EIC0767

Written evidence submitted by the British Dental Association

Introduction and summary

1. The British Dental Association (BDA) is the professional association and trade union for dentists in the UK. Members engage in all aspects of dentistry: general practice, community dental services, the armed forces, hospitals, academia research, and our membership also includes dental students.

2. We welcome the Committee's decision to hold this inquiry. Dentistry is both a vital healthcare service and a major industry, a fixture on the high street making a contribution of £8.7 billion to the UK economy. 12,000 high street practices operate both as NHS contractors and as independent private businesses. The sector functions as significant source of revenue for HMT and as an employment sector for over 100,000 clinical staff.

3. The COVID-19 pandemic prompted the suspension of routine care on the high street across all four UK nations. While face to face care resumed in England on 8 June, practices are now operating at a fraction of their former capacity, seeing fewer patients while facing significantly higher costs. Gaps in Treasury support compared to other high street businesses continue to jeopardize this sector's long term sustainability. Lack of support for a largely self-employed dentist workforce relative to those on PAYE has deepened these problems.

4. While across the UK NHS dental contractors are receiving some support – a proportion of existing contract values - dentistry operates predominantly as a 'mixed economy', with the majority of practices reliant on both NHS and private income streams. While the furlough scheme remains invaluable, there is insufficient support for the dynamic and hitherto growing private side of this sector, beyond extension of debt to already vulnerable businesses. These practices are uniquely exposed, and operating without an adequate safety net. Many of the 3,000 wholly private practices have seen cash flow fall to zero, as have the taxable earnings of a large proportion of the estimated 5,000 dentists working at them. Should these practices fail, an underfunded NHS service has no capacity to meet patient need.

5. A post lockdown environment – defined by lower patient numbers and higher costs – is fatally undermining the model on which all practices operate. This will require both a break from the current 'activity'-based business model on which NHS contractors operate, and stable long-term funding for public health programmes.

6. Maintaining the financial sustainability of this sector not only has economic imperatives, but will clearly have direct consequences on pre-existing levels of oral health inequality, and the public's ability to access to dental services, close to home and appropriate to their needs.

7. The BDA would be pleased to give oral evidence if it would be helpful to the inquiry.

The context: The need for government support

8. **The suspension of non-urgent dental care impacted the cash flow of nearly all practices, particularly those with high private commitments, leaving many facing imminent financial ruin. Those reopening on 8 June have faced new challenges, most operating at significantly lower than a quarter of their pre-pandemic capacity.**

9. Around 35,000 dentists work in high street practice. An additional 70,000 dental care professionals brings the workforce to over 100,000, not factoring in a wider range of non-clinical administrative or support staff. In the wider supply chain - including 2000 dental laboratories with a value of £0.6 billion, and a materials sector also worth an estimated £0.6 billion - activity also effectively ceased.

10. In early April 2,860 owners of UK dental practices (24 per cent of an estimated total of 11,800) answered a BDA survey on financial sustainability in the pandemic. With all routine care suspended 72 per cent of practices reported they could only remain financially sustainable for 3 months or less.

11. The majority of UK practices are mixed, delivering both NHS and private care in varying proportions. Practices performing a greater share of private work appear most exposed, with 75 per cent of those with low or no NHS commitment (0-25 per cent NHS) stating they will face imminent difficulties in the next three months, falling to 61 per cent among those with the highest NHS commitments (75-100 per cent NHS). A month after the survey was conducted examples began to surface of practice and dental group closures.

12. The resumption of practice in England shows support is needed now more than ever. Recent BDA surveys indicate a little over a third of practices were in a position to reopen on 8 June. While over 80 per cent of practices are expected to have seen patients by the end of June, all are operating at a fraction of their pre-pandemic capacity, over 60 per cent expecting to see less than a quarter of their pre-pandemic patient numbers. Practices that once saw over one hundred patients a day are now seeing fewer than 10, in order to keep to social distancing and decontamination guidelines, including the need to leave surgeries fallow between patients.

13. Costs for necessary Personal Protective Equipment (PPE) have also increased dramatically. In June industry sources estimated that (ignoring all other treatment costs) the cost for treating a single patient using aerosol-generating procedures (AGPs) – using high-speed instruments like a drill – was around 35-45 pence pre-pandemic, but had increased to £20-30 depending on exact PPE requirements and usage. Costs per patient have increased by around seven times (or 700 per cent) for non-AGP activity, and around 60 times (or 6,000 per cent) for AGP activity when compared with pre-COVID-19 activity.

14. Just eight per cent of practices surveyed indicated they are capable of maintaining their financial sustainability under these conditions. Put simply the combination of higher costs and lower patient numbers fatally undermines the business model on which all practices operate.

15. Private practices have been particularly badly hit; left with little or no income during lockdown, while a range of fixed business costs remained in place. Now they have very limited scope to negotiate a new environment. This dire situation is only compounded by these small businesses being excluded from the Small Business Businesses Rate Relief Scheme and difficulties accessing the

Coronavirus Business Interruption Loans.

16. Private dentistry cannot be considered an 'optional extra', given the co-dependency, and cross subsidy operating within the sector. There are around 3,000 purely private practices, but many dental practices with an NHS contract will also rely on private work for a significant proportion of their income. As such, private dentistry accounts for well over half of spend on high street dentistry; an estimated £5.2 billion of the £8.7 billion spent in 2018-19 was on private care. Many practices who provide both NHS and private dentistry use their private incomes to subsidise their NHS work. If private dentistry is left to collapse, as looks very possible at present, this will have a disastrous effect on the overall provision of care to patients and to the viability of NHS dentistry.

17. This sudden loss of income has been aggravated by the wider failure of insurers to pay out on business interruption policies**.** We understand only around 10 per cent of claims made by practices for cover relating to the pandemic are being accepted. Many practices had taken out these policies out of a sense of personal responsibility to protect against the unexpected. This failure underlines the need for government support.

The Job Protection Scheme

18. The 'furlough' scheme has enjoyed widespread uptake. BDA surveys indicate up to 80 per cent of practices in England have made use of the scheme to cover staff in proportion to their private work. This has covered non-clinical administrative and clinical salaried staff like dental nurses but not largely self-employed dentists or dental hygienists.

19. 66 per cent of practices surveyed in June indicated the removal of this scheme before they can restore a significant level of clinical activity would represent a risk to their business.

20. Furlough has represented the only tangible support for the private sector beyond taking on additional debt, and for the moment appears to have maintained the integrity of highly trained teams. Any end or even scaling down of the scheme needs to be pursued in tandem with progress towards restoring capacity to high street services.

Self-employment Income Support Scheme

21. While NHS support for practices has been conditional on maintaining pay to self-employed 'associate' dentists working at the practice at normal levels, most associates engaged predominantly in private treatment have been ineligible for any government coronavirus income support.

22. The Chancellor indicated that the £50,000 profit threshold for the Self-Employed Income Support Scheme was intended to exclude those with very high earnings. However, BDA research found that 60 per cent of associate dentists excluded from the Scheme earn less than £75,000 a year. It is not clear to us why an employee earning £51,000 would be eligible to receive £2,500 per month under the Coronavirus Job Retention Scheme, but a self-employed person on the same income receives nothing.

23. The very low levels of clinical activity possible in practices post 8 June suggest bleak prospects for self-employed dentists in wholly or largely private practice.

24. The dentists losing out are not the 'super-rich'. They are frontline health professionals, who do not know where their next pay cheque is coming from, or if they will have jobs to return to. Their status adds to the grave uncertainty facing private practice UK-wide.

Coronavirus Business Interruption Loan Scheme

25. Cash flow was an immediate risk to most UK dental practices, and in the absence of other support seeking credit became an immediate priority.

26. Based on BDA polling in early April 26 per cent of practices had already attempted to secure an interruption loan, but 93 per cent of applicants were unable to secure credit. 47 per cent of those who failed reported already had to seek commercial loans to stay afloat, at reported rates of interest of over 20 per cent.

27. While the scheme has been made more 'accessible' since, we continue to receive feedback on difficulties accessing credit. However with a major reduction in patient numbers post lockdown, adding to debt is not a sustainable solution for many practices (see below: A New Model for High Street Services).

Other government intervention

28. As a healthcare service utilised by tens of millions of people annually, the Government has a responsibility to offer resources to support both NHS and private providers.

29. The extension of the business rates holiday offered to retail and leisure sectors is the most obvious approach the Government could take with immediate effect. It has cost many practices a fortune to remain closed during lockdown. Now high overheads and low capacity mean it will be difficult for some to keep their doors open.

30. Rates relief has already been extended to the gambling industry – with a similar value to the economy. Dedicated health professionals deserve the same support offered to their neighbours on the high street.

<u>Economy, public finances and monetary policy</u>

A new model for High Street Services

31. As outlined COVID-19 infection control and social distancing requirements mean practices are now delivering a tiny fraction of pre-pandemic levels of clinical activity.

32. Across all four UK nations the contractual model for NHS dentistry is based on 'activity', with payment for either for specific items of service or courses of treatment completed. Both models require a significant turnover in patients seen. The collapse in capacity means this is no longer a tenable basis on which to base a healthcare service.

33. The profession now requires a clear plan of action from UK governments. A plan that offers financial stability for practices facing lower patient numbers so they can actually remain open, and that

recognises the significantly higher costs of delivering a more PPE intensive service.

Impact on inequalities

34. Oral health inequalities in the UK were already profound, and will likely be exacerbated by the economic impact of this crisis on the service.

35. Disruption and reduced capacity in the sector will inevitably put pressure on availability of appointments. Post lockdown a more limited service would have to prioritise treatment over practice-based prevention and check-ups. This could drive an even further increase in dental disease for the future. (*Further commentary on access is covered below under 'Levelling up Agenda').*

36. The loss of treatment and wider preventive services during and post-pandemic will disproportionately affect people from disadvantaged and vulnerable groups. These patients have a higher baseline level of dental disease (ADHS, CDHS, PHE survey of five-year-olds), and are the key targets of public health programmes. The latest PHE oral health data for five-year-olds, showed a more than ten-fold difference in severity of dental decay between those in more and less deprived areas. Before lockdown, preventive programmes including fluoride varnishing and supervised toothbrushing for children were targeted at disadvantaged and vulnerable groups, and we would expect these people now to feel the greatest effect of their cessation, and any cuts to these programmes longer term.

Impact on the public finances

Revenues

37. Disruption to this sector will inevitably lead to a reduction in tax revenues for HMT, particularly from what was a dynamic and growing private sector.

38. Private services, not in receipt of government funds (i.e. NHS contracts), are a major net contributor to the exchequer via the £5.2 billion revenue they generate.

The NHS Budget and status of Patient Charge Revenue

39. Dentistry is unique within NHS services in England for operating on a lower budget (both in cash and real terms) than it received in 2010, and has had to extract great efficiencies on a worse than flat line budget.

40. Contract values in England are continuing to be passed to contractors during the pandemic. However it is unclear how the service will be funded going forward.

41. In England the total NHS budget has been growing increasingly reliant on the direct patient contributions (the patient charge component), as net state contributions have fallen year on year since 2010. Charges now represent over 31 per cent of the total budget, up from 22 per cent in 2010. We have long expressed concern that this represents a concerted strategy to move charges from a '*contribution*' to a *'substitute'* for state investment, which if left unchecked would leave patients paying more at the point of delivery than the state within a generation.

42. This year's expected patient charge increase of five per cent (due on 1 April) was suspended, following lockdown. This was appropriate, and we see no case for passing greater costs to patients, given the well documented impact charges have on lower income patients' willingness to seek care, and the additional costs bottling up problems places on the wider NHS, including GP and A&E services.

43. While urgent dental care centres have attempted to collect charges, we would anticipate a drop in revenue for the current period of well over 95 per cent from normal levels. This will clearly impact on available resources for budgets going forward.

44. Any future funding solution needs to end the overreliance on patient charges, recognising the need to remove barriers to care in a system with potentially much reduced capacity.

Public Health Grant

45. Pre-pandemic the Public Health Grant had already been subject to significant cuts, which fell disproportionately on oral health provision. 130 out of 152 local authorities (85 per cent) reduced their public health budgets in 2018/19. Studies by the Kings Fund have found the single biggest areas for cuts have been miscellaneous services, including dental public health.

46. The Government had recently expressed interest in expansion of schemes, including targeted supervised brushing in schools. Stable long-term funding is required to address to the challenge of widening oral health inequalities going forward, particularly given the very substantial reduction in capacity of treatment services due to the pandemic.

Levelling up agenda

47. While the Government's levelling up agenda to date has focused on areas like transport and broadband, it would be remiss not to consider the impact of budgetary choices on healthcare infrastructure, particularly in areas that were in crisis pre pandemic.

48. Access to NHS dental services was fragile prior to the pandemic. BDA analysis of the Government's 2019 GP Survey indicated that over 1.4 million adult patients had tried and failed to access dental care, with a further 2 million estimated not to have tried in the belief they would be unable to secure an appointment. Furthermore, 130,000 adults reported that they were on waiting lists and over 700,000 cited cost as a barrier to seeking care, the pre-pandemic level of unmet dental need was over 4 million people, or nearly 1 in 10 of the adult population.

49. The recent NHS Digital statistics show that in the 24 months ending December 2019, 50 per cent of adults were seen by an NHS dentist and in the previous 12 months 58 per cent of the child population. Over recent years approximately half of the population has received NHS dental care. Given levels of unmet need we cannot realistically expect demand for services to fall below this level.

50. The highest levels of pre pandemic access problems for dental services have been concentrated in areas outside London and the South East, often in post-industrial communities and areas of rural and coastal poverty, particularly across West Yorkshire, Cumbria, Cornwall and Lincolnshire. It is reasonable to conclude, both through business failure and reduced capacity these problems will

deepen significantly.

Recommendations

51. To safeguard the nation's oral health support is necessary for dental practices during the pandemic and to preserve them in the future. We would see as priorities:

    a) Extension of business rates relief to high street healthcare providers, with measures to apply retrospectively to suspension of routine dental care on 25 March.

    b) Removal of cap for support for self-employed contractors, with retrospective provisions for those who have been left with no income during lockdown.

    c) Any changes to scaling down of furlough scheme in this sector to be directly linked to restoration of routine care, and the capacity of dental services to bear costs through revenue generating activity.

    d) Lines of affordable government credit should be readily available to those that need them. However all practices – especially those with larger private commitments - require alternative models of support beyond simply expanding debt.

    e) Any approaches to NHS funding need to be pursued in tandem with wider change to the fundamental contractual model on which high street services operate.

    f) Increasing the proportion of state contributions within NHS budgets, ending dangerous and increasing over-reliance on patient charge revenue, the volume of which we expect to fall significantly, and cannot underpin a comprehensive service at any scale.

    g) Budgets for local authority public health grants and prevention to be maintained, and where appropriate expanded to protect against widening oral health inequalities.

    h) Explore the removal of VAT on PPE, reflecting the higher overheads of a more PPE intensive model of care post-lockdown.

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