Title: Dental Patient Charge Uplift 2019/20
IA No: 14007
Lead department or agency: Department of Health and Social Care

Impact Assessment (IA)

Date: 12/02/2019

Stage: Final

Source of intervention: Domestic

Type of measure: Secondary Legislation

Contact for enquiries:
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Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option (in 2019 prices)			
Total Net Present Social Value	**Business Net Present Value**	**Net cost to business per year 2018/19 (EANDCB)**	**Business Impact Target Status**
£80.8m	N/A	N/A	N/A - Non Qualifying provision

What is the problem under consideration? Why is government intervention necessary?

Dentistry is one of a small group of NHS services where patient charges apply (unless the patient is exempt).Patient charges were first applied in 1952. Historically patient charges have been uplifted annually by the rate of inflation. In 2015 a policy decision was taken to increase charges for the duration of the 2015 spending review period by 5% as part of wider policy to address financial pressures. The proposed 5% uplift for 2019/20 continues the aim to strike an appropriate balance between the contribution the charges represent to the overall NHS budget and the cost to charge paying patients. The uplift would generate an additional £27.1m in cash terms in 2019/20 for the NHS as a whole compared with an inflationary uplift in 2019/20. Revenue generated has been accounted for within the 2015 Spending Review.

What are the policy objectives and the intended effects?

The Department of Health and Social Care proposes to uplift dental charges by 5% in 2019/20 delivering an increased revenue of £27.1m. Charges are reviewed annually.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option A: (Do Nothing) – increase all charge bands uniformly in line with inflation as measured by GDP deflator.
Option B: Apply above inflation rates of 5% to all bands. **This is the preferred option.**

Both options require secondary legislation.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 02/2020

Does implementation go beyond minimum EU requirements?	N/A			
Is this measure likely to impact on trade and investment?	N/A			
Are any of these organisations in scope?	**Micro** N/A	**Small** N/A	**Medium** **N/A**	**Large** N/A
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)	**Traded:**	**Non-traded:**		

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: Baroness Blackwood Date: 7th March 2019

Summary: Analysis & Evidence

Policy Option A

Description: Do Nothing

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:**

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate				

Description and scale of key monetised costs by 'main affected groups'

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline.

Other key non-monetised costs by 'main affected groups'

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate				

Description and scale of key monetised benefits by 'main affected groups'

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline. Any income that may be generated would be where a decision is taken to uplift dental charges in 2019/20. However, that is a separate decision to this one, and therefore is one that we won't consider within this IA.

Other key non-monetised benefits by 'main affected groups'

In line with impact assessment guidance the do nothing option has zero costs or benefits as impacts are assessed as marginal changes against the do nothing baseline.

Key assumptions/sensitivities/risks **Discount rate (%)** -

All estimates are based on 2017/18 volumes, uprated for assumed volume changes each year up to 2019/20 in line with historical trends.No price elasticity effects have been assumed between the options. Any figures throughout these options are based on a uniform increase across all bands, with patient charges rounded to the nearest 10p.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:** N/A
Costs: N/A	**Benefits**:N/A	**Net:** N/A	

Summary: Analysis & Evidence

Policy Option B

Description: Increase of dental charges across all bands of treatment by 5% in 2019/20

FULL ECONOMIC ASSESSMENT

Price Base Year 2019	PV Base Year 2018	Time Period Years 1	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate: £80.8m**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate			£27.1m	**£26.2m**

Description and scale of key monetised costs by 'main affected groups'

The monetised costs are the increase in NHS dental charges. The main affected group is charge paying patients. This will increase revenue by £27.1m in 2019/20 (£26m discounted) compared to what is forecast for the year if charges were raised in line with inflation from 2015/16. Children and non-charge paying adults are not affected.

Other key non-monetised costs by 'main affected groups'

None

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate			£108.6m	**£108.6m**

Description and scale of key monetised benefits by 'main affected groups'

The increased revenue from dental charges can be used by the NHS to produce Quality Adjusted Life Years for patients on average at £15,000 per QALY. The number of QALYs the extra revenue will allow the NHS to produce is 1783 (discounted). Each QALY is valued at £60,000.

Other key non-monetised benefits by 'main affected groups'

None

Key assumptions/sensitivities/risks | **Discount rate** | **3.5%**

All estimates are based on 2017/18 volumes of delivered dental services, uprated for each year to 2019/20 in line with historical trends. No price elasticity effects have been assumed between the options. A discount rate of 3.5% has been used for costs, and 1.5% for QALYs in line with DHSC guidance.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs:	**Benefits:**	**Net:**	No	NA

Evidence Base

Section 1 – Problem under consideration

1. NHS services are funded through general taxation. For dental services fee-paying adult patients pay an NHS patient charge when receiving dental care. The dental charges represent an important contribution to the overall cost of the NHS.
2. As part of the Spending Review settlement in 2015, it was agreed to uplift patient dental charges for those not exempt (see Annex A), over and above routine inflationary uplifts (currently around 1.8%) for the remainder of the spending review period (i.e. until 2020/21). This is the fourth consecutive year of uplifting dental patient charges by 5%.
3. Uplifts to patient charges are considered annually. Although, the first two years of the SR 2015 commitment (2016/17 and 2017/18) were put through as a single regulation in March 2016. As patient charges are set out in regulations any increase requires an amendment to regulations.

Section 2 – Rationale for the intervention and policy objectives

4. The implementation of dental charge uplifts needs to be applied so that they remain appropriate and fair to all patients. Dental charges uplifts will only apply to charge paying patient groups. All patient groups currently exempt from charges, e.g. all those under 18 and those under 19 in full time education and adults who are exempt (expectant and new mothers) will remain exempt. In addition, adults on specified benefits or low incomes will remain eligible for full or partial remission of charges Please see **Annex A** for a full list of those exempt from charges or entitled to remission of charges.

Section 3 – Description of options considered

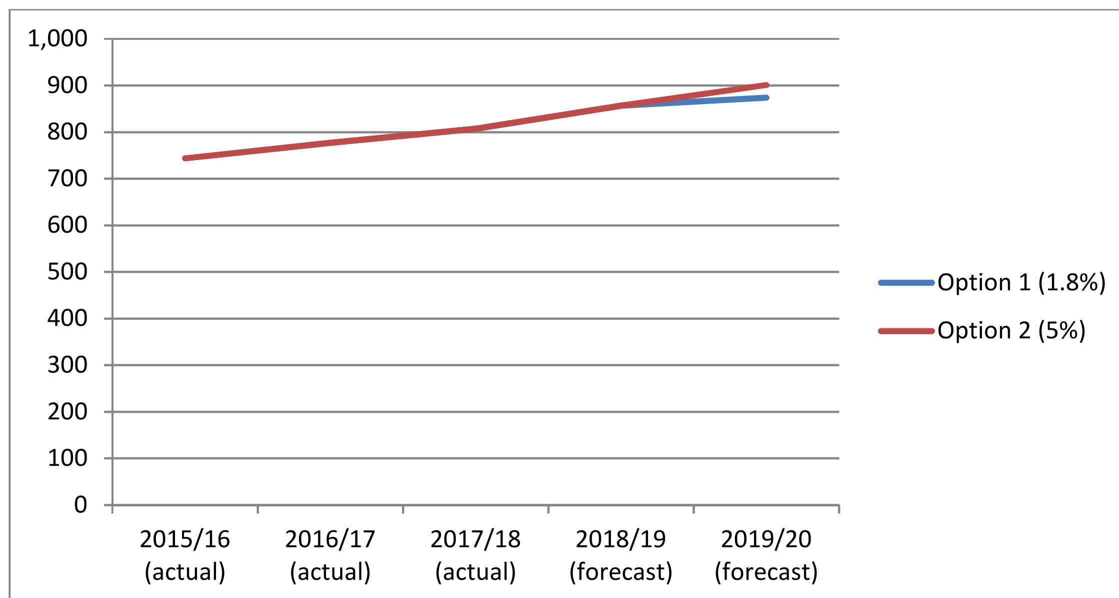
5. It is important to consider the way in which uplift charges are applied. The options are:

   Option A: (Do Nothing) – increase all charge bands uniformly in line with inflation as measured by GDP deflator.

   Option B: Apply above inflation rates of 5% to all bands. **This is the preferred option**.

6. In terms of the benefits, there will be continued NHS care to improve the oral health of patients, and the costs are extra charges to be borne by patients. The risk is that patients do not visit an NHS dentist or decline more complex treatment because of the increased charge, potentially leading to a deterioration in oral health – see risks section.

Chart 1 – Patient Charge Revenue for each proposed option, 2015/16 to 2019/20, £m



Option B is the preferred option, because it offers the best compromise between delivering value for money and raising sufficient revenue to balance the NHS resource requirement.

Option A – Do nothing

7. Since 2006, dental courses of treatment have been arranged into four main bands. Courses of treatment (CoT) within each band attract the same patient charge level. These are shown in the table below.

Table 1 – Description of Course of Treatment Bands

Band	Description
1	This band includes examination, diagnosis (including radiographs), advice on how to prevent future problems, scale and polish if clinically needed, and preventative care (e.g. applications of fluoride varnish or fissure sealant)
2	This band covers everything listed in band 1, plus any further treatment such as fillings, root canal work or extractions
3	This band covers everything in bands 1 and 2, plus course of treatment including crowns, dentures, bridges and other laboratory work
Urgent	This band covers urgent assessment and specified urgent treatments such as pain relief or a temporary filling or dental appliance repair

8. Patients in receipt of NHS dental services are divided into three broad groups for charge paying purposes: children; charge paying adults and non-charge paying adults. Only adults in the charge paying group are liable and affected by the charge. The baseline year for the model is 2015/16 which is the year immediately prior to the spending review 2015 when the decision was taken to raise charges by more than inflation. Charge-paying adults accounted for approximately 21m of the 39m CoT delivered in 2015/16 and raised £743 million. More details are shown on Table 2.

Table 2 – Patient Charges, Courses of Treatment and Revenue by Band, 2015/16

	Band 1	Band 2	Band 3	Urgent	**Other**	**Total***
Patient Charge	£18.80	£51.30	£222.50	£18.80	**-**	**-**
CoT (non- charge paying adults)	2,804	2,769	1,067	1,165	**36**	**7,841**
CoT (charge paying adults)	11,761	5,805	998	2,067	**190**	**20,820**
CoT (children)	7,970	2,723	70	499	**6**	**11,267**
CoT (Total)	**22,534**	**11,296**	**2,136**	**3,731**	**231**	**39,928**
Patient Charge Revenue (£'000)	£219,973	£270,470	£214,479	£38,921		**£743,843**

*Figures may not sum due to rounding

Source – NHS England Financial Strategy & Allocations

9. Table 3A shows implemented patient charges by band for 2015/16 to 2018/19 and the 'do nothing' option for 2019/20 of inflationary uplift of 1.8%.Table 3B shows actual revenue for 2015/16 through to 2017/18 and forecasted revenue for 2018/19 given a 5% uplift and for 2019/20 for inflation. For modelling purposes we assume that there is no change to commissioning policy of NHS dental service capacity. These modelled changes in volumes are the same for all proposed options.

Table 3A – Implemented Patient Charges by Band 2015/16 to 2018/19 and inflation only uplift for 2019/20

	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Band 1	£18.80	£19.70	£20.60	£21.60	£22.00
Band 2	£51.30	£53.90	£56.30	£59.10	£60.20
Band 3	£222.50	£233.70	£244.30	£256.50	£261.10
Urgent	£18.80	£19.70	£20.60	£21.60	£22.00

NOTE – The actual PCR figures presented are sourced from the NHS England Finance Team throughout this year (last year 2015/16 actuals were sourced from NHS Digital. These are slightly different from those published by NHS Digital due to definitions.

Table 3B – Patient charge revenue by band, actual plus forecast (with 5% uplift in 2018/19 and inflation only uplift in 2019/20)

£million	2015/16 (actual)	2016/17 (actual)	2017/18 (actual)	2018/19 (forecast)	2019/20 (forecast)
Band 1	£220.0	£234.9	£247.7	£267.5	£277.5
Band 2	£270.5	£281.1	£291.2	£306.8	£310.1
Band 3	£214.5	£220.1	£225.2	£236.6	£238.7
Urgent	£38.9	£40.7	£43.3	£46.1	£47.2
Total	**£743.8**	**£776.8**	**£807.3**	**£857.0**	**£873.5**

Option B – Uplift in charge levels across all bands of treatment by 5%

10. This option puts in place uniform above inflation rises across all bands in 2019/20 by 5%. It is the convention to round charges to the nearest 10p. The impact assessment published in 2016 covered a 5% rise in 2016/17 and 2017/18. The actual charges implemented for 2016/17 to 2018/19 along with the proposed charges for 2019/20 are shown in Table 4A below. Table 4B shows the revenue raised in 2015/16 – 2017/18 and estimated revenue for 2018/19 and 2019/20 given the charges from Table 4A and expected activity.

Table 4A – Implemented charges for 2015/16 to 2018/19 and proposed charges with 5% rise in 2019/20.

	2015/16	2016/17	2017/18	2018/19	2019/20
Band 1	£18.80	£19.70	£20.60	£21.60	£22.70
Band 2	£51.30	£53.90	£56.30	£59.10	£62.10
Band 3	£222.50	£233.70	£244.30	£256.50	£269.30
Urgent	£18.80	£19.70	£20.60	£21.60	£22.70

Table 4B –Patient Revenue by Band 2015/16 to 2017/18, 2018/19 estimated and 2019/20 modelled with 5% rise in charges

£million	2015/16 (actual)	2016/17 (actual)	2017/18 (actual)	2018/19 (forecast)	2019/20 (forecast)
Band 1	£218.7	£234.9	£247.7	£267.5	£286.2
Band 2	£266.9	£281.1	£291.2	£306.8	£319.9
Band 3	£213.2	£220.1	£225.2	£236.6	£246.2
Urgent	£38.7	£40.7	£43.3	£46.1	£48.7
Total	**£743.8**	**£776.8**	**£807.3**	**£857.0**	**£901.1**

11. Table 5 shows the expected level of revenue for each band given the charges for 2019/20 as shown in Table 4B plus the increase in revenue compared to 2015/16 and an increase in revenue compared to expected baseline revenue as shown in Table 3B. This is expected to raise an additional £157.2m and £27.5m respectively.

Table 5: Patient Charge Revenue 2019/20

£million	2019/20		
	Estimated Patient Charge Revenue	Increase in PCR (compared to 2015/16 revenue)	Increase in PCR (compared to expected baseline level in Table 3C
Band 1	£286.2	£66.2	£8.7
Band 2	£319.9	£49.4	£9.8
Band 3	£246.2	£31.8	£7.5
Urgent	£48.7	£9.8	£1.5
Total	£901.1	£157.2	£27.5

Assumption

12. The modelling of the revenue raised builds in an assumption about the changes in volumes of dental services in each band based on historic volume increases. These have been modelled separately for Band 1, Band 2, Band 3 and urgent courses of treatment, for fee paying, non-fee paying and children, based on historic volume increases and using ONS demographic data and projections and thus vary for each group. Overall, however, an output from the model (not an input assumption) suggests a 1.5% increase year-on-year in activity for fee-paying adults between the period 2018/19 and 2020/21.
13. All the options presented reflect the same volumes of dental activity. Implicitly this assumes a price elasticity of demand of zero between the options. It is likely that patients are relatively insensitive to modest changes in price in respect of dental services, particularly where they are for “essential” interventions and/or where the patient benefit often outweighs the price. The outturn figures for 2016/17 have not been suggestive of any strong price effect on dental courses of treatment for charge-payers: NHS dental activity continued to rise, even with a price increase, which would suggest that price effects are likely to have been modest.
14. As discussed in the risks section, there remains uncertainty about whether higher charges would lead to significantly lower levels of patient demand for services. We are not aware of relevant publications that refer to NHS dental services in England. Previous impact assessments have highlighted research by the RAND Corporation indicative of a price elasticity of demand for medical care in the US in the region of -0.1 to -0.2, potentially rising to -0.4 for medical services regarded as preventative care. However, this was not dental specifically.
15. Any change in demand for NHS dental services by charge paying patients will continue to be monitored as it could also have an impact on patient’s oral health and the business of the dental practice. Also see risk section.

Section 4 – Monetised and non-monetised cost and benefits of each option

Option A - Do nothing

Costs

Patients

16. As set out in Section 3, the do nothing option is expected to raise £873.5m in 2019/20. This falls on charge paying patients. NHS dental services delivered to children and groups exempt from charges remains unaffected.

NHS and providers (including administrative burden)

17. Patient charges are collected by dental practices on behalf of the NHS. The collection of charges is channelled to the NHS through the payment system administered by the NHS Business Services Authority. Raising charges in line with inflation does not increase the cost burden faced by these organisations.

Option B – Uplift in charge levels of 5% across all bands of treatment

Costs

Patients

18. Section 3 gives a breakdown of the changes in patient dental charges. In 2019/20 this is expected to raise a total of £901.1m in revenue. The extra cost that will be borne by charge paying patients is £26.2m. This is shown in the table below -

Table 8 – Cost to patients from 5% rise in patient charges in 2019/20

	2019/20
Cost (£)	£27.1m
Cost (£, discounted at 3.5%)	£26.2m

19. If patients choose not to go to the dentist, there is a risk that their oral health could decline. As discussed in this document, charge payers appear to continue to attend the dentist and this potential cost has not been monetised.

NHS and Providers (inc. administrative burdens)

20. As with the do nothing option, there are already systems in place to collect NHS dental charges from patients. The burden on this system is not expected to change as a result of the proposed increases. NHS dental providers, potentially, do face an increased burden if patients question the change in charges and are less inclined to pay. This would be faced by receptionists and practice managers. This has not been monetised.

Benefits

21. NHS services including spend on dentistry are paid for by general taxation. The dental patient charge contributes to the overall NHS budget. The level of expenditure on NHS dental services is therefore not directly affected by changes in dental patient charge revenue. As with other NHS services spend on dentistry is determined by commissioners based on need and taking account of overall NHS priorities.. The increase in charges will not change this process and, therefore, will increase the level of funding available for commissioning NHS services in general.

22. Assuming, the NHS can produce a Quality Adjusted Life Year (QALY[1]) for £15,000, the increased resources will lead to extra services that will lead to an improvement in health. The extra QALYs are shown in table below -

Table 9 – Benefit from 5% rise in patient charges in 2019/20

	2019/20
Benefit (QALY)	1810

[1] Each QALY has been monetised at £60k each

Benefit (QALY, discounted at 1.5%)	1783
Benefits (£)	£107.0m

Summary of cost and benefit

23. The net benefit of option B is the difference between the present value of the benefits and the costs. The net present value is £80.8m. This is shown below.

Table 10 – Net Benefit from 5% rise in patient charges in 2019/20

	2019/20
Cost (Present Value)	£26.2m
Benefit (Present Value)	£107.0m
Net Present Value	£80.8m

Summary of the Options

Table 11 below shows the net present value for options B.

Table 11 – Net Benefit from rise in patient charges in 2019/20

	Option B
Cost (Present Value)	£26.2m
Benefit (Present Value)	£107.0m
Net Present Value	£80.8m

Risks

24. The original impact assessment for patient charge rises prepared in 2016 to accompany the regulations discussed the risk that if charges are raised above inflation, then some charge paying patients may choose not to seek dental treatment. There are no published studies on the price elasticity of NHS dental services, so the impact assessment relied on research by the RAND corporation which estimated price elasticity of demand for healthcare to be between -0.1 and -0.2 (and up to -0.4 for preventative care). Scenario modelling of the changes in demand on the amount of revenue raised can be found in Annex B of that IA[2].

25. The modelling work for revenue does include changes in volumes which is the same for each option presented and based on historic outturn. Therefore while the IA in 2016 drew on past volume changes where change levels had only risen in line with inflation for many years, the current IA draws on outturn since charge levels have started to rise by 5%. As the volume increases are based on historic trends it has built into it any elasticity effects. This method is perhaps of more value than the scenario modelling done previously based on the RAND study, which drew on hypothetical elasticities.

26. If patients no longer visit the dentist for regular check-ups there is risk that this could lead to fall in oral health of those patients. This would lead to a rise in dental caries, periodontal disease and

[2] https://www.legislation.gov.uk/uksi/2016/324/impacts

tooth extractions. At present, there is no published research that links oral health to quality adjusted life years or monetised values.

27. The change in charges could also have two small knock-on effects for the business model of the dental practice if fewer charge paying patients seeking NHS appointments: i) dentists may look to use their commissioned capacity of NHS services more intensely on non-charge paying patients which could mean the existing population base receive more appointments with a negligible impact on their oral health (assuming they currently receive services to meet their needs) or ii) new patients may be taken on to replace those deterred.

28. NHS Digital publishes a breakdown of the course of dental treatment received by different patient groups each year. This can be found in table X3 of Annex 3 which accompanies the annual publication of dental statistics[3]. The tables below show the total number of course of treatment by band and the year on year changes.

Table 14 – Course of Treatment for Charge Paying patients 2006-07 to 2017/18

	Band 1	Band 2	Band 3	Urgent	Other	Total
2006-07	9,754,977	5,075,259	729,590	1,595,620	-	17,155,446
2007-08	9,827,126	5,254,059	788,602	1,673,798	671,525	18,215,110
2008-09	10,175,014	5,560,129	852,609	1,745,237	690,839	19,023,828
2009-10	10,285,288	5,619,024	920,422	1,776,998	695,412	19,297,144
2010-11	10,423,613	5,737,202	962,895	1,841,456	670,044	19,635,210
2011-12	10,518,030	5,785,584	958,045	1,863,468	668,146	19,793,273
2012-13	10,635,443	5,811,665	972,299	1,913,870	444,330	19,777,607
2013-14	11,057,400	5,862,670	975,233	2,016,196	149,583	20,061,082
2014-15	11,382,506	5,758,935	983,937	2,042,791	141,212	20,309,381
2015-16	11,717,122	5,783,801	995,065	2,046,527	142,498	20,685,013
2016-17	12,115,641	5,780,303	986,091	2,086,956	156,277	21,125,268
2017-18	12,106,275	5,666,259	958,491	2,091,344	144,253	20,966,622

29. Table 14 shows the course of treatment received by charge paying patients since 2006-07 when the current form of the NHS dental contract began. The figures for 2016-17, shows the outturn figures for that year following the above inflation rise in charges of 5% in April 2016.

30. Table 15 below shows that percentage changes in volumes for each year.

Table 15 - Percentage changes in volumes by band for charge paying patients, 2006/07 to 2017/18

	Band 1	Band 2	Band 3	Urgent	Other	Total
2006-07	-	-	-	-	-	-
2007-08	0.7%	3.5%	8.1%	4.9%	-	6.2%
2008-09	3.5%	5.8%	8.1%	4.3%	2.9%	4.4%
2009-10	1.1%	1.1%	8.0%	1.8%	0.7%	1.4%
2010-11	1.3%	2.1%	4.6%	3.6%	-3.6%	1.8%
2011-12	0.9%	0.8%	-0.5%	1.2%	-0.3%	0.8%
2012-13	1.1%	0.5%	1.5%	2.7%	-33.5%	-0.1%
2013-14	4.0%	0.9%	0.3%	5.3%	-66.3%	1.4%
2014-15	2.9%	-1.8%	0.9%	1.3%	-5.6%	1.2%
2015-16	2.9%	0.4%	1.1%	0.2%	0.9%	1.8%
2016-17	3.4%	-0.1%	-0.9%	2.0%	9.7%	2.1%
2017-18	-0.1%	-2.0%	-2.8%	0.2%	-7.7%	-0.8%

[3] https://digital.nhs.uk/catalogue/PUB30069

31. This shows that there was an overall reduction of -0.80% in the total courses of treatment for NHS dental services by charge paying adults. There is a bigger decrease in those receiving Band 3 and Band 2 treatments compared to those having Band 1 (check ups) which saw a smaller fall. This pattern is also seen in the non charge payer group. The falls in this group are somewhat greater than in the charge payer group. While we need to be cautious in interpreting this as the drivers for treatment differ between the groups it suggests that the reductions are not likely to be a direct result of patient charge increases. While one year of data in 2017/18 is not sufficient to note any trends, the pattern of a shift in treatment towards band 1 fits with the long term trend in dental provision of best practice dictating a move towards more preventative treatment (band 1) and a more conservative approach to restorative treatments as general levels of oral health improve.

32. We conclude that it is unlikely that demand for NHS dentistry for charge payers was influenced strongly by the previous 5% price increases. Any change in demand for NHS dental services by charge paying patients however will continue to be monitored as an indicator that charges may be acting as a deterrent.

33. Raising NHS charges could also have an impact on the private business of a dental practice. Higher NHS charges mean that the cost of NHS treatment will be closer to the prices for private dental care. Some patients may now choose to receive private care as the cost differential is lower, leading to increased demand for private services. These effects are expected to be small or negligible, given the size of the increase in NHS charges, and have not been quantified.

Equality

34. The Department of Health and Social Care has prepared an Equality Analysis for these regulations as well as this impact assessment.

35. The uplifts to dental charges will affect adults who are not classed as exempt from dental charges, and are not considered to be on low enough income to come below the various thresholds set for income based help with dental charges. Raising NHS dental charges has the potential to have a greater impact on patients from lower incomes than more affluent patients. The Government recognises this.

36. All children are excluded from charges as are adults who are expectant or nursing mothers. Adults on specified income related benefits are entitled to full remission of charges Those not entitled to full remission of dental charges on income grounds, but who are on low incomes, may also be eligible to receive help with health costs. A low income scheme exists for those not automatically entitled to dental charge exemptions but who are on low incomes and have savings of less than £16,000.[4] More details of exemptions are given in Annex A. No changes are planned as a result of this uplift to the categories of patient eligible for help or to the help available.

37. We continue to maintain the balance between the fact that it is right that those who can contribute do so, whilst maintaining exemptions and help with health costs for those with the greatest need.

38. We have limited information on the distribution of incomes among the patients who do pay dental charges. Therefore no adjustment has been made to the costs or benefits for distributional impacts from relative prosperity.

[4] https://www.nhsbsa.nhs.uk/nhs-low-income-scheme

ANNEX A – Exemptions to Dental Charges

You do not have to pay for NHS dental treatment if, when the treatment starts, you are:

- under 18 (under 19 and in full-time education)
- women who are pregnant or who have had a baby within the 12 months before treatment starts
- staying in an NHS hospital and the hospital dentist carries out treatment
- an NHS Hospital Dental Service outpatient (although you may have to pay for your dentures or bridges)

You do not have to pay if, during the course of treatment, you or your partner, receive:

- Income Support,
- Income-based Jobseeker's Allowance
- income-related Employment and Support Allowance
- Pension Credit guarantee credit
- Universal credit

or

- you are named on, or entitled to, a valid NHS tax credit exemption certificate
- you are named on a valid HC2 certificate issued under the NHS Low Income Scheme.

NHS Low Income Scheme

- The NHS Low Income Scheme provides financial help to people not exempt from charges, but who may be entitled to full or partial help with healthcare costs if they have a low income. The scheme covers:

  - Prescription costs
  - Dental costs
  - Eye care costs
  - Healthcare travel costs
  - Wigs and fabric supports

- Anyone can apply as long as they don't have savings or investments over the capital limit. In England, the capital limit is £16,000 (or £23,250 if you live permanently in a care home). Any help you're entitled to is also available to your partner and any dependent young people.