States of Jersey
States Assembly

États de Jersey
Assemblée des États

Health, Social Security and Housing Scrutiny Panel

Dental Health Services Review

Presented to the States on 8th November 2010

S.R.12/2010

CONTENTS

1.1 TERMS OF REFERENCE

1. To establish whether the current provision of all dental health services is affordable to all;

2. To examine funding arrangements in public and private dental health services;

3. To examine the eligibility criteria for States-run dental health services;

4. To review how the Island's dental services are regulated;

5. To consider any other pertinent matters that may arise during the course of the review.

1.2 PANEL MEMBERSHIP

The Health, Social Security & Housing Panel comprised the following members:

Deputy G P Southern (Chairman)
Connétable D W Mezbourian
Deputy D J De Sousa (Lead Member for Dental Health Services)
Connétable S.A. Yates of St. Martin (until 21st June 2010)

2. CHAIRMAN'S FOREWORD

Following approaches from constituents on the high cost of going to the dentist and complaints that dental treatment was beyond the financial reach of the average family, I suggested to the Health, Social Security and Housing Scrutiny Panel that we should review dental services. The Panel agreed and I was invited to lead the review.

I was aware that the Dental Fitness Scheme had not been updated for 18 years and that the existing provision of dental schemes offering financial assistance excluded a large proportion of the population between the ages of 18 and 65. However, I was surprised to learn that neither of the Ministers with a remit for dental healthcare, had looked at the difficulties people are facing when it comes to affording basic dentistry. More concerning was that those Ministers have not fulfilled their function in providing a modern dental health service as part of the primary health care system.

The evidence we have received suggests that Jersey residents are having a serious problem affording dental treatment. This is particularly frustrating because the Health Insurance (Jersey) Law 1967 makes provision for assistance with dental costs. That provision in the law has simply not been enacted. The Health Insurance Fund does have an annual surplus, so there is absolutely some scope for this to be done. Another omission is that there is no statutory regulatory body for dentistry in Jersey and no ombudsman to deal with disputes.

I am pleased to present this report, which evidences issues in service provision and cost of dental treatment that have been highlighted to us from a broad cross section of Jersey residents. The Ministers must now fulfil their remit by undertaking the 18 recommendations made by the Health, Social Security and Housing Scrutiny Panel.

Finally I would like to thank all those who made submissions and the service providers that assisted the Panel in gathering the evidence for this report..

Signed

Deputy D. De Sousa

3. KEY FINDINGS AND RECOMMENDATIONS

KEY FINDINGS

1. The Dental Fitness Scheme income bar is unfair on families with more than one child. (Para 5.3)

2. The Dental Fitness Scheme has not been updated for 18 years. (Para 5.5)

3. The existing Westfield 65+ Plan requires payment at the point of treatment (Para 5.6)

4. More flexibility is needed in the fund management of the Westfield 65+ Plan (Para 5.6)

5. The Minister for Social Security has devolved his responsibilities for the Westfield 65+ Plan to the administrating body. (Para 5.7)

6. The loss of statistical data following the withdrawal of screening in schools does not allow for future planning and may prove to be a false economy. (Para 5.14)

7. The Minister for Health and Social Services has a duty of care to residential patients being cared for by her department, which extends to ensuring that all professional carers are properly trained in the delivery of oral hygiene. (Para 5.17)

8. The Consultant in Restorative Dentistry advocates the use of fluoride toothpaste for patients in residential care. Para 5.18)

9. Dentists rather than the Minister for Health and Social Services appear to have been left with responsibility for the management and delivery of dental health. (Para 5.22)

10. The Minister for Health and Social Services and the Minister for Social Security have failed to communicate in order to co-ordinate a coherent policy. (Para 5.24)

11. The public is insufficiently informed of the dental schemes available in the Island. (Para 5.29)

12. The Dental Fitness Scheme has no mechanism for dealing with parents who stop paying their monthly fee for their child's dental treatment. (Para 5.29)

13. Submissions received from the public suggest that the existing provision of dental schemes excludes a large proportion of the population between the ages of 18 and 65. (Para 6.15)

14. There is no statutory regulatory body for dentistry in Jersey. (Para 7.1)

15. There is no ombudsman to deal with disputes relating to dentistry. (Para 7.4)

16. The sections of the Health Insurance (Jersey) Law 1967 relating to dental treatment have not been enacted yet the Health Insurance Fund has an annual surplus. (Para 7.8)

17. The Consultant in Restorative Dentistry in his role as advisor to the Minister for Health and Social Services appears to be conflicted as he is also in local private practice. (Para 7.11)

RECOMMENDATIONS

1. The Minister for Social Security should provide an incremental means tested system within the Dental Fitness Scheme to accommodate families with more than one child. (Para 5.3)

2. The Minister for Health and Social Services together with the Minister for Social Security must deliver an updated Dental Fitness Scheme before 8th July 2011.(Para 5.5)

3. The Minister for Social Security must remove the necessity for payments at the point of treatment within the Westfield 65+ Plan by 8th July 2011. (Para 5.7)

4. The Minister for Social Security should ensure more flexibility in the administration of the Westfield 65+ Plan by 8th July 2011. (Para 5.7)

5. The Minister for Social Security must immediately take responsibility for the Westfield 65+ Plan. (Para 5.7)

6. The Minister for Health and Social Services should recommence screening in schools immediately to ensure that statistical data is available for the development of dental policies. (Para 5.14)

7. The Minister for Health and Social Services must provide adequate oral hygiene training provision for all carers working in public or private residential care by 8th July 2010. (Para 5.17)

8. The Ministers for Health and Social Services should discuss the introduction of fluoride toothpaste for those in residential care with the relevant professionals. (Para 5.18)

9. The Minister for Health and Social Services must immediately take responsibility for the provision of the existing dental schemes. (Para 5.22)

10. The Minister for Health and Social Services and the Minister for Social Security have overlooked their remits for dental services and failed to communicate in order to co-ordinate a coherent policy.(Para 5.24)

11. The Ministers for Health and Social Services and the Minister for Social Security should immediately undertake a publicity campaign to promote dental health services provided in Jersey. (Para 5.29)

12. The Minister for Social Security should identify and implement a mechanism for dealing with members of the Dental Fitness Scheme who do not maintain the monthly fee. (Para 5.29)

13. The Minister for Social Security must provide dental benefit to ensure that all residents can access at least basic dental care. (Para 6.13)

14. The Minister for Health and Social Services and the Minister for Social Security must establish an independent statutory regulatory body to oversee the delivery of dentistry services in Jersey. (Para 7.1)

15. The Minister for Social Security must establish an independent dental ombudsman's service. (Para 7.4)

16. The Minister for Social Security must consider the introduction of a dental benefits scheme as outlined within the Health Insurance (Jersey) Law 1967 by 8th July 2010.(Para 7.11)

17. The Minister for Health and Social Services must ensure that advisors are not conflicted. (Para 7.14)

18. The Ministers must review policy in order to deliver a modern dental health service as part of the primary health care system. (Para 8.2)

4. INTRODUCTION

4.0 A complaint that many will be familiar with in Jersey is that dental treatment is too expensive for the average family. If something goes wrong dentally, as much pain can be expected from the bill as from the drill. The submissions received in response to this review reflect the level of dissatisfaction and show that the cost of dentistry is a common complaint in Jersey. Comments received by the Panel include:

> *"Financially I can not afford any more [treatment] as I have a mortgage to pay and 2 children to look after."*
>
> *"I find the bills for even just a check-up and clean have risen unbelievably over the past few years - and if you need more serious dental work done, it can cost as much as a second hand car…"*
>
> *"As you are probably aware dental care in Jersey is far too expensive, and is very much out of reach for the poor, go and take photos of bad teeth in Jersey, maybe you will get the picture."*
>
> *"Dentists are not regulated over here with no cap on price, nobody to monitor bad practice, poor dentistry, or any other issues."*
>
> *"…We are a middle income family of four with two children in higher education. This puts a huge burden on our family finances. The result is that regular dental visits are skipped."*

4.1 There are two main themes within the submissions;

1. The cost of dental care in Jersey is too high; and,
2. The States provision of a dental health service is inadequate.

4.2 This report evidences that Ministers have neglected their remit in relation to dental health. The Panel identified that the Health Insurance (Jersey) Law 1967 made provision for the introduction of a dental health scheme. It was obviously the intention of the States to introduce a dental provision as part of

the Health Insurance Scheme which to date has been ignored. The evidence received shows dental health care provision in Jersey, to be outdated and insufficient. Problems also appear to exist in Ministers taking responsibility for dental health. This may be due to overlaps between the Minister for Health and Social Services and the Minister for Social Security. The evidence suggests that their failure to maintain a firm grasp of the tiller at ministerial level has allowed the private dental profession to be running the provision.

4.3 The Panel recognises that there are provisions for States funded dental treatment, for some sections of the community; these are discussed later in the report. Some submissions showed a lack of understanding of schemes available; a situation recognised by the Minister for Health and Social Services who agreed that work was required on promotion of the existing schemes. However, a large proportion of islanders fail to meet the criteria for assistance for one reason or another. This report discusses the above points and examines evidence relating to the arguments but even at an early stage, having consulted the views of the public, the Panel could attest to a real and widespread sense of dissatisfaction at the Island's current delivery of dental health services. A large number of people are simply unable to afford the proper level of dental care, for themselves or their families. This problem is not confined to those in low-income brackets: the majority of submissions came from residents who belong to 'Middle Jersey'.

4.4 The Panel noted with interest that the Consultant in Restorative Dentistry, who accompanied the Minister for Health and Social Services to a Public Hearing on the 26th July 2010, also runs a private practice.

4.5 This report identifies areas of work that is required by the Minister for Health and Social Services and the Minister for Social Security. The Panel believes that the incumbent Ministers should address the issues. In order to provide sufficient time for the work to be undertaken a completion date of 8th July 2011 has been included within the recommendations.

5. FUNDING

There are various forms of funding relating to dental provision in the Island: the Dental Fitness Scheme, which is funded jointly by Health and Social Services and Social Security. The Westfield 65+ Plan and the Income Support Dentistry Special Payments are funded by Social Security alone.

Dental Fitness Scheme funded by Health

5.1 This scheme is aimed at all 11 to 18 year olds and those 18 to 21 year olds in full-time education. Where a child is presented to the dentist, that dentist will examine the child's teeth and undertake any treatment required to bring that child to 'Dental Fitness'. The £28,000 funding for this treatment comes from the Health and Social Services Department. It is a taxpayer funded benefit and there is no cost to the family, providing that they fall below the income bar of £43,197. Once the child reaches 'Dental Fitness' they become eligible for the Dental Fitness Treatment Scheme.

Dental Fitness Scheme funded by Social Security

5.2 At this point, the arrangements change. The scheme began in 1992 when the arrangement was that a dentist taking on a 'Dentally Fit' child would receive £6 per month for the maintained treatment of that child. If the work were expected to cost more than the monthly-accrued amount agreed with the parents, then a payment plan would be agreed with those parents for the outstanding amount. At that time, £6 per month was usually sufficient to cover the costs involved. Although the Minister for Social Security alleged that the scheme has been reviewed over the years[1], the payment to dentists has remained at £6 per month since the inception of the scheme 18 years ago. This was confirmed by the Consultant in Restorative Dentistry, stating that:

> *"£6 per month is what the States provides and that £6 per month comes from the £140,000 held by S.S. (Social Security)."*[2]

[1] Transcript of Public Hearing with the Minister for Social Security 30th July 2010
[2] HSSH Public Hearing transcript from 26th July 2010 quote from the Consultant for Restorative Dentistry

Worryingly, he went on to say:

> *"I think what is more noticed by the providing dentist is the £6 per capita which was introduced in 1992. The States pay the dentist £6 per month per child enrolled by that dentist and that has not gone up. That is the bit, I have to say, that there is a level of concern and disquiet by the providing dentists."*

The Panel believes that this 'concern and disquiet' amongst the providing dentists could lead to some dentists withdrawing from the scheme. As will be discussed further, these private practice dentists appear to be responsible for the delivery and management of the schemes.

5.3 Costs to parents are now regularly £6 to £10 per month, per child. The Panel questions the affordability of this, particularly where a family has three or more children. The income bar, which is set at £43,197, takes no account of the number of children within the family. The system works well for a single child family but places pressure on a family with more children. The Consultant in Restorative Dentistry explained:

> *"So if the parents have 10 children or one child it is much the same. Again, you can imagine where there is discomfort and perhaps an element of resentment in the family where they have 3 or 4 children and they are already on a low income and they have got to pay 3 lots of capitation charges for their children."*[3]

If this is not affordable, the children can suffer dental ill health, the parents could be considered irresponsible for failing to meet the payments and at some point, the system will be required to sweep up the worst cases who end up in hospital or other areas of the emergency treatment structure.

KEY FINDING 1

The Dental Fitness Scheme income bar is unfair on families with more than one child.

[3] HSSH Public Hearing transcript from 26th July 2010 quote from the Consultant for Restorative Dentistry

RECOMMENDATION 1

The Minister for Social Security should provide an incremental means tested system within the Dental Fitness Scheme to accommodate families with more than one child.

5.4 It is evidenced that the lower quintiles of society suffer the worst dental health, which can be due to poor diet or lifestyle.[4] Why then should those sectors of society be hardest hit by a system which has failed to meet modern standards due to a historical funding system based on financial standards, which are 18 years old? The Panel recognises that this system needs a complete restructure.

5.5 Such a change would, in principle, seem to be straightforward to achieve. The problem is that the system relies on the partnership between the Minister for Health and Social Services and the Minister for Social Security. The Panel expects both Ministers to deliver on their given assurances at the Public Hearings of 26th and 30th July 2010 to update existing dental schemes.

KEY FINDING 2

The Dental Fitness Scheme has not been updated for 18 years.

RECOMMENDATION 2

The Minister for Health and Social Services together with the Minister for Social Security must deliver an updated Dental Fitness Scheme before 8th July 2011.

The Westfield 65+ Plan funded by the Social Security Department

5.6 The Plan for over 65's has an income bar of £14,110 for single people and £23,220 for a couple. The Panel recognises, but questions, the presumption that a couple need less treatment than two single individuals. The submissions received by the Panel have outlined the following two problems with the Plan;

- Payment for any treatment received is required 'up-front' at the point of treatment and claimed back after the event, which causes

[4] HSSH Public Hearing transcript from 26th July 2010 quote from the Consultant for Restorative Dentistry

unnecessary layers of administration and could prove prohibitive to low income individuals; and,

- The Plan covers the treatment of teeth, eyes and feet. Funding within the scheme is compartmentalised to those areas with no provision for moving funds across the categories. Dentistry frequently exceeds the allocation leaving funds unused within the ophthalmic and chiropody budgets. The Panel questions why the money is ring fenced and why there is not more flexibility in the Plan to accommodate high dental costs.

KEY FINDING 3

The existing Westfield 65+ Plan requires payment at the point of treatment.

KEY FINDING 4

More flexibility is needed in the fund management of the Westfield 65+ Plan

5.7 The problems with the Plan were recognised by the Minister for Social Security who stated during the hearing:

> *"Just to go back to your other point about paying up front. You are absolutely right and that is another reason why it needs to be reviewed."*[5]

In a point of clarification, he accepted that it was his responsibility to review the Plan and bring it up to date.

> *"Perhaps there is an argument to say that some of those parameters should be changed because you have got the eyes, feet and teeth, you have allowances under each of those headings, you cannot transfer the benefit from one to the other, as you would not expect in a normal insurance scheme…But that perhaps is an area we should look at and see whether we cannot get a slightly more flexible policy…"*[6]

[5] HSSH Public Hearing transcript from 30th July 2010 quote from the Minister for Social Security

RECOMMENDATION 3

The Minister for Social Security must remove the necessity for payments at the point of treatment within the Westfield 65+ Plan by 8th July 2011.

RECOMMENDATION 4

The Minister for Social Security should ensure more flexibility in the administration of the Westfield 65+ Plan by 8th July 2011.

When asked about the management of the 65+ plan, the Minister for Social Security stated:

> *"Well it is managed by… we are responsible for it but it is managed by Westfield in effect, yes."*[7]

The Panel is concerned that the Ministers are not fulfilling their responsibilities for dental services and the related schemes.

KEY FINDING 5

The Minister for Social Security has devolved his responsibilities for the Westfield 65+ Plan to the administrating body.

RECOMMENDATION 5

The Minister for Social Security must immediately take responsibility for the Westfield 65+ Plan.

Income Support Dentistry Special Payments funded by Social Security

5.8 Special Payments are targeted at recipients of Income Support or households with an income of just above the Income Support threshold. It has two separate sections

(i) Where an individual is suffering pain.

(ii) Follow up corrective dental treatment.

[6] HSSH Public Hearing transcript from 30th July 2010 quote from the Minister for Social Security

Where an individual is in pain, he may attend a dentist and treatment will be offered to alleviate that pain, supported by a telephone call to the Social Security Department by the dentist.

Follow Up Corrective Dental Treatment

5.9 If corrective treatment needs to be carried out the department will authorise treatment within the Special Payments, which the Minister for Social Security claimed to be reasonably quick. There is no dental expertise within the department and it relies on the dentists for advice of the necessity or urgency of the treatment.

The Panel recognises that there have been significant improvements in the delivery of the Special Payments since its inception.

School Dental Screenings

5.10 Every Thursday morning during the school terms two dentists conduct visits to Primary Schools along with a dental nurse to assist them. The visit consists of a short examination looking for early signs of dental decay, tooth eruption problems, gum and soft tissue (lips, cheek and tongue) problems. If a child has a problem spotted at this visit then a letter is given inviting the Parents/Guardian to book at the Dental Clinic for further assessment and possible treatment. This is funded by the Health and Social Services Department,

5.11 The Panel recognises the value of School Dental Screening and encourages the Minister to recommence it through the forthcoming period of austerity and cuts that lie ahead for the Island.

[7] HSSH Public Hearing transcript from 30th July 2010 quote from the Minister for Social Security

Annual Dental Epidemiology Survey

5.12 Survey programme was on a 4-year rolling cycle to survey a range of age groups (5, 11, 12, 14 year olds) anonymously in accordance with the British Association for the Study of Community Dentistry. It was carried out once a year with the last one conducted in 2008. A Consultant in Dental Public Health, who was assisted by a certified scribe, carried out the survey,

5.13 The statistics gathered were included in the U.K. figures for comparisons with other areas in Britain. Perhaps more importantly, the statistics were valuable at a local level for the planning for oral health education and the future needs of the service.

5.14 This programme ceased following the States approved efficiency savings of two per cent across every States Department in 2009.

KEY FINDING 6

The loss of statistical data following the withdrawal of screening in schools does not allow for future planning and may prove to be a false economy.

RECOMMENDATION 6

The Minister for Health and Social Services should recommence screening in schools immediately to ensure that statistical data is available for the development of dental policies.

Residential Care

5.15 The Panel has found that there is a further vulnerable group who require particular care within society. People in high risk groups who are in residential care require particular services. During the discussion with the Minister for Health and Social Services, the following issues were raised:

(i) The Minister has given no thought to the people in these groups:[8]

[8] HSSH Public Hearing transcript from 26th July 2010 quote from the Consultant for Restorative Dentistry

"No, to be blunt. Until we had this review it had not been on my radar, so to speak. But it is interesting and full marks to the Consultant in Restorative Dentistry and his team too. I think it is those areas that perhaps Health and Social Service do not fly the flag saying this what we do. But obviously we do it."

(ii) The Consultant in Restorative Dentistry considered that large improvements could be achieved in residential care if patients mouths were cleaned with a fluoride toothpaste.

(iii) Cleaning inside the mouth is considered invasive, and as recognised by the Panel Members, cannot therefore be done. The Consultant confirmed this saying:[9]

"Yes. I came into conflict with the manager of one of the homes over that precise issue. When a carer brought a patient in to see me at the hospital and I was frankly appalled at the poor oral hygiene. It was not the patient's fault, the patient does not know what to, they cannot do it, the patient has lost their self-awareness and it is the responsibility of the carer. I challenged the carer. I said: "Why is this patient not having their teeth cleaned?" He said something that upset me, he said something along the lines it is against their human rights and I thought: "My goodness.""

5.16 It has not taken the Panel a great deal of effort to establish that the local guidelines on dental care within residential communities are not clear. The Consultant in Restorative Dentistry further stated:[10]

"They [persons in care] are not getting their teeth cleaned because people fear that it infringes their human rights, that really need to be addressed."

[9] HSSH Public Hearing transcript from 26th July 2010 quote from the Consultant for Restorative Dentistry
[10] HSSH Public Hearing transcript from 26th July 2010 quote from the Consultant for Restorative Dentistry

5.17 United Kingdom's Mental Capacity Act 2005 Code of Practice offers a best practice model for professional carers working in a residential care environment in the absence of any local legislation. The Code of Practice makes it clear that care should be in the interest of the patient, not the interest of the staff or carer. Insufficient training appears to have created an environment caution with regard to delivering oral hygiene which can be viewed as invasive[11].

KEY FINDING 7

The Minister for Health and Social Services has a duty of care to residential patients being cared for by her department, which extends to ensuring that all professional carers are properly trained in the delivery of oral hygiene.

RECOMMENDATION 7

The Minister for Health and Social Services must provide adequate oral hygiene training provision for all carers working in public or private residential care by 8th July 2010.

5.18 The Panel notes the suggestion of the Consultant in Restorative Dentistry that a solution may be to supply all residents in care with fluoride toothpaste. He suggested that this should require minimal funding.[12]

KEY FINDING 8

The Consultant in Restorative Dentistry advocates the use of fluoride toothpaste for patients in residential care.

RECOMMENDATION 8

The Ministers for Health and Social Services should discuss the introduction of fluoride toothpaste for those in residential care with the relevant professionals.

Overall Responsibility

5.19 It has been made very clear to the Panel that the responsibility for the dental health of islanders lies with two Ministers. The Minister for Health and Social

[11] HSSH Public Hearing transcript from 26th July 2010 quote from the Consultant for Restorative Dentistry

Services has responsibility for all surgical dentistry, referrals to the General Hospital and for children from birth to 11 including ensuring that they are dentally fit to access the Dental Fitness Scheme. The Minister for Social Security has responsibility for the funding of the Scheme, oversight and funding of the Westfield 65+ Plan together with the delivery and funding of Special Payments. Currently neither Minister appears to have given attention to the dental issues causing Islanders problems.

5.20 The lack of clarity over responsibility was further highlighted when the Minister for Health and Social Services was asked:

> *"Whose responsibility is it to try to keep dental fees down in some way or to arrange for access and availability to dental services at reasonable sort of rates?"*

The Minister replied:

> *"I think mainly the responsibility lies with the dental surgeons themselves but I am sure you might have a view."*

The Consultant in Restorative Dentistry, disagreed, saying:

> *"I believe it is the States responsibility to arrange some form of access to dental care."*[13]

5.21 The Panel finds it difficult to accept that the Minister for Health and Social Services should be so unaware of her responsibility for the dental health of islanders. The Minister has failed in this area of her remit. The question must be asked, who has been at the helm for the last 18 years? The Panel has a serious problem with that concept that dentist have been left with the responsibility of keeping dental fees down and for the availability of dental services. It is no wonder that the public is dissatisfied with dental costs[14]

[12] HSSH Public Hearing transcript from 26th July 2010 quote from the Consultant for Restorative Dentistry
[13] HSSH Public Hearing transcript from 26th July 2010 quotes from the Minister for HSS and the Consultant for Restorative Dentistry

5.22 It is completely unacceptable for the service providers to be expected to take over the responsibility which is firmly within the brief of the Minister of Health and Social Services.

KEY FINDING 9

Dentists rather than the Minister for Health and Social Services appear to have been left with responsibility for the management and delivery of dental health.

RECOMMENDATION 9

The Minister for Health and Social Services must immediately take responsibility for the provision of the existing dental schemes.

5.23 The problems do not stop there. When asked if there had been regular communication between the Ministers to maintain a co-ordinated service to the public, the Minister for Health and Social Services stated:

> *"No, I have not. Obviously the Minister for Social Security and I do talk quite regularly, especially regarding the Health Insurance Fund, but in saying that specifically the dental treatment has not come up in conversation."*[15]

5.24 The Panel finds it completely unacceptable that there should have been no formal communication between the Ministers on this subject and even more incredible that there has not even been informal conversation relating to the subject.

KEY FINDING 10

The Minister for Health and Social Services and the Minister for Social Security have overlooked their remits for dental services and failed to communicate in order to co-ordinate a coherent policy.

RECOMMENDATION 10

The Minister for Health and Social Services and the Minister for Social Security must co-ordinate their efforts to provide a coherent policy with immediate effect.

[14] See section 6 of this report – comments from public submissions

Take Up

5.25 The problems of the Dental Schemes are further compounded by evidence of a low take up. The Consultant in Restorative Dentistry informed the Panel:[16]

> *"…we look at ways to try and attract new membership and expand membership because we are concerned at the relatively low uptake of the scheme by people who probably ought to be seeking it."*

5.26 During the hearings, it was explained to the Panel that the original funding of £35,000 to bring children to the required dental fitness had failed to be effectively utilised, as a result funding was cut back to £28,000. The Panel questioned why the money available had not been fully utilised. It came to the conclusion that there is insufficient publicity and promotion of what is available and therefore take up is low. An immediate and significant campaign is required to raise awareness of what is available to residents with targets for improving take up.

5.27 The problems are recognised by the Minister for Health and Social Services who stated:[17]

> *"…a lot of promotion work needs to be done…"*

KEY FINDING 11

The public is insufficiently informed of the dental schemes available in the Island.

RECOMMENDATION 11

The Ministers for Health and Social Services and the Minister for Social Security should immediately undertake a publicity campaign to promote dental health services provided in Jersey.

[15] HSSH Public Hearing transcripts from 26th July 2010 quote from the Minister for Health and Social Services.
[16] HSSH Public Hearing transcripts from 26th July 2010 quote from the Consultant of Restorative Dentistry.
[17] HSSH Public Hearing Transcript from 26th July 2010 quote from the Minister for Health and Social Services

Membership fall out

5.28 The Panel noted that no mechanism exists within the systems to assist individuals who fail to meet payments. Where a child is confirmed as 'dentally fit' and the family then commences to pay the capitation fee, be it £6 or £10 per month, what happens when the payment stops being made? The Consultant in Restorative Dentistry stated:[18]

> *"That is a very difficult area and it has not ... there had not been a mechanism to pick that up. What typically happens is that the member might stop paying their money. If they do that, if the dentist is so inclined, he may terminate the membership, in which case that parent might have to refund the enabling treatment that was done in the first place to get them dentally fit. They are liable to pay that, although I cannot recall a case where it has happened it is part of the rule that it could happen. But what typically happens is that the capitation fee ... the parental contribution would be stopped for a period of time and all would be well, meanwhile the child might have a poor diet and there is an increase in dental caries, that is tooth decay, and then at some point the child develops toothache and they then re-present at the dentist. They have not attended for a number of months, they have not had preventive care, they have not had fluoride treatment, they have not had the dentist watching to detect every disease and suddenly they re-present and there is a lot of disease but the dentist is then obliged to treat that and feels out of pocket. So it is an inherent problem within the scheme that that can happen. There is not automatic termination of membership if they miss one payment and it is a grey area."*

5.29 There appears to be a moral problem falling on the shoulders of the dentist. Either treat the patient who has not been paying or allow that patient to go untreated. This is an area that requires consideration and it may be that the role of an independent regulatory body or an ombudsman is required to address these issues. If no action is taken and dentists are regularly out of pocket, they may start to withdraw from the scheme.

[18] HSSH Public Hearing transcripts from 26th July 2010 quote from the Consultant of Restorative Dentistry

KEY FINDING 12

The Dental Fitness Scheme has no mechanism for dealing with parents who stop paying the monthly fee for their child's dental treatment.

RECOMMENDATION 12

The Minister for Social Security should identify and implement a mechanism for dealing with members of the Dental Fitness Scheme who do not maintain their monthly fees.

6 THE COST OF DENTISTRY

The issue of personal affordability coloured every submission from members of the public. It was a levelling analogy for the Panel to note the submission quoted earlier (para 4) which likened the cost of attending the dentist to the purchase of a second hand car. Another stated as follows -

> *'The cost of a check up alone is equivalent to some household weekly shopping bills'*[19]*.*

6.1 Whilst there are significant costs in providing a private practice service, the demand by the people of Jersey for dental services is driven by necessity rather than by aspiration. In other words, when you have a problem with your teeth, you have no choice but to visit the dentist. It is, to all intents and purposes, a captive market.

6.2 A number of submissions suggested that the average family struggles to afford maintaining the cost of ongoing regular check ups and dental treatment. Other submissions suggested that families in the middle-income bracket are experiencing significant difficulty in maintaining their standard of living and some of those identify the cost of dentistry as a key contributor to the onset of a debt spiral.

6.3 Submissions indicate that patients are often obliged to opt for a course of less costly corrective treatment, rather than that which may be best for their dental health in the longer term. Submissions also reported the high cost of treatment:

- 6 from Pensioners
- 9 from Middle Income Families
- 1 from a Low Income Family
- 2 from Single Parent Families
- 7 Anonymous or from families with unknown circumstances.

(a list of the subjects contained in the submissions can be found within the appendices of this report)

[19] Anonymous submission from a member of the public

6.4 Furthermore there is evidence that members of the public are simply avoiding going to the dentist because of cost. The Panel believes this will have a long-term impact to the general health of Islanders if no provision for addressing the costs associated with dentistry is introduced. This will increase overall costs in the long term.

6.5 This is evidenced by a submission, which explained how the lack of affordability of regular dental maintenance resulted in a hospital stay for an adult and respite care for their disabled child. This raises issues of the knock on effects of a dental system that appears to be beyond the financial capabilities of the average family.

6.6 The cost of dentistry appears prohibitively high especially as there is no mechanism to allow for the publication of fees or average fees that are likely to be incurred. That lack of information precludes individuals from having an opportunity to plan expenditure for dentistry work and accommodate it within their budgets.

6.7 One submission received highlights the misunderstanding by the public of what is actually available.

> *'Children up to the age of 18 should have free dental treatment as a starting point.'*

6.8 As mentioned previously in this report dental schemes do exist to assist residents with aspects of treatment. However, there are large sections of the community who are not provided with any assistance and submissions suggest those that do exist are insufficiently advertised. The Panel believes that more inclusivity is required to provide access to a broader section of the community.

Practitioners View

6.9 In the words of the States' Consultant in Restorative Dentistry:

> *"I cannot think of any way in which the States could control dental fees. The dental fees are drawn up on an individual basis by each dentist based on their cost to operate.*

6.10 The Consultant goes on to explain in some detail the costs that could be incurred by a dental practitioner, included at Appendix II of this report.

6.11 Whilst schemes exist locally for certain sectors of society, there is no provision to provide support for the majority of those between the ages of 18 to 65 years of age.[20] The public appear to be entirely at the mercy of fees and price structures that are set according to the judgement of each individual General Dental Practitioner.

KEY FINDING 13

Submissions received from the public suggest that the existing provision of dental schemes excludes a large proportion of the population between the ages of 18 and 65.

RECOMMENDATION 13

The Minister for Social Security must provide dental benefit to ensure that all residents can access at least basic dental care.

[20] Supported by submission received from dental practitioner

7. RESPONSIBILITY AND LEGISLATION

Key Findings 5 and 9 point out that the Minister for Health and Social Services and the Minister for Social Security are failing to undertake their responsibilities with regard to dentistry in Jersey. The Panel found that the problem is more serious and noted that, there is no local authority regulating dentistry in Jersey. This was confirmed by a local practitioner.

7.1 Members of the profession in Jersey tend to follow the guidelines published by the British General Dental Council (GDC). There is a Jersey Dental Association (JDA), which is a voluntary professional association, with no statutory powers or authority to oversee the delivery of services in the Island. So who does regulate dentistry in Jersey? The dentists do. The Panel considers this to be wholly inappropriate, considering that this relates to an important aspect of public health that has a direct impact on every member of Jersey society.

KEY FINDING 14

There is no statutory regulatory body for dentistry in Jersey.

RECOMMENDATION 14

The Minister for Health and Social Services and the Minister for Social Security must establish an independent statutory regulatory body to oversee the delivery of dentistry services in Jersey.

7.2 The Panel was advised that the Jersey Dental Association's former practice of surveying its members to discover their average fees for treatment was recently prohibited by the Jersey Competition Regulatory Authority, on the grounds that it may lead to an artificial standardisation of prices. However, as one practitioner suggested:

> *"The competition people told us some time ago that for dentists to discuss fees between ourselves was illegal and to survey our membership on fees in order to discover an average was also illegal.*

I can understand the need for competition laws but in my opinion this interpretation of the law is ridiculous."[21]

7.3 Article 8 of the Competition (Jersey) Law 2005, deals with issues of directly or indirectly fixing prices preventing data relating to goods or services, including pricing, being collected or published within a group such as dentists. The JCRA, who are responsible for the application of the Law, maintains that collection of data relating to prices could lead to price fixing. The Panel has received a submission that this effectively prevents dentists or members of the public from knowing what an average fee would be, which, it could be argued, makes lower and more competitive fees difficult to achieve.

7.4 Being that there is no regulatory body, it follows that there is nowhere for people to go should they enter into a dispute with a dentist, other than the recourse to normal litigation procedures. This cannot be appropriate as dental health issues relate to the general public health of residents. The Panel recognises that there is an urgent and genuine need for a regulatory body with power to enforce best practice within the dental profession. This could be as simple as the appointment of an independent dental ombudsman in Jersey. It would be appropriate for an ombudsman service to be established by the Minister for Social Security, as he is not responsible for delivering the dental service.

KEY FINDING 15

There is no ombudsman to deal with disputes relating to dentistry.

RECOMMENDATION 15

The Minister for Social Security must establish an independent dental ombudsman's service.

[21] Submission from a dental practitioner

Health Insurance (Jersey) Law 1967

7.5 In 1964, the States of Jersey adopted P69/1963 thereby creating the Health Insurance (Jersey) Law 1967.This legislation created a system whereby a percentage of earnings was taken from both employees and employers to fund certain health benefits for insured members of the scheme. The descriptions of the benefits are contained within article 7 of the Law:

The description of the benefit provided by this law are as follows-

(a) medical benefit;
(b) dental benefit;
(c) ophthalmic benefit;
(d) pharmaceutical benefit.

7.6 Dental benefit is afforded the same importance as medical and pharmaceutical benefits throughout the Health Insurance (Jersey) Law 1967. It is clear that the intention of the law was to provide residents not only with medical and pharmaceutical benefits but also with dental and ophthalmic benefits.

7.7 The Health Insurance (Jersey) Law 1967 provides for the introduction of each of these benefits by regulation.

7.8 Subordinate regulations for medical and pharmaceutical benefits were introduced, however dental and ophthalmic benefits were omitted.

7.9 Each year the Health Insurance Fund pays out in benefits approximately three quarters of the money it collects from Social Security contributions.[22] The balance of that fund, as at December 2009, was £77, 476,000.[23] Medical Benefits paid for that year were in the amount of £5,785,000. The surplus of income over expenditure for that year was £5,378,000. The Panel believes that in view of those figures there is the potential to develop a dental benefit

[22] Page 49 Social Security Report and Accounts 2009
[23] Page 54 Social Security Report and Accounts 2009

scheme of similar cost to the provision of medical benefits. As previously stated this clearly was the original intention of the States.

7.10 The Panel have noted the Report by the Government Actuary on the financial condition of the Health Insurance Fund as at 31st December 2007 and recognise that the forecast for the fund suggests diminishing returns. However, the report states:

> *'For these reasons, there is considerable uncertainty about the future progress of the Fund. While the assumptions adopted form a reasonable basis for the review, in practice the Fund's experience, and hence its financial progress, will be different. These differences will be analysed and taken into account in subsequent reports. It is important for readers of this report not to place undue emphasis on a single set of projection results. Instead, it is appropriate to consider the effect on the Fund if actual experience differs from the principal assumptions.'*

7.11 Nonetheless with a £3,000,000 annual surplus there remains scope for the Health Insurance Fund to provide funding for improved dental care.

KEY FINDING 16

The sections of the Health Insurance (Jersey) Law 1967 relating to dental treatment have not been enacted yet the Health Insurance Fund has an annual surplus.

RECOMMENDATION 16

The Minister for Social Security must consider the introduction of a dental benefits scheme as outlined within the Health Insurance (Jersey) Law 1967 by 8th July 2010.

7.12 Whilst it is recognised that it is outside the remit of this particular review the Panel was interested to note that administration for the Health Insurance Fund costs £1,489,000 in 2009. The Panel would be interested to know why the cost is so high.

7.13 The Panel noted with interest that the Consultant in Restorative Dentistry, who accompanied the Minister for Health and Social Services to a Public Hearing on 26th July 2010, also runs a private practice.

7.14 The Panel considers it inappropriate for the Consultant to be advising the Minister, as he appears to have a direct pecuniary interest in private dentistry, which represents a clear conflict.

KEY FINDING 17

The Consultant in Restorative Dentistry in his role as advisor to the Minister for Health and Social Services appears to be conflicted as he is also in local private practice.

RECOMMENDATION 17

The Minister for Health and Social Services must ensure that advisors are not conflicted.

8. CONCLUSION

The Panel has identified **17** key findings showing areas in which Jersey's dental health services require consideration. It is not the role of Scrutiny to suggest alternative policy nor to propose new theories as to how the States might progress its broader strategies. Our role has simply been to discover the problems with current policy and to that end, we have made **18** recommendations.

8.1 There is an urgent need for an informed debate on this subject, both in the States Assembly and between the relevant departments and stakeholders. Consideration must be given to the cost of doing nothing. Attention must be paid to the implications on general health arising from poor dental health.. There is urgent need for the development of a modern dental strategy.

8.2 The Panel has been able to uncover a number of flaws in the existing system just by looking at the headline issues, such as which services are provided and who is able to access them. The onus is now on the two Ministers to find solutions to these problems. A quick win could be achieved with a dental health promotional campaign. In the longer term, the role of the Health Insurance Fund in making dental health services more affordable to Jersey residents, as part of primary health care must be undertaken.

RECOMMENDATION 18

The Ministers must review policy in order to deliver a modern dental health service as part of the primary health care system.

APPENDIX I

Evidence gathering

Public Hearings –

Minister for Health and Social Services; Deputy Chief Officer, Health and Social Services; Directorate Manager for Surgery; Consultant in Restorative Dentistry; Consultant in Orthodontics – 26th July 2010.

Minister for Social Security; Chief Officer, Social Security; Policy and Strategy Director, Social Security; Business Manager, Social Security – 30th July 2010.

Written submissions –

The Panel received the following written submissions from professionals working in the public and private sectors.

- Health and Social Services Department
- Jersey Dental Association
- Mr J Mulry, Dental Department
- Dr M P Bennetts
- Dr E D Sharpe
- Jurat P Liddiard
- D Pyper BDS, DGDPRCS
- Headteacher, La Moye School
- Dr D J Bailey

Background Fact Finding Visits, Lead Member and Officer -

States of Jersey Dental Department: 14th May 2010
Visit to Princess Elizabeth Hospital Dental Department Guernsey: 18th May 2010

Appendix II

Consultative in Restorative Dentistry at a Public Hearing with the Minister for Health and Social Services on 26th July 2010.

So operating costs, dentists need premises, so they need to find freehold premises and how much would that cost? £500,000-£600,000 to buy freehold premises from which to operate or they can rent premises. In my own case, I set up my private practice in 2003: I identified a place in Broad Street, 1,400 square feet, ground rent £36,000 a year. That was an empty shell that then had to be divided up into treatment rooms, waiting rooms and toilet facilities, instrument preparation, sterilisation and then heavy duty equipment had to be installed. An expensive electronic dental chair times 2, plus all the sterilising equipment, hospital grade autoclaves, they come in at about £8,000 each. You need 2, one to use and one for back up, and then the instruments themselves. The lovely delightful dental drill that everybody's familiar with, you need about 12 of those to circulate. They cost about £1,000 each. Then in my case there are 2 dentists using the premises and we have 3 dental nurses. Now each of these dental nurses has an expectation of a salary and the senior one will want more so we have 2 on about £15,000 and one on £20,000 a year. Then you have got insurance and all the other ongoing costs in order to comply with health and safety requirements, educational requirements, continuing education requirements, training. When you add all that up it comes to a very scary sum, and who would take the risk to provide that service with no return. So dentistry, although it is a health delivery service, follows the same business principle as every other business and it boils down to an hourly overhead. Now, I am happy to share my hourly overhead with you in private practice, it is £110 an hour. That is with nothing in it for me, there is no change for me. So if somebody comes and spends an hour with me I have got to cover £110 in order to just stay afloat. That is why dental fees are not cheap. The practice of dentistry is not cheap to deliver."

Appendix III

Dental Review Submissions

Subject	Amount of Submissions
Dental Provision around the world is never affordable	1
State funded extractions and routing scale and polishing would ensure a basic oral hygiene level	1
Treatment often not the best as patients can't afford that	3
Nobody from Social Security has told dentists what is acceptable treatment	1
65+ scheme out of date	1
Regulation seems OK	1
Published average of fees needed	2
Cost of Antibiotics etc	1
Lack of information to parents	1
Dental surgeries are expensive to maintain	2
Cost of missed appointments	1
High cost of treatment (Pensioner)	6
High cost of treatment (Middle income Family – 2 Children)	9
High cost of treatment (Low income)	1
High cost of treatment (Single parent Family)	2
High cost of treatment anonymous or unknown circumstances	7
Average family simply cannot afford dental treatment	4
Extortionate costs encourage poor dental health	3
Difficult to find prices for treatment	2
Many adults with poor teeth	3
People reluctant to spend money on dental treatment	1
High charges sends people abroad for inferior treatment.	8
Pricing morals of Dentists	1
Children should have free treatment	3
Show me a dentist in the lower quintile?	1
Lack of support for dental costs has resulted in hospital stay for adult and respite care for disabled child.	1
Can cost as much as a second hand car	1
Price of a check-up is equivalent to some households weekly shopping bill	1
State regulation needed for dental fees	1
Why are prices so very high in Jersey	1
Creates debt spiral.	2
States should be more involved	2
Westfield Health (65+) Unclaimed money from one section of the scheme should be transferable to the other.	1