Amalgam costings

May 2024

Overview

The full financial impact of an amalgam ban is difficult to pin down precisely, but it is imperative that DoH arrives at a fully informed approach to calculating all costs that would be incurred by general dental services (GDS) in Northern Ireland.

It is BDA's view that the Department's estimated c£3.6m falls far short of the true financial impact of an amalgam ban on practices here.

BDA has asked its economic analyst to undertake some costings work to assess the cost – not just in terms of the cost of extra clinical time incurred, plus the increased cost of materials – but to also estimate the level of displaced private earnings. This is the only true picture which takes cognisance of all financial impacts at practice level if we moved to a ban, and therefore which must be fully mitigated.

We refer to acceptance at European level in the passing of an amendment which states that Member States should mitigate the impact of an amalgam ban on practices:

'To limit the socio-economic impact of a shift to mercury-free fillings on the costs of dental care for patients and dentists, Member States should endeavour to ensure appropriate reimbursement is made available for mercury-free alternatives. The phase-out of dental amalgam should be accompanied by professional training for dentists, where appropriate, in order to adjust to new techniques'.

Our latest costings work show that Department of Health should be budgeting in excess of £20m - a total cost of approximately £22m/£23m for impact on GDS alone per annum.

What follows is our rationale on how we have arrived at this figure, which we ask DoH to fully consider in the work it is doing in this important area.

The larger sum quoted is what we estimate would be required to avoid ***any*** adverse impact on practices/practitioners from an amalgam ban, to include the impact of

displaced private earnings, and in moving to pay fees at a reasonable and sustainable level. It is based on the following factors:

- The extra time taken to place non-amalgam fillings; DoH is on public record as saying it takes x3 times longer to place a non-amalgam posterior filling compared to amalgam.
- BDA estimates that if composite were used now, going by 2023 volumes it would take an additional 40,000 hours which equates to 89,000 treatments lost annually.

Displaced private income

- BDA estimates the total revenue generated by private composite fillings at present to be £19,549,795.00, moving to a non-amalgam era would displace this private income for dental practices.
- As private fees range between 2.5 and 3 times the amount of typical NHS fees, and because private fees are valued appropriately, this could mean a net loss of private income as high as £13 million.
- The c£19 million for composite fillings is calculated using the reduction in amalgam IOS from 2016 to 2023 and converting the appropriate codes to the average composite fees for similar fillings as per a survey of published private prices.
- If composite fillings are included under the SDR, this would be the net loss of private income as only a third of the private fee price would be paid, based on the SDR fees.
- The net loss per practice depends on each practice profile.

Potential costs to government

The current NI spend on amalgam fillings is around £3.8 million.

If the composite replacement fillings were brought under the SDR, there is potential for a serious gap in funding at practice level if the fees are not representative of the cost to practices due to the added length of treatment and associated complexities.

We believe it would be wholly inadequate and unreasonable if the composite fees in a non-amalgam era were remunerated at the current SDR posterior fees; we estimate there would be an additional £3.7 million required to fund at the same level (a similar figure being quoted by DoH).

If the overall cost difference would represent an additional £3.7 million on top of what is currently spent on fillings on the SDR, the budget would be approximately £7.6m. This has been estimated using current treatment volumes and the fees available for both composite and amalgam on the SDR.

However, if renumerated at this amount then the basic costs of this treatment would not be adequately covered and inevitably practices would leave

Actual costs

This is what BDA estimates as the *actual* cost based on our timings study and our assessment of expenses.

This takes into account that currently NHS treatment is considerably underpaid in relation to costs and when compared with private.

Posterior composites must be renumerated more accurately, fairly and at an adequate level. We estimate the cost for the new fillings to be between £22 and £23 million – based on current treatment volumes, historic treatment volumes, a survey of NIDPC members and by research on published fees.

If these costs are not remunerated accordingly all our research points to the end of health service dentistry.

Summary

It is clear there is urgent work to be done by DoH in terms of analysing its figures, to measure and mitigate the *actual cost* to dental practices of an amalgam ban from 1st January 2025.

We are deeply concerned that the Department's estimate of c£3.6m for GDS falls far short of the actual cost to provide care, the time involved to provide care, the considerable impact on practices of displaced private income and the funds needed to stabilise the service.

Practices - and practitioners - should incur no financial detriment in relation to developments around amalgam outwith their control. DoH, liaising with UK colleagues should ensure this is the case by supplying fully costed, realistic data for purposes of putting mitigations in place.

Of course, it remains the BDA position that we should adhere to a phase-down approach which is properly funded and supported to improve population oral health, to introduce a properly funded, prevention focused GDS contract, and which enables us to continue to move away from amalgam use while putting the service on a sustainable footing.

These additional costings do not include the extra investment that would be required by DoH into aforementioned population oral health/prevention initiatives and reform of contracts/increased dental workforce, training required that are

prerequisites of a phase-out of dental amalgam according to our unique circumstances.

The priority is to find a workable solution for NI that avoids any further detrimental impact on oral health provision, such as a scenario where additional costs are not fully and adequately mitigated, and which could precipitate collapse of a vital public service.

We urge DoH, in working with its counterparts at national and EU levels to not only aim to mitigate the very live threat, but the ideal scenario would be if we can seize the opportunity to fully fund the reforms and modernisation needed in the service to put HS dentistry on a sustainable financial footing, and to invest in population dental public health.

<u>Action:</u>

1. We would ask DoH to fully consider revised BDA costings. We would be happy to facilitate DoH to engage with our economic analyst to further work through costings.