We have now arrived at a point where we have numerous reports from patient groups, widespread media criticism, the Health Select Committee (HSE) report, the Steele review and of course around 10 per cent of dentists leaving the NHS, but the UDA system still grows older. When the Steele review was announced, this initially kicked the debate over NHS dentistry out of the political spotlight and into the long grass, but now (at the time of writing) with no new government reports, reviews or quango bodies planned, the question ‘where does NHS dentistry go from here?’ must be asked.

Cash boost needed
The Steele review has received both favourable press and acceptance since its release. Now, without entering into a debate regarding its content and recommendations, it seems to me that any change that may arise out of this needs money; money which the DH has already spent. The Steele review recommends a shift in the way dentists are paid from a fee-per-item system, towards a part-capitation and part-fee per item system. While this would probably help resolve issues regarding access to NHS dentistry by encouraging dentists to take on new patients, what it does not do is address issues regarding quality within the NHS.

It is clear that among many GPs working within the NHS, there is a genuine feeling they don’t feel able to provide good-quality treatment under this contract. Irrespective of where you may sit on this particular fence, the statistics are clear: the number of teeth being saved is down, while the number of dentures being made is up. Whether this phenomenon is down to the need for complex treatment decreasing as the often seems to suggest, or a genuine failure of the new contract, one thing is clear – the current contract is certainly not based around quality.

Finding a balance
The sensible debate that needs to take place is exactly what level of care NHS dentistry is willing to fund. To clarify, I accept that under this current contract dentists are now paid more for many items of treatment compared with before, however at the same time, it only takes a few patients with high dental needs to take up much of a dentist’s time, leaving a great deal of uncertainty within this system. The funding which is derived from the UDA system is also relatively static and does not take into account the ever-growing costs of cross infection, laboratory and staff costs, as well as material costs such as single-use endodontic files. All things being equal, some things were poorly funded in the old system and some things are still poorly funded in this new system, but because of the unpoliced ‘swings and roundabouts’ approach to funding dentistry, it’s hard to tell exactly which procedures are affected and how this may affect the quality of treatment provided by individual dentists.

Implementation, implementation, implementation
With no new reports, reviews or quango bodies planned, Neel Kothari thinks about where NHS dentistry can and will go from here.