

MODERNISING NHS DENTAL SERVICES IN SCOTLAND

Consultation by the Scottish Executive Health Department

Response by NHS Borders

Introduction

NHS Borders welcomes the consultation on NHS Dental 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.

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

In 1948, with the introduction of the NHS, dentistry was initially free but direct patients charges were introduced in the early 1950s thereby removing two of the stated ideals of the NHS. Therefore, dentistry has always been viewed as slightly outside or apart from the remainder of the NHS. There is an urgent need to re-integrate dentistry back into the NHS. The differences between the structure of NHS dental care and the remainder of the NHS are confusing to patients and may be an influence in the failure of dental health in Scotland to improve in recent years.

Most patients receive their dental care from the General Dental Services who are independent contractors in the NHS. In introducing any new system there should be no detriment to existing NHS dental practices or dental practitioners.

Any change to the current GDS or any new system must have a primary role of improving access to dental care. The first priority is emergency dental care.

Emergency Dental Services

To have credibility health services have to 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 should be developed.

The second priority must be an emphasis on delivering preventive dental care.

Prevention in General Dental Practice

A systematic review of oral health promotion has shown that face-to-face prevention is effective in improving oral health. General Dental Practitioners and their teams must be encouraged to provide this evidence-based intervention and they must be adequately funded. Prevention, especially for children, is an essential part of primary dental care. One vehicle for this for all ages might be via a comprehensive assessment of oral health, general health and lifestyle such as smoking & diet. This could replace the dental check-up with an all round, structured and comprehensive assessment of oral health.

Attempts must be made to attract general dental practitioners back into the NHS although doubts have been raised that they will want to return from the private / independent sector. Incentives such as golden hellos have proved successful. However, many incentives and improvement grants have been seen as rewarding dentists and practices that have neglected regular investment. There must be recognition of individuals and dentists (and staff) who achieve further qualifications or recognised quality improvement standards.

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 & 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.

Funding of Dental Services

As earlier reviews of the system of remuneration have stated; the Bloomfield report on a "Fundamental Review of Dental Remuneration" in 1992, and the Tattersall Report in 1964, the efficiency of the GDS is readily acknowledged. While everyone would welcome abandoning the GDS treadmill, any changes to the current remuneration system will need to try and maintain the efficiency of the GDS. The shortage of dentists and supporting oral healthcare professionals (PCDs) in Scotland is reducing access to dental care and any reduction in service efficiency will exacerbate access problems to NHS dental care.

All of the entrepreneurial risk associated with general dental practice is borne exclusively by the dentists themselves. The investment of existing GDS practice owners should be protected from financial risk as a result of changes in Scottish Executive policy.

Private Finance Initiatives in the public sector are one favoured method for funding major projects. There is almost wholly private funding of GDS dental premises to provide a largely public service. One major difference is that in current 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 dictates the financial level. The process of moving a dental practice from the NHS to largely private provision often involves accurate assessment of the costs of running the practice. This is then converted into an hourly target for the practice to be financially viable. One new approach may be that any new NHS system of remuneration should be broadly based on the true costs of running each dental practice. This will avoid a one-size fits all approach. It may also be fairer as the true cost of the service will form the basis of the remuneration system. Direct reimbursement of these running costs could be considered.

There are large parts of Scotland, including the Borders, 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.

Workforce

The shortage of dentists and supporting oral healthcare professionals (PCDs) in Scotland is reducing access to dental care and must be addressed by training more dentists and PCDs. The shortage is reflected in the number of NHS dental practices in Scotland which have closed with a disproportionate number being in rural areas (62 closures from 1999 to 2002, 15 or 24% were in R&R areas with only 5% of the population). We must train, recruit and retain more dentists in Scotland.

There were local suggestions that dentists from EU countries may be a solution to the shortage of NHS dentists. Others felt that without addressing the underlying problems of NHS dental practice there would be no incentive for the new overseas dentists to remain in the NHS. If this approach was adopted at best it is likely to be a temporary solution.

NHS Systems & Infrastructure

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 any NHS oral healthcare provision 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 may be no single solution that will fit all circumstances in all parts of Scotland.

Robust IT systems must be provided to encourage integration of oral healthcare with general healthcare, and of primary with secondary oral healthcare. As a start the connection of GDS practices to the NHSnet should be a priority as was recently announced for Community Pharmacists (HDL(2004)02, Connection of Community Pharmacists to NHSNET).

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, oral health promoters, 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.

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. An increase in dental undergraduates could be achieved by changing the present system. Currently all non-clinical as well as clinical training is carried out in Scotland's three dental teaching hospitals. This could change such that a large proportion of clinical work is done in outreach dental clinics throughout Scotland including the Borders. This would enable the teaching hospitals to concentrate on early development of young students. It might also enable them to train more students without a long lead-in time or major rebuilding program.

Outreach teaching, as part of dental undergraduate training, is an exciting development but it needs to be educationally robust and adequately funded from new monies.

Health Improvement

We welcome the consultation on NHS Dental Primary Care 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.

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.

Prevention of Oral Disease

The level of child dental health in Scotland is poor for a Northern European Country. Although there have been improvements in oral health over the last three decades, these have plateaued and serious inequalities persist. As the Health Department's own document "Towards Better Oral Health for Children" recently pointed out:

- 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.

NHS Borders sees the need to introduce evidence-based health improvement measures to improve oral health and we feel that the Scottish Parliament should consider enacting laws to introduce the following measures.

Water fluoridation

NHS Borders notes the considerable evidence supporting the benefits of the fluoridation of water. The SEHD could bring forward guidance on fluoridation of the domestic water supply

for Health Boards in Scotland, to allow the local community to make a decision about this effective public health measure (the legislation for this is already in place in England & Wales). The evidence is 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).

NHS Borders also notes the Medical Research Council recommendation that water fluoridation should be introduced and rigorously evaluated with respect to outcomes such as health inequalities, prevalence of dental abscesses and treatment required such as extraction of teeth.

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 other bodies have suggested the addition of VAT to confectionery, specifically to foodstuffs with a high proportion of added sugars. An alternative is a sugar tax. Improving diet will have wider benefits on other key Government priorities such as obesity, coronary heart disease, stroke, cancer and diabetes.

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 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. Again 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.

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.

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 recommendation 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 long-term objective.

We can see the benefit of reintroducing universal free school meals for all children as one 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.

NHS Borders 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?"

Clearly emergency dental care for all patients must be available and it should be integrated into NHS 24 to provide a single telephone point of access for patients.

If funding is available "routine" dental care should be free for everyone. "Routine" is not easy to define but should include care to keep an individual dentally fit. This may not include all of the dental care currently available on the NHS and it may vary between individuals. Some dentists refer to this as a "core service." Evidence based preventive care and advice is essential and should be central to all NHS dental services. Dental care such as, simple fillings, scaling, etc. should also be included. The level of routine care may largely depend on available funding. By virtue of paying taxes and national insurance contributions it can be argued that everyone should have access to routine NHS dental care.

Cosmetic dental treatment should normally be excluded from the NHS.

1.2 "Should services be prescribed and limited or unlimited?"

If NHS dental care is designed to keep an individual dentally fit then there should be no limit on the amount of "routine" care prescribed.

1.3 "What system should there be for reviewing and updating?"

Healthcare needs to change and evolve in response to changes in population demographics, new evidence of clinical effectiveness, changing disease patterns, etc. The system chosen for updating services should be transparent and accessible. The process of, and information included in a review should be accessible for patients and healthcare providers. There should be no sudden overnight changes with adequate lead-in time of at least 12 months where possible.

Following this consultation we feel that during any changes introduced to the GDS system, individual dental practitioners should be fully supported in managing the change to a new system.

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

In a holistic approach to oral health, prevention must be central to all patient care. In addition to the health improvement initiatives suggested, Systematic Reviews of oral health promotion have shown that prevention of oral disease on a one-to-one basis is effective. Interventions such as fissure sealants also have a good evidence base. Once new evidence of clinically effective interventions becomes available, these can be introduced into the service.

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 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 - Primary prevention of dental disease is one essential 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.

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 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.

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.

Direct reimbursement of staff and practice running costs, similar to what happens in general medical practice, should be considered while retention of some element of fee-for-item payments maintains an incentive for an efficient service. The current fee-for-item list of over 400 items must be markedly 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 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. It is worth emphasising that in an ideal world we should move to a system that does influence where GDPs set up business. This would only be possible where a more comprehensive system of funding for set up / running costs of practices was in place. However, if these were in place it would be ethical to only agree to fund these by the NHS where it was in the NHS patient's interest for a new NHS service to be introduced.

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.

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.

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**

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

Whilst agreeing that patients should make a contribution towards their treatment costs, 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, preventive care and "routine" care (however defined) should be free for everyone.

Some general dental practitioners considered that a statutory charge should be introduced for patients who simply fail to attend for appointments. Emphasis should be placed on the responsibility of the patient to attend regularly to maximise the benefits of preventive care and advice.

3.2 *"What are the views on the options listed?"*

Charges should be simple and fair and should perhaps reflect the true costs of treatment.

3.3 *"Are there other approaches that merit consideration?"*

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. The NHS may have lessons to learn from best practice in the private sector in order to improve the provision of NHS dentistry.

Dentists are currently responsible for bad debts and this is unfair to NHS dentists as they are out-of-pocket when patients failed to pay for their treatment.

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