NHS Overview and Scrutiny Briefing Note

Dentistry

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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, self-employed contractors. 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 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, 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. For the first three years of the NHS, dentistry was available to NHS patients free at the point of use. However, in 1951 patient charges were introduced (primarily as a means of limiting demand) and they have remained ever since, in one form or another (with exemptions from charges for children and for adults falling into certain low-income categories).

In 1990, a new General Dental Services 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 country.

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 General Dental Services 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)

Subsequently, 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 GDPs, which took effect on 1 April 2006.

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”.

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 2006):

- Band 1: Diagnosis, treatment planning and maintenance – also urgent and Out of Hours treatment (£15.50)
- Band 2: Diagnosis, etc. *and* simple treatment (£42.40)
- Band 3: Diagnosis, etc. *and* simple treatment *and / or* complex treatment / provision of appliances (£189.00)

Any further treatment required at the same charge-level within two months was now free of charge. Replacements for lost or damaged appliances were now subject to a charge of 30% of the Band 3 charge (£56.70).

This new patient-charge regime meant that the maximum patient charge for a course of

treatment was now £189.00 (the previous upper limit had been £384.00). However, the cost of a simple check-up, with no further treatment, effectively rose from £5.84 to £15.50.

Under the new arrangements, patients were no longer required to register with a dentist in order to obtain treatment; but a dentist was only required to treat as many patients as necessary in order to reach the target number of Units of Dental Activity stipulated in his or her contract.

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

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

Dentists were still permitted to see only children and charge-exempt adults on the NHS; but they could not 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. PCT dental allocations are ring-fenced during that time. At the end of this initial three-year transitional period, PCTs will assume full responsibility for commissioning dental services in their area, using money from a (now non-ring-fenced) budget 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.

Issues around the new contract

The Department of Health (DoH) argued that the new contract freed dentists from the "treadmill" style of working associated with the "fee per item" system and encouraged a more preventive approach. Dentists' representatives, however, argued that remuneration through Units of Dental Activity 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 Units of Dental Activity, 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.

The DoH maintains that more NHS dentistry is now being commissioned than ever before. However, there remains a widespread perception (endorsed by dentists' representatives) that access to NHS dentistry has not improved since the introduction of the new contract – and may actually have worsened.

It has recently been reported that PCTs are experiencing financial problems in respect of dental services, due to revenue receipts from dental patient charges being (for several reasons) lower than was forecast when the new contracts were issued in 2006.

Given that dental allocations are ring-fenced for the first three years of the new contract, funds earmarked for primary-care dental provision cannot be diverted by PCTs in order to address financial problems. However, it is feared that this could happen once ring-fencing ends.

It is noteworthy that, in the turnaround plan agreed by South West Kent and Maidstone Weald PCTs in July 2006, it was stated that £700,000 remained from the PCTs' 2006–7 dental allocation and that "delays in providing alternative arrangements for more NHS dentistry" would "result in a one off saving". It is questionable whether unspent ring-fenced dental allocations can actually be retained in this way by PCTs – or whether they should instead be passed back to the Strategic Health Authority.

Possible themes for questions:

- Whether the new dental contract has permitted the commissioning of adequate:
    - access to NHS dental care for all those who need it, in all areas;
    - Out of Hours dental services;
    - specialist dental services (particularly orthodontics).
- The possible effect on service provision of contractual disputes that remains outstanding, if these cannot be satisfactorily resolved.
- Whether the reported shortfalls in dental patient charge revenue will affect service provision.
- Whether significant gaps in services will open up at the end of the three-year transition period, when significant numbers of dentists may wish to withdraw from the contract; and when ring-fencing of PCT dental allocations will come to an end.
- Whether PCTs are able adequately to fulfil their commissioning role in terms of:
    - accurately gauging local need for services; and
    - directing provision towards areas or communities that are underserved.

Number of dentists (General Dental Practitioners) on open NHS contracts in Kent & Medway as at 30 September 2006 (including orthodontists)

Primary Care Trust	Total number of dentists (performers) on open NHS contracts	Population per dentist
Ashford PCT	68	1,606
Canterbury and Coastal PCT	68	2,452
Dartford, Gravesham and Swanley PCT	87	2,567
East Kent Coastal PCT	57	4,106
Maidstone Weald PCT	94	2,544
Medway PCT	362	725
South West Kent PCT	111	1,624
Shepway PCT	46	2,119
Swale PCT	41	2,383

Sources:
The Information Centre for health and social care
NHS Business Services Authority

Units of Dental Activity commissioned by Primary Care Trusts in Kent & Medway, as at 30 November 2006

Primary Care Trust	UDAs commissioned			UDAs re-commissioned		
	and provided	but not yet provided	Total	and provided	but not yet provided	Total
Eastern and Coastal Kent PCT	929,990	33,664	963,654	39,187	6,232	45,419
Medway Teaching PCT	419,401	8,750	428,151	5,176	-	5,176
West Kent PCT	739,278	8,576	747,854	22,832	265	23,097

Source: Department of Health

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Disputed dental contracts in Primary Care Trusts in Kent & Medway, as at 30 November 2006

Primary Care Trust	Total initially in dispute		Unresolved		Resolved - outcome accepted		Resolved - outcome not accepted	
	Contracts	UDAs	Contracts	UDAs	Contracts	UDAs	Contracts	UDAs
Eastern and Coastal Kent PCT	51	488.593	32	294,591	18	177,227	1	16,755
Medway Teaching PCT	19	138,916	1	453	18	138,462	-	-
West Kent PCT	44	376,667	8	85,256	36	291,411	-	-

Source: Department of Health