Response to Scottish Executive consultation: Modernising NHS dental services in Scotland

March 2004

SCC Scottish Consumer Council
Making all consumers matter

About the Scottish Consumer Council

The Scottish Consumer Council (SCC) was set up by government in 1975. Our purpose is to promote the interests of consumers in Scotland, with particular regard to those people who experience disadvantage in society. While producers of goods and services are usually well-organised and articulate when protecting their own interests, individual consumers very often are not. The people whose interests we represent are consumers of all kinds: they may be patients, tenants, parents, solicitors' clients, public transport users, or simply shoppers in a supermarket.

Consumers benefit from efficient and effective services in the public and private sectors. Service-providers benefit from discriminating consumers. A balanced partnership between the two is essential and the SCC seeks to develop this partnership by:

- carrying out research into consumer issues and concerns;
- informing key policy and decision-makers about consumer concerns and issues;
- influencing key policy and decision-making processes;
- informing and raising awareness among consumers.

The SCC is part of the National Consumer Council (NCC) and is sponsored by the Department of Trade and Industry. The SCC's Chairman and Council members are appointed by the Secretary of State for Trade and Industry, in consultation with the First Minister. Martyn Evans, the SCC's Director, leads the staff team.

Please check our web site at www.scotconsumer.org.uk for news about our publications.

Scottish Consumer Council
Royal Exchange House
100 Queen Street
Glasgow G1 3DN

Telephone 0141 226 5261
Facsimile 0141 221 0731
www.scotconsumer.org.uk

The SCC assesses the consumer perspective in any situation by analysing the position of consumers against a set of consumer principles.

These are:

ACCESS

Can consumers actually get the goods or services they need or want?

CHOICE

Can consumers affect the way the goods and services are provided through their own choice?

INFORMATION

Do consumers have the information they need, presented in the way they want, to make informed choices?

REDRESS

If something goes wrong, can it be put right?

SAFETY

Are standards as high as they can reasonably be?

FAIRNESS

Are consumers subject to arbitrary discrimination for reasons unconnected with their characteristics as consumers?

REPRESENTATION

If consumers cannot affect what is provided through their own choices, are there other effective means for their views to be represented?

Published by the Scottish Consumer Council
March 2004

We can often make our publications available in braille or large print, on audio tape or computer disk. Please contact us for details.

RESPONSE TO MODERNISING NHS DENTAL SERVICES IN SCOTLAND

INTRODUCTION

The Scottish Consumer Council (SCC) welcomes the opportunity to respond to this important consultation. One of our key objectives is to make markets and public services work for all consumers. There is clear evidence in Scotland that publicly funded dental services are not meeting the needs of many of Scotland's population. This consultation provides an important opportunity for a fundamental reassessment of how the present system is working, and how NHS dental services can be reorganised to meet the needs of Scottish citizens, particularly those from disadvantaged groups.

To inform our response we held a seminar for people working with groups at risk of exclusion from services, including homeless people, refugees, people from ethnic minority groups, and disabled people. Input from the seminar has informed this response.

1. BACKGROUND

Existing services are failing on two counts: they are failing to have a significant impact on the very high levels of oral disease in Scotland; and they are not providing an accessible service which meets the needs of Scottish consumers. Criticisms of the way the service is provided have been powerfully made by the Audit Commission in England, and by others, and the SCC considers that these criticisms are equally applicable to the situation in Scotland.

2. CONSUMER TESTS

Looking at NHS dental services against five of the consumer tests which the SCC uses in assessing policies and services can help to highlight some of the problems with the present situation and offer suggestions for the goals which any reorganised system should seek to achieve.

2.1 Access

An increasing number of people in Scotland cannot access services because they are not available where they live. In addition, even where a service is available, some people are either unable, or choose not to, access it for a range of reasons. This may be because of physical barriers, stairs, lack of transport or parking. It might be because of fear, cost, or the fear of cost, or because of other barriers such as difficulties in communicating with a dentist. Deaf patients often find it very hard to contact a dental surgery to make an appointment, and this is even harder in an out of hours emergency situation. It may be that a chaotic lifestyle associated with a mental health problem or drug dependency means that making appointments and attending them is problematic. Or there may be difficulties for certain patients, for example patients with learning disabilities, in recognising that they have a dental problem or in communicating this to their carers.

The consultation states that one of its aims is to improve access to NHS dental services, and the SCC agrees that this is fundamental to this review.

2.2 Equity

At present there is no equity of provision between different parts of Scotland: some parts of Scotland are relatively well served, while other parts have very few services or none. There are fewer services in deprived areas.

It is also relevant to look at equity in relation to how people pay for NHS dental services. All tax payers at present contribute to the funding of services, but some of these people are unable to access any service. This is inequitable. While some do not have to pay any charges for NHS dental services, for example, children, those on various benefits, and pregnant and nursing mothers, everyone else pays a standard 80% of NHS costs. This hits people on low incomes harder than others, and so is a greater deterrent to poorer people.

The SCC believes we should be moving towards a position in which resources are allocated in relation to need; those in need of services should have equity of access to those services; disadvantaged consumers should not get a poorer service; and the system for funding dental services should be progressive, and not impact disproportionately on those on a lower income who are not exempt from payment.

2.3 Information

In relation to information, the SCC believes that consumers in Scotland should know:

- what dental services are available on the NHS;
- what they are entitled to;
- what they will have to pay; and
- what to do if they are not happy about the care or treatment they have received.

However, the evidence is overwhelmingly that people have very little information about any of these. The Audit Commission report in England showed that people were frequently unclear about whether they were being treated on the NHS or privately, whether their treatment was necessary, and what they were being charged for. Research has shown that most people do not know they pay 80% of NHS costs at present. Work by the OFT last year showed that more than half of those surveyed were not provided with an invoice following treatment.

It would be helpful if any changes to the way dental services are provided make it easier for dentists to communicate with patients, and for patients to get the information they need in all these areas.

2.4 Choice

Choice is probably not a major concern for people who find it difficult to find a dentist who will take them on, whose premises are accessible, or who can provide an interpreter. However, we should be moving towards a system in which people do have a choice. Choice means having an opportunity to get a second opinion, and having a greater chance of finding a dentist who will meet one's needs. For example, some women from ethnic minorities would prefer a female dentist.

Even where there is no choice of dentist, patients want to be able to make informed decisions and choices about their treatment – in partnership with dentists who explain treatment options, and can explain the evidence about different types of treatment. As in other parts of the NHS, patients should be involved in such choices and decisions.

2.5 Redress

In general, consumers in Scotland have a low awareness of how to complain about dental services. This is partly because consumers are not always clear whether they have received NHS or private treatment, partly because elements of both are often mixed, and partly because there is very little information available in dental surgeries about what to do if patients are not happy with the care they have received. This has been clearly shown to be the case in the work done by the Office of Fair Trading (OFT) in relation to private dental services. They found that 70% of NHS patients and 84% of private patients did not know how to complain.

It is important in any review of the way NHS dental services are provided that patients are much better informed about how to complain about or comment on services they have received. There should ideally be one route for all complainers, and complaints about private work should be channelled down a clear complaint route of their own.

3 CONSULTATION QUESTIONS

3.1 What sort of dental services should be provided under the NHS? What services should come within the NHS for the future? Should they be prescribed and limited or unlimited? What system should there be for reviewing and updating?

There is a need to review what is currently provided on the NHS, to ensure that treatment is provided on the basis of clinical need, based on evidence. For example, a six monthly examination is not considered necessary for many NHS patients, and it would free up the time of dentists if they were able to relate the frequency of examination to clinical need. Much current practice is driven by the so-called treadmill effect which results from the piecework system by which general dental practitioners are currently paid. They have an incentive to see patients frequently and to carry out work which may not be

clinically necessary. The most obvious example of this is the scale and polish which almost routinely accompanies a dental check up. The Audit Commission reported that 50% of such scale and polishes are not clinically necessary. They account for 10% of GDS expenditure in England and Wales, and there is no reason to suppose that the figure will be any different in Scotland. A scale and polish, if required, can be done by a dental hygienist or therapist, and does not require the skills of a dentist.

A review of what treatment should be available on the NHS will need to be accompanied by a change in the way dentists are remunerated to remove perverse incentives to provide services which are not based on clinical need. The SCC understands that such a review of the NHS dental contract is likely to follow this consultation.

The SCC believes that NHS dental services should not be limited to a core, but should be provided in relation to clinical need, and be limited to evidence-based practice. This would have the effect of excluding treatment which was purely or primarily cosmetic, or for which there was no good clinical evidence.

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

The balance between preventative and repair services is clearly wrong at present, as described above. While dental practices need to be encouraged to do more preventative work, it is also important to recognise the contribution of many other people to preventing oral disease, and promoting oral health. For example, work carried out by health promotion staff, and projects and activities which encourage healthy eating and tooth-brushing from an early age have considerable potential to improve oral health.

The SCC believes that there is considerable scope to make better use of staff like hygienists and dental therapists, both in preventative and repair work, and to develop team working in dental care. This would have the effect of freeing up time for treatments which need the types of skill and training which only the dentist has.

3.3 Should the "dental public health" role of the Community Dental Service be kept separate from the "family health" role of dentistry in the community?

The "dental public health" role of the CDS service focuses on the screening of school pupils. This aspect of oral health should not be lost in any rearrangement of the service, as it forms part of the safety net, and is particularly important in relation to children's oral health. The SCC is in favour retaining this function in the context of a more integrated service.

3.4 How can dentists' contractual arrangements support the delivery of these services?
What are the views on the range of delivery and funding options listed on page 19 of the consultation document?

The SCC is in favour of moving towards a system based on capitation payments in order to move away from the so-called "treadmill". A capitation system would need to recognise the varying needs of different patients, and be related to an assessment of oral health. Patients could be grouped into one of several bandings, so that capitation and continuing care payments would be broadly related to the level of treatment required.

One danger with a system based on capitation is the possibility of "supervised neglect" whereby the dentist has no incentive to carry out any work on the patient, but simply claims the payment for having the patient on his books. It is therefore important that a change to such a system is accompanied by monitoring and quality assurance procedures to audit the levels of care provided.

The use of salaried dentists, either working in the Community Dental Service, or employed by NHS boards or trusts has been shown to be an effective way of meeting the needs of potentially excluded groups. The SCC supports a greater use of salaried dentists to meet the needs of excluded groups and to provide or improve service where current provision is inadequate.

3.5 Are there specific issues about future funding of infrastructure, eg premises?
Are there other approaches or incentives that merit consideration?
How best should any new arrangements be put in place?

The integration of CDS with GDS should be one aspect of a more extensive integration of dental services back into the NHS. The SCC is strongly in favour of a greater integration of care services in community settings, and can see clear advantages in modern accessible premises being provided with funding from the NHS. In return for being able to relocate in such health centres, dentists could be required to make a commitment to continuing to provide an agreed percentage of NHS work.

3.6 How should patients contribute to the cost of the service?
What principles should be pursued in determining a system for patient charges?
What are the views on the options listed on pages 20-21?
Are there other approaches that merit consideration?

The present charging scheme is problematic in two respects: on the one hand its complexity acts as a deterrent for consumers on low incomes, and limits the amount of dental treatment they can afford to have done; on the other hand its complexity adds to the burden of paperwork for dentists. For both these reasons, the SCC is in favour of fundamental change to the charging

system. As a matter of principle, the SCC believes that funding public services from general taxation is the fairest method, as it is directly related to ability to pay.

One criticism of not having patient charges is that it can lead to a problem of unlimited demand. This is sometimes described as being a problem with GP services, although work in several parts of Scotland has shown how demand can be managed more effectively to ensure that patients are able to see a member of the primary care team within 48 hours. In contrast, where there are charges this has the effect of limiting demand, and charges penalise those who are older, frailer or have a greater need for care and treatment.

The present charging system is regressive as everyone pays the same, up to the current maximum of £372, irrespective of their income, apart from those who are exempt from payment. The people who suffer most are those living on a low income, but not exempt from charges. There is evidence that patients are having to make hard choices about whether to go to the dentist, and what dental treatment to get done, as they are not able to afford everything that is needed. While there is a low income scheme for those who are not exempt from charges, the process of applying for this assistance involves filling in a complex form which would deter all but the most persistent claimants.

Research by the National Association of Citizens Advice Bureaux in 2001 showed that 44% of those surveyed found charges hard to afford. Research from other European countries has shown that user charges increase inequalities in access to healthcare.

Work by the National Consumer Council on the effect of charges in healthcare in 2003[1] recommended, among other things, that there should be a review of NHS charges so there is greater consistency, for example in the way older people are treated, charges should reflect ability to pay, and exemptions should be reviewed.

While any type of charge can have an effect on whether people access services, there are certain aspects of the charging regime in dental services which distinguish it from other NHS charges. For example, the charge for prescriptions is a flat rate charge which most people are well aware of, and it is set at a level that, for most people, will not act as a deterrent. In NHS dental services, because of the complexity of the system, there is a very high level of ignorance of what charges are likely to be for different types of treatment. The maximum charge of £372 is a very large sum of money for many people. While health inequalities are prevalent in Scotland, they appear to be more pronounced, and particularly serious in dental health, requiring radical solutions.

---

[1] S Sihota, *Creeping Charges: NHS prescription, dental and optical charges – an urgent case for treatment,* London, National Consumer Council, 2003.

For these reasons the SCC believes that it is particularly important in dental services that patient charges are fundamentally reviewed. The SCC does not believe that abandoning, reducing or simplifying charges would result in demands on services which could not be met. Any resulting variation in demand should be addressed by a combination of the following:

- making better use of the whole dental care team
- restricting NHS care to what was clinically necessary
- greater use of salaried dentists to meet demand.

If it impossible to get rid of charges completely, then we are in favour of relating the level of payment to the ability to pay rather than to the state of oral health of the patient. At the same time, we would be in favour of a review of exemptions, with a view to possibly extending these, for example to include people over pensionable age.

The SCC believes that abandoning or radically simplifying the charging scheme, provided it is combined with a radical redesign of the way dentists are paid, could have the benefit of removing one of the major irritations about NHS practice for dentists, and result in reduced bureaucracy for dentists, and more dentists prepared to continue to work in, or even return to the NHS.

4 GUIDING PRINCIPLES

The SCC agrees with the principles set out in sections 4.3 and 4.4 of the consultation document. In the list of principles relating to patients we would add information and the importance of this for patients – good quality, current information should be available to patients about services, about what they are entitled to, about costs and what to do if they have concerns or complaints.

The principles set out in section 4.4 encapsulate the key requirements of any new system, and the SCC endorses these.

4.1 Quality assurance

The SCC believes that in parallel with any changes in the contractual arrangements for dentists, and changes to the charging regime, it is important to address the question of quality assurance in dental provision. The model which is being introduced in England appears to have merit. Dentists should be required to give all patients an oral health assessment at the start of treatment, and required to follow best practice in the treatment of their patients. This would be aided by the development of clinical pathways to treatment, similar to those being developed in England.

In England, these changes will be supported by information and communication technology (ICT) developments which are intended to re-integrate dentistry into the NHS, for example through the development of an electronic dental record which can be shared with other parts of the NHS and which will be more easily transferred when a patient registers with a different

dentist. ICT will also support the development of the clinical pathways to treatment described above. There may be a role for NHS Quality Improvement Scotland to play in this area.

4.2 Planning, provision and monitoring of services

The SCC agrees with the suggestions in section 5.3 that the responsibility for planning and providing dental services should be devolved to the NHS boards.

5 CONCLUSION

In summary, the SCC considers that

- What is provided on the NHS should be limited to treatment which is clinically necessary and follows best practice.
- There should be a greater emphasis on preventive work, by all those working on oral health, and by others, for example working on food and diet.
- Dentists' remuneration should not be based predominantly on payments for items of service (a piecework system) but on capitation and continuing care payments for patients registered.
- There should be greater integration of dentists into NHS primary care provision.
- The General Dental Service (GDS) and the Community Dental Service (CDS) should work together more closely.
- There should be greater use of professions complementary to dentistry (PCDs) to free up the time of the dentist and to make more effective use of the skills of other staff.
- Patient charges restrict access of consumers on low incomes, and should either be abandoned, or replaced by a system which reflects ability to pay.
- Quality assurance in dental services must be given a higher profile.

It is important for policy makers to remember that the provision and accessibility of NHS dental services is a major area of concern for consumers in Scotland. Sadly, the consumer voice was not represented to any great extent in the consultation events organised by the SEHD throughout Scotland, which were largely dominated by dental professionals. The SCC believes it is essential that the voice of patients is not lost in the continuing negotiations and debates which follow on from this consultation exercise.