Windsor Framework
Democratic Scrutiny Committee

OFFICIAL REPORT
(Hansard)

COM (2023)395 Proposal to Amend Regulation (EU) 2017/852: Department of Health; Executive Office

18 April 2024

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Philip McGuigan (Chairperson)
Mr David Brooks (Deputy Chairperson)
Dr Steve Aiken
Mr Patrick Brown
Mr Jonathan Buckley
Ms Joanne Bunting
Mr Declan Kearney
Ms Emma Sheerin

Witnesses:

Mr Gearóid Cassidy	Department of Health
Ms Caroline Lappin	Department of Health
Mr Michael O'Neill	Department of Health
Mr Anthony Miller	The Executive Office

The Chairperson (Mr McGuigan): I welcome Caroline Lappin, the Department of Health's Chief Dental Officer; Gearóid Cassidy, the Department's director of primary care; Michael O'Neill, head of general dental and ophthalmic services, and Anthony Miller, the director of the Executive Office's EU exit coordination group. I do not want to cut anybody short, but we are running way over schedule. I will probably limit members to one question and one supplementary question each. If you want to, you can lean ar aghaidh. *[Translation: go ahead]*

Mr Michael O'Neill (Department of Health): We have some remarks to make, Chair: I will be as quick as possible. Thank you for the opportunity to brief the Committee. I am the head of dental and ophthalmic policy in the Department of Health; Caroline Lappin is our Chief Dental Officer; and Gearóid Cassidy, is the director of primary care. Anthony Miller is director of TEO's post-EU exit coordination group.

Members may be aware that at a European Parliament plenary on 10 April, MEPs, by a significant majority, adopted the final text of the mercury proposal, which impacts on the use of dental amalgam. We have been advised by the EU Council that there still needs to be a vote on the final text at a future Committee of Permanent Representatives (COREPER) meeting, and we do not yet have a date for that meeting.

As the Committee will be aware, the key date is the publication date of the new regulations, at which point the scrutiny period will begin. We expect that to be in May or June, but it is clearly in the hands of the relevant EU institutions. On 20 March, the Department of Health, via the Executive Office,

provided the Committee with views on the impacts of the proposals. I know that the Committee is aware of the policy background and purpose of the proposed regulations, so I will limit my remarks to our concerns around the likely impact in Northern Ireland.

It is important to state at the outset that we are committed throughout the UK to phasing down the use of amalgam. The UK is co-signatory to the Minamata convention, which is the global treaty to protect human health and the environment from the adverse effects of mercury. We have already ceased using dental amalgam for the treatment of deciduous teeth, the treatment of children under the age of 15 and the treatment of pregnant and breastfeeding women, except when it is deemed to be strictly necessary by the dental practitioner, based on the specific medical needs of the patient.

There is no doubt that the direction of travel across the globe is significantly reduced usage, and the British Dental Association (BDA) was of a similar view when it addressed the Committee. A key concern of ours, however, is the proposed timescale. Under the proposals, amalgam would no longer be an option for the vast majority of our patients. Alternative materials such as composites and glass ionomers would need to replace the use of amalgam. Those are materials that we currently use in the health service, but, for adults, they would generally be for only smaller fillings in front teeth. The Department's concern is primarily about fillings in back teeth; the larger fillings that are mostly treated with amalgam.

I will not repeat the written views already provided by the Department, but, in short, we are concerned about the impact on service capacity, which has not yet recovered to pre-pandemic levels, and the cost to the taxpayer, which we estimate will be £3·6 million, as well as the £2·9 million cost to patients who would need white fillings. Our cost estimates do not include the fact that the new materials do not last as long and so need to be replaced more often. Despite gradual improvements, the alternatives to dental amalgam still have technical and clinical limitations, and in certain clinical situations there is still no viable long-term alternative.

The increased cost implication represents a 4% increase to the Department of Health's dental budget at a time of post-COVID pressure on the dental health system and significant pressure on public finances. While there is a process in place to bid to the Treasury for cost pressures related to divergence due to EU exit, and while we continue to develop a robust case to seek to recover any additional costs, there are no cast-iron guarantees that they will be fully funded. Even if the additional costs were met, the composite fillings take longer to place. Therefore, there would be an inevitable impact on activity and capacity at a time when activity levels are around 73% of pre-COVID levels.

To address the risks that we face, the Department established the Northern Ireland mercury working group that we co-chair with DAERA, which is the policy lead generally on mercury and hazardous materials. The group is tasked with monitoring the passage of proposals, identifying the rising impacts and risks and agreeing a range of actions to plan for and mitigate those risks. Unfortunately for us, whilst other member states can plan with certainty regarding January 2025, it will be a number of months at least before we know for sure which laws will be in place in Northern Ireland in January, and we do not underestimate the difficulties that that will cause for our practices.

Whilst we expect significant impacts in January if the laws come into force, practices are already being impacted in terms of their short- and medium-term practice planning arrangements. Therefore, we must contingency plan for implementation. That means developing guidance for medical exemptions, amending our payment systems, assessing training needs across the sector, considering impacts to enforcement regimes and continuing to engage with UK Government Departments regarding the ongoing issues. The Department has, for many years, worked closely with other UK nations to develop a joint UK approach and policy position in relation to the Minamata convention responsibilities. Indeed, Northern Ireland, along with the rest of the UK, exceeds the current requirements of the Minamata convention.

The Northern Ireland position has been clear throughout: phase-down rather than phaseout. The position was stated publicly in the joint letter by the four Chief Dental Officers in December last year. The letter also pointed to the existing arrangements at UK Government level to engage on matters of divergence, including the issue of dental amalgam. The Cabinet Office has been responsible for engaging with the EU on this matter, and we have been engaging with the Department of Health and Social Care (DHSC) since July around these specific proposals.

The Committee will have noted the Minister's comments on 27 March, when he expressed his view that the impact would be significant in terms of service capacity. He reiterated his commitment to phase-down in line with the wider UK position rather than phaseout, as that was in the best interests of

patients in Northern Ireland. He noted the important role that the Committee now has in assessing the impact, and he wants to help and support the Committee in the coming weeks on this issue.

I am happy to answer any questions that Members may have.

The Chairperson (Mr McGuigan): Thank you. You were in the room for the previous evidence session. I presume that you also listened to the BDA's evidence. We have a responsibility to look at this in terms of EU legislation, and it is important that we take evidence from everybody. When the BDA representatives were in, Declan, I think, managed to elicit from them that there was an issue but the legislative change would have been less impactful had there been proper funding for dentistry.

I listened to Joanne questioning a witness in the previous session; she said that there was no doubt of the arguments against mercury amalgam. Are we in the Assembly or on the Committee being asked to make a potentially bad decision, in terms of the environmental impact on the citizens whom we represent and the impact on their health, because of economics and the underfunding of dentistry in the North?

Mr O'Neill: The previous speaker's contribution focused mainly on the merits of the law rather than on its impacts and timescales. We have focused on what we think will happen in January. Our main concern, in addition to the timescales due to the lack of time that practices will have in which to implement the new law, is about service capacity. In 2022-23, we carried out 200,000 amalgam fillings. The number of fillings will be significantly reduced, when we already have an access problem. That is the impact that we have focused on.

The Chairperson (Mr McGuigan): Are those problems because of the underfunding of dentistry in the North?

Mr Gearóid Cassidy (Department of Health): I will add to what Michael said. The position on the phase-down is consistent across the UK. Our approach is not determined by the particular circumstances of Northern Ireland; it is a consistent position across the UK. As Michael indicated, our concerns around the timescale, as it is presented to us, are to do with the capacity in the system, our reliance on amalgam in Northern Ireland versus other parts of the UK — we have more reliance here — and the general state of oral health here, which is an outlier in relation to the UK and the Republic of Ireland.

There are a number of factors at play. It is beyond question that dental services are under pressure, but other factors are at play. The key issue for the Committee is whether external forces are driving Northern Ireland to a position ahead of the timescale towards which we are already working.

The Chairperson (Mr McGuigan): OK. Thank you. I said that members would have one question and one supplementary, so I will move on, but if there is time, I will come back to everybody.

Mr Brooks: Thank you for your evidence so far. I note that you are in opposition to the points that were made earlier about the costs being similar; your position is that the alternatives to dental amalgam at this stage would present a significant increase in cost.

Can you confidently say that people who have dental amalgam fillings should not be worried that they are at significantly greater risk of MS, Alzheimer's, Parkinson's, chronic fatigue syndrome or brain damage, to borrow Patrick Brown's point? Anyone who tuned in to that part of the previous session could be quite alarmed at what might be caused by having amalgam fillings. Can you allay those fears and tell us that that may not be the case?

Ms Caroline Lappin (Department of Health): I will take that question. Absolutely. I am in agreement with my colleague. I gave evidence to you previously. The greatest levels of exposure to mercury vapour happen when an amalgam restoration is placed and when it is removed. We advocate that amalgam restorations that are stable be left. Replacing them would put the patient at risk, unnecessarily, from a procedure that, clinically, they do not need to have and would increase their exposure to mercury for a defined period of time. That is our policy.

I understand that the Committee is meeting to discuss the impact of the timescales on Northern Ireland. At risk of getting into, "He said, she said", situation, the views expressed earlier are not the recognised position in the UK. Your colleague referred to the scientific committee of the European Commission, which would refute the evidence that was given this morning.

Mr Brooks: In the placement or removal of those fillings, will best practice minimise or negate the risks for the vast majority of people?

Ms Lappin: Absolutely.

Mr Brooks: Thank you very much.

Mr Buckley: Thank you for your presentation.

First, I want to ask about the UK-wide phase-down approach, which has been adopted by all Chief Dental Officers and the profession. I would like an update on where we are with that, because there was some evidence that that is being stalled. Secondly, the impact on service capacity has been mentioned by the Minister of Health, the profession and the Department of Health. How serious is the impact on service capacity?

Lastly, we are nine months out — you say that it could happen sooner — from this coming into effect. We must have clarity on feasibility. If this ban comes into place on 1 January, where do we stand in Northern Ireland?

Mr O'Neill: I will pick up the first point on the use of amalgam. Pre-COVID, from 2015 to 2019, we reduced our amalgam usage by 30%. We are currently using 50% less amalgam than in 2015-16. Whilst we need to do more, that is the kind of progress that has been made. Caroline, do you want to pick up the second point?

Ms Lappin: Each area of the UK has a national plan that came in during 2018-19. Our national plan is a three-legged stool. One leg is oral health improvement, the second is improvement in materials to make the alternative to amalgam more suitable and the third is the contractual arrangements in the health service system under which dental care is delivered.

As Chief Dental Officer, I would like us to have made, as the population of Northern Ireland, more improvement on our oral health. We have made significant improvement. Look back to where we were, say, in our child dental health survey in 2013, or even at our child dental survey that came out in 2018-19, the findings of which were published last year. We have flipped the situation on its head. One third of children under the age of five had some evidence of dental decay in 2018-19, whereas in 2013 it was two thirds of children. So we have made significant improvement.

However, there is still a way to go. For me, that is a significant concern, when I, along with my colleagues the other Chief Dental Officers in the UK, know the value of that particular material within our population as it stands. Other materials deliver in lots of different ways, but nothing, despite significant improvements having been made, gives us the longevity of amalgam and is less clinical-technique sensitive. When you look at a population, not everybody finds it easy to go to a dentist, sit in the chair and have a really good-quality filling placed. The ban will put our patients at something of a disadvantage, particularly in the light of the oral health of the population not being where it needs to be.

Mr Buckley: As Chief Dental Officer, it feasible for the change to happen for 1 January?

Ms Lappin: My opinion is that it is not feasible for 1 January.

Ms Bunting: The charge has been laid that you have known about this and that progress is slower than it should be. Jonathan has picked up on where we are now. My question is whether the UK and the Department of Health are slow-walking this? Is there benefit in having a cut-off point to encourage action? Caroline, you said that one element of the three-legged stool is essentially a campaign to promote better oral health. What is the plan to improve oral health faster?

Ms Lappin: We have oral health improvement programmes in place in Northern Ireland, albeit not ones that cover swathes of the population that you see in other areas of the UK. We are working through a process. We have recently been consulting on oral health improvement plans for the two most vulnerable groups in Northern Ireland: our younger children — because we know that early-years targeting helps to improve oral health throughout the life course — and our older people. As everybody knows, the older population is growing, and we are a victim of our own success in dentistry in that our old population are keeping their teeth much later in life, which presents significant

challenges. The use of amalgam is really beneficial to those in the older population who have certain musculoskeletal conditions or Alzheimer's or other dementia-related conditions and find it difficult to cooperate with treatment: use of a material that is easier and faster to place is really important in those cases.

We put oral health improvement plans out for public consultation. That consultation closed in March. Some responses came in slightly late, which has delayed the process a little. We are analysing those responses to look at the most prioritised recommendations that, at a population level, would help to improve our oral health. That is being done against the backdrop of significant financial challenges in the Department of Health — I am fully aware of that — but that population-level approach is really important. For example, we know that the best evidence base is on the application of fluoride to teeth, so do we need to target younger children by extending our supervised tooth brushing programmes? Looking at our older population, how can we help improve the oral health of dependent older people, which becomes much harder to improve as their manual dexterity decreases and their other ailments increase. We are making a concerted effort to improve that.

Mr Cassidy: On the question of whether progress has been slower here, Michael has indicated that we have made very good progress in Northern Ireland to reduce amalgam use in dentistry. The UK as a whole is a signatory to the United Nations Minamata convention. At that level, no date has been set for an appropriate phase-out because there is no consensus yet on when it should be. The EU has moved proactively in that space, but that is not to say that the UK as a whole is dragging its feet on this; it has not arrived at a settled position.

Dr Aiken: Just a quick one. The Committee is beginning to hear the word "significant" a lot. If we had to go along with this European directive, what would be the significance of that?

Mr Cassidy: Michael outlined the significant impact on the public purse — £3·6 million, which is 4% of the Department of Health's dental budget — and on people receiving the service, whose contributions would be in the order of £2·9 million. It is hard to gauge the exact impact on capacity. We estimate that it takes approximately three times longer to do a composite filling for a posterior tooth than it does to do an amalgam filling for such a tooth. That would, with a finite workforce, inevitably have an impact on people's ability to access services. We cannot quantify that. There would also be impacts on what in the current business model is the split between what is done privately and what is done in the public sphere. Those things are not for us to determine, but they are significant. The business on 1 January would look very different from how it looks now.

Dr Aiken: Thank you very much. That is all I needed to know.

The Chairperson (Mr McGuigan): OK. Everybody was very good *[Laughter.]* That was very useful, and I thank you for coming along. I say to all who give evidence that we are doing an investigation and that, should we be notified of further issues, we will, in all likelihood, come back to you to ask for additional information. Thank you very much for your attendance.