

SUMMARY



1 Since the creation of the NHS in 1948, NHS dentistry has played an important part in improving oral health. Indicators of oral health have tended to focus on children and over the years children's oral health has improved significantly. Children in England have lower levels of decay than their European neighbours and a higher percentage of children have no dental decay, with results for 12 year olds being particularly good.

2 Dentistry is a £3.8 billion service industry provided by some 23,000 registered dentists, of whom some 18,300 are high street dentists operating under the General Dental Services scheme¹. Traditionally dentists are independent contractors who choose where to locate their practices and how much, if any, NHS treatment they provide. Since 1998, however, the Department of Health (Department) has been piloting Personal Dental Services contracts aimed at allowing the NHS to have more influence over where dental practices are located and how much NHS treatment they provide.² By September 2004 some 2,500 dentists in around 1,000 locations were voluntarily working in this way.

3 The NHS net funding contribution in 2003-04, of some £1.8 billion, covered NHS treatments provided by some 19,300 primary care dentists (dentists working under either the General Dental Service or Personal Dental Services contracts), together with specialist hospital and community dental services (Figure 1). Over the last ten years, private dentistry has grown several-fold, with over a quarter of adult patients visiting the dentist paying for some private treatment.³

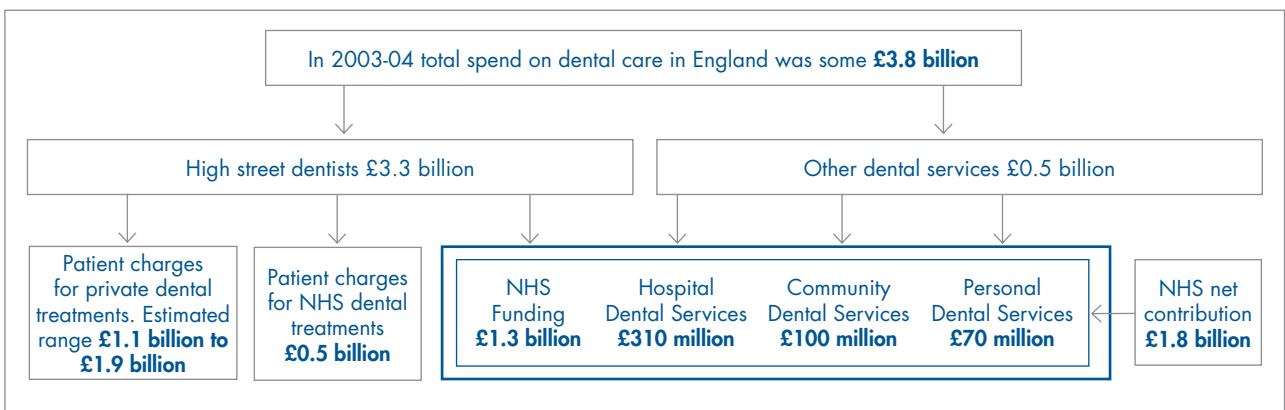
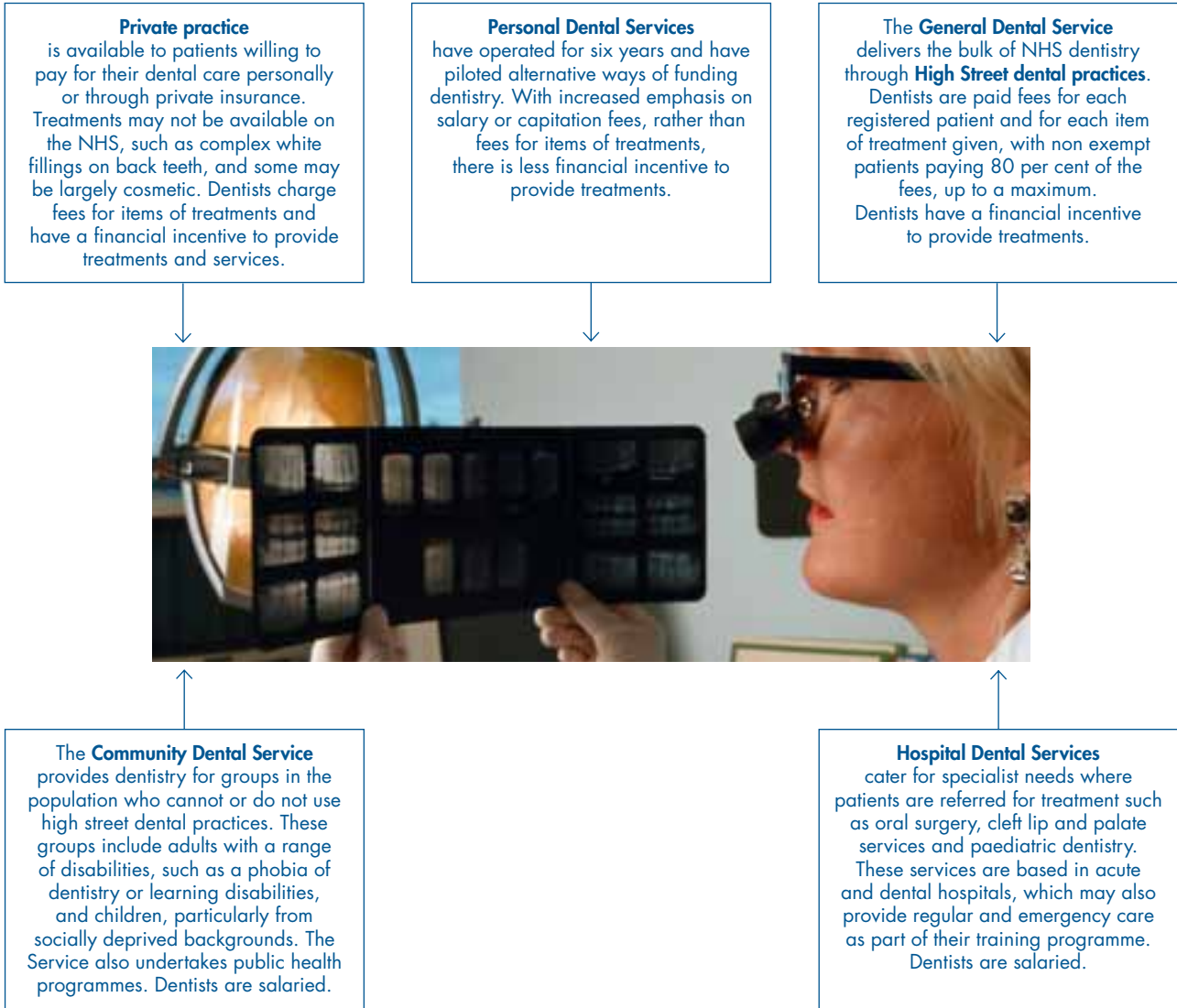
4 Historically, under the provisions of the General Dental Service Regulations, the NHS has paid fees to dentists according to the NHS treatments they provide, including since 1990 a fee for each registered NHS patient. This piece work arrangement had advantages in the early years of the NHS as it encouraged dentists to carry out items of treatment. Under a piece work system dentists have little financial incentive to improve the quality of their services or provide wider oral health promotion advice and education as they are not paid fees for these activities. There may also be a risk of over treatment. Many reports have argued for change, including our 1984 report⁴ and the Audit Commission's 2002 report.⁵

5 In addition to the calls for an overhaul of NHS dentistry, during the last ten years there has been an increase in reports of patients experiencing problems accessing NHS dentistry. In the early 1990s, many dentists reduced their commitment to the NHS and developed their private practice work. This has led to shortages of dentists providing NHS services in some more affluent areas. In other areas where there are high levels of social deprivation, dentists are in short supply and patients have experienced difficulties registering for NHS treatment.

6 Under the 1997 NHS (Primary Care) Act, the Department established Personal Dental Services contracts for dental practices to pilot new systems for paying dentists and new ways of working, including establishing dental access centres.² The pilots, which are based on locally negotiated contracts between dental practices and Primary Care Trusts, show that by paying dentists in a different way it is possible to maintain and increase their NHS commitment. In 2002, the Department published its Options for Change report proposing a radical reform of NHS dental services in England which builds on the Personal Dental Services pilots.⁶ The "Options" paper suggested that any new system should be voluntary and would operate alongside the existing piece work system.

1 The delivery of dental care

High street dentists deliver the majority of dental care in England with private dental charges approaching NHS funding and patient charges for NHS treatment.



Source: National Audit Office, Department of Health and UK Dental Care 2003, Laing & Buisson

7 In 2003, the Health and Social Care (Community Health and Standards) Act⁷ paved the way for major changes to dentistry. Primary Care Trusts will be required to commission dental services “to the extent that it considers necessary to meet all reasonable requirements”. They will be allocated funds specifically to commission local dental services in response to local needs. Dentists will be paid for delivering local contracts where they provide NHS dentistry to meet patients’ oral health needs, rather than for each item of treatment. The Department set an April 2005 target date for implementation but, in response to consultation, in July 2004 announced that the changes would be implemented from October 2005.

8 This report examines the rationale for the changes the Department is to make to NHS dentistry in England. It analyses the strengths and weaknesses of the existing system and identifies the risks that the Department and the NHS will need to manage if the new system is to overcome the problems facing NHS dentistry. We commissioned a comparative evaluation of different remuneration systems for dentistry and a patient survey. We visited Options for Change dental field sites and other providers of dental care, analysed the Dental Practice Board’s data, and convened an expert panel. We also drew on the work of the Audit Commission, the Commission for Health Improvement, the Office of Fair Trading and others who have all reported on Dentistry in recent years. Appendix 1 gives further details of our methodology.

There is a strong rationale for reforming NHS dentistry but significant risks will need to be managed if new systems are to be effective and provide value for money

9 While NHS dentistry has contributed to improved oral health, particularly in the early decades of the NHS, there is a need to modernise. Modern dental practice emphasises prevention rather than intervention but the current remuneration system does not provide sufficient incentives for such an approach. Given the overall shortages of dentists and the difficulties some patients are experiencing in accessing NHS dental treatment, NHS dentistry needs to provide a more responsive service. As Primary Care Trusts will be responsible for managing the new arrangements, they will need to develop appropriate expertise and resources to encourage dentists to maintain and increase their commitment to NHS dentistry. The Department will need to ensure it has effective oversight of the changes, capturing the necessary data for monitoring and analysis, and that it evaluates the changes during the three year transition.

Targets for NHS dentistry: improving oral health and access

10 The Department has set key targets for children's oral health: that by 2003, for children aged five the average number of decayed, missing or filled teeth should be no more than one, and in 70 per cent of five year olds there should be no dental caries. Over the years there has been good progress in reducing disease, but there is still some way to go to meet the targets (by 2003, the average number of decayed, missing or filled teeth was 1.5 and 59 per cent of five year olds had no dental caries). Indeed, since 2000 there has been a marginal increase in dental decay of five year olds.

11 While there has been a general improvement in oral health of adults and children since the establishment of the NHS, the reasons are complex. In addition to dental treatment, fluoride toothpaste, water fluoridation and healthier diet contribute to improved oral health. The Department, through the Dental Practice Board, has collected comprehensive data on the numbers of treatments over many years, primarily for reasons of financial probity. Data have also been used to consider cost effectiveness issues but the evidence base is not sufficiently developed to support strong conclusions on such issues. From our commissioned survey, 82 per cent of dental patients were satisfied with their oral health and 77 per cent considered NHS dentistry provided good value for money. Patients also rated highly their experience of visiting the dentist.

12 In addition to children's oral health, the Department has set targets for patients being able to access NHS dentistry. In September 1999 the Prime Minister pledged that by September 2001 anyone would be able to see an NHS Dentist just by phoning NHS Direct.⁸ NHS Direct provides access to information on local NHS dental services, using information provided by Primary Care Trusts. As for all its call services it does not as a matter of routine follow up with patients to determine whether they were satisfied with the information given or whether they obtained NHS treatment. The Audit Commission reported concerns about the accuracy of information provided to NHS Direct and we also found some inaccuracies.

13 From our analysis we identified problems of access, particularly in some areas:

a Expenditure on high street dentistry has increased steadily over the years, but has not kept pace with other NHS spending. Whilst 98.5 per cent of the population of England is within five miles of a high

street dentist providing NHS services, dentists may not provide a full range of NHS treatments, and many are not registering new NHS patients.

- b Poor oral health is associated with social deprivation. Some areas where there are high levels of social deprivation have relatively few dentists and consequently high levels of registrations per dentist, and most dentists who provide NHS treatments have full lists. It can be difficult to attract dentists to set up practices in these areas and for dentists to sell their practices.
- c In more affluent areas patients may experience difficulties registering for NHS treatments as dentists have reduced their commitment to NHS dentistry. In 1990 the Department introduced registration and fees for continuing care in an attempt to encourage regular attendance and more engagement in NHS dentistry by stabilising incomes. Dentists registered more patients than expected and there was a significant increase in treatments provided, resulting in NHS dentistry costs exceeding forecasts and dentists exceeding the approved pay targets recommended by the Doctors' and Dentists' Review Body. The Department responded by cutting fees in 1992, resulting in falling incomes and profits, and creating significant ill feeling in the dental profession. Some dentists scaled back their NHS work and expanded private treatment, for example only registering children for NHS services, with adults paying privately for their own treatment.
- d For patients, availability of treatment when required is more important than being able to register with a NHS dentist, a finding supported by our survey of 1,760 adult patients. The Department's support for dental access centres and NHS Direct's role in providing information on local services are, in part, responses to patients' concerns about access to necessary treatment.

14 In July 2004 the Department published *NHS Dentistry: Delivering Change*⁹, a report by the Chief Dental Officer for England. The report stated that the Department's vision is "to build an NHS dental service that:

- offers access to high quality treatment for patients when they need to see a dentist;
- focuses on preventing disease so that everyone, and in particular children can enjoy healthy teeth for life; and
- gives a fair deal to dentists and their teams and improves their working lives."

15 The Department has undertaken a number of initiatives to tackle the most pressing access difficulties. Forty-seven new NHS dental access centres have been opened in areas where people are experiencing particular difficulties, and these are now treating over 300,000 extra NHS patients a year. An NHS support team backed by £9 million is working with those Primary Care Trusts facing the greatest challenges in improving dental access and a further £50 million has been made available to the NHS to improve access. The Department nevertheless acknowledges that more still needs to be done.

16 In July 2004, the Department also published, on its website, the results of its Primary Care Dental Workforce Review. In this, the Department estimated in 2002 that, in 2003, there would be an overall shortage of 1,850 dentists (equivalent to an under supply of dental time of around nine per cent of that required to meet demand). Whilst the review took into account the role played by dental hygienists and dental therapists, given the timing of the review it did not take into account the proposed changes in contractual and remuneration arrangements or planned changes in working practices such as extensions in the range of duties that dental therapists and dental hygienists may carry out. Allowing for the impact of these changes, in July 2004, the Department set out plans to improve access by increasing the numbers of dentists by 1,000 whole time equivalents by October 2005.⁹

17 To achieve this increase in numbers, the Department has launched a Returning to Practice Scheme and expects to recruit additional dentists from overseas, focussing on countries where there is government to government agreement and an acknowledged surplus of dentists, for example India and Poland. For the longer term the Department is to expand training places (170 extra places at a cost of £29 million by 2010-11 with capital investment of £80 million over four years to support this expansion) and to make greater use of skills across the dental team. Professionals complementary to dentistry will undertake more routine work with dentists providing more complex treatments.

18 At the same time the Department also announced that from 2005-06, there will be additional funding of £250 million a year for NHS dentistry, an increase of 19.3 per cent compared with 2003-04 spending. The British Dental Association has welcomed the Department's announcement of additional funding for NHS dentistry and proposals to increase the workforce.

Improving effectiveness: redirecting resources and simplifying patient charges

19 Part of the rationale for changing the system is to improve the effectiveness of NHS dentistry by switching resources towards areas of need, reducing inequalities and promoting better oral health. There are a number of ways in which NHS resources are not being used effectively under current arrangements.

- a The current system encourages dentists to recall patients at fixed periods, traditionally six months, rather than intervals tailored to patients' needs. The National Collaborating Centre for Acute Care, commissioned by the National Institute for Clinical Excellence, investigated the recall period, although the absence of a comprehensive evidence base has limited the precision of its recommendations. Its October 2004 report calls for more flexibility with routine recall periods being determined for individual patients, tailoring recall intervals according to risk assessed clinical need. For some adults two years may well be appropriate, whilst others may need to be seen every three months.¹⁰
- b Over half of the courses of treatment provided by dentists under the General Dental Service arrangements are for examinations only or for examinations and scaling and polishing. The Audit Commission in 2002 considered that the NHS was spending £150 million a year on over-frequent examinations and unnecessary scaling and polishing.⁵
- c Where dental services are funded through salaries or capitation fees, rather than on a piece work basis, treatments such as fillings tend to fall by some 10 per cent. Our own commissioned evaluation work, comparing a matched sample of patients treated under salaried or per capita schemes and the traditional piece work system, showed a similar fall in treatments. Our work also demonstrated that the changes in treatment patterns did not impact on oral health as both groups of patients showed similar levels of oral health. There is, however, need for further research on the long term effects of changes in treatment patterns, examining larger groups of patients.

20 Fundamental to the introduction and stability of the new system will be the new base contract between Primary Care Trusts and primary care dentists. This is based on the Personal Dental Services contracts and is being developed jointly with the British Dental Association. It aims to offer financial security to practices as gross earnings will be guaranteed for three years, provided the practice continues to provide the same degree of NHS commitment. In the meantime, Primary Care Trusts are offering dentists Personal Dental Services contracts, to enable dentists to move to local contracts ahead of the October 2005 timetable (during the three year transitional period, dentist will be able to continue to operate under these contracts subject to any amendments necessary to reflect changes in patient charges and monitoring arrangements).

21 Under the present dental remuneration system patient charges are set at 80 per cent of piece work fees up to a maximum of £378 for one course of treatment and total some £500 million a year. With piece work fees being abolished from October 2005, there will no longer be such an obvious mechanism for calculating patient charges. For the new system to work there will be a simplified system of patient charges. The NHS Dentistry Patient Charges Working Group¹¹, which involved experts from national patient, consumer and dentist organisations, has made recommendations to Ministers who are currently considering them.

22 Since 1948 dentists have had to collect patient charges and submit details of treatments to the Dental Practice Board in order to get their NHS fees. Under the new arrangement, dentists will be contractually required to collect patient charges and submit timely activity data. Primary Care Trusts will monitor activity levels to ensure that dentists deliver a continuing commitment to the NHS for the level of payment agreed under their contract. As part of the Department's review of Arm's Length Bodies¹², the functions of the Dental Practice Board are to be assumed by the new NHS Business Services Authority. The detailed arrangements for this new body are yet to be announced.

Need for greater clarity over NHS and private dentistry

23 The NHS/private interface is blurred, with dentists providing both NHS and private treatment during a patient's visit. Many patients are unsure which treatments are provided under the NHS and which are paid for privately, a finding confirmed by our survey of patients. Dentists may provide NHS examinations but complex white fillings in back teeth can only be provided privately. The Office of Fair Trading published its findings on private dentistry in 2003¹³, calling for greater clarity of services and charges and proper procedures for dealing with complaints. The Government accepted the report's recommendations.

24 The Department is working with the General Dental Council to ensure that all dental staff comply with guidance on displaying prices, providing treatment plans and itemised accounts, and making explicit what NHS treatments are provided and what treatments are private. The Department and the General Dental Council are also reviewing the complaints procedure. In July 2004 the Department published a consultation paper on strengthening the role of the General Dental Council, together with proposals for establishing systems to take action when things go wrong in private practice and to provide assurance on the quality of patient care.¹⁴

International comparisons

25 Worldwide there are different systems for providing dentistry but with some common characteristics in the way services are delivered. Dentists are largely self-employed with state assistance available for some patient groups such as children and those on low incomes with other patients often being covered by insurance schemes. Most dentistry systems are based on fees for treatments provided. No country attempts to provide comprehensive care for all or operates a system similar to that proposed by the Department, underlining the risks that will need effective management if the new system is to prove value for money.

26 There are also wide variations between countries in the number of active dentists and other professions complementary to dentistry compared to the size of the population. Whilst England has a relatively high population per active dentist it also has relatively high numbers of dental hygienists and dental nurses providing dental services as part of the wider dental team.

New ways of working

27 In 2003 the Department's NHS Modernisation Agency set up a programme of Options for Change 'field sites' which build on the Personal Dental Services pilots, testing new remuneration systems and new ways of working to improve the quality of care received by patients. The Department is learning emerging lessons whilst developing detailed arrangements for implementation of the new system for NHS dentistry in England. The dental profession's initial reaction was sceptical of the proposed changes. In April 2004, the British Dental Association surveyed 25,000 dentists and, of the 7,500 who responded, 60 per cent stated that they will reduce their NHS work or abandon NHS dentistry altogether.¹⁵

28 However, in the six months to September 2004, there has been a notable increase in the number of dental practices transferring to a Personal Dental Services contract. Between September 2001 and September 2003 the number of participating schemes increased from 75 to 96, but in the year September 2003 to September 2004 the numbers more than doubled, from 96 to 196. As a result by September 2004 some 2,500 dentists (out of 19,300) in around 1,000 locations were working under a Personal Dental Services contract. The Department was also considering applications from 700 further dental practices.

KEY FACTS ABOUT NHS DENTISTRY

- There are over 19,300 dentists in primary care, more than in previous years, but many spend a lower proportion of their time on NHS work which has left some people unable to get the routine treatment they want on the NHS, unless they are prepared to travel.
- Some 17 million adults (45 per cent) and 7 million children (62 per cent) are registered with an NHS dentist. Between 1994 and 1998, adult registrations fell by 5 million but for the last few years have decreased only marginally. Part of the reason for fall in registrations was due to the change in registration period from 24 to 15 months introduced in 1996.
- Everyone is entitled to see an NHS dentist for emergency or urgent treatment, whether registered or not.
- NHS dentists currently receive a capitation fee for each registered patient and a fee per each item of treatment.
- Oral health in England is improving generally, with oral health in 12 year olds the best in Europe.
- There are inequalities, with children in parts of the north of England having on average twice as much decay as children in other parts of the country.
- All treatment necessary to maintain oral health is available on the NHS, although some are only provided through the hospital dental service. Overall there are some 400 items of treatment.
- Patients liable for dental charges currently pay 80 per cent of the dentist's fee, ranging from £3.50 for one X-ray to £297.70 for a fixed orthodontic appliance – 'train tracks' braces. The maximum charge is £378 for one course of treatment. Full exemptions from fees apply to all patients under 18 years of age and expectant and nursing mothers; full remission of fees applies to adults in receipt of tax credits, job seekers allowance and income support. Additionally, some patients on low incomes are entitled to partial remission of fees.
- NHS treatment does not include purely cosmetic procedures such as tooth whitening. Complex tooth-coloured fillings on back teeth are generally not permitted, primarily because they are generally less reliable than silver amalgam.
- Some treatments are provided free to all patients. These include denture repairs, arrest of haemorrhage, removal of sutures, home visits and attendance to open the surgery in an emergency.
- From 2005-06 investment in NHS dentistry is set to increase with Primary Care Trusts set to receive an increased allocation of £250 million a year (a 19.3 per cent increase over the equivalent spend in 2003-04).
- The NHS Workforce is set to increase by the equivalent of 1,000 dentists by October 2005 when a new contract is to be introduced and dentists will no longer be tied to fees for treatment but will be able to decide treatment on the basis of clinical need.



CONCLUSIONS AND RECOMMENDATIONS

29 Part of the Department's rationale for changing NHS dentistry is to encourage dentists to maintain and increase their NHS commitments. To that effect the Department has announced additional funding to provide the necessary incentives for growing the service. But given the scepticism of some dentists compounded by a lack of detail on how the new system will operate we consider that there is a risk that dentists will reduce their NHS commitments, as they did in the 1990s following cuts in fees. As dentists are being guaranteed gross earnings for three years, the risk continues through the transition and may not materialise until the end of the period.

30 The Department has set itself an ambitious programme and some key milestones have been delayed and new initiatives have been introduced. Given the radical nature of change and the opportunity to reform NHS dentistry for the first time since 1948, it is vital that the Department gets it right. The Department's decision to postpone implementation to October 2005, in response to concerns of dentists and the NHS, is welcomed. The Department now needs to be more transparent about their plans and timetable for managing the change process to achieve the revised target date, and ensure that these are conveyed to dentists and patients.

31 In addition we have identified the following risks that the Department will need actively to manage, together with our recommendations which show how these risks might be mitigated:

Contracting arrangements

- a** While Primary Care Trusts have commissioned hospital and community dental services since April 2002, they have little experience of high street dentistry. With the emphasis and current resources directed to implementing the general medical practitioner contract, Primary Care Trusts have limited capacity and they will need to develop new expertise in dentistry. The Department have allowed a longer lead-in time to set up these contracts and have allowed three years transitional period to full local commissioning. Primary Care Trusts will need to ensure that priority is given to delivering appropriate contracting arrangements, including providing sufficient expertise and resources.
- b** The Department has guaranteed dental earnings for three years where dentists demonstrate continuing commitments to provide similar levels of NHS dental care, with its focus on patient needs rather than activity. Measurement will not be as simple as the current system where dentists are paid for items of treatment. Contracts must make clear what is to be delivered and who is accountable. All Primary Care Trusts will need to analyse dentists' broad patterns of working by numbers of patients treated under the NHS taking account of complexity of treatment. It will be important to ensure that whatever data are collected, and whatever methods of monitoring of standards of care are adopted, they aid the evaluation of the new system and ensure probity.

Utilising and increasing capacity

- c** Unless there are clear incentives for dentists to extend access and take on socially disadvantaged patients, there is a risk that freed up capacity potentially flowing from more flexible recall periods and changes in the methods of working may not be used effectively for the NHS. The Department and Primary Care Trusts will need to monitor the position closely to ensure that appropriate spare capacity is utilised to the benefit of the NHS.
- d** In moving away from piece work systems, there is a risk of 'under treatment' replacing 'over treatment' as a perverse incentive. The Department will need to monitor national data and sample the quality of care provided to ensure this does not happen. Equally, the Department and Primary Care Trusts will need to establish effective clinical audit and evidenced based quality assurance arrangements, and disseminate lessons. The Dental Reference Service project to examine clinical effectiveness and performance of practitioners should provide further support to Primary Care Trusts to help mitigate this risk.
- e** The Department has set ambitious targets for increasing the capacity of NHS dentistry, including recruiting dentists from abroad, increasing the NHS commitment of existing dental practices, and expanding the numbers of dentists in training for the longer term. There is a risk that these targets will not be met and there will continue to be shortages of dentists. Overseas recruitment poses other risks and the Department will need to monitor the success of its initiatives.
- f** Given that the Workforce Review noted that it was unable to measure precisely the gap between demand and supply because of the unknown effects of the proposed changes to NHS dentistry, there is a risk that planning assumptions will not be soundly based. Primary Care Trusts, together with Strategic Health Authorities, should monitor their dental workforce numbers in relation to needs, taking into account the development of new roles and skills within the dental team. This should feed into a national review prior to the end of the transition period in 2008.

Income from patient charges may fall

- g** With a move towards prevention, there is a risk that treatments patterns may affect the overall level of charge income. The Department, together with the new NHS Business Services Authority, will need to develop a system to monitor overall charges to ensure that it continues to recover a similar contribution

towards the overall cost of NHS dentistry. Primary Care Trusts will need to establish effective audit arrangements to monitor dentists' compliance with this and take timely action to ensure collection of patient charge income. Underpinning this, the Department will need to agree a charging system and set charge levels to reflect the new treatment patterns likely under local commissioning so that it continues to recover a similar contribution towards the overall cost of NHS dentistry.

Monitoring and evaluation

- h** The Department has collected data on dentistry through the Dental Practice Board for many years but the evidence base does not provide conclusive answers to issues such as the appropriateness of the recall period, how accessible NHS dental services are, and what role dentistry plays in promoting oral health. The Department and the NHS Business Services Authority will need to review their data requirements to ensure that available data can support further research on cost effectiveness.
- i** NHS Direct has an important role to play in promoting access but there is a risk that it cannot fulfil this role effectively because of the inaccuracies in the information provided to it on local NHS dental services. Primary Care Trusts need to ensure that, when they commission NHS Direct services to provide information on dentists supplying NHS services, this data is accurate and up to date.

Patients' services

- j** There is a risk that patients will not understand their entitlements, will still not know what services are available on the NHS and what they are paying for. In developing new arrangements for patient charges, the Department should aim for simplicity, recognising that in any new system there may be winners and losers. As part of their monitoring, Primary Care Trusts and Patient Advisory and Liaison Groups should monitor whether dentists are providing information on patient charges and entitlements.

Learning lessons

- k** Given the time constraints required to get the new contracting arrangements in place, there is a risk that good practice developments in Options for Change field sites and Personal Dental Service pilot sites may not be used effectively. It is important that the Department and Primary Care Trusts continue to evaluate and disseminate the lessons that emerge from these sites.