Submission by the Irish Dental Association

Review of Regulations made under the Financial Emergency Measures in the Public Interest Act, 2009

Relating to fees payable to dentists participating in the Dental Treatment Services Scheme

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EXECUTIVE SUMMARY

The Irish Dental Association makes this submission as part of the review announced on 5th December 2012 by the Minister for Health of Regulations, citing the Financial Emergency Measures in the Public Interest Act, 2009.

The relevant Regulations are:

- **S.I. 171/2009 - Health Professionals (Reduction of Payments to Registered Dentists) Regulations 2009**

- **S.I. 135/2011 - Health Professionals (Reduction of Payments to Registered Dentists) Regulations 2011**

While these Regulations had an immediate negative effect on the income of dentists participating in the Scheme, we must highlight the drastic effect of the cuts on the oral health of the Irish nation. We therefore take this opportunity to inform the Minister of the effects of the cuts to the scheme on our patients.

The reduction in the state's contribution towards patient care (and therefore dentists' incomes) represented a significant contribution, estimated at €100 million per annum, on the part of dentists towards addressing the difficulties in the public finances. On the basis that there are approximately 1,000 dental practices in the country, this amounts to a cut of €100,000 for each individual practice per annum. We will elaborate on the reasons that show that no case can be sustained for any further reduction in fees in the DTSS.

The Association expects the Minister to consider and fully evaluate all relevant information and to consider the consequence of any possible changes for patients, dental services and employment in the dentistry sector. We note according to Section 9 (5) (d) the Minister must have regard to *"the general nature of expenses of health professionals providing those services".*

The Association believes that any fair and reasonable review of the fees paid currently to participating dentists participating in the DTSS must conclude that **there can be no case for any further reductions in the fees payable**.

Specifically, we cite the following considerations:-

1. **The serious implications for public health of the cuts to the state dental schemes (DTSS and DTBS);**

2. **The cuts imposed on the state dental schemes amount to €100 million per annum being taken out of funding for dental care with huge implications for the viability of many dental practices;**

3. **The decline in patient attendance and practice income associated with the state dental scheme cuts and the overall economic downturn;**

4. **The results of a cost-benefit analysis of the cuts to the dental schemes;**

5. **Evidence that the fees in the state dental schemes offer the Government excellent value for money as the fees have been shown by a state agency, the National Consumer Agency, to be significantly below private practice rates;**

6. **The commitment given in the Public Service Pay Agreement that no further reductions in pay for public servants would be implemented;**

7. **The absence of any financial state support for dentists.**

INTRODUCTION

Currently, 1.3 million people are entitled to dental treatment under the Medical Card Dental Scheme.

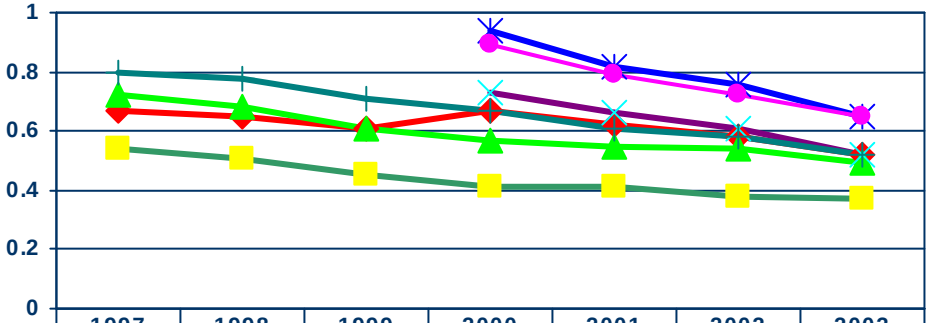
According to Section 67 of the Health Act, 1970, the HSE is obliged to provide dental treatment and dental appliances to persons with full and limited liability under their medical card. Since 1994 the HSE has fulfilled this obligation through the operation of the Dental Treatment Services Scheme. The Scheme is managed by the HSE. Private dentists are contracted to provide the treatment in their own practice and are paid on a fee per item basis i.e. not on a capitation basis.

According to a study conducted by the Oral Health Services Research Centre (OHSRC) in UCC, the DTSS was introduced in 1994 in order to address an anomaly highlighted by the results of the National Survey of Adult Health (1989/90) *"there was evidence of a lower level of oral health among some sections of the community such as medical cardholders….Consequently, optimal strategies should be identified to specifically target such groups."* [1]

Proven Improvements in Oral Health

Up to 2010, the treatment available under the scheme consisted of routine dental treatment which allowed medical card holders maintain and improve their oral health. An examination of the Scheme in 2003 by the OHSRC revealed significant improvements in oral health since the introduction of the Scheme in 1994. The study showed a steady downward trend in the number of extractions for all age groups.

Steady Decrease in the Mean Number of Extractions



	1997	1998	1999	2000	2001	2002	2003
All	0.67	0.65	0.61	0.67	0.62	0.58	0.52
16-24	0.54	0.51	0.45	0.41	0.41	0.38	0.37
25-34	0.72	0.68	0.61	0.57	0.55	0.54	0.49
35-44				0.73	0.66	0.61	0.52
45-54				0.94	0.82	0.76	0.65
55-64				0.89	0.79	0.72	0.65
65+	0.8	0.78	0.71	0.67	0.61	0.58	0.52

The OHSRC's analysis also revealed:

[1] O'Mullane and Whelton, 1992

- A downward trend from the year 2000 in the number of restorations (fillings) per patient;
- A downward trend from the year 2000 in the number of dentures per patient;
- A declining DMFT (Decayed, Missing, Filled Teeth) in all age groups with a steady decline in the 65+;
- A declining DT (Decayed Teeth) in all age groups; suggesting the level of untreated decay is falling;
- An increase in tooth retention in all age groups, particularly those aged 65+.

DTSS – BUDGET CAP

In the Budget for 2010, the budget for the Scheme was capped at the 2008 level of expenditure (i.e. €63 million) despite the surge in medical card holders.

It is particularly reprehensible to report that some two and a half years since the introduction of these radicals cuts, the HSE has still not organized a public information campaign to advise eligible medical card holders of their entitlements when visiting their dentist. Neither has the HSE made any arrangement to organise care and treatment where it refuses to authorise general practitioners to provide badly needed dental care. Finally, it is shameful and unacceptable that the Department of Health has not arranged to undertake any assessment of the impact of these cuts on the oral health of medical card holders affected by these savage cuts.

The decision by the HSE to restrict access to dental care in April 2010 fundamentally altered the scheme from a demand-led scheme to a budget-led scheme. Given the increase in the number of medical card holders, we estimate that at least €80 million is required to adequately fund the DTSS in 2013. (This estimate is made on the basis of the existing limited range of entitlements being offered.)

Treatment available prior to 2010	**Treatment Available 2010 Onwards**
Biannual Scale and Polish	Suspended
Extended gum cleaning	Suspended
X-rays	Suspended
Fillings	2 per annum in an ‘emergency situation’
Root Canal Treatment	In ‘emergency circumstances’ only
Dentures	In ‘emergency circumstances’ only
Denture repairs	In ‘emergency circumstances’ only
Miscellaneous items	In ‘emergency circumstances’ only
Extractions	**Unlimited number provided!**

The rationale behind a scheme that places a limit on fillings (i.e. saving a tooth) while allowing an unlimited number of extractions are extremely worrying. On a pure financial basis, the state will ultimately have to pay not only for the extraction but for the cost of a denture in the future. For the patient it means a lifetime of embarrassment, decreased nutrition and loss of wellbeing.

Rate of Decrease in Dental Treatment for Medical Card Holders

New analysis of the number of treatments provided in 2012 compared to 2010 reveals worrying developments, such as:

- a stark decrease in the number of preventive and restorative treatments while
- emergency treatments such as extractions and surgical extractions are actually increasing!

Treatment Type	Number of Treatments Year to July 2010	Number of Treatments Year to July 2012	Rate of Decline
X-rays	22,966	85	99.6%
Scaling & Polishing	153,797	1,979	98.7%
Protracted Periodontal Treatment	36,023	4,442	87.7%
Fillings	411,000	234,006	43.1%

Meanwhile the rate of increase in tooth extractions is rising rapidly as shown by the table below.

Treatment Type	Number of Treatments Year to July 2010	Number of Treatments Year to July 2012	Rate of Increase
Surgical Extractions	24,096	31,746	31.7%
Extractions	71,722	72,493	1.1%

Increase in demand for DTSS

While the expenditure on the Scheme has been capped, the number of eligible medical card holders has increased by nearly 20%.

Year	Total Expenditure	% Difference
2009	€87 million	
2011	€51 million	**41.4% Decrease**

Year	No. of eligible persons	% Difference
2009	1,112,738	
2011	1,304,675	**17.25% Increase**

So while the number of eligible medical card holders has risen in the two years to 2011, by over 17%, the expenditure has fallen by over 41%.

'Dual Eligible' Patients

When dealing with the increase in the demand for the DTSS, we must point out that there are around half a million patients who are described as *'Dual Eligible'* i.e. they are both PRSI insured and also hold a medical card. Traditionally these patients were treated under the Dental Treatment Benefit Scheme. As the DTBS has been effectively abolished, these patients are now seeking dental treatment under the DTSS. This group are expected to have a higher level of utilisation of the scheme thus increasing the demand on the DTSS even further.

PUBLIC HEALTH IMPLICATIONS OF BUDGET CAP

Medical card patients have lower oral health levels, a greater need for treatment and a lower access rate to the care and treatment. Therefore it is extremely worrying that preventive and restorative treatment has been removed from the Scheme. The withholding of these types of treatments goes against everything a dental student is taught at dental school. It is also disconcerting that more than two and a half years since deciding, the HSE and the Government has failed to actually inform medical card holders of the changes and have failed to give any warnings with regard to the implications for their oral health. The Irish Dental Association and its members deal with queries on a daily basis from patients who are trying to figure out what they are entitled to. Patients and even treating dentists are unsure of what is provided and the availability of treatment is extremely subjective – a patient in Kerry may receive dentures; while his / her counterpart in Donegal may have to endure life without teeth and not knowing where to turn for help. A lot of the savings achieved by the HSE heretofore is simply due to the confusion surrounding the scheme.

The **latest Irish Dental Association survey (November 2012)** shows the impact of these cutbacks on our patients[2]. The survey found that:

Survey Results re Effect on Patients

- 77% of dentists reported an increase of patients presenting in pain;
- 92% of dentists reported an increase in patients presenting with in gum disease;
- 88.8% of dentists reported an increase in patients presenting as emergencies;
- 88% of dentists reported an increase in patients presenting with dental infections;
- 84.6% of dentists reported an increase in patients presenting with multiple decayed teeth.

This is evidence of the infliction of unnecessary pain and suffering on the public at large. It is outrageous and unacceptable that pain that could be prevented is being inflicted on patients. Clearly these cuts are resulting in the deterioration of oral health for the Irish nation. Can Ireland afford this?

Survey Results re Results re Operation of the Scheme

- 56.4% of dentists reported that the HSE does **not** provide an emergency dental service in their area;
- 98% believe the DTSS does **not** provide adequate preventive treatment for patients;

[2] Survey carried out November 2012. Response Rate 33% of general dentists. Total number of respondents 312.

- 89.4% do **not** have confidence in the HSE operating the DTSS;
- 87.7% of dentists do **not** believe the DTSS to be an effective scheme.

Survey of Public Entitlements to Dental Care

Behaviour and Attitudes, an independent research company, carried out a survey in **November 2012** on the general public in relation to public entitlements to dental care. The results of the survey reveal that:

- 29% of medical card holders (population estimate: 474,000) postponed dental treatment in the previous year due to the restrictions to dental benefits;
- 26% of medical card holders (population estimate: 123,000) or a member of their family have missed time from work due to a dental problem;
- 38% of medical card holders (population estimate: 604,000) said they would visit their dentist less frequently from now on due to the restrictions (this compared to 14% in 2010).

An Ombudsman's Perspective

The Ombudsman investigated a refusal by the HSE in 2010 to provide dental treatment to a medical card holder and surmised that it is *"a sad reflection on a system where a person with decaying teeth, who has no resources to fund private treatment, has to put up with decaying teeth until his annual entitlements recommence*".[3]

[3] Ombudsman Annual Report 2010

EFFECT OF BUDGET CAP AND REDUCTION IN FEES ON DENTAL PRACTICES

From 2009 to December 2011, the expenditure on the scheme decreased by over 41% (€86m to €51m.) Given this decrease in expenditure, the income for dentists participating in the Scheme has been drastically affected. Dentists with a high reliance on the scheme have reported a massive decrease in income. Due to the fixed nature of overheads in dental practices, it is not possible to change the cost base in direct co-relation to practice income changes so the effect of sudden drops in income is devastating.

Omega Financial Management carried out a survey of Irish dentists in Quarter 4 of 2011 which found **49% of dentists' income fell by more than 20% in 2011 compared to 2010**. **24% of dentists plan to reduce staff numbers in 2012.**

Independent research conducted by Behaviour and Attitudes in March 2010 showed **70% of dentists participating in the DTSS said their net income had decreased** from 2009 with **24% being the average decrease.**[4] This survey also found that close to half of dentists **(48%) have reduced their fees for the most common treatment items, examinations, fillings etc. 49% had frozen their fees**.[5]

The IDA carried out a survey of dentists participating in the DTSS in April 2011. The results found that in response to the reduced DTSS income:

- 64% of decreased the number of staff in the practice
- 74% of dentists reduced the working hours of staff

We estimate there have been 1,500 job losses in the dental profession since April 2010.

Difficulties in Getting Paid

Cash flow is a major problem for all small businesses in Ireland. For dental surgeries this difficulty is exacerbated by the difficulties they experience in getting paid on time or at all by the HSE's Primary Care Reimbursement Service (PCRS). The administration of the scheme is an administrative nightmare for dentists. Dentists and their practice staff are spending more and more time chasing up payments and trying to get in contact with the PCRS.

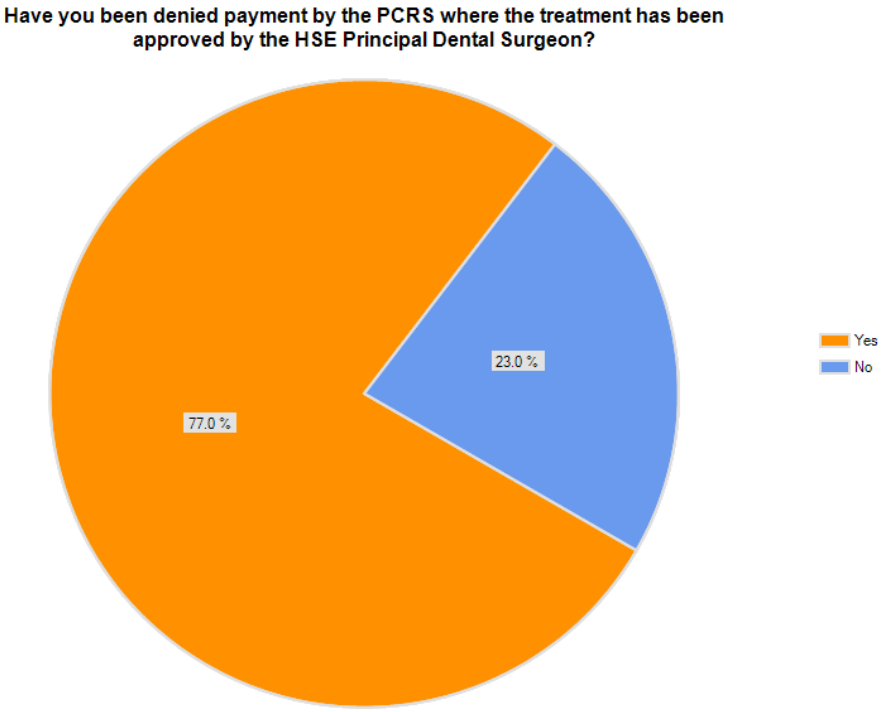
Incorrect Payments

[4] Behaviour and Attitudes Survey March 2010
[5] Behaviour and Attitudes Survey March 2010

The PCRS incorrectly applied Statutory Instrument 135 of 2011 Health Professionals (Reduction of Payments to Registered Dentists) Regulations to dentists who were excluded from the scope of the S.I., namely dentists in Dublin, Wicklow and Kildare. It is shocking that a government agency would misapply legislation in that manner.

Claims approved by local HSE Principal Dental Surgeon

Another major difficulty is that dentists have claims approved by their local HSE Dental Surgeon. The dentist carries out the treatment in good faith and in the expectation that he or she will be paid for work done. The PCRS will then decline the payment for one reason or another. According to a survey we carried out of our members in October 2011, 77% of dentists reported that they have been denied payment of DTSS claims by the PCRS where the treatment has been approved by the HSE Principal Dental Surgeon.



Administrative / System Difficulties

There are also problems with the administration of monthly payments. There are claims that are never paid and the dentist is not informed of any difficulty with their claim. Our recent survey found that 47.5% of dentists have claims that are outstanding for over 12 months.

In addition to the administrative difficulties, there is a general delay on the receipt of payment for claims submitted. We call on the Government to ensure the PCRS adheres to the 15-day ‘Prompt Payment’ rule with regard to the DTSS.

The HSE’S online ‘Checker’ system is not accurate. A dentist could carry out treatment on a patient in the good faith that he / she will be paid without the knowledge that the patient has already used up his / her annual entitlements. The claim is then sent to the PCRS for payment. If the patient has already used up his / her annual entitlements, the second treating dentist will go unpaid. A system should be introduced to prevent this occurring.

COST BENEFIT ANALYSIS OF DTSS RESTRICTIONS

These cuts do not make economic sense. The current 'patch and forget' service provides no long-term benefit. Every case of delayed treatment will eventually require more complex treatment at a greater cost.

The true price of an extraction is not just the €39.50 the HSE pays the dentist to take out a tooth. Patients who undergo multiple extractions lose supporting bone and tissue causing them to appear older beyond their years and confining them to a lifetime of denture-wearing; possibly at a greater cost than the treatment required to save the teeth in the first instance.

In response to a Parliamentary Question dated 18th October 2011 the Minister of State at the Department of Health, Deputy Róisín Shortall stated that ***"A cost benefit analysis comparing the cost of preventative dental health care and emergency dental care was not carried out in advance of budget 2010."***

Oral diseases are to a very large extent preventable, yet when they occur they can be among the most expensive to treat or cure.[6] In the context of dental health 'prevention is most definitely cheaper than cure'. Dental problems do not go away without treatment, they only get bigger. These cuts do not make economic sense. Any immediate savings achieved are only storing up problems for the future.

Value for Money – Comparison of DTSS Fees with Private Fees

The excellent value for money the Government receives in respect of dentists provided under DTSS is evidence that the fees cannot be reduced any further. The results of a survey carried out by the National Consumer Agency in 2010 showed that the professional fees paid under the DTSS have fallen significantly behind rates for private practice.

- DTSS Oral Examination fee (includes X-ray) = **75%** of the NCA Survey Average Fee (does not include X-ray).[7]
- DTSS Scale & Polish fee = **50.82%** of the NCA Survey Average Fee.[8]
- DTSS Extraction fee = **48.17%** of the NCA Survey Average Fee.[9]

[6] Dr Burton Conrad, President FDI World Dental Federation, 2007-2009 *The Oral Health Atlas* FDI 2009

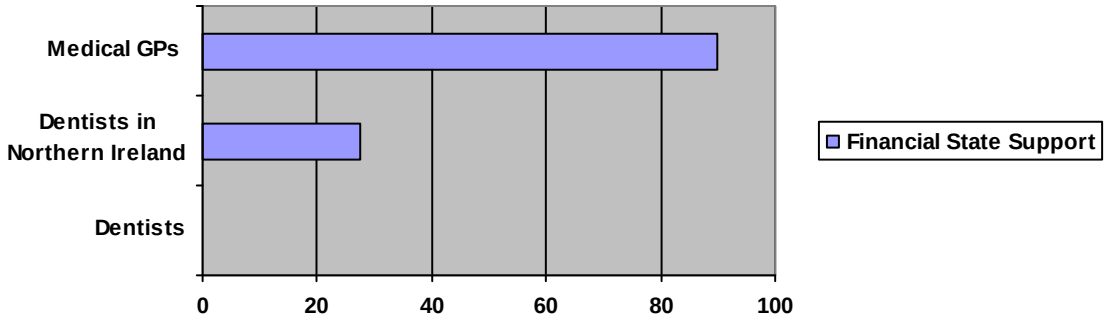
[7] NCA Average Fee for Oral Exam. €44, DTSS Fee €33

[8] NCA Average Fee for Scale & Polish €61, DTSS Fee €31

[9] NCA Average Fee for Extraction under Local Anaesthetic €82, DTSS Fee €39.50

OPERATING COSTS FOR DENTAL PRACTICES

Financial State Support for Medical Professions



Dentists are one of the only health professionals that do not receive any financial support from the state. Instead they rely solely on their own self-generated funds to set up in practice and adhere to increasing regulatory costs.

Notwithstanding this lack of support, the cost of dental treatment in the Ireland is often unfairly compared (usually by Government commentators) to the cost of dental treatment in Northern Ireland.

Dentists in Northern Ireland

On average NHS committed practices receive approximately €37,000 p.a. in practice allowance grants alone. Recent research found that this support could impact on the relative competitiveness of general dental practitioners in the two parts of the island and have implications for dental tourism.[10] Practice costs for principals in the Republic are €102,000 per annum more than the costs faced by principals in the North. In Northern Ireland in 2007/2008 practices received between them €3.77 million in decontamination grants and €5.023 million in practice allowance grants. Dentists in Northern Ireland operating under the NHS also receive capitation payments for patients. This affords them a greater degree of certainty regarding their income stream which may in turn bring advantages when planning investments, obtaining loans or insurance. They are also reimbursed their non-domestic local authority rates which are a major contribution towards the running of a dental practice.

The dental profession in Northern Ireland may incorporate dental practices thus enjoying the resulting significant tax and pensions benefits which offer dentists in Northern Ireland a significant cost advantage over their southern counterparts who are advised that they are not authorised to introduce such business arrangements according to the provisions of the Dentists Act, 1985.

General Medical Practitioners

[10] *The O'Neill Report 2010* Professor Ciaran O'Neill

Medical practitioners in the Republic receive state support in the form of practice support grants, rurality payments, locum cover during periods of sickness, holidays, maternity/paternity etc. under the GMS Capitation Agreement, eligible practices can claim annually between €32,904 and €25,592 for secretarial support, €32,904-€40,216 for nursing support and €32,904 in practice management support. Practices in rural areas may claim up to €19,066 per annum. There is no suggestion that such support is not wholly appropriate, the difference in public funding between general and oral health is evident.

We believe this state support is of course entirely appropriate; what we seek are steps to bring funding for dentists to at least a similar level to enhance services for patients in better facilities and offering a wider range of treatments.

Contribution of the Dental Profession to Employment in Ireland

We calculate that, by conservative estimates, there may be as many as 8,000 persons employed or whose employment is directly associated with the practice of dentistry in Ireland. We believe it is critical that the difficulties which are already apparent are not exacerbated by a decision to reduce fee income further, the only source of income and support from the state for the dental profession.

Regulatory Costs for Dental Practice

The Irish Dental Association is, of course, supportive of proper regulation however the increasing cost of regulatory fees is having a negative financial effect on dental practices. The following is a list of regulatory costs which a dental practice must discharge:

- Dental Council Registration Fees
- Professional Indemnity
- Radiological Protection Society of Ireland Fees
- Waste Management Fees
- Data Protection Registration Fees

The Irish Dental Association has made a significant contribution to improving regulation in the dental sector. The Association collaborated with the Dental Council on introducing a fee display policy in dental practices. In 2012, the Association established the Dental Complaints Resolution Service which deals with complaints relating to dentistry. The Association made this contribution in a genuine effort to improve the dental experience for patients.

IDA RECOMMENDATIONS

The Irish Dental Association is realistic about the state of the country's financial situation and we would like to a proactive approach by suggesting a number of ways in which efficiencies may be achieved and funding may be generated for oral healthcare.

Recommendation 1:
Explore with the Irish Dental Association the potential participation of dentists in health promotion and chronic disease management.

The mouth is a gateway to the body and is an early warning system for health practitioners. Oral diseases share common risk factors with chronic diseases, such as diabetes and heart disease. Oral diseases impact on general health and systemic diseases show symptoms in the oral structures.

As oral health is an integral part of general health and well-being, it must be integrated in general prevention and health promotion at national and EU level. Tackling oral diseases separately from general diseases is neither medically effective nor cost-efficient. Prevention and early treatment will substantially reduce the overall costs of oral diseases for the State and the patient.

The *Platform for Better Oral Health in Europe* recently issued the following key policy recommendations:

- Recognise the common risk factors for oral disease and other chronic diseases;
- Develop the role of oral health professionals in generic health promotion to address risk factors such as cigarette smoking, poor diet, high alcohol consumption, and sedentary lifestyles.

The Irish Dental Association's recommendation is that dentists can play an important role in chronic disease management and we urge the Government to explore this potential.

According to the Central Statistic Office, 43% of adults visit a dentist once a year. The highest incidence of visits occur in the age groups 34 to 44 (48% attendance rate) and 45 to 54 (47% attendance rate).[11]

Dentists are therefore well-placed in the community to fulfill this role of chronic disease management. They have regular contact with patients and are usually the first to see the effects of tobacco in the mouth. Dentists are therefore in an ideal position to reinforce the anti-tobacco message, as well as being able to motivate and support smokers willing to quit.

[11] Central Statistics Office, Quarterly National Household Survey, 2010 Health Module

Dentists can also play a valuable role in health promotion campaigns with respect to the following conditions: osteoporosis, diabetes, renal disease as well as the fact that dentists are often in a position to detect symptoms of many other general health conditions, drug use and a variety of disorders when examining patients.

Mouth Cancer Awareness Day is a voluntary initiative where dentists provide advice free of charge in an effort to raise awareness of mouth cancer. It is striking that 13 cases of mouth cancer were discovered in Mouth Cancer Awareness Day 2011. (The results for 2012 are currently being collected.)

Recommendation 2:
Introduce a National Oral Health Policy that provides equitable access to a range of treatments required to achieve and maintain optimal oral health for all citizens.

The National Oral Health Policy has not been updated since 1994 despite the huge changes in the state dental schemes. Any oral health policy the Department of Health is operating under is obsolete and should be reviewed. The Irish Dental Association is willing to take part in a consultation programme with the Department of Health to review the National Oral Health Policy.

Recommendation 3:
Appoint a Chief Dental Officer to the Department of Health.

The post of Chief Dental Officer in the Department of Health has been vacant for almost a decade. We ask the Government to fulfill its commitment of appointing a Chief Dental Officer. The Irish Dental Association is willing to take part in a consultation programme with the Department of Health to review the role of the Chief Dental Officer.

Recommendation 4:
Divert a percentage of any taxes raised through consumption taxes on tobacco or high sugar / fat products are diverted towards an oral healthcare programme.

Due to the clear association between the consumption of tobacco products and the development of numerous oral health diseases an allocation of the existing tax revenue could be allocated to fund the dental services.

In the event that a sugar or confectionary tax is introduced, we would ask that a percentage is diverted towards an oral health programme.

CONCLUSION

The most recent national survey of oral health in adults carried out in 2003 revealed considerable improvements in the level of oral health amongst Irish adults compared to the previous 20 years. Unfortunately since Budget 2010, we are now beginning to see a rapid reversal of these advances. Dentists witness the effect of the cuts to dental care on a daily basis and are extremely concerned that the nation's oral health will revert to 1950s levels.

This silent epidemic is set to become Ireland's screaming epidemic given the alarming deterioration in dental attendance and in the oral health of the increasing numbers of patients, particularly the young and poor. Many of these patients are presenting in need of emergency care and preventive care is sadly no longer a meaningful option given the damage they have suffered.

We do not believe the cuts to dental care make sense and will ultimately cost the state more in the long term. The failure by the Government to carry out any impact or cost-benefit analysis prior to the cuts may be explained by the lack of dental input at policy level.

We note that according to Section 9(5)(d) the Minister must have regard to *"the general nature of expenses of health professionals providing those services".* We have set out clearly in this submission the reasons for our contention that there can be no case for a further reduction in DTSS fees and we ask that the Minister decides accordingly and commits to removing the perceived legislative difficulties which have prevented a long overdue review of the terms and funding associated with the DTSS.