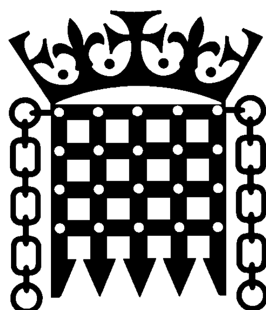
Dentists' pay and the *National Health Service (Primary Care) Bill*

Research Paper 97/17

5 February 1997



For over four years, there has been a dispute between the dental profession and the Government, based both on the way dentists have historically been paid for their NHS work and disagreements over the adequacy of these payments. The dispute has recently been formally settled and this Paper summarises its cause, recent announcements on changes to the dental service and the possible impact of the *National Health Service (Primary Care) Bill* [HL Bill 91 of 1996-97] on NHS dentistry. A fuller description of the beginning of the dispute is found in Library Research Note 92/67, *Dentists' pay - the current dispute*; Members are also referred to Library Research Paper 97/16 for a more detailed analysis of the *National Health Service (Primary Care) Bill.*

Katharine Wright
Social Policy Section

House of Commons Library

Library Research Papers are compiled for the benefit of Members of Parliament and their personal staff. Authors are available to discuss the contents of these papers with Members and their staff but cannot advise members of the general public.

CONTENTS

		Page
I	Introduction: the current system of remuneration	5
II	Suggestions for reform	6-9
	A. The Green Paper, *Improving NHS dentistry*	6
	B. April 1995 statement	7
	C. June 1996 statement	8
III	The White Paper and the *National Health Service (Primary Care) Bill*	10-12

I Introduction: the current system of remuneration

Dentists are currently paid on the basis of a fee for each adult treatment carried out ("fee per item of service"), together with monthly flat-rate "capitation" payments to cover children's treatment and much lower "continuing care" payments for adults on their lists. Until recently the Doctors and Dentists Review Body would recommend a target income which the "average" dentist should receive; the fee scale for check-ups, fillings and other treatments would then be set in such a way that this average dentist would receive the target income. However, if, overall, dentists received *above* the intended income (ie by carrying out more work than anticipated and therefore receiving a greater number of fees), then the Department of Health would claw back the overpayment the following year. Arguments against payment on this basis include both the problem that speed of work is rewarded, regardless of quality (with the danger of patients being treated conveyor-belt style) and also the question of the perverse incentive: through the claw-back procedure, dentists may be penalised for working hard.

The recent dispute between the Department of Health and the dental profession came to a head in 1992, when the Department announced its intention of implementing a 7% fee cut in the scale for 1992/93, in order to claw back some of the "overpayments" made in 1991/92. Dentists regarded this not as an "overpayment" but as proof that they had been successful in delivering NHS dental care. The British Dental Association responded to the fee cut by balloting its members on the possibility of refusing to accept new NHS patients; 60% stated they would be unwilling to accept any new patients, while 80% would be unwilling to accept adult charge-paying patients[1]. Although anecdotal evidence has suggested that dentists have not acted quite as drastically as this, it still appears that in certain parts of the country it is increasingly hard for patients to find a dentist willing to treat them on the NHS, or are having to travel considerable distances for dental treatment.

Part II of this Paper describes some of the flaws in the current system of remuneration and summarises the possibilities for change which have been put forward and the subsequent negotiations with the dental profession. Part III sets out how the long-term solution for dentists' pay, that of encouraging local commissioning of general dental services, will be implemented through the *Primary Care Bill* [HL Bill 91 of 1996-97].

---

[1] BDA press notice, 9 October 1992

II Suggestions for reform

It is generally accepted that the current remuneration system is seriously flawed, and in the past three years, the Review Body has refrained from recommending a target income and has instead simply recommended increases in the fee scale, pending changes in the way dentists are paid. Meanwhile, in 1992 the Government commissioned Sir Kenneth Bloomfield to undertake a review of the dental remuneration system. One issue considered by Sir Kenneth in his report was the question of how the individual fees for particular treatments compared with the charges levied for such treatments in the private sector: as an example he cited a crown commonly used in the NHS attracting a fee of £74.60 (at 1992 rates), as compared with private charges of between £124.50 and £276.50. It should be noted that under the current remuneration system the fee of £74.60 should not be regarded simply as the "cost" of the crown, because dentists are also receiving income through continuing care payments; nevertheless, some dentists suggested to Sir Kenneth that this difference amounts to dentists using their private practice to subsidise their NHS practice. It has also been argued that the relatively low NHS fee leads to pressure on laboratories to produce appliances and materials as cheaply as possible, with the subsequent possibility of NHS work becoming the "poor relation" of private work.[2] Another criticism of the "target income" system cited by Sir Kenneth was that there is no such thing as an "average" dentist, and so the current system may be delivering a very fair income to some dentists, while others paying particularly high rates for their premises, or with high expenses for other reasons, may have great difficulties making ends meet.

A. The Green Paper, *Improving NHS dentistry*

The so-called "Bloomfield report"[3] was published in January 1993 and the Government then consulted on the various options for change identified by Sir Kenneth. In July 1994, a Green Paper, *Improving NHS Dentistry*[4] was published by the Department of Health on behalf of all four UK Health Departments, containing both long-term and short-term proposals for dentists' remuneration. For the long-term, the Government proposed that the current "fee per item of service" system should be replaced by Family Health Services Authorities' (now Health Authorities') becoming "purchasers" of dental care. This would create the same "purchaser/provider" split which has existed in secondary and community health services since 1991. Resources for dental services would be channelled through Health Authorities (Health Boards in Scotland) who would then be able to purchase dental care on the basis of local needs and priorities; remuneration would also be decided locally. The Green Paper emphasises

---

[2] eg in Nuffield Foundation, *Education and Training of Personnel Auxiliary to Dentistry*, 1993 p.74

[3] Dept of Health, *Fundamental Review of Dental Remuneration*, December 1992

[4] Cm 2625

that such a change in the way dentistry services are financed and delivered should not be rushed, and that careful evaluation and piloting of the proposals would take place.

In the meanwhile, two possible short-term measures were proposed. The first was that dentists should be paid on a "sessional" basis, so that dentists are paid for the time spent seeing patients, rather than for the number of treatments carried out. The second was to reform the "fee per item of service" system in order to place more emphasis on quality of care and preventative work. In both possible systems, it was suggested that the charge for a dental examination should be significantly reduced, in order to encourage patients to attend surgeries. NHS resources would be concentrated on diagnosis, prevention and basic maintenance work, and patients (other than those exempt from charges) would pay up to the actual cost of "advanced" treatments, subject to a specified maximum, rather than 80% of the cost as at present. Prior approval for advanced treatments would have to be gained, and approval would only be granted if no clinically acceptable less costly form of treatment were available. These proposals on charges originally emanated from the Health Select Committee; in their investigation into dental services[5], the Committee recommended that a basic core service of diagnostic and preventative work should be available free to all patients, with the cost met through increasing the charges for advanced treatments.

The Green Paper was out for consultation until 1 November 1994. On 31 October, the General Dental Services Committee (GDSC) of the British Dental Association sent its formal response to the Department of Health, expressing grave concern over the effects of the proposals on patients and the NHS, and opposing both the proposed "purchaser/provider" split and the short-term sessional model. Reforms to the present fee per item of service model were felt to be more acceptable.[6]

B. April 1995 statement

On 5 April 1995, the Government published their final proposals on the future of NHS dentistry in the form of a written answer.[7] This reaffirmed the long-term aim of introducing local contracts between Health Authorities and dental practices (the "purchaser/provider split" model), and promised primary legislation "in due course" to enable pilots to be set up.

In the short-term, the sessional payment model had been put aside and instead a package of reforms were announced to change the way the current fee-based system works. These reforms included:

---

5 Health Select Committee, *Dental Services*, 26 May 1993, HC 264-I 1992-93 para 215

6 "The GDSC response to the Green Paper", *BDA News*, November 1994 p.12

7 HC Deb 5 April 1995 cc 1213-1215W

- improving the current flat rate "capitation" system for child dental treatment to make it more sensitive to disease levels in individual children;

- introducing more rigorous prior approval procedures for the more expensive adult treatments;

- reforming the "continuing care" payments made to dentists for the patients on their lists;

- developing the role of the community dental service to meet the needs of patients in areas where it is difficult to find general dental practitioners offering NHS treatment; and

- discussing past "overpayments" with the dental profession, with the possibility of waiving past overpayments if satisfactory progress was made in the general review.

It was also stated that no changes to the structure or level of dental charges was envisaged. Both the Health Select Committee report and the Green Paper had put forward the proposal of reducing the check-up fee (or, in the case of the Health Select Committee, abolishing it altogether), in order to encourage attendance.

According to press reports, the British Dental Association welcomed the decision to rule out sessional payments, but was not enthusiastic about the remaining proposals. A spokesperson for the General Dental Practitioners' Association was quoted as saying that "Today's announcement will do nothing to stop dentists leaving the NHS".[8] More recently, the BDA stated its position in its *Manifesto for dentistry*,[9] expressing the view that the dental service is underfunded and that more resources will be needed to ensure that access to NHS dentistry for all patients is maintained.

C. June 1996 statement

Nevertheless, negotiations over the Government's proposals continued and a further announcement on dentistry was made by the Health Minister on 12 June 1996. After a year of "constructive and detailed discussion" with the General Dental Services Committee (GDSC) of the British Dental Association, agreement had been reached on the Government's April 1995 proposals, with some amendments to the current system to be implemented from 1 September 1996.[10] The main points of the statement are summarised below.

---

8 "Dentists disappointed by reform plans", *The Independent*, 6 April 1995 p.5
9 BDA, July 1996
10 HC Deb 12 June 1996 cc 313-315

- for child patients, as well as monthly "capitation" payments, dentists would also receive fees for individual items of treatment;

- the current registration period for adults and children (2 years for adults and from date of registration to the end of the following calendar year for children) would be harmonised at fifteen months, reducing bureaucracy for dentists;

- more rigorous prior approval mechanisms for some courses of treatment would be introduced from 1 December 1996; a joint working party between the Health Departments and the GDSC would be set up to develop this proposal further;

- a system of local contracting for primary care dentistry would be piloted and evaluated; this would require primary legislation and the Department aimed to produce a draft Bill for consultation in the autumn;

- the Department would also discuss other measures which could be included in such a Bill such as amendments to the *Dentists Act 1984* to enable the work of dental auxiliaries to be developed, new sanctions to be imposed in disciplinary hearings against dentists, and complaints systems for private patients to be introduced;

- an Access Fund would be established to enable Health Authorities to fund local solutions where there is a shortage of dentists accepting NHS patients;

- "overpayments" in previous years would be waived completely.

As a result of the agreement, the four-year long dispute between dentists and the Government is formally at an end. However, representatives of the British Dental Association, quoted in the press after the announcement, were still doubtful about the future of adult dentistry. John Renshaw, the vice-chair of the GDSC, is quoted in the *Independent* as saying that "On its own, this won't bring anybody who has quit the NHS back in ... but it will allow some of the people still there to carry on a bit longer. The best we can hope for is that it will slow the rate of exit."[11] However he also went on to say that the deal "would allow new negotiations in a more positive atmosphere over adult services where fees and allowances remain inadequate".

[11] "Pay deal bridges gap in NHS treatment", *The Independent*, 13 June 1996 p.6

III The White Paper and the *National Health Service (Primary Care) Bill*

Over the past year, the Department of Health has been carrying out a consultation exercise on how primary care in general could be developed, culminating in the discussion document *Primary care: the future*[12] and the White Paper, *Choice and opportunity*.[13] Although dental services were not explicitly covered in the consultation exercise, on the basis that a separate review had already taken place, the proposals for changes in the way general medical services (GP services) should be delivered have very similar legislative implications to the changes proposed in dentistry and both have, in fact, been covered in the same Bill, the *National Health Service (Primary Care) Bill* [HL Bill 91 of 1996-97]. A separate draft dental Bill is still expected (although it has not yet been published) covering the other areas of reform promised in the June 1996 statement, such as the role of dental auxiliaries.

In *Choice and opportunity*, the Government proposed that amendments should be made to the *National Health Service Act 1977* and the *National Health Service (Scotland) Act 1978* to allow far more flexible contracts between local Health Authorities (Boards in Scotland) and GPs and dentists. In the case of GPs, this could lead to Health Authorities having contracts with whole GP practices, rather than with individual GPs, NHS trusts employing salaried doctors, and even GP practices being given a budget for both general medical services and hospital and community services, with the right to move funds from one part of the budget to another if this would benefit patients. In the case of dentists, individual dentists or dental practices might be contracted to provide a full range of dental services for a defined population (ie a form of "purchaser/provider split"); dentists could also contract to be paid on a sessional basis, or be employed by NHS trusts. Alternatively, dentists could opt to remain on their existing contract, with or without small local modifications.

All these contracts would initially be in the form of pilot projects, approved in advance by the Secretary of State, and would be evaluated before being "rolled-out" on a wider basis. The White Paper emphasises that participation would be voluntary and that proposals for pilot projects should come from dentists and Health Authorities themselves; they would not be imposed from above. Dentists would retain the right either to remain on their existing contract, or to treat some of their patients on the existing contract, while treating others under new arrangements. Patients would continue to have the right to choose their dentist (provided that the dentist is willing to accept them, as now). A single national charging system would apply to patients, regardless of the contractual status of their dentist, and the current exemptions from charges and maximum charge per course of treatment would remain in place.

---

[12] Dept of Health, *Primary care: the future*, June 1996

[13] Cm 3390, October 1996

The White Paper also lists a number of safeguards which would have to be in place to ensure that standards are maintained on a national level. The Secretary of State would have the power to:

- require Health Authorities or Boards to consult locally on the proposed pilot;
- decide which pilots will go ahead. Only those which he approves will be able to do so;
- decide elements which must appear in any contracts and the way in which they must do so;
- end a pilot if that seemed appropriate in the interests of the NHS;
- ringfence money transferred to Health Authorities or Boards for the piloting of new methods of delivering GMS [general medical services] and GDS [general dental services];
- make arrangements for evaluation of a pilot, including approving the criteria and process;
- require Health Authorities and Boards to monitor the quality of the service provided;
- require Health Authorities and Boards to provide information locally about the pilot to those affected, particularly on the quality, volume and cost of services so as to ensure patients are protected and tax- payers receive value for money and on the criteria for evaluation and the process for doing so.[14]

The *National Health Service (Primary Care) Bill* which would implement these proposals received its Third Reading in the House of Lords on 30 January 1997; at the time of writing no date for the Second Reading in the Commons has yet been set. Library Research Paper 97/16 considers the provisions of the Bill in detail and discusses the main points of contention which have arisen out of it. The British Dental Association has stated that it "broadly support[s] the tone of the proposals in the White Paper" and that it is willing "to collaborate in pilot schemes, while keeping an open mind on the long-term viability of local commissioning."[15] However, it has raised a number of concerns over the Bill itself, including: the need for consultation with both patients and members of the dental profession before the implementation of pilot schemes, on their evaluation and before the introduction of subsequent

---

[14] *ibid* pp 19-20
[15] British Dental Association, comment on the *National Health Service (Primary Care) Bill*, 22 January 1997

permanent arrangements; the need for national quality standards; and the implications of the possible involvement of the commercial sector in pilot schemes. These points are all broadly similar to those raised by other organisations representing NHS patients and professions, and are discussed at greater length in Research Paper 97/16.

Recent Research Papers

96/100	The Crime (Sentences) Bill and the Crime and Punishment (Scotland) Bill: provisions for mentally disordered offenders	31.10.96
95/126	The Health Service Commissioners (Amendment) Bill [Bill 10 of 1995/96]	02.12.95
95/71	The Mental Health (Patients in the Community) Bill [Bill 122 of 1994/95]	07.07.95
95/44	The Medical (Professional Performance) Bill [Bill 83 of 1994/95]	31.03.95
94/124	Health Authorities Bill [Bill 2 of 1994/95]	29.11.94