‘A tax on teeth’

Patient charges in NHS dental services in England
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Foreword

NHS charges exist to lower demand for health services. That was the reason for their introduction, and that is what they have succeeded in achieving ever since.

It is widely recognised this approach has ‘unintended consequences’. Certainly the impact on demand has never been uniform. Added costs do little to discourage the ‘worried well’ yet have a significant impact on patients on low incomes, and so in turn have helped sustain Britain’s persistent oral health inequalities.

Yet in practice the distinction between ‘unintended’ consequences and deliberate policy has blurred. Since 2006 NHS dentistry has operated as a cash limited system, and the imperatives to limit demand and raise revenue are now hard-wired into every part of the service.

Yes we have the exemptions that are meant to take the ‘edge’ off charges. Yet many vulnerable patients either cannot navigate the bureaucracy that governs the system or are simply never made aware of their entitlements.

This looks like confusion-by-design. Where patients handed £100 fines for misclaiming, yet 9 out of 10 appeals are won. Where the perception that costs apply are so widespread that while nearly 5 million children are failing to attend at an NHS dentists in a given year, many parents are simply unaware that these check-ups are free of charge.

And higher charges have not meant extra investment. Far from putting extra cash into the service in England NHS charges have become a substitute for direct funding. We now have the realistic prospect of patient charge revenue overtaking state contributions within a generation, and it raises existential questions about the future of NHS provision.

NHS dentists take no pleasure in our role as ‘tax collectors.’ It has always strained the relationship between patient and practitioner, and the impact is felt most acutely by the very patients that need us most. We want to see dentistry unlocking its unrealised potential to deliver on the mantra of prevention outlined in the Five Year Forward View. Yet every patient that finds a reason to delay or avoid care takes us one step further away from that vision.

If we have to live with NHS charges - and the idea the public need to make a ‘contribution’ toward the costs of their care - then they will have to work for both patients and practitioners, so no one in real need is discouraged from seeking our help.

Henrik Overgaard-Nielsen,  
Chair, General Dental Practice

Michael Cranfield,  
Chair, England Community Dental Services
Introduction

Despite access to healthcare on the basis of clinical need, not ability to pay, being a founding principle of the NHS in 1948 – restated in the NHS Plan (2000) and NHS Constitution (2015) – dental services have been subject to patient charges since 1952.

NHS charges were initially intended to raise money, to reduce demand and unnecessary use of the NHS, and, in the case of dental and sight test charges, to fund rearmament prior to the Korean War. Since then, numerous studies have found patient charges to be among the main barriers to accessing oral healthcare.

Since 2006, dental charges in England have reflected the Unit of Dental Activity (UDA) band to which the treatment corresponds. In March 2016, the government announced its intention to increase patient charges by five per cent for each of the next two years. This uplift means that the costs of Band 3 treatments will increase by more than £20 to £244.30 by 2017/18. This uplift of five per cent compares to CPI inflation which stood at just 0.6 per cent in the 12 months to July 2016.

NHS dentistry remains free for under-18s, 19-year-olds who are in full-time education, pregnant women and women who have given birth in the last 12 months, and those on qualifying benefits. Support is also available for those on low incomes. Despite these exemptions, in 2001, 75 per cent of adults received no support with the costs of NHS dental treatment and among those aged over 60 years this increased to 82 per cent.4

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1 NHS Charges, House of Commons Health Select Committee, 18 July 2006
2 NHS Dental Charges from April 2016, Department of Health, 11 March 2016,
3 Inflation and Price Indices, ONS, 16 August 2016
4 Unhealthy Charges, Citizens Advice, 1 April 2001
The principles of charging

The initial intention behind dental charges was two-fold: raising money and reducing demand. However, this needn’t be incompatible with wider healthcare policy objectives. Charges can be used to discourage certain behaviours, such as unnecessary use of health services, accessing low value care, or non-attendance at booked appointments. They can also be structured so as to incentivise patients to access the most cost-effective care and thus generate health efficiencies.

In general, where one is in place, it is desirable to have “a charging system which is sensibly linked to the overall objectives of promoting oral health and minimising barriers to care”5.

Barriers

It is widely acknowledged that patient charges act as a barrier to accessing dental services; in part, this is the intention behind them. Patients consider dental treatment to be expensive and openly acknowledge that cost – both real and perceived - is a key reason for postponing dental appointments or non-attendance6,7.

It is difficult to estimate the number of patients who have avoided treatment as a result of dental charges, but there is a wide range of evidence on the extent to which cost is a barrier to accessing dental services and the percentage of the population affected. The 2009 Adult Oral Health Survey found that for 26 per cent of the public cost had influenced the type of dental treatment they had opted to have and 19 per cent had delayed dental treatment due to cost8. These findings were supported by a 2016 survey conducted on behalf of Healthwatch, which found that 17 per cent of those who had visited a dentist said they had delayed or cancelled planned treatment because of the cost, and 36 per cent of those who hadn’t been to the dentist said this was because it was too expensive9. A 2007 poll on access to NHS dental treatment10 found that 4 per cent of respondents cited cost as a major factor in avoiding treatment – a small percentage which equates to 1.7 million people deciding not to seek care.

A Citizens Advice survey of its clients found that 43 per cent stated that they had not had a dental check-up in the previous twelve months because they could not afford the costs11. It also found that, of those respondents who had paid NHS dental charges, 44 per cent had found them difficult to afford and that this was particularly the case for working-age single people and single parents. A further study stated that charges acted as a barrier to dental care for between 30 and 61 per cent of the population12.

Nearly 1 in 5 patients have delayed treatment for reasons of cost

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5 NHS Dentistry: Options for Change, Department of Health, 2002, p.17-18
6 ‘What patients think of dental services’, Land, T., British Dental Journal, 189:1, 2000
9 ‘Access to NHS Dental Services’, Healthwatch, November 2016
10 Access To NHS Dentists, Ipsos MORI, 7 - 13 December 2007
11 Unhealthy Charges, Citizens Advice, 1 April 2001
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A Scottish study exploring the uptake of dental services between 1982 and 1998 observed that patient charges for routine dental check-ups reduced attendance by 7.6 per cent and suggested that it was likely that those whose oral health could be most improved by accessing dental services are also those who are most likely to consider cost to be a barrier\(^\text{13}\).

Other studies have\(^\text{14}\) found that cost acted as a particular barrier for irregular attenders and those whose attendance had lapsed. These groups were particularly likely to fear that an initial examination would identify the need for further treatment which they could not afford and they wished to avoid the social embarrassment of having to admit this. For extreme non-attenders, it was more likely that other factors were the main barrier to seeking dental care, however, cost was raised as an additional reason for not attending.

The availability and accessibility of NHS dentists and dental anxiety also present notable barriers to receiving dental care. However, it is worth noting that more regular attendance can help reduce dental anxiety and therefore a "gradual increase in cost, by gradually reducing attendance, could in turn produce an increase in dental anxiety, thus perpetuating the cycle of non-attendance and a reduction in oral health status."\(^\text{15}\)

Ministers have stated that "In considering the possible impact on patients of the increased charges for 2016/17 and for 2017/18, we concluded that the existing exemptions and Low Income Scheme will protect the most vulnerable, ensuring there should be no significant impact on an individual’s inclination to visit the dentist"\(^\text{16}\).

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\(^{14}\) Barriers to the Receipt of Dental Care: A Qualitative Study, Finch et al, 1988


\(^{16}\) Dental Services: Fees and Charges: Written question – 904952, 2016,
Impact across the NHS

The presence of charging illustrates the limitations of viewing dentistry as a discrete ‘silo’ within the NHS. From a patient’s point of view the NHS operates as a whole system, and the presence of cost barriers in one part of the service will have unintended consequences elsewhere.

Recent academic studies have highlighted the volume of patients seeking treatment for dental problems at both Accident and Emergency (A&E) and General Practice.

GPs certainly appear to be the primary destination of patients avoiding NHS charges. Research has suggested approximately 600,000 consultations for patients with dental problems are taking place in General Practice every year. Based on research from Newcastle University’s Centre for Oral Health Research of A&E attendances, the BDA has estimated that systematic under-reporting could conservatively place dental attendees at A&E at close to 135,000 patients per year at an annual cost of nearly £18 million.

Further research is required on the other drivers, including dental anxiety and other socio-economic and cultural factors that turn patients with dental problems away from General Dental Practice.

The NHS resources expended on dental problems at A&E and in General Medical Practice confer limited health benefits. As patients with emergency dental problems (including toothache and abscesses) typically require some form of operative intervention, which GPs and A&E medics are not trained or equipped to provide, the majority will usually be referred on to a dentist, incurring further costs. In many if not all cases treatment cannot be avoided permanently. The costs of delay are difficult to quantify in this context, but are likely to be significant.

There is significant evidence on the role charges can play in driving patients towards high-cost care and in doing so generate inefficiencies.

A widely-cited RAND study found that people – across all income groups – who faced patient charges reduced the use of effective care almost to the same extent that they reduced their utilisation of ineffective care. Given that most individuals are not sufficiently informed about their own health needs, this inability to discern which treatment and care options are most cost and health effective is unsurprising. Moreover, charges which do not relate to ability to pay disproportionately impact on the poor, yet there is no evidence to suggest that they are more likely to make unnecessary use of dental services than those with higher incomes.

The main consequence of charges on patient behaviour is to delay the point at which oral healthcare is sought and in many cases these delays will lead to a reduction in the benefits that can be produced by treatment and/or increase the costs of achieving those benefits. The main impact of charging is not just preventing a very small number of patients from accessing care altogether, but that it has a more general effect to deter a much larger group of patients from seeking care as much, as often and as soon, and, in doing so, fails to improve oral health and increases the costs of providing oral healthcare.

18 Dental consultations in UK general practice and antibiotic prescribing rates: a retrospective cohort study, Br J Gen Pract 2016; 66 (646)
20 Co-payments and charges in the NHS, King’s Fund, 2005
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The risk of gradually increasing the costs of dentistry in real terms is to create a situation where those who are able to afford it will engage in regular preventive oral healthcare, and those who cannot delay seeking care and will come to rely upon emergency treatment, which is more expensive and less effective.\(^{21}\)

**Charges and NHS funding**

Despite its function to discourage ‘trivial’ appointments, patient charges have increasingly served as substitute for direct state funding from general taxation.

Direct investment in the service in England has fallen by £170 million since 2010, while the gross budget has been topped up by patient charges. Based on current trends, patient charges in England are on course to contribute one third of the total dental budget within the next 3 years - and remain on track to exceed funding from government by 2031/32.

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However this trend has not been uniform across the UK nations. While patients in England are paying a far greater share of their treatment costs at the point of use, administrations in Northern Ireland, Wales and Scotland have chosen the opposite path, and have largely reduced their dependence on patient charge revenue.
Exemptions

It is often asserted - in defence of NHS charges - that those who can afford to pay for health services should contribute to the costs of providing them. However, it has been suggested that the current structure of NHS charges, and the exemptions to them, do not achieve this. Instead, patients are faced with a complicated and confusing system that is incredibly difficult to navigate.

As a result, every year patients, entitled to free dental care but unaware of their exempt status, are going without dental examinations and treatment that they need, but do not feel they can afford, or are paying for care that they should be receiving free.

Children under 18

Children receive arguably the most comprehensive exemptions within NHS dentistry. The service remains free at the point of use for all NHS treatments that commence before a child reaches the age of 18, or 19 in the event they remain in full time education.

However it appears there is fairly limited awareness of these exemptions among parents charged with overseeing care. Certainly the perception that charges may well apply appears widespread.

Research conducted by Yougov on behalf of the BDA explored parental awareness of exemptions on a range of treatment options – all of which are available free of charge to child patients\(^2\). Only 74% of all respondents were aware that check-ups were free of charge for children aged under 18. The consistency of respondents of different social grades, who may have more or less reliance on NHS services or experience of private alternatives raises worrying questions about what is supposed to be a bedrock of dental policy.

Only 74% of parents are aware that NHS dental check-ups for children are free of charge

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\(^2\) Polling by YouGov Plc. Total sample size was 910 parents of children aged under 18 years old. Fieldwork was undertaken between 29 - 31 March 2017. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+).
The only noticeable variation appears to be among younger parents, who demonstrated less knowledge of free check-ups for their children, with awareness at 67% among parents aged 25-34, and falling to 62% among parents aged 18-24.

The direct impact of limited parental awareness on treatment options is difficult to quantify. Tooth decay is now the leading reason for children to be admitted to hospital, and non-attendance among children remains high. The last annual report on patients receiving NHS dental care in England suggested 4.9 million children (42% of the total) have not had a check-up in the 12 months to June 2016, despite NICE guidelines recommending children should be seen by a dentist at least once a year.

While 42% of parent respondents stated they had delayed a routine NHS dental check-up for themselves because of costs, just 8% stated they had delayed check-ups for one or more of their children aged under 18 for the same reason. Yet that nearly 1 in 10 parents had made this choice – when their children are exempt from all charges – offers cause for concern.

The low levels of awareness of other treatments raises further questions. Demand for orthodontic treatment is increasing, yet only 54% of parents have shown awareness that braces are free on the NHS. The 2013 Children’s Dental Health Survey reported that at the age of 15, the proportion of children who still had unmet need was significantly higher amongst children who were eligible for free school meals than among children from more affluent families (32% compared to 17%). It is unclear how imperfect knowledge of NHS charges and provision influences these inequalities.

**Vulnerable Patients**

Hundreds of thousands of those in receipt of benefits such as Pension Credit Guarantee and income-based Employment and Support Allowance miss out on NHS dental charge exemptions annually.

Patients who wrongly claim an exemption, or who are exempt but complete the paperwork incorrectly, can be charged a fine of up to £100, in addition to needing to pay the original patient charge. 117,882 fines have been issued since May 2014, generating a potential revenue of £4 million per year.

Figures released by the NHS agency which checks exemptions and issues fines show that of more than 30,000 fines challenged by patients from May 2014 to July 2016, nearly nine in 10 are overturned on appeal. This statistic only serves to underscore the difficulties in determining whether a patient is exempt or not. In particular, dentists have reported the particular challenges that are faced by patients with special educational needs, dementia or other cognitive conditions, and their carers, in navigating the patient charges system and in communicating their exempt status to practices. This can leave these vulnerable patients facing fines for wrongly submitted claims or being charged for treatment that they are entitled to receive free of charge.

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26 Child Dental Health Survey 2013, England, Wales and Northern Ireland, 19 March 2015
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Further to these issues, as is acknowledged in the 2000 NHS Plan, “exempting low income families from user charges can create inequities for those just above the threshold”27. Those with incomes slightly above the level which qualifies for exemption can still find it very difficult to meet the costs and are felt to be harshly treated.

In addition to exemptions, additional means-tested relief is also available to people on low incomes who are not exempt to help meet the costs of dental treatment. However, the NHS Low Income Scheme has been criticised for its complexity, inadequacy, inaccessibility and inequity28. For example, the NHS advice leaflet explaining the scheme to patients is 39 pages long and the application form and accompanying advice is 20 pages long. It is not clear to patients whether they will qualify for support before subjecting themselves to a means assessment. The Race Equality Foundation has identified these long and complicated forms as a particular barrier to accessing support for migrants and ethnic minorities due to lower levels of English language proficiency29, and they may also present a difficulty for those with low literacy levels or who are illiterate.

Case studies – NHS Charges and vulnerable patients

**Case 1**
A 94-year-old patient was brought by carers for dental treatment, she lived in a residential care home. Carers did not know if she was in receipt of any benefits and therefore could not complete the PR1 declaration.

No declaration was made and the patient was sent an invoice for the NHS charges. The invoice remained unpaid and a phone call was made to staff at the care home. They explained that they do not hold financial information regarding her exemption status and we should contact her next of kin.

Her next of kin were contacted and they explained that they had not been forwarded the invoices for treatment from the care home. Her next of kin explained that the patient was on a low income and should be exempt from NHS charges. We explained that they would need to apply for these type of benefits, it was not an automatic entitlement. The system of NHS charges and exemptions was explained but the next of kin remained very upset and angry and have refused to pay the NHS charges.

**Case 2**
Care home staff attended with a patient. Dental staff explained that they would need to make the declaration on the PR1 form for the patient. They said that as the patient was in a care home, they would definitely be exempt and therefore ticked every type of benefit as they didn’t know which, if any they received.

Care home staff were upset when we explained that we needed the declaration to be accurate and they could not be in receipt of all the benefits which were listed on the form. Care staff refused to re-sign the form and could not provide accurate information.

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27 NHS Plan, Department of Health, 2000, p.37
28 Unhealthy Charges, Citizens Advice, 1 April 2001
29 ‘Oral health and access to dental services for people from black and minority ethnic groups’, Marshman et al, Better Health Briefing (Race Equality Foundation), 2013
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Case 3
A patient from a neurodisability unit attended with a carer. The carer could not complete the PR 1 form, as they said they did not know the patient’s exemption status.

We suggested that they call the unit’s manager and ask for the required information. The carer spoke to the manager and said the patient is exempt but she didn’t know which benefit they received. It was explained that we need to know the type of benefit which the patient receives.

They then called the manager again and they said the patient received disability living allowance. It was explained that this benefit does not give exemption to NHS dental charges. The carer was upset by the questioning. In order to support the carer and the patient, a dental nurse agreed to meet the unit’s manager and explain the procedure.

The dental nurse established that they thought all their residents were exempt because they were in receipt of disability living allowance or incapacity benefit and had been making incorrect declarations of income support for all the residents. The dental nurse explained the system of NHS dental charges and left HC1 forms to be completed, for those who required it.

Case 4
A carer ticked the income support box believing that the patient was in receipt of this benefit.

The patient was sent a fine and the carer contacted dental staff to say that the patient received incapacity benefit. It was explained that this benefit does not give exemption for NHS charges and that she had ticked the incorrect box.

The carer was very upset and felt that dental staff had not explained the form correctly and that it was their fault that she had made an inaccurate declaration and the fine should be revoked.
Oral health inequalities

It goes without saying that those on lower incomes will experience the costs of dental treatment disproportionately to those with higher levels of disposable income. Patients on low incomes may be concerned that a dental check-up may identify the need for further treatment that would incur additional costs, and may be particularly deterred from attendance as a result.

In exploring ‘options for change’ for NHS dentistry in 2002, the Department of Health acknowledged that “Patient charges are a driver of health inequalities and this issue needs to be addressed by the government. Dental disease is related to socio-economic factors and at present, those in greatest need are least likely to access the service and often pay the most for their dental care.” Yet more than a decade later, there has been no serious effort to identify the contribution that NHS charges make to oral health inequalities and how these consequences can be mitigated or avoided.

Despite significant general improvements in oral health since the foundation of the NHS, there remain substantial, persistent and growing oral health inequalities. Deprived socio-economic groups have the highest proportion of edentate people and pre-school children from less affluent backgrounds have more decayed teeth than their peers. There is evidence to suggest that those without any natural teeth are less likely to perceive a need for or to access dental services, thus perpetuating their poor oral health. Research has also suggested that attitudes towards dentistry and the value of preventative treatments are shaped by socio-economic class and income.

These health inequalities have also been found to intersect with other forms of social exclusion; for example, 26 per cent of Bangladeshi people living in London have never attended a dental appointment. The explanations for this may be complex, but it is likely that the high levels of poverty among Bangladeshi communities plays a consequential role.

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30 NHS Dentistry: Options for Change, Department of Health, 2002, p.40
32 Ibid.
33 ‘Class Attitudes to Dental Treatment’, Dickson, S., The British Journal of Sociology, 19:2, 1968
34 ‘Social Exclusion, Barriers and Accessing Dental Care: Thoughts on Planning Responsive Dental Services’, Freeman, R., Journal of Oral Sciences, 1:1, 2002
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**Patient information, attitudes and expectations**

There are mixed views among patients regarding NHS dentistry charges; some consider them to be entirely unacceptable (particularly in addition to paying National Insurance contributions\(^{36}\)), others consider them to be reasonable, but, in general, there is a great deal of confusion about the level of charges and how they are calculated\(^{37}\). Our research into perceived costs of NHS dentistry for children appears to reinforce this picture.

Unlike most other NHS services, dental patients make a substantial contribution to the costs of their care and as a result have high expectations of receiving something tangible in return. This is perhaps why charges for check-ups, which have mostly ‘hidden’ benefits, are the element to which people are most likely to object\(^{38}\). Research conducted prior to the introduction of the new dental contract in 2006, when patients made an 80 per cent co-payment up to a stated cap, found that this was generally considered to be unfair, and a 50/50 split or a reversal of the 80/20 split would be preferred\(^{39}\). This is relevant given the proposed uplift in dentistry charges will bring Band 3 treatment charges to approximately 80 per cent of the average UDA value for providing that treatment.

**Problems with the current charging structure**

The structure of the current dental charging system, based around UDA treatment bands, has a number of unintended and unfair consequences in the view of many within the profession. The main source of this unfairness is felt to be for patients with good oral health who attend regularly and would find themselves subject to higher charges and may even be deterred from attending as a result. One dentist interviewed considered this to amount to a ‘tax on teeth’\(^{40}\). There is also a perception that the banded system often does not reflect the level of treatment and that this creates unfairness; for example, one filling being charged at the same rate as several fillings. There is also a concern that the structure of the charges may lead patients to favour certain treatments over others based on cost rather than health benefit\(^{41}\).

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\(^{36}\) Barriers to the Receipt of Dental Care: A Qualitative Study, Finch et al, 1988
\(^{38}\) ‘What patients think of dental services’, Land, T., British Dental Journal, 189:1, 2000
\(^{39}\) Ibid.
\(^{41}\) Ibid.
GP Charging – lessons from dentistry?

In light of NHS funding pressures, the debate on levying similar charges for General Practice continues among the medical profession, despite opposition from both the BMA and the RCGP.

Debate has recently focused around a nominal charge - £10 per visit – which would serve to raise revenue and discourage ‘trivial’ or missed appointments, or charging for weekend appointments.

As with dentists, GPs do not operate in a silo, and difficulties in securing convenient appointments are already driving significant volumes of patients towards A&E services. Figures from the GP Patient Survey have suggested that 9.75 per cent of patients who were unable to secure an appointment with their GP went to A&E or a walk-in centre. Extrapolations to the wider population have suggested this could amount to nearly 1 million A&E visits annually. No doubt if GPs’ patients are similarly sensitive to charges as the dental patients this could add significantly to pressures on A&E services.

It is hard to speculate on the administrative costs of collecting any charge, and what exemptions could apply. However, it is reasonable to conclude that additional costs would be incurred from those deterred from visiting their GPs and requiring more costly treatment at a later date.

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42 Should patients pay to see the GP? BMJ 06 January 2016
43 GP Patient Survey, National Summary Report, Jan 2015, NHS England
Alternatives

It is clear that there are a number of aspects in which the current system of charging, and exemptions from charges, could be reformed so as to enhance their capacity to contribute to the improvement of oral health, the reduction of oral health inequalities and to relieve pressures elsewhere in the NHS. The alternatives suggested below summarise ideas put forward by a number of healthcare and patient organisations as to how the NHS dental charge could be reformed.

*Inflation-linked uplifts* – The increase in charges from 1 April 2017, and the previous 2016 hike, are considerably above the rate of inflation, whether measured by RPI or CPI, and will therefore increase the costs of dental services in real terms. Linking dental charges to inflation would ensure that the value of the patient contribution to the costs of NHS dentistry is not eroded over time, while also giving patients a reassurance that any increases fairly reflect the increasing costs of delivering treatment and dental care is not becoming increasingly expensive in real terms.

*Dental check-ups* - Given patient objections and their value in preventive oral healthcare, Citizens Advice has recommended that all patients should be entitled to regular free dental check-ups. While this may have positive impacts on access and oral health, it would not overcome the anxiety many feel that an initial check-up will identify the need for costly treatment. It is a particular anomaly that, despite receiving free prescriptions and other age-related benefits, over 60s do not receive free dental check-ups. The costs of delivering this, providing demand remained the same, are estimated to be £25.1 million and to relieve over 60s of all dental charges would cost £329.2 million.44 Further age related exemptions could also be applied to young adults, it is estimated that the cost of removing 18-21 year olds from all NHS dental charges would be £15.7 million45.

*‘Amnesty periods’* - In light of the particular impact charges have on those whose attendance for dental treatment has lapsed, an ‘amnesty period’ could be introduced so that lapsed patients can receive an initial course of treatment without charges. Whilst this may decrease the extent to which charges prevent lapsed patients from attending, it would not necessarily lead to these patients becoming regular attenders and maintaining good oral health long-term. It may also be perceived as unfair by those who attend regularly and must pay for their treatment and the administrative costs would likely prove prohibitive.

*Missed appointment fines* - From 2006, dentists have been prevented from imposing fines for non-attendance at NHS scheduled appointments. Such fines can help to stress to patients the value of dental services and discourage a wasteful approach to the resources available through the NHS. Dental professionals have raised concerns that, by being unable to fine patients that miss appointments, these patients soon find themselves excluded from service at that practice and therefore encounter difficulties in accessing dental services46.

*Reforming the banded charges* - There is clearly a case to be made that the banding of treatments creates unfairness and inconsistency, and this is as much the case for patients as it is for dentists. There is an obvious need to reform the UDA-based dental contract, however, a return to a more complicated fee per item charge system may not be desirable given that one of the benefits of the banded system was to simplify the charges for patients and to make them easier and cheaper to administer.

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44 Dental Services: Older People: Written question – 49437, 2016
45 Ibid.
Means-testing - Contrary to other proposals to expand free treatment to the over 60s, there is also a case that exemptions unrelated to patients’ ability to pay should be removed. Instead, a sliding scale of charges related to income could be introduced, with free treatment available to those on the lowest incomes. This would fulfil the oft-stated aspiration to ensure that those who have the ability to pay contribute towards the costs of care, whilst reducing the impact of charges on those on lower incomes. However, as can be seen with the current means assessment of the Low Income Scheme, this can introduce a degree of complexity that is undesirable, off-putting and expensive to administer. Moreover, as costs would relate to an individual’s income, it would be difficult for dentists to publicise the costs of particular treatments or to ensure patients were fully informed of them before commencing treatment. There is also no guarantee that a means-tested charge scale would not create inequities for those whose incomes are just above certain thresholds, but nonetheless would struggle with the costs to a similar extent as those with slightly lower earnings who find themselves in a lower charge band.

Reducing charges - There are various proposals on the method and degree to which charges should be reduced. Based on the pre-2006 charging system, Citizens Advice proposed a reduction in the patient co-payment from 80 per cent to 50 per cent and a lower maximum charge of £100. At the time, these reforms were estimated to cost a total of £170 million (provided demand remained the same)\(^\text{47}\). However, there has been little assessment on the relative costs and benefits of reducing NHS dental charges and if there is any level at which they could be used to generate sufficient income without acting as a barrier.

Reforming NHS patient charges

In light of the general problems with charging for dental services – rather than those related to a particular structure of charges and exemptions – some have called for abolishing charges altogether. However, given the current pressures on NHS funding, it is not realistic to expect at least £685 million a year to be spent from limited funds on abolishing NHS dental charges.

In this context, reforms must:

- achieve a charging system which is sensibly linked to the overall objectives of promoting oral health and minimising barriers to care
- reduce the complexity of the NHS dental charging system for patients, practices and the NHS, and improve signposting particularly among parents and vulnerable patients.
- ensure patients and their carers can easily check and prove whether they are exempt from charges
- end year-on-year inflation busting charge increases to subsidise declining public investment in NHS dentistry.

These changes would make NHS dental charges fairer for patients, simpler for dentists and would help reduce pressure on other parts of the NHS.

\(^{47}\) Hansard, 20.3.2001, col. 137