Divided by a common tongue – 'Access'

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EDITORIAL

Last November, The NHS Information Centre reported that, in the 24 months ending 30 June 2008, 26.9 million NHS patients were seen by dentists in England; a decrease of 1.2 million on the two years ending 31 March 2006.[1]

The BDA response was that 'More than 1.2 million fewer people in England are able to access an NHS dentist now, than was the case before the reforms were implemented'. The Chief Dental Officer's view was 'The access statistics are old - they cover a two-year period looking backwards that does not reflect the extra £209m investment in NHS dentistry this year and all the new dental services that are opening now'. Clearly, they speak with a linguistic division over the word 'access'.

How did this come about? With the introduction of the 2006 contract, when most information about NHS dental practice was jettisoned, one remaining measure of supply was elevated to prominence; the number of individual patients seen by an NHS dentist, at least once in the most recent 24-month period. The NHS Information Centre simply reports this as 'patients seen'.

Somewhere in the Department of Health, this measure of supply was rebadged 'access', and so it appears in the NHS *Operating Frameworks* with specific references to requirements for dentistry.[2] This neologism might make sense to the sort of person who makes an appointment to 'access' a dentist (presumably having first 'sourced' a suitable practice!), but not to most of us in the real world.

The choice of words matters because 'access' has had a special significance in health care policy for perhaps 30 years. In a seminal paper in 1981 Penchansky and Thomas[3] conceptualised access as the level of fit between the expectations of people who might use services, and what providers offer to meet those expectations. Importantly, removing barriers to reduce the gap between the two improves this fit, and brings more people into contact with the services they need. Their paper conceived five groups of characteristics of access to care: affordability, availability, accessibility, accommodation (how far the preferences and constraints of a service user are 'accommodated' by the service being offered) and acceptability. The BDA was associated with The Finch Report[4] (1988) which explored this field of research and others appear to have reached a broad consensus that such factors are interrelated.

English PCTs have been set targets for 'year on year improvements in the number of patients accessing [*sic*] NHS dental services'. This is unlikely to be achieved if people (for example those with limited treatment needs), believe that the current fee structure makes regular attendance for NHS dental care poor value for money. PCTs striving to achieve this 'Access Target' (a steady increase in NHS patients seen by local dentists) will be tempted to deliver at the lowest per capita cost, rather than truly improving access through addressing the more complex barriers to care affecting those with greatest need. Perhaps somebody should move the Target.

If measuring what you should value is difficult, it seems the easy way out is to learn to value what you can easily measure. So, for a Strategic Health Authority, monitoring the actions of a PCT is simplified if a target can be devised which is based on an available measure, such as 'patients seen in the last 24 months'. Paradoxically, an increase in the number of patients seen - the greater utilisation of a health care service - can be regarded both as success (if it allows more people to get the treatment they need) and a failure (when the diseases being treated are mainly preventable). What actually matters most to many people, is that they can get good advice or kindly, effective treatment promptly and easily when they need it. That would be a sensible target to achieve.

The recent *Further Government response to the Health Select Committee Report on Dental Services (January 2009)*[5] highlights three strands of work which might make a difference:

- The Independent Review of Dental Services, remitted *inter alia* to identify ways to increase access to dental services and reduce inequalities in oral health
- An expanded national dental access programme to support PCTs
- The development of an access indicator that more closely reflects patient experience against which to monitor progress.

Let us hope they all start by agreeing to use language with clarity and precision, and wage war on the evil of 'Access'.

1. The Information Centre for Health and Social Care. *NHS dental statistics for England. Quarter 1: 30 June 2008.* London: NHS Information Centre, 2008. www.ic.nhs.uk.
2. Department of Health. *The operating framework for the NHS in England 2009/10.* London: Department of Health, 2008. www.dh.gov.uk.
3. Penchansky R, Thomas J W. The concept of access: definition and relationship to consumer satisfaction. *Med Care* 1981; **19:** 127-140.
4. Finch H, Keegan J, Ward K. *Barriers to the receipt of dental care – a qualitative research study.* London: Social and Community Planning Research, 1988.
5. HM Government. *Further Government response to the Health Select Committee Report on Dental Services.* London: The Stationery Office, 2009. www.official-documents.gov.uk.

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