

Modernising NHS Dental Services in Scotland

Comments for discussion.

1. Introduction

- 1.1 This document is finally saying something which dentists working in Scotland have been thinking for a long time. The current NHS provision of dental services, both in primary and secondary care settings, is not working in Scotland. It is not delivering equitable access to NHS dentistry to all groups in Scotland. It is not providing reasonable access to emergency or routine NHS dental services. It is failing to retain or recruit dentists within its service. It mainly provides, when available, restorative treatment where disease has already occurred rather than preventative. The dental profession, who courageously continue to work in this failing NHS, seem to be "fire-fighting" against and treating disease processes rather than proactively trying to prevent them.
- 1.2 Having listened to a number of my colleagues discussing the contents of this document I have been a little dismayed at their lack of vision. Rather than concentrating on our individual practice and our local environment, we should take this opportunity and broaden our horizons. I have therefore put forward some rather contentious suggestions to stimulate discussion. If anyone wishes to take issue with any of my suggestions then I will have succeeded in stimulating an opinion.

2. The present system

- 2.1 The document details the expenditure of the GDS in 2002/03 as £194m. If we add the cost of the CDS at 22.5m and the HDS at £40.5m, a total of £257m is spent on dental services each year. That approximates at about an average of £51.40 per head of population. Realistically though, we know that only half of the population attends for regular treatment. The average for those receiving treatment would therefore average at £103 per person. Neither of these figures are very much when you consider what some people spend on hair care in a year. It has been said that people will generally care more for things which they have to pay for. Maybe we should ask people to contribute more for their oral health care.
- 2.2 The document does identify (item 4.2) some factors which the Executive believes has led to the growing momentum for change but they do not seem to ask "Why is it not working?". Should they not have asked this simple question before trying to answer it? I believe that some of the factors are included below:
- Dental professionals do not always feel they receive sufficient recognition for their expert advice and intricate surgical skills they have spent many years in training to achieve. Some members of the public refer to dentists as "butchers". Others decide to spend their income on what they consider are more important aspects of self-imagery i.e. fortnightly hair-dressing appointment only to moan at having to pay an average of £20 for a completed course of treatment. Patients receiving care for free do not all feel committed to working towards their own oral health care plans. They miss appointments, do not maintain expensive restorations and have a disregard to their own responsibility towards their own health.
 - Under the existing system within the GDS, the present fee scales are geared towards "fire-fighting" restoration biased treatment plans rather than proactive preventive based programmes.
 - The fee-based and dual patient/government payment system is too complex and bureaucratic. Patients resent having to pay for something which they have already contributed to, and yet see others getting treatment for free. From a small business perspective, the fee per item of service does not facilitate smooth cash-flow planning and long-term investment.
 - There is too much demand for everyone. Patients are clambering to every dental professional for their treatment needs. When this gets too much in the GDS, the practitioner has the option of lessening their stress by seeing less patients but charging them private fees. This has a knock-on effect on adjoining practices and, especially in more rural areas, we see the majority of practices moving towards non-NHS practice. This again has a knock-on effect on the remaining salaried services both within primary and secondary dental care who cannot refer back to NHS services and have difficulties meeting patient expectations.

- Dental professionals feel that they are being asked to provide day-time emergency dental services and out-of-hours emergency dental services for minimal return. These feelings are exacerbated when some emergency dental services are over-run by routine emergencies (which could have been treated if there was sufficient access during the day) rather than true dental emergencies. Provision of routine treatment in this fashion is an ineffective use of valuable resources. It also adds considerable strain when the dentists providing this service then have their own routine clinics the following day.
- Continued problems of service availability (due to the above) and difficulties in access.
- Inequalities of responsibility and payment of dental professionals both in terms of pay and non-pay benefits e.g. low, fixed salaries with holiday benefits within salaried services against higher, variable salaries (along with NHS commitment payments e.g. seniority payments, golden hellos etc.) in the GDS. All practitioners in GDS, CDS and HDS who show commitment to the NHS and/or work in rural areas should receive similar benefits i.e. commitment payments, seniority payments etc.
- How does it look to salaried staff who have committed themselves to staying in rural areas providing badly needed NHS dental services for a number of years to see young newly qualified dentists receiving a bonus of £10,000 to come into the area. So much for loyalty to the NHS.
- GPs who have invested in their practices over their working lifetime are now finding it difficult to sell their practices as "going-concerns" when they come to retire.

Having looked at why NHS dentistry is not working in Scotland we should also be looking at the resources available i.e. number of dental professionals. It does not take a rocket scientist to work out that there are insufficient dentists available, or will be available in the near future, to provide a similar range and quality of service under the NHS with the resources available. Without change in the level of service delivered, and the conditions in which they are currently delivered, there will be continued stress, burnout and emigration of dental professionals to other countries, private practice and beyond. This document possibly has the cart before the horse. The Executive seems to be attempting to comply with political demand, to make things better for the patient and consider the dental profession as an afterthought. It should be clear that we should be trying to retain and involve the existing NHS dental professionals to stay within the NHS rather than assume that if we make things better for the patient, the profession will follow.

3. What sort of dental services should be paid for under the NHS?

3.1 The key features described in the document (item 4.1) will only work if dentistry has a chance to become more integrated within the "health services team". For too long, especially in primary dental care, dentistry has been excluded in self-isolation. Dentistry, as a profession, has to be re-introduced to the health services as an "equal" partner. This will require the building and reinforcement of existing links to ensure that primary and secondary care dental health professionals are fully included and recognised within the newly forming integrated Health Board structures. They will require equal partnership with their medical counterparts and should have equivalent representation on Health Board committees. Medical and Dental services should be able to work together, with guidance from their public health colleagues, to provide the appropriate NHS care to appropriate groups within the resources available.

3.2 Funding for NHS dentistry in Scotland averages at £103 per person for those receiving treatment. If the Executive are serious about continuing to provide the same level of services to the whole population, provided they could identify enough dental professionals to provide the services, they would have to accept that the funding would have to double. Can they absorb that? Even if they did, I do not think that that would solve the problems outlined earlier.

3.3 Whatever the solution is likely to be, it will not be popular. Patient expectations on what they should receive will have to change. The way in which dental services are funded and organised will have to change. The short-term instability and turmoil will have to be endured for the long-term reward. The public will have to be made very aware of that.

Based on my observations above, I do not think that the Executive can afford to provide a fully comprehensive NHS dental system under the existing terms for everyone in the country. We know it does not work. We know it is not attractive to the profession. We know it does

not encourage patient responsibility for their own oral health care. Whatever the solution might be, it is imperative that it is consistent and fair throughout Scotland.

3.4 One possible approach could be:

- Restrict comprehensive free NHS dental care to specific groups e.g. children and special needs (to be defined).
- Provide a free "core" NHS dental service (yet to be defined but excluding advanced restorative and orthodontic work) to all other groups.
- Non-"core" dental services would be provided by independent private contractors.
- There should not be an NHS funded, out-of-hours, emergency dental service. This should be provided, where necessary, by private contractors.
- The Scottish executive should consider purchasing the practices of GDPs who are about to retire, or wish to move, at the market rate for the building (just like Estate Agents do when they want to sell you a house) and resell them, even with a slight loss, on the open market. The GDPs who want to move can now be attracted into health centre or larger dental health centres to provide dentistry (both NHS and private) under controlled quality standards.

3.5 All "core" services should be free but patients would be entitled to receive a voucher (possibly to the value of the average course of treatment i.e. £50) which can be used towards private courses of treatment. The definition of "core" NHS services would have to be defined more fully and avoid confusion with staff and public.

4. Proposal for NHS Dental services in Scotland

NHS Dental Services in Scotland		
PRIMARY CARE	NHS	PRIVATE
	<ul style="list-style-type: none"> • Children All children (up to 18 years) Provide all treatments (?orthodontics) and prevention to secure oral health. 	- ? Orthodontics
	<ul style="list-style-type: none"> • Adults All adults eligible to receive "core" NHS service. This would include day-time emergency dental services. 	<ul style="list-style-type: none"> - Orthodontics - Crowns - Bridges - Implants - ? advanced dentures - ? molar endodontics
	<ul style="list-style-type: none"> • Special needs Provide all treatments (? Orthodontics) and prevention necessary to secure oral health 	- ? Orthodontics
		Emergency Dental Services
SECONDARY/TERTIARY CARE	NHS	PRIVATE (elective procedures)
	<ul style="list-style-type: none"> - Paedodontics - some orthodontics (to be defined) - some restorative (to be defined) - Oral Maxillo Facial Surgery - Radiology - Oral Medicine - Some prosthodontics (to be defined) 	<ul style="list-style-type: none"> - ? orthodontics - ? restorative - ? OMFS - ? prothodontics

	- Perodontics - Research	- ? periodontics
TRAINING	NHS	PRIVATE
	Training (to be defined)	Training

5. Emergency dental services

5.1 When is a dental emergency a true dental emergency? Rarely. It is very rare for a dental emergency to be truly life threatening. In terms of the efficient and effective use of scarce dental manpower resources, should this service be provided free, at point of source, under NHS regulations? I would suggest that it should not.

5.2 Existing out-of-hours Emergency Dental Services see many patients with routine dental emergencies which could easily have waited until the following morning where they could have been dealt with an in-hours emergency dental service. If we look at how much money is being spent each year on EDS in Scotland i.e. approximately £4 million, that could equate (at existing salaried dental staff rates) to an extra 70 dental teams throughout the country (providing we could find the staff).

5.3 The few occasions where there is a true, life-threatening dental emergency could be picked up via NHS 24 triage and referred to their local district general hospital. If necessary, with tele-medical video-conferencing with experienced OMFS surgeons at larger hospitals. If the public feel that there is a need for an out-of-hours emergency dental service then they should expect to pay for it privately. Many of the independent private practitioners will already have their own rotas and could expand this to include non-registered private emergency services.

6. Contractual arrangements

6.1 With the development of Community Health Partnerships (CHP) within integrated NHS Health Boards, dentistry, more than ever, will need adequate inclusion and representation. It is assumed that the local health needs (including those for dentistry) will be identified at CHP level in conjunction with public/dental public advice and local provider(s) input. The local dental health needs having been identified would then be contracted out to a range of providers. Initially this would be mainly to existing salaried CDS/GDS services, individual independent general dental practitioners and some bodies corporate. A contract would be arranged for the contractors to provide dental services for an agreed rate and agreed quality of service. Contracts would be monitored by the Health Board based on processes and outcomes of services (i.e. changes in dmft).

7. How should patients contribute to the costs?

7.1 Many patients tend to value only what they pay for and take the rest for granted. All "core" treatments should be free. Patients would be given a voucher to the value of £51 (equivalent to the average cost of a course of treatment under the existing funding arrangements) to supplement any additional non-"core" services they require. It will then be patient choice (not expectation) as to what treatment options they elect to pay for.

8. What is the balance between preventive and repair services?

8.1 Using the successes of Scandinavian countries as an evidenced based example (i.e. Finland), it can be shown that intensive preventive services aimed at pre-school and schoolchildren can make significant changes to dmft over the long-term. This requires significant resources and commitment from the Scottish Executive. It would require significant investment in the targeted group and exclusion of other groups which may be politically unpalatable. It may not be seen as fair by those who are excluded. In the long-term however, it should deliver the greater good.

9. Vision of the future.

9.1 NHS dental health care must become more integrated with other "health care" facilities. Ideally this would evolve to include the sharing of premises and patient bases thereby encouraging networking and inclusion with other healthcare workers.

9.2 The larger block contracts for Primary Care NHS Dental Services will most likely be filled initially by existing NHS salaried services but could include bodies corporate. For those GDS practitioners who wish to remain committed to providing NHS dental care, I would see them banding together to form co-ops (not unlike LHCCs) to jointly bid for contracts.

9.3 In Secondary and Tertiary Dental services, I see the emergence of a NHS/private split being an opportunity. Assuming that the HDS will continue to receive similar funding to provide "core" services, the private income could contribute valuable additional funds (just like Universities do) to develop existing services.

9.4 From the patient point of view, after the initial culture shock, the new system should be clearer. The "core" NHS services would be free to those eligible and the advanced/elective procedures would have to be paid extra for and be part of the patient's choice on the treatment services they should receive.

10. Conclusion

10.1 Whatever is finally decided for the modernisation of NHS dentistry in Scotland, it will require a bold and radical change from the existing system. Tinkering with the existing system is not an option. This will undoubtedly cause confusion and unrest initially but will result, in the longer term, with an efficient and effective system which can be monitored and shown to produce benefits for all.