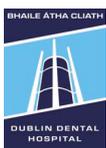




A VISION FOR IMPROVED ORAL HEALTH IN IRELAND

Outcome from the First National Oral Health Forum
November 21, 2013

Report by Professor Jimmy Steele and Edel Hackett
National Oral Health Forum 2013





A VISION FOR IMPROVED ORAL HEALTH IN IRELAND

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1 Foreword by Professor Jimmy Steele, Dean and Professor of Restorative Dentistry, University of Newcastle upon Tyne.

Health care systems profoundly influence health, and health care budgets are always limited. These two simple statements apply to every country and every health service in the world.

As our population ages and the demands on our health services incrementally increase, so it is beholden upon all of us who care about health also to care about how it is delivered and paid for. In times of financial stress these considerations come into even sharper focus.

These simple tenets apply to oral health just as they do to general health. Oral health is different only in the sense that those who provide most oral health care have training in a unique skill set and work in a slightly different setting, but they care no less about the health of their patients than any other clinicians.

This report is the first from an Oral Health Forum convened to capture the views and vision of a group of stakeholders, including clinicians, academics and representatives from across the spectrum of oral health in Ireland. The intention is to try to develop solutions for Ireland, to try to grow an oral health care system that is both good for the population and for those that work within it. As we move forward it would be good to see an even greater input from patients and the public, but this is a first step.

The timing is critical. As Ireland emerges from austerity, getting the vision and building blocks correct, right at the beginning, is critical. The devil will be in the detail of course, but if the basics are wrong, it will be impossible to deal with the detail. This document outlines the vision that emerged and the first steps we may need to take.

Policy is of course a matter for elected politicians, the Chief Dental Officer, the teams who take responsibility for the delivery of health services and the wider population. This document is not intended to interfere with that process of defining policy, but to provide ideas and a considered view about the priorities and opportunities as seen by a well-informed group of stakeholders.

2. Immediate Actions

5 Key Recommendations

- 1. There must be absolute clarity on the responsibilities and relationships of all key stakeholders in oral health. In particular, the roles of the Department of Health and the Health Service Executive (HSE) in the delivery of oral and dental care must be clearly defined.**
- 2. Delivery decisions need to be matched to clinical needs and prioritised in line with the available resources. The role and responsibilities of the HSE in this process requires detailed clarification.**
- 3. Primary dental care should mirror the Primary Health Care Strategy. In order to ensure a dental service with patients at its heart, primary dental care should act as the hub and provide continuity and clear lines of responsibility for oral health outcomes for both the patient and the dental team.**
- 4. Securing and maintaining oral health early in life is an urgent concern (0-5 age group) and consideration should be given to how this can be achieved in an Irish context.**
- 5. There is a clear business case for Foundation Training in Dentistry. This is urgent and critical for the development of clinical patient services, better quality care and patient safety as well as both the education and retention of dental professionals.**

A comprehensive list of action based on recommendations from the Oral Health Forum follows in section 5 of this document.

3. The Big Picture

The Oral Health Forum took place against the following background.

Catalysts for a new Oral Health Strategy

- Dr. Dympna Kavanagh, the Chief Dental Officer (CDO), has indicated that one of her first priorities is the development and implementation of an evidence informed National Oral Health Policy, responsive to the requirements of the Irish population.

The CDO and the Minister for State at the Department of Health have indicated that the oral health policy review will have three components.

- An assessment of the oral health status of the population, taking into account the reduction in fluoride levels in public water supplies since 2007, and the impact of the economic climate.
 - A review of the resources required for oral health services in particular the volume, profile and distribution of manpower.
 - Engagement with the public to assess preferred models of care and delivery with an initial focus on contracted care.
- The Dental Action Plan is now in place for nearly 20 years. It was considered appropriate in 1994 but a new approach is now considered essential.
 - The Dentists Act, which was enacted in 1985, established the Dental Council to safeguard patients by promoting high standards of professional education and professional conduct among dentists. It is now under review. The proposed new legislation will form part of a suite of legislative instruments to ensure greater accountability of all professions within the healthcare sector and to protect the public, according to the Minister of State and the Department of Health Alex White TD (IDA Annual Seminar for HSE Dental Surgeons, 2013).
 - In total, 125 submissions were received by the Department of Health in response to the public consultation on the Dentists Act which ran from June 10 to July 26, 2013.

Oral Health Status of the Irish Public

- A recent Irish Dental Association (IDA) National Survey on attitudes to dentists and dental health (November 2013) found that the dentist is the healthcare professional that Irish people have most contact with, after the GP. Typically, one in two Irish adults visits the dentist at least once a year – that’s 1.7m Irish adults every year.
- The IDA survey found that annual attendees are much more likely to be middle class females under 44 years. Frequency of dental visits show a strong age pattern, declining sharply from 45 years onwards. The correlation between visit frequency and social class is confirmed by the much higher frequency among those with private medical and dental insurance.
- The survey suggests that the economic crisis has had an influence on dental health attendance. 23% of those surveyed have been attending the dentist less frequently since 2010 – in population terms this equates to 760,000 adults. This rises to 26% of those with a medical card; and to 28% of occasional visitors to the dentist (every 2-5 years). Even one in six (16%) of the most regular visitors to the dentist have been attending less often since 2010. Over the same period, visits by the public to the GMP have, on balance, increased.
- The IDA survey also provides some insight into self-assessment of oral health. Three out of five people (61%) said that they understand very well what they need to do at home to maintain oral health. Practically all Irish adults surveyed considered their teeth and gums to be in good health (82%) and beyond that, looking good too (86%).
- However, dental research carried out over the past decade, some of which was presented to the Forum by Dr. Jacinta McLoughlin (Senior Lecturer in Public Dental Health, Dublin Dental University Hospital) would seem to indicate otherwise. A study on the oral health of Irish adults (Whelton et al., 2007) shows that the frequency of twice daily brushing ranges from a high of 71% for 35-44 year olds, to 68.5% for 16-24 year olds to just over 50% for people over 65 years.
- The same study showed that less than one fifth (18%) of young adults were found to have healthy gums. This dropped to 8% for adults aged between 35 and 44 and 7% for those over 65 (Whelton et al., 2007).
- Irish dietary habits are often not conducive to good oral health. A Eurobarometer Report on Oral Health (Special Eurobarometer 330, February 2010) showed that Irish people topped the European Union league for consuming biscuits and cakes often (28% reported eating them often, compared to the EU average of 18%). A Health Behaviour in School Children (HBSC) 2001-02 survey showed that 41 percent of 15-year-old girls and nearly 49% of 15-year-old boys drank a soft drink every day, putting Ireland near the top of a sugary drinks consumption table for 34 countries. Fifteen-year-olds topped the table for eating sweets every day. Members

of the Forum felt that consumption of sugary drinks and sweets daily had more likely increased in the intervening time.

- In a 2012 pan European survey carried out in seven countries (Smiling Europe Campaign, complementing the Platform for Better Oral Health in Europe) over 42% of Irish adults reported that they do not have all of their teeth.
- Inequality remains a trait of oral health, as indicated in the IDA survey, and as set out by the Minister of State and the Department of Health Alex White TD (IDA Annual Seminar for HSE Dental Surgeons, 2013), who said that groups with low income, people with disabilities and those without access to fluoridated water supplies can be vulnerable to poor oral health.

Review of State Dental Services

- PA Consulting was commissioned to carry out a review of the management and delivery of HSE dental services in 2010 (Strategy Review of the Delivery and Management of HSE Dental Services, March 2010). The key findings point to a fractured, often discretionary system without clear leadership, direction or systems of measurement or assessment. Key findings included the following:
 - The public dental service is essentially 32 local dental services with significant variations in priorities and service provision (although it should be noted that changes have been introduced since the report was published).
 - It is very difficult to get an accurate picture of what the Public Dental Service (salaried service) is delivering and for whom.
 - The service operates with significant operational discretion at local level.
 - There has been no national advocate for oral health policy at senior management level to lead the development of oral health services.
 - The salaried service is delivering what it can deliver based on current resources rather than what it should deliver based on an agreed national service model.
- There is a strong sense that oral health policy is not prioritised and not on the national radar in the same way as other health and social care services.
- Since 2009, the numbers of dentists working in the public service, caring primarily for children, special needs and elderly patients has dropped by almost 20%. A moratorium a recruitment in the state sector means that vacant dental positions cannot be filled.

The Impact of the Economic Crisis

- As with all health services, oral health services have had to manage with constrained resources, particularly since the economic crash in 2008.
- The Irish Dental Association (IDA) estimates that the State has removed €400m in dental support from the general public over the past four years in tax relief, cuts to the PRSI scheme and cuts to the Medical Card scheme, amounting to approximately €100m per annum.
- Spending on the PRSI dental scheme has fallen from over €70m to barely €10m per annum, affecting over two million adults. Previously, funding was available for basic or routine items of treatment such as scale and polish, fillings and gum treatments. Removing these supports from amongst the most severely affected citizens in recent times has had particularly serious consequences for their oral health. More than any other policy decision, the ongoing curtailment of PRSI dental care illustrates the impact of the unprecedented withdrawal of state support towards dental care in recent times.
- Services available for medical cardholders have been severely curtailed. Patients who have a medical card are eligible for an annual check, two fillings a year and emergency extractions. Key preventive measures including cleaning and x-rays have been suspended. Dentures and denture repair is no longer provided except in case of a clinical emergency. Root canal treatment is restricted to front teeth and only in the case of an emergency and the great majority of those with periodontal or gum disease cannot access any treatment.

Summary points:

Typically, one in two Irish adults visit the dentist at least once a year – that's 1.7m Irish adults every year.

There is a strong sense that oral health policy is not prioritised and not on the national radar in the same way as other health and social care services.

The Irish Dental Association (IDA) estimates that the State has removed €400m in dental support from the general public over the past four years.

4. Overview of the Forum – A Collaborative First Step

Since 2011, a group of senior members of the dental profession in Ireland, including representatives from the dental schools, the Faculty of Dentistry, the Royal College of Surgeons of Ireland (RCSI), the Irish Dental Association and the HSE have engaged to consider significant issues related to oral health in Ireland.

It became clear that there was a need, not just to consider issues of significance in isolation, but to consider them within the context of the need to develop an effective, progressive and comprehensive oral health strategy for Ireland with a legacy that will extend for decades beyond.

National Oral Health Forum

The first National Oral Health Forum took place on November 21st, 2013. It brought together a broad range of stakeholders in dentistry and oral health, from general dental practitioners to oral hygienists to representatives of the dental service industry. The Forum included delegates from the Republic of Ireland and Northern Ireland, which meant that there could also be all-island comparison and analysis of issues, policies and structures.

The Forum comprised some set introductory presentations followed by group work to address specific issues. After the group work, plenary sessions pulled together the responses from the groups and sought to resolve some very clear and simple recommendations with a view to identifying solutions. The Forum recognised the need to work co-operatively and to look forward. At this early stage in the process the focus was on some very high level concerns that would benefit from early attention.

A Focus on Solutions

The Forum was intended to be a collaborative first step designed to explore, discuss and reach consensus on key issues, which the dental sector agrees should be integral to an effective, and practical Oral Health Strategy for Ireland. The emphasis throughout was on solutions and implementation, not just on strategy.

It was also acknowledged that a mirror exercise to examine the needs and views of the public on oral health and the dental profession was critical to the development of a comprehensive strategy.

This could take the form of a consultative survey or a facilitated event such as the Dental Forum event itself with a representative sample of patients, consumer and patient groups.

Critical Timing

This is a critical time for oral health development in Ireland. The next year provides a window of opportunity to shape and re-imagine the role and position of oral health care, with three important contexts:

- The reform of the general health system has been identified as an important aspect of Government policy. The Department of Health is commencing its first major reform in 21 years.
- The appointment of a part-time Chief Dental Officer is an indication of a commitment to the development of a reformed oral health policy. The Forum members saw this as a positive indication that the Government regards oral health as an important aspect of healthcare in general. However, the Forum strongly advised the need to appoint a Chief Dental Officer on a full-time basis.
- The Dental Bill is expected to be published in 2014. The current Dentists Act has been in place since 1985. This legislative backdrop provides a timely opportunity for the dental sector to have meaningful input into the development of the wider service and drafting of the Bill to ensure that critical issues such as dental regulation, multi-disciplinary service provision and specialisation are reflected in statute in the most appropriate way.

It is opportune that oral health policy and legislation are being reviewed in parallel as this will facilitate a streamlined approach and a comprehensive outcome for the future direction of oral health.

Resources Reality Check

Addressing the Forum, Dr. Ambrose McLoughlin, Secretary General of the Department of Health, said that the country was slowly moving from economic crisis, although recovery would be slow and statutory funding for health care and oral health care would continue to be restricted.

Dr McLoughlin noted that the current cost base, both within the public and private oral health sectors, was not sustainable and that key issues such as skills mix and specialisation within the dental health team would have to be reviewed in order to ensure an effective yet value-driven service to people.

The Forum acknowledged the benefits of better utilisation of skills mix. However, the recommendations made by the Forum were not limited by the background of resource restraints

only. Many recommendations put forward dynamic ways in which current resources could be optimised and supplemented to improve service delivery and patient care.

Holistic Dental Care

There was a consistent observation across the Forum that policy on oral health historically had often been divorced from general health policy.

Oral health must be viewed by policy makers, and the public as part of an holistic approach to healthcare.

Oral health issues are integral to many other areas of health concern. Examples include; poor nutrition, which is a fundamentally important cause of dental disease whilst the reverse is also true in that poor oral health can have a negative impact on nutrition; chronic conditions, such as diabetes, also have a bi-directional relationship with oral health. Furthermore, poor self-rated oral health and poor self-rated general health are closely correlated in many populations, whilst poor oral health is one of the most obvious and certainly one of the most visible manifestations of poor health overall.

In her address to the Forum, the Chief Dental Officer stated that in her opinion the separation of dental services from the rest of the health services was not necessarily a bad thing. It allowed the oral health profession to have its own council and to have autonomy over its own regulation, for example.

Future Proofing – Putting Oral Health on an Equal Footing

There were references throughout the Forum to the lack of political, policy or indeed, public priority given to oral health. The dominant interest in dentistry related to fluoridation and orthodontics, with little or no political representation about issues such as the prevalence, cost or suffering caused by childhood caries, or the provision of specialist services for people with disabilities, for example. When medical card for dental care, which had been in place since 1970, were curtailed there was no public outcry.

As one of the recommendations of a PA Consulting Review of the Delivery and Management of HSE Dental Services (2010) states: “there is a strong sense amongst stakeholders consulted that oral health policy is not prioritised and not on the national radar in the same way as other health and social care services.”

Fostering a Culture of Self-Care

Both of the dominant oral diseases (caries and periodontal diseases) are avoidable to a large degree with good self-care and health behaviours. The Forum agreed that a fundamental role of primary care was to help foster good self-care and that a priority focus for the oral health profession must be on facilitating and educating the public to maintain and manage its own oral health. An emphasis on good monitoring and early diagnosis, as well as early intervention and prevention, should be the desired approach rather than waiting for disease to cause damage and reverting to treatment as a (too-often) first line of defence. In any strategy, priority should be given to the development of a strong primary prevention policy, with service entitlement to identified priority groups.

Linked to this was discussion about the culture of health prevention in Ireland and the value that Irish people attach to oral health in particular. Comparisons were drawn with the Scandinavian countries, where it was suggested that the over-riding societal culture and value system was based on collective responsibility rather than individualism. If the oral health profession in Ireland is to be successful in fostering a culture of active self-care, there must be a corresponding shift to a value system that not just acknowledges responsibility for self-care in health but which appreciates fully the collective inter-dependency within finite resources. History and culture may make this transition more difficult, but certainly not impossible, particularly if the language and actions of government, the profession and academia are well aligned.

Summary points:

This is a critical time for oral health development in Ireland. The next year provides a window of opportunity to shape and re-imagine the role and position of oral health care.

Oral health must be viewed by policy makers, and the public as part of an holistic approach to healthcare.

If the oral health profession in Ireland is to be successful in fostering a culture of active self-care, there must be a corresponding shift to a value system that not just acknowledges responsibility for self-care in health but which appreciates fully the collective inter-dependency on finite resources.

5. Recommendations – Towards An Oral Health Strategy

Eighteen overarching recommendations or key outcomes from the Forum are outlined below. These are recommendations which the dental profession, as represented in the Forum, has prioritised for serious consideration in the development of a new Oral Health Strategy for Ireland.

These recommendations have been grouped under:

- 1. Policy recommendations**
- 2. Legislative recommendations**
- 3. Forum action recommendations**

1. Policy Recommendations:

The Forum put forward a list of policy focused recommendations towards the development of a national oral health strategy for Ireland. These have been grouped into three categories; responsibilities and roles, dental profession and prioritising needs.

Under each of these categories, the recommendations are listed in order of priority. The number one recommendation is considered as an issue which should be acted on immediately. Recommendations further down the list may be dependent on the outcome of a previous recommendation, or may, for a variety of reasons, have to be considered at a later stage.

Responsibilities and Roles

- There must be absolute clarity on the responsibilities and relationships of all key stakeholders in oral health. In particular the roles of the Department of Health and the Health Service Executive (HSE) in the delivery of oral and dental care must be clearly defined.
- Delivery decisions need to be matched to clinical needs and prioritised in line with the available resources. The role and responsibilities of the HSE in this process requires detailed clarification.
- When oral health care priorities are set, a level of national and regional oversight, measurement and management needs to be put in place to ensure that they are applied uniformly.

- Oral health plays a major role in maintaining good general health. Those involved in oral health services are skilled, willing and able to offer valuable advisory and diagnostic/preventive care and treatment in ensuring better oral health contributes to better general health.

Dental Profession

- Primary dental care should mirror the Primary Health Care Strategy. In order to ensure a dental service with patients at its heart, primary dental care should act as the hub and provide continuity and clear lines of responsibility for oral health outcomes for both the patient and the dental team.
- Primary care services should link into appropriate secondary care services.
- Methods to ensure the continuity of care should be explored.
- There is a clear business case for Foundation Training in Dentistry. This is urgent and critical for the development of clinical services, better quality care and patient safety as well as both the education and retention of dental professionals.
- The optimum skill mix use within the dental team must be explored fully. There may be the opportunity to develop thinking around skill mix in the context of a pilot for the 0-5 year olds.
- Definitive decisions on skill mix will need to await decisions on service structure and priorities.

Prioritising Needs

- Water fluoridation should remain an important support for oral health policy.
- Securing and maintaining oral health early in life is an urgent concern (0-5 age group) and consideration should be given to how this can be done in an Irish context.
- There is an urgent need to put into place a process of priority setting which takes into account the needs and views of the public and professions.
- Priority should be given to the development of a strong primary prevention policy, and service entitlement for children, special needs and vulnerable groups.

2. Legislative Recommendations

The Forum made a number of recommendations on issues which may be worthy of consideration within a new Dental Act, which is urgently required:

- Regulation of all aspects of dental practice should remain under the control of the Dental Council.
- The intelligent use of patient co-payments should be explored as a tool to manage demand and improve oral health. If this requires legislation, it may also be considered as separate legislation to a new Dental Act.
- The development of the optimum skill mix should also include extended scope of practice for existing members of the team

3. Forum Action Recommendations

The Forum looked at activities that the oral health profession should undertake to ensure that oral health is recognised as a key part of the general health strategy and health culture. The primary recommendation was:

- To develop, as an immediate requirement, an advocacy strategy which links to priorities and which identifies the responsibilities of different agencies and individuals.



6. Putting the Recommendations into Context

This section outlines some of the rationale for the overarching priority recommendations – taking into account discussion which took place in the small group sessions as part of the Forum event.

Roles and Responsibilities

The over-riding feedback from members of the Forum was that the roles and responsibilities of the key stake-holders in oral health (Department of Health and the Health Service Executive) were unclear and should be defined as a matter of urgency.

While the severe curtailment in resources to the HSE was acknowledged, service delivery in general was considered to be patchy, with no uniform patterns of delivery decisions or priority setting. The skill mix within the HSE was not considered such that it could provide holistic care to patients. In tandem with the appointment of the Chief Dental Officer at the Department of Health, it was felt that there was a need for a separate Dental Clinical Director for the HSE to ensure implementation and enforcement of policy decisions.

Dental Schools were seen as having key advisory, education and training, research, advocacy and specialist delivery roles. The research capacity of schools was underfunded but was considered critical for evidence based policy and decisions. It was also felt that schools should take a bigger role in continuous professional development (CPD) and that there should be a structured and co-ordinated approach amongst providers of CPD education. It was considered important that dental schools should remain autonomous and that dentistry should not get lost into the general medical or general hospital systems.

The Department of Health was seen as a central point for policy. However, there was a lack of clarity in the Department's relationship with wider oral health services and the HSE. The appointment of a part time Chief Dental Officer was cause for some optimism that oral health may now be given greater priority within the Department.

The role of patients and parents received considerable attention from the Forum. Many groups and individuals considered that the patient – including parents of younger children – should assume greater responsibility for their oral health. The role of the individual, and the best way to support people to adopt this responsibility, requires careful consideration in an Irish context.

There was more clarity about the role of General Dental Practice, which was seen as a hub for general oral health – the central point for continued care, providing clear lines of responsibility for all members of a dental team and a patient.

The Dental Profession

It was acknowledged that patients were more mobile now with regard to their dental care. A recent Irish Dental Association (IDA) survey on attitudes to dentists and dental health (November 2013) found that Irish people, on average, had been visiting the same dentist for over 11 years. The clear majority of those who had switched dentists had done so for neutral reasons (e.g. moved house, retired etc.). However, 39% of those (15% of all adults) did so for service or value reasons.

The general dental practice was universally seen by the Forum as the hub for general dental care. It was agreed that it should be the first and most cost-effective point of contact for patients and should also have responsibility for the most appropriate clinical care of the patient over time – either as part of the GDP team or externally. Primary care services should also provide the link to appropriate secondary care services. The relationship between dentist and patient is also critical in supporting excellent health behaviours and prevention.

Foundation training for dental graduates was regarded as an urgent and mandatory requirement for all Irish dental graduates. An evaluation of a pilot foundation training scheme, carried out in 1999, already bears out the value of such programmes (McKenna et al., 2010).

The Irish tax payer supports the training of over 60 dentists a year and yet, at present, few of them stay in Ireland after qualification. Despite the fact that many parts of the country have poor access to primary dental care. Ireland needs well trained dentists but the complexity of dentistry now means that graduates can be considered safe beginners but not fully competent, rounded professionals. The introduction of foundation training in Ireland would provide a rapid return on the public investment. It would mean greater patient safety, cheaper provision of service and more equitable access to oral and dental care by the public. Salary costs would be low but for dental graduates, foundation training would ensure there were better, home grown dentists, attuned to the needs of the country in the long-term. It would also ensure that dental graduates give something back to society after graduation. The scheme would require an initial modest investment, but after a short period of time, it should be at least cost neutral, and ultimately cost beneficial, to the state. The immediate need for its introduction is made all the more critical because the current route to foundation training in the UK, where in recent years dozens of Irish graduates have received such training, is expected to be substantially curtailed by the middle of 2014.

Skill mix also provides some potential solutions for cost-effective care. Within the oral care team the use of skill mix should be based on need, specific to the Irish context. The issue of skill mix and specialisation requires further exploration. However, any exploration should include a discussion

around the potential for extended scope of practice for existing members of the dental team. Ultimately, decisions on skill mix would be dependent on the structure and strategic direction of the Irish oral health service. There was agreement that it may be possible to explore thinking on skills mix in the context of a pilot for the 0-5 year old age-group (see below).

It was agreed that regulation of all aspects of dental health practice should remain the preserve of the Dental Council and set out in legislation.

Prioritising Needs

While the majority of Forum members said that they would like to see state-funded, universal entitlement to basic preventive (minimum, free check and hygiene visit once a year, for example) and primary care, basic dental treatment, there was an acknowledgement that this scenario, while desirable, may not be a reality in the foreseeable future.

As an alternative, and as a way of ensuring cost-efficiency in the delivery of dental services, it was agreed that the intelligent use of patient co-payments should be explored as a tool to manage demand and improve oral health.

The need to prioritise treatment for the 0-5 age group came up repeatedly throughout the Forum's discussion. The Government's recent decision to provide universal health care for all children under five provides an opportunity to seamlessly extend entitlement to dental care. The Forum recognised that there was a need to better encourage better attendance of the 0-6 age group and that earlier engagement with dental services would allow for more disease prevention. Prioritising this cohort makes sense from an economic, preventive and early intervention sense. It could also ensure a trickle-down effect, making families and particularly mothers more aware of the importance of oral health as a central part of their child's development and well-being.

The Forum members agreed that fluoridation should remain a key tenet of Irish oral health policy as a priority preventative measure for the whole population.

There was general consensus that primary prevention and service entitlement should be given to other vulnerable groups – such as cancer patients, special needs groups, cleft palate, diabetics, or those with acute pain or emergency care requirements, for example. It was agreed that the way in which inequalities were managed would ultimately determine the adequacy of the Irish health service.

Finally, it was also recognised that priorities could not be set without the input of the needs and views of the general public.

Advocacy

Improved advocacy was seen as a key role of the oral health profession and an issue which had to be taken up as a priority action by the Oral Health Forum.

However, it was also acknowledged that there were many different interpretations of, and elements, to public advocacy. Everything could not be tackled at once.

Many groups looked to the way in which the pharmacists had repositioned and rebranded themselves, not just as dispensers of medicines but as dispensers of advice, community care and information. The idea of a “Dental White Flag” – under brand Healthy Ireland – was put forward by one group as a way of branding and marketing good oral health. The Dental Flag could operate in the same way as the Schools Green Flag which encourages environmentally friendly behaviour and culture.

It was recognised that oral health plays a major role in maintaining good general health. Oral health advocacy could not be compartmentalised – it would have to be seen as being integral to overall health outcomes. Oral health professionals were willing to take on the role of advocates for good general health, however, other healthcare professionals (e.g. GPs) would also have to be more aware of the close connection between general health and oral health issues.

Summary points:

The general dental practice was universally seen by the Forum as the hub for general dental care.

The introduction of foundation training in Ireland would provide a rapid return on the public investment. It would mean greater patient safety, cheaper provision of service and greater access for oral care by the public.

The Government’s recent decision to provide universal health care for all children under five provides an opportunity to seamlessly extend entitlement to dental care.



7 ● Appendices

Appendix 1 – National Oral Health Forum Programme

09.00	Welcome – Chair	Dr Eamon Croke Large lecture Theatre
	Secretary General, Dept of Health, and the Chief Dental Officer	Dr Ambrose McLoughlin Dr Dympna Kavanagh
09.15	Scene-setting: Where do you want to be in 2020?	Prof Jimmy Steele
09.30	People and oral health in Ireland – who cares?	Dr Jacinta McLoughlin
09.45	Round table discussion	Breakout rooms
10. 30	Feedback	Large Lecture Theatre
11.15 – 11.45	TEA/COFFEE	Board Room
11.45	Issues for the dental professions	Dr Garry Heavey
12.00	Round table discussion	Break-out rooms
12.45	Feedback	Large Lecture Theatre
13.30	LUNCH	Board Room
14.15	Models of Care	Professor Ciaran O’Neill
14.30	Round table discussion	Break out rooms
15.15	Feedback	Large Lecture Theatre
16.00	TEA/COFFEE	
16.15	Pulling it all together	Professor Jimmy Steele Large Lecture Theatre
16.45	CLOSE	

Appendix 2 – Speakers

Dr Ambrose McLoughlin BDS; MBA

Secretary General of the Department of Health and Chairman of the Board of the HSE

Appointed in April 2012, he has over 30 years' experience as a practitioner, policy maker and within the management structures of the health services in Ireland. In recent years, he has been a leading advocate for and contributor to a number of major change programmes. His previous posts include; Registrar/Chief Executive of the Pharmaceutical Society of Ireland (PSI), the pharmacy regulator; CEO North Eastern Health Board (NEHB) and Deputy CEO NEHB, responsible for Acute Hospitals and Community Services.

Dr Dympna Kavanagh BDS; PhD; FDS RCSEng; DDPH RCSEng; MSc ULond

Chief Dental Officer

Dympna Kavanagh was recently appointed as Chief Dental Officer. A graduate of University College Cork Dental School, with a PhD in Preventive Dentistry, Dr Kavanagh's main focus in this post will be on the development of a new Oral Health Policy. Following graduation, Dr Kavanagh worked in the NHS and in the Irish Health Service. She subsequently worked with Unilever Dental Research for four years and completed her higher training in Dental Public Health in Guys Hospital, King's College, London where she worked as a Senior Registrar and Lecturer.

While in London she worked across several strategic health authorities in Dental Public Health, including East and West Kent, East London and Lambeth, Southwark and Lewisham. Ms Kavanagh returned to Ireland in 2001 taking up a post with the Mid Western Health Board in General Management. She returned to dentistry in the post of Principal Dental Surgeon for the Limerick/North Tipperary area in 2003. Dr Kavanagh has also worked in HSE Corporate for the Quality and Risk section of the former Primary, Community and Continuing Care Directorate and is currently National Oral Health Lead in the HSE.

Professor Jimmy Steele CBE; BDS; PhD; FDS; RCPS

Dean and Professor of Restorative Dentistry, University of Newcastle upon Tyne.

Author of "An Independent Review of Dental Services in England" (The Steele Report, 2009).

Chair of the Evidence and Learning Group on the dental contract reform programme in England.

Advisory role to the HSE on a review of orthodontic and oral maxillofacial services.

Jimmy Steele graduated in dentistry from Dundee in 1985. After hospital appointments in Dundee, Perth and Glasgow and obtaining FDS in 1988, he was appointed as a lecturer in Restorative Dentistry in Newcastle in 1989 and was awarded his PhD in 1994. He was made a personal Senior Lecturer in Restorative Dentistry in 1999 and then a personal chair in Oral Health Services

Research in 2003. He is also a clinical dental specialist and works as consultant in Restorative Dentistry in Newcastle. Professor Steele has taken a leading role in several large scale national epidemiology surveys (including NDNS 65+, ADHS 1998 and 2009/10 and CDHS 2003) whilst work in health services research includes research in primary care, quality of life and health economics. He is oral and dental research lead for the UKCRN (NIHR). In 2009 he led the Independent Review of NHS Dental Services in England for the Secretary of State for Health and has continued to work with the Department of Health to develop contract pilots in England.

**Dr Jacinta McLoughlin BA; B Dent Sci; MDS NUIrel; FDS RCSI; FFD RCSI
Senior Lecturer in Public Dental Health, Dublin Dental University Hospital.**

Jacinta graduated from Trinity College Dublin in 1976. Thereafter she worked in general dental practice in the UK before returning to Ireland to work in the HSE in the Midlands and Mid Western Health Boards. In 1983 she took up a Senior Dental Surgeon (Paediatric) post in the Mid Western Health Board and in 1990 became Acting Principal Dental Surgeon in the same Health Board. In 1991 she took up the Principal Dental Surgeon role with the North Eastern Health Board with responsibilities for the Meath Community Care Area. In 1998 Jacinta was appointed Senior Lecturer in Public Dental Health in the Dental School, Trinity College Dublin. Currently she is the Director of Teaching and Learning (UG) and Curriculum Coordinator in the Dublin Dental University Hospital. Jacinta chairs the Advisory Committee of the ICSTD in Public Dental Health and she is a Member of the Dental Council and its sub-committees in Education and Fitness to Practice.

Dr. Garry Heavey B Dent Sci; Dip Clin Dent.

Dr Garry Heavey qualified from the Dublin Dental Hospital prior to working as a General Practitioner in England and for the last twenty seven years in Sandycove, Co Dublin. He gained his Diploma in Clinical Dentistry from Trinity College Dublin and was elected a fellow of the International College of Dentists in 1999.

Dr Heavey is a past president of the Irish Dental Association and the Irish Dental Council. He served as Vice Chair of the Board of the Dublin Dental Hospital and is currently chair of the Irish Dental Association's Continuing Professional Development Committee. He is the Dento-Legal Consultant for Dental Protection in Ireland and a member of the Dental Protection Limited Board. Dr Heavey has lectured nationally and internationally on a wide range of dental topics – notably Practice Management.

**Professor Ciaran O'Neill BSc; PhD
Dean of the College of Business, Public Policy and Law, NUI Galway**

Ciaran O'Neill was educated in Queens University Belfast where he was awarded a degree in economics in 1986 and a PhD in agricultural economics in 1990. He joined the Department of Economics in Queens as a lecturer in 1990, moving to the University of Nottingham in 1997. He

was appointed Professor of Health Economics and Policy at the University of Ulster in 2003 and re-joined Queens University's School of Medicine and Dentistry in January 2007 as Professor of Oral Health Research. He joined NUI Galway's J.E.Cairnes. School of Business and Economics as Professor of Health Technology in 2008 and currently serves as Dean of the College of Business, Public Policy and Law.

He has held various visiting positions including positions at the RAND Corporation in Santa Monica and the University of Michigan. He was a Harkness Fellow in Healthcare Policy and Practice in 2001/2002, has been Chair of the Northern Ireland Health Economics Group and of the Health Economics Association of Ireland. He has served on several national scientific committees and provided advice to Departments of Health north and south on aspects of oral health policy. He has published over 75 peer reviewed publications as well as various reports including examinations of oral health and health-care on the island of Ireland and internationally. In 2013 he received one of six HRB Research Leader Awards in Ireland.



Appendix 3 – Discussion Questions for Small Group Sessions

Session 1: People and Oral Health in Ireland – Who Cares?

1. Is it possible to be clear about the various roles of the key players in oral health in Ireland – the HSE, the Department of Health, the Dental Schools, dental teams in primary care, parents and patients?
2. How can we make advocacy better – How can we ensure that everyone understands the value of oral health and who is responsible for it?

Session 2: Issues for Dental Professions

1. Should general dental practitioners have responsibility for the long-term and co-ordinated care of the patient?
2. How can you decide how best to use the oral health skill mix – who decides what’s best and how do you legislate for that?
3. What is the business case for Formational or Vocational Training for oral health graduates?

Session 3: Models of Care

1. What should the State provide? What should it commission and what should be left to the market?
 - Should there be universal entitlement to any services?
 - Are there any groups for which specific services are a priority?
2. How can you incentivise private sector dentists? Should this be activity or outcome based?
3. Is inequality an issue?

Appendix 4 – Oral Health Forum Steering Group

Professor June Nunn Dean, School of Dental Science, Trinity College Dublin

Professor Gerry Kearns Dean, Faculty of Dentistry, RCSI

Mr. Fintan Hourihan CEO, Irish Dental Association

Professor Martin Kinirons Dean, Cork University Dental School

Appendix 5 – Oral Health Forum Invitees

Angela Connelly	Irish Dental Nurses Association
Anne O’Neill	Society of Chiefs & Principals
Brian Edlin	Dental Protection
Christine McCreary	Cork University Dental Faculty
Ciaran O’Neill	Speaker
David O’Flynn	Dental Council – Apologies
Dermot Jewell	Consumers Association – Apologies
Donncha O’Carolan	Health and Social Care NI
Donald Burden	Director, Centre for dentistry, Belfast – Apologies
Eamon Croke	General Dental Practitioner, Chairman
Enda Connolly	HRB
Fintan Hourihan	Steering Group
Frank Ormsby	Irish Faculty Primary Dental Care
Garry Heavey	Speaker
Glenn McEvoy	Dental Technicians Association
Jacinta Mc Loughlin	Speaker
James Turner	Irish Dental Association
Jane Renehan	Society of Chiefs & Principals
Jerry McKenna	Cork University Dental Faculty
Jimmy Steele	Newcastle University Dental Faculty
John Lee	IMPACT
John Walsh	RCSI
June Nunn	Steering Group
Kelly O’Shaughnessy	Irish Dental Hygienists Association
Kieran O’Connor	Irish Faculty Primary Dental Care
Martin Kinirons	Steering Group
Mary O’Farrell	IMPACT
Michael Kilcoyne	Consumers Association
Michael O’Sullivan	Dublin Dental University Hospital
Patricia Gilsenan	Dental Health Foundation – Apologies
Pat Bolger	Irish Dental Trade Association

Peter Cowan	RCSI
Peter Gannon	Irish Dental Association
Peter Morris	Irish Dental Trade Association
Seamus Hickey	Expert Body on Fluorides
Sean Malone	Irish Dental Association
Stephen McDermott	Society of Chiefs and Principals
Sue Boynton	Dental Protection
Susan Johnson	Irish Dental Hygienists Association
Tatjana Baum	Dental Technicians Association
Tina Gorman	Irish Dental Nurses Association
Paul O'Grady, Ann-Marie Hardiman, Orla Murray	Journal of the Irish Dental Association

Appendix 6 – Speakers/facilitator/Rapporteur

Speaker	Designation	Affiliation
Dr Ambrose McLoughlin	Secretary General	Department of Health
Dr Dympna Kavanagh	Chief Dental Officer	Department of Health
Dr Jacinta McLoughlin	Associate Professor, public and Child Dental Health	DDUH
Dr Garry Heavey	General Dental Practitioner	General Practice
Professor Ciaran O'Neill	Dean of the College of Business, Public Policy and Law	NUI Galway
Professor Jimmy Steele (Facilitator)	Dean, School of Dentistry	University of Newcastle upon Tyne
Ms. Edel Hackett (Rapporteur)	PR Director	Persuasion Republic

