Can’t change, won’t change?

As the economy shows no sign of improvement, how will NHS dentistry respond to the changing needs of the public? Neel Kothari finds out

The Health Select Committee (HSC) review into NHS dentistry was expected to ignite an ambition for change from the Government, but rather than set a framework for change, we are now left with the anti-climax of yet another review. While another review will help set a framework for future change and development, it does very little to help patients access NHS services in the immediate future. As the economic downturn deepens we must expect demand for NHS treatment to increase as some patients may shy away from private dentistry. Reports from America are already showing many cosmetic treatments such as veneers on the decrease with patients opting to take on cheaper alternatives.

No free reign

NHS dentists no longer have free reign to a slice of taxpayers’ money, instead PCTs are now charged with the responsibility of local commissioning for local needs. Under the auspices of the old NHS contract, dental practitioners had the ability to increase capacity, but they are now faced with numerous barriers, which give little incentive for dentists to take on new patients or even invest in new practices. What is more of a concern is the damning verdict by the HSC of the Department of Health’s (DH) financial forecasting where the DH had overestimated patient charge revenue by £159 million in 2006-07. Surely this must give PCTs very little room for manoeuvring when commissioning new services?

Is access affordable?

Much emphasis has been placed on giving PCTs the ability to commission NHS services in areas previously deprived. The problem we now face is not a question of the Government’s desire to improve access, but can the Government now afford to? Regardless of the Government’s increase in spending within the NHS, we are likely to see a vast rise in patients claiming dental exemptions within existing services. This begs the question of how much of this extra money will get to the front lines, rather than be engulfed by an ever decreasing patient charge revenue?

So with whatever is left in the pot, PCTs have to now take tough decisions as to how best allocate this funding. While policy documents by the DH have aimed to give some guidance to PCTs, little is mentioned about how to ensure a good quality service is obtained other than, ‘If a service is not offering good quality or, exceptionally, is risking patient safety, it is by definition poor value for money no matter how low the price.’ Perhaps a shorter way of phrasing this might have been; ‘If it’s rubbish, don’t buy it’. This leads me to question just why something so obvious has to be said in an official Government policy document. Does the Government have evidence that PCTs are poorly commissioning? Or that perhaps some PCTs have commissioned dentistry purely on cost? While this does little to appease an ever-growing cynicism from critics of the new contract, it does indicate the scale of the problems faced by PCTs when commissioning new services.
A mixed service

Given the overwhelming level of criticism of the new contract from the HSC, it is not surprising NHS dentistry is offering a mixed service nationwide. The link between amount of work done and remuneration is not only blurry, but has completely lost its previous transparency. Budgeting practices by setting a target also means dentists have to work within these funds made available to them by their PCTs. If dentists are given unrealistic targets they may struggle to cope with the demands placed on them.

April 2009 has brought an end to the three-year ring fenced term. PCTs and central Government must now look closely at the real cost of providing dental treatment. If PCTs fall into the trap of chasing low UDA values it would be reasonable to expect quality to be affected. PCTs as commissioners must now show with open transparency exactly how they are prepared to fund dentistry to meet local needs. Of course, I’m not suggesting PCTs should pay more than what is a fair rate for NHS dentistry, but if PCTs wish to commission good quality treatment, they must fund this appropriately. Section 1.1 of Standards for dental professionals by the GDC guides dentists to ‘put patients’ interests before your own or those of any colleague, organisation or business.’ By budgeting dental treatment, removing patient registration and actively discouraging complex courses of treatment, the architects of the new contract must surely be questioning if they have met the same minimum standards.

Value for money?

What we now need is a debate on what the real cost of dentistry is in the UK. At a time when the country is in a recession, the taxpayer quite rightly will be looking for value for money. But as the health minister herself has made clear, if a service is poor quality, it is not value for money. As advances in dentistry continue to progress, so do the costs. If we take a routine procedure such as endodontic therapy, the material cost of providing this could range from tens of pounds to well over a hundred. As dentists have to work within their allocated funds, the DH must give patients an honest idea about the level of care they can expect from a budgeted system. After all, even dentists have to follow Section 1.10 of Standards for Dental Professionals, which says: ‘Do not make any claims which could mislead patients.’

Meeting public needs

As mentioned earlier, the effects of the economic downturn may place further demands on NHS dentistry. But how will dentistry as a profession adapt to the needs of the public? While many other professions struggle to survive in this current economic climate, NHS dentistry is in a unique position. Many patients may no longer afford private treatment and this may cause a surge in demand for NHS treatment. But ultimately regardless of how bad the recession develops as the philosopher and close friend Nitesh Doshi once said when confronted with this issue, ‘If people need to eat, they need to eat’.

Neel Kothari

qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice. Immediately post graduation, he was able to work in the older NHS system and see the changes brought about through the introduction of the new NHS system. Like many other dentists, he has concerns for what the future holds within the NHS and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.

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