Committee for Health, Social Services and Public Safety

OFFICIAL REPORT
(Hansard)

Funding for Dental Services: Departmental Briefing

2 May 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Ms Michelle Gildernew
Mr John McCallister
Mr Kieran McCarthy
Mr Conall McDevitt

Witnesses:

Mr Paul Gibson	Department of Health, Social Services and Public Safety
Mr Donncha O'Carolan	Department of Health, Social Services and Public Safety
Mr Eugene Rooney	Department of Health, Social Services and Public Safety
Mr Michael Williamson	Department of Health, Social Services and Public Safety

The Chairperson: Donncha, I assume that you will lead the presentation.

Mr Donncha O'Carolan (Department of Health, Social Services and Public Safety): You assume wrongly, Chair; it will be Eugene.

The Chairperson: Eugene, I assume that you will lead. *[Laughter.]* I ask you to introduce the rest of the team and give your presentation. I will then open up the meeting for questions.

Mr Eugene Rooney (Department of Health, Social Services and Public Safety): Thank you, Chair. I will make the opening remarks. Mr Donncha O'Carolan is the Chief Dental Officer; Michael Williamson is from the dental services team; and Paul Gibson is from the finance team. You mentioned that you received our background briefing paper on funding for dental services. It covers some of the key points that we will address this afternoon. I will briefly describe for you some of the key issues: the current arrangements for the provision of dental services; pressures on the general dental services (GDS) budget, which the Committee raised with the previous witnesses; measures that the Department

proposes to help to address those pressures; steps that the Department will take to consult stakeholders; and engagement with the Committee.

I will start with the current GDS arrangements. The current dental services contract was introduced in 1992 and pays dentists using a blended system of remuneration. Items of service payments account for approximately 60% of GDS income, 20% comes from allowances and 20% comes from capitation payments. The statement of dental remuneration (SDR) is issued annually by the Department and sets out the payment levels for the more than 400 items of service and the conditions that claims must fulfil to be valid. The SDR also describes the conditions that apply to capitation and allowance payment for dental practitioners. Therefore, there is a lot of detail on how the budget is allocated and the charges and fees involved.

Dentists are independent contractors who, in general, own their premises and employ their own staff. They are free to carry out as much, or as little, health service work as they choose. The current GDS contract is demand-led in that the Health and Social Care Board (HSCB), as commissioner, is obliged to pay any registered dentist for whatever treatment is carried out under the SDR.

Pressure on the GDS budget has grown because of several factors: an increase in the number of patients registered with dental practices under the health service; an increase in the total number of dentists and dental practices; and an increase in the amount of health service dental treatment being provided. Those issues were touched on in discussion with the previous witnesses on the amount of health service work now being undertaken by practices that previously did more private work.

Over recent years, there has been a year-on-year increase in general dental expenditure. Demand currently exceeds the budget allocated for dental services at the outset of the financial year. That pressure has been managed by the Health and Social Care Board across its total budget allocation to secure an overall break-even position at the end of each year. However, we currently have no way of limiting the number of dentists, dental practices or treatments carried out and, therefore, no way of limiting the overall expenditure on the general dental services budget.

Given the pressures on the overall budget, the Department, with its arm's-length bodies, has been examining how potential savings could be made across spending areas within the allocations set for health and personal social services. To live within the budget, we need to review all aspects of activity. In that context, services and organisations are required to examine the scope for savings. The GDS budget is no different in that regard.

The Department and the Health and Social Care Board have developed several proposals that would help to mitigate the pressures on the budget, and the Minister advised the Committee of those proposals in a letter in November. They include moving to a core service of treatments under the SDR; changing the existing time bar for providing scale and polishes; introducing criteria for the provision of orthodontic treatment; increasing the threshold for claiming practice allowance; and ceasing the payment of commitment allowances.

The proposals have been put forward because they have the potential to realise savings in the budget. They could be implemented within the existing contract or with minor regulatory changes, and they would be consistent with relevant legislation and other regulatory requirements, as well as with the direction that has been set for developing a new general dental services contract. In addition, and very importantly, in deciding on specific savings proposals, the aim is to avoid impacts on oral health here.

The proposals have been the subject of discussion with the British Dental Association (BDA), and we have been considering the detail that it highlighted in its comments. The paper provided to the Committee in November indicated the possibility of the index of orthodontic treatment (IOTN) increasing to IOTN 4. The Minister has decided that it will be set at IOTN 3.6, which is in line with the level set in England, Scotland and Wales.

Mr Wells: Will you explain that, please? What does that mean?

Mr O'Carolan: The index of orthodontic treatment need is a grade of complexity divided into three groups. The first group comprises patients who absolutely need orthodontic treatment, and they are at

IOTN, 4, 5, 6 and upwards. The second is those who have no real need, such the case that Ms Brown highlighted about a slight twist in the front teeth. With no health gain, that person would be rated as very low and not needing orthodontic treatment. In between, there is a grey area of those who are borderline. So a cut-off point of 4 includes all those who absolutely need orthodontic treatment. By moving it down to the lower rating of 3.6, we move into the grey area, which is a generous threshold, or cut-off point, and is consistent with England, Scotland and Wales. The Republic of Ireland's threshold is set at 4.

Mr Wells: That is helpful.

Mr Rooney: The Department would need to take a number of steps before the proposals could be implemented. As stated in the previous session, these are proposals. The introduction of criteria for orthodontic treatment and the cessation of commitment payments would require amendments to the National Health Service (General Dental Services) Amendment Regulations 1993. Such amendments require consultation with the BDA and other stakeholders, including the Patient and Client Council, the wider dental profession and the public. In addition, following consideration of the consultation responses, any amendments to the regulations would be submitted to the Committee for scrutiny and approval.

I will move to core services treatment. Altering the claims and conditions for treatments and increasing the threshold for practice allowance payments would require amendments to the statement of dental remuneration, and, subject to the Committee approving the amending regulations, as outlined earlier, there would also be consequential amendments in the SDR to account for the introduction of criteria for orthodontic treatment and the cessation of commitment payments. However, consultation with the BDA is required before amending the statement of dental remuneration. So there has to be a formal consultation with the BDA on the amending regulations, and there will have to be engagement with, and approval from, the Committee. The proposals have a wider impact on patients and the public, and the Department intends to have a wider consultation. We are finalising the impact assessment and relevant documentation that will form part of the consultation, along with draft amendments to the legislation, and the Department will then issue those for consultation to stakeholders.

The Chief Dental Officer wants to add a few additional comments to my opening remarks.

Mr O'Carolan: I want to add a remark about oral health because there has been some misunderstanding. As I said on the previous occasion that I was at the Health Committee, if you wanted to reduce the rates of lung cancer in Northern Ireland, you would not employ more doctors; you would focus on smoking cessation. It is exactly the same with oral health: we need to focus on the causes. The first of three available options is fluoride. We will continue our funding of toothpaste schemes; we continue to fund fluoride varnish on teeth, which the Minister spoke about at last week's research briefing; and the Minister mentioned that he and his Executive colleagues are considering water fluoridation. The second option is the use of preventive fissure sealants, which we fund through the GDS and will continue to fund. The third option is to improve diet, which we fund and promote as part of general public health.

I am confident that the gains that we have made in improving oral health over the past 10 years will continue in the coming years. I am confident that the proposals that we are putting forward will not impact on oral health. That is an important point to make.

The Chairperson: Thank you.

Mr McCarthy: It is good news, but it is hard to take in —

The Chairperson: Kieran, I have given a lot of leeway in the Committee today. It is important that members make their points through the Chair.

Thank you for your presentation. I think that it addressed some of the points made earlier. As a Committee, our role is to scrutinise, but we are also here to ensure that our constituents get the best

service to which they are entitled. Donncha, your last point was about the gains made in the past 10 years. However, we are told that we still have the worst oral health in Europe.

Mr O'Carolan: We do not have the worst oral health in Europe — we are in the bottom half — but we have the worst oral health in the UK. We have been doing an awful lot over the past 10 years to address that. Fluoride toothpaste schemes were introduced in 2004, and we have noticed a dramatic drop in the number of extractions in young children. Extractions are down by 30%, and fillings are down by 30%. We introduced the fissure sealant scheme into the GDS in 2005, and there has been a good uptake. General health promotion and diet apply across the piece: for diabetes, obesity, dental decay, and so on. It does not focus only on dentistry. We also have a research trial that is being funded with £1·7 million. We have been very proactive.

As for measuring the absolute gain, a UK-wide survey is carried out every 10 years. The most recent one was in 2003 and showed no gain between 1993 and 2003. The next UK-wide survey will be in 2013, and we will have the results the following year. You will not notice an instant improvement in decay rates, you will not notice it over a year or six months, but, over a decade, you should notice a significant change. We are using proxy measures, such as rates of extractions and fillings, all of which are heading in the right direction. We will take a robust scientific approach to that next year, but we will have to wait for the survey to give you an absolute answer.

The Chairperson: You jumped in before letting me finish my point.

Mr O'Carolan: Sorry.

The Chairperson: I was not going to be critical. I appreciate that much of the work involved is long term. However, we are still in the bottom league, whether in Europe or, in your words, the UK. The paper that you sent to us shows that costs have been increasing over the past number of years. Therefore, the real message in all that you say is that we are still not getting everything right. Where does the Public Health Agency fit in? You mentioned obesity and other campaigns. Convince me that the Public Health Agency is playing a part to put the onus back on the patient, community and population also to play their part.

Mr O'Carolan: In the past, we ran dental diet improvement schemes. We have moved away from that and said that there was no point in focusing solely on dentistry. We now link in with all the other areas. If you are asking me to list all the Public Health Agency's initiatives, I would need to look into that.

The Chairperson: I would appreciate that. Will you run a public health advertisement campaign? Are you considering any ideas in that area?

Mr O'Carolan: There was a dental section in the Department's public health strategy. The previous one has now run its course, and the Department is drafting a new one. The Department is ensuring that there is a focus on dentistry, but not sitting on its own. It is integrated with various schemes such as reducing diabetes, obesity and cancer, because the same poor diet that causes those conditions leads to dental health problems. My role is being in the Department and feeding into strategic documents; that is where I link in. Unlike my dental counterparts on the HSCB, I do not work day-to-day with the Public Health Agency. A group comprising dental health professionals from the board and the Public Health Agency considers various initiatives. The Public Health Agency, for example, works hand in hand with dental colleagues on the fluoride toothpaste schemes and also covers elderly care, diet, and so forth. I am not involved in those meetings, because they take place between the board and the Public Health Agency, but I am aware of them. I would need to contact the board to obtain the exact details of all the schemes that they are developing at the moment.

The Chairperson: It would be useful to get that information during the consultation period so that we can have an overview of the targets and the Department's strategy. That leads me to the proposals. Your briefing paper stated that the proposals would go out for consultation in May. Do you have an idea of the exact date?

Mr Michael Williamson (Department of Health, Social Services and Public Safety): We are completing the regulatory impact assessment, which is an economic document that will show the impact of the proposals. It has to be included in the consultation pack, so when it is finished, we will be in a position to get the Minister to sign it off and release it.

The Chairperson: Will it be screened out or screened in for equality impact?

Mr Williamson: We have carried out the equality screening, and because —

The Chairperson: So is it screened in or screened out?

Mr Williamson: I do not think that there is a need to carry out a full equality impact assessment (EQIA).

Mr Rooney: The screening documents will set that out.

The Chairperson: OK. We will come back to that later. Where does the new dental contract sit at the moment?

Mr O'Carolan: There are three elements to the contract. There is an oral surgery pilot, and there will be an orthodontic contract and a general dental services (GDS) contract. The oral surgery pilot is ready to go. In fact, it was ready in January until we noticed a glitch in the pensions legislation, which did not allow us to take it forward. We now have to change that legislation, but that is well advanced.

Orthodontics will be phased in, so this will be the first phase. The new orthodontic contract is a simplification of the existing contract. We are phasing in a certain amount this year and a certain amount next year. The overall shape of the GDS contract and its broad detail indicate that it will be a blended system with weighted capitation and some items of service. However, our limited capacity dictates that we could not run all three pilots together.

I know that the board will take forward the pilots and is considering recruiting additional staff. However, the dental team from the Department and the board is very small, so we have to do this in bite-sized lumps, if you will forgive the pun.

The Chairperson: You said that you would find out from colleagues about what was happening in conjunction with the Public Health Agency. Have you any more information on the fluoride toothpaste scheme?

Mr O'Carolan: Fluoride toothpaste schemes were introduced into the 20% most deprived wards across Northern Ireland. We used the primary schools in those wards. The advantage of the fluoride toothpaste schemes is that we know that fluoride toothpaste works, because it targets children who, by and large, do not regularly attend the dentist.

About 70% of children are registered with a dentist. That is the highest ever percentage. It has been a great success. That means that 33% are not registered, and they tend to live in the more deprived parts of society. The advantage of the fluoride toothpaste schemes is that we are able to target children in deprived areas, and they have the highest decay rates.

The Chairperson: Is that done through schools?

Mr O'Carolan: It is done in three ways. Some is distributed through Sure Start and some through play schools, because the scheme targets children up to the age of five, so it includes primary 1 and 2 pupils. Also, some is posted, and some is used in primary 1 and 2 settings in supervised toothbrushing sessions.

There is a variety of schemes, and the idea is to look at all those to determine which is the most effective. The dental folk on the board are doing that work with the Public Health Agency. Those schemes are funded through Investing for Health, and we continue to fund them because we feel that they are exceptionally important.

General anaesthetic extractions went down from 40,000 to 26,000. When children have to have a general anaesthetic for an extraction, it means that their teeth are very heavily decayed. We can see from their postcodes that those children come, largely, from deprived areas, and they tend not to go regularly to the dentist. We have asked the community dental service, which is trust-based, to focus on that group of patients as one of its priority areas, along with special needs patients. We have written that into the service level agreement.

The Chairperson: For members' information, health inequalities come up in much of our work. So the Committee Clerk and I are looking at trying to bring together the people involved in tackling health inequalities, whether in the Public Health Agency, the Department or the board, to try to do some specific work on that. It struck me that the Public Health Agency has an important role in tackling oral hygiene, and so on. We can get more information on that.

Mr O'Carolan: As the dental team is so small, the decision was made to focus all its members in the HSCB, rather than splitting them over the Department, board and Public Health Agency. The team comprises only about seven or eight people, maybe 10 maximum. As the dental public health function is located in the board, I tend to do most of my work with it, even though the team wears a twin hat, if you like, of Public Health Agency and board.

The Chairperson: For members' information, our next step we will be to look at health inequalities.

Ms Gildernew: At an earlier event, we talked about how lower socio-economic groups and working-class people have worse outcomes and are less likely to engage with health professionals through vaccination, screening or attending their dentist. So we have to focus on those groups and try to get rid of those health inequalities. I am, therefore, concerned about the equality impact assessment because it does not sound as though it has been screened in. It sounds to me as though we need to look further at the equality impact of the proposals.

My 10-year-old has not had a filling yet, but he had fissure sealants, which were very helpful, and my six-year-old has since had them applied as well. No matter how much we nag, children will try to avoid brushing their teeth. Often, we have to stand over them to make sure that they brush twice a day. All of that is important, but fissure sealing has definitely been a good way of preventing tooth decay.

I was disappointed, Donncha, that diet was the last thing that you mentioned because, from what I can see as a layperson, it is probably the most important factor in ensuring good oral hygiene. I know parents whose children have had every single baby tooth extracted before reaching primary 1. That happens not because they guzzle coke all day but because they are probably given children's drinks, such as Fruit Shoot. Parents think that those are not harmful, but they clearly are, and that message is not getting through.

Mr O'Carolan: May I tell you why I mentioned diet last? It is not that diet is not important — all elements are important — but, from a dental perspective, the two most important are fluoride and fissure sealants. A dental health improvement scheme called Boost Better Breaks focused purely on diet and was based in the Southern Trust area. The children who were part of that came out with worse decay than the children who were not, because everybody knows that taking a lot of sugary drinks and foods is bad for your teeth. Parents understand that and children, depending on their age, may understand it, but they do not change their behaviour. The evidence base now suggests that telling people just to change their diet does not prevent dental decay. However, fluoride in toothpaste, in varnish form or in the water does work, and fissure sealants also help. From a dental perspective, I have to concentrate on evidence-based initiatives that will work. Diet is extremely important, but it is important for areas of health beyond dentistry. It is better that we link, as the Chair said, with the Public Health Agency and link that message to those on obesity, diabetes, general health and cancer. I do not have the answer to how to change behaviours. It is incredibly complex, but we have discovered that, when dentists try to do it on their own, it does not work.

Ms Gildernew: One area is providing information, and I am glad that you are working with the PHA. The parents whom I mentioned knew that fizzy drinks were bad for their children's teeth and avoided them,

but they did not realise that the alternatives were equally bad. The best message is to tell parents to give their children water or milk, but that message does not seem to be getting through. As a result, tooth decay is at a much higher level than we would like.

I am concerned by the lowering of the IOTN threshold. It is up to dentists' discretion whether children need orthodontic treatment for cosmetic or genuine reasons. If left to the discretion of the dentist, some children may get orthodontic treatment and some may not. My fear is that children in most need of orthodontic treatment might not be those pushing hardest for it.

Mr O'Carolan: The system will become easier for orthodontics. If such treatment is required, prior approval will no longer be needed. So an orthodontist will be able to say, "Your child fits within the categories and criteria that have been set." However, we must remember that orthodontic conditions are not dental health problems. They do not affect dental health in the slightest. However, as one of your colleagues mentioned, they affect self-esteem. As Jim said, the health service has only x amount of money. This is a cosmetic treatment, and we have to draw the line somewhere. In moving to 3·6 on the IOTN, we are being very generous. Many orthodontists said to me that we should have stuck to 4·0, because that would be a very definite cut-off point. However, the public and patients would probably have thought that a bit radical. I think that going down to 3·6 is a very reasonable compromise, and it is what the rest of the UK does. As I said, in the Republic of Ireland, it is 4·0. I am very comfortable with 3·6, and I know from orthodontists that they are as well. Given that the budget is under pressure, we have to spend the money judiciously. We should spend it on the biggest problem, which is dental decay, rather than on a cosmetic issue.

Ms Gildernew: I would not say that orthodontic problems affect only self-esteem. Anyone who has been through painful orthodontic treatment is more likely to look after, respect and appreciate their teeth. It is about oral hygiene, looking after teeth and being more conscious of them. Individuals who do not feel that their teeth are their best asset and, therefore, that keeping them clean and looking after them makes little difference, are less likely to have an eye to oral hygiene.

My main area of concern is that I come from a constituency that had a large number of dentists who were not taking on new patients. I wrote to the previous Minister about that, asking him to take action, and I am very grateful to him for doing so. I am afraid that, if there are further challenges to the budget, rural areas will be hit first. Last night, I spoke to a dentist from my constituency who said that his profits have gone down by 50% in four years. Large increases in the cost of treatments, the equipment that he needs, and so on, mean that his business is not as profitable. He thinks that, if these further proposals came in, his business would make zero profit. He told me yesterday that the Department's figures show that he should be making £240,000 profit a year but that he would not make that in a million years. He is extremely concerned.

You talked about formal consultation with the BDA. Then I heard the words "wider consultation". Do you mean that there will be a full public consultation?

Mr O'Carolan: It is all simultaneous.

Ms Gildernew: OK, but will there be any element of public consultation? I did not hear those words, and I am concerned.

Mr O'Carolan: I am glad that you mentioned the access issue. Access became an issue when dentists in specific areas — they tended to be in rural areas outside Belfast — decided to withdraw from the health service because it was more profitable to do so than to stay in it. To be fair to the profession, I should say that the vast majority of dentists stayed in the health service, although it did not feel like it at the time. At the height of the access problem, about 850,0000 people were registered; now, the figure is 1·1 million. So we had to take the initiative and go out to tender to bring in additional dentists. Current access is good, and many dentists are looking for patients. The Minister told us to make sure that any proposals that we brought forward would not impact on access. You can never say never, but we have more dentists now per head of population than any other part of the UK. There are many dentists out looking for patients, so I do not envisage an access problem. However, it is never possible to be absolute, so we could monitor the situation. Given the supply of dentists and the fact

that the private market has dried up to a large extent, I am reasonably confident that access will still be very good.

Ms Gildernew: We will keep a close eye on it, too.

Mr McCarthy: I hope that that will be the case.

My understanding is that the Minister told us that all treatments currently available will remain so when clinically necessary. However, patients expect dentists to advise them what treatment is necessary. Are you telling us that dentists will have to refer cases to the Health and Social Care Board so that it can decide what is clinically necessary for the patient? Surely little can be saved by that and you will create, as stated in the earlier session, only further bureaucracy and more disgruntled patients.

Mr O'Carolan: The majority of the proposals do not deal with treatment; they deal with other areas, such as allowances. The treatments that we propose to place on the list requiring prior approval include cosmetic veneers, which Jim mentioned. Chrome dentures are still available if absolutely clinically necessary, but there is the alternative of acrylic dentures. The majority of bridge work currently requires prior approval. There is very little evidence that a single scale and polish has any health gain, so we are considering the frequency with which it should be provided on the health service. We proposed a year initially, and we are now looking at that again, because the BDA pointed out a discrepancy in how often a single scale and polish or double scale and polish could be claimed. We are looking at the figures, and we will put another proposal to the Minister on that. There is no evidence to show that there is any health gain from a single scale and polish. The items that will need prior approval are not wide-ranging. For the vast majority of treatment, people can continue as they do currently.

Mr McCarthy: I think that you were present when members of the BDA gave evidence. They were clearly concerned that they would have to spend more time seeking and awaiting approval. They were worried that that would create more pain for patients, who would have to wait longer for treatment.

Mr O'Carolan: I missed out molar root treatment. The board has made it clear that anyone in pain can be treated immediately. If dentists need prior approval immediately for urgent treatment, current mechanisms enable them to get that by phone. We have no intention that anyone should suffer pain..

Mr McCarthy: That is good. Given the increased contacts that will be required between the board and dentists, will the exercise produce any savings?

Mr O'Carolan: There are significant cost savings. One of the biggest areas requiring prior approval is orthodontic treatment. Virtually every orthodontic case has to go for prior approval because it costs over the limit of £280. If the patient meets the criterion of 3·6 or higher on the index, the orthodontist can go ahead and do that treatment. The board will check afterwards to make sure that it was absolutely necessary for that treatment to take place. That will cut down significantly on bureaucracy in the business services organisation (BSO) because a significant amount of its prior approval is for orthodontic care, which has boomed in recent years. As some of your colleagues said, the demand for it now is phenomenal.

Mr Wells: If I read the figures for expenditure correctly, you have gone from £66·7 million in 2007-08 to £95·4 million in the year just ended. That is an increase of about 50%, but there was only a 26% increase in patient registration. That strikes me as being an extraordinarily generous settlement. What happened to the other half of that money? Why has expenditure rocketed in such a short time?

Mr O'Carolan: The previous Minister made a number of investments in general dental services because of problems that we were experiencing and rising costs. A practice allowance is about £8 million a year, and that helps with running costs and improvements to decontamination, which is important for patient safety. Additional money was invested in training, as we could not get enough dentists to come forward to train graduates. Money was also invested in salaried dentists in places such as Ballymena, Magherafelt and Cushendall. Although they appear on the top sheet, they would not appear in some of the other figures. Apart from activity, investment was made in other areas to address other problems.

Mr Wells: Yes, but could you be guilty of having created an expectation among dentists that never-ending increases in funding were available? Then, out of nowhere, you put the brakes on almost immediately and expect dentists suddenly to operate in a situation totally different from the one that they have been used to.

Mr O'Carolan: The GDS budget was underspent from 1993 to 2010, which is a significant period. As Peter Crooks pointed out, a significant number of dentists left the health service and went into the private sector. It was very difficult to predict whether they would come back to the health service side en masse. As it turns out, an awful lot have returned, and that means that it could almost be argued that we have enough dentists, if not too many. Yes, there is an element of guesswork involved. Many dentists said that they had left the service and would not return because they could not afford to, and it did not provide the high quality that they wanted to deliver. However, a year or two later, they are back doing exactly the opposite. It is difficult to predict that behaviour. You are right that the economic situation meant that demand for the private market dropped off, which led to dentists thinking of a return by the back door to the health service. It was also difficult to predict the economic downturn and the effect that it would have.

Mr Wells: I am very interested in the index, the IOTN?

Mr O'Carolan: Yes, the index of orthodontic treatment need.

Mr Wells: The Department has set the level at 3·6 and, in the Republic, it is set at 4. What was it before the change was made?

Mr O'Carolan: Nothing.

Mr Wells: So, in other words, everybody got everything that they wanted?

Mr O'Carolan: Basically, it was on demand.

Mr Wells: Is that except for orthodontic treatment over the £280 limit?

Mr O'Carolan: Yes, that is correct.

Mr Wells: Up to now, had I wanted my daughter to look like Cheryl Cole, the X Factor lady, I could have demanded —

Mr O'Carolan: Even if the orthodontist told you that he or she did not think the treatment necessary, you could have said that, if it was available under the health service, you wanted the application to be made.

The Chairperson: She needs more than her teeth done to look like Cheryl Cole.

Mr Wells: You have not seen my daughter.

The Chairperson: I was not implying anything about your daughter; I was saying that Cheryl Cole had a lot of work done to look like she does. You jumped in too quickly.

Mr O'Carolan: We are the only part of the UK that does not have a limit, so I think it right that we introduce a needs-based system.

Mr Wells: If the demand for that type of advanced treatment continued to grow, where would we have been in five years' time, say, within the CSR period, if we had simply continued the way that we were going?

Mr O'Carolan: Again, I cannot give you an exact figure, but the market has to balance out at some stage. We have a very good supply of dentists. When I chat to other dentists, they say that they are not as busy as they were and that they have free appointments in their books. That has a braking effect: people decide not to take on any new dentists or open a new practice. I do not think that the line will be linear. I think that it will plateau in the next couple of years, but I cannot predict the exact figure at which that will happen.

Mr Wells: I have a very difficult question to put to you on the dreaded fluoride issue — you might well pass on it, and you would probably be right. If we had introduced the compulsory fluoridation of the water supply in Northern Ireland 10 years ago, what impact would that have had on the figures that we are looking at today?

Mr O'Carolan: Decay rates would have dropped among young people, so we would be paying out for fewer fillings and fewer general anaesthetics. About 5,500 treatments under anaesthetic are still carried out on children, and anaesthetics in a hospital situation are expensive. There would have been savings on fillings and on general anaesthetic admissions to hospital. Patients would have needed less complex treatments. Those working in fluoridated areas in the South of Ireland, for example, do not see the same high rates of decay in children as we do. So there would be fewer fillings and extractions, as long as dentists did not replace that with something else, if you know what I mean. If the cost of fillings was displaced by that of orthodontic treatment, the bill could be the same. So the savings would have to be defined, which would be done by reducing funding in line with the reduced problem. I cannot give you an exact figure.

Mr Wells: Clearly, you recommended to the Minister that we go down this route. He issued a statement recently that it was the way forward. Presumably, there is a cost as well?

Mr O'Carolan: Yes, there is an initial capital cost. It is reckoned that the capital cost for a population of 500,000 is around £2 a head, which would equate to about £1 million. The recurrent costs are then 50p a head after that. Compared with what is currently paid out for fillings and extractions per head of population, that is very cost-effective. However, it is just not as simple as that. It depends then on the water supply. I do not know what the water distribution is in Northern Ireland, but if a water plant supplies a small population, it might not be economically viable to put in the plant to do that. It requires large populations with high decay rates to be cost-effective.

Mr Wells: Finally, you said that a record number of dentists now practise in Northern Ireland. Will all those practices remain viable under your proposals? As far as I can see, you are taking £9 million out of their income.

Mr O'Carolan: The only money that could be guaranteed is for allowances, and so on. However, dentists could change their behaviour. Say, for example, the number of scale and polishes goes down, they may start doing more of something else. Therefore, when it comes to treatment, it is difficult to predict. There is bound to be a saving in orthodontics because the non-essential treatments will not take place. That is a guesstimate. However, if we remove the commitment payment, that definitely saves £3 million. We have made a minor change to the practice allowance, but, then again, dentists could change their practice so that they have more of the type of patients who would allow them to claim that allowance.

Mr Wells: I have no doubt that a well-heeled dentist or orthodontist on the Malone Road or in north Down will be fine, but what about dentists working in places such as Rostrevor or Belleek? Is there not a danger that, because you are restricting the budget, the type of service that will suffer and may have to close will be the one most needed by a rural community?

Mr O'Carolan: Eugene or Paul may want to take on the question on restricting the budget. Although we have set down a ring-fenced budget for GDS to the board, there is still latitude within the board to pay any additional money.

Mr Paul Gibson (Department of Health, Social Services and Public Safety): That is right. The current allocation in the dental budget for next year is £89 million. Obviously, that is not enough to cover all

the demand that we have seen over the past couple of years. However, the board also has its central commissioning budget, which it can move into this area. There is also the alternative of identifying efficiencies throughout the system, which could then be redirected.

Mr Wells: Does that mean that, if there is a threat to a service in Belleek or Belcoo — some isolated rural area — money could be diverted to sustain that service, or does it have to take the same hit as a specialist dental practice in somewhere such as Crawfordsburn, which will take it on the chin and just move on?

Mr O'Carolan: If that practice in Belleek or Belcoo is committed to the health service, it will still get paid for all the health service treatment that it does. The health service demand will still be there. If the practice continues to address that demand, it will still get paid for it. So why would it go bankrupt?

Mr Wells: It may be on the edge of viability at the moment, particularly with the new onerous system of licensing. They now have to fill in all these forms and register to pay a fee per chair. Such a practice may just about be surviving and have a very small client base because it is in an isolated rural area. Taking another 9% or 10%, depending on what way you look at it, out of the budget may be the tipping point. It could be the difference between that practice surviving and going to the wall.

Mr O'Carolan: There are nearly 400 practices, so it is difficult for me to comment on what the business model for each one is and what their profits are. Fermanagh is the area in which we had the highest access problem. So practices were doing extremely well financially.

Mr Wells: Let us say Ballycastle rather than Belleek. You understand the rurality issue. Will your proposals leave rural communities without a service because this is simply the tipping point? Will some practices be lost?

Mr O'Carolan: In 1993, the Government implemented a 7% cut across the entire GDS. All fees were cut by 7%, but practices did not go out of business then, be they in rural or urban areas. That is the only recent example that I can give. The reason for that was that profits are reasonably healthy in dental practices. We monitor their profits year on year. Last year, the average profit for a practice owner was £123,000 before tax. We will continue monitoring to see whether it drops significantly. I do not know what individual incomes are, as those vary from practice to practice. On average, according to our most recent figures, dental practice owners still make healthy profits.

Mr Rooney: Part of the purpose of the consultation will be to hear views generally on issues such as the potential impacts of changes arising from the proposals. As Donncha says, we have no evidence of specific cases in which they would create the sort of problems that were outlined earlier. Clearly, the aim of the engagement will be to hear views about the issues from the profession.

Mr O'Carolan: Ballycastle was a good example. In 2008 or 2009, I think, a practice owner in Cushendall was retiring, and he was running into problems of continued viability. When he approached what was then the Northern Board and asked whether it could help, it put a salaried dentist into that practice. So there is a mechanism in place to address problems in those isolated rural areas as and when they arise. The options were that the dental practice in Cushendall closed or that the board intervened and provided help through funding from the Department. That is the only recent example of a practice owner coming to the board for economic or logistical reasons. It is sometimes harder to recruit into more isolated areas.

Mr Dunne: How many dental practices are there in Northern Ireland?

Mr O'Carolan: The most recent figure that I saw was 394. It changes because practices close and new ones open.

Mr Dunne: Is it your impression that there are too many dentists?

Mr O'Carolan: Well, it could always be argued that there are too many. However, without 100% registration, how could that be said? Three or four years ago, there were significant access problems.

I have spoken to the board on several occasions recently, and it has told me that it is not getting complaints about access, which seems to be good in most parts of Northern Ireland.

Mr Dunne: It has definitely improved. How successful have the Oasis Dental Care contractors been?

Mr O'Carolan: That contract has been extremely successful. The tender was announced in the Assembly in 2009, the contract was awarded in spring 2010, and the first practices were open by the end of 2010. The contract was to register 57,000 patients, and, in the midst of the access problem, Oasis could have achieved that immediately. However, in the interim, because competition had arrived, dentists in those areas came back into the health service, which made it more difficult for Oasis to —

Mr Dunne: Was there a change of mind?

Mr O'Carolan: There was a change of mind, yes. It was a classic example of how breaking a monopoly changes the marketplace. There are some areas, particularly in the west, where the contractors have hit their targets, but there are other areas where they have struggled. They are working with the board to vary their approach. So, for example, they are putting extra dentists into areas with high demand and taking them out of areas where demand is low. The contract was to register 57,000, and Oasis has registered almost 50,000.

Mr Dunne: Good. Do Oasis dentists do any private work?

Mr O'Carolan: According to their contract, they are allowed to do —

Mr Williamson: They are allowed to do up to 10% of private work.

Mr O'Carolan: The reason for that is that some treatments are not available on the health service, such as a sports mouth guard or a white filling on a back tooth, so we had to build something into the contract to allow for that.

Mr Dunne: Are you satisfied that the paying public get value for money from dentists' charges? Are prices properly regulated?

Mr O'Carolan: You asked that question in the earlier session. Health service fees are set in the statement of dental remuneration. We and the BDA agree that they are certainly not too high. I think that the fees are reasonable, and the patient pays 80% of those. The charges are transparent: patients can see what treatments are available and how much they will cost. What was not answered in the earlier session — you were trying to allude to it — was the question about the private sector, in which prices are not regulated.

Mr Dunne: Not at all?

Mr O'Carolan: No. It is up to dentists to set their fees at whatever rate they wish. Private dentistry is regulated by the Regulation and Quality Improvement Authority (RQIA) against a set of minimum standards. One of the requirements is that dentists must explain their prices to patients and that patients must be given a verbal estimate. They can also be given a written estimate if they so wish. Government could not set private fees; that is done by market forces.

Mr Dunne: Should the fees not be within set bands or limits.

Mr O'Carolan: I would need to look at the legal aspect of that. It is a private market, and it is a bit like asking whether we could set the private market for private medicine. I do not know whether we could, and it might be beyond our remit to try. The remit of the Department of Health, Social Services and Public Safety is to ensure the quality and safety of patient care. Whether we could —

Mr Dunne: Dentists have a captive market — patients come to them when in pain.

Mr O'Carolan: That is why we included transparency of pricing in the minimum standards. There should also be transparency about the available options, and the dentist must explain those to patients. An Office of Fair Trading (OFT) report that is due to be published also stresses that point. As you implied, when patients are sitting in a dentist's chair, they do not always feel empowered to ask for that information. It is written into our standards, and if dentists do not comply with those, we have a mechanism through the RQIA to address that.

Mr Dunne: I appreciate what you said about the cost of dentistry, whether that is private or through the health service. However, I feel that people are concerned about, and deterred by, the cost of dentistry. You said that you wanted to increase the number of people who go to dentists. You recognise that as an issue and have initiatives aimed at increasing attendance. However, cost is an issue, and how that is portrayed needs to be addressed.

Mr O'Carolan: I have seen an initial draft of the OFT's UK-wide report, and it raises exactly that point. It found that patients do not have clarity on prices, on what is private dentistry as opposed to health service dentistry and on what treatment will cost. The report makes some suggestions about how that information could be made directly available to patients, and we could consider those.

Mr Dunne: The internet should be used.

Mr O'Carolan: Yes.

Mr Dunne: My last point is on root canal treatment, which I have undergone, and it is very painful, before and after. I note that it will not be subject to prior approval. Is that correct?

Mr O'Carolan: Prior approval would be required only from the first molar back. If you have wisdom teeth, you have three molars: top and bottom, right and left. Any other root treatment would not be subject —

The Chairperson: Jim Wells is counting. *[Laughter.]*

Mr Wells: Get it done quickly.

Mr O'Carolan: Prior approval kicks in only with root canal treatment on the back teeth, which is more complex and expensive.

Mr Dunne: So root canal treatment will be subject to prior approval?

Mr O'Carolan: Yes, on specific teeth.

Mr Dunne: Thank you.

Mr McDevitt: I apologise to the witnesses and my colleagues for being delayed. I am interested in the GDS budget. I am reading the table, provided by the Department, showing historical dental service expenditure: is the GDS budget the top line that was £81·8 million in 2007-08, £90·4 million in 2008-09 and £112·9 million in 2011-12? Does that line become the £89·4 million, £91·7 million and £94·2 million in your briefing paper?

Mr Rooney: Yes. You are looking at the out-turn and the budget allocation for the next three years.

Mr McDevitt: Is the budget allocation what you call "Dental Services" in your out-turn table and what you call "General Dental Services" in your briefing paper? Is that correct?

Mr Gibson: No, the budget allocation is the smaller of the two figures. What you have is total expenditure less any receipts that come in: the budget will be net of any receipts.

Mr McDevitt: So you have projected receipts for 2012-13 as well.

Mr Gibson: Yes.

Mr McDevitt: How much in receipts is included in the £89·4 million for 2012-13?

Mr Gibson: £17 million.

Mr McDevitt: And in 2013-14?

Mr Gibson: That amount would be along the same lines. We are looking at the net rather than the gross figure and *[Inaudible.]*

Mr McDevitt: Will it be the same —£17-odd million — in 2014-15?

Mr Gibson: Yes.

Mr McDevitt: I want to make sure that I am not misreading the paper, on the basis of which, there is no difference in out-turn. You are telling me that the "Dental Services" line in your briefing paper is the same as the "Dental Services" line in the additional paper, which is the before income figure.

Mr Rooney: The line in our briefing paper that denotes "Total Outturn" is a net line because it reflects income. The allocations for the next three years are also net line figures.

Mr McDevitt: Therefore, there is no change in the budget.

Mr Gibson: The budget does change: it increases over the next three years, including this year.

Mr McDevitt: What will be the real change in the year-by-year budget over the next three years?

Mr Gibson: It increases from £89·4 million in 2012-13 to £91·7 million in 2013-14 and then to £94·2 million in 2014-15.

Mr McDevitt: To which figure for 2009-2010, 2010-11 and 2011-12 does that projection relate?

Mr Gibson: The 2010-11 budgeted figure was about £87 million, and the 2011-12 figure was about £87·4 million.

Mr McDevitt: I have a bit of a problem, because I do not have any of those figures in front of me. The figure that I am looking at for 2010-11 is either £107 million or £89·9 million, depending on which row it is in. The figures in the additional paper are £107 million for dental services and an out-turn of £89·9 million. I have been out of the Health Committee for a while and so have not read up on the Department's budget recently, but I cannot recognise the figures that you guys are describing.

Mr Rooney: The figures that you have show £107 million for dental services in the year 2010-11 and a total out-turn of £89·9 million after income is taken into account. The latter figure is the net out-turn in expenditure.

Mr McDevitt: Yes.

Mr Rooney: The figures for the next three years are the budget allocations. So the Department has an overall health budget, of which £89·4 million has been allocated to general dental services. That is a net position that assumes that there will be some income.

Mr McDevitt: When does that income of £17 million take you up to?

Mr Gibson: May.

Mr McDevitt: So there is a small but not significant change. How can you assume the same level of income against a static budget? What model have you used to assume that dental income will not change over the next three years?

Mr O'Carolan: Historically, the pattern of patient fees shows that that has not happened. I recently gave a presentation on this, and patient fees, at their lowest, produced about £15 million; at their maximum, they produced about £17 million. The figure has stayed relatively static. The private market is one reason for that. People who pay for their treatment have been moved into the private market. The other effect has been the economic one: previously employed people are now unemployed, and, therefore, do not pay the patient's portion. So we find that that figure is increasing, but the patient portion has been relatively static. Over the past decade, it has not shot up that much.

Mr McDevitt: It seems to me that the efficiency proposals will have an impact on services. There are potential equality issues concerning communities. Those may be spatial issues, in that the proposals will have less impact on dental services in a city than in a rural area. Would you say that the proposed changes will have an impact on an individual's dental service?

Mr O'Carolan: It is impossible to answer that definitively. Patients who need treatment will go to the dentist. Unless a dentist says that he or she is no longer prepared to treat an individual, the proposals should not have an impact on patients. I could have answered that better five or six years ago, when I would have said yes, because dentists would have said that they were just going to move into the private sector. Since then, although the private sector has not completely evaporated, it has shrunk, so dentists are left with the option of not treating patients and getting no income, or treating them under the new parameters.

Mr McDevitt: Have you conducted an equality impact assessment on the changes?

Mr Williamson: Yes. We have carried out an initial screening, which will be part of the consultation.

Mr McDevitt: What does the screening say?

Mr Williamson: When I carried out the screening — as I said, it will be part of the consultation — I did not predict any differential impact on the section 75 groups.
As this is based on oral health studies —

The Chairperson: Conall, I asked that question before you came in. We will deal with the EQIA at a later date.

Mr McDevitt: Sorry, Chair, I do apologise. I will refer to the minutes.

I found one line in the allocation of the GDS curious, which is the £3 million to re-equip the school of dentistry. Is it normal that you fund dental education from a service budget?

Mr O'Carolan: Not all investments in dentistry will have come from the GDS budget. The money for the school of dentistry came from the Department's capital budget, and the terminology should have reflected that.

Mr McDevitt: I want to ensure that the Committee is clear on which budget provided the money for various areas, so I will go through the list, albeit that some answers will be obvious. First, the £4 million annually into practice allowance?

Mr O'Carolan: That is from the GDS budget.

Mr McDevitt: The £500,000 annually into vocational training grants?

Mr O'Carolan: GDS.

Mr McDevitt: The £400,000 annually for salaried dental services?

Mr O'Carolan: GDS.

Mr McDevitt: The grant of approximately £500,000 for extending dental registration?

Mr O'Carolan: GDS.

Mr McDevitt: The £1·1 million in commitment payments?

Mr O'Carolan: GDS.

Mr McDevitt: The £3 million into quality improvement?

Mr O'Carolan: That was a split of unspent GDS money and unspent general medical services (GMS) money.

Mr McDevitt: How much from each, roughly?

Mr O'Carolan: £1·5 million.

Mr McDevitt: The £120,000 to fund continuous professional development?

The Chairperson: Boys, it is not a race. You can take your time. You would think that this was a quiz show.

Mr O'Carolan: I am following his pace.

The Chairperson: I thought that it was a tennis match.

Mr McDevitt: I am racing again, Chair.

The Chairperson: He is trying to get in a final training session before the marathon.

Mr O'Carolan: That £120,000 came out of the human resources directorate (HRD) budget, so it was not from the GDS budget.

Mr McDevitt: What about the £300,000 for dental students?

Mr O'Carolan: Again, that was not from the GDS budget; it came from the human resources directorate budget.

Mr McDevitt: The £100,000 for registrar posts?

Mr O'Carolan: That is also from the HRD budget.

Mr McDevitt: The £5·7 million to fund the additional dental services contract to improve access?

Mr O'Carolan: That is from the GDS budget — the Oasis contract.

Mr McDevitt: Just for the record, the £3 million to re-equip the school of dentistry?

Mr O'Carolan: General capital.

Mr McDevitt: The money for occupational health services?

Mr O'Carolan: It is met within existing resources from headroom in the medical occupational health budget.

That information was lifted from a presentation that we gave to the profession to demonstrate the broad investment from the Department into dentistry. Sorry if that misled you, but not all investment was from the GDS budget.

Mr McDevitt: Thanks, Donncha. Apologies for the speed, Chair.

The Chairperson: Did you ever hear that wee saying?

Mr McDevitt: No, you have not said it.

The Chairperson: OK, I will not say it.

A lot of issues have been raised. You are probably aware that we do not have a Committee view on this, as we await further information. A key issue is that of the proposals going out to public consultation. We will look at the EQIA under a different agenda item. On the back of the pharmacy judicial review, there was an issue about the impact on wages in pharmacy. The judge was critical of that in his review. Could the same thing happen with dentistry?

Mr Williamson: You are referring to the regulatory impact assessment, which we are carrying out.

The Chairperson: So some lessons were learned.

We have had a long discussion, and it is important that the Committee is kept up to date. We probably need, as quickly as possible, to know the exact date of the proposals going out to public consultation. May was mentioned, and I know that it is only the start of May, but I ask you to let us know what is happening with that and to forward any information that we have requested. On behalf of the Committee, thank you very much.