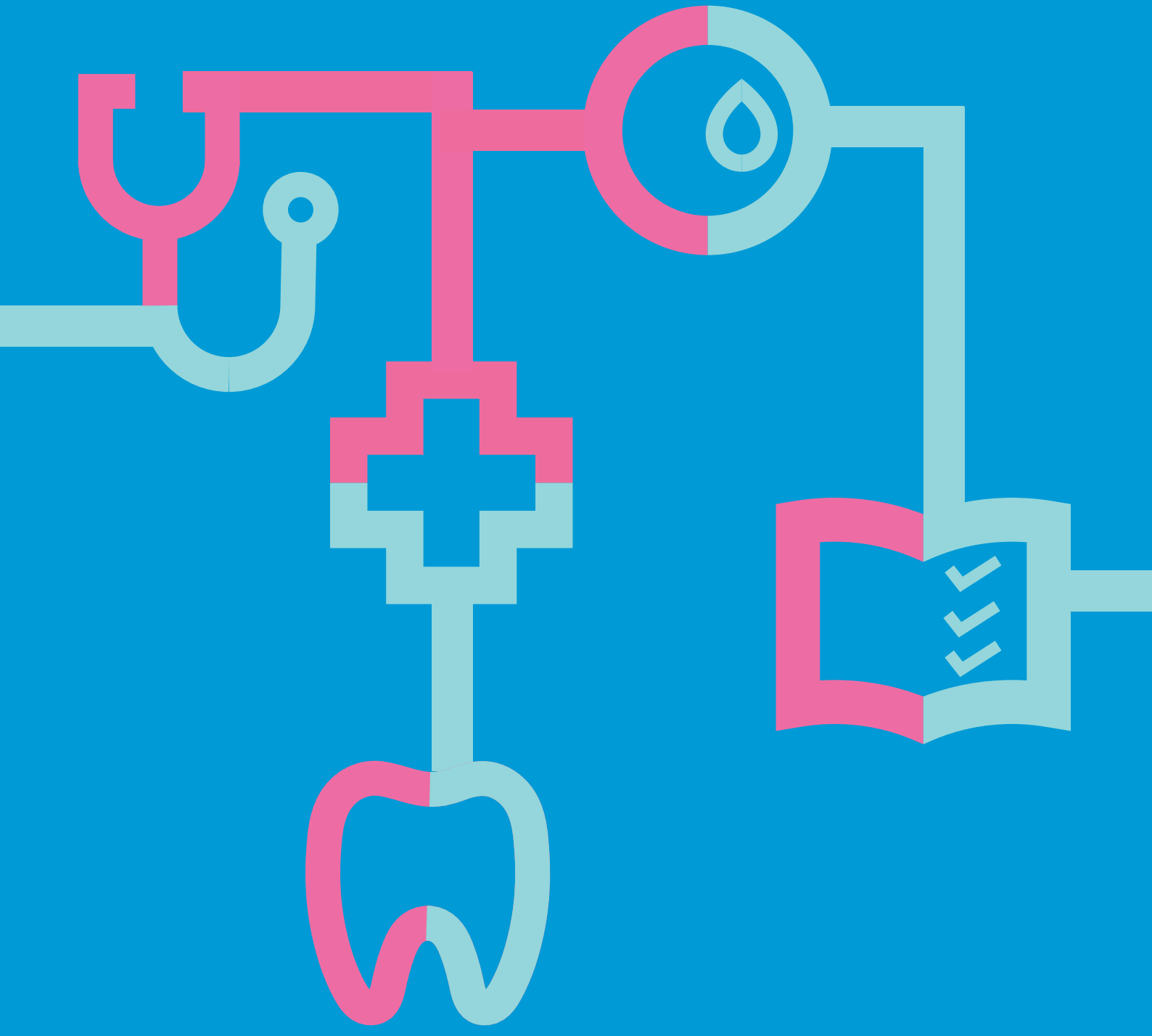
ombudsman
do leanaí
for children

Behind Every Smile

The impact of the ongoing crisis in children's public dental health services in Ireland



Executive summary

Ireland's public dental service is currently failing to consistently meet the needs of all children. Since the publication of the National Oral Health Policy Smile agus Sláinte in 2019, the HSE public dental service has been in a state of decline amid increasing pressures on the healthcare system. The most recent figures we can obtain show there are over 11,000 children on waiting lists for dental or orthodontic care across the country, with 8,000 of those waiting longer than 2 years.[1] More than 105,000 (50%) of primary-school children have not received targeted dental screening despite the State's statutory obligation to provide it.

Our *Behind Every Smile* report seeks to address these issues and makes ten recommendations to Government which we hope will be incorporated into its action plan due to be released shortly. Our report also features the story of Lucy*, a young girl in contact with the OCO whose experience illustrates what can happen when a child with a serious, time-sensitive need is placed on a waiting list without adequate review.

Complaints to the Ombudsman for Children's Office (OCO) over the years from families affected by delays in accessing public dental services highlight the impact this is having on their children first hand. Our work on the issue reveals recurring problems: excessive waits for treatment, uncertainty about prioritisation, inconsistent communication and a significant variation in access to treatment between regions. This impact is not only clinical. Our Office has seen complaints where dental and orthodontic delays have affected children's health and psychosocial wellbeing.

The OCO is also concerned that children from disadvantaged communities or those deemed vulnerable, children with additional needs, and families who cannot afford private treatment are disproportionately affected when public dental services are unavailable or delayed.[2] For these children, public dental care is their only realistic route to care. The evidence examined by the OCO points to a system characterised by long waits, uneven access, insufficient capacity, inconsistent data and inadequate communication with children and families. Most importantly, the system does not consistently recognise that a child's clinical need can change while they wait.

Behind every smile is a child who may be living with pain, have difficulty eating, disrupted sleep, anxiety, embarrassment, missed learning or declining confidence. Poor oral health can also affect speech, social confidence, and emotional wellbeing at critical stages of development.

We will follow up with the Department of Health and HSE and their relevant oversight and governance committees in 12 months to determine if the proposed plan adequately addresses children's right to timely access to dental and oral healthcare.

1 https://www.oireachtas.ie/en/debates/debate/dail/2026-06-23/14/

2 https://pubmed.ncbi.nlm.nih.gov/41355175/

*Lucy's name has been changed to protect her identity

2. Lucy's* Story

Lucy's parents contacted the OCO to make a complaint about the lack of information from the HSE about the severity of her orthodontic treatment needs and the impact of the extensive delay waiting for orthodontic care.

Lucy was screened in school by the HSE at 11 years of age and assessed by the HSE Orthodontic Service in 2020 when she was 12. She was placed in the highest category of orthodontic treatment, which was category 5a treatment need within the Index of Orthodontic Treatment Need[3](IOTN). She was deemed eligible for treatment. Lucy's family was told that the waiting time was approximately two years.

However, Lucy remained on the waiting list for five years.

During this time, her parents received regular correspondence asking whether they wished to remain on the waiting list, which they did. Lucy's parents told us that at that time no one explained to them what this IOTN categorisation meant in terms of severity of need, or what the impact of delay might mean on Lucy.

There was no meaningful reassessment of her needs, no review of the impact of continued delay and no alternative treatment pathway offered.

When the family sought clarity in 2025, they were told that staff shortages meant that no timeframe could be given.

At 17, Lucy attended a private orthodontist paid for by her family.

This orthodontist explained that because of the severity of Lucy's needs, braces alone would not now resolve the issue, and that her jaw would need to be broken in two places to realign it alongside extensive use of braces. This major surgery was expected to have a significant impact on Lucy's day to day life.

According to the orthodontist, Lucy's surgery might not have been needed had she received orthodontic treatment sooner.

This was deeply upsetting for Lucy and her parents. Private care was extremely expensive, running into thousands of euro given the complexity of the required surgery and treatment plan, and unfortunately for Lucy and her family was not an affordable option.

The HSE told us there had been significant staff shortages in Lucy's area and there were 2,700 orthodontic children waiting to commence treatment. This included over 1,500 Grade 5 patients awaiting treatment. They explained that for some children, there is a need to wait for growth and stabilisation to happen before treatment can take place. They told us waiting list timeframes varied from three years to nearly nine years due to limited services.

The HSE confirmed the private orthodontist assessment that Lucy's treatment needs were extensive and that she would need jaw surgery as part of her treatment plan. However, Lucy has still not been treated. At the age of 19, she is currently 11th on the 5a waiting list.

Lucy entered the system as a child with an identified and treatable need. She reached adulthood still waiting and with a substantially more complex treatment requirement and the psychological impact of years of unmet need.

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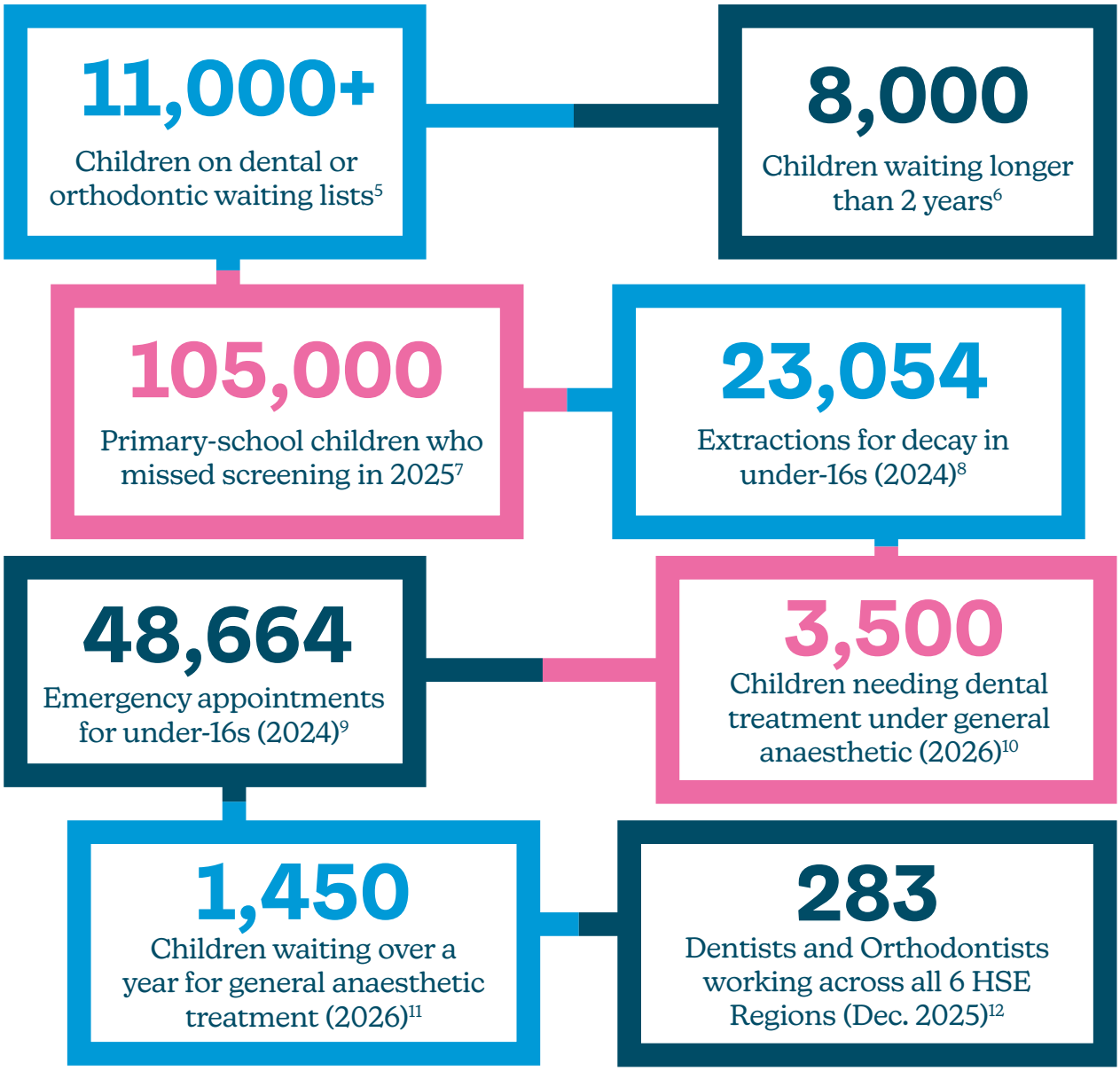
3 IOTN is a dental scale used to objectively assess the severity of malocclusion and determine eligibility for orthodontic treatment using the Dental Health Component (DHC) to measure functional need & the Aesthetic Component (AC) to measure visual impact and determine prioritization based on greatest need. There are graded categories from 1 – 5, with 5 being the most severe. The Health Service Executive has, since 2006, used a modified version of the IOTN index.

3. The situation in numbers

The figures show a service under pressure:



4 https://www.oireachtas.ie/en/debates/debate/dail/2026-06-23/14/

5 As above

6 HSE Joint Health Committee Submission January 2026 https://data.oireachtas.ie/ie/oireachtas/committee/dail/34/joint_committee_on_health/submissions/2026/2026-04-10_submission-health-service-executive_en.pdf

7 As above

9 As above

9 https://about.hse.ie/api/v2/download-file/file_based_publications/PQ_4069-26_-_Marie_Sherlock.pdf/

10 https://about.hse.ie/api/v2/download-file/file_based_publications/PQ_4069-26_-_Marie_Sherlock.pdf/

11 HSE Joint Health Committee Submission January 2026 https://data.oireachtas.ie/ie/oireachtas/committee/dail/34/joint_committee_on_health/submissions/2026/2026-04-10_submission-health-service-executive_en.pdf

12 As above

4. Our work on this issue

The Joint Health Committee published a report on public dental and oral healthcare in April 2026. These recommendations seek to address a broad range of core structural deficits in both the Department of Health scope and HSE dental and oral healthcare service delivery, stating the need for consistent funding streams with a call for robust oversight and governance structures to be put in place by the Department of Health and HSE without delay.

These recommendations relating to children are very helpful and fully endorsed by the OCO.

We were already engaged in a preliminary examination of Lucy's complaint with the HSE and Department of Health Chief Dental Office during the same timeframe as the work of the Oireachtas Joint Health Committee.

Given the overlap between the timing of our examination of children's dental and oral healthcare and the work of the Department of Health and HSE in developing their own action plan, we decided to provide them with a summary of our key concerns for children so that they could be factored into that plan.

We also engaged with the Irish Dental Association (IDA) and some dental clinicians to get a better sense of the issues of concern around dental and oral healthcare for children.

Key issues raised in our correspondence with the Department of Health and HSE National Oral Healthcare Office included:

Experiences of children and families in contact with the OCO

The complaints we receive from families and subsequent engagement on the issue reveal recurring problems: excessive waits, uncertainty about prioritisation, inconsistent communication and significant variation in access between regions.

This lack of clear, accessible communication with parents regarding their child's status on waiting lists and treatment prioritisation and expected timelines leaves many families unable to make informed decisions about their child's care and contributes to significant uncertainty and distress.

In some cases, children's conditions may deteriorate during these prolonged waits, yet families may not realise that re-referral or reprioritisation is possible or necessary.

Children are experiencing pain, untreated dental disease and lengthy delays in accessing care, sometimes leading families to seek private treatment they can't afford.

Children may be aware of their dental issues and the impact on their appearance or comfort but have no clear sense of when help will be available.

HSE dental clinicians described to us assessing young vulnerable children in huge discomfort with multiple abscesses in their mouths, and children needing multiple extractions under general anaesthetic due to the level of tooth decay.

They have described the requirement for antibiotics and extensive dental treatment, knowing that these children have been in discomfort with serious dental decay issues for some time before they get treatment.

Beyond the clinical implications, the psychosocial impact on children is considerable, and we believe, frequently underestimated and overlooked.

Data collection

Inconsistent data collection across HSE regions makes it difficult to determine how many children are receiving services, the extent of waiting times, and the impact delays are having on children's dental health. We could not properly decipher the number of children who are and are not receiving a HSE public dental service; if and when they are getting their school based screening appointments; how long children are waiting for access to dental care; and how much, if any, they have experienced deterioration in their care needs as a result.

Preventative Healthcare Strategy

There is a notable gap in preventative oral healthcare for children aged 0 to 5 years, with limited visibility of this age group within the current public dental service and no comprehensive early-years prevention strategy.

School based dental screening service

The HSE is currently screening only approximately half of the children it is supposed to see in primary school. We are concerned that within this, there are significant geographical inequalities evident, with some of the most vulnerable children across the country not being screened. Some children are receiving their first screening appointment in 6th Class while others are not receiving any screening in Primary School.

Dental Care under general anaesthetic (GA)

We are particularly worried about the impact of poor access to, and significance of delays, in treatment for children with special care needs, because we know they can't always explain their pain in ways that are easily recognisable. Children with special needs who required dental treatment under general anaesthetic were difficult to identify as they were categorised alongside Special Care Adults in some regions so there is no child specific data. Indeed, we noted some areas did not gather any waiting list data as there was no service available to these children.

Orthodontic Care

The predominant complaints to the OCO around orthodontic care are from families who report excessive waiting times, the HSE not providing them with a clear understanding of IOTN eligibility criteria, and inconsistent communication. Access to treatment varies significantly by region, and alternative treatment pathways such as the Northern Ireland Planned Healthcare Scheme (NIPHS) are not financially accessible for many families. This is because the necessity to pay the full cost of the treatment upfront is simply not an option for many families.

Managing waiting lists

Current HSE standard operating procedures for wait list management of orthodontic treatment do not appear to adequately assess the impact of delay or deterioration in a child's condition over time, particularly for children like Lucy with time-sensitive treatment needs. The impact of delay on this group of teenagers is not recognised or appropriately accounted for within the current HSE standard operating procedure.

5. Our recommendations

Every child has the right to grow up free from preventable pain, disease and suffering and to access the healthcare necessary for their development and wellbeing. Ireland's current public dental system is not consistently delivering that right.

The problem is not just that children are waiting. It is that while they wait their conditions can change and their treatment options become more complex.

Lucy's story is an extreme example of what that can mean for a child. As with all healthcare services, every child should receive the dental treatment they need as and when they need it. Children should not be put on lengthy waiting lists for treatment with no guarantee when they will get it.

1	A time-bound reform plan	Prioritise dental screening for children in DEIS Plus, DEIS Band 1 and 2 schools and special education settings, aiming to complete 6th Class screening by June 2027.
2	Target the greatest gaps	Identify children who have aged out of primary school without screening and address this backlog alongside current 6th Class children.
3	Clear the screening backlog	Move towards delivering two of the three recommended targeted school-age screening appointments, with clear funding pathways and delivery milestones.
4	Separate specialist waiting lists	Maintain child-specific regional waiting list data for children with special care needs and those requiring care under general anaesthetic.
5	Oversight and Monitoring	Develop a time-bound action plan to ensure that children with additional or special care needs get access to their required dental treatment as priority issue across all HSE regions and regularly monitored by the governance and oversight committees within the HSE and Department of Health.
6	Address orthodontic delay	Provide additional ring-fenced funding for eligible Grade 4 and 5 patients waiting more than two years for orthodontic treatment, including through contracted care where appropriate.
7	Reassess children over time	Review orthodontic waiting list management so that deterioration, developmental timing and the impact of prolonged delay can affect prioritisation.
8	Improve communication	Develop a communications pathway with children and their families that includes information on what the child's treatment needs are, if there is a necessity to prioritise them for treatment and why, the indicative waiting time, when reassessment should be sought and what alternatives or interim supports exist. Children and families require transparent and reliable information to be available to them so they can make informed choices about their healthcare.
9	Strengthen early years pathways	Explore preventative screening pathways for children aged 3–5 years in Early Start, ECCE and other early years settings.
10	Build capacity	Use public-private collaboration and robust contracted care arrangement where necessary in the short to medium term to ensure children are getting access to equitable and timely dental services while developing sustainable HSE dental and allied health workforce and service capacity.