619 LONDON ROAD
BRIDGETON
GLASGOW
G40 1NE

MODERNISING NHS DENTAL SERVICES IN SCOTLAND (CONSULTATION)

A response by Graham McKirdy B.D.S. M.F.G.D.P.
General Dental Practitioner (Glasgow and Hamilton)

If access to NHS dentistry in Scotland is going to be saved then SEHD must tackle five main areas:

Funding
Workforce
Premises
Bureaucracy
I.T.

The principles that should underpin the way forward are:

Trust
KIS (keep it simple)
Ability of CSA to make payments

My personal comments are made in the following pages

Parts 1 and 2 are self-explanatory

Part 3

3.1.2. Supporting NHS Dentistry

The document lists the various incentives introduced by SEHD with agreement from S.D.P.C. (Scottish Dental Practice Committee) to support NHS dentists.

Unfortunately the take up of these has not been universal as shown by Practitioners Services Division of C.S.A in a report released on 3/02/04.

The new general dental practice allowance has only a take up of around 60% of practices, there has to be a real concern as to why.
In monetary terms instead of around £4.3m going to support NHS practice the actual spend is £2.5m. On this allowance alone, there is a potential shortfall of up to £1.8m.

Also of concern, has to be the fact that the remote area allowance only 1 in 3 dentists eligible have claimed.

3.2 Workforce Planning

S.E.H.D. acknowledge that while in crude numbers there are an increase in dentists, there is in reality a fall in whole time equivalents and list the major factors.

Unfortunately these statements do not reveal the true facts of the three biggest factors.

Older Dentists

In evidence to Doctors and Dentists Review Body 2003/04, Appendix A by the D.o.H., shows numbers of dentists in age bands over a twelve year period (each band covering 5 years). These are for England and Wales but I am certain Scotland would show same trend over the period.

In the period 1990/91 to 2002/03 it shows: -

An overall 3% rise in total number of dentists. But!
A **drop** of 49% in dentists under age 30,
A **drop** of 24% in dentists between ages 30-34.
A **rise** of 48% in dentists between ages 50-54.
A **rise** of 46% in dentists between ages 55-60.
A **drop** of 26% in dentists under age 60,

I would welcome the increase in dental workforce proposed but as these statistics show there is a large shortage in dentists under age 35 who are the potential providers of NHS dentistry over the next 25 years.

Women Dentists

In 1990/91
There were 5126 dentists under age 34
1534 (30%) were women

In 2002/03
There were 3280 dentists under age 34
1420 (43%) were women

There has been an overall drop of 114 (8%) in this period and this is the age group is where women are most likely to have families.
Some will come back full time, but most will either work part time or have a career break until families are older. This is likely to have a major effect on whole time equivalents.

There is an enhanced return to work scheme. This is not enough, as it only looks at those who have not worked for several years. S.E.H.D. must look at ways of supporting these dentists to allow greater choice to return to work.

Private Dentistry

There has been huge growth in private dental provision.

There are various factors: -

Patient demand to have more time and better materials not available under the NHS.

Patient expectations and demand are raised without the supply side being funded.
Large increase in demand and provision of cosmetic treatments.
Increased non-funded government legislation in health and safety, cross infection control and employment falling solely on practice owners.
The continued and increasing failure to fund properly over the last twelve years the costs of running an N.H.S. dental practice

Part 4 is self-explanatory

Part 5

5.1 and 5.2 I would agree with. However unless the funding is greatly increased no matter the change, there will be no future for N.H.S. dentistry. Increased funding has to be fundamental otherwise it will be like moving the deckchairs on the Titanic.

I believe that SEHD has recognised this, with the supporting payments made to Scottish GDPs, which have helped. However these payments are "sticking plaster" solutions at best.

5.3 States that there needs to be more powers to Health Boards. I strongly believe that whatever changes take place they should be Scotland wide and not based on local control. Local control will only lead to more bureaucracy and costs, while not necessarily delivering more service.

Is there the experience and willingness to have multiple delivery systems across Scotland?
Will there be a postcode lottery for treatment?

It may be that we can see what develops in England over time and learn from their experience.

I.T. systems must be in place to support N.H.S. dentistry.
There must be full funding for capital costs, software costs, training and future upgrading costs. At present the one off £700 grant does not even meet the costs of linking up to C.S.A. never mind the costs as above.
It is wrong that dentists delivering N.H.S. care are funding I.T. out of their own pockets or are subsiding it from private patients.

THE QUESTIONS POSED AND MY RESPONCE

Part 6

This rightly refers to instability and risk, the lessons of 1990/92 are detailed earlier and cannot be ignored.

It is my belief that the three areas covered are in the incorrect order.

If you are to make change you have to detach patient charges from the system. Then look at the delivery system and lastly what it could/should deliver.
My response will follow this pattern.

6.4 Patient Charges

Assumptions: -

After 14 years of experience on BDA GDSC/GDPC Remuneration sc I am totally convinced that patient charges must be detached from the system.

SEHD wish to recover the same amount of patient charges either as the amount or as percentage of current level (£54m).

SEHD wish to deliver free examinations

What dentists and patients wish from a system is that it is simple to collect, easy to understand and need to eliminate fiddly amounts. Exemptions must be simplified to avoid confusion and potential fraud.

COLLECTION

While moving payments to third party collector (Post Office/Health Board) may seem attractive there would be cash flow effects. I question would transfer of information as to who has or has not paid to practices be easily made. If a dispute arises, then yet another party would be involved.

BAD DEBTS

I believe strongly that GDPs should be able to pass on these to NHS, on whose behalf they have to collect. This could be after a set recovery system of say, two or three standard letters.

TAX ON HEALTH

As most dental disease is preventable then charges should be levied on need or requirement of treatment. However the maximum charge should be looked at. Is it set too high or too low, should it be dependent on the system of charging agreed.

EXEMPTIONS

There must be a simplified partial or total exemption system for those that cannot afford NHS dentistry.
In the short term a simple exemption card system be introduced. This would be straightforward for staff and patients and reduce confusion.
A medium term IT solution could be found.

As the majority of young people go on to further education it must be administratively costly to check exemptions. While keeping payments starting at age 18, I would automatically exempt patients under 21 who are in full time education, unlike the current age 18 only.

Six possible systems are listed, what could work?

Single charges for specific procedures - Yes - My preference

Single charge for a filling £A, a crown £B, x-ray £C examination £D...
This could produce a sample estimate, which is simple to understand and have clarity for patients and dental staff.

TREATMENT	NHS COST	NUMBER	TOTAL
EXAMINATION	£0	1	£0
X-RAY	£3	2	£6
GUM TREATMENT	£20	1	£20
FILLINGS	£10	2	£20
CROWN	£90	1	£90
TOTAL			£136

All the above are indicative, knowing from CSA the numbers of treatments, then a spreadsheet could give estimation the amounts that would have to be charged for each "family" of treatments.
It would also allow for lower patient charges for preventive treatments and higher for repair treatments and zero charges as SEHD wish.
It could also lead to patient charges being more than 100%, but this exists in prescription charges currently.

Change to the percentage (or amount) charged depending on the nature of the service.

YES to the amount
NO to differential percentages.

My understanding is such a system would have price bands and that treatments would be put into an appropriate band.

There should be an optimum number, say 10-20.

Change to the percentage (or amount) charged depending on the patient's characteristics e.g. age, dental status

Fixed charge for each visit, which could be related to time in the practice

Separate payment arrangements for dental appliance (dentures, bridges, crowns) rather than through the fee related system.

These for varying reasons would be even more administratively difficult to apply and would be even more confusing for patients.

Insurance type system (similar to some private dental plans) with or without assessment of dental health.

This could work with an assessment, but who pay the administrative costs per month for collection and could be very difficult for practices to update records month by month without IT.

6.3 The Delivery of NHS Dental Services

In Scotland patients receive a high standard of treatment within the confines of what the NHS allows.

The method of funding at its most basic is a way of paying dentists, the current system is in difficulty.

Any change must be gradual rather than big bang so as to reduce risk to dentists (and staff), SEHD and patients.
It should be a Scottish system with possibly some local additions on the margins.
Piloting would be advantageous but given time scales and the current crises do we have that luxury?

Item of service

The most common method of funding is item of service.
Any change should still retain this as its core but must tackle what has undermined this system. These are the funding shortfalls and the huge increase in non-remunerative time in dealing with red tape, cross infection control and meeting government non-funded policy.

In the short term, payment should have practitioner basis but increased amounts should be moved into (targeted) practice funding. The long-term goal may be total practice funding but the potential disruptive effect of this method cannot be underestimated.

Simplification of existing fee scale can be possible if patient charges are detached. Previous UK attempts on extractions and fillings have proved to be difficult.

Many dentists could welcome greater support for staff and infrastructure costs in return for specified NHS commitment.

Premises

Premises are one of the problems and the solution is key to solving access to dentistry.

Most practices are in unsuitable premises due to chronic historical capital under funding; it is being brought into focus by the DDA act and its full

implementation in October 2004. This is increasing the number of NHS practices that are unsellable and unattractive to young dentists.
Is single-handed practice the future? I think not.

A menu of methods of capital funding must be introduced ASAP with the simple focus of making ownership of a dental practice more viable and attractive. This does not necessarily mean non-dental ownership of the building, but this should be an option.

New premises should not only replacing like with like, but look at future needs for delivery of dentistry by PCDs, outreach and ability to meet new legislation.
It is also important to look at the investment that some practices have already made, often funded by private treatment money. If the package were attractive, some may be persuaded to increase their NHS commitment again.

Legislative Issues

There are increasing employment, family friendly government policies, cross infection and environmental legislation being introduced, in what appears a weekly basis. Administrative and funding support of these edicts must be part of a package. This is an area practice owners are being hammered on at present and in turn increases stress, leading to young dentists having no wish to own a practice.

As a practice owner there are legal penalties attached to the above. What about my quality of life and stress values?

Capitation

Funding by solely by capitation I am against.

After the introduction of capitation to pay for children's dentistry, within two years it was obvious that capitation based on age was a disaster to those dentists working in high caries areas (i.e. Scotland). In 1996, negotiation led to a mixed item of service and capitation payment system being introduced.
This addressed the funding problems for dentists treating high caries children.

There is a lesson also here that a mixture of payment systems, if simple, can be used. It was also possible to make this change, as there is no patient charge on children's payments. This allowed negotiations to proceed with out having to take patients charge into account.

Registration

This must continue and be extended to two years.

Sessional or Block Payments

I am against as a payment system, but there is a place for specific parts. Sedation services and emergency time are two examples where sessional payments could be used.

Quality payments

Incentives for meeting quality targets, yes but who decides the targets and it should be new money not redistribution. Carrot rather than the stick.
It is noticeable that in the rest of the NHS, almost all promoted posts require a further degree but in GDS there is no reward for this.
How many MSc graduates are delivering GDS NHS care?

Remote and Rural

The whole issue of remote, isolated and single-handed practices needs to be looked at urgently. There needs to be better support, where there is no alternative, if due to geography.

Salaried

Salaried practice could be part of a delivery package especially for dentists with young families and older dentists.

There would need to be separate funding for the practice to support other costs. Currently a big problem for practices owners is that they need to use a surgery full time to meet capital and revenue costs.

6.2 The Extent and Nature of N.H.S. Dental Services

What services should come within the N.H.S. for the future?

Ideally it should deliver treatment and not cosmetic dentistry, the problem is of definition. If however S.E.H.D. cannot fund fully a comprehensive system, then it should be up to S.E.H.D. in consultation with the public and profession to decide what can or cannot be included.

Core or Essential services fall into three areas, limitation by treatment, limitation by patient type or a combination.

When limited by treatment the issue of those patients who cannot meet treatment costs need to be addressed. For example molar root treatments are excluded. Does this mean if you are on income support, you will only have extraction of a tooth as your choice?

When limited by patient is S.E.H.D. willing to tell people who pay their taxes to support the N.H.S. that part or all treatment will not be available?

Until the system and funding is known, I am not willing at this stage to list my options.

It is vital that S.E.H.D. remember that whatever method is chosen this will have a detrimental effect on the value and attractiveness of practices in the more deprived areas in Scotland, where need is greatest.

Should they be prescribed or unlimited?

Whatever is chosen it is essential that there is clarity to all, dentists, staff and patients what is in and what is out. It must be black or white.

What system should there be for reviewing and updating?

There should be a system that involves all the directly affected groups, Patients, S.E.H.D. and G.D.S. dentists.
All others with a view should only have a supporting role.

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

I think it is important to state here that there is not going to be a reduction in need and demand. The main reason for this is not the level of decay in the younger population but the impending big increase in the older age groups. There is a huge increase in the numbers of older people keeping all their natural teeth. This will result in much greater demand to maintain these teeth in the retired age groups. Due to physical and mental degeneration, patient oral health maintenance will diminish. Side effects from drugs and the natural slowing of salivary flow will lead to more decay.
Preventive measures need to be from birth to death and most are best effected by P.C.D.s, Health educators and others.

The aim of dentistry in Scotland should to have natural teeth in our corpses.

What government can carry do.

To reduce demand for treatment, government has a vital role to play. Fluoridation of the water supply must be considered. If not then other measures must be considered.

Adding V.A.T. to all sugar containing products, hopefully to reduce intake, this would also help in the general health of population in other ways such as diabetes.
The mouth is not detached from the body. Today's bad children's teeth are tomorrow's heart and diabetic problems. This increased tax could be diverted to support dentistry.

7% of children have 50% of the decayed teeth, they must be identified and targeted for the oral and general health of these children.

There must also be better labeling, not just for sugar content, but also acidity warnings.

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

This is not a clear question, but if it means that all branches of dentistry should work together, the answer is yes.

Other Issues not covered by Consultation Document

England

With the huge change in England taking place in April 2005 SEHD cannot ignore its possible effects. If we lose 50 dentists to England this would be more significant, than England losing 50 dentists to Scotland There will also be lessons on patient charges collection, oral health assessment, pensions and intended practice payments.

Practice Staff

Therapists

In GDS they will be new and will take time for dentists and patients to accept their role. Large number of practices cannot due to space pressure accommodate extra staff. It should be noted that as with Hygienists they require the same levels of staffing, cross infection control and other costs so there will be not so great a cost saving as some may think.

Hygienists

Currently an accepted part of the team in most practices, but are costly and current system does not take this into account. Should have a greater role in prevention and must be funded.

Dental Nurses

With registration coming and the change in training (SVQ) not properly in place there is a huge concern for the future. They do a wonderful job but are generally underpaid and have no access to the NHS pensions scheme. Retention for many practices is difficult.
Coverage for illness, training and maternity would improve access and patient care.

Reception Staff

They play a vital and much ignored role in delivering dentistry and again are generally underpaid and have no access to the NHS pensions scheme. Retention for many practices is difficult

Manager

Larger practices have been forced, due to increased legislation to employ managers (usually ex DSA). Funding is not built into current system and SEHD should look at a system of proper training, funding and part time availability to support small practices.

Dental Technicians

There is a dire shortage and unless this is urgently addressed then delivery of dentures and crowns in the future will be compromised.
The funding of NHS fees with laboratory costs has not increased beyond inflation and has put huge financial pressure on laboratories.
Look at the price of gold, silver palladium and especially platinum in last year and ask will 2.9% on treatment items meet this?

Training

Better and funded training for all members of the dental team is required. Recognition must be made that when staff are not available, then the delivery of dentistry is affected and there is cost to practice owners to meet this.

Prior approval

There should be some system in place, but an agreed definition of what it is designed to achieve.
There is a large resistance by paying patients. The SEHD pay 20%, but SEHD can have a final decision on treatment which patient needs and has agreed with their dentist.
A solution could be that if cost based, it could be higher for paying patients.

CSA Dental Practitioner Services

There are limitations on the MIDAS computer payment system to cope with even minor change. This must be borne in mind by all parties when future change is planned.

Regional Officer Service

The current system is not working, only 37% of patients attend, leading to GDPs and others questioning its effectiveness.
This needs to be improved.

Doctors and Dentists Review Body

It is my personal view that the DDRB is the single most important cause of the crisis in delivery of NHS dentistry.

It has failed dentists, government and most importantly the public since 1993. DDRB have ignored the changes taking place and failed dismally to retain dentists in the NHS. As to recruitment, they're other remit, ask a young dentist if they wish to work in a GDS NHS practice for the answer to that!

SEHD would seem to agree with my assessment using the evidence of the introduction of allowances and incentives introduced in Scotland over the last three years. These have been welcomed but are they too little too late?

I have expanded on my DDRB views in the attached appendix.

REFER to appendix 1

I hope that this is consultation will lead to genuine and long lasting improvements to delivery of NHS services in Scotland. GDS is on edge of a precipice, this could be the last chance for NHS dentistry.

Graham McKirdy BDS MFGDP
grahammckirdy@btopenworld.com
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APPENDIX 1

Doctors and Dentists Review Body

In October 1990 the "new dental contract" was introduced. It introduced patient registration, the right for out of hours cover to these registered patients, a capitation payment system for children and the prior approval level was set at £600 and not based on treatments.

It should be noted that over 70% of Scottish G.D.P.s voted against it.

It was anticipated by government and the profession that output would drop by 3% as dentists did different work. In fact output rose by an astonishing 10%. This meant that many more patients were seen and treated; in any other business this would have been a major success.

However the government of the day decided it could not afford this level of treatment and discussions were started on reducing the total spend on G.D.S. dentistry to the level budgeted for. The D.D.R.B. recommended an award on dentist's net pay of 8%. Despite this the government cut fees on gross income (turnover) by 7% and reduced prior approval to £200.

Following a legal ballot G.D.S. dentists voted heavily to stop seeing adult fee paying patients under the N.H.S. There was not an immediate mass change but over the last 13 years more and more practitioners have reduced their N.H.S. commitment.

After this the D.D.R.B. stated that they would recommend an increase in gross fees while the government and the profession negotiated a way forward. There was running parallel to this, the Bloomfield report. This report led to no change.

To this day there has been only D.D.R.B. awards on gross pay (turnover). There have been several years where the award was staged which lead to the actual award not being paid. Apart from the financial loss in turnover it also meant that dentists were operating two fee scales in one financial year this was an administrative burden and also confusing to patients.
In year 2003 GDS dentists had to operate three fee scales!!!!

One other effect of an award on gross fees was that dentists could never receive the actual award given. It only applies on treatment started after the award date. If salaried then full ward given say from 1st April. In the case of G.D.S. dentists all patients undergoing treatment some lasting months after the 1st April did not attract the recommended rise. This year the B.D.A. in evidence quantified this as a 7% loss on actual award. This means that last years D.D.R.B. award of 3.225% would actually deliver 3.0%.

The recommendations from D.D.R.B. were almost the same as those to salaried employees. This meant that they did not account for increased costs properly.

Each year these actions led to more G.D.P.s reducing their N.H.S. commitments to meet their financial costs and improve their practices.

Dentists over the years have lost trust in the system actually delivering a proper reward and meeting their costs. So much so that the D.D.R.B. award is now a non event and most dentists do not perceive the D.D.R.B. as independent.

The 2004 award gives the latest example of what has occurred over last 11 years.

GDPs and their staff as utterly condemn a 2.9% rise in fees (real increase because of lag effect 2.7%). Will this retain dentists far less attract dentists to increase their NHS commitment?

I pick out three parts to justify my first statement from 2004 report.

3.45 Lag effect

DoH estimated the cost of meeting lag effect would be £12m in England
3.49 DDRB
Comment: *We do not intend to re-open the matter at this time....*

They have DoH admitting lag effect and costing the loss to GDS dentists then do nothing about it.
Loss per dentist = £600

3.61 Expenses

BDA had stated that due to increased private work being more profitable this was undermining the expense ratio (statistically reducing the actual costs to NHS practices)
3.64 DoH investigated this and *The department said this showed that NHS earnings (turnover) weighted results produced an expenses ratio only two percentage points lower than the result covering all dental work.*
Loss per dentist = £2700 (2% of £136,632; 3.59 of report)

3.68 Capital Support and return on capital

3.76 *We must repeat our view set out in previous reports, that we do not consider capital support to be strictly a remuneration issue and therefore it is not within our remit.*
As they have applied a percentage on turnover since 1993, just whose remit is it?
Loss per dentist = unknown

British Dental Association figures show, over the last ten years, the spend on dentistry as a proportion of NHS spend has gone from 5% to 3%.
If the percentage were nearer 5% today, would the access problem exist?