

# “IMPROVING NHS DENTISTRY” A CRITICAL ANALYSIS

Gareth R Thomas © 1994

## Introduction

*Improving NHS Dentistry*, is not the title that would have been chosen for this paper if given a choice. The title has been taken from the Government Green Paper, "**Improving NHS Dentistry**"<sup>1</sup>. It was felt appropriate to incorporate the title of the Green Paper in an analysis of the paper.

The Green Paper has been a long time in preparation, being the Government's response to the **Bloomfield Report**<sup>2</sup> and the crisis facing NHS general dental services, following the introduction of the New Contract in 1990 and the subsequent disillusionment with the Service by general dental practitioners.

There is little doubt that NHS general dental services are in a state of flux, if not in actual chaos. Much of the responsibility for this situation rests with the Government and the New Contract for general dental practitioners, introduced in 1990 and the subsequent alterations made to the New Contract. The responsibility, however, is not solely the Government's. Blame must also be attached to the dental profession for accepting the New Contract in the form in which it was introduced. The dental profession and general dental practitioners in particular are moving away from NHS practice to private practice with the consequence that in certain parts of the country there is no universal access to NHS dental treatment, a situation which did not exist before the New Contract was introduced.

The Green Paper is the Government's response to the crisis in dental health care provision. It needs to be analysed and judged to see whether it has met the objects set for it, namely, that of improving the NHS general dental services and access to the services for the population of the United Kingdom.

## Aims and Objects

The Aims and Objects of this paper can be briefly summarised in a single statement and that is to analyse the contents of the Green Paper on dentistry and the provisions contained therein.

The brief statement above, whilst covering the Aims and Objects of the paper needs to be expanded to detail exactly what the Aims and Objects are. Previously, NHS general dental services have been available to all whom wished to take advantage of them. However, following the introduction of the New Contract, this universal 'right' is no longer available to all who wish to benefit from the provisions of NHS general dental services health care arrangements. The acid test for the Government's proposals contained in the Green Paper, is whether or not the system of universal access to dentistry will be reinstated for NHS patients.

The Aims and Objectives of this paper are therefore the analysis of the recommendations of the Green Paper and whether they meet the requirements to ensure that NHS general dental services are available to all those who require them for as long as they require them. Arguably, NHS general dental services are an integral part of the NHS even though they operate in a different manner to the rest of the Service, in that dentists are employed under a contract for services rather than a contract of service. General dental services are also aimed at a different patient base in that many, if not the vast majority of dental patients are either fit, healthy adults or developing children with no medical problems. Thus, when the Green Paper is analysed, the provisions for these groups need to be examined in detail to see whether arrangements have been made for them to benefit under the Green Paper proposals.

A summary of the conclusions and recommendations will be made at the beginning of the paper rather than at the end. This novel approach having been adopted to enable the reader to appreciate the "small print detail" which becomes apparent as the Green Paper is analysed.

## *Summary of the Findings*

## Discussion and Conclusions

The Green Paper is the Government's response to the problems facing NHS general dental practice and has introduced a number of options for discussion. There is, however, a very serious error in the Government's approach in that it is based on a flawed hypothesis. The Government's hypothesis is that the general dental services problems are all based on financial problems and can be solved by money. It is not based on a thorough review of dentistry as a profession with the hopes and aspirations of the individual dentist given an airing.

Given the seriousness of the problems that face the dental professional and the population at large concerning the provision of dental services to the population it was to be expected that there would have been a fundamental review of the provision of dental services. This has not proven to be the case. There are problems facing dentistry as a whole and some solutions are needed to meet the general difficulties facing

---

<sup>1</sup> Cm 2625 London HMSO July 1994.

<sup>2</sup> Fundamental Review of Dental Remuneration, December 1992, HMSO.

patients and dentists alike. The Green Paper, unfortunately does not start off with such open ideals and premises, but is biased in favour of one particular premise namely, that all the difficulties are caused by finance without looking at the greater problems faced in the provision of dental health care in the United Kingdom.

Since the beginning of the modern dental profession and even before then, dentists or the practitioners of dentistry have for the most part operated on an item of service payment scale. The exception being those dentists in salaried posts whether private or Government funded. The majority of dental practitioners have also practised as private individuals whether in private practice or NHS service. These are two basic facts of United Kingdom dentistry that cannot be denied.

Until 1990, the population of the United Kingdom was well served dentally by these two historic precedents of item of service payment and small individual dental practices. 1990 with the introduction of the New Contract was a watershed for dentistry with cataclysmic changes for the provision of dental health care. Arguably, the New Contract was both the vehicle and the catalyst for change. It is only since then that there has been pressure for change in dentistry. The previous system of dental provision may not have been perfect, but it worked for most of the population for most of the time. The populace as a whole had access to dental health care.

After 1990, and 1992<sup>3</sup>, the provision of dental treatment whilst not in turmoil was in a state of flux. The changes introduced by the New Contract for the first time placed emphasis on prevention and continuous care of patients. This was a revolutionary principle when applied to dentistry and following its introduction, dentists could limit their practices to a maximum number of patients that they could see and treat. A figure of approximately 2,000 patients would appear to be the norm for patient acceptance.

This ability to limit the number of patients by the individual dentist has resulted in a serious shortfall in the provision of NHS dental services. It is to be expected that not all the patients will attend all the time, but given the fact that there are approximately 20,000 dentists in general dental practice and if they all have 2,000 registered patients, 40 million of the country's population will have access to a dentist. This leaves approximately 18-20 million people not catered for under the present system. Thus, from the given figures, there is a shortfall in dental personnel if all patients are to have access to NHS dental services. It is a crisis in operation as can be seen from the political capital being made out of dentistry. The Government's response has unfortunately been to concentrate on one aspect of this dilemma and that is the financial aspect rather than the overall picture of changing treatment patterns, patient expectations and improvements in dental health.

The Government in the Green Paper has made general commitments without making specific commitments to the provision of dental services. It is possible to argue from the Government's point of view that they are unable to give specific commitments in a Green Paper that is a document for discussion. The difficulties arise from the fact that there is no specific commitment to NHS general dental practice, only to a NHS dental service.<sup>4</sup>The importance of the absence of the word 'general' will only become apparent with time.

The other point that the Green Paper fails to address is that of the accepted standard of care. There is again no specific commitment to make NHS patients "dentally fit" or "orally sound". Making this point may appear pedantic, but given the proposed limitations on treatments, it is an important point to raise. Throughout the Green Paper, emphasis has been placed on the purchaser/provider model and the reduction in the availability of advanced treatments.

The non-specific commitment to general dental practice and the reduction in proposed treatments would suggest that the role of the general dental services is to be reduced to one of repair and maintenance rather than one of providing the 'best' possible treatment. The "better treatments" would be more expensive than the routine treatments proposed in the Green Paper, but may very well be more suitable for the patients. The difficulty with this approach is that patients oral health long term may suffer more with the so called "cost effective" model than the more expensive, advanced techniques.

One apparent difficulty that would need to be emphasised is the dilemma dentists can face when with a restricted budget they are expected to provide treatment to the standard demanded by the General Dental Council. Do they provide treatment to the standard paid for by the NHS or to the standard expected of a competent dentist by the General Dental Council? The difficulty of this question is further enhanced by the

---

<sup>3</sup> 1992 saw the Government introduce "claw-back" mechanisms to prevent the continued overpayment of dentists in the government opinion and to recover the monies that they considered to have been overpaid.

<sup>4</sup> See the Foreword to the Green Paper.

fact that the Green Paper has placed emphasis on the fact that dentists have an ethical responsibility that is under the control of the General Dental Council and that they (dentists) need to satisfy these requirements.

There are difficulties with this approach. It is one that can increase the momentum for a two tier dental system. The question is can a general dental practitioner meet the terms of the NHS contract by providing treatment to a price or should he provide the treatment necessary to satisfy the professional requirements of the General Dental Council and subsidise the NHS?

The restrictions on clinical practice that would be introduced under the proposals contained in the Green Paper would undoubtedly influence dentists to leave the NHS for private practice where clinical freedom whilst not guaranteed can be modified to meet the patients' expectations. The drift from NHS to private practice could become a flood especially if patients have to pay one hundred per cent of the costs of treatment up to an unspecified limit.

This movement of dentists from NHS to private practice would appear to have been anticipated by the Government in making proposals in the Green Paper to modify the roles played by the Community Dental Service and salaried dentists to provide a safety net. The safety net, however, is an open-ended commitment at present for all those who desire NHS treatment. Given the open ended nature of the commitment, it can be anticipated that it would only be a matter of time before the commitment was reduced to exempt groups and other deserving cases rather than the population as a whole.

It is possible to argue that the Green Paper and the proposals therein are a blueprint for a two tier system of dentistry in the United Kingdom rather than a streamlined NHS system providing treatment for all. Whilst it may be politically unacceptable for the Government to admit that NHS dentistry will not be available to all, that is the most likely outcome if the proposals are followed through.

The favoured option of the Government is the purchaser/provider model based on the local area and capable of meeting the changing demands and needs of the locality. The difficulties with this approach will be described later, namely that dentists may not want the local FHSAs to play a role in the provision of the services and secondly, need may be determined by administrators. A third difficulty with this approach is that of professional fees. Given the nature of the proposals and the setting of wages locally, it is possible that the areas that give greater financial return will have more dentists committed to the NHS than areas where the NHS financial return is not so great.

The purchaser/provider model whilst the favoured political option has yet to be proven as a satisfactory vehicle for the long term provision of health care in the United Kingdom. The internal market philosophy is difficult to justify in a dental context when there is a set price to charge the patient, it is a distorted free market model on one hand and a non-continuous planned 'socialist' model on the other. The reforms might have worked if the end price to the patients was flexible or if there was a set fee to the dentist and a set end price (the current model). The proposals, however, are neither free market nor state controlled. The mixture of the two are unworkable and dentists may find the restrictions on their clinical judgement to be such that their preferred option will be a move into private practice.

The Green Paper contains proposals for change without a fundamental review of dentistry as a whole. The review of dentistry should have included a number of topics rather than the Government's single one of finance. A fundamental review would have examined the NHS - dentist relationship, the dentist - patient relationship, the professional ethics of dentistry, the legal practice of dentistry and a thorough examination of the role to be played by the General Dental Council.

A fundamental review would have enabled the Government to target priorities in a justifiable manner. The difficulty with differentiation on financial grounds is that clinical decisions may not be made in the best interests of the patients' welfare short term, let alone long term. The Government arguably has fallen into the trap that something “must be seen to be done”, and has acted accordingly. A long-term approach and developing a strategy for health care into the Twenty-first century should have been taken. The result has been proposals that show short-term financial expediency and fail to provide a service, which will produce a long-term cohesive dental service to improve the dental health of the population.

The end result of the proposals is likely to be a two, if not three-tier system of dentistry. The first two being a private system where the patients can afford to pay for the most advanced treatments, the second, private patients who have basic NHS treatment, but for financial or other reasons are unable to find a NHS dentist. The third grouping will be those patients who come into the cover provided by the safety net and have pain relieving treatment as a priority and then join long waiting lists for NHS treatment.

Dentistry and good dental health are an integral part of a healthy body and health care system. Failure to secure good dental health can lead to long term problems that may throw greater strain on other aspects of the NHS. Dentistry and dental health provision, needs a fundamental review and appraisal, something which the Green Paper has singularly failed to achieve.

The Green Paper has tried to put in place cost effective measures without adopting a health care strategy for dentistry and therefore, the recommendations and proposals in the Green Paper are flawed from the outset. Greater thought needs to go into the development of a dental health strategy and the dental profession than has been shown.

### **The Government's Commitment to NHS Dentistry**

The actual title of the Green Paper, "**Improving NHS Dentistry**" is a thought provoking statement in its own rights. The complaints that have been elucidated are about NHS general dental Services and if there was a Government commitment, it should be to the NHS general dental services, not NHS dentistry. Either the Government is not fully committed to the NHS general dental services, or a more appropriate title for the Green Paper could have been thought of.

"The Government is committed to an accessible and effective NHS dental service. It is committed to a high quality service providing comprehensive diagnostic and preventive treatment, and restorative work for all those who need it. In particular, we want to see continued improvements in the oral health of children." <sup>5</sup>

On first examination, this is an unequivocal commitment to NHS dentistry and its availability to all those who need it. However, on closer examination, this first paragraph of the Green Paper, is not a commitment to the NHS general dental services. The "NHS dental service", consists not only of the general dental services, but also the community services and the hospital services. Given the diversity of the services and the ranges of treatments offered and the patients treated, commitment to the NHS dental service, is not a firm undertaking to provide NHS general dental services that it first appeared to be. There is no separate commitment to the general dental services as provider of dental treatment for the population in general. The commitment is to NHS dentistry, which may or may not include a commitment to the general dental services. The Government's commitment may be to the specialised dental services rather than the general dental services. The specialised services may be of great importance to those members of the population who have need for them, but arguably, they are not as important to the majority of potential patients as universal access to the general dental services.

The second point made in the Foreword to the Green Paper is that the system of remuneration needs to be changed.

"We are equally committed to rewarding fairly those who provide this service. To achieve this we must use the money spent on dentistry, some 4.5% of the total cost of the NHS, effectively and efficiently to maintain and improve oral health in the United Kingdom. The review of the dental remuneration system has provided an opportunity to build on the success of the NHS dental service to meet the challenges now and in the next century."

and

"The current remuneration system is poorly matched to present needs. It has lost the confidence of the profession and others, especially since the problems caused by the major overpayments in 1992. An over- or under- payment happens every year. The system is unstable and when it goes badly wrong, as it did in 1992, it requires unsettling remedial action. Change is needed, and that change should reflect the demands facing the service." <sup>6</sup>

These two paragraphs on dental remuneration attempt to lay the blame at the feet of the dental profession for the difficulties that have arisen since the introduction of the New Contract for dentists. This can be seen as an attempt to avoid the shortcomings caused by the Government's intransigence. At the time the New Contract was introduced and when the financial "clawback" was introduced in 1992 there was criticism that the policies being pursued by the Government would lead to difficulties in the provision of general dental services.<sup>7</sup>

It is my opinion that the provision of general dental services has been placed at risk because of the failure of the Government to act in a responsible manner when the New Contract was introduced. The New Contract was introduced unilaterally by the Government. There had been no acceptance of its provisions by the

<sup>5</sup> Improving NHS Dentistry Cm 2625 London HMSO July 1994 p.1

<sup>6</sup> Improving NHS Dentistry *ibid* p.1

<sup>7</sup> See both the dental and the national press at the time the new contract was introduced.

dentists who were expected to make it work. The dental negotiating bodies accepted the New Contract in the face of opposition from dentists. The fear at the time being that the New Contract would have been imposed by the Government on NHS dentists.

Initially, the New Contract, whilst not an outstanding success was operating reasonably efficiently. The greatest difficulties arose in 1992 when the Government applied a financial "clawback" as dentists had been "overpaid" because they had registered too many patients. This has since been the focus for the 'industrial dispute' between the Government and general dental practitioners.

To many an unbiased observer, the difficulties in providing NHS general dental services can be seen to rest with the Government and its "poorly" thought out policies and the manner in which they have been implemented. Unfortunately, an inescapable conclusion to be drawn is that the Government is not committed to the NHS general dental services, but will provide a limited "NHS dental service"<sup>8</sup>. The obvious conclusion to be drawn is that dentistry for the majority of people in the United Kingdom will become a private affair between private practitioners and patients who are able to pay for their treatment. This philosophy of private enterprise for health care provision, fails in one important respect, namely that many people who are in work fall into the so called "poverty trap". People earn too much to benefit from Government support, but not enough to pay for their health care after other necessary expenditure.

It is incumbent on any Government who take their responsibilities in health care provision seriously to provide adequate access to health care provisions for all who so desire them even if they do not fund the service. There should be no differentiation between peoples' access to health care provision on financial grounds. Priority access to health care provision should be based on sound medical principles and not on financial means of payment.

### **In-depth Analysis of the Green Paper on Dental Health Provision**

#### **Introduction**

The Green Paper is the Government's answers to the difficulties facing patients who require NHS dental treatment following the introduction of the New contract in 1990. There has been much speculation in both the National and Dental Press regarding the future of NHS dentistry since the reforms introduced by the New Contract and the subsequent watershed of 1992 and the withholding of finances.

#### *Background Information*

There were 19,095 dentists in the general dental services at 30 September 1993 and 19,400 at 31 March 1994<sup>9</sup>. In some respects this is an encouraging trend in that given the long running dispute between dentists and NHS, more dentists than ever are 'employed' in the system. Unfortunately, these figures do not inform the reader of the amount of time that the individual dentist has committed to the NHS so they are not a reliable source of information regarding the availability of NHS dental treatment.

A better illustration of the success or otherwise of the NHS general dental services, is the number of patients registered with the individual dentist. In the case of children, the numbers registered under the capitation scheme have increased from 2,8000,295 at 31 December 1990 to 8,090,124 at 31 March 1994<sup>10</sup>. There are also 25,379,251 adult patients registered as continuous care patients at 31 March 1994<sup>11</sup>. Thus at 31 March 1994 there were, 33,469,375 adult and children registered with general dental practitioners.

Given the number of dentists in the NHS general dental services at the same time, a mean figure (average) of 1,725 patients per dentist is obtained. A figure close to the 2,000 found, in discussions with dentists. The difference arguably is made up of private patients.

The great problem arises from the fact that there are approximately 58,000,000 people in the United Kingdom and only about 33,500,000 are registered patients. This leaves roughly 24,500,000 of the population as unregistered persons. Admittedly, some of these will be private patients and others in the care of the Community Dental Services, but unfortunately, this still leaves a vast shortfall in the number of dentists available to treat patients. A shortfall in numbers which the Green Paper does not acknowledge let alone attempt to redress.

The number of patients registered also fluctuates, as re-registration is not an automatic process, but one in that the patient is expected to visit the dentist before the process is completed. Thus, patients may not be re-registered even though they (the patients) regard themselves as patients of that particular dentist/practice.

<sup>8</sup> See dental press for opinions on Government policy.

<sup>9</sup> Improving NHS Dentistry, *ibid* p. 6.

<sup>10</sup> Improving NHS Dentistry, *ibid* p. 7.

<sup>11</sup> Improving NHS Dentistry, *ibid* p. 8.

It is obvious that there are difficulties concerning the availability of dental treatment in the United Kingdom. The approach adopted by the Government in the Green Paper, is one of "if we sort out the money side of dental practice everything will be fine". This attitude unfortunately completely misses the point that given the figures for patient numbers per dentist, the number of dentists and the population of the United Kingdom, there is a built in deficiency in the system which can only be corrected by facing the fact that it exists. No amount of tinkering with the financial side will enable the equation to be balanced. There needs to be either more dentists or more patients per dentist for universal availability of dental treatment to exist.

The crisis in dental health care provision is not a financial one as the Government claims. The financial side has acted as a catalyst in the same manner as the New Contract. Dentists have been exposed to sudden changes in their NHS working conditions and practices at the same time as facing financial alterations in the system of payment.

One of the great changes, which has been an unexpected consequence of the New Contract is the realisation by dentists that they do not need a large patient base to have a successful practice. The ramifications of this arguably have led to the dental health crisis. The pre New Contract days when very few potential patients were turned away has gone, arguably forever. The dentists' perceptions of dental practice have also changed, but the Government's is still rooted in the past as will be shown with the examination of the contents of the Green Paper. The New Contract has acted as a catalyst for change. Change had been required when the New Contract was introduced to face altered circumstances, but the consequences of the change, have not been anticipated by the Government or arguably by the dental profession.

"The 1990 contract for primary dental care aimed to improve the oral health of the nation by encouraging patients to visit their dentist regularly, and dentists to practise preventive care. This was to reflect the picture of oral health needs of the population, which had changed from the general need for much restorative work in the 1940s when the payment system was created, to an overall need for a basic care and maintenance service."<sup>12</sup>

These aims are laudable in that the Government's dental health strategy was to increase the amount of prevention practised by general dental practitioners and at the same time ensure that dentists made an adequate living. The reality has been somewhat different as will be seen in the following section.

### ***The Reasons for the Review***

The title of this section of this paper has been taken from the Green Paper (p.9). It would have been possible to paraphrase the reasons given for the review, but it was thought better to quote the relevant sections from page 9 of the Green Paper.

"11. In recent years the system for paying and reimbursing dentists has lost the confidence of many dentists and others involved with NHS dentistry."

"12. The weaknesses of the system have been shown very clearly. The scale of fees introduced in 1991 led to gross payments to dentists of some £200 million over and above planned expenditure. The system ... aims to give to the average dentist a given level of income whilst meeting NHS expenses. Its success depends on the accuracy of forecasts of the number and type of treatments to be done and the costs incurred providing them. In 1991 these forecasts were badly wrong. Dentists grossed an average of some £12,500 each more than intended for that one year alone, at a total gross cost of some £200 million."

"13. For 1992/93 the Government accepted in full the recommendation of the independent Review Body on Doctors' and Dentists' Remuneration (DDRB) that dentists should receive an 8.5 per cent increase in net income. The Government also increased the allowance for practice expenses by 11.6 per cent. Implementing these substantial increases within this system, perversely, should have meant a reduction in fees of 23 per cent. The Government decided, however, to limit this to a reduction of 7 per cent which meant dentists still received far more than their intended income."

And

"14. The profession in response to this action called for an independent review of the remuneration system. They felt that the present system was unable to reward them for their work and had become so unstable that it was impossible to provide good quality care for their patients."<sup>13</sup>

These bland statements exonerate completely the Government from the disastrous consequences of the financial “clawback” of 1992. The “clawback” occurred because of an in-built discrepancy in the system.

---

<sup>12</sup> Improving NHS Dentistry, *ibid* p. 9, s. 9.

<sup>13</sup> Improving NHS Dentistry, *ibid* p.9.

At the time of the implementation, the Government was warned by various dental bodies<sup>14</sup> that this would place an intolerable strain on the NHS general dental services and their continued existence. A warning duly ignored by the Government with the result of the well known consequences of difficulty in finding NHS general dental practitioners. It is unrealistic for the Government to deny the consequences of its actions and lay the blame on the system of financial accountability as causing the difficulties in providing general dental services.

When the government introduced the New Contract in 1990, it did not introduce a consecutive change in the financing of general dental practice. The difficulties have arisen because dentists who had the contract imposed on them took advantage of its terms to increase their practice finances whilst still benefiting from the old system of item of service payments. It should have been obvious to those who made the changes that the New Contract should have been introduced at the same time as changes in the financial method of financing general dental practice.

The upheavals associated with the New Contract have been exacerbated by the financial difficulties imposed by the patient system. Arguably one complete alteration of the system giving a revolutionary change may have been better, if followed by a period of consolidation. Since 1990, there has been a continuous revolutionary period in general dental services, which is set to continue given some of the proposals in the Green paper, without a period of consolidation. Unfortunately in this period, it is the patients who are suffering and experiencing the difficulties involved not the protagonists to the dispute. The Review again appears to be more interested in finances and doctrine than patients as can be seen below.

"17. The aim of the review has been to point the way to an effective and an accessible NHS dental service and one which has the confidence of all the interested parties, not least the public and the dental profession. It must provide a proper framework for financial control and be fair to dentists, patients, the rest of the NHS and tax-payers generally. It should be as simple as practicable. The remuneration system is not merely a way to pay dentists. It must enable the development of the NHS dental service so that it can play its part in the improvement of the nation's health." <sup>15</sup>

The statement (above) assumes one point and that is; there is nothing wrong with NHS dentistry only the way in which it is financed. This attitude has unfortunately led to the present state of dissatisfaction. It is plain to the unbiased observer that the difficulties with NHS general dental practice are deeper than the superficial financial problems. There are difficulties with the Service Committees, administration of the system and most importantly dentists' confidence in the system. The Government has not addressed these points in the Green Paper and thus what has been claimed to be a fundamental review of the system is not such a complete review as first thought. Indeed, dental professional ethics and associated difficulties have been completely ignored.

Finance and control of finance are important, but there are other considerations that need to be taken into account when discussing general dental practice. These have not been considered in the green Paper. Ultimately, the Green Paper is the Government's response to the **Bloomfield Report** and it has not considered other aspects of general dental practice including how the NHS general dental services can be saved, let alone improved.

#### **The Bloomfield Report**<sup>16</sup>

The **Bloomfield Report** was the Government's response to the dentists' request for an independent review of the system of remuneration following the introduction of the New Contract in 1990 and the problems associated with the contract. The Green Paper is the Government's "considered response" to the **Bloomfield Report** and its contents.

"21. He suggested ways of improving the current system, including a move away from the item of service approach, step by step and with adequate safeguards, towards a system of "bulk payments" which would cover most treatment needs. This shift, he argued, would make dentists' income and Government spending more stable and predictable. Some of the fixed and near-fixed expenses of dentists could be drawn out of the fee structure to be directly reimbursed to make the system more sensitive to real variations in such costs. The payments might, he added, be open to change if at a later point in the year an over- or under-spend seemed likely." <sup>17</sup>

<sup>14</sup> The National and Dental Press for 1992 have carried numerous articles on this matter.

<sup>15</sup> Improving NHS Dentistry, *ibid* p. 10.

<sup>16</sup> Fundamental Review of Dental Remuneration, December 1992, HMSO

<sup>17</sup> Improving NHS Dentistry, *ibid* p. 11.

The **Bloomfield Report** also considered changes to the concept of a uniform system of reimbursement and targeting priorities and concentrating on particular groups of patients.

"24. In doing so he questioned whether there should be one, uniform system (as now) or whether variable conditions should be developed to recognise the varying circumstances of GDPs. He also considered whether such changes would be better and more effectively managed at local rather than national level.

"25. One section of his report was devoted to looking at how priorities could be set and targeted. He considered a "core service" approach to focus on health gain which would categorise treatments into those normally available, those available only under strict control, and those not available under the NHS. This "concentration" he said "could permit more effective targeting to advance key health objectives and to respond to need rather than demand".

"26. He also looked at whether a "concentration" on certain groups of patients might achieve the same ends. In this approach, services (however defined) would be available only to those afforded high priority on social, economic and/or health grounds.

He [Bloomfield] concluded that:

"[a] greater concentration of available resources on providing a smaller number of treatments could (subject to proper controls) lead to a desirable shift in emphasis from quantity to quality."<sup>18</sup>

The difficulty with responding to the **Bloomfield Report**, is the fact that the Report was concerned with the financial reimbursement of general dental practitioners and not NHS general dental services as a whole. Undoubtedly, the **Bloomfield Report** has provoked discussion on the future of NHS general dental services, but it was not a comprehensive review of the service and its provisions. The Report was concerned with producing an equitable system of reimbursement for dentists in the general dental services, whilst at the same time providing the Government with a fixed financial commitment, not an open ended obligation to fund the general dental services.

Unfortunately, a fundamental review of the system of reimbursement should have been associated with a complete reappraisal of general dental practice and the services provided under the NHS. This was not the case, though there has been a House of Commons Select Committee on dental services.

#### ***The Health Select Committee Report***

The House of Commons Health Select Committee's report on dental services (10 June 1993) made four important statements:

- a. there should be an oral health strategy for England to provide guidance to dentists and the health service as to the priorities for oral health, and to point the direction for oral health services in the future;
- b. there should be a stable system of remuneration that rewards high quality work, high productivity and is effectively monitored;
- c. there should be greater co-ordination of local services and increased involvement by local health authorities in the delivery of primary dental care to ensure that services are properly directed; and
- d. dental treatments should be split into three categories, "diagnostic and preventive services", "maintenance services" and "advanced treatments". The first category should be free to everybody, the second category should be free to those who attend the dentist regularly and the "advanced treatment" should attract a 100 per cent charge from those who can afford to pay."<sup>19</sup>

The Select Committee Report and the Bloomfield Report, both pay lip service to the concept that the NHS general dental services and dentistry in the United Kingdom are synonymous. In any review/s of dental services in the United Kingdom, the relationship between the dental profession (as a whole), that is the profession, as governed by the General Dental Council and the NHS needs to be established. The General Dental Council is the governing body for the dental profession, but most dentists' experiences of discipline and authority come from the knowledge of Service Committees and their proceedings.

There is need for the fundamental relationship between the NHS and the dental profession to be formalised before any reorganisation of general dental services can justifiably be formulated and undertaken. This is a bold statement to make, but one that I will attempt to justify here.

Dentistry is a health care profession whose professional conduct and ethics are regulated by the General Dental Council and legal requirements by the Courts. Thus, as a member of the dental profession, the

<sup>18</sup> Improving NHS Dentistry, *ibid* p.11.

<sup>19</sup> Improving NHS Dentistry *ibid*. p. 12.



individual dentist must satisfy the legal requirements of the Courts and the professional duties imposed by the General Dental Council. The difficulties arise from the terms of service which NHS general dental practitioners practise under. It is possible to argue that the NHS terms of service have usurped the authority and role of both the Courts and the General Dental Council. Thus, the statement that the relationship between the dental profession and the NHS needs to be formalised is not such a wild statement. It recognises the fact there are difficulties in the relationship that needs to be clarified before altering the conception of NHS dentistry.

### **Consultation**

One of the key methods of data research used in the Government's Green Paper was that of 'consultation'. The consultation process may not have produced the desired 'quick fix' anticipated by the Government when they initiated the process.

"38. The lack of consensus about solutions has made more difficult the production of proposals for the future which will command ready support. Every proposed model, including continuation of the current system, has found opposition from some. Any change and no change divide the profession. Whether or not there is change and whatever change is proposed, it is unlikely that all dentists will be wholly satisfied." <sup>20</sup>

The consultation process whilst not a success in one way because there was no consensus of opinion was a success in revealing the differences in opinion which exist in the dental profession. It is possible as a generalised statement to claim that there are as many opinions as there are dentists.

"Some common themes which emerged from the consultation include:

- a. children should be the highest priority;
- b. the recognised benefits of fluoridated water supplies should be more widely available;
- c. dentists want to be treated as health care professionals able to put emphasis on quality and prevention;
- d. the remuneration system should be more sensitive to variations in costs and needs;
- e. the so-called "treadmill" should be removed. Some alleged that item of service payments encourage dentists to work faster and faster, even to intervene unnecessarily, and could have a detrimental effect on quality;
- f. a way to focus on priorities should be introduced. A core service should be developed. Most advocated a treatment based "core" rather than a patient based definition;
- g. quality not quantity should be encouraged;
- h. dentists' income should be more stable and predictable;
- i. dentists do not want any interference in their affairs. They want to remain independent contractors and be able to select which patients they will accept and what treatments they will provide to them under NHS terms. In particular dentists did not want FHSAs to be given any role in determining service patterns;
- j. the concept of the "average dentist" is inherently flawed;
- k. no major change should be introduced without consultation with the profession." <sup>21</sup>

Most, if not all of these themes are to be expected as being common to general dental practitioners. Indeed, most of the suggestions are reasonable not contentious conditions. The only theme that is at all contentious is that of fluoridated water supplies. Fluoridation of the general water supply has always aroused great controversy amongst the public and the dental profession. The arguments for and against are outside the scope of this paper, but as it is mentioned as a common theme in the Green Paper it cannot be ignored.

Fluoridation of the water supply has been mooted as a 'cheap solution' to the 'deterioration' in children's dentistry since the introduction of the New Contract. There is, however, a problem with this idea and that is, children's dentistry has suffered since the introduction of the New Contract because of the terms and conditions in the contract. The fluoridation of water supplies would merely mask the symptoms rather than address the problem. Dentists, arguably recognise that children should be the highest priority, a priority that the NHS and the Government has failed to recognise so far.

It is possible to advance the argument that dentists advocate fluoride, in the water supplies, as a means of giving children the highest priority in the provision of dental services. Fluoridation, as stated previously was the only theme that was contentious amongst the opinions and suggestions of general dental practitioners. The consultation programme also took into account the views of NHS management. These again appear

---

<sup>20</sup> Improving NHS Dentistry *ibid.* p. 14

<sup>21</sup> Improving NHS Dentistry *ibid.* p. 14, s. 39.

relatively bland on first examination, though, on more detailed examination, they are not so bland as first appearances would imply.

"40. Many in NHS management agreed with much of this and placed particular emphasis on other points made by the profession:

- a. the system should be more flexible and responsible to local circumstances;
- b. need rather than demand should be the focus of the system;
- c. local health strategies should be developed for all areas and all parties should work together at a local level to achieve them.

"41. NHS management were clear that the preferred model would be one broadly analogous to the "purchaser/provider" system, which differentiates between the roles of determining need and the consequent funding on the one hand, and the actual provision of a service on the other. A similar model is established and is reaping benefits elsewhere in the NHS."<sup>22</sup>

As stated above, these opinions on first reading are fairly innocuous and would appear to be a natural follow on from the views expressed by the dentists. On closer examination, this is not the case. In some cases, these views are at variance with the views expressed by dentists and in others, administrators would be determining what would or would not be acceptable clinical practice. These points will be explained more fully below.

S.40.c.<sup>23</sup> places emphasis on the NHS management's agreement with dentists that "local health strategies should be developed" and that in the development of these strategies "all parties should work together at the local level". The NHS management of general dental services at the local level comes under the auspices of the FHSAs. This is in direct contrast to s.39.i.<sup>24</sup>, where in the common themes expressed by dentists there was the strong desire that "dentists did not want FHSAs to be given any role in determining service patterns". The two sections are mutually exclusive if they come from the same representative sample of general dental practitioners. If the opinions are not from the same sample, then there must be some significance in the sample selection to give such diverse views on the same subject. Unfortunately, this is not made clear in the Green Paper.

This brings into question the contents of the Green Paper and whether the 'evidence' produced has been designed to fit in with the Government's chosen strategy of health care provision, namely the 'purchaser/provider' system.

The item of service payment system has been the method of paying dentists since the inception of the NHS, but has recently become a discredited system of payment. To replace this discredited system, the NHS management and Government would appear to wish to employ the 'provider/purchaser' model of funding health care. The 'purchaser', determining the need for treatment. This idea immediately arouses questions about the proposal. A 'well policed' item of service payment scheme appears to be the ultimate purchaser/provider model for health care provision. The need is determined at the clinical level, by the dentist undertaking the treatment whilst the purchaser only has to fund the treatment claimed for. This purchaser/provider model of item of service payment, where the clinician decides the need for treatment, has been discredited in favour of the purchaser determining the need for treatment.

The purchaser/provider model where the purchaser determines the need and provides the finance to pay the provider may well be the Government's chosen method of financing the NHS, but it is apparent to the unbiased observer that this system is fraught with difficulties. Some of these difficulties are listed below.

1. How is the need determined?
2. Who decides what the need of the population is?
3. Are sample populations used to determine need?
4. Is the need modified by financial constraints?

The questions outlined above bring into focus the difficulties of the Government's purchaser/provider scheme. Under the Government's model of the purchaser/provider system of health care provision, the need will be determined by administrators not clinicians. Once the determination of the need becomes an administrative rather than a clinical task then the shortcomings in the system of determining need become apparent.

---

<sup>22</sup> Improving NHS Dentistry, *ibid.* p. 14.

<sup>23</sup> improving NHS Dentistry, *ibid.* p. 15.

<sup>24</sup> Improving NHS Dentistry, *ibid.* p. 14.

The difficulties in determining need undermine the concept of the purchaser/provider model of health care management. If the need is determined on previous years' figures then the difficulties with the present item of service arrangement recur. If there is an arbitrary system, there is the same difficulty with the item of service arrangement of over and under payments. Using sample populations means that the difficulties in choosing representative samples need to be addressed. The final point made was that of financial constraint determining need, that is in a good financial year patients may be entitled to treatments which are not available in a poor financial year.

The determination of dental health care needs should be based on the clinical judgement of those providing the service and not on administrators operating under restrictive guidelines. It is possible to argue that the discrediting of the item of service payments started with the introduction of the New Contract, against the wishes of general dental practitioners. The radical overhaul of the general dental services has resulted in a system of payments which is a mixture of systems which does not have the confidence of dentist and patient alike judged by the reported responses of both parties. Arguably, instead of another radical change to the system of provision, smaller changes will result in a better service.

If changes are wanted, these changes could include the limitation of the number of patients on a dentist's book. Two thousand patients would appear to be a reasonable maximum for any dentist to be responsible for after discussion with practising dentists. Dentists could as under the present system be paid a retainer for having the patients, whether adult or child as registered patients, and then be paid on an item of service basis. This system has a number of advantages, one of the most important being that the dentist has a guaranteed income to start with and with careful husbandry of his/her patients to ensure their dental fitness, a patient base which should have improved oral health as time progresses. This last point needs to be explained. Under an item of service arrangement, the more treatment the dentist undertakes the greater the gross payments, but the higher the overheads. Under my proposals, the gross payments should become less (allowing for inflation), but the practice overheads will also be less and thus the income from the practice should be steady.

***The Government's Proposals for Reform.***

The heading for this section has again been taken from the Green Paper to allow ease of analysis and reference to the Green Paper. The Green Paper splits this section of the paper into five different topics.

1. A local system.
2. The direction of change.
3. Sessional fees.
4. A dental fee scale.
5. Implementation: managing change.

***1. A Local System***

A local system of dental health management may have some benefits for the Government, but its overall contribution to the provision of health care needs careful analysis before introduction not after its inception and failure. The Green Paper makes the idea of different potential populations being treated differently as being a prime reason for introducing such changes that can bring this about. Unfortunately, the reasoning behind these ideas is flawed from the aspect that the 'poorest' population is usually the poorest represented and the least able to manipulate the system to its benefit when compared to better off areas. This potential failure of a population to represent itself leaves it open to the manipulation of others parties, who can decide what its priorities are. This point was not in the Green Paper as can be seen from the extracts below.

43. Dentists working in different areas serve populations with very different needs. Even within small areas these differences can be marked. A typical health authority may have groups within its resident population with relatively poor oral health alongside others with very good oral health.

44. Sir Kenneth [Bloomfield Report] defined a "locally-sensitive" system in his report which would aim to make the system more responsive to these different circumstances. It involved giving the available money to the appropriate tier of local NHS management who would then develop local strategies with the dentists in the area for improving oral health. They would then target resources through buying the necessary care and services from local dentists to achieve these improvements.

45. This would allow more sensitive approaches to be developed and used. Local NHS managers would discuss and agree objectives with local dentists within the overall strategy and then agree contracts, backed with money, to buy the services needed. Only in this way can rational decisions about dentistry as part of the

wider local NHS service be taken. Only in this way can local strategies for improvement be developed and implemented.<sup>25</sup>

These sound reasonable, balanced arguments for implementing local strategies, decided upon by local dentists and health care managers. Unfortunately, they are not as reasonable as first appears. The concept of local 'experts' deciding for the local population, immediately runs into trouble over the exact nature of how local is local and who will represent the interests of the local dentists, patients and management. The foreseeable difficulty, is that of how representative the local knowledge will be. To have the local knowledge necessary to make decisions on the health care provisions of a well defined locality such as that implied in the Green Paper, the decision makers will not only have to work and provide the services for the restricted community, but more importantly live there and be part of the community before they can claim to be in a position to make a decision for that particular locality. Local knowledge needs to be collected from many sources and unless the person acquiring the knowledge has intimate knowledge of the locality, they will inevitably interpret their "local knowledge" subjectively in their opinion rather than objectively.

To the independent observer, it is apparent that difficulties can arise with this concept. For the most part, the decision makers; that is, the dentists and managers will be resident in the better off areas of the community and will undoubtedly have the knowledge and expertise to make decisions for their section of society. The difficulty arises with the inner city areas and large (council) estates that arguably have the greatest need as communities. These are the communities that do not play host to those people who decide what their dental health care priorities are.

Given this scenario, it is possible to see that experts could make informed and reasoned assumptions as to what a particular community may require. However, unless they become an integral part of the community they arguably would be providing services that they think the community needs, not what the community may wish upon itself. Thus, it may be that what starts out as a community project and an example of local democracy in action can well become an even greater example of paternalism than the present centralised system of determination of need.

The advantage of the centralised system of determination over the local system of health care determination of priorities is the basic concept that all will be treated the same. For better or worse local communities that have difficulties are still part of the same system as the better areas. The obvious answer that resources can be targeted by locality on the smaller scale if priorities are decided by locals singularly fails to meet the even more obvious response. Those who know the system are better placed to manipulate a system to their advantage, if based locally rather than a national system with some semblance of uniformity of health care provision. Given the accepted difficulties certain parts of the country already have with NHS general dental services. It is possible that local negotiations may result in an even greater imbalance than at present with dentists being attracted to the more affluent areas of the country where they are better supported by the community and its representatives.

The thinking of the Government is plain, that only the purchaser/provider system of health care management can provide services, a view that fails to appreciate the services provided by the NHS prior to reorganisation and the confidence the population had in the NHS, an eroded confidence these days. The Government's approach can be seen in the following quotations.

46. This approach [of local sensitivity] is similar to the model used in the secondary and community health services since the Government's reforms of 1991. Since then it has been possible to take better account of local variations in needs for health care by separating the roles of " purchasers" and "providers" of care. The purchaser identifies local needs and priorities, taking account of available resources and, in a series of NHS contracts, agrees with providers the levels and standards of services, which should be made available for a local population. This means that the levels and types of care provided are based on objective decisions about needs and priorities. This is a powerful model, which could have a major role to play in assessing and meeting local priorities for oral health.<sup>26</sup>

This section, in my opinion, is one of the most important in the Green Paper if not the most important. It is also the most frightening in content. It arguably is a model for destroying cohesive standards in NHS dentistry. "The purchaser identifies local needs and priorities, taking account of available resources..., agrees with providers the *levels and standards of services*, which should be made available for a local population." A uniformity of minimum standards has been one of the key planks in the General Dental

---

<sup>25</sup> Improving NHS Dentistry, *ibid* p. 16.

<sup>26</sup> Improving NHS Dentistry, *ibid.* p. 16.

Council's disciplinary procedures against dentists. Here, the Government through the NHS is setting about the diminishing of the standards imposed by the GDC. From the above quote it is possible to make a statement that questions whether the Government is seriously concerned about the general dental services remaining as part of the NHS, the quote being: “The purchaser... taking account of available resources... agrees with providers the levels and standards of services.”

Thus, an in-depth analysis, section 46, brings a new outlook to NHS dentistry, the standards and needs for dental health care are to be based on financial resources not on professionally identified need by the individual dentist as well as the dental profession as a whole.

This analysis exposes the hypocrisy of the subsequent sentence, "the levels and types of care provided are based on objective decisions about needs and priorities". The statement, is a deception as the previous sentence makes it clear that the "available resources" determine the standards and levels of service to be provided. The question to be asked is, how can a contract for services be objective in standards when the standard is determined by financial availability of funds? The answer must be that the standards are subjective based on the availability of funds.

The response to this must be to make the acceptable standards independent of financial constraints and thus be objective for both purchaser and provider. The difficulty, from the Government's point of view, with imposing a uniform objective standard is that it reduces the possibility of saving money by reducing the quality and quantity of service to levels determined by local NHS managers. If, an objective standard of dental health care for the individual patient will be imposed by the General Dental Council on dentists then the attractions to the Government of the purchaser/provider model of health care and the potential savings involved would be greatly reduced. The continued pushing of the local purchaser/provider system can be compared with the military objective of "divide and conquer". A fragmented general dental service would not have uniform standards of health care provision and in such a division it is unfortunately an unspoken maxim that those who are least able to look after themselves suffer the most. Here the Government has made a disaster of the New Contract for dentists and its ideas of correcting those difficulties can only make the situation worse. People who rely on the NHS general dental services will if the purchaser/provider model is adopted find that they are in no better a position than at present and in many cases they will have less affordable access to dental health provision.

This purchaser/provider model is also given 'preference' by other observers and commentators according to the Green Paper. These include the Health Select Committee<sup>27</sup> and the DDRB<sup>28</sup>. It has been acknowledged in the **Bloomfield Report**<sup>29</sup> that there are other methods of financing the provision of dentistry to the public. (The term general dental services not being used as there is no specific commitment to the GDS.) The Government would however, from the tone and implications of the Green Paper, seem to have already decided on the purchaser/provider model and now seeks to justify its conclusions.

51. The Government agrees [see s.50, p17 G.P.]. Individual patients and the population overall would benefit if NHS dentistry were more fully in the mainstream of the NHS. The system for funding secondary and community care now works well, with significant benefits for patients. General dental services cannot be compared directly with hospital care but it should, nevertheless, be possible to introduce similar principles with the same benefits for patients overall. Decisions on standards and levels of oral health care should be taken in the context of decisions about general health care provision. Within their overall health budgets local NHS managers would target resources to meet these variations and to achieve the strategies developed locally by all involved.<sup>30</sup>

The drawback with this approach is the same as for section 46<sup>31</sup>, namely that the standards and levels of care are to be determined by managers. Clinical standards are thus to be determined by non-clinical decisions. Unless the Government is prepared to underwrite the professional indemnity of the dental practitioners then there is the potential for litigation in the Tort of Negligence by plaintiffs. There would in theory, be little difficulty in proving that dentists in general, as well as the individual, had fallen below the accepted standard of care owed to the patient (a legal duty). This would be true, even though they may have acted in accordance with the local conditions and standards accepted from the dental practitioners in the given area.

---

27 Improving NHS Dentistry, *ibid.* p. 16.

28 Improving NHS Dentistry, *ibid.* p. 16.

29 Improving NHS Dentistry, *ibid.* p. 17, s. 50.

30 Improving NHS Dentistry, *ibid.* p. 17.

31 Improving NHS Dentistry, *ibid.* p. 16.

The difficulty with adopting a standard determined at the local level is the variation that is introduced into the system. Standards, in any measurement or subject should be based on a national standard, not a local one. Adoption of a local standard undermines the principles of the GDC and their control over professional ethics and standards for dentists.

The maintenance and integrity of professional standards are essential if a health care profession is to maintain the trust of patients. These standards are not subjective standards, but are objective standards imposed by the regulatory authority and are set to the highest acceptable minimum standard, which a member of that profession should attain. The idea of locally imposed standards is at variance with those of nationally imposed standards especially when acceptable local standards are to be determined by finance rather than clinical need. This dilution of professional standards can only be at the expense of patient care and as such should be opposed if patient standards are to be maintained for all those who seek treatment.

There is undoubtedly the potential for a conflict of interests between the professional standards demanded of dentists by the GDC and the proposed authority to be given to local NHS managers to set the standards for dentists in their own areas. This conflict of interests needs to be resolved before any trial scheme of full-scale implementation of the purchaser/provider model is introduced.

The question needs to be asked what are the standards to be expected from the local NHS managers' requirements of dentistry? Unless it is made plain from the outset that there will be no diminution of the present standards then the Government is placing a fearsome burden on general dental practitioners. They may have to resolve the conflict between their professional standards and the lower standards demanded and paid for by NHS management. The purchaser/provider model is a model that if applied to dentistry in its proposed form will hasten the move of dentists to private practice if the client/patient base is sufficiently wealthy to pay. For those dentists with a poor patient base then there is a greater risk of becoming bankrupt under the Green Paper proposals. If the dentist drops below the accepted standards required by the GDC then he/she would face an appearance before the GDC. The difficulty comes when the dentist is paid for inferior quality and maintains the quality at his/her expense. This is a recipe for bankruptcy or a move to private practice.

53. The Government believes that this model [purchaser/provider] offers the best way to meet the objectives of the review and to address the main points put forward during the consultation.<sup>32</sup>

Thus it is made clear where the Government's preference lies with regard to NHS dentistry and its provision to the public.

## ***2.The Direction of Change***

The Government has already determined the direction of change that the NHS general dental services are to take. The proposals in the Green Paper whilst nominally for discussion are the favoured path of future NHS dentistry. As such the Government even in the Green Paper makes every effort to justify the purchaser/provider model as being the most efficient for patients and dentists alike with benefit to the finances of the country a pleasant after effect.

54. Under the system described above [purchaser/provider model] the remuneration system would be determined locally, through negotiation. That offers clear advantages for all concerned. ... Patients and dentists stand to gain from earlier reform of the general dental services. It is clear that the present flawed remuneration system cannot be left in place while the purchaser/provider model of delivery is being tested and evaluated.<sup>33</sup>

This section thus seems to place the emphasis on dentists and patients rather than the Government, but the next section, s.55, needs to be read with s.54 before any discussion can take place.

55. Similarly, any reform introduced will need to include some mechanism for dealing with the large sums of money owed by the profession to the Government under the current balancing mechanism. It is indefensible that, when large sums of money are owed, repayment is not swift and effective, but instead can be spread over many years, possibly decades. The Government will discuss with the profession ways of ensuring that, in future, repayments are made as soon as possible.<sup>34</sup>

When sections 54 and 55 are taken together, the logic behind the desire for the purchaser/provider model becomes apparent. The purchaser/provider model will involve the Government in a fixed fee to provide NHS dental services. The services provided will be regulated by the fixed fees not the need for dental

<sup>32</sup> Improving NHS Dentistry, *ibid.* p. 17.

<sup>33</sup> Improving NHS Dentistry, *ibid.* p. 17.

<sup>34</sup> Improving NHS Dentistry, *ibid.* p. 18.

treatment. In contrast, the present system is an open ended system where the fees paid by the Government to dentists are determined by the number of patients seen and the amount of work undertaken.

There is little evidence that there is a systematic defrauding of the NHS by general dental practitioners by performing excessive and unnecessary treatment. Undoubtedly, some dentists do circumnavigate the rules and regulations, but the mechanisms of check and counter-check are in place to catch the offenders. This being the case, the Government in the Green Paper, is unfairly criticising dentists for undertaking justifiable treatment which patients need. In contrast the Government's ideas of the purchaser/provider model with fixed amounts of money available, determined at the local level means that the dentists will need to prioritise patients needs according to the finance available. Patients will not of right be entitled to all the treatment that they need, only that which there is money available for. This method of finance and provision of services would leave little choice for both dentists and patients to move into private practice if they wished to be the recipients and providers of good quality dentistry.

The Government proposals, then sets out to mask this point by emphasising the deficiencies in the present item of service payment system. There was criticism in the Health Select Committee's report about the incentives of the item of service payments, a point latched onto in the Green Paper.

58. As the Government noted in its response (to the Health Select Committee), there is no evidence in a fall of quality. There are safeguards in place for the patient. Chief amongst these is the fact that dentists are members of a long-established professional group which sets great store by high standards of clinical and ethical duty. ... Nevertheless, the Government must give due weight to the Health Select Committee's views and consider the incentives in the current system. In the main any perverse incentives derive from the basis of payment by fee for item of service. The incentives to high throughput of patients and restorative work for high earnings could not be removed without the replacement of that system.<sup>35</sup>

The Government emphasises the professional role of dentists in this section, but then in previous sections (s.46 and 51 in particular) that the standards are to be determined locally. Prior to the Green Paper there was the unspoken suspicion that the Government was preparing the way for a two tier dental system of private and NHS patients. The interpretation placed on the contents of the Green Paper considers this idea to be a distinct possibility, with the even more frightening prospect for patients of a two tier standard of dentistry.

The private patients will have their treatment and standards of treatment performed as to their needs whilst NHS patients will have their standards and needs determined by the available finance.

The Government is critical of the 'incentive' motive provided by the item of service scheme, but then claims that there is little difficulty in obtaining NHS treatment. The difficulty that should be apparent is that the majority of dentists can cope with a maximum of 2,000 patients. (Figures that the Government's own statistics would support see Green Paper as well as discussion with practising dentists.) There are less than 20,000 general dental practitioners so there will be a shortfall in availability of treatment given that these figures add up to less than 40 million people and that there are in the region of 58 million inhabitants in the United Kingdom. The Government either needs to recognise the benefit of an incentive scheme or increase the number of dentists available to serve the public. Indeed, it is possible to argue that the attitude of the Green Paper is to remove the fee paying NHS patients from the General Dental Services and that the non-fee paying (exempt patients) will be left with a rump service.

59. The decisions a dentist takes about the type and scope of treatment to be offered to an individual patient need to be quite divorced from questions of personal financial gain. Clinical decisions must be taken solely on a clinical basis, taking full account of the informed views of the patient. This is what most dentists do already. Yet the Health Select Committee felt the need to point out the "inherent incentives in the present system" and the scope for "unconscious influence". The Schanschieff Report, the Public Accounts Committee before it, and most other commentators have noted the incentive to intervene and the effect that this might have on provision. The payment system should reinforce professional incentives towards quality in clinical care rather than providing perverse incentives to ever higher throughput.<sup>36</sup>

It is apparent that the Government wishes to divorce itself from the item of service scale and provide a fixed sum of money for NHS dentistry. If this path is followed then the question must be asked, how can the Government ensure that every member of the public has access to a dentist? The present incentive system fails to provide access for all so it would be most unusual if the incentive system is removed and productivity increases.

---

<sup>35</sup> Improving NHS Dentistry, *ibid.* p. 18.

<sup>36</sup> Improving NHS Dentistry, *ibid.* p. 18.

The Government proposes working with dentists to provide answers to the "challenges facing the service".

64. The Government believes the system of payment for dentists should provide the right incentives for the challenges facing the service. ... The Government intends to work with the profession and others to develop these proposals.<sup>37</sup>

Unfortunately, the only challenge that the Government has identified is the financial one of saving money by allocating a fixed budget and providing the service to the budget and not the budget to the service. There has been no identification of the major problem to be addressed and that is dentists have a captive market of more patients than there are dentists capable of treating the patients. Until this imbalance is corrected, there will be the continued stories raised in the press that an adult is unable to obtain NHS dental treatment and that 75% of dentists are willing to go privately for dental treatment (Denplan survey 1:9:94). The problems facing dentistry are not just financial, but an accumulation of various problems of which finance is only one.

### **3. Sessional Fees**

Sessional fees, is again the heading employed in the Green Paper and for ease of usage has been adopted in this thesis and used as the heading for this section.

The Government having decided upon its chosen preference for a dental model, the purchaser/provider system, and shown it to compare favourably with the alternatives suggested in the Green Paper has followed up by discussing the financing and development of such a system of dental provision.

65. A system is needed which is capable of evolving smoothly through managed change toward the locally commissioned system described earlier.

66. The emphasis in the system should be on the quality of care. It should focus on patients. It should divorce financial from clinical incentives and give proper reward for preventive work. It should allow dentists to make personal judgements about their businesses and their commitment to the NHS, and their NHS reward should reflect these judgements. NHS income should reward them fairly and variations in costs should be reimbursed more sensitively. It must operate within a framework of proper financial control for the tax-payer. Dentists want to keep their independent contractor status and to be treated as health care professionals. The system should respect both wishes. The service should be tailored to the needs of the population. Priorities must be set and resources targeted towards them.<sup>38</sup>

Section 65 again makes it clear that a local system of dental health provision will be introduced. The only question is, when? Section 66, places emphasis on the quality of care and the need for dentists to express their own independence and commitment to the NHS with adequate reimbursement for this commitment. At the same time financial control is to be exerted for the benefit of the taxpayer. Unfortunately, the reasonableness of these suggestions is destroyed in the last two sentences of s.66. The needs of the population are to be determined by NHS managers as are the priorities to be targeted. There is no commitment here to ensure that all those who wish to have access to NHS dental treatment can do so.

On in depth analysis of the Green Paper, the lack of commitment to the general dental services is apparent and only certain parts of the system will survive. Given this approach, it is possible to argue that many patients will find it more difficult than ever to receive dental treatment given that they are not eligible for the targeted NHS services and cannot afford to go privately.

The Government has proposed that dentists should be rewarded for the sessions that they spend treating NHS patients, s.67, 68 and 69. This is a reasonable suggestion if there were adequate dentists to provide universal access to dental services for the whole of the population. There is a suggestion in these sections that if a dentist does not perform enough work in the session that there will be an enquiry into why with the possibility of a Service Committee hearing. This is a dangerous suggestion to make, given the emphasis placed by the Government on reducing the incentive for financial gain. This is to be achieved by doing away with the item of service payments. Either fewer patients will be treated under the sessional scheme or dentists will be forced to reach targets proposed by administrators. This is no improvement on the item of service scheme. The difference being in one, the item of service scheme, there is no minimum number of patients to be seen or time to be spent in a session. The incentive to treat more patients is the increase in fees earned. The other (sessional payments), sets target numbers which if not met can involve the Service Committee and fines. One encourages more work by an incentive scheme and the other greater productivity by a system of fines.

---

<sup>37</sup> Improving NHS Dentistry, *ibid.* p. 19.

<sup>38</sup> Improving NHS Dentistry, *ibid.* p. 19.



The difficulty can be eliminated fairly simply by the application of common sense. There is little doubt that a maximum of 2,000 patients is capable of being accommodated by the individual dentist if committed full-time to the NHS dental services. Given these figures, no dentist should be permitted to be responsible for the dental health of more than two thousand patients, and be remunerated accordingly. Given a limit of two thousand patients, a sessional fee scheme may well work, but with no patient limit, the levels of treatment and patient numbers will be set by administrators in accordance with finances available.

The difficulty with the proposal to limit patients to 2,000 would mean a registration process would be required and the shortfall in dentists' numbers would be highlighted.

Sessional fees have their merits, but given the present shortage of dentists compared to the population as a whole, the adoption of sessional fees may exacerbate the difficulties in obtaining NHS dentistry. The difficulty with the purchaser/provider system in health care management is that it is an artificial internal market that cannot readily respond to changes in demand. The emphasis on local need may be admirable, but the determination of local need is open to interpretation. The reality of the situation is such that there are finite resources for an infinite demand and unless, this is acknowledged by the Government, and resources given to those who can benefit most from them, namely children, it will continue to be a demand which cannot be satisfied.

#### **4. A Dental Fee Scale.**

A dental fee scale is dependent on the system of remuneration chosen. Until the health care model is chosen then the discussion can only be theoretical. The item of service fee scale has failed to meet with the approval of the Government, but until 1990, it had been accepted as being adequate even if not perfect. Since then difficulties have arisen in NHS general dental practice following the introduction of the New Contract.

However, with private patients, the item of service fee is still the preferred method of payment. The Government is committed to the free market approach throughout the economy, but when this is applied to NHS dentistry it is wrong whereas it is the accepted approach for private patients. The purchaser/provider model is not a free market model, but a regulated planned model with treatments dependent upon the finances available.

76. No change is not an option. The present system has many faults which have recently been drawn into sharp focus. ... Any system based on fees would be prone to the problems encountered with the present one. Such serious flaws mean that a fee-based option offers no prospect of forming a long-term basis for the NHS dental service in the future. The Government recognises, however, the case for stability which has been pressed by some in the profession and elsewhere. In the short-term, it could be possible to make changes to the current system to address some of the flaws and to go some way towards the objectives of the review.<sup>39</sup>

The system of item of service remuneration whilst not perfect in use enabled those people who wished to benefit from NHS dentistry to do so. It is also the system employed by dentists in private practice treating private patients. The difficulty with this system from the Government's viewpoint is that the finances required are open to fluctuation. The purchaser/provider model ensures that the Government's financial commitment is a closed commitment and that the flexibility is in the amount of treatment that the money can purchase. There is little or no danger of the Government being asked to pay more for dental services after the contract for the specified period of time has been fixed.

The Green Paper has failed to examine all aspects of general dental practice, but has unfortunately concentrated on the financial side of the service and all the proposals are concerned with reducing the Government's financial commitment to dentistry. This may save money in the short term but the problems being developed will more than offset any short-term gain.

#### **Developing the Community Dental Service**

The Government has even included suggestions concerning the Community Dental Service in the Green Paper and the availability of a 'safety net'.

80. The Government is committed to an effective and accessible NHS dental service. Whatever reforms are introduced the Government intends to take steps to ensure the accessibility of the service. The first step in that process is to ensure that local services are maintained for all who want them and that there is an adequate "safety net" to cope if general dental services are not readily available.<sup>40</sup>

---

39 Improving NHS Dentistry, *ibid.* p. 21.

40 Improving NHS Dentistry, *ibid.* p. 22.

This would appear to be acceptance of the fact that general dental services are now no longer able to cope with all those who wish to benefit from their provisions. Community dentists are already treating patients in certain parts of the country for emergencies if they are unable to find a NHS dentist willing to see and treat them. The difficulty comes with the commitment to a 'safety net'. There is no information on whether this will be a service dedicated to the relieving of pain, or a comprehensive dental service for those unable to find a NHS dentist willing to accept them as NHS patients.

81. Since then (July 1992), FHSAs have generally reported that they have been able to advise anyone who contacted them on how to get a NHS dentist locally. Yet, to do that, some FHSAs have on occasion had to have recourse either to salaried dentists employed by FHSAs or to the Community Dental Service. These represent important "safety nets" for those unable or unwilling to use general dental services. The Government intends to strengthen this function to ensure all patients who want NHS services have adequate access to them, even if their regular dentist decides to decline NHS work in favour of the private sector.<sup>41</sup>

The Government would appear to have accepted the fact that NHS dentistry will now not be available to all who require it from the general dental services and are putting into place a 'safety net' for those who are unable to find a NHS general dental practitioner. This may be regarded as forward planning on behalf of the Government or just as poignant acceptance that NHS general dental services will now not be available for all that require them. The Government also wishes to strengthen the 'safety net' by combining the Community Dental Services contributions to this 'safety net' with those of the dentists employed directly by the FHSAs.

82. It makes little sense, though, for there to be two quite distinct groups of dentists, each with an explicit function of providing a "safety net" in those parts of the country where at any given time the GDS provision is not fully adequate for all who wish to make use of it. Nor does it make sense for one sector to be able to levy charges whilst the other cannot. The Government therefore intends to strengthen the CDS to take over this "safety net" role, thereby reinforcing its existing function of primary care dentistry for those who, for whatever reason, cannot have ready access to the GDS. This is consistent with the announced intention to enable, in England and Wales, District Health Authorities (DHAs), responsible for the CDS, and FHSAs, responsible for salaried GDS dentists to merge. Subject to Parliamentary consent, the Government would also propose amending legislation to allow the CDS similar to those applicable in the GDS on patients not otherwise exempt.<sup>42</sup>

The Government has accepted the fact that the NHS general dental services will not return to the pre New Contract days of access for all those who wish to benefit from the service. Thus, they are putting into place a 'safety net' for those unable to or unwilling to find a dentist who will treat them as NHS patients. The obvious difficulty with this system is the simple expedient one of finance. The Government has made the purchaser/provider model the key stone of its proposed NHS changes, as this will give a fixed financial commitment and then immediately it responds by giving an open-ended commitment to provide access to dental services for all who require it. This is a commitment without limitation. The only limitation will be the number of dentists that the CDS will be able to recruit.

Given the strict financial control imposed by the purchaser/provider model and the Government's claimed commitment to value for money and financial management, this commitment to the safety net raises questions which need to be asked given the Government's commitment to the free market.

1. Is the Government trying to establish a two-tier system of dentistry, NHS and private?
2. Will the services provided and the materials as well as the staff conditions be rigidly controlled in NHS dentistry when compared to private practice?
3. Will CDS salaries equate with target income of general dental practitioners?
4. A difficulty in general dental practice is the non-payment of fees, will the Government fare better?
5. If NHS dentistry is only available to those not able to or unwilling to pay for private dentistry: that is the 'poorest' patients', will this mean that the CDS will only be able to employ the worst dentists?

Obviously, the Green Paper is a document for discussion and the safety net is only part of the provisions to be discussed in the context of NHS dentistry. The difficulty with the Government's proposals is that if, as stated previously, they wish to award a finite amount of money to NHS dentistry, then there is an open-ended commitment to providing a safety net. The unfortunate thing is that tight financial control and a safety net do not go together unless the safety net is to be limited in scope and available finance.

---

<sup>41</sup> Improving NHS Dentistry, *ibid*, p. 22.

<sup>42</sup> Improving NHS Dentistry, *ibid*. p. 22.

The questions raised above will not be answered here, but have been included to demonstrate the difficulties which need to be faced in discussing general dental services. The commitment to the safety net will undoubtedly mean the need for a recruitment drive to the Community Dental Service. The difficulty can arise in attracting people. Salaries will need to be pitched at a level to be competitive with general dental practice. Thus, the safety net may impose greater financial strain on the NHS resources than the Government has anticipated.

The use of the Community Dental Service as a safety net is far removed from the original concept of a Schools Dental Service. Whilst children are undoubtedly a major part of the system of priorities, the Government in its proposals is suggesting making the CDS a rival and subsidised competitor for general dental practice in direct contradiction of its stated free market policy. The Government may have to accept that health care systems do not readily lend themselves to free market policy. The positioning of a safety net can distort the free market policy to such an extent that a compromise is achieved that is neither a controlled health care policy nor free market policy, but an unworkable compromise of both.

### **Implementation: Managing Change**

Given the Government's preferred option for change, there is the need to supervise both the change in orientation of dental services and provisions as well as ensuring the long term maintenance of standards. These difficulties have been faced in the Green Paper.

83. A payment and prior approval authority is needed in both the sessional and the fee based models. There must also be an effective inspectorate. The Government proposes that for both options the existing authorities continue to be responsible for these roles, at least until the longer-term structure of the service is known following evaluation of the purchaser/provider pilots.<sup>43</sup>

The Government in its proposals for NHS dentistry has recognised the fact that there needs to be administrative control over the system chosen, if any will be picked, and at the same ensuring that there is a measure of quality control. The surprising aspect that has not received any attention in the Green Paper is the matter of clinical audit. It is possible to argue that both the dental profession and the Government have "boxed themselves in" with regard to general dental services and changing its orientation and the services provided.

Both the Government and the dental representative bodies have concentrated on the financial aspects of general dental services as being the major cause of the dispute between dentists and the Government. This is not the complete truth, finance is only the most obvious aspect of a complex relationship which is in difficulty. The concentrating of both sides on this one aspect has been at the expense of patients and dentists alike. Patients have been abandoned by the system and dentists have been forced to break their ties with the NHS.

The administrative and inspectorate systems for general dental practice may in the near future find themselves administering and inspecting non-existent NHS general dental services, though rumour is persistent in the dental profession that the inspectorate wishes to spread its services to private practice.

Recognition of the need to administer and inspect is fine as long as the Government maintains the NHS general dental services in a recognisable form. The difficulty can and will arise with the drift of practitioners away from the NHS to private dental practice and the consequent growth in the Community Dental Service that already possesses an administrative system. Even greater difficulties are liable to arise from the inspectorate and its role in the Community Dental Service. The sanctions used against general dental practitioners who breach their terms of service; that is the withholding of fees, are not applicable to the Community Dental Service with its salaried staff. As the methods of payment are different, it would appear to imply that a new role needs to be found for the inspectorate. Possibly, however, CDS staff would be liable to the sanctions proposed for NHS medical staff, namely that they will be prevented from treating NHS patients if they do not reach the appropriate standard. This point will, or should, become clear when the appropriate Act is passed.

Sections 84 and 85 are also further developments of the administrative procedures and the possibility of legislation to introduce purchaser/provider pilot schemes and the long-term establishment of such schemes.

Conclusions to the Green Paper cannot be made until the annexes have also been discussed in some detail as some of the most important proposals are contained within them.

---

<sup>43</sup> Improving NHS Dentistry, *ibid.* p. 22.  
Gareth R Thomas © 1994

### The Annexes to the Green Paper

There are three annexes to the Green Paper, which will be discussed before conclusions can be made. The annexes are

1. The present system
2. Sessional fees
3. A dental fee scale

#### *The Present System*

Annexe A dealing with "the present system" [of the NHS general dental services] is concerned with the various stages in the development of the general dental services to the present day. The early history of the NHS general dental services are littered with failed schemes of financial recompense and reductions in fees on the item of service basis. The annexe works its way through the financial development of the general dental services and the remuneration system for dentists from the inception in 1948 to the present.

The basis of the scheme/s even though item of service based were to reward dentists for the time that they spent at the chairside with different items of treatment valued according to the time that they would take to give a balanced income for dentists. The difficulty with this system has been the emphasis placed on individual treatments which as techniques and methods improve have resulted in more complex treatments becoming accepted if not the norm. The great complaint about the item of service fee scale was that there was no reward for preventative treatment, only for interceptive work.

The worries about the general dental services and the remuneration scheme reached a climax with the **Schanschieff Report** (A Committee of Enquiry into Unnecessary Dental Treatment 1984).

" It [the Schanschieff Report] found that it was likely that a significant amount of unnecessary orthodontic treatment was carried out in the GDS and that in general the level of unnecessary orthodontic treatment in the GDS as a whole was significant though not so significant as to lead patients to lose confidence in their dentists. It concluded that out of date treatment philosophy might be the primary cause of this, rather than deliberate abuse. <sup>44</sup>

Having highlighted a supposed weakness in the system the modifications to an existing system that worked would and should have been minor. The changes would have involved the simple expedient process of removing orthodontics from general dental practice and giving it specialist recognition as envisaged by orthodontists themselves. This together with a process of continued further education and increased use of the inspectorate would probably have solved the difficulties at that time. Subsequently greater preventative measures could have been produced with time. Dentistry was no exception and the result was the New Contract for dentists in 1990 which has ultimately led to this Green Paper and the need to provide access to dental services for all who so require it.

The Government in its Green Paper has equated "finance and dentistry" and "finance, dentistry and dissatisfaction" as being synonymous. The Government has fallen into the same trap as others in believing that dentists would be satisfied with 'their position', if they were paid enough. It would appear to have passed the notice of the Government and its advisers that dentists have left the NHS for private practice and are satisfied with the terms and conditions of private practice. Emphasis on finance is fine, but not at the expense of the other difficulties facing the provision of dental treatment to the population of the United Kingdom.

The present system aims to give to the average dentist a pre-determined net income from the NHS and to pay for all expenses associated with running an NHS practice. The amount an individual dentist will earn will depend on the amount of work that individual does and the net element will depend upon the actual expenses incurred. There is a wide variation in NHS earnings between practitioners. <sup>45</sup>

In all other aspects of Government policy including other parts of the NHS the Government actively encourages people to work harder to achieve more, in accordance with free market policies. The free market policy has been applied to NHS general dental services since the beginning and this has met with disapproval of various bodies and reports. It is apparent that the Government has decided upon the purchaser/provider model to be used in the NHS general dental services and other schemes and systems must be blackened in comparison with this scheme chosen by the Government.

---

<sup>44</sup> Improving NHS Dentistry, *ibid.* p. 26, Annexe A, s. 17.

<sup>45</sup> Improving NHS Dentistry, *ibid.* p. 26, Annexe A, s. 20.

At present, a general dental practitioner is reimbursed through five different categories of payment. These are:

1. Adult continuing care payments;
2. Child capitation fees;
3. Child entry payments;
4. Adult item of service fees;
5. Child item of service fees.

It is obvious from the above system when compared to the pre New Contract situation of two payments: viz 1. Adult item of service fees; and 2. Child item of service fees:

that the administrative responsibility of dentists has greatly increased. There is no recognition of the fact that the administrative load may be responsible for the difficulties facing the NHS general dental service. The difficulties facing the NHS general dental services are going to increase rather than decrease if the Government persists in its attitude to dentists. This is borne out by the section below.

29. At present every dentist owes the Government a considerable sum, probably an average of well over £15,000. The scope for recouping these sums quickly is severely limited within this mechanism. The system can be so protracted that dentists who gained from the overpayment may retire or leave the GDS whilst those joining or remaining repay the debt.<sup>46</sup>

This insensitive attitude at a delicate time for the NHS general dental services can lead to widespread dissatisfaction by dentists with the whole concept of NHS dentistry and withdrawal from the system entirely. The threat of losing £15,000 pounds could well be the incentive that many dentists need to spur them to leave the NHS for private practice. Given the precarious nature of NHS general dental practice, the Government in its handling of the situation is either very indelicate or is deliberately provoking a confrontation which will result in the NHS dental services consisting of a salaried rump whose function is the relief of pain.

Minor tinkering with the system of remuneration as envisaged in sections 32, 33 and 34 of the annexe are regarded as short term measures and these will not be discussed only acknowledged as having been proposed pending major revision.

### **"Sessional Fees" and "A Dental Fee Scale"**

"Sessional Fees" and "A Dental Fee Scale" are the headings of the last two annexes to the Green Paper on dentistry. The concept of TANI (Target Average National Income) is a non-runner in future financial development of the NHS general dental services. The Government has made clear that there is no such person as the 'average dentist' and accordingly this person cannot be used as the basis for determining income levels. This leaves the two schemes of sessional fees and a dental fee scale.

#### ***B. Sessional Fees.***

Sessional fees would appear to be the preferred option of the Government, but the difficulty with sessional fees is the obvious attraction of performing as little dentistry as is compatible with the maximum financial remuneration. Once the productivity targets have been reached there is no incentive to undertake further work unless given a financial inducement to do so. There are two obvious responses to this, the first is to set high targets and the second is to award greater productivity.

The obvious disadvantage of either of the two schemes is that finance is based on the ability to do work quickly, the so called drawback with the item of service payment scheme. If the sessional fee scheme is introduced great care needs to be taken to ensure that it is not a rehash of the item of service treadmill where dentists are paid on their productivity.

1. The level of remuneration for a dentist working full-time in the GDS would be set. Full-time would be defined as a 35 hour week for 46 weeks a year. From this annual figure the health departments would derive a sessional fee based on 10 sessions of 3.5 hours a week as a "full-time" commitment. The dentist would then be paid for the number of sessions completed, subject to a global annual limit determined by the health departments. The number of sessions available to a dentist would depend in part on the pattern of NHS treatment provided by that dentist in the past. Out of session activities, such as out of hours emergencies, could be dealt with through a notional figure in the sessional fee or through payment of a sessional fee credit or by other means.<sup>47</sup>

---

<sup>46</sup> Improving NHS Dentistry, *ibid.* p. 28.

<sup>47</sup> Improving NHS Dentistry, *ibid.* p. 30.

The annex 'B' then goes on to deal with the expenses and the way they would be incorporated into the sessional fee<sup>48</sup>. The inflexibility of the present system was then discussed and how expenses and costs vary throughout the country and by implication the need for financial remuneration. The tone of the suggestion being, those in the more affluent parts of the United Kingdom should be better rewarded than those in the least affluent parts of the country. The sole criteria being that those in the affluent parts face larger expenses precisely because the parts of the country are affluent. The suggestions being couched in language that suggests reasonableness in the matter. *"He [Bloomfield Report] also noted, however, that those who serve populations with poorer oral health but in an area where costs were higher could be in the worst situation.<sup>49</sup> This is a difficulty which applies to each and every individual dental practice. Either the Government faces the prospect of paying for staff, surgery and equipment expenses or the individual dental practice will have to submit detailed accounts of legitimate expenses if the system is going to be equitable.*

The arguments being that property in some parts of the country due to the prosperous nature of those areas are more expensive than the less affluent areas. This may well be the situation, but in these areas there are greater numbers of private patients and unless the individual dentist is prepared not to accept private patients, the situation will undoubtedly arise where the taxpayer is subsidising private patients. The introduction of any scheme to differentiate remuneration on grounds of locality is fraught with great difficulties and the Government may well be better advised to pay a percentage of the fixed expenses such as the business rate depending on the time spent treating NHS patients.

If the Government follows through with these proposals, there is every possibility that there will be a drift to the more affluent areas with the 'better clientele'. Dentists would have greater financial return as well as having a relatively easier practising life when compared to the less affluent areas of the country.

The annex then goes on to deal with the problems of dentists claiming sessions and the financial planning of the services in sections 5 and 6 respectively.

5. Once the net income for a full-time NHS dentist had been set, and the level of expenses determined, these would form the elements of the sessional fee. The health departments would then determine the number of sessions which could be afforded and dentists would seek the number they would wish to perform each week, taking account of their current level of NHS practice. They would know, in advance, the level of the fee and so how much they would earn from the NHS. This would improve substantially dentists financial stability and planning generally.

and

6. The number of sessions would be agreed before the start of the year. That means there would be no need for in-year or later corrections to take account of errors in forecasting the amount of work dentists would do. The move from Inland Revenue costs enquiries to a different system of cost enquiries would make it possible to take account of any significant under-or over-payment when setting the expenses for the following year. There would be no need for unsettling in-year changes to control spending. Taken together these are significant improvements in control over tax-payers' money.<sup>50</sup>

These two section together emphasis the fact that the Government's first priority is not to provide a dental service available to all who so require it, but to control the financial purse strings of such a service. A major difficulty with this approach is that demand is determined by finance rather than need. Health care provision is not comparable with the providing of utilities to the population at large. Health care reforms arguably have streamlined the provision of health care and made the service more efficient, but equally arguably the system of health care provision is less efficient as each and every patient is treated as being the same. This may work with inanimate objects, but every human being whether a man, woman or child is an individual person who is different to each and every other person.

The individuality of the person needs to be taken into account in any system and unless recognition is made of these difficulties any health care system will suffer by attempting to classify each individual as being the same as the next. The old item of service fee scale also made the same mistake in that each individual treatment item was classified as the same whoever the patient was. Given the potential limitation on the number of NHS sessions and the need to reach targets to justify a session, the potential is apparent for abuse of the system. Dentists may well see and treat the more pliant patients as NHS patients, then justifiably refuse to treat the more difficult cases as they would be in breach of their terms of contract with the NHS and

---

48 Improving NHS Dentistry, *ibid.* p. 30, s. 2.

49 Improving NHS Dentistry, *ibid.* p. 30.

50 Improving NHS Dentistry, *ibid.* p. 31.

would not have fulfilled the required number of treatments in a given session. Patients may be forced either into the Community Dental Service or to pay private fees. Recognition of the 'difficult' patient should arguably be included in any reform of the system.

Sections 7 and 8 of annex B then deal with the administration of the proposed sessional fees model for general dental practice. Section 7 is concerned with the maintenance of standards whilst section 8 is a 'catch-all' section of administrative procedures and the possibility of mixing NHS and private dentistry.

7. Dentists are health care professionals and deserve to be treated as such. Equally the Government has a duty to make sure that the best value is obtained for tax-payers' money spent. This means that treatments provided by dentists would be monitored so that if levels or standards of activity fall, steps could be taken to put this right.<sup>51</sup>

The proposals are at odds with section 46 of the Green Paper (page 16) where the standards will be determined locally taking into account the finance available. The Government is caught between two forces, one to save money and the other to maintain standards. The concept of one is at odds with the ideas of the other. It is imperative for any health care profession that the highest standards are aimed for and achieved, both for the public standing of the profession and the benefit to the patients' health.

Section 8, aims to demonstrate that the new proposals will be less administratively complex and that dentists will not need to register individual treatments only, "details of the treatments provided in each session". To an unbiased observer, there appears to be little difference between recording each individual's treatment at the end of the course of treatment and recording all the patients seen and their treatment at the end of the session. The amount of work recorded will eventually tally to be the same after an equitable period of time. The old system and the proposed system are two ways of recording the same data so the resulting savings cannot be as great as anticipated.

The other difficulty mentioned in this section of the annex, is that of mixing private and NHS treatments. Section 8 of the annex acknowledges that there are difficulties with mixing NHS treatment and private treatment, but fails to anticipate that given the Government proposals, some patients may prefer to pay more for a better treatment which could not be justified as NHS treatment, but could be justified clinically. The availability of treatments has also been covered in the annex.

9. People who need dental treatment should have it readily available to them. That is the cornerstone of the NHS, in dentistry as elsewhere. It will remain so. However, treatment should be targeted at where it will achieve most benefit, taking account also of priorities elsewhere in the NHS.<sup>52</sup>

This is a commitment to the NHS which given its importance should have been included in the body of the report and not the annex. It is, however, not a commitment to the general dental services only the NHS dental service as a whole. There is, a fundamental failure in the Government's proposals for the 'availability of treatments' that raises concern and that is the failure to recognise the fact that as treatments become more advanced and complicated, the basic legal duty of the standard of care in Tort also changes. The basic concept of dental restorations has changed and more advanced techniques can now be considered to be the norm. Given the **Bolam test**<sup>53</sup> and its requirements dentists may find themselves either in breach of the NHS terms and conditions of service or failing to meet their legal duty in Tort. Before the Government introduces the moratorium on more advanced techniques, the simple question of what are the standards of care expected from a general dental practitioner should be answered. The standard is not that demanded by the Government, but that accepted by the Courts. Unless the Government is prepared to indemnify general dental practitioners against such claims, it is possible that further cutbacks in NHS dental health provision will occur. The accepted standard being that the technique used was acceptable to a reasonable body of opinion. However, the Courts have the power to declare the whole process invalid and not of a satisfactory standard. Thus any practitioner who failed to reach the standard expected in law would be negligent. The approach advocated by the Government of accepting a lesser standard would thus fail to meet the legal standard and the dentist would be liable for damages in Tort.

13. The Government agrees with the thrust of the Health Select Committee's proposals. The central principle will remain that clinically essential need will be met, as in the rest of the NHS. Resources should be focused on diagnosis, prevention and basic maintenance to reflect the needs of the population. Emergency work should, of course, be readily available. Advanced (and so costly) treatments should be available only after a

<sup>51</sup> Improving NHS Dentistry, *ibid.* p. 31.

<sup>52</sup> Improving NHS Dentistry, *ibid.* p. 31.

<sup>53</sup> *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582  
Gareth R Thomas © 1994

rigorous prior approval process has confirmed that a particular course of treatment is necessary for the dental health of that individual patient and that alternative approaches would not be clinically acceptable and cost the charge-paying patient or taxpayer less.<sup>54</sup>

Not only are these proposals a recipe for a legal disaster in that NHS patients are not receiving treatment to the accepted standard of care, they are also the blueprint for a two-tier dental service. The private patient to receive the best treatment and the most modern techniques and procedures whilst the NHS patient will be limited to basic dental treatment of fillings, extractions and basic prosthodontic appliances.

The end product of the Government's proposals will be a service adapted to relieve dental pain as quickly and as cheaply as possible, ultimately an extraction based service. A return to the “bad old days” which since its inception NHS dentistry and the general dental service have fought against. If the orientation of the NHS dental services are to be altered then it must be accepted that those practitioners who are conscientious in the care of their patients will drift away from the NHS into private practice. Indeed, it is possible to argue that the Government's proposals are carefully worded to give credence to the belief that they wish to strengthen NHS dentistry whilst in reality they are a means of destroying the universality of the service. The proposals will leave a rump of patients unable to afford private dentistry who have their requirements dealt with not by clinical need but by available finance.

This problem of what can and cannot potentially be undertaken as NHS treatment has also been dealt with in the Green Paper which has endorsed the Health Select Committee, Fourth Report, 1992-93.

***Diagnostic and Preventive Treatment***

Examinations  
Small X-Rays  
Scaling

***Maintenance Treatment***

Fillings  
Root Fillings  
Extractions  
Exempt treatments (ie: treatments which do not attract a charge)  
Other

***Advanced Treatment***

Other periodontal work  
Surgical  
General anaesthetics  
Veneers  
Inlays and Crowns  
Bridges  
Dentures  
Adult orthodontics<sup>55</sup>

The recognition that there are different health care requirements for diagnostic, maintenance and advanced treatment is a very simplified approach to a complex problem. The difference in the Government's approach between maintenance and advanced treatment would appear to be based not on the clinical practice of dentistry, but on the potential cost of the treatment. It is possible to argue that clinically, root treatments, especially for posterior teeth, require more advanced dental techniques than full/full dentures. One, however, the dentures, requires laboratory support, whilst the other, the advanced conservative treatment does not and so is acceptable as maintenance treatment. The difficulty arises that many, if not all, root filled teeth require crowns on them as the underlying tooth structure becomes brittle. Thus arguably the successful maintenance effort is dependent upon advanced treatment to make it a complete success.

16. These changes will protect the patient from being offered treatment in which the clinical benefit does not match the cost. They will enable health resources to be targeted at priorities.<sup>56</sup>

The argument contained in section 16, is a dubious one given that full/full dentures would be regarded as advanced treatment. The benefit that an edentulous patient would get from new dentures is inestimable.

---

<sup>54</sup> Improving NHS Dentistry, *ibid.* p. 32.

<sup>55</sup> Improving NHS Dentistry, *ibid.* p. 34, s. 14.

<sup>56</sup> Improving NHS Dentistry, *ibid.* p.34.



Given that many patients do not change their dentures until forced to do so by necessity, what may initially be expensive short term may actually be reasonable cheap given the expected time that the dentures will last.

The other topic discussed in Annex B is that of patient charges. It is proposed that the patient will not pay the full cost of the dental examination, but a proportion of it. The Government recognises that the dental examination is an essential part of the programme of health maintenance especially after the article in the *BMJ*<sup>57</sup>. However, there is still no attempt to re-establish the free examination only that a reduced charge should apply. The corollary to this is that fee paying patients after the examination should pay the whole cost of their treatment up to an unspecified maximum figure. The exempt groups would remain the same as at present. Priority would also be given to children if the proposals are implemented, though the actual means of doing so are vague.

### **Annex C; A Dental Fee Scale.**

Annex C; a dental fee scale, uses as the basis of its recommendations the present remuneration system and intends to build on this base, if the Government accepts the proposals in Annex C rather than Annex B. The major change which is proposed in this section which if adopted would be the move away from the 'average dentist', to the concept of a 'full-time commitment' to the NHS. The charges for a dental examination would again in these proposals be reduced though the fee paid to the dentist would remain the same as at present. The difference being made up by the Government.

When the New Contract was introduced, the radical departure from the previous system was the introduction of the children's capitation scheme and the adult continuous care payments. The Green Paper goes on to praise the children's capitation scheme, but not the adult continuous care payment system.

3. The capitation scheme for children and the underlying philosophy is now widely welcomed by the profession and their representatives ... The principles which underpin it are good ones. Under this option this aspect of the remuneration package would remain so that its strengths could be built upon.<sup>58</sup>

4. It is essential, though to monitor closely the effects on the dental health of children of paying dentists in this way to avoid potential problems, in particular "supervised neglect". ... Children's teeth are too important to leave to chance. Parents need to have confidence that all necessary work is done. There would need to be a development of the monitoring of the scheme supported by reports from dentists of work done within it. Evidence of neglect by any practitioner should be vigorously pursued and penalties invoked.<sup>59</sup>

The watchword with the children's capitation scheme is one of careful supervision of the dental health of the developing child. These are admirable thoughts that should enable the individual child to develop a dental health strategy to last a life-time.

In contrast to the success of the children's scheme there is doubt over whether the adult continuing care payments have achieved the desired improvements in adult dental health that was anticipated when they were introduced.

5. Continuing care payments have, ... , not demonstrated any significant benefits to patients. They were introduced ... to recognise and promote the continuing relationship between dentists and patient and to provide a more stable element of income for the dentist. Yet that relationship largely pre-dated the new contract. It is in the interest of the dentist to maintain it. Experience has shown that little is gained by providing a specific payment for it.<sup>60</sup>

The limitations of the continuing care payments have also been highlighted in the Green Paper.

6. [D]entists can register patients under the NHS, receive the money for doing so, and then offer treatment only under private terms. ... Once a patient is registered, dentists continue to receive a monthly payment for that patient for two years, whether that patient is seen again in that time or not. Some patients may be registered with more than one practice, perhaps following a change of home address or dentist, yet the other dentist or even dentists will continue to receive these payments. This has proved poor value for money for taxpayers' funds.<sup>61</sup>

The next section, s.8 of Annex C then places emphasis on the role played by the General Dental Council in safeguarding the patient/dentist relationship even though the continuous care payments would cease.

---

57 BMJ March 94 article on oral cancers.

58 Improving NHS Dentistry, *ibid.* p. 35.

59 Improving NHS Dentistry, *ibid.* p. 36.

60 Improving NHS Dentistry, *ibid.* p. 36.

61 Improving NHS Dentistry, *ibid.* p. 37.

8. ...The continuing responsibility of dentists for their patients would remain as a central feature of the service. It is one of the key ethical principles of the profession, and is emphasised as such by the General Dental Council. It would remain essential for dentists to keep full records of patients for whom they have continuing responsibility, including all patients accepted under NHS terms.<sup>62</sup>

The Government in this set of proposals, wishes to do away with the legal patient/dentist relationship based on the two year registration period because of difficulties with the administration of the system. It, however, proposes that the ethical relationship as implemented and enforced by the General Dental Council would ensure that the patient has continuous care even if the dentist is not legally obligated to the patient. The great difficulty with these proposals are that they were very much part of the pre New Contract state of affairs and then a dentist's legal responsibilities to a patient ceased at the end of the course of treatment. Relying on the General Dental Council to maintain a legal responsibility through the enforcement of professional ethics is an ill advised development when there has been a legal relationship between patient and dentistry.

The other overt criticism was that a patient may be registered with two or more dentists. This is an administrative procedure that could be quickly corrected by adopting the general medical practice solution of changing the registration when changing doctors. The final criticism was that the continuing care payments did not necessarily mean that the patient had been seen and treated, but there is an equally obvious reply to this complaint and that is registration of the patient guaranteed access to a dentist if the patient so required. Indeed, the New Contract, should have made it compulsory for the patient to be dentally fit before being registered as a continuous care patient. The unanswerable criticism was that patients registered for NHS continuing care payments could not have NHS treatment. This is unethical and it would be paramount upon any FHSA faced with such a prospect to refer that dentist to the General Dental Council for the unethical practice of dentistry.

The continuing care payments have been the cause of the long running industrial dispute between dentists and the NHS, but by removing them, the Government is not going to return to the “halcyon days” before the introduction of the New Contract.

A dental fee scale which Annex C deals with, has at its basis a 'neutral' policy towards individual dental treatments. This neutrality is based on the premise that each individual treatment should be costed the same as every other treatment with regard to time spent and profit made on that time. Imbalance in this can and does lead to the fact that some procedures will generate more profits than others and lead to imbalances in the forms of treatment undertaken. It is difficult to see how these imbalances can be avoided and this is one of the major drawbacks with the item of service payments. These points being dealt with in sections 10, 11, 12 and 13 of Annex C (p.37-38) of the Green Paper.

Annex C in common with Annex B of the Green Paper carries the proposals that advanced treatments would not be available on the NHS unless there was no viable alternative and that these treatments had to be given prior approval after vigorous examination of the proposed treatments. There would however, be no changes to the exemption requirements that patients had to meet to receive free treatment.

There are also included in the Annex (C) various sub-headings which for convenience will be discussed as one entity these are

1. Flexibility.
2. Expenses.
3. Rewarding Quality.
4. Financial Control.
5. Setting the Expense Allowance

The flexibility of the system would according to section 17<sup>63</sup> result in "*enhancement of fees where there are high costs*" as well as the dental health status of the individual patient.

Expenses and the running costs of dental practices are topics which need careful examination, but the Green Paper has illustrated the point that fixed overheads such as property rent or mortgage are not dependent upon the amount earned. Thus the high grossing dentists are benefiting from the in-built cost factor for fixed overheads when compared to the 'average' dentist. The Government's answer is to introduce a "taper of fees".

Section 18<sup>64</sup> deals with the possibility of rewarding dentists for the quality of their work even though based on an item of service fee scale. "*The aim should be to introduce a greater incentive for quality and efforts*

---

<sup>62</sup> Improving NHS Dentistry, *ibid.* p. 37.

<sup>63</sup> Improving NHS Dentistry, *ibid.* p. 39.

*directed at meeting the strategic aims of the NHS.*<sup>65</sup> This is fine in theory, but the question needs to be asked what would the standards for quality be set at and who would determine whether the individual has reached the set standards?

The financial control of the NHS general dental services is of paramount importance to the Government and has been a constant theme running through the Green Paper and its attached annexes. The Government is more concerned with the finance of the service than the development of the health care problems that the service faces. Undoubtedly, financing the service is of great importance, but arguably, the Government is placing emphasis on finance before a suitable dental health care system has been put in place, which can then be adjusted to meet the financial constraints imposed by the Government.

The final section of the Green Paper section 22 of Annex C is concerned with accurate information on the expense element of running a dental practice. The Government has a readily available source of practice expenses information and that is the Community Dental Service and its running costs. These if the Government so wishes could form the basis from which general dental service expenses could be extrapolated and based on the NHS earnings decide the proportion of private and NHS practice to avoid subsidising NHS practice.

### ***Discussion and Conclusions***

In a break with established practice, the discussion and conclusions were included at the beginning of the chapter. Then the chapter was developed as it was thought to be a more appropriate method of analysing the Green Paper and discussing its contents rather the accepted method of discussing the individual aspects of the paper and then drawing out the conclusions. The conclusions were obviously made after analysis of the paper, but have been placed first.

---

64 Improving NHS Dentistry, *ibid.* p. 39.

65 Improving NHS Dentistry, *ibid.* p. 39.