Improving NHS Dentistry

Cm 2625

LONDON: HMSO

Improving NHS Dentistry

Presented to Parliament by the Secretary of State for Health by Command of Her Majesty July 1994

Cm 2625

LONDON: HMSO

Foreword

The Government is committed to an accessible and effective NHS dental service. It is committed to a high quality service providing comprehensive diagnostic and preventive treatment, and restorative work for all those who need it. In particular, we want to see continued improvements in the oral health of children.

We are equally committed to rewarding fairly those who provide this service. To achieve this we must use the money spent on dentistry, some 4.5% of the total cost of the NHS, effectively and efficiently to maintain and improve oral health in the United Kingdom. The review of the dental remuneration system has provided an opportunity to build on the success of the NHS dental service to meet the challenges now and in the next century.

There has been a substantial improvement in the oral health of the population since NHS dentistry began in the 1940s, yet the way we pay dentists has changed little.

In the post-war years there was widespread untreated dental disease and the oral health of the nation was poor. Then, people did not expect to keep their teeth for life. The NHS dental service of the 1940s, '50s and even the '60s was faced with an enormous demand for surgical and restorative treatments. Sadly the outcome for many people was to have their natural teeth replaced with dentures in middle age or even earlier.

The fee per item base of the system rewarded dentists for each and every treatment given. This gave a strong incentive for a dentist to see and treat patients. The fact that dentists were members of a well-established health care profession was the main safeguard of quality and clinical standards.

For most of the population in many areas of the UK, the demand for such treatment has been met. Regional variations remain, but there is now a reasonable expectation that people will keep their own teeth into old age. Today's children need never experience the pain and discomfort associated with dental disease.

The NHS dental service now faces quite different demands and challenges from those which existed when it was established. They will change further over the coming years. There are still areas where dental disease remains high and these must be tackled, but many people require only good diagnostic and preventive services with access to emergency services and more advanced treatments should they ever need them. The dental profession is unanimous that quality of care and prevention of dental disease should be paramount. This is what patients want and dentists want to provide it.

The current remuneration system is poorly matched to present needs. It has lost the confidence of the profession and others, especially since the problems caused by the major overpayments in 1992. An over- or under-payment happens every year. The system is unstable and when it goes badly wrong, as it did in 1992, it requires unsettling remedial action. Change is needed, and that change should reflect the demands facing the service.

We have listened carefully to all the views put forward as to how we might change the NHS dental service to meet present needs. We are particularly grateful

for the work of Sir Kenneth Bloomfield and the Health Select Committee who have made major contributions to developing policy. We have sought to identify ways to improve the system which keep the needs of patients to the fore. This is also what the profession wants. All are agreed on this aim, but there has been no consensus on how this might be achieved.

Both Sir Kenneth and the Health Select Committee concluded that provision of dental care should be managed at the local level. The Government agrees there would be benefits for all if decisions about local needs and priorities were taken locally, in the same way as secondary health care and community services following our reform of the wider NHS. Those reforms are now well-established to the benefit of patients. It would be equally powerful in this sphere of the NHS where needs and priorities can vary widely. This approach would allow local health strategies to be developed and implemented, in line with the national strategies each health department in the UK is bringing forward.

The Government recognises that this would represent a major change for dentists. We have decided, subject to Parliamentary approval, to pilot and evaluate this model thoroughly in several areas around the UK prior to any wider implementation. We have also decided to develop the important role of the Community Dental Service. Our aim is to enable local decisions on priorities and targeting of resources to need.

In this consultative document, we put forward two distinct sets of proposals which could operate while the wider reforms are developed. One seeks to reward dentists according to time committed to treating NHS patients. The other, likely to be a temporary measure, is based on a system of treatment fees.

We will also consult on changing the structure of patient charges, to give greater encouragement to patients to visit the dentist. All the present exemptions and remissions from patient charges would remain unchanged. This means that children under 18 and full-time students under 19, as well as pregnant women and nursing mothers, would continue to receive free treatment. The current exemptions and remissions for those on low incomes would also continue to apply.

We now want to work with the profession and others over the coming months to see which of these options, including the model to be piloted, can best meet the aim of the review and achieve our common goal: improving the NHS dental service for all involved so that the quality of life of the population can be significantly improved.

Secretaries of State for Health, Northern Ireland, Scotland and Wales.

Contents

	Para	Page
Part I: Background		
Introduction	1	5
Oral Health in the United Kingdom	2–5	5
The Scope of the General Dental Services -Key Facts	6	6
Historical Summary	7–10	9
The Reasons for the Review	11–17	9
The Bloomfield Review	18–30	10
The Health Select Committee Report	31–32	12
Consultation	33–35	13
The Result of Consultation	36–37	13
Building on the Consultation	38–42	14
Part II: The Government's Proposals for Reform		
A Local System	43–53	16
The Direction of Change	54–64	17
Sessional Fees	65–74	19
A Dental Fee Scale	75–79	21
Developing the Community Dental Service	80–82	22
Implementation : Managing Change	83–85	22
Annexes		
Annex A : The Present System		24
Annex B : Sessional Fees		30
Annex C : A Dental Fee Scale		36

I Background

Introduction

1. This section sets out the reasons for the review of the NHS dental service together with relevant background information. First it reviews the way oral health has developed over the last half-century and sets out some key facts about the current strength of the service. Then it provides a brief history of the system and highlights the reasons for the review. The rest of this section reports on the findings of Sir Kenneth Bloomfield and the Health Select Committee from their recent reviews of the system. It concludes with a description and analysis of the extensive consultation carried out.

Oral Health in the United Kingdom

2. In the 45 years since the NHS began there have been major improvements in the oral health of the population. In large part this is due to the success of the NHS alongside the long-established and significant private sector in dentistry. Other factors, such as improved standards of living, greater awareness of oral health issues, fluoridation of water and the use of toothpastes containing fluoride have also played their part.

3. The improvements in dental health have continued in recent years. A series of surveys conducted between 1978 and 1991 by the Office of Population Censuses and Surveys indicated that the proportion of adults with no teeth fell from 28% to 17%. There are regional variations. For instance adults in the north of England are twice as likely to have no natural teeth as those in the south and dental caries is three times more prevalent in Greater Glasgow than in West Dorset. Surveys since 1973 of the dental health of children have shown even more marked improvements with major decreases in numbers of decayed, missing or filled teeth. The recently published Monitor from the 1993 Survey of Children's Dental Health confirms this encouraging trend: the proportion of 15 year olds with active, untreated decay has fallen from 42% to 30% and more than five times as many are free from caries in 1993 (37%) than in 1983 (7%). Similarly the proportion with fillings is now 45% compared with 85% ten years ago and fewer than one in ten (7%) have had teeth extracted because of decay compared with almost a quarter (24%) in 1983. Similar patterns of improvement are found in all age groups and across the four constituent countries of the UK. In general, English children have the lowest levels of decay, followed by Welsh and Scottish children, while the children of Northern Ireland have the highest levels.

4. There seems no good reason why these differences should persist. The Government is determined to encourage further overall improvements and to tackle the variations. This document proposes changes to the structure of the NHS dental service to underpin this aim.

5. Oral health also depends on factors other than the NHS dental service. A strategy for improvement must look wider than the dental service. Each of the UK health departments intends to produce an oral health strategy to identify the challenges of the coming years. This approach reflects the different patterns of oral health in each country. The Welsh Office has already published its approach

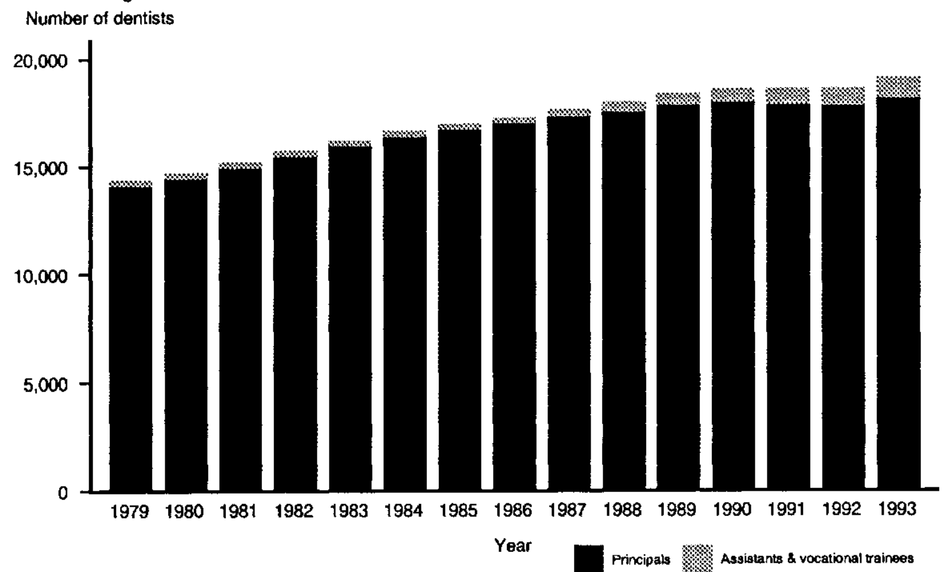
in its document "Protocol for Investment in Health Gain: Oral Health". The Strategy for England is being published at the same time as this document, and those for Scotland and for Northern Ireland will be published separately.

The Scope of the General Dental Services - Key Facts[1]

6. The General Dental Services (GDS) has been developed and expanded over recent years and is well placed to meet the needs of the population:-

— There are now more dentists practising in the GDS than ever before, a total of 19,095 in the United Kingdom at 30 September 1993 and 19,400 at 31 March 1994;

Figure 1: Number of dentists in the General Dental Service, at 30 September, 1979 to 1993
United Kingdom

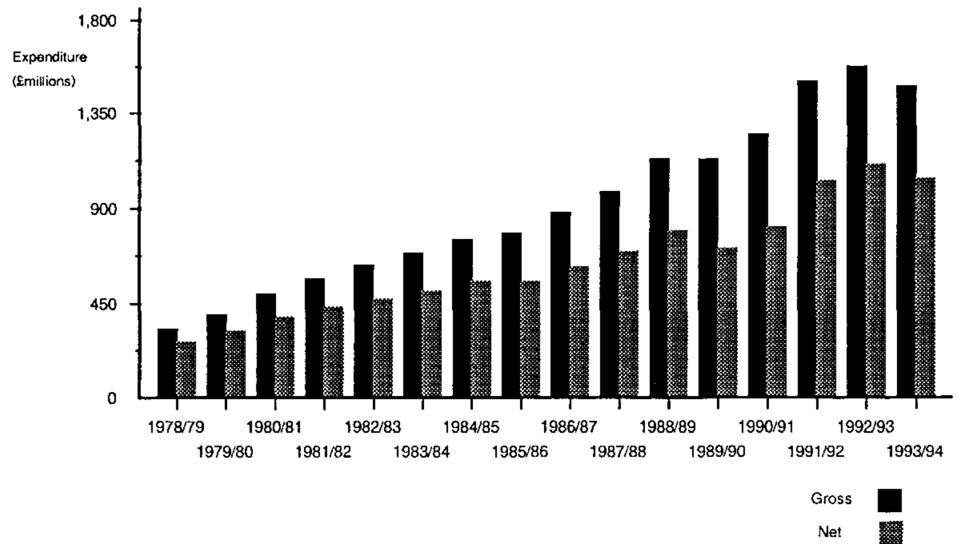


— Gross expenditure on the GDS in the United Kingdom increased by 57 per cent *in real terms* between 1978-79 and 1993-94 to some £1,475 million;

— Net expenditure on the GDS in the United Kingdom increased by 37 per cent *in real terms* between 1978-79 and 1993-94;

1 The data sources of the graphs and diagrams in this publication are: the Dental Practice Boards for England and Wales, and Scotland, and the Northern Ireland Health and Social Services Central Services Agency, as appropriate.

Figure 2: General Dental Service gross and net expenditure, 1978/79 to 1993/94 (£millions)
United Kingdom

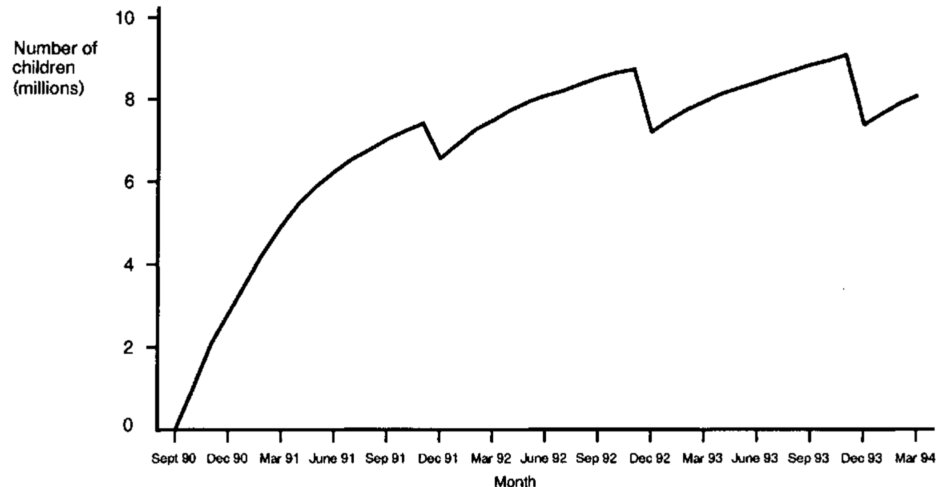


Source: Expenditure has been aggregated, mainly from individual Health Departments' Appropriation Accounts for the relevant years, although some elements have had to be derived from financial returns from NHS authorities, or estimated. Gross expenditure excludes refunds of patient charges. Net expenditure represents costs after taking into account patient charge income

Note: 1993/94 figures are provisional

— The number of children registered under capitation in the United Kingdom has increased from 2,800,295 at 31 December 1990 to 8,090,124 at 31 March 1994;

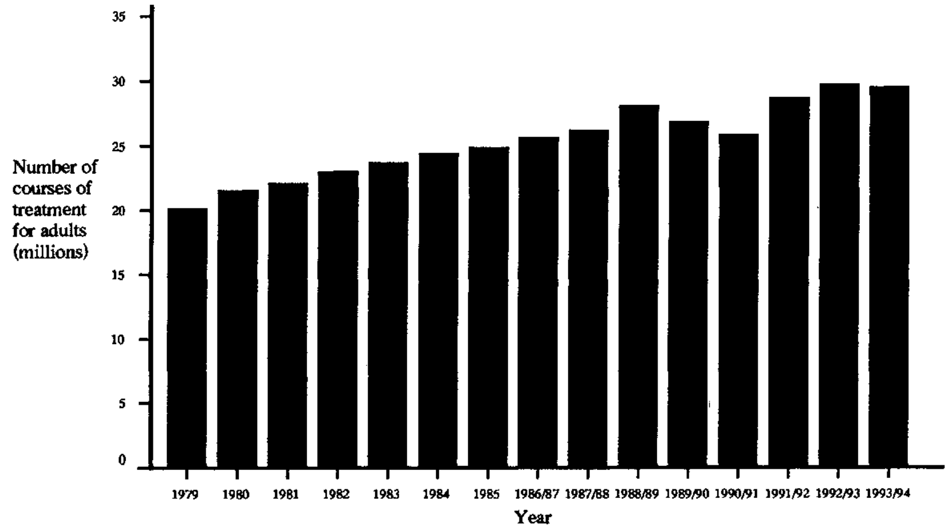
Figure 3: General Dental Service, number of children registered with an NHS dentist at month end. September 1990 to March 1994[1]
United Kingdom



1 A capitation payment is paid monthly for each child registered with a GDS dentist. The payments last until the end of the calendar year following their arrangement. A child needs to be seen in each calendar year if capitation payments are to be rolled forward. The seasonal pattern above shows capitation payments lapsing at 31 December.

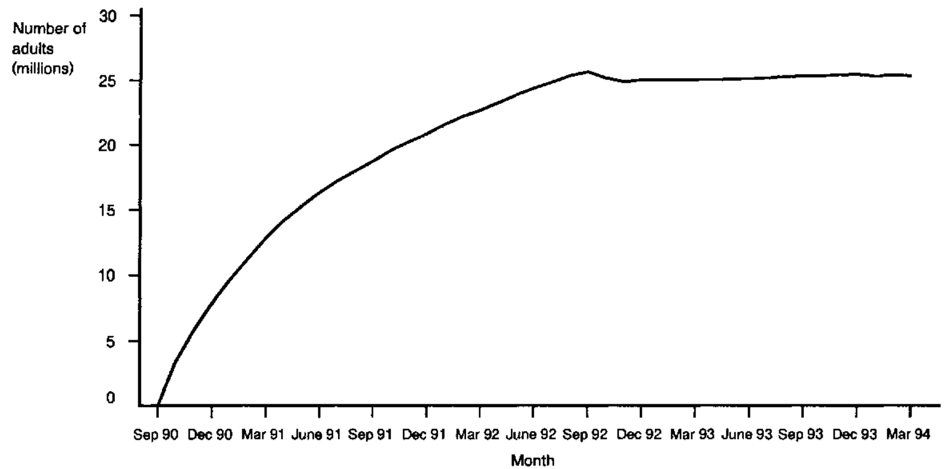
— The number of NHS courses of treatment provided to adults by general dental practitioners (GDPs) in the United Kingdom has increased from 20 million in 1979 to 29 million in 1993-94;

Figure 4: General Dental Service, number of courses of treatment for adults from 1979 to 1993/94
United Kingdom



— The number of adult patients registered with an NHS dentist in the United Kingdom has increased steadily and at 31 March 1994 stood at 25,379,251.

Figure 5: General Dental Service: Number of adults registered with an NHS dentist at month end. September 1990 to March 1994[1]
United Kingdom



1 Continuing care payments are paid monthly for each adult patient registered. These payments will cease two years after the date of acceptance into continuing care unless the patient's acceptance is "rolled-on"during that period when a declaration is made by both patient and dentist on an occasion when the patient is seen. The down turn at October 1992 shows the first lapses on the second anniversary of the introduction of the scheme.

These facts show the Government's commitment to an effective and accessible NHS dental service and how well dentists have responded to the incentives provided to them.

Historical Summary

7. The current system for dental remuneration was developed in the 1940s. The main features are little changed. The service has been subject to many reviews and reports in the past. The points made by observers and the problems the system has encountered have been remarkably similar throughout its history. They have led to relatively minor changes but have not tackled the root causes of the problem.

8. Dentists have traditionally been paid through fees per item of service provided. That principle predated the NHS and the NHS system was created on that basis in the immediate post-war years. It remains much the same today. The most significant change was made in 1990 when the Government introduced the new dental contract which paid capitation payments for all children and continuing care payments for all adults registered.

9. The 1990 contract for primary dental care aimed to improve the oral health of the nation by encouraging patients to visit their dentist regularly, and dentists to practise preventive care. This was to reflect the picture of oral health needs of the population, which had changed from the general need for much restorative work in the 1940s when the payment system was created, to an overall need for a basic care and maintenance service.

10. A more comprehensive history of the system, together with a description of how it operates now, forms Annex A of this document.

The Reasons for the Review

11. In recent years the system for paying and reimbursing dentists has lost the confidence of many dentists and others involved with NHS dentistry.

12. The weaknesses of the system have been shown very clearly. The scale of fees introduced in 1991 led to gross payments to dentists of some £200 million over and above planned expenditure. The system is described in more detail in the first annex to this document but, in essence, it aims to give to the average dentist a given level of income whilst meeting all NHS expenses. Its success depends on the accuracy of forecasts of the number and type of treatments to be done and the costs incurred providing them. In 1991 these forecasts were badly wrong. Dentists grossed an average of some £12,500 each more than intended for that one year alone, at a total gross cost of some £200 million.

13. For 1992/93 the Government accepted in full the recommendation of the independent Review Body on Doctors' and Dentists' Remuneration (DDRB) that dentists should receive an 8.5 per cent increase in net income. The Government also increased the allowance for practice expenses by 11.6 per cent. Implementing these substantial increases within this system, perversely, should have meant a reduction in fees of 23 per cent. The Government decided, however, to limit this to a reduction of 7 per cent which meant dentists still received far more than their intended income.

14. The profession, in response to this action, called for an independent review of the remuneration system. They felt that the present system was unable to reward them for their work and had become so unstable that it was impossible to provide good quality care for their patients.

15. The overpayments of 1991/92 and the reduction in fees that followed it are stark demonstrations of the flaws in the system. But the system has always been bureaucratic and difficult to understand. Its reliance on forecasts and averages has made remuneration targets remote from many dentists since divergence from

the average is so marked. The DDRB reinforced this view in their 1994 report, stating,

> "The instability and unpredictability of the payments system make it impossible to foresee what effect such a recommendation on TANI [Target Average Net Income] would have on the level of fees. Moreover, the fundamental flaws of the system...provide further evidence that a recommendation on TANI would be inappropriate."

The dependence on forecasting costs and numbers of treatments inevitably leads to under- and over-payment in different years. These have required the introduction of a complex balancing mechanism to try to compensate for them in subsequent years.

16. By the start of 1992 the DDRB were clearly unhappy with their role in recommending remuneration for an "average dentist" who did not exist. They also called for a fundamental review of the dental remuneration system. The DDRB commented on their views in their 1994 report:

> "We said the present system did not work and that the concept of the *average* GDP was seriously flawed. The *average* GDP simply did not exist because of the wide variation in such factors as turnover, practice costs, geographical area, types of patient and practitioners' own circumstances. We said there were large numbers of GDPs at each end of the remuneration range, and that key elements of the system such as work volume, and practice costs were difficult to forecast with any degree of accuracy."

> "We indicated that we were likely to have reservations about continuing to recommend a level of Target Average Net Income (TANI) when the averaging concept was not able to produce an equitable result. We said we thought fundamental change was necessary if GDPs' net income was to be distributed on an equitable basis and if the profession's confidence in its remuneration system was to be restored."

In the light of the representations of the profession and the comments made by the DDRB, the Government agreed that a review should be carried out. That review is now complete. The Government has considered the options for change and all the views put forward during extensive consultation in forming this response.

17. The aim of the review has been to point the way to an effective and an accessible NHS dental service and one which has the confidence of all the interested parties, not least the public and the dental profession. It must provide a proper framework for financial control and be fair to dentists, patients, the rest of the NHS and tax-payers generally. It should be as simple as practicable. The remuneration system is not merely a way to pay dentists. It must enable the development of the NHS dental service so that it can play its part in the improvement of the nation's health.

The Bloomfield Review

18. The Government met the request of the profession by inviting Sir Kenneth Bloomfield to undertake a fundamental review of the system. He was given wide terms of reference. He was asked to identify options for change, and weigh the advantages and disadvantages of each. His resulting report was published on 18 January 1993, and made widely available. An extensive consultation exercise was then conducted. This is discussed in more detail in paragraphs 33 to 42 below.

19. Sir Kenneth's report analysed the existing system and concluded that it had served the nation well since its inception in the 1940s. He found that the 1990

contract had not been the direct cause of the difficulties in 1992, but had introduced an element of uncertainty into the forecasting process which is a central feature of its operation. He believed the system could be adapted to make improvements in areas where it was weakest and identified possible ways of doing this. He concluded, though, that whilst the system could be made to function reliably again, without more radical change some significant weaknesses would remain. He said:

> "I am not persuaded that difficulties in controlling *overall* costs of remuneration are so substantial as to constitute *of themselves* sufficient grounds to disengage entirely from a system which has operated for so long."

He went on to say:

> "I am more concerned that, in some fundamental respects, the remuneration framework fails to recognise and reward what is best."

20. Among the weaknesses he identified in his report were the concept and the practical effects of a system based on the arithmetic notion of an average dentist; the inflexible nature of the system; the lack of prioritisation; the incentives and effects of a system based on a fee for item of service approach; and the fact that it may not be right for the demands of the NHS dental service now and in the years ahead.

21. He suggested ways of improving the current system, including a move away from the item of service approach, step by step and with adequate safeguards, towards a system of "bulk payments" which could cover most treatment needs. This shift, he argued, would make dentists' income and Government spending more stable and predictable. Some of the fixed and near-fixed expenses of dentists could be drawn out of the fee structure to be directly reimbursed to make the system more sensitive to real variations in such costs. The payments might, he added, be open to change if at a later point in the year an over- or under-spend seemed likely.

He noted that:

> "None of this is easy territory, either in practical or other terms".

22. He then looked at various, more radical, approaches to produce a system to achieve the objectives of the review.

23. In particular he considered ways to ensure that:

> "...the available money buys for NHS patients both a decent quantity and a decent quality of care and treatment, while providing individual dentists with a reasonable return for their efforts, with differences in net earnings justifiable rather than fortuitous."

24. In doing so he questioned whether there should be one, uniform system (as now) or whether variable conditions should be developed to recognise the varying circumstances of GDPs. He also considered whether such changes would be better and more effectively managed at local rather than national level.

25. One section of his report was devoted to looking at how priorities could be set and targeted. He considered a "core service" approach to focus on health gain which would categorise treatments into those normally available, those available only under strict control, and those not available under the NHS. This "concentration" he said "could permit more effective targeting to advance key health objectives and to respond to need rather than demand".

26. He also looked at whether a "concentration" on certain groups of patients might achieve the same ends. In this approach, services (however defined) would

be available only to those afforded high priority on social, economic and/or health grounds.

He concluded that:

> "...a greater concentration of available resources on providing a smaller number of treatments could (subject to proper controls) lead to a desirable shift in emphasis from quantity to quality."

27. He looked at whether one, national system would be able properly to recognise the varying circumstances in which GDPs work, and considered the advantages and disadvantages of passing the money available for NHS dentistry to the competent local health authority to buy services in line with local priorities. He concluded that a move towards a more locally sensitive system would allow:

> "...for a much more sensitive and finely tuned approach to the variety of circumstances in which the GDS operates."
>
> "It would", he continued, "facilitate closer co-operation or even amalgamation of the CDS [Community Dental Service] with the GDS, and it would allow FHSAs [family health services authorities] to design a coherent local dental strategy and contract for the provision of services to pursue it."

28. He looked at the possibility of drawing up a variety of terms at national level which could be selected locally to reflect more closely the local circumstances. Here he considered the mix of employment terms which together might provide for the needs of the local population.

29. He went on to consider the proposals for so-called "voucher" or "grant in aid" schemes and concluded that with such schemes it "would not be easy to justify either:

a. maintaining price control even for patients in respect of whom the State made no contribution; or

b. making substantial sums of State money available towards costs of treatment wholly at the discretion of practitioners."

He set out a path of implementation for the options.

30. The Government is most grateful to Sir Kenneth for his careful and detailed analysis. The proposals set out below have been much informed by his report and the discussion and debate it has provoked.

The Health Select Committee Report

31. A further major contribution to the debate was provided by the House of Commons Health Select Committee, who published a comprehensive report on dental services on 10 June 1993. It made a number of detailed recommendations, and, in summary, made four key points:

a. there should be an oral health strategy for England to provide guidance to dentists and the health service as to the priorities for oral health, and to point the direction for oral health services in the future;

b. there should be a stable system of remuneration that rewards high quality work, high productivity and is effectively monitored;

c. there should be greater co-ordination of local services and increased involvement by local health authorities in the delivery of primary dental care to ensure that services are properly directed; and

d. dental treatments should be split into three categories, "diagnostic and preventive services", "maintenance services" and "advanced treatments". The first category should be free to everybody, the second category should be free to those who attend the dentist regularly and the "advanced treatment" should attract a 100 per cent charge from those who can afford to pay.

32. In its formal response to the Health Select Committee Report, published on 10 August 1993, the Government welcomed the Committee's report. Many of the proposals outlined below draw on the Health Select Committee's views. The Government is very grateful for the work that the Committee has done in this area and for its continuing interest.

Consultation

33. The publication of the Health Select Committee Report marked the end of an extensive consultation exercise which had begun with publication of the Bloomfield Report. A personal copy of the Bloomfield Report was sent to every dentist in the GDS in the United Kingdom with a letter from the Health Ministers which asked each to submit views. Copies of the report were given to the main representative bodies so that they could distribute it even more widely. Throughout the consultation further copies were available, free of charge, on request.

34. The consultation was led by the Health Ministers in each country within the UK. The key interested parties gave oral presentations to the Health Ministers. These included representatives of the General Dental Services Committee (GDSC), the General Dental Practitioners' Association (GDPA), the Faculty of General Dental Practitioners, the Standing Dental Advisory Committee, the General Dental Council, the Dental Laboratories Association, NHS management, the Association of Community Health Councils in England and Wales and the Patients' Association. Many of these groups supported their oral presentations with written submissions to the health departments.

35. In addition to meeting the representative bodies, the views of the grass-roots of the profession were sought. Many individual dentists responded to the Ministerial letters inviting their views. Health Ministers met regional representatives of the profession, and representatives from each Local Dental Committee in England were invited to a meeting with the Health Minister.

The Result of Consultation

36. This extensive consultation confirmed that there was no consensus about solutions amongst the profession or between other interested groups. Sir Kenneth and the Health Select Committee had both found this in their enquiries. Sir Kenneth, commenting on the large volume of oral and written evidence he had received, said in his report:

> "...it became clear that there was more general agreement on diagnosis than treatment."

Later he added:

> "I doubt if there has been any exercise when quite so many views from the dental profession have been on the table".

The Health Select Committee said:

> "There was however... much more consensus amongst witnesses concerning the problems than concerning the solutions".

37. The Government's consultation produced similar results.

Building on the Consultation

38. The lack of consensus about solutions has made more difficult the production of proposals for the future which will command ready support. Every proposed model, including continuation of the current system, has found opposition from some. Any change and no change divide the profession. Whether or not there is change and whatever change is proposed, it is unlikely that all dentists will be wholly satisfied. Sir Kenneth put it well in his report when commenting on the reactions faced when money is redistributed, even if it is to a more equitable system. He said:

> "On the face of it, this process could encounter a familiar reaction to any redistribution: acceptance from the gainers and vociferous opposition from the losers."

39. While there is no consensus about solutions there are, as Sir Kenneth and the Health Select Committee noted, some common views about the most significant problems to be addressed. Many claimed the system was simply under-funded, but the level of remuneration has always been set from recommendations of the independent DDRB and there seems no desire amongst the profession for that to change. It is clear, as Sir Kenneth Bloomfield points out, that simply increasing fees will not address the weaknesses of the system. Moreover, Sir Kenneth noted:

> "It will be seen ... that in real terms target average net income has been increasing steadily since 1982/83 and is currently at its highest historic level for the period reviewed in the data".

Some common themes which emerged from the consultation include :

a. children should be the highest priority;

b. the recognised benefits of fluoridated water supplies should be more widely available;

c. dentists want to be treated as health care professionals able to put emphasis on quality and prevention;

d. the remuneration system should be more sensitive to variations in costs and needs;

e. the so-called "treadmill" should be removed. Some alleged that item of service payments encourage dentists to work faster and faster, even to intervene unnecessarily, and could have a detrimental effect on quality;

f. a way to focus on priorities should be introduced. A core service should be developed. Most advocated a treatment based "core" rather than a patient based definition;

g. quality not quantity should be encouraged;

h. dentists' income should be more stable and more predictable;

i. dentists do not want any interference in their affairs. They want to remain independent contractors and be able to select which patients they will accept and what treatments they will provide to them under NHS terms. In particular dentists did not want FHSAs[2] to be given any role in determining service patterns;

j. the concept of the "average dentist" is inherently flawed;

k. no major change should be introduced without consultation with the profession.

40. Many in NHS management agreed with much of this and placed particular emphasis on other points made by the profession:

[2] The term FHSA is taken to cover family health services authorities in England and Wales and Health Boards in Scotland and Northern Ireland.

a. the system should be more flexible and responsive to local circumstances;

b. need rather than demand should be the focus of the system;

c. local health strategies should be developed for all areas and all parties should work together at a local level to achieve them.

41. NHS management were clear that the preferred model would be one broadly analogous to the "purchaser/provider" system, which differentiates between the roles of determining need and the consequent funding on the one hand, and the actual provision of a service on the other. A similar model is established and is reaping benefits elsewhere in the NHS.

42. The Government has considered carefully all the options for change and all the views expressed during consultation. In the absence of any consensus, or even a clear majority view amongst the profession about a preferred solution, it has not been easy to distinguish one model which would meet the objectives of the review and address the main points which emerged from the consultation. Nor should this be done without further discussion with the profession. The Government has developed proposals which could meet the objectives of the review and address the chief concerns of the profession. These proposals are set out in the following sections of this document with more detailed descriptions in annexes. The Government will now discuss with the profession and others how these proposals should be developed.

II The Government's Proposals for Reform

A Local System

43. Dentists working in different areas serve populations with very different needs. Even within small areas these differences can be marked. A typical health authority may have groups within its resident population with relatively poor oral health alongside others with very good oral health.

44. Sir Kenneth defined a "locally-sensitive" system in his report which would aim to make the system more responsive to these different circumstances. It involved giving the available money to the appropriate tier of local NHS management who would then develop local strategies with the dentists in the area for improving oral health. They would then target resources through buying the necessary care and services from local dentists to achieve these improvements.

45. This would allow more sensitive approaches to be developed and used. Local NHS managers would discuss and agree objectives with local dentists within the overall strategy and then agree contracts, backed with money, to buy the services needed. Only in this way can rational decisions about dentistry as part of the wider local NHS service be taken. Only in this way can local strategies for improvement be developed and implemented.

46. This approach is similar to the model used in the secondary and community health services since the Government's reforms of 1991. Since then it has been possible to take better account of local variations in needs for health care by separating the roles of "purchasers" and "providers" of care. The purchaser identifies local needs and priorities, taking account of available resources and, in a series of NHS contracts, agrees with providers the levels and standards of services which should be made available for a local population. This means that the levels and types of care provided are based on objective decisions about needs and priorities. This is a powerful model which could have a major role to play in assessing and meeting local priorities for oral health.

47. Many of those commenting on Sir Kenneth's report, including the Health Select Committee, see the future of NHS dentistry as being within this type of "purchaser/provider system".

48. The Health Select Committee concluded that there should be:

> "... a longer term remuneration strategy ... whereby the dental budget is devolved to FHSAs for the development of locally sensitive diverse economies of dental care."

49. The DDRB also stressed the potential merits of this model. In its most recent report it noted the fact that the self-employed contractor status of GDPs meant they needed to be viewed differently from directly employed staff. It said:

> "This need not prevent their remuneration being related more to local circumstances..."

> "For our part we believe that there are many opportunities to make the remuneration of GMPs [general medical practitioners] as well as GDPs more sensitive to local circumstances and the lack of progress on this front causes frustration for many practitioners, quite apart from the general level of fees. Many are understandably impatient for change."

50. In the course of the consultation on Sir Kenneth Bloomfield's report, several different ways of achieving a locally sensitive system were proposed and several FHSAs offered themselves as volunteers to pilot such schemes. While there are many in the health service who want to work at developing models to make this concept an effective reality, most within the dental profession regard the model with suspicion. Sir Kenneth noted that some dentists would be concerned to maintain their freedom as independent contractors and might fear this would be diminished under this system. He believed that such fears could be much assuaged by full consultation with the profession and, in particular, by involving them in the creation and achievement of local health strategies. Sir Kenneth said:

> "it would be an irony if many of those who expressed to me their concern about the poor fit between the single national remuneration system and their actual local conditions did not grasp the opportunity for partnership in the locally-devolved administration of this element of the NHS."

51. The Government agrees. Individual patients and the health of the population overall would benefit if NHS dentistry were more fully in the mainstream of the NHS. The system for funding secondary and community care now works well, with significant benefits for patients. General dental services cannot be compared directly with hospital care but it should, nevertheless, be possible to introduce similar principles with the same benefits for patients overall. Decisions on standards and levels of oral health care should be taken in the context of decisions about general health care provision. Standards of oral health vary between regions and so do priorities. Within their overall health budgets local NHS managers would target resources to meet these variations and to achieve the strategies developed locally by all involved.

52. As Sir Kenneth said, such a radical change should not be introduced in a comprehensive fashion until it has been discussed with the profession, and only after careful piloting and evaluation. The Government therefore intends, subject to Parliament approving the necessary legislation, to introduce pilot schemes for the introduction of the purchaser and provider roles into general dental services. The health departments will work with volunteer health authorities to develop protocols for these pilots in full consultation with the profession. The timing of introduction will depend upon the necessary supporting legislation but the Government's intention is to work with those selected to conduct these pilots so that they can begin quickly once that legislation is enacted. It is important to make good progress so that the potential benefits can be rigorously evaluated and, as appropriate in the light of that, extended across the country. The earliest possible date for commencing these pilots would be Autumn 1995. The projects would run for two years, to allow reasonable time to assess the results. The evaluation would allow a decision to be made on whether and how to implement the system nationwide.

53. The Government believes that this model offers the best way to meet the objectives of the review and to address the main points put forward during the consultation.

The Direction of Change

54. Under the system described above, the remuneration system would be determined locally, through negotiation. That offers clear advantages for all concerned. Yet the process of developing, introducing, conducting and evaluating

the pilots of the purchaser/provider model will take some time. Patients and dentists stand to gain from earlier reform of the general dental services. It is clear that the present flawed remuneration system cannot be left in place while the purchaser/provider model of delivery is being tested and evaluated. The Government is keen to introduce short-term reforms in addition to developing a new system for the future. This two-speed approach was recommended by Sir Kenneth Bloomfield. The Government has therefore developed proposals which could be introduced while these pilots àre developed. Any reform introduced at this stage would need to be adaptable to later introduction of the purchaser/provider system, if evaluation of the pilots confirms this to be the model of choice.

55. Similarly, any reform introduced will need to include some mechanism for dealing with the large sums of money owed by the profession to the Government under the current balancing mechanism. It is indefensible that, when large sums of money are owed, repayment is not swift and effective, but instead can be spread over many years, possibly decades. The Government will discuss with the profession ways of ensuring that, in future, repayments are made as soon as possible.

56. The proposals set out below flow from the issues and solutions identified and put forward by Sir Kenneth Bloomfield, the Health Select Committee and others.

Alternative Approaches

57. Any change needs to produce the right incentives to provide the type of care needed. The Health Select Committee pointed to the possibility of the incentives in the system having an effect on provision, be they conscious or unconscious. It said:

> "We concur ... that the productivity incentives in the current system exert a pressure on the quality of care"

and

> "We conclude that it is the underlying skew towards quantity of throughput in the system that should most concern dentists and their patients."

and added

> "We conclude that, while any system of remuneration is open to manipulation, the inherent incentives in the present system appear to blur the line between the results of deliberate abuse and those of unconscious influence."

58. As the Government noted in its response, there is no evidence of a fall in quality. There are safeguards in place for the patient. Chief amongst these is the fact that dentists are members of a long-established professional group which sets great store by high standards of clinical and ethical duty. The Dental Reference Service (DRS) - in Scotland the Regional Dental Officer Service - carries out an inspectorate role for which it is widely respected. Nevertheless, the Government must give due weight to the Health Select Committee's views and consider the incentives in the current system. In the main any perverse incentives derive from the basis of payment by fee for item of service. The incentives to high throughput of patients and restorative work for high earnings could not be removed without the replacement of that system.

59. The decisions a dentist takes about the type and scope of treatment to be offered to an individual patient need to be quite divorced from questions of personal financial gain. Clinical decisions must be taken solely on a clinical basis, taking full account of the informed views of the patient. This is what most dentists do already. Yet the Health Select Committee felt the need to point out

the "inherent incentives in the present system" and the scope for "unconscious influence". The Schanschieff Report, the Public Accounts Committee before it, and most other commentators have noted the incentive to intervene and the effect this might have on provision. The payment system should reinforce professional incentives towards quality in clinical care rather than providing perverse incentives to ever higher throughput.

60. In theory, a salaried service would allow a better managed service and one which divorced any conscious or sub-conscious financial consideration from clinical judgements. The payment of dentists by salary has its place in the Community Dental Service (CDS) but since the NHS began most dentists have vigorously rejected this as a method of paying them. Nor would a salary itself adequately meet the need to reimburse dentists for the expenses they encounter in providing care. Dentists are proud of their independent contractor status and the Government has no proposals to alter that status.

61. Some have proposed that fees for item of service should be replaced by payment on a wholly capitation basis, but that too could provide the wrong incentives. In particular, it might lead to dentists' preferring to take onto their lists only those patients with the least need of dental treatment. It would pay no recognition to the time spent treating patients. It could lead to widespread "supervised neglect". A registration fee may be required instead of individual treatment-related charges, and this has been opposed by the profession. A "weighted capitation" system, which aimed to cover the whole range of different circumstances for the entire population who may or may not come forward for NHS treatment, would be very complex if it were fine-tuned sufficiently to address the different needs of different patients. It seems unlikely that such a system could be created to everyone's satisfaction.

62. A "mixed" system of part capitation/part fee per item runs the risk of skewing clinical decisions due to financial considerations, so that those under capitation receive little care and time while activity is focused on those who offer potential fee income. A system which is sophisticated enough to categorise patients under the scheme which best fitted their personal needs is likely to be more bureaucratic and complex than most in the profession seem likely to find acceptable.

63. As independent contractors, dentists are free to take individual decisions about the level of their commitment to the health service. The Government believes that the system of payment for dentists should reflect those decisions. The system should allow dentists to exercise the clinical freedoms on which they place a high value. Equally the system must allow and encourage dentists to fulfil their responsibility to secure and maintain the oral health of patients accepted under NHS terms. This responsibility will be the same in each of the options discussed in this document.

64. The Government believes the system of payment for dentists should provide the right incentives for the challenges facing the service. The following section sets out the principles of such a model. The Government intends to work with the profession and others to develop these proposals.

Sessional Fees

65. A system is needed which is capable of evolving smoothly through managed change toward the locally commissioned system described earlier.

66. The emphasis in the system should be on quality of care. It should focus on patients. It should divorce financial from clinical incentives and give proper reward for preventive work. It should allow dentists to make personal judgements about their businesses and their commitment to the NHS, and their NHS reward

should reflect these judgements. NHS income should reward them fairly and variations in costs should be reimbursed more sensitively. It must operate within a framework of proper financial control for the tax-payer. Dentists want to keep their independent contractor status and to be treated as health care professionals. The system should respect both wishes. The service should be tailored to the needs of the population. Priorities must be set and resources targeted toward them.

67. The proposal is to reward dentists for the time they spend treating NHS patients through a system of sessional fees. The details of the scheme are discussed in Annex B of this document. This approach means dentists' income will be linked directly to their personal commitment and their input to the NHS. Removing the incentive for rapid throughput of patients will shift the emphasis toward quality and promote a preventive philosophy - a key message of the Bloomfield and Health Select Committee reports. Each patient can have the optimum amount of care and attention dictated by their needs. The financial and clinical incentives will be balanced. While there is no direct analogue of this system elsewhere in the NHS, the closest comparison is with hospital consultants. There is, however, no intention to introduce a salaried basis to remuneration in the GDS. Dentists will remain independent contractors who would themselves decide how many sessions they would seek to perform within the NHS.

68. The Government recognises that such a system would be a radical departure from the way dentists have been paid in the past. Nevertheless there would be significant advantages for patients, dentists and the NHS generally from introducing such a scheme. It carries forward many of the objectives of the fundamental review.

69. In terms of the quality of the service to be provided, paying dentists for sessions should remove any lingering incentives for dentists to offer patients unnecessary or over-expensive treatment. Yet dentists would have an incentive to use their sessions to further the oral health of patients. Activity would be monitored. If monitoring displayed an unacceptably low level of activity, this would first result in an attempt to find out why a particular dentist's pattern of treatment or performance was markedly different from that of other dentists in the area with similar lists. If this was not apparent and was not satisfactorily explained, and there were no grounds for a service committee complaint, this would result in fewer sessions being allocated to that dentist for the future.

70. The treatments available would be categorised along the lines suggested by the Health Select Committee. Changes to the charging structure and relativities would be made to focus resources and effort on priorities. The Health Select Committee stressed the importance of the dental examination. It would be possible to reduce the charge to patients for this essential element of diagnosis. The cost of this would be met by increasing patient charges for advanced treatments so that they were closer to the full cost to the NHS, as proposed by the Health Select Committee. There would be no change to the eligibility criteria for charge exemption and remission. The Government will be interested to hear the views of the dental profession and the public on its proposals for altering the charge structure.

71. Dentists would have every incentive to place a high premium on preventive work and to provide a high quality service to their patients. There would be no fear of a "treadmill".

72. Nor would a dentist have any incentive not to accept a patient for treatment simply because he or she required a lot of attention to achieve dental fitness. Subject to the dentist's being able overall to demonstrate proper levels of productivity, the time spent on any given patient would have no impact on the level of remuneration received. A dentist would give to a patient the time dictated

by the patient's dental condition without fear that other fee income was being foregone.

73. This means that dentists would be free to devote the time and care to individual patients which some claim is presently only available in the private sector. Their incomes would be more predictable and, because of a new survey of actual expenses and flexibility from the proposed banding of fees by location, the reimbursement of expenses would more closely match actual costs. Dentists would be able to take clear decisions about how much of their professional time they wished to devote to the NHS and this would be readily apparent to patients and to NHS management. They would receive a fair reward - taking full account of the recommendation of the independent review body - and in direct proportion to their input to the NHS.

74. This system could evolve toward a purchaser/provider arrangement and could be the start of a contractual relationship between local health authorities and local dentists, all working together towards agreed aims and strategic objectives. It offers potential to extend the facilitating and advisory roles of health authorities in the current system gradually to a more sophisticated contractual relationship which aimed to secure the locally agreed strategy.

A Dental Fee Scale

75. Pending the evaluation of the pilot schemes, the preferred option, the one which would meet more fully the objectives of the review and the health needs of patients, is the sessional fee model described above. These proposals would allow careful management of change, through evolution, towards the purchaser/provider system.

76. No change is not an option. The present system has many faults which have recently been drawn into sharp focus. Sir Kenneth and the Health Select Committee both drew attention to these and the DDRB recently reiterated many of them. Any system based on fees would be prone to the problems encountered with the present one. Such serious flaws mean that a fee-based option offers no prospect of forming a long-term basis for the NHS dental service in the future. The Government recognises, however, the case for stability which has been pressed by some in the profession and elsewhere. In the short-term, it could be possible to make changes to the current system to address some of the flaws and to go some way towards the objectives of the review. Proposals for doing so are contained in Annex C of this document.

77. Some proposals can be implemented at an early date. This option can therefore be viewed as a short-term one, open to fairly rapid implementation but only able to operate while the wider reforms are developed.

78. Taken as a package, these proposals would go some way to addressing the concerns expressed and to meeting many of the objectives of the fundamental review. Dentists would be paid a fee for every procedure carried out on adult patients and an amended capitation scheme would cover children. The patient charge for the dental examination could be significantly reduced whilst maintaining its fee value for dentists. Through a categorisation of treatments along the lines of the Health Select Committee's recommendation, resources and effort would be focused more sharply on need and priorities, and the system would operate within a financial framework which would be fairer to all. There would be no change to the eligibility criteria for charge exemption and remission.

79. This option, however, has the disadvantage of retaining many of the incentives and failings identified by both Sir Kenneth Bloomfield and the Health Select Committee. In particular, it maintains the incentives to high throughput of patients at the potential risk to the quality of care given to patients. It does not

fully address the issue of health priorities for the population as a whole. Nor does it enable adequate standards of financial control. This package of proposals would, however, represent a marked improvement over the current system. Most aspects could be introduced quickly, pending Parliament's approval of the legislation for pilots of the purchaser/provider model and their evaluation.

Developing the Community Dental Service

80. The Government is committed to an effective and accessible NHS dental service. Whatever reforms are introduced the Government intends to take steps to secure the accessibility of the service. The first step in that process is to ensure that local services are maintained for all who want them and that there is an adequate "safety net" to cope if general dental services are not readily available.

81. At present the leading associations representing dentists, the British Dental Association (BDA) and the General Dental Practitioners' Association (GDPA), have advised general dental practitioners to seek to maximise the private sector element of their practices. This is regrettable, and was an unnecessary reaction to the fee adjustment introduced in July 1992. Since then, FHSAs have generally reported that they have been able to advise anyone who contacted them on how to get a NHS dentist locally. Yet, to do that, some FHSAs have on occasion had to have recourse either to salaried dentists employed by FHSAs (there are about 130 throughout the UK) or to the Community Dental Service (CDS). These represent important "safety nets" for those unable or unwilling to use general dental services. The Government intends to strengthen this function to ensure all patients who want NHS services have adequate access to them, even if their regular dentist decides to decline his NHS work in favour of the private sector.

82. It makes little sense, though, for there to be two quite distinct groups of dentists, each with an explicit function of providing a "safety net" in those parts of the country where at any given time the GDS provision is not fully adequate for all who wish to make use of it. Nor does it make sense for one sector to be able to levy charges whilst the other cannot. The Government therefore intends to strengthen the CDS to take over this "safety net" role, thereby reinforcing its existing function of providing primary care dentistry for those who, for whatever reason, cannot have ready access to the GDS. This is consistent with the announced intention to enable, in England and Wales, District Health Authorities (DHAs), responsible for the CDS, and FHSAs, responsible for salaried GDS dentists, to merge. Subject to Parliamentary consent, the Government would also propose amending legislation to allow the CDS to levy charges similar to those applicable in the GDS on patients not otherwise exempt.

Implementation: Managing Change

Managing Change in the Short Term

83. A payment and prior approval authority is needed in both the sessional and the fee based models. There must also be an effective inspectorate. The Government proposes that for both options the existing authorities continue to be responsible for these roles, at least until the longer-term structure of the service is known following evaluation of the purchaser/provider pilots. Over the longer-term, local health authorities, under whatever option, will be drawn progressively into the management of the service, as recommended by Bloomfield and the Health Select Committee.

Next Steps

84. The Government intends to conduct a period of intensive consultation on the proposals described above. Timing of implementation will depend on which model is pursued. The sessional model would require amendment to primary legislation. An early opportunity would be sought to legislate if it emerged as the

model of choice. The fee based model could be introduced within existing legislation and could therefore be implemented sooner.

85. The purchaser/provider model and its pilots require amendment to primary legislation, and, in the light of the results of the consultation, this would be brought forward at an early opportunity. The Government will now consult the profession and health authorities on establishing pilot studies to develop the purchaser and provider roles of each. In due course, FHSAs will receive an invitation to declare an interest in taking part in the pilot projects.

Annex A The Present System

History

1. The NHS dental service was developed in the immediate post-war years and was based on a fee per item - the traditional method of payment to dentists. In 1946 an "Inter-Departmental Committee on the Remuneration of General Dental Practitioners" was formed, led by Sir Will Spens. This considered the range and the level of remuneration for dental practitioners. It reported its findings in 1948. Its recommendations recognised differences between practice in rural and urban areas and it expressed its conclusions in terms of time spent providing services or a "chairside week". The scale of fees informed by these recommendations was introduced in 1948.

2. This fee scale fast ran into problems. It led to earnings so high that the Government of the day needed to take action to control spending. In 1949, it introduced measures so that any earnings above a certain point would attract only 50 per cent of the fee. Later that year this was replaced with a new scale of fees which introduced a 17 per cent reduction across the board. In 1950, fees were reduced by a further 10 per cent. In 1951, charges for certain treatments were introduced. More charges followed in 1952.

3. These changes were made pending a review and possible revision of the fee scale. The 1950 fee reduction was reversed in 1955, as an interim measure, whilst the wider remuneration issues were discussed. Agreement on revising the 1949 scale of fees was not reached until 1957.

4. In 1957 a Royal Commission on Doctors' and Dentists' Remuneration was established. It reported in 1960. This recommended that a fee for item of service approach should remain but did not see that simple increases in the number of procedures should, of themselves, lead to dentists earning more. This was based on the finding that although the number of treatments had risen, the amount of time dentists spent providing them (and it saw this as a good indicator of effort) had not changed correspondingly. Advances in technique and technology had allowed greater productivity without necessarily requiring any greater effort.

5. It recommended that the remuneration of dental practitioners should be linked not exclusively to the number of treatments provided but rather it should be broadly linked to the number of hours worked. It created the Dental Rates Study Group to convert the recommendations for pay into fees which were relative to the amount of time taken to earn them. Dentists' fees would be set to deliver a pre-determined level of pay, including all expenses, for the average dentist.

6. These reforms were introduced but the system continued to attract criticism. In 1964 a special sub-committee, often called the Tattersall Committee, of the profession's representatives - the General Dental Services Committee (GDSC) - which had been tasked to study this issue, published its report. It was highly critical of the system. It said, and added emphasis to the statement:

> "there is no future for the profession, or indeed for general dental practice as an art and a science, in the system of remuneration as presently operated."

7. It considered alternative approaches. None was seen as an easy option and no one system, it argued, could address the problems facing the service. It concluded in recommending a mixed fee per item/ capitation system.

8. There were many important reports about dentistry in the 1970s. The Court Report of 1976 recommended that the emphasis in dental care should move away from adult dentistry and restorative work and toward children's dentistry and a preventive approach and said that capitation might be the remuneration system to underpin that move. The Expenditure Committee's First Report of the 1976/77 Session recommended ways to place greater emphasis on preventive work.

9. In 1979 The Royal Commission on the National Health Service, under the Chairmanship of Sir Alec Merrison, published its report. This too was critical of the system though it pointed out that:

> "...the task of finding a more acceptable system is by no means easy."

and added:

> "It seems likely that no one system could suit every type of practice in every part of the country..."

10. It was concerned that the remuneration and organisational arrangements of the service were not geared to the needs it faced. These needs had changed since the system was created yet the system had not adapted to them. It wanted greater emphasis on quality rather than quantity of care and stressed the need for prevention above restoration.

11. The Nuffield Foundation Report of 1980 supported many of the conclusions of these earlier reports and made many recommendations on how it thought these might be taken forward.

12. All this work was considered by the Dental Strategy Review Group, set up by Government in response to a recommendation of the 1979 Royal Commission, to "review the development of dental health policy and in particular a preventive strategy and the future function of the Community Dental Service." Its report was published in 1981. It recognised the by then well-documented flaws of the remuneration system. It made many recommendations about various aspects of the service, particularly aimed at placing greater emphasis on prevention of disease, and since its report, many have been put into practice.

13. The Auditor and Comptroller General reported on the GDS in 1984. This report again drew attention to the weaknesses of the system. Apart from some specific points of concern, the report noted:

> "...the current arrangements are open to the general charges that they provide little incentive for dentists to concentrate more on prevention rather than treatment of disease, in accordance with current dental strategy, and that they place the emphasis on quantity rather than quality of dental work."

14. The House of Commons Committee of Public Accounts studied the service in 1984 and made some similar observations. While mainly concerned with the finance arrangements and concentrating on fairly technical matters, it was concerned that the system lacked direction and might be better targeted. It thought that money might be spent on the wrong if not unnecessary treatments.

15. A Committee of Enquiry into Unnecessary Dental Treatment (often called the Schanschieff Committee after its Chairman) was set up in 1984 in response to the concerns expressed by the Public Accounts Committee, the Comptroller and Auditor General and others that such treatment might be given since the remuneration system and structure of the service might not only allow it but

encourage it. It was to enquire into the extent of unnecessary dental treatment and consider ways such treatment might be detected and prevented. It found that it was likely that a significant amount of unnecessary orthodontic treatment was carried out in the GDS and that in general the level of unnecessary treatment in the GDS as a whole was significant though not so significant as to lead patients to lose confidence in their dentists. It concluded that out of date treatment philosophy might be the primary cause of this, rather than deliberate abuse.

16. The Government has issued proposals which have responded to the issues raised by all these commentators. The Green Paper "Primary Health Care: An Agenda for Discussion", published in 1986, aimed, across the primary care sector, to make services more responsive to the needs of the consumer; to raise standards of care; to promote health and prevent illness; to promote choice; to improve value for money; and to enable clearer priorities to be set for these services in relation to the rest of the health service. The White Paper which followed, "Promoting Better Health", set out the steps Government would take to achieve those aims. These attempted to build on the service without root and branch reform of the structure though it was clear that reform of the remuneration system which underpinned the service was crucial to meet these objectives. The Government therefore undertook to discuss new arrangements with the profession to develop a new system which would incorporate incentives both for high efficiency and high standards.

17. This work was taken forward and in 1990 the New Dental Contract was introduced. The new contract for primary dental care aimed to improve the oral health of the nation by encouraging patients to visit their dentist regularly, and dentists to practise preventive care. This was to reflect the picture of oral health needs of the population which had changed from the general need for much restorative work in the 1940s, when the payment system was created, to an overall need for a basic care and maintenance service. These reforms aimed to build from the existing system which was familiar to all parties and to make changes to promote these aims. Capitation payments for children and continuing care payments for adults were introduced.

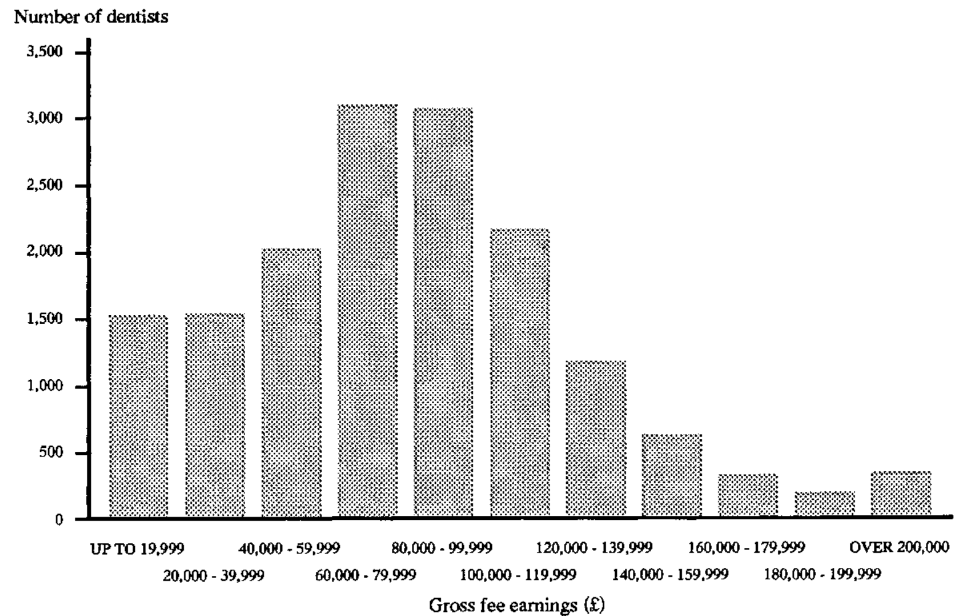
18. The current system, including these later changes, is described in more detail in the paragraphs below.

A Description of the Present System of Remuneration

19. The DDRB recommendations for 1994/95 have challenged the basis of the present system. This is discussed in more detail in paragraphs 32-34 below. It made its recommendations as a short term measure, pending reform flowing from this review. It is, however, important when considering reform and proper management of change to have a good understanding of where we now stand. These paragraphs, therefore, explain the present remuneration system.

20. The present system aims to give to the average dentist a pre-determined net income from the NHS and to pay for all expenses associated with running an NHS practice. The amount an individual dentist will earn will depend on the amount of work that individual does and the net element will depend upon the actual expenses incurred. There is wide variation in NHS earnings between practitioners, as shown in the graph below.

Figure 6: Distribution of Dental Rates Study Group dentists, by gross fee earnings, 1993-94
Great Britain



21. The income which dentists should earn is recommended to Government by the DDRB which expresses the recommendation in terms of a Target Average Net Income (TANI) which is the level of income dentists should, on average, earn from the NHS after all associated expenses have been paid. When the Government has considered the recommendation and made a decision, the Dental Rates Study Group (DRSG) considers how it should be implemented. The DRSG is led by an independent Chairman, with membership from the health departments and the General Dental Services Committee (GDSC) which represents the profession. It has two central functions:

— to forecast an amount for dentists' practice expenses (using historic data derived from a confidential enquiry conducted by the Inland Revenue and known or expected changes in expenses). This is added to TANI to produce the gross Amount Due or Target Average Gross Income (TAGI);

— to set a fee scale to deliver that Amount Due to the "average dentist".

22. A small amount is put aside to pay for the direct reimbursement of business rates, and other payments such as those for maternity and sickness. What remains (about 95 per cent) is used to set the fees for the individual items of treatment and for capitation and continuing care payments. In setting each fee the DRSG has to consider the laboratory and materials costs associated with each treatment; a weighting according to the length of time that each item of treatment takes; and the likely incidence of each item in the coming year. It must also forecast how many patients will be registered and re-registered under capitation and continuing care.

23. Based on these forecasts, a scale of fees covering every item of treatment is drawn up and capitation and continuing care payments are set. Dentists then claim the appropriate fees from the Dental Practice Board (DPB)[3].

24. Since the 1990 contract, payments have been made through five categories of fees:

a) Adult continuing care payments

---

3. The Dental Practice Board covers England and Wales. There is a separate Scottish Dental Practice Board covering that country, and in Northern Ireland the equivalent authority is the Central Services Agency.

b) Child capitation payments

c) Child entry payments

d) Child Item of Service Fees

e) Adult Item of Service Fees

25. Adult continuing care payments were introduced in the 1990 contract and are paid monthly in respect of each adult patient registered with the dentist. They do not commit the dentist to provide any specific treatment. Nor do they attract any patient charges. Registration lasts for two years, after which the patient must be re-registered. Capitation fees are paid monthly for children registered with the dentist and cover a range of items of care and treatment. Taken together, capitation and continuing care payments make up rather more than 20 per cent of the value of fee payments to dentists.

26. A range of entry payments are available when a dentist accepts a child into capitation. These recognise and pay for treatments sometimes needed to correct the oral health of children before the capitation payment (which are weighted for the age of the child and the clinical intervention required) takes over. Although many entry payments were claimed when children were first accepted into capitation in 1990, now that the scheme is well established they form a smaller proportion of payments made. Child item of service payments are also available for some specialised, complex or unusual treatments. Taken together, these payments contribute to about 10 per cent of the total value of payments through fees.

27. The remaining 70 per cent of payments are made through the individual fees for treating adults. There are over 400 individual items of treatment.

28. As noted already, the system depends on accurate forecasting of volume of treatment performed and the level of expenses incurred. There is a mechanism to compensate for any errors in forecasting - called the net income balancing mechanism. This operates once final gross income and expenses data for any one year is known, when the actual net income that the average dentist received can be compared with the target income. Any under- or over-payments are then taken into account when setting fees for the next year. In any one year, however, the current convention is that the sum which can be repaid in either direction is limited to 5 per cent of the TANI for that year, or 20 per cent of new money for that year, whichever is the least. These conventions could be changed but under these present rules the system is not able to deal effectively with the situation where large sums of money are owed. Repayments are made over many years unless an error in the opposite direction is made.

29. At present every dentist owes the Government a considerable sum, probably an average of well over £15,000. The scope for recouping these sums quickly is severely limited within this mechanism. The system can be so protracted that dentists who gained from the overpayment may retire or leave the GDS whilst those joining or remaining repay the debt.

Recent Developments

30. The fact that the fee reduction introduced in July 1992 was limited to 7 per cent and was therefore less than was actually needed to bring spending back into line meant the new fee scale still stood to deliver a higher net income to dentists than was intended for that year. Not only was the outstanding debt not being re-paid, it was probably increasing. It also had repercussions for the following years.

31. For the following year, 1993/94, GDPs were awarded the full 1.5 per cent increase in remuneration, the maximum award in the public sector for that year.

This took target average gross earnings to some £85,000. Since, however, the fee scale was already delivering sums above the previous year's intended earnings it seemed at least possible that the same fee scale would deliver this increase. It was not possible, however, to predict with any confidence at that stage. The Dental Rates Study Group (DRSG), which recommends the fees to deliver intended earnings, therefore decided that changes to the fee scale at that time would be unwise and instead agreed that the same fee scale should remain in place. Meanwhile payment data would be monitored, and there was an agreement that either the profession's representatives or the health departments (who comprise the DRSG under an independent Chairman) could re-open the DRSG to revise the fee scale if the data showed a marked divergence from target in either direction. As it happened, the General Dental Services Committee (GDSC), the profession's representatives, requested a re-opening as it believed payments were likely to under-deliver the intended earnings. The reconvened DRSG agreed to increase fees by 2.9 per cent from 1 January 1994.

32. The DDRB's recommendations on dentists' pay for 1994/95 were announced on 3 February 1994. The Government accepted these in full. For general dental practitioners it recommended a 3 per cent increase in fees. This recommendation marked a significant departure for the DDRB. Until then the DDRB had recommended the target average net income (TANI) i.e. the amount the average dentist should earn in a year after all NHS expenses have been paid. The expenses were calculated separately by the DRSG and fees then set to deliver the total sum. The DDRB, in making this recommendation, recognised it was a short-term measure since it anticipated major reform flowing from this review. It declined to make a recommendation in the normal way, even in the short-term, because, it said:

> "The instability and unpredictability of the payments system make it impossible to foresee what effect such a recommendation on TANI [Target Average Net Income] would have on the level of fees. Moreover, the fundamental flaws of the system...provide further evidence that a recommendation on TANI would be inappropriate."

33. It set out these flaws in its report. It reiterated the points it had made to the Health Minister:

> "We said the present system did not work and that the concept of the *average* GDP was seriously flawed. The *average* GDP simply did not exist because of the wide variation in such factors as turnover, practice costs, geographical area, types of patient and practitioners' own circumstances. We said there were large numbers of GDPs at each end of the remuneration range, and that key elements of the system such as work volume, and practice costs were difficult to forecast with any degree of accuracy."
>
> "We indicated that we were likely to have reservations about continuing to recommend a level of Target Average Net Income (TANI) when the averaging concept was not able to produce an equitable result. We said we thought fundamental change was necessary if GDPs' net income was to be distributed on an equitable basis and if the profession's confidence in its remuneration system was to be restored."

34. These points demonstrate the overwhelming case for review and reform.

Annex B Sessional Fees

Setting the Fee

1. The level of net remuneration for a dentist working full-time in the GDS would be set. Full-time would be defined as a 35 hour week for 46 weeks a year. From this annual figure the health departments would derive a sessional fee based on 10 sessions of 3.5 hours a week as a "full-time" commitment. The dentist would then be paid for the number of sessions completed, subject to a global annual limit determined by the health departments. The number of sessions available to a dentist would depend in part on the pattern of NHS treatment provided by that dentist in the past. Out of session activities, such as out of hours emergencies, could be dealt with through a notional figure in the sessional fee or through payment of a sessional fee credit or by other means.

Expenses

2. Part of the fee received by the dentist would be an element to take account of expenses. This would be based on a new survey of actual costs incurred, drawn from a statistically valid sample of practices. The resultant data would supplement the results of the Inland Revenue survey, which are not available until two years after that financial year ends. The allowance would, therefore, be based on more up to date figures than now. It would cover all NHS practice costs (with the exception of business rates which would continue to be directly reimbursed and any laboratory costs associated with treatments subject to prior approval which are discussed below). It would be a set allowance and would not require the current complex balancing mechanism.

Flexibility

3. Sir Kenneth and the Health Select Committee both criticised the inflexible nature of the current system in that it fails to recognise the differing circumstances and the variations in costs around the UK. Direct reimbursement of some costs has been suggested as one method to address this. Direct reimbursement of costs which can vary would require a complex system of checks for probity and value for money. These would involve more bureaucracy than dentists are used to and would not be generally welcomed. The consultation revealed little enthusiasm in the profession for more direct reimbursement of costs, even among those in the profession who could have been expected to benefit financially from it. Even those who supported it opposed the controls needed to achieve proper accountability.

4. The expenses of dentists are not the same everywhere. Capital costs, staff costs and the dental health status of the population served all contribute to regional variations in average expenses. Sir Kenneth noted the "rough justice" of an average which tends to even out these differences and that would be the same of the set allowance proposed here. He also noted, however, that those who serve populations with poorer oral health but in an area where costs were higher could be in the worst situation. The Government would address this potential problem by variations in the sessional fees in those areas with higher costs. Similarly there

would be an adjustment for local oral health status. The detail of how this might operate would be discussed fully with the profession.

Claiming Sessions

5. Once the net income for a full-time NHS dentist had been set, and the level of expenses determined, these would form the elements of the sessional fee. The health departments would then determine the number of sessions which could be afforded and dentists would seek the number they would wish to perform each week, taking account of their current level of NHS practice. They would know, in advance, the level of the fee and so how much they would earn from the NHS. This would improve substantially dentists' financial stability and planning generally.

Financial Planning

6. The number of sessions would be agreed before the start of the year. That means there would be no need for in-year or later corrections to take account of errors in forecasting the amount of work dentists would do. The move from Inland Revenue cost enquiries to a different system of cost enquiries would make it possible to take account of any significant under- or over-payment when setting the expenses for the following year. There should be no need for unsettling in-year changes to control spending. Taken together these are significant improvements in control over tax-payers' money.

Administration

7. Dentists are health care professionals and deserve to be treated as such. Equally the Government has a duty to make sure that the best value is obtained for tax-payers' money spent. This means that treatments provided by dentists would be monitored so that if levels or standards of activity fall, steps could be taken to put this right.

8. Each dentist would submit, as well as a claim for payment for the sessions completed, details of the treatments provided in each session. This return would be kept simple, consistent with effective monitoring. In practice the paperwork should be a considerable simplification compared with the present system since dentists may not need to register centrally every patient, nor enter an individual claim form for every course of treatment provided. The Government would discuss with the profession whether "mixing" between NHS and private work within an NHS session would be permitted. The "mixing" concept allows a dentist to perform both NHS and private work on a patient in the same course of treatment. This offers choice both to the dentist and patient, and would encourage dentists to provide flexible appointment times. However, the concept would not fit easily in a system which paid a dentist for the time spent giving NHS treatment. Dentists would have to declare any private work done during an NHS session and the system would need careful monitoring to ensure value for money and to avoid any danger of abuse. It could become complex and bureaucratic. The Government will want to explore these issues with the profession.

Availability of Treatments

9. People who need dental treatment should have it readily available to them. That is the cornerstone of the NHS, in dentistry as elsewhere. It will remain so.

However, treatment should be targeted at where it will achieve most benefit, taking account also of priorities elsewhere in the NHS. Sir Kenneth in his report observed that concentration on priority treatments could permit "more effective targeting to advance key health objectives".

10. Many commentators have expressed the view that the current system is poorly directed and may encourage restoration and intervention above prevention. Many have also noted its potential to encourage unnecessary work or work of limited clinical value, perhaps even for solely cosmetic reasons.

11. The Health Select Committee recommended that treatments should be considered under three categories: diagnosis and prevention; maintenance; and advanced treatment. They suggested that the advanced treatment category should only be available to patients after need had been proven and prior approval sought. They suggested that for those who pay NHS charges, the charge should be 100 per cent (up to a specified maximum) of the cost.

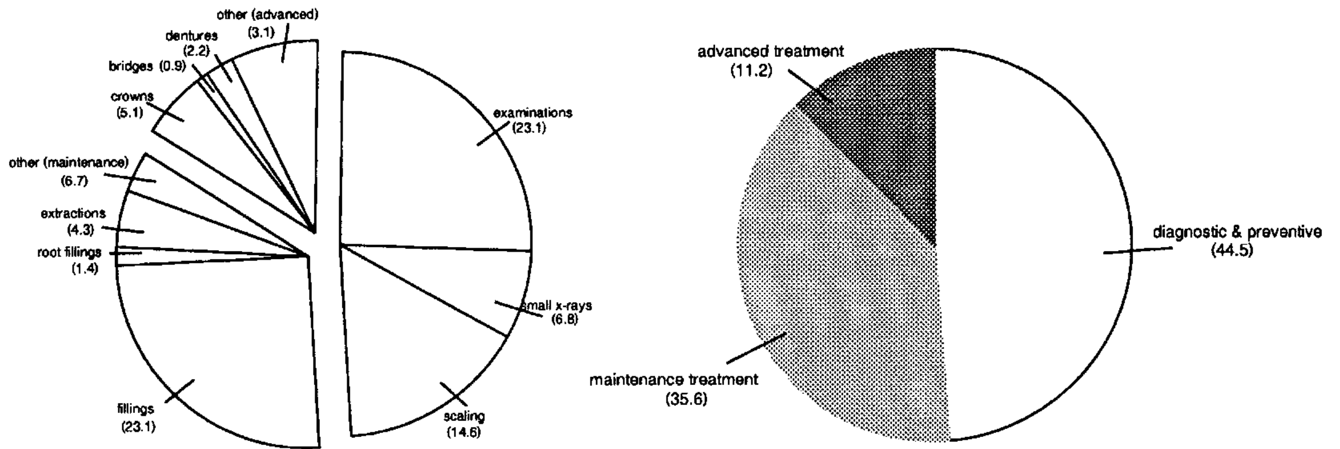
12. Current trends in needs, practice and treatment philosophy support this approach. The figures on the following page show how current GDS provision breaks down between these treatment groupings (using the Health Select Committee's definitions).

13. The Government agrees with the thrust of the Health Select Committee's proposals. The central principle will remain that clinically essential need will be met, as in the rest of the NHS. Resources should be focused on diagnosis, prevention and basic maintenance to reflect the needs of the population. Emergency work should, of course, be readily available. Advanced (and so costly) treatments should be available only after a rigorous prior approval process has confirmed that a particular course of treatment is necessary for the dental health of that individual patient and that alternative approaches would not be clinically acceptable and cost the charge-paying patient or taxpayer less.

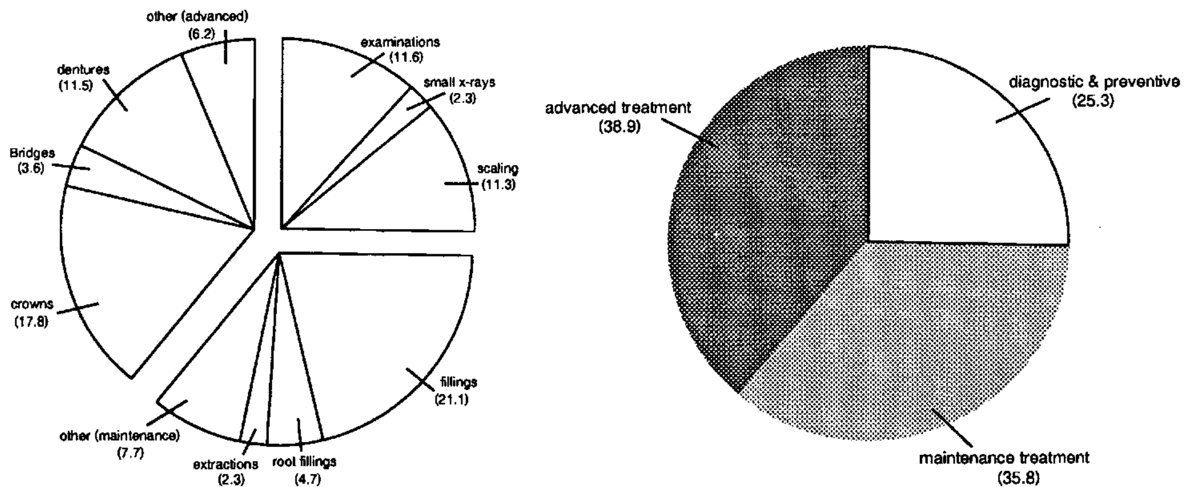
Volume and cost of different categories of treatment[4]

General dental service - United Kingdom

Number of adult item of service treatment (millions) 1993/94



% cost of adult item of service treatment 1993-94



Data includes estimates for N. Ireland

[4]. In these charts, the advanced category includes associated treatments exempt from patient charge, which the Select Committee had allocated to the maintenance category.

14. The definition of advanced treatments proposed by the Health Select Committee will form the basis for discussions with the profession about what should constitute such treatments. The breakdown of categories suggested by the Health Select Committee is reproduced below:

Diagnostic and Preventive Treatment
Examinations
Small X-rays
Scaling

Maintenance Treatment
Fillings
Root fillings
Extractions
Exempt treatments (ie: treatments which do not attract a charge)
Other

Advanced Treatment
Other periodontal work
Surgical
General anaesthetics
Veneers
Inlays and Crowns
Bridges
Dentures
Adult orthodontics

Source: Health Select Commitee, Fourth Report, 1992-93

15. Work would be put in hand, in consultation with the profession, to develop guidelines and protocols for prior approval. The general principle would be that advanced and costly treatments will only be given if it is clear that the treatment is necessary and that there is no clinically acceptable, less costly, form of treatment. No one in need of treatment which is clinically necessary will be denied it.

16. These changes will protect the patient from being offered treatment in which the clinical benefit does not match the cost. They will enable health resources to be targeted at priorities.

17. Where treatment requiring work by a dental laboratory has been done, following prior approval, the laboratory costs would be paid to the dentist by an appropriate authority who would hold a budget for this purpose. This would be paid once the dentist had completed the work and submitted a claim.

Dental Examination

18. During the consultation, many argued that the dental examination was the key element to improving dental health. It is the necessary first stage to ensuring that diagnosis is done so that informed decisions can be taken by both patient and dentist about treatment options, if any are necessary. It is an opportunity for the early diagnosis of oral cancer. To give patients an increased incentive to come to dentists' surgeries, the Government could reduce significantly the patient charge for an examination.

Patient Charges

19. Patient charges are at present a set proportion of the dentist's fee. There are over 400 individual fees. In this system there will be no need for the current complex statement of fees. Patient charges can be simplified so that it will be

more obvious to a patient what a particular course of treatment is likely to cost. The aim should be to reduce the number of charges to below fifty.

20. The Government also accepts the Health Select Committee's advice that charges for the advanced treatments should reflect (or more closely reflect) the full fee for those liable to charges, who would themselves meet the actual costs of the laboratory work. As recommended by the Health Select Committee, the charges could represent 100 per cent of the costs, up to a specified maximum. This would enable NHS resources to be concentrated on essential care and maintenance.

21. All the present exemptions and remissions from patient charges would remain unchanged. The following groups are currently exempt from charges:

children under 18

full-time students under 19

pregnant women and mothers of children under 1 year old

those receiving income support or family credit.

Patients can also apply for full or partial remission from charges, on the basis of low income.

Priority for Children

22. Children must remain the highest priority for NHS dental care and the fee structure would reflect this, although this would not simply be based on a measure of how many children are on a dentist's list nor the treatments provided to them. These could provide the wrong incentives. Rather, a measure of the productive time spent with children would be used to inform decisions about distribution of this element of pay. Other measures of rewarding quality of service would also be possible, and these will be discussed with the profession and others.

Annex C A Dental Fee Scale

Setting the Rate of Remuneration

1. The concept of TANI is based upon the "average dentist" which, given the wide range of practice by actual dentists, is a fiction too far divorced from reality for it to be a sensible basis for the remuneration system. The DDRB have indicated that it is a poor basis for their work and they seem unlikely to be happy making a recommendation in that way again. The case for moving away from TANI is clear and beyond doubt. If the Government eventually decides to follow the option of building on the existing system rather than more radical reform in the medium term, it intends to enter into urgent discussion with the profession about a more satisfactory basis for determining levels of remuneration, such as the concept of a "full-time commitment". This does not imply that there would be no role for the DDRB.

Dental Examination

2. As in the earlier option, the charge for a dental examination for those liable to pay could be reduced significantly, while leaving unaltered the dentist's fee, to encourage attendance for diagnosis.

Children's Capitation Scheme

3. The capitation scheme for children and the underlying philosophy is now widely welcomed by the profession and their representatives, as shown by their evidence to the Health Select Committee. The principles which underpin it are good ones. Under this option this aspect of the remuneration package would remain so that its strengths could be built upon. The health departments and the profession's representatives have already started to discuss possible ways to improve the scheme and those discussions would continue. It may be possible to take greater account of epidemiological factors and these discussions would aim to explore such possibilities.

4. It is essential, though, to monitor closely the effects on the dental health of children of paying dentists in this way to avoid potential problems, in particular "supervised neglect". This point was emphasised particularly by Sir Kenneth Bloomfield and the Health Select Committee. Children's teeth are too important to leave to chance. Parents need to have confidence that all necessary work is done. There would need to be a development of the monitoring of the scheme supported by reports from dentists of work done within it. Evidence of neglect by any practitioner should be vigorously pursued and penalties invoked.

Continuing Care Payments

5. Continuing care payments have, on the other hand, not demonstrated any significant benefits to patients. They were introduced in the 1990 contract to recognise and promote the continuing relationship between dentist and patient

and to provide a more stable element of income for the dentist. Yet that relationship largely pre-dated the new contract. It is in the interest of the dentist to maintain it. Experience has shown that little is gained by providing a specific payment for it.

6. In fact having such a payment has apparently led to some misunderstanding in the profession. Dentists tend to look to the fee scale alone as the basis for their earnings. Yet the individual treatment fees have not shown the full effects of the year on year increases the Government has made to dentists' remuneration because a part of their money is now being paid through continuing care payments, away from the fee scale and before any treatment is given. From 1 April 1994 dentists receive £5.04 per year for every adult patient registered with them. The significance of this additional source of income has been over-looked by some who claimed that the fee scale had been static or reduced over recent years and implied this showed a reduced income, despite the markedly increased funding in real terms.

7. As Sir Kenneth noted in his report, dentists can register patients under the NHS, receive the money for doing so, and then offer treatment only under private terms. Neither the NHS nor patients receive any significant benefit from money spent in this way. Once a patient is registered, dentists continue to receive a monthly payment for that patient for two years, whether that patient is seen again in that time or not. Some patients may be registered with more than one practice, perhaps following a change of home address or dentist, yet the other dentist or even dentists will continue to receive these payments. This has proved poor value for money for taxpayers' funds.

8. Under this option, therefore, continuing care payments would end. The continuing responsibility of dentists for their patients would remain as a central feature of the service. It is one of the key ethical principles of the profession, and is emphasised as such by the General Dental Council. It would remain essential for dentists to keep full records of patients for whom they have continuing responsibility, including all patients accepted under NHS terms.

9. This does not necessarily imply a central registration system of the present type. The Government would discuss with the profession and others the advantages and disadvantages of change and the details of how it should be implemented.

Fee Scale

10. The current fee scale aims to be neutral, that is, to offer the same reward for the same amount of time regardless of what particular treatment the dentist undertakes. In practice this is not possible, since dentists work at different speeds and in different ways. As the Health Select Committee noted when considering specialist treatments:

> "We are deeply concerned ... that there is a significant divergence between theory and practice with regard to the financial neutrality of the fee scale."

11. Neutrality is not only an unattainable ideal, it is also a lost opportunity to give dentists encouragement to perform some treatments rather than others which objectively could be of more benefit to the patient. Other treatments could be discouraged. Many have said that the examination should be cheaper or free for patients, to recognise its importance. This shows that some procedures are valued differently from others. Some concern has been expressed that some items are done, or at least are done so frequently, principally because they earn a fee. There must be real doubt whether the 14.6 million scale and polishes done in 1993/94 in the United Kingdom at a cost to the NHS of £108 million were all essential on

clinical grounds. It would be more worrying if there were incentives to do more radiographs than were essential since this would clearly not be in the interests of patients. This is a valuable and sometimes essential tool for the dentist but needs to be used with due caution. There is only limited evidence that at present it is performed more than clinically necessary but the remuneration system should not contain incentives for over-use. In 1993/94, in the United Kingdom, there were claims for 7.9 million radiographs, costing £30.9 million.

12. The "Schanschieff Report" noted that:

> "Although ostensibly 'neutral' and intended to reimburse strictly the time spent on each item, there is bound to be some financial incentive to undertake restorative work...."

It recommended, in line with an earlier recommendation by the Public Accounts Committee, that the health departments and the profession should:

> "reconsider whether the present neutral system of remuneration is appropriate in furthering preventive dentistry."

13. At the margins there is scope for using the fee scale to encourage some treatments and to remove incentives for others. This is essentially a clinical matter and the health departments would discuss with the profession any significant movement in this direction.

Availability of Treatments

14. As in the proposals set out above, all clinically necessary treatment would be available to all NHS patients. But the Government again draws upon the advice of the Health Select Committee and others in proposing that advanced treatments should be available only after a rigorous prior approval process has confirmed need. The aim would be to make sure that any complex and costly treatment proposed was indeed clinically necessary and that other treatment of similar or greater efficacy was not available at less cost to the charge-paying patient or the taxpayer. Again the Health Select Committee's definition of advanced treatments would form the basis of the Government's. After consulting the profession the health departments would produce guidelines and protocols to enable effective prior approval processes. As under the sessional fee system, the general principle would be that approval would be granted if it was clear that some form of treatment was needed and there was no clinically acceptable, less costly, form of treatment.

15. The Government would also follow the proposal of the Health Select Committee that patients liable to NHS charges should pay a charge for advanced treatments based on the actual cost of the work done, up to a specified maximum. However, all the current exemptions and remissions from patient charges would remain unchanged. The following groups are currently exempt from charges:

children under 18

full-time students under 19

pregnant women and mothers of children under 1 year old

those receiving income support or family credit.

Patients can also apply for full or partial remission from charges, on the basis of low income.

Flexibility

16. To recognise variations in circumstances, as in the earlier option, the Government proposes that there would be an enhancement of fees where there are high costs. Similarly, fees would be adjusted to take account of dental health status. The detail of how this should operate would be discussed further with the profession.

Expenses

17. Sir Kenneth observed that it is probable that high grossing dentists are over-reimbursed for their fixed and near fixed costs. TAGI was set to cover all NHS costs. Those who earn significantly more than TAGI (more than a third of dentists gross more than £100,000 from the NHS) are, therefore, likely to be over-reimbursed for such costs. TAGI is a concept which will end but the system will still aim to reimburse costs and any system based on individual fees would be prone to this problem. The Government therefore proposes that fees would be adjusted at the top end of earnings to reflect the fact that by a certain point all these costs have been wholly reimbursed. A taper of fees would be introduced once a dentist's earnings had reached a certain level (say $1^1/_2$ times TAGI at current rates) so that each fee earned thereafter was reduced to remove the element intended to reimburse fixed costs (which at that point had already been wholly paid). At a higher level, further fees would simply reflect the remuneration and laboratory elements. The Government would discuss the mechanics of this with the profession.

Rewarding Quality

18. The Government is committed to allowing sufficient flexibility in pay to reward commitment and effort. The fee per item of service system gives direct reward for any and every intervention. In this model, remuneration would still be made mainly in this way. The Government would discuss how quality of service should be measured and rewarded in this model. The aim should be to introduce a greater incentive for quality and efforts directed at meeting the strategic aims of the NHS. Quality standards, whether in the surgery or in the laboratories used, could be encouraged through incentives in pay. Other measures, for example computer links to the payment authority, could be used (though at present this could only apply to England and Wales).

Financial Control

19. Financial control in this aspect of the NHS, as with others, is essential, not least so that considered decisions on priorities can be taken and implemented.

20. To protect public spending targets and to avoid other parts of the NHS sacrificing funds to meet overspending in the dental services, Government needs to be able to adjust fees and control spending in-year if spending runs above plan. Errors need to be corrected quickly. The health departments would discuss with the profession the mechanics for an in-year review procedure.

21. In this model, a balancing mechanism would still be needed to correct errors made by incorrect forecasting, even with a formal provision for in-year review of fees. The existing balancing mechanism cannot be left unaltered.

Setting the Expense Allowance

22. Accurate and up to date information is needed to establish the expenses element of remuneration. It is also needed to establish whether a fee adjustment is needed and to facilitate more rapid repayments of debt from either side. The data currently available on actual expenses incurred is out of date and needs to be improved. At present, data is obtained from an Inland Revenue survey. This has in the past proved adequate but is not able accurately to inform the fee-setting process in a period of change. It cannot readily identify a change in the balance between private and NHS practice and hence expenses. NHS money should not be used to subsidise private practice. The Government would therefore use the same survey of expenses referred to in discussion of the sessional fee model to supplement the Inland Revenue data as the basis of calculations. This would allow reliable and more speedy data to inform decisions.

Printed in the United Kingdom for HMSO.
Dd.5062801, 7/94, C360, 3398/3A, 5673, 294457.

HMSO publications are available from:

HMSO Publications Centre
(Mail, fax and telephone orders only)
PO Box 276, London, SW8 5DT
Telephone orders 071-873 9090
General enquiries 071-873 0011
(queuing system in operation for both numbers)
Fax orders 071-873 8200

HMSO Bookshops
49 High Holborn, London, WC1V 6HB
071-873 0011 Fax 071-873 8200 (counter service only)
258 Broad Street, Birmingham, B1 2HE
021-643 3740 Fax 021-643 6510
33 Wine Street, Bristol, BS1 2BQ
0272 264306 Fax 0272 294515
9-21 Princess Street, Manchester, M60 8AS
061-834 7201 Fax 061-833 0634
16 Arthur Street, Belfast, BT1 4GD
0232 238451 Fax 0232 235401
71 Lothian Road, Edinburgh, EH3 9AZ
031-228 4181 Fax 031-229 2734

HMSO's Accredited Agents
(see Yellow Pages)

and through good booksellers

ISBN 0-10-126252-3