

Briefing note on NHS dentistry

Background

Ever since the inception of the National Health Service in 1948, General Dental Practitioners (GDPs – “High Street” or “Family” dentists, providing primary-care NHS dental services) have been independent contractors, working for themselves (alone or in partnership), for another dentist or for one of a few small corporate dental chains.

As such, GDPs have always been free to provide as much, or as little, private dentistry as they wish, alongside their NHS commitment. And they have always had to pay for their own premises, staff, equipment and materials out of their practice incomes (NHS and private). Dentists working in the NHS do, though, receive NHS pensions.

From 1948 until the introduction of the 2006 dental contract, an NHS dental contract was available to any dentist who wanted one; and dentists were free to provide NHS dentistry wherever they wished to.

Also until the introduction of the 2006 contract, remuneration for NHS dentists was based mainly on a “fee per item of service” system – i.e. dentists were paid a “piece-rate” for each individual treatment they carried out, with specified fees for each type of treatment (fillings, extractions, crowns, bridges, dentures, etc.). This method of remuneration was introduced in order to give dentists an incentive to tackle the large amount of pent-up unmet need for treatment that existed in 1948. Subsequently, however, the “fee per item” system came to be criticised for:

- giving a potential incentive to “over-treatment” (encouraging dentists to err on the side of “drilling and filling”, going against trends in clinical best practice);
- leading to an emphasis on the speed of treatment rather than quality; and
- failing to encourage a preventive approach (since dentists were not paid to spend time with patients explaining how they could maintain their dental health).

There has always been (and continues to be) universal entitlement to NHS dental treatment – i.e. anyone who needs it is entitled to access it.

Initially, dentistry was available to NHS patients free at the point of use. However, patient charges were agreed in 1951 and introduced in the following year (primarily as a means of limiting demand). They have remained ever since, in one form or another. The following are exempt from paying charges:

- children and young people aged under 18;
- young people aged 18 in full-time education;

- women who are pregnant and those who have given birth in the last 12 months;
- people on benefits / a low income (as defined).

In 1990, a new General Dental Services (GDS) contract was implemented, introducing registration of dental patients. The fees set for 1991–2 underestimated the number of patients that would register and this led to a substantial overspend in the NHS dental budget. This was followed in 1992–3 by a 7% cut in the fees paid to dentists, in order to bring spending on NHS dentistry in line with government targets. This fee cut led to much resentment among dentists.

Subsequently, dentists felt themselves to be chronically underpaid for NHS practice, meaning that they had to work on a “treadmill”, spending less and less time with NHS patients in order to ensure sufficient throughput to maintain their income and cover their practice expenses. In consequence, over time significant numbers of dentists changed the balance of their practices substantially (or entirely) away from the NHS and towards private practice. This led to a chronic shortage of access to NHS dentistry in many parts of the UK.

Many dentists restricted their NHS practice to children and to adults exempt from paying charges; in some cases, dentists stipulated that they would only see children as NHS patients if their parents attended the practice as private patients (on the grounds that private patients were effectively subsidising NHS patients).

In 1999, the Prime Minister indicated that within two years anyone who wanted to see an NHS dentist would be able to do so. However, the access problem persisted.

The perception that NHS dentistry was chronically underfunded was reinforced by a National Audit Office report in November 2004. This found that, since 1990–1, NHS spending on GDS had increased by 9% – compared with a 75% increase in overall NHS spending per head of population over the same period.

New ways of providing NHS dentistry were piloted through the Personal Dental Services (PDS) and “Options for Change” schemes – including Dental Access Centres for unregistered patients.

The new dental contract (2006)

The passing of the Health and Social Care Act 2003 laid the basis for a radical reorganisation of NHS dentistry, the central aspect of this being a new contract for GPs, which took effect on 1 April 2006.

In England this meant that, for the first time, Primary Care Trusts (PCTs) were responsible for contracting locally with dentists to provide services, as part of PCTs’ “commissioning” role. And remuneration of dentists was no longer

based on the “item of service” principle – dentists began to be paid per *course* of treatment provided; and they were required to hit a target, expressed in “Units of Dental Activity” (UDAs).

At the same time, the old complex system of patient charges was replaced by simple charge-bands covering courses of treatment – priced as follows from 1 April 2008:

- Band 1: Diagnosis, treatment planning and maintenance – also urgent and Out of Hours treatment (£16.20)
- Band 2: Diagnosis, etc. *and* simple treatment (£44.60)
- Band 3: Diagnosis, etc. *and* simple treatment *and* / *or* complex treatment / provision of appliances (£198.00)

Any further treatment required at the same charge-level within two months is free of charge. Replacements for lost or damaged appliances are subject to a charge of £59.40 (30% of the Band 3 charge).

This new patient-charge regime means that the maximum patient charge for a single course of treatment is now £198.00 (under the old system the upper limit was £384.00). However, a simple check-up, with no further treatment, is now substantially dearer (at £16.20) than the £5.84 that it cost under the old patient-charge regime.

Under the new arrangements, patients are no longer required to register with a dentist in order to obtain treatment; but a dentist is only required to treat as many patients as are required to reach the target number of UDAs stipulated in his or her contract.

Out of Hours services are no longer provided under the standard dental contract, and PCTs have to commission these through separate Out of Hours contracts with service providers.

For specialist practices (such as those providing orthodontics), a new PDS contract exists, which is broadly the same as the new GDS contract (with remuneration for orthodontists being based on “Units of Orthodontic Activity”).

Dentists are still permitted, if they wish, to see only children and charge-exempt adults on the NHS; but they cannot stipulate that the parents of children seen on the NHS must attend the practice as private patients.

The new contract was available to all dentists who were already practising within the NHS, provided they signed up before 1 April 2006. Dentists who signed before that date were also guaranteed the same yearly gross fees as they earned during a 12-month “reference period” (2004–5) for the next three years (until 2009). PCT dental allocations are ring-fenced during that time – and ring-fencing has now been extended a further two years, to 2011. At the end of the transitional period, in 2009, each PCT will assume full responsibility for commissioning dental services in its area, using money from a budget (still ring-fenced until 2011) for this purpose. The intention is that PCTs will

structure services according to local need, directing dentists towards areas where access problems exist, as part of their commissioning function.

In July 2005 the law was changed to remove restrictions on the number of Dental Bodies Corporate (limited companies providing dentistry) that were allowed to exist. Previously, the maximum number of Dental Bodies Corporate permitted to operate had been fixed by law at 28 (the number operating when this legal provision was enacted in 1956 – apparently due to concerns about low professional and ethical standards among such dental companies). Any corporate body can now carry on the business of dentistry, provided that a majority of the directors are registrants of the General Dental Council (either dentists or Dental Care Professionals). Dental Bodies Corporate are bidding for, and in some cases winning, GDS contracts that are being put out to tender by PCTs.

Issues around the new contract

When the new contract was introduced, the Department of Health (DoH) argued that it had freed dentists from the “treadmill” style of working associated with the “fee per item” system and would encourage a more preventive approach.

However, dentists’ representatives (including the British Dental Association, and Local Dental Committees – statutory bodies representing GPs in each area) argued that remuneration through UDAs was merely another form of “treadmill”, since it was target-driven.

The overwhelming majority of NHS dentists did sign up to the new contract. However, a significant minority of around 10% of them did not sign, thereby withdrawing from the NHS. The DoH insisted that the vast bulk of routine NHS dental provision had been secured through the new contract, with service levels, measured in UDAs, being successfully maintained. Those dentists refusing contracts were, it was claimed, mostly those who had been providing only minimal NHS services. And PCTs were confident that they could make good any shortfall in provision through other dentists expanding their NHS commitment and through the commissioning of new services.

A substantial number of dentists signed contracts on an “in dispute” basis. The DoH argued that this would not constitute a significant impediment to service provision – the dentists concerned were merely showing that they were opposed in principle to the new contract.

In August 2007 the DoH published *NHS Dental Reforms: One year on*, in which it stated that:

- the new contract had successfully removed incentives to undertake more complex and invasive treatment than necessary (“over-treatment”) and was encouraging a more preventive approach;

- new dental services had been successfully commissioned – with more NHS dentistry now being provided than in the last year of the old contract;
- there was no shortage of dentists willing to work under the new contract;
- access had stabilised and PCTs were now able to begin building on this more secure basis, identifying local need and commissioning new services appropriately;
- progress had been made in resolving disputed contracts – with over 99% of disputes ending with the dentist deciding to stay in the NHS;
- shortfalls in patient-charge revenue (which accounts for about a quarter of PCTs' primary-care dentistry budgets) were not a major or permanent problem – and interim additional funding would be provided to help ease the situation.

Despite the DoH's optimism regarding access, there remains a widespread perception that access to NHS dentistry has not improved since the introduction of the new contract – and may actually have worsened. Reports by the Citizen's Advice Bureau, *Which?* and the Commission for Patient and Public Involvement in Health have all found significant continuing problems with access.

Dentists' representatives have endorsed this view, as well as raising the following issues:

- Where dentists achieve less than 96% of their agreed UDA target in a given year (as many appear to be doing), they are at risk of having contract payments "clawed back" by PCTs if agreement cannot be reached about making up the shortfall subsequently.
- The government's own figures show substantial shortfalls in patient-charge revenue. Some PCTs are reportedly responding by requiring dentists to take more charge-paying patients (who will tend to have less need for treatment than charge-exempt patients) as a condition of receiving NHS capital funding for premises and equipment. Some PCTs are having to raid other budgets to make up the shortfall in patient-charge revenue.
- Under the new contract, dentists are more likely to "under-treat", i.e. to fail to provide complex (and costly) treatment, even if it is clinically necessary.
- The new contract tends to undermine continuity of treatment and discourage a preventive approach because the pressure to meet targets means dentists cannot spend time with patients discussing their oral health.

- PCTs' ability to determine local need and commission accordingly is weakened by the precarious position of dental public health in the context of PCTs raiding public-health budgets to help balance their books.
- It is feared that, once ring-fencing of GDS budgets ends in 2011, those budgets could likewise be raided by PCTs, damaging the provision of dental services.

In July 2008 the House of Commons Health Committee reported as follows:

- The available data indicated that access to NHS dentistry was actually deteriorating.
- There were problems associated with the new charging system, including some courses of treatment being more expensive than under the old system; and patients having to pay the same amount for very different treatments that fall within the same charge band.
- There was evidence of a large drop in the number of complex treatments being provided and of an increase in the number of tooth extractions. Also more patients were being referred by GPs to dental hospitals and to community dentists (PCT-employed dentists mainly treating special-needs patients) for more complex treatments. This raised the fear that dentists were "under-treating" and not giving appropriate care as a result of the new contract.
- There had been an overestimation of patient-charge revenue, due to poor forecasting by the DoH.
- Too many PCTs were poor at commissioning dental services.
- Too many PCTs were setting inflexible and unrealistic UDA targets.

In August 2008 the NHS Information Centre published data showing the following:

- In 2007–8 in England there was a 2.7 per cent rise on the previous year in dental courses of treatment; and the number of UDAs carried out increased by 4.5 per cent.
- During 2007–8 the number of dentists in England with NHS activity rose by 3.2 per cent compared to 2006–7.
- A total of 27 million NHS dental patients were seen in England in the 24-month period ending 31 March 2008 (the first two years of the new GDS contract), a decrease of 3.9 per cent (1.1 million) on the 24-month period ending 31 March 2006 (the two years immediately prior to the new contract).

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