National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from Public Health Wales – OS 04

Response to the National Assembly for Wales' Health and Social Care Committee Short Inquiry into Orthodontic Services in Wales.

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Purpose and Summary of Document:

To provide a response to the National Assembly for Wales' Health and Social Care Committee`s Short Inquiry into Orthodontic Services in Wales.

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We have aligned our response to the key questions and issues set out in the Inquiries' terms of reference. As a team of consultants and Specialists in dental public health, working across Wales, we have collated our knowledge of orthodontic provision at local level. We considered orthodontics in the context of the oral health priorities of the population, the difficult financial position facing the NHS and the Welsh Government`s call for prudency. In that context we present our honest opinion on the issues we identified.

The impact of the dental contract on the provision of orthodontic care and whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money?

1. Value for Money

1.1 After reflecting on the Welsh Government's definition of prudent healthcare we ask:

- How much is orthodontic treatment contributing to treating the nation's greatest health needs?
- How strong is the evidence base underpinning the long term outcome and the impact of orthodontic treatment?
- Is orthodontic treatment really doing the minimum necessary?
- Is orthodontic treatment about equal partnership of patient and professional?
- Is orthodontic treatment co-creating wellness?
- Is orthodontic treatment doing no harm?

1.2 The key question is the first one i.e. where should orthodontics fit in terms of priorities within NHS dental services and overall interventions provided by the NHS?

1.3 If orthodontics was being considered as a new type of treatment/Specialty probably only a relatively few patients needing multidisciplinary care, usually in a secondary care setting (e.g. clefts and other craniofacial anomalies), would be given access to it within the NHS. The great majority of orthodontic treatment would likely be considered to mainly address aesthetic concerns, and it would be closely questioned as to what and how much orthodontic treatment the NHS should provide in the context of other priorities.

1.4 It should be expected that orthodontic treatment in hospital should be limited to those children and adults who require complex and multidisciplinary management such as cleft lip and palate patients and craniofacial jaw surgery patients. Currently it is not clear what kind of variation exists between Local Health Boards (LHBs) in the provision of adult orthodontics in hospitals. The data system in secondary care orthodontics needs require improvement if we are to understand these variations. Robust national criteria for receiving adult orthodontics treatments in hospitals are required.

1.5 Recently orthodontists have been extolling the preventive benefits of orthodontic treatment e.g. that with straight teeth it may be easier to achieve and maintain good oral hygiene. The financial cost for achieving such an outcome would be very high. Irregular teeth are much less destructive to health at population level than caries, gum disease and oral cancer. It is our opinion that the majority of orthodontics provided in primary care does not impart any major preventive benefit that would lead to an acceptable level of health gain, and certainly not for the cost.

1.6 In the context of the above; diversion of primary dental care resources to orthodontics means that we do not prioritise the greatest need as a higher priority e.g. pain and tooth decay. The health gain (wellness) generated by much of orthodontic treatment, and the long terms stability of many of these costly treatments has been questioned.

1.7 If we were asked to consider provision of more access to particular types of dental/oral health services, we would prioritise the following before primary care orthodontics:

- Better access to urgent dental care
- Increased provision of evidence based population level dental prevention interventions
- Higher proportion of population accessing general continuing care in the General Dental Services and improved access for vulnerable groups
- Comprehensive and equitable care for the most vulnerable, the frail and those needing special dental care
- Domiciliary services
- Provision of conscious sedation services for anxious and phobic patients and reduced waiting times for GA where this is the only treatment option
- Provision of intermediate services such as services provided by dentists with Specialist or enhanced skills in oral surgery and endodontics.

2. Affordability and Sustainability

2.1 During the last years of the previous dental contract, NHS spend on primary care orthodontics raced ahead of spending increases in other NHS budgets. Under the non-cash limited arrangements from 1992 to 2006 there was an upward trend for annual expenditure on orthodontic treatment driven partly by new providers

simply setting up where they chose. To a large degree the relatively high spend on orthodontics and the high remuneration enjoyed by orthodontists is an historical accident that was "allowed to happen" under the pre-2006 arrangements.

2.2 Further, it is prudent to ask if the level of orthodontic remuneration now fully captures the technical advances made which have reduced the time needed to fit and adjust fixed appliances, and the increased use of less costly orthodontic therapists in hands-on provision of the treatment.

2.3 The Welsh Government document *The Delivery Plan Together for Wales: A National Oral Health Plan for Wales 2013-18*[i], was issued on 18 March 2013. It noted the **£13 million** spend on primary care orthodontics per annum and that this accounts for:

'*approximately 10% of the primary care dental budget and 40% of the total spend on children's dentistry in primary care dental services.*'

2.4 As a letter from the Chief Dental Officer for Wales in 2006 pointed out, a letter most applicable for the times of austerity in which we now find ourselves, "*there is a need to balance the priority of orthodontics against other dental and general health services".* It has to questioned whether the current level of spend on orthodontics is sustainable in Wales. Wales is a country that has the highest prevalence of child dental decay in Great Britain and which annually puts 9000 of its children through the trauma and risks of tooth extractions under general anaesthesia, because their poor oral health means there are few other treatment options available. One could conclude that we should be spending less on the aesthetic elements of orthodontic provision and more on the treatment of child dental decay and oral health prevention initiatives to prevent it?

2.5 A report which investigated public opinion on NHS dental services, on behalf of LHBs in Wales, was published by Cardiff University Dental School in 2008[ii]. This showed that the public had clear preferences when it came to different treatments. The public ranked orthodontics lowly when pitched against a range of other dental types of dental care/treatment.

3. Impact of the current contract

3.1. One thing that has changed is that orthodontic treatment delivered in primary care is provided by fewer dentists, holding contracts with LHBs, and working out of specialist orthodontic practices.

3.2 Orthodontic services in Wales have been reviewed both regionally and nationally. *The Delivery Plan Together for Wales: A National Oral Health Plan for Wales 2013-18* summarises the findings of two national reviews; the Independent Task and Finish Group established by Welsh Government to review orthodontics in Wales and an Inquiry conducted by the Welsh Assembly Health, Wellbeing and Local

Government Committee. Both of these highlighted the need for more effective planning and management of orthodontic services, and improvement in the efficiency and effectiveness of delivery. Some progress has been made towards implementing the various sets of recommendations but most of the inefficiencies in delivery identified by the reviews persist.

3.3 The 2006 dental contract capped spending at 2004-05 levels and introduced qualifying criteria and reporting of outcome requirements. It is questionable whether the criteria are universally applied. In addition, perverse incentives/variable interpretations of the contractual and regulatory requirements were introduced by the 2006 dental regulations which further opened the door to more inefficiency (discussed below).

3.4 In hard financial times, consideration of the effectiveness and efficiency of current orthodontic provision should come before any decision on additional non-recurrent and/or recurrent investment. Investing more public money into orthodontics, without making the system efficient first, will be akin to 'pouring water into the sand'. Ad Hoc waiting list initiatives are examples of this waste. Under the current GDS/PDS contracts orthodontic providers essentially receive the payment for a case "up front". Combine this with the situation where the orthodontic contract does not stipulate the number of treatments that an orthodontic contractor has to complete to fulfil his annual contract and the recipe for wasting public funding is compounded.

3.5 The NHS pays the same amount of money for completed and incomplete orthodontic treatments. As a result we believe there is a greater potential for treatments to be abandoned before completion. While some patients are waiting a long time for treatment, others may well be getting repeat courses of treatment. Moreover, the current requirement on reporting treatment outcomes is not fit for purpose. Orthodontists are required to enter referral dates, assessment dates and appliance fit dates and other treatment details on the NHS claim forms, but we understand that compliance with this requirement is variable. Therefore, comprehensive data is not available to inform commissioning, monitoring and planning of services. Also, LHBs have variable access to patient waiting list data within the orthodontic practices; information that would help to gauge numbers of 'premature/early', multiple and/or inappropriate referrals.

3.6 The current contract arrangements are loose and inappropriate incentives are in place. This has simply resulted in less of the available money being spent on completed courses of treatment and more on 'assessment only' and treatment starts, while completion rates are unknown. In addition, we believe that a greater shift of emphasis to quality and outcome of treatment is still required.

Access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales

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4. The need for orthodontic treatment in the context of other dental needs

4.1 The level of orthodontic need in Wales is little different from the level of need in the rest of the UK, *while the need for general dental care for children and adults in Wales is greater than that for the UK*. Unlike dental decay, there does not appear to be a significant difference in prevalence of malocclusion in children residing in the most deprived and less deprived areas[iii]. Social inequality is not deemed to be a predictor of non compliance with orthodontic treatment although it may be a risk factor for discontinuation[iv]. Inequalities in access to and low uptake of orthodontic treatment have been reported for districts of high deprivation in the UK.[v,vi] It has been postulated that Local Authority areas with more deprived areas will have higher levels of dental decay and a lesser proportion of children would demand and access orthodontic are. However, a study in Wales did not concur with these findings with no association being evident when data was analysed at Local Authority level[iii], but this study reflected the service delivery in old 'fee per item' system.

4.2 On the surface, inequality is not an issue – orthodontic "need" is spread equally with similar levels of access for deprived and less deprived.

However, it should be noted that the high spend on orthodontics means less money is available to address dental conditions like tooth decay which are strongly associated with deprivation. Hence it can be argued that less money is available to address oral health inequalities because of disproportionate spend on orthodontics.

5. Need as defined by orthodontic indices

5.1 A standard scientific methodology for calculating orthodontic treatment need in a population has not been agreed, although recently the various methodologies used across the UK share similarities. Orthodontics is, however, one of the few dental disciplines where treatment need indicators have been developed by the providers of care.

5.2 The Index of Orthodontic Treatment Needs (IOTN) is part of the criteria associated with the current contract. However, not all patients who qualify on IOTN grounds want orthodontic treatment, and not all those who qualify and want orthodontic treatment are suitable for a two year long course of orthodontic treatment.

5.3 The benefits and risks associated with orthodontic treatment have been identified by Richmond et. al.[vii] Despite the benefits listed, relative health gain from much of the orthodontic treatment provided is questionable. Therefore, it could be argued that there is a case for raising the qualifying bar for NHS orthodontic care and closely monitor the treatment outcomes achieved.

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6. Demand as opposed to need

6.1 The current system is still demand driven rather than need-based and outcome focused. Payment for assessment of patients is a factor driving waiting lists and waiting list initiatives. Careful patient selection is essential to reduce risks and both referring dentists and the orthodontist should have an important role to play in counselling patients *against* orthodontic treatment where this is unlikely to result in a health gain. Inappropriate referrals in terms of age and qualifying criteria, plus multiple referrals (one person referred to more than one provider), have historically helped to clog the whole system, generating payment for orthodontists and long waiting times. As we have already described, there is no incentive for orthodontists to actually complete cases to receive full remuneration, the inefficiencies are compounded by the remuneration system.

6.3 LHBs have funded one-off waiting list initiatives when dental budgetary positions allow, usually in response to public, media and political pressure. These initiatives are poor 'sticking plasters' and do little to solve access; indeed they often have the reverse effect. Orthodontic waiting lists are not validated lists and are partly generated by defensive practice and the prevalent "belt and braces" approach where dentists refer patients almost as routine for specialist orthodontic advice. Throwing more money at orthodontic waiting lists without correcting the causes described is an imprudent and wasteful approach.

Whether orthodontic services is given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector?

7. Reconsidering priorities

7.1 As we have presented above, given the current level of funding for primary care orthodontics, we are of the opinion that the Welsh Government and the LHBs have placed orthodontics higher on the list of dental priorities than it should be.

7.2 In the context of our opinions above, one part of the current dental contractual arrangements that the Welsh Government need to prioritise for revision is orthodontics, during which it would be commonsense to re-orientate the bulk of reimbursement to the point of completion of treatment.

7.3 If the Welsh Government is not going to prioritise reform of the primary care orthodontic contract, we believe that primary care orthodontic funding should be divorced from the rest of the GDS budget at the earliest opportunity, in conjunction with the development of a national commissioning framework for Primary Care Orthodontic Services. Further, orthodontics services might be better planned and commissioned on a regional, if not national, basis.

7.4 Orthodontics is unique within dentistry in that for the majority of cases it rearranges irregularly arranged teeth rather than treat harmful disease. At a population level the adverse health impacts of tooth decay, gum disease and oral cancer are much higher than the impact of irregularly arranged teeth, and the NHS should prioritise treatment of these oral diseases and oral health promotion initiatives to prevent them.

8. If the current orthodontic arrangements are to remain

8.1 Further investigation of waiting times and referral practices is required as there are a number of contributory factors that have been identified nationally. These include:

i. Premature referrals resulting in a high number of assessments and reviews
ii. Referrals of individual patients to more than one provider
iii. Referral to inappropriate setting/provider
iv. Inaccurate recording and reporting of waiting lists
v. Referrals of patients who are unsuitable to commence orthodontic treatment on grounds of:

- Having poor oral hygiene
- Being irregular attenders for routine dental care
- Having a high caries rate which has not been stabilised
- Having untreated caries which has not been identified in the referral
- Being unwilling to undergo treatment which has not been determined before referral

8.2 Some LHBs have introduced a centralised referral management centre while others have started to use standardised referral proforma in attempts to reduce inappropriate referrals and to guide patients to the most appropriate provider. LHBs should work to install systems that ensure their orthodontic planning and spend is not based on reaction to demand, with all the potential for low health gain and possible excessive commercial profit that might attach. The tasks being undertaken by the Orthodontic MCNs in terms of their Quality and Safety Agenda; recognition of Dentists with Enhanced Skills and referral and pathway guidance should help to reduce inefficiencies, but it is our opinion that *much greater reform is required to have a real impact*.

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