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REPORT

ON

EASTERN HEALTH BOARD

DENTAL SERVICES

October 1999

The Minister for Health published the Dental Health Action Plan in 1994 (Appendix A). The main recommendations of the 1994 Dental Health Action Plan are set out hereunder.

1. The setting of oral health goals and the improvement of oral health promotion and preventive programmes, including substantial capital investment in the national fluoridation programme.

2. A significant enhancement of the public dental services through a more clearly defined role for health board dentists, concentrating to a large extent on oral health care and services for children. There will be a significant increase in manpower.

3. The extension of eligibility to children under 16 years of age.

4. The improvement of secondary care orthodontic services through the recruitment of additional consultant orthodontists and support staff.

5. The expansion of hospital based oral surgery services through the appointment of additional consultant oral surgeons and support staff.

6. The introduction of new arrangements for the provision of adult dental services with the participation of private dental practitioners. Health board dentists will be entitled to participate in these arrangements. The provision of services for adults will be phased in on the basis of age cohorts commencing with the over 65's.

7. An emergency service will be available to all medical cardholders on demand.

8. A programme commencing shortly to provide full dentures to medical cardholders over 65 who require them.

9. A new Dublin Dental Hospital and School.

The Dental Health Action Plan gives the backdrop for the development of our Board's Dental Services since 1994.

1. ORAL HEALTH/PREVENTION

In 1991 our Board employed eight dental hygienists to support dental surgeons in the provision of educational and preventative services to children and special needs groups. Children in specific primary school classes - 2nd, 4th and 6th and previous year 6th - are now screened and referred for treatment as necessary. This is a preventative approach, which ensures equity of access according to need. Our Board is currently in the process of recruiting eight oral health promoters to co-ordinate and further develop oral health promotion activities with patient groups, particularly those with special needs, as well as school goers.

Our Board provided capital funding in the sum of £0.294m over the last three years to upgrade fluoridation treatment and monitoring equipment in the local authority water supplies in our Board's area. Fluoridation plants have been upgraded at Leixlip, Kilternan, Arklow, Ballykelly, Monasterevan, Blessington, Glencullen, Ballyedmonduff, Wicklow, Ballytore, and Kilberry. Currently 100% of the population of Dublin receive optimally fluoridated water supply, while the figures for Co. Kildare and Co. Wicklow are 80% and 65% respectively.

In non-fluoridated areas, our Board provides a school based fluoride mouth rinsing scheme.

Our Board has been appointed the agency, on behalf of all eight health boards, to manage a consultancy contract to carry out an evaluation of the quality of oral health services throughout the country.

2. PRIMARY CARE DENTAL SERVICES

The following groups of children are eligible for treatment by our Board's dental services: -

- Pre-school children;
- All children attending national schools;
- All children under 14 years who have attended national school;
- Dependants of medical cardholders up to 16 years.

The routine service for pre-school children is largely an educational one for parents or carers.

Children in national schools in 2nd, 4th and 6th classes, and one post-primary class (up to 14 years) are targeted for preventive and treatment strategies. The children in those classes are screened and referred for treatment at their designated clinics, when necessary. The provision of fissure sealants for vulnerable teeth is an important element of the preventive programme. This structured, targeted approach enables the clinician to identify and follow up those children at greater risk of dental disease.

Children of 14 and 15 years of age who are covered by a medical card, can apply for dental treatment through their local clinic and will be assessed for treatment as soon as possible.

Except in exceptional circumstances, emergency services are available for all eligible children, without appointment, at any clinic, on any day on which the clinic is open. An emergency can include any concern a parent may have regarding any aspect of a child's oral health.

Treatments provided by our Board's dental staff to eligible patients in 1998 were:

Treatments	*Children*	*Adults*
Attendances With Appointment	162,956	21,762
Attendances Without Appointment	25,622	2,197
Failed Appointments	56,549	6,131
Fillings	81,363	6,340
Extractions	23,581	3,437
Fissure Sealants	102,952	
Scale and Polish	15,467	4,211
Endodontic Treatments	549	269
Dentures Fitted	469	2,267
Crown/Bridge Fit		221
Other Treatment: (x-ray, specialist referral, dressings, orthodontic adjustments, fluoride application, oral hygiene instruction, drugs prescribed)	101,270	9,214

Our Board's overall policy is to ensure that the majority of targeted school classes receive treatment during the same academic year and that waiting lists do not build up. In circumstances where children are not treated during the academic year, those children are attended to early in the following academic year.

2(i) *Special Needs Groups*

In addition to primary dental care for children, our Board considers dental care of patients with special needs as an integral part of the service provided by our Board's dental staff.

Up to 1996, the equivalent of two dentists was providing services to patients with special needs. The appointment of eight senior clinical dental surgeons was approved by the Minister in 1996 (one in each dental area) with responsibility for identifying and co-ordinating services to special needs groups. Services to these groups are now provided by approximately twelve staff (w.t.e.).

Special needs patients would comprise the following:

1. Children and adults who attend special schools and sheltered workshops.
2. People in residential care.
3. Psychiatric patients.
4. People who are housebound, requiring domicilliary visits.
5. Medically compromised adults and children.
6. The travelling community.
7. Homeless persons
8. Refugees.
9. Other people who have difficulty accessing the normal service.

Our Board developed outreach services in special centres and has recently completed developments at St Ita's Hospital, Leopardstown Hospital, and James Connolly Memorial Hospital. It is hoped to develop other such centres, e.g. the National Rehabilitation Centre, as further funding becomes available.

3. EXTENSION OF ELIGIBILITY

Services have been extended to children up to 14 years as far as is practicable. Earlier this year our Board proposed that services would be extended by the Minister, for children up to 16 years of age. This development will require additional funding - revenue and capital. Our Board also proposed that the Minister would extend earlier intervention for school children with a further screening programme at senior infants - the estimated cost of this development is approximately £0.80m.

4. ORTHODONTIC SERVICES

Our Board's Regional Orthodontic Unit opened at St James's Hospital in September 1996. Prior to September '96, an ad-hoc service was provided by a number of private orthodontists on a sessional basis, together with four of our Board's dental surgeons who had the Masters of Orthodontic qualification.

The number of sessions provided by the private orthodontists was approximately twenty per week - the equivalent of two clinicians directly employed by our Board. There were major problems with this method of service delivery:

- Quality standards associated with a consultant led service;
- Deciding policy in relation to eligibility for service in line with clinical protocols established by the Department of Health;
- Overall accountability for the management of the waiting list, treatment programmes and clinical standards overall;
- Costs associated with the employment of private orthodontist;
- Limitation on service.

With the opening of the Regional Orthodontic Unit, a consultant led service was established, with eligibility for services being brought in line with the clinical standards set by the Department; arrangements were also put in place to integrate our Board's dental surgeons with M. Orth. qualifications, with the consultant service and to phase out the use of private sessional orthodontists. The unit in St. James's was developed and equipped to a very high standard and has twelve treatment chairs overall.

In early 1998, the consultant orthodontist at St. James's Hospital took on a part-time commitment to our Board's Regional Orthodontic Department and staff were recruited on a phased basis to bring the overall staff complement to thirty-two.

4(i) *Staffing*

Staff Discipline	*Staff Numbers*
Consultants	1 + 1 (part-time) 1
Senior Registrar	1
Senior Dentist with a M. Ortho. Qualification	5
Senior Dental Surgeons	8
Dental Surgery Assistants	10
Radiographers	2
Clerical Staff	4

Prior to the opening of the Regional Orthodontic Department in September 1996, the average waiting period for assessment was 4 - 5 years. At present the waiting periods are as follows:

Category	*Waiting Period*
Category I	No waiting time for assessment or treatment.
Category II	Waiting period is three years and ten months for assessment. Those assessed as eligible for treatment, commence their treatment programme as soon as it is convenient (particularly for the patient).
Category III	In the main, Category III patients are not eligible for treatment in line with the Department of Health and Children protocols. However, these patients have now been re-assessed on a planned basis. Those patients who meet the Department of Health and Children assessment protocols, were placed on the Category II treatment list in date order.

Category	*No. on Waiting List*		*Waiting Time for Assessment*	
	1996	1999	1996	1999
Category I	681	Nil	4 - 5 yrs	Nil
Category II	11,365	8,018	4 - 5 yrs	3 yrs 10 months
Category III	6,805	Nil		Nil

- All patients on existing category 1 lists and subsequent referrals have been provided with orthodontic assessments and appropriate treatment.
- All patients in category 3 have been assessed and either categorised as Category 2 or discharged from the waiting list.

4(ii) *Protocols for Referrals to the Regional Orthodontic Service*

It is Board policy that all referrals from the community dental service are made through the principal dental surgeons.

Additional sources of referrals to the Regional Orthodontic Department include medical specialists, speech and language pathology departments, Dublin Dental Hospital, other regional orthodontic services, and overseas dental schools and equivalent regional orthodontic services.

4(iii) *Satellite Orthodontic Clinics*

Orthodontic treatment/assessment is provided at the following centres as satellite services from the Regional Orthodontic Department:

Treatment Centres	*Assessment Centres*
Crumlin Health Centre	Crumlin Health Centre
Ballyfermot Health Centre	Roselawn Health Centre
Wellmount Centre	Coolock Health Centre
	Wicklow Health Centre
	Newbridge Health Centre
	Ballinteer Health Centre
	Bray Health Centre
	Kilbarrack Health Centre

Further clinics are planned for:

- North Strand Health Centre
- Deansrath Health Centre
- Dun Laoghaire Health Centre

4(iv) *Orthodontic Service for Special Needs Patients*

Links have been established with all principal dental surgeons and senior clinical dental surgeons involved with the delivery of dental care to special needs children. Immediate orthodontic assessment or opinion is available to all special needs children.

Arrangements have also been established to permit a joint clinic with the special needs senior principal dental surgeon, when necessary.

4(v) Service Development

A planning brief for a second Regional Orthodontic Unit on the campus of Beaumont Hospital has been completed and approval is awaited from the Department of Health and Children in the context of its capital development programme. A submission has also been made to the Department of Health and Children with regard to the development of a third regional unit in Dublin south-east and this proposal is also awaiting approval from the Department.

5. ORAL AND MAXILLO-FACIAL SURGERY

In 1998 a Review Group, involving representatives from the acute general hospitals, the Dublin Dental Hospital and our Board, was established to examine the oral and maxillo-facial service in our Board's area and to make recommendations for service development. The report from the Review Group was adopted by our Board in January 1999 and its recommendations have been accepted by the Department of Health. Amongst the recommendations being currently pursued is the establishment of a day unit for oral surgery at St James's Hospital. The brief for this unit is now completed. Other recommendations relate to increasing the numbers and improving the skill mix of clinical staff in the service; in this context consultation with the various services and staff interests is progressing satisfactorily.

An allocation of £0.250m was made by the Department towards a waiting list initiative for patients wait-listed for oral surgery in 1998; a similar allocation was made in 1999. A dental surgeon with specialist training in oral surgery was assigned to reassess the patients on the waiting list and refer patients for treatment to the Dublin Dental Hospital or St. James's Hospital, in line with patient need. Both hospitals have made additional facilities/resources available in line with agreed funding norms; considerable progress has been made on reducing the waiting list in the last two years.

5(i) Advanced Restorative Services

This service was established, on a pilot part-time basis, with the assignment of a dental surgeon with specialist qualifications, to a unit at Baggot St Hospital, in September 1998,. He provides advice and treatment services to patients on a referral basis from dental surgeons in both primary care and orthodontic service.

During the year, our Board's management has been in consultation with the management of St. James's Hospital on developing a joint post of consultant prosthodontist; the work schedule and job description is now complete - the post will be advertised shortly.

6. DENTAL TREATMENT SERVICES SCHEME (D.T.S.S.)

This scheme was introduced in November 1994. It consisted of three elements - an emergency scheme; a routine treatment scheme, and a full denture scheme, whereby medical cardholders are treated by contracted general dental practitioners. Budgetary concerns at Department of Health and Children level meant that the scheme was introduced incrementally, based on age cohorts. Whilst all medical cardholders aged 16 years and over can access the emergency scheme, only certain age-groups can avail of the routine treatment scheme - those aged 16 - 34 and those aged 65 years and over.

During 1998 approximately 101,870 units of treatment were provided under the Choice of Dentist Scheme (D.T.S.S.) at a cost of £3.10m. The objective in the 1998 Service Plan to approve all applications within thirty days was achieved and has been maintained during 1999. Our Board's dental surgeons also allocate fifty session per week to adults to compliment the service provided by the private dentists.

The Minister has provided additional funding in the current year to facilitate the 35 - 64 year old cohort to enter the scheme in September 1999. Consultations are taking place with the I.D.A. at present to finalise protocols and payment scales for this patient group. This will mean that all medical cardholders have access to dental treatments provided by private practitioners.

Additional development funding was made available in 1999 as follows:

D.T.S.S. - to strengthen the base for the existing cohorts	£0.754m
Administrative support for monitoring of D.T.S.S.	£0.250m
D.T.S.S. - to enable our Board to extend services to 35 - 64 year age cohort, when this is introduced by the Department.	£0.562m
TOTAL	**£1.566m**

7. EMERGENCY SERVICES

Emergency services are available for all medical cardholders on demand through the D.T.S.S. and in exceptional circumstances through our Board's services.

8. FULL DENTURE SERVICES

A full denture service is provided for all medical cardholders over the age of 65.

9. NEW DUBLIN DENTAL HOSPITAL

The Dental hospital was replaced and officially opened in 1998

GENERAL

(a) Staffing

The number of dental surgeon/dental nurse teams has steadily risen over the years from 1993.

Year	*1993*	*1999*
Dental Teams	80	105

In 1991 our Board employed 8 hygienists to work as part of the dental team. Hygienists' duties include:

- cleaning and polishing of teeth;
- scaling teeth, i.e. removal of tartar deposits, accretions and stains from tooth surfaces;
- application to the teeth of prophylactic solutions, gels and sealants;
- giving of advice in relation to oral health.

These tasks are performed on the prescription of a registered dentist.

The number of dental nurses' posts within our service has risen to 113.

Our Board is in the process of employing eight oral health promoters. The oral health promoters will focus on co-ordination of oral health promotion activities in various groups of patients, particularly those with special needs.

Prior to the introduction of the Dental Treatment Services Scheme in 1994, adult medical cardholders could access emergency treatment only through health board clinics. This volume of work accounted for a considerable percentage of clinical time. Since 1994 the D.T.S.S. has allowed these patients to be seen by contracted general dental practitioners, thus freeing our Board's staff to devote more sessions to children and special needs groups.

Resources

The allocation for Dental Services has more than doubled since 1992:

1993	*1999*
£7.40m	£16.10m

(b) Quality Initiatives

Our Board continues to support a policy of continuous improvement of treatment facilities and continuous professional development of staff. In 1999 £0.250m has been allocated to continue the planned programme of upgrading surgeries to the highest standards and replacing obsolete equipment. Surgeries in the following locations have been upgraded this year: -
Arklow, Ballinteer, Ballymun, Baltinglass, Greystones, Larkhill, Limekiln Lane, Millbrook Lawns (Tallaght), Old County Road (Crumlin), Rathangan, Roselawn, Wicklow.

The current programme of developing new health centres and upgrading existing health centres is also accommodating the developing needs of the dental services - new dental suites were provided in recent years at Swords, Neilstown, Athy, Celbridge, Newbridge, Jobstown, Baltinglass. Dental suites are also included in the briefs for new centres at the planning stage.

The importance of a customer-friendly ethos continues to be underlined by the refurbishment of patient waiting areas; the purchase of toys for these areas and the introduction of audio-visual aids for patients to enjoy oral health education messages. A policy of encouraging parents to participate in their children's dental treatment has also been introduced in our Board's clinics.

One of the main provisos in the Health Strategy is that services should be accessible. Our Board's policy is that dental suites are provided in all major and medium sized health centres. Some of the clinics are staffed by a single team. There are some drawbacks with these arrangements when one or other member of the team (dental surgeon or nurse) may not be able to attend for duty at short notice (usually illness); this may require cancellation of the clinic as all of our Board's staff complement must be rostered for duty. As far as possible, our Board's staff endeavour to minimise inconvenience to patients and accommodate clients with a new appointment as early as possible. This problem could be overcome with larger centralised clinics; we are satisfied on balance, that the accessibility and associated diverse assignment of staff is the best option from a quality perspective.

A continuous education programme has been introduced where experts in many aspects of dentistry lecture to staff. In addition, staff are being sponsored on courses of higher training in order that they can keep up to date with the most modern techniques available in dentistry today.

(c) Development Needs

- The immediate priorities for service developments involve:
  (a) The development and staffing of the orthodontic units at Beaumont Hospital and in Dublin south.

(b) The implementation of the recommendations of our Board's policy document - *Development of Oral and Maxillo-facial services in the Eastern Health Board Region.*

- The proposed extension of eligibility for services to 14 and 15 year olds will require additional resources, both financial and manpower. Whilst some multi-clinics will have sufficient surgery space to accommodate these additional patients, smaller single and two-surgery locations, which are already working to full capacity, will not be able to deal with this extra eligible group without some compromise on existing services.

- Customer surveys have highlighted a need for dental services to access school children at a younger age. This finding is supported by our Board's 1997 oral health survey. Consideration must be given to earlier intervention measures and screening prior to 2nd class. The estimated cost of this development is £0.80m.

- A high rate of failure to attend for appointments has been identified in areas where there are large numbers of people from lower socio-economic groups. The 1997 survey showed that the highest decay rates were to be found in children from these groups. It is important, therefore, to encourage attendance at clinics in these areas. Research initiatives to encourage attendance for treatment are being pursued.

- It is recognised that carers play an important role in the maintenance of the oral hygiene of persons with special needs. There is a need to promote oral health in this group by educating carers in oral health messages. It is planned to address this issue by the production of a manual of best practice to assist all parents, carers, and care staff.

- Homeless persons are a group with special needs. A multi-disciplinary health assessment initiative is being carried out amongst this group to determine their heath needs. Dental services are included in this initiative as part of an integrated healthcare plan for the homeless.

- Oral health promoters, when appointed, will, as part of their remit, focus on oral health promotion initiatives with various groups of patients with special needs. It is planned that they will further reinforce health promotion messages being given by other members of the primary care team, as part of a policy of integration of primary care services within the community.

(d) Service for the Future

Our Board's dental service is robust and is continually evolving to meet the needs and expectations of both patients and staff. The current development and expansion of secondary care services in orthodontics and oral maxillo-facial surgery will provide a model for development in other specialist areas e.g. prosthodontics and paedodontics. This will require the up-skilling of a cadre of existing clinicians to specialist level in those areas.

Dental nurses employed by our Board have further developed skills in dental hygiene and in oral health promotion; some of these staff will be encouraged and facilitated to further develop their skills to take on duties as dental auxiliaries, enabling them to take on work at the lower level of clinical scale currently carried out by dental surgeons. In this way, the service of the future will be a vibrant, highly skilled dental service, capable of delivering complex treatments to our Board's patients, in conjunction with comprehensive preventive programmes, delivered in a cost-effective manner by dental auxiliaries.

The future planning and development of the service must take cognisance of the impact that the *Celtic Tiger Economy* is having on the public sector, particularly in the area of staff recruitment and retention. It is becoming increasingly clear that our Board faces a growing challenge to maintain staffing levels up to approved complements, in the face of ever increasing competition from the private sector.

Michael Walsh
Programme Manager

30th September 1999

APPENDIX A

The Dental Health Action Plan 1994

THE DENTAL HEALTH ACTION PLAN
26 MAY 1994

DEPARTMENT OF HEALTH
AN ROINN SLÁINTE

Shaping a Healthier Future

CONTENTS

* Summary of Dental Action Plan

* Main Elements of the Dental Action Plan

* A review of present dental services and dental health issues.

SUMMARY

The Dental Action Plan provides for:-

* The setting of oral health goals and the improvement of oral health promotion and preventive programmes including substantial capital investment in the national fluoridation programme.

* A significant enhancement of the public dental services through a more clearly defined role for health board dentists concentrating to a large extent on oral health care and services for children. There will be a significant increase in manpower.

* The extension of eligibility to children under 16 years of age

* The improvement of secondary care orthodontic services through the recruitment of additional consultant othodontists and support staff

* the expansion of hospital based oral surgery services through the appointment of additional consultant oral surgeons and support staff

* the introduction of new arrangements for the provision of adult dental services with the participation of private dental practitioners. Health board dentists will be entited to participate in these arrangements. The provision of services for adults will be phased in on the basis of age cohorts commencing with the over 65s.

* An emergency service will be available to all medical card holders on demand.

* A programme commencing shortly to provide full dentures to medical card holders over 65 who require them.

* A new Dublin Dental Hospital and School.

The revenue cost of the 1994 phase of the Dental Plan is estimated at £5.65 million. An additional £4.4 million has been provided in the 1994 Health Vote and the remaining expenditure required will be found from current expenditure.

The final phase of the Dental Development Plan will be implemented in 1997. Full year revenue costs will arise in 1998 and in subsequent years. These costs are estimated at £25.4 million per annum.

The Dental Action Plan

The main elements of the plan are:-

* Oral Health Goals.
* Oral Health Promotion and Preventive Programmes.
* Improved oral health care for children including the phased extension of eligibility for public dental services to children under 16 years.
* The phased improvement of primary and secondary care orthodontic treatment for all children who need it.
* The phased introduction of new arrangements for the provision of dental care to eligible adults involving participation by private dental practitioners.
* The expansion of hospital based oral surgery services.
* Provision of new Dublin Dental Hospital and School.

Details of the Dental Action Plan

General

For the first time in the history of the state a clear statement about the aims and health objectives of the dental service is being formally promulgated.

The aim of the public dental service is to improve the level of oral health of the whole population.

This will be achieved by setting Oral Health Goals for key age groups in the population and by using a combination of investigative, preventive and treatment strategies to help reach these targets.

* Oral Health Goals

The following Oral Health Goals for the year 2000 have been adopted.

- At least 85% of five-year-olds in optimally fluoridated areas and at least 60% of five-year-olds in less than optimally fluoridated areas will be free of dental caries in their deciduous teeth.

- Twelve-year-old children in optimally fluroidated areas will have on average no more than one decayed, missing or filled permanent tooth and, in less than optimally fluoridated areas on average no more than two decayed, missing or filled permanent teeth.

- The average number of natural teeth present in 16 - 24 year olds will be 27.7. This compares with a current average of 27.2.

- Not more than 2 per cent of 35 - 44 year olds will have no natural teeth.

- Not more than 42 per cent of people aged 65 years and over will have no natural teeth.

These Goals have been set on the basis of the most recently available epidemiological information from national and regional oral health surveys and from the World Health Organisations' Global Oral Health Data Bank in Geneva. Many of the Oral Health Goals which were set in 1984 have already been achieved.

Achieving these Oral Health Goals, and remedying the existing deficiencies in the dental services which have already been outlined is going to be a tremendous challenge to everyone concerned, including dental professionals and their support staff in the health board dental services and in the national educational system. Cross sectoral support from other areas such as the local authority services and industry will be integral to the success of the Dental Plan.

Many of the deficiencies in the present situation can be traced to a lack of coordination between the different sectors. An integrated plan will be implemented over the next four years in support of the aims which have been outlined.

In order to monitor changes in oral health and to measure the progress towards oral health goals for the whole population and for defined groups within the population who have special needs a standardised oral health data based information collection system will be established in each health board.

Dental epidemiological information will be collected by health boards with the help of appropriate departments in the university dental schools and international agencies.

* <u>Oral Health Promotion and Preventive Programmes</u>

Most of the improvement in oral health which has taken place in Ireland has been due to the strategy adopted in the 1960's to fluoridate water systems nationally.

Further improvements in oral health can be achieved by closer monitoring of fluoridation plants, continual upgrading of existing plants and relatively small increases in the number of new plants. Water fluoridation as a public health measure benefits the whole population equally and does not rely on compliance of individuals. That is the basis of its strength and efficiency.

At present 74% of the population resides in areas serviced by fluoridated water supplies. This varies from almost complete coverage in the Eastern Health Board area to about 50% in many parts of the Western seaboard area. A significant proportion of the fluoridation plant is now more than 20 years old and needs to be replaced.

During the course of the Dental Action Plan the efficiency of water fluoridation schemes will be increased by upgrading existing plants where necessary and merging inefficient smaller plants into larger regional schemes.

A sum of £250,000 has been allocated in 1994 as the first instalment towards these developments. Detailed consideration is being given to the submissions from each of the health boards for their fluoridation capital requirements for the next four years.

Wider Use of Fluorides

Fluoride Toothpastes

Dental decay is now understood to be a dynamic process which occurs on tooth surfaces which remain at risk throughout life and as a result need continuous exposure to preventive regimes. This fact has greatly increased the importance of the widespread and frequent use of fluoride toothpaste as a decay preventive measure for the whole population.

Industry has played a large part in promoting the benefits of fluoride and good oral hygiene. Media campaigns by the oral health products industry has created a demand for toothpaste and mouthwashes. The continuing fall in the incidence of dental decay in Ireland can be attributed in part to the use of fluoride toothpastes and rinses.

The regular daily use of fluoride toothpastes by the whole population over three years of age against dental decay will be promoted as a public health measure.

A sum of £50,000 has been committed in 1994 to a project which will be coordinated by The Health Promotion Unit in the Department of Health and by the Irish Dental Health Foundation in support of this aim.

Fluoride Mouthrinsing

Fluoride mouthrinsing programmes which are already in operation in schools in some areas, will be extended to other areas, especially in rural areas not serviced by fluoridated water supplies or where the fluoridated water system is deemed to be inefficient.

Oral Health Education

It is recognised that changes in oral health behaviours which benefit oral health occur slowly as a result of changing norms in society. Support for these changes comes primarily from the transmission of accurate oral health messages in the family situation and these messages must be reinforced in healthcare and educational settings and through the media.

Integrated oral health education programmes which stress the common risk factors between general health and oral health will be implemented. Some of the common risk factors which affect both general health and oral health are diet, hygiene, tobacco, alcohol, accidents and stress. It is clear that there needs to be multisectorial involvement in the establishment of effective programmes between a variety of health care and educational personnel and other groups.

Support for these programmes at a national level will be provided by the Health Promotion Unit in the Department of Health and the Irish Dental Health Foundation which is already setting up a framework for implementation.

* <u>Improved dental care for children including the phased extension of eligibility to children under 16 years.</u>

The services of health board dentists will largely be concentrated on providing oral health and treatment services to children and "special needs" groups with an emphasis on preventive programmes.

The method of delivery of oral health services to national school children is not yet uniform in all areas. For the past number of years health boards have been progressively adopting a planned targeted approach to the delivery of these services to national school children while phasing out a demand-led system. This ensures the optimum use of these resources and equal access for all national school children to the same level of dental care.

The school based approach puts an important emphasis on dental health education and prevention. Children in specific classes (usually 2nd, 4th and 6th classes) are targeted for preventive measures under the school based approach. The children in these classes are screened, and referred for treatment as necessary. The provision of fissure sealants for vulnerable teeth is an important

element of the preventive programme. The programme has been specifically designed to ensure that children are dentally fit before they leave national school.

The small number of children who require more frequent attention are identified and the required level of advice, check-ups, treatment etc. is provided as necessary.

An accident and emergency service for the relief of oral pain and infection is available on demand.

The targeted approach to the delivery of school dental services will be consolidated and extended under the Dental Action Plan.

The commitment to extend eligibility on a phased basis is made in the Programme for a Partnership Government.

Eligibility for free oral health care to children after they leave national school

is at present limited to the dependants of medical card holders. This means that 2/3 of all adolescents lose their eligibility for free dental services before the full eruption of their permanent teeth. All children, however, remain eligible for any unprovided secondary care services, e.g. orthodontics in respect of defects which were diagnosed while they were still at national school.

Children often experience an increase in dental decay after they leave national school. The presence of untreated decay in the teeth of these children often causes further complication and problems extending into adulthood and can make treatment in adulthood more difficult and more expensive.

The range of dental services to be provided will include preventive primary care dental services such as dental health education, examination, scaling and cleaning, and preventive treatments such as fissure sealing plus basic treatments. Those children who need orthodontic treatment will have been identified while in national school and will retain their eligibility for orthodontic treatment until it is completed.

Under the Programme for Partnership Government eligibility for free dental care will be extended up to age 16 (i.e. up to the 16th birthday) which will give entitlement to an additional 190,000 children. This will be phased in with eligibility extended to cover children under 14 years of the age in the first instance in 1994.

An amendment to the Health Act, 1970 to allow the Minister to make the necessary regulations extending entitlement has now been enacted.

* **The phased improvement of primary and secondary care orthodontic treatment for children**

The successful recruitment by most health boards of a consultant orthodontist has began to improve the position It is estimated, however, on the basis of the numbers who need treatment that a total of 9 consultant orthodontists and 31 appropriately trained dental support staff will be required to meet the service needs.

Provision for this staffing level is made in the action plan and additonal requirements will be phased in over the four year period.

* <u>The phased introduction of new arrangements for the provision of dental care to eligible adults</u>

A satisfactory dental scheme for adults is central to the successful provision of dental services to other groups. The services to those other groups will be delivered by dental personnel designated to individual areas of the dental services. The overlap between children's and adults' services in the past has restricted the development of both areas.

A new Dental Scheme for eligible adults is proposed. Following complex negotiations between the Department of Health and the Irish Dental Association both sides have been considering the outcome. The Minister is now pleased to announce that he is accepting the proposals. The Minister looks forward to the response of the Association. He understands that the National Council of the Association will shortly be considering the proposals with a view to balloting their members.

Under the proposals the services to be provided will include routine items of treatment plus an emergency service and the provision of dentures for the elderly. In the initial phasing the over 65s have been identified as the the first priority group. Private dental practitioners under contract to the health boards will be major providers of services.

From the outset emergency treatment will be available to all adults while routine treatment will be phased-in for identifiable priority groups within the eligible population over the period of the Plan.

* **The expansion of hospital based oral surgery services**

The major deficiency in secondary and tertiary care services is in the area of oral surgery. It is estimated that up to 25% of cases requiring consultant orthodontic treatment can have an integral oral surgery requirement which must be attended to as part of orthodontic treatment.

At present there is only one consultant oral/maxillo facial surgeon employed in the health services outside the dental hospitals. Initially two additional consultant posts are required to meet the need for treatment.

These posts are being created as part of the Dental Action Plan

* **Provision of New Dublin Dental Hospital and School**

The Government have approved of the extension and refurbishment of the Dublin Dental Hospital and School.

In the 1994 Health Vote £1m is being provided to commence this project and it is envisaged that the work will be phased over four years at an estimated total cost to the Exchequer of £8m.

A review of present dental services and dental health issues

The Oral health status of children as measured by the average number of decayed, missing and filled teeth (DMFT) index is continuing to improve. The rate of improvement is greatest in optimally fluoridated areas, including the cities and larger towns. For instance, the most recently available epidemiological information indicates that in an optimally fluoridated area up to 80% of 5 year old children are free from dental decay in their baby teeth. For 12 year old children the average number of decayed, missing or filled teeth has declined from 2.5 teeth to 1.5 in the last decade.

The oral health status of Irish adults is improving as measured by the DMFT index and by the percentage of adults who are retaining their own natural teeth.

Weaknessess which the Action Plan will address

* There is no systematically organised care for preschool children except for an accident and emergency service.

* The delivery of primary dental care to school children is uneven throughout the country. In some health board areas the level of access to care is poor because of chronic shortages of staff relative to the numbers of persons who are eligible for care. This imbalance needs to be redressed urgently.

* The improvement in oral health in adults is less notable in some sections of the population especially medical card holders. The lack of access to dental care for this group, because of the absence of a national treatment scheme for medical card holders, is a major contributory factor in this respect.

* There is a need to significantly increase the provision of dentures.

* Improving levels of oral health combined with rising standards of living have led to higher expectations in the population for dental care. While the adult population continues to focus on the demand for curative care for the common oral diseases of dental decay and gum disease there has also been a very big increase in the demand for more complex and

expensive dental procedures such as orthodontics.

* Access to necessary orthodontic care for children is limited in most parts of the country because of a mismatch between the need for care and the available number of appropriately trained personnel. The demand for orthodontic care continues to exceed our capacity to provide it.

* Oral and maxillo-facial services are concentrated almost exclusively in the Dublin and Cork areas.

* Comprehensive multidisciplinary oral health care services for medically compromised children and those with congenital facial abnormalities are in the early stages of development in this country.