REPORT OF WORKING GROUP

APPOINTED TO REVIEW

THE DELIVERY OF DENTAL SERVICES

DEPARTMENT OF HEALTH

JUNE 1988
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CHAPTER 1
INTRODUCTION

1.1 In March 1988, Dr Rory O'Hanlon, T.D., Minister for Health, recognising the problems which exist in the delivery of dental services, requested his colleague Mr Terry Leyden, T.D., Minister of State, to chair a Working Group which would report on ways in which the delivery of dental services should be improved.

1.2 The members of the Working Group were:

Mr Terry Leyden, T.D., Minister of State at the Department of Health (Chairman);
Mr Joseph O'Rourke, Assistant Secretary, Department of Health;
Mr Seamus O'Hickey, Chief Dental Officer, Department of Health;
Dr John Clarkson, Deputy Chief Dental Officer, Department of Health;
Mr Patrick Murtagh, Programme Manager, Community Care, North-Eastern Health Board;
Mr Diarmuid Shanley, Dean of Dental Affairs, University of Dublin;
Mr Martin Gallagher, Finance Officer, Eastern Health Board;
Ms Pauline Moreau, Higher Executive Officer, Department of Health (Secretary).

1.3 The terms of reference set the Working Group were:

To report to the Minister on ways in which the delivery of dental services should be improved.

The Group should, as well as considering the question of general improvement in the services, consider specially the
question of improving orthodontic services and the question of assisted borrowing of money or deferred payment for individuals to assist in payment for expensive orthodontic services.

1.4 The Working Group met on six occasions.

1.5 The Chairman and members of the Working Group wish to express their appreciation of the contribution made to its work by the Secretary, Ms. Pauline Moreau. She was at all times most attentive to the requirements of the Group and her efficiency and courtesy helped in no small way to expedite the completion of the task.
CHAPTER 2
SUMMARY OF RECOMMENDATIONS

FUTURE ROLE AND STRUCTURE OF THE HEALTH BOARD DENTAL SERVICE

2.1 The Working Group strongly recommends the adoption of a national strategy for the delivery of dental services to ensure that an equal standard of service is available to all eligible persons. (Paragraph 4.1)

2.2 The Working Group recommends that this national strategy should be based on a clearly defined role for the health board dental service and the health board dental surgeons. (Paragraph 4.2)

2.3 The Working Group recommends that the Department of Health should develop national guidelines for the implementation of a systematic approach to the delivery of services. (Paragraphs 4.5-4.6)

2.4 The Working Group strongly recommends that all posts which fall vacant in the health board dental service should be filled as a matter of course to maintain what is already an inadequate dentist/population ratio. (Paragraph 4.8)

2.5 The Working Group recommends that the health boards play a major role in the pilot establishment of the proposed new class of dental auxiliary. (Paragraphs 4.9-4.10)

PREVENTIVE PROGRAMMES

2.7 The Working Group strongly recommends that a specific allocation be provided in the Public Capital Programme to clear the debts associated with water fluoridation already incurred by the health boards and also that an additional specific allocation of £200,000 be provided annually to facilitate the forward planning of fluoridation of new water supplies. (Paragraph 5.7)

2.8 The Working Group strongly recommends that a further allocation of £200,000 be made available forthwith and annually for five years to facilitate the immediate development of the programme aimed to replace defective and deficient fluoridation plant and equipment. (Paragraph 5.8)

2.9 The Working Group recommends that each health board institute fluoride mouth rinsing programmes in those areas which are not served by fluoridated water. (Paragraph 5.9)

2.10 The Working Group recommends the development as part of the school dental service of a programme to apply fissure sealants to the vulnerable teeth of children in first and sixth classes of national schools. (Paragraph 5.10)

**ROUTINE DENTAL TREATMENT FOR CHILDREN**

2.11 The Working Group considers that it is imperative that a solution be found to the problems which are occurring in regard to the lack of provision of dental services to eligible adults in order to maintain and improve upon the services for children. (Paragraph 6.2)
2.12 The Working Group recommends the establishment of a school-based structured and systematic approach to the delivery of children’s dental services. (Paragraphs 6.3-6.7)

2.13 The Working Group recommends that national guidelines should be drawn up by the Department of Health for children’s services. (Paragraph 6.9)

2.14 The Working Group recommends that the service should concentrate on children in first and sixth class in the first instance and that children in those classes should be given appropriate treatment as necessary. (Paragraph 6.9)

2.15 The Working Group recommends that children who are found to be at high risk of dental disease at the examination in first class should be referred for regular follow up screening. (Paragraph 6.9)

2.16 The Working Group considers that the health board dental surgeon should, when carrying out conservative treatment, give priority to the treatment of permanent teeth. (Paragraph 6.10)

2.17 The Working Group recommends that, as a first step towards a better treatment provision for adolescents, the health boards should establish a routine screening and treatment service for eligible children aged 15 years. (Paragraph 6.12)

2.18 The Working Group believes that it would be desirable to extend eligibility for health board dental services to all children aged under 16 years when resources permit. (Paragraph 6.13)
ROUTINE DENTAL TREATMENT FOR ADULTS

2.19 The Working Group considers that the health boards are failing in their statutory obligation to provide dental treatment for eligible adults. (Paragraph 7.5)

2.20 The Working Group endorses the contribution made by dentists in private practice to the treatment of eligible adults under the Ad Hoc Scheme and strongly recommends that the health boards should establish a similar type of scheme as the most appropriate method for delivering routine dental treatment to eligible adults. (Paragraph 7.12)

2.21 The Working Group strongly recommends that a special allocation be made available to clear, within a period of 18 months, the present excessive waiting lists of adults requiring routine dental treatment. (Paragraph 7.13)

2.22 The Working Group would wish to see a marked improvement in accessibility to dental services for eligible adults and therefore recommends that an additional specific allocation be provided annually for this purpose. (Paragraph 7.14)

2.23 The Working Group considers that it might well be appropriate to introduce a charge for dentures if a change permitting the imposition of charges on medical card holders for specific services were to be made to the Health Act at some time in the future. (Paragraph 7.15)
SECONDARY DENTAL CARE - ORTHODONTIC TREATMENT

2.24 The Working Group recommends that health boards make renewed efforts to recruit salaried consultant orthodontists. (Paragraph 8.4)

2.25 The Working Group recommends that the consultant staffs of the two dental hospitals should give priority in the provision of orthodontic treatment to eligible children referred to the hospitals by the health boards. (Paragraph 8.5)

2.26 The Working Group considers that the present arrangements for the provision of orthodontic treatment for children with cleft lip and palate are inadequate and therefore recommends that they should be upgraded. (Paragraph 8.6)

2.27 The Working Group considers it would be appropriate to impose a reasonable charge in respect of orthodontic treatments provided for children whose parents are in health eligibility categories II and III and that moneys raised should be redistributed within the health board dental service. (Paragraphs 8.8-8.13)

2.28 The Working Group recommends that if, at some time in the future, charges were imposed on medical card holders in respect of certain services, it would be appropriate to impose a reasonable charge for orthodontic services. (Paragraph 8.10)

2.29 The Working Group recommends that children with cleft lip and palate should be exempt from such charges irrespective of the eligibility category of their parents. (Paragraph 8.11)
2.30 The Working Group endorses the orthodontic guidelines drawn up by
the Department of Health and recommends their continued usage in
the assessment of need for treatment. (Paragraph 8.14)

SECONDARY DENTAL CARE - ORAL SURGERY AND PAEDIATRIC DENTISTRY

2.31 The Working Group recommends the creation of consultant posts in
oral surgery in the South-Eastern and Western Health Boards.
(Paragraph 9.2)

2.32 The Working Group also recommends the re-creation of the
consultant oral surgeon post in the Eastern Health
Board. (Paragraph 9.2)

2.33 The Working Group recommends that the health boards avail of the
expertise available in the dental hospitals to develop paediatric
dental services (Paragraph 9.5)

2.34 The Working Group recommends that each health board should appoint
a Senior Clinical Dental Surgeon to take specific responsibility
for dental services for the handicapped on a health board-wide
basis. (Paragraph 9.6)

2.35 The Working Group considers that close cooperation between the
consultants in paediatric dentistry in the dental hospitals and
the relevant Senior Clinical Dental Surgeons who have
responsibility for services for the handicapped will lead to an
enhancement of the services available for the handicapped.
(Paragraph 9.7)
3.1 Section 67 of the Health Act, 1970 governs the provision by the health boards of dental services to eligible persons. The section states that

67(1) A health board shall make dental, ophthalmic and aural treatment and dental, optical and aural appliances available for persons with full eligibility and persons with limited eligibility.

(2) A health board shall make dental, ophthalmic and aural treatment and dental, optical and aural appliances available in respect of defects noticed at an examination under the services mentioned in section 66. (*)

(3) Save as provided for under subsection (4), charges shall not be made for treatment and appliances made available under this section.

(4) The Minister may, with the consent of the Minister for Finance, make regulations -

(a) providing for the imposition in specified circumstances of charges for services under this section for persons who are not persons with full eligibility or for specified classes of such persons; and

(b) specifying the amounts of the charges or the limits to the amounts of the charges to be so made.

Note: (*) Section 66 relates to the Child Health Services.
3.2 The provisions of the Health Act are qualified by article 9 of the Health Services Regulations, 1972 which states that:

9. Services under section 67(1) of the Act shall be made available only to persons with full eligibility.

ELIGIBILITY FOR HEALTH BOARD DENTAL SERVICES

3.3 Those eligible for health board dental services are

(a) Medical card holders and their dependants;

(b) Pre-school and national school children in respect of defects noted at child health examinations;

(c) Other persons adjudged by the Chief Executive Officer of a health board to be unable to provide a particular service for themselves without experiencing hardship.

3.4 It is estimated that about 1.96 million persons are eligible for the health board dental services. This statistic can be broken down by category as follows:

<table>
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<tr>
<td>Pre-school children</td>
</tr>
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<td>National school children</td>
</tr>
<tr>
<td>Medical card holders and</td>
</tr>
<tr>
<td>their adult dependants</td>
</tr>
<tr>
<td>Adolescent dependants</td>
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<tr>
<td>Total</td>
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3.5 Some medical card holders who are fully insured workers or the dependent spouses of fully insured workers may also be entitled to routine dental treatment provided in accordance with the Dental
Treatment Benefit Scheme operated by the Department of Social Welfare. It is estimated that between 300,000 and 400,000 persons have dual eligibility under the two State schemes. The Department of Social Welfare’s Dental Treatment Benefit Scheme provides routine treatment including a preliminary assessment, fillings, extractions and scaling and polishing without charge. The Scheme provides a closed grant-in-aid towards the cost of routine dentures and an open grant-in-aid for more sophisticated dentures.

DENTAL MANPOWER

3.6 There are six professional grades of dentist in the health board dental service at present. These are:

- Chief Dental Surgeon
- Principal Dental Surgeon
- Consultant Orthodontist
- Senior Clinical Dental Surgeon
- Clinical Dental Surgeon Grade II
- Clinical Dental Surgeon Grade I

3.7 The most recent statistics available show that in February 1988 there were 246.5 wholetime equivalent dental surgeons employed in the health board dental service. In addition the health boards employ dental surgery assistants to assist the dentist at the chairside and to carry out reception and other duties. The dental team receives back up administrative assistance at local and central health board level from the health boards’ administrative and clerical staffs.

3.8 The health boards formerly engaged the services of dentists in private practice to provide treatment for eligible adults in
accordance with the provisions of the "Ad Hoc" Dental Scheme. (See paragraphs 7.2 – 7.3). However in recent times the health boards have curtailed or withdrawn this Scheme. In a few areas the health boards continue to make limited use of private dentists to treat eligible children in their private surgeries. Some boards also engage private dentists to treat eligible patients on a sessional basis in health board clinics.

3.9 Although six posts of consultant orthodontist for the health board dental service were created in 1983 and have been advertised on many occasions over the years, only one post has been filled so far. The health boards avail of the services of specialist orthodontists in private practice to treat eligible children. Arrangements vary from health board to health board and even within health boards. The method of remuneration also varies and can be either a sessional payment or fee per item of service. (See paragraphs 8.1 – 8.5).
CHAPTER 4
THE FUTURE ROLE AND STRUCTURE OF THE HEALTH BOARD DENTAL SERVICE

4.1 The Working Group believes it is desirable to initiate a more structured approach to the Health Board Dental Service. At present there are wide variances between health boards and even within health boards in their approach to the delivery of dental services. The Working Group strongly recommends the adoption of a national strategy for the delivery of dental services to ensure that an equal standard of service is available to all eligible persons.

4.2 The Working Group recommends that this national strategy should be based on a clearly defined role for the health board dental service and the health board dental surgeons. The service should be planned, implemented and evaluated by the Chief and/or Principal Dental Surgeons who would have managerial responsibility for the delivery of dental treatment. Criteria should be developed and introduced to evaluate the performance of the public dental service on a regular basis.

4.3 The Working Group would like to emphasise the benefits it sees in continuing education and believes that every encouragement should be given to the dental staff of the health boards to participate in continuing education and post-graduate training in clinical and administrative skills.

4.4 It is suggested that the future role for the health board dental service should encompass

- an epidemiological basis for the planning, implementation and evaluation of services;
- the development of a standardised data-based management information service;
- a preventive approach to services including the organisation and implementation of preventive programmes;
- monitoring water fluoridation;
- the direct delivery of services for pre-school and national school children;
- the delivery of services for the handicapped;
- the supervision and monitoring of service delivery for adults;
- the organisation of necessary secondary care services for eligible persons;
- oral health services research.

4.5 In advocating the development of a national strategy for the delivery of health board dental services, the Working Group recommends that the Department of Health should develop national guidelines for the implementation of a systematic approach to the delivery of services. Areas in which it would be desirable to develop such guidelines immediately include

- the delivery of services for children and adolescents; (Paragraphs 6.7-6.10)
- the delivery of services for adults; (Paragraphs 7.12-7.14)
- the delivery of services for the handicapped. (Paragraphs 9.3-9.7)

Guidelines on the provision of orthodontic treatment have already been issued by the Department of Health and have been adopted by most health boards.
4.6 The implementation of such guidelines may lead to initial problems in some areas, for example in those areas where treatment has been available on demand for children. The introduction of a structured approach in line with recommendations of this Report may diminish access on demand to routine services. However if the changes are seen in the context of a new, more structured and more equitable approach to the delivery of services, public perception of, and reaction to the changes will be favourable. The Working Group believes the onus will be on the health boards to implement the changes to bring a better service to the client population.

4.7 The Working Group also believes that, in asking the health boards and the health board dental service to implement these changes, the staffs of the health boards will benefit from a more structured and positive approach to the delivery of dental care and will achieve greater satisfaction from their task.

4.8 The present dentist/population ratio in the health board dental service is one dentist per 7,967 eligible persons. When the estimated numbers of persons with dual eligibility under both the Treatment Benefit Scheme and the health board services are excluded the ratio improves to at best one health board dental officer per 6,344 persons relying upon the health board dental service. This ratio falls far below the level considered acceptable in developed countries. The Working Group strongly recommends that all posts which fall vacant in the health board dental service should be filled as a matter of course to maintain what is already an inadequate dentist/population ratio.
4.9 At present there are six professional grades and one auxiliary grade in the salaried public dental service. The Dental Council has recently recommended that a new class of dental auxiliary be established on a pilot basis to carry out a specified range of procedures. The duties appropriate to this class of auxiliary might include scaling and polishing, the application of topical fluorides and fissure sealants and the provision of dental advice. The employment of such auxiliaries in the health board dental service could be expected to be cost efficient.

4.10 The Working Group recommends that the health boards play a major role in the pilot establishment of the new class of dental auxiliary and that the boards should engage the services of these auxiliaries to carry out the full allowed range of procedures. However, the Working Group stresses that the creation of new posts of dental auxiliary should be regarded as an additional development and should not under any circumstances lead to reductions in the numbers of dental surgeons or dental surgery assistants employed in the health boards.
5.1 The Joint Working Party on the Dental Services which reported in 1979 recommended that prevention of dental disease must be promoted, not only in the interest of the well-being of the community, but also as a practical economic measure to contain the treatment load within limits which the community can reasonably afford. The Working Party argued that priority must be given to the development of preventive services and the adoption of a philosophy of prevention and stressed that while the provision of treatment and restorative services for eligible persons must remain a function of the health board dental service, it can only succeed within the framework of prevention.

5.2 Preventive measures in dentistry have long been established in Ireland. The Health (Fluoridation of Water Supplies) Act, 1960 mandated the introduction of fluoride to public piped water supplies specified in secondary legislation. Fluorides were first added to the major urban water supplies in 1964 and over the following ten years a national development programme led to the installation of fluoridation plant in all suitable water supplies which served a population of at least 1,500 persons. The development programme has continued through the installation of plant in newly developed and replacement regional water supplies. More than 2.3 million persons or almost 67 per cent of the population are now served by fluoridated water supplies.

5.3 The benefits of water fluoridation as a public health measure have long been recognised thanks to research findings from other
countries. As a result of the National Survey of Children’s Health, 1984, we in Ireland are now in a position to contribute to the international literature on the benefits of water fluoridation, which was conducted on behalf of the Minister for Health by University College Cork. The Survey which examined 9,473 children on a nationwide basis found conclusive evidence that while there has been an overall decline in the prevalence of dental caries over the past twenty years, this decline was most marked in children who were lifetime residents of fluoridated areas.

5.4 The Working Group welcomes this endorsement of the benefits of water fluoridation and awaits with interest the findings of the National Survey of Adult Dental Health which is also being carried out by University College Cork with funding from the Health Research Council and the Commission of the European Communities. Field work for the Adult Survey will commence in late 1988.

5.5 The annual capital cost per head of population has been estimated at 3.8 pence, while the annual operating cost per head of population is about 21.2 pence in current terms. The overall cost is therefore 25 pence per head of population per annum. However only 67% of the population are served by water from fluoridated supplies. Thus the overall cost per head of population who actually receives fluoridated water is 37.3 pence.

5.6 The National Survey of Children’s Dental Health found that the average number of teeth affected by decay in an eight-year-old living in a fluoridated area was 3.6 compared to 4.9 per child living in a non-fluoridated area. Among 12-year-olds the
difference was between 2.6 in fluoridated areas and 3.3 in non-fluoridated areas. Therefore the treatment need of children in fluoridated areas is significantly lower than the treatment need of children in non-fluoridated areas. The saving is likely to be at least £4-£5 per child which compares very favourably with the cost of providing fluoridated water.

5.7 In terms of value for money the fluoridation of public water supplies has proved to be a most cost beneficial preventive measure. However the Working Group is aware that a lack of capital funding is now seriously threatening the fluoridation programme and this must be tackled immediately if a legacy of demand for expensive dental treatment in the future is to be avoided. The Working Group strongly recommends that a specific allocation be provided in the Public Capital Programme to clear the debts associated with water fluoridation already incurred by the health boards, and also that an additional specific allocation be provided annually to facilitate the forward planning of fluoridation of new public water supplies. It is estimated that an annual provision of the order of £200,000 would cover needs in this latter regard.

5.8 The Working Group acknowledges that the water fluoridation programme does not always function at optimal levels due in the main to the age of the equipment, some of which is now in place for over twenty years; to the lack of stand by or short-term replacement pumps which can be called into service during a pump failure and finally to the lack of adequate storage capacity for fluoride in some water supplies. The Working Group understands that the Department of Health and the Department of the
Environment have had informal discussions on a possible programme to alleviate these problems. It was estimated that a capital injection of £200,000 per annum over a five year period would be adequate to finance a site development programme to be jointly undertaken in order to identify and remedy problems at each water supply on a phased basis. The Working Group strongly recommends that the sum of £200,000 be made available forthwith and annually for five years to facilitate the immediate development of the review programme aimed to replace defective and deficient water fluoridation plant and equipment.

5.9 The public water supplies are not all suitable for water fluoridation due to their small size or engineering structure. As a result, only two thirds of the population can benefit from the water fluoridation programme. In endorsing the benefits of water fluoridation as a measure for the large scale delivery of fluoride, the Working Group also recommends that an alternative method of fluoride delivery should be put in place in areas where water fluoridation is not feasible. One such method which has been used already in a number of rural areas is a fluoride mouthrinsing programme. Existing programmes are school-based and are administered on a regular basis under supervision. While this method of fluoride delivery is not as cost efficient as water fluoridation, the Working Group recognises that a fluoride mouth rinsing programme would extend the therapeutic benefits of fluoride to a further proportion of the population. The Working Group strongly recommends that each health board institute fluoride mouth rinsing programmes in those areas which are not served by fluoridated water. The Working Group recommends that a number of existing fluoride mouth rinsing programmes be fully
tested and assessed under the supervision of the dental officers from the Department of Health.

5.10 The National Survey of Children's Dental Health found that most of the dental caries in children up to the age of 15 years is confined to the first permanent molar teeth and that only the biting and chewing surfaces are involved in 50 per cent of these teeth. The Working Group recommends the development of a programme to apply fissure sealants to the vulnerable teeth of children in first and sixth classes as part of the school dental service. The Working Group recommends that a research project should be established under the supervision of the dental officers of the Department of Health to evaluate this programme, including the role of dental auxiliaries in the delivery of such a service.

5.11 The Working Group endorses the policy of the Department of Health on health promotion and urges the health boards to make it an integral part of their oral dental health programmes. Dental health education is a vital element in health promotion and disease prevention. Formal and informal schemes of instruction for the individual patient and for groups, for example expectant and nursing mothers, school classes, etc., must be designed and implemented to promote the ideas of self-help and personal responsibility for oral health. The role of the Health Promotion Unit and the Dental Health Foundation is emphasised to encourage health boards to make the fullest use of their services.
CHAPTER 6
ROUTINE DENTAL TREATMENT FOR CHILDREN

6.1 The health boards have statutory responsibility for the dental treatment of pre-school and national school children and the adolescent dependants of medical card holders. The service is provided almost entirely by the health board dental surgeons although in a few areas the boards refer children to private practitioners, albeit on a limited basis.

6.2 The number of children treated annually continues to increase. In 1983, the number of children treated by the health boards was 296,154. In 1987, they treated 318,966 children. However with the curtailment of routine dental services for adults (see paragraph 7.4), there has been a massive increase in demand for emergency treatment by eligible adults. This is hampering the development and in certain areas the maintenance of dental services for children. The Working Group considers that it is imperative that a solution be found to the problems which are occurring in regard to the lack of provision of dental services to eligible adults in order to maintain and improve upon the services for children.

6.3 The statutory base for the dental health service prescribes a service based upon referral from the child health examinations organised by the health boards. However practice varies from health board to health board. The lack of a coordinated approach to the delivery of routine services has given rise to considerable criticism over the years. A review of administrative procedures in the health boards reveals three main methods of delivering dental services for children.
6.4 The first relies entirely on patient demand. When a parent seeks treatment for a child, the child's name is placed on a waiting list and the child is called for treatment at the earliest opportunity. A public dental service based on client demand rather than need does not always serve those in greatest need. Indeed there is ample evidence that persons in disadvantaged areas or from disadvantaged backgrounds place a lower priority on dental care than do persons from advantaged backgrounds. This view was confirmed by the National Survey of Children's Dental Health, 1984 which found that 71 per cent of 8-year-old children from social classes AB had attended a dentist within the previous year compared with only 52 per cent of children in social classes DE. It can therefore be inferred that self-referral is far from ideal as a method for the delivery of child dental services.

6.5 The other two methods are school-based. The second is based on rotational visits to each school within a health board area. Each child in the school is assessed and referred for treatment as necessary. The problem here lies with the long time interval between visits. In some areas inspections only take place every three years. Thus a child examined initially in first class can expect a follow-up check in fourth class but will have moved into secondary school prior to the next visit by the public dental officer to the school and the child would not necessarily be dentally fit when it moves out of the health board system.

6.6 The third method aims to assess and treat all children in specific classes on an annual basis. The selected classes are usually either first or second class and sixth class. Some areas
also aim to treat children from an intervening class. The two main advantages of this approach are firstly that it is clearly structured and secondly that the children are made dentally fit before they pass from the health board system.

6.7 **In discussing the role of the health board dental surgeon in Chapter 4, the Working Group gave a high priority to the provision by the health board dental surgeons of an excellent service for children. The Working Group wishes to reemphasise that view and to recommend the establishment of a school-based, structured and systematic approach to the delivery of children's dental services.**

6.8 **The Working Group recommends that national guidelines should be drawn up by the Department of Health for children's services. The Working Group is confident that the strict application of such guidelines will lead to a uniform availability of services throughout the country.**

6.9 **While the Working Group would wish to see an annual screening service for all eligible children as the norm, it recognises that the resources to implement such a comprehensive service are not available. The Working Group recommends that the service should focus on children in first and in sixth classes in the first instance and that children in those classes should be given appropriate treatment as necessary. If and when surplus resources become available, a full screening service might be introduced for children in other classes. The Working Group recommends that children who are found to be at high risk of dental disease at the first examination should be referred for regular follow up screening.**
6.10 In drawing up guidelines, the Working Group recommends that clear directions should be formulated with regard to the conservative treatment of baby teeth. Health board statistics suggest that in some areas a high proportion of conservative treatment carried out in children involves the filling of baby teeth. While this may be ideal in times of plentiful resources, the Working Group considers that the health board dental surgeons should, when carrying out conservative treatment, give priority to the treatment of permanent teeth.

6.11 The Working Group has already recommended the application of fissure sealants to vulnerable teeth (see paragraph 5.10) and wishes to reemphasise the recommendation that they be applied as part of the dental service for national schools.

6.12 The Working Group considers that services provided for eligible adolescents have fallen far short of desirable levels in most areas. Indeed there is evidence that this group receives the lowest priority in most areas. The Working Group believes that dental services for this group should, in the future, also be subjected to a structured approach. The Working Group recommends that as a first step towards a better treatment provision for adolescents, the health boards should establish a routine screening and treatment service for eligible children aged 15 years.

6.15 The Working Group believes that it would be desirable to extend eligibility for dental services to all children aged under 16 years at some time in the future. However the Working Group acknowledges that resources do not permit such an extension at the present time.
CHAPTER 7
ROUTINE DENTAL TREATMENT FOR ADULTS

7.1 It is estimated that about 1,056,000 adults and adolescents have eligibility for dental services provided by the health boards. Of that number, between 300,000 and 400,000 would also have entitlement to the Dental Treatment Benefit Scheme administered by the Department of Social Welfare which provides routine dental treatment without charge although it only makes a contribution equivalent to one third of the cost of dentures. Thus about 700,000 adults and adolescents are relying exclusively on the health boards as sources of dental treatment.

7.2 The Joint Working Party which reported in 1979 recommended that in a situation where health boards are unable to provide an adequate primary care service for all eligible persons, any spare capacity in the private practice area should be availed of in order to improve the level of service for public patients. As a result the health boards introduced new Ad Hoc arrangements in 1980 to provide dental services for medical card holders and their adult and adolescent dependants. The health boards were authorised to use the services of dentists in private practice to provide routine dental treatment for eligible adults referred to them by the health boards.

7.3 At its peak in 1982 and 1983, about 32,000 adults received treatment annually under the Ad Hoc Scheme while a further 32,000 received routine treatment and 17,000 received emergency treatment from the health board dentists. The fee scale which applied under the Ad Hoc Scheme was similar to the scale which operated under
the Department of Social Welfare's Treatment Benefit Scheme. The Scheme was quite expensive to operate, possibly due to the high average age structure of the medical card population, which increases the demand for dentures and also to the accumulated dental treatment need. The health boards began to curtail the Scheme as early as 1984 in some areas and it now only operates in two boards and even there its scope is severely curtailed.

7.4 The health board dentists provide emergency treatment for adults and adolescents and they provide a limited amount of routine treatment for eligible adults at after-hours sessions. The lack of routine treatment for adults and adolescents has led to a significant increase in demand for emergency treatment and this service makes considerable inroads into the time of the health board dentists and prevents them from providing the necessary levels of service for children. In addition, emergency treatment usually only consists of a single tooth extraction or other immediate measure for the relief of immediate pain. Adults seeking courses of routine treatment are placed on waiting lists in most health boards although some boards now recognise the futility of waiting lists and have suspended them. All boards make routine treatment available to some extent to persons who are considered to be in priority groups. These usually include the elderly, the handicapped, and pregnant and nursing mothers.

7.5 The Working Group considers that the health boards are failing in their statutory duty to provide dental services for eligible adults. As the table below shows, fewer than 39,000 eligible adults received routine dental treatment in 1987. This represents only six per cent of the adult and adolescent population who rely
on the health boards to provide them with dental care.

<table>
<thead>
<tr>
<th>Number of adults for whom treatment was provided 1983 and 1987</th>
<th>1983</th>
<th>1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Health Board dentists</td>
<td>17,201</td>
<td>27,890</td>
</tr>
<tr>
<td>- Ad Hoc Scheme</td>
<td>363</td>
<td>461</td>
</tr>
<tr>
<td>Routine Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Health Board dentists</td>
<td>38,822</td>
<td>33,035</td>
</tr>
<tr>
<td>- Ad Hoc Scheme</td>
<td>31,698</td>
<td>5,830</td>
</tr>
<tr>
<td>Total number of adults treated</td>
<td>88,084</td>
<td>67,216</td>
</tr>
</tbody>
</table>

7.6 Although some health boards have ceased keeping waiting lists of adults seeking dental treatment, there is evidence to suggest that at least 50,000 adults are awaiting dental treatment from the health boards. Because some of the waiting lists are over four years old the Working Party had certain doubts about their validity and initiated a small research exercise based on a postal questionnaire addressed to a randomly selected sample of persons drawn from the waiting lists of two community care areas, Dublin and Roscommon.

7.7 The sample size was 445, based on 307 in Dublin and 138 in Roscommon. The response was 176 (57.3%) in Dublin and 65 (47.1%) in Roscommon. The response rate compares favourably with that usually received in postal questionnaires. A further six replies from Dublin and three from Roscommon were found to be invalid due to the death or change of address of the respondent.
7.8 Replies were first analysed on the basis of age and a marked difference in the age profile of the waiting lists of an urban (Dublin) and rural (Roscommon) community was found. The results are summarised below:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Dublin</th>
<th>Roscommon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25 years</td>
<td>34.1</td>
<td>22.6</td>
</tr>
<tr>
<td>25 years - 44 years</td>
<td>36.4</td>
<td>19.4</td>
</tr>
<tr>
<td>45 years - 64 years</td>
<td>17.1</td>
<td>21.0</td>
</tr>
<tr>
<td>65 years and over</td>
<td>5.9</td>
<td>33.9</td>
</tr>
<tr>
<td>Total not stated</td>
<td>6.5</td>
<td>3.2</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.1</td>
</tr>
</tbody>
</table>

The age structure of the waiting list influences the treatment need of those awaiting treatment. Almost 60 per cent of those awaiting treatment in Roscommon are seeking dentures while only a third of the Dublin persons say they need dentures. Only six persons, all in Dublin, said they only required advanced treatment, usually crowns. Thus it can be deduced that the treatment need of most of those on the waiting list is ordinary routine treatment. However the fact that 40 per cent of those on the waiting list require dentures signifies that the cost of providing treatment for all those awaiting treatment is likely to be very high.

7.10 The respondents were asked whether they had received dental treatment from any source since they had applied for treatment
from the health board. In all, 63 persons (37.1%) in Dublin and 25 persons (40.3%) in Roscommon obtained treatment. In Dublin, the majority of these were treated by the health board while in Roscommon 16 cases received treatment from sources other than the health board. However of the 88 persons who obtained interim treatment, only nine persons, (five in Dublin, four in Roscommon) said they no longer need health board dental services in the immediate future.

7.11 On the basis of the Survey findings, no more than ten per cent of those who are on the waiting lists would no longer require treatment due to death, change of residence (untraceable) or because treatment has been obtained elsewhere. It can therefore be assumed that about 45,000 adults and adolescents are awaiting dental services from the health boards at present.

7.12 The Working Group recognises that the health boards do not have the manpower resources to provide an adequate dental service for both adults and children. The Working Group endorses the contribution made by dentists in private practice to the treatment of eligible adults under the Ad Hoc Scheme and strongly recommends that the health boards should establish a similar type of scheme as the most appropriate method for delivering routine dental treatment to eligible adults.

7.13 The Working Group strongly recommends that a special allocation be made available to clear, within a period of eighteen months, the present excessive waiting lists of adults requiring routine dental treatment.
7.14 However it is not merely adequate to clear existing waiting lists. The Working Group would wish to see a marked improvement in the accessibility to dental services for eligible adults and therefore recommends that an additional specific allocation be provided annually for this purpose.

7.15 The Working Group acknowledges the high cost of providing dentures for eligible adults. While the introduction of a charge for this service is constrained at present by the provisions of the Health Act, 1970, the Working Group considers that it might well be appropriate to introduce a charge for dentures if a change permitting the imposition of charges for specific services on medical card holders were made to the Health Act at some time in the future.

7.16 The two dental schools and hospitals receive subventions from the Department of Health. Discussions are in progress on the performance of the hospitals in order to ensure that the best possible value in terms of the treatment of eligible patients is obtained. The Working Group welcomes these discussions and recognises that, while the hospitals are constrained by their requirements vis a vis their under-graduate and post-graduate training programmes, in times of financial constraint and pressure upon the public dental services it is desirable that the dental hospitals contribute fully to the delivery of services to eligible persons.
8.1 The principal secondary care demand for children is orthodontic treatment to correct the malalignment of teeth. In 1979, the Joint Working Party on the Dental Services recognised that needs for orthodontic treatment, particularly those requiring more complicated therapy, were not being met. That Working Party recommended that consultant posts in orthodontics should be created on an appropriate population basis. It has already been pointed out that efforts to fill these posts have, except in one instance, been fruitless.

8.2 Health boards provide limited orthodontic treatment for eligible children through the services of their own salaried dental surgeons as every dentist is qualified to provide simple orthodontic treatment. However the more severe problems require advanced treatment which can only be carried out either by or under the guidance of a fully trained specialist orthodontist. The scarcity of consultant orthodontists in the health board service is hampering the provision of complicated treatments.

8.3 Nevertheless the health boards continue to provide specialist orthodontic services through various local arrangements. The Mid-Western Health Board is the only Board which has the services of a full-time consultant orthodontist. This had led to the provision of a comprehensive service within the area and has also given rise to the training of three clinical dental surgeons from the Mid-Western Health Board area. In addition the consultant orthodontist treats eligible patients from the South-Eastern
Health Board on a sessional basis and is also assisting in the orthodontic training pathway of a dentist from the South-Eastern Health Board area.

8.4 The Working Group recommends that the health boards make renewed efforts to recruit salaried consultant orthodontists.

8.5 The Working Group considers that the consultant staffs of the two dental hospitals should give priority in the provision of orthodontic treatment to eligible children referred to the hospitals by the health boards.

8.4 In the absence of its own consultant orthodontist, the Eastern Health Board has reached an arrangement with Dublin Dental Hospital whereby the senior lecturer/consultants in orthodontics assess and treat eligible children on a sessional basis. The Eastern Health Board is also funding a registrar post in orthodontics in the Dublin Dental Hospital while the senior lecturer consultants are also training public dental officers from the Eastern and South-Eastern Health Boards. Initial discussions are currently taking place on the possibility of one or more public dental officers from the North-Eastern Health Board participating in a Dublin Dental Hospital higher training pathway in orthodontics. The Working Group recommends that other health boards consider similar arrangements with the dental hospitals.

8.5 The health boards also avail of the services of orthodontists in private practice, sometimes on a sessional, sometimes on a fee per item of service, basis. These orthodontists carry out either removable or fixed appliance therapy as necessary. Although fee
scales were agreed, there has been some disagreement between the Department of Health and the Irish Dental Association on arrangements applicable to the provision of fixed appliance therapy.

8.6 The Working Group considers that the present arrangements for the provision of orthodontic treatment for children with cleft lip and palate are inadequate and recommends that they should be upgraded.

8.7 At present, the health boards spend slightly more than £1 million on orthodontic appliances plus laboratory fees and fees paid to private orthodontists. There is a further hidden cost in so far as health board dentists provide orthodontic treatment as part of their everyday work. Thus a sizeable proportion of the health boards' dental budget is consumed by the orthodontic service.

8.8 Fees payable by the health boards to private specialist orthodontists for treatment with upper and lower removable appliance are £169 at present while a full treatment using a fixed appliance costs £586. Given the high cost of this treatment, several health boards have put forward to the Department of Health proposals to introduce charges for orthodontic services. The Working Group has given these proposals full consideration and has concluded that it would be appropriate to impose charges for orthodontic treatment for children whose parents are not medical card holders. Such charges would be imposed on a national basis following the making of regulations by the Minister with the consent of the Minister for Finance in accordance with the provisions of section 67(4) of the Health Act, 1970.
8.9 The Working Group considers it would be appropriate to impose a reasonable charge in respect of orthodontic treatments provided for children whose parents are in health eligibility categories II and III. This charge would be payable in instalments but the Working Group is of the opinion that it would be appropriate for the health boards to receive a deposit of about a quarter of the total cost to ensure that a commitment to the ongoing nature of the treatment is made by the parents. The balance might be paid in instalments over the duration of the treatment.

8.10 The Working Group estimates that at present levels of treatment provision the imposition of charges on children from category II and category III could raise a substantial sum annually. The Working Group recommends that moneys raised should be redistributed within the health board dental service. The health boards will have to continue to meet the full cost of orthodontic services for the children of medical card holders. However if at some time in the future a change in legislation were to permit the introduction of charges on medical card holders, it might be appropriate to levy a lesser charge on parents in Category I for orthodontic services.

8.11 The Working Group also recognises that it would be inappropriate to levy charges for the orthodontic aspect of the treatment of children with cleft lip and palate and recommends that orthodontic treatment be provided for these children without charge, irrespective of family income.

8.12 The Working Group wishes to point to the high cost of providing orthodontic treatment and to the high fees which are charged of
private patients by specialist orthodontists. Indeed the Working Group believes that an investigation of these high fees would be appropriate. While the Working Group acknowledges that the imposition of charges for orthodontic treatment may be seen as a burden on parents, it is aware that the Finance Act, 1967 allows relief against income taxation for medical and non-routine dental treatments and in most cases persons with category II or category III eligibility could expect to benefit from this provision of the Finance Act thereby obtaining a refund of at least a third of the charge imposed by the health board.

8.13 The Working Group considered the possibility of seeking special arrangements with the lending institutions to help parents to meet the charges imposed by the health boards for orthodontic treatments. The Group believes that, given the small size of the "market", the lending institutions would be unlikely to make special concessions. The Group also believes that as the treatment period usually extends over a period of eighteen to twenty-four months, so too can the charges be extended over a long time period to avoid hardship.

8.14 The Working Group acknowledges that demand for orthodontic treatment often outstrips need for treatment. It is not feasible for a public dental service to provide this expensive service on demand even if recipients who are not the dependants of medical card holders are called upon to contribute towards their treatment. The Working Group endorses the orthodontic guidelines drawn up by the Department of Health and recommends their continued usage in the assessment of need for treatment. The guidelines enable health boards to pick up priority cases among children awaiting orthodontic treatment.
CHAPTER 9
SECONDARY DENTAL CARE – ORAL SURGERY AND PAEDIATRIC DENTISTRY

ORAL SURGERY

9.1 The Report of the Joint Working Party published in 1979 recommended the creation of four consultant posts in oral surgery. At present the health boards only have the part-time services of an oral surgeon based in Dublin, while the consultants attached to the two dental hospitals also provide oral surgical care for eligible persons in their respective catchment areas.

9.2 The Working Group considers that the present level of oral surgery is grossly inadequate to meet the needs of a population of 3.5 million persons. The Group recommends that priority be given to the creation of consultant posts in oral surgery in the South-Eastern and Western Health Boards. The Working Group also recommends the re-creation of the consultant oral surgeon post in the Eastern Health Board.

PAEDIATRIC DENTISTRY

9.3 Paediatric Dentistry covers every aspect of dentistry for the child but it places a special emphasis on the treatment of handicapped children for whom dental disease is a major clinical problem and dental treatment can be a clinical hazard. The target group includes children who live in residential care and children who have severe handicapping conditions and blood disorders.

9.4 The Working Group acknowledges the establishment of a consultant paediatric service at Cork Dental Hospital to provide paediatric
dental services for handicapped children from the Southern Health Board and adjoining areas. Developments have recently been made in the Dublin Dental Hospital to expand the consultant paediatric service it provides in conjunction with the Eastern Health Board.

9.5 The Working Group recommends that the health boards avail of the expertise available in the dental hospitals to develop paediatric dental services.

9.6 The Working Group welcomes the decision of some health boards to appoint Senior Clinical Dental Surgeons to assume responsibility for dental services for the handicapped. The Working Group recommends that each health board have the services of a Senior Clinical Dental Surgeon to take specific responsibility for dental services for the handicapped on a health board-wide basis.

9.7 The Group suggests that close cooperation between the consultants in paediatric dentistry in the dental hospitals and the relevant Senior Clinical Dental Surgeons who have responsibility for services for handicapped would lead to an enhancement of the services available for the handicapped.