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Repositioning dentistry

Bernard Ingham, Mrs Thatcher's press secretary, became infamous for his lobby briefings at which he regularly debunked members of her Cabinet. In a memorable put-down, he described one hapless minister as "semi-detached". It was a clever phrase, expressing both that minister's lack of involvement in the Thatcher plan, and his consequent lack of influence on government policies.

"Semi-detached" also seems to be a fair description of the relationship of dentistry to the NHS since 1948. Dentistry has never been fully involved in the NHS, and its influence on the direction of health care policy has thus been limited. Yet for a great deal of this time, this seems to have suited both the profession and the government.

General dental practitioners have greatly valued their independence, and they have kept their contractual relationship with the NHS distant. As a consequence, successive governments have exploited this arms-length relationship, gaining maximum output for minimal investment. By adjusting fee rates on items-of-service, for over 50 years the Department of Health has contrived a "pile 'em high, sell 'em cheap" dental service. The result is that GDPs have become machines - highly efficient and productive machines - of health care output. And since oral health in the UK has improved decade on decade, it would seem that we have a 1948 model of care that has stood the test of time. If it ain't broke, why fix it?

Only, it is broke. As will be evident to everyone, dentists, often with long and proud service to NHS care, are everywhere reducing or abandoning their NHS commitment. Young dentists entering the profession, tell anyone who will listen to them, that they have no intention of working in the NHS. Were Nye Bevan to return to today's NHS, he would recognise very little of the New Labour Model of 2002, and rightly so too. But he would recognise dentistry, for it is the only unchanged part of his 1948 Plan, although he might be a bit surprised to see that the £1 maximum fee over which he resigned from Atlee's Government has now risen to £366.

In a time of yet more change in the NHS, others may look enviously at the unreformed General Dental Services. In fact, the lack of change and progress in this important aspect of primary health care is a dreadful indictment of neglect by successive governments. Now, after 54 years, the model is breaking down. There are, perhaps, four principal reasons.

First, professional choice. Dentists have had enough of trying to make the system work. In the last decade, the growth of alternative models of care, principally in the private sector, have given dentistry viable alternatives. Ten years ago, it was only the very bold or very secure who made the move away from GDS. Today, every dentist in the country will know a local colleague who has reduced or abandoned NHS dentistry. These colleagues talk about practising higher quality dentistry, with less stress and more patient and professional satisfaction, for the same financial reward. After years of being the machines of state production, they have rediscovered their enjoyment in their professional vocation. Nobody who made this move talks about returning to the NHS.

Second, consumer demand. The current model of NHS dentistry simply cannot deliver the service that a more affluent and demanding population expects. People want high-quality care, delivered in a pleasant and stress-free environment. They are becoming more demanding of their dentist's time. They have been encouraged (by the same politicians who want cheap labour) to be active in enquiring about their care, discussing alternatives, and generally becoming more involved. But with NHS fees beginning at around £6, what interaction of any meeting can take place between clinician and patient? Moreover, many treatments that these more inquiring and demanding patients choose are not available on the NHS. The NHS does not deliver the quality they want, nor the range of care they are seeking, and what is does provide, it charges them for. Why bother with it at all?

Third, regulation. Like medicine, dentistry is becoming more highly regulated. But the plethora of demands, from an ever-growing number of agencies,

means that no dentist could provide dental services on NHS rates and expect to gain a clean regulatory bill of health. Infection controls, environmental pressures, access demands, workforce directives, quality audits, clinical governance, complaints procedures, litigation threats, registration requirements, and many others, all require the attention of the practitioner. None of these issues are trivial; all need time and attention; and none can be done on the cheap. If we want a high-quality service, working to the highest standards, run by a profession which is regulated, reviewed, and engaged with its public, then we will have to pay for it.

Finally, political momentum. This Government and in particular, this Secretary of State for Health, has flown the flag for modernisation of the health service. They have promised a modern NHS, fit for the needs of all citizens, and they have undertaken to tackle health inequality. Oral disease is one of the first health inequalities to emerge in childhood. It discriminates very clearly between young children of different social backgrounds, causing pain, misery and social stigma. It is an unacceptable and wholly preventable inequality. It will not be tackled without concerted efforts of organised public care. If the NHS cannot tackle this, what can it do?

So we are at a crossroads. We could do nothing and muddle on with the old system. If we do, there will be no NHS general dental services worth speaking about in five years time. NHS dentistry would become a residual service, available only to those who cannot pay, or who are particularly vulnerable. Or we can take seriously the task of positioning dentistry within the modernised NHS.

Since last summer, the BDA has been working with officials in the Department of Health in England on an "Options for Change" report on the future direction for primary dental care services. It proposes a radical set of options, which, if adopted, could, over time, sweep away the 1948 system.

The Options Report severs the link between clinical treatment and payment that is the bulwark of the current system, and also proposes to abolish the centralised one-size-fits-all regime. In England, NHS dentistry would be commissioned by PCTs, who would take account of the oral health needs of their populations, and contract with local professionals to provide a range of services. The universality of NHS care would be safeguarded, with everyone being entitled to an oral health assessment, focused on prevention and health promotion, as well as treatment. NHS treatment would be guided by a set of clinical pathways, based on best evidence and good practice. Outside their NHS contract, dentists would be able to offer private care for treatments not covered by NHS services, but which are clinically effective and are desired.

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There are dangers. Ten years ago, miscalculations by both the BDA and Department of Health left dentists struggling after a huge fee cut destroyed their faith in the system. This time the profession will want to move carefully, evaluating the impact of any new proposals before it moves into the new world. It will also need to gain much greater understanding of dentistry within a modern NHS. Despite its position as most-used NHS service, policy makers do not usually consider dentistry. Yet it is important to general health, crucial to health of the youngest, oldest and most vulnerable members of society, and modernised, it could provide an important plank in the NHS of the future.

The 1948 NHS was built on the principle of utility, the greatest gain for the greatest number, yet this founding virtue has recently become its greatest weakness. Utility is not enough, for patients, professionals and public expect a lot more. We want a quality health service that meets our individual needs. A modernised dental service can deliver this, but not until we have decided what we want the profession to do, and have developed a system that treats dentists as highly-trained professionals delivering quality care to a discerning population.

[This article is based on a talk given at a recent IPPR seminar in London]

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