IN BRIEF

- A survey was carried out in the Summer of 2001 to elicit patients' perceptions of dental services (as part of the national evaluation of personal dental services).
- Access to general dental services is problematic. Patients report that emergency dental services have improved.
- Cost is still considered to be a major barrier to dental care.
- Information regarding treatment availability under NHS arrangements was reported to be confusing for patients.
- Patients appeared to be more concerned with the barriers they faced in receiving dental care, such as cost, dentist's image and access, rather than the type of organisation they were attending.

VERIFIABLE CPD PAPER

National evaluation of personal dental services: a qualitative investigation into patients' perceptions of dental services

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In 2001, qualitative research was carried out to investigate patients' views on dental services, in particular personal dental services. This article outlines the main themes to emerge from these interviews. Before outlining the key themes, it is important to describe the background to the study. Prior to 1997, NHS general dental services could only be delivered by general dental practitioners *via* a national contract with a nationally negotiated scale of fees. The *NHS (Primary Care) Act 1997* allowed for the voluntary establishment of pilot schemes to test alternative ways of delivering dental services, in particular general dental services, through local contracting arrangements.[1]

These dental pilot schemes were set up in response to patients' complaints regarding access to NHS dental care. A national evaluation of personal dental services (PDS) was commissioned by the Department of Health in 1999, with the purpose of assisting the development of primary dental care. This evaluation examined the extent to which pilots achieved their original stated aims, and explored the relationship between what was achieved and why.[2-5] The Department of Health were particularly interested in barriers to healthcare and patient satisfaction. Therefore, a comprehensive research proposal was developed to examine patients' experiences of dental services.

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Refereed Paper
Received 09.05.03; Accepted 28.08.03

STUDY DESIGN

During 1999, ethical approval was sought to carry out a user-involvement study. The purpose of this study was to examine patients' perceptions of dental services though qualitative semi-structured interviews. Twelve sites were selected, these being six PDS, three GDS and three CDS in areas with similar demographics, comprising of a mix of rural and urban areas. The sites were selected on the basis that PDS pilot sites could be compared with their equivalent within the GDS and CDS (Table 1). A draft topic guide was designed and piloted after brainstorming sessions with the PDS research team. A total of 28 out of 32 interviews were conducted with users from the sites.

Table 1 Subject area

Sample selection — matched groups	
Test	Control
PDS (CDS origins) (Wolverhampton)	CDS (Dudley)
PDS (CDS origins) (Cornwall)	CDS (Cornwall)
PDS (GDS origins) (Rugby)	GDS (Nuneaton)
PDS (GDS origins) (South Cheshire)	GDS (South Cheshire)
PDS (CDS origins) (Liverpool)	CDS (Liverpool)
PDS (GDS origins) (North Essex)	GDS (North Essex)

Subjects were selected for interviews on the basis of answers given in a recruitment questionnaire. The selection criteria for inclusion in the interview ensured that patients were selected from a variety of ages, sex and occupational status (Table 2). Of the sample (n=28) who were selected for interview, 12 held either professional positions (n=6) or were blue collar workers (n=6) whilst the other 16 were unemployed (n=6), retired (n=5) or nursing mothers (n=5). Dental attendance, attitudes and the additional comments section of the recruiting questionnaire were used to aid selection of patients for face-to-face interviews. The participants were not paid for their involvement.

The interviews, which lasted between 45 to 60 minutes, were conducted face-to-face, usually across a dining room table, and recorded on a cassette tape recorder. Following the interview the tape was transcribed *verbatim* into scripts and data analysed. Data analysis in qualitative research means breaking down the data and searching for codes

Table 2 Age, gender and occupation of all respondents

Respondent	Occupation	Gender	Age range	Qualifications
1	Accountant	Female	35-44	Professional
2	Care assistant	Female	25-34	GCSE
3	Service engineer	Male	25-34	HNC/ONC's`
4	Martial arts instructor	Male	25-34	---
5	Unemployed	Female	25-34	---
6	Nurse	Female	35-44	RGN
7	Teacher	Female	35-44	Degree/PGCE
8	Train buyer	Male	45-54	---
9	Retired	Male	65-74	---
10	Nursing mother	Female	25-34	---
11	Retired	Male	65-74	---
12	Unemployed	Male	35-44	---
13	Retired	Male	65-74	---
14	Retired	Male	65-74	---
15	Retired	Female	65-74	---
16	Personal manager	Female	35-44	Degree
17	Lecturer	Male	45-54	Masters degree
18	Nursing mother	Female	25-34	---
19	Nursing mother	Female	25-34	---
20	Nursing mother	Female	35-44	GCSE's
21	Nursing mother	Female	35-44	'A' Levels
22	Unemployed	Male	25-34	---
23	Unemployed	Male	55-64	---
24	Unemployed	Male	55-64	---
25	Unemployed	Male	35-44	---
26	Teacher	Female	35-44	Degree/PGCE
27	Shop assistant	Female	55-64	---
28	Shop assistant	Female	45-54	----

and categories which are then reassembled to form themes. Data analysis takes place from the beginning of data collection. A framework of respondents' categories was developed after the information was coded and categorised.

MAIN THEMES TO EMERGE FROM THIS STUDY

During the interviews, specific barriers to the receipt of dental care emerged as major themes, these included:

- Patient satisfaction
- Cost
- Access, and
- Fear and anxiety

Patient satisfaction

Patient satisfaction has been established as an important factor that influences whether or not a person seeks medical advice, complies with treatment, and maintains a relationship with a practitioner. There are growing political reasons for considering the views of patients. A recent publication by the Department of Health, *Options for Change* emphasised the patient-focused dental service, which would enable patients to be more active in treatment decisions.[6] Several recommendations were suggested in *Options for Change*, which included empowering patients, adequate information regarding treatment and cost, patient forums to ensure quality and access to care and the development of communication strategies.

Respondents suggested several similar recommendations including having a central number to access NHS dentistry. The task force set up to investigate patients' needs suggested, *'NHS direct should ensure callers get full information about what service they can expect from NHS dentistry, including charges and how to apply to the low-income scheme'*. Patients from all the sites commented on the qualities of a good dentist, which are summarised below:

- Friendly
- Has a personal touch
- Good chair side manner
- Explains what s/he is doing
- Explains what the cost of treatment is prior to starting
- Is caring, gentle and reassuring
- Good technical skills
- Inspires confidence

This list appears glaringly obvious, but it is important to note that these characteristics are seen by patients to be as important as technical competence. Respondents generally measured their satisfaction with dentistry on the personalities of the dentist.

Cost

Subjects interviewed expressed the opinion that dental treatment was too expensive and were confused about the availability of treatment under the NHS. Cost of dental treatment was given as a reason for non-attendance or postponing a trip to the dentist. Patients reported that dental charges were confusing and felt very suspicious of dentists' motives for providing treatment. These comments were expressed across the three services as a major cause of anxiety for patients. Patients expressed concerns that they would not go into a shop and buy something without knowing the cost, so dentists should openly advertise the cost of dental treatment. A general feeling was of concern related to the fear of the cost rather than the actual cost of treatment. This misinformation about dental charges left patients feeling confused about the nature and availability of NHS dentistry. Patients want to know what they are paying for and what is available under the NHS.

The 1998 *Adult Dental Health Survey*[7] also reported that patients were concerned

over the cost of dental treatment, the drift away from NHS dentistry, and difficulty in accessing an NHS dentist.

Other studies have also showed that the public remains uncertain about dental charges.[9,10] The costs of dental care as a barrier to the uptake of dental services may affect between 30–61% of the population[8] and may be due as much to fear of the potential cost as to the actual cost experienced. In addition, subjects may be unaware of the availability of free dental treatment if they are receiving benefits.[9,10] Results highlighted in this paper demonstrate that patients' perceptions of dental care have remained similar to those reported by Finch and co-workers.[9]

Results presented in this study highlighted the current government thinking detailed in *Options for Change,* that patients need more information about the cost of dental treatment.[8] The standards set out in *Options for Change* state that patients should receive written details regarding cost and what is available under NHS care. This type of information would alleviate most patients' concerns regarding cost.

Access

Access to general dental services remained problematic for people during this study. Respondents reported a particular dislike of the 15-month registration period under the NHS GDS arrangements. They generally commented that they had not found accessing emergency care problematic, which differs from the findings from other studies.[9,10] PDS patients reported increased access to emergency care within their location, but this comment was not across the board. For example, patients in the Cornwall PDS pilot site reported a noticeable difference in the availability of emergency dental care, but did not link this to developments in dental services. Patients reported that accessing an NHS dentist was still very difficult, with many dentists closing their NHS list or having a waiting list. They also reported difficulty in identifying which dentists were still accepting patients for NHS care. Patients reported that NHS helplines sometimes gave outdated information.

The more recent York research[10] showed geographical variation in problems associated with finding, registering with and receiving NHS dental services. Respondents reported difficulties, particularly if an individual had to leave one practice and join another.

Problems of equity are presented by dentists' autonomy over the level of NHS service (if any) they offer. There is a concern that dentists can refuse to accept people as NHS patients without open discussion.[10] The view of participants was that dentists should not have this option and should be more like general medical practitioners. Prevailing opinion appears to be that all dentists should offer NHS care.

Fear and anxiety

Dental anxiety may range from feeling mild apprehension experienced when visiting the dentist, to such inordinate fear of dentists and dental situations that it prevents the sufferer from receiving all but emergency care when *'the pain is worse than the fear'*. There is anecdotal evidence expressed within the dental profession, and it has been stated that '*there is a substantial proportion of dentally anxious individuals in the general population'.*[10]

Some interviewees reported avoiding attendance at a dentist because of anxiety or fear. One patient expressed great happiness that dental services were being changed so that patients could just drop in for emergency care. *'I hate going to the dentist and therefore only attend when I am in pain...I went about a year ago and found access to emergency care had improved and I did not need to be a registered patient...great improvement'*. Respondents reported that they felt happy to visit the dentist.

Dentists' public image suffers from the problem of association with pain. Patients reported that the dentists were considered impersonal in their approach to patient care, pre-occupied with technical aspects of treatment and how much money they could make. Patients reported that the *'dentists only see you as a mouth'*, this exact comment was reported by Finch and co-workers.[9] Patients from GDS and PDS expressed concerns that *'dentists are only motivated by the potential earnings'*. Patients believed that *'dentists operate a conveyor–belt service, seeking to treat patients as much or as fast as possible'*.

COMMON MESSAGES WITH OTHER RESEARCH

In 1988 a report called *Barriers to the receipt of dental care* was published by Helen Finch and co-workers.[9] The aim of their study was to investigate obstacles to accessing dental treatment. A secondary aim was to generate ideas on ways of overcoming these barriers. Emphasis was placed on soliciting the views of the irregular or non-attender. There was considerable overlap in terms of access to dental treatment, confusion over the cost of dental treatment and fear and anxiety, with those findings reported by University of York and Finch.[9,10] The fact that studies carry sometimes identical messages from the public adds weight to the validity of their findings.

CONCLUSIONS

During the course of this study, patients reported difficulty in accessing dental care. They were often unaware of the nature of the service and were more focused on their immediate concerns, particularly costs and fear. In this respect the findings of this study are no different to findings from other studies.

This work was undertaken by the University of Birmingham who received funding from the Department of Health; the views expressed in this publication are those of the authors and not necessarily those of the Department of Health. The authors would also like to acknowledge the help and support of Dr Gill Bradnock.

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