DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 26 Meitheamh 2019

Wednesday, 26 June 2019

The Joint Committee met at 9 a.m.

Comhaltaí a bhí i láthair / Members present:

John Brassil,*	Colm Burke.
Bernard J. Durkan,	
Alan Kelly,	
Louise O'Reilly.	

* In éagmais / In the absence of Deputy Stephen Donnelly.

I láthair / In attendance: Deputies Maria Bailey and David Cullinane.

Teachta / Deputy Michael Harty sa Chathaoir / in the Chair.

The joint committee met in private session until 9.26 a.m.

National Oral Health Policy: Discussion (Resumed)

Chairman: The purpose of the meeting is to gather some insights into the operation of our national oral health policy. We had a meeting on this matter on 15 May where we heard from the Irish Dental Association and the faculty of dentistry at the Royal College of Surgeons Ireland, RCSI. This morning we have the opportunity to hear the views of officials from the Department of Health and the Health Service Executive, HSE, along with representatives from the oral health policy academic reference group, which was established to help to provide the Department with independent research data and policy advice to improve oral health in Ireland.

On behalf of the committee, I welcome Mr. Finian Judge, principal officer; Dr. Dympna Kavanagh; and Mr. Fergal Goodman, assistant secretary in primary care, Department of Health. I welcome Dr. Alison Dougall, Professor Brian O'Connell and Dr. Jacinta McLoughlin from the oral health policy academic reference group. I also welcome Mr. Pat Healy, national director of community and strategy planning at the HSE and Dr. Joe Green, national lead for oral health, HSE. I bid our guests a good morning.

By virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. I also advise the witnesses that any opening statements they make to the committee may be published on the committee's website after this meeting.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable.

I call Mr. Goodman to make his opening statement.

Mr. Fergal Goodman: I will not take long as my colleague, Dr. Kavanagh, will do most of the talking on the policy. I will just make a few opening introductory comments.

The national oral health policy was approved by the Government in March 2019, so it is now Government policy. The chief dental officer, Dr. Kavanagh, led the development of the policy over a period and will set out for members the ethos, principal features, key plans and actions in it. The policy is quite wide-ranging and takes an intersectoral approach as well as being consistent with the primary care philosophy of prevention, treatment at the lowest level of complexity and recourse to specialist care where this is clinically appropriate. This work is the culmination of a comprehensive programme of research, analysis and consultation over a number of years and, over time, we will update models of care and service delivery that have been with us for 25 years or more.

The policy is not only aligned with international models of good practice but with the ideals

and approach in other healthcare policy areas, such as Sláintecare and Healthy Ireland. It is important to say that it does not seek to change all aspects of service delivery overnight, but it puts in place the framework for real and substantive change on a phased basis. As with any area of public service provision, implementation will need to be planned and managed in consultation with all interested parties, particularly the dental profession, as well as all those who use and depend on the services. It might benefit the committee to know that in the development of the policy and the planning for implementation, the Department and the Minister are fully appreciative of the professional contribution made by the dental profession; namely, those in the salaried services of the HSE, contracted providers in private practice and those in specialist services.

I will now hand over to Dr. Kavanagh.

Dr. Dympna Kavanagh: Thank you, Chair, for inviting me here today to outline the key aspects of the national oral health policy, Smile agus Sláinte, which was launched in April this year by the Minister for Health and the Minister for Employment Affairs and Social Protection. As Mr. Fergal Goodman said, it is a comprehensive and evidence-based policy informed by extensive research and consultation. Its aim is to better facilitate oral health for everyone and to support continued professional development. The programme is transformative, introducing and managing a series of changes over eight years. The policy is aligned with other Government policies, including Sláintecare, Healthy Ireland and First 5, which is a whole-of-Government strategy for babies, young children and families, as well as the national strategies on disability and mental health. It conforms to the international policies of the WHO and the European Union. The policy embraces the "no child is left behind" principle of First 5 and the education policies.

This is the first major oral health policy statement in 25 years and much has changed in Ireland in that period, including the standard of general and oral health, the materials and technology used in dentistry, and the types of services we aim to provide. In developing the policy, we have ensured that it is supported by up-to-date information about the oral health of the population, as well as by appropriate international evidence. A broad range of stakeholders was consulted, including those who use the services and those providing the care.

Our current oral health system is out of step with other Irish and international health services. There are gaps remaining in routine dental care for the very young and the vulnerable, including people in residential care, people with disabilities and older people. Smile agus Sláinte reorients how care is provided in line with Sláintecare so that most dental care is provided in people's own communities, as close as possible to where they live. This is beneficial for service users and allows acute services to focus on more complex care. What is described in Smile agus Sláinte is not a demand-led service. Instead, it enables the Irish public to access services and forge a relationship with their chosen dental practice; we call this their "dental home".

To support this universal primary care approach, a safety net system will identify those who do not or cannot attend their local dentist. This safety net system is part of the surveillance system outlined in the policy and ensures that the most vulnerable children and adults, including those on lower incomes, will be supported and receive the same quality of service as the rest of the population. The existing public dental service will be stronger. A key service will be to identify, support and deliver care for vulnerable children and adults when it cannot be provided in the local dental practice.

The measures set out in the policy will provide professional opportunities for staff in areas such as health promotion, special care services and public health.

I will pick out some of the key policy strategies and proposals, which members have in front of them. Water fluoridation is one key reason we have such good oral health in Ireland and will remain a cornerstone of oral health policy. Health promotion programmes will be put in place for the whole population and to target the most vulnerable. Most children and eligible adults will be treated in local dental practices and a package for children from birth until the age of 16 will, in a phased way, replace the existing schools programme. It is the first time that those under the age of 6, teenagers and adults will have lifetime access to preventive treatment such as fissure sealants and fluoride varnishes, as well as access to dietary advice in dental practices. The expansion of primary care is proposed from birth until old age, across the whole life course. We have focused on improving access for vulnerable groups such as those on low incomes, rural dwellers and people with disabilities. Enabling them to get to local dental practices is key. As I mentioned, the safety net service is essential to ensure that their needs are addressed and they get comprehensive care. We must not forget that we need advanced care and specialist care services, and that includes the concerns around general dental anaesthesia. Monitoring systems will have to be put in place to identify people who are not taking up the services, overall dental needs and the policy's impact. There must be a full review of dental undergraduate education, in tandem with career-long professional mentoring for dentists.

I will talk briefly about the development of the policy. As mentioned, it was informed by oral healthcare professionals through a series of working groups and consultations. We are indebted to the Oral Health Policy Academic Reference Group, and we drew expertise from Irish universities in this regard. These experts assess current needs and how best to meet them. In addition, we had an external international independent panel made up of leaders in different aspects of policy development. From this, recommendations and research from the reference group were quality assured in line with international standards. All research undertaken, including the additional facts study analysis, was robust, representative, ethically compliant and externally quality assured.

At the start of policy development in 2014, and again in 2016, more than 5,000 letters were sent from the Department of Health to the whole profession inviting all dental registrants to comment and engage in policy. A stakeholder day was held, with more than 70 attendees from 16 representative organisations. There was one-to-one engagement with dental practitioners in independent practice and with those in the public dental service. Their views overall highlighted an appetite for change in oral healthcare services but emphasised the challenges of such a change. The Dental Council of Ireland training bodies, including the RCSI and the Expert Body on Fluorides and Health, were also consulted and given a draft document. These engagements informed the direction of policy in key aspects of service provision and training for professionals.

I have outlined the key findings from both the public and from dentists. I will mention a few points arising from the public point of view. The public indicated that the current system is complex and very difficult to navigate and they were worried about cost, particularly in relation to children's care. Young children rarely attend the dentist before six years of age. Of concern to us is that over the age of 55, there is a decline in quality of life, which sharply declines beyond 70 and into a person's later years. Overall, all age groups and social classes perceived that their main access to care is via their general dental practice.

Stakeholders and practitioners insisted that very early childhood care is needed and also want special care services for the vulnerable. They expressed frustration with bureaucracy, barriers to accessing care for patients and an outdated State payment system. There is a need for a

greater emphasis on primary care in the profession to bring it forward. Those in the public dental service emphasised the need for prevention and for opportunities to expand their skills. The information from the consultations fundamentally changed the direction of a lot of our policies. Leadership roles in primary care to refocus the profession and facilitate leadership from within it is a key action being called for by dentists. The policy also includes very early intervention for children, to give them the best start, and the need for comprehensive support for the most vulnerable through specific support services within the reoriented PDS.

Along with the policy action, a career-long mentoring framework will be put in place, as exists for other professions such as social work and psychology. Undergraduate and graduate education is the first priority within the policy, with an emphasis on training and primary care.

The policy includes a review of dental technology and clinical dental technology training. This was a key issue that arose from the public, regarding the needs of those in residential services, and from dentists, regarding the need to maintain a workforce in this direction in relation to dentures and prosthetics for those with total tooth loss.

The committee will be particularly interested in implementation, which is where all the action is. We have shared with members an overview document showing 41 actions and the priority for each of those over the next eight years. The implementation period is needed to commit actively to engagement on significant and complex issues. First, we need to build a framework to support long-term sustainability, the education review, a mentoring framework and a focus on legislative issues. The Department has already begun to discuss the priorities with key agencies and we are agreeing targets and timescales. As an example, action 29 in the policy, which is a priority, is the national plan for amalgam phase-down on which we worked closely with our colleagues in the Department of Communication, Climate Action and the Environment and key stakeholders. It is being finalised in line with Ireland's EU legislative obligations to publish on 1 July and submit to the EU in August.

I mentioned the full review of undergraduate training which, along with graduate mentoring programmes and upskilling for graduate dentists, are key immediate actions. The Dental Council, through the Irish committee for specialist training in dentistry, will lead in developing the advanced centres of care framework for specialists. We are convening in July to commence this work.

For the First 5 strategy, the Department of Children is working with the Department of Health to support the framework for the under sixes policy in programmes of health promotion and services. We have already met the Clinical Dental Technicians Association and we have its support to assess dental technology training.

Water fluoridation remains and we continue to review it and we will link with the expert body on fluorides and health.

The HSE has two main service focuses. Epidemiology data indicate that those in residential settings require urgent attention and support. The reorientated public dental service and community oral health care services will identify their needs and put in place a treatment programme for those who cannot use primary care. The second priority is that the very young, up to six years of age, receive packages of preventative and primary care. This is in line with Healthy Ireland and the First 5 strategy. It will also give the public dental service an opportunity to release capacity.

Implementation of a transformative policy such as Smile agus Sláinte will present challenges. All change is challenging. However, those challenges will present opportunities for the staff in private practice and the public dental service. It is important that implementation is owned by the profession while listening to the voice of the public. To achieve these priorities, we need key leadership roles operationally and in dental schools. Primary care, special care, advanced or specialist care delivery and public health leaders must be in place so that implementation is sustainable and placed where it belongs in the services.

I thank the Chairman for this opportunity to outline the national policy. We look forward to working with our colleagues in the HSE services, professionals and key stakeholders to implement this change.

Chairman: I now call Professor Brian O'Connell from the oral health policy academic reference group.

Professor Brian O'Connell: I have been a practising dentist for 35 years. I am a consultant in dentistry and dean of the dental school in Trinity College. I am accompanied by my colleagues, Dr. Jacinta McLoughlin, a specialist in dental public health, and Dr. Alison Dougall, a consultant who treats patients with serious illnesses and disabilities. We are here on behalf of the reference group whose chairman, Professor O'Mullane, has submitted a letter that addresses a number of specific points raised about the group's work.

The reference group was established to help provide the Department of Health with the best independent evidence that could be used to improve oral health in Ireland. It is a broad group with a range of backgrounds and disciplines relevant to policy development. Like all dental professionals, and indeed members of the public, we are acutely aware of the shortcomings of current dental services in Ireland. There remains huge inequality in oral health, especially among vulnerable groups and those living in rural areas. We see parents of children with disabilities who are often desperate to access appropriate care. Far too many young children turn up at hospitals needing emergency extractions, and those who are frail, living with dementia or in residential care often find their oral health completely neglected. The training pathways needed to sustain oral health services have not been developed or, in some cases, have been dismantled.

The committee should also know that most dental disease is preventable. Dental decay and gum disease, which are the main reasons for tooth loss, pain and infection, are two of the most common diseases worldwide but preventing these diseases, and oral cancer, is possible to a large degree with simple primary care measures.

The reference group proposed principles that might frame an oral health policy. Members will have seen some of these in the final Smile agus Sláinte document. There is the common risk factor approach, which recognises that some of the same factors are involved in oral and other diseases, so controlling these risk factors can have a big impact on health. For example, high sugar intake is the main cause of tooth decay but is also implicated in obesity and type 2 diabetes. Reducing sugar intake should, therefore, be the business of the whole primary health care team, including dentists. Importantly, the provision of a service such as dental treatment must be surrounded by broader public health policies to make a real difference. The life course approach means that individuals need access to different services throughout life and depending on their circumstances. However, at all ages our population should have a home in a dental practice setting that is focused on prevention and empowering them to maintain their oral health and independence. As part of Sláintecare, oral health care must be available to all who need it,

regardless of income, location and disability. These are just a few examples of policy recommendations that have been included in Smile agus Sláinte, which will be crucial to transform oral health in Ireland. The principles are not only well established in Government policy, but are also contained in recommendations from internationally recognised professional bodies.

Those of us who want to provide appropriate care for patients know that an oral health policy will accomplish nothing without determined and sustained implementation. Continuing with current services will not improve the oral health of the population and will exacerbate inequalities. Available evidence is strongly supportive of change. It is vital to build confidence in the public and in dental professionals that we will be supported in our roles. Most of the population can be readily treated in a practice setting and a strong primary care system reduces the need for more complex interventions. Nonetheless, primary care providers cannot be asked to take responsibility for patients unless they know there is access to backup and specialist care when needed, as outlined in the policy's advanced centres of care. It is also essential that we monitor progress as we proceed, to make sure we are achieving the goals of the policy for all people. The evaluation and research parts of the policy are critical to a successful outcome, as emphasised already in the Healthy Ireland framework. All of these issues have been recognised in Smile agus Sláinte and we welcome the publication of priority actions to be addressed in the coming years.

We would like to highlight the need to develop a workforce that is fit to deliver the best oral health care across disciplines to the greatest number of people, as stated clearly in Sláintecare and described in the oral health policy. Smile agus Sláinte proposes a review of dental education and the development of primary care leadership throughout the dental schools and, I hope, the HSE to ensure that dentists will be central pillars of the primary health care team. This may include extending education in a mentored environment to encompass broad community experience, inter-professional teamwork and general practice skills. The oral health policy provides for ongoing access to retraining through a skills match programme, so the dental team can keep abreast of changes in the population, disease patterns and technology. In order to support patients and practitioners, specialist and academic training must be put back on a firmer footing within the established medical model. As the policy has stated, it is also time to look at the scope of practice of the whole dental team so the population has the greatest possible access to good quality care.

My colleagues and I have the privilege of working not only with students but all members of the dental team at all stages of their careers. I assure the committee that in this country we have a talented and dedicated workforce whose skills are recognised everywhere. I am confident they are capable of meeting any challenge they embrace.

Chairman: We will now open the meeting to members. Deputy John Brassil is substituting for Deputy Stephen Donnelly.

Deputy John Brassil: I thank the witnesses for coming before the committee and giving us their statements. As I understand it, the vast majority of members of the public believe they ring up the local dentist if they have a problem and they attend and pay accordingly. To whom is the public dental system available? Is it medical card holders only? Is it the general public, even if most of them are not aware that the service is available to them? Does the future strategy involve a roll-out of public services or will it include the dental practices in every town and some villages throughout the country? I did not pick up from the statements exactly how existing dental practices will feed into the new strategy.

Dr. Dympna Kavanagh: I will respond to the Deputy's earlier questions and I will then hand over to my colleagues to respond to the others. If I understood him correctly, the Deputy's first question was if the public is aware of current public system entitlements? The Irish Longitudinal Study on Ageing, TILDA, and marketing research with the public through Amárach found that the public did not have an understanding of their entitlements or what was available to them. Those involved in TILDA might want to pick up on that issue. In terms of the current arrangement in the public dental service for children, ideally pupils are seen at second, fourth and sixth class level although in general it appears that second and sixth class are the main focus. Emergency services are provided beyond that, and disability services as well.

Deputy John Brassil: Are those services free of charge?

Dr. Dympna Kavanagh: Everybody under 16 years of age can access them service free of charge.

Deputy John Brassil: In the case of a sixth class student in respect of whom an extraction or a filling is needed, is that service provided free of charge?

Dr. Dympna Kavanagh: Yes, if the student is in sixth class. If it arises as an emergency outside of classes they get emergency treatment but they do not get additional primary care. They do not get a full check up or added on primary care.

For the adult service, there are two separate schemes: the dental treatment services scheme, which is for medical card holders; and the dental treatment benefit scheme, which is operated by the Department of Employment Affairs and Social Protection. As I said, they are two separate schemes: one is a health scheme and the other is a social protection scheme.

Deputy John Brassil: People who are outside of those schemes have to go to private practice.

Dr. Dympna Kavanagh: Yes. We would estimate that approximately 10% of people take-up private care. On top of that, there is a mixture of public and private care in that people do not rely only on public care. The Deputy may be aware that the vast majority of care is paid for from the public purse.

Deputy John Brassil: I ask Dr. Kavanagh to elaborate on the Smile agus Sláinte strategy.

Dr. Dympna Kavanagh: It is part of Sláintecare and the move towards universal care. We are taking the first step by focusing on people who are currently eligible. It was launched by the Departments of Health and Employment Affairs and Social Protection, which are working together to ensure both sectors receive the same services. In terms of medical card holders and those on the welfare side, the intention is to bring the two populations together in terms of service provision. This will be a huge majority of the population. Ultimately, the ambition in terms of the roll-out of Sláintecare is this would be the first step towards universal care, but not immediately.

Deputy John Brassil: My concerns are in regard to capacity.

Mr. Frank Goodman: To pick up on the final point made by Dr. Kavanagh, one of the tasks of Sláintecare, which is a substantial piece of work, is to review the health services whole system of eligibility for services, payment structures and so on. There are a lot of schemes in being at the moment, a mixed public-private system to which the Deputy alluded not only in

dental care but in other services in the community and in the hospital system as well in respect of which we have a variety of arrangements. One of the core objectives of Sláintecare is to take a stand back from that, to do the analysis and come up with sustainable options for consideration. That is a sizeable job of work. This will inform what will happen in oral health services as well, because they will have to be included in that consideration.

Deputy John Brassil: Dr. Kavanagh outlined in her opening statement that in developing the policy she wrote to 5,000 dental registrants. Did she get much feedback?

Dr. Dympna Kavanagh: Yes. It was considerably successful. In response to the second letter, we received 256 responses. We also got a number of responses from professional organisations, including the Irish Society for Periodontology, the Irish Society for Disability and Oral Health, the Irish Dental Hygienist Association and others. As I said, 256 general practitioners responded.

Deputy John Brassil: Did the Irish Dental Association respond?

Dr. Dympna Kavanagh: It was specifically written to and asked to submit a response. It responded in writing that it was declining to submit its responses. We had briefings and engagements with the association, as outlined. We met it specifically on the policy and we will meet it again on other issues. On the policy specifically, we met the association in 2018 and 2019, where we gave it a comprehensive briefing of the policy and an overview of the ethos. From our records, I do not think there was anything left out. We then met it again in 2019 before the policy was launched. I also had one-to-one engagement with the former president to discuss issues.

Deputy John Brassil: I am sure Dr. Kavanagh is aware of the Irish Dental Association's claim that it was not properly consulted. It claims that the new policy will make dental health worse instead of better. There is an element of clarification or relationship building required. What is being fed into the political system by the Irish Dental Association is that it is not overly impressed with the consultation process on this strategy. I am not sure if Dr. Kavanagh is aware of it but the Irish Dental Association is telling us that it was not properly consulted. Whether that is factual, I do not know but it is out there in ether.

My colleague, Deputy Donnelly, has tabled a number of parliamentary questions on waiting lists, the responses to which are complex. On the final page of one response, it is stated that the number of people on the treatment waiting for less than two years is just over 10,000. The number for those waiting two to four years is 7,133 and for those waiting greater than four years is 1,316, which is a total of 18,400, which is a substantial number of people. How is it planned to tackle this backlog?

Dr. Dympna Kavanagh: I will hand over that question to my colleagues from the HSE to answer.

Deputy John Brassil: It is a considerable backlog, particularly the over 7,000 people waiting between two and four years.

Mr. Pat Healy: In preparing for our appearance before the committee, we submitted a report to it which includes those figures and sets out the services we provide, including in regard to the waiting list for orthodontics. We are currently treating under 18,000 and there are 18,000 on the waiting list, as the Deputy said. There are currently working with us, on a whole-time equivalent basis, 13 consultant orthodontists, 45 orthodontic specialists and 64 dental nurses, in

our regional orthodontic services. We acknowledge that those who are being treated currently are the most severe and the highest risk. That is the basis on which we are treating people. I will ask Dr. Joe Green to comment on what arrangements are in place in terms of prioritising treatment.

Dr. Joe Green: I thank the Deputy for his question. In response to the long waiters in particular, in 2016 the HSE initiated a procurement process. Currently, there 1,489 patients being treated through that process. We are hoping to extend that process later this year or early next year funding permitting.

Deputy John Brassil: Is it being extended into the public-----

Dr. Joe Green: Yes, with specialists in private practice.

Deputy John Brassil: Similar to the National Treatment Purchase Fund.

Dr. Joe Green: Yes. The are other options, assuming the criteria are retained. There is a threshold, as Mr. Healy stated. The HSE provides orthodontic treatment for the most severe and complex cases. An assessment system is in place through which a decision is made in respect of each child referred from the dental service. We are considering initiatives to increase capacity of the regional orthodontic departments through an expansion of the number of specialists and the possible introduction of the grade of orthodontic therapist to the HSE. Orthodontic therapists are important members of the dental team who work directly with specialist and consultant orthodontists. It will allow us to increase quickly the capacity of the service. We are currently in discussions about that and we hope to introduce the grade in the regional orthodontic service next year. There is work to be done.

Deputy John Brassil: Given that the HSE has approximately 18,000 waiting, does it have a target to reduce that to, say, 10,000 next year, or a three, four or five-year plan to reduce it further?

Dr. Joe Green: Yes, in the context of last year's Estimates, we had a plan to reduce the wait time to three years, which would take approximately 18 months or two years, before incrementally going further. If we can make progress with the introduction of the grade of orthodontic therapist, it would help substantially.

Deputy John Brassil: The National Treatment Purchase Fund is available.

Dr. Joe Green: We are considering all the options.

Deputy John Brassil: At my weekly clinics and so on throughout County Kerry, I am visited at least once a month by constituents with young children. Apart from the issue of dental health and concern, there is a significant psychological attachment for young people, given that they are often image conscious. It is not only about healthy teeth but also about one's well-being. When assessing the urgency of a case, it needs to be taken into consideration, although I am sure it has been, that young people are far more conscious of their self-image than they were in the past.

Dr. Dympna Kavanagh: I wish to clarify a point about the Irish Dental Association. We held a stakeholder day, which was attended by 16 of the 22 representative organisations that were invited. The association sent three or four representatives, who led the round-table discussions. In addition, I outlined the briefing we gave them and I understand they have spoken

about it as being a meaningful consultation. I hope I have outlined how much attention we paid to the consultation and how much we took on board in respect of policy.

We also carried out a year-long structured engagement for dentists and salaried services. There were intensive structured interviews and the engagement was analysed by the University of Sheffield. Many of those who participated were Irish Dental Association members.

Professor Brian O'Connell: In addition to what Dr. Kavanagh stated, over the years the association and many other associations have produced much of their own documentation, policy suggestions and recommendations. We considered all of them and one will find a great deal of crossover between the consistent recommendations of bodies such as the Irish Dental Association and what is in the policy. Such recommendations are not especially controversial. For example, children should be seen much earlier in order that problems can be prevented before they end up in hospital with acute emergencies. These are the policy and recommendations the Irish Dental Association and every other professional organisation have published.

Deputy John Brassil: I take it, therefore, that Professor O'Connell believes that all the bodies, including the Irish Dental Association, have bought into the new policy.

Professor Brian O'Connell: I cannot speak for those bodies. Nevertheless, on the policy, there is significant agreement on most of the areas. I speak to dentists every day. Their concerns are largely about the implementation of the policy rather than the policy itself. They ask whether there will be enough funding for it, whether the entire policy will be implemented and so on. I can certainly understand those concerns, as can most of us who work in the system, given that we do not always have a great track record of funding everything properly and ensuring that all parts of it work. Ultimately, dentists, like any health professionals, want to deliver a service for the population but want to do so in a safe, sustainable way. If they start to take care of a new group of patients such as children or people with disabilities, they need back-up. If it is 4.30 p.m. on a Friday and somebody appears at a surgery with a problem, there needs to be someone who can be called and who can see the patient if it is an emergency.

Those are the main kinds of concerns that underpin much of what I have heard.

Dr. Alison Dougall: I am a special care dentist. I started work in general practice and moved to the equivalent of the public dental service, developing a special interest in the treatment of people with disabilities. I undertook considerable training and now provide care for people with complex disabilities. As well as perusing the evidence, we consulted extensively professionals working in the field and, along with our medical colleagues, people with disabilities. I draw the committee's attention to an excellent document published in 2005 that brought together the viewpoints of people working in the field, such as people from the HSE and the National Disability Authority, who were all in agreement that the key to managing the problem for people with disabilities was mainstreaming their oral health. There was wide agreement in that regard.

The availability of appropriate care is *ad hoc*. People with disabilities are grossly underserved, they experience high levels of unmet need, along with reduced treatment options even when they are able to access care, and their outcomes are poorer. A recent study from IDS-TILDA showed that people with intellectual disabilities who live into older age are twice as likely to have lost all their teeth. More importantly, they are 12 times more likely not to wear dentures, not to mention bridges or crowns, to replace their teeth, ensure their dignity and allow them to chew a healthy diet.

There is agreement among the profession that such inequality is unjust, unfair and unnecessary. Most people from vulnerable groups have needs that can be met with small, reasonable adjustments in primary care. As was noted in the consultation, we must be mindful that when the public service fails to meet such people's needs, the fact that they have been affected by social inequality and had less access to education or well-paid jobs means that their ability to pay for alternatives will be greatly reduced. From the literature, we know that only between 8% and 10% of people with disabilities require specialist care. Where that care is required, however, it needs to be produced by well trained staff with access to adjuncts such as general anaesthesia and sedation and who are well informed on consent, ethics and working with teams in social care. It is clear that people with disabilities want availability of care in mainstream services. It is what they have asked for and there are great models to showcase this working very well. However, what is required by people with disabilities, long-term conditions and frail older people is well-signposted pathways to services in a timely fashion as for many of these people, the only way they can receive basic care is with general anesthesia, sedation or experts. The oral health policy and the consultation that we have gone through provides the structure and opportunity to address the frank inequalities that we see right from early intervention in childhood to frail older age. For the first time targeted, preventive packages in primary care and establishment of these community-based services is really important.

Evidence shows that educating the general dental workforce and exposing them to diversity in their training gives them the skills and knowledge to manage most people with disabilities. The training of the workforce, supported by specialists, is really important. We cannot expect our primary care providers to accept people with complexities into their workforce without a very well structured framework and pathways to support them, for the few patients for whom it is beyond their scope.

Deputy Louise O'Reilly: I apologise for being late - I was showing solidarity with workers on the picket line this morning and got caught in traffic - but I have had the opportunity to read over the submissions.

I am unclear about the matter of the Irish Dental Association. Its representatives appeared before the committee and were very clear. Their considered view was that the association was not consulted, that there was no meaningful consultation, and they do not see their views or position reflected in any of the documentation. I struggle to understand how we can have two people in for two different sessions who can have such completely divergent views of the same process. Dr. Dougall calls what happened detailed consultation, while the Irish Dental Association is certainly not of that view. There appears to have been some meetings but the Irish Dental Association says that it cannot see its views in the policy. It is the body which represents the profession. Maybe we will never get to the bottom of it but it is worth noting that it was very strong in its view that there had not been meaningful engagement. We could detail all the meetings - we could have 100 meetings here and maybe it could be that I did not listen or the witnesses did not speak. It is a difficulty and I hope that the partnership can be rebuilt. The two views contradict and I do not know if we can square the circle. In the absence of a time machine it cannot be fixed but it is important that the relationship is re-established. I am not necessarily asking the witnesses to accept that the relationship has broken down or put words in their mouths but it is difficult for us as we have heard two divergent views of the same process. I find it curious that two groups of professionals could be involved in a dialogue the end result of which is that one group is firm that it was not consulted and the other is firm that it was.

Something that was not in the submission, or if it was I missed it, was the audit of orthodon-

tic services carried out in 2015. This was reported in the press. There have been calls for this to be published. I think I read that the position of the HSE and Department of Health was that this was just a scoping exercise and there is no need to publish it but can Mr. Healy explain why it was not published?

Mr. Pat Healy: I checked with my colleague, the head of operations on the community side, in whose area this falls, before the meeting. I am advised that, as the Deputy said, the report or scoping exercise was one part of a process which advised the HSE on the actions it should take in determining the range of risk or if there was harm etc., in relation to particular cases. That has led to an audit and a particular clinical review which is currently under way and nearing completion. When that is complete, a serious incident management team will look at the outcome and determine the best course of action. The important thing is that the clinical review and audit is actioned and any action is followed up. My colleague, Dr. Breen, can provide any other detail the Deputy might need.

Deputy Louise O'Reilly: The detail is fairly simple, it is just a copy of the original exercise that was undertaken in 2015. It does not seem outrageous to me that this be published. We have just been through the Scally inquiry, for instance, which was a scoping inquiry. Its terms of reference were very public. The scoping inquiry itself was very public as were its recommendations, which were first shared with the people affected - or maybe not in all cases, which we will not dwell on, but that was the intention - and then put in the public domain. Mr. Healy will understand that there is some concern because there seems to be some secrecy surrounding the report which has caused people to wonder what is in the report. The attitude seems to be one of "Ah, there is not much in it," but if that is the case, why not just publish it?

Mr. Pat Healy: Today's meeting was focused on policy. There is no question of secrecy and there has been media coverage on it, as the Deputy noted. I will arrange that a formal note be sent to the committee to outline what the position is.

Deputy Louise O'Reilly: That is great. I thank Mr. Healy.

Chairman: This refers to an issue relating to the mid-Leinster area where orthodontic services were discontinued and there was a sense that some children had suffered as a consequence. The health committee, under a previous Government, held meetings on this. I believe it was in 2005. Two experts from the UK looked at the evidence and those two experts have called for their review to be published. They completed it in 2015 but it has not been published. That is the issue. Myself and other Deputies have been approached on this and have all asked parliamentary questions. The answer we receive is that the review is ongoing but the review that the two specialists from the UK completed in 2015 has not been published.

Mr. Pat Healy: I will get a formal response to the committee to clarify the exact position. It is being operationally managed within the system.

Deputy Louise O'Reilly: I assure Mr. Healy that the intention is not to ambush him but I want him to understand that if the detailed note is just a rehash of the answers to parliamentary questions, it will not be good enough. I am not speaking for anyone else but I do not expect anyone will disagree with me. We are all wondering why the information that is there cannot be shared.

Mr. Pat Healy: I will establish that and arrange for a response to be provided to the committee.

Chairman: Does Mr. Goodman wish to add a comment?

Mr. Fergal Goodman: On the point about the Irish Dental Association, IDA, the Deputy has reasonably summarised that different parties can be involved in a process and at the end of it still have different perspectives. We may have to agree that is as it is but, as we move to implement the policy undoubtedly it will require a high level of engagement with the IDA in its representative role of the external providers and as the union for salaried staff in the HSE. Mr. Healy and I, as the Chairman may be aware, recently were involved in a process in respect of general practitioners and despite much toing and froing, tension and differing perspectives, as the end of it we came out with an agreement. That is what we will also be aiming to do with the reform of dental services. Mr. Healy might want to amplify that, as he has been involved in many significant change programmes in the HSE.

Mr. Pat Healy: I agree with what Mr. Fergal Goodman said. As a number of Deputies mentioned, concerns have been identified by the IDA. As we progress towards implementation, we are clear that we and the Department, collectively, will have to be engaged in a comprehensive consultation process with all the stakeholders involved in it, whether it be providers, our staff, patient groups or other interests. The Deputy can be assured there will be a comprehensive process of engagement. If there are bridges to be built we will try to use that process to arrive at a shared understanding of where we need to go and we will address the concerns identified. I carefully read the IDA's submission and while it identified a range of concerns, it also identified four or five positive areas where there is common ground. Those are areas on which we can build and concerns we can address as we proceed.

Deputy Louise O'Reilly: I have a number of specific questions. The first one concerns the existing number of clinics. I will put my cards on the table. This policy and announcement sound like further privatisation of the service, which is contrary to what is recommended in the Sláintecare report, which places heavy emphasis on public provision. That is the perspective from which I am approaching this.

What is the number of HSE dental clinics currently in existence? Under the new model, how many of those will be closed, or will they remain open but will do different work? What will the HSE clinics look like under the new model? Essentially, how many of them are there and what will happen to them?

Mr. Pat Healy: I will ask my colleague, Dr. Joe Green, to comment on that detail. We set out in the report we provided the detail of all the services. It also references the clinics. A significant number of staff, numbering 657 whole-time equivalents, currently work in the service. I will ask Dr. Green to cover the detail of that. It is important we emphasise that while the policy identifies a roadmap for the future, there is recognition of the good quality service currently provided by the HSE. It is targeted and we have prioritised need towards a targeted group. The issue of access must be addressed and under the policy we seek to do that. It reorientates the role of the HSE service, particularly focusing on special care in terms of those with special needs, our ageing population, vulnerable groups and so on. That is part of the implementation process in which we will be involved and we will have to work that out.

Deputy Louise O'Reilly: Given that the HSE is doing such a good job, would it not make more sense to expand what it is doing.? Nobody has a difficulty with the quality of dental care provided within the HSE, access to it is the issue. In my simple view, expanding what the HSE is doing would improve access to what Mr. Healy has said is a good service.

Mr. Pat Healy: In terms of the policy, account has been taken of what is happening internationally. We are relatively good at what we do within the limitations that apply and the resources allocated. If we look to countries that have well developed services they are all moving in a different direction. The policy builds on that and sets out a roadmap. Will there be challenges in that respect? There will and that is why we will have a comprehensive implementation process to work through those. It is important we reassure our staff working in the service that there will be full engagement and consultation with them. The policy provides for that. I will ask Dr. Green to cover the detail of our existing clinics.

Dr. Joe Green: The direct answer to the Deputy's question is that there are 221 dental clinics. I thank her for her comments on the quality of service provided. I think our staff do a great job-----

Deputy Louise O'Reilly: A fantastic job.

Dr. Joe Green: -----in difficult circumstances. As the Deputy knows, they deal with children under 16 years of age and children and adults with special care needs. Sadly, for many children their first interaction with a dentist is as a consequence of having pain. We would like children to be seen at a much earlier age. If children have pain they attend our clinics and are dealt with by a highly skilled and well motivated staff who do a very good job in difficult circumstances.

Many people's first experience of dentistry is quite difficult. It might come as a result of pain or trauma, possible loss of sleep or the onset of infection. No one, if he or she has symptoms, is in the best of form when he or she turns up at a dental clinic. The staff deal with that on a daily basis. Since the start of this meeting, probably 300 children experiencing pain have walked into dental clinics and private dental practices. There are in excess of 70,000 attendances for emergencies in the HSE service. That is quite a large quantum of service. We are very proud of the efforts our staff make to look after children. Not many of us look forward to having dental treatment. Clinical dentistry in young children requires a highly skilled and well motivated staff together with high standards of care, which is what we strive to provide. The same group of staff provide services for children and adults who require special care and they also provide treatment under general anaesthetic for children and adults in many of the hospitals.

Deputy Louise O'Reilly: My question related to the 221 dental clinics. On full implementation of the new policy direction, will some of those be closed, will they change what they do, or will they continue to do what are currently doing? Presumably, the staff comprising 657 whole-time equivalents, as outlined by Mr. Healy, will continue to be employed. Is it planned to expand the number of workers, will 657 remain the staff complement or is it planned to phase out some of them?

Dr. Joe Green: We are not planning on phasing out anyone. The policy was only published recently and the HSE's intention is to work with the Department of Health and other stakeholders to deliver an implementation plan. The future role of HSE dental clinics will depend on the profile of services to be developed. I envisage the existing staff will undergo quite a level of upskilling in order to provide a greater level of service for people with disabilities who require special care. That would involve investment in skills and in facilities.

I cannot cite the number of clinics that will be in existence in five to ten years because they change from time to time in order to build better facilities but I can say we will be investing in staff. There is quite a lengthy transition period under the plan. We will be providing our exist-

ing service at all times with the priorities of care currently in place. If a parent who has a child experiencing pain contacts a clinic, they will be offered an appointment the same day or the following day. We aim to keep that service in place at all times.

Deputy Louise O'Reilly: Were any other models examined? I regard this move as the further privatisation of the service.

On the cost-benefit analysis, Mr. Healy and I had conversations previously on the home help service. Without putting too fine a point on it, I was correct and much of it was privatised. At the time, I was told it would not be and it would enhance the service. Of course, it did not. Was there a cost-benefit analysis in terms of the investment in the public service building up from the 221 clinics, increasing staffing, delivering more through the public service versus purchasing from the private sector? For example, we saw it happen with the home help service. Directly employed home helps would provide the service for approximately €13 to €16 an hour. Once one headed towards the private sector, one was knocking on the door of €45 an hour, as well as losing control of the service and deskilling the public service.

It is not good that this would be lost. What sort of cost-benefit analysis was done? I appreciate that other jurisdictions may be travelling in another direction. As my mother used to say, however, if all one's friends stuck their fingers in the fire, would one do it as well? It does not necessarily make it right.

Dr. Joe Green: That is a policy development question for the Department of Health.

Dr. Jacinta McLoughlin: I worked in the then health board dental services for 21 years, for seven of which I was a principal dental surgeon in County Meath. I understand the Deputy's question and concern for the staff in place. I was a principal dental surgeon when the last policy was launched and implemented. Part of that was that the Department kindly offered us more dentist posts and it coincided with the introduction of dental hygienists. We had great difficulty in County Meath filling those positions, however. I had to go to Stockholm to recruit some dentists to fill those posts.

The problem is that, as currently set up, the HSE dental service is not attractive, particularly to new graduate dentists who would be young and enthusiastic. Unlike in medicine, dentists graduate with a wide range of clinical skills. In Dublin, they start treating patients doing irreversible procedures on patients in year two of a five-year programme. They come out with an accomplished range of skills. If one works in the salaried dental service, it does not allow one to use those skills. In the past, there were more opportunities to use them. When I was in the health board dental service, there were opportunities to treat adults. For example, I did some of that kind of treatment in psychiatric hospitals.

Having extra positions does not necessarily solve the problem if the posts are not attractive. Salary cuts, changes in the pension arrangements and so forth have an impact on the attractiveness. The model of care needs to change. This has been clearly outlined in the policy. As Dr. Green said, there will be much support for that as people understand that if one goes to reorientate a service, one must give people the skills to deliver it. Just offering extra posts is not going to work with the current model. The policy proposal, accordingly, is to change the model.

Deputy Louise O'Reilly: My question was about cost-benefit analysis and how it was done.

Dr. Dympna Kavanagh: We absolutely had to address that issue. It took four separate

phases to look at it. The first was commissioned and given to University College Cork by the reference group to look at the cost-benefit analysis of the various services. There was much international research on salaried services. We looked at the Scandinavian models and at introducing different types of models. They did not involve privatisation but public contracts in local communities. It was found that salaried services were best suited to providing services to vulnerable and special care services. For healthy patients in primary care, it was not as effective or efficient. There are multiple international studies in that regard. We looked at countries which were similar and there are theoretical constructs of it. The Dutch and Icelandic models are more similar culturally to where we are sitting and we examined those models closely.

The second stream looked at all insurance models internationally and what was successful and otherwise. It just did not look at the oral health outcomes of those models. Oral health is influenced by many other issues such as social determinism, disease and water fluoridation, and not just by the service. It looked at the uptake and the buy-in culturally from the countries involved. Insurance models work well in Ireland. We saw extremely good and fast outcomes from many of those models.

The final phase was done by the ESRI. It started examining various types of models such as mixed-payment models. This involved looking at a preventive package overlaid by a fee-for-item system and further overlaid by service level agreements. The reason we went down that model was because it was familiar to the public and it understood it more. The outcomes from such a model are good in a short period, particularly for a preventive-oriented scheme. It is good for the type of oral health we are experiencing at present, whereby the vast majority of children from middle to high-income families have good oral health. Then there is the smaller group of vulnerable persons.

We looked at the Medicaid model in America, whereby it increased access through practices. It found that ironically inequalities did not get worse but were much better for the high-risk and low-income groups when they got in early. The higher income groups did not tend to use it as much but it really benefitted lower income groups.

We undertook four separate phases because it is a significant change for us to undertake. We had to look at the economics. The Department of Public Expenditure and Reform certainly put us through our paces in that regard.

Deputy Louise O'Reilly: I am sure it did.

Dr. Dympna Kavanagh: Changing the model was not a decision taken in any way lightly. As our colleagues and the HSE have outlined, it would be in a phased stage in order to release capacity in line with Sláintecare to ensure fewer services are provided in a secondary care service. As young children and teenagers would be taken up in local practices, this would release capacity in the HSE. The only intention is that the HSE's salaried service would be stronger. As was pointed out by Dr. McLoughlin, it would provide an opportunity for dentists to use a broad range of their skills. We have had a significant amount of support from the disability organisations. They are employed by the HSE in this regard.

Dr. Alison Dougall: I provide care for a population with haemophilia. Ten years ago they would have all travelled to Dublin for all of their dental care. This led to waiting lists and decreased access. People who had difficulty travelling needed to come from counties Mayo and Roscommon. Over a period of four years, both by training primary care practitioners and offering shared care, where people can receive their preventive, minimal invasive care near their

homes regularly, a saving of €2.5 million for factor usage for dentistry in a two-year period was achieved. Economics is not the driver. It also showed increased access to care and less invasive surgery. The price of having to provide complex care in a secondary stage, whether it is general anaesthetic or an integrated medical model in a tertiary or secondary care unit, is significant. There is an ability to prevent, by working with networks of well-supported, well-trained primary care professionals in the HSE clinics or in general practice, as the patient prefers. Patients have to have choice. The greatest thing about this policy is giving choice to people as to where they take their preventive packages. That has been a big factor with patients. They want a choice and to be able to attend the same practitioner, if possible, as their families, and not to be medicalised.

There is choice but economics also is a really big factor. We can show that in many models with medically complex patients.

Deputy Louise O'Reilly: Can the cost-benefit analysis be published?

Dr. Dympna Kavanagh: It has been developed by academics in University College Cork. I do not know if they have an intention to publish it themselves academically. We shared it with the Department of Public Expenditure and Reform when we engaged with the Department and I can certainly ask the academics to provide it.

Deputy Louise O'Reilly: There will have to be an increase in administrative work in the model proposed, given that one is dealing with service level agreement and a fee per item approach. Is this assumption correct on my part?

Dr. Dympna Kavanagh: In fact it is the other way around. In a packaging system, when one takes a preventive approach, it is all in one single menu. It is not about picking and choosing and looking then for each item. That is the beauty of it from an insurance perspective and is why we follow the insurance models. They do not do it unless it is very easy for them to administer. The packaging model is very simple and straightforward. It is one package and one deal. We are trying to put as much as we can into the routine care on fee per item package. Some of the care should obviously be picked and selected between the dentist and the patient themselves. We are trying to lessen that.

For very complex care, which we want to bring more into practice, as was highlighted in line with Sláintecare, we may then be looking at different models. It may remain fee per item or may remain service level agreements.

Internationally, the majority of other public services use implants for retaining dentures in the care of the elderly. We do not use that here. We will have to see then where our clinical dental technicians and technologists come in and will look at contracts in that regard. It is simpler for the patient. They do not have to worry because they have their package and within that it is simply a menu selection. The dentist can then simply send in a package, regardless of what they pick from the menu.

Deputy Louise O'Reilly: I have other questions but I am conscious that other people may wish to come in. Will there be a second round opportunity?

Chairman: Yes, there will. I thank Deputy O'Reilly and I call Deputy Durkan.

Deputy Bernard J. Durkan: I welcome our guests and thank them for their responses and a number of questions arise.

How would our guest speakers rate water fluoridation as a fundamental support to good general health and dental hygiene? How does one then specifically respond to the lobbyists who are opposed to it, as and when required?

How are specific groups targeted such as, for instance those in the workplace, that is, people who are at work, or work for most of the day and are not available during the practitioners' working day? They then neglect their dental care until it becomes a serious matter. We all attend to it then, when it is probably too late. Have our guest speakers found a particular means to contact people, maybe in the workplace or by some other means, through, for example, the sporting areas? There are continuous contacts in the sporting areas due to injuries, but apart from the injuries area, how is contact made with that cohort of people of a certain age group who may have particular issues?

Has an oral health system been devised whereby cases that are serious or likely to become more serious can be caught at an earlier stage?

On the issue of the Irish Dental Association, without wishing to go over the issue that already has been raised, but would greater interaction with the Irish Dental Association be considered or for the association to interact with the groups represented here? Should an established structure be put in place whereby a situation would not then arise where the association was progressing on a particular route while the groups present here were progressing on a parallel but different route? How will the bodies present here address the sort of crossover that may be necessary?

Is there any certainty as to the provision of access to all those most likely to be in need of assistance right across all the socio-economic groups, and if not, how is this to be addressed, given the particular importance of dental and oral hygiene?

Together with the answers to these earlier questions, can the witnesses address the extent to which women of childbearing age have ready access to and contact with the dental services in order that their progress and the value and quality of the support that they receive can be monitored, and as to how their particular health situations in and out of pregnancies may be affected by a lack of adequate attention?

Dr. Dympna Kavanagh: I will begin with the question on water fluoridation and probably will link in with some of my colleagues on that. From a policy perspective, as we stated, water fluoridation remains a cornerstone of the policy because it is the single most influential change in the improvement of our oral health and that has been monitored since it was introduced in the 1960s.

More recently, a Health Research Board study was commissioned known as Fluoride And Caring for Children's Teeth, FACCT, which was set up expressly to look at the impact of this, and whether it still is as impactful as it was before. The outcomes are that it is and there is a distinct difference between children who receive fluoridated water and those who do not, in both the severity and distribution of their disease.

In addition, the Department itself also commissioned a separate study directly with the Health Research Board to look at the benefits and risks because concerns were coming from the public on risks. The Health Research Board produced a very clear evidence-based document and assessed all of the risks and the evidence underlying them. There is no evidence that there are risks associated but it does indicate that ongoing research and monitoring is necessary, which is why we have reappointed an expert body for fluorides in health in place. That deals

with water fluoridation but does anybody else on the group here-----

Deputy Bernard J. Durkan: I do not wish to ask awkward questions but there are some other countries that do not do fluoridation.

Dr. Dympna Kavanagh: Yes, that is true, they do not. They use alternative methods of fluoridation. They may use salt fluoridation, fluoridation through milk, or other schemes such as varnish programmes, or may use other access to fluoride in different ways.

Deputy Bernard J. Durkan: How successful are these?

Dr. Dympna Kavanagh: They are extremely expensive programmes and there is also a sense pragmatism. Perhaps Dr. McLoughlin might wish to speak on the this aspect of the question, which I will hand over to her.

Dr. Jacinta McLoughlin: The Deputy is reflecting concerns that have received much airing in the media. The use of fluoride in the prevention of dental decay is one of the most researched areas in dentistry. The search engine for scientific publications shows huge volumes of research on it. The United States is one of the key countries. Over 300 million people worldwide receive fluoridated water. In the United States there is quite an amount of naturally occurring fluoride in water supplies. In this country we reduced the level in the water supply in 2007 because on the basis of research carried out here it was considered that a reduced level would perhaps be better. The range now is 0.6 to 0.8. The maximum allowed in EU drinking water regulations is 1.5. There is a very cautious approach being taken here. In the United States in the past there was a maximum allowable concentration of four parts per million, which is considerably higher than the EU figure. This is something that has been shown worldwide to be effective because everybody gets it. People do not have to make any effort to get it, whereas in a programme which involves the application of a topical fluoride in some form or a varnish, or however it is put onto teeth, they have to come into the surgery. Water fluoridation occurs for everybody. That is why it is so beneficial. It has had a huge beneficial impact on oral health in this country, not just for children but also for adults. A whole generation has retained natural teeth, something that perhaps would not have happened in the past without water fluoridation. It remains a cornerstone of policy because it is a key aspect of preventing one of the main dental diseases that afflicts people. People do not look forward to going to the dentist, which is understandable. The problem is claims can be made, but in the scientific world a very careful evaluation is made before talking about cause and effect. People do not do this lightly. They want to have lots of evidence to show a positive or negative effect. It is a really important part of policy and will remain so.

Dr. Alison Dougall: I would like to respond to Deputy Durkan's question about access to care and how to nudge people to access it before something becomes a problem. The major change required is oral health has to become everybody's problem. We have to integrate the mouth with the rest of the body and work with our medical colleagues, community nurses and midwives to nudge people at appropriate times. This is really important in early childhood, but it is critical in older age, too. We find that for the first time older people are retaining their teeth. In the past they went into older age with dentures. People make more medical appointments as they get older but fewer dental appointments, although their risks are higher because of medicine, poor eyesight, lack of dexterity and finances. Pathfinder surveys examine how we can signpost people in order that they have really good levels of oral health as they age. As one in five people over the age of 80 years will get dementia, we need to make sure the teams that are caring for people with dementia take oral health seriously because we have the technology

to prevent and reverse disease if we catch it early. Our problem is that people with dementia who have not received any care for perhaps eight or ten years present with advanced problems which at that point are very difficult to treat. That is a real priority. It is a new problem, but the nudges about which the Deputy talks mean redesigning the way we provide care. For homeless populations, we need more drop-in centres; for older people, we need to make sure services are local because they are least likely to be able to travel. Therefore, we need to make services accessible and affordable and design domiciliary care services in such a way that we can take teams into residential homes. They do not need to be dentists; we can work with teams of hygienists who can effectively and economically reverse disease. This is incredibly important and it is highlighted in the community services. We need to work with the professions and our colleagues in other areas of medicine to design services to reach more people at risk.

Dr. Dympna Kavanagh: On the point made about water fluoridation, like Ireland, Israel had mandatory water fluoridation and it was pulled out. It tried to replace it with toothpaste and other programmes outlined by Dr. McLoughlin. For all those reasons, the level of decay has increased phenomenally. The only area in Israel that has maintained its oral health rates is a place in which water is naturally fluoridated. Now that water fluoridation has been taken away, it is impossible to put it back in. It is really important that we protect water fluoridation as there are stark and dramatic outcomes, as we see in Israel.

The point made about the workforce is very important, especially because we have put in place the World Health Organization, WHO, safety net surveillance network. On focusing on children only, the WHO is very clear that we must consider five year olds, 12 year olds, adolescents from 15 to 19 years of age and 35 to 45 year olds, the prime ages for childbearing, and then move to 60 and 70 year olds. The overarching safety net monitoring and surveillance service has been recognised by the WHO since the early 2000s and all European countries are moving in this direction exactly for the reasons outlined by the Deputy to make sure people in the workforce are encouraged and formally nudged to tell them that their oral health is not okay, as they need to be signposted to the dentist and assured on where they are going.

The view from other countries, particularly the Dutch models, is that there is much more flexibility when the message is sent to the profession in communities that dentists are providing care because they can afford to be more flexible, work on a Saturday, or late if they so chose because it is up to them to get their patients into the clinic. A core part of oral health policy is to establish a dental home as early as possible because the first two years are crucial, not just for children but also their parents because the effect is twofold. When they bring in their child, it nudges them. There is a lot of evidence to support this. We can be absolutely certain that certain socio-economic groups have access to services. One of the key points in the policy is to say it is a universal approach, but it must be overlaid with a targeted approach. That comes through in the oral health promotion programmes and services, but at no point do we say universal access stands on its own. We are absolutely aware of the vulnerable and people with disabilities. That is why we have put in place the WHO safety net surveillance network to ensure we can pick up those in the vulnerable groups.

Mr. Brian O'Connell: The safety of water fluoridation has been raised as an issue over and over again in every country. I can understand this. Most English speaking nations use water fluoridation to a greater or lesser extent. I have examined this issue. The WHO, the European Union, the Food and Drug Administration, FDA, and others have examined it in great detail and never been able to find any problem with its safety. The Health Research Board commissioned a study a few years ago, examined every piece of evidence and could not find a problem with it.

Last year Public Health England recommended that more water fluoridation schemes be rolled out. More people in England receive fluoridated water than in Ireland. It is a smaller percentage of the population but there are big fluoridated communities in the UK.

The Deputy is right about catching serious cases at earlier ages. We spoke earlier about on-demand services and children turning up in pain and with infection. Why are 70,000 children turning up in pain and why do 7,000 children have to go into hospital to have teeth extracted? By the time they are seen, it is too late. I agree with Dr. Green. No parent wants his or her child's first time visiting a dentist to be because the child has a serious infection and needs to be bundled into hospital and put to sleep to have teeth removed. Nobody wants that. No organisation or dentist wants that. This is why one of the key aspects of the policy, in line with all international recommendations, is to see children when their teeth first appear and start to give basic advice to them and their parents about looking after their teeth, diet, brushing and so on to ensure we do not have young children turning up in hospital needing extractions. That is very important.

At a later age, there is a growing problem with diabetes. There is a well-known relationship between gum disease and diabetes. The more one improves one, the more one improves the other. Some of the health insurance companies in the US will pay for people to have as much gum treatment as they want if they are at risk of diabetes because the more a person improves his or her gum health, the better controlled his or her diabetes will be and it will stop people from going into hospital. It also saves money. The preventative approach is important and runs through the everything.

Deputy Bernard J. Durkan: It is not just a question of, for want of a better example, bad breath. There are serious underlying health issues with particular reference to diabetes.

Professor Brian O'Connell: Absolutely.

Deputy Bernard J. Durkan: How do we get that across to all segments of the population? In the past, I have criticised the fact that we often lack information. We lack the information needed to make the necessary changes in our lifestyles to try to prevent the kinds of interventions that eventually become necessary. How do we do that?

Dr. Dympna Kavanagh: We looked at that through the Healthy Ireland survey. We looked at all the different professions providing more general care, for example, with regard to smoking. Results related to pharmacists, dentists and medical doctors but we noticed the contribution from dentists was 20-odd percent. It is about having an integrated approach so that we are all on the same team. This is a key part of the policy and has been mentioned over and over again. We no longer consider ourselves just dentists but as being integrated with the rest of the team. We consider ourselves to be common health professionals like everybody else so we are not stuck in a silo that is only about dentistry. There is considerable evidence from the British and Canadian systems on the advantages and the fact that people, particularly in Great Britain, regard the pharmacy as the best place to receive their oral healthcare advice. While that might not translate to Ireland, there is certainly strong evidence to suggest that this information should come from several different sources. Finland is another example of a country that changed its system. The pharmacy is the first point of contact, which means that if person goes into a health service where the first point of contact happens to be a pharmacist, that pharmacist will guide him or her through the system. We are not saying we will Finland but that it is important that we are part of an overall team and that that team is part of our team as well. We want other health professionals to provide dental advice and for us to participate in supporting obesity, smoking

and dietary messages that are important for good health.

Professor Brian O'Connell: I will not repeat what Dr. Kavanagh said. The HSE has a very good programme called Making Every Contact Count, MECC, which is an integrated programme rolled out to all health professionals. We are doing it now and teaching it to staff and students. It involves all care providers working together so that they all provide the same health messages about smoking, diet and exercise. Everybody eventually interacts with somebody, be it the dentist, pharmacist, GP or community health nurse. The important point is that we all give the same messages on health.

Dr. Dympna Kavanagh: I have one final point to make on water fluoridation. It is important to note that national surveys in Ireland are carried out across Northern Ireland and the Republic of Ireland. When we compare Northern Ireland with the Republic, we can see there is a distinct difference in the outcomes relating to oral health. The argument would always have been that Northern Ireland had a much more accessible health service than we have, but we benefited enormously from water fluoridation compared with Northern Ireland. That is a very clear-cut comparison for us.

Deputy Bernard J. Durkan: Orthodontics has been an issue for many years, particularly in cases involving children with double impacts or where teeth progressing from the roof of their mouths arrive. There is a critical age that is regarded as being the proper time to interact. In the meantime, the pain and suffering of the child while waiting for that age to progress can sometimes be severe. The amount of medication the child must take to prevent the pain is considerable. In some cases, the conclusion is not what would have been intended. Is there a procedure is in place whereby health professionals are alerted to the existence of such cases where the pain is likely to become extreme or the damage done in the waiting period might require major rebuilding of the jaw or face?

Chairman: Does Dr. Green wish to respond?

Dr. Joe Green: In HSE services, every child aged up to 15 years can attend if he or she has pain. In a case where an orthodontic condition - a malocclusion - is identified, usually around the age of 12, referral will be made to the HSE orthodontic service. If the assessment is successful, the child is placed on the waiting list and called for treatment. Within the system, priority is given to more complex cases. If a child is in pain, he or she will not be left in pain. The pain will be managed. If there is an orthodontic element to the condition, the dental service will liaise with the orthodontic service and try to resolve the matter and deal with the pain and symptoms

Deputy Bernard J. Durkan: What about waiting lists? Are there waiting lists?

Dr. Joe Green: Yes, there are waiting lists.

Deputy Bernard J. Durkan: To what extent does that affect the period during which the pain treatment must be dealt with while awaiting a satisfactory conclusion?

Dr. Joe Green: If a child has pain through dental decay, infection or trauma or for some other reason, he or she will be treated in a local dental clinic. The referral to the orthodontic service has already been made. If there is an element of the orthodontic condition - the malocclusion - that is affecting the child and causing some physical pain, we would liaise immediately with the orthodontic staff to deal with that. Malocclusion by itself would rarely give rise to pain. There could be something else going on.

Deputy Bernard J. Durkan: There could be, which is why I am pursuing the question. There could be a situation where the child may go past 12, 14 or 16 years of age while still awaiting an outcome - perhaps on very good advice. However, the child may reach the age of 18 or 19 years of age and be left with a serious problem that requires major surgery to correct, whereas if the service and attention had been available during that window of between 12 and 15 years of age, the effect on the child would not have been as severe and the outcome could have been much better. What I am trying to get at is the delay. Some of those cases cannot afford a waiting time.

Dr. Joe Green: I am not an orthodontist. I am a primary care dentist. My understanding is that cases where the malocclusion is severe and the treatment is complex may include a planned episode of surgery. These are known as orthomatic cases where the orthodontists works in conjunction oral with maxillofacial surgeons. The vast majority of those cases are identified at the point of referral and the point of assessment. While those cases are prioritised within the current system, some of the surgery is dependent on the completion of growth in the jaws and that is not completed in most instances until the very late teens. Therefore, the surgery will be planned at the end of the teens rather than at age 12 or 13 which is the optimal age for the majority of children to have orthodontics. In a small number of cases, the planned approach will be that some orthodontic treatment is undertaken with a possible delay thereafter to allow growth to be completed followed by more intervention by the orthodontist and the surgeon working together. There are a small number of such cases, but they are dealt with on a priority basis within the system. However, they are in a parallel stream to most of the other cases where priority is determined according to the extent of malocclusion. There is serious management of those cases, but inevitably some of those adolescents will be treated right through until their late teens or even early 20s because of the nature of their condition and the physical limitations on what can be achieved in the early to mid-teens. It is not my area, but that is my understanding of it.

Deputy Bernard J. Durkan: I know the Chairman is anxious for me to finish, but I have been waiting a long time. When one has a long drought, one generally drinks from the pool for a little bit longer, similarly with dental care and orthodontics. We have covered the interaction with the general population but I have not really got any great response on interaction with the Irish Dental Association even though previous speakers have asked that question too. Dentists in the field are working in that business every day and they should have first-hand accounts of whether progress is being made. If they are complaining that we or the authorities do not liaise with them sufficiently, somebody is wrong. It might not be deliberate, but if someone is wrong, that is to the detriment of the quality of the service. That is not a criticism, it is just a statement. Could we have some further elucidation on that if it is a possibility?

Chairman: We have probably dealt with that previously, unless there are short additional comments to make.

Mr. Fergal Goodman: My note is that Deputy Durkan talked about us interacting more with the Irish Dental Association. I think what he is getting at is improving the relationship.

Deputy Bernard J. Durkan: Yes.

Mr. Fergal Goodman: The Department and, if I can speak for it, the HSE would not have a difficulty in doing that. If one looks back at the last decade, in particular from the perspective of those working in both salaried health services and in contracted services, salary reductions and fee cuts probably left everyone in an uncomfortable position. There may have been a feeling among those providing services that things were done to them rather than they were part of

a process, which was the traditional model of engagement. As I said earlier, the new policy is a very good basis on which to engage and we have an absolute obligation and necessity to do so.

Deputy Bernard J. Durkan: That obligation extends to putting in place a formal structure as opposed to an occasional structure.

Mr. Fergal Goodman: If we have formal contractual business to do, for example, there is an absolute formality and practicality to doing that. In addition, something that came out of discussions with the Irish Medical Organisation in respect of GPs was the need to have a form of clearing house for a whole series of issues between contractors and those contracting services from them. There is a necessity to have engagements of a number of different sorts. Sometimes it is on the basis of a formal, clear and specific agenda and at other times, it is about an opportunity for parties to bring issues of concern to a table to work them out. There are various models for doing that and we are in the process, coming out of the agreement with the GP organisation, of putting such an arrangement in place. It is about relationship building, in which regard improvements have already been achieved and that will continue. I see us doing the same with dentists and other contracted professionals. We recognise that it is a job of work we have to do.

Dr. Dympna Kavanagh: I will make one final point in that regard. There is a distinct difference regarding engaging with dentists. I appreciate and understand that there may be some confusion but there is absolutely engagement directly with the profession. It is important to note that we got a mass of responses when we contacted 5,000 registrants twice and when we had a year-long structured engagement via structured interviews with a particular sample across a wide range of dentists. They engaged in three-hour interviews and we got a massive amount of consultation from that process. I appreciate where the Deputy is coming from with regard to the Irish Dental Association, but I have to stand firm and say there was in-depth consultation directly with the dentists on the ground as well as with the public. When one looks at any of the other policies that have been produced, the engagement directly with the dentists was extremely comprehensive in comparison. I hope I will be supported in that regard. There was a great deal of other consultation that was carried out separately with the academic reference groups and a separate practitioners' group. I want to ensure that is made very plain and clear.

Senator Colm Burke: I thank the witnesses for their very comprehensive presentations. I apologise for having to leave the meeting but I had a prior commitment on another issue. I am not sure if the following issue was raised while I was away. It is about the whole area of training. The RCSI made the point to us regarding training that there was no foundation year. When one is training in medicine, there is an intern year. The RCSI says, however, that there is no foundation year in dentistry. The second issue is the lack of available training for people who want to specialise. We do not appear to have a structure or the structure we have is not training enough people. We have people who require specialist treatment, but we do not have enough practitioners in the area. How do we improve training? There are many people who come out with qualifications from university and appear to leave the country at a very early stage. Some of them come back but many do not. How do we work on that?

I refer to the number of dentists employed in the public sector and trying to provide the required support for children going to school. The committee has been advised that some children might be in sixth class before they receive any dental examination. How do we deal with that issue?

I refer to the development of primary care centres, of which there are more than 120 nationally. Dental health is an important aspect of people's health. How many primary care centres

have facilities for dentists to operate in? I am not sure that has occurred. I have seen new primary care centres open with facilities for every other part of healthcare but not dentistry. Has any lobbying taken place to ensure that when primary care centres are rolled out, they cover all health areas, including dentistry? Could we have some figures on the number of primary care centres with the capacity to accommodate dentists? I am not clear that provision is being made. Those are my initial questions on those issues.

Professor Brian O'Connell: I mentioned training in the statement. It is certainly something for the reference group. It is contained in the policy. Obviously, if one wants to have a good and functioning primary care system, and one wants to have a good ecosystem, one needs to have people trained at primary care level - we have spoken a fair amount about that - but one also needs people with special skills who can treat the more complex patients and provide the training for the people on the ground to be able to see the widest number of patients possible, and those are the specialists and academics. Indeed, some of that has been hollowed out over the past ten, 15 or 20 years. When we had the then Postgraduate Medical and Dental Board, it was medical and dental and there was more attention given at that point to having a structured career through dentistry. That was disbanded when the HSE was set up and it feels like much of that responsibility for further training and dentistry in specialisation and in academic pathways seems to have dissipated. We have spent a lot of time over the past years trying to find it and we do not know where it has gone. Certainly, we need to put specialist training and consultant academic training back on a firmer footing and that is recognised in the policy.

Senator Colm Burke: Do we have a five-year plan to do that? It is great to present documentation and to talk about it but I wonder have we a five-year plan with clear targets.

Professor Brian O'Connell: I will let the HSE talk about that. Senator Colm Burke is correct. We talked about implementation. It is recognised - we would be clear on it - that this needs to be implemented together. If we ask dentists to see children in practice or people with disabilities on Monday morning, by Monday afternoon in some cases they will need to contact a specialist. It is critical it be rolled out together.

Dr. Dympna Kavanagh: Yes, absolutely. I welcome those points and an opportunity to talk about that. We worked closely with the Dental Council. Indeed, it set up a separate working policy group to work with us, particularly around the areas of education and training. We are proud of our graduates. They are fit for practice. It is important to say they hold their own among all of the European graduates.

However, what was clear, indeed, in our consultation that came back from the dentists, was that they want primary care at the heart of it and, as Professor O'Connell articulated, they want to have more exposure to practice and all those areas of managing one's own practice in primary care right through their graduate programme, and those who we asked were not necessarily convinced that what is being proposed in "foundation training", as it was then called, would rectify their problems. In fact, the older graduates said that they were still having problems. That is why we started to look at it moving more towards a mentoring programme, which, I suppose, is a super extension of that programme.

Let us focus on the specialist side of it because that is an important area. The Irish Committee for Specialist Training in Dentistry, which is the formal recognised group over specialist training and part of the Dental Council, has welcomed this policy in writing and is very supportive of it. We have already started working with the Dental Council and the Institut Spécialisé en Technologie D'Art Dentaire, ISTD, to put in place advanced centres of care. That involves

not only a name. That involves credentialling, looking at the work and at the workforce we need at all the different levels. Specialists in dentistry in Ireland, and, indeed, in Europe, are different from those in medicine in that they are independent practitioners. That adds a different dimension to our workforce. Unlike in medicine, it does not mean that one automatically jumps into consultancy. We have this firm grade in between. This is a piece of work and they are well placed to lead in it. In fact, they have done a tremendous amount of work already to prepare for specialisation and for the advanced centres of care coming through. When we talk about it being a five-year plan, this is a priority - education and training, mentoring, and then moving forward into the advanced centres of care and credentialling those. This is a key piece of work with the Dental Council. We have met already and the working group will start to get going in July on it. We want to start commissioning, certainly early next year, a look at our undergraduate training in the first instance. We have so much groundwork done on the specialisation. There is great leadership there. We hope that we are in a strong position to move them in parallel.

Senator Colm Burke: What of the issue of the foundation year?

Dr. Dympna Kavanagh: That is the mentoring scheme, which I identified. Instead of leaving it to the last year, because dentists start using their clinical skills right through, we want to get more of that into the undergraduate training. However, we recognise it is jam-packed already and we will need to have a mentoring framework afterwards. We are not naive. Dentistry changes fast. Every five years it changes. It is not only for new graduates. It is for all those other graduates who are out there. We looked at psychology, as mentioned previously. We looked at social work. We looked at other systems that are in place for long-term mentoring. This is the position that we are looking at. What we are looking at is like a super-extended type of foundation training.

Senator Colm Burke: Of the number of graduates with a degree in dentistry at the end of the year, what percentage stay in Ireland and what percentage leave immediately after graduation? A person who comes out with a medical degree will do an intern year here. What happens in the case of graduate dentists?

Dr. Dympna Kavanagh: I will defer to my colleagues in this regard. One of the issues that has been raised is that they want to have the opportunity to use all their skills. According to the dentists in the salaried service with whom we consulted directly, they were concerned they had not the opportunities to broaden their skills. Perhaps others can pick up on that.

Senator Colm Burke: Of the number coming out of the dental school, what number is staying in Ireland?

Dr. Dympna Kavanagh: I hope Professor O'Connell has the answer.

Professor Brian O'Connell: We do not formally keep track of those numbers because we have no particular mechanism to do that. It is highly dependent on the state of the economy at the time. During the recession, when there were no opportunities here, the majority of graduates emigrated. In the past couple of years, the majority of graduates have stayed here because they can go right into practice.

To be clear about the foundation training the Senator asked about and what we are talking about, as was mentioned, when dentists graduate, the way the system is designed has worked well. When dentists graduate, they have an excellent set of skills that enables them to do a wide

range of tasks. There is no evidence that there is any difficulty with that. If goes to the Dental Council and looks at who is appearing before its fitness to practice committee, complaints from the public or any metric, there is no problem with new graduates. In fact, in many ways the way they practice may be better and safer than established practitioners. What they do not have is the broadest experience of treating a wide range of patients about whom we have been talking here, for instance, people with disabilities, very young children and people living in residential care. If we are looking at a so-called extended year or foundation training, we must look specifically for an Irish system as to the gap needed to be filled here. I would definitely agree we need to look at extended training in a mentored environment, as stated, but we should not replicate exactly what has been done in the UK because it is not fit for purpose. My colleagues in Cork would feel the same.

Senator Colm Burke: Would it not be important to establish what happens to the numbers going through? The degree course is a fairly big cost to the State. Would it not be appropriate to establish what percentage of graduates over the past ten years are now in Ireland, what number have left and at what stage they left? One of the problems is that the State is giving significant funding to the universities and it is about a return to the State for that investment. If we are educating a considerable number of graduates who are leaving, we need to ask what we need to adjust in order to make it more attractive for them to stay, not only for one year but thereafter. If they need to gain further experience by travelling abroad, we need to work on that issue also. It is one that is coming up. As the delegates are aware, we are facing significant challenges in many areas of the workforce because of a shortage of people. I do not want us to have a shortage of dental practitioners because we have not responded to their needs after they have come out of college. I wonder whether it might be appropriate at this stage to try to find out what level of return we have got from our investment in dental training.

Professor Brian O'Connell: I could not agree more with the Senator. It is a very fair point. As in medicine and other areas, it is a little complicated because we must also consider why people leave. If someone cannot find a job here, we can hardly blame him or her for leaving. Others go because they want to have the training opportunities about which the Senator has spoken. Such opportunities are not always available here. People in such circumstances leave with the intention of coming back. The Senator is absolutely right. They leave for complex reasons.

Dr. Dympna Kavanagh: It is of particular interest that when we undertook workforce analysis as part of our policy development, we found that almost 40% of new registrants who came into the State every year came from other European countries. As the Senator rightly said, Irish graduates are registered. It is important to note that many students in the dental schools come from other countries. As part of an agreement with Canada, the Canadian authorities provide a substantial contribution to the education aspect. When we talk about people graduating from Irish schools, we are not necessarily talking about Irish people. Canadian graduates might want to go back to their homes in Canada. People who came here for their education might want to go back to other areas. There is a phenomenal degree of mobility in the European Union. A sizeable majority of those who come here from other European states - I have the figures available - stay beyond five or seven years. I think our policy on this point aims to give graduates more opportunities to acquire a breadth of skills from the time they graduate. It is about having a mentored environment for them, not for one, two or three years, even if the work done in these years is of benefit, but for a much longer period. It is about helping them to establish in practice in order that they can set up principalships in practice after five years. This is all knowledge nobody is going to gain overnight. It is important that we focus on the mentoring framework in the long term. Many other professions have done it. Ours tends to be very

isolated. This emerged clearly when we consulted dentists. They told us that they felt isolated from their peers, particularly in rural environments. That led to a fundamental change in how we were approaching education. We realised something much more substantial than a one-year programme was needed. My colleague, the chief dental officer in Britain, is very firm on the point that this is an NHS scheme, rather than an education scheme or an intern scheme. I think it has been somewhat misrepresented. She constantly berates me for the misrepresentation of the scheme. The scheme in the United Kingdom is linked with an NHS practice and attached to that practice only. If one is entering into private practice as a UK graduate, one enters into practice in the same way as every other European graduate. The scheme is linked with the NHS system only.

Senator Colm Burke: Do we have any information on primary care centres?

Dr. Dympna Kavanagh: I will speak about them briefly from a policy perspective before handing over to my colleagues from the HSE. We have spoken about integrated care. It is important for us to be part of an overall health team. All of the supports included in the policy indicate that we will be seen as primary care members who are the equivalents of the other health teams.

Mr. Pat Healy: A number of the primary care centres mentioned by the Senator have dental clinics. I do not have the exact number, but I will get it for the Senator. A small number of the centres that have been developed have dental clinics. The earlier development of primary care centres focused on the core team. Mental health was added thereafter. In the more recent development of our guidance we have taken account of the overall accommodation needs in a particular location. In those circumstances a wider range of services can be provided. That is what has happened in more recent times. I will get the exact figure, but I think the number of primary care centres that have dental services is small. Dr. Green will set out the position on the 221 clinics in the system. These locally based clinics link with the team and are clearly seen as part of it as we move forward with the development of a network of services.

Senator Colm Burke: The primary care centre that opened recently on the St. Mary's campus in the Gurranabraher area of Cork serves a population of 42,000. I am not sure if there is a dental-----

Dr. Joe Green: I think there is a large one.

Senator Colm Burke: There is a dental-----

Dr. Joe Green: Yes. That is my understanding.

Senator Colm Burke: Okay. The dental facilities were not mentioned in the briefing we received when it was being opened.

Dr. Joe Green: My understanding is the dental facility is in place. I am not certain that it has been fully commissioned.

Senator Colm Burke: I ask Dr. Green to come back to me on that issue.

Dr. Joe Green: I will come back to the Senator on it. I will also come back to him to confirm the number of primary care centres with dental facilities. We have 221 locations. That takes account of over 430 dental surgeries. Certain dental equipment safety standards have to be met to ensure infection control is up to speed. We tend to take a ten or 15-year view on the

installation of a dental surgery. If a primary care centre is being developed on the same campus as an existing dental clinic, it may not be appropriate to include a new dental facility on the same site.

Senator Colm Burke: I accept that.

Dr. Joe Green: Just one of the two primary care centres planned for Ennis, for example, will have a dental facility. It is not necessarily the case that facilities are duplicated. There are solutions that are appropriate to each location.

Senator Colm Burke: How many dental graduates are coming out of the colleges each year?

Professor Brian O'Connell: There are 48 dental graduates each year in Dublin, approximately one third of whom are non-EU students and two thirds of whom are EU students. The numbers in Cork are broadly similar. In some years many people from outside the European Union register with the Dental Council. It is a mobile population. In some years we may have 80 graduates here. There have been years in which over 100 new dentists have registered here from other EU countries. It is a mobile workforce.

Chairman: Before I bring in Deputy Cullinane, I have a few questions for the Department and the HSE. What percentage of dentists who are working in private practice or the community hold a contract to supply public services under PRSI and other contracts? Is there any move to reverse the FEMPI cuts for dentists? In recent months we have had a move to restore funding for general practice, but I do not think there has been a move to reverse the FEMPI reductions that are affecting dentists. The delegates might comment on that matter.

What level of funding will be needed to fund implementation of the oral health strategy? What funding is available for it at present? What increase is needed? We have been battling with the amount of money that will be needed to implement Sláintecare. We are trying to determine how much money will be needed each year and when it will be released. I ask the delegates to respond to these questions.

My next question relates to public orthodontic waiting lists. I understand there are 13 public orthodontists. Is that right? How many would be needed to clear a waiting list of 1,800? It seems that there are more people waiting than in treatment. Surely the way to address this issue is by increasing the number of orthodontists, rather than using private dentists to pick up the slack through an NTPF-type mechanism which does not really address the problem. Such mechanisms try to fill the gap, rather than addressing the actual problem. Will Dr. Dougall address the issue of where treatment is provided for those with complex special needs? There are probably patients in all our constituencies who cannot have such treatment delivered by their community dentist. Is it delivered through dental hospitals or general hospital services? How and where can people access those services?

We received a submission from dental hygienists, the main point of which is that they are entirely focused on prevention. They do not seem to be involved in the oral hygiene policy. Where do they fit into it, particularly in regard to prevention?

Dr. Alison Dougall: On where people with disabilities are seen, some 643,000 people self-report with a disability, so the answer is that they are seen everywhere. Approximately 13,000 people require complex care at some time. Access to services is *ad hoc*. A large number of patients are particularly at risk. A relatively small number of people are specifically trained

to treat such patients, which is an issue. Access to general anaesthesia is also *ad hoc*. There are some pockets of brilliance and excellence, but in many other areas there is nothing. Some people must travel a great distance to a dental hospital or across borders to access treatment. The dental hospital is not an acute setting as it does not have general anaesthesia facilities. General anaesthesia is provided throughout the country but it is severely limited and many people with disabilities have their treatment options severely limited by poor access to it. For example, extraction-only services may be offered or, within the general anaesthesia setting, the patient is not offered root canal, even to save a front tooth. It is well recognised that there are no well-defined care pathways and not enough people trained to provide the required care. That needs to be addressed in the policy and there will undoubtedly be a need for more people to be trained in this area.

On training at undergraduate level, evidence has shown that we can train people in general practice to do the bulk of the work, but undergraduate is not the time to work on complex patients because students are honing their basic dental skills. The mentoring of graduates following qualification is extremely important. Special care dentistry is a specialty. We offer three-year specialist training on an international basis. Most Irish graduates travel overseas for training in this area because of its cost in Ireland. Unlike orthodontics or periodontics, in regard to which people can thereafter go into general practice to earn a living, it is currently difficult to self-fund a expensive course of treatment.

On succession planning, I am a consultant but there is no formal recognition for a consultant training pathway to, for example, replace me when I retire in ten years. The provision of training across the board in this area is a priority and it has been recognised as such. It is possible to achieve very good levels of care for people with disabilities, as evidenced by the literature. It will be a challenge, but we know it is possible and the evidence shows that the training is available in Ireland. We have the methodology and curricula to train our undergraduates, postgraduates and practising dentists to give them the skills to prevent the need for extensive treatment. We always seek to avoid general anaesthesia being necessary. Prevention works very well for people with disabilities. We need general anaesthesia to be available and people to be trained to provide sedation, which opens up bigger options of care than general anaesthesia, but we mainly wish to prevent the necessity of sedation or general anaesthesia by having good, well orientated preventative services in primary care.

Chairman: When RCSI representatives appeared before the committee last month they made the point that only two dental specialties are recognised by the Dental Council of Ireland, whereas 13 are recognised by the equivalent body in England. Will that be addressed in the oral health policy?

Dr. Alison Dougall: Special care dentistry is a specialty in some countries, along with many other specialties. To retain or train staff in regard to treating those with disabilities, a career structure is required, as is the case with every specialty, because that will get people interested in it. I will hand over to Dr. Kavanagh, who will address policy.

Dr. Dympna Kavanagh: On policy, the EU recognises two specialties, namely, oral surgery and orthodontics, and we have conformed with that. In the UK in particular, there is a plethora of specialties. There is much debate, particularly among my chief dental officer colleagues, about the merits of having multiple specialties in smaller countries such as ours with a population of 4.5 million. A dentist practising in a specialist limited area needs a body of work to maintain his or her skills and that is a dilemma for us. Many people first look to the practice in Scandinavian countries, where they have developed a concept of specialist generalist training

and are moving away from limited specialties. Although I do not wish to pre-empt what will be in the policy, practitioners could combine several specialties, which would be of particular benefit to us in respect of rural areas, which are a challenge for us. It would be difficult for us to appoint a paediatric specialist, a special care specialist and several other specialists to such areas as there would be a shortage of applicants for such posts.

To come back to the policy, the advanced care centres provide credentials in this regard. On a national level, we need a broad range of specialties available to us. However, if we are looking into the community, we would have to consider that workforce planning in a certain way. It is important that practitioners maintain their skills. One of the important concerns raised in the consultation with dentists on the ground was that they are primary care dentists with a broad scope of practice, but feel squeezed by the specialties and auxiliaries coming in and want a clear definition of their scope of practice. The view of the Dental Council of Ireland is that primary care covers all eventualities unless, as Dr. Dougall rightly pointed out, it is an advanced part of care and this network is required to provide it. It is a mutual relationship. We currently only have two specialties and are conforming to EU standards in that regard. We recognise that more specialties are needed in key areas, but I am unsure whether having 13 specialties would be appropriate for us as we do not have a population of 78 million. The four key pillars, involving primary care, special care, looking at public health and looking at the advanced centres, such as in the areas of restorative and, perhaps, periodontal care, are key in considering the needs of our communities. That is our first port of call.

Dr. Joe Green: I will address the Chair's other question. There are approximately 1,400 active contractors under the dental treatment services scheme. Last year, treatment claims amounted to slightly less than €60 million. That is covered-----

Chairman: How many dentists are there altogether?

Dr. Joe Green: There are approximately 3,200 on the register, but that does not equate to the workforce, given that some do not-----

Chairman: Some 1,300 hold a contract.

Dr. Joe Green: Approximately 1,400 are active. There might be slightly more, but some of the contracts may not be active. Approximately 1.1 million treatments were provided at a cost of slightly less than €60 million to slightly fewer than 390,000 medical card holders. The uptake rate on the scheme is approximately 31%, that is, 31% of adult medical card holders attended a dentist last year, as far as we can tell.

I do not have figures on expenditure under the treatment benefit scheme. My understanding is that the cohort of dentists is approximately 1,600 or slightly higher. It is the same group, with the aforementioned 1,400 dentists being a subset of the 1,600, by and large.

Dr. Dympna Kavanagh: My colleagues in social welfare have noted a significant upsurge in the take-up of contracts. Dr. Green rightly pointed out that there has been a change to the scheme in the past year. Since the Department changed its scheme in the last year, the number of contracts now far surpasses the number it held before. The Department has also noted that many dentists who were previously entirely private and not on the medical card system are now opting to be on just the social welfare system. That is a challenge and it is why we are working so closely with our colleagues in the Department of Employment Affairs and Social Protection. There is quite a difference in the numbers taking up the social welfare contracts *vis-à-vis* the

medical card contracts.

Chairman: What were the changes?

Dr. Dympna Kavanagh: The Department included periodontal care and scaling and polishing in the scheme.

Chairman: I thank Dr. Kavanagh. Before asking the rest of my questions, I will give Deputy Cullinane the opportunity to ask some short, succinct questions before he leaves because he has been very patient.

Deputy David Cullinane: I thank the Chairman for his indulgence. I am not a member of the committee but I have a number of questions that I wanted to ask. What is the referral pathway for somebody to be referred to a public orthodontist?

Dr. Joe Green: A child is seen through the dental service run by the HSE. The HSE dentist assesses whether there is a need for an orthodontic treatment. A system called the modified index of treatment need is used. If the dentist assesses the child and believes the condition or emerging condition is likely to be accepted for treatment, the referral will be made and the regional orthodontic department makes the assessment.

Deputy David Cullinane: I imagine that if somebody is referred to an orthodontist, it is for a good reason. Even if it is for a routine treatment, it needs to be done. Dr. Dougall spoke earlier about nudging people to make sure that they are treated as quickly as possible. Dr. Kavanagh spoke in a similar vein. If a person is referred to an orthodontist, how quickly should that person be assessed, inspected, treated or go through whatever else is needed? If a person was referred but left it on the long finger for as long as six months, would that be a wise thing to do? What is done to make sure that a person gets the treatment needed or that the inspection is carried out to see what the problem is? How important is it that the person is seen as quickly as possible?

Dr. Dympna Kavanagh: I can speak on policy but I want to be clear that I am not speaking on behalf of the service. When we are looking at this with regard to policy and in line with Sláintecare, the intention would be for the assessment to happen as quickly as possible. We have talked quite a lot about advanced care and the importance of specialist care but one of the key points of Sláintecare is to ensure that as much as possible is carried out in the local primary care setting. This is a key task for the Dental Council, secondary care services and orthodontic care services. What elements of orthodontics can be appropriately conducted in a primary care setting to speed up care provision? That is the type of service that is provided in other European countries when they provide orthodontic care. The UK has traditionally operated a specialist service but it is now looking at many treatments being in primary care, where that would be possible and appropriate. I am not suggesting that it happen for advanced care services but where possible and appropriate, the Dental Council will look at that in conjunction with the committee for specialist training.

Deputy David Cullinane: I will come back to Dr. Green. Constituents visit our clinics and ask us to raise issues of concern to them. Orthodontics is sometimes one of those issues, especially in the south east because waiting times for treatment are longer. I submitted a parliamentary question which I think Dr. Green responded to about waiting times in the south east. I was taken aback by the response, which broke down waiting times by year from 2014 to 2019. The average waiting time for routine orthodontic treatments across the south east in 2014 was

42 months. The average waiting time now is 60 months. In Waterford, my constituency, it was 37 months in 2014, 47 months in 2015, 51 months in 2016, then dropped to 47 months in 2017, possibly because of the national procurement process that the witnesses spoke about earlier, while it was 54 months in 2018 and 60 months now. How could 60 months be an acceptable wait time?

Dr. Joe Green: I do not believe that it is.

Deputy David Cullinane: Why is the waiting time 60 months? That is five years. How could somebody have to wait for five years for an inspection? Even priority waiting times, while they were up to date in 2014 and 2015, went to nine months in 2016, 13 months in 2017, 16 months in 2018 and 18 months in 2019. That is a year and a half for priority cases. Those are astounding figures. We talked about policy earlier. We heard a great deal about policy and encouraging people to get checked up to make sure they get the treatment they need as quickly as possible, nudging and supporting them and raising awareness. If the capacity and services are not there, a routine appointment takes five years to get and what is called a priority takes 18 months, it makes a mockery of the policy. Why is it that people in Waterford and, by extension, the south east, since the numbers are similar, have to wait for 60 months for an inspection and 18 months for more serious cases? What is the problem?

Dr. Joe Green: The problem is the capacity of the system.

Deputy David Cullinane: Why has it not been dealt with for five years? If it is increasing every year, surely the people who are tasked with making sure that waiting times come down would put solutions in place? If something is a problem for that length of time, the people who are responsible for making sure that solutions are in place are obviously not delivering solutions because the times are increasing. Dr. Green has acknowledged that waiting times are going up, not down. What specific capacity issue is causing the problem? Is it orthodontists?

Dr. Joe Green: It is the number of orthodontists. Thankfully, there has been some recruitment in the south east. An orthodontist took up duty in New Ross in April. The number of orthodontists required is much higher than the number in place currently. As I said in response to Deputy Brassil, to increase capacity, we either increase the number of specialists or introduce the grade of orthodontic therapist and provide the appropriate number. The introduction of the grade of orthodontic therapist is in our workforce planning.

Deputy David Cullinane: I know the Chairman wants to come back in so I will finish on this. It is frustrating that I have listened to this for about an hour and a half. I thought that Dr. Kavanagh's and Dr. Dougall's responses were first class in setting out the policy and vision, as well as what needs to be done and what people need to do to look after their oral health, dental health and so on. We have also heard from others. It makes a mockery of policy if there is a 60 month waiting list in the south east. It takes five years to see an orthodontist. Priority cases were up to date in 2014 and 2015 but have slipped back to 18 month waiting times. It is hard to sit here and listen to all that has been said about policy when the reality for people is somewhat different. Children suffer most. If children have been waiting for five years for a routine case, they have been referred for a reason, even if it is a routine one. If it gets worse over five years, the child could be 13 or 14 when he or she is referred and could be 19 before he or she is seen. It seems outrageous. I commend the people who passionately champion the policy but policy is one thing, while the implementation and outworkings of policy are another. The policy and what is available for people in the south east seem to be two different things.

Dr. Dympna Kavanagh: This highlights exactly why we say there is a need for change and to look towards the other European countries. Technology has changed enormously in dentistry, even in the past five years. A person has only to walk down the high street to see the number of dentists working in practice who are providing orthodontics. This was undreamt of before. I am not just talking about orthodontics but also about implants and other elements. I am not talking about any advanced areas. We absolutely need our specialists for those areas, but it is important to see what we can do in the primary care setting, reasonably and appropriately and supported by specialists and consultants. I am not just talking about orthodontics. A very clear example has been given of why we need a new way to look at features. The model has worked excellently for us. We have excellent oral health in Ireland but the model needs to change now. As said, we just cannot keep up. Changes in technology have now allowed us to have the facilities to look at this in a different way and make sure that, where possible and appropriate, people in Waterford can gain access through their local primary care dentist, with support from the specialists and the advance centres. Support is key. I am referring to what we want in the policy. We are so keen to start on the advanced centres of care so quickly so we can have the specialists in place. Their jobs would not just be about treatment but also about mentoring and support. Also, primary care dentists should have the opportunity to provide what they believe they can provide. In consultation, they were adamant that they have the skills, want to use all of them and want to provide services in other areas of secondary care. They just need the support. It is an urgent piece of work. It is a priority in the policy. We must move forward in that direction. In all the areas of secondary care, let us move forward with the rest of Europe.

Deputy David Cullinane: I seek a final response from Dr. Green. He mentioned capacity. There is a capacity problem. He has said there has been some additional capacity. Is that additional capacity enough to reduce the waiting times? If not, what more is needed?

Dr. Joe Green: What is needed is a comprehensive workplace plan, not just with the south east but also for the wider orthodontic service. The correct school mix needs to be achieved within that across consultants, specialists, orthodontic therapists and dental nurses. The staff do a very fine job. The outcomes from our orthodontic treatment are very good. That should be said.

Chairman: To go back to what Deputy Cullinane was saying, there is significant dissatisfaction among the public, including parents of children who have to wait for a prolonged period. Quite often, there is no knowing when one will be seen. A person is put on a waiting list but he or she has no idea whether he or she will be seen in one year, two years, three years or five years. That creates great anxiety among patients. As a consequence, patients end up borrowing, stealing or remortgaging their houses and putting themselves at great financial risk to obtain privately the service that should be provided through the public system but is not. They may have two or three children who need orthodontic treatment, not just one. This puts them under serious financial pressure. That is the issue. The policy is fine and the intention to change it is fine, but the practical reality, as Deputy Cullinane said, is that the lists are growing rather than reducing.

Mr. Pat Healy: That is acknowledged and Dr. Green has said that. From the HSE's point of view, it is clear there is a particularly enduring problem in orthodontics. There has been a recruitment and retention issue. Dr. Green and the team involved have done significant work on trying to bring forward solutions to improve capacity. He has gone through that. The workforce planning element is important. The idea of the orthodontic therapist could make a contribution. It has to be acknowledged that the points the Deputy makes are understood. A lot has

been done to try to address the capacity position to improve the situation for the service users who are waiting. We prioritise the highest number. There are 18,000 in treatment at present. That is not adequate. There are another 18,000 on the waiting list. That is fully understood. A significant amount of work has been done by the profession and the clinical lead, Dr. Green, to try to make proposals to deal with this. That is what we will try to do.

Professor Brian O'Connell: I sympathise very much with the HSE because, when it had the system working, it worked very well. It is correct that it has dedicated people. All the changes need to be implemented together. Essentially, specialty training has fallen apart. Those who wish to train to be an orthodontist, here or abroad, are paying for their own education. In Dublin or Cork, it is €25,000 per year for three years to train as an orthodontist. In such circumstances, it is impossible to attract those concerned back into the public service, especially when salaries have been cut. It is simply not an option. We are training the staff but they are paying for the training themselves, so there is no incentive for them to go into the public service. Here is where we need some joined-up thinking.

Specifically at the request of the public service, we set up a training programme for orthodontic therapists in Trinity but the health service does not employ orthodontic therapists. We have private petitioners lining up to send their staff in to be trained as orthodontic therapists to work in private practice but they are not working in the public service. The public service is not employing them. We need the joined-up thinking and the plans need to be implemented as one or they will not work together.

Chairman: To go back to one of my original questions, what is the position on the funding of the implementation of this policy? I had a question on the reversal of the financial emergency measures in the public interest, FEMPI, cuts.

Mr. Fergal Goodman: When talking about the reversal of the FEMPI cuts, it is important to note that the mandate the Department and HSE would have were they engaging in a fee discussion with dental professionals would concern modernisation, reform and service development. That would be the context in which the Government may commit to additional funding. There would not be a mechanism just about undoing a fee change and changing nothing else. That is the basis on which we would engage. That was the mandate we had in regard to general medical practitioners, as the Chairman is probably aware. I am not saying that in a negative way but that would be the basis on which I would anticipate we would be mandated to engage. In the context of the implementation discussion we referred to earlier in this meeting, that is where the fee construct will come into it.

I was asked about the funding implications of the policy and the costings, which are subject to evolution over time, an eight to ten-year period. Taking into account current fee levels, probably in the region of €80 million would need to be committed.

We have heard quite a few discussions here on resource issues of one sort or another. Some issues are structural and some pertain to resources. We all know the health service is challenged all the time trying to live within resources and finding the resources to do additional things. The process for decisions on additional funding will essentially be annual in the context of each year's Estimates. We have a job of work to construct the proposition for a contractual engagement. Going into that process, we would need to understand that the money will be or can be provided when we come with an outcome from it, which is what we did with general practitioners.

Chairman: In the context of the €80 million, what is the cost of providing dental services now?

Mr. Fergal Goodman: The figure for the dental treatment services scheme, DTSS, to which Dr. Green referred, is in the region of €60 million per annum.

Chairman: Are the delegates talking about an additional €80 million to develop the service and policy?

Mr. Fergal Goodman: Yes-----

Chairman: So that is an increase of over 100%.

Mr. Fergal Goodman: When spread in a multi-annual way; in health service expenditure terms and spread over a number of years, it should not seem insurmountable.

Chairman: Where do dental hygienists fit into the picture? What function would they have in respect of the policy?

Dr. Dympna Kavanagh: I am glad the Chairman raised that. We met the professional group of Irish dental hygienists a few times. We are meeting them in July as well. They are a key part of the policy. We also met representatives of the Clinical Dental Technicians Association Ireland two weeks ago. These are the two key auxiliary groups under the new dental legislation that will be independent practitioners. A key issue for us is the opportunity for them to take on independent contracts if they so wish, and particularly when we devise packages of care, to look at the Dutch system in particular, which has embraced auxiliaries and therapists in this way, as well as other groups. That is exactly how the construct was and so we had a mind to the new dental legislation bringing in these independent practitioners. A concern was raised by the clinical dental technicians that this would be a backward step and we said it would absolutely not be such a step and the intention was to expand the scope of practice of auxiliaries where possible. We have been very clear about that in the policy. Where it can be expanded, it should be but in a way that is mindful of the benefits and risks, of which the Dental Council of Ireland, as a regulatory organisation, would be aware. These are two independent professions that we would see coming forward and that is extremely important to the policy and provision of care.

Chairman: What legislation is required to implement the policy? How far advanced is that legislation?

Dr. Dympna Kavanagh: The legislation we refer to is to make continuing professional education mandatory. That is not to say such education cannot be undertaken currently. We require legislation not for clinical dental technicians but for hygienists. Student registration is another key aspect, although we have not discussed it here. That relates to continuity of care and other reasons. With regard to education and training, just two dental schools are specified. One of the issues to which we alluded is the increase in the number of European graduates coming here. We also have private schools in Ireland and the Dental Council of Ireland does not have jurisdiction over them. Across Europe there has been a huge increase in the workforce of dental graduates but they are all from a variable mix. We need legislation in that regard. The Dental Council of Ireland does not have the wherewithal to go into premises and inspect them. Dr. Green alluded to the need for us to have high-quality standards in dental care. The HSE service is exemplary in that regard. It is important that for all premises and practices, the Dental Council of Ireland should be able to put in a programme of work whereby it can inspect

practices. The main issues for the policy are for the continuing professional development to be mandatory and for there to be registration and fitness to practice for the two key groups of hygienists and clinical dental technicians.

Chairman: Will the Dental Act 1985 need substantial review?

Dr. Dympna Kavanagh: It has already undergone substantial review. All the consultation has been undertaken. Work will gain momentum once the Regulated Professions (Health and Social Care) Amendment Bill completes its passage through the Houses of the Oireachtas. It has been much tied up with that Bill but all of the infrastructure is now in place to move forward with that legislation. We would love to say it will be there tomorrow but we will keep on with our plan of work. The committee can see the urgency we have to move forward. We will proceed with a skill matching programme and have everything ready and prepared once the Bill comes through.

Chairman: I thank Deputy Louise O'Reilly for her patience.

Deputy Louise O'Reilly: I am conscious that our guests have been here for a while so I will try to be brief. I am not brilliant at being brief but I will try. The point was made by Dr. Green that the staff do a fine job and they absolutely do. There is no question or doubt about that at all. The problem is there are not enough of them for everybody who needs to see them. The issue is not with the quality of the work carried by the staff but rather that nobody can get in to get that high-quality work.

We spoke a little at the outset about consultation. This concerns a change in the model of care for children's oral health. Will the witnesses talk me through what input Tusla would have had? Was it part of the consultation, given that much of the focus is on children's oral health?

Dr. Dympna Kavanagh: When we drafted the policy, we sent it across various Departments and all the involved agencies. They would have been contacted through the Department of Children and Youth Affairs and we would have received feedback through them.

Deputy Louise O'Reilly: Did it make submissions?

Dr. Dympna Kavanagh: It was very positive about the policy because all the evidence supports a universal approach, particularly for those who are vulnerable and low incomes, which could be available as early as possible. That approach should be as locally accessible as possible.

Deputy Louise O'Reilly: It is good that there was no concern about moving from the current setting to a new model of care. There were no child protection issues or anything of that sort. Was Tusla happy enough that they could be dealt with?

Dr. Dympna Kavanagh: The dental ethics, if one is working with vulnerable groups or children, are similar to those in other professions. Interestingly, Tusla is commissioning work through practices in the south of the country. That demonstrates the confidence it has in the area.

Deputy Louise O'Reilly: We know the planned moves to phase in a new model of routine care. Will our guests provide some detail on the level of emergency care that is provided? If there is not enough routine care happening now, there will be a shift to emergency care, although that is not what people want. What is the level of emergency care with respect to ap-

pointment numbers? How is this going to change when the new model is fully implemented? If there is a flashing blue light emergency, where will people go?

Dr. Joe Green: In the current system, if a child or vulnerable adult attends the HSE dental service with symptoms, there would be contact with the clinic or the person often just turns up. We are recording in excess of 70,000 emergency appointments each year. The vast majority of those are children and many are very young at three, four, five or six years old. Many of them are five, six or seven years old. Most of the issues relate to decay in deciduous or baby teeth. With those, treatment can either restore the tooth or perhaps it has to be extracted. If multiple extractions are indicated or infection must be controlled prior to treatment, a course of antibiotics may be indicated. If it is not possible to complete the treatment or if multiple extractions are indicated, that could lead to a referral for treatment under general anaesthetic in one of the hospitals. That happens approximately 7,000 times per year between emergency patients and some patients who have been referred without symptoms but whose treatment is completed under general anaesthesia.

Deputy Louise O'Reilly: How does that compare with other jurisdictions, such as Scotland or somewhere with a relatively similar population?

Dr. Joe Green: It is broadly similar.

Deputy Louise O'Reilly: It seems like a lot.

Dr. Joe Green: It is a lot but dental care is a public health issue and remains so. Dental decay follows a socioeconomic gradient, in that we tend to see it more in lower socioeconomic groups than higher ones. We would like children to be seen at a much earlier age, particularly in order to identify those who are at greatest risk of dental decay, or who may have a medical condition that would make treatment risky in itself. Prevention is therefore of even more value for them. That treatment risk could also include an assessment of their risks of being treated under general anaesthetic or sedation. We would seek to avoid the worst possible treatment scenario, where someone is in a hospital for treatment for what is, as Professor O'Connell said, largely a preventable condition. In transitioning to a revised system, the HSE's priorities would be to try to protect the strengths of the existing service, including a same-day or following day response for anyone who is in pain. If the HSE service were involved, we would strive to continue to provide that. That would be our plan, and it would be an upfront requirement in any contracted situation. However, that might not be the easiest thing to put in place. We have yet to reach the starting point for all of that, and there would need to be extensive consultation with prospective service providers, our own staff, the Department, and any other stakeholder which might be involved. Putting that in place would be a priority.

Deputy Louise O'Reilly: I thank Dr. Green. I have some areas specific-----

Dr. Dympna Kavanagh: In line with policy, that was included as part of assessments when the Economic and Social Research Institute, ESRI, was doing its model calculations on emergency care, so there is no question that emergency care was included as part of the primary and preventative care bundle.

Deputy Louise O'Reilly: The intention is that it would be similar to what is offered at the moment.

Dr. Dympna Kavanagh: The person who is treating is required to provide it under Dental Council ethics. That is an important statement to make. If someone is providing care, they

must provide emergency care. It is not up for negotiation, but is part of their professional dental ethics. We must be completely clear about that.

Deputy Louise O'Reilly: The issue is that it will be provided as it is, which means a child would be seen within 24 hours.

Dr. Dympna Kavanagh: They are required under their dental ethics to provide emergency services within a specific period of time. That is a requirement for every dental professional.

Deputy Louise O'Reilly: Is it within 24 hours?

Dr. Dympna Kavanagh: It is within the appropriate period of time. Generally it is within 24 hours, though it does not have to be. For example, if a patient rings in and the dental professional decides it is not necessary for them to be seen because they are not in pain, that is their decision. It is not a question of where it is best set or seated. It is part of one's dental professional ethics and emergency care must be provided.

Deputy Louise O'Reilly: When there is an emergency situation, care will be provided as appropriate.

Dr. Dympna Kavanagh: Yes, and it must come from the dentist whose care that patient is under. That is very clear in the dental professional ethics.

Deputy Louise O'Reilly: Excellent. I thank Dr. Kavanagh.

I have two questions relating to specific areas. My first, unsurprisingly enough, relates to my own constituency of Dublin Fingal. Figures from replies to parliamentary questions show that of the 84,000 children who are on waiting lists, there are 4,450 in my own area who have been waiting longer than 52 weeks. That is the number of children currently in fourth class with no guarantee that they will be offered a screening appointment. That is clearly very worrying. I happen to represent the constituency with the fastest-growing population in this State, and possibly even in Europe, so that should be enough. I see parents in my advice clinics on a weekly basis who are concerned because their children's teeth are deteriorating and they are stuck on waiting lists. The witnesses know the figures so I am not going to go through every single waiting list, but the list of children waiting for more than 52 weeks jumps out at me. That is a year. If someone is due a test in fourth class and they have to wait a year, one does not have to be a genius to figure out that they will not be in fourth class at the end of it. What happens to these children? According to the witnesses' own figures, it is highly unlikely they will get the screening. I talk to their parents, so I know that, in many instances, the money is not there for them to go private. Why should they have to, aside from the fact that their children are left waiting? What are the likely outcomes of missing that important appointment for those children? I presume it is important, otherwise it would not be on the schedule.

Dr. Joe Green: Will I deal with the first part first?

Deputy Louise O'Reilly: Yes.

Dr. Joe Green: The HSE sets priorities of trying to see children in second class, sixth class, and fourth class if possible. There are a number of areas in the country where fourth class has not been reached due to capacity, as we discussed earlier. The amount or increment of treatment that is often required at fourth class is much less if children have been seen in either first or second class. Focusing on permanent teeth for the moment, if fissure sealants have been placed

on the permanent teeth in either first or second class, by fourth class visits would hopefully concentrate more on looking for dental milestones such as the eruption of permanent teeth, occlusion, and reinforcing preventative measures such as dietary advice, advice to parents, tooth brushing, as well as reinforcing good dental attendance. In the event that children are not seen in fourth class, the increment of decay that may have occurred between second class and fourth class would be the one that could not be treated at that time. Where possible, those children are followed up on if resources allow, and they would then be seen in either fifth or sixth class, depending on the approach of their local area. As I said, the outcome of treatment at first or second class is critical. If those children had been seen, a lot of preventative treatments would have been put in place, and that can help.

Deputy Louise O'Reilly: I thank Dr. Green. Reference has been made to some staff shortages in certain areas across Dublin North, and in Balbriggan in particular. As it goes, not only do I represent a constituency with the fastest-growing population in the State, but Balbriggan is also the youngest town in Ireland. This is a fairly easily identifiable cohort, and one does not need to be a brain surgeon to figure out that if a whole load of young families buy houses, the inevitable consequence of that is children, and the inevitable consequence of children is children's teeth. Notwithstanding the fact that much of this was predictable, there is a particular problem with the recruitment of staff in Balbriggan. Do the witnesses have any words of comfort for me to bring back to north County Dublin? Is there anything I can say to the parents of these children?

Dr. Joe Green: I will be in that area tomorrow and I will follow up with the Deputy directly on what is happening at the moment. There was a dentist in Balbriggan who left the service at the end of January, so I will follow up with the Deputy on that dentist's replacement. There has been a 15% increase in population in the community healthcare organisation, CHO, of Dublin north city and county and it is impacting on our orthodontic service as well. It is a serious question.

Deputy Louise O'Reilly: It is one of those things people should talk about more. Before people start to build much-needed houses, they should talk about the services that need to follow.

I have a question on behalf of my colleague Deputy Funchion, which relates to the Carlow-Kilkenny area. There are a few things in the answer we received to this parliamentary question. Some 1,748 people have been on a waiting list for longer than 52 weeks in Carlow, and 2,181 in Kilkenny. They are going to have the same complications Dr. Green has just outlined. That is one thing, but reference is also made to a fire in St. Dympna's Hospital which led to the cessation of dental services and the cancellation of surgeries for four months. What is the current state of play for children in Carlow and Kilkenny with regard to access and services?

Dr. Joe Green: I do not have the information in front of me but my recollection is that services are back in place in Carlow, and that additional clinics were run in order to catch up with the backlog in the course of late 2017 and 2018.

Deputy Louise O'Reilly: This parliamentary question is from April 2019.

Dr. Joe Green: I will follow up on this to get the full picture on Carlow for the Deputy. The fire was some time ago but the facility was obviously out of commission.

Deputy Louise O'Reilly: According to this reply, it was out of commission for four months

but it was out of commission for longer than that.

Dr. Joe Green: I will revert to the Deputy on that.

Deputy Louise O'Reilly: Reference is also made to a current difficulty with the recruitment and retention of dentists in the south east community healthcare area. Does Dr. Green have any insight on why there is a particular difficulty there? He might outline what efforts are being made to recruit.

Dr. Joe Green: My recollection is that following a competition last year, someone who was at the point being offered a contract decided not to take up the position. There have been some difficulties in that respect. Our process is quite lengthy but it is very robust. Matters such as Garda clearance and police clearance from other jurisdictions are obviously part of that and the process is necessarily lengthened by those requirements but I will revert to the Deputy with information on that and her other inquiries.

Deputy Louise O'Reilly: I note Dr. McLoughlin is indicating but before she responds, on the issue of recruitment and retention, one of the measures implemented in the broader health service, as I am sure Mr. Healy will be aware, was the devolution of power. The system in the Public Appointments Service is fantastic. It is robust and everything it does is beyond question but it can be a little cumbersome. People may get an offer of a job from a private contractor which they can start the following morning, whereas in the Public Appointments Service applicants will go through a lengthy process that leave people believing the PAS does not want to employ them. It becomes difficult and the system can sometimes make it difficult. Has any thought or consideration been given to streamlining the process for recruitment? It has worked elsewhere. I am not saying it has fixed everything but it has had limited success in other areas of the health service.

Dr. Joe Green: The Public Appointments Service usually only deals with the recruitment of consultants.

Deputy Louise O'Reilly: Is all other recruitment done locally?

Dr. Joe Green: Yes, that is all done by the community healthcare organisations. We also use panels. After a competition is held a panel is created. We are trying to merge those across the CHOs.

Deputy Louise O'Reilly: What is the current state of the panels?

Dr. Joe Green: A number of CHOs have live panels.

Deputy Louise O'Reilly: Do Carlow, Kilkenny and the south east have panels?

Dr. Joe Green: I will follow up on that and get the Deputy that information.

Dr. Jacinta McLoughlin: The questions the Deputy has raised clearly illustrate the problem for the HSE dental service and make the case for change.

Deputy Louise O'Reilly: They do not make the case for privatisation, however. They make the case for investment.

Dr. Jacinta McLoughlin: They make the case for change. If it could be contracted out, it would be an improvement. We can argue about the words-----

Deputy Louise O'Reilly: We can.

Dr. Jacinta McLoughlin: -----but it still makes the case for change, whatever the change may be.

Deputy Louise O'Reilly: I agree with that 100%. I am finished with my questions.

Chairman: We have been meeting for three hours. I thank the witnesses for their time. I am sorry we did not get an opportunity to quiz Mr. Judge from the Department but I thank him. I also thank Dr. Kavanagh and Mr. Goodman from the Department, Dr. Dougall, Dr. McLoughlin and Professor O'Connell from the oral health policy academic reference group and Mr. Healy and Dr. Green from the HSE.

The joint committee adjourned at 12.33 p.m. until 9 a.m. on Wednesday, 3 July 2019.