

## **Modernising NHS Dental Services in Scotland**

### **Comments from Borders Local Health Council**

This is a comprehensive but readable document, with a good explanatory overview of oral health and dental services in Scotland. In spite of what has been done to improve the overall provision of dental services in Scotland as outlined, however, it appears to stumble on from one crisis to the next. This is the impression given by the popular press and TV, where "whole towns" queue to apply for a limited number of places on a dentist's list. It is clear that for the many and varied reasons given for such crises, there is a move among many Dentists to opt for private practice.

Paragraphs 4.3 and 4.4 clearly indicate the principles for an appropriate framework and the way forward for future arrangements. It highlights the two main players, namely patients and professionals in determining what is required.

Modernising NHS Dental Services in Scotland needs to be an ongoing commitment and challenge if people's dental health is to improve and lift its position from the bottom of the league table of dental decay in Europe.

There are 3 main areas to be considered

1. No. of dentists
2. Remuneration
3. Dental services

#### **1. Dentists**

There are too few dentists in general, let alone in NHS practice. Protests from the dental profession were ignored and Edinburgh Dental School of Dentistry was closed about 12 years ago. If this is a factor in the shortage of new dentists, then this should be reinstated.

Many dentists, who were originally committed to NHS dentistry, have now left for private practice. This is because of the restrictions placed on the services that they can offer and the need to work fast to generate a reasonable income - the "treadmill". Although the treatment carried out would be of an acceptable quality, there are necessary compromises, compared with private practice.

The document outlines plans to increase the number of dental graduates, but what incentives will be in place to ensure that they: remain in Scotland; set up practices in areas where they are most needed; and focus mainly on NHS work. The working environment in private practice is so much better than in NHS, with patients who tend to be interested in caring for their teeth, that there is little incentive for new graduates to go into NHS practice. If this is not addressed in the reasonably near

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future it may be very difficult to recruit even a minimal NHS workforce in the years to come.

Training more hygienists and therapists who could then undertake the more basic treatments may alleviate the problem of number of dentists.

Consideration could perhaps be given to the feasibility of offering a shorter, condensed, graduate course for more mature students (say 25-35) with a first degree in a science-based subject. It may be that there is a pool of suitable candidates who are looking at a change of career. Grants and tuition fees could be linked to an undertaking of a significant NHSS commitment/taking up a salaried post for a minimum specific period post-graduation. There are similar models for clinical medical courses in England, where there is an existing drive to produce GMPs.

As the document suggests, there must be more emphasis on local responsibility and accountability. NHS Boards should determine, in partnership with professionals and patients, what the local needs are and how they can be met. This is particularly important for children's dental services, where preventative dentistry and oral hygiene issues should be provided from pre-school to early adulthood, free of charge.

## 2. Remuneration

The present fee for item of service system is complex and supports a service which treats disease rather than prevention and the maintenance of good oral health. The whole subject of remuneration and rewards needs to be addressed in more detail if any significant progress is to be made. In particular, there needs to be higher incentives to dentists to provide preventive advice - and not just treatment. For GDPs, there must be a greatly simplified system of charges.

There is a need not only to make the service attractive overall for dentists but also more accessible and acceptable in terms of costs for patients.

A system that pays for prevention should be introduced (prevention at all ages, not just children). There are 3 main groups of patients when it comes to treatment needs:

1. Children - prevention is possible.
2. Middle-aged - those who grew up without the benefits of fluoride toothpaste etc. who therefore have greater caries experience. Fillings will need to be replaced as they age, but prevention of new cavities is possible.
3. Old age - there are problems associated with large restorations and brittle teeth. There is a likelihood of ill health which can also affect oral health.

There could, perhaps, be a scaled capitation system with the scale weighted towards prevention and maintaining good oral health. This could include an entry fee for making the patient dentally fit on registration, with a subsequent capitation, higher for those who remain free of treatment. This would need to take into account the potential treatment needs of the 3 groups, with higher funding being needed for groups 2 and 3. Payment would need to take into account the special treatment needs of the elderly. However, these groups will reduce in number over the years and so the funding should gradually reduce. This will need long-term planning and commitment of the necessary funding.

### **3. Dental Services**

Although a family dental service is probably the ideal, taking patients through from infants to old age, dentists should be encouraged to specialise in treatment groups, eg children, elderly, special needs. Training is essential, should be funded by grants and be rewarded with additional remuneration. Dental practices could then have a number of specialities within the one practice, catering for all needs.

Alternative - or complementary - specialist services should be instituted for children, the elderly and special needs as they have special treatment requirements, including environment and length of time needed for treatment.

**Borders Local Health Council**  
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