Assessment of Impact:

Views received from dentists in Northern Ireland

Re. EU proposal to replace Regulation (EU) 2017/852 of the European Parliament and of the Council on Mercury

It is BDA's firm position that this replacement EU act satisfies the criteria laid out for initiating a Committee Inquiry, namely:

i) it significantly differs from the content or scope of the original EU Regulation, and

ii) **it would have a significant impact specific to everyday life of communities in Northern Ireland in a way that is liable to persist.**

The BDA Dental Amalgam Position paper sets out clearly why a phase-down approach must be maintained. What follows is a collection of views received from individual dentists following engagement with members of our three committees, representing:

1. **General Dental Services** (NI Dental Practice Committee), which provides around 90% of dental care.
2. **Community Dental Services** (NI Community Dental Committee) which represents practitioners who provide a range of specialist dental services in health centres and hospitals to a diverse group with a range of disabilities and complex additional needs, or whose dental care cannot be provided in general practice. This is a referral-only service.
3. **Hospital Dental Services** (NI Hospital Dental Services) - The Hospital Dental Service which provides specialist care for the most complex patients.

We sought the views of each of the above cohorts as to the impact Amalgam Phase-out by January 2025, if applied directly would have on their ability to provide safe, effective services and the impact on patient care in the short, medium and long term. We asked:

"An amalgam phase-out (ban) in January 2025 is continuing its progress through EU channels and looking increasingly likely. BDA has produced a UK-wide position paper on amalgam which is now with the DOH. This ban carries risks that are unique to our position in Northern Ireland from a contractual, clinical and capacity perspective. Please list the risks as you see them from your perspective."

The views which follow (by way of qualitative research) clearly indicate that such an outcome would be detrimental for service delivery, and in consequence, would have, '**a significant impact on the everyday life – oral health and well-being – of communities in Northern Ireland that is likely to persist.'** In particular, it will widen oral health inequalities, and adversely impact the most disadvantaged in our society.

<u>General Dental Services</u> -comments are organised into x4 main categories as follows:

1. Widening Health Inequalities

- *'We have a patient group with very, very high need. We may have to reconsider taking on patients with high need.'*

- *'Since this ban was announced, myself and my colleagues in practice have talked about this at great length. And the fear amongst us is very real. One practitioner who plans to retire in the next 5 years has indicated it may result in him choosing to retire early as the stress of working life had already increased to a level that this may be the final straw.'*

- *'I have treated patients on multiple occasions and thought if amalgam was not available then could I realistically restore this tooth, and the answer is no.'*

- *'Amalgam has prolonged the lifespan of many teeth that were never suitable for composite.'*

- *'In the practice I work it will result in more extractions as I personally won't take the risk of placing a suboptimal restoration if the tooth/patient is not suitable. That doesn't help the patient, but the risk of litigation long term is high.'*

- *'This could force the transition further to private.'*

- *'Working in a high caries risk area, we still provide a large number of amalgam fillings on a daily basis. There is no financially viable alternative at present. Even if the fees were to be increased on the SDR [Statement of Dental Remuneration], I fear they would not come anywhere close to what they would need to be, given the increased cost of the restorative alternatives and the chairside time taken to place them.'*

- *'Due to the increased clinical time it takes to place non-amalgam materials then patient waiting times will increase. It will take longer to complete courses of treatment as you're probably not going to get as much done in each visit.'*

- *'For some patients the only suitable material is amalgam, especially in highly deprived areas or high caries risk. Potentially patients will increasingly require dental extractions in practice. This could increase referrals to the secondary services – community and high Street oral surgeons.'*

- *'These factors will adversely affect older patients more. Amalgam often allows a procedure to be completed quickly and often they have large amalgams that can be repaired.*
  These patients due to medical conditions will not tolerate longer appointments well. The use of rubber dam with not be well tolerated in patients with chest/ breathing problems.'

- *It already takes me at least 10 minutes more to do amalgams on patients in their 80s and these are the relatively fit ones. Composite/ GI costs would need to be set with these patients in mind.*

2. Patient Exemptions

- *'Once we have a ban, even if patients fit into the medical exemption, we may not get consent to use it.'*

- *'It will Impact on patient care, for example osteo patients.'*

- *'Patient exemptions are unspecific. It is up to each 'Member-State'. Who will enforce this – DoH or DAERA? There are more unknowns than knowns.'*

- *The ban on import/export [of dental amalgam] could make the continued case for patients exempted extremely difficult. Where would we get material from? At what cost? How will the extra time taken to treat patients be paid?'*

3. Supply

- *'What are the legal and financial implications? NI would be treated 'as an EU member state' and so would have continued access to amalgam from EU, for example Germany – but this would have cost implications. Given the current budgetary pressures, what prospects are there for DoH to afford this?'*

- *'Is there a Managing Divergence workstream which links with HM Treasury on the financial impacts of divergence? We need clarity on this.'*

4. Cost

- *'Even if we are allowed to continue using amalgam, the rest of Europe won't, which will* ***drive up the price*** *as not being manufactured in bulk anymore - putting massive pressure on already tight margins, or even just increasing the loss per amalgam filling.'*

- *'We also do not have NHS denture labs to fill these gaps either. I had a dentist tell me that they now have to take* ***4 months to get NHS dentures made*** *which is really not providing very adequate care.'*

- *'The fees available will be the barrier here.'*

- *Capacity/throughput of patients will be significantly impacted, which is intolerable'.*

- *'The extra time involved would need factored in: [from] 17 to 59 mins (x3 times) vs amalgam; different techniques, not just materials; the high volume, low margin NHS system - it would mean reducing the number of patients that can be seen, which would equate to less dentistry'.*

- ***'If amalgam is banned and fees aren't increased, NHS dentistry is definitely not sustainable'.***

- *'From* ***the orthodontic perspective****, if extractions are required for orthodontic treatment, these proposals could result in an increased incidence of molars with compromised*

prognoses. Consequently, enforced molar extractions as opposed to the more normal premolar extractions, will reduce the prognosis and increase the complexity of orthodontic treatment. This may have a detrimental effect on orthodontic treatment outcomes and increase the cost of delivering orthodontic treatments.'

Finally, one of our members submitted this powerful correspondence on the issue:

- *'I am one of the owners of a large 4 dentist practice in an area of Belfast recognised as a low socioeconomic area with population who suffer with high demand for restorative and remedial dental care. I have been privileged to work there for more than 20 years. We have always been proud to support the NHS and to serve our patients accordingly. We see other dentists making more money doing less work privately, but we enjoy fixing patients' oral health and contributing to the area we work in.*

  'As I'm sure you are aware dental practices are under incredible financial pressure post COVID, as are most businesses. Increase in wages. Increase in utility bills. Increase in lab bills. Increase in demand but not capacity. We were able to save some money from our COVID support but on a monthly basis we are simply spending more money than we are bringing in. As we cannot increase our fees in line with inflation we lose money treating patients on the NHS. And we have (been losing money) working in the NHS a long time. We are fast, efficient dentists. But the more NHS patients we see the more money we lose. This has led us to (in the last month) only registering new patients privately in an attempt to balance the books. Our accounts show our income up to now was 95% from NHS work. It can't stay at that level.

  'As for amalgam. It's not a pretty material to work with, and everyone would prefer a white filling. But it's cheap, reliable, fast to place and long lasting. It has a place in the NHS. The fees we are paid to place an amalgam filling range between £8.13-£20.92! That includes diagnosis, informed consent, local anaesthetic, placing the filling and post op instructions. To use a white composite filling takes all of the above and much more time as the material is sensitive to moisture and technique. It requires etching and good bonding system, possibly rubber dam isolation. More materials, more expense and more time. Our current fees for placing a white filling are £80-150 per filling. And we are priced at the lower end of the private market. Unless we are to be paid at this rate for providing white fillings it will be impossible to provide posterior white fillings on the NHS. Fillings are such a high percentage of our work it will simply put us straight out of NHS dentistry.

  'That's approximately 8000 more patients not registered and having nowhere to go for NHS care. In one of the most deprived areas in Northern Ireland. It's sounds dramatic, but it's how it is.

  If you can reverse this ban please do so. And soon. Many practices, including our own are already being forced to take more private work and a last minute reprieve may be too late as business decisions are being made now for the future.'

Community Dental Services:

- *'Amalgam will remain an essential restorative material in the provision of Special Care dental treatments for the foreseeable future. It is a hardwearing restorative material that possesses a high degree of latitude in the oral conditions required for its successful placement. This is often essential in patients with significant additional needs.*

  Amalgam is the first material of choice in many additional needs cases where bruxism (grinding) is common and the longer mean survival time of the material placed is essential to reduce the necessity for repeat General Anaesthetics often necessary to provide treatment.

  NI remains the region with the highest prevalence of dental disease in the UK. Preventative programmes are in place but the culture change that these programmes aim to effect require significant additional time to reach a point where amalgam use would effectively become close to zero. Additional preventative programmes, such as the OHIP (Oral Health Improvement Plans – Children and Older Persons) initiatives need defined action plans and dedicated resources to place NI in a position to significantly reduce amalgam use.

  Alternative materials still do not match amalgam in terms of its ease of use, wear resistance and costs. Glass ionomer and composite materials are adding costs onto the CDS budgets at a time when staffing levels are lower than required and demand is outstripping capacity. This results in longer waiting lists and higher caries prevalence, or more advanced disease progression by the time treatment can be provided. This in turn places stresses on the CDS workforce and burnout is a significant issue.

  [HSC] Trusts have been working over the last 7 years to reduce reliance on amalgam as a restorative material. Relative percentage of amalgam use as a restorative material has decreased from 17.7% to 5.7% over this period. To extrapolate this trend would require not only a potential 30-month period, but also the development of alternative materials to match the current properties of amalgam. More R&D is essential.

  Alternative materials to amalgam are (at this time) more technique sensitive and require more time to place successfully. This means longer treatment times per patient and an inevitable increase in patient waiting lists. To try to maintain or improve waiting times for vulnerable patients means that staffing levels, across all clinical skill-mix dental team members is essential. CDS Special Care Dental Teams must be increased across all grades.

  It must be recognised that whilst the direct impact of the proposed amalgam legislation will be reduced in CDS, as compared to GDS colleagues; the indirect impact of increased referrals of patients who may require specialist behavioural modification techniques to allow alternative restorative material placement could be catastrophic to already over-burdened referral rates to the CDS.

  Community Dental Services are in agreement with the NI plan (2019) which seeks to ensure a gradual reduction in the use of dental amalgam through three key pillars:

  1.Increased effective Prevention

  2.Availability of equal and/or better alternatives to amalgam in terms of speed in use, techniques required to place, latitude in oral conditions necessary for successful restoration, equity in access and cost.

3.Ensuring that the GDS dental contract reflects 1&2 above to minimise both population impacts and indirect CDS impacts. CDS Special Care needs to be strengthened already to meet current demand and the additional impact of the amalgam legislation could be the final straw'.

General anaesthetic

'Amalgam is a predictable outcome in the majority of situations when placed under GA in posterior teeth. Composite can be less so and therefore is less likely to be placed under GA especially in situations where the patient is unable to express issues after the treatment. The worst case scenario will be the situation whereby if amalgam is unavailable and we do not wish to take chances, the tooth will be extracted. This already occurs occasionally in patients who do not wish amalgam fillings (sometimes parents of children who have Autism). It's a very difficult decision for those clinicians undertaking the treatment.

'By right, posterior composites should be placed under Rubber dam. This would not be suitable in the majority of patients attending the CDS. Also, it would be a very difficult thing to do under GA to use a rubber dam. If composites are not placed under ideal situations, there is a higher chance of failure and what then? No amalgam as a failsafe to fall back on in this situation. The chances of crown preparations would be extremely unlikely then. CDS patients would have difficulty recognising post-operative sensitivity after composites are placed, and this could be very distressing for them even if it resolves.

'Oral Health improvement needs to be a priority throughout all the dental disciplines for the phase out not to have an impact on the services in the future'.

Hospital Dental Services:

The impact of the amalgam ban on general practice and community dental services, also potentially has unforeseen consequences and implications for hospital dental services (and dentists in training):

'I appreciate the serious impact the amalgam ban will have on general practice, and I'm sure the Dental School will have issues, especially in regard to training.

'One thing I would ask of my restorative colleagues – if Northern Ireland dental students are not able to place amalgam restorations, will the GDC have a problem with them not fulfilling their requirements for training? If so, will they be able to graduate and practice in GB? Will the GDC continue to recognise the qualifications of EU trained dentists who have not been trained to use the workhorse of NHS dentistry?

Additional comments:

- **Training:** '*Dentists will need support to upskill to provide amalgam alternatives. This needs to be funded. The whole dental team will be impacted and not just dentists.'*

- ***'General Dental Services*** *are seriously unstable as it is. Costs of care/operating costs would be heavily impacted. DoH has a track record of not funding GDS properly any time there is a legislative change imposed'.*

- ***'Private care*** *cross-subsidises NHS care in most practices. This private income from posterior composites income would be displaced'.*

- **Personal impact:** *'there would inevitably be further withdrawal from NHS dentistry impacting on thousands of patients unless there is a serious approach to measure costs and pay accordingly'.*

- ***'The impact on NHS dentistry*** *should not be under-estimated. If the DoH is serious about a future for NHS Dentistry, it needs to assure the profession by moving along similar lines to Scotland on fee uplifts – and acknowledge the cost to provide properly'.*

Notes:

Amalgam use:

a) 2015/16-Q2 2023:

BSO/Northern Ireland Health Service statistics for Amalgam fillings in *adults* from 2015/16-2023/Q2 show a total of 2,641,487 permanent fillings.

BSO/Northern Ireland Health Service statistics for Permanent Amalgam fillings in *children* from 2015/16-2023/Q2 show a total of 366,948 permanent fillings. Non-amalgam accounts for only 82,018. A total of 241,960 are amalgam (the remainder 124,988 accounts for items such as Tunnel Restorations, Composite / Synthetic Resin Fillings, Glass Ionomer / Silicate Fillings etc).

b) 2022/23:

BSO/Northern Ireland Health Service statistics for all fillings in *adults* for financial year 2022-23 (the most recent available full financial year) amounts to 639,250. Amalgam accounts for 181,989. Non-amalgam (Composite/Synthetic Resin Fillings; Glass Ionomer/Silicate Fillings) accounts for 457,261.

For *children*, there were 112,027 permanent fillings. 18,219 were amalgam. Non-amalgam (Composite/Synthetic Resin Fillings; Glass Ionomer/Silicate Fillings) accounts for 93,808.