Title: Dental Patient Charge Uplift 2022/23 **IA No:** **Lead department or agency:** Department of Health and Social Care	**Impact Assessment (IA)** **Date:** 15/03/2023 **Stage**: Final **Source of intervention:** **Type of measure:** Secondary Legislation **Contact for enquiries:** Chrissie Frankland Robert Betts Charlotte Bryant
Summary: Intervention and Options	**RPC Opinion:** Not Applicable

Cost of Preferred (or more likely) Option			
Total Net Present Social Value £29m	**Business Net Present Value** N/A	**Net cost to business per year 2018/19 (EANDCB)** N/A	**Business Impact Target Status** 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 a patient is in an exempt group. A decision is required regarding the level of the dental patient charge uplift to be implemented in 2023/24. In setting the uplift, it is important to strike a balance between the contribution the charges represent to the overall NHS budget and the cost to charge-paying patients, recognising the primary policy objectives of improving oral health and guarding against creating financial barriers to accessing NHS dentistry. The implementation of dental charge uplifts needs to be applied so that charges remain appropriate and fair to all patients. Those patients who are exempt from dental patient charges are unaffected by the uplift.

What are the policy objectives and the intended effects?

The policy objective is to provide funding for NHS services through reasonable charging, whilst maintaining existing exemptions, to the overall benefit of oral health.

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

Option A – increase charges in line with GDP deflators (Business as Usual Option) (7.7%)

Whilst this uplift would be implemented in 2023/24, it combines (delayed) uplifts for 2021/22 to 2022/23 with the uplift for 2023/24. Together, these uplifts compound to an uplift of 7.7% to be implemented in 2023/24.

Option B – increase charges by HMT 5.0% (2021/22) and GDP deflators (2022/23 and 2023/24), with an adjustment for cost of living pressures (Preferred Option) (8.5%)

Whilst this uplift would be implemented in 2023/24, it combines (delayed) uplifts for 2021/22 and 2022/23 with the uplift for 2023/24. Together, these uplifts compound to an uplift of 11.3% to be implemented in 2023/24. To account for cost of living pressures, this uplift has been adjusted down to 8.5%.

Option B is the preferred option because NHS budgets for 2023/24 have been set to account for both the HMT required 5% uplift, and GDP inflation increases. It is therefore necessary to increase patient charges in order to reduce pressures on NHS budgets.

As NHS Dental Patient Charges are set within the regulations, both options require an amendment to secondary legislation.

Will the policy be reviewed? It **will be** reviewed. **If applicable, set review date: Q4 2023/24**

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: Neil O'Brien Date: 27 March 2023

Summary: Analysis & Evidence

Policy Option A

Description: Option A – increase charges in line with GDP deflators (Business as Usual Option) (7.7%)

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 inflationary uplift option has zero costs or benefits as impacts are assessed as marginal changes against the baseline**.**

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

In line with impact assessment guidance the inflationary uplift option has zero costs or benefits as impacts are assessed as marginal changes against the 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 inflationary uplift option has zero costs or benefits as impacts are assessed as marginal changes against the baseline**.**

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

In line with impact assessment guidance the inflationary uplift option has zero costs or benefits as impacts are assessed as marginal changes against the baseline**.**

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

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: Option B – increase charges in line with the SR21 condition (2021/22) and GDP deflators (2022/23 and 2023/24), adjusted down to reflect cost of living pressures (Preferred Option) (8.5%)

FULL ECONOMIC ASSESSMENT

Price Base Year 2023	**1PV Base Year** 2023	**Time Period Years** 1	**Net Benefit (Present Value (PV)) (£m)**		
			Low: £22m	**High:** N/a	**Best Estimate: £25m**

COSTS (£m)	**Total Transition** (Constant Price) Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Low		£5.7m	£5.7m
High			
Best Estimate		£6.7m	**£6.7m**

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

The monetised costs are the increase in NHS dental charges. This option will increase patient charge revenue (PCR) by an estimated £7.0m in 2023/24 (£5.9m discounted) as compared to Option A (BAU). This cost falls on charge paying patients. Non-charge paying adults and children (all non-charge paying) are not affected.

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

There is a risk that higher patient charges could lead to reduced access to dental care for some individuals. This may have long term impacts on oral health and could have knock on effects on demand for NHS services and NHS revenue.

BENEFITS (£m)	**Total Transition** (Constant Price) Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Low		£27m	**£27m**
High		N/a	**N/a**
Best Estimate		£32m	**£32m**

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

The increased revenue from dental charges could 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 could allow the NHS to produce is 466. Each QALY is valued at £70,000. This gives an overall (discounted) benefit of £32m.

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

None

Key assumptions/sensitivities/risks **Discount rate (%)** **3.5%**

It has been assumed that in 2022/23 NHS dental activity is 100% of that which would have been expected had there been no pandemic (best estimate). A low estimate (85% activity level) is also provided.
It has been assumed that demand for NHS dental services is unaffected by patient charge increases. The risks section considers the uncertainty around this assumption and the possible implications for oral health, patient access and patient charge revenue.

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. However, for NHS dental services, some patients pay an NHS dental charge when receiving dental care. Patients in receipt of NHS dental services are divided into three broad groups with regards to charges: 'paying adults', 'non-paying adults' and 'children' (children are all exempt). Annex A provides further detail regarding those patients who are exempt from charges or entitled to remission of charges.
2. Since 2006, dental 'Courses of Treatment' (CoTs) have been arranged into four bands. CoTs within each band attract the same patient charge (i.e. payable by 'paying adults'). A description of what is included within each CoT band, along with the current patient charges, is provided in the table below:

Table 1 – Description of Course of Treatment Bands

Band	Description	Patient Charge (as at Jan 2023)
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)	£23.80
2	This band covers everything listed in Band 1, plus any further treatment such as fillings, root canal work or extractions	£65.20
3	This band covers everything in Bands 1 and 2, plus course of treatment including crowns, dentures, bridges and other laboratory work	£282.80
Urgent	This band covers urgent assessment and specified urgent treatments such as pain relief or a temporary filling.	£23.80

3. On average, the cost to the patient of NHS dentistry tends to be lower than the cost of accessing dental services privately. However, private dentistry charges vary widely. For example, as set out above, for NHS dental care, a Band 1 CoT attracts a charge of £23.80 whereas Which? found that private providers charged between £20 and £120 for this service. For NHS dentistry, fitting crowns attracts a Band 3 charge of £282.50, whereas 'Which?' found that private providers offered this service for £250 to £1,180[1]. At some point, uplifting dental patient charges could result in NHS dentistry becoming more expensive than private care if private care does not also see an increase in baseline fees.
4. Table 2 sets out the proportion of NHS dental patients that are 'charge paying' and 'non-charge paying' (i.e. exempt). The figures provided are for 2020/21[2] since this is the latest full year data that has been published. Despite 2020/21 being heavily affected by the Covid-19 Pandemic, the proportions of charge paying adults are similar to previous years. The figures show that, of all 'Courses of Treatment' (CoTs) delivered, 53% were for 'paying adults', 19% were for 'non-paying adults' and 28% were for children.

[1] https://www.which.co.uk/reviews/dentists/article/private-and-nhs-dental-charges-al0jA6J1Swyl

[2] NHS Dental Statistics for England - 2020-21 Annual Report - NHS Digital

Table 2 – Courses of Treatment (thousands), 2021/22

	Band 1	Band 2	Band 3	Urgent	Other	Total	% of total
Paying adult	**6,927**	**4,073**	**670**	**2,148**	**85**	**13,902**	**53%**
Non paying adult	**1,255**	**1,347**	**667**	**1,120**	**0**	**4,390**	**17%**
Children	**5,592**	**1,908**	**55**	**515**	**0**	**8,070**	**31%**
Total	**13,774**	**7,328**	**1,391.90**	**3,783**	**85.4**	**26,363**	**100%**

5. NHS dental patient charges are typically uplifted on the 1st April each financial year.
6. NHS dental charges need to be set so that they remain appropriate and fair to all patients. In setting the charges it is important to strike a balance between the contribution the charges represent to the overall NHS budget and the cost to charge-paying patients, recognising the primary policy objectives of improving oral health and guarding against creating financial barriers to accessing NHS dentistry.
7. A commitment was made in the Spending Review 2015 (SR15) settlement to uplift dental patient charges by 5% each year for the duration of the SR15 period (i.e. from 2016/17 to 2020/21). These uplifts were implemented, however, due to the pandemic, implementation of the uplift for 2020/21 was delayed until December 2020.
8. As part of the Spending Review 2020 (SR20), an agreement with HMT was made to uplift dental patient charges by 5% in 2021/22 and 2022/23. However, no uplift has been made during these years due to the pandemic and the recent cost of living.
9. The table below provides a summary of the patient charge uplift %'s implemented since 2016/17.

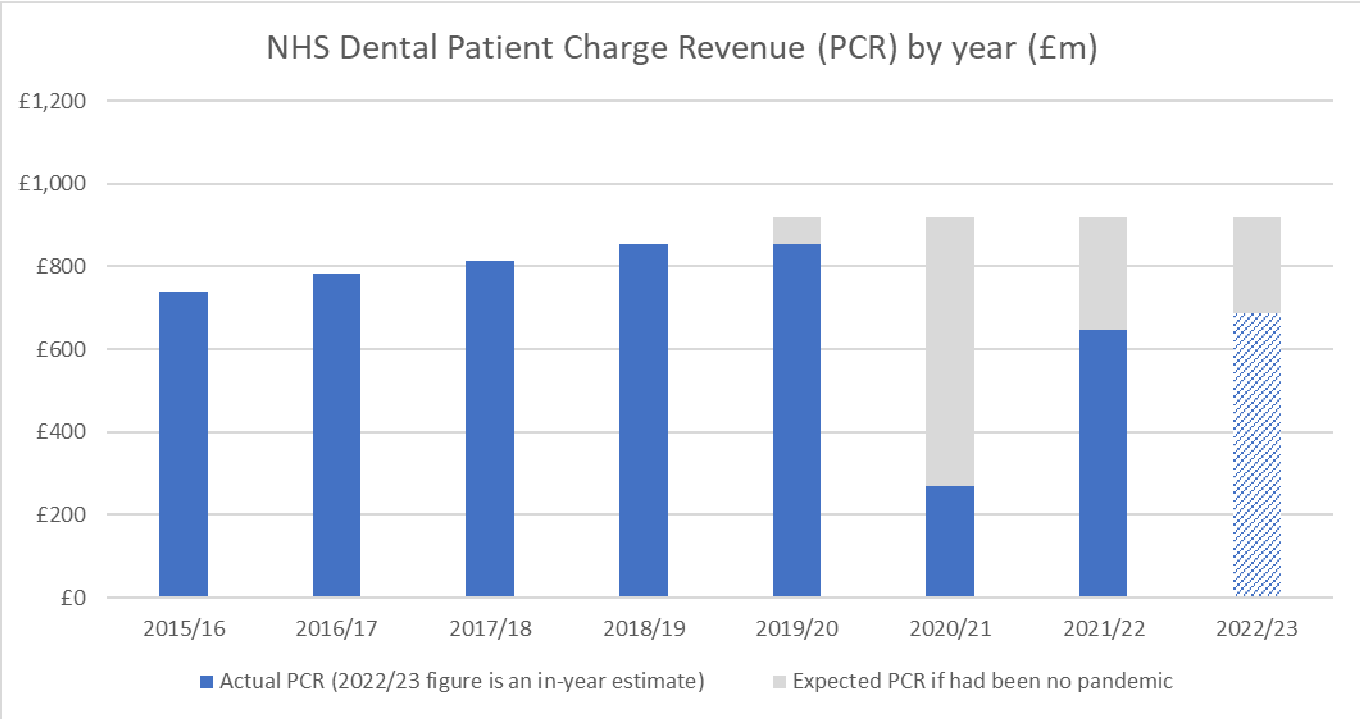
Table 3 – Patient charges uplifts[3] 2015/17 to 2022/23

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
						Uplift delayed and implemented in Dec 2020		
Band 1	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80
Band 2	£51.30	£53.90	£56.30	£59.10	£62.10	£65.20	£65.20	£65.20
Band 3	£222.50	£233.70	£244.30	£256.50	£269.30	£282.80	£282.80	£282.80
Urgent	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80
Uplift %		5%	5%	5%	5%	5%	0%	0%

[3] When patient charge uplifts are applied, patient charge values are rounded to the nearest 10p

10. The pandemic has had a significant impact on NHS dentistry. Although dental practices remained open throughout the pandemic, between March and June 2020 practices only provided emergency or urgent care. After June 2020, practices reopened for non-urgent care, but the level of activity has since increased back towards pre-pandemic levels. In February 2023, 90% of Units of Dental Activity (UDAs) were delivered. Following the pandemic, the UDA delivery rate target of 100% was re-established in June 22.

11. The chart below shows Patient Charge Revenue (PCR) in nominal terms from 2015/16 to 2022/23 and indicates that for 2019/20, 2020/21 and 2021/22, activity levels were at 93%, 29% and 70% of what would have been expected had there been no pandemic, respectively. For 2022/23, the current activity levels for the year so far is 75% of what would have been expected had there been no pandemic. We would expect this level to rise during the rest of the year as further activity will be delivered in March 2023.



12. UDA targets were adjusted during the pandemic recovery period. NHS dentists were provided their full contract value (minus agreed deductions for variable costs) for delivering to a lower threshold, in place of their 100% delivery targets. This was done to protect NHS dentistry and ensure provision remained viable following the pandemic. The target was re-established at 100% in June 2022. Dentists are required to hit their UDA targets to receive the full payment of their NHS contract.

Section 2 – Rationale for intervention and policy objectives

13. A decision is required regarding the level of the dental patient charges uplift to be implemented in 2023/24. The additional revenue from this will contribute to funding NHS dental care.

14. As set out above, NHS dental charges need to be set so that they remain appropriate and fair to all patients. In setting the charges it is important to strike a balance between the contribution the charges represent to the overall NHS budget and the cost to charge-paying patients, recognising the primary policy objectives of improving oral health and guarding against creating financial barriers to accessing NHS dentistry. The uplift only affects charge paying adults.

Section 3 – Description of options considered

15. The options are:

Option A – increase charges in line with GDP deflators (Business as Usual Option) (7.7%)

Whilst this uplift would be implemented in 2023/24, it combines (delayed) uplifts for 2021/22 to 2022/23 with the uplift for 2023/24. These uplifts are all based on the GDP deflators for each year are:

- -0.5% for 2021/22
- 4.9% for 2022/23
- 3.2% for 2023/24[4]

Together, these uplifts compound to an uplift of 7.7% to be implemented in 2023/24.

Option B – increase charges by HMT 5.0% (2021/22) and GDP deflators (2022/23 and 2023/24), with an adjustment for cost of living pressures (Preferred Option) (8.5%)

Whilst this uplift would be implemented in 2023/24, it combines (delayed) uplifts for 2021/22 and 2022/23 with the uplift for 2023/24. The uplifts for each year are:

- 5% for 2021/22, in line with the conditions agreed in SR20
- 2.7% for 2022/23[5]
- 3.2% for 2023/24[6]

Together, these uplifts compound to an uplift of 11.3% to be implemented in 2023/24. To account for cost of living pressures, this uplift has been adjusted down to 8.5%.

Option B is the preferred option because NHS budgets for 2023/24 have been set to account for both the 5% HMT required uplift, and GDP inflation increases. It is therefore necessary to increase patient charges in order to reduce pressures on NHS budgets.

16. Both options require secondary legislation and regulations to be laid.

17. **At an earlier stage, other options were considered and ruled out for various reasons.**

Option C – no uplift to dental charges

This option would keep dental charges frozen for the third year in a row.

This option was ruled out because, while dental charges were frozen during the Covid-19 pandemic, it is not sustainable for NHS budgets to not increase patient charge revenue. It also would not meet the SR20 condition agreed with HMT that charges should be increased (even retrospectively) by 5% for the year 2021/22.

Option D - increase charges by HMT 5.0% (2021/22) and GDP deflators (2022/23 and 2023/24), with no adjustment for cost of living pressures (11.3%)

Whilst this uplift would be implemented in 2023/24, it combines (delayed) uplifts for 2021/22 and 2022/23 with the uplift for 2023/24. The uplifts for each year are:

- 5% for 2021/22, in line with the conditions agreed in SR20
- 2.7% for 2022/23[5]
- 3.2% for 2023/24[6]

Together, these uplifts compound to an uplift of 11.3% to be implemented in 2023/24. There would be no adjustment to account for cost of living pressures.

This option was ruled out as, although it would relieve NHS budget pressures to a larger degree, it was decided that the additional pressure on patients may have deter patients from accessing dentistry treatment services.

[4] All GDP uplifts in option A are based on the latest GDP deflators from the Autumn Statement 2022, published in December 2022. These reflect the best estimate of inflation increase between 2020/21 and 2023/24.

[5] For option B, the GDP uplift for 2022/23 is based on the SR21 deflators published in October 2021.

[6] For option B, the GDP uplift for 2023/24 is based on the Autumn Statement deflators published in December 2022.

Option A – increase charges in line with GDP deflators (Business as Usual) (7.7%)

18. Table 4 shows the patient charges by band for this option (final column).

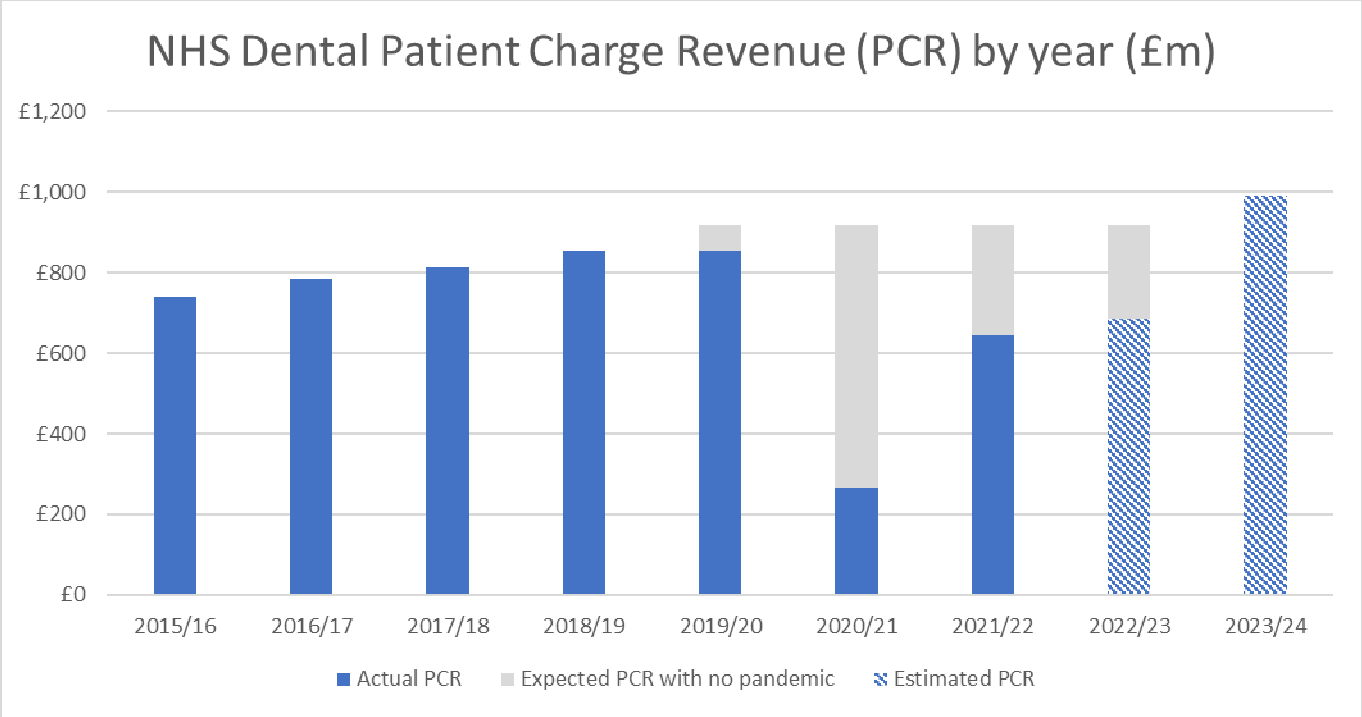
Table 4 – Option A, Patient Charges

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Actual	Actual	Actual	Actual	Actual	Actual (Uplift delayed and implemented in Dec 2020)	Actual	Actual	(Estimated)
Band 1	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80	£25.60
Band 2	£51.30	£53.90	£56.30	£59.10	£62.10	£65.20	£65.20	£65.20	£70.20
Band 3	£222.50	£233.70	£244.30	£256.50	£269.30	£282.80	£282.80	£282.80	£304.70
Urgent	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80	£25.60
Uplift %		5%	5%	5%	5%	5%	0%	0.0%	7.7%

19. Table 5 (and the corresponding chart) shows expected Patient Charge Revenue (PCR) for this option (final column). The PCR estimate assumes that the UDA target of 100% is met.

Table 5 – Option A, Patient Charge Revenue (millions)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	In-year estimate	Estimate based on 100% activity
Band 1	£219	£237	£249	£270	£279	£53	£166	£205	£295
Band 2	£269	£283	£293	£307	£301	£96	£244	£252	£364
Band 3	£213	£222	£227	£231	£226	£67	£185	£182	£263
Urgent	£39	£41	£44	£47	£49	£51	£52	£47	£68
Total	£739	£783	£813	£855	£854	£268	£646	£686	£990



20. Patient charge revenue (PCR) for 2015/16 to 2021/22 are Actuals. The figure for 2022/23 is an in-year estimate, and the figure for 2023/24 is modelled reflecting a 100% UDA delivery target being met.

Option B – increase charges by HMT 5.0% (2021/22) and GDP deflators (2022/23 and 2023/24), with an adjustment for cost of living pressures (Preferred Option) (8.5%)

21. Table 6, below, show the patient charges by band for this option (final column).

Table 6 – Option B, Patient Charges

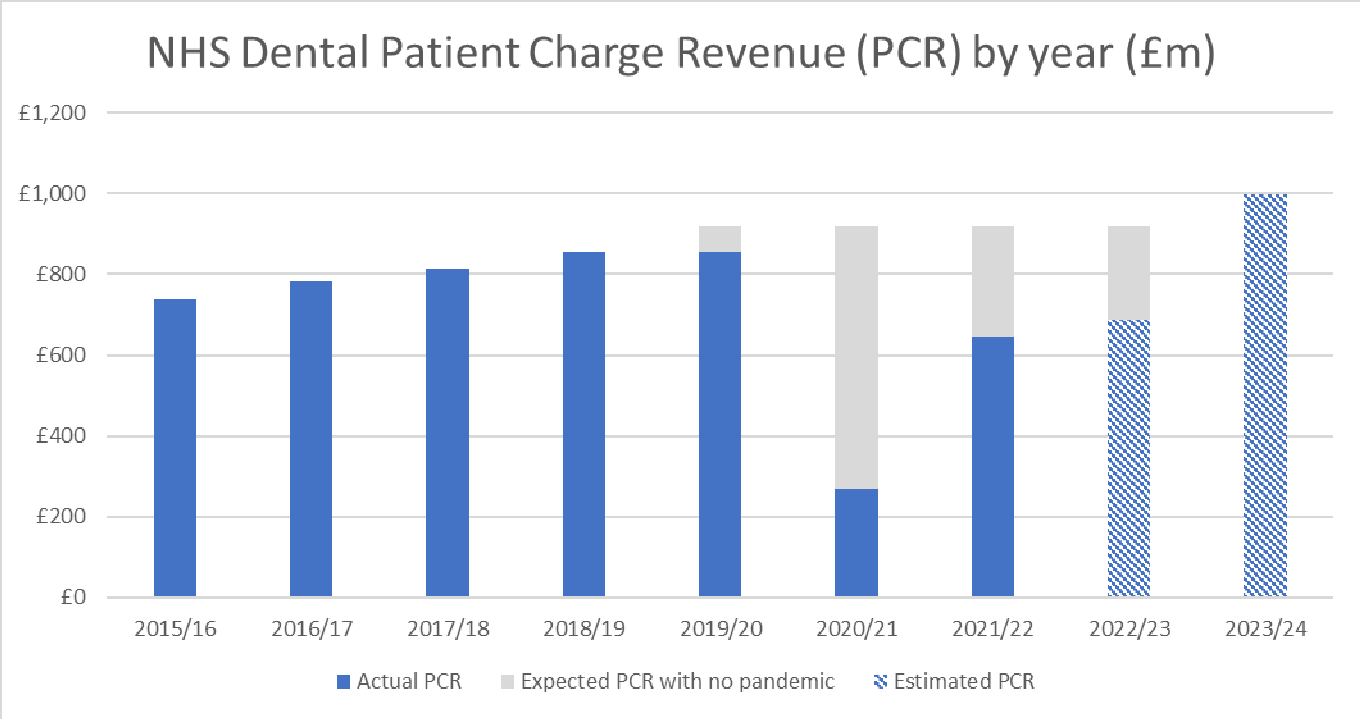
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Actual	Actual	Actual	Actual	Actual	Actual (Uplift delayed and implemented in Dec 2020)	Actual	Actual	(Estimated)
Band 1	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80	£25.80
Band 2	£51.30	£53.90	£56.30	£59.10	£62.10	£65.20	£65.20	£65.20	£70.70
Band 3	£222.50	£233.70	£244.30	£256.50	£269.30	£282.80	£282.80	£282.80	£306.80
Urgent	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80	£25.80
Uplift %		5%	5%	5%	5%	5%	0%	0.00%	8.5%

22. Table 7 (and the corresponding chart) shows expected Patient Charge Revenue (PCR) for this option (final column). The PCR estimate assumes that the UDA target of 100% is met.

Table 7 – Option B, Patient Charge Revenue (millions)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	In-year estimate	Estimate based on 100% activity
Band 1	£219	£237	£249	£270	£279	£53	£166	£205	£298
Band 2	£269	£283	£293	£307	£301	£96	£244	£252	£366
Band 3	£213	£222	£227	£231	£226	£67	£185	£182	£265
Urgent	£39	£41	£44	£47	£49	£51	£52	£47	£68
Total	£739	£783	£813	£855	£854	£268	£646	£686	£997



23. Patient charge revenue (PCR) for 2015/16 to 2021/22 are Actuals. The figure for 2022/23 is an in-year estimate, and the figure for 2023/24 is modelled reflecting a 100% UDA delivery target being met.

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

24. In line with previous dental patient charge uplift Impact Assessments, this IA uses a one-year time horizon for assessing costs and benefits.

Option A – increase charges in line with GDP deflator (Business as Usual) (7.7%)

Costs

Patients

25. As set out above, this option is expected to raise £990m of PCR in 2023/24. This cost falls on charge paying patients. NHS dental services delivered to children and adults exempt from charges are unaffected.

NHS and providers (including administrative burden)

26. Patient charges are collected by dental practices on behalf of the NHS. The collection of charges is carried out by the NHS through the payment system administered by the NHS Business

Services Authority. Raising charges in line with GDP deflator is not expected to increase the burden faced by these organisations. However, under this option a GDP deflator uplift for 2021/22, 2022/23 and 2023/24 are combined to be applied as an uplift in 2023/24. As such, NHS dental providers could potentially face an increased burden if patients question the uplift and what it represents. This burden would be faced by receptionists and practice managers. This cost has not been monetised. We have not considered additional costs if more treatments are needed in future.

Option B – increase charges by HMT 5.0% (2021/22) and GDP deflators (2022/23 and 2023/24), with an adjustment for cost of living pressures (Preferred Option) (8.5%)

Costs

Patients

27. As set out above, this option is expected to raise £997m of PCR in 2023/24 - £6.7m (discounted) more than Option A (Business as Usual). This cost falls on charge paying patients. NHS dental services delivered to children and adults exempt from charges remain unaffected. This assumes no changes in demand.

NHS and Providers (inc. administrative burdens)

28. Patient charges are collected by dental practices on behalf of the NHS. The collection of charges is carried out by the NHS through the payment system administered by the NHS Business Services Authority. The burden on this system is not expected to change as a result of the proposed increases. However, NHS dental providers, do potentially face an increased burden if patients question the change in charges and are less inclined to pay. This burden would be faced by receptionists and practice managers and a potential additional cost to businesses if demand drops. This cost has not been monetised due to a lack of evidence to state the effect.

Benefits

29. NHS services including spend on NHS dentistry are paid for by general taxation. Revenue from dental patient charges contributes to the overall NHS budget. 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.
30. Assuming that the NHS can produce a Quality Adjusted Life Year (QALY) for £15,000, then the increased revenue raised under this option could potentially result in the provision of 466 QALYs which would translate to a monetised benefit of £32m (discounted). A QALY has been monetised at £70,000 in line with latest update of the Green Book[7].

Risks

31. There remains uncertainty regarding whether higher patient dental charges would lead to lower levels of patient access. Although there is limited research on the impact of increases in patient dental charges on patient access in England, it is very likely that higher charges will reduce the number of patients seeking NHS dentistry services relative to there being no patient charge uplift. If the risk of reduced patient access due to increase in charges materialises there would be implications for oral health and the NHS budget. Section 5, below, explores these risks further. This risk has not been quantified.
32. There is also a risk that increases in NHS charges could mean that the cost of NHS dental treatment becomes closer to prices of private dental care. Some patients may choose to receive private care if the cost differential is lower, leading to increased demand for private services and reduced NHS revenue. Currently, for NHS dental care, a Band 1 CoT attracts a charge of £23.80 whereas Which? found that private providers charged between £20 and £120 for this service. For

[7] The Green Book (publishing.service.gov.uk)

NHS dentistry, fitting crowns attracts a Band 3 charge of £282.50, whereas Which? found that private providers offered this service for £250 to £1,180[8]. However, more research is required to understand consumer choices in the UK dental market.

33. Additionally, a potential impact of the pandemic and current economic conditions is that some of the population will have experienced a decrease in their income and may now be eligible to be exempt from charges. Therefore, there is a risk that the actual patient charge revenue could be lower than forecasted but we do not hold any data to measure the size of this risk.

34. The effects on demand of an uplift in patient charges should also be considered alongside the dental backlog caused by the pandemic. The interactions of these effects are difficult to measure, but is likely that any negative effects of this uplift on patient access or demand will take a while to become apparent, due to the amount of people requiring NHS dental care.

35. There is limited research on the impact of patient charges on patient access to dental services in England, but evidence from other healthcare settings suggests that higher charges for healthcare lead to lower demand. Given the current fiscal context with the rising cost of living, it is likely that adverse impacts on patient access to services will be exacerbated by a single charge increase of 8.5%, among those who are not exempt from charges. Current inflation levels are also expected to be putting pressure on peoples' incomes.

Section 5 – Analysis on the Impacts of Price Changes

36. The analysis set out above for Options A and B assumes that demand for NHS dental services is unaffected by patient charge increases - i.e. that demand is price inelastic with regards to the price changes (charge increases) being considered.

37. There remains uncertainty about whether higher patient dental charges would lead to lower levels of patient access. Although there is limited research on the impact of increases in patient dental charges on patient access in England, it is very likely that higher charges will reduce the number of patients seeking NHS dentistry services, relative to their being no patient charge uplift. However, it is possible that some patients are relatively insensitive to modest changes in price in respect of NHS dental services, particularly where they are for 'essential' interventions and/or where the patient benefit often outweighs the price.

<u>Elasticity</u>

38. However, research by the RAND Corporation suggests that price elasticity of demand for medical care is roughly in the region of -0.1 to -0.2 [9]. However, it should be noted that this research is based on the US health system and focusses on general medical services with no specific reference to dentistry. We have increased the range to (-0.1, -0.3) to attempt to account for the recent increased cost of living. However, more research needs to be carried out in this area to understand the effect of price increases to dental patient access.

39. Using an elasticity range of -0.1 to -0.3, the preferred option to uplift Dental Charges by 8.5% could result in demand for dental care decreasing by a range of 0.8% to 2.5%. Uplifting by the BAU option of 7.7%, could result in dental demand decreasing by a range of 0.8% to 2.3%. General increases in the cost of living or other pandemic effects could impact this further, but there is currently insufficient data in this area.

40. As part of the cost benefit analysis, the costs and benefits over 10 years have been considered to understand the longer term impacts of the charge uplift.

41. Using the amended RAND price elasticity parameters and assuming 100% activity, cost-benefit analysis suggests that option B (8.5%) will give a 10-year net benefit in the range of £160m to £250m by 2032, compared to option A (7.7%). Therefore, if price elasticity does impact demand, we estimate that the difference in net benefit could be up to £95m.This can be seen in the chart below.

[8] https://www.which.co.uk/reviews/dentists/article/private-and-nhs-dental-charges-al0jA6J1Swyl

[9] https://www.rand.org/content/dam/rand/pubs/monograph_reports/2005/MR1355.pdf

Table 8 – 10 year net benefit by elasticity band

Elasticity	10-year net benefit (Option B compared to Option A)
0	£250,191,741
-0.1	£220,154,216
-0.2	£190,116,691
-0.3	£160,079,166

42. The cost benefit analysis over 10 years shows that the benefit each year decreases. This is because the standard discount factors from the HMT Green Book[10] have been applied to each year whilst also adjusting for a constant year-on-year demographic and demand increase, holding the nominal value of charges constant. Therefore, the 10 year net benefit described in table 8 is not equal to ten times the one year net benefit described in the Analysis and Evidence section above.

York University research on the effects of increasing patient charges

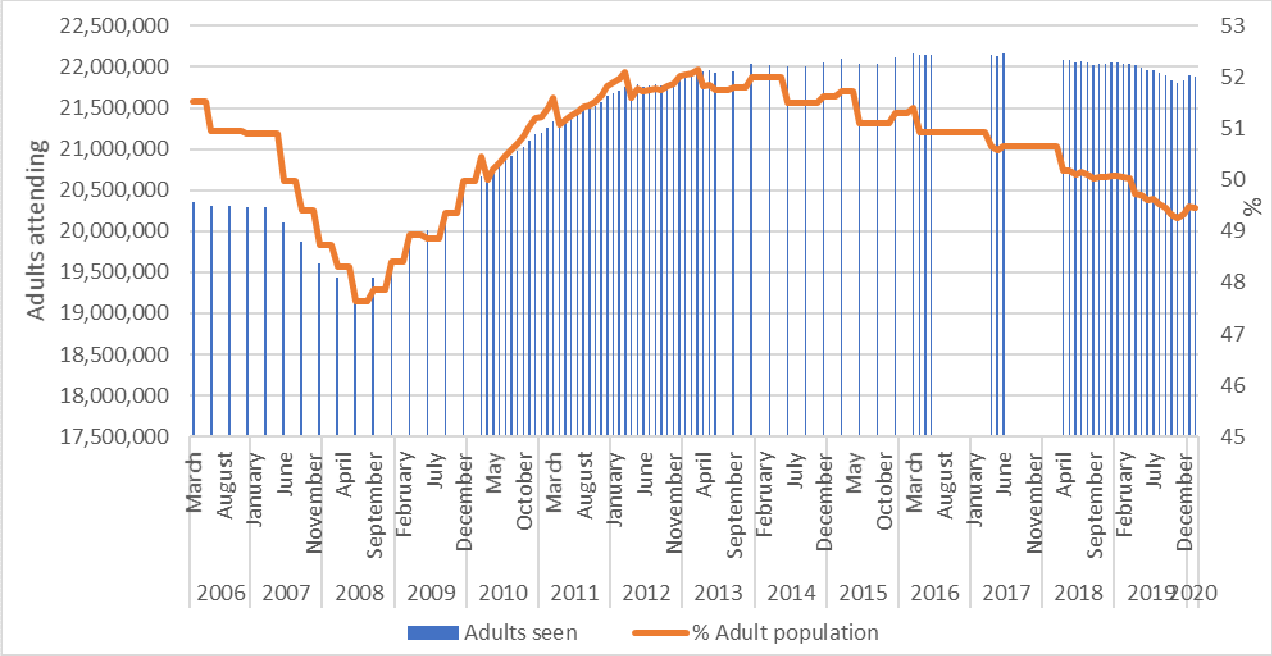
43. Due to the limited evidence, DHSC commissioned additional research from York University to help understand the impact of raising patient charges on demand for NHS dentistry.[11] The research was commissioned in response to the SR15 commitment to increase patient charges by 5% each year during the SR period. The research did not find a statistically significant link between higher patient charges and reduced demand but does not rule out such a link. Finding such a link is complicated by general population-wide improvements in oral health over time; the changing size and shape of groups who are exempt from charges; and the difficulty in disentangling the impact of availability of NHS dental services from the level of charges. The chart below shows that since 2013, the percentage of adults that reported visiting a dentist has been falling as the number of adults seen has not kept pace with a growing population. In the last two to three years, the absolute number of adults seen has also fallen slightly, however, it is not possible to be certain about any link between dental patient charges and this change.

Number and percentage of adults reporting having visited a dentist in the previous 24 months (rolling total)[12]

[10] The Green Book (2022) - GOV.UK (www.gov.uk)

[11] https://www.york.ac.uk/media/healthsciences/images/research/prepare/NHS%20dental%20charges%20and%20the%20effect%20of%20increases%20on%20access%20-%20an%20exploration.pdf

[12] https://www.york.ac.uk/media/healthsciences/images/research/prepare/NHS%20dental%20charges%20and%20the%20effect%20of%20increases%20on%20access%20-%20an%20exploration.pdf



44. However, point estimates from the York University work suggest that higher charges may reduce access, particularly in less well-off areas. This would be in line with the broader literature on patient charges in healthcare. If higher charges do reduce demand, there are a number of risks that could follow from that.

45. The York University research focuses on adults, as children are exempt from charges. However, if patients no longer attend the dentist due to an increase in costs, there is a risk that they do not take their children to the dentist either which may have consequences for their oral health. The PHE Oral Health Inequalities report also suggests that cost is reported as a barrier to dental care for children[13]. This may be due in part to availability of NHS dentists or a lack of knowledge of exemptions.

Dental System Reform

46. The recently announced Dental System Reform[14] took effect by November 2022. This should allow a higher capacity of UDAs and will also change the balance of band treatments to support the delivery of a higher proportion of Band 2 and 3 CoTs compared to pre-pandemic levels. These reform items could affect total revenue and it will be difficult to differentiate between any positive effects of the reform and any potential negative effects of patient charge uplifts on patient access and demand.

Impact on patients

47. Additionally, an impact of the pandemic and cost of living crisis is that some of the population will have experienced a decrease in their income and may now be eligible to be exempt from charges. Although there is no clear data on the impact this may have on NHS dental revenue, there is a risk that the actual revenue could be lower than forecasted, as it has been calculated assuming that the percentage of CoTs for the individuals exempt from charges remains the same as in 2019/20.

48. There is a potential risk that this uplift would cause a decrease in patient demand. However, this decrease may not be apparent due to the size of the NHS dental backlog. Although some patients may be lost due to the increased cost of living and uplift in dental costs, those who still

13 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/970380/Inequalities_in_oral_health_in_England.pdf

14 NHS England » First stage of dental reform

need care but couldn't access it at the time during pandemic could result in an overall increase to demand. The risk here is that it appears that the uplift has not had an impact on patient access, but these figures are distorted by the backlog and in usual circumstances a decrease would have been seen.

49. Increased costs could lead to patients choosing to defer treatment. If patients no longer visit the dentist for regular check-ups and decline more expensive treatment options because of increased costs, there is risk that this could lead to fall in oral health of those patients. This could lead to a rise in dental caries, periodontal disease and tooth extractions. We have performed some analysis that estimates roughly 3.5% and 0.5% of missed Band 1 appointments result in an additional Band 2 and Band 3 treatments needed, respectively. Therefore, there is a risk that patients who do not attend check-ups due to the price increase may develop more complex oral health issues.

50. The risk of patents deferring treatment and requiring urgent A&E care also risks additional strain on this part of the NHS – this risk has not been quantified.

51. We have also considered movement of patients from NHS to private provision after the pandemic. This showed that roughly 2% of the NHS backlog may have already been met by private dental provision, based on revenue figures in both private and NHS dental practises. However, this may not be a recurring trend of patient shift to private care, especially due to other factors such as the increased cost of living. There is currently no robust analysis to outline what might happen in the future on the movement between private and NHS provision.

Impact on businesses

52. 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 seek 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, which may have a positive impact on equalities considerations.

53. The risks to patients have been outlined above, but there are also potential risks posed to businesses. An increase in the costs of NHS dental care could lead to patients either not being able to afford NHS dental care or choosing to use private care, resulting in a loss to NHS businesses. This risk is currently unquantified as further data would be required to carry out this type of analysis. Current demand for NHS dentists could mean that an imminent risk to a loss of businesses is unlikely, however this may still be a risk for the future.

54. Raising NHS charges could have an impact on the private business of a dental practice. Higher NHS charges means that the cost of NHS treatment could be closer to the prices for private dental care. Some patients may choose to receive private care as the cost differential is lower, leading to increased demand for private services and reduced demand for NHS services. However, as above, current demand for NHS dentists would suggest that demand for NHS dentistry services is unlikely to fall below the current supply. It is difficult to quantify these costs and the resulting impact of patient behaviour.

Section 6 – Evaluation & Future Work

55. As identified in section 5, evidence to support the elasticity calculations is limited. Research carried out by York University (commissioned by DHSC) went some way to filling the gap on the impact of raising patient charges on demand for NHS dentistry. To build on this research, we are currently exploring commissioning additional work in this area. This would allow us to understand more definitively the impact on demand for dental care when patient charges increase.

56. As part of this work, we also considered break-even analysis to determine the point at which total cost and total revenue are equal and the benefits of implementation are neutralised. To carry out a meaningful break-even analysis, it would be beneficial to have a better understanding of how dental charge uplifts affect consumers' choices and a more accurate estimate of price elasticity in the dentistry. We would also need to consider cost of living pressures and pressures on other parts of the NHS caused e.g., increased A&E dental care.

57. Research is currently being commissioned through NIHR to better understand unmet need for dentistry. It is hoped this work will then lead to a better understanding of potential demand and how uplifted patient charges might impact dentists' ability to meet this need. The first stage of the research is currently being undertaken by PRU-Comm who are seeking to understand and draw conclusions from the literature and data currently available on unmet need.

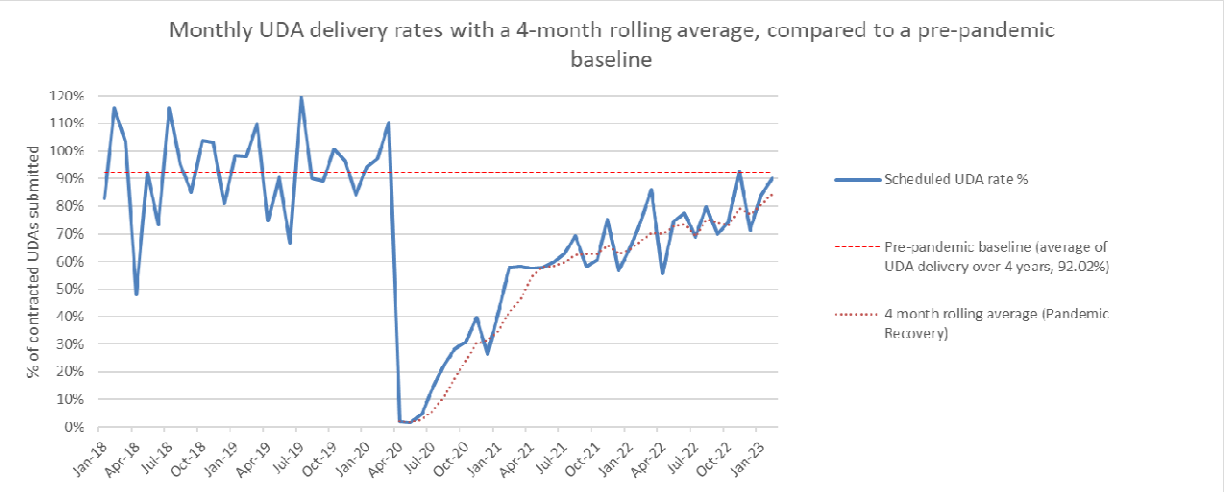
58. We are also currently exploring other research options to commission further work on NHS dentistry.

Section 7 - Summary of the Options

59. Table 9 sets out the net benefit of Option B (the preferred option) as compared to Option A (the Business as Usual option).

60. As described earlier, the costs and benefits set out above assume that activity levels in 2023/24 are at 100% of that that would be expected had there been no pandemic. Table 8 also provides costs and benefits reflecting a lower activity level of 85% in 2023/24 being achieved.

61. The decision to base the low estimate on 85% of UDA activity is derived from the current rolling average performance of NHS dentists in the 2022/23 financial year so far.



62. The 4 month rolling average of UDA delivery rates seen in the graph above show that the trend of delivery rates is increasing towards 85%. It is therefore reasonable to set a low estimate of 85% for UDA delivery rates in 2023/24.

63. There have been regional disparities on progress for hitting these recent targets, with the lowest activity levels in the South West. The 4 month rolling average of UDA delivery for the South West is 64%, while the 4 month rolling average UDA delivery rate for London, the highest performing region, is 89%.

Table 9 – Option B, Net Benefit, Full Year

	Low estimate	**Best estimate**

	(85% activity in 2023/24)	(100% activity in 2023/24)
Cost (Present Value[15])	£5.7m	£6.7m
Benefit (Present Value[16])	£27m	£32m
Net Present Value	£22m	£25m

64. Should option B be implemented, the impact of the change can be measured through two measures; Patient Charge Revenue and in particular demand, in terms of both Courses of Treatments and Units of Dental Activity, to see how these compare against pre-pandemic years.

Equality

65. The Department of Health and Social Care has prepared an Equality Assessment for these regulations in addition to this impact assessment.
66. 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. The Government recognises that raising NHS dental charges has the potential to have a greater impact on patients from lower incomes than more affluent patients and has sought to address this through the policy design.
67. 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.[17] More details of exemptions are given in Annex A. No changes are planned as a result of this uplift to the categories of patients eligible for help or to the help available.
68. We do not have any 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.
69. The Equalities Impact Assessment identifies some potential impacts to groups with protected characteristics and sets out how policy options meet the requirements of the Public Sector Equality Duty.
70. As referenced in the risks above, one concern is a spillover effect on children. If adults stop attending the dentist, they may be less likely to take their children too, despite there not being a charge for children's dental care.

[15] A discount rate of 3.5% has been used for costs in line with DHSC guidance.

[16] A discount rate of 1.5% has been used for benefits (QALYs) in line with DHSC guidance.

[17] 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.