What patients think of dental services

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In 1998, research on 'What the general public wants from the general dental service' was carried out by the Centre for Dental Services Studies (CDSS) at the University of York and was commissioned by the British Dental Association (BDA). The research culminated in the report: 'User Priorities for General Dental Services'. This article outlines the main message from the research and contains the researcher's personal observations.

This article outlines some of the main themes to emerge from qualitative research commissioned by the British Dental Association (BDA) from the Centre for Dental Services Studies (CDSS) at the University of York in 1998. The research culminated in the report: *'User Priorities for General Dental Services'*.

In addition to some of the research findings, this article contains the researcher's personal observations. It is important to note that these views do not necessarily represent the viewpoint of the BDA, nor indeed the CDSS.

This article is not intended as a summary of the research findings — a copy of the report is available from the BDA. Instead, based on the author's presentation at the BDA annual conference in April of last year, it outlines the main messages from the research with relevance to the questions: 'How do patients see dental services?' and 'What are patients looking for?'. It draws the striking similarities with findings from a study undertaken 12 years ago, and highlights the challenges that the public's perceptions present for the dental profession in the opening months of the 21st century. It will argue that dentistry needs to grasp these challenges urgently in bringing about change from within.

Background

Before outlining the key themes, it is important to describe the background to the

study. In May 1998, the CDSS was commissioned by the BDA to undertake qualitative research to discover what the public wants from a general dental service, and its views on the relative priorities for developing dental services in the future.

The outcome of the research was intended to be set alongside other consultation undertaken by the BDA with local dental committees on the future of general dental services. Both strands were to inform a submission by the BDA to the Government on a national strategy for dental services.

Figure 1 shows the ten broad headings under which the report presents the research findings.

In brief

A survey commissioned by the BDA in the Summer of 1998 on what the general public wants from a general dental service found:

- Access to general dental services is problematic. A more comprehensive and guaranteed NHS emergency dental service is considered necessary.
- Cost is a main barrier to access. There should be a national, standardised and regulated scale of charges for NHS and private dental care.
- Dentists' public image is of being too impersonal in their approach to patients.
- Poor information is a common criticism.

The research culminates in a number of recommendations to address these issues.

Methodology

Six sites were initially selected in which to conduct the three strands of the research: focus groups with members of the public, telephone interviews with GPs and health visitors, and postal surveys of community health councils. The sample was chosen to give a mixed demographic and socio-economic spread, comprising two inner city, two urban, one suburban and one rural health authority. Of the original health authorities approached, two (Lambeth, Southwark and Lewisham, and Manchester) had to withdraw, because of problems presented by the tight timescale. Substitute sites were then approached. This resulted in the following pragmatic mix of participants in each element of the research:

- Focus groups in Settle, Bristol, Coventry, East Surrey and York with 37 members of the public
- Telephone interviews with 19 GPs and health visitors in Settle, Bristol, Coventry, East Surrey and Lambeth
- Postal surveys of seven community health councils (CHCs): Airedale, Bristol and District, Coventry, East Surrey, Lambeth, Southwark and South Tees.

For the purposes of focus group participant selection, dental advisors were asked to arrange for their health authority to extract a sample of 50 patient names from general (medical) practitioner lists. The samples were stratified by sex, age and ethnic origin. Later recruitment sought to identify an appropriate number of parents to reflect the service issues associated with children. The letters of invitation to participate in focus groups came from the dental advisors. Those people who took part in the focus groups were paid a £15 participation fee.

The main report contains more detailed descriptions of the background and methodology.

Common messages with other research

In 1987 a report called *'Barriers to the Receipt of Dental Care'* was published by Helen Finch and colleagues. The aim of their study was to investigate obstacles to accessing dental treatment and the factors influencing take-up. A secondary aim was to

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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 the findings of the York research and the earlier study. The fact that the two studies carry sometimes identical messages from the public adds weight to the validity of their findings and to the imperative of acting on those messages.

The main parallel themes to emerge from both studies were as follows.

Access

Access to general dental services is highly problematic for people and needs to be improved. The more recent York research showed geographical variation in problems associated with finding, registering with and receiving NHS dental services. More than half the GP and health visitor participants and four out of seven CHCs raised difficulty in registering with a dentist or receiving NHS services as a problem in their area. Some focus group participants 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. The view of participants in the recent research was that dentists should not have this option — in this respect, dentists should be like general medical practitioners. Prevailing opinion appears to be that all dentists should offer NHS care. This culminated in a call for a more regulated system which provides standardised NHS cover for those groups agreed as eligible, regardless of location.

GPs and health visitors emphasised the limited public awareness of the need to register with a dentist and attend regularly. This is particularly an issue in poorer areas, where health service use is typically irregular, occurring only when there is an emergency. All three groups of research participants in the York research suggested that the regulations about regular attendance which go with registration are inappropriate for certain people (such as those

Figure 1	Section headings from the CDSS report
<ul style="list-style-type: none">• Difficulty in registering with an NHS dentist or receiving NHS services• Views on having to be registered with a dentist• What people think they should get from being registered — what level of service?• Views on the current system of co-payment• Alternatives to the current system for funding dental services• Costs of dental care• The basis on which elements of a dental service should be available• Priority groups for free NHS dental care• Possible exclusions from free or subsidised NHS dental care• 'Other' observations.	

on low incomes and the homeless). In particular, there was considerable dislike of the 15 month re-registration rule. The 6-monthly check-up schedule which accompanies registration was regarded by some participants as unaffordable for certain groups and a way by which dentists 'create' work. Furthermore, there was a frequent call for a more comprehensive and guaranteed NHS emergency dental service for anyone, regardless of whether they are registered.

Those with a consumer-centric view argued against mandatory registration, calling for a more flexible service, which would allow people to visit a dentist of their choice, as and when needed. Given that the system is based on payment by the patient, people with this viewpoint want the freedom to shop around, within the context of competition on price (as with the optician model).

Cost

Cost emerged as another of the main barriers. The Finch study showed that dental treatment was considered by many to be expensive. The cost was openly acknowledged as a reason for non-attendance or for postponing a trip to the dentist, especially following a lapse in attendance. Participants in both studies articulated resentment towards paying dental charges on top of national insurance contributions and both studies uncovered confusion, suspicion and ignorance about the charging system. How-

ever, the intervening 12 years between the two studies had led to a resigned pragmatism in the findings from the York research.

Focus group participant views on costs were split between those who thought they were quite reasonable and those who regarded them as unacceptable. Views obviously depend on personal means and priorities. Clearly, participants' views were also coloured by whether they were currently registered as NHS or private patients.

Those who oppose the current system of co-payment, argue that charges restrict the use of dental services, particularly by those with limited resources. It is considered unfair that all NHS patients pay the same charges, with no sliding scale to reflect income.

There is a lack of public awareness that NHS patients pay 80% of the cost of treatment. There was a widespread perception that this 80/20 ratio is unfair. Preference was stated for a 50/50 split (or a reversal of the current ratio to a 20% patient contribution).

Costs were perceived by the majority of GPs and health visitors as quite reasonable, when compared with the cost of a single prescription, and given the safety net of exempt categories. However, they maintained that people on low incomes would have difficulty paying for the cost of treatment 'up front'. Charges for check-ups are the element to which people are most likely to object, on the grounds that the benefits are often hidden.

The majority of CHCs expressed concern about the costs of dental services on the same grounds. They regarded the upper limit (£348 ceiling) as prohibitive for many and the threshold for free treatment as too low (currently the payment of Social Security benefits). Some people a little above this threshold (particularly pensioners) are considered harshly treated by the current system. It was recommended by several participants that the ceiling on savings should be raised with regard to the point at which older people incur dental charges. CHCs and focus group participants also commented on the lack of an incentive to preserve teeth in the current cost structure.

Patients are often unsure what costs to expect from treatment. Focus group participants felt strongly that dentists should prominently display their scale of charges and discuss the likely cost of care with patients *before* treatment. This is a basic courtesy one would expect from any service. A plea was made for more explicit communication about charges and proposed work as *standard practice*.

A view expressed was that there should be a national, standardised and regulated scale of charges for NHS and private dental care.

Considerable confusion is caused by dentists' dual practice of NHS and private dentistry. There is a lack of clarity about what proportion of work is NHS and what private (sometimes within the same episode of treatment) and discomfort about this ability to mix. Patients are unsure whether they are getting the full benefit of NHS entitlements before private charges are levied.

Inherent perverse incentives to the current system are not seen to serve the best interests of the patient — the fee-per-item basis of dentists' income generates the potential for unnecessary work.

The profession's public image

Dentists' public image suffers from the problem of association with pain. The Finch study showed that dentists are considered impersonal in their approach to patients — pre-occupied with the technical aspects of treatment to the detriment of the personal touch. 'They see you as a mouth' was a frequent comment in the earlier study. This is

reinforced by a commonly expressed view of dentists as being highly paid, motivated by earning potential and therefore operating a 'conveyor belt' service, seeking to treat patients as much or as fast as possible. The piece-work remuneration framework only serves to enhance this image.

Information

Poor information emerged as the final main theme in common to the two studies. Examples cited included:

- No prior information issued by a surgery when transferring to more private practice
- A lack of clarity by the patient about their status (are they NHS or private?)
- Lack of formal information about how to access an NHS dentist
- No publicised scale of charges.

It is perhaps pertinent here to draw on direct quotation from one of the East Surrey focus group participants, regarding the need for improved information and the absence of a consumer-orientation by the profession:

'They don't seem to feel under any obligation to ever contact us, their patients, we who are paying their wages, that they are intending putting up the costs or whatever. There is no communication with dentists. You wouldn't put up with that from a garage, having 20% put on the bill without being told...'

Other issues

The responses to a concluding question to participants throw further valuable light on the way in which dentists and dental services are perceived by members of the public. The following examples are taken from a miscellany of points which emerged from an 'additional comments' question. The recommendations from the York study which sit alongside some of the issues are presented later in this article and should be considered seriously by the profession.

- The organisation of general dental services needs rethinking — it is structured around where dentists choose to set up

practice, rather than being configured around population need.

- Dentists are too reactive and should show greater initiative in providing information, engaging in positive oral health education and meeting patients' needs. Examples of this include:
 - ♦ Longer opening hours in dental practices (evening/weekend surgeries) to accommodate the needs of working people
 - ♦ The need to improve provision for people who are nervous/dental phobic
 - ♦ Dentistry for children should be more actively promoted. High Street dentists do not give the impression of being child-friendly.
- There is a perceived dearth of preventative dentistry because of the present system which discourages attendance and places emphasis on income for *treatment*, at the expense of oral health promotion. There was a call for greater emphasis on the latter.
- There is a perception that there is very little dental health education for children, with a call for more emphasis on school-based oral health education, to encourage children to become regular attenders. Dental nurses were considered suitable to take on such a role.
- The current system is perceived as wide open to abuse by dentists in 'over-treating'. Professional accountability to the patient needs to be strengthened (a salaried dental service was seen by some as being the obvious alternative to correct the flaws in the current system).
- There is a considerable lack of information about local services.
- Dentists should improve the way in which they communicate with their patients.
- Comment was made on the lack of a system for communicating with other members of the primary healthcare team.
- Lack of consistency (of approach and quality) between dentists is confusing.
- There is a perceived absence of redress for substandard dental work.
- There should be clear mechanisms to ensure that dentists of all ages keep up-to-date with developing technologies and evidence-based practice.

Recommendations

Both studies put forward a number of recommendations aimed at removing the barriers described above.

On improving access to dental services participants' recommendations included:

- Extending opening hours
- Open surgeries, where no appointment is necessary
- Surgeries located in more accessible sites
- Mobile dentists, and
- Making the waiting room and surgery as comfortable and inviting as possible.

Addressing the anxiety barrier will involve changing the image and approach of dentists. A 'good' dentist was described by the earlier study as one who is:

- Friendly
- Has a personal touch
- Explains what s/he is doing
- Is caring, gentle and reassuring, and
- Inspires confidence.

This may appear glaringly obvious. But it is important to note that these characteristics are seen by patients to be *as important* as technical competence.

On the cost barrier, the most frequently made suggestions in the Finch and York research were:

- A reduction in the level of dental charges (with a number of permutations ranging from free check-ups to certain elements of free treatment)
- A clearer charging system
- The *routine* communication of estimates

of cost *prior* to commitment

- Clearly displayed scale of charges
- Clarity about the mix between NHS and private charges in one episode.

The CDSS findings, summarised above under 'other issues', were presented alongside the following recommendations:

- The BDA should put its full support behind schemes aimed at more closely meeting the expressed needs of the public.
- The BDA should work closely with the Department of Health to encourage health authorities and trusts to sponsor more active and effective school-based oral health education programmes.
- The BDA should exert national influence on practitioners and health authorities to improve information about local services.
- It is imperative that improved patient communication is given a high profile by the BDA within the professional development framework.
- The BDA, in conjunction with health authorities, should actively encourage the development of better links between dentists and other members of the primary health care team, and encourage full participation in primary care groups.
- The complaints system should be the subject of widespread publicity.
- The BDA must exert strong influence on the importance of evidence-based practice and continuing professional development to ensure optimal competence for all its practitioners.

Conclusion

What became clear at the end of the study was the urgency with which the profession needs to grasp the challenge of becoming more consumer-focused. Elements of the practice of dentistry are now highly anomalous with the characteristics of successful modern services — examples include:

- An absence of real competition
- A lack of openness on charging
- A service configured around the interests and convenience of practitioners, and
- An all-too-often 'take it or leave it' approach to the customer.

A study like the recent York work inevitably raises consumer expectations about the prospect of change. It is essential that the profession engages fully with the process of change and makes an appropriate and positive response. The choice lies between controlling the modernisation process from within or having it externally imposed. The profession must grasp that nettle now without further delay.

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- 1 *User Priorities for General Dental Services*. York: Centre for Dental Services Studies, University of York, 1998.
- 2 *Barriers to the Receipt of Dental Care: A Qualitative Research Study*. London: Social and Community Planning Research, 1987.