Quality dentistry? Part 2

In the second part of this interview, Neil Kothari continues his talk with Chief Dental Officer Dr Barry Cockcroft to find out more about how well he thinks the NHS system of dentistry is working and what standards it should be aiming for.

NK: How have the new arrangements affected the workforce balance between performers and providers?

CDO: In our evidence to the review body, we suggested that they look at the relationship between those who hold contracts and their performers, obviously the providers have done very well out of this financially and the workforce situation has fundamentally changed. We asked the review body to comment on the transparency of the relationship between providers and performers. We would like to see PCTs including that in the governance arrangements between providers and PCTs.

NK: Do you think there needs to be more transparency between principals and performers?

CDO: Yes, I think there should be more honesty and transparency in the relationship between providers and performers. I was in practice for 25 years and there was a time when you couldn’t get associates to come to your practice. If you had advertised for an associate on many occasions they would actually interview you to see if they wanted to come to your practice. The workforce problem now isn’t the same as it was previously, there is no shortage of people wanting to work in practices, and this is just market forces starting to have an impact.

NK: What about the Health Select Committee’s (HSC) concern about the large number of overseas dentists being recruited?

CDO: I think overseas recruitment is an emotive topic and we also recognised that we needed to grow our own graduate numbers and we’ve done that. We increased the number of dental graduates by 25 per cent and we will see the first impact of that with 100 extra graduates coming out this year, and beyond that we will have more UK graduates from this year.

NK: Is it fair to charge patients the same amount of money for simple treatment such as a single filling compared with another patient who may need 10 fillings?

NK: Is there then a risk that some patients may wish to shop around, as they will be better off financially?

CDO: We have no evidence that this is happening. People keep saying that, but quite frankly, I think we have no evidence to support that.

NK: Many patients on low incomes do not qualify for NHS welfare packages, so what can the Government do to help these people with the NHS charges?

CDO: The new system for patients’ charges was designed to be fiscally neutral. In actual fact, if you look at patients’ charge revenue, the proportion has gone down a bit. As I say, 30 per cent of adult treatments are free of charge, all children are free of charge and if you’re on what is judged to be a genuinely low income then you are exempt, and that’s a judgment the Government has to make.

NK: Why did registration need to be removed from this current contract?

CDO: What is important is not registration; what is important is continuity of care, and if you read the BDA’s evidence, they recognise that as well. I worked in general practice from 1975 until 2002; most patients I saw over that period had considered themselves to be registered with me for that whole period, but in actual fact registration was only introduced in 1990 and for the period between 1975 and 1990 patients thought they were my patients and I considered them my responsibility. Registration didn’t give patients any other rights, other than to be able to identify a dentist who would provide them with out-of-hours’ service. That’s the only right the patients got and as the PCTs now have the duty to provide out-of-hours care, then it seemed a reasonable thing to do. All registration was, a payment to dentists. We expect continuity of care; we’ve got no evidence to

NK: How does the BDA feel about what was envisaged with the BDA’s evidence?

CDO: First of all, the patients’ charges legislation is based on the work of a patients’ charges working group, which had heavy influence from patients. The BDA was also on it. Department people were on it, and everybody signed up unanimously. There was a huge problem over the complexity of the previous system, where people didn’t know what they were getting. I think the moment that you introduce extraneous incentives to people to do more or less, you start to influence clinical judgment. If you look at these costs and compare them to the either the private sector in this country or any dental system anywhere in the world, this is hugely good value for patients. Bear in mind that 50 per cent of adults get their care free and all children get their care free. There is never a bang-on-right answer, but this has been widely welcomed by the patients’ groups, Citizen’s Advice Bureau, as well as Which?. I do not want to get into a system where we are paying dentists more for doing more fillings.

NK: You talked about reducing the incentive to over-treat. Is there now an incentive to under-treat?

CDO: Any system, no matter how you construct it, will have some incentives one way or another, and firmly believe despite the publicity that the vast majority of dentists just want to provide ethically appropriate treatment to their patients. I strongly believe that the vast majority of dentists will always provide what’s clinically appropriate for their patients and we should not build a system around those dentists with disappointing behaviour; we have to build a system around those who behave properly and that’s what we’re committed to doing.

NK: What is important is not registration; what is important is continuity of care, and if you read the BDA’s evidence, they recognise that as well. I worked in general practice from 1975 until 2002; most patients I saw over that period had considered themselves to be registered with me for that whole period, but in actual fact registration was only introduced in 1990 and for the period between 1975 and 1990 patients thought they were my patients and I considered them my responsibility. Registration didn’t give patients any other rights, other than to be able to identify a dentist who would provide them with out-of-hours’ service. That’s the only right the patients got and as the PCTs now have the duty to provide out-of-hours care, then it seemed a reasonable thing to do. All registration was, a payment to dentists. We expect continuity of care; we’ve got no evidence to
say that people are not getting continuity of care.

NK: In a recession, does the Government expect a higher demand for NHS dentists if people move away from their private dental schemes? Is there any evidence that this may happen?

CDO: I think it’s a little bit early to say how significant the effect of the recession would be, but I think if you go back to the Mori poll the Citizens Advice Bureau (CAB) did, they said that 4.7 million people who would have liked to use NHS dentistry were going private, compared with the 27 million on the NHS. The CAB said about 50 per cent of those people would like to access NHS care if they could. Now, the commitment the NHS has just been made to say anybody in the committed Care Trusts (PCTs) providing access to patients relatively quickly, and dentists are actually saying their doors are open, yet people are not coming in. And it’s because there’s still that perception out there that you can’t get NHS treatment, and in some areas it’s more difficult than others, but I think that when that perception changes, you will see people starting to move a little bit in that direction. The important thing for me is that not everybody goes from the private sector to NHS, because a lot of patients would choose to stay with their existing dentist, since it’s a personal decision. How- ever, I think we’ve put enough money in and the commission- ing capacity we’ve got means that if people wish to choose to do that, the NHS will have the capacity to deal with it.

NK: Are PCTs able to cope with the effects of a recession which may place a greater burden on the NHS system?

CDO: Well, we gave them 11 per cent extra funding last year, we’ve given them 8.5 per cent overall this year, and that’s guaranteed. And obviously there’s a third year of the Comprehensive Spending Review; we don’t actually know what’s coming in that, but certainly there’s further investment to be made.

NK: The Government has recently announced another review into NHS dentistry. Is this a good use of tax payers’ money? Why do we need another review when we already have an in-depth review from the HSC?

CDO: First of all, we announced the review in March last year. We told the HSC we were going to create a vision for the future of dentistry, and also the HSC wasn’t a review, it just took evidence and its report was very much based on projecting the evidence it heard. Many of the things it actually said have of course not come to pass, but I think it did highlight the difficulties and issues and I think it was right that we commissioned an independent review, engaging with all stakeholders, to see what the way forward across a range of areas. The review is reporting in the short-term with medium and long-term significance the aim is to report in the spring. I think the thing that we will get major stakeholder involve- ment – Jimmy Steele is out doing it as we speak, and he’s independent and knows a lot about health services – the cost of that is much less than the cost of not doing it.

NK: As dentistry advances, treatment options such as dental implants are becoming more commonplace. Is NHS dentistry ever going to fund complex treatments such as implants?

CDO: NHS dentistry already funds implants in the secondary sector for people who’ve had fac- cial cancer, facial trauma, cleft lip and palate as well as a range of other conditions. What hasn’t done so far is fund it through pri- mary care dentistry, and there are alternatives which are clinically effective. Obviously technology develops and we need to constantly update ourselves with technology. I think there are some significant issues around implantology that people need to think about, and do patients have informed consent when they make a decision to go down the implant route? I’m certainly wor- ried about a cohort of older people who in the next 20 years will have implants and have implant fail- ure and may not be able to access the complex care that they will need to resolve it. So I think im- plantology is a very complex issue. We fund it where it’s clinically appropriate in the secondary sector, but at the moment it’s not part of primary care.

NK: You have mentioned a higher amount of preventative work being done under these new arrangements. What changes in particular have taken place?

CDO: All around the country now I’m being asked to go and open new schemes where dentists and PCTs are working on flu- oride varnish schemes in Skelmersdale, Knowsley, Tower Hamlets, for example. The use of high-concentration fluoride toothpaste has gone up by 15 per cent in a year that actually pre- dated Delivering Better Oral Health guidance, so we are changing the culture to a more preventative way of working. To change culture takes more time than anything else, but I’m very encouraged now by what I see happening locally.

NK: Do you think local councils should be put under more pressure to consider water fluoridation?

CDO: We’ve already said in the Choosing Better Oral Health document in 2005 that if there were high levels of decay, the NHS should look at us- ing fluoridation and all of its tools. We’ve finished one consultation and we’re awaiting the outcome, but there’s lots of interest in other places as well.

NK: How should the NICE recommendations be interpreted, as a fixed or flexible guideline based on dentists’ judgments?

CDO: It’s about clinical judg- ment. The patient should be re- called according to what the dentists judge to be clinically appropriate for that patient. So somebody like myself, who is definitely the wrong side of 50, and relatively decay-free, rela- tively disease-free, with no his- tory of smoking or drinking to ex- cess, would warrant a recall pe- riod of longer than six months. But for somebody who’s smoked heavily, drunk heavily, got a very dirty mouth, got periodontal disease, had white lesions, it may be that six months or three months is the ap- propriate period. NICE guidance says you should use your clinical judgement and money should play no part in that.

NK: Do you feel by and large that dentists are adhering to the NICE guidelines?

CDO: I think it’s taking a long time to change a culture, and that’s not always the dentist’s fault, as I found out myself in 1998. Patients are wedged to reg- ular six-month check-ups, even though there is no evidence to support that at all, and changing that culture is important. Where a practice is recalling 40 per cent of its patients at three monthly in- tervals, I can think of no ethical reason to justify that at all. But it’s to be sorted out locally. A lot of it is about understanding the new system.

About the author

Neel Kohari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He qualified as a graduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with cur- rent 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 for the NHS and as an NHS den- tist, appreciates some of the difficul- ties in providing dental healthcare within this widely criticised system.