BDA NI response to the Northern Ireland Affairs Select Committee Inquiry - Funding priorities for the 2018-19 Budget: Health

EXECUTIVE SUMMARY

- Successive health budgets have seen services commissioned on a shoestring, with little evidence of investing in safeguarding Health and Social Care for the future.
- There has been an abject failure to invest in the people who deliver Health Service dentistry. General dental practitioners have not been compensated for the significant cost increases they have incurred in delivering Health Service dentistry, while the Community Dental Service Contract remains unimplemented.
- Rising expenses and pay caps have reduced general dental practitioner incomes in real terms by between 25% and 33% over the past 7 years. Future sustainability of dental practices delivering Health Service dentistry is at risk, and morale is low.
- Additional monies awarded under Barnett should be spent appropriately; the Sugar Levy funds of £12.3m with no additional spend for child public health initiatives a case in point.
- Oral health in Northern Ireland continues to be among the worst in the UK, due to lack of investment and low prioritisation. As well as child health, ever complex dental needs of a growing elderly population have not been provided for.

1. Introduction

1.1. The British Dental Association (BDA) is the voice of dentists and dental students in the UK. As a trade union and professional body, we represent all fields of dentistry, including general practice, salaried primary care dental services, the armed forces, hospitals, academia, public health and research.

1.2 Our vision regards dentists as being critical to the health of the nation. We want to see better oral health for all, standing up for dentists, so they can deliver the very best care for their patients.

1.3 The overall size of the Health budget in Northern Ireland, and decisions taken over the prioritisation of how funds will be allocated, will have a direct impact on our vision of better oral health, and wider public health outcomes. Moreover, the future sustainability of dental practices, the livelihoods of practitioners, and the conditions in which they operate will be directly impacted by these budgetary decisions.

1.4 As key stakeholders of this process, it is imperative that the dental perspective is considered by the Committee in this Inquiry. We would also wish to be fully involved and consulted, where appropriate, in further work and would welcome future
engagement. If you require clarification on any of the issues covered in our submission, we would be most happy to provide this.

2. A wholly inadequate funding context

2.1 The Northern Ireland Health budget has been wholly inadequate during the austerity era. It has proved impossible to square constrained public finances with meeting the increased demands of a growing elderly population, while providing new and ever more costly treatments, in a context of rising healthcare inflation.

2.2 It has resulted in intolerable pressure being placed on those professionals who deliver care, not least dental professionals; waiting times have increased, and inequity in access to new treatments such as cancer drugs has widened for people living in Northern Ireland. It has resulted in a health service that is barely able to sustain core services, and little headroom to deliver transformation.

3. Impact on dental services/oral health

3.1 Austerity budgets have resulted in unprecedented erosion in the take home pay of dentists. We have witnessed cuts to the GDS budget in the form of the removal of commitment payments; the imposition of a maximum 1% pay cap for salaried dentists and general dental practitioners has resulted in a real term reduction in income of between 25% and a third coincide at a time of rising costs to deliver Health Service dentistry.

3.2 The human impact of relentless budgetary pressures in operating a dental practice, and for providing community dental services has been immense. Morale is at an all-time low, with Northern Ireland dentists continuing to exhibit the lowest levels compared to dentists in the rest of the UK whilst research has shown that dentists experience high levels of work-related stress. The wellbeing of staff and dental professionals who deliver Health service dentistry needs to be acknowledged.

3.3 While we have had sight of high-level allocation figures, including £109.7m to Dental Services out of a total Resource DEL of £5,420.7m, there has been very limited information shared regarding how funds are to be allocated and prioritised within each of the Service areas. In the absence of a NI Executive, we have no sense of any high level strategic priorities that will guide the commissioning of services.

4. Spending funds more strategically

4.1 There is considerable work to do to ensure finite funds are spent more strategically, and that a greater priority is given to the strategic themes of improving public health, prevention and transformation.

4.2 At a time of intensifying pressures on the health budget, prioritising the General Anaesthetic (GA) extraction rate - which is three times per head of the population

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2 Calculations for real income by the BDA, using the Retail Price Index (RPI) as the deflator. Using the RPI as the measure of inflation with 2008/09 as the base year, we obtain real falls in taxable income between 2008/09 and 2015/16 of 24.9% for practice owners and 32.7% for associates.

3 BDA research on burnout and dentists’ well-being at work. Available online https://www.bda.org/dentists/policy-campaigns/research/workforce-finance/Dentists%20well-being%20and%20work-related%20stress/Pages/default.aspx

than in England—could lead to considerable financial savings. In Northern Ireland, 5,122 children were admitted to hospital last year for the removal of 22,699 teeth. BDA estimates the procedures could cost the service in the region of £9million\(^5\)\(^6\). Real savings could be made with additional investment in oral health prevention initiatives. However, dentistry operates within a policy vacuum, with the Northern Ireland Oral Health Strategy\(^7\) dating back to 2007.

4.3 Defunct, outdated strategies in key areas of health such as oral health and cancer curtail the ability to ensure finite resources are directed in the optimum ways of delivering the desired outcomes relevant to the challenges of this time.

4.4 BDA Northern Ireland’s appeal is that any future cash injections into Health, including the estimated £600m NHS 70\(^{th}\) Birthday money by 2023, is invested in keeping more of our people living well for longer, and in tackling protracted health inequalities. Dentists are ideally positioned to help deliver the move away from a ‘sickness’ service, towards a ‘keeping well’ service.

4.5 There must be sufficient headroom created within the Health budget to be able to adopt new innovative approaches, and to benchmark services with the best on offer elsewhere. The overarching priority must be to shape services in ways that seek to enhance health outcomes for the public and invest adequately in services and the people who deliver these.

4.6 The HSC Workforce Strategy 2026\(^8\) claims to signal a new approach to HSC employees. However, there needs to be a holistic approach to ensure desired outcomes are realised for employees and contractors alike. For community dentists, it means the immediate introduction of their ‘new contract’ now after over two years since this was formally agreed. For general dental practitioners, it means addressing the deep financial impact created by 7 years of soaring expenses and capped uplifts, and the much-reduced incentive to continue to deliver Health Service dentistry.

5. **Realising ‘win-win’ budgetary savings and enhanced outcomes**

5.1 At present, an estimated £9m is being spent on hospital admissions for child teeth extractions under general anaesthetic. With adequate investment in prevention there is considerable scope to bring these costs down. Based on modelling from Public Health England, we estimate a universal nursery tooth brushing programme – a model which has secured transformative improvements in decay rates in both Wales and Scotland - could be delivered for as little as £350,000 a year, securing over £1million in savings to the Northern Ireland budget in five years\(^9\).

5.2 Despite the Joint Committee on Vaccination and Immunisation recommending in July 2018 that the HPV vaccine should be extended to boys on ‘cost effectiveness

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\(^6\) The BDA has analysed official data for tooth extractions. Returns from Belfast, Northern, South Eastern, Southern and Western HSC Trusts indicate there were 5,122 cases of General Anaesthesia (GA) Dental Extractions carried out on children in secondary care in 2016/17. Health Service schedule of costs for elective procedures in that period attribute a mean cost of £1,825 for Extractions of Multiple Teeth, among children of 18 years and under.


Northern Ireland is the only part of the UK unable to extend its vaccination programme due to not having a Health Minister in post. This is just one clear example where health outcomes will suffer, and where savings will not be realised to the Health budget in 2018-19 unless there is the necessary intervention to make this happen.

6. **Utilising all available monies to improve health outcomes**

6.1 The Committee might consider as part of its investigations looking at how additional monies coming to Northern Ireland under Barnett, awarded to deliver improved health outcomes are actually spent.

6.2 Despite an additional £12.3m to Northern Ireland as a result of the Sugar Drinks Industry levy in 2018-19, the Department of Education confirmed to us via an FOI response that ‘there is no planned increased spend in 2018/19 by the Department of Education on child public health initiatives equivalent to the Healthy Pupils Capital Programme in England’.

6.3 ‘Health-in-all policies’ was an approach that appeared in the draft Programme for Government 2016-21. It is based on the premise that decisions taken outside of the Department of Health can have a bearing on the health and wellbeing of the population. There is a need to ensure better collaboration for the sake of improving health outcomes to reduce pressure on the Health Budget. This needs to be directed under a ratified Programme for Government.

7. **Investing in unmet need**

7.1 Tooth decay is the most common oral disease affecting children and young people in Northern Ireland, yet it is almost entirely preventable. Despite improvements, Northern Ireland continues to be among the worst performing of the regions for oral health anywhere in the United Kingdom. Our current Oral Health Strategy refers: ‘The oral health of Northern Ireland’s population is the worst in the United Kingdom, and this has been the case for many years’.

7.2 There is clearly significant unmet need within oral health, whereby we need to fund and enable dental professionals to develop healthy behaviours in our population, as well as continuing to treat dental disease. Investment in a dedicated regional prevention programme for children would be an important first step.

8. **Addressing health inequalities**

8.1 A key measure of a Health budget that is ‘fit-for-purpose’ will be a budget that has tackling health inequalities at its core. Within oral health, health inequalities are apparent. Children from lower income families are much more likely to have poorer diets and consume more sugary drinks – in Northern Ireland almost a quarter (24%) of...
children on free school meals drink sugary drinks four or more times a day, compared to just 1 in 10 (10%) of children who are not eligible for free school meals.\textsuperscript{14}

8.2 If we are serious about improving health outcomes and keeping more of our population healthier for longer, we need co-ordinated and funded initiatives aimed at reducing sugar consumption and improving diets, especially amongst children in Northern Ireland. Sugar is fuelling an avoidable epidemic of tooth decay, not to mention diabetes and childhood obesity and other associated health conditions. Dentists see patients with dental decay and early obesity long before they present with type II diabetes, and can play a key role in frontline prevention.

8.3 BDA has campaigned extensively for properly resourced public information campaigns to improve public awareness of oral health issues in children, action on advertising, marketing and food labelling. It is completely unacceptable to us that at a time when an additional £12.3m\textsuperscript{15} is coming to Northern Ireland from the Sugar levy, it would appear that none of this money is being used to try to address child public health issues, including oral health. We urge that a significant proportion of the money raised through the sugar levy is spent on oral health initiatives.

9. Caring for an ageing population

9.1 The additional pressures of providing care to an increasing elderly population is particularly apparent within dentistry. More of our older people are retaining some dentition into their old age and have increasingly complex oral care needs. In many cases, and particularly in care homes, capacity issues mean that the oral health needs of older people are simply not being met, causing considerable discomfort and impacting disproportionately on the quality of life of older people. There are ever growing pressures on Community Dental Services (CDS) staff to maintain the dentition of this vulnerable group and provide preventative interventions. In spite of the growing demand, domiciliary services are under increasing pressure due to wholly inadequate budgets. Adequate resource for dental/oral care for the older demographic must be a feature of Health Budget 2018-19 spend.

10. Oral Cancer

10.1 Investing more in cancer prevention, for example through obesity prevention measures, and public information campaigns to highlight the signs and symptoms of oral cancer, and encourage behavioural change, is long overdue; so too will agreeing to fund the HPV vaccine for boys living in Northern Ireland to reduce the rates of oral cancer, as has been the case recently by all other governments in the UK. Such a decision has been met with cross-party political support in Northern Ireland but cannot be signed off in the absence of a Health Minister.

11. Alleviating pressures within Dental Services

11.1 BDA supports the aspiration contained within the HSC Workforce Strategy: ‘By 2021, health and social care is a fulfilling and rewarding place to work and train, and our people feel valued and supported’\textsuperscript{16} This must apply equally to independent


\textsuperscript{15} Written question – 116036 Answered on: 01 December 2017. Soft Drinks: Taxation. Available online at: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-11-28/116036/

contractor dentists delivering Health Service dentistry under GDS, as to employed staff. As previously described, the dental workforce is under enormous pressure due to wholly inadequate budgets and increased workloads. It will require tangible commitments to be realised, not least on the back of the gross failure to update the terms and conditions of public sector employees and contractors.

12. **Pressures in General Dental Service (GDS)**

12.1 Over the past seven years, GDS dentists have come under enormous financial pressure to deliver Health Service dentistry, absorbing rising expenses at considerable personal expense, while being subject to a maximum 1% pay cap. Commitment payments have been withdrawn in order to curtail the dental budget, while indemnity costs have risen sharply. The net consequence has been that the future sustainability and financial viability of many dental practices delivering mainly Health Service dentistry is in jeopardy.

12.3 Morale in the GDS workforce in Northern Ireland is now so low that we have grave concerns about the future sustainability of health service dentistry. Over a third of dental practice owners in Northern Ireland (33.6 per cent) with a Health service commitment of 75 per cent or more reported their morale as ‘very low’ and 29.5 per cent as ‘low’ and this is linked to longer working hours and carrying out more health service work\(^{17}\). These low levels are totally unacceptable amongst a profession delivering patient care.

12.4 Essentially, the more time dentists spend on Health Service work, the lower their levels of morale, and the less they earn. The strain of inadequate health service remuneration is evident as figures clearly show that those dentists whose Health Service earnings accounted for at least 75% of their gross earnings had the lowest taxable income\(^{18}\).

12.5 Reconciling the pressures individual dentists are under to deliver Health Service dentistry, the huge oral health gaps, and that we had a significant GDS underspend of £3.9m\(^{19}\) in 2017/18 is simply impossible. The current lack of vision and foresight for advancing dental services and improving the oral health of the population reinforces the need for an updated Oral Health Strategy.

13. **Costs associated with delivering Health Service dentistry**

13.1 As small businesses, dental practices are sensitive to the wider economic climate and global forces in relation to the purchase of essential equipment and materials, a situation which has worsened since the vote to leave the European Union through the devaluation of Sterling, and which could worsen considerably post-withdrawal. Compounded with an increase in non-clinical/unremunerated time due to increased regulation and additional inspection/compliance regimes, the cost of delivering Health Service dentistry has risen at rates well in excess of the maximum 1% DDRB pay uplift, effecting a real term fall in income for dentists of between 25% and 33%. The ability to invest within dental practices has been severely curtailed, while workforce issues, including a shortage of dental nurses has also arisen.


13.2 Provision must be made within the 2018-19 Health budget to implement in full the recommendations contained in the 46th DDRB Report of a minimum 2% pay uplift for all UK dentists, including dentists in Northern Ireland. The absence of an Executive has prevented the Department of Health providing clarity on this issue. As the Health Budget has come under pressure, the Department has previously delayed awarding even meagre 1% pay uplifts. The funds must be found, and the mechanism identified to make pay awards in excess of the historic 1% pay cap for the benefit of a sustainable Health Service in Northern Ireland.

14. Community Dental Service (CDS)

14.1 On top of considerable delays around the DDRB process, Northern Ireland community dentists have not had their new contract implemented over two years since Ministerial approval was granted. They are the last remaining group of staff in the NHS to remain on terms and conditions dating back to 1989, which is completely unacceptable.

14.2 The Committee may wish to inquire how in the case of community dentists the monies have been allocated to Trusts for the purpose of implementing the new contract, yet to date, they have not yet been released as backdated pay to individual community dentists. Monies allocated for the purpose of contractual implementation must be released immediately for that purpose.

15. CDS pressures

15.1 Community Dental Service dentists provide care to some of the most vulnerable in our society, including those with disabilities, special needs and elderly patients. As mentioned previously, the service is bursting at the seams as it has to deal with a disproportionate burden of childhood GA extractions, combined with an ever-growing elderly population. A long term, sustainable approach must be taken to the future of dental care for vulnerable groups, not least the elderly, in co-production with CDS dentists.

15.2 Hospital and academic dental services are also under considerable strain, with long waiting lists for hospital dental service referrals. For example, in the Southern HSC Trust, waiting times for non-urgent referrals to Oral Maxillofacial Surgery is 2.5 years. Referrals to paediatric dental department in the RBHSC is over 2 years. BDA is concerned that waiting lists which have grown significantly over the last number of years will get worse; will have a knock-on effect on other parts of the Health Service and will ultimately continue to impact on the delivery of care to patients.

16. RECOMMENDATIONS

1. HM Treasury to allocate additional funding to Health to put services on a sustainable footing and create headroom for transformation.
2. UK Government to announce an end to the pay cap in Northern Ireland for dentists and other public sector workers/contractors. Pay uplifts should be announced immediately in accordance with the recommendations of the Doctors and Dentists Review Body.
3. In lieu of a NI Executive, UK Government to authorise immediate implementation of ‘new’ Community Dental Services Contract.
4. UK Government to instruct Department of Health and HSCB to engage with BDA Northern Ireland towards compensating GDPs for increased expenses incurred in delivering Health Service dentistry.

5. In the absence of an Executive, UK Government to mandate Department of Health to develop a new Oral Health Strategy to be co-produced with the dental profession.

6. In the absence of a NI Executive, UK Government to sign-off ‘spend to save’ initiatives in dentistry, including: universal nursery toothbrushing initiatives; HPV vaccine extended to boys as ‘cost effective’.

7. UK Government to intervene to ringfence Sugar levy monies to be spent on improving child public health, including a significant proportion on improving oral health.

8. Additional investment in addressing gaps in provision of oral care of the growing elderly population, particularly those living in care homes, with input from dental profession.


10. Increased funding to Public Health Agency, and a clear remit established for improving oral health.

11. Additional investment into addressing long waiting lists for hospital dental service referrals, including for Oral Maxillofacial Surgery and to paediatric dental departments.

12. ‘Government’ to guarantee the long-term sustainability of Health Service dentistry by investing adequately in provision of services and dental professionals who deliver these.