Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Dental Services: DHSSPS Briefing

3 July 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Mr Samuel Gardiner

Witnesses:

Mr Brian Dooley	Department of Health, Social Services and Public Safety
Mr Simon Reid	Department of Health, Social Services and Public Safety
Mr Eugene Rooney	Department of Health, Social Services and Public Safety
Mr Michael Williamson	Department of Health, Social Services and Public Safety

The Chairperson: Agenda item 9 is a briefing from departmental officials on the general dental service (GDS).

Mr Beggs: I declare an interest as I have several relatives who are dentists.

The Chairperson: I refer members to a briefing paper from the Department at page 187 of members' packs. I welcome the officials here. It is quite useful that you were in the Public Gallery listening to some of the issues. I do not know who is taking the lead on this.

Mr Eugene Rooney (Department of Health, Social Services and Public Safety): I will take the lead, Chair.

The Chairperson: Do you want to say a few words and then we will open up for questions?

Mr Rooney: OK. Thank you. I would like to introduce my colleagues. Simon Reid is the acting chief dental officer and Brian Dooley and Michael Williamson are from the general dental and ophthalmic services branch of the Department.

The current GDS contract was introduced in 1992, and pays dentists using a blended system of remuneration. Items of service payments account for approximately 60% of GDS income, 20% comes from allowances and 20% comes from capitation payments. I know that Committee members were asking British Dental Association (BDA) representatives about that. It is not salaries; it is income from providing services. A statement of dental remuneration (SDR) is issued by the Department annually and sets out the payment level for the 400-plus items of service and the conditions that claimants must

fulfil in order to be valid. The SDR also describes the conditions that apply to capitation and allowance payments for dental practitioners.

Dentists are independent contractors who generally own their own premises and employ their own staff. They are free to decide how much or how little health service work they choose to do. Indeed, that has led to access problems for patients in recent years, which the Committee raised earlier in respect of access to health service treatments.

The current contract is effectively demand-led in that the Health and Social Care Board has commissioners obliged to pay dentists on its lists for whatever treatment is carried out under the SDR. Pressure has grown on the dental services' budget in recent years due to an increase in the number of patients registered with general dental practitioners, an increase in the total number of dentists and dental practices — the number of dentists is currently at its highest ever level in Northern Ireland — and an increase in the amount of health service dental treatment being provided.

An increase in the level of oral health treatments provided is, of course, to be welcomed. The level of investment by the Department and general dental services has increased by about 25% since 2007-08. However, we currently have no way of managing the number of dentists, practices or treatments carried out and, therefore, controlling the spend on general dental services.

Given the pressures on the overall health and social care budget, the Department and the board have examined how potential savings could be made across spending areas within the allocations set for the next two years. In that context, services and organisations were required to examine scope for savings, efficiency and productivity improvements. In that regard, the GDS budget is no different from other budgets in health and social care.

The Department and the board developed several proposals that would help to mitigate the pressures on the budget. The Minister advised of those proposals in 2011, and, last year, officials gave evidence to the Committee on the proposals before those went out to consultation. A key consideration since deciding on specific savings proposals was to avoid adverse impacts on the oral health population and to minimise any effects on the sustainability of dental practices.

The consultation ran from 7 January to 3 April this year. In total, we received 232 responses. The individuals and organisations that responded are listed in the appendix to the briefing paper, which was provided to the Committee.

I would like to briefly outline to the Committee the responses to the consultation on each of the key proposals and how the Department plans to proceed.

On orthodontic treatment, which was mentioned earlier, over the past number of years, there has been a significant increase in the provision of that treatment. Orthodontic treatment has been judged to have a minimal direct impact on oral health improvement, and the Department concluded that health service orthodontic care and treatment should be provided where there is a clear clinical need rather than simply on demand.

The proposal was to use the internationally recognised measure of the index of orthodontic treatment need (IOTN) at a level of 3·6 as the threshold. The vast majority of respondents agreed with the introduction of criteria and the proposed threshold in the consultation. There was limited support for a stricter threshold, and some respondents felt that there should not be any restriction on the availability of that type of treatment. Overall, there is support for using the same criteria that have been in place in England, Scotland and Wales.

Just over three quarters of respondents were against a core service of treatments, but the main concern focused on the proposed restriction on the availability of root canal treatment on molar teeth. The results called for clearer guidance on what would constitute clinically necessary treatment. The view of respondents was that the prognosis of teeth could be compromised and that patients could experience poorer outcomes if the provision of root canal treatment on molar teeth was restricted. The Department has decided that there were grounds for not restricting the availability of root canal treatment on molar teeth. Therefore, that will not be included as part of the changes. The Department will introduce a core service of treatments through the SDR, and veneers, metal dentures, large bridges and bridges at the back of mouth will only be available through prior approval.

In the consultation, the Department proposed amending two of the allowances currently claimed by dentists through the SDR. The first amendment would increase the threshold for the higher rate of

practice allowance from 500 to 750 patients and increase the number who must be fee-paying adults from 100 to 200. The ability to include adults in partial remission from charges will continue. The second allowance proposed to be amended would be the withdrawal of commitment payments, which was mentioned earlier.

On practice allowances, many respondents felt that changes to the criteria could mean that they were no longer eligible to receive the higher level of allowance, which would impact on practices. Others were concerned that practices, which, until recently, have been, largely, private, would now be able to claim significant levels of support through the allowance. Therefore, a difference of views came through in the consultation on that. The practice allowance plays an important part in supporting health service-committed dental practices. The Department has sought to protect it. An analysis of the potential impact of change showed that the majority of practices that claim the higher rate of allowance would continue to be eligible to do so.

Commitment payments received significant attention in the consultation. The Department gave careful consideration to the alternative proposals made. Quite a number of suggestions came through in the consultation, which we had to go through and assess. We did not consider that they could be implemented without significantly increasing administration in practices, the board and the Business Services Organisation (BSO), while reducing the potential levels of savings that could be realised. However, in order to provide a period of adjustment for practitioners, the Department has decided to phase out commitment payments, rather than end them simply in one year.

With regard to scale and polish treatments, the Department proposed to change the timescale for claiming a single scale and polish from three to nine months and a two-visit scale and polish from nine to 12 months. Responses to the consultation indicated that if the threshold were to be changed, it should be to six months. That related to concerns that it could interfere with the recall of patients for periodic examinations, whereby many patients return every six months. Dentists saw that as an opportunity to encourage attendance and good oral hygiene. So, the intention is to go for a scale and polish every six months, rather than every nine months.

Those were the main issues raised during the consultation and the main changes that the Department has sought to address. The next steps are to finalise the statement of dental remuneration, which I mentioned earlier. Then, that would be issued to the BDA for comments. The orthodontic treatment criteria require changes to the dental service regulations. Amending regulations to that affect would need to be submitted to the Committee for scrutiny and approval following recess.

To pick up on a couple of points made earlier; recognising the pressures on the budget in dental services, the initial budget allocations for this year and next are higher than they would actually have been set and indicated in the consultation document. The general dentistry services budget has generally been going up year-on-year over recent years. We recognise the pressures on that and on the initial allocations, which are shown in the summary paper that the Committee has received. They are set at levels that are similar to the expenditure out-turn for last year. So, it is not really about cuts: it is about trying to reduce pressures on a budget that has been increasing year-on-year and doing it in a way that minimises any impact on oral health and the sustainability of dental practices, but recognises that we have to try and address the pressures because, as the number of dentists and treatments have increased, that continues to drive up the overall expenditure that the board has to provide.

In conclusion, the changes from the consultation were not to restrict molar root-canal treatment, alter the timescales for scale-and-polish treatments from nine to six months, and phase out commitment payments over a two-year period rather than in a single year. Thank you.

The Chairperson: Thank you, Eugene. You heard the BDA representatives give evidence just before your presentation. They said that there have been some changes that they welcome, but some that they do not. I know that, in the next steps, you say that you will issue the changed regulations to the BDA. Are you due to meet the association before then in order to try to work through some of its concerns?

Mr Rooney: We have had a lot of engagement since the development of proposals commenced in 2011. So, there has been a lot of engagement with the BDA in the exchanges of views on issues. In the consultation, we received a submission from the BDA and from a lot of other interested parties. We spent some time going through the detail of the concerns and the suggestions made during the consultation. There is no problem whatsoever in the Department meeting the BDA, now that we have

gone through that exercise and reached conclusions on changes to the initial proposals and those proposals which we have decided, following the consultation, we should continue to implement.

The Chairperson: What will be the consequences, or impact, if any, of that new policy on dental services for the patient?

Mr Rooney: I will ask Simon to come in on that. We looked at those areas where we could try to reduce the pressures on the budget. We focused on areas where we thought that the impact on the patient would be minimal. This is not about affecting oral health; as I say, we want to improve oral health. The number of treatments, and the number of patients registered with dentists, have been going up and that is to be welcomed. The amount of investment that the Department has put into general dental services in recent years has been going up. Again, that is in recognition of the level of care and treatment provided. So this is in no way intended to reduce the oral health of patients, but to look at areas where we could reduce costs without impacting on patient care. Simon, as the acting Chief Dental Officer, might like to add to that.

Mr Simon Reid (Department of Health, Social Services and Public Safety): Indeed, yes. We looked at a number of other options as well, and we excluded quite a lot of those because they would impact on the oral health of individuals.

It is important to recognise that only a relatively small number of core treatments will be restricted, but they will still be available when required due to exceptional needs. In the statement of dental remuneration (SDR), you have over 400 treatments but we are only talking about 10 or 12 treatment categories, or "treatment items", as we would call them, for which approval has to be requested. So, the vast majority of treatment items are still available. It is important to stress that.

We recognise that where a patient comes in to have his teeth scaled — what we would call "a one-visit scale and polish" — the evidence with regard to health benefits is limited, but we recognise that it might impact on whether patients choose to attend, have a recall and have their teeth cleaned which, for this particular treatment, is largely cosmetic. However, we recognise that it encourages them to maintain their oral health. That is why we have extended our time scales. Rather than restricting them further, we have relaxed them to try to encourage people to attend.

We have kept the practice allowance. We have changed the thresholds on it but we are keeping it, because it is the most important allowance, we feel, in enabling practices to maintain their viability.

With regard to orthodontic treatments, we believe that it is very important to prioritise, so that treatments are available to those people, generally children, who are very high need. We are trying to prioritise their care and treatment and objectively manage those cases that do not have a high need. We think it important to try to use that money to provide oral healthcare to the wider population, improve its oral health and reduce inequalities.

The Chairperson: That is quite useful. Can I ask you a question that might seem totally daft?

Mr Reid: No problem.

The Chairperson: Do dentists get a lump sum for the patient list, similar to GPs?

Mr Reid: They get what is called a "capitation payment" for children and for continuing care; again there is a capitation payment for adults. That is a sum of money paid per registered patient per month. So that comes in regardless of whether the patient attends.

The Chairperson: And here is the daft part of the question. Say I am a dentist, and I have 10,000 patients. Out of those 10,000, 4,000 pay. How do you work it out? Do I get a set amount for 6,000 patients, or do I get it for the 10,000?

Mr Reid: They would get paid for each registration, so they would get paid on the 10,000 registrations.

The Chairperson: If I pay —

Mr Reid: The individual patient does not contribute towards that cost; the Department meets it. Paying patients are paying only for treatments that they have had carried out. The capitation fees

depend on the individual's age. They are increased in more deprived areas to try to encourage registrations from those areas, and they are increased for individuals who have medical needs.

The Chairperson: I need to double check this, because I went to my dentist only recently. Do I not pay even when I go for a check-up?

Mr Reid: You do. A paying patient pays 80% of the treatment cost. So, you pay 80% of your check-up fee, but you do not pay to be registered with your dentist. That cost is not charged to the patient.

The Chairperson: I am trying to work this out in my head — my dentist is going to kill me if he ever hears this. *[Laughter.]* GPs get a set amount that is based on their patient list.

Mr Reid: Yes.

The Chairperson: Do dentists get a set amount that is based on their patient list?

Mr Reid: Yes, they do.

The Chairperson: GPs do not get paid. I do not pay when I go to see my GP.

Mr Reid: That is correct.

The Chairperson: However, I pay when I see my dentist.

Mr Reid: Yes, that is right.

The Chairperson: So, does that take into account the fact that some people who see a dentist might pay?

Mr Reid: Yes. Every month, BSO calculates the schedule. It can calculate the number of individual patients who attend and how much their treatment costs. Where an individual pays towards the cost of their treatment, that amount of money is deducted from the payment that is made to the dentist. I hope that that makes things clearer.

Where a patient is exempt, the payment is made of 100% of the total cost.

The Chairperson: I have taken you down a different road, so I will come back to that. Let me do a wee bit of work on that.

Mr Rooney: A table in the summary responses document may be helpful. It shows the allocation that the Department determines and the dental service expenditure. You can see that there is an income from patient charges. An amount is received from patients that contributes to the overall expenditure. Clearly, the allocation from the Department that is paid through the board and the BSO makes up the majority of the expenditure that is shown in that table.

The Chairperson: OK. That is something that we will probably look at. What is the average salary or take-home pay of a dentist nowadays?

Mr Reid: The information that we have is for 2010-11. The average taxable income for a principal dentist — a practice owner — was £114,000. The average taxable income for an associate dentist was £59,000.

The Chairperson: So, a practice owner earned £114,000 and someone who worked in the practice got £59,000?

Mr Reid: Yes.

Mr Rooney: There would be income from health service work and private dentistry. Some dentists do private work as well. So, taking those two incomes together, the overall average figure for 2010-11 was almost £80,000.

Mr Gardiner: You touched on this point, but I will put you over it again. What guidelines exist for the use of clinical dental procedures on patients? Is there any evidence of unnecessary procedures being carried out?

Mr Reid: There is a range of guidelines, but I do not know whether it has been audited at all. My only knowledge of that is from my experience of working in the board in the past, when I looked at prior approval cases — treatment plans — and checked them over. There would have been a proportion of those in which the treatment plan was arguably not appropriate and we had to question part of the treatment. Occasionally, the treatment may have been turned down and alternative treatments recommended, but, largely, the range of treatment plans coming in was appropriate. We have to recognise that there is more than one way to treat a particular dental condition and that practitioners may have a range of different approaches. However, there were occasions when the treatment plans were inappropriate and we had to question them. The approval process is there as a check that the treatment plan is appropriate.

Mr Gardiner: Are you satisfied that you are protecting the patient under all circumstances?

Mr Reid: To my mind, we are doing that as best we can. We have a lot of higher-value treatments, or particular treatment items, that require approval. So, most courses of treatment that most people have carried out would not require approval. We are checking only the more complicated courses of treatment or those where the treatment item requires us to check it. That is really a way of our checking that the range of care and treatment provided is of a good quality and appropriate.

Mr Brady: Thanks for the presentation. To follow on from what the Chair was saying, dental and optical charges are means-tested. Whenever you fill in a HSC1 form, the charge is worked out on the basis of your income. Depending on the level of benefit, etc, some people are exempt. So, the percentage of what you pay is then worked out depending on your income and capital and so forth.

I will go back to the commitment payments; I seem to be obsessed with them today. Eugene said that it was not about cuts, but it really is about cuts. Your briefing paper suggests that the rationale for the proposals seems to be the pressure on the budget. Although it is being phased out over a two-year period, some dentists undoubtedly will consider that private practice is a more lucrative way of operating. That will, undoubtedly, impact on patients. We live in a very low-wage economy. As in many other things, some people are just missing out on the exemption or the percentage that you pay, and they may not then be able to afford private practice. Apart from the actual common sense issues that are involved in dental and oral hygiene, in some cases, people cannot afford to go to their dentist. So, I do not think that that will necessarily have a positive impact on patients. From our perspective and, indeed, that of dentists and yourselves, patients and their well-being are paramount.

I am not saying that it is disingenuous to say that the proposals are not about cuts. Everything that happens, whether it is in the benefit area or the health area, is about cuts. It is about prioritising resources and then deciding where you are going to spend the money. It seems that, when we are talking about health, in many cases, that issue seems to be well down the pecking order, whether it be dentistry or health in general. Waiting lists and all those issues have been raised.

I just wanted to make that point, because I think that it is about cuts. It will possibly have a greater impact in the future than is currently anticipated.

Mr Reid: We have spent a lot more money than was originally allocated. The board has had to make a lot of difficult calls, such as calling on money from other allocations. These choices are very hard, and there is no easy way to do this. We have looked at a range of options, and we have been talking with the BDA from 2011. We have even talked to it about any ideas that it may have. It brought a number of proposals to us. Unfortunately, when we looked at them, a lot would not work out or would cost us more money.

We cannot carry on like this. We have to try to reduce the pressures, and we are trying to manage it. We are not trying to change everything at once; we are just trying to control it as best we can. However, that is a really difficult job, I am afraid.

Mr Beggs: The BDA's briefing paper indicated that, in 2009-2010, about 15% of a dentist's time was spent on paperwork, admin, etc. Two years later, in 2011-12, regulatory burdens, etc meant that that went up to 20% of their time. What is the Department doing, in conjunction with the regulator, to bring

about efficiency savings — not cuts — so that more time can be spent treating patients than filling out paperwork?

Mr Michael Williamson (Department of Health, Social Services and Public Safety): We have created the option to introduce a threshold through the index of orthodontic treatment (IOTN). We have agreed with the BDA that all cases that meet IOTN 3.6, which is the threshold that has been set, will not have to go through prior approval any more. That means that the practitioners will not have to fill in the prior approval forms —

Mr Beggs: Do they have to do that at present?

Mr Williamson: They do, yes. There is a £280 threshold, and any treatment that is above that has to go for prior approval. We are removing that for orthodontics, so that will be taken out.

Mr Beggs: I am glad to hear it. I hope that you continue to look at that area in conjunction with the regulator, because there are impacts on the decision that is made.

The briefing paper states that the Oasis contract is for £120·35 — I assume that that is for each patient for a year — and the GDS contract is £75·12 for each patient for a year. That is a 60% difference. How is that justified?

Mr Reid: The issue is to recognise that they are actually two different types of contract. The Oasis contract had to come in, because a lot of dentists excluded treating people and would treat them only privately. So, we introduced a different type of approach whereby patients could access care and treatment, they would be able to get the same broad range of treatments and, importantly, we were trying to increase the preventative care element so that a lot more time could be spent on that.

Looking at the actual costs, we would not agree completely with that analysis. The GDS contract calculates at roughly £100 for each registration, and that is exactly the same level that is paid to Oasis. The new contract that we are moving towards is not really targeted at treatment items. You have to recognise that, where contracts remunerate through clinical activity, there is a drive to provide clinical activity, whereas the vogue nowadays is to use much more of a preventative mechanism to try to prevent dental and oral disease progressing and trying to use preventative care to prevent our having to carry out reparative treatment.

Mr Beggs: I am with Oasis. Where I was working, in my main office, there was no other option for me if I wanted to receive NHS care. It is a good service, but I am not aware of anything particularly different to what I would have received from my previous dentist. Therefore, how is the service meant to be different?

The Chairperson: It is about supply and demand at the time.

Mr Reid: That service is planned to provide the broad range of care and treatments that are available. It is working under a different model where it is paid for each patient who is registered. It is then able to spend more time on preventative care. If anyone needs preventative care, more oral hygiene instruction, fluorides and such things, more time can be spent with those patients. Quite often, the people who could not get care had high oral health needs and were quite often from more deprived communities. They were then able to have much more care and help to try to improve their oral health, and they could also have restorative treatment carried out.

The Chairperson: Thank you very much. I hope that that was painless.