



Dentistry

Primary dental care services in England and Wales

The Audit Commission is an independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high-quality local and national services for the public. Our work covers local government, health and criminal justice services.

Our national studies on the performance of health services examine services from a user's perspective and identify and promote examples of good practice. We also appoint auditors to all health authorities, primary care trusts and NHS trusts in England and Wales.

Our work focuses on:

- Whether there are firm foundations of good management to improve services to patients and provide value for money.
- How well organisations inside and outside the NHS work together to provide the best care for patients.
- How effectively key resources, for example, doctors, nurses, theatres, equipment and budgets, are managed.



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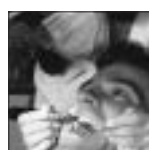
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Preface

Dental diseases include some of the most common diseases of all – for example, tooth decay. This is caused, or avoided, largely by our actions – by whether we brush daily with a fluoride toothpaste, and how often we consume sugary and acidic food and drink. This means that common dental diseases are mostly preventable and treatable. Dental services are one of the most widespread forms of healthcare, with most people using the General Dental Service (GDS) at periods throughout their lives.

This report gives the key messages from the Audit Commission's study of primary care dental services. The findings of the report will be of interest to:

- *The public:* there are messages about how patients can protect their own dental health, about what care is necessary for the good of their health and what is cosmetic, about access to different kinds of services, and about the information that they should receive about charges and about what is being provided as NHS care and what is provided privately.
- *Primary care trusts (PCTs) in England and the future local health boards in Wales (LHBs):* the report gives case study examples of how some local managers have made use of special schemes, such as personal dental services (PDS) pilot schemes in England and the Welsh Dental Initiative, to improve local services.
- *Dentists:* in addition to debating the management and care quality issues that concern dentists, the report reflects what patients think about dentists' services and the issues that concern them.
- *The Government:* the report points out those areas where dental policies are not aligned with other NHS policy. Most of the recommendations for change are directed at government level.

The report makes extensive use of direct quotations from patients and dentists. A more detailed report including a fuller description of the methods that the study team used, and more details about the results, can be found on the Audit Commission's website (www.audit-commission.gov.uk). Use of the symbol  in the margin in this report indicates that further information is available in the web document in the paragraph cited.

Dr Richard Waite, David Bird, Charlotte Brown and Deborah Causer carried out the study, under the direction of Wendy Buckley. Patricia French, Catherine Cawley, Ann Richardson and Helen Finch contributed directly as members of the study team or as consultants. Dr Ivor Chestnutt answered many of our early queries, and commented on an early draft. A note on acknowledgements and methods is in Appendix 1. Responsibility for the findings and conclusions in the report rests entirely with the Audit Commission.

1



Introduction

The national piecework system for funding dentists is poor value for money. Money is spent on unnecessary activity, yet in some places people cannot get NHS care. The system does not sufficiently help to meet the needs of people in deprived areas whose dental health is poor.

Stark contrasts

1 Dental services are one of the most widespread forms of healthcare. Most of the population use the General Dental Service (GDS¹) at periods throughout their lives. Under the GDS scheme, a core of important healthcare is delivered very efficiently by hardworking professionals. But the service also shows signs of strain, and our review reveals important contradictions:

- Most peoples' dental health has improved dramatically over the last 50 years, yet inequalities in health are worse. In deprived communities levels of dental disease remain high.
- People who drink fluoridated water have much less dental decay, and a majority of the population support fluoridation – but all attempts since 1985 to have further local supplies fluoridated have been unsuccessful.
- In 1999 the Prime Minister made a pledge that, by October 2001, anyone would be able to find an NHS dentist by calling NHS Direct. The Government say that the pledge has been largely met but many commentators and patients do not agree. This disagreement boils down to a difference of definitions – whether the pledge referred to urgent care only (which has improved), or also to continuing care via registration (which has not improved).
- Large numbers of people are very satisfied with their dentist, and have had a long-lasting relationship with the same person. But others voice complaints about poor and expensive treatment.
- Some dentists say that NHS payments are insufficient to allow them to provide good-quality treatment. But some NHS patients are being persuaded to pay much higher prices for private treatment that evidence has shown to be less effective.
- The Government say that charges should be fair and should not deter those who need care from seeking it. But the charging rules for dental care are different from those for other types of healthcare, and some patients say that charges are a barrier to seeking care.
- NHS costs increase in real terms every year – yet large sums are spent on unnecessary and cosmetic activity rather than on meeting health needs. There is confusion over what is really necessary for good health and should, therefore, be available under the NHS, and what can make a cosmetically more pleasing result and which should, therefore, be paid for privately.
- Under GDS rules, dentists are very productive – they work hard and fast. But the system also reinforces inefficiency by offering a reasonable income to single-handed dentists, whose overhead costs are higher because they cannot spread the cost of premises, staff and equipment.
- The number of dentists increases every year – but the use of less expensive staff to deliver some services is very limited.
- The GDS is one of the significant areas of NHS fraud, yet local finance managers feel less well prepared to tackle fraud here than in other areas of healthcare.



Web report paragraph 13

¹ A list of abbreviations is given in Appendix 2.

2 Not surprisingly, therefore, there is concern on all sides:

- Patients can be confused. For example, patients frequently complain that it is unclear whether they are being treated under the NHS or privately, whether their treatment is really necessary, and what they are being charged for. They are confused about what the Prime Minister's pledge meant and about whether or not it has been met. They do not understand why they may be exempt from some NHS charges (for example, drug prescriptions) and not from charges for dental care.
- Dentists are increasingly angry about how hard and fast they have to work with NHS patients to earn the sort of incomes that they want in order to pay for their premises and staff costs – they call it the 'treadmill'. Two-thirds of dentists recently surveyed on behalf of the Doctors' and Dentists' Review Body (DDRB) thought that their workloads prevented them from providing a standard of care that they were happy with for their NHS patients.
- There is also frustration for local NHS managers – it is their job to improve access and quality, but they have much else on their agenda and few levers with which to improve dental services. They have been told by the Government that NHS dentistry is being moved 'up the NHS agenda', yet they have no direct control over four-fifths, or more, of expenditure.

3 The contrasts just described above – the very best aspects of the system and the worst – are largely the result of the same thing – a payment system that is mainly based on piecework. Many reports from the 1960s onwards, both for Government and by independent bodies, have pointed out that the GDS remuneration system has serious drawbacks. There is limited ability to distribute dentists to parts of the country on the basis of need. The system provides a strong incentive for dentists to carry out as many activities within as short a time as possible. This may include activity that is unnecessary, thus wasting public money, and failing to meet patients' health needs.

4 This was the context in which the Audit Commission study was carried out. The study team reviewed what had been written about dental services, and made use of the detailed information about activity and costs within the GDS that is collated by the Dental Practice Board (DPB). In addition, the team visited many of the interested parties to discuss issues and to collect documents. Thirteen health authorities (eleven in England, two in Wales) were visited, just as they were handing over responsibilities to PCTs in England, and as preparations were being made to handover to LHBs in Wales. Six focus groups with patients were held in three large cities – Cardiff, London and Newcastle – and patients' experiences were catalogued via a survey.



How the dental healthcare system works

5 People may seek different types of care:

- *Continuing:* Patients have their dental status monitored on a regular basis and any necessary planned preventive or maintenance care carried out. The current NHS system for this is via registration with a dentist for continuing care. In some ways this is similar to the way that we register with a GP for general medical care.
- *Occasional:* 'A range of NHS treatments are available in this way, including an assessment, extractions, x-rays, fillings (normally not more than two in a course of treatment), denture repairs and replacements and some types of new dentures, root canal treatment on teeth other than molar teeth and the repair of crowns and bridges.' (Ref. 1). These are services that some people seek especially on a 'drop in' basis, or on an appointment basis if they are not registered with a specific dentist. Not all dentists offer occasional treatment, and of those that do, not all offer the full range of these treatments to unregistered patients. But in addition, some people, in effect, use the registration system to access occasional care, by coming on and off the register whenever they wish to seek care. Others seek occasional care in different ways, described in the next paragraph.
- *Urgent:* Urgent NHS treatment is necessary when people are in pain or other immediate need.

6 These different types of care are delivered in several different ways and locations. Some patients are served under the NHS by the Community Dental Service (CDS) which, for example, provides periodic check-ups and services for school children, and services for people who cannot easily visit a GDS dentist, such as people with learning disabilities or those who live in residential care homes. Others receive treatment within acute or dental hospitals, including orthodontic, restorative, oral surgery, cancer care and other specialist services, such as cleft lip and palate and paediatric dentistry. Occasional and urgent care, in particular, is increasingly provided via special arrangements (described later in the report). However, most NHS dental care is delivered within the GDS system [Box A]. In addition, some patients pay for private treatment (often delivered by dentists who provide a mix of NHS and private services).

Box A

How the GDS system works

Dentists can contract with primary care trusts, and in the future in Wales with local health boards, to provide NHS services under the GDS system. These dentists are called General Dental Practitioners (GDPs). Patients receiving NHS care are normally registered with the GDP. Registration lasts for 15 months, but it is extended if the patient returns to the dentist within this period, and for as long as the dentist wishes to continue the registration. A dentist can choose whether to register someone or not, and can also de-register patients without giving a reason. GDPs provide urgent care for registered patients, and some also provide occasional NHS care for non-registered patients. Dentists are paid a capitation fee for each person registered with them for

NHS care – this amounts, on average, to about one-fifth of GDS expenditure. Most GDPs also provide private care.

The GDS works mainly on a ‘piecework’ basis. A detailed list of activities can be carried out and paid for under the NHS (over 300 activities, called ‘items of service’). When dentists carry out these activities during a patient’s course of treatment – for example, seeing a patient for a check-up, taking an x-ray, filling a tooth – they complete a form to claim payment¹. These forms are dealt with centrally by the DPB, who assess whether the claims match the rules of the GDS and, if so, send payment to the dentist. In addition, miscellaneous, relatively small amounts of money can be received for other things (for example, maternity pay, reimbursement of business rates, professional development).

The fees for each activity are set so that the dentist can make a personal income from the work, but also to take account of ‘overhead’ costs, including the costs of premises, staff, equipment and materials. In recent years, extra central funding has been available in the form of ‘one-off’ grants to purchase new equipment or replace old. For example, one scheme offered dentists whose bids were successful new equipment at two-thirds of the cost price.

This, of course, only describes the very basics of how the GDS works. ‘It would be impossible to characterise the existing system as simple. Even to describe its principal features, let alone to spell out the full range of detail in the Fee Scale, takes a good deal of time and space’ (Ref. 2).

The system provides a strong incentive for dentists to carry out as many activities within as short a time as possible. The quality of the work must satisfy the examiners of the DPB (on average, about two patients per year per dentist are examined), the dentists’ own sense of professional standards, and the immediate concerns of the patient. By contrast with many professions, there is little emphasis on rewarding quality and the ‘premium which many professions pay for age and experience is not obvious’ (Ref. 2).

NHS dental care that is delivered via the GDS is free for all children under the age of 18. For some adults (for example, those on income support), care is also free ‘at the point of delivery’. But most adult patients pay directly a large proportion of the total costs of their care. In England, they pay 80 per cent of the costs of examinations and treatments, up to a maximum of £366 for one course. For example, a dentist receives a fee of £6.65 for a straightforward examination, of which a non-exempt adult pays £5.32. If other activities are linked to the examination – for example, if x-rays are taken, or if teeth are ‘scaled and polished’, then extra charges apply. In Wales, the rules are the same except that examinations are free for people aged under 25 and for people aged 60 and over, and the maximum has been frozen at £354. Patients directly meet about 30 per cent of GDS total costs. The dentist is responsible for collecting this money. All patients who are not exempt potentially pay 80 per cent of the charge – the fees are not tapered to take account of income. However, those people near the threshold for free treatment may be eligible for help with charges, as described later in the report.

¹ Many GDPs now do this via electronic data transmission to the DPB.

The cost of services

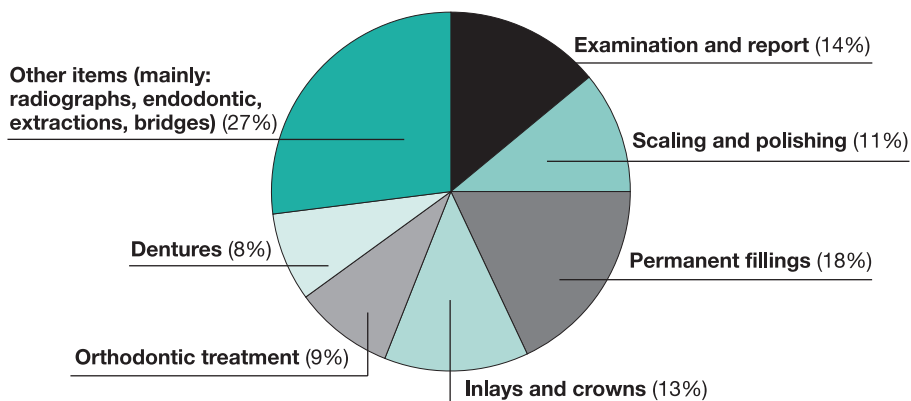
- 7 Very substantial sums of public money are involved in providing dental services. The biggest proportion – about 85 per cent of total NHS oral care expenditure – is spent within the GDS^I. The total amount claimed for this care, and the total number of dentists making claims, rises each year in real terms. In 2001/02, expenditure on GDS activities (examinations, treatments, and so on) was about £1.23 billion across England and Wales [Exhibit 1].

Exhibit 1

The main component costs of GDS activity, 2001/02, England and Wales

Most NHS dental care is delivered by dentists working within the GDS. In 2001/02, expenditure on GDS activities (examinations, treatments, and so on) was about £1.23 billion across England and Wales.

Expenditure on GDS, England and Wales, 2001/02



Total expenditure:
England £1,162m
Wales £67m

Children's services consume 18% of total 'fee for item' expenditure; orthodontics consumes 50% of children's 'fee for item' expenditure; some children's activities (for example, most examinations) are paid for under capitation and not included here – see text. Expenditure breakdown on the different items differed little between England and Wales.

Source: Drawn from data in Ref. 3

- 8 On top of these payments for specific activity, capitation payments amount to 22 per cent of the total GDS spend. When capitation is added in, expenditure on children's services rises from the 18 per cent given in Exhibit 1, to about 28 per cent. Adding in the cost of special schemes, maternity pay, and so on brought the GDS total up to about £1.7 billion during 2001/02 in England and Wales. Patients paid about 30 per cent of this total 'at the point of delivery'. This percentage has varied over time (for example, between 29-39% over the period 1987-1992) (Ref. 4). Adding in the costs of the CDS and hospital services brings the total NHS spend on dental care to about £2 billion a year. Although treatment costs for individual patients are usually small when compared with the costs of more dramatic diseases like cancer or coronary heart disease, dental diseases affect so many of us that this total cost is high and accounts for about five per cent of all NHS spending. In addition, increasing numbers of patients pay for private dental care. There is no current accurate account of how much

I Source: Ref.4, House of Commons Select Committee on Health, 1993.

we spend privately, but a recent estimate is that it is as much as another £1.07 billion (Ref. 5). In addition, as consumers we spend on toothbrushes, toothpastes and so on.

What the report aims to do

- 9 The purpose of this report is mainly to highlight the problems with the current system, and to make suggestions about how things could be improved. However, it would be unfair to state only the problems, and ignore the considerable successes of our dental services. At the same time, the Audit Commission does not wish to duplicate information that is already available. Patients who wish to learn more about what services are available, and how the latest treatments work, can find such information elsewhere – for example, in Government and BDA publications, and on websites with a patient focus.
- 10 Many dentists (and their staff) work very hard and are committed to providing a quality service for their patients. The views of many patients during our study demonstrated that this is the case. When the British Social Attitudes survey first began in the 1980s, satisfaction with NHS dentists was similar to that with GPs – about three-quarters of patients were very or fairly satisfied. During the 1990s there was a decline, but the majority of patients remained satisfied. A different study reports a higher overall level of satisfaction with dentists in Wales (93 per cent) (Ref. 6).



Web report paragraph 11

I had a lovely dentist and, in all honesty, because he was so nice I would rather have gone to the dentist than have my hair cut. He used to tell you what he was doing – that is nice to know what they're doing and why. (Patient, London)

The receptionists were marvellous. They were friendly, they were talkative, they included you. They didn't just sit in the corner in the back speaking among themselves, but it was 'good morning, how are you this morning? how's the wife?'. I found that eventually I wasn't as nervous going there as I'd previously been. (Patient, Cardiff)

Source: Audit Commission focus groups

I have a very good dentist who has known my mouth for years – I have been lucky with continuity and a dentist who has very good records so a visit is not independent of earlier events. (Patient, Trent)

Very efficient and considerate...I'm a very nervous patient when it comes to dentists and ... my current dentist ... has picked up on this and tries to make the treatment as bearable as possible. (Patient, south west England)

Source: Audit Commission employees' survey

- 11 In addition to this overall degree of satisfaction, the following chapters highlight, in particular, two other aspects of success – first the good news that, for most people, dental health has been improving, and secondly improvements in the availability of care for patients who are in pain. Nonetheless, as the study progressed it became very clear that there are major problems with the service, and the majority of patients, dentists and managers were so concerned about these that they dominated discussions. Inevitably, therefore, the report focuses on these problems – what has caused them, what effect they have on patients and how they might be put right. The following chapters group the issues under several headings. First, the report reviews difficulties with access to NHS continuing care. The next chapter considers one of the key problems – that the current system allows considerable inequalities in health to continue and, perhaps, to even be made worse. The evidence on the system of charges is then reviewed. Next, the report shows how considerable public money is wasted, sometimes leading to poor quality care. The report ends with an explanation of why the problems have evolved, why they have not been effectively tackled, and what needs to be done to improve the service.

2



Access to services – has the Prime Minister's pledge been met?

Access to urgent and drop-in care has improved since 1999, but 40 per cent of dental practices are not accepting children or adults for registration for NHS continuing, preventive care. In some places, no dentists will accept adult NHS patients. This is of particular concern because people who are on low incomes have to pay higher, private sector charges or travel long distances to obtain NHS treatment.

The pledge

- 12 In 1999 the Prime Minister made a pledge that, by October 2001, anyone would be able to find an NHS dentist by calling NHS Direct. The pledge is not taken as applying to Wales, but attention to access has also been given there. Whether or not the pledge has been met depends on how the word 'find' is defined. For the Government, the main priority has been to improve the availability of urgent and occasional treatment. There has been good progress in this area. For example, there are nearly five times more NHS emergency dental sessions held across England and Wales now than a decade ago. These sessions are often provided in new Dental Access Centres. This means that people who want to visit the dentist only occasionally – usually when they are in pain – can do so in most parts of the country within a reasonable waiting time and without travelling very far. Two case studies are described later in this report (page 46).



Web report paragraphs 14-18

Registration for continuing and preventive care

- 13 Some people view their dentist in a similar way to their GP – they visit the same practice regularly, usually near to where they live or work, often over a period of many years. The dentist can spot developing dental problems and treat them non-invasively, or less drastically, than would be needed if treatment were delayed.

I go to the dentist regularly and I wouldn't miss it ... I like to have nice teeth and I don't want to suffer any pain ... You hopefully don't get any pain because they sort it out before it happens. (Patient, London)

Source: Audit Commission focus groups

- 14 The main way to gain regular access to an NHS dentist is by registering with a GDP. Registration has never been universal since it was first officially introduced just over a decade ago. In fact, the number of adults who are registered has declined, partly because the registration period was reduced from 24 to 15 months **[Exhibit 2]**. Currently only 45 per cent of adults are registered for continuing care (although the percentage of the population who have been registered at some time but whose registration has lapsed is higher). Registration rates for children, whose care is free and for whom dentists receive a bigger capitation fee, are higher (60 per cent) and have stayed at about the same rate from the beginning (with minor within-year variations). In one age group (10-14 years old) three-quarters of the population are registered.



Web report paragraphs 19-20

Exhibit 2
The change in registration rates with a dentist

The numbers of adults who are registered with an NHS dentist has declined. Registration rates for children are higher and have stayed at about the same rate since registration was introduced.

Percentage of England and Wales populations registered with an NHS dentist



Source: Ref. 7

Finding a dentist who will register patients

15 If people ring NHS Direct to ask about registering with a dentist for NHS care, some people, in some places, have no difficulty. Others can find an NHS dentist if they are prepared to wait for some time, or travel a long way. But for other patients, there is evidence that access to registration has become problematic over the last decade or so. In a random sample of postcode districts across England and Wales in October 2001, we found that 57 per cent of practices were accepting new NHS registrations (the same results as a Consumers' Association survey, carried out a few months earlier using a different method). Recently repeated (in May 2002), the situation has changed little, with 60 per cent of practices accepting new NHS registrations. Of the 13 health authorities visited, 11 reported that people have difficulties in finding a dentist to register with (including both health authorities visited in Wales).



Web report paragraph 25

16 The problem is worse for some types of patient – especially adults – because practices who are accepting patients do not necessarily accept everyone; the most common category being accepted is children. Many of those accepting NHS registrations placed restrictions on who they will accept – for example, some say that they will take only charge-exempt adults, while a similar proportion will take only charge-paying adults. In the worst cases (two per cent of practices) dentists say that they will only register children for free care if their parents agree to pay privately.

17 The situation in some places is much worse, and can be particularly apparent in and around small towns throughout England and Wales. One situation described to the study team during visits to several health authorities was that the main practice in a town started to offer only private treatment. Overnight a large percentage of people could no longer access NHS continuing care, and lost the right to emergency cover from ‘their’ dentist. Some health authorities are worse hit than others. For example, one health authority had seen adult registrations fall from 64 per cent in 1992 to 28 per cent a decade later, with only 4 of about 90 practices taking NHS patients, and even then only exempt adults and children were being accepted. Especially in the south of England, the spread of private practice is probably a major reason for access problems.

I cannot find a NHS dentist at all in this area – I’d be prepared to travel – say 20 miles in any direction. If I wanted NHS treatment it would be at the emergency clinic once a week – no choice about when you could go. (Patient, south west England)

I couldn’t register with an NHS dentist when I moved ... so stayed with my existing NHS dentist and now have to travel for approx. an hour each way (approx. 50 miles) to see him. (Patient, Midlands, England)

I moved to my present address in 1997 but was unable to find an NHS dentist in any of the neighbouring areas and so I travel a 72 mile round trip to my NHS dentist. (Patient, northern England)

Source: Audit Commission employees’ survey

Patients’ rights to registration are limited

18 Under the current rules, patients must visit their dentist at least every 15 months, or they automatically lose their registered status (they can, of course, be re-registered if they can find a dentist who is willing to accept them). Some people we spoke to did not understand why they had been removed from their dentist’s list. For example, some pensioners with false teeth had not felt a need to visit their dentist for several years, but when they did wish to go they were not taken back as an NHS registered patient, and could be faced with higher charges for private care.

You're not registered if you don't go there regularly. If you miss say two years or something, you're cancelled, you're taken off the register. I think that's wrong. (Patient, London)

If you don't go every six months, eventually your name's taken off and you'll never get back on again. (Patient, Cardiff)

Source: Audit Commission focus groups

- 19 The current arrangements are centred round dentists rather than patients. For example:
- A dentist can choose whether to register someone or not, or whether to take them as a private patient or not – ‘dentists are under no obligation to accept any patient either under the NHS or privately’ (Ref. 8).
 - Dentists can specify that they will only register certain types of patient (for example, exempt or charge-paying adults only, or the children of those who are private patients).
 - A dentist ‘can de-register patients at any time without giving any reasons. Sometimes de-registration may happen due to failure to attend booked appointments or failing to pay the fees. Often it is because the dentist is reducing the number of patients on the NHS list or has decided to practice private dentistry only,’ (Ref. 8). Three months’ notice must normally be given to the patient by their health authority. In England during 2001/02, 4 per cent of adults and 3 per cent of children were de-registered by their dentist (in Wales, the figures were 3 per cent of adults and 2 per cent of children) (Ref. 7)¹.
 - The rights of patients under dental registration compare less favourably than with GP registration arrangements.



Web report paragraph 29

The impact of private practice on the availability of NHS continuing care

I As an example of this, of 315 survey respondents, over a two-year period one-quarter had been told by their dentist that they would no longer be offered NHS treatment (Ref. 53).

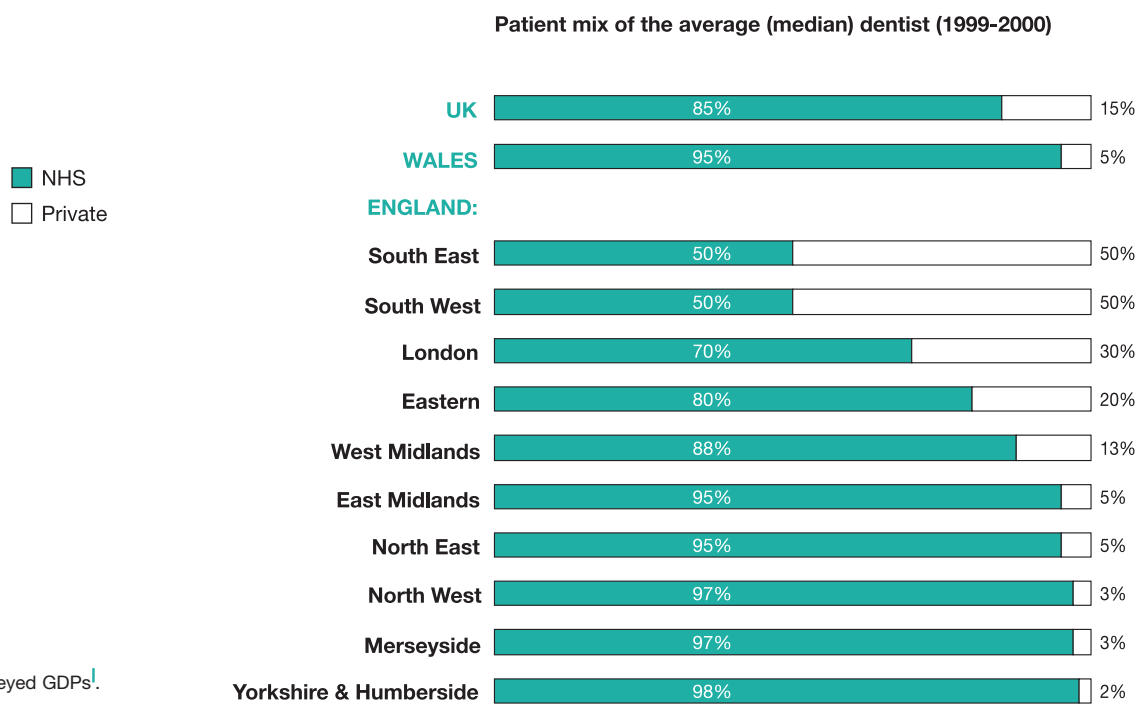
II A recent survey found that private sector prices are typically two-three times higher than equivalent NHS charges, with some prices five-six times higher (Ref. 54). As a result, the Consumers’ Association used its powers to make its first ‘super complaint’ to the Office of Fair Trading, urging them to investigate private dentistry (Ref. 55).

20 There are relatively few dentists who work entirely on a private basis. Recent estimates suggest that only 1-10 per cent of people who are registered to work as dentists in the UK do solely private work (figures provided by BDA and (Ref. 9)). Most private practice is delivered by GPs who do both private and NHS work. However, the amount of private practice has risen, and although across the country as a whole GPs say that they take only 15 per cent of patients on a private basis, in the south of England this rises to 50 per cent, leading to access problems to continuing care especially for those on low incomes [Exhibit 3]. The spread of private practice is an important issue for the less well off, especially in the south. For the poorest, who are exempt from NHS charges, the high proportion of private practices reduces their chances of finding free continuing care. For those who are not exempt, yet not well off, the often substantially higher private charges make affordable continuing care difficult to find^{II}.

Exhibit 3

Geographical variation in the balance of NHS to private practice reported by dentists (England and Wales, 2000)

Although across the country as a whole GPs say that they take only 15 per cent of patients on a private basis, in the south of England this rises to 50 per cent, leading to access problems to continuing care for those on low incomes.



Based on self-reports by 1,260 surveyed GPs.¹
Source: Ref. 9

¹ This study is based on a sample of GPs; a case study with self-report replies from all GDS practices in a southern health authority visited by the Audit Commission confirmed the findings, with an average 49:51 ratio of private to NHS work. A slightly earlier study with a slightly smaller sample size found roughly similar results, but with an overall average of 24 per cent private practice self-reported compared with the 15 per cent of the study exhibited here.

I always went every six months, then he went sort of semi-private, so then it was once a year and then ... because of the cost, I only went if I got a toothache. Gradually it got less and less. (Patient, London)

Source: Audit Commission focus group

...[this photograph is of] the queue at the post office next to my practice. This is the queue seen every Monday morning. These are people waiting for their state benefits. Do you think they are queuing to deposit savings? Do you think they are queuing because they have not managed to spend last week's benefits? Above all, do you think that they would be queuing for private dentistry at 2-3 times the cost of NHS dentistry? (Dentist, North of England)

Source: Ref. 10

 **Web report** paragraph 31

The frequency of check-ups

- 21** One of the main problems with the current registration system is that it encourages attendance for a check-up more frequently than may be needed – indeed, it requires attendance within fifteen months or the patient is usually de-registered. But some people may not need to attend within this period for a check-up. It is unfair to deny them registration if they do not need to attend, and it is poor value for money if the system has an in-built bias to make them attend.

Every six months they're getting me to come and they've got that amount. I feel people are having to pay that in order to keep a dentist, because if they don't go they're off the list. (Patient, Cardiff)

Source: Audit Commission focus groups

I am constantly reminded that if I don't come in for regular (six-monthly) check-ups then I will be struck off as an NHS patient. (Patient, London)

Source: Audit Commission employees' survey

- 22** The traditional message is to visit the dentist for a check-up every six months, a hangover from 20-30 years ago when peoples' dental health was very much worse than it is today¹. The regulations allow dentists to claim a fee for an examination at no more frequent interval than six months, and the statistics, not surprisingly, show a big peak of activity at this interval (**Ref. 11**). Patient survey results confirm a six-monthly pattern for over 80 per cent of those patients who say that they attend regularly for a check-up (**Ref. 12**). But a review of the evidence 25 years ago concluded that there was no scientific basis for this interval (**Ref. 13**), and this finding was confirmed by a more recent review (**Ref. 14**). Improvements in oral health over the years confirm that the six-monthly attendance of those patients surveyed by the Office of National Statistics (ONS) is no longer related to lower tooth loss in the way that it used to be.

 **Web report** paragraph 33

¹ In fact, historians have traced the origin of the six-monthly attendance back a century or more.

23 Many commentators now agree that it would make more sense to recall most adults at much wider intervals – perhaps two-three years – and most children every one-two years (**Refs. 15 and 16**). These longer intervals better fit the time periods over which decay takes place. Individuals with poorer dental health, or those who are at risk of it, should be recalled more frequently. Despite these findings no rules have been introduced to make this happen. The result is that substantial sums are spent on unnecessary activity. Extending the time between check-ups for those people with the most healthy teeth could save perhaps £79 million in England and nearly £4.5 million in Wales. One way forward is to introduce evidence-based criteria for determining the best check-up attendance interval for each individual patient. Capitation payments could be varied according to the number of patients registered under each risk category. The National Institute for Clinical Excellence (NICE) has now been asked to prepare guidance for the NHS in England and Wales on the clinical and cost effectiveness of a dental recall examination for all patients at an interval based on the risk from oral disease (**Ref. 17**).

3



Inequalities in health

In deprived areas dental health is worse, and fewer people are registered with a dentist. In some localities children's decay levels are as bad as they were 15 years ago. People who use fluoridated water have much less dental decay and fluoridation benefits the poorest communities most, but no new schemes have been introduced since 1985.



Web report paragraphs 35-36

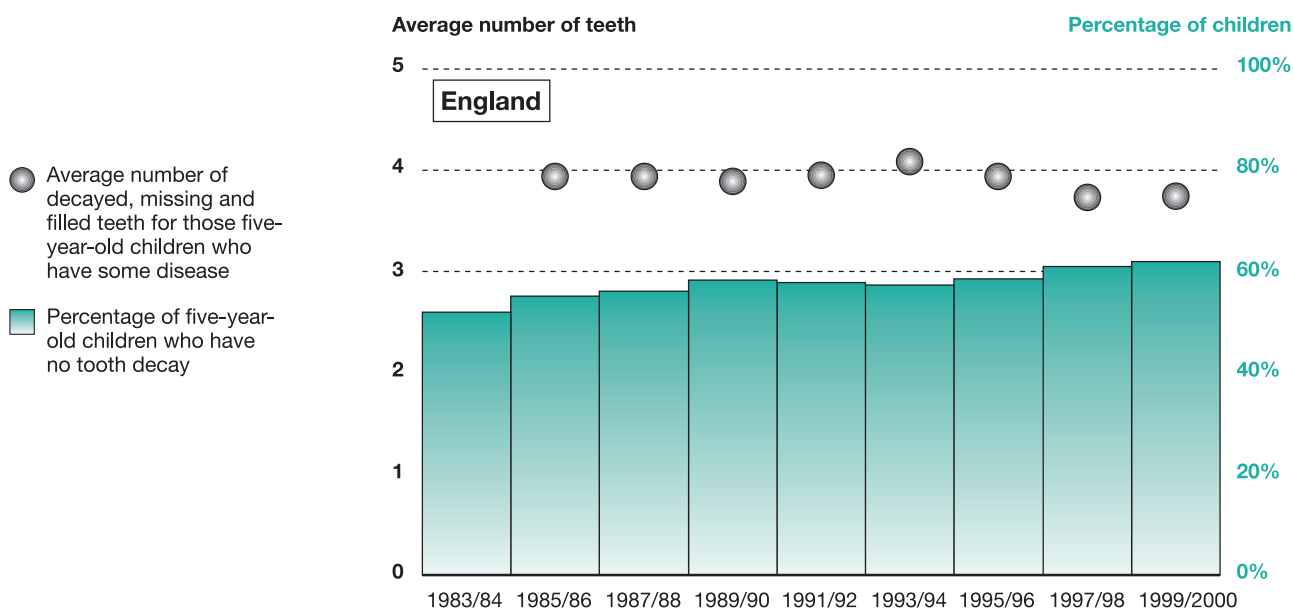
Dental health status

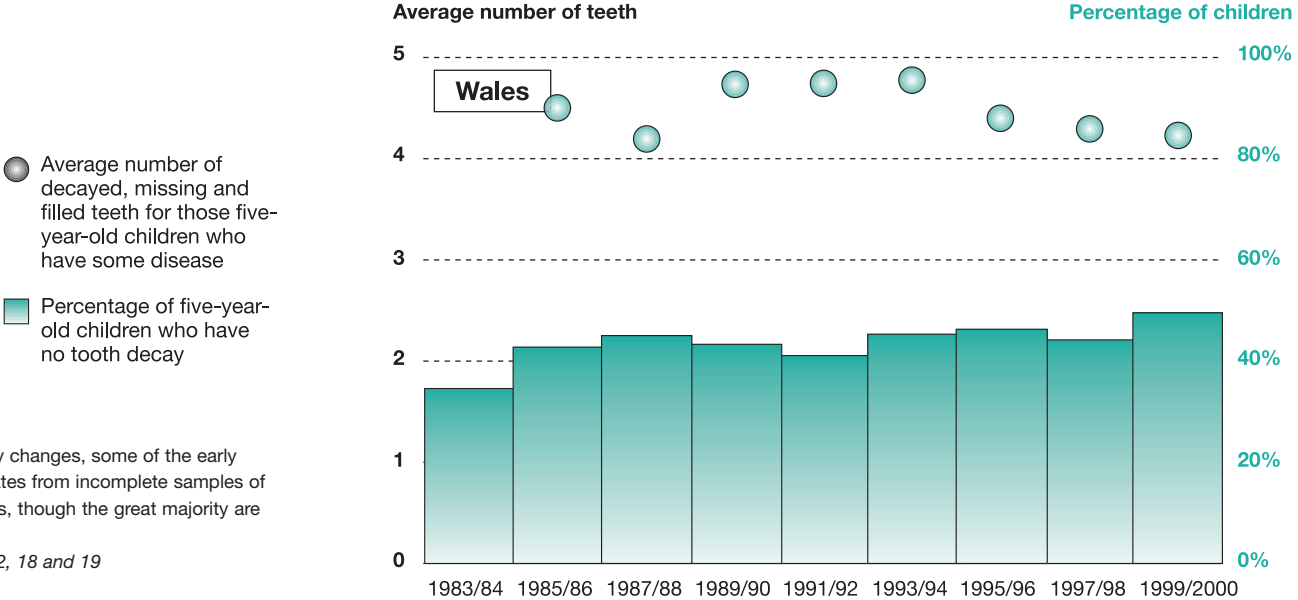
24 The dental health of the majority of the population improved markedly over the second half of the last century. For example, in 1973 nearly all teenagers had some decayed permanent teeth. By 1993, two in five of older teenagers faced the start of their adult lives without any decay at all. The main reasons for these improvements in dental health are widely acknowledged to be an increase in the use of fluoride toothpaste, better dietary habits and the presence of fluoride in water supplies in some parts of England. More recent data show continued general improvements, although the fast rate of change seen during the 1970s and 1980s may now have slowed. However, in those people who do have dental disease, levels remain stubbornly high [Exhibit 4]. Similar trends to improved health show up in children of other ages and in adults. The average five year old who shows some decay has 3-4, of their total of 20 or so teeth decayed, missing or filled. It is a major public health concern that, at the beginning of the 21st century, so many children should be suffering from such preventable distress.

Exhibit 4

Trends in the dental health of five-year-old children

While the percentage of the population who have no decay at all in their teeth is increasing, the number of decayed, missing or filled teeth of those who do have dental disease remains stubbornly high.





Due to boundary changes, some of the early years are estimates from incomplete samples of health authorities, though the great majority are included.

Source: Refs. 12, 18 and 19

The most deprived communities

25 Poor dental health is more prevalent in the most deprived sections of our society. Generally speaking, people who live in deprived communities have fewer of their own teeth, and those that they do have are in poorer condition. This holds for children of different ages and for adults, and has been demonstrated by many different studies¹. It is also still the case even when differences between men and women, and which part of England and Wales people live in, are separated out [Exhibit 5, overleaf].

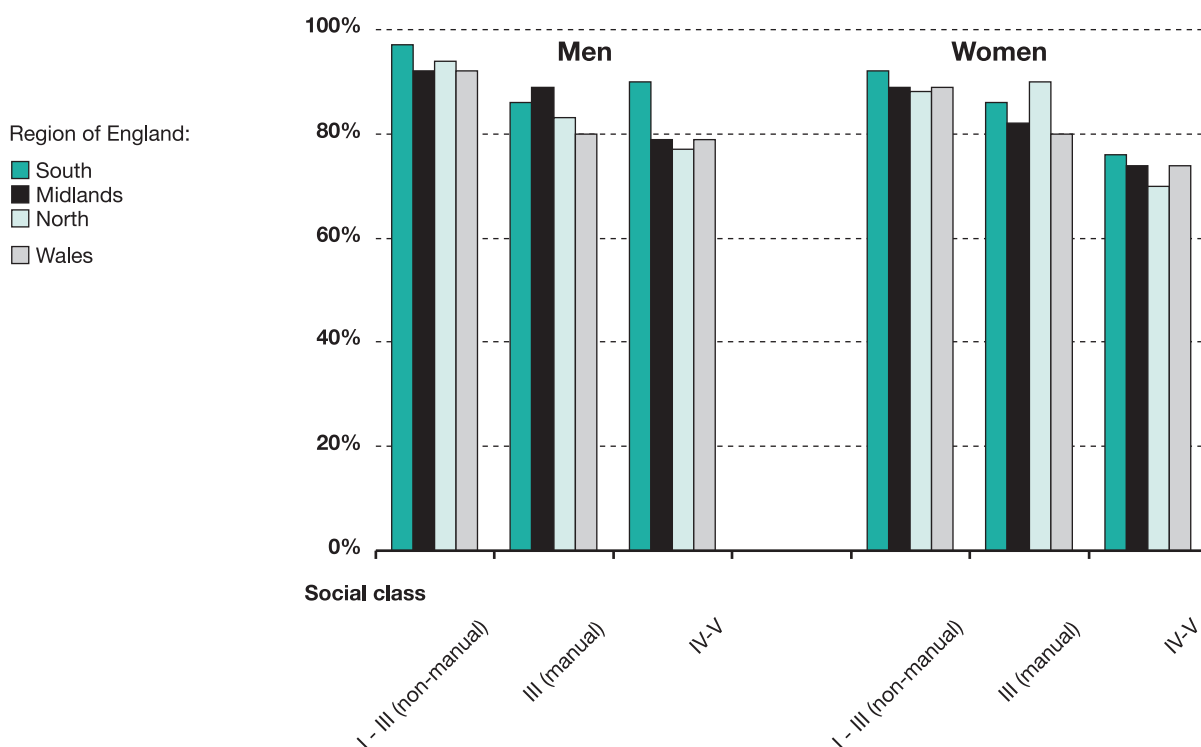
¹ A fairly recent review of studies can be found in Ref. 56.

Exhibit 5

Differences in the proportion of adults with one or more remaining natural teeth by social class, gender and where they live

Poor dental health is more prevalent in those from lower social classes, even when differences between men and women, and which part of England and Wales people live in, are separated out.

Adults with some natural teeth (%)



Source: Ref. 12

- 26 Water fluoridation is another important factor in explaining differences in disease levels. But with a minority of England, and none of Wales, fluoridated, it is socio-economic differences that are the main reason for differences in health. The two factors interact, with people living in the poorest communities benefiting the most if their water is fluoridated. Levels of decay in deprived health authorities whose water is fluoridated are lower than in health authorities with similar levels of deprivation but whose water is not fluoridated. What makes matters worse is that, not only do deprived communities have more dental disease, but in populations where more individuals are affected by disease, those individuals have more severe disease levels – ‘9 per cent of five year olds and 6 per cent of fourteen year olds have 50 per cent of the disease’ (Ref. 20).



Web report paragraphs 40-41



Web report paragraphs 42-43

The distribution of dentists

- 27 Given that areas with more deprivation have greater need for dental care, it would be desirable to find more dentists in those areas. In fact, overall there are no statistically significant relationships between the number of dentists per head of population, and measures of dental disease levels for any age group, or measures of met need or social deprivation^I. People who live in the most deprived communities are also much less likely to be registered with a dentist and to attend for regular check-ups^{II}.

Geographical variation and Government targets

- 28 The end result of all the factors described above is that there is considerable variation between different geographical areas in the amount of tooth decay [Exhibit 6]^{III}. In England, the Department of Health (DH) has set a target to reduce decay in five year olds to low levels by 2003 – some of the old health authority areas already meet the target, while others have little hope of meeting it without water fluoridation. In Wales, where there is no fluoridation currently, levels equivalent to the English target are unlikely to be met. The official target in Wales is expressed differently – rather than an average number of affected teeth, the Welsh target is for no more than 48 per cent of five-year-old children to show any signs of decay by 2002. This may have been met (up-to-date figures are due soon), since in 1999 52 per cent showed some decay. The average in England is about 38 per cent.

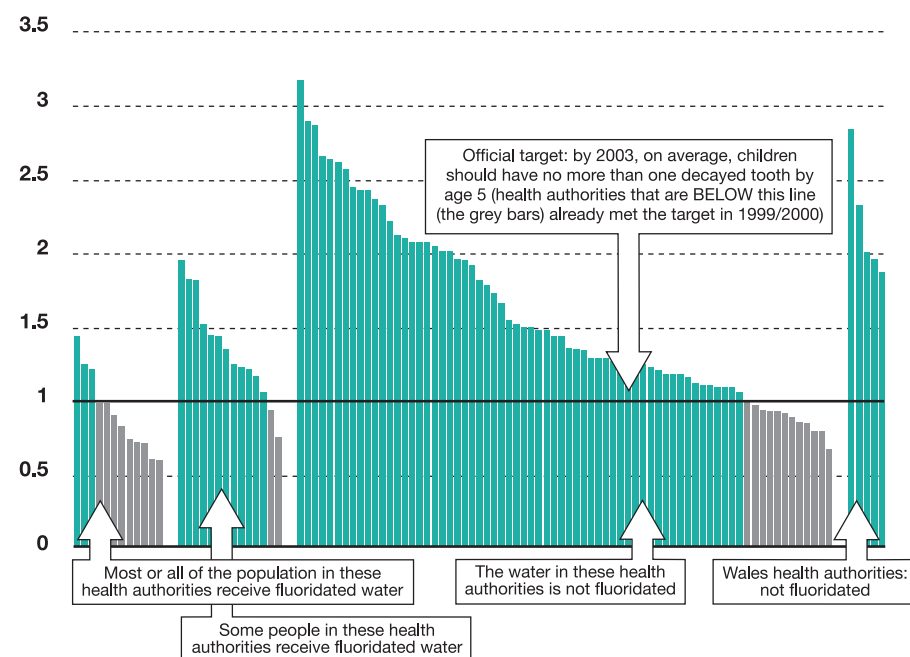
- I Using the 'care index' – a measure of the amount of diseased teeth that have been dentally treated.
- II The most recent analysis of this commonly found trend is Ref. 57. This study found that one-third of the variation in the percentage of children in local populations who were registered with a dentist could be explained by social deprivation. Those children from deprived communities who were registered also lapsed their registrations at a faster rate (two-thirds of variation in lapse rate explained).
- III These differences between areas are very stable year-on-year, and the statistical 'confidence intervals' around the average for each health authority in the exhibits are small. This means that we can be confident that the differences between health authorities are meaningful and not just due to random factors or small sample sizes.

Exhibit 6

Tooth decay at the age of five within the English and Welsh health authorities, and water fluoridation

There is considerable variation between different geographical areas in the amount of tooth decay. One of the main reasons for geographical differences is exposure to fluoride in the water.

Average number of decayed, missing and filled teeth (dmft) at age 5 in 1999/2000 by health authority

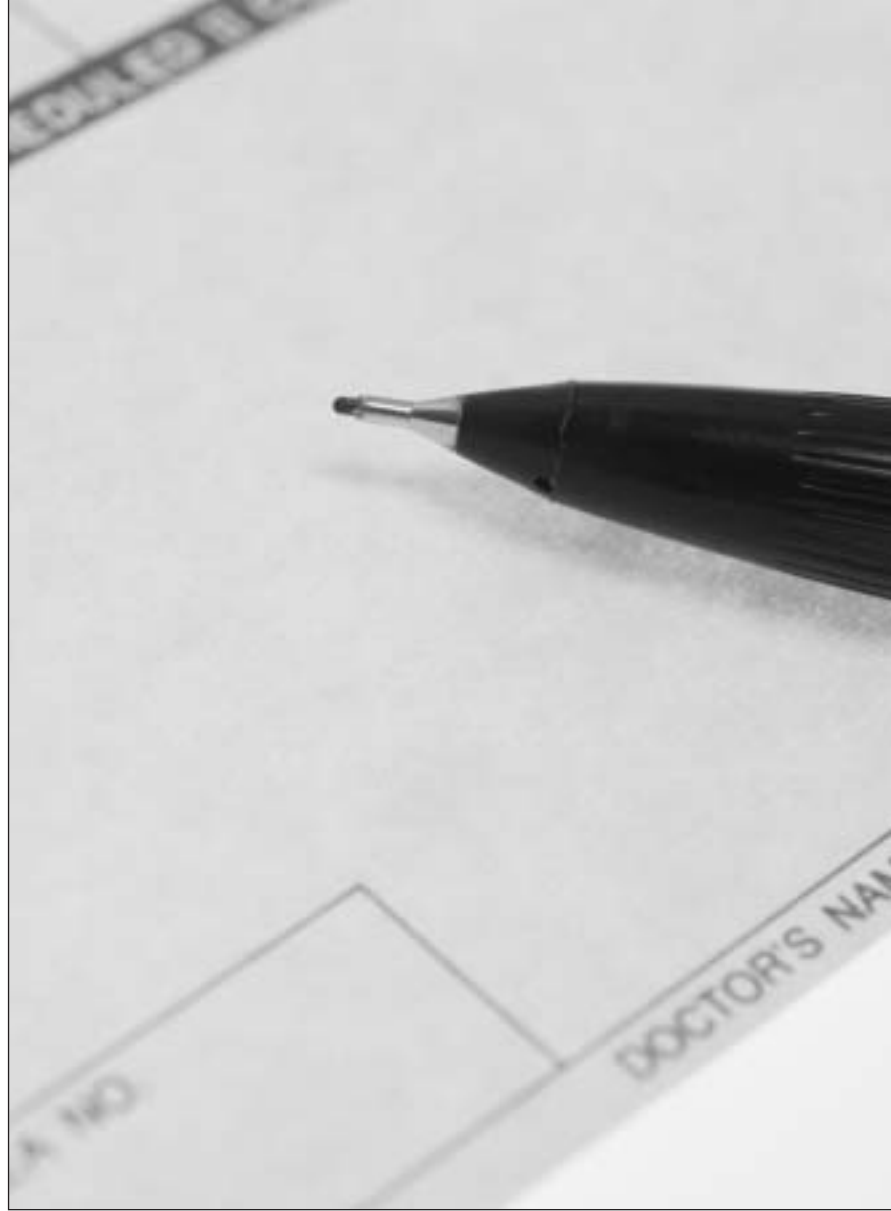


Fluoridated water is defined as either naturally occurring or water-authority adjusted levels of fluoride at 0.7 ppm.

Source: Refs. 19 and 21

- 29 Although in overall terms the dental health of our population is improving, as depicted in Exhibit 4, not all areas of the country have enjoyed this improvement in dental health. In fact, in some localities there has been no improvement at all over the last 15 years in children's decay levels – the NHS commissioning bodies in these areas will need to make extra efforts in order to improve the dental health of their populations.

4



Charges

People on low incomes are deterred from seeking dental healthcare because of its cost. People can be confused about whether their dentist is charging them for NHS or private care, and about the amount they will be charged.

Charges for people on lower incomes

- 30 Some patients are exempt from charges, with extra exemptions in place in Wales. But the safety net is not wide – there are problems for working people and pensioners on low incomes. Pensioners are not automatically exempt from most NHS dental charges, as they are for charges for prescription medicines. There is no income-related sliding scale, so people on low incomes pay a higher proportion of their income than the more affluent. It is possible for people on lower incomes to claim partial redemption via special forms (form HC11 explains who is entitled to help; form HC1 can be used to make a claim or form HC5 to claim a refund), but few of the people we spoke to knew about this and, of those who did, some had found the process to be slow and bureaucratic.
- 31 Some of the charges do not in themselves look very high. For example, the charge for a basic check-up is £5.32 (free for everyone aged under 25 or 60+ in Wales). But as some patients have explained to us, for an average family to visit, the cost is twice this for the two adults, plus transport costs and the cost of time off work, since not all dentists open outside normal working hours. In addition to this cost, many dentists prescribe teeth scaling and polishing in conjunction with a check-up, and, of course, there may be other activity prescribed, bringing the total costs higher still. This helps to explain why the average charge for a non-exempt patient in 2000/01 was in fact £24 (**Ref. 5**). Although relatively few people are faced with the maximum charge for a course under the NHS, those who do have high-cost care can report difficulties. This is illustrated by a case described by the Citizen's Advice Bureaux (CAB): 'A client had to have four teeth removed. The bill came to £354 and the amount he had to pay was reduced to £298.44 because of his low income. He paid £100 and then continued to pay the remainder in small amounts when he could afford to. The dentist would not, however, provide him with his replacement teeth until the full bill was paid. When he visited the CAB two months after the extraction, he complained that he was not able to eat properly' (**Ref. 22**).
- 32 A major qualitative research project sponsored by the DH and the BDA in the 1980s found that cost was an important problem for patients (**Ref. 42**). A number of other similar studies also found this to be the case, and research commissioned for this study concluded that the issue that people are most concerned about is the cost of dentistry. Patient survey results also confirm that cost is frequently cited as a reason for not attending in both England and Wales (**Refs. 6 and 12**). A study in the north of England found that the lower paid were less likely to attend the dentist regularly, and more likely to say that they had not visited the dentist at some point because of the cost (70 per cent of the lowest paid group said the latter). There is upset among retired people about how much they must pay in addition to taxation for their NHS care.



Web report paragraphs 48-49

My husband doesn't earn that much, I'm only part-time, we are just a fraction over too much for family credit, so I cannot get free dental treatment and I cannot afford it, I really can't. (Patient, Cardiff)

All of us round this table have worked – we pay National Health stamps, we pay into the service. You've worked all your life to make things better when you retire and what they do is penalise you, because they charge you for everything. (Patient, Newcastle)

I've just had a quadruple by-pass and it was paid for ... You've paid your stamp all your life and you go into hospital, they don't present you with a bill but when you go to a dentist, they do. It should be part of the National Health. (Patient, Newcastle)

Source: Audit Commission focus groups

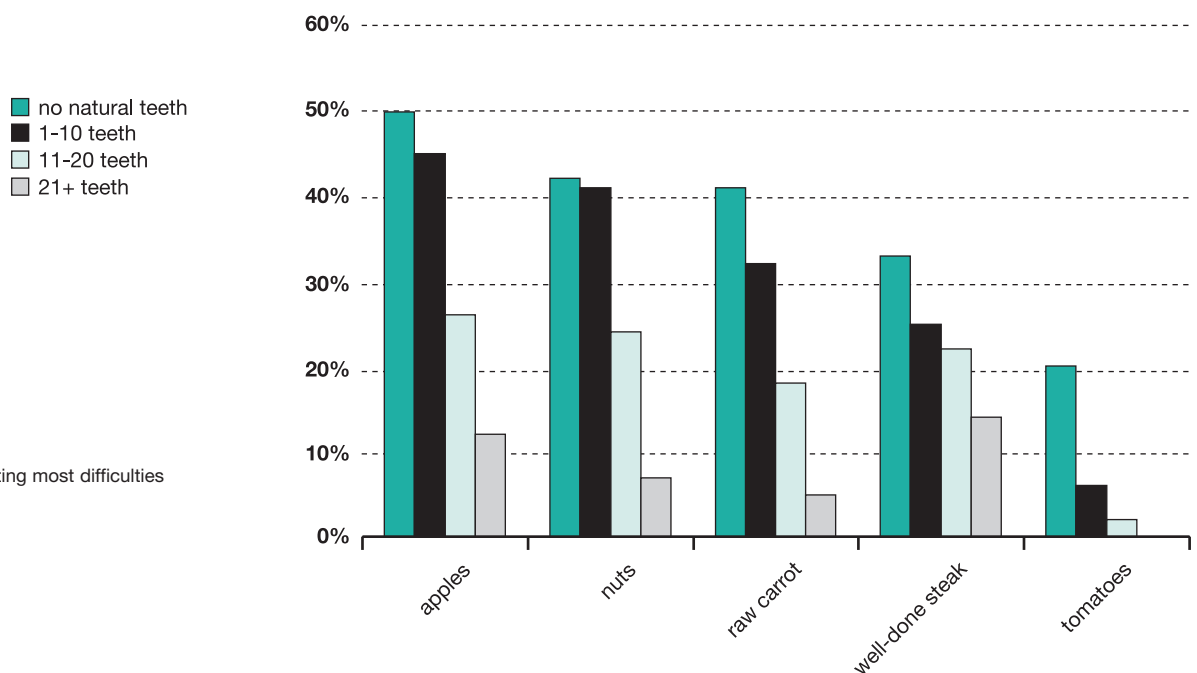
- 33 At the most recent survey date (1998) about 45 per cent of people aged 65 years or over had lost all of their natural teeth (the figure is a little higher in Wales). With a properly fitting set of dentures ('false teeth'), people without natural teeth can eat and talk normally and be confident socially. But a substantial proportion of elderly people with dentures say that they are unable to eat certain foods [Exhibit 7] and a major study found that their general health and nutritional status was poorer (Ref. 23).

Exhibit 7

Eating difficulties of elderly people in relation to the number of natural teeth they retain

A substantial proportion of elderly people with dentures say that they are unable to eat certain foods.

Percentage of elderly people who report difficulty with eating, or cannot eat at all, different food types (in 1997)



The five food types presenting most difficulties have been depicted.

Source: Ref. 23

- 34 Making sure that the dentures of elderly people fit well is of great importance to their general health and well-being. These findings suggest that a large number of elderly people do not have well-fitting dentures and some have not had their dentures checked for many years. Some report that they cannot afford to have their dentures changed.

I should go in and get my dentures redone, but I'm not going to. I'll just have a mouthful of yuck that I don't want. (Patient, Newcastle)

I went to have dentures and I paid about £65 basic. When I came home they were so bad, my son said 'Mum, why haven't you got your teeth in?' They looked terrible, so I went back to the dentist and I said I'm not happy. She said there's nothing you can do about it, now they're made ... They went in the bin and I put my old ones back in. If it was anything else I could have recourse, couldn't I? (Patient, Cardiff)

Source: Audit Commission focus group

- 35 Direct charges for GDS care were first introduced in 1951. While some charges have changed as the prices of equipment and consumables have altered, for others the amount patients pay has hardly changed. In equivalent terms to today's prices, the average charge in 1951 for a check-up was £3.57 compared with £3.68 in 1992 (Ref. 2)^I. In 2002 patients are faced with charging levels that have more to do with history than with a modern policy, based on what level of charges can best promote good dental health and, at the same time, provide the taxpayer with appropriate value for money. There is, therefore, a strong case for the charging system, including the current exemption criteria, to be reviewed. This would fit with the recent Wanless report's (Ref. 24) recommendation that the wider issue of charging in all areas of the NHS should be reviewed, and the Government's own recent re-assertion that 'any system for delivering healthcare must uphold the founding principle of the NHS – that it is free at the point of use based on need, not ability to pay' (Ref. 25) and that charges may be inequitable if they 'increase the proportion of funding from the unhealthy, old and poor compared with the healthy, young and wealthy. In particular, high charges risk worsening access to healthcare by the poor' (Ref. 26)^{II}. Any review should assess the evidence that shows that some people appear not to access necessary dental healthcare because of its cost.

^I That is, 80 per cent of the dentist's fee of an equivalent to £4.46 in 1950 compared with £4.60 in 1992.

^{II} 'Where out-of-pocket payments are levied on what are clearly regarded as clinically necessary services, such charges are inequitable unless accompanied by adequate exemptions to ensure that those with a clinical need are not discouraged or prevented from receiving treatment' (Ref. 24); but the views of patients cited in our report suggests that some people do not seek care because of its cost. 'Health policies should be drafted in such a way that they favour the less well off, not the least well off' (Ref. 51); but the exemption safety net is narrower for dental care than most other healthcare.

^{III} For example, the inclusion of an example estimate form in 'Modernising NHS Dentistry'.

Information on charges for patients

- 36 People can be confused about whether their dentist is charging them for NHS or private care, and the amount that they will be charged. Despite Government guidelines^{III}, estimates are not commonly given in advance. Plans to ensure that dentists provide written estimates of charges and a treatment plan explaining what they will be doing are good news (Ref. 17). However, dentists are not required by law to display a schedule of NHS or private prices. The clinical governance standards that are being adopted across Wales include an expectation that fee scales will be on display. Under current GDS regulations, there is no direct way to enforce this.

They don't explain to you that this is going to cost such and such. They just say you need three fillings. One filling could be £5 or it could be one at £14. You don't know until the bill comes. Nothing's itemised ... It's the unknown. It comes to you, it hits you that bill. (Patient, Newcastle)

If I go to the dentist, I know it's going to cost to have an extraction and a clean and whatever he does, he's also going to tell me your top set is loose and you do need new ones. You're in that chair and you agree with him. Maybe you're so terrified you've got no option if you like but to say OK. When I'm in that chair, I've committed myself and it's going to cost me x amount of money. I don't know the exact price but it's going to be expensive. (Patient, Cardiff)

...they said they'd have to take my tooth straight out. I was devastated and I said 'well how much is it going to cost?' because I only had like £15 on us at the time and he said 'it'll be about £15' so I said 'just take it out then'. When I went to pay for it about three minutes later, she went 'that will be £29.12' and I said 'he's just told me £15' and she said 'well he had to remove a little bit of bone as well'. I was gob smacked. I rang querying the bill because the dentist told me one price and then it's double and I was a bit annoyed. I didn't get any money back. But they shouldn't be allowed to say that. (Patient, Newcastle)



Web report paragraph 54

Source: Audit Commission focus groups

- 37 But information is good in some areas. A few of the health authorities visited during this study had produced leaflets with guidance on charges, and other information, and had sought to influence GPs to use them. One health authority has produced a guidance leaflet about dental health and services in eight different languages. In some cases, GPs have produced their own patient information. In Wales, one health authority had also featured dental care in its free general health newspaper, thus bringing the need to attend the dentist regularly to the attention of those who might otherwise only see leaflets when already at the dentist.

Yesterday, I got an estimate for what he was going to do today. What had to be done in preparation, what fillings and all the rest of it and then what each item cost. I knew exactly what I was paying for. (Patient, London)

Source: Audit Commission focus group

Yes they've generally been really good [about explaining treatments and costs]. They were a great help in getting me an HC1 certificate (which I didn't know I was entitled to) to cut costs for me. Discussed all the treatment options with costs and let me decide how much I wanted to spend. (Patient, London)

Source: Audit Commission employees' survey

5



Unnecessary costs and quality problems

Most people's dental health has improved in recent years. However, NHS funds are spent on over-frequent examinations for many people whose dental health is generally good – and on treatment that is not of proven benefit to health, or that is cosmetic. At least £150 million in England, and £8 million in Wales, is wasted in these ways.

The difference between healthcare and cosmetic treatment



Web report paragraph 56

- 38** Most people would agree that cosmetic activity should not be available on the NHS. This is not a new or controversial statement – there have been many previous statements from independent bodies and Government. This does not mean that only obvious physical disease should be treatable – treatment that can reduce serious psychological distress caused by the state of the mouth is, of course, justifiable healthcare. However, a major difficulty with dental care lies in defining exactly what is necessary *healthcare*, and what is of cosmetic value. Although reports since the 1980s have raised these issues, the regulations have not been changed, and reports have continued to describe cosmetic activity being carried out. As a result, large sums of NHS money are, in fact, being spent on cosmetic rather than health needs.
- 39** In *Options for Change* (**Ref.17**), the Government commits to developing clinical pathways for primary care dentistry that will define the evidence-based treatment appropriate to the clinical need of the patient. These pathways will be national standards and will define what the NHS will pay for. This work is critical to securing standardisation of treatment between patients and therefore greater fairness, and value for money for the taxpayer. Representatives of patients as well as the profession should be involved in developing these pathways. Until this commitment is implemented large amounts of spending on the GDS will continue to be poor value for money. This section describes some of the most common examples.

The scaling and polishing of teeth

- 40** There is no doubt that gum disease is a serious health problem for large numbers of people. Some experts think that this disease is under-treated – for example, because those people at risk from gum disease may require more complex procedures than are usually carried out (**Ref. 27**). By contrast, straightforward ‘scaling and polishing’ of teeth accounts for 11 per cent of total GDS costs (£130 million a year in England, £7.1 million in Wales), and this activity has increased. Over 90 per cent of surveyed 55-64 year olds say that at some time over their life they have had their teeth scaled and polished, and 59 per cent of adults in England (52 per cent in Wales) say that they had this procedure the last time they had attended the dentist (**Ref. 12**). Many commentators, from the 1994 Government Green Paper (**Ref. 28**) onwards, have said that far too many procedures are being carried out. According to the scientific evidence, straightforward ‘scaling and polishing’ does not keep most peoples’ teeth and gums healthy – it might make them feel and look cleaner for a while, but this is a cosmetic effect and not a health gain. Even on a crude estimate that 50 per cent of this activity might be unnecessary – and the evidence just given suggests that this figure may be higher – about £65 million in England and £3.5 million in Wales could be saved.



Web report paragraph 58

It may be that once a year cleaning 'has questionable health benefit'; or that 'intervals between recalls should be increased.' It may well be the NHS should not pay for the so-called 'worried well', or for a scale and polish because the patient is going to a wedding. (BDA Special Adviser)

Source: Ref. 29

Whenever I go for a check-up my dentist would always clean and polish my teeth and, of course, charge until I asked if it was really necessary, and when he said no then now I do not always have it done. It feels now that they are out to make money rather than look after your dental health. (Patient, West Midlands)

Source: Audit Commission employees' survey

Orthodontic treatment

- 41 One of the fastest rates of growth in treatment has been in orthodontics – the total spent on this treatment has nearly doubled in the last five years¹. The important *Report of the Committee of Enquiry into Unnecessary Dental Treatment* (Ref. 30) in 1986 concluded that orthodontics was one of the main areas where unnecessary activity was being carried out, taking NHS funds from other needed areas, and causing, at the least, inconvenience to children and their parents. But little has been done to regulate what treatments the NHS pays for in the intervening years. In 2000, the DH stated 'there is evidence of some inappropriate and ineffective treatment, and even abuse of the system by some dentists' (Ref. 16).
- 42 The Government recently announced that it intends to restrict NHS activities to those children who score at certain levels on the 'Index of Orthodontic Treatment Need'. This is a welcome step. At the moment this index is not routinely used everywhere, and it is impossible to know how much of the current orthodontic activity is justifiable as care that should be delivered on the NHS because it will contribute significantly to improving peoples' psychological health – and what, by contrast, is activity that most would agree is 'cosmetic' and therefore should be paid for privately. On the one hand, some parents who contributed to this study complained about NHS waiting times (for example, one described a wait of six months to see the orthodontist, and then a likely 18 months before the treatment began). On the other hand, dentists and managers interviewed during this study said that treatment was being carried out that the dentist had suggested when neither parent nor child had perceived a problem.
- 43 The same difficulty – a lack of evidence about how much treatment should be defined as necessary healthcare, and how much should be deemed cosmetic – arises in the case of crowns and similar treatments. Because of this lack of evidence, the Audit Commission has not been able to estimate how much NHS money is being spent on cosmetic treatment rather than on healthcare. This should be urgently reviewed.

So there are a lot of things where I think you could toughen it up, and have a more core service because people are starting to have their fillings changed because they don't like their appearance, which, to a certain extent, maybe they should pay for that privately if the front tooth is getting discoloured or the filling is getting discoloured. (Dentist)

...the high-tech is verging on, what I think is cosmetic. I mean there are two sides of dentistry to my mind. You've got what I would call the core service, which is really what I think the health service is about, which is basically keeping you healthy and making sure you've got enough teeth to be able to chew your food so that you can survive, be free of pain and look reasonable. If you're going into the realms of having wall-to-wall crowns and trying to look like a film star then that is not the sort of bill that the health service ought to be picking up when it is cutting back on other things like kidney dialysis. (Dentist)

Source: Ref. 31

Quality

- 44 Concerns about quality have been raised in a number of areas. For example, research has been carried out into problems with the quality of root canal treatment, and into the over-extraction of wisdom teeth (about which NICE has now issued guidance). In addition, some dentists are worried that the cheaper materials that they must use for some NHS treatments (for example, nickel in crowns, rather than precious metals) may harm some patients – although there are not enough good-quality, randomised controlled trials to draw firm conclusions. This section considers two other examples of quality problems – the number of fillings being carried out, and how long they last.

Too many fillings?

- 45 The profession has largely changed from the 'drill and fill' approach of the past, and the amount of permanent fillings has been reducing as disease levels have reduced and non-invasive alternatives are promoted (for example, the use of fissure sealant). The situation has probably improved since the 1986 'Schanschieff' report (Ref. 30), which concluded that there was 'a small but significant and unacceptable amount of deliberate unnecessary treatment...and a larger amount attributable to an out-of-date treatment philosophy'.

She has given me advice about avoiding the need for further treatment and seems to err on the side of avoiding unnecessary treatment for aesthetic reasons. (Patient, London)

He generally takes a non-interventionist approach which suits me fine – I have no worries about him carrying out procedures just for the sake of it, which I suspect is what often happened when I was a child. (Patient, south east England)

Source: Audit Commission employees' survey

46 However, some academic dentists still believe that too many fillings are being carried out, especially replacements for old fillings^I. A case study of Dental Reference Service (DRS) examiners^{II} – who ought to be at the leading edge of appropriate treatment – found that, in a class room situation, 64 per cent ‘prescribed’ fillings for five case study patients where small or early decay was present, and 28 per cent ‘prescribed’ sealant restoration. They then took part in a workshop, with acknowledged experts in the field, about the clinical criteria to use when deciding between the use of sealant restoration and permanent fillings (and other possible courses of action). Following this, the examiners re-assessed the five cases, and some changed their prescriptions – now three-quarters ‘prescribed’ sealant restoration. Although there will always be room for some degree of individual clinical judgement, the ‘gold standard’ treatment in these cases, according to guidelines, would be to use sealant restoration (Ref. 32).

47 If there is over-treatment, then, of course, it increases taxpayer costs without improving health. It also risks harm to the patient and some patients seem to harbour doubts about whether their treatment has been necessary.

You’re totally in their hands. You hear the horror stories of people that have had twenty fillings, paid x amount of money and didn’t need them in the first place... You’ve got absolutely no way of knowing. (Patient, London)

I went for a check-up and they took the nerve out the front tooth and the dentist commented ‘you know if your nerve’s out, your front tooth will discolour – would you consider getting it capped?’; so I said OK. They had to cut the tooth down and he cut too much, then he had to take it out and...it was £500 by the time he finished and that was twelve years ago...It’s been replaced about three or four times at £250 a go. (Patient, Newcastle)

Source: Audit Commission focus groups

I am currently concerned about the quality of treatment. My dentist has recently taken over the practice and has introduced x-rays, which have identified a number of ‘shadows’ requiring further examination – where I was experiencing no pain or discomfort. One assumes it must be genuine because it’s impossible to establish otherwise. (Patient, eastern England)

Instead of renewing the bit of missing tooth, as the other dentist had done before, periodically, when it became discoloured the new dentist did radical reduction of all the front teeth and put on crowns on them all – extensive cosmetic type work that was not necessary and has caused problems ever since. (Patient, West Midlands)

Source: Audit Commission employees’ survey^{III}

I Example paper: Deligeorgi V et al, ‘An overview of reasons for the placement and replacement of restorations’, *Primary Dental Care*, 8:5-11, 2001.

II The DRS consists of dentists who examine the quality of GDPs’ treatments on behalf of the DPB.

III It is important to note that these statements illustrate how patients feel – the treatment that they received may, in reality, have been clinically necessary.



Web report paragraphs 66-67

How long fillings last

- 48 Despite the dissemination of scientific results showing that older-style (amalgam) fillings last longer and are safe (**Ref. 33**), nearly one-half of the fillings that are paid for by the NHS are newer types (composite or synthetic resin, or glass ionomer). Recent analysis has confirmed that amalgam fillings that are provided on the NHS do last longer (**Ref. 34**). This study looked only at the short-term longevity of fillings placed in the first molars, taking account of GDS rules about the circumstances in which different materials may be used. It found that one in ten teeth filled with amalgam were re-treated within one year, compared with 15-18 per cent of those filled with 'white' fillings. Comparisons between the different areas of the mouth showed a range from a low of four per cent replacement within a year for amalgam applied to two or more surfaces for teeth in the lower right, to 20 per cent replacement for glass ionomer materials placed in the lower left. Even using just short-term analysis (the extra cost of replacing failed newer-style fillings within a year of being done, compared with the lower failure-rate had they been amalgam fillings) shows that between £6 million and £17 million was wasted during 2000/01 across England and Wales, and about 450,000 patients put up with renewed pain and the inconvenience of revisiting the dentist earlier than they might have had to.

I had six fillings done at my dentist and...about six months later he said 'I have to redo them' and I said 'you've just done them six months ago' and he said they haven't taken...And he did them again and it was about six months after that three of them had to be replaced again. It was £117 the first time and £136 the second. (Patient, Newcastle)

Source: Audit Commission focus group

When I last went to the dentist I needed a couple of fillings. The dentist offered me the choice of NHS amalgam fillings or white fillings that I would have to pay privately for. As I dislike having fillings I asked her which would last the longest. She told me the white ones were better quality and would last longer, and so I chose to pay over £50 each for two of those, compared with approximately £10 each for amalgam fillings. (Patient, London)

Am normally 'encouraged' to go for the private treatment – for example, white fillings, as am told that this is better in the long run for teeth. Obviously have no idea if this is true. (Patient, London)

I have had white fillings which have cracked and leaked after about 2 years, but I'm told this is usual. It may be, but the advertisements in the dentists do not point out the pros and cons of white fillings, and no leaflets to help you make a judgement are available. I now have a cracked tooth which I think is the result of the top of the tooth being left vulnerable after a deep filling being filed right down, but I can't be sure. (Patient, London)

Source: Audit Commission employees' survey

I know I'll get more money for the white resin one to make ends meet...It's quite difficult...because it's in a business situation...' (Dentist)

Source: Ref. 31

Quality control and fraud identification

- 49 Official inspectors disagreed with some (mainly minor) aspects of patients' treatment in 60 per cent of cases^I. They disagreed in a major or fundamental way in a further 1-2 per cent, based on examination of nearly 100,000 cases in 2000/01 (**Ref. 35**).
- 50 In addition to inspecting sample cases, the DPB uses computer algorithms to spot dentists whose activity differs significantly from that of most dentists, and reports them to others to investigate further where fraud may be involved. Approximately one per cent of GDPs are referred to health authorities for potential disciplinary action each year. However, relatively few cases result in prosecutions. Managers in several health authorities visited during this study said that one reason for this is that, although the DPB system works well to detect possible problems, the steps that must then be taken to bring action are difficult to complete in the time periods allowed by the regulations. A second difficulty is that, because the information is collated centrally by the DPB, local internal and external auditors have given less coverage to fraud within the GDS in recent years, compared with the attention given to other areas of NHS primary care, such as general medical services (GMS), pharmaceuticals and ophthalmic services (**Ref. 36**). Health authority finance directors felt that, in terms of a series of measures for combating fraud, they were less well prepared to tackle fraud within the GDS.
- 51 The Government established a Counter Fraud Service in 1998, and has reported a drop in claims for recalled attendances and domiciliary visits after counter-fraud measures were introduced (**Ref. 37**). However, five years on, its national dental fraud team is not due to be fully operational until autumn 2002 (**Ref. 38**).

^I Official inspectors are appointed by the DPB to take part in DRS examinations of randomly sampled patients.

6



Why the problems exist

The piecework system is at the root of the problems. Dentists call the system ‘the treadmill’. Changes have been proposed for over 40 years but the system remains essentially the same as in 1948.

- 52 Two main factors lie behind the problems outlined in the previous chapter. First, the nature of the remuneration system, and secondly the fact that the organisations that commission NHS services have fewer powers and levers to use than those in other areas of healthcare. This chapter considers these factors in turn.

The piecework system

- 53 It is easy to blame dentists for the problems, but they are working within a system that makes it very difficult for them to do better. The more activity, and the quicker it is done, the bigger their annual income will be. Dentists are increasingly angry at how hard and fast they have to work with NHS patients to earn the sort of incomes that they need to pay for their premises and staff costs, which they must meet themselves – they call it the ‘treadmill’. Many dentists use very robust language when describing the adverse effects of the fee system, and some patients, who know about the piecework system, seem to distrust their dentist because of it. Even dentists’ leaders agree that the standard of care is not right: ‘the way we work is often driven more by the way we are paid than by the treatment needs of our patients’ (British Dental Journal leader by J Renshaw, BDA, April 28th 2001).

[The] positive encouragement to produce more and more items of treatment in order to generate greater cash turnover has led to a danger of over-treatment... The financial advantage to the dental practice that flows from treating patients rather more regularly than may be necessary has created a whole way of life for NHS dentists. They have been encouraged to behave as businessmen and have responded admirably. (BDA)

Source: Ref. 39

Some of them like working within the NHS, what they call ‘bash the Nash’. Somebody who needs four crowns, they fit six instead, you know, that sort of thing. It’s a mess. (Dentist)

Source: Ref. 31

I’m scared because the more fillings they do, the more money they get. I’m afraid that they’re going to do work on my teeth that don’t need work doing on them, just to make more money out of me or whatever. They’ve got a hidden agenda... You’re in a vulnerable position, aren’t you, when you’re in the dentist’s chair. (Patient, Cardiff)

The dentist I go to, he’s going between two patients. So he’s dashing around like a scalded cat. It puts you off when you’re sat there by yourself thinking what’s he going to do next? (Patient, Newcastle)

Source: Audit Commission focus groups

I Some change will also be due to other factors that affect demand, for example, changes in the regulations about which treatments are allowable under the GDS, or changes in the amount of an activity, such as crowns, which are carried out privately.

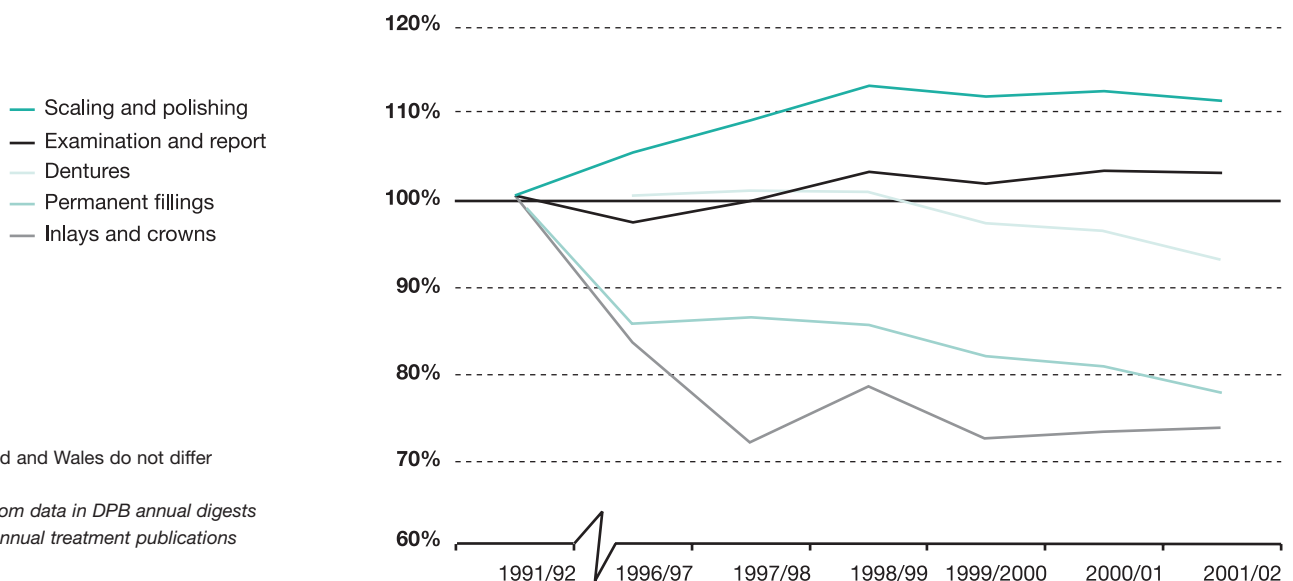
54 The nature of the payment system is that individual dentists must carry out a certain level of activity or they would be unable to meet their overhead costs and provide an income for themselves and would go out of business. But the 'mix' of activities is likely to change as the demand for different types of care changes. As the dental health of the majority is improving, people need less of some types of treatment (such as fillings)¹. Activity trends confirm that changes are indeed taking place. For example, as the number of fillings and other decay-related treatments in adults has declined, the number of examinations and scaling and polishing has increased [Exhibit 8]. The other major increase has been in the rate of orthodontic treatment, as described in Chapter 5. Another commonly used measure – the percentage of adults with 'no dental intervention' – shows a steady increase every year between 1991/92 (when it was 42 per cent) and 2001/02 (49 per cent in England and 48 per cent in Wales, with a very similar pattern of change).

Exhibit 8

Trends in the annual number of claims for the main types of adult dental services delivered by GPs (England and Wales)

The number of fillings and other decay-related treatments in adults has declined as dental health has improved, while the number of examinations and scaling and polishing has increased.

Change in adult activity rates (index set at 100 in 1991/92; England and Wales totals)



Trends for England and Wales do not differ significantly.

Source: Drawn from data in DPB annual digests of statistics and annual treatment publications

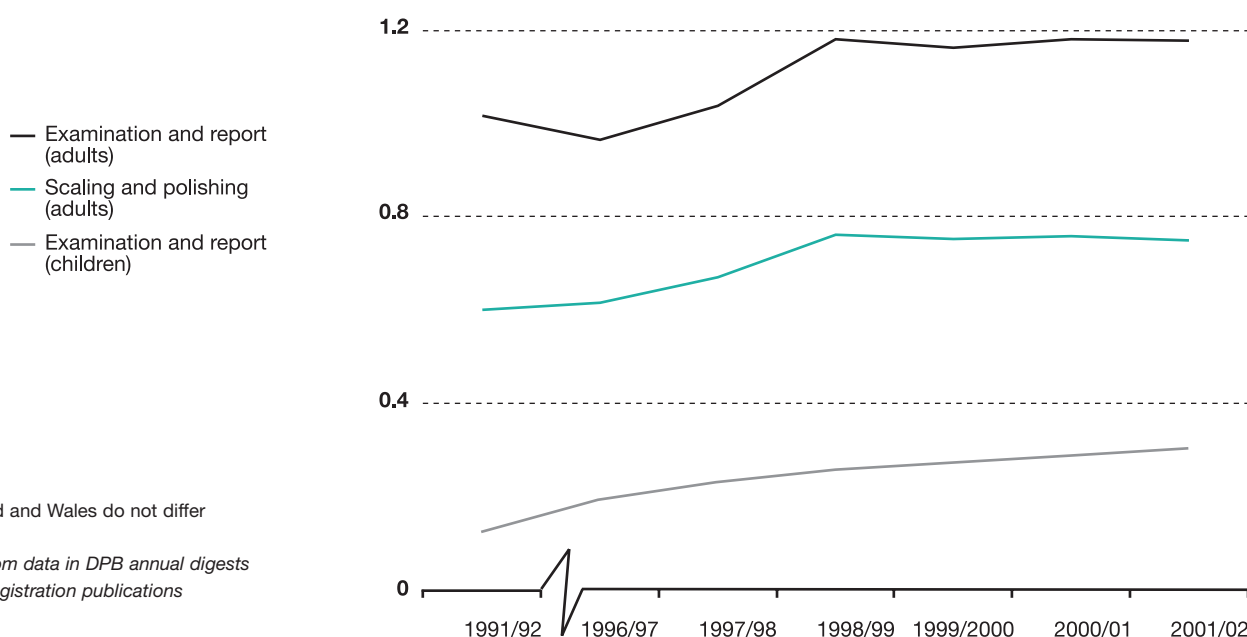
- 55 As well as the number of claims for reimbursement increasing (and, therefore, the total amount of public money involved increasing), it is also the case that the rates per patient of examinations and scaling and polishing have increased [Exhibit 9].

Exhibit 9

Trends in the number of claims for check-ups and scaling and polishing in relation to the number of patients registered with GPs

The rates per patient of examinations and scaling and polishing have increased.

Average number of claims per registered person per year in England and Wales



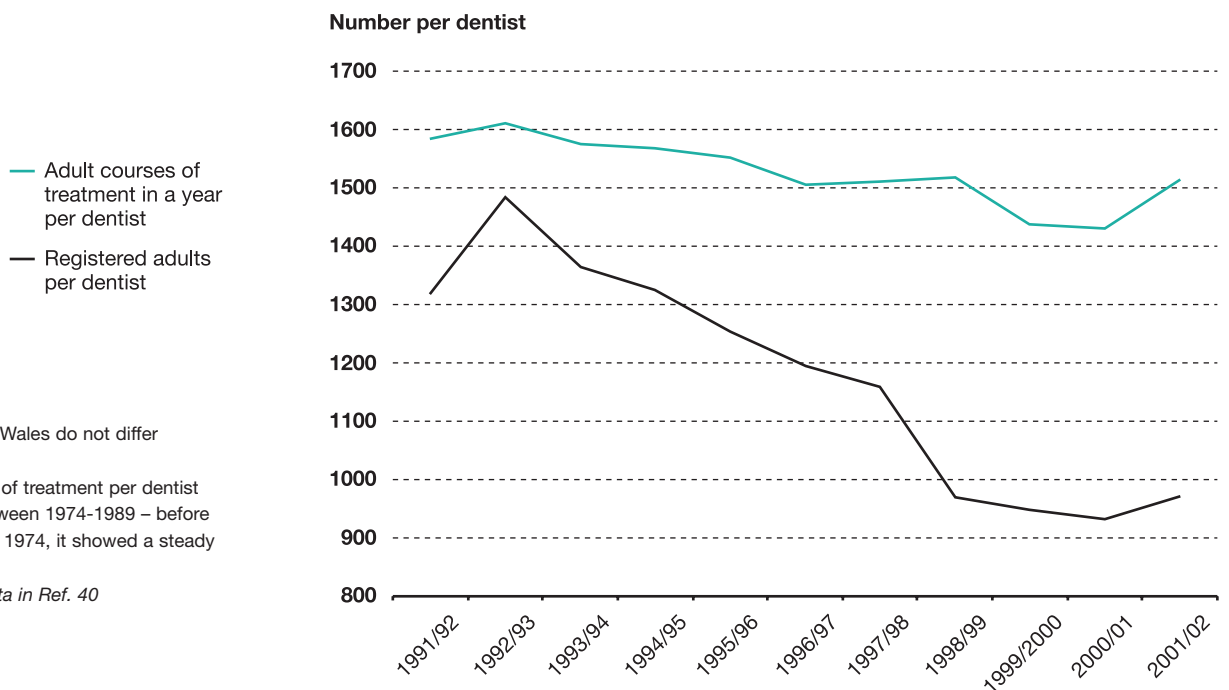
Trends for England and Wales do not differ significantly.

Source: Drawn from data in DPB annual digests of statistics and registration publications

- 56 At the same time, the number of dentists competing for patients has been growing by about 3 per cent each year. The combined effects of these differing trends are that, while the number of registered patients per dentist has decreased by about one-third over the last decade, increased activity means that the average number of courses of treatment each year per dentist has stayed about the same [Exhibit 10]. This in turn is reflected in dentists' incomes, which stay more or less stable year on year, within certain fluctuations (Ref. 5).

Exhibit 10**Trends in the number of GDS dentists in relation to the number of registered patients and courses of treatment (England)**

While the number of registered patients per dentist has decreased by about one-third over the last decade, increased activity means that the average number of courses of treatment each year per dentist has stayed about the same.



Trends for England and Wales do not differ significantly.

The pattern for courses of treatment per dentist was similarly stable between 1974-1989 – before that, between 1952 and 1974, it showed a steady rise (Ref. 2).

Source: Drawn from data in Ref. 40

- 57 Many dentists are uncomfortable with this – they want to work more in accordance with what the scientific evidence recommends, and provide a quality service with greater job satisfaction. But if they do so, they might not generate enough work to survive. These contradictions were noted 15 years ago (by Schanschieff, Ref. 30), yet the conditions that encourage them have still not been tackled.



Web report paragraph 78

Overheads and efficiency

- 58 At the same time, some dentists have been slow to modernise and reduce their overhead expenses by joining partnerships. The system is designed to offer a reasonable income to single-handed dentists, even if their overhead costs are relatively higher. Partnerships are also better placed to offer a wider range of health benefits for patients. Compared with GPs, there are far more single-handed GPs^I, sometimes working from cramped and relatively ill-equipped premises. The use of less-expensive staff to deliver some services is very limited, compared with the development of practice nurses and community nurses working alongside GPs^{II}. This introduces efficiency issues – public money is paying for duplicated equipment that is used for only part of the day, for supplies bought without a bulk discount, for larger numbers of administrative and other support staff than would be needed in larger practices, and for a comparatively expensive skill mix.

A history of failure to fundamentally change



Web report Appendix 1

- 59 The failure to fundamentally change the piecework system goes back over many years. The system was a good one when it was introduced at the start of the NHS in 1948 – it provided the incentive for dentists to quickly deal with the high levels of dental disease then present in the country. But once peoples' health began to improve, it became outdated. A series of Government and independent reports over the years, especially since the 1980s, have recommended change. The language used in these reports is often very robust. For example, 'we concur with Sir Kenneth Bloomfield [author of an earlier report] that the present system of remuneration for dentists, viewed objectively, is likely to give higher financial rewards to the poorer practitioner...[and it] consequently cannot assure the vast majority of diligent and honest practitioners that good practice will be rewarded and bad practice punished. This is both immoral and demoralising' (**Ref. 4**). The 1994 Government Green Paper baldly states that 'The current remuneration system is poorly matched to present needs. It has lost the confidence of the profession and others' (**Ref. 28**).
- 60 Yet, though the system has been tinkered with, the fundamental principle of 'piecework' has remained, with no effective control over dentists' activities. Similarly, patient charges were noted as a major barrier preventing people from accessing NHS care by a Government-sponsored report in 1988 (**Ref. 60**). Despite this, patients report the same problem today, as the charging system has remained basically the same. Another example is the lack of effective regulation of the dental laboratories that make dentures, crowns, bridges, and so on. The same issues – for example, lack of quality control – were raised by the Dental Laboratories Association at the time of the Bloomfield report (**Ref. 2**). These problems persist, but have not been acted on.

I 38 per cent of dental practices are single-handed compared with 10 per cent of general medical practices; two-thirds of dental practices are either single-handed or have two GPs, compared with one-quarter of general medical practices (Ref. 58).

II Commendably, the Government has recently lifted some restrictions on the use of other types of staff. This should facilitate change.

- 61 The consequences of inaction are poor value for money, as well as continued difficulties for poorer patients. For example, in 1994 a Government Green Paper stated: 'There must be real doubt about whether the 14.6 million scale and polishes done in 1993/94 in the United Kingdom, at a cost to the NHS of £108 million, were all essential on clinical grounds' (Ref. 27). In 2000 a DH document repeated this sentence word for word, just updating the sums. In the intervening time, almost £1 billion has been spent on this activity.

NHS commissioning bodies lack levers

- 62 NHS commissioning bodies have few levers to promote more appropriate care. They have little budgetary control over most dentists – most of the money is given out by a centralised body when dentists send in claim forms. They cannot regulate how many dentists practise in their area or where they practise. Nor can they directly influence which patients GPs will accept for NHS continuing care. There are no incentives for those who do the work to control costs, no managers whose responsibility it is to keep to a budget, no system for prioritising what is spent where, on what and on whom. All of which means that there is no mechanism for directing activity and spending according to an agreed local health strategy.



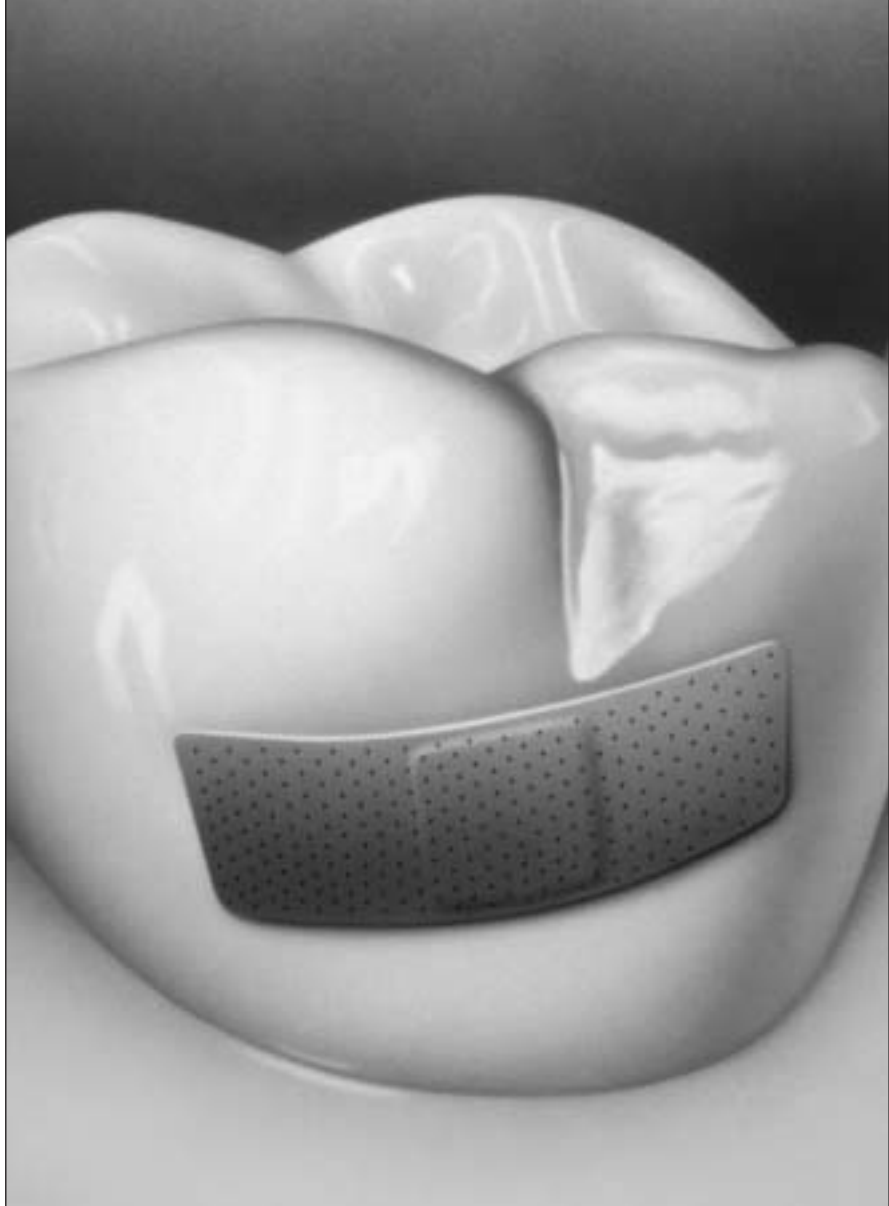
Web report paragraphs 84-87

- 63 There is also variation in how much public health resource is available. This is reflected in the degree to which dental health issues are addressed in local health improvement and modernisation plans (HIMPs in England, HIPs in Wales)^I and separate dental health strategies. These are strategic planning documents for achieving health improvement, and it is important that dental health is given attention during this process. But coverage of dental health issues is patchy in these plans^{II}. Nine of every ten plans include some mention of dental health, but only a minority go further than this.

^I Thus called at the time of analysis.

^{II} Source: Audit Commission analysis of plans from all English and Welsh health authorities, as included in a CD-ROM issued by Binleys in February 2002. The plans were the latest made available towards the end of 2001, and mostly cover a three-year planning period from 1999/2000 onwards.

7



What is being done

Since 1997 some useful initiatives have been started, but they cover only 1 per cent of the population. Proposals in *Options for Change* include demonstration sites to test new ways of working, including alternative funding systems.



Web report paragraphs 89-90

64 The Government published *Options for Change* in August 2002 (**Ref. 17**). This invites PCTs and dentists in England to volunteer to be demonstration sites to test new ways of working, including using alternative funding systems and the clinical partnerships discussed in Chapter 8. The demonstration sites will be in volunteer PCTs supported by the Modernisation Agency. These proposals follow a range of Government initiatives that were introduced around the margins of the GDS from 1997. These have allowed a degree of influence to those local bodies that have been successful in applying for funds. This chapter describes some of the main ways that these initiatives have been used in response to some of the problems described above.



Web report paragraphs 91-92

65 In England since 1997 the Personal Dental Services (PDS) pilot scheme has been emphasised (**Case studies**). Funds have also been earmarked for such things as rewarding dentists' long-term commitment to the NHS, implementing clinical governance and improving premises and equipment. A major review of women in dentistry has led to further investment to support its recommendations. Schemes have also been introduced in Wales – for example, since 1995 the Welsh Dental Initiative has allowed some local managers to attract new dentists to areas of Wales that have shortages. Extra sums have also been earmarked for several schemes that aim to improve children's health in deprived communities, including a fissure sealant programme.

What the best health authorities have been doing¹

66 This section describes case study examples of health authorities that have used the available initiatives to address some of the problems discussed in earlier chapters.

Improving dental health

Case study 1

A midlands health authority has included a target to reduce child decay levels by 20 per cent by 2006. It has supplemented the national Sure Start initiative, aiming to increase early use of fluoride toothpaste in deprived areas. The health authority, together with other health authorities in the area, has discussed water fluoridation, but the water authorities have not proceeded. This example is typical of the most common ways in which health authorities have tried to improve the dental health of the children in their populations.

Source: Audit Commission fieldwork

¹ In England health authorities' powers to shape primary dental health services were transferred to PCTs during 2002.

Access to urgent and drop-in NHS care

Case study 2

Earlier in this report we highlighted general improvements in this type of NHS care. Some areas of the country had lost so many NHS practices to private care that the ground to make up was massive. For example, a south-western health authority calculated that, to make up the shortfall, they would need to double the number of GPs, finding an extra 170. Faced with this, the health authority concentrated first on extending their salaried service under PDS arrangements in order to offer urgent appointments for those in trouble, within reasonable waiting time and travel distances. Even this has been very difficult to achieve, but since 1998 the travel distance and waiting time standards that the health authority has applied have improved (at the time of visiting, patients living in most areas could be offered urgent access to a dentist within 15 miles of their home). The amount of extra funding received for the PDS scheme was equivalent to an extra 20 per cent of that being claimed for GDS work in this health authority's area. But there are still some problems in some areas, and, more generally, for those people without ready access to transport. In addition, the widespread difficulties in registering continue, with the health authority helpline receiving about 750 calls per month from people seeking to register.

Source: Audit Commission visit

Case study 3

A health authority in Wales has established a weekend and public and bank holiday out-of-hours service for both registered and unregistered patients who are in pain. Nearly 200 dentists participate in the rota, simplifying their on-call responsibilities and providing a more co-ordinated response for patients.

Source: Audit Commission visit

Encouraging access to continuing care in deprived communities

Case study 4

The PDS aims of a London health authority included increasing registrations, particularly of children. The problem was not to fund new GDPs because people were unable to find a dentist accepting new registrations. The issue here is that registration rates are lower than the national average because of low demand. Yet deprivation levels are high, with associated high levels of poor dental health – the health authority believed that it has one of the largest open access emergency dental services in the country. The issue to be tackled, therefore, was how to persuade people with poor dental health to access continuing care. In particular, their aim was to encourage the mothers of very young children to bring them for continuing care in order to help to prevent dental problems developing to the unrestorable degree that is characteristic of many who currently attend only when in trouble. Although successful in increasing registrations within the PDS practices (equivalent to about 25 per cent extra registrations between 1998 and 2001), few practices are involved, in comparison with the scale of the problem across the whole health authority – the PDS initially involved only 7 (now reduced to 5) of 121 practices. Thus the registration increases are equivalent to only 4 per cent of child and 2 per cent of adult total health authority registrations. The increases were achieved by a mix of actions – for example, health visitors, GPs, schools and nursery classes were contacted to spread the word. This generated demand – and it was matched by capitation incentives for the participating dentists to meet that demand.

Source: Audit Commission fieldwork

Emphasising capitation over piecework to improve quality

- 67 A number of PDS pilots in England have introduced new remuneration systems. Although they differ in detail, they all share the characteristic of replacing an emphasis on piecework with capitation. Another characteristic shared by these PDS pilots is that all report increased dentist satisfaction with the change, since it allows them to provide the quality of care that meets the needs of their patients. In one health authority, this was evaluated by a comprehensive interview study with the staff involved.

The dentists no longer need to look at a patient and think, how much of my necessary income and overheads can I get from this patient; now they can look at the patient's oral health needs. (Consultant in Dental Public Health)

Source: Audit Commission fieldwork

Case study 5

One London health authority's PDS scheme aimed to increase registrations of deprived patients with poor dental health. The scheme also emphasised capitation as a way to encourage a preventive approach, rather than excessively high levels of restorative work, as a strategy for improving the health of those registering. The health authority stated that activity monitoring showed a reduction in the proportion of invasive treatment compared with preventive activity. Capitation payments are linked to deprivation scores. Patients who are not exempt pay the same fees as they would under GDS, but the dentist does not retain the fee income – for the dentist, all payment is on a capitation basis. Evaluation via interviews with the staff involved suggested that the income of the dentists involved had changed little, but the majority expressed a preference for the stability of income that the scheme gave them, coupled with a sense that they were providing a more appropriate, needs-based service. Example statements made by the dentists involved include: 'you know you have done what they needed'; 'treatment planning ends up being influenced more by caring for that person appropriately rather than thinking what the value of each item is'. Another stated that they felt like a clinician rather than a technician.

Case study 6

A north-western health authority's capitation-based PDS scheme has resulted in a reduction in the rate of teeth filled, and a reduction in the rate of 'scaling and polishing' by 3 per cent over the period, when GDS rates of this procedure increased by 9 per cent (Ref. 41).

Source: Audit Commission fieldwork

- 68 The initiatives described above are important locally. But they are of less significance in overall national terms in improving access to continuing care via registrations. This is mainly because the percentage of the population covered by the schemes in either England or Wales is very small. For example, seven of the first-wave PDS pilot schemes included an aim to increase registrations among their objectives. But they represent less than 10 per cent of all health authorities, and, in turn, their schemes covered only between 1-10 per cent of those seven health authorities' populations. The DH estimates that the PDS scheme covers about 1 per cent of the population (Ref. 5).

8



What needs to be done

The NHS should emphasise prevention. The piecework system should be replaced. Local health commissioning bodies should shape services in order to achieve national standards and to secure fair access through local contracts with dentists.

Emphasis on prevention

- 69 The first main change is the need to move the emphasis from treating urgent problems to preventing their occurrence in the first place:

The early decay process may be seen as a contest fought at the tooth surface between the acids (resulting from the intake of sugars) causing demineralisation of the tooth surface and a number of factors including fluoride and saliva promoting the remineralisation of the tooth surface...[And so prevention] can be approached in two principal ways. The first is by using fluoride and the second is to reduce the severity of attack by decreasing the consumption, and particularly frequency of consumption, of sugars. (Ref. 43)

- 70 The main factors that prevent disease are, therefore, fluoride intake (via water or toothpaste), a diet and behaviour that minimises the time that sugar and acids stay in contact with the teeth, and daily brushing. In addition, falling smoking rates will lead to a reduction in gum disease. Both in England and Wales there are health promotion schemes underway¹, but in neither country are they the main emphasis of dental policy, although *Options for Change* proposes prevention should be a key theme in England (Ref. 17). Government has noted the findings of a review strongly suggesting that decay levels are dramatically reduced when water is fluoridated (Ref. 44). Surveys have shown that a majority of the population in both England and Wales support fluoridation. The Acheson report baldly states that ‘We recommend the fluoridation of the water supply’ (Ref. 45); but this has not happened. Instead, Government has called for better quality research before deciding what action to take. One interim suggestion for central Government has been to remove VAT on fluoride toothpaste.
- 71 The DH and the Welsh Assembly Government expect local health commissioning bodies to use their powers to improve matters, on top of their already large agenda. But their powers are quite limited, and there are obstacles in their way. For example, it is down to local health bodies to gain the agreement of local water companies before fluoridation of local supplies can take place. Although about one-half of all health authorities requested this, no new schemes have occurred since 1985. Unless legislation changes, local PCTs and LHBs will need to concentrate on trying to increase the number of people who brush daily with a fluoride toothpaste, or on experimenting with fluoride in school milk, bottled water or diluted sugar-free fruit drinks, thereby enabling individual parents to choose (Ref. 46). One health authority visited already has a fluoridated milk project in place.
- 72 Aside from fluoridation, attempts to improve dental health via education and other programmes of promotion have, so far, not been very effective. There are a number of reasons for this. First, education does not necessarily lead to a change in behaviour – the majority of children and adults in a recent large-scale survey knew about the adverse effects of sugary and acidic food and drink, of smoking and alcohol, and of the benefits of brushing – but they did not always change their behaviour because of

this knowledge (**Ref. 47**). Other problems can include the fact that programmes reach too few of those people in need, or that the results are not sustained (**Refs. 48 and 49**).

- 73 The current emphasis, which PCTs and LHBs should embrace, is on helping to create environments that will directly affect health (for example, by fluoridating water) or promoting ‘supportive environments’ (for example, altering the availability, cost and appeal of food and drink in schools; and encouraging community development projects, such as facilitating food co-operatives). The ‘Brushing for Life’ programme, introduced by the DH in England, directly distributes toothbrushes and fluoride toothpaste to disadvantaged children, and in Wales there is a national fissure sealant programme that aims to directly prevent caries developing in children’s teeth, and is targeted at reducing health inequalities.

A new remuneration system

- 74 The piecework system should be replaced with arrangements that remove the business incentive to over-treat and carry out rushed, poor quality treatment. At the same time local NHS commissioning bodies should be provided with more powers. The remuneration system is so fundamental to helping or hindering the Governments in achieving their aims that the case for modernisation is overwhelming – yet the system in its basics is virtually the same as when it was introduced in 1948. *Options for Change in England* recognises this in that it sets out the case for payments systems that do not influence the type of treatment delivered (**Ref. 17**). But change has already been piloted for the last four-five years. What is needed in both England and Wales is a firm commitment to change. Dentists should not have the option to continue to be paid piecework by the NHS because this is a system that most agree is discredited and wasteful.
- 75 The new system should incorporate the following features:
- incentives for continuing care with a preventive emphasis, such as a risk-based capitation system, whereby patients who are at high risk of decay and gum disease can receive more frequent check-ups than those with generally good oral health;
 - national definitions of the treatments needed for good dental health that will be funded by the NHS, and those that are cosmetic and therefore will not be paid for by the NHS; these definitions should be developed with user and professional involvement;
 - a review of the charging system to ensure that people on lower incomes are not deterred from seeking necessary dental healthcare;
 - flexibility for local NHS commissioning bodies to invest in preventing dental disease and to shape local dental health services to meet local needs, tackle inequalities and support local dental services where needed, for example, by letting local contracts and investing in infrastructure;

- robust means to ensure that NHS national standards for access and quality assurance, and information for patients, are achieved; and
- adequate means for the Government and local health commissioning bodies to control the costs of NHS primary dental care services.



Web report paragraphs 104-105

76 The situation is complex and change will not be a simple process. Possibilities include:

- *Capitation:* Paying dentists according to how many people they care for, rather than what they do for them, removes the incentive for excessive or inappropriate activity. But it also risks 'supervised neglect', which commentators say happened at first when capitation was introduced in the early 1990s. Ways would therefore need to be devised that avoided this – eg, by the use of guidelines, clinical audit and the Dental Reference Service to ensure that the current terms of service requirement to provide a course of treatment to secure 'dental fitness'^I is achieved.
- *Shifting the balance of piecework and capitation,* for example, a system where the present approximate balance of 75:25 in favour of piecework is turned round in favour of capitation, with a risk-based weighting for patients whose dental health status requires frequent examination.
- *Enabling local health commissioning bodies to negotiate contracts with GPs,* perhaps on the lines of 'cost and volume' contracts and contracts for individual cases, such as those used by some GP fundholding practices for hospital activity in the past (**Ref. 50**). Champions of such arrangements under fundholding claimed that this system kept a cap on expenditure, while offering incentives for extra necessary work carried out, avoiding both over-activity and 'supervised neglect'. The contracts could be placed with individual GPs, or even with groups of GPs who work together in a local area. Local contracts could also be used to specify quality requirements.
- *Sessional payments:* PDS pilots and 'mini-PDS', have already trialled sessional payments – for example, to provide out-of-hours urgent care under the NHS.
- *Salaried dentists:* Some PDS schemes have used this option, and, of course, the CDS and hospital services operate in this way. Mechanisms to encourage and reward efficiency would be required, as mentioned above under 'capitation'. Recruitment difficulties experienced by some PDS pilots suggest that only some dentists are likely to be attracted by salaried arrangements.

77 Some of these arrangements have already been trialled via PDS pilots in England during the last five years, as described in the case studies. *Options for Change* acknowledges that some of the issues raised in this report will be more easily tackled if NHS dental services are commissioned locally, and further trials are proposed via the NHS Modernisation Agency (**Ref. 17**). It also proposes that NHS Local Improvement Finance Trusts (NHS LIFT) are extended into dentistry to counteract difficulties with large-scale capital investment in new premises. A dental strategy being developed by the Welsh Assembly Government may also recommend action

^I Defined in the regulations as the reasonable standard of dental efficiency and oral health as is necessary to safeguard general health.

closely in line with many aspects of this report. These developments are highly commendable. However, we believe that the current mix – with PDS and similar schemes affecting only a minority of patients and taking up a minority of total expenditure – should be reversed quickly, so that the majority of expenditure is on systems that offer better value for money. Change of this kind has been recommended for many years, and schemes emphasising capitation over piecework have now been piloted in at least five PDS sites since 1998. Arguably, the time for pilots is past, and the majority of GDS expenditure should by now be governed by these different systems, under local PCT (and, in future, LHB) control.

- 78 It must be acknowledged that a probable consequence of such change would be a drop in productivity, because under the present system many dentists work fast and hard. However, there is no merit in the efficient production of activity that is not needed, and most would consider this to be an acceptable trade-off in return for improved quality and a more patient-centred service. In addition, the concerns that some dentists have about ‘second class’ treatment under the NHS, because it is rushed or uses inferior materials, can be addressed by using the scientific evidence to ensure that the dental care necessary for good *health* is available to a first-class standard on the NHS. Just using the examples examined in Chapter 5, about £160 million in England and £9 million in Wales might be made available. These are minimum estimates and, given that we were not able to estimate the probable over-spending on orthodontic and other activity (such as crowns) – areas that are currently a mixture of necessary healthcare and cosmetic activity – then very substantial sums could be released.
- 79 Scope, however, must be found for retaining some of the best aspects of the current arrangements. As described below, the current system has developed as a unique form of public-private partnership within the NHS. The positive aspects of this include not only high productivity, but also the development of an entrepreneurial spirit that is characterised by a willingness to try new techniques and new ways of working. And although the spread of private practice, and the attitudes and reasoning of those who prefer to practise privately, have been widely publicised, research suggests that a large number of dentists have a strong sense of commitment to providing NHS care (Ref. 31).

I had a belief that...the man on the Clapham omnibus should have access to healthcare, primary healthcare and I still think that's very true. So we stayed [in the NHS]. (Dentist)

My commitment is more to do with the patients than with what the government is doing. As I said I can still earn a living, a very good living, so I'm prepared to stick at it at the moment. (Dentist)

I think if people are wanting, have extremely high demands of ultra cosmetic dentistry then...there's plenty of people around to provide for it [privately]. But we like to meet the needs of 95 per cent or more of the population. So that's our core if you like. (Dentist)

Source: Ref. 31

Empowering patients

- 80 Better value for money can also be promoted by empowering individual patients to ask for care that is targeted at meeting their health needs. For example, most patients who visit the dentist every six months think that it is good for their health, and they are surprised when the evidence that contradicts this is described to them. Therefore, it is essential that the Government's intention to provide clear information to patients about their rights and charges is supplemented by clearly written leaflets that explain how often check-ups are needed to ensure good dental health. Information should explain that only a very few people with particular conditions need to have their teeth scaled and polished – and that, for most of us, it is a cosmetic exercise. It should also explain that 'white' fillings do not usually last as long as amalgam fillings. If the public are informed about such things, then they can choose whether to pay for cosmetic care, rather than paying because they think it is necessary for their good health.



Web report paragraphs 108-111

Achieving change within a clash of cultures

- 81 The difficulties in achieving these changes should not be underestimated. There is a fundamental clash of cultures at the moment, largely stemming from the way that dentists who provide NHS services have been treated and paid in the past. We often talk about 'my doctor' or 'my nurse' when thinking about our relationship with health service professionals. We think of them as 'NHS doctors' or 'NHS nurses'. Those who regularly visit the dentist also talk of 'my dentist', and we think of our relationship in similar terms. Even those who only visit occasionally probably tend to think of 'NHS dentists'. But, in fact, most dentists who work within the GDS scheme do not think of themselves as 'NHS dentists'. They are independent professionals, contracted to provide a service to NHS patients. For example, they run the risks of equipment breaking down, and must find the money to repair it from within their own resources – the exact costs will not be reimbursed by the NHS. The source of much of the money may be from taxpayers and patients, but from the GDP's point of view that should not confer ownership or direct managerial control.


It's a tough small business in many respects. It requires the same sort of supports from banks, in terms of overdrafts, for many people. The majority of dentists survive like most small businesses: they have rents, rates, and staff wages to account for. Staff salaries can quite often be considerable in large practices. If you want quality people you have to pay for them. If you want a quality practice you have to have a lot of input into these things. (Dentist)

There are many parts to it. There's the looking after staff, there's hiring staff, there's training staff, there's health and safety, there's all the regulations...and everything else. The actual dentistry side of it sometimes is simple because most of it you've done before and you have your techniques and everything and you know it's going to

work...Sometimes it's the business side of it, the running of the whole affair that can be the tricky part, the time consuming part and the hassle part. (Dentist)

Source: Ref. 31

- 80** The following analogy was suggested to us. If you contract with a builder to work on your house, the builder will price the job to take into account, not just the cost of the materials that will be used on your house (the bricks, cement and so on), but also an amount to cover overheads – your share of the cost of employing the building staff, the lorries that will be used to transport materials, the cement mixer, and so on. This doesn't mean that you, having paid for the job, end up owning the lorries or the cement mixer. GDS dentists' contractor status is similar – because we, as taxpayers, pay fees that cover the dentists' overheads, it doesn't mean that we own the premises or the equipment used. The contrary argument, of course, is that the public in a collective sense, pays and therefore this should confer an element of control – irrespective of the rights and wrongs of this analogy, it illustrates the view held by many GDPs.
- 81** A second, simmering issue lies behind the 'culture clash'. In the early 1990s new registration schemes were introduced. However, the total number of people registering, and the amount of treatment given to them, exceeded government expectations and the total costs for that year were much higher than expected. At the time, a system was in place to adjust fees up and down each year to make sure that dentists' incomes, and total NHS costs, were roughly in line with what the Government wanted to spend on NHS dentistry (influenced by the recommendations of the Doctors and Dentists Review Body). The result was that the Government cut fees in 1992/93 by 7 per cent, acting in accordance with the rules. Many dentists feel that they were unfairly treated by Government – their attitude was that they had done extra work and not been paid for it.

 Web report paragraphs 116-118

Concluding remarks

- 82** Under the current GDS system, those people with less disease receive disproportionately more care, while many of those with most disease only receive care when they are in pain, by which time it may be too late to conserve their natural teeth. Dental policies in England and Wales are not joined up with the rest of Government policies. They do not square with stated policy aims to reduce inequalities in health and to have patient-charging systems that do not deter the less well off from seeking necessary care. In 2001 Parliament's Health Select Committee issued a report on dental care, based on evidence from many organisations and individuals (**Ref. 51**). Almost every contribution was critical of current policies. The Committee noted the history of inaction that we have described, and concluded that there should be no more reviews, but immediate action. The conclusion of the Audit Commission's study is the same – the case for immediate, fundamental change is strong.

Recommendations



Web report contains more recommendations

The Government should¹:

1. Replace the current payment system (that is predominantly based on piecework) with a system, or mix of systems, that emphasises prevention and treatment based on evidence of cost-effectiveness, that addresses health need and is implemented by local health commissioning bodies. The new system should :

a) Define which activities are needed for good health, and allow only these on the NHS. Users and professionals should be involved in developing these definitions. This could form the basis for a system of national standards, backed up by NICE guidance, that are more specific than the current requirement to maintain dental fitness. NHS funding for unnecessary and cosmetic activities, or those that scientific evidence shows do not represent good value for money, should stop.

b) Implement the recommendations of the NICE review on risk-based recall intervals to allow dentists to offer more individual recall intervals for patients. Consider taking this further by using the risk categories to vary capitation payments, allowing longer registration periods while still providing value for money.

c) Enable local commissioning bodies to negotiate local contracts implementing national standards for NHS dental healthcare and national access standards. Instead of piecework, local contracts should be predominantly based on capitation, 'cost and volume' agreements or sessional and/or salaried payments, with safeguards built in that limit expenditure and discourage 'supervised neglect'.

d) Give local commissioning bodies discretion to support investment to modernise infrastructure (premises, equipment) and reduce overheads, allowing some degree of direct reimbursement for the cost of premises, staff payments, equipment and consumables.

¹ At the moment, changes to the remuneration system are negotiated on a UK-wide basis.

2. Review the charging system for activities that improve patients' health, in the light of evidence that some (for example, pensioners with low incomes and lower-paid people) are deterred from dental healthcare because of its cost.

3. Begin a campaign to help patients to become informed consumers. They need understandable information that allows them to know what is necessary for their health, and what is for cosmetic purposes only. They also need clear information in advance about charges.

4. Act to secure fluoridation of water supplies.

Local NHS bodies (PCTs and LHBs from 2003 in Wales) should:

5. Ensure that they have the expertise and capacity to plan for, and shape, primary dental care services and to involve local GPs in this work.

6. Focus effort on improving dental health, and access to continuing care for those with the worst health, in the most deprived communities.

7. In addition to pursuing the fluoridation of water supplies, explore other ways to improve dental health, for example by getting fluoride toothpaste used by those most at risk, promoting fissure sealant programmes, sponsoring schemes that make good food available in local communities, and investigating the targeted use of fluoride in school milk, bottled water or diluted sugar-free fruit drinks.

Individual dentists should:

8. Review the frequency of check-ups, and whether treatments offered have been shown to be effective in improving dental health and not just cosmetic appearance.

9. Ensure that Government guidance on providing written estimates and a treatment plan in advance are followed, and that there is a good range of other information available to patients on how to care for their teeth and gums.

Appendix 1: acknowledgements and methods

We are grateful to the many individuals and organisations, too many to list separately, who generously gave their time for interviews and provided us with data and documentation. In addition, we are grateful to the many clinicians and managers who spoke to us during visits and provided case study information within selected study sites:

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Cornwall & Isles of Scilly Health Authority

Doncaster Health Authority

Ealing, Hammersmith & Hounslow Health Authority

Gloucestershire Health Authority

Lambeth, Southwark & Lewisham Health Authority

Newcastle & North Tyneside Health Authority

North Nottinghamshire Health Authority

Oxfordshire Health Authority

Shropshire Health Authority

South & West Devon Health Authority

Warwickshire Health Authority

We commissioned research involving six focus groups (**Ref. 52**). The focus groups comprised 48 ordinary members of the public, selected to cover a range of characteristics, and were facilitated by a professional moderator. They took place in London, Newcastle and Cardiff during early 2002. In addition, a survey of Audit Commission employees was carried out in March 2002.



Appendix 2: abbreviations

BDA	British Dental Association.
CDS	Community Dental Service.
DAC	Dental Access Centre; a focus for providing urgent and occasional dental care, often via PDS pilots.
DDRB	Doctors' and Dentists' Review Body; the body that makes recommendations to Government health departments on levels of remuneration.
dmft	The number of decayed or missing or filled natural teeth in a child; the lower case signifies that this is the abbreviation used for deciduous or milk/first teeth.
DMFT	The number of decayed or missing or filled permanent/secondary teeth.
DH	Department of Health (for England).
DPB	Dental Practice Board. The statutory body that administers the GDS, accountable to the DH and to the Welsh Assembly Government. The DPB pays dentists for treatment that is provided under the NHS in England and Wales. It approves more complex treatment for NHS dental patients, monitors the quality of NHS dental treatment and carries out regular checks to detect and prevent fraud. It provides information on GDS activity and cost.
DRS	Dental Reference Service. Dentists who examine the quality of GDPs' treatments on behalf of the DPB.
GDP	General Dental Practitioner; the term for a dentist who contracts to provide NHS care under the GDS system.
GDS	General Dental Service; the system under which about 85 per cent of NHS dental care is delivered.
GMS	General Medical Services; the system under which general practice medical care is delivered.
GP	General (Medical) Practitioner.

LHB	Local Health Board; from 2003 LHBs will take on responsibility for certain aspects of dental services from the old health authorities in Wales.
ONS	Office of National Statistics (now called National Statistics).
PCT	Primary Care Trust; from 1 April 2002, PCTs took on responsibility for certain aspects of dental services from the old health authorities in England.
PDS	Personal Dental Services; the NHS (Primary Care) Act 1997, operated via health authorities, enables new ways of delivering dental services. Those health authorities that are awarded funds for such pilot schemes could run locally managed dental services.

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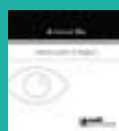
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