

British Association for the Study of Community Dentistry

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BRITISH ASSOCIATION FOR THE STUDY OF COMMUNITY DENTISTRY (BASCD)

Response to the consultation document issued by the Scottish Executive Health Department in November 2003 - Modernising Dental Services in Scotland.

1 Introduction

The British Association for the Study of Community Dentistry welcomes the publication of the consultation document on NHS Primary Care services by the Scottish Executive Health Department.

We note that the consultation paper was prepared to support the delivery of the undertaking in the White Paper "Partnership for Care" that the SEHD would "take forward proposals for changes to the system for rewarding primary care dentistry in order to promote prevention, improve access to services and improve recruitment and retention".

We note that the consultation paper sets out;

- the background to oral health and dental services in Scotland
- provides a summary of what is in place to support NHS dental services
- describes the pressures and need for further change,
- puts forward options for changing the current system,

It also sets the context within which legislative provision may be needed to underpin agreed changes for the future.

The SEHD seeks the views of the public, professionals, NHS bodies and others concerned with the sustainable delivery of NHS dental services in the community.

We are disappointed that as the UK specialist society for Dental Public Health, the British Association for the Study of Community Dentistry was not included in your initial mailing requesting responses to the consultation document. We hope that this oversight will be corrected in future consultations.

2 Health Improvement

While welcoming the consultation on services and in recognition of the problems of access to dental care in many areas of Scotland, we feel consideration should also be given to reducing need for dental care by addressing health improvement. Any new system should promote a holistic and preventive approach to oral healthcare provision.

The level of child dental health in Scotland is poor for a developed country. There have been improvements over the last three decades, but these have plateaued and serious inequalities persist. The Health Department's own document "Towards Better Oral Health for Children" pointed out that:

- By the age of 3, over 60% of children from areas of deprivation have dental disease.
- Over quarter of a million (250,000) teeth are removed from children each year.
- By the age of 14, over 67% of children already have decay in their adult teeth.
- Tooth extraction remains the largest single reason for children receiving general anaesthetic.

We see a great need to introduce evidence-based health improvement measures to improve oral health and hope that the Scottish Parliament will find legislative time to enact laws and make the necessary changes to introduce the following measures.

3 Poverty reduction

As with most chronic diseases, oral health is related to the socio-economic circumstances of individuals. We strongly believe that efforts to reduce the level of child poverty in Scotland will lead to narrowing of oral health inequalities. Poverty reduction is not beyond the influence of the Scottish Executive and we welcome the many policies and initiatives currently running under the health and social justice agendas. We strongly encourage those who can make a difference to the health of the socially excluded to vigorously pursue the eradication of child poverty.

4 Water fluoridation

BASCD believes that the SEHD should bring forward guidance on fluoridation of the domestic water supply for Health Boards in Scotland. The legislation for this effective public health measure is already in place in England & Wales. There is good evidence that water fluoridation would reduce the prevalence of dental decay for the next generation of Scottish children. This will produce both a step change in dental health across Scotland where introduced as measured by indicator 1.05.01 in the Performance Assessment Framework (Dental Disease – Proportion of 5 year olds with no experience of dental disease) and there is evidence it would also reduce dental health inequalities. Dental health inequalities are measured by indicator 1.14.02 in the Performance Assessment Framework (Dental Disease - Children under 5 Years, The ratio of the percentage of five year olds with dental caries who live in the most deprived postcode sectors to the percentage who live in the most affluent. Postcode sectors grouped by Carstairs quintiles).

BASCD supports water fluoridation in principle and urges the Government to enable the introduction of water fluoridation for the largest water supplies in Scotland. We also agree with the Medical Research Council that water fluoridation should be introduced and evaluated with respect to outcomes such as health inequalities, prevalence of dental abscesses and extraction of teeth. The establishment of a demonstration site for water fluoridation in Scotland would be one way to meet these objectives.

5 Fluoride toothpaste, Value Added Tax and confectionary

We welcome the SEHD oral health demonstration project distributing toothpaste and toothbrushes to all 8-month-old children and targeted to children in deprived communities. We suggest that fluoride toothpaste should also be reclassified to make it exempt of value added tax and therefore cheaper to buy. We do recognise the need to maintain tax receipts for the Treasury and we suggest the addition of VAT to confectionery. Specifically to foodstuffs with a high proportion of added sugars. An alternative is a sugar tax, which has

been proposed. Improving diet will have wider benefits on other key Government priorities such as obesity, coronary heart disease, stroke, cancer and diabetes.

6 Ban advertising aimed at Children and improve food labelling

The Scottish Executive should introduce legislation to prohibit advertising to children under 12 years of age, as is the case already in some European countries. These countries typically have better dental health than Scotland. We would ask the Scottish Parliament to ban all advertising aimed at children under 12, not just food, all advertising. Parents and carers want the very best for their children and this ban would remove the direct influence of the vested interests of commercial companies on children. We believe this should be a statutory change.

For the benefit of everyone to allow them to make healthy choices, there should be statutory improvements to food labelling so people can truly understand what they are buying and eating. We believe that voluntary guidelines have proved ineffective and feel that mandatory standards to improve food labelling should be introduced.

NHS Health Scotland has stated that access to good affordable healthy food impacts more on diet than health education. For those families that exist on a low income improving access to good affordable healthy food should be a priority. The health benefits would extend beyond better dental health to other key Government priorities such as preventing obesity, coronary heart disease, stroke, cancer and diabetes.

7 Tobacco Control

Tobacco is a major cause of premature death and disease both for general and oral health; specifically periodontal disease and oral cancer. In addition to more stringent enforcement of current laws on retailing and using tobacco with regard to children, the Scottish Executive should enable legislation to ban smoking in public places. The evidence that passive-smoking kills is now incontrovertible as confirmed by the English Chief Medical Officer, Sir Liam Donaldson in July 2003. He stated that people who live with smokers have a 20-30% higher risk of lung cancer and heart disease and that passive smoking is associated with cot death, asthma, respiratory illness and middle ear disease. No one should be involuntarily exposed to second-hand tobacco smoke. This should be achieved by education and encouragement in domestic situations so parents and other adults stop exposing children to smoke in the home and by legislation and regulation in the workplace and in public places such as hotels, railway stations, bus stops, bars and restaurants.

8 School Based Prevention

The provision of chilled, attractive drinking water from fountains in schools is essential. Plain milk in schools is also safe for dental health. We welcome the recommendations in "Hungry for Success," specifically steps should be taken to make healthier choice more readily available and to make sure that any advertising contained on the casing of vending machines is in line with the whole school approach. The removal of soft drinks and confectionary vending machines from schools premises is suggested as a medium-term objective.

We can see the benefit of reintroducing universal free school meals for all children as a way to avoid the stigma currently associated with the free school meal system and to ensure every child has a balanced diet at school. Ideally, school meals should be of such high

quality that children, parents and carers would prefer to access them in schools. We applaud the introduction of fresh fruit in schools.

9 The NHS and Dentistry

The three central tenets' of the NHS are;

1. that care is free at the point of treatment
2. that care is funded from general taxation and
3. that care is available regardless of ability to pay

When the NHS was introduced in 1948, dentistry was initially free but direct patients charges were introduced in the early 1950s thereby removing the first two ideals of the NHS. Therefore, dentistry has always been viewed as slightly outside or apart from the NHS. There is a need to re-integrate dentistry into the NHS.

10 Workforce

The shortage of dentists and supporting oral healthcare professionals (PCDs) in Scotland is inevitably reducing access to dental care and must be addressed by training more dentists and PCDs. Scotland has one of the lowest number of dentists per head of population in Europe.

11 Secondary Dental Care Services

Secondary care dental services are essential for patients who require care which is beyond that provided in the GDS. The influence of the secondary care sector is important for sustaining and supporting all primary care dental services. Throughout Scotland there is a shortage of consultants in the specialities of Oral and Maxillo-facial Surgery, Orthodontics and Restorative Dentistry. Long waiting lists for these specialities confirm the shortage. There is an urgent need to expand secondary care services in all parts of Scotland to ensure that patients receive the specialist care they require and that the primary care dental services are properly supported in patient care.

Within the Universities there must be transparency of funding for training dental students. There is currently a tension between the influence of the research assessment exercise which rewards Universities on excellence in research, not on the need to educate undergraduate dental students and PCDs.

12 NHS Systems & Infrastructure

NHS dentistry has been a huge success as seen by improvements in oral health since 1948. A large part of the population has received effective care but there is now dissatisfaction with the current system and oral health in children has reached a plateau.

Any new system should promote a holistic and preventive approach to oral healthcare provision. Patients must be given a clear understanding as to what is included in NHS dental care and what will be excluded. Oral healthcare provision should evolve (i.e. no "big bang") and recognition must be given to the fact that there is no single solution that will fit all circumstances in all parts of Scotland. In introducing any new system there should be no detriment to existing practices or practitioners

Robust IT systems must be provided to encourage integration of dentistry into the NHS. As a start the NHSnet must be available to general dental practice to integrate dentistry with general healthcare. This was recently announced for Community Pharmacists (HDL(2004)02, Connection of Community Pharmacists to NHSNET) and the same development should be extended to dentists.

13 Health promotion and health education

Dentists and other members of the dental team have an important contribution to make to health promotion and health education. Professionals complementary to dentistry (PCDs) – dental nurses, hygienists and therapists – should be trained and encouraged to take on greater educational and preventative roles in primary care. This wider role for PCDs would bring several benefits; alleviating some of the responsibilities of the dentist, promoting job satisfaction amongst PCDs themselves and widening access for patients.

14 Education & Training

We need to train more dentists and PCDs. The dental schools in Dundee, Edinburgh and Glasgow require support and funding to train the dental workforce of tomorrow. Outreach teaching, as part of dental undergraduate training, is an exciting development but it needs to be educationally robust and well funded from new monies.

15 Personnel and management systems

A critical element in this process is efficient and robust management systems and personnel. No longer is it be appropriate for dentists untrained in management and human resources skills to provide the senior management role in their spare time between treating patients. The personnel involved must be appropriately skilled and remunerated and this must be an element fully considered in the development of this process.

BASCD response to the specific questions within the SEHD consultation document.

1. EXTENT AND NATURE OF NHS DENTAL SERVICES

1.1 What services should come within the NHS for the future?

There are large parts of Scotland where access to NHS primary care services within the GDS is now very limited. Indeed there are areas, particularly in rural Scotland, where access to any dentist is impossible without the patient having to travel considerable distances. This situation is unacceptable in a country committed to addressing inequalities in health provision.

To have any credibility health services must be able to provide emergency care for their population. Access to emergency dental care should be available to everyone in Scotland and any new system must include a comprehensive emergency dental service. Obvious linkages to NHS 24 as a single point of telephone access to the NHS must be developed.

Permanent registration for children with an NHS dentist (as happens with their doctor) should be extended until they reach 18 years of age. This ensures they have access to

emergency dental care, routine care and preventive dental care. This would require a change to the national terms and conditions under which dentists work.

A fully comprehensive NHS dental service should be available to all. However, the availability of NHS care is entirely dependent on funding, of which there is little mention in the consultation document.

1.2 Should services be prescribed and limited or unlimited?

Services provided on the NHS should be effective and clinically necessary. Purely cosmetic dentistry should not be available on the NHS.

1.3 What system should there be for reviewing and updating?

There will be changes and evolution of any system in response to changes in population demographics, new evidence of clinical effectiveness, changing disease patterns, etc. The system chosen should be transparent and accessible. All information included in a review should be accessible for patients and healthcare providers and an evidence-based approach to policy should be promoted. There should be adequate lead-in time of at least 12 months if possible.

1.4 What is the right balance between preventative and repair services and what, in particular, should be included in the former?

Systematic reviews of oral health promotion have shown that prevention of oral disease on a one-to-one basis is effective. In a holistic approach preventive care must be central to all patient care for both children & adults.

Fissure sealants should be available on the NHS where clinically indicated.

1.5 Should the 'dental public health' role of CDS be kept separate from the 'family health' role of dentistry in the community?

The role of the Community Dental Services is defined in central guidance: DGM(89)15 and updated by NHS: 1997 PCA(D)10. The activities the CDS carries out are listed below and should substantially remain:

Oral Health Promotion - The promotion of good oral health encompasses toothbrushing, diet, appropriate use of fluoride, avoiding tobacco and regular attendance at a dentist. Oral health promotion programmes must be maintained and must continuously develop based on evidence of effectiveness. Multidisciplinary working is one way to improve effectiveness through closer working with the rest of the primary care team and Local Authorities

Special Needs Dentistry - There are groups of people who have additional individual needs with regard to dentistry. Primary prevention of dental disease is one essential need. New systems of working must ensure that vulnerable individuals continue to receive the preventive care/advice and treatment they need.

Safety net function - The CDS provides facilities for a full range of treatment to patients who have experienced difficulty in obtaining treatment in the GDS. This is the safety net function of the CDS. To provide a safety net for all adults the CDS would be unable to undertake the dental care of vulnerable groups.

Specialist Services (Dental General Anaesthesia & Sedation) - In fulfilling their complementary and supportive role to the GDS, the CDS currently provides a referral service for patients for whom routine dentistry is a challenge (e.g. individuals with challenging behaviour, people with disabilities, phobias, mental health problems, learning disabilities, very young children, etc). General anaesthesia should only be used when clinically necessary and should be provided within a Hospital (HDL(2001)29). The development of conscious sedation (relative analgesia) is strongly supported and other sedation services must be developed. Sedation is also available in General Dental Practice and should be an integral part of this strategy to provide alternatives to general anaesthesia for dental treatment.

Dental Inspections - In accordance with central guidance, DGM(89)15 and 1997PCA(D)10, the children identified with asymptomatic disease should be directed to GDPs for their routine dental care where this service is available. In areas where there is no GDS available, the CDS provides treatment for schoolchildren.

The Community Dental Service carries out school dental inspections and they have the experience and expertise to carry it out cost effectively. It provides invaluable data on oral health and disease across the UK, for the performance assessment framework and must be maintained. Other models could be explored and evaluated to see if they have demonstrable benefits while maintaining the data quality we currently enjoy.

There would be benefits in closer working between CDS oral health promotion and general health promotion services and personnel. Public Health Practitioners should also be involved in this closer working especially in rural areas. Establishment of joint posts between health and education departments of Local Authorities has also enhanced partnership working in schools.

The CDS also has a safety net role for priority groups. (e.g. special needs and children especially in rural areas). Any new system should be designed to provide general dental services for all groups obviating the need for this safety net. However, we recognise that this will not always be achievable and this vital safety net function should be retained.

2. DELIVERY OF NHS DENTAL SERVICES

2.1 What are the views on the range of delivery and funding options?

NHS dentistry should remain available on the High street and in Health centres. There are advantages in groups of dentists working together to avoid professional isolation but easy patient access is essential.

As the Bloomfield report, a "Fundamental Review of Dental Remuneration," stated in 1992 the efficiency of the GDS is readily acknowledged.

The fee-for-item system in general dental services means that time taken away from the dental practice results in a significant loss of earnings. The overheads of running the practice continue to accrue. This may be a factor in further isolating dentistry from the NHS. No one doubts the benefits of training, audit, clinical governance and management in the NHS, but they must be properly funded within the GDS to reflect the true costs to independent contractors. This will also apply to any period of change if a new GDS system is introduced.

The process of moving a dental practice from the NHS to private or independent provision often involves accurate assessment of the costs of running the practice. Often, this is then converted into an hourly target for the practice to remain financially viable. This business

planning may be an approach that the NHS could adopt for independent contractors. We suggest that any new NHS system of remuneration could be broadly based on the true costs of running each dental practice. This will avoid a one-size fits all approach. It will also be fairer as the true cost of the service will form the basis of the remuneration system. Direct reimbursement of these running costs, as happens in general medical practice, should be considered. Retention of some element of fee-for-item payments maintains an incentive for an efficient service but the current fee-for-item list of over 400 items must be radically rationalised.

2.2 "Are there specific issues about future funding of infrastructure, e.g. premises?"

GDPs are independent contractors who have traditionally assumed all of the entrepreneurial risk associated with general dental practice. This risk is now unwelcome by many dentists. This is clearly an issue that needs to be addressed within any new national system.

Practices which undertake training of any member of the dental team should be fully supported in this role.

2.3 "Should we continue to allow dentists to decide themselves where to practice on the NHS?"

While GDPs are independent contractors and assume all of the entrepreneurial risk associated with general dental practice, there is little chance of influencing dentists as to where they practice. In other words we rely on market forces. The private funding of GDS dental premises to provide a largely public service has never been fully acknowledged. The major difference is that in current public sector PFI projects the provider of the capital funding negotiates the fees and charges for the use of those premises while in the GDS the public sector side decides the financial levels. If a new system of contracting with dentists is chosen, then the actual costs of running the practice could be taken into account. A system more like funding for general medical practices and their staff may be an answer.

The investment of existing GDS practice owners should be protected from financial risk as a result of changes in Scottish Executive Health Department policy. This is necessary to maintain support for and stability of current NHS practices and to protect the livelihoods of the considerable number of staff working in general dental practice.

To address access inequalities the NHS will have to develop a new system which directs dentists to work in areas of need.

2.4 "Are there other approaches or incentives that merit consideration?"

It is widely acknowledged that funding in the form of commitment payments, practice improvement grants, practice allowances and Dental Access Initiative grants are effective and have helped dentists in recent years. Evaluation of these and other current recruitment and retention incentives must be undertaken to guide policy and learn how best to attract NHS dentists to specific areas.

The current eligibility criteria for grants and fee for item payments ignore quality and are based on measuring "output" rather than "outcomes". There should be a move towards measuring NHS commitment in terms of outcomes that lead to improvements in oral health. Conditions of service based on "time" commitment to the NHS might be fairer. Quality could be measured in other ways; recognition of a second registerable qualification, postgraduate activity, dental reference officer gradings, etc.

2.5 "How best should any new arrangements be put in place?"

We suggest a measured approach to make sure emerging mistakes can be corrected and in recognition that there may be no single solution that will fit all circumstances in all parts of Scotland. In introducing any new system there should be no detriment to existing practices or practitioners. A situation where the old and a new system run in parallel might exist. Any new system should promote a holistic and preventive approach to oral healthcare provision. Patients must be given a clear understanding as to what is included in NHS oral healthcare provision and what will be excluded.

3. Patient Charges

As the Bloomfield report on a "Fundamental Review of Dental Remuneration" stated in 1992 the efficiency of the GDS is readily acknowledged. We agree that the GDS treadmill is unacceptable but note that changes to the current system will need to try to maintain the accepted efficiency of the GDS.

3.1 What principles should be pursued in determining a system for patient charges?

The approach of abolishing all patient charges and making primary care services fully funded through general taxation is attractive. Patient charges provide a resource for funding the current system, (currently £50m in Scotland), how would government match this if charges were abolished?

Whilst accepting in the current system that patients make a contribution towards their treatment costs, if this is retained it should not be a disincentive to receiving treatment. Treatment for children and students should remain free. The principle of a maximum limit on the patient's charge should also be retained.

Emergency care and preventive care should be free for everyone.

3.2 What are the views on the options listed?

We have few comments about the options except that charges should be simple and fair. The patients charge could reflect the true cost of any item of treatment so a percentage charge or a charge based on treatment time seems intuitively fairer. While intuitively this may seem fair it does mean that those with the highest disease levels pay proportionally greater fees for their dentistry. As we know that those from the lower socio-economic sectors have higher disease levels they will be less likely to attend for treatment. We also know that cost is a barrier, not just to the lower income sector that may be exempt so currently receive some help, but also to middle income families.

Devising a fair and equitable system for NHS dentistry which does not restrict access to some sectors of the population is difficult and may be a good reason for abolishing patient charges altogether.

3.3 Are there other approaches that merit consideration?

Dentists are currently responsible for bad debts which is unfair to NHS dentists as they are out-of-pocket when patients failed to pay for their NHS treatment. No other health professional faces these risks and such debt should instead be collected by SEHD centrally.

Perhaps exemption categories should be consistent across the NHS so that patients understand exactly the range of treatments and care they are entitled to.

Comment:

It is assumed that dentists join the private sector to simply make more money. This does not appear to be universal as suggested by broad analysis of income tax returns. Issues of clinical freedom and freedom from bureaucracy and quality of life are acknowledged. Stress is one of the factors cited by dentists when leaving the NHS workforce, along with early retirement. A survey commissioned by the Scottish Committee for Postgraduate Medical and Dental Education (now NHS Education for Scotland) in 2000 (toothousand report), reported that two-thirds of general dental practitioners planned to retire early, with stress identified by a third of general dental practitioners (GDPs) as a reason for early retirement. The NHS may have lessons to learn from best practice in the private sector in order to improve the provision of NHS dentistry. A Dental Business Trends Survey published by the BDA between 1998 - 2002 reported that financial advisors, banks and accountants, believe that NHS commitment has a detrimental impact on a dental practice's financial viability. Clearly this must be reversed.

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