EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (DENTAL CHARGES) REGULATIONS 2005

2005 No. 3477

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

This memorandum contains information for the Joint Committee on Statutory Instruments.

2. Description

2.1 These Regulations replace the NHS (Dental Charges) Regulations 1989 which provide for the charge for dental treatment to be paid by a patient under general dental services to be based on the remuneration paid to the dentist. In particular, the existing regulations provide for the charge to be calculated on an item of service basis .

2.2 From 1 April 2006 it is intended to establish new contractual arrangements for high street dentists which move away from the item of service remuneration to an annual payment no longer directly related to the dentists activity. This will enable dentists to spend more time with their patients and adopt a more preventive approach to oral health care.

2.3 Breaking the link between remuneration and items of treatment provided requires a new system of dental charging no longer based on the dentists' remuneration. These Regulations, therefore, introduce a new system of charging for dental services based on a 3 banded system, where treatment provided or appliances supplied will attract one of the 3 set charges depending on the complexity of the treatment provided.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 Commitments were given to the Domestic Affairs Committee and to the House during the passage of the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act") that the new dental charging system which this legislation provided for would raise the same proportion of patient charges as the old system. After due allowance for the new working patterns of dentists encouraged by the new contracting arrangements, the charges set out in regulation 4 are at 2006-07 levels and will not therefore be subject to any further uplift in line with inflation until April 2007.

3.2 The Regulations are being presented to the House now to enable the remaining regulations concerning the new contracting arrangements, which rely heavily

on the banded courses of treatment to come into force in January 2006 to allow a three month preparatory period for contractors and primary care trusts to agree contracts for April 2006.

4. Legislative Background

4.1 Consumer groups have reported that dental charges, both for NHS and private treatment, are unclear, difficult to understand and raise concerns about the potential cost of treatment.

4.2 A review group was set up to review patient charges and make recommendations. The review group recommended that in future there should be a series of banded charges per course of treatment related to the level of service provided.

4.3 The National Health Service (Dental Charges) Regulations 2005 bring the recommendations of that report for a banded system of patient charges into effect. The new arrangements for dental charges are not intended to increase the proportion of revenue raised from patients' charges but to create greater clarity about the cost of NHS treatment for both dentists and the public.

4.4 The system is consistent with the new contracting arrangements for dentists to be introduced in April 2006. These arrangements will move away from the current item of service remuneration treadmill to one significantly less dependent on dentists' activity.

4.1 This is the first instrument made under section 79 of the NHS Act 1977 inserted by section 183 of the 2003 Act. By virtue of section 126(1A) of the NHS Act 1977 (also inserted by section 183 of the 2003 Act), the first regulations made under section 79 are to be subject to the affirmative resolution procedure.

5. Extent

5.1 This instrument applies to England only.

6. European Convention on Human Rights

The Minister of State, Rosie Winterton, has made the following statement regarding Human Rights:

In my view the provisions of the National Health Service (Dental Charges) Regulations 2005 are compatible with the Convention rights.

7. Policy background

7.1 From 1 April 2006, there will be two types of contract for the provision of dental services: general dental services (GDS) contracts and personal dental services (PDS) agreements. GDS contracts will be between a PCT and a dental practitioner, a partnership which includes a dentist, or a dental corporation. Under a GDS contract, the contractor will be required to provide a range of dental services set out in the draft National Health Service (General Dental Services Contracts) Regulations 2005 ("the GDS Regulations").

7.2 New PDS agreements, under the draft National Health Service (Personal Dental Agreements) Regulations 2005 ("the PDS Regulations"), will be the 'permanent' version of PDS piloting under the NHS (Primary Care) Act 1997 and provide for greater flexibility in the services to be provided. Under PDS Agreements a wider range of potential providers are permitted to hold contracts to provide dental services including NHS trusts, foundation trusts and healthcare professionals other than dentists. PDS agreements will, for example, be used for commissioning specialised services such as orthodontics.

7.3 In other material respects the mandatory terms of contracts are similar under both the GDS Regulations and the PDS Regulations.

7.4 Alongside these practice based contracts, there will be a move to a more preventive approach to the provision of dental services. Reliance on 'fee per item of service' as a method of paying dentists in place since the foundation of the NHS also ends. This requires a new system of dental charging which is no longer related to item of service payments.

7.5 A review group led by Harry Cayton, the Department of Health's National Director for Patients and the Public, with considerable input from representatives of consumer interests and dentists, was set up to review patient charges and make recommendations. The review group considered options including a flat rate per course of treatment and charging per visit but finally proposed that there should be a series of banded charges per course of treatment related to the level of service provided.

7.6 The draft National Health Service (Dental Charges) Regulations 2005, based on that report have been the subject of a twelve week public consultation which ended on 30 September. The consultation provided for responses by questionnaire as well as written responses to the consultation questions.

7.7 The were 238 completed questionnaires as well as nearly 200 written responses. Consumers' representatives commented that a reform of the current system of patient charges for NHS dental care was long overdue. Whilst supportive of the proposed system, they had some concerns about the charge levels, particularly band 3. They also acknowledged widespread misconceptions about the new system of patients charges among the media, the public and the profession. Given that the new system is such a radical

departure from the previous system they had known for most of their working lives, the profession clearly had difficulty grasping the notion that the new charges are no longer directly related to the actual cost of providing the treatment.

7.8 The responses to the consultation, both written and from analysis of the responses to the multiple choice questionnaire, were inconclusive and inconsistent. In general, however, it can be concluded that patients and consumer groups were in favour of many aspects of the proposals, while dentists generally were against the proposals.

7.9 It is worth commenting that many of the responses to the dental charges consultation were in fact dentists commenting on the draft NHS (General Dental Services Contracts) Regulations 2005 and the draft NHS (Personal Dental Services Agreements) Regulations 2005, published for information on 1st August 2005. Under both contracting arrangements, monitoring of the services provided is in terms of courses of treatment weighted by complexity. The proposed weightings for these courses of treatment are derived from the weightings inherent in the banded charging system. Again, this is not well understood by dentists.

7.10 The profession have, for most of their working lives, been familiar with a remuneration system based on payments for items of service provided and under which any change in prescribing profiles has a profound affect on their personal remuneration. Because hitherto their patients paid 80% of the item of service remuneration, the dental charge system has been inexorably linked to their actual remuneration. Dentists naturally continue to assume any change in the dental charging regime will have a significant knock-on affect on their earnings.

7.11 Under the proposed banded charging system this direct link between treatments provided and the individual dentist's remuneration is severed. This means that the contractor dentist will receive the same agreed annual remuneration whatever the split between PCT payment and patient contribution. This proportion however remains crucial to the Department of Health in relation to the forecasting of future levels of patient charge revenue.

7.12 It is also worth adding that no dentists professional representative organisations or patients who responded to the consultation proposed an alternative system of patient charges.

7.13 In summary, the review group considered all the options in detail and with considerable care and came to the unanimous conclusion that a three banded system best met their aims of fairness and clarity. These regulations are based on the unanimous report, endorsed by its two BDA representatives, and the consultation undertaken by the Department on the draft Regulations.. The Department accepts that more needs to be done to explain the new system of patient charging to the public. More is already being done to explain to dentists the weighted activity monitoring derived from the proposed banded charging regime.

8. Impact

8.1 A Regulatory Impact Assessment is attached to this memorandum.

8.2 The Dental Practice Board (DPB) is currently responsible for all payments to, and monitoring of, dentists providing services under the current general dental services. The DPB is to be replaced by the NHS Business Services Authority (BSA) in 2006. The intention is that the DPB (and thereafter the BSA) will be used in the same way in the new regime as in the old i.e. to pay and monitor providers of dental services. This will significantly reduce the impact on the public sector.

8.3 It is planned to delegate PCTs' administrative functions in relation to GDS Contracts and PDS Agreements to the DPB/BSA . The DPB/BSA will verify patient charges in relation to the appropriate treatment band and provide the PCT with regular monitoring information. PCTs' administrative costs should not increase. As it will be easier to track patient charge levels, the DPB/BSA will also gain from the reduced bureaucracy of the new contracting arrangements and patient charging regime.

8.4 For patient charge verification under the current system, it is necessary for dentists to record and transmit to the DPB information on each of the items of service provided. The move to a banded charging system will significantly reduce the information burden on dental practices and their staff. The Department is preparing training material to familiarise dentists and their staff with new forms and reporting requirements.

8.5 The dental practice software systems suppliers are working with the DPB to ensure the electronic submission of data will be effective from the start of the new arrangements. The Department has been in discussion with the major IT suppliers and it is believed major suppliers will be upgrading most modern systems free of charge.

9. Contact

Chris Audrey
Department of Health
New King's Beam House
20 Upper Ground
London SE1 9BW
Tel 020 7633 4149
GTN 396 34149
Chris.Audrey@dh.gsi.gov.uk

can answer any queries regarding the instrument.

FULL REGULATORY IMPACT ASSESSMENT

1. Title of Proposal

The National Health Service (Dental Charges) Regulations 2005.

2. Purpose and intended effect of measure

(i) The objective

To devise an improved system of charging patients for NHS dental services in England which raises the same proportion of patient charge revenue as is raised under the current system. The new system is to be in place by April 2006.

The Government also wants the new system of patient charges to:

- improve clarity for both the public and dentists about the costs of NHS dental care; and

- reduce complexity and bureaucracy for dentists and the public by moving from over 400 different payments for each item of treatment to a less complex system of patient charges.

(ii) Background

In the main, NHS dental care and treatment is currently provided by "high street" dentists under general dental services arrangements under section 35 of the National Health Service Act 1977 ("the 1977 Act"). About 70% of these dentists' earnings are derived from fees for the individual items of service they provide. The remaining 30% is derived from other monthly NHS payments which are not directly related to treatment provision but are intended to reimburse the dentists for the provision of facilities in relation to the NHS. These payments to dentists are set out in the Statement of Dental Remuneration (SDR). Patient charges under general dental services are regulated by the National Health Service (Dental Charges) Regulations 1989 ("the 1989 Regulations") and are set at 80% of the treatment fees paid to the dentist, subject to a maximum charge per course of treatment of £384. The NHS pays the remaining 20%.

Since 1998 an alternative system of dental service provision has been piloted under the National Health Service (Primary Care) Act 1997 ("the Primary Care Act"). Under these Personal Dental Services (PDS) pilots an annual contract sum is agreed between the provider of the service and the Primary Care Trust (PCT) commissioning the service for an agreed level of NHS commitment. Payments under the PDS agreement are made in twelve instalments. The Primary Care Act requires dental charges paid by the patient under a PDS pilot scheme to be the same as if the treatment had been provided under the general dental services. The patient charges are deducted from each monthly instalment of the contract sum paid to the provider.

Remuneration payments to dentists both under general dental services and PDS pilots are undertaken by the Dental Practice Board for England and Wales ("the DPB") established under section 37 of the 1977 Act. The DPB is also responsible for

establishing the probity of NHS payment claims and the verification of dental charges in relation to each course of treatment. A Special Health Authority, the NHS Business Services Authority ("BSA") is to be established in 2006 and will take over the functions of the DPB. Payments to dentists under both systems are made net of the dental charges due under the 1989 Regulations.

PDS piloting has proved popular with dentists and their patients. Under these pilot arrangements, dentist are better able to use their professional skills to relate dental services more closely to patients' oral health needs. Patients with lower treatment needs are seen less frequently and courses of treatment become simpler. Evidence from over 5 years of piloting PDS shows at least a 10% reduction in dentists' overall activity (courses of treatment and individual items of treatment) can be expected with an improvement in clinical effectiveness, cost effectiveness and appropriateness of treatment provided.

In general dental services, 53% of courses of treatment involve examination, scale and polish and no other dental intervention. At least some of these courses of treatment are of questionable health gain. By adopting the new ways of working demonstrated in the PDS pilots, dentists are able to undertake fewer courses of treatment and yet see greater numbers of patients. This has the potential to improve the working lives of dentists and their teams and also improve access to NHS dental services.

Building on the experience of PDS piloting, provisions in the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act") will underpin modernised, locally sensitive primary dental services properly integrated with the rest of the NHS. Under the new arrangements PCTs will be able to enter into contracts for the provision of primary dental services to meet all reasonable requirements or provide the services themselves. Remuneration of providers under the contract will be by annual contract value as under the PDS piloting arrangements.

Following implementation of the 2003 Act, the 1977 Act will provide for two types of contract: general dental services (GDS) contracts and personal dental services (PDS) agreements. Under a GDS Contract, the contractor will be required to provide a range of dental services set out in the draft NHS (General Dental Services Contracts) Regulations 2005. New PDS agreements will be the 'permanent' version of PDS piloting and provide for greater flexibility in the services to be provided. Additionally, a wider range of potential providers are permitted to hold contracts including healthcare professionals other than dentists. PDS agreements will, for example, be used for commissioning specialised services such as orthodontics.

The current general dental services system of item of service fees will cease on implementation of these local contracts on 1 April 2006. A new system of patient charges, not related to the fees for the provision of items of treatment, is therefore needed. The change in charging structure is also provided for in the 2003 Act which implements all these changes by amending the provisions 1977 Act.

When the National Health Service (Dental Charges) Regulations 2005 ("the 2005 Regulations") come into effect on 1 April 2006, the 1989 Regulations will be revoked.

(iii) Rationale for Government intervention

There is a high level of discontent with the current arrangements for the provision of general dental services. Dentists tell us the remuneration system, based on payment for individual items of service, feels like a treadmill and is the main cause of

dissatisfaction amongst dentists. It is thought to act as a barrier to dentists agreeing to undertake NHS dental work.
Patients, their representatives and others tell us that dental charges, both for NHS and private treatment, are unclear, difficult to understand and raise concerns about the potential cost of treatment. In future, dental charges will continue to bear relation to the level of service provided but will no longer be directly related to the dentists' remuneration.

As dentists working in PDS pilots are spending more time with each patient and doing less of the work for which patient charges currently apply the revenue raised by patient charges has fallen in pilot areas without a corresponding fall in the cost of the service. These desirable improvements in clinical effectiveness and cost effectiveness would potentially reduce the overall revenue raised from dental charges once the new contractual arrangements are in place if the 1989 Regulations remained in force. The full 10% reduction in activity experienced in most PDS pilots could lead to a reduction of around £50 million in overall dental charge revenue in a full year with a corresponding reduction in NHS dental services.

To tackle the twin objectives of making the NHS a more attractive working environment for dentists and to improve the clarity of patients charges, the 2003 Act provides for new contracting and charging arrangements, which build on PDS piloting of local contracting. The 2003 Act inserts a new section 79 (dental charging) and Schedule 12 ZA (dental charging: exemptions) into the 1977 Act.

The *NHS Dentistry: Patient Charges Working Group* led by Harry Cayton, the Department of Health's National Director for Patients and the Public, with considerable input from representatives of consumer interests and dental interests, was set up to review patient charges and make recommendations for a replacement system.

The Working Group considered a number of charging options alongside the current system including standard payments per visit, a fixed annual charge and a closely banded system. Within all of these options laboratory fees were considered and what if any of these costs should be passed on to the patient.

Priorities for the Group were:

- to meet the Terms of Reference by recommending a patient charging system which was easy to understand, practicable to deliver, and cost neutral;
- to promote good oral health and clinical practice;
- to improve the overall affordability of NHS Dentistry; and
- to reduce health inequalities which could arise from a patient payment system.

The *NHS Dentistry: Patient Charges Working Group* reported its deliberations to Ministers and advised that in future there should be a series of banded charges per course of treatment related to the level of service provided. The draft 2005 Regulations are intended to bring the review group's main recommendations into effect.

Charges for each band forecast to raise the same proportion of charges as the current system across both GDS and PDS (including 2.5% inflation) at 2006-07 prices are:

Band 1 – Diagnosis, treatment planning and maintenance	£15.50
Band 2 – Treatment	£42.40
Band 3 – Provision of appliances	£189.00
Urgent treatment	£15.50

3. Consultation

i) Within government

The Secretary of State has new powers pursuant to the amendments made to the 1977 Act by the 2003 Act to make regulations providing for the making and recovery of dental charges for primary dental services. By virtue of section 126(1A) of the 1977 Act, the first set of regulations made under section 79 of the 1977 Act will be subject to the affirmative resolution procedure and therefore to a debate in both Houses.

ii) Public Consultation

A twelve week public consultation began on 7 July 2005 and closed on 30 September 2005. The consultation document included a Partial Regulatory Impact Assessment.

The consultation provided for responses by questionnaire as well as written responses to the consultation questions. There were 238 completed questionnaires as well as nearly 200 written responses. Consumers' representatives commented that a reform of the current system of patient charges for NHS dental care was long overdue. Whilst supportive of the proposed system, they had some concerns about the charge levels, particularly band 3. They also acknowledged widespread misconceptions about the new system of patients charges among the media, the public and the profession. Because the new system is such a radical departure from the previous system they had known for most of their working lives, the profession clearly had difficulty grasping the notion that the new charges are no longer directly related to the actual cost of providing the treatment. .

Responses to the questionnaire showed similar widespread misconceptions about the new system of patients charges among the public and the profession as mentioned by the consumer groups. The Department accepts that further information needs to be given to the public to explain the way the new system will work and to explain its benefits given that most people agreed that dental charging needed an overhaul but a large number of people didn't agree that a banded system would be fair. Many did however acknowledge the approach would help those with high treatment needs.

The inconsistency in the responses and the lack of suggestion of an alternative model indicates that further information for the public about the proposal is needed.

The BDA commented that with only three charging levels, the price differential between private and NHS treatment for selected procedures will narrow significantly, for example in relation to the provision of partial dentures.

The BDA was alarmed that the new system had not been piloted. However, there is no power under the 2003 Act to pilot the new GDS or PDS arrangements or regulations for the new charging regime. This has meant that although much

modelling and forecasting work has been done in relation to dental charging no piloting has been possible.

The BDA also commented that whilst under the new system the dentist's incentive would be to provide only that treatment necessary to secure oral health, the dentist may be pressurised by the patient to provide excessive care. The Department considers this unlikely and the dentist's relationship with the patient should ensure dentists can meet their contractual requirements to provide the proper and necessary dental care and treatment which the patient is willing to undergo.

The BDA agreed that the inclusion of two extractions and one filling is more than sufficient to deal with urgent dental problems. Nevertheless, the BDA considered that having these treatments available under the urgent treatment band did nothing to promote preventive dentistry and could lead to undesirable incentives where patients wait until they can be seen in the lower cost band.

In response to consultation question 3 "Do you agree that the advantages of the three-banded charging system outweigh any disadvantages", the BDA said they were aware this was a new system for charging but were not convinced either way that three bands was an appropriate number of bands, however they did feel there were too many treatments in each band and that certain treatments should be compensated with higher Units of Dental Activity to reflect their complexity.

The Dental Practitioners Association ("DPA") said that moving to a three banded system would lead to higher charges for patients overall, with rises of up to two hundred percent for some treatments and would encourage private treatment. The DPA also thought the proposed system would be less easy to explain or to understand, would lead to a reduction in the amount of NHS dentistry provided and would create perverse incentives and distort treatment patterns and demand.

The Office of Fair Trading welcomed the measures to make charges clearer and were encouraged that the proposals were designed to tackle their earlier observation that consumers currently find dental charges confusing. The OfT agreed that, for the reasons set out in the consultation document it would appear that the three band system holds the greatest advantage over the other options considered.

Citizens Advice were in broad agreement with the specific questions set out in the consultation, on which they were in a position to respond (questions 1 to 5). However Citizens Advice expressed concerns about the illustrative figures for the band charges, particularly bands 2 and 3, which were higher than those quoted in the review group report. Nevertheless, they understood the Government's commitment to raise the same proportion, rather than amount, of the significantly increased funding for NHS dentistry. Which? made a similar point in their response.

Citizens Advice also pointed out, as did the British Orthodontic Society, and Which? that under the consultation draft of the Regulations, the replacement of a dental or orthodontic appliance which had been damaged or lost by the act or omission of the patient (or where the patient was under 16, the act or omission of the patient or the person having charge of him) could be charged for at the full Band 3 rate. At the illustrative Band 3 charge, this could be punitive. In response this charge has been reduced to 30% of the Band 3 charge.

Which? welcomed the Government's package of reforms intended to modernise dental provision, including the new dental contract, system of patient charges and PCT commissioning of services. They also commented that sustained reform and

investment would hopefully re-establish dentistry as an integral part of the NHS and significantly improve access to NHS dentistry in those communities that are currently hardest hit.

Which? also commented that a reform of the current system of patient charges for NHS dental care was long overdue. Whilst extremely supportive of the proposed system, they too had some concerns about the charge levels, particularly band 2. They also acknowledged widespread misconceptions about the new system of patient charges among the media, the public and the profession. Because the new system is such a radical departure from the previous system, it appeared that people have considerable difficulty grasping the notion that the new charges are unrelated to the actual cost of providing the treatment. They considered there was an urgent need for an effective information campaign to convey this message clearly to the public, profession and media.

Which?, originally made the "Super-complaint" on the private dentistry market to the Office of Fair Trading in October 2001, and highlighted the way the complexity of the NHS charges contributed to patients' confusion about whether treatment was NHS or private. Which? therefore wholeheartedly agreed that reform of the system of patient charges for NHS dental care was long overdue.

Which? also considered the treatment categories set out in schedules 1 to 3 provided a very clear system of grouping treatments that can be easily understood by patients and dentists. They also expressed some concern about the potential cost of the replacement of appliances lost or damaged beyond repair by an act or omission of the patient.

Several dental representative bodies, including dental academics, commented on the inclusion of non-surgical periodontal treatment (gum treatment) in band 1, and endodontic treatment (root canal treatment) in band 2 and suggested these treatments were more appropriate to band 2 and band 3 respectively. The more convincing argument was that, unlike other treatments included in band 1, non-surgical periodontal treatment was not a reversible procedure and therefore more properly belonged in the treatment band. The additional time which be required for some more complex endodontic treatment is an argument more for contractual arrangement than dental charges for patients.

As a result of consultation, non-surgical periodontal treatment has been moved to band 2.

Many of the responses to the dental charges consultation were in fact dentists commenting on the draft NHS (General Dental Services Contracts) Regulations 2005 and the draft NHS (Personal Dental Services Agreements) Regulations 2005, published for information on the 1st of August 2005. Under both contracting arrangements, monitoring of the services provided is in terms of courses of treatment weighted by complexity. The proposed weightings for these courses of treatment are derived from the weightings inherent in the banded charging system. Again this is not well understood by dentists.

4. Options

The following options were considered before the powers were taken in the 2003 Act:

Option 1	Leave things unchanged
Option 2	Introduce legislation to remove the requirement that dental charges are calculated in relation to dentists remuneration and replace the system with a new one where charges are made in relation to clinical complexity.
Non-regulatory option	The charge per course of treatment, exemption arrangements and charge free treatment qualifications must be the same for all patients throughout England. Dental charges contributed about £425 million in the general dental services in 2004-05. This significant contribution to NHS funding needs to be maintained. For these reasons a non-regulatory option was not considered.

5. Costs and Benefits

(i) Sectors and groups affected

The 1989 Regulations already affect:

- patients who need dental services and either pay NHS charges under 1989 Regulations, are exempt (and patients who use private dental services, as although they are not covered by the 1989 Regulations, changes to the dental charging system may attract them back to NHS dental services) treatment
- dental practices providing dental services under the NHS;
- dental practice management software systems suppliers, in relation to the administration of the charging system, and
- to a limited extent the dental laboratory industry which supplies dental appliances such as crowns and dentures

The 2005 Regulations will have a similar effect, when in force.

Those under 18 years, pregnant women and nursing mothers and those under 19 years and in full-time education are currently exempt from paying charges, those on income support are entitled to full remission of charges and help is available to others on low income. In all, about a quarter of all patients are exempt from dental charges or entitled to full remission of charges. The amendments to the 1977 Act by the 2003 Act and the 2005 Regulations provide for the same exemptions and remissions as the current provisions of the 1977 Act and the 1989 Regulations.

Patient charges for NHS dental treatment do not affect voluntary organisations or charities.

The policy for a new dental charging regime will not have any race equality impact.

The new arrangements will apply throughout England and are not intended to increase the proportion of total revenue costs raised from patients' charges (around 26%, representing about £425 million, in general dental services in 2004-05) but to ensure there is greater clarity about the cost of NHS treatment for both dentists and the public. Charges for NHS dental treatment will continue to be collected at the

dental practice, although the simplified system proposed should reduce bureaucracy for dental practice owners and their staff.

Administration of the new contracting arrangements and associated patient charging will be the responsibility of PCTs. The BSA will undertake activity monitoring and patient charge verification on behalf of all PCTs. Both option 1 and option 2 have a similar effect on administration by these public bodies.

Option 1 and option 2 would have a differential effect on patients using NHS dental services. The main beneficiaries of option 1 would be those with simple treatment needs who fall into lower end of new band 1.

The main beneficiaries under option 2 would be patients whose treatment falls at the high end of band 1 and the majority of patients in bands 2 and 3. Those patients who lose out under option 2 will be those patients at lower ends of bands 2 and 3 – those with lower treatment needs.

(ii) Analysis of costs and benefits

Costs and Benefits

Option 1

Economic impacts

The new dental charging regime is a consequence of changing the contracting and associated remuneration arrangements for dentists. If the reforms did not go ahead PCTs would not have to implement the new regime which would save administrative work. Dental practices would leave practice management systems as they are at present, subject to the annual dentists' fees uplift.

Evidence from over 5 years of PDS piloting, most recently in the 'field sites' managed by the Modernisation Agency as part of the *Options for Change* learning programme, show that dentists change their working patterns once freed from an item of service remuneration system without any adverse effect on the oral health of their patients.

These desirable improvements in clinical effectiveness and cost effectiveness would potentially reduce the overall revenue raised from dental charges if the 1989 Regulations remained in place. A permanent 10% reduction in activity across the current volume of general dental services could lead to a reduction of around £50 million a year in overall dental charge revenue, and consequent reduction in funding for NHS dentistry, compared with present general dental services arrangements.

Social impacts
The current system with its very wide range of charges may deter people from seeking NHS treatment because of uncertainty about what they may have to pay. The system also undermines efforts to tackle health inequalities since people with poorest oral health, who are also more likely to be on low incomes, often pay the highest charges and because higher levels of bad debt may discourage dentists from providing services in deprived areas.

The current charging related to items of treatment provided is proportional to the level of service provided under the current remuneration system. A benefit of leaving

charges as they are is that those with minimal treatment needs will only pay for what they receive and so pay a lower charge. However, a recurrent theme of recent reports on dentistry is that the current system lacks clarity for patients and the public about which charges apply to NHS treatment and which to private treatment.

Environmental impacts

There are no environmental impacts from continuing with current charging arrangements.

Option 2

Economic impacts

There are currently 8,963 dental practice addresses in England, some providing general dental services and others services under PDS pilot agreements. The 2005 regulations will apply to all dental practices holding GDS Contracts and PDS Agreements from 1 April 2006. Both paper and electronic changes to the practices' administrative systems will be required for the new charging regime. Currently, as dentists' NHS fees and the related charges change each year requiring amendments to practice administrative systems, upgrades to adjust the systems to the new regime for April 2006 should not incur significant additional costs.

Dentists and practice staff will benefit from reduced bureaucracy and detailed form filling as a result of the move from over 400 different charges related to individual items of treatment to 3 band charges.

About 30 million items of service claims are submitted to the DPB each year, 70% of which are electronic (21 million). If the simpler data to be submitted saves 1 minute per electronic claim and 1.5 minutes per paper claim then the saving at the dental practice is the equivalent of around 300 full time posts per year (assuming 40 hours a week, 45 weeks a year).

It is planned to delegate the PCT administrative functions in relation to GDS Contracts and PDS Agreements to the BSA. The BSA will verify patient charges in relation to the appropriate treatment band and provide the PCT with regular monitoring information. PCTs' administrative costs should not increase. Given that it will be easier to track patient charge levels, the BSA will also gain from the reduced bureaucracy of the new contracting arrangements and patient charging regime.

As a result of introducing three bands the cost of the basic check-up would increase. However, for this cost most patients will also benefit from an oral health screening, x-rays, simple gum treatments and preventative advice. The NICE guidance on dental recalls (*Dental recall: recall interval between routine dental examination*) advising a recall interval related to the patient's oral health risk factors means patients will typically only need to visit the dentist every 18 months as opposed to the current 6 monthly norm.

The main beneficiaries under option 2 would be patients whose treatment falls at the high end of band 1 and the majority of patients in bands 2 and 3. For example, a patient who has an examination, x-rays, a scale and polish and an adjustment to dentures would currently pay £27.44, but as this would still be in band 1 would pay only £15.50 under the new regime. In band 2, we estimate that 75% of patients will

pay less (but 25% more) and in band 3, 80% will pay less (but 20% more). Similarly, the maximum charge for a course of treatment will drop under the three band option from £384 to £189.

The 2005 Regulations also provide for free repair or replacement of certain restorations for 12 months from the date they are provided and for some additional treatments to be provided without further charge, should that become necessary, within a specified period.

The 2005 Regulations provide protection for those patients whose course of treatment straddles the transition from the old charging system to the new. Regulation 13 of the 2005 Regulations makes transitional provision for GDS and PDS patients to ensure that they only have to pay whichever is the lower of the charge calculated in accordance with the old system and the charge calculated in accordance with the new system.

Under the new contracting arrangements, dentists will agree an annual contract value to be paid to the contractor in monthly instalments. As now the patients' charges due will be collected by the contract holder and the monthly contract payment will be reduced by the amount of the patient charges due. Data submitted by the contractor to the BSA will provide the information to verify that the correct charge has been levied.

Given that the total annual contract value is agreed in advance with the PCT, in future, there will be no financial incentive for dentists to complicate unnecessarily a course of treatment to maximise earnings.

Social impacts

Following an oral examination under the new charging system, a dentist would set out for the patient the type and extent of dental work required and which band that falls into. The patient could then make the payment for that banded course of treatment and be entitled to, within that course of treatment, all the necessary treatment agreed to or the patient could make the payment for that banded course of treatment when the course of treatment has been completed . Since the payment is set in advance the patient knows exactly what the course of treatment will cost and what treatment he will receive and can plan accordingly.

Having a relatively small number of bands carrying a different charge provides a balance between reducing the charge to high need patients and the problems with having a high charge for low need patients. This balance is achieved because the band charges need not directly correspond to the costs of treatment covered in the band. This feature of banding helps encourage those with significant dental health needs, particularly older people on low incomes to seek the treatment they need. Also, within any one band those with least need will pay the same as those with most.

As was pointed out in the consultation responses, there is potential to deter those who just want a basic exam from seeking treatment because the cost of a basic exam will rise. However with less frequent recalls as the NICE guidelines are followed and a more preventive approach to dental care the basic exam should be replaced by a preventive package for a band 1 charge.

The new charging regime is not intended to increase the overall proportion of revenue raised from dental charges. Those with higher treatment needs will pay less and the maximum charge per course of treatment will reduce significantly.

The new charging system may help encourage dentists to do more NHS dental work because it is simpler to calculate charges and for patients to understand.

Environmental impacts

There are no environmental impacts from this measure.

Summary of Costs and Benefits

Option	**Total benefit : economic, environmental, social and administrative**	**Total cost per annum: economic environmental social and administrative**
Option 1 Do nothing	Some saving of any additional costs to practice administrative systems, including possible costs upgrading DOS based software, would be avoided Possible savings upgrading DPB/BSA payment and monitoring systems Cost of dental check-up remains low Patients with low treatment needs continue to have treatment at minimum cost	Dentists would continue to levy patients charges under the 1989 Regulations based on a "shadow" dental fees scale. Changes in working patterns under the new contracting arrangements would reduce patient charge revenue in England, across both GDS contracts and PDS agreements, in the order of £200 million, which would impact on NHS dental services Patients with high treatment needs continue to pay higher dental charges up to the maximum of £384
Option 2 Implement new patient charging regime	Patient charge revenue maintained under the new contracting arrangements for dentists Charges clearer for patients and practice staff Clearer distinction between private fees and NHS charges Patients with high treatment needs pay lower charges Reduced administrative burden on businesses	Additional costs for the DPB/BSA setting up new payment and monitoring systems to monitor activity and verify dental charges collected Possible costs for dental practices upgrading older software systems and practice administration Patients with low treatment needs and exam only pay higher charges.
Option 3 Non-regulatory option	No statutory requirement for patients otherwise liable to pay charges to make a contribution to the cost of dental treatment	Unpredictable dental charge revenue. Inequitable financial burden on users of the service

6. The Small Firms' Impact Test

The British Dental Association and Dental Laboratories Association contributed to the work of the *NHS Dentistry: Patient Charges Working Group* that was set up to review patient charges and make recommendations. From this, limited initial soundings did not identify any significant impact on small businesses.

One of the consultation questions asked "Do dental practice owners and managers think the banded charging system proposed will reduce the administrative burden on small businesses? Almost half of respondents expressing an opinion thought the proposed banding system will reduce the amount of administration for small dental practices. About one-third disagree (two-thirds of whom strongly disagree).
.
Small practices and businesses were particularly encouraged to participate in the consultation and to contribute their views.

Almost half of the 238 respondents to the consultation questionnaire expressing an opinion think that the proposed banding system will reduce the amount of administration for small dental practices. About one-third disagree, two-thirds of whom strongly disagree.

7. Competition Assessment

The current dental charging system involves some 400+ charges, which are generally thought to be unclear and not understood by patients. The 2003 Office of Fair Trading report *The private dentistry market in the UK* concluded that better information was needed on prices and treatments (both NHS and private) to promote competition and increase consumer choice. The new regime with fixed band charges will make an important contribution towards clarity about the NHS side of mixed dental practice.

Because of the nature of the NHS dentistry market, the new dental charging regime is likely to have little or no impact on competition. The new regulations will impose no additional burden on small businesses providing NHS dentistry and will have no adverse effect on competition. Publication of the simplified banded charges at dental practices may make the NHS dental care option more attractive to charge payers than the private one.

There are currently 8,963 dental practice addresses in England, some providing general dental services and others PDS. The 205 regulations will apply to all dental practices from 1 April 2006, in relation to dental services they provide under the NHS.

Some of these practices may be owned by dental corporations. A dental corporation means a body corporate which, in accordance with the provisions of the Dentists Act 1984, is entitled to carry on the business of dentistry. It is not thought that any dental corporation has more than a 10% market share in England.

It is therefore unlikely that any costs involved in calculating and collecting dental charges under the 2005 Regulations will have a substantially different effect on dental businesses than under the 1989 Regulations, nor are they likely to change market structure. New dental practices entering the market would incur no extra penalty in operating under the 2005 Regulations.

There are a limited number of relatively small companies providing and maintaining dental practice software management systems although some of these are subsidiaries of much larger companies. The new dataset necessary for the administration and verification of the new charging regime is a subset of the item of service codes currently submitted to the DPB for payment purposes. The Department has been working closely with all IT suppliers and it is believed major suppliers will be upgrading most modern systems free of charge.

8. Enforcement, Sanctions and Monitoring

There are measures requiring those holding contracts for the provision of primary dental services and dentists employed directly by a PCT, NHS trust or NHS foundation trust to collect NHS dental charges only in accordance with the new regulations. Failure to comply with the regulations may amount to a breach of contract or the employee's terms and conditions of service. PCTs have sanctions, under the terms of the contract, including the issue of remedial notices and breach notices, to contractors who breach the requirements in relation to charges. A breach of contract could mean the contractor can no longer provide primary dental services because his contract is terminated.

Contract holders will be required to submit to the BSA data for activity monitoring and patient charge verification. Data from this process will be provided regularly to both PCT and the provider of the service. The efficiency of the new regime will be reviewed regularly by the Department of Health and annual adjustments made to the level of charge in relation to the amount raised and to inflation.

The Department of Health is planning a public communications campaign in the run-up to April 2006. This will explain to patients what the changes will mean for them, how their future care will be provided and how the new charges system will work. This is likely to include an information leaflet for practices to give to patients.

9. Post-implementation review

There is no power under the 2003 Act to pilot the new GDS or PDS arrangements or regulations for the new charging regime. This has meant that although much modelling and forecasting work has been done in relation to dental charging no piloting has been possible.

Once the new arrangements both for contracting and dental charging are in place data will be submitted by contractors on the courses of treatment provided and the persons to whom services have been provided. Weightings to reflect complexity of the course of treatment derived from the charges bandings will be applied by the BSA for contract monitoring purposes.

The underpinning principle of the new charging system is that it should raise the same proportion of patient charges as the current system The forecasting of the band charges for the new system has been based on this principle. The new data returns from contractors will allow an analysis of the charges raised and the patients seeking treatment under the new regime.

The results of this analysis will demonstrate how the new policy for charging is working in practice and influence changes in the level of charges in future years. NHS charges, including dental charges, are usually reviewed and uprated annually in April.

Declaration

I have read the regulatory impact assessment and I am satisfied that the benefits justify the costs

Rosie Winterton

15th November 2005

Minister of State, Department of Health.

Contact point

Chris Audrey
Dental & Ophthalmic Services Division
New King's Beam House
Tel 020 7633 4149

Annex

Implementation and delivery plan

Option 1
The draft NHS (General Dental Services Contracts) Regulations 2005, and the draft NHS (Personal Dental Services Agreements) Regulations 2005 would be implemented to the same timetable but with monitoring arrangements in relation to weighted courses of treatment unrelated to the item of service charges regime. This would require parallel reporting arrangements for contractors to monitor activity under the contracts and verification of NHS charges.

Option 2
Following approval of the National Health Service (Dental Charges) Regulations 2005, by a resolution of each House of Parliament, they will be published on the Department of Health website http://www.dh.gov.uk and the NHS Primary care Contracting website http://www.primarycarecontracting.nhs.uk for the information of stakeholders. It is hoped that the Regulations will have been approved by both Houses and made by the end of December. The Regulations will come into force on 1 April 2006, which will amount to more than a 3 month period in which preparations can be undertaken for implementation.

The draft NHS (General Dental Services Contracts) Regulations 2005, and the draft NHS (Personal Dental Services Agreements) Regulations 2005 are both constructed on the basis of the provision of courses of treatment weighted by complexity. The categories of course of treatment and weightings, to be known as units of activity, are derived from the banded charging regime. These draft Regulations will come into force early in January 2006 for the purpose of agreeing contracts and for provision of services from April 2006. This provides a three month preparatory period.

Publication of the finalised NHS (Dental Charges) Regulations 2005 will enable the DPB to provide definitive information to dentists on their contract values for 2006-07 and the number of units of dental activity (UDAs), and where appropriate, the number of units of orthodontic activity (UOAs) they are to provide in relation to the contract value. This will be sent to dentists and their PCTs early in December 2005 to enable contracts for 2006-07 to be finalised

Publication of the NHS Dental Charges) Regulations 2005 will also enable the DPB to finalise new payment systems for payments to contractors and the validation of patient charges raised for dental services provided under contracts. Similarly the dental software systems suppliers will finalise the dental practice based software systems to run the new contracting arrangements. The Department has worked closely both with the DPB and the dental systems suppliers to ensure a smooth transition from the current arrangements to the new regime.

The implementation timetable for option 2 is:

Information for dentists, PCTs, system suppliers	end November 2005
Draft GDS Contracts regulations	laid December 2005
	in force January 2006
Draft PDS Agreements Regulations	laid December 2005
	In force January 2006

Statement of Financial Entitlements	December 2005
Transitional Provisions Order	December 2005
Performers Lists Regulations	January 2006

Option 3

For the reasons stated above, a non-regulatory option is unworkable and so no implementation plans have been developed for this option.