Health Committee Inquiry into NHS dental services

British Dental Association memorandum of evidence

1. Executive summary

The new dental contract has failed to meet the Government’s own success criteria for the future of NHS dentistry, as set out in the Department of Health (DH) report *NHS Dentistry: Options for Change* and which was widely supported by the profession.

Despite its stated aims, the new contract has both failed to free dentists from the workload ‘treadmill’ and to allow time to provide the preventive care that is essential to reduce the oral health inequalities which still exist across the country.

A prevention-based system could be delivered if the NHS contract used a range of quality-based performance indicators rather than sole reliance on a single flawed output measure. Instead, dentists are facing financial penalties derived from untested targets.

Patient groups, dentists and the Government’s own figures reveal patients still face problems finding NHS dental care. Confusion also exists over the ‘registration’ of dental patients, which was abolished by the reforms. Clarity is required over what is meant by ‘access’ to dental care and the impact on the nation’s oral health of a new system which seems to work against continuity of care for individual patients.

Primary care trusts (PCTs), now responsible for the local commissioning of dental services, must be given the resource required, in both funding and expertise, to fulfil their new role effectively and meet the oral health needs of their communities. Strong working relationships should be developed between primary care trusts and dentists to enable them to plan how to meet these needs.

The majority of dentists work in a mixed economy, providing both NHS and private care. The relation between the two is complex with many practices effectively using private income to subsidise NHS work. The private market is now growing and set to expand further. Dentists who move towards private practice are prompted by the opportunity to spend more time with individual patients and focus more on prevention, and do not experience significant increases in income.

To date, dentists have propped up NHS dentistry by virtue of their professional relationships with patients. However, the target-driven nature of the new contract, which fails to encourage prevention, threatens the continuity of care. The financial
penalties and uncertainty faced by many dentists puts the future of NHS dentistry at risk.

2. Introduction and background

The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 23,000-strong membership is engaged in all aspects of dentistry including general practice, salaried services, the armed forces, hospitals, academia and research, and includes students.

The new dental contract impacts on dentists in all areas of the profession. The focus of this evidence is principally on general practice, but also has consequences for salaried primary dental care services. This evidence applies equally to general dental services and personal dental services contracts which, in contrast to their equivalents in primary medical services, are almost identical.

The House of Commons Health Committee last reported on NHS dentistry in 2001. The committee called for a new, long term strategy for NHS dentistry, reporting that the system of remuneration in the general dental service at that time was the main factor for dissatisfaction among both professionals and patients\(^1\). Following that report, the DH and BDA worked together on *NHS Dentistry: Options for Change\(^2\)*, a report which considered radical options for modernising NHS dentistry. The DH and BDA’s key aims for reform were to:

- move towards locally commissioned and funded services, responsive to local health needs
- experiment with different ways for paying dentists
- place prevention at the centre of dental care.

Consensus exists among the dental profession and patient groups that these aims are not being met. The Government’s own data demonstrates that its reforms are failing to meet important aspects of its own success criteria.

The fundamental cause of the failure of these reforms remains that which was identified by the committee in 2001: a system of remuneration which is directly and indirectly causing dissatisfaction among both professionals and patients and hindering the provision of prevention-focused dentistry.

The BDA welcomes the Secretary of State’s commitment to make public health the priority of the DH, but is concerned that these reforms will stall positive progress to promote good oral health and tackle health inequalities, which continue to blight the health chances of the most disadvantaged groups\(^3\).

3. The role of PCTs in commissioning dental services

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\(^1\) Access to NHS Dentistry, report of the House of Commons Health Committee, 2001, paragraph 22


\(^3\) According to a survey of five year olds conducted by the British Association for the Study of Community Dentistry, there is a seven-fold difference between PCTs in England with the best dental health and those with the worst. By the age of five, more than a third of British children have suffered tooth decay, missing teeth or fillings; in some parts of the country as many as three-quarters of children are affected.
The BDA supports the development of dental services to meet the needs of local patients. Providing services based on assessment of local communities’ needs, allows longstanding health inequalities and ‘dentistry deserts’ to be addressed.

To commission dental services successfully, PCTs must have the right resources, in terms of both funding and expertise, and engage with local dentists and patients. However, the varying success with which PCTs have been either willing or able to do this has resulted in a new postcode lottery of NHS dental provision. The difficulty faced by some PCTs when commissioning dental services results from their commissioning budgets being based on previous spending levels. Therefore, areas which were historically under-funded before the new contract continue to be so.

The BDA has called for the Government to allocate full dental budgets for PCTs so that they are no longer reliant on patient charge revenue. In the first year of the new contract, PCTs were required to collect approximately 25 per cent of their dental commissioning budget via payments from patients who must pay for NHS dentistry. However, in 2006/07 patient charge revenue was £159 million (26 per cent) lower than expected by the DH. PCTs were forced to cover this deficit by a combination of commissioning less dentistry than they otherwise should have and by implementing inflexible performance targets for dentists. Reliance on patient charge revenue ensures that PCTs’ dental commissioning budgets remain unpredictable for future years.

The funding predicament faced by PCTs comes in the wider context of the chronic under-funding of NHS dentistry. The proportion of the NHS budget spent on dentistry in England is now lower than it was in 2002-03, at only 2.8 per cent. Unless the Government invests additional funding into NHS dentistry the only source of further growth to meet demand is through the private sector.

The National Audit Office warned in 2004 that PCTs would need “to develop new expertise in dentistry” given that they had “little experience of high street dentistry”. The development of effective working relationships with local dental committees and local dentists is a crucial part of addressing this requirement. The BDA is playing a proactive role in providing advice to support this process, a contribution recognised by the DH.

The expertise of consultants in dental public health is also vital for effective strategic commissioning. The recent loss of a number of consultant posts is therefore of great concern. This loss of dental public health capacity also undermines the

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5 According to figures published by the Department of Health, 23 August 2007, patient charge revenue only generated £475 million instead of the expected £634 million, resulting in a shortfall of £159 million in the dental budget. The NHS Dental Statistics for England 2006/7 are available from the Information Centre for Health and Social Care.
6 NHS Primary Dental Care expenditure data for 2006-07 provided in a parliamentary answer. NHS data from the NHS Operating Framework for 2007-08
8 Barry Cockcroft, Chief Dental Officer for England, Speech to BDA Conference, May 2007
Secretary of State’s elevation of public health to the top of the national agenda, and his recognition that this is “pivotal” to reducing health inequalities.

It is vital that PCTs, having drawn on these resources, publish plans on how they intend to reduce health inequalities and improve the oral health standards of their communities.

To commission effectively, PCTs also need information about the oral health of their patient cohort. The Adult Dental Health Survey, carried out every ten years by the Department of Health, is an invaluable tool to monitor populations’ oral health – and indeed will be essential to evaluate the impact of the current reform programme. The BDA is calling for the funding of the survey, which has been delayed a year, to be secured.

4. **Numbers of NHS dentists and the numbers of patients registered with them; and the numbers of private sector dentists and the numbers of patients registered with them**

When considering the relationship between NHS and private care, it must be recognised that the vast majority of dentists work in a mixed economy. It should also be noted that since 1 April 2006 a patient can no longer be registered within the NHS.

The vast majority of general dental practitioners make available to patients a combination of NHS and private care. The *Options for Change* report acknowledged that this model of mixed provision should be welcomed: “private dentistry contributes to patient choice, provides dentists with options and independence and delivers those treatments that the Government does not wish to finance”.

Analysis of DH data suggests that the value of the private dentistry market is now at least equal to that of NHS provision and that it is continuing to expand. The 2005/06 report of the review body on doctors’ and dentists’ remuneration showed that in most practices there was cross subsidy of costs between private and NHS work. General dental practices are independently managed businesses that contract to provide services for the NHS. Unlike general medical practitioners, dentists have to buy their own premises, buy their own equipment and employ their own staff. This report demonstrates that, in effect, the income from private treatment is keeping NHS practices in business.

According to the DH, there are now 570 fewer dentists holding NHS contracts in England than there were prior to the introduction of the new dental contract. However, the BDA believes the real loss to the NHS since April 2006 is approximately 1,000 dentists.

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9 ‘The Healthy Society’, Speech in the House of Commons, Rt Hon Alan Johnson MP, Secretary of State for Health, 12 September 2007
12 DDRB supplementary evidence, analysed and published in the BDA ‘Policy Bulletin’, August 2005
13 According to the DH, at 31 March 2007 there were 21,041 dentists performing NHS dental services in England. The BDA argues that the comparable figure for pre-April 2006 would be approximately 22,073. This is derived by taking the old England and Wales general dental services figure of 21,254, a
A further indicator of change in the current dental market is the rise in the number of patients who have joined private capitation schemes to pay for their dental care. To take just one example, Denplan, one of the UK’s largest providers, has seen a 30 per cent increase in patient registration since 2004\textsuperscript{14}.

Patient registration was first introduced to NHS dentistry as part of the contract reforms in 1990. It was abolished as part of the 2006 reforms. BDA members are told by their patients that they greatly value a long term relationship with their dentist. The BDA is concerned that the loss of registration may have an adverse effect upon the continuity of care received by patients. The 2006 contract has created a system that favours episodic, pain-relief oriented treatment rather than promoting disease prevention. We discuss the number of patients accessing dental services in section 6.

5. The work of allied professions

Major changes are underway in relation to Dental Care Professionals (DCPs) with the advent of regulation bringing additional responsibilities and accountability. The BDA has strong links with the DCP associations, and welcomes and is committed to the development of the wider dental team and the professional growth of individual team members.

Dental nurses have always played an essential role in the dental team. A wider group of professionals, including therapists and hygienists, also have positive contributions to make. However, their potential is not being fully realised because of the cost pressures within NHS general dental practice (discussed at section 8, below). In addition, DCPs and dentists share many of the same concerns about the viability and stability of NHS dental practices.

6. Patients’ access to NHS dental care

The BDA urges the Department of Health to define what ‘access’ to NHS dental care should mean. The BDA argues that the new system favours sporadic and discrete treatment episodes rather than long term continuing care for those patients seeking a regular treatment pattern.

Even taking the DH’s reductive interpretation of access, the April 2006 reforms have failed to improve access for patients to NHS dentistry. The latest figures from the DH show that over a 24 month period – the maximum recommended period between dental examinations\textsuperscript{15} – 27.8 million patients accessed NHS dental services\textsuperscript{16}. This is a reduction of 266,000 patients since the 2006 reforms.

\textsuperscript{14} Denplan currently has 1.8 million registered patients, compared with 1.3 million patients three years ago, an increase of approximately thirty per cent. Information from the Denplan Media Centre.
\textsuperscript{15} Dental recall: recall interval between routine dental examinations, National Institute for Health and Clinical Excellence, 2004.
\textsuperscript{16} NHS Dental Statistics for Quarter 1, 2007, Information Centre for Health and Social Care
In March 2007 the BDA published the results of a survey of dentists’ experience of the new general dental services contract. Eighty-five per cent of respondents said that the new contract had not improved access to NHS dental services for patients, 88 per cent said that access to orthodontic services had not improved and only ten per cent were able to take on new patients\textsuperscript{17}.

Research conducted by patients’ organisations reinforces these concerns. Citizens Advice states that patients still face significant problems finding a dentist\textsuperscript{18}. Market research published by Which? also shows significant regional variation in the availability of NHS dental care, with an average of just a third of practices across England taking on new NHS patients\textsuperscript{19}. The most recent Wanless review on healthcare spending shows public satisfaction with NHS dentistry to be lower than for all other NHS services, with a decline of 20 percentage points between 1998 and 2005\textsuperscript{20}.

The pressures in general dental practice have also led to increased demand on the salaried primary dental care services and on dental hospitals. A BDA survey of clinical directors showed that 87 per cent of services were experiencing increased waiting times for specialist care due to these additional referrals\textsuperscript{21}. These services are often designed specifically to treat patients with special or complex treatment needs; any disruption therefore risks creating difficulties for patients in the greatest need of care.

It has been at least seven years since the Government conducted even a rudimentary assessment of the unmet need for dental care. It found then that two million patients who wished to receive NHS dentistry, were unable to do so\textsuperscript{22}. The BDA believes this underestimates the size of the current problem. The Healthcare Commission’s national patient survey in 2005 found that 69 per cent of patients not registered with an NHS dentist would like to have been\textsuperscript{23}. This equated to approximately 15 million people.

7. The quality of care provided to patients; and the extent to which dentists are encouraged to provide preventive care and advice

Dentists want to provide high quality care for patients within a prevention-based system, as proposed in Options for Change. Yet patients’ quality of experience is now threatened by the time pressures on dentists generated by the new target-driven system.

\textsuperscript{17} BDA survey of members, March 2007

\textsuperscript{18} Gaps to Fill: CAB evidence on the first year of the NHS dentistry reforms. Citizens’ Advice, 2007

\textsuperscript{19} Check-up on NHS Dentistry: dental contracts one year on, Which?, March 2007


\textsuperscript{21} BDA survey of clinical directors, September 2006

\textsuperscript{22} Modernising NHS Dentistry: Implementing the NHS Plan, Department of Health, 2000, par 2.17


ONS data shows the population of England to be 50.8 million. The Healthcare Commission found that 43% of patients were not registered with an NHS dentist; of those, 69% wanted to be. This equates to approximately 15 million people.
These contract reforms have introduced a new system for measuring the performance of NHS dentists. A target for the number of units of dental activity (UDAs) a dentist or practice must perform annually is written into each contract. For simple procedures, such as a check-up, dentists are awarded one UDA; work that also involves intervention, such as fillings and root canal treatment is worth three UDAs; and dentists are awarded 12 UDAs for work that also necessitates laboratory involvement such as bridge-work or dentures.

There are significant anomalies within this system, which result in it being more complex and unfair than the above description would suggest. Dentists earn the same number of UDAs regardless of the number of items of treatment provided within a course of treatment. For example: a patient requiring one filling would fall into the Band 2 course of treatment, earning for the dentist three UDAs. A patient requiring four fillings and root canal therapy would fall into the same band, also generating for the dentist just three UDAs.

As well as appearing arbitrary, this system of performance measurement fails to promote a more preventive approach to care because of the pressures on time it creates. A recent report from the London Assembly called on the DH to “consider how it could revise the current NHS dental contract so that preventive care is built into the way PCTs manage and monitor dental contracts and should consider whether dentists should be financially rewarded for providing preventive advice”\(^{24}\).

One of the Government’s stated aims of the reforms was to get dentists off the workload ‘treadmill’ to allow additional time for preventive care. The last official study into general dental practitioners’ workload showed that a fully committed NHS dentist worked 43 hours per week, in that time seeing 140 NHS patients\(^{25}\). In a survey of dentists’ attitudes to the 2006 reforms, 82 per cent strongly disagreed with the statement that “the new NHS contract has removed the treadmill effect”. For fully committed NHS dentists this figure was 88 per cent\(^{26}\).

The UDA is more than a performance indicator: it is the principal unit of currency of the new contract. Anything less than 96 per cent of UDA performance may lead to serious repercussions for NHS dentists. Data supplied by the NHS following a freedom of information request showed that in 2006/07 almost half of dental contractors actually failed to provide the required number of UDAs\(^{27}\). The proportion of dentists who met their UDA target was only 20 per cent, if those who performed additional unfunded NHS services – i.e. at their own expense – are also included.

BDA research found some areas where PCTs have taken a constructive and sensitive approach to dentists missing their UDA targets; but others did not. The variability of PCTs’ approach is illustrated by the research, which found that of practices that had not achieved 96 per cent of their target in the first year of the new


\(^{26}\) BDA survey of members, March 2007

\(^{27}\) BDA analysis of information supplied by the NHS Business Services Authority showed that 47% of dental contractors failed to provide at least 96% of the contracted number of units of dental activity.
contract, almost 40 per cent faced clawback of money already paid by their PCT. Just over 35 per cent said that their PCT had insisted that the uncompleted UDAs be performed in the 2007-08 contract year.\(^\text{28}\)

The BDA is aware of clawback where dentists’ work rate has remained unchanged from previous patterns; some of these cases involve clawback of tens of thousands of pounds. To take just one example: a fully-committed NHS dentist in the Wirral felt forced to close his practice having been required by his PCT to pay back £20,000.\(^\text{29}\)

The BDA supports the DH’s oral health plan, Choosing Better Oral Health, and the ‘prevention toolkit’ that derives from it. But the reality is that when dentists spend additional time with patients to explain about oral hygiene, nutrition and disease prevention they do so at the risk of missing their UDA requirement or by disproportionately increasing their clinical working time.

The BDA has consistently argued that the UDA is a flawed measure, which was untried and untested before implementation, and has called on the Government to scrap it as the sole indicator of performance. It supports the Department of Health’s advice to PCTs to include factors such as oral health, access, quality and patient experience in dentists’ contracts. This approach would enable PCTs to develop and agree contracts with dentists and practices that reflect the needs of patients in their area.

It appears from two reports that the contract reforms have resulted in a change to the complexity of NHS courses of treatment.\(^\text{31}\) According to the DH “the new contractual arrangements were designed to encourage simpler courses of treatment, where clinically appropriate, with less complex and invasive procedures.”\(^\text{32}\) These preliminary changes to treatment complexities should be seen in the context of the majority of dental contractors missing their UDA targets, as discussed above.

8. **Dentists’ workloads and incomes; The recruitment and retention of NHS dental practitioners**

The implementation of the new contract has prompted many dentists to question their future in NHS dentistry. BDA research shows that, a year into the reforms, dentists were more concerned than ever about their long term future in the NHS. Dentists’ concerns relate to the target-driven nature of the new contract and how this influences their clinical practice and the financial security of practices.

The BDA argues that issues around recruitment and retention can only be addressed by tackling the faults in the new contract and safeguarding future funding levels for NHS dentistry.

\(^{28}\) BDA survey of local dental committees and PCTs, August 2007
\(^{29}\) The case referred to was that of Dr Clive Morgan, of Greasby in Wirral PCT.
\(^{31}\) NHS Work Stabilised at All Time Low, the Dental Laboratories Association, 2007.
\(^{33}\) BDA survey of members, March 2007. This showed that 57 per cent of dentists were less confident about the future of their practice than they were two years previously. This compared to only 27% when asked that same question in 2002.
Dentists have been moving away from the NHS since the early 1990s, a trend which the 2006 reforms have exacerbated. This movement is manifest in individual dentists leaving the NHS entirely and others changing the balance of their practice to carry out a greater amount of private care. Information from the NHS highlights the extent of the shift towards private dentistry. Using NHS earnings as an indicator of commitment, the percentage of total NHS work fell from an average of 47.6 per cent of earnings in 2004–05 to 41.9 per cent in 2005–06, a fall of 5.7 per cent. The largest reduction was for dentists aged under 35, whose NHS earnings as a percentage of total earnings fell by 20.7 per cent. Analysis of the attitudes of senior dental school students suggests that the future dental workforce expects to spend a smaller proportion of its time delivering NHS dentistry. The supply of NHS dental hours could be further reduced by these students’ intention to take longer career breaks to raise children and earlier retirement than the current workforce.

The reason for this shift towards private practice is not to earn more money. Data from the DH suggests private dentists are more able than NHS dentists to invest in their practices, in terms of the ability to pay for modern equipment and premises. The same DH data demonstrates only a small difference in earnings between predominantly NHS and predominantly private dentists, of approximately 6 per cent. Instead, the BDA’s research identifies that dentists move away from the NHS in order to spend greater time providing prevention-based care to their patients.

In terms of recruiting new NHS dentists, a survey of last year’s vocational dental practitioners – newly qualified dentists – found that by the summer, more than one in five had still not managed to secure employment for the coming year; this is three percentage points up on the same time 12 months before. Among those that had yet to secure a job, many reported that their lack of experience was a key factor hampering their search for employment. This is symptomatic once again of the new target-driven UDA system which strongly favours productivity over a focus on prevention.

9. Oral evidence

The BDA would be pleased to give oral evidence to the committee if it would be helpful to the inquiry.

British Dental Association
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34 Dentists’ Earnings and Expenses Report 2005/6, The Information Centre for Health and Social Care
36 Dentists’ Earnings and Expenses Report 2005/6, The Information Centre for Health and Social Care
37 BDA Private Practice survey, 2002
38 BDA survey of vocational dental practitioners, June-August 2007