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Challenges to dental access – England as a case study*

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Abstract – Access to dental services because of an insufficient workforce is a historic challenge faced by many developing countries. In recent years, however, it has become a major issue for many industrialized countries. The growing demand for cosmetic dentistry, an increase in patients' willingness to pay for dental treatment, and growing numbers of older dentate patients have all put pressure on dental systems. Ways of meeting these challenges and ensuring reasonable dental access will vary from country to country, but the solutions often lie in how the dental workforce is regulated. This case study of the dental reforms currently being implemented in England highlights progress at a particular point in time (Summer 2005). It is clear that it will take a number of years to find a new national dental payment system (the National Health Service) to replace the system which has changed little since 1948. However, the political pressure to address poor access to state-funded dental services calls for more immediate actions. The initial approach was to increase the dental workforce via international recruitment, and in the medium term to increase the number of dental students in training and to expand the numbers of other members of the dental team. An additional stratagem is to retain those already providing dental care under the National Health Service by the introduction of a new method of remuneration. England is trying to improve both access to care and the oral health of the population by creating a workforce more suitable to public demands and changing oral health needs.

Key words: access; dental care utilization; dental workforce

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Access to dental services remains a challenging issue for many countries. Market forces are changing. In industrialized countries, in particular, we are witnessing a sharp rise in demand for cosmetic dentistry, an increased willingness on the part of patients to pay for treatment and services. At the same time, we are witnessing a workforce that is currently insufficient to meet the changing and growing demands emerging. The problem is compounded by the fact that it is often hard to create the right configuration of skill mixes among members of the wider dental team. Furthermore, regulatory restrictions frequently obstruct the mobilization of dental care professionals to areas of high need/demand.

The aim of this presentation is to outline the approach we are undertaking in England to address the difficulty of dental access to primary dental care services.

The starting point: National Health Service Dentistry: Options for Change

In September 2002, the publication of the report document National Health Service (NHS) Dentistry: Options for Change (1) took the form of a landmark commentary on how government dental services are provided and explored opportunities for changing them. The report documented how, since 1948, the main delivery of dental services in the UK has been via a 'fee for item' approach, with dentists being paid according to an agreed-upon national tariff according to treatment provided. While this system worked well for a population with a high level of dental disease, it incorporated over 400 separate fee items, in low caries populations it became inappropriate. The fee for each patient had to be calculated individually, with the

dentist submitting details to a central payment system (the Dental Practice Board) who subsequently paid the dentist.

Moving forward: NHS Dentistry: delivering the change

A commentary on how these changes are progressing is available in my report *NHS Dentistry: delivering the change* (2). The three underlying drivers behind the changes being proposed can be summarized as follows:

- To enable community dental services to be commissioned locally. While this shifts the balance of power from the dentist to the local community, standards and treatment planning for individual patients remains the responsibility of the dentist.
- To simplify the current system of patient charges. (Note: in July 2005 it was announced that payment system was to be made easier and 400+ items were to be incorporated into three banded courses of treatment.) A consultation process was duly launched (3).
- To sever the link between dentists' remuneration and the level of treatment activity they undertake. To this end, a reform agenda was announced indicating that the old system of paying dentists would cease on 31 March 2006, and that a new locally determined contract would be given to all dentists who wished to provide care under the NHS.

The spring and summer of 2004 saw an increasingly negative portrayal in our national media of the problem of access to NHS dental services. A few instances of patients waiting outside NHS dental practices to register attracted a great deal of media interest. However, the solution to greater access to dental services is more complex than simply increasing the remuneration of dentists. We believe that the reforms due to be introduced in April 2006 will not only address the access challenge, but will also improve morale among the dental profession, removing them from the 'drill and fill' treadmill and enabling them to focus upon prevention and improve the quality of care.

Delivering the change also presented a short-term solution to addressing access in response to the situation arising in summer 2004, with a view to achieving the following three main objectives:

- To increase the workforce by 5% (net) via a government-led recruitment drive geared to attracting 1000 whole time equivalent dentists into the most difficult dental access areas.
- To increase the funding for dentistry by 19.3%, thereby giving more flexibility to health commissioners to secure more dental provision in their area.
- To convert 25% of all dentists into Personal Dental Service (PDS) contracts and to see a 5% increase in patients registered.

The desired net result of this three-pronged action was manifold:

- To increase workforce capacity;
- To introduce an element of flexibility with regard to the location of work;
- To increase financial investment;
- To pilot the early introduction of new contractual arrangements in areas where access was particularly challenging.

Focus on the 1000 project

Revealing a significant gap between supply and demand of dental treatment, the recent dental Workforce Review (4) estimated that an additional 1850 dentists were needed in England. In response, a target to recruit 1000 whole time equivalent dentists by October 2005 was set. Recruits were drawn from a combination of international recruitment initiatives and many were able to come over to England as a result of improved access and availability of registration examinations (International Qualifying Examination, known as the IQE) which overseas trained dentists have to pass in order to register with the UK regulatory body, the General Dental Council. In conjunction with this activity, an aggressive domestic recruitment drive (Keeping In Touch Scheme) helped those who had left the profession – mainly women – to return to practice. Additionally, negotiations took place with a view to 'buying back' additional services from dentists already working in England.

Having never previously undertaken an international dental recruitment campaign, one of the government's first tasks was to make a clear statement of its code of ethical recruitment policy, and in particular its policy of not recruiting in any country where there was not a government-to-government agreement for the initiative. Within a few months, dental recruitment staff were

deployed in Poland, Spain and India. High profile visits were undertaken in each of the countries and I was given opportunities to meet my counterparts and potential recruits.

As a result of these endeavours, the dental workforce increased by approximately 5% (net). As at 31 March 2005, the number of General Dental Service and PDS dentists was 20 088, some 775 more than in March 2004. Plus, the recruitment target of 1000 is on track to be met. We have also accelerated the process for people waiting to take the IQE, which enables dentists from non-EU countries to practice in England. Accordingly, I am delighted to report that 199 candidates passed the IQE in 2004, compared with 81 in 2003.

Alongside the international expansion schemes, the government made a clear commitment to augmenting our home-grown workforce and, most significantly, the move to increase the number of undergraduate dental training places in England by 25%, as from the October 2005 entry. This increase is supported by capital investment of £80 million over 4 years to improve facilities in dental schools, and will also facilitate an exponential increase in the number of dental therapists in training, from 50 to 200 students per annum.

Personal Dental Services

Personal Dental Services pilot contracts were introduced in 1998. The initial aims of the PDS pilots were to improve access to NHS dental and oral health services and to pilot innovative ways of working and of remunerating dentists.

Completely voluntary, the pilots were initially implemented in a series of limited waves, culminating in 90 schemes in operation covering 830 dentists by March 2002. The underlying objective was to introduce new, locally negotiated contracts which would give greater flexibility to local health commissioners with a remit to provide dental services. As a result, these commissioners would then be granted the flexibility to change payment arrangements, thereby moving away from the requirements of national contractual arrangements based on piecework.

We set ourselves the target of attracting 25% of English dentists into PDS contracts by April 2005, with an emphasis on dentists working in access-challenged areas. As a general rule of thumb, there is an expectation that where the move to PDS frees up, say, 10% of capacity, half of that should go to the NHS by way of, for example, open access sessions for unregistered patients. This target was achieved and PDS is now being undertaken by over 6000 dentists in 2200 practices. The total proportion of dentists now in PDS is 30%. These dentists are enjoying new ways of working that are also proving popular with patients.

Thank you for the invitation to address this conference. The reforms of our dental services in England are radical and far-reaching and the ultimate purpose of the reforms remains not solely to improve dental access but to improve oral health of the population in England and support the working lives of all members of the dental team.

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