ISSUE 5 SEPTEMBER 2001

Health Policy Matters

HELPING DECISION MAKERS PUT HEALTH POLICY INTO PRACTICE

This issue

NHS DENTISTRY – MODERN AND DEPENDABLE?

Introduction

Despite high levels of public expenditure, over £2 billion in 1997/98,[1] many dentists have reduced their commitment to the NHS with the result that services are not available to the whole population. This, together with large social and regional differences in the levels of dental disease, sustains major inequalities in both dental health and health care.

The national dental plan addresses these problems through a number of initiatives, which may fail to tackle more fundamental issues including the determinants of dental disease. The basis of the dental service has changed little since the start of the NHS and Health Authorities (HAs) have had no effective levers to encourage the development of a high quality, equitable and locally available service. The plan will provide some additional powers but major reform of the General Dental Service will be necessary if dentistry is to achieve the levels of quality, equity and access expected of other health services. The re-election of a government with a reforming agenda provides an opportunity to modernise dentistry.

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Background

There are approximately 20,000 practising dentists and a larger number of personnel employed in ancillary and supporting roles. In 1997/98 the cost of NHS dentistry was estimated to be in excess of £2 billion per annum,[1] twice that expended by NHS hospitals on specialist cancer services.[2] Almost 90% of dental care is provided by general dental practitioners (GDPs) working in the primary care sector, who as independent contractors to the NHS, are remunerated through what is largely a fee-per-item mechanism.[3] Unlike their medical counterparts (GPs), there are no controls over where GDPs site their practices or which patients they decide to treat. Providing a GDP is prepared to register a patient for NHS care (who need not reside within the same Health Authority), the patient is required to attend the practice within a 15 month period to remain registered. The differences between GDP and GP controls provide possible explanations for the wide variation in both the resident population to dentist ratio and the take-up rate per resident population seen (Table 1), although the data refer only to scheduled principal dentists. Barnet, for example, with the highest dentist to resident population ratio has the lowest take up rate.

With the exception of the introduction of patient charges, almost half a century ago, the only significant reform of the dental contract was in 1990 with the development of a capitation-based remuneration system for children.

However, these changes to the remuneration of dentists have not always worked in the interest of patients, the NHS or the profession. Successive governments have been prepared to make minor incentive system changes but have refrained from undertaking a radical review of dental care. The publication of *Modernising Dentistry – Implementing the NHS Plan*[4] and the subsequent response to the Health Select Committee's Report[5] suggest that the government has an intention to reform the financing, organisation and delivery of dental services as part of the NHS reforms.

This issue of *Health Policy Matters* has been written by Peter J Nicklin, Director, Centre for Dental Services Studies, University of York and Dr Paul Batchelor, Senior Lecturer and Consultant in Dental Public Health, University College London.

It explores the current challenges facing dentistry following the publication of the national dental plan, in the context of major inequalities in both dental and health care generally. Some suggestions and solutions for policy makers are proposed.

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PRODUCED WITH AN EDUCATIONAL GRANT FROM Pfizer

The strategy for NHS dentistry

Modernising Dentistry – Implementing the NHS Plan identifies three areas for development: Access, Quality and Health Improvement. These link with plans for the rest of the NHS.[6,7] For each area government has set targets (Table 2).

Table 1: The variation in the distribution of dentists and resident population registration rates in England and Wales.

Health Authority	Dentist to resident population ratio	Take up rate per resident population (%)
Barnet	1:1509	33
Buckinghamshire	1:1915	39
Stockport	1:1995	61
Isle of Wight	1:2493	47

Source: Dental Practice Board Quarterly Reports: Registrations July-September 2000

Access

A number of authors have highlighted that wide variations in access to health care exist.[8,9] In its strategy the government places a singular emphasis on access, but does not consider key dimensions of access such as affordability, acceptability and appropriateness. Services may be available but not accessed, for example due to concerns over the potential costs of treatment, a desire to have private dental care or a lack of perceived need. Crucially, the scale of the problem is unknown. Analyses of Dental Practice Board (DPB) data suggest that anywhere between 27 and 39 million people in England and Wales (54-75% of the population) accessed the NHS General Dental Services within the 15 month period commencing July 1999. Each month about a million patients change their registration status within the NHS dental care system: the reasons why they do so are unknown. Unlike medical care arrangements, after 15 months, an individual becomes de-registered from the dental system. Anyone who wishes to re-register needs to find a dentist who has both capacity and is willing to register the individual.

NHS Direct has been assigned a key role in enabling people to find a dentist. HAs are expected to monitor the local situation regularly to provide data on service availability.[10] However the strategy assumes that if the infrastructure is developed, for example, by building sufficient Dental Access Centres (DACs), and the necessary staff trained and recruited, the access problem will be solved. This ignores the evidence on reasons for not using the system, such as patient charges, a barrier to dental care identified by Finch et al over a decade ago.[11]

Quality

The quality targets include better information for patients, strengthening self-regulation and implementing clinical governance. These could and should have been extremely challenging but are simply general targets with no rigorous outcome measures and consequently will be difficult to fail. There are however financial targets for capital investment. As with the NHS in general, capital investment in dental practices has been limited. Governmental thinking has progressed since setting the original quality performance targets for dentistry.[12] The opportunity to direct specific funds to HAs with low levels of NHS dentistry, particularly if they are tied to improvements in capital stock is to be welcomed. However, there is little consideration of either the causes of, or remedies for, the problem of variation in practice quality.

Table 2: Targets set in *Modernising Dentistry – Implementing the NHS Plan*

Theme	Target	Issue
Access	By September 2001 everybody who needs NHS dentistry will be a phone call away from finding it	NHS Direct and key HA role
Quality	NHS dental services will be more clinically effective and cost effective	Implementation of clinical governance
Oral Health	By 2003, 5-year-old children on average should have no more than one decayed missing or filled primary tooth	Intersectoral collaboration

Improving oral health

Dramatic improvements in the nation's oral health have occurred over the last 30 years.[13] In absolute terms, disease levels have fallen and the remaining relative variations are strongly associated with socio-economic conditions. The target is to reduce disease levels in 5-year-olds to an average of no more than 1 decayed, missing or filled tooth. The most recent survey of 5-year-olds in Great Britain found an average of 1.57 decayed, missing or filled teeth.[14] But the question is to what extent would any changes in dental services help meet this target? The public health approaches prescribed include

intersectoral working, a review of water fluoridation, and an emphasis on reducing tobacco usage. Although it ignores the role of diet, this shift in policy to recognise the environmental determinants of oral ill health is welcome; but the government's record to date on effective intervention has been poor.[15]

Much of the government's strategy was scheduled for implementation by September 2001. Guidance notes for HAs[16] and a consultation document on orthodontic services[17] have been issued. This timescale also coincides with the end of the first wave Personal Dental Services (PDS) pilot programmes.[18] The government is already emphasising the benefits of PDS in advance of any formal evaluation of the pilots. The promotion of pilots before evaluation is reminiscent of the manner in which the 1990 contract[19] was introduced which heralded the move of dentists away from a reliance on the NHS for their income.

Challenges and potential solutions

What can dentistry contribute?

Four major challenges face dentistry. The first is to differentiate between what dentistry can and, importantly, cannot contribute to the nation's oral health. While dental interventions will have little direct impact on inequalities in oral health, the dental profession can help to support and encourage the implementation of social policies that are effective in addressing this issue. For its part, dentistry must ensure that those in need of dental care can receive effective treatments. However, the evidence base underpinning dental interventions is woefully poor.[20,21] The first step must be to move beyond the current subjective acrimonious arguments to an objective and rigorous scientific debate to address this shortcoming.[22]

Ensuring access

Having identified effective interventions, the second challenge is to ensure appropriate access. To achieve this, government could make dental registration meaningful, by moving towards long-term dental registration similar to that for General Medical Practitioners. Data on registration with medical practitioners at a local level are both more valid and useful. There are geographical boundaries limiting where patients can register, no obligation to attend within a given timescale and no charges for doing so.

Workforce

The third challenge is to determine the optimal size and composition of the dental workforce. The difficulty in workforce planning is highlighted in the consultation document issued in April 2000.[23] The current annual in-flow of nearly 800 graduates from abroad is now the same as the number who qualify in the UK. Changes in those countries that currently export dentists to the UK, such as improved remuneration, a reduction in the numbers in training or changes in the political regime, could (overnight) reduce the number of dentists available to the UK labour market.

The government's announcement of a review of workforce requirements is to be welcomed.[24] The review must examine how contextual changes influence personnel requirements. Reasons given for the apparent shortage of dental care providers include GDPs moving to the non-NHS sector and the effect of a higher percentage of females in the workforce combined with part-time work. Yet, only 'more flexible recall intervals' and 'maximising the contribution of dental therapists and hygienists' are offered as solutions. While the former may indeed create additional time to treat patients, changing the skill-mix could be the most fertile area of scrutiny. Using Professionals Complementary to Dentistry (PCDs) may provide an enduring solution but the current restrictive practices endorsed by the General Dental Council limit this option. A key question is whether changes in the number of PCDs would be aimed at the substitution of dentists. Any changes would have major educational and cost implications that have yet to be calculated. A systematic review of the evidence for PCDs is currently being undertaken and may provide answers. Again, contractual changes moving more closely to that of medical practitioners with a capitation-based system and grants for supporting differing support staff are options. This would help to plan local services to meet local needs.

Delivering change

The final challenge is implementing change. The government states in its Plan that 'salaried primary care services…are not funded or managed consistently across the country' yet argues that Health Authorities (HAs) should play a bigger role. With the formation of Primary Care Trusts (PCTs) and demise of Health Authorities, the personnel with the expertise necessary to implement changes in dental services are migrating from HAs to PCTs. The logic must be for PCTs to be responsible for locally managed dental services.

Two groups that could help improve dental performance are the Consultants in Dental Public Health and Dental Practice Advisors. The variation in their distribution within the country is almost as great as that of dentists. With the publication of

guidelines identifying the roles expected of the HAs, Chief Executives would be wise to ensure that the necessary individuals are in post.

Conclusions

The dental sector perhaps highlights the dilemma any government would find itself in when dealing with the differences between lay and professionally defined need. How does one formulate policies aimed at ensuring a more consumer orientated service and at the same time reduce inequities when the measurement of the problem cannot be made with clinical indicators alone? With current disease levels, one section of society may have needs based more on self-esteem, self-image and feelings of social well-being met through treatments offering improvements in aesthetics, while another section's needs are based on pain and suffering.

The objective must be to develop a dental care system in which society as a whole receives appropriate care through an inclusive system. It should ensure care is evidence based, provided to agreed standards using an appropriately skilled workforce.

While *Modernising NHS Dentistry - Implementing the NHS Plan* correctly describes the problems facing dentistry, it fails to offer any long-term prescription. Improved access to dental services in the short term may be temporarily achieved but the long-term solutions to ensuring improved quality of care, reduced inequalities and the provision of an appropriately trained workforce remain rhetorical.

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Health Policy Matters is published periodically by the University of York, with the aid of an educational grant from Pfizer Limited. It is distributed free of charge to chief executives, chairs and senior managers in the health and social services sectors. It may be photocopied freely. The content focuses on health and social policy issues relating mainly to England and therefore the distribution is limited to English health and social care organisations.

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All issues of Health Policy Matters are available electronically via our website: www.york.ac.uk/depts/hstd/pubs/hpmindex.htm

Acknowledgments: We would like to acknowledge the helpful assistance of the following who commented on the text:
John Ashton (NHS Executive North West), Mark Baker (North Yorkshire Health Authority), Tony Culyer (University of York), Ron De Witt (King's College Hospital NHS Trust), Tom Dowell (Avon Health Authority), Louise Dunn (University of York), Alan Maynard (University of York), John Renshaw (British Dental Association and Professional Director CDSS), Aubrey Sheiham (University College London), Melvyn Smith (South Essex Health Authority), Geoffrey Taylor (University of Manchester), John Taylor (Dental Practice Board), Ray Wilk (Wakefield & Pontefract NHS Trust).