National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from Dr David J. Howells – OS 10

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Short inquiry into orthodontic services in Wales

Submission from Dr David J. Howells, BDS (ULond), MScD (Wales), LDS, DOrth, MOrth, FDSRCS (Eng).

I am writing to provide evidence on the provision of orthodontics, concentrating on the former county of Dyfed, based on my experience of working here as a consultant and specialist in orthodontics since initial appointment over 26 years ago. I am now semi-retired; working part-time in the only remaining specialist treatment service in the area as well as providing orthodontic outreach assessment advice.

1. The waiting list for NHS funded orthodontic treatment in Dyfed is over three years from referral. This is undesirable for several reasons:
   a. The optimum time for most orthodontic treatment is starting at 11-13 years of age, around the time of establishment of the permanent dentition. Patients referred at that ideal time will get their treatment late.
   b. Some orthodontic treatment, such as myo-functional orthopaedic appliances, are growth dependent. Many otherwise suitable patients are seen too late to benefit from this therapy.
   c. Patients treated late find it harder to combine their treatment with educational or work commitments, and to cope with it socially.
   d. In an increasingly mobile society, many children are forced to relocate. Long waiting lists make it very difficult for these individuals to obtain the care they need.
   e. Contracts for orthodontic treatment specify that patients will be below 18 years of age at the commencement of therapy. Although assurances have been given that patients who attain this age on the waiting list will still have their treatment fully funded, this only applies to treatment provided locally; those moving away for education or work miss out. All older patients will still have to pay for restorative dentistry or surgery associated with the orthodontic treatment plan.
   f. Lengthening waiting lists have led to early referral, general dentists attempting to predict dental development. This has the potential for introducing inefficiencies.

2. The waiting list is not static. It continues to grow as funding for orthodontic treatment is inadequate to keep up with need in the community. When the present orthodontic contracting system was introduced in 2006, the volume of orthodontic treatment being provided in Dyfed was growing fast. Two new specialist practices had been established, and awareness of the potential of orthodontics was growing in the population and the dental profession. No doubt the rapidly growing

expenditure on treatment was a big factor leading to the introduction of the present style of fixed volume contracts. The size of those contracts was fixed on then historical data, effectively fossilizing orthodontic treatment volume at a lower level than that then current.

3. I do not know the relative waiting times throughout Wales, but many of our patients who have friends or relatives in England point out how unfavourably our waiting lists compare. In many parts of England there is no waiting list at all for acceptance for NHS funded treatment in an orthodontic specialist practice.

4. These differences in waiting times must reflect differing priorities accorded to the specialty. Orthodontics has the potential to provide sometimes dramatic and lifelong enhancement to dental health and psycho-social well-being. It is relatively inexpensive, effective, and highly valued by our patients and their families - it is great to work in a field which is so well appreciated. It could serve as a cost-effective means to enhance public appreciation for the local NHS.

5. The Local Health Board has taken over management of the waiting list for NHS orthodontic treatment, which should provide an appreciation of the scale of under-provision.
   One recent innovation has been the introduction of separately contracted orthodontic assessment outreach clinics so that patients on the list can be assessed and triaged early. (Funding for this service came from a former non-specialist orthodontic treatment contract, further reducing local treatment capacity). Cases in need of urgent multi-disciplinary treatment in the hospital service (in Swansea) can be referred appropriately; those with low objective treatment need and not eligible for NHS funded care can be removed, as can those not wanting treatment or otherwise unsuitable, validating the remaining list.
   In practice, the great majority of patients are found to be appropriately referred and need to remain on the long and growing validated list. All patients seen benefit from advice about the nature of their problem and the services available.

6. When I was appointed a consultant in 1987, half the funding for the new post was to provide a hospital based treatment service in Llanelli, the largest population centre in the area. This joined already well established consultant led services in Aberystwyth, Carmarthen and Haverfordwest. Consultants worked with clinical assistants and Community Dental Service based senior dental officers to provide a substantial volume of treatment for the highest priority cases. All of these services including their supporting nursing, secretarial, clerical, and dental laboratory services are now closed down. Little if any of the significant cost savings appear to have been applied to the re-provision of orthodontics.

7. The quality of care provided in specialist practices has been audited effectively for many years now using independent, calibrated technicians to apply objective measures of outcome (Index of Orthodontic Treatment Need and Peer Assessment Rating). In the early 1980's as part of my initial orthodontic specialist training in Cardiff, we examined treatment standards in the General Dental Services using the then newly developed Indices. The improvement in standards today is dramatic; largely due the increasing (now almost universal) use of sophisticated fixed appliance systems incorporating much improved technology. Treatment standards described as aspirational in a previous Welsh Government Orthodontic Working Party report are now routinely and consistently far exceeded in specialist practice in west Wales.

8. The cost of treating orthodontic cases in specialist practice has been substantially cut in recent years (my estimate here, over 40% in real terms over 5 years). The old NHS dental contract (pre-2006) was based on a fee per item of treatment, including each appliance and service provided for orthodontic patients. This system was market sensitive – funding followed the patient in a very real way so that, with economies of scale, specialists were able to raise finance for the capital needed to establish new practices and develop new services. Such service development is now inconceivable under the present system.
   That large cost savings have been attained at the same time as maintaining quality improvements is a function of two factors:
   a. The widespread introduction of Orthodontic Therapists who can more cheaply provide the great majority of operative care under specialist supervision.
   b. Real cuts in the income of professionals providing the service.

9. Although there is spare treatment capacity available locally, none of the saving made in the cost of treating orthodontic patients (*i.e.* the value of the NHS contract) appears to have been applied to increasing the volume of treatment contracted for.

10. To cope with fee reductions, orthodontic practices have needed to make stringent economies in staffing and materials. Quality has been maintained; though only the most cost effective treatments can now be offered. Some more expensive appliances (for example low friction "ligation-free" brackets) can no longer be offered routinely to NHS patients. I believe the scope for further reduction in the real value of fees without impacting upon quality is now non-existent.

11. The current contract uses a currency, the Unit of Orthodontic Activity, which is based only on assessments and case starts. No-one designing a new contract from scratch would propose the same UOA, but we need to be wary of change which could impact practice income and therefore quality of care.
    Some patients do move away before completing treatment, this is largely outside

the clinician's control and does not appear to be a great problem. I would suggest leaving a system we have become accustomed to alone, with continued monitoring to check no practices are reporting higher than acceptable failed completion rates. Changes could have unintended consequences, for example a move to count case completions only will make practitioners reluctant to start treatment for cases whose parents are in an occupation likely to relocate.

12. I have no doubt that substantial extra funding for additional treatment volume is needed to meet the needs of the population in Dyfed. In the short term, funding substantially more than that required to match the need will be essential if the huge backlog of untreated cases is to be dealt with. It should be noted that, in this part of Wales extra funding for orthodontics will involve no more than re-allocation of some of the savage cuts and large savings which have already been made.
A suggestion has been made that demand could be further reduced by redefining the criteria for rationing NHS funds to exclude the lowest class of objective treatment need (IOTN 3.6+). This would be easy to apply and rational, but like waiting list validation it is only likely to have a small impact on numbers.

13. We all appreciate that funding in the NHS is finite and limited. At a previous Welsh Health and Social Care Committee Inquiry into orthodontic services in Wales I gave evidence on behalf of the British Orthodontic Society. The chairman asked as a final question: what was my suggestion to match need and supply if no increase in funding is possible? My solution was to further reduce eligibility for NHS care by means-testing. This was described as lobbing a hand grenade into the debate, and I left the Committee Room in no doubt of the political difficulty of such a proposition in Wales; but just cutting fees and risking compromised quality of care seems far worse.

14. State funding of orthodontics is uncommon worldwide. In most countries families need to weigh a desire for orthodontics against other priorities such as holidays, cars or other material goods. Where state aid is given, fees available to service providers greatly exceed those available in the NHS. Up to the present the Government's solution to reducing costs has simply been to reduce fees to providers (in a way impossible in the salaried services) – leaving no scope for capital development and compromising equipment maintenance and replacement. Unless further fee cuts are halted, quality will suffer and that is unfair to both patients and service providers.

15. Orthodontics does provide very real advantages to the recipients, but wider society is not generally advantaged. For the majority of the population, it can be argued that independently funded treatment, where the professional is hired directly by the client, has advantages – it avoids delay starting, gives more choice of provider, and more choice of treatment method including expensive cosmetic techniques

such as clear aligners or brackets placed lingually (out of sight on the inside). If orthodontics were to be further withdrawn from the NHS (as it is some are unhappy about the exclusion of even minor cosmetic problems), provision would need to be retained for poorer families or those with severe dento-skeletal deformity requiring complex, multi-disciplinary care. Perhaps the time is approaching to open this debate, though I do appreciate the political difficulty; particularly if it invites further unfavourable comparison of English and Welsh NHS provision.

16. The **first access priority** must be to provide **adequate treatment volume**. Ceredigion, Carmarthenshire and Pembrokeshire together cover a vast, rural geographic area. The availability of just one treatment centre provides additional access problems. Getting children to our Carmarthen practice can involve well over three hours total travelling time.
    An efficient, high quality orthodontic service requires specialist manpower supported by therapists and orthodontic nurses. Considerable investment is needed including at least two dental surgeries as well as pan-oral and cephalometric radiography. Outreach assessment clinics have started to address geographical access problems. Contracts could be invited for treatment services – if the Health Board is willing to make under-utilised hospital and community clinics (whose capital and maintenance costs are already funded) available.

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