.

Thank you,

Southern Health Board Orthodontic Service Jan '01-Dec '01

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Regional Orthodontic Department,  
St. James's Hospital,  
Dublin 8.

Joint Oireachtas Committee on Health and Children  
January 24th, 2002

Oral Submission

Orthodontic Services Nationally.

Summary:

• It is possible to deliver a good quality cost effective orthodontic service.
• It has been done and it can be done again.
• It is recognised by everyone that money is not the problem.
• There is a solution. It is simple and has no cost implications.

Recommendation and Solution:

• That orthodontic services, within the Department of Health, are moved from the Community Care section to the Hospital Care section.

Triona McNamara  
Consultant Orthodontist
Background:

The Department of Health’s policy is that orthodontic services are consultant-led.

The Department achieved much success with this policy from 1985 to 1999, when it gave into pressure groups and created the current crisis.

During this 14-year period improvements occurred in orthodontic services, nationally, every year.

- The number of children getting quality orthodontic treatment with fixed appliances increased.
- Waiting lists and waiting times improved every year.
- Health Boards recruited consultants, orthodontic units were built, staff were trained.
- At the same time as staff were trained, they were willing to deal with orthodontic waiting lists in an effective and efficient manner, resulting in thousands of children getting treatment throughout the country.
- Satellite orthodontic services were created in order to improve local access for patients.
- Public money began to be spent more efficiently and the squandering of public money on orthodontics, which was appalling in some Health Boards, was on the decline.
- While not ideal there was general recognition that orthodontic services were improving nationally, and that the system was fair.

Problems did exist, much more needed to be done but in the overall context we were going in the right direction, nationally, with orthodontic services.
Consultant-led services were introduced by the Department of Health to replace specialist orthodontists' services, which they recognised as having failed.

- There is nothing 'new' about specialist orthodontists' services.
- The claim by the Department, that the specialist orthodontists' services per se will solve our problems is wrong.
- There is nothing 'new' about the current training programme.
- This type of training programme has failed us in the past nationally and will fail us again.
- In reality it prevents patients' services.
- It ensures the thousands of children we could be treating now will not get treatment over the next five years.
- Most significantly it removes our only mechanism of dealing with our large waiting lists and it will delay recovery, to what we had back in 1999, by 15 to 20 years.
- There is nothing 'new' about the suggestion of sending patients into the private sector.
- All these so-called 'new' systems have been tried by the Department in the past and have failed us and there is evidence everywhere that they will fail us again.
- My colleagues and I welcome the introduction of orthodontic auxiliaries, but are alarmed at the lack of understanding by the Department of their needs.
- Should auxiliaries, as it appears, be introduced in the same unstructured way as has befallen clinicians, even more chaos is inevitable.
- The Department’s suggestion that the specialist register might help is wrong.
- This register restricts orthodontic practice.
Track Record with Orthodontic Services:

Personally I have provided quality efficient orthodontic services in both the Western Health Board and Eastern Health Board when supported by the Department of Health. (1992-1999)

Western Health Board & Eastern Health Board: 1992 - 1999

For the Western Health Board, I reduced waiting times from over 6 years to 2 years. I trained four dentists and supervised a workload of over 3,000 patients in fixed appliances annually. I established and ran a central unit in Merlin Park Hospital, Galway and satellite services in Castlebar, Roscommon, Claremorris, with review clinics in Clifden and Ballina.

With the support of University College Galway, I succeeded in having the Medical Faculty open up their Masters’ of Medical Science programme, which was then restricted to medical graduates only.

Not alone is this postgraduate programme now open to dentists but it is also open to pharmacists and other medically related post-graduates.

I began work for the Eastern Health Board in 1996. Within 2 years I reduced waiting lists from over 18,000 to 6,600 and at a time when the annual referral rate onto these lists was 2,000 patients.

All Category I lists were dealt with and I established a successful system whereby all Category I patients for the Region were seen immediately and started treatment within six weeks of their assessment. I reduced waiting times for Category II patients by 3.5 years and provided assessment services to all Category III patients. I trained 8 dentists and had over 4,000 patients in fixed appliance treatment.

As well as establishing the central orthodontic service in St. James’s, I established and ran satellite services for patients in Wicklow town, Ballineer, Coolock, Wellmount and Ballygal in Finglas, Roselawn, Kilbarrack, Larkhill, Crumlin, Athy, Naas and Newbridge.

As in the Western Health Board, my staff and I interacted with our community dental colleagues and held calibration clinics to help referring dentists who put patients on lists.
The service was not without difficulties. Problems existed but in the overall context the service worked well. I saw the achievements as a good start that could be built upon in the Region.

When the consultant-led service was supported everyone was a winner: the Department of Health, the community, management, the trainees, myself. It was a very happy and productive time in the E.H.B., just as it had been in the W.I.B. It was also fair to everyone.

Support staff were very much part of this successful process. Nurses, radiographers, clerical staff, all, were provided with opportunities for training and staff development. Nurses I trained have gone on to do formal MSc's and one was the first Irish orthodontic nurse to obtain a prize at a British Orthodontic Conference.

All staff, both clinical and non-clinical, were encouraged to attended courses and conferences. In addition I guided clinical staff to do some research work and they published and presented material at Scientific Conferences both nationally and internationally.

At no extra cost management and the Department of Health got a fine quality service for thousands of patients in the E.H.B./ERHA Region. At the same time as services were provided, my trainees received expert skills and the opportunity to develop their careers and increase their earning capacity. The trainees also benefited since it can cost over £200,000 to obtain orthodontic training and qualification. As consultant I benefited by being involved in training and interacting with young, keen, motivated dentists.

The Department of Health abandoned its successful policy in 1999. This 'political whim' has caused chaos and confusion for everyone: patients, parents, politicians, managers, and consultants alike. It has also caused tremendous unfairness to be re-introduced for everyone.

All the systems that had been tried and failed in the past are now re-introduced; training with no service commitment, fee-per-item. The unaccountable specialist services that had been eliminated, in every Health Board but the E.R.H.A., are now being re-introduced nation-wide.
Despite all the extra money, extra consultants, extra specialists, extra managers, extra money to the private sector, extra trainees, etc. etc. fewer children are getting orthodontic treatment now throughout the country, than back in 1999.

Conclusions:

* Change is needed within the Department of Health. All the difficulties experienced by orthodontics can be traced back to the Department of Health.

* The first breakthrough for orthodontic services happened back in the 1980’s, when regionally, orthodontics in Health Boards was separated and moved from the community care programme to the Hospital programme.

* The Department of Health is the only place where this separation has not taken place.

* It is time to complete this process and separate orthodontics from the Community section of the Department of Health and move it to the Hospital section.

Thank you for giving me the opportunity to make this presentation. I wish you success in bringing normality back to orthodontics.

Triona McNamara
Consultant Orthodontist
I wish to state I am here in a personal capacity and not representing the Western Health Board.

I have been working with the Western Health Board for twenty-four years. I am Principal Dental Surgeon in Mayo. I have always been interested in orthodontics and from 1993 have been actively involved with the Regional Orthodontic Department in Galway. My clinical time is confined to orthodontics. In 1998 I was awarded a Master of Medical Science on a study of the orthodontic and other dental needs of cleft lip and palate children in the West of Ireland.

Until 1993 there were basically no orthodontic services in the Western Health Board except what was undertaken by individual dentists in primary care. They did their best, but a lot of cases were too severe to be treated with removable appliances. Children in the West with extreme and handicapping malocclusions were placed on a large orthodontic waiting list. From this in the fullness of time (approximately six years), if they were lucky they might receive treatment through the private sector on a fee per item basis, but only if the Board had funds available and the private practitioner could facilitate the patient within his practice. It was an ad hoc unsatisfactory arrangement.

One of my first duties after taking over as principal dental surgeon in December 1989 was to review our orthodontic waiting list in Mayo and ensure the children on it fulfilled the Department of Health 1985 eligibility criteria. In Mayo we had upwards of a thousand children on our waiting list and the waiting time for treatment was almost six years, but in reality a significant proportion of these children never received orthodontic treatment.

In November 1992 Dr. Triona McNamara was appointed consultant orthodontist to the Western Health Board and she set about setting up and developing a Regional Orthodontic Service for the three counties Mayo, Galway and Roscommon. She used the same model as the MidWestern Health Board, which was devised and developed by her brother Mr. Ted McNamara. I am not aware that it has ever been acknowledged that Mr. Ted McNamara stands alone in his service to public orthodontics and orthodontic education. It was he who conceptualised and worked tirelessly to establish consultant led Regional Orthodontic Departments for the purpose of providing a top quality highly productive and efficient service to public patients. He is also exceptionally well qualified and is the only Irish graduate ever to be appointed Senior Registrar at the world-renowned Eastman Dental Institute in London. In the field of education he has been equally generous, having trained or assisted in the training of most of the consultant fraternity and many of the specialists trained in this country. All this was achieved while still continuing to deliver a first class public orthodontic service.
The very fine Regional Orthodontic Department in Galway was officially opened in 1994. The effect on the service in the region was revolutionary. Waiting time for treatment dropped significantly and a highly productive efficient service of the highest quality was provided. In the years 1994 to 1996, a total of 4,355 children started treatment. The high quality of this treatment was confirmed by independent audit (Burden et al, Belfast 1997). At the time of her departure in June 1996 waiting time for treatment was at two years and heading for eighteen months. Mr. William Moran, the then General Manager for Galway Regional Hospitals wrote of Dr. McNamara: "You have developed a service which is the envy of all and you have moulded a most dedicated, skilled and enthusiastic team". He further wrote "It has been a great pleasure for myself and all in the Management Team to have worked with you and experienced the quality of work which you have achieved".

The fine fully functional department with a highly trained and committed staff worked to a new consultant from 1997. The department continued to function satisfactorily until towards the end of 1999. Then problems began to arise. Children in the West with severe malocclusions who were deserving of treatment and who would have been deemed eligible for treatment prior to 1999 were now being denied treatment. The waiting time for treatment also began to increase and now stands at over four years.

This has caused immense distress for children and parents and also for colleagues like myself who have been involved in providing orthodontic treatment in the region in times when chronic lack of funding was the problem. It is inexplicable in these times of unprecedented prosperity that children in the West of Ireland are finding it harder to receive essential orthodontic treatment.

The disintegration and collapse of the fine orthodontic service we had has been very difficult to witness. As previously stated I have been twenty-four years with the Western Health Board and have seen a range of efforts to deal with orthodontics. I have experienced the private fee per item. It is not cost effective for a Health Board. An independent analysis of the cost of the two systems was carried out in the Western Health Board. For every one child treated in the private sector up to three children could be treated through the consultant led service we had. The consultant led service has been without doubt the most effective, when not interfered with.

In conclusion, the West, for the first time had a fine top quality regional orthodontic service for children. The West has been marginalised enough. It is wrong that genuinely deserving children in the West of Ireland are being unfairly denied essential orthodontic treatment because of politicking by powerful lobbies in Dublin. I am disappointed that the Department of Health allowed this happen.

Signed: Antonia R. Hewson, Principal Dental Surgeon.
PRESENTATION BY
THE ORTHODONTIC SOCIETY OF IRELAND
TO
THE JOINT OIREACHTAS COMMITTEE ON HEALTH AND CHILDREN

24TH JANUARY 2002
INTRODUCTION

The Orthodontic Society of Ireland is the only professional body which represents Irish orthodontists in all areas of clinical practice – academic and regional consultants, specialists in private practice and the public service, and graduate students on formal training pathways. The OSI is affiliated to the World Federation of Orthodontists and is a member of the society of the European Federation of Orthodontic Specialist Associations. The OSI organises continuing professional development for its members by way of lectures courses which attract the world’s most eminent speakers to its scientific meetings.

It is an inclusive clinical and scientific society whose membership includes over 90% of registered specialists in Ireland. Across the whole spectrum of our membership, there is support for the co-ordinated, planned development of orthodontic services to deliver high quality treatment in an equitable and affordable system. The OSI endorses the current policy of the Department of Health and Children, with regard to the consultant-led delivery of service and the training of specialist personnel.

Orthodontics is the branch of dentistry concerned with the growth and development of the face and jaws, and the diagnosis and treatment of occlusal anomalies. Orthodontic treatment is a highly sophisticated health care service which results in excellent treatment of malocclusion and facial deformity, based on the premise that treatment is provided by well educated, skilled, and experienced specialists.

Orthodontics is a recognized specialist branch of dentistry as defined by European Directive 78/687, in accordance with which the Dental Council in Ireland holds the Register of Specialists (Orthodontics). Registration depends on successful completion of approved training courses in academic institutions, which comply with international guidelines and are subject to approval by The Irish Committee for Specialist Training in Dentistry (ICSTD). Arising from the European Directive, the Erasmus Project has outlined strict criteria for a 3-year university-based postgraduate academic and clinical
training, entry to which must be by open competition between applicants who have achieved the basic entry requirements. Under EU law, graduates of such courses have automatic right of specialist registration in other EU countries.

The OSI fully endorses a planned programme of training under the auspices of the ICSTD. “Training” courses which do not meet the Erasmus regulations or receive ICSTD approval cannot result in specialist status or registration, and have no place in the future development of orthodontic services in Ireland. “Great harm can be done by incompetent orthodontic treatment” (Houston, Tully and Stephens) and it is no longer acceptable for children in the public sector to receive compromised orthodontic treatment.

The Dental Protection Society in a recent publication to members, ‘Riskwise Ireland’, advised that dentolegal problems are more likely to arise where a general dental practitioner with no formal training in orthodontics is undertaking the treatment.

CURRENT DELIVERY OF SERVICE: History of service and current problems

Current problems arise due to the inability of the hospital orthodontic service to meet the extraordinary demand for orthodontics from the increasingly dentally aware population of this well developed Western society.

No society has ever successfully delivered high quality free orthodontic treatment on demand, and in Ireland, the hospital service has signally failed to do so. The service, as structured, was doomed to fail since the problem of inexhaustible demand was compounded by both the limitations on productivity and the high costs inherent in the system.

There has been no universal system for the delivery of orthodontic treatment in the public sector but, as demand for orthodontic treatment increased, there was an ad hoc response in a localized and fragmented way. Following the appointment of the first Regional
Consultant in 1985, a model of service delivery was adopted based on consultant supervision of public service dentists. This arose in circumstances where manpower constraints were severe, but it has been adhered to since, and expanded to apply to many Health Boards in the country, in spite of increased availability of specialist manpower in both the private and public sectors. It was adopted as the preferred model in the then EHB region as lately as 1996, with the recruitment of general dentists from the community service to the newly established Regional Unit, despite the fact that qualified specialist orthodontists who were then in full time salaried employment of the EHB were excluded from the Unit.

This model of consultant-led and dentist-delivered service had the following deficiencies

Low Productivity:

Since key clinical decisions must be made by the competent clinician, in this case the consultant, the productivity of this one individual limits the productivity of the whole system. Productivity is further reduced where consultants avail of their contractual entitlement to fulfill their public service hours in four working days per week. It might be noted also that the entire functioning of the system depends on a single individual, as was demonstrated recently with catastrophic results in the ERHA.

Consultants' clinical time is necessarily further reduced due to their commitments in other areas—administration, assessment clinics, research/audit and teaching. Indeed, the planned development of a graduate training programme within Health Boards will further reduce the amount of consultant time available for service supervision.

Although exact figures are not available to this Society, a review of the published statistics from Health Board Annual reports, seems to confirm the fact that productivity of the system is low. The published national figures for the productivity of the public orthodontic service shows that total annual completed treatments do not exceed 5000 and this is despite a massive programme of capital spending to establish new treatment units,
and expenditure on pay and non-pay budgets which is high relative to all other dental budget spending.

Specifically, for instance, in 1998, the Regional Orthodontic Department in the Eastern region, which was established in 1996 with a clinical staff of 7, reported:

<table>
<thead>
<tr>
<th>Finished cases</th>
<th>289 (41 per staff)</th>
</tr>
</thead>
</table>

This was in the year that the Moran Report based its assumptions on productivity within the system of 350-400 completed cases per practitioner per year.

**High Costs**

Salaries of dental staff properly reflect their professional training and qualifications but this model of service delivery under-utilises these clinical skills and essentially uses qualified professional staff in the role of auxiliaries.

These professionals are then lost to the understaffed general dental service where they would be a valuable resource in the delivery of both primary dental care and interceptive orthodontics. An effective secondary service depends on an efficient primary care service, with adequate monitoring of occlusal development, diagnosis of abnormalities, appropriate primary interventions and timely referrals to the hospital service. It was always entirely self-defeating to have a secondary service which acted as a drain on primary care professional staff.

Precise figures are not available to this Society, but we estimate that direct professional and non-professional salary costs alone would amount to over £800 per case, if productivity could be maintained at 200 completed cases per specialist annually.
This would seem to be confirmed also by the figures put forward to this Society by Mr. Michael Walsh, Assistant Chief Executive of the Northern Area Health Board, in our recent negotiations on the proposed public/private mix pilot scheme. The proposal to fund Medical Card Holders in the private sector with a grant of £2,000 was based on Board estimated costs per case in the St. James Hospital Unit of approximately £2,000.

In summary, the model of the hospital orthodontic service, consultant-led and dentist-delivered, although conceived as a mechanism for delivering high volume/low cost treatment has in fact proved to be the opposite. The system, since 1985, has been enormously and increasingly expensive and has failed to meet demand resulting in the current waiting list crises in most Health Board areas.

It is apparent that provision of service directly by registered specialists, with a full time clinical commitment, would allow for greatly increased productivity, by removing the dependence of the service on a single clinician whose other duties necessarily reduce his/her availability for clinical supervision. It is the position of the OSI that this system would also reduce total costs per case. Consideration should be given to the use of orthodontic auxiliaries to support the specialist staff, to further increase productivity.

DEMOGRAPHICS AND MANPOWER

Studies on manpower levels are relatively few and there is no recognized ideal orthodontist:population ratio. Extrapolation from the most recent published figures for Ireland suggests that there are currently 79 specialists eligible for specialist registration in Ireland. (Blake, Garvey and Healy, 2001)
The total number of orthodontists in the country has increased over the last twenty years so that the orthodontist:dentist ratio has almost doubled and the ratio of orthodontist:12 year olds has improved almost threefold.

### TABLE 1

**Orthodontic Specialist Manpower**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Sector</td>
<td>47</td>
</tr>
<tr>
<td>Public Sector</td>
<td>17</td>
</tr>
<tr>
<td>Regional Consultants</td>
<td>10</td>
</tr>
<tr>
<td>Academic Consultants</td>
<td>4</td>
</tr>
<tr>
<td>Tertiary Care Consultant</td>
<td>1</td>
</tr>
</tbody>
</table>

### TABLE 2

**Orthodontist : Dentist**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>No. Dentists</th>
<th>No. Orthodontists</th>
<th>RATIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>1033</td>
<td>22</td>
<td>1:47</td>
</tr>
<tr>
<td>1998</td>
<td>1713</td>
<td>69</td>
<td>1:25</td>
</tr>
</tbody>
</table>

### TABLE 3

**Orthodontist : 12-year old**

<table>
<thead>
<tr>
<th>Year</th>
<th>No of 12-year olds</th>
<th>No of orthodontists</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>61,004</td>
<td>22</td>
<td>1:2773</td>
</tr>
<tr>
<td>1998</td>
<td>61,425</td>
<td>69</td>
<td>1:8000</td>
</tr>
</tbody>
</table>
The age profile of Irish orthodontists is young with 60% having over 20 years to retirement. Studies suggest that natural wastage will require 29 replacement orthodontists to maintain the current orthodontist: 12-year old ratio over the next 20 years. Relative to other European countries, levels of orthodontic manpower in Ireland are quite high and the manpower ‘crisis’ is not one of absolute numbers but rather one of access, with uneven distribution between public and private sectors, and uneven spread geographically.

TRAINING

The Dublin Dental School is currently the only recognized centre for training of orthodontic specialists in Ireland. An approved programme of specialist training was established in 1989 by Dr Bryan Jones which produced 12 specialists and 5 consultants over the next twelve years, in circumstances of poor resources and low staffing levels. More recently, with the involvement of Regional Consultants from 5 Health Board areas, it has been possible to expand this programme so that 10 postgraduate students are currently in training. This programme which is capable of expansion in the coming years with the involvement of other regional consultants, particularly if funding is made available to expand the Cork Dental school facilities.

This is in marked contrast to the productivity of regional departments as ‘training units’ independent of the academic institutions in Ireland. Over the 17 years since the first centre was opened, only 5 specialists have been trained. Of the 10 graduate students currently in approved training, 8 are sponsored by Health Boards and are committed to the service for three years post-qualification. Of the 12 specialists trained prior to 2001, 7 were sponsored by Boards and are currently employed in the public sector.
The Orthodontic Society of Ireland supports the Dental School training pathways. However, it is important to realize that training is costly in terms of financing and time. It involves:

- Investment in the teaching facilities of the dental schools—academic and support staff
- Uptake of the limited clinical time of the available regional consultants
- Treatment facilities and supporting staff of regional units devoted to trainees and therefore lost to service production.
- Salaries of trainees for 6 years—3 training and 3 post qualification
- Low productivity during training

Training is incompatible with the simultaneous delivery of an efficient service and if trained specialists are not retained in the service, massive public expenditure will have been wasted without producing any benefit to the service whatever.

RECRUITMENT

Recruitment of trained specialists is obviously an attractive option since it removes the burden of training costs from the service.

There are currently 15 Irish postgraduate students training in UK/USA, some of whom may be expected to return to the state. Manpower studies in Britain suggest an overall shortage of orthodontists, so it is likely that most British trained specialists will find employment in UK. Recruitment from other European countries faces the problem that conditions of employment are generally less favourable in the Irish public sector than in European systems.

To date, there has been only limited success in recruiting trained specialists. Country wide, there have only ever been 10 specialists recruited to salaried dental service, 1 Irish, 4 UK, 2 US, and 3 European. Retention of recruited staff has been even more
unsuccessful with 4 of these specialists leaving the service after very brief periods, and only one of the remainder having taken up permanent employment with a Health Board.

The principal obstacle to the recruitment of specialists has been the absence of a grade of specialist, other than consultant, within the service. Retention was poor due to the lack of a career pathway and the relatively poor remuneration offered by Boards in a piecemeal way in different areas. The recent introduction of the specialist register has allowed progress to be made on the establishment of specialist grade, and negotiations have recently been completed with the HSE to agree the responsibilities, duties, terms and conditions of the post. The grade provides for a full time clinical commitment of staff trained to treat all cases, at a salary approximately 75% of that of the consultant. It is to be hoped that these developments will prove sufficient to attract specialists in the future.

It should be noted however, that although the post has been approved by the HSE, it has not yet been processed through the Department of Health and Children. The OSI would urge the Department to proceed forthwith with the establishment of these posts.

Orthodontics is a clinical discipline with a protracted treatment time and continuity of care with one practitioner is critical to the success of treatment. Retention of staff is crucial for both the standards and efficiency of the service.

TREATMENT NEED – Epidemiology of occlusion

Orthodontics involves the treatment of dental anomalies which arise in almost 100% of cases as a result of individual variation and not as a result of disease. The extent to which poor alignment can affect dental health has been extensively researched and it is established that it is only at the very extremes of normal variation that orthodontics confers any health or functional benefit. (Shaw et al 1981)

The majority of orthodontic treatment is carried out for aesthetic reasons, and the extent to which this carries psychosocial health benefits is also extensively researched. (Shaw et
Again, it is established that only extreme deviations from the norm carry any psychosocial handicap.

Thus treatment 'need' can be defined in terms of patients who will show a measurable health benefit from treatment, in contrast to 'demand' for treatment which is determined by a subjective desire for improved dental appearance, and is almost inexhaustible. Demand for treatment even when third party funded, is higher in higher socio-economic groups (Proffit and Fields, 2001), and may approach 60% of population where there is free access to services. International experience shows that demand for orthodontic treatment has the potential to overwhelm the capacity of any service to provide it, and that there would be minimal health benefit in establishing such a service.

It is necessary therefore to distinguish between need and demand, and much scientific research has led to the development of indices capable of identifying patients who will show a measurable health benefit from treatment - such as the IOTN (Shaw et al 1991) which incorporates both the functional and aesthetic components of treatment need. The OSI favours the use of an index such as IOTN in the public service, since it is internationally accepted as reliable and valid, is administratively simple to apply, and can be used with much greater objectivity than the current guidelines of the Department of Health and Children. Eligibility under current Department guidelines probably extends to around 18-20% of 12-year old population, or 10,000-12,000 eligible cases per year; expansion of the scheme to include all IOTN Categories 4 & 5 may extend eligibility to 30-35% of 12 year olds, or 18,000-20,000 cases per year. The actual uptake of treatments would be somewhat less. The cost to the state of providing orthodontic care to all patients in IOTN categories 4 and 5 would be in the region of £36,000,000.

In view of the limited health benefit to be gained from this level of service, and the costs involved, it may be appropriate to consider a rationalization of the eligibility criteria, to include an assessment of the patients' ability to pay. Such measures might require a review of the Health Act or the directive of 1985.
Structure of services

The OSI considers that successful planning of future orthodontic services must involve two separate approaches:

1. Long term strategic planning.

2. Management of the existing localized acute problems created by current regional waiting lists-waiting list initiatives

1. Long term strategic planning of services

This Society believes that the structure of the public orthodontic service should be planned to cater for the level of service it ultimately intends to deliver and that current waiting lists should be addressed by separate measures. Since there is no definitive clinical cut off point which determines a health or functional indication for treatment, the level to which free orthodontic treatment is to be provided is essentially a political or administrative decision.

Principal options for delivery of service are:

1. Exclusive provision of service within the salaried public service, which would require manpower based on productivity of 200 cases per year per specialist, or 300 per year where the specialist is supported by an auxiliary.

2. Partial provision of service within the private sector, possibly by the creation of a category of partial eligibility based on clinical criteria and/or ability to pay.

2. Management of current Situation:

The ongoing inability of the Hospital services to meet the demand for service has resulted in waiting lists in most Health Boards, with a total of 23,686 awaiting assessment and 11,995 awaiting treatment.
Table 4

Orthodontic Waiting lists (November 2001)

<table>
<thead>
<tr>
<th>Health Board Area</th>
<th>Awaiting Assessment</th>
<th>Awaiting Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>11,781</td>
<td>964</td>
</tr>
<tr>
<td>Southern</td>
<td>5,962</td>
<td>4,470</td>
</tr>
<tr>
<td>Midwest</td>
<td>3,380</td>
<td>1,392</td>
</tr>
<tr>
<td>Northwest</td>
<td>1,210</td>
<td>2,173</td>
</tr>
<tr>
<td>Western</td>
<td>719</td>
<td>1,479</td>
</tr>
<tr>
<td>Midlands</td>
<td>377</td>
<td>473</td>
</tr>
<tr>
<td>Southeast</td>
<td>257</td>
<td>462</td>
</tr>
<tr>
<td>Northeast</td>
<td>None</td>
<td>642</td>
</tr>
</tbody>
</table>

It is most interesting to note the geographic spread of the areas with highest waiting lists, with 89.2% of the assessment waiting lists in the three areas where the model of consultant-led and dentist-delivered service has been long established, and where it is advocated that this model be continued. It is ethically unacceptable and indeed probably illegal to allow patients to remain on a waiting list for possibly over two years, only to deny them service by reason of non-eligibility. If clinical guidelines are to be used to target patients with maximum occlusal handicap, then the assessment must be provided within weeks or months of referral.

Treatment waiting times are absolutely unacceptable also, doing a great disservice to patients who have treatment delayed long beyond the ideal time clinically.

Waiting List Initiatives

1. Assessment waiting lists

The waiting list for assessment should be cleared in 2002 and in future, assessment waiting times should be kept below three months. Such assessments can only be carried out by consultant/specialist and should ideally be provided by "in-house"
salaried staff, since there would be a perceived conflict of interest if specialists from the private sector conducted assessments.

This is not the impossible task that it might appear. In the East Coast Area Health Board, (ERHA) the newly established regional unit commenced service in September 2001, and by the end of January 2002, it will have successfully cleared an assessment waiting list of almost 2,500, without a full complement of specialist staff. In four other Health Board regions, the total assessment waiting list is only 2,563 and could presumably be cleared in a similar time frame.

2. Treatment waiting lists:

Possible strategies for immediate effect include:

- Increasing capacity of public service – along lines of scheme implemented recently by NAHB where salaried specialists are given use of public facilities on a fee per item basis out of hours. Such schemes might address some of the problems of recruitment and retention of specialist staff.

- Accessing treatment in the private sector- options:

  1. Full funding of private sector fees for eligible patients.
  2. Grant in aid for eligible patients – contrary to Health Act, but may be possible through Social Welfare system
  3. Reduced fee to private specialists providing treatments in Health Board facilities- reducing direct expenditure for Boards and maximizing the return on the capital investment of establishing the regional units.

Any proposals to involve the private sector should be introduced on a national basis and the Orthodontic Society of Ireland would be happy to engage in negotiations should any such scheme be considered.
RECOMMENDATIONS:

1. The immediate national implementation of the agreed specialist posts and commitment to an exclusively specialist delivered service.

2. Training of further specialists through the approved academic training pathways, in conjunction with regional consultants.

3. Recruitment of European registered specialists.

4. Consider the introduction of orthodontic auxiliaries to increase the productivity of the specialist delivered service.

5. Strategic planning of service to deliver chosen level of service annually.

6. Waiting list initiatives to deal with the current problems:
   a) Assessment waiting lists to be eliminated as a priority
   b) Treatment waiting lists to be reduced by a combination of:
      i) expanding the capacity of public service
      ii) accessing private sector by nationally agreed schemes.
REFERENCES


PRESENTATION BY
THE IRISH CONSULTANT ORTHODONTISTS’
GROUP
TO
THE JOINT OIREACHTAS COMMITTEE ON
HEALTH and CHILDREN
24th January 2002
Introduction

Orthodontics is that branch of dentistry concerned with the alignment of the teeth, the growth of the jaws, and the treatment of facial abnormalities. Such abnormalities can range from cleft lip and palate, overgrowth or undergrowth of one or more jaws, and extreme variations of normal, to crowding of the teeth.

The general public see orthodontics mostly as "straight teeth". Crowding of the teeth is the most common orthodontic problem, and very few people have absolutely straight teeth. Variations from the ideal can range from very slight to extreme.

Studies in the field of social psychology show that a significant degree of social gain can be obtained from orthodontic treatment. Shaw et al (1980) in a study of schoolchildren have shown that teasing and nicknames about teeth are more hurtful than comments about other bodily features. Ramstad et al (1995), Shaw et al (1980, 1981), Speltz et al. (1993) have found modest or varying degrees of improvement in self-esteem, social skills, and social interaction in patients who have had orthodontic treatment. Dann et al. (1995) found that patients' self-concept does not improve during orthodontic treatment, while Albino et al. (1994) found that while parent, peer, and self-evaluation of dental and facial attractiveness significantly improved after treatment, self-esteem was not affected.

The demand for all forms of free medical care is, in theory, limitless. Helm (1990) found that if all barriers to orthodontic care (financial, lack of specialist personnel, severity-indexed, etc) were removed, 60% of the population would demand it.

In the past, it was believed that tooth crowding resulted in dental decay and gum disease. Despite numerous scientific investigations in a number of countries in recent years, the evidence for such a link is very weak (Addy et al, 1988, Addy et al, 1990; Dummer et al, 1990a; Dummer et al, 1990b; Helm and Petersen, 1989a; Helm and Petersen, 1989b). Dental crowding, therefore, has little dental health implications. Extremely prominent upper front teeth ("buck teeth") are more prone to trauma (Burden, 1995; Holland et al., 1988; Hunter et al., 1990), and 1-2% of the population have impacted upper canines ("eye teeth"), of which 12% cause varying degrees of damage to the roots of the adjacent teeth (Ericson and Kurol, 1987a; Ericson and Kurol, 1987b). Extremely deep bites can cause trauma to the hard and soft tissues, but overall, the dental health implications of malocclusion are modest, to say the least (Shaw, et al, 1991).

The prevalence of crowding has increased due to the effect of fluoride in the drinking water supply, with consequent reduction in dental decay (O'Mullane, et al. 1996). Before the 1960's an intact dentition was a rarity in Irish patients, with tooth extractions being common. This tended to relieve crowding. Access to orthodontic care was minimal or non-existent for the vast majority of the population, firstly because of the lower patient expectations, secondly because there were so few orthodontists working in the country, and thirdly, because of the expense of treatment in the private sector. Since that time, however, awareness of orthodontics has increased exponentially, and demand for such treatment has increased in parallel with this.

In summary therefore, social and psychological gain is more common with orthodontic treatment. The dental health implications of the vast number of orthodontic malocclusions are modest.
Epidemiology of orthodontic treatment need.

Studies by Burden and Holmes (1994), Burden et al (1995), and Burden (1995) in the UK show one-third of adolescents are in definite need of orthodontic treatment, one-third have borderline need for treatment, and one-third have little or no need for treatment, using the Index of Orthodontic Treatment Need (IOTN). This agrees with figures from the USA's Public Health Service (Kelly, 1977; Proffit, 2001).

In the Republic of Ireland, 53,000 children are born every year. Assuming that one-third are in need of orthodontic treatment, this would translate into 18,000 patients starting and finishing treatment every year. In total, the number of patients that would need to be under treatment at any particular time would be approximately 40,000. Current figures suggest that approximately 10,000 patients are under treatment around the country.

Orthodontic manpower

Currently there are approximately 77 qualified specialists in orthodontics in Ireland. The majority of these (45) work in purely private practice. There are approximately 16-20 specialists working within the Health Board orthodontic services, with 10 consultants in regional hospitals, 1 consultant at tertiary care level, and 4 academics.

The distribution of orthodontic specialists is very uneven, with most concentrated on the East and south coasts.

<table>
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<th>Health Board service</th>
<th>No. of specialists within the Health Board service</th>
<th>No. of Consultants</th>
</tr>
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<tr>
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</tr>
<tr>
<td>ERHA – East Coast</td>
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<td>1</td>
</tr>
<tr>
<td>ERHA – South Western</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>South-Eastern Health Board</td>
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<td>1</td>
</tr>
<tr>
<td>Southern Health Board</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mid-Western Health Board</td>
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<td>1</td>
</tr>
<tr>
<td>Western Health Board</td>
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<td>1</td>
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<tr>
<td>Midlands Health Board</td>
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<td>1</td>
</tr>
<tr>
<td>North-Eastern Health Board</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

The role of the consultant orthodontist

The consultant orthodontist’s role is to carry out orthodontic assessments of patients referred from the schools dental service and from other dentists; to supervise those under training for specialist qualifications; to carry out treatment for those patients with the most severe and extreme orthodontic problems; to do research and audit; to manage the service and plan its strategic development; and to ensure quality control.
Projected manpower needs

Approximately 20,000 patients each year need treatment.

The maximum safe caseload for a specialist in full-time practice is approximately 400 patients.

The average length of treatment is approximately 18 - 24 months.

Assuming a two-year treatment cycle, this would equate to 200 patients per year finished by each specialist (and an equivalent number taken on for treatment). Dividing 20,000 by 200 results in a figure of 100.

Therefore, 100 specialists within the service would be needed to treat the one-third of the adolescent population in need of treatment.

Recruitment of specialists

The difficulties in recruiting trained specialists to work within the Health Board orthodontic services has, up to now, been very marked. Pay and conditions have not compared favourably with those in private practice.

The use of untrained non-specialist dentists recruited from the schools dental service has been used in the past. However, while such a system may have been politically expedient, the long-term implications of this give rise to a number of concerns, viz:-

(a) such dentists are being used as orthodontic auxiliaries, needing constant supervision by the consultant. Many such dentists may not wish to undergo specialist training due to lack of interest in acquiring such qualifications, or due to domestic commitments.

(b) If such dentists decide to leave the service they would require retraining to allow them to return to general dentistry

(c) When orthodontic auxiliaries are introduced, the cost implications of having two different grades of personnel, one much more highly paid than the other, carrying out the same work, will immediately become obvious to management.

(d) Requiring non-specialist orthodontists or trainees to undertake a caseload of 500 patients is not only clinically unwise, it is unsafe. It does not allow a specialist trainee to learn properly from the consultant, and utilises the non-specialist as a mere auxiliary.

Training of specialists in orthodontics

Currently the only dental school in the Republic that can offer a recognised postgraduate training programme in orthodontics is the Dublin Dental School. The Cork Dental School cannot offer such a programme because it does not have sufficient number of senior trained academic consultant orthodontic staff to do so (currently there is only one full-time orthodontic consultant in the Cork Dental School).
At present, ten graduate dentists are under specialist training in the Dublin Dental School. Two are under training in collaboration with the Western Health Board, two in collaboration with the SWAHB, two with the ECAHB, and one each with the NEHB and SEHB. Two are on the full-time dental school course. Four of these will complete their course in 2002 (including the two from the WHB). It is anticipated that further trainees will commence training in 2002.

The facilities and staff in the Dublin Dental School are currently stretched to the limit. New consultant academic staff need to be appointed, and extra clinical facilities made available to expand orthodontic specialist training. A number of the regional consultants teach and supervise on a part-time basis in the Dental School, but this is not a sufficient substitute for full-time academic staff. Senior staff appointments also need to be made in the Cork Dental School, in order to commence a specialist training programme.

In order for a dentist to become a registered specialist in orthodontics, European directives require a three-year postgraduate training programme. Entry to such programmes is competitive. The reason why such programmes have to comply with EU regulations is to allow mutual recognition of each member state's professional qualifications, and to allow free movement within the EU of qualified professionals.

Part of the time in training is spent in a regional unit, and part in a university dental school. Candidates enrol for a Master's degree and almost all will undertake a membership examination of one of the Royal Colleges of Surgeons of the UK and Ireland. In 2000, the Dental Council of Ireland opened its register of dental specialists with divisions of orthodontics and oral surgery. The entry of a candidate's name on this register allows the public to identify those dentists who are bona fide specialists.

The Specialist Advisory Committee report to the Chief Dental Officer (1999) recommended a maximum of 10 training posts in the Dublin Dental School, with 4-8 in the Cork Dental School, assuming that sufficient staff were available. This would result in a maximum of 18 specialists being graduated every 3 years (or the equivalent of 6 every year). In view of the fact that 80 more specialists are needed for the orthodontic service, at the most optimistic forecast, it would take a minimum of 13 years to bring the numbers up to this level if such a scheme was fully operational, and assuming that all trainees were health board staff and remained within the service after achieving specialist status.

**Recruitment of specialists from outside Ireland**

A number of Health Boards have attempted to recruit specialists in orthodontics from outside the state, but so far with limited success. Three orthodontists are currently working in the Health Board service (2 in the North Western Health Board: one from the Lebanon, one from Sweden) with 1 orthodontist from Denmark working the SWAHB of the ERHA.

Up to now, the UK has been the main location for recruiting medical and dental staff from outside the state. This is due to a number of reasons - geographical, historical, language, and common training pathways in medicine and dentistry. The British Orthodontic Society in a recent manpower report (2001) found that there is a severe shortage of orthodontists in the UK, and it proposes increasing the number under training.
With such a manpower shortage in the UK, it is unlikely that it would prove a major source of recruitment for orthodontic specialists.

**Irish trainees in the UK and USA**

A number of Irish dentists are currently enrolled in courses in the UK. Many may continue to work in the UK, within practice or the NHS, which is well structured and organised.

A few Irish dentists are training on courses in the USA. It is likely that if they return to live and work in Ireland that they will set up their own private practices.

**Infrastructure to service and supporting specialities**

In order for a comprehensive service to be delivered, the relevant number of dental nurses, secretaries, and laboratory support would be needed.

For each specialist, at least one dental nurse would be required to assist them. Each department would require secretarial staff, and the laboratory support for the construction of appliances would also be needed.

**Supporting specialities** – the main associated speciality that would be required to support the orthodontic service is the oral and maxillofacial surgery service. Since the introduction of the orthodontic service, the oral surgeons in both private practice and hospital departments report a major increase in the number of patients that they are receiving for treatment for impacted teeth, retained roots, buried wisdom teeth, and for the treatment of patients requiring major jaw surgery for the correction of facial deformity. Proffit (1994) estimates that up to 0.4% of the entire population require such corrective surgery – this would amount to approximately 250 new patients in the country every year (or 25 per health board).

The work of oral and maxillofacial surgeons also encompasses the treatment of patients with mouth and facial cancers, road traffic accidents and other trauma, and collaboration with the other head and neck surgical specialities such as neurosurgery, ophthalmic surgery, ENT surgery, and plastic surgery.

The ideal surgeon to population ratio is 1:150,000, based on recommendations from both the British and US Associations of Oral and Maxillofacial Surgeons. In Ireland, this would equate to 25 consultant oral and maxillofacial surgeons throughout the country. Currently, there are five such surgeons; 3 in Dublin, one in Cork and 1 in Limerick.
SOLUTIONS

1. RECRUITMENT OF SPECIALISTS
2. TRAINING OF SPECIALISTS
3. RECRUITMENT OF AUXILIARIES
4. PRIORITISING PATIENTS FOR TREATMENT
5. UTILISING THE PRIVATE SECTOR
6. INSURANCE SCHEMES

1. RECRUITMENT OF SPECIALISTS

Long-term priority must be given to training sufficient numbers of orthodontists within Ireland. It is unlikely that significant numbers of orthodontists can be recruited from outside the State. Up to recently, salary, career structure, and conditions have not been attractive for orthodontists. Most European countries offer more attractive working conditions.

In the long term the majority of non-Irish orthodontists may not wish to remain here. As orthodontic treatment is a long-term modality, such continuity within departments is extremely important.

Without a good salary very few orthodontists will wish to take up such posts, especially in the more unpopular areas. A system whereby Health Boards would sponsor orthodontists’ training in return for an equivalent number of years service should become the norm, as is already being done in some health boards.

2. TRAINING OF SPECIALISTS

The training capacity within the Republic is limited. Even with the projected numbers under training in both Dental Schools (assuming that sufficient academic staff are in place), it would take 13 years, at the most optimistic forecast, to train sufficient specialists for the public service, even assuming every single one entered the health service after training (see appendix 1).

3. RECRUITMENT OF AUXILIARIES

Orthodontic auxiliaries are extensively used in many European countries, and in the USA and Canada. These are recruited from the dental nursing grade and undergo a one-year training programme. They are then employed to undertake the main tasks of placing and adjusting appliances on patients’ teeth, and work under the supervision of a specialist or consultant. They are not allowed to work independently and must be supervised at all times.

Currently orthodontic auxiliaries are not legal in Ireland, but the Dental Council has submitted a proposal to the Minister for Health for their introduction.
4. PRIORITISING PATIENTS FOR TREATMENT

Up to recently, the only guidance that has been available in regard to which patients should receive treatment is in a letter from the Department of Health dated January 22nd 1985, signed by a Mr. Dewey. This sets out the original guidelines as to which patients are eligible for treatment. There are 3 categories – category A, which includes patients with cleft lip and palate, category B, which includes patients with 10mm overjets, and finally category C – which is vague and unsatisfactory, and which could allow almost any patient to be placed on the treatment waiting list.

In recent years, waiting lists in orthodontics around the country have given rise to concern. Some Health Board areas have waiting lists of a few months for assessment, and a waiting list for treatment of approximately one year, while others have a waiting list for treatment of 6,000 patients, with an assessment waiting time of up to two years.

Such long waiting lists are unsatisfactory and result in patients with very severe problems being kept waiting while those with lesser problems receive treatment. The Consultant Group have been advised by the Medical Protection Society that placing patients on a waiting list for treatment from which they are not likely to be called for treatment is unethical and wrong.

The assertion has been made that delaying treatment for some patients can result in them requiring major jaw surgery at a later date. No scientific evidence has ever shown that orthodontic treatment at an early age obviates the need for jaw surgery. Growth of the jaws is under close genetic control. Orthodontic treatment has never been shown to have any effect on the growth of the jaws. Orthodontic effects are confined to the teeth and the supporting bone, and not the skeletal bones of the jaws.

The 1985 guidelines have been revised and updated by the Irish Consultant Orthodontists' Group and the Dept. of Health and Children to reflect contemporary orthodontic opinion and to prioritise resources on those patients with the greatest need. It has been found that approximately 15-20% of referred patients would be placed on the waiting list using these guidelines. This would allow the system to cope with the present numbers.

Ideally, some internationally used and validated index (such as the Index of Orthodontic Treatment Need, IOTN) should be used, but this would overwhelm the system at the present time. Figures by Richmond et al (2001) show that up to 60% of all referrals would fall into the grades 4 and 5 (those in most need of treatment) using the IOTN. This has been confirmed by data from the Western Health Board (2000).

5. UTILISING THE PRIVATE SECTOR

As it is unlikely that sufficient numbers of specialists can be recruited in the short to medium term, consideration should be given to utilising the resources of the private sector. This has been used in the past, most notably in the Midlands Health Board, where the waiting list is extremely low, and where, up to recently, there was no consultant service.
A number of possibilities exist to treat patients within the private sector:

(a) Full funding of treatment within the private sector
(b) Partial funding of treatment within the private sector
(c) Allowing private treatment within the health board service

(a) Full funding of treatment within the private sector.

This has already been used within a number of health boards, most notably within the Western Health Board to treat 250 patients from the treatment waiting list. The patients are given a letter of approval, which they can then take to the private specialist of their choice. The private specialist then invoices the Health Board with their fees.

The advantage of this system is that it is popular both with the patients and the private orthodontists. There is little difficulty in administration and the scheme has worked well so far.

The disadvantage is that it is expensive as full fees are paid.

(b) Partial funding of treatment within the private sector ("grant-in-aid")

Partial funding of treatment ("grant-in-aid") has recently been proposed within the Northern Area Health Board. However, the scheme was abandoned as it was found to be contrary to the Health Act, 1972.

Grant-in-aid was proposed as follows: £1000 (Euro 1270) would have been provided to non-medical cardholders, while £2000 (Euro 2540) would have been given to medical cardholders. The patient would then have attended the private orthodontist of their choice, paid the relevant fees to the orthodontist, and those who paid tax would have received tax relief on the balance of the fees that they would have had to pay.

Such a scheme would be more cost-effective than option (a). However, it would require a change in the Health Act to make it operational. It remains a possibility for the future.

A considerable number of EU countries have full or partial reimbursement by central government/social insurance for orthodontic treatment (e.g. Norway, Sweden, Denmark, Finland). Others fund orthodontic treatment purely through social insurance (as in Germany) or private insurance schemes (see appendix 2). All such countries have indexes of severity that determines the level of third-party funding for treatment.

(c) Allowing private treatment in Health Board premises

Specialist-trained staff would be allowed to undertake private treatment and to receive private fees from the Health Board for undertaking treatment for patients out of hours.

Such private fees would need to be at least 50% of that in private practice. Figures from the Orthodontic Society of Ireland (OSI) estimate that at least 50% of a private orthodontic practice’s income goes in expenses (staff, supplies, heat, light, electricity, rent, rates, stationery etc), while the remainder is taxed at the maximum tax rate (currently 42%).
Therefore, a private orthodontist in solo practice will only receive approximately £600 (Euro 760) for two year's work for a patient that originally paid them fees of £2,500 (Euro 3170)

Private practice in Health Board clinics would be another cost-efficient way of treating more patients and would be an incentive to retain trained specialist staff.

6. **INSURANCE SCHEMES**

No insurance schemes currently exist in this country for the funding of orthodontic treatment (VHI / BUPA do not cover orthodontic treatment). Social insurance schemes exist in the Netherlands and Germany, which cover orthodontic treatment in whole or in part.

Prepayment / savings schemes are in place in the UK and other countries. These are started when the child is at a very young age and come to maturity at the age that orthodontic treatment is usually needed. If orthodontic treatment is not needed, then the funds can be used for something else.

Friendly societies and occupational medical aid schemes (St. Paul's, Garda medical aid, etc) offer grants to cover part of the cost of treatment. Tax relief is available for the remainder of the fees.

Currently, tax relief is available (up to 42%) for orthodontic treatment. It is estimated by the Orthodontic Society of Ireland that the cost of orthodontic treatment is £1.80 (Euro 2.30) per day for two years under this scheme.
SUMMARY

• Orthodontic problems, in varying degrees of severity, affect between 30-50% of the entire adolescent population – this is unparalleled compared to any other medical or surgical discipline.

• The vast majority of orthodontic malocclusions have little dental or general health implications.

• The majority of patients seek treatment for cosmetic and/or social reasons.

• If no barriers to orthodontic treatment existed, up to 60% of the population would demand it.

• Currently in Ireland there are insufficient numbers of trained orthodontists working within the public health service to satisfy consumer demand.

• Approximately 100 trained specialists working within the health service (10 per health board area) would be needed to treat those patients who come within the most severe categories of treatment need.

• The training of dentists as specialists in orthodontics needs to be augmented with cooperation between the health boards and the dental schools. The appointment of new academic staff in orthodontics in both the Dublin and Cork Dental Schools is essential.

• Grading of patients according to the degree of severity is essential to ensure that those patients with the most severe clinical treatment need receive treatment.

• Given the limited resources available to the orthodontic service at the present time, blanket entitlement of the entire population for free orthodontic care is impracticable. The Dept. of Health and Children has to make this clear to all interested parties – patients, politicians and health professionals.

• The numbers of consultants in orthodontics in the country needs to be doubled, with at least two consultant orthodontists in each health board area.

• Infrastructure support to the service is severely lacking. There is a need for the appointment of up to 25 consultants in oral and maxillofacial surgery to deal with the surgical need generated by the orthodontic service and to treat patients with severe facial deformities. Such surgeons are also needed to treat patients with oral and facial cancers, trauma of the head and face, and severe dental problems, in collaboration with other surgical specialties.

• Utilisation of the private sector in the short to medium term to deal with waiting lists, needs active consideration, with either the payment of full fees or the use of grant-in-aid to patients. This latter, however, would require a change in the relevant Health Act.
Insurance or prepaid schemes with tax relief should be introduced to allow those families with higher incomes to opt for private orthodontic treatment.

The legalisation, training and recruitment of orthodontic auxiliaries would help to reduce the waiting lists significantly. It must be emphasised that such auxiliaries cannot work unsupervised and therefore the need for training of specialists cannot be downgraded. Also, the productivity of an auxiliary will not be the same as a trained specialist and an auxiliary should not be considered as a substitute for a specialist.

IN ALL PUBLIC HEALTH CARE SYSTEMS

DEMAND > NEED > RESOURCES
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Dummer, P.M. Oliver, S.J., Hicks, R., Kingdom, A., Addy, M., Shaw, W.C. (1990a). Factors influencing the caries experience of a group of children at the ages of 11-12 years and 15-16 years: results from an ongoing epidemiological survey. *Journal of Dentistry, 18, 37-48*

Dummer, P.M. Oliver, S.J., Hicks, R., Kingdom, A., Addy, M., Shaw, W.C. (1990b). Factors influencing the initiation of carious lesions in specific tooth surfaces of a 4-year period between the ages of 11-12 years and 15-16 years. *Journal of Dentistry, 18, 190-197*


Other references:

APPENDIX 1—Projected number of specialist trainees in orthodontics 2002–2025 between the two dental schools (Dublin and Cork)

This model makes a number of assumptions:

(a) that the Dublin Dental School will continue to train 10 specialists every 3 years
(b) that the Cork Dental School will start a specialist training programme in 2002 for the middle and upper lines
(c) that the graduates will go into the Health Board orthodontic service after training and will stay in the service
### Appendix 2 - European Union Comparisons for Orthodontic Manpower, Treatment Need, Orthodontists' Place of Work, and Financing of Treatment

<table>
<thead>
<tr>
<th>Country</th>
<th>Population (millions)</th>
<th>Births / annum</th>
<th>No. in need of tx each year</th>
<th>No. of orthodontists</th>
<th>New patients / orthodontist each year</th>
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</thead>
<tbody>
<tr>
<td>Norway</td>
<td>4.4</td>
<td>57000</td>
<td>19000</td>
<td>227</td>
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</tr>
<tr>
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<td>264</td>
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<table>
<thead>
<tr>
<th>Country</th>
<th>Orthodontists' place of work</th>
<th>How treatment is financed</th>
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</thead>
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<tr>
<td></td>
<td>% private practice</td>
<td>% community service</td>
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<tr>
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<td>75%</td>
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<td>Greece</td>
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Sources: Moss (1995); UNICEF population statistics website [www.unicef.org/stats]; Federation Dentaire Internationale website [www.fdi.org.uk]