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HOUSES OF THE OIREACHTAS

JOINT COMMITTEE
ON
HEALTH AND CHILDREN

REPORT
ON
THE ORTHODONTIC SERVICE
IN IRELAND

FEBRUARY 2002



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	▪ The Orthodontic Society of Ireland	
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	▪ Ms. Triona McNamara, Consultant Orthodontist	
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Foreword by the
Chairman,
Batt O'Keeffe T.D.



The Joint Committee on Health and Children was established in November 1997. As part of its work programme for 2001 and 2002, the Joint Committee decided to examine the issue of the orthodontic service in Ireland. This has included an examination of current policy and practices, educational and training requirements and public concerns about the severe delays in the provision of services.

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

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

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

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

Department of Health and Children

- *Mr. Tom Mooney*
- *Dr. Gerard Gavin*

Eastern Regional Health Authority

- *Mr. Pat McLoughlin*
- *Dr. Brian Burke*

North Western Health Board

- *Mr. Pat Gaughan*

Mid-Western Health Board

- *Mr. John O'Brien*
- *Mr. Ted McNamara*

Southern Health Board

- *Mr. Tony McNamara*

Western Health Board

- *Dr. Mary Hynes*

South-Eastern Health Board

- *Mr. Richard Dooley*

Midland Health Board

- *Dr. Dan O'Meara*

- *Mr David Hegarty*

North Eastern Health Board

- *Dr. Ambrose McLoughlin*

The Dental Council

- *Mr. Joe Le Masney, President*

- *Mr. Brian Murray, Vice President*

- *Professor Robert McConnell, Chair of Education Committee*

- *Mr. Tom Farren, Registrar*

The Royal College of Surgeons in Ireland

- *Dr Peter Cowan, Dean, Faculty of Dentistry*

- *Dr Denis Field, Consultant Orthodontist, Dental School, NUI*

Cork

Dublin Dental Hospital

- *Mr. Brian Murray, Chief Executive*

- *Professor John Clarkson, Dean of Faculty*

- *Dr. Therese Garvey, Senior Lecturer/Consultant in Orthodontics*

- *Dr. Paul Dowling, Senior Lecturer/Consultant in Orthodontics*

Cork University Dental School

- *Professor Robert McConnell, Head of School*

- *Ms. Kathryn Neville, Hospital Manager*

The Orthodontic Society of Ireland

- *Dr. Therese Garvey, President*

- *Dr. Burga Healy, Specialist Orthodontist*

The Irish Consultant Orthodontists Group

- *Mr. Patrick McSherry, Chairman*

- *Mr. Niall McGuinness, Secretary*

- *Mr. Brian Jones*

- *Dr. Brian Burke*

- *Mr. David Hegarty*

- *Dr. Paul Dowling*

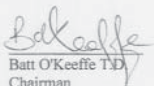
- *Dr. Maria Blake*

Mr. Ian O'Dowling, Consultant Orthodontist

Ms. Triona McNamara, Consultant Orthodontist

Dr. Antonia Hewson, Principal Dental Surgeon

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



Batt O'Keeffe T.D.

Chairman

21 February 2002

Summary of Recommendations

The Joint Committee recommends that:

Relationships

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

[Chapter 8.12]

Orthodontic Service Strategy

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

[Chapter 3.7(i)]

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

[Chapter 3.7(iii)]

Guidelines for prioritising Service

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

[Chapter 4.8(i)]

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

[Chapter 4.8(ii)]

Training

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

[Chapter 5.12(i)]

7. Dublin Dental Hospital and School receive State funding to upgrade their facilities for orthodontic postgraduate training with a view to catering for up to 18 trainees.

- [Chapter 5.12(ii)]
8. All specialist training places in Dublin and Cork be funded by the State and attached to health authorities until health authorities have a minimum of 50 specialists.
[Chapter 5.12(iii)]
9. A second Consultant Orthodontist be appointed to each Health Board to speed up assessments and facilitate training of Dentists and trainee specialists.
[Chapter 5.12(iv)]
10. The minimum number of trainee specialists in training be increased to 24 by 2004 at latest, with not less than 6 of these being trained in Cork
[Chapter 5.12(v)]
11. Flexibility be shown to Dentists with considerable experience in Orthodontics so that they can avail of specialist training.
[Chapter 5.12(vi)]
12. Health authorities encourage and with the Department facilitate dentists to apply for specialised courses in the U.K. and N.I.
[Chapter 5.12(vii)]
13. That Health Boards be facilitated in developing links with U.K. and N.Ireland Dental Colleges to train specialists in view of the inadequate training facilities available at present.
[Chapter 5.12(viii)]
14. Section 34 of the Dentists Act, 1985, which sets out the duties of the Dental Council in relation to education and training, be amended to require the Council to ensure that the number of people in training is adequate to meet public dental needs.
[Chapter 5.12(ix)]
- Manpower levels**
15. Specialist manpower levels should be based on the 1985 guidelines and on a caseload of 250 completed cases each year per Specialist Orthodontist.
[Chapter 6.4]
- Recruitment**
16. The qualifications for the grade of Specialist Orthodontist be directed by the Minister as a matter of urgency.
[Chapter 7.7(i)]
17. The number of permanent whole-time posts of Specialist Orthodontist in each Health Authority be decided as a matter of urgency and that the position of

existing qualified Specialists and trainees be sorted so that the remaining posts in Health Boards are clearly identified.

[Chapter 7.7(ii)]

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

[Chapter 7.7(iii)]

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

[Chapter 7.7(iv)]

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

[Chapter 7.7(v)]

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

[Chapter 7.7(vi)]

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

[Chapter 7.7(vii)]

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

[Chapter 7.7(viii)]

Delivery of Orthodontic Service

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

[Chapter 8.4]

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

[Chapter 8.5]

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

[Chapter 8.6]

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

[Chapter 8.7]

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

[Chapter 8.8]

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

[Chapter 8.9]

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

[Chapter 8.10]

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

[Chapter 8.11]

1. Introduction

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

Definitions of Orthodontics

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

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

(Source: Encyclopaedia of Family Health)

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

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

(Source: Moran Report 1998)

Reasons orthodontic treatment is undertaken.

- 1.3 Orthodontic treatment is undertaken for the following reasons:

- Dental Health
- Speech
- Appearance

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

Dental Health

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

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

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

Speech

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

Appearance

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

Demand for orthodontic treatment

- 1.4 The position in relation to orthodontic waiting lists as of December 2001 is set out in table 1 with category A and B figures for awaiting treatment.

Table 1: Orthodontic Waiting Lists (December 2001)

Health Board/ Authority	Awaiting Assessment	Awaiting Treatment		In Treatment
		'A'	'B'	
Eastern - SWA - NA - EC	9,438	93	965	3,776
Southern	5,657	-	4,575	2,300
Midwestern	3,596	-	1,005	1,593
North-western	1,300	276	1,879	2,099
Western	509	-	1,605	1,511
Midlands	201	-	437	1,700
South-eastern	176	-	498	2,024
North-eastern	-	11	546	2,292
Totals	20,877	380	11,510	17,295

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

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

Health Area	No. of 12 year olds	One third	One Quarter	One Fifth
Eastern	19,059	6,353	4,765	3,812
Southern	8,259	2,753	2,065	1,652
Midwestern	4,864	1,621	1,216	973
North-western	3,277	1,092	819	655
Western	5,269	1,756	1,317	1,054
Midlands	3,370	1,123	843	674
South-eastern	6,171	2,057	1,543	1,234
North-eastern	4,924	1,641	1,231	985
Totals	55,193	18,396	13,799	11,039

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

Table 3: Potential Orthodontic Patients for each year 2003 to 2012

Year	Number	One third	One quarter	One fifth
2003	52,690	17,563	13,173	10,538
2004	51,584	17,195	12,896	10,317
2005	49,456	16,485	12,364	9,981
2006	47,929	15,976	11,982	9,546
2007	48,530	16,177	12,133	9,706
2008	50,390	16,797	12,598	10,078
2009	52,311	17,497	13,078	10,462
2010	53,551	17,850	13,388	10,710
2011	53,354	17,785	13,339	10,671
2012	54,239	18,080	13,558	10,848

Areas of general consensus

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

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

Areas of debate

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

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

Relationships between key players

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

It is not within the present remit of the Joint Committee to give views on the rights or wrongs of these difficulties. However having regard to the magnitude of the problems facing the service the Joint Committee would appeal to all involved

to now give priority to the National interest in this area. The Joint Committee note the recent appointment of a Director of Training by the Irish Committee for Specialist training in Dentistry and would ask all key players to co operate with him in the development of existing training programmes and establishing new programmes.

Legislative Framework

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

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

The Act requires that training, recognition etc., conform with EU directives (e.g. Directive 78/687).

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

2. Development of Orthodontic Services in Ireland

- 2.1 In the 1950s the demand for orthodontic treatment in Ireland was low. Some simple treatments were carried out by both public and private dentists.
- 2.2 In the 1970s Health Boards engaged the services of orthodontists in private practice who treated patients with removable appliances on a capitation fee system. These fees covered removable appliance costs but did not cover the cost of fixed appliance treatment. Where fixed appliances were considered necessary, application was made to the Department of Health on a case by case basis. Very few patients received this treatment which was expensive and approved at private fee rates. There was no overall severity rating system and as the demand for orthodontics increased this placed an excessive burden on an extremely limited service.
- 2.3 In the late 1980s fixed orthodontic appliances became more readily available. Structured fees were established. This allowed some fixed appliances to be provided by private orthodontists. Health Board fees were lower than private fees and the level of funding available was limited. Consequently, there was considerable difficulty in meeting the growing demand of public patients.
- 2.4 The first appointment of a consultant orthodontist to a Health Board was made in 1985.
- 2.5 When the first appointment was made, a number of dentists with appropriate support staff were assigned to work in orthodontics under the direction, training and supervision of the consultant. Some dentists are attracted to providing orthodontist services under the supervision of a Consultant Orthodontist, and value the opportunity of being trained towards a recognised qualification. Using this combined-care approach, it has been possible to treat larger numbers of patients and while most of the work is done by non-orthodontists, the process and outcomes are monitored by the consultant and the standard of treatment where external evaluation has been carried out has proved to be satisfactory. This pattern of service provision was adopted as standard as further consultants were appointed.
- 2.6 The current strategy for developing the orthodontic service is set out in the Dental Health Action Plan 1994. The Action Plan provides for the development by each Health Board of a Consultant-led secondary care orthodontic service thus continuing the practice developed after the first consultant appointment in 1985.
- 2.7 In 1996, the Department wrote to the Chief Executive Officers of the Health Boards recommending that a group, representative of Health Board management and Consultant Orthodontists review the orthodontic service.

- 2.8 in 1997, the Dublin Dental School received approval for its specialist Dentist in Orthodontics training programme. That approval derived from an assessment by the Specialist Advisory Committee (SAC) of the Joint Committee for Specialist Training in Dentistry which is representative of the Royal Colleges of Surgeons in Ireland and Great Britain and was established to oversee acceptable standards of postgraduate training.
- 2.9 In 1998, the review group reported, the Moran Report, and the key recommendations was that appropriately trained, qualified and registered orthodontists be employed in Regional Orthodontic Units to ensure the provision of a timely and high quality service. This recommendation was accepted by the Department.
- 2.10 In 1999 the Dental Council established a Specialist Register with divisions of Orthodontics and oral Surgery with the consent of the Minister for Health and Children in exercise of its powers under the Dental Act, 1985. Following upon the establishment of the Register of Dental Specialists the Council appointed the Irish Committee for Specialist Training in Dentistry as the body within the State that it would recognise for the purpose of granting evidence of satisfactory completion of specialist training.
- 2.11 At present, the Eastern Regional Health Authority (ERHA) and the other seven boards have a consultant-led orthodontic service. Consultant Orthodontists, in addition to their clinical role, are also responsible for planning services and for training health board dentists within an appropriate framework.

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

3. Orthodontic Services Strategy

- 3.1 A Government decision in 1994 to proceed with a Consultant-led strategy for developing orthodontic services led to the setting up of Regional Orthodontic Departments. This development was an essential component of the National Health Strategy, "Shaping a Healthier Future". The Health Strategy stressed the importance of focusing on the concept of equity, quality and accountability when evaluating existing services or making decisions to set up new services.
- 3.2 The current strategy for the orthodontic service is the Dental Health Action Plan dated 26 May 1994. The overall objectives of dental health policy as set out in the Dental Health Action Plan of 1994 were:
- to reduce the level of dental disease in children
 - to improve the level of oral health in the population overall
 - to provide adequate treatment services to children, Medical cardholders and persons over 70.

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

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

- 3.3 the Department of Health and Children Strategy Statement 1998 – 2001 provided for the following steps relevant to the orthodontic service to meet dental services objectives:
- Continue implementation of Dental Health Action Plan.
 - Develop specialised dental services through the establishment of regional consultant services.

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

- (a) identification of the critical success factors
- (b) setting of performance indicators and
- (c) indication of what corrective action might be taken in the event of objectives not being reached.

3.4 The recent Health Strategy "*Quality and Fairness. A Health System for You*" provides for the expansion of specialist dental services and indicates that:

- (i) following review of the Dental Health Action Plan, new goals for oral health will be formulated
- (ii) the objective of the orthodontic service is to provide timely treatment to patients most in need
- (iii) patients with less severe needs will be treated as quickly as the availability of trained specialists allows
- (iv) a new grade of Specialist in Orthodontics has been created and training programmes have been put in place so that dentists can reach specialist level
- (v) a special needs-based approach will be taken to developing dental services over the next five to seven years as follows: -
 - a plan for the delivery of specialist dental services on a prioritised basis will be prepared and implemented
 - areas of specialisation in dentistry will be approved and publicly funded specialist training programmes will be established in these areas
 - the services of orthodontists in the private sector will be used on a more widespread basis. This, together with additional sessions by health board specialist staff, will enable the treatment of a further 3,500 patients annually.

3.5 The recent strategy also indicates that:

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

Conclusion

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

Recommendations:

3.7 The Joint Committee recommends that:

- (i) an Orthodontic Action Plan should be prepared within the next six months by the Department of Health and Children in which the critical success

factors, performance indicators including target timeframes for access to the service and possible corrective actions are clearly spelled out

- (ii) a sessional orthodontic adviser be appointed by the Department to assist in the preparation of the Orthodontic Action Plan in view of the timescale involved
- (iii) the proposed legislation for an independent Health Information and Quality Authority provide that the relevant Houses of the Oireachtas Committee may request it to review matters it considers appropriate, in a similar manner to the Public Accounts Committee's access to the Controller and Auditor General.

4. Guidelines for Prioritising Service

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

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

Category A: the most severe cases e.g. cleft lip and palate (less than 1%).

Category B: cases with a functional handicap e.g. marked distortion between the upper and lower jaws (approximately 6%).

Category C: non-handicapped cases but having a need for treatment (approximately 16%).

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

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

4.3 The report of the Health Board group (The Moran Report mentioned in Chapter 2.4) recommends the adoption of an internationally recognised index, the Index of Treatment Need (IOTN), for the assessment of orthodontic patients. Under this index cases are placed in categories 1, no need for treatment, to 5, great need, in ascending order of "handicap".

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

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

The report recommended the provision of orthodontic treatment for Categories 4 and 5 of the I.O.T.N. Under these recommendations 50% of 12-year-old children would qualify for orthodontic treatment. The report recommends the service should provide for the treatment of one third of children. This is more than double

under the 1985 guidelines. In relevant tables in this report one third has been used as the number of potential patients under I.O.T.N. guidelines.

- 4.4 The guidelines for prioritising the service have been under review and presentations before the committee suggest that draft / revised guidelines circulated in June 2000 and October 2001 would reduce the number of potential patients to be treated to a figure below that proposed under the 1985 guidelines.
- 4.5 Potential patients for the years 2003 to 2012 under guidelines discussed at 4.2, 4.3, and 4.4 are set out in table 3.
- 4.6 The target number of patients to be treated each year at specialist level under the Dental Health Action Plan was 10,500 or Categories A, B and C of 1985 guidelines. This was to be achieved with 40 orthodontic teams with each team completing 250 cases each year. The committee has been informed that returns supplied by the health boards relating to cases completed in considerably lower than the target figure and consisted of Category A and B patients only. Factors seen as contributing to the poor figures are:
- the majority of support staff have been trainees
 - trainees are restricted in number of cases they can deal with
 - the high turnover of staff at specialist level
 - no specialist grade in the service.

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

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

Recommendations

- 4.8 The Joint Committee recommends that:
- (i) a mechanism is put in place to ensure that guidelines for prioritising the orthodontic service are not amended before they have been considered by an appropriate Committee of the Houses of the Oireachtas and that an agreed copy is laid before the Houses of the Oireachtas.
 - (ii) a reduction in the 1985 guidelines, if considered appropriate, should apply only to the next group of 12 year olds to be assessed and not to children on the existing waiting list for assessment or treatment.

5. Training

- 5.1 The current Health Strategy, as indicated in Chapter 3.4, provides for the delivery of specialist dental services and the provision of publicly funded specialist training programmes.
- 5.2 State funding was first provided to people to train as specialists in orthodontics in 1999. Eight trainees are being funded at present and are working for the following Health Boards.

<u>Health Authority/Board</u>	<u>No.</u>	<u>Due to qualify</u>
Western	2	2002
Eastern	4	2004
South Eastern	1	2004
North Eastern	1	2004

- 5.3 Council Directive 78/687 sets out EU requirements for specialist training by Member States. Article 2(1) provides that: -
"Member States shall ensure that the training leading to a diploma, certificate or other evidence of formal qualifications as a practitioner of specialised dentistry meets the following requirements at least:

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

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

- 5.4 Article 2(3) of the Directive provided that Member States would designate the body to recognise evidence of satisfactory completion of specialist training. The Dental Council was designated for this purpose in the Dentist Act 1985, and as indicated in Chapter 2.10, it established a Specialist Register in Orthodontics in 1999, and appointed the Irish Committee for Specialist Training in Dentistry as the body to grant evidence of satisfactory completion of specialist training.

- 5.5 The recognised training bodies in Ireland for postgraduate training are the University of Dublin, University College Cork and the Royal College of Surgeons. The Dublin Dental School and Hospital commenced orthodontic postgraduate training in 1989. The Cork Dental School and Hospital has not been in a position to commence postgraduate training to date. The Royal College of Surgeons is unable to provide clinical training facilities on site. Therefore postgraduate training in Ireland to specialist orthodontic level is limited to Dublin and Cork Dental Schools and Hospitals.
- 5.6 Postgraduate Orthodontic training prior to 1999:
- (i) Dublin Dental Hospital and School
In the period 1989 – 1999 the Dublin Dental School and Hospital was only able to graduate 10 orthodontic specialists and train 5 specialists to consultant level because of a shortage of consultant staff both in the Dental School and in the Health Boards.
- (ii) Cork Dental Hospital and School
Cork Dental School has been unable to provide specialist training in orthodontics because it does not have a second orthodontic consultant in post.
- (iii) Regional Orthodontic Units
It has been indicated to the Committee that the Regional Orthodontic Units produced 5 specialists in the period up to 1999.
- 5.7 The present position in relation to the number of Specialists, Consultants and Trainee specialists with the Health Board Service is set out in table 4.

Table 4: No. of Specialists and Consultants within Health board Service

Health Board / Authority	Specialists	Consultants	Total	Trainee Specialists
Eastern - SWA	2	1	3	4
- NA	2	1	3	
- EC	2	1	3	
Southern	0	1	1	0
Midwest	2	1	3	0
Northwest	3	1 (1/2 time)	4	0
Western	1	1	2	2
Midlands	0	1	1	0
Southeast	3	1	4	1
Northeast	3	1	4	2
Totals	18	10	28	9

- 5.8 Table 5 sets out the projected number of consultant/specialist orthodontists required in each health authority by 2008 under various case loads while still

operating under the 1985 classification guidelines. The population projections for each Health Board area used are taken from the Moran Report.

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

Health Board / Authority	Present Number	Minimum 2008* Requirement	Minimum 2008** Requirement	Minimum 2008*** Requirement
Eastern - SWA - NA - EC	9.0	11.2	18.0	22.4
Southern	1.0	4.5	7.1	9.0
Midwestern	3.0	2.7	4.3	5.4
Northwestern	3.5	1.7	2.8	3.4
Western	2.0	2.8	4.5	5.6
Midlands	1.0	1.8	2.9	3.6
Southeastern	4.0	3.3	5.2	6.6
Northeastern	4.0	2.6	4.2	5.2
Totals	27.5	30.6	49.0	61.2

* 2008 Requirement based 400 completed cases per year. (Moran Report)

** 2008 Requirement based on 500 completed cases each 2 years.

*** 2008 Requirement based on 400 completed cases each 2 years.

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

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

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

Training Capacity

5.9 (i) Dublin Dental School and Hospital

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

(iii) Cork Dental School and Hospital

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

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

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

Orthodontic Auxiliaries

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

Training Outside Ireland

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

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

Recommendations

- 5.12 The Joint Committee recommends that:
- (i) the primary Dental Degree course in Dublin and Cork be upgraded / amended to cover primary level orthodontics
 - (ii) Dublin Dental Hospital and School receive State funding to upgrade their facilities for orthodontic postgraduate training with a view to catering for up to 18 trainees

- (iii) all specialist training places in Dublin and Cork be funded by the State and attached to health authorities until health authorities have a minimum of 50 specialists
- (iv) a second Consultant Orthodontist be appointed to each Health Board to speed up assessments and facilitate training of Dentists and trainee specialists
- (v) the minimum number of trainee specialists in training be increased to 24 by 2004 at latest, with not less than 6 of these being trained in Cork
- (vi) flexibility be shown to Dentists with considerable experience in Orthodontics so that they can avail of specialist training
- (vii) Health authorities encourage and with the Department facilitate dentists to apply for specialised courses in the U.K. and N.I.
- (viii) That Health Boards be facilitated in developing links with U.K. and N.Ireland Dental Colleges to train specialists in view of the inadequate training facilities available at present.
- (ix) Section 34 of the Dentists Act, 1985, which sets out the duties of the Dental Council in relation to education and training, be amended to require the Council to ensure that the number of people in training is adequate to meet public dental needs.

6 Manpower Levels

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

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

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

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

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

Country	Ratio
Norway	1 : 251
Germany	1 : 278
Sweden	1 : 287
USA	1 : 352
Denmark	1 : 391
Finland	1 : 422
France	1 : 474
Netherlands	1 : 680
Ireland	1 : 688
UK	1 : 873
Spain	1 : 952
Greece	1 : 970
Italy	1 : 1,687
Portugal	1 : 2,040

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

Table 7: Existing Orthodontic Specialist Manpower

Source	Number
Private	47
Public Sector	18
Regional Consultant	10
Academic Consultant	4
Tertiary Care Consultant	1
Total	80

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

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

Projected manpower needs in Public Sector

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

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

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

The potential number of orthodontic patients from 2002 to 2012 under IOTN guidelines, 1985 guidelines and 1985 reduced guidelines is set out in table 8.

Table 8: Potential Orthodontic Patients for each year 2002 to 2012 under various Guidelines

Year	Number	IOTN	1985	Reduced 1985
2002	55,193	18,396	13,799	11,039
2003	52,690	17,563	13,173	10,538
2004	51,584	17,195	12,896	10,317
2005	49,456	16,485	12,364	9,981
2006	47,929	15,976	11,982	9,546
2007	48,530	16,177	12,133	9,706
2008	50,390	16,797	12,598	10,078
2009	52,311	17,497	13,078	10,462
2010	53,551	17,850	13,388	10,710
2011	53,354	17,785	13,339	10,671
2012	54,239	18,080	13,558	10,848

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

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

Health Board / Authority	Present Number	Minimum 2008* Requirement	Minimum 2008** Requirement	Minimum 2008*** Requirement
Eastern - SWA - NA - EC	9.0	15.0	24.0	30.0
Southern	1.0	5.8	9.3	11.6
Midwestern	3.0	3.5	5.7	7.0
Northwestern	3.5	2.3	3.7	4.6
Western	2.0	3.7	6.0	7.4
Midlands	1.0	2.4	3.9	4.8
Southeastern	4.0	4.4	7.0	8.8
Northeastern	4.0	3.5	5.5	7.0
Totals	27.5	40.6	65.1	81.2

* 2008 Requirement per Moran report at 400 completed cases per year.

** 2008 Requirement based on 500 completed cases each 2 years.

*** 2008 Requirement based on 400 completed cases each 2 years.

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

Guidelines	400*	250*	200*
1985	30.6	49.0	61.2
IOTN	40.6	65.1	81.2

Recommendation

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

(* Number of completed caseloads each year)

7. Recruitment

Consultant Orthodontist

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

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

Specialist Orthodontist

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

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

- 7.3 In the circumstances outlined the Joint Committee consider that there has been a marked lack of urgency among all concerned to implement government policy in the provision of an effective orthodontic service.
- 7.4 In order to operate a successful recruitment policy for specialist orthodontists the following factors are considered important:
- a decision on the number of wholetime permanent posts appropriate to each Health Authority having regard to contract obligations of trainees
 - the provision of attractive salary and conditions of service
 - directing appropriate qualifications for the grade
 - knowing the schools / institutions who produce the likely applicants and when they are going to come on stream

- focused advertising in relevant journals at the appropriate time, including targeting individual potential applicants
- the provision of an attractive information pack by employers to aid recruitment
- speedy processing of applications and clearance of applicants for appointment
- competent selection personnel prepared to travel to facilitate the active pursuit of scarce applicants.

7.5 During consideration of this matter, the Joint Committee was made aware that there are currently 15 Irish postgraduate students training in the U.K. / U.S.A. Planning should now commence so that every effort is made to recruit as many of these as possible to the Irish Orthodontic Service.

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

Recommendations

7.7 It is recommended that:

- (i) the qualifications for the grade of Specialist Orthodontist be directed by the Minister as a matter of urgency
- (ii) the number of permanent whole-time posts of Specialist Orthodontist in each Health Authority be decided as a matter of urgency and that the position of existing qualified Specialists and trainees be sorted so that the remaining posts in Health Boards are clearly identified
- (iii) planning should now commence involving the appropriate recruitment body (L.A.C.?), the Department and the Health Authorities to:
 - identify and target the recruitment of the 15 Irish postgraduate students mentioned in 7.5
 - identify countries and schools training prospective Specialists and identify appropriate times for focused targeting of personnel.
 - travel to interview applicants for Specialist posts in their country of residence, if necessary.
- (iv) the health authorities prepare an attractive information pack for circulation to prospective Specialist applicants
- (v) priority in the filling of permanent whole-time Specialist posts be given to health authorities with the greatest need e.g., Southern and Eastern Authorities
- (vi) a recruitment campaign for permanent whole-time Specialist posts focusing on Scandinavia, Northern Europe and the U.S.A. be undertaken as soon as

possible in view of the perceived overproduction of Specialists in these areas

- (vii) State funding be provided to train Consultant Orthodontists, to try to avoid a shortage at this level and to facilitate manpower planning
- (viii) consideration be given to the provision of free accommodation or an accommodation allowance, for the first two years, to qualified applicants from abroad.

8. Delivery of Orthodontic Service

Existing Services

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

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

Ideal Service

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

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

Dealing with the existing awaiting treatment arrears

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

The Joint Committee would support any mix of public / private staff and facilities that would lead to a continuous reduction in the arrears. It considers that the

Orthodontic Strategy Plan recommended at 3.7 should include the arrangements in place to deliver the 3,500 treatments targeted.

Dealing with existing waiting assessment arrears

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

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

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

Effective Appointment Rostering

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

Grant-in-Aid for eligible patients

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

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

- Consultant to indicate the nature of the treatment required, maximum fee appropriate and a list of private orthodontists patient may or may not use.
- 50% of fee provided by Health Board.
- 50% of fee paid by individual (with a 20% or 42% tax refund still available to person paying income tax).

The grant-in-aid option should be provided for either in amended Health legislation or through the Social Welfare system.

Treatment capacity of trainee specialists and use of Dental Hospitals

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

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

Video conferencing link

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

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

Status of Chief Dental Officer

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

Demand for Oral Surgery

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

System of outcome measurement and audit

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

Co-operation of Regional Consultants

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

Recommendations

- 8.13** The Joint Committee recommends that:

- (i) Each Health Board initiate a review of its awaiting assessment lists immediately.
- (ii) An Automated Appointment system be considered for use by each Health Board.
- (iii) A Grant-in-Aid option be provided for persons on the treatment waiting lists and over 16 years either by amending legislation or through the Social Welfare system.
- (iv) Arrangements with the Dental Schools be negotiated to treat the maximum number of public service patients at the minimum fee.
- (v) Video conferencing links with Cork, Galway and other appropriate Orthodontic Units be the subject of public funding to facilitate more efficient training.
- (vi) The Joint Committee consider that the Chief Dental Officer of the Department should be at least of equal status with Consultant Orthodontists.
- (vii) Planning for the orderly provision of oral surgery in the Health Boards commence immediately.
- (viii) An accurate system of outcome measurement and audit is put in place as a matter of urgency to verify completed cases, confirm quality and facilitate cost comparisons.

- (ix) In the continued absence of agreement from all Regional Consultants, the areas of dispute should be referred to an expert panel.

9. Orthodontic Fees

9.1 During the Joint Committees consideration of the Orthodontic service two issues regarding fees arose:

- cost effectiveness of public, health board, sector compared to the private sector,
- fees charged for orthodontic treatment in the South compared to Northern Ireland.

Schedule of fees approved by Department

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

Initial Examination Fee	€ 50.04
Treatment Fee	€ 267.08
Fixed Appliance Orthodontic Treatment	
Both Arches	
(a) Initial Examination	€ 50.04
(b) Active Treatment (including construction, and fitting of appliances, maintenance, changing appliances in the course of treatment and debanding)	€ 950.09
(c) Retention period, where applicable	€ 99.67 €1,099.80
Single Arch	
(a) Initial Examination	€ 50.04
(b) Active Treatment (including construction, and fitting of appliances, maintenance, changing appliances in the course of treatment and debanding)	€ 635.91
(c) Retention Period, where applicable	€ 99.67 € 785.62
The cost of appliances supplied may also be met	

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

Private Orthodontists fees

- 9.3 The private orthodontists contend that when off cost factors are taken into account in the selling up of regional units they would be more cost efficient. Taking a €2,920 scenario as the average cost of any orthodontic treatment in the private sector the cost can be broken down as follows:

• Cost of treatment over two years	€2,920
• Average % expenses in Private practice, 51%	€1,490
• Profit for Private Orthodontist	€1,430
• Tax return on profit, 42%	€ 600
• Cost to State per completed treatment	€2,320

Public Sector costs

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

Comparison with fees in Northern Ireland

- 9.5 A schedule of fees to do a comparison with Northern Ireland has not been located. Orthodontic treatments include:

- Single Fixed Appliance
- Upper and Lower Fixed Appliances
- Single Appliance Removable
- Upper and Lower Removable Appliances
- Functional Appliance
- Single Orthodontic Retainer Replacement
- Upper and Lower Orthodontic Retainer Replacement
- Single Essix Replacement Retainer
- Single Orthodontic Retainer Repair

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

Orthodontists contacted in N.I. would require a precise treatment plan before quoting a price. Therefore in order to provide a worthwhile cost comparison it would be necessary to arrange a visit or visits to Orthodontics in the South, get a precise treatment plan and a price quoted and then get a price for this treatment plan from an Orthodontist in N.I.

The Joint Committee considers that the Department, through the Health Boards should carry out a limited survey for different treatments in the South and Northern Ireland and supply the Committee with the results as soon as possible.

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

Service	Average fee Jan. 2000	Highest fee Jan. 2000
Initial Exam	Free	\$ 250.00
Comprehensive Orthodontics – Youth	\$3,876.00	\$5,314.00
Comprehensive Orthodontics – Adolescent	\$4,125.00	\$5,626.00
Comprehensive Orthodontics – Adult	\$4,438.00	\$6,251.00
Replace Lost Retainer	\$ 239.00	\$ 373.00

10. Information on Dental Schools and Hospitals in U.K. and N.I.

Dental Schools

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

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

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

Number of trained orthodontists likely to graduate each year

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

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

Salary of specialist orthodontics in UK and Ireland

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

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

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

Appendices

APPENDIX 1

Members of the Joint Committee

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

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

Notes:

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

Appendix 2

Orders of Reference

Dáil Éireann

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

Ordered:

- (1)(a) That a Select Committee, which shall be called the Select Committee on Health and Children, consisting of 14 members of Dáil Éireann (of whom 4 shall constitute a quorum), be appointed to consider such –
- (i) Bills the statute law in respect of which is dealt with by the Department of Health and Children, and
 - (ii) Estimates for Public Services within the aegis of that Department,
 - ** (iii) Proposals contained in any motion, including any motion within the meaning of Standing Order 149(A) concerning the approval by the Dáil of international agreements involving a charge on public funds,

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

- (b) For the purpose of its consideration of Bills under paragraph (1)(a)(i), the Select Committee shall have the powers defined in Standing Order 78A(1), (2) and (3).
 - (c) For the avoidance of doubt, by virtue of his or her *ex officio* membership of the Select Committee in accordance with Standing Order 84(1), the Minister for Health and Children (or a Minister or Minister of State nominated in his or her stead) shall be entitled to vote.
- (2)(a) The Select Committee shall be joined with a Select Committee to be appointed by Seanad Éireann to form the Joint Committee on Health and Children to consider
- (i) such public affairs administered by the Department of Health and Children as it may select, including bodies under the aegis of that Department in respect of Government policy,

- (ii) such matters of policy for which the Minister in charge of that Department is officially responsible as it may select,
- (iii) the strategy statement laid before each House of the Oireachtas by the Minister in charge of that Department pursuant to section 5(2) of the Public Service Management Act, 1997, and shall be authorised for the purposes of section 10 of that Act, and
- (iv) such Annual Reports or Annual Reports and Accounts, required by law and laid before either or both Houses of the Oireachtas, of bodies under the aegis of the Department(s) specified in paragraph 2(a)(i), and the overall operational results, statements of strategy and corporate plans of these bodies, as it may select.

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

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

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

and shall report thereon to both Houses of the Oireachtas.

- (b) The quorum of the Joint Committee shall be 5, of whom at least 1 shall be a member of Dáil Éireann and 1 a member of Seanad Éireann.
 - (c) The Joint Committee shall have the powers defined in Standing Order 78A(1) to (9) inclusive.
- (3) The Chairman of the Joint Committee, who shall be a member of Dáil Éireann, shall also be Chairman of the Select Committee.

Seanad Éireann

19 November 1997. (*30th April 1998)

Ordered

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

- (i) such public affairs administered by the Department of Health and Children as it may select, including bodies under the aegis of that Department in respect of Government policy,
- (ii) such matters of policy for which the Minister in charge of that Department is officially responsible as it may select,
- (iii) the strategy statement laid before each House of the Oireachtas by the Minister in charge of that Department pursuant to section 5 (2) of the Public Service Management Act, 1997, and shall be authorised for the purposes of section 10 of that Act, and
- * (iv) such Annual Reports or Annual Reports and Accounts, required by law and laid before either or both Houses of the Oireachtas, of bodies under the aegis of the Department(s) specified in paragraph 2(a)(i), and the overall operational results, statements of strategy and corporate plans of these bodies, as it may select.

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

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

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

and shall report thereon to both Houses of the Oireachtas.

- (b) The quorum of the Joint Committee shall be 5, of whom at least 1 shall be a member of Dáil Éireann and 1 a member of Seanad Éireann.
 - (c) The Joint Committee shall have the powers defined in Standing Order 62A(1) to (9) inclusive.
- (2) The Chairman of the Joint Committee who shall be a member of Dáil Éireann.

Appendix 3

Proceedings of the Joint Committee

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

THE JOINT COMMITTEE ON HEALTH AND CHILDREN

Imeachtaí An Chomhchoiste

Proceedings of the Joint Committee

Dé Déardaoin, 21 Feabhra 2002

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

2. MEMBERS PRESENT.

The following members were present:

Deputies Batt O'Keefe (*in the chair*), Bernard Allen, John Dennehy, Cecilia Keaveney, Liz McManus, Gay Mitchell, Dan Neville and Michael Ring
Senators Mary Jackman and Pat Moylan.

3. DRAFT REPORT ON THE ORTHODONTIC SERVICE

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

Ordered: To report accordingly.

4. ADJOURNMENT

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

Appendix 4

Presentations to the Joint Committee

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

Introduction

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

Aims & Policy of the Service

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

The Moran Report

In 1996, I wrote to the Chief Executive Officers of the Health Boards recommending that a group, representative of health board management and Consultant Orthodontists, review the orthodontic services. The objective of this review was to ensure an adequate and equitable provision of orthodontic treatment throughout the health boards. One of

the key recommendations of this Review Group – known as the ‘Moran Report’ – was that appropriately trained, qualified and registered specialist orthodontists be employed in Regional Orthodontic Units to ensure the provision of a timely and high quality service.

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

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

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

Specialist Dentist in Orthodontics

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

Training

It is considered essential that Specialist Dentist in Orthodontics training programmes meet internationally recognised standards. As I have already said the Dental Council has established and maintains a Specialist Register in exercise of its powers under the Dentist's Act, 1985. In this context, it has recognised the **Irish Committee for Specialist Training in Dentistry** as a body within the State to advise it on the granting of evidence of satisfactory completion of specialist training. The Irish Committee for Specialist Training in Dentistry fulfils its role through its **Specialist Advisory Committee in Orthodontics**.

In 1997, the **Dublin Dental School** received approval for its Specialist Dentist in Orthodontics training programme. This approval derived from an assessment by the Specialist Advisory Committee of the **Joint Committee for Specialist Training in Dentistry**. That Joint committee is representative of the **Royal Colleges of Surgeons** in Ireland and Great Britain and was established to oversee acceptable standards of postgraduate training. Currently, the Irish Committee has taken over this role of the Joint committee in accordance with Irish and EU legislation.

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