Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Funding for Dental Services: British Dental Association Northern Ireland

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

Witnesses:

Ms Claudette Christie	British Dental Association Northern Ireland
Dr Peter Crooks	British Dental Association Northern Ireland

The Chairperson: I welcome Ms Claudette Christie and Dr Peter Crooks to the meeting. Thanks very much for coming and for your briefing paper to the Committee. I will hand straight to you for the presentation, after which we will have questions and comments from members.

Dr Peter Crooks (British Dental Association Northern Ireland): Thank you very much for giving the British Dental Association (BDA) the opportunity to come before the Committee. I am chair of the Northern Ireland dental practice committee, and Claudette Christie is the director of the British Dental Association in Northern Ireland.

We are here today because the Department of Health, Social Services and Public Safety (DHSSPS) proposes cuts to health service dentistry. Its proposals would reduce the allocation per patient for health service dental care in Northern Ireland. Effectively, they would cut spending on dental services to patients by 9% in a single year by taking £7·7 million from the £84·1 million currently used for patient treatment, patient registration and dentists' commitment to the health service. The BDA opposes the cuts and urges Committee members to oppose the cuts and their impacts on oral health and the dental service that the public require. We need your help to oppose the cuts.

At present, some 1·12 million people in Northern Ireland are registered as health service patients with a dentist. The health service is where most people receive most of their dental care most of the time. They receive their dental care on the high street from any of the 1, 010 dentists in Northern Ireland's 380 or so dental practices.

In 2010-11, the gross cost of health service dentistry, including charges from patients, amounted to £105 million. In that year, that amount went towards supporting the health service aspects of a Northern Ireland-wide service comprising more than 3,000 specialised staff, 380 or so premises and the health service care of more than 1 million people. In such an efficient service, any cut anywhere — particularly one of the size proposed — would lead to an unavoidable reduction in the service available and a consequentially detrimental impact on the population's oral health.

So what is a budget cut? Cuts can come about in a variety of ways. At the end of March 2011, there were 1 million registered patients. In the past 12 months, the dental service has experienced a 10% increase in that number. If fixed funding is applied based on the number of patients, and funding does not match an increase in patients, that is a cut. That is what the Department proposes for health service dentistry.

Northern Ireland's oral health record is already poor. At the launch of a major fluoride trial just last week, we were reminded that a typical five-year-old in Northern Ireland has an average of two and a half decayed teeth. That trend does not stop when children reach secondary-school age. Our 12-year-olds have more than double the UK average level of decay.

In 2007, the Minister in the previous Assembly produced a package for assisting access to health service dentistry in Northern Ireland. Assisting access helped to address poor dental health, and great progress has been made. Now, more health service patients than ever before are registered with dentists. The number of children and adults registered with a dentist has never been higher. Demand for health service dentistry continues to increase. More people have more teeth than ever before. Patient registrations are up 10% in the past year and 26% over the past two years. However, the cuts proposed would undermine all that progress.

In a situation such as this, I would expect the Department to highlight to you the additional pressures on the general dental services (GDS) budget due to the increased number of patients, dentists and dental practices, as well as the rise in orthodontics and health service dentistry. For the Department, this is primarily about spending; for patients and dentists, it is primarily about oral health and health service dental care — its availability, provision and timeliness. The DHSSPS solution is to restrain future dental expenditure. Therefore, just as we are succeeding in increasing the public's engagement with dental services, the proposed cuts would dash our success. Cuts on this scale cannot be made without slashing public expectations of oral health, the availability of care and what the health service provides.

I have no doubt that the Department will insist that patients would not be negatively affected by the proposals. Indeed, in a recent written answer, the Minister advised that the proposals would maintain:

"a core of services under the health service to protect and maintain the oral health of the population".

The Minister said that, where clinically necessary, all treatments currently available on the health service would remain so — so far, so good. However, what concerns dentists is that, under the proposals, when a patient presents, instead of proceeding with the clinically necessary treatment, a dentist would have to seek approval from the Health and Social Care Board (HSCB).

I will give you an example: a patient comes to me with a painful molar tooth. After discussing the available options, we decide that the best clinical outcome is to save that tooth through carrying out a root canal treatment. Undoubtedly, the patient asks me whether he or she can get the treatment on the health service, and I have to say that I do not know because I have to seek approval to carry out and complete the treatment.

That would lead to an increase in bureaucracy for me and a delay in treatment for patients, before ending up, I hope, with the same result. That strikes right at the heart of the dentist-patient

relationship and highlights the need for patients to be absolutely clear about what the health service will and will not provide for them.

The proposals would inevitably create a barrier between patients and health service dentistry. Patients would lose confidence in their dentist's judgement if they saw it being questioned by increasing bureaucracy. Unless the Health and Social Care Board intends routinely to overrule dentists' professional opinions on what is clinically necessary for a patient, the proposals will not produce any savings. They would produce savings only if the Health and Social Care Board intended routinely to overrule. What they would produce, however, is increased bureaucracy and delay.

The Department needs to be honest with the public about what it proposes, because all patients believe that they are special and that their clinically necessary health service care should not be prevented or delayed. What the health service provides must be made absolutely clear to patients and the profession. The Department may give the impression that the changes will minimally affect the service that patients receive, but it must make clear to patients that it is driving the changes. Otherwise, patients will take out their frustrations with health service dentistry on dentists.

The cuts would also make dental practice much more difficult. Dentists are highly skilled clinicians who employ highly skilled staff in maintaining standards for patients. They run small businesses and invest their own money in buying, equipping and running the practice. Unless health service dental practices remain viable, they will not be able to stay in business, and their patients may struggle to get dental care. The escalating cost of running a dental practice is one of the great challenges facing dentists at present. The DHSSPS has introduced a practice allowance to help dentists with their costs, and that money continues to be extremely welcome. However, since that fund was introduced, the Department has placed a raft of new policy requirements on dental practices, all of which come with associated costs. Dentists have to find funds for running costs and for the buildings and equipment that they are expected to provide. You may think that those costs are all covered in the health service fees that dentists receive. However, over the past three years, the fees for health service dental care have risen only slightly — by 0·5% this year, the same the previous year and by just over 0·2% the year before that.

The truth is that health service dentistry is constrained by rising costs set against fixed fees. Over the past three years, dentists have had to absorb cost increases of over 10% in health service dentistry. We realise that times are tight, but there is no scope to enact the proposed cuts without severely damaging the service provided by Northern Ireland dentists. The sweeping changes proposed by the Department threaten the viability of many dental practices that operate largely in the health service.

The BDA recently prepared a case study document that examined the effect that the cuts would have on individual dentists and on health service dentistry as a whole. It is impossible fully to anticipate or quantify all the ramifications of the proposed changes, but we conclude that they would be catastrophic for many practitioners. We fear that they would severely impact every aspect of dental care and health service dentistry. The Department has no mandate for its proposed changes to dentistry, so we believe that it is vital that it consults thoroughly before introducing any such changes. Cutting the dental budget now would have health repercussions for decades to come. The cuts would inevitably lead to an increase in oral health problems and, in turn, a need for greater spending. The public have a right to know what is proposed, and Northern Ireland's dentists should be given the opportunity to have a say in how limited resources should be used to deliver the best possible oral health outcomes for patients.

Again, we urge the Committee to oppose the cuts.

The Chairperson: Thanks very much for your presentation, Peter.

Over the past weeks, I have been keen to have officials from the Department here to listen to presentations that relate to it. That serves the purpose, should members ask leading questions, of making the Department aware of what answers we are looking for when its witnesses come to the table. Although they may not have all the answers with them, they will be aware of where we are going with our questions, which cuts down the time that the Committee spends chasing back and forward to get answers.

What impact would the proposed cuts have on the assisting access to dentistry policy, which has been out for only — how long did you say?

Dr Crooks: It was a very valuable policy, and, as I said in my presentation, access has increased by 26% over the past two years. The increase has been phenomenal, with a rise of more than 200,000.

Ms Claudette Christie (British Dental Association Northern Ireland): In September 2007, the then Minister recognised that access for patients was an issue and announced a package of funding to help dental practices to provide more access to the public. The consequences of providing greater access are more service, more prevention, more people treated, more care, more awareness, and so on. At that point, a raft of proposals was made, including a practice allowance. Subsequently, however, the value of funding has increased, but so has the raft of policy requirements that dental practices are being asked to implement. So the funding that is available is being outstripped by the demands being made upon it, leaving dental practices pretty much back where they were in 2007. The funding available is simply insufficient to meet the demands on it.

The Chairperson: Your briefing paper states that the proposed cut to the budget would restrict future health service dental care and that the BDA expects that oral health problems would increase as a result.

Ms Christie: Absolutely.

The Chairperson: Peter, you mentioned root canals. If you told a patient tomorrow that he or she needed root canal work, what would happen? Would you do it there and then or would another appointment have to be made?

Dr Crooks: There are different opinions on that. Some people take two or three visits to try to ensure that everything goes OK. There is some current thinking that a root canal can be done in one go, but it is a complicated treatment, and, personally, I prefer to do it over two or three visits.

The Chairperson: I would hate you to be my dentist.

Dr Crooks: I would not mind you being my patient.

Ms Gildernew: Do you two want us to leave the room? *[Laughter.]*

Dr Crooks: At the moment, we can go ahead with the treatment. I have carried out molar root treatments on teenagers. Under the proposals, if a teenager came to my practice with a sore molar tooth, I would have to say that I could help out with some treatment but that I needed permission to complete it.

The Chairperson: That is why I asked the question. The requirement to ask for permission could lead to another visit, which, in turn, would lead to increased administration costs.

Dr Crooks: It would inevitably do so, because a requirement for prior approval means that we are not supposed to complete a treatment without it. If we did, things could get uncomfortable and questions might be asked of us. Currently, it takes some weeks to get approval. In fact, some dentists say that it takes months. In the meantime —

The Chairperson: — somebody could be in pain.

Dr Crooks: We can help to alleviate pain, but the problem is that the bacteria inside the tooth that is causing the problems could change, and the longer treatment is delayed, the less the likelihood of a successful outcome. There is no doubt about that.

The Chairperson: What services would be restricted or impacted?

Ms Christie: The Department has set out in its proposals what services it intends to impact. Essentially, the Department wants to move to a policy through which the simplest types of treatment are approved. Think about the clinical aspects of something that can happen to you. You may have, for example, a missing tooth. The options are not to replace it at all; replace it with a simple plastic denture; replace it with a more complex metal denture that is healthier for the mouth; or replace it with a bridge that is fixed in place and attached to the teeth. The bridge option requires a different process, but the result is a fixed replacement that does not come out like a denture. You could also have an implant that is fixed into the tooth and gum. The dentist concerned would have to refer to the health service, say that he or she had discussed treatment options with the patient and recommend one of those options. The health service favours a plastic denture, I believe.

Dr Crooks: Yes. Under the proposals, metal dentures would require prior approval, whereas we have always been told that they are preferable to plastic dentures.

Ms Christie: Essentially, it means that a dentist cannot look patients straight in the eye and tell them what is being offered because they do not know. That creates confusion, bureaucracy and delay for patients, and patients bring that back to the dentist.

The Chairperson: Yes, but there was also an issue a number of years ago, especially in the rural community, of people not being able to access dental facilities. There needs to be a balance.

Ms Christie: Absolutely.

Dr Crooks: The implementation of the policy to increase access to dentistry was very successful. However, I am not convinced that it was realised at that time —

The Chairperson: — how successful it would be?

Dr Crooks: Yes, and that has caused difficulty. "More dental activity" is the phrase often quoted to us. Someone should have foreseen that an increase in funding would be required to match the success of the policy.

The Chairperson: A number of members have indicated that they want to ask questions. Any others who want to do so should let me know as quickly as possible.

Mr McCarthy: What we have heard is unbelievable. As I understand, there was a success story in 2007 when the investment was made. All elected representatives around this table had been inundated with people who could not access a very simple service. The investment was made, and now you are telling us that its success will be undone. That is undoubtedly what is happening, given what you said. Who at the head of the Department is crazy enough to go back to where we were? I do not want people coming to my constituency office every day, crying because they cannot get a dentist.

Dr Crooks: The policy has been very successful. As I said, there are more practices, more dentists and more NHS activity. The Department tells us that it does not have enough money. It feels like dentists are being told, "I tell you what: you have done all this work and seen more patients — you take the hit."

Mr McCarthy: The report issued at the beginning of the week, or maybe last week, stated that Northern Ireland had the worst oral health in Europe, or maybe it was the UK.

Dr Crooks: It is certainly the worst in the United Kingdom.

Mr McCarthy: The consequence of what is proposed now would be to set us back even further, unless someone comes in and says —

Dr Crooks: I cannot see that it will help.

Ms Christie: Arguably, one of the benefits of the policy to increase access was that it raised public awareness of the benefits of good oral health, the need to have good oral health and the benefits of dental attendance. Suddenly, the public warmed to that, took the message on board and responded to it in their droves. Registrations increased, and people had a big appetite for what the health service offers. The public will be the ones who have the rug pulled from under them, because they are now looking for the service. They are much more aware of it and much more conversant with what it offers.

Mr McCarthy: Finally, this is all about saving money, and we want to save money as best we can. Is there anything that dentists can do, or are doing, to save money? What is the threat to the structure of dental practices? If the proposals go ahead, will there be closures in my town and everybody else's?

Dr Crooks: You are absolutely right: the aim of the proposals is not to spend more. They are being suggested to make savings, so there will be less money around. What are dentists doing? We continually look at what dentists can do. We run small businesses, and we have every interest in trying to keep our businesses alive and viable, so we try to keep our costs down. Unfortunately, this year, for the first time ever in my 25 years as a practitioner, I could not give my staff a pay increase. We are trying to tighten our belts, but the cost of dental materials alone in 2010-11 went up by 9·6%, while fees went up by 0·5%. We have every interest in trying to keep our costs down.

Some measures have been very welcome. Recently, I received a lower rates bill because of the help for small businesses. There will be help with some allowances but costs are spiralling, no matter what we do. We are doing our best.

Mr McCarthy: Finally, Chairperson, bureaucracy —

The Chairperson: I thought that you said "finally" a minute ago.

Mr McCarthy: Yes, but this is so important. Surely the proposals are moving things in the wrong direction if they mean that you, as skilled practitioners, would have to ask permission to carry out a particular treatment. That is bureaucracy gone mad.

Dr Crooks: Prior approval for some treatment items has been necessary for some time. However, the proposals increase the number of treatments that require approval, so that we would have to ask for permission to go ahead with treatments not previously regarded as exceptional — that is the big change — and the delay in the process could be detrimental to patient care.

Mr McCarthy: Thank you, Chairperson.

The Chairperson: Are you sure that you have finished now?

Mr McCarthy: Do you want me to go on?

The Chairperson: No, you are OK.

Mr Wells: In 2007-08, the total budget was £66·7 million. In 2011-12, it was £95·4 million.

Ms Christie: Are you sure?

Mr Wells: Those figures are from the table provided by the Department. If that is the case, it certainly does not suggest to me a Department acting Scrooge-like with the members of the BDA. In fact, that is a 50% increase.

Ms Christie: It is all about activity. Dental services are paid for according to the amount of treatment carried out. Dentists are paid for providing treatment. That is the basis of the payment system. They are also paid for the number of patients registered and an amount in allowances, which includes the practice allowance. There are other small factors, on which I will not go into detail, but the crux of the

payment system is payment for items of service, meaning treatment, and the associated registration payments.

It is important to note that dentists are paid to treat patients. At any one time, one dentist can treat only one patient. Dentists cannot carry out more treatment than time allows, and they can only work as fast as they can work. The whole dental budget is centred on the number of patients who are treated. Obviously, if there are more patients being cared for, that will have a bigger call on the budget. That highlights one of the issues with the dental budget, which is that it is demand-led. When patients demand health care service care and receive it, the budget is dedicated to paying for it. It just means that more activity was paid for; it does not mean that the value for money remains the same. Dentists cannot work faster.

Mr Wells: Equally, the Department cannot have a completely open chequebook and meet all demands.

Ms Christie: Of course not.

Mr Wells: Am I not right in thinking that, when the economy was booming, one of the reasons why people such as Mr McCarthy's constituents had difficulty in registering with an NHS dentist was that many dentists decided to pursue a more private-based business model? Now, of course, with the downturn in the economy, fewer people can afford to go private, and there has been an increase in the amount of NHS work being done. To some extent, therefore, the dentists are the architects of their current situation. Four or five years ago, when the economy of Northern Ireland was booming, many dentists were not interested in any form of NHS work. They wanted the more lucrative private work. Is that not why we are in the situation that we are in today?

Ms Christie: It is a dual situation, as patients were also demanding more aesthetic treatments. Dentistry is a service industry, so if the patients demand the service, the dentists will supply it. When the patients no longer demand it, the dentists will not supply it. Dentists have to work with their patients. Remember that patients, too, were experiencing a time of increased economic activity and so demanded different treatments. The dental service delivered it to them.

Mr Wells: Is it really the role of the taxpayer to pick up the bill for treatments such as cosmetic veneers, bridges and cleaning? Those strike me as services that, frankly, people should pay for themselves because they are not essential to the oral health of the community. They are add-ons that are nice to have, and, if the state pays for them, that is great. However, cosmetic veneers do not strike me as essential to a person's health.

Ms Christie: That is your view.

Dr Crooks: Maybe I could answer both of your questions. You mentioned a 50% increase in the budget, although it is maybe not quite that.

Mr Wells: It is more.

Dr Crooks: I have already explained that, in the past two years, the number of patients has increased by 26%.

Mr Wells: So you are quids in.

Dr Crooks: Treating more patients leads to an increased cost. You mentioned scaling and polishing. In 2007, the 'Oral Health Strategy for Northern Ireland', which was a really good document, recommended:

> *"Oral health professionals should ensure that they effectively communicate to patients the importance of good oral hygiene".*

Your Department wrote that, and it is tremendous. I am not convinced that saying that we should not provide a scale and polish more than once a year meets that recommendation.

Mr Wells: We are not saying that.

Dr Crooks: Another target was:

> *"To reduce the proportion of dentate adults with visible plaque present on their teeth from 66% to 50%".*

That does not mean our not providing professional cleaning and polishing, not giving the oral health messages and not encouraging good oral health. Part of our job is to strive for excellence.

Mr Wells: Nobody is stopping you doing anything; they are stopping you expecting the taxpayer to pick up the bill. If someone wants their teeth cleaned professionally more than once a year, they can pay £30 and get it done. No one is stopping anyone doing that, and no one is stopping you delivering that service. However, to me, the fact that someone does not get their teeth cleaned and made to shine brightly will not, in my opinion, lead them into ill health. It is a nice add-on, but it is not essential. Surely, if we are to spend £94·7 million, which is more than a 50% increase in the budget, it should be on essential treatment that prevents the suffering of pain, loss of teeth or a deterioration in oral health. How do you justify bridges?

Dr Crooks: I will go back to the scale and polish. I think that it is entirely justified to encourage patients to have clean teeth.

Mr Wells: They should pay for it. What is wrong with people reaching into their back pocket and paying £30 to get that done?

Dr Crooks: If it is essential, should the health service not pay towards that? Are you advocating that patients should go private?

Mr Wells: I do not believe that having teeth polished more than once a year should be paid for from the NHS budget. If people wish to have it done, after the first treatment, which is free, they should pay for the second and third treatments. Equally, cosmetic veneers may make me look like a film star, which would be difficult at my age, but I can try, and I envy young people with fantastic teeth, which I do not have. However, I expect that my wife, kids and I should reach into our back pockets to pay for such treatment. We are not stopping you doing anything. You seem to be saying that the Department is proposing that you must not shine people's teeth or put in cosmetic veneers or bridges. It is not; the Department is saying that you should provide the basic treatment and that the patient should pay for anything on top of that. In the present economic situation, I cannot see what is wrong with that approach.

Dr Crooks: If a treatment was purely cosmetic, like getting your hair trimmed, I would agree. This is more about looking after people's oral care.

Mr Wells: It is more about how they look, full stop.

Dr Crooks: I do not agree, but that is your opinion.

Mr Wells: Most people believe that the 50% increase was very generous. We are now cutting back on some of the non-essential add-ons.

I have to raise a very difficult issue, and you would expect me to do so. Two years ago, the 'Belfast Telegraph' published a list of payments to NHS dentists in Northern Ireland during the boom. Some dentists did exceptionally well and received very large payments. The figure for one practice in Great James Street in Londonderry was about £600,000. That level of payment suggests to me that, far from being restrictive, the Department is, as many people believe, overly generous. Therefore, what is happening now is being done to try to rein in a system that had clearly got out of control.

Ms Christie: I think, Jim, that you also need to recall that the list published on the front of the 'Belfast Telegraph' was an error. If you read the Hansard report, you will see that we have already had this conversation.

Mr Wells: The list was corrected; I am talking about the corrected figures.

Ms Christie: No; those were not the corrected figures, but we can go back and look at that. I am disappointed by that.

As I said, dentists are paid for treatment activity. That, by its nature, is limited because, for each individual patient, dentists need their hands and a dental nurse. Some might work more hours and have dentists working under their list. So the figure that you saw could have been the turnover for more than one dentist. Remember that turnover is what dentists use to pay for all of their business. That figure is not what dentists take away. Out of that, they have to pay for everything that happens inside the practice building from the health service aspect of their business.

Mr Wells: You mentioned consultation. The Minister seems to believe that he is consulting, as we speak, on the proposals. In other words, the BDA and all those in the profession are being consulted, but you seemed to say that it was a done deal.

Dr Crooks: A public consultation that is open to the general public is needed because it will affect them.

Mr Wells: I presume that, if members of the general public write to the Department, their submissions will be taken into account rather than scrapped.

Ms Christie: There is due to be a public consultation.

Dr Crooks: As far as I understand it, that has not yet been opened.

Mr Wells: Paragraph 9 of the Minister's letter states:

> *"The Department is finalising consultation documents and associated impact assessments on these proposals. In addition, to the pre-existing engagement with the BDA, the Department will be consulting on these proposals with BDA, the Patient Client Council, wider dental profession and public."*

It seems to me that proposals are being made and that the Department awaits with interest the responses to the consultation.

Dr Crooks: I do not think that the consultation is open to the public just yet. However, if that is the intention, that is very good, and we look forward to that.

The Chairperson: The paper from the Minister states that consultation will "begin in May 2012."

Mr Wells: So it is not a done deal.

Dr Crooks: I check the website from time to time, and it has not yet appeared.

The Chairperson: We will get clarification on that from the Department.

Mr Dunne: Thank you for your presentation. Is it the case that dentists chose to prioritise private work and move away from the health service and trust work, thus creating access difficulties? Is it fair to make that point?

Dr Crooks: I am sure that there was a time when more private work was done, and, as Mr Wells said, when times became more difficult, patients looked after their hard-earned money more. The access

problem has been addressed, but there is an increasing numbers of patients. As I said, the number has increased by 10% over the past year. That is causing some difficulties now.

Ms Christie: It is important to note that there is a finite supply of dentists. You cannot —

Mr Dunne: Are there too many dentists in Northern Ireland?

Ms Christie: Queen's has an undergraduate school. A large cohort of undergraduates from Northern Ireland study in England or elsewhere. Typically, they come back and work in dentistry, so it is all about supply and demand. Certainly, in times past, it has been hard to recruit dentists.

Mr Dunne: I understand, from the information that we have been given, that there are now more registered dentists in Northern Ireland than ever.

Dr Crooks: We have been told that there are more dentists, more NHS activity, and, as I said earlier, more practices opening.

Ms Christie: There is a public demand for it.

Mr Dunne: What about Oasis Dental Care? What is your understanding of how successful that has been, with 38 practices opening to meet the demand?

Dr Crooks: I am not really in a position to say how successful it is.

Ms Christie: A couple of years ago, the Minister announced that he was applying funding to Oasis dental practices to provide access for 50,000 patients.

Dr Crooks: I do not get input from Oasis at all. Of the 26% increase in patient registration, 21% was with general dental services and 5% was with Oasis.

Mr Dunne: As Jim said, most people visiting the dentist suffer pain twice: before the treatment and when paying for it. That is the public's general impression, so I do not think that the public would have much sympathy for your case. It is important that you sell your concerns to the public strongly.

How strongly regulated are charging policies?

Ms Christie: For health service dental care, the fees for the care itself and for patient charges are set by government, so there is no variety of patient charges in the health service system. You mentioned, for example, the pain felt when a patient pays for dental care, but it is important to note that, at present, a routine six-monthly check-up attracts a fee of £8·80 to the dentist. The patient pays 80% of that, which is about £6·60. Saying that that is inordinately expensive is —

Mr Dunne: Treatment is certainly expensive.

Ms Christie: Treatment is priced in the same way, so a filling that attracted a fee of £10 to the dentist would cost the patient £8. I do not think that —

Mr Dunne: With all due respect, I do not think that many fillings cost £8 or £10.

Ms Christie: There are £17 million of patient charges lifted through the health service, and that is the level of fee paid.

Mr Dunne: Is that the private rate?

Ms Christie: No, health service fees are not private. However, people pay for health service dental work.

Mr Dunne: You do very little health service work.

Ms Christie: No; health service work is the stock-in-trade of the dental profession. Some 1.1 million people receive their dental care under the health service.

Mr Dunne: You moved away from health service work, which resulted in the government having to fund private contracts.

Ms Christie: It is important to note that, as of today, 1.1 million people are registered with dentists as health service patients. So health service dentistry is the stock-in-trade of the public and the profession. That is how most people receive most of their care most of the time. That care attracts patient charges, and £17 million in charges was lifted in the past year.

Mr Dunne: Do the public get value for money?

Ms Christie: Absolutely. The public get enormous value for their money.

Mr Gardiner: Are there any occasions on which people qualify for free dental care?

Ms Christie: Patients under the age of 18 receive free dental care, as do those under the age of 19 and in full-time education. People in receipt of certain benefits or with a valid certificate of exemption, ladies with a child under a year old and pregnant ladies also receive free dental care. Those are the only ones who qualify.

Mr Gardiner: So senior citizens do not qualify?

Ms Christie: No.

Mr Gardiner: I was just wondering.

Mr Wells: Tough luck, Sam.

Mr Gardiner: It is all right — I still have a few teeth left.

Dr Crooks: Senior citizens do not qualify unless on pension credit or something similar.

Mr Gardiner: I do not qualify under that either.

Ms Christie: Yes, they can apply for a means test.

Mr McCallister: It is a pretty staggering statistic that 1.1 million people in Northern Ireland are registered with dentists as health service patients.

Ms Christie: Yes, it is an awful lot, given that many people never go to a dentist.

Mr McCallister: When people who do not go to a dentist and those who go privately are added to that figure, it accounts for most of the population. That means that many people come into regular contact with a dentist.

Gordon made the point that many people might not sympathise with your case. My issue with that is that, if we removed health service dentistry or charged more for it, there would be uproar, given that 1.1 million are registered. The basic message from you guys is that more people have registered and more treatment is being given, but you are receiving less money for that.

Ms Christie: Our costs outstrip —

Dr Crooks: We are here today because the proposals do not reflect the fact that more NHS dentistry is being done, not less.

Mr McCallister: So the efforts to increase access to dentists succeeded.

Dr Crooks: Yes, and our problem relates to that success. I wish that it had been foreseen that this would happen.

Mr McCallister: The increase happened because of the drive over the past four or five years to increase access. In 2007 and 2008, it was a problem for some people even finding an NHS dentist with whom they could register, never mind receiving treatment. So we have been successful in getting to that point. Is anyone waiting to be registered with a dentist? Is there a large group of people waiting?

Dr Crooks: People are continuing to ring practices to look for a dentist.

Ms Christie: There is a big demand. The awareness of oral health issues is enormous, which is a wonderful success. Suddenly, people have become acutely aware of the importance and benefits of good oral health as part of life.

Mr McCallister: Should we be looking at various treatments to determine whether they should be on NHS lists?

Ms Christie: That is a matter for you guys. Jim has given us his opinion on what he believes should —

Mr McCallister: You disagreed with Jim's opinion.

Mr Wells: Not everyone should have wonderful, straight, shiny veneers.

Dr Crooks: I urge that a 16-year-old should have every chance to have a molar tooth saved, if at all possible, without having to go through an approval process and wait for weeks, if not months, to find out whether we can complete that treatment.

Mr McCallister: Surely we could speed that process up. Why does it take weeks and months to get approval?

The Chairperson: We can ask the Department that question. Some people suggest that it does not take as long, and others say that it does.

Dr Crooks: I was talking to a dentist who does not work in my area, but in an entirely different one. He told me that he and other dentists in his practice have had to wait up to six months. I could not believe that when I heard it. It could be that the courses of treatment involved were very complicated. Personally, I thought that it was more a matter of weeks than months, but that is what he assured me. That is anecdotal.

The Chairperson: If you have any evidence of that happening, Peter, will you send it to us?

Dr Crooks: I will do that, absolutely.

Ms Gildernew: Thank you for your presentation. The discussion has been a bit robust, but you can imagine that the next session will probably be equally as robust. At the moment, there are treatments for children for which you have to seek prior approval. You mentioned root canals and treating 16-year-olds —

Dr Crooks: These are proposals for the future; they are not in place at the moment.

Ms Gildernew: So, at the moment, you do not have to seek prior approval. If a child needs treatment, you can supply that under the National Health Service.

Dr Crooks: We can provide treatment for, say, a young teenager who comes to me with a painful molar tooth. If it looks very broken down, it may not be worthwhile, but if it can be saved, we can do that.

Ms Gildernew: OK. If a child came in with a heavy excess of plaque, would a dentist normally carry out a clean, scale and polish without charging?

Dr Crooks: Yes, under the capitation fees, it is free for those children. We can go ahead and do that. We do not have to charge the patient or incur an extra fee.

Ms Gildernew: Is there a set figure for a tooth extraction or a current ballpark figure? That may be an unfair question, but can you give us an idea of how much it would cost to get rid of the tooth without needing any further treatment?

The Chairperson: Go out in Belfast on a Friday night, and it will cost you nothing. *[Laughter.]*

Ms Christie: How much is an extraction? *[Interruption.]*

Dr Crooks: It costs about £14 or so. I defer to my learned colleague in the Public Gallery.

Ms Gildernew: We will hear from the Department next, but it has said that the intention is that the consultation process will begin in May and that the Committee will be notified in advance. It is May now, so there may be news in the later session.

Mr Brady: Thank you very much for your presentation. You said earlier that, when you make a decision for treatment based on your expertise and what you think best for the patient, it has to be approved. Who approves that? Is it a bureaucrat? Is it somebody who knows more than you do?

You talked about a replacement tooth being metal or plastic, and there is, in a sense, a preventative element involved. Presumably, if the job is done right, patients will not have to come back as often and, therefore, money is saved in the long run. That seems a common sense approach. However, as you say, it can take weeks or months for approval. Are the people who make that decision as well qualified as you are? It seems to me that, if not, they are undermining your professional integrity and expertise.

Dr Crooks: They are not as qualified in so far as knowing what my patient looks like, because my patient is sitting on a dental chair in front of me.

Mr Brady: So you have to make a judgement on the best type of treatment for that person.

Dr Crooks: Those making the decisions are equally, if not more, qualified than me. They will have been practising dentists in the past, some longer ago than others perhaps. The aim of prior approval has always been to limit cash flow and costs. A large course of treatment, whether it requires prior approval or not, will sometimes come in above a certain financial level.

Mr Brady: If you make a decision that has to be approved, how much detail do you have to go into? You make a subjective decision based on the patient, and they make an objective decision based on cost. Given that you have decided on the best form of treatment, there does not seem to be any other reason for them to do that. How much detail do you have to go into to convince them? Do they come back to you, say what they think and ask you for a further opinion? It just seems a very drawn-out and bureaucratic process for people waiting for essential treatment that may affect their future health.

Dr Crooks: We can carry out emergency treatment. If a patient is in pain, we can alleviate that and then send off for approval. We will write as full a request as we can. It might necessitate taking impressions of a person's mouth and sending those off. Some dentists might take photographs. It will often involve taking X-rays of teeth, sending in radiographs and trying to provide as full a picture as possible. Sometimes, we are asked for more information and have to send that in. We have been

assured that, if we have to ask for a reapproval, it will be fast-tracked. It all takes time. We are not talking about days.

Mr Brady: How fast is "fast-tracked"?

Dr Crooks: The officers of the board would have to tell you that. I would hope for reapproval within 10 working days.

Mr Brady: It seems a very laborious process to get someone's tooth sorted out.

Dr Crooks: It can be. We are told that approval for complex courses of treatment will take longer. I do not know whether it is laborious for them or not.

Mr Brady: Presumably, given the report on the state of oral hygiene in the North, many patients will require fairly complex treatment because they have not bothered going to a dentist for many years. That is an added problem that you face.

Jim talked about veneers, and so on, and, last year, he talked about doctors giving people prescriptions for suncream. If a doctor is prepared to do that, there is something wrong, and we would have to question his or her professional integrity. I am sure that you do not envisage offering everyone who comes into your practice a veneer on the health service.

Mr Wells: If you ask for it, you get it.

Mr Brady: Maybe in Ballynahinch; certainly not in Newry.

Dr Crooks: Some people have not been to the dentist in a long time and, therefore, need a lot of treatment. The dentist will probably need approval to carry that treatment on to completion. As I say, dentists can alleviate pain, but the approval for full treatment can take some time.

Mr Brady: What you decide is the best course of treatment is based on your professional judgement.

Dr Crooks: What we ask approval for is, yes.

Mr Brady: You do not start with a figure and work backwards. You start by identifying what treatment is required. That seems to me the professional approach, and I am sure that that is the way that you do it. Much of what you do is being undermined by financial constraints.

Dr Crooks: To be honest, there are not an awful lot of complex courses of treatment at present. If a patient has not been to his or dentist for some time, the dentist will have to write for approval. However, as far as we can see, that would happen much more often under these proposals.

Mr Brady: Everybody will not come out with glistening smiles, presumably.

Dr Crooks: They do not come in with glistening smiles, but I hope that they will leave with them.

Mr Brady: They will leave with less pain.

Dr Crooks: A glistening smile is not the priority; good dental health is.

Mr Brady: I was not being facetious.

The Chairperson: I am a bit confused. These are only proposals, and you gave an example of a dentist talking about facing a six-month delay. Maybe you or the Department could give us a list of what has to be approved now and what you believe will have to be approved should the proposals be implemented.

Dr Crooks: What will require prior approval is listed under the proposals.

The Chairperson: Does any treatment require approval now?

Dr Crooks: If the cost of a complex course of treatment is above a certain level, we have to ask for approval.

The Chairperson: OK. We can get that information from the Department.

I understand Jim's point about veneers and other cosmetic treatment. If somebody went into a surgery today with one colour of filling and wanted to continue getting the same colour of filling, might that have to be approved?

Dr Crooks: Do you mean a white filling in a back tooth, for example?

The Chairperson: Yes.

Dr Crooks: Any white filling on a back tooth that involves the biting surface is not paid for by the health service because that is more cosmetic. The patient has to pay for it.

The Chairperson: I know people who have white fillings.

Dr Crooks: If a filling is on the side of certain teeth, dentists can go ahead. However, if the required filling is on a biting surface, that cannot be done on the health service.

The Chairperson: Technically, a white filling could be cosmetic, but might it not be regarded as such if it is to keep a patient's fillings in line with what he or she already has?

Ms Christie: It is important to understand that the health service is, essentially, a set of rules by which dentists must abide. Those rules set out very clearly, and at some length, what is allowed. Typically, at the moment, dentists treat patients on the health service, but the patients are mostly unaware of that set of rules because it does not impinge on them terribly unless approval is required and that leads to a delay. In that event, the rules of the health service would, most likely, impinge on the patient. We must remember that the rules also set out how much patients pay for their health service dental care.

The proposals bring the rules much closer to patients so that more patients would become aware of banging up against health service rules and not automatically being able to have their molar root canal, metal denture or fixed tooth replacement. That is an inconvenience for patients, and they will then bring that anxiety to the dentist. At the moment, we keep them away from that, if you understand me.

The Chairperson: You do not — anybody who has to go to a dentist is very anxious.

Ms Christie: They are not anxious about the health service rules, just about the treatment.

Dr Crooks: Your friends with white fillings on the biting surface of their back teeth would not have got them on the health service. It does not allow them.

Ms Brown: Thank you for your presentation; I apologise for being late. Does the dental expenditure listed in the information from the Department include orthodontic treatments?

Ms Christie: We have not seen that information. However, if it sets out the spend, it will include orthodontics. I can give you the orthodontic spend year-on-year. I have some detail on that.

Ms Brown: That might be interesting. When my kids were younger, train-track braces were almost like a fashion accessory, and they were gagging to get them. Am I right in thinking that orthodontic treatment changed under the previous Health Minister?

Ms Christie: The previous Assembly consulted on a change to orthodontic treatment, but it was never implemented. It is still available —

Ms Brown: On demand?

Ms Christie: Pretty much. It requires approval, but there is no mechanism not to approve it.

Ms Brown: If my 14-year-old has a tooth that overlaps ever so lightly but is not a big deal, can I demand orthodontic treatment for that?

Dr Crooks: At present, that could probably be provided. It may not seem like a big deal to you, but it could be a big deal to your 14-year -old. One proposal is to limit the more minor orthodontic treatments provided on the health service.

Ms Brown: It would be a good saving to limit it in some way. In saying that, all of my three children had train-track braces. My son's teeth were badly crooked. There are huge implications for mental health and well-being as much as anything else. His treatment was a huge success — so much so that, two years ago, I paid to have mine done. It makes a tremendous difference to people's lives. However, I have also heard children talking about waiting to get braces, and I cannot see anything wrong with their teeth. They are looking for absolute perfection. There is a happy medium to be found, and savings could be made. That is essential, as is the focus on oral hygiene. I remember my granny telling me many years ago that her teeth were on display in the school of dentistry as a perfect set, but she had lost them all to gum disease, so oral hygiene is very important.

Dr Crooks: Absolutely. I would like dentistry to progress, rather than going back to those days.

The Chairperson: We can send you a copy of the information that the Department provided to us.

Dr Crooks: That would be good.

The Chairperson: Earlier, somebody — I think that it was Michelle — mentioned dentists offering to clean children's teeth. Are all patients not allowed that?

Dr Crooks: If patients come in with a lot of plaque on their teeth, I would not be comfortable sending them out again without having cleaned them. That is certainly available to my patients. I think that the proposal for an adult is that there will be a time bar of one year, although prior approval could be sought. However, dentists would have to wait for that approval.

The Chairperson: My reason for asking is that the issue was raised with me a number of weeks ago. I was told that not all patients are told that they are entitled to have their teeth cleaned. It is probably something that you need to relay through your members. Sometimes, people are shy when they go to the dentist. They want to get out quickly and do not realise that they are entitled to have their teeth cleaned.

Dr Crooks: So people are not getting their teeth cleaned?

The Chairperson: They are not being told that they are entitled to a free clean as part of their treatment.

Dr Crooks: Was the case that you heard about of a young person or an adult?

The Chairperson: An adult.

Dr Crooks: Adults get free treatment if they are on benefits, pregnant or —

The Chairperson: Their teeth being cleaned is not part of that.

Dr Crooks: I am certainly keen for people to have their teeth cleaned. As I said earlier, we should reinforce health messages and do all that we can to encourage clean —

The Chairperson: Patients receiving dental treatment through the health service are not being told that, as part of that treatment, they can have their teeth cleaned.

Dr Crooks: I would have thought that they should be able to get their teeth cleaned.

The Chairperson: It is probably something that you can take up with your members.

Dr Crooks: Yes. As I said, dentists are being told that, in future, we will be able to clean a patient's teeth only once a year unless we get prior approval.

The Chairperson: You will probably not be able to answer this now, but there is a difference in charges between dentists. There might be a standard price that dentists charge health service patients, but there are different charges for people who pay. How can dentists do that?

Ms Christie: Health service items of service carry a fee set by government. They carry a fixed fee that the dentist receives and a fixed fee for patients who pay for their health service care. It is important to be aware that over 400 separate items of treatment are available through the health service, so everyone's menu is different. There are, for example, three sorts of check-up, each of which carries a different price. Your check-up might be a different sort of check-up, with a different code applied to it, depending on when you last visited the dentist. The same applies to a scale and polish. Each X-ray is individually priced and then it changes. It is not a per-price X-ray; it depends on highly complex factors.

Part of the issue that needs to be addressed is that the current service is not easily understood by patients. The proposals would make it even less transparent. At the moment, Peter cannot look me in the eye and tell me what my treatment will be, because he has to go away and work it out on his computer system. That opaqueness is one of the inadequacies of health service dental care as it stands.

The Chairperson: Are you aware of any practices that did away with health service patients? Jim Wells made the point earlier that, during the boom years, practices did away with health service patients. Now that they are feeling the pinch, they are trying to attract health service patients.

Dr Crooks: We are told that that is part of the problem. The difficulty is that dentists who did more private work in the past are now doing less and encouraging more NHS patients, and that is why we are where we are. I suppose that that is responding to the market.

The Chairperson: It meant that we were faced with a difficulty a number of years ago, because health service patients could not access a dentist. The situation has come full circle.

Dr Crooks: That is why we are where we are. Certainly, patients' expectations are very high. You mentioned folk who have white fillings in their back teeth. Many more people ask for white fillings now than ever before. There is no doubt that people want quality treatment, and they want to like the appearance of that treatment.

Mr Wells: Should the state pay for that? It is a bit like cosmetic surgery: some people would like to get their nose straightened. Undoubtedly, cosmetic dental treatment can help self-esteem, but the issue is whether the National Health Service should pick up the tab. Some of what you are talking about moves away from what is essential to people's health to what people might like as a cosmetic addition. The Department is trying to bring under control the non-essential work, which, of course, you can continue to do and charge people for. No one will stop dentists doing that. So you would lose money only if people refused treatment; if they decided to go ahead and pay for it, you would be fine.

Dr Crooks: The case in point about the white fillings is that those would not be done by the health service anyway. Increasingly, patients want white fillings, but those have to be provided privately

because the NHS does not provide them. However, the NHS should be able to cope with what is clinically necessary.

Mr Wells: Yes, but people's expectations are rising dramatically, as far as teeth are concerned. What do you call the girl from the north-east with the Geordie accent? What is her name?

Mr Brady: Cheryl Cole.

Mr Wells: Everyone wants to have Cheryl Cole's teeth. They want their teeth to be perfect.

The Chairperson: She is your hero, Jim.

Mr Wells: I am a Tammy Wynette man — that shows my era.

Although that is what people want, we cannot meet that demand. Unless we try to bring some control into the system, everyone will demand a perfect smile and want the state to pay for it. I am sorry, but there must be some language that says that it is fine to expect and desire the perfect smile but it must be paid for.

Dr Crooks: I am not arguing for private dentistry. I am arguing against, for example, a situation in which a patient comes in with a painful molar tooth and faces a delay in treatment. I think that a youngster should be able to get the necessary treatment on the health service without a dentist having to write off for prior approval. There are essential forms of treatment that we should be able to go ahead and provide for patients.

I do not expect to provide veneers on the health service for every patient. We have gone off the point of the argument here. I feel that we should be able to provide essential treatment on the health service and, in many cases, without having to ask for permission from a non-working dentist who has not seen my patient and sits behind a desk.

The Chairperson: We will hear from departmental officials shortly, and some of the questions that have been asked will be relayed to them. You are more than welcome to sit in the Public Gallery to listen to that discussion. We will find out from the Department when the consultation will start. On behalf of the Committee, thank you very much.

Dr Crooks: Thank you very much for inviting us.