Title: Dental Patient Charge Uplift 2024/2025
IA No:
Lead department or agency: Department of Health and Social Care

Impact Assessment (IA)

Date: 19/02/2024

Stage: Final

Source of intervention:

Type of measure: Secondary Legislation

Contact for enquiries:
Charlotte Bryant
Robert Betts

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option

Total Net Present Social Value	Business Net Present Value	Net cost to business per year (EANDCB)	Business Impact Target Status
£130.4m	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 a patient is in an exempt group. A decision is required regarding the level of the dental patient charge uplift to be implemented in 2024/25. 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 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 – no uplift to dental charges (Business as Usual Option) (0%)
This option would keep dental charges frozen at the same level as 2023/24.

Option B – increase charges by 4% (Preferred Option) (4%)
For the 2023/24 increase, a two-year uplift was agreed of 8.5% in 2023/24 and 4% in 2024/25. This two-year uplift combines (delayed) uplifts for 2021/22 and 2022/23 with the uplifts for 2023/24 and 2024/25. During a period that has been financially challenging for many, it was decided this uplift would be split across 2 years – 8.5% in 2023/24 and 4% in 2024/25 – giving a combined uplift of 12.8%. Therefore, option B is to implement the second of the two-year uplifts agreed last year– this is 4% for 2024/25. Option B is the preferred option because it will reduce pressures on NHS budgets for 2024/25. These pressures have grown as patient charge uplifts have not kept up with GDP inflation (GDP Deflator).
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 2024/25**

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: Andrea Leadsom Date: 1 March 2024

Summary: Analysis & Evidence

Policy Option A

Description: Option A – no uplift to dental charges (Business as Usual Option) (0%)

FULL ECONOMIC ASSESSMENT

Price Base Year 2024	PV Base Year 2024	Time Period Years 1	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 no uplift option has zero costs or benefits as impacts are assessed as marginal changes to the baseline.

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

In line with impact assessment guidance, the no uplift option has zero costs or benefits as impacts are assessed as marginal changes 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 no 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 no 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 by 4% (Preferred Option) (4%)

FULL ECONOMIC ASSESSMENT

Price Base Year 2024	1PV Base Year 2024	Time Period Years 1	Net Benefit (Present Value (PV)) (£m)		
			Low: £116m	**High:** £144.9m	**Best Estimate: £130.4m**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low			£31m	£31m
High			£38.5m	£38.5m
Best Estimate			£34.7m	**£34.7m**

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 £36m in 2024/25 (£34.7m 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 contact with dental care for some individuals, such as those with an income that is not low enough for them to be exempt from charges but are still facing financial hardship. 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			£147m	**£147m**
High			£183.4m	**£183.4m**
Best Estimate			£165.1m	**£165.1m**

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 2,358. Each QALY is valued at £70,000. This gives an overall (discounted) benefit of £165.1m.

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

None

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

It has been assumed that in 2024/25, NHS dental activity is 90% of that which would have been expected if 100% of commissioned activity was delivered (best estimate). A low estimate (80% activity level) and a high estimate (100% activity level) is also provided. The low estimate is based on a lower delivery rate than current performance of contracts in this financial year. The high estimate is based on all contracts delivering 100% of their commissioned dental activity.

It has been assumed that the amount of NHS dental services delivered in the year 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.

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' (all children are 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 (Jan 2024)
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)	£25.80
2	This band covers everything listed in Band 1, plus any further treatment such as fillings, root canal work or extractions	£70.70
3	This band covers everything in Bands 1 and 2, plus course of treatment including crowns, dentures, bridges, and other laboratory work	£306.80
Urgent	This band covers urgent assessment and specified urgent treatments such as pain relief or a temporary filling.	£25.80

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 £25.80, whereas Which? found that private providers charged between £40 and £130 for this service. For NHS dentistry, fitting crowns attracts a Band 3 charge of £306.80, whereas 'Which?' found that private providers offered this service for £450 to £1,050[1]. At some point, uplifting dental patient charges could result in NHS dentistry becoming more expensive than some 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 2022/23[2] since this is the latest full year data that has been published. The figures show that, of all 'Courses of Treatment' (CoTs) delivered, 52% were for 'paying adults', 16% were for 'non-paying adults' and 31% were for children.

Table 2 – Courses of Treatment (thousands), 2022/23

	Band 1	Band 2	Band 3	Urgent	Other	Total	% of total
Paying adult	9,406	4,704	722	2,131	84	17,047	**53%**

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

[2] NHS Dental Statistics for England, 2022-23, Annual Report - NHS Digital

Non-paying adult	1,531	1,860	774	1,084	0.01	5,249	**16%**
Children	7,125	2,449	72	535	0.2	10,182	**31%**
Total	**18,063**	**9,013**	**1,567**	**3,750**	**84**	**32,478**	**100%**

5. NHS dental patient charges are typically uplifted on the 1st of April each financial year.
6. NHS dental charges need to be set so that they remain appropriate and fair to 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. There was no uplift to dental patient charges in 2021 or 2022 due to the impact of the pandemic. The 2023/24 uplift of 8.5% was put in place to reduce pressure on NHS budgets after two years of no uplift and to provide important revenue to deliver care. The decision to split the uplift needed to keep up with inflation over 2023 and 2024 was made to reduce impact on patients during a period reported to be financially challenging for many. This 4% uplift is the second year of the two-year proposal.
9. The table below provides a summary of the patient charge uplift %'s implemented since 2016/17.

Table 3 – Patient charges uplifts[3] 2015/16 to 2023/24

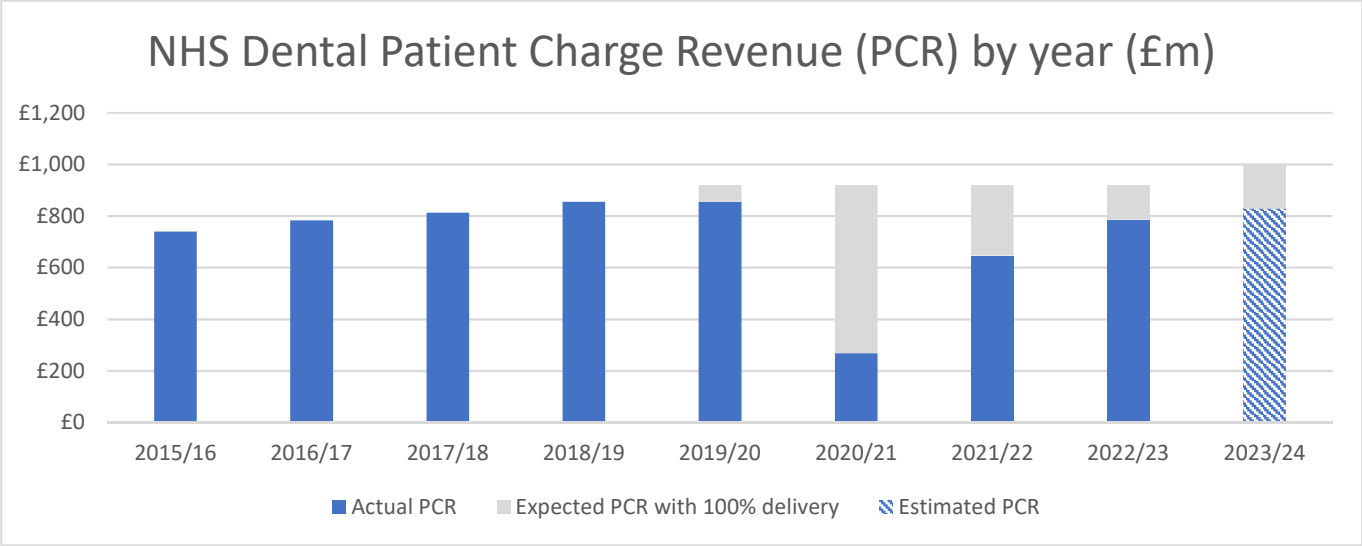
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
						Uplift delayed and implemented in Dec 2020			
Band 1	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80	£25.80
Band 2	£51.30	£53.90	£56.30	£59.10	£62.10	£65.20	£65.20	£65.20	£70.70
Band 3	£222.50	£233.70	£244.30	£256.50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

10. The chart below shows Patient Charge Revenue (PCR) in nominal terms from 2015/16 to 2023/24. The NHS Business Services Authority published data[4] shows that for 2019/20, 2020/21, 2021/22 and 2022/23, activity levels were at 89%, 27%, 64% and 79% of what would have been expected if 100% of commissioned activity was delivered, respectively. For 2023/24 so far, activity levels show that 83% of commissioned Units of Dental Activity (UDAs) have been

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

[4] English Contractor Monthly General Dental Activity - Datasets - Open Data Portal BETA (nhsbsa.net)

delivered, which is shown in the chart below, but this level is likely to rise in the final months of the financial year.



11. 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

12. A decision is required regarding the level of the dental patient charges uplift to be implemented in 2024/25. The additional revenue from this will contribute to funding NHS dental care.
13. As set out above, NHS dental charges need to be set so that they remain appropriate and fair to 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

14. The options are:

Option A – no uplift to dental charges (Business as Usual Option) (0%)

This option would keep dental charges frozen at the same level as 2023/24.

Option B – increase charges by 4% (Preferred Option) (4%)

For the 2023/24 increase, a two-year uplift was agreed of 8.5% in 2023/24 and 4% in 2024/25. This two-year uplift combines (delayed) uplifts for 2021/22 and 2022/23 with the uplifts for 2023/24 and 2024/25. The uplifts for each year are:

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

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

- 3.2% for 2023/24[6]
- 1.3% for 2024/25[7]

During a period that has been financially challenging for many, it was decided this uplift would be split across 2 years – 8.5% in 2023/24 and 4% in 2024/25 – giving a combined uplift of 12.8%.

Therefore, option B is to implement the second of the two-year uplifts agreed last year– this is 4% for 2024/25.
Option B is the preferred option because it will reduce pressures on NHS budgets for 2024/25. These pressures have grown as patient charge uplifts have not kept up with GDP inflation (GDP deflator).

The most recent GDP deflator forecasts suggest that the forecasts that these uplifts were based on (Autumn 2022) predicted lower levels of inflation than has actually been seen in the last year. The latest forecast shows that, since 2020, prices have increased by 14.2%. The combined 8.5% and 4% uplifts – equivalent to a 12.8% uplift overall – is therefore lower than this latest estimate of inflation.

15. Both options require secondary legislation and regulations to be laid.
16. In both options, it has been assumed that in 2024/25, 90% of commissioned UDAs will be delivered. As discussed above, since UDA delivery rates fell during the pandemic, there has been recovery year on year. It is expected that the delivery rate for 2023/24 will be around 83%. It is therefore assumed that delivery rates will continue to increase in 2024/25, and that these rates will also be boosted by initiatives outlined in the new Dentistry Recovery plan, published in February 2024[8].
17. **At an earlier stage, other options were considered and ruled out for various reasons.**

Option C – increase charges in line with GDP deflators[9] (2024/25) (1.7%)

While this uplift is in line with expected inflation in 2024/25, it does not account for the issue that the uplift implemented in 2023/24 was lower than GDP inflation (GDP deflator).

This option was therefore ruled out because the lower revenue from patient charges will not relieve NHS budget pressures.

Option D - increase charges by 5.0%

This uplift would be consistent with the 5% uplift condition that was agreed in SR20.

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 deter patients from accessing dentistry treatment services.

Option A – no uplift to dental charges (Business as Usual) (0%)

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	2024/25

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

[7] For option B, the GDP uplift for 2024/25 is based on the Autumn Statement deflators published in December 2022

[8] Faster, simpler and fairer: our plan to recover and reform NHS dentistry - GOV.UK (www.gov.uk)

[9] For option C, the GDP uplift for 2024/25 is based on the Autumn Statement deflators published in December 2023

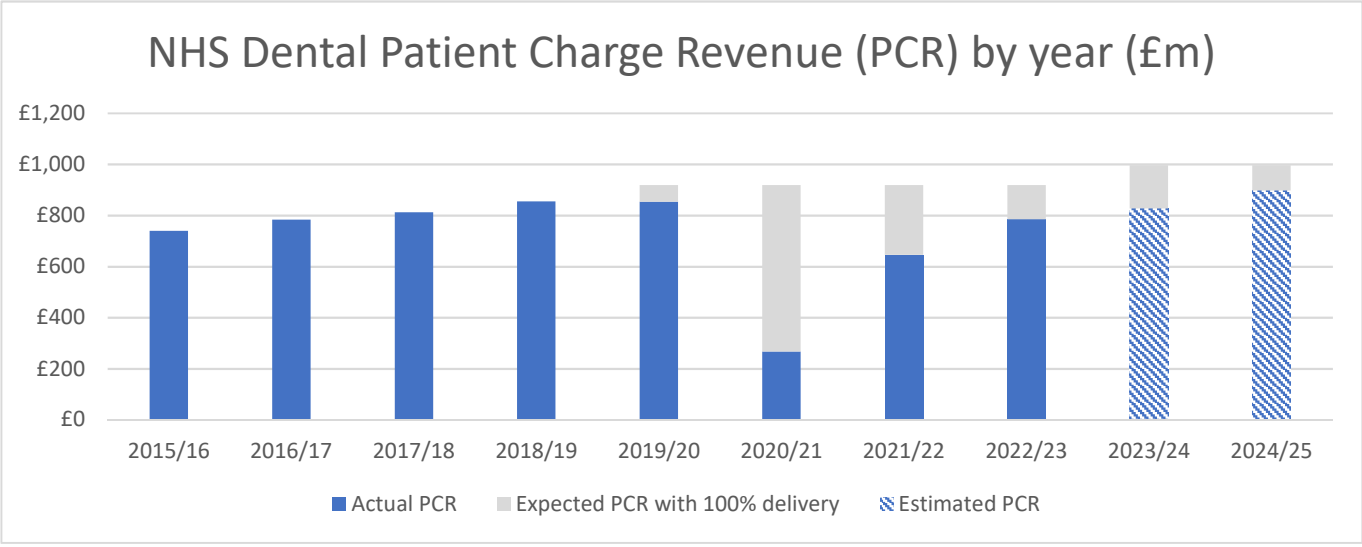
	Actual	Actual	Actual	Actual	Actual	Actual (Uplift delayed and implemented in Dec 2020)	Actual	Actual	Actual	(Estimated)
Band 1	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80	£25.80	£25.80
Band 2	£51.30	£53.90	£56.30	£59.10	£62.10	£65.20	£65.20	£65.20	£70.70	£70.70
Band 3	£222.50	£233.70	£244.30	£256.50	£269.30	£282.80	£282.80	£282.80	£306.80	£306.80
Urgent	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80	£25.80	£25.80
Uplift %		5%	5%	5%	5%	5%	0%	0.0%	8.5%	0%

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 90% 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	2024/25
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	In-year estimate (based on 83% delivery)	Estimate based on 90% activity
Band 1	£220	£239	£249	£270	£278	£54	£165	£224	£247	£268
Band 2	£297	£312	£319	£334	£329	£107	£366	£307	£304	£330
Band 3	£221	£230	£234	£239	£234	£71	£189	£204	£220	£238
Urgent	£38	£41	£43	£46	£49	£52	£51	£51	£57	£62
Total	£777	£822	£846	£889	£891	£283	£671	£785	£828	£898

20. Patient charge revenue (PCR) for 2015/16 to 2022/23 has been calculated using annual published stats[10] and the patient charge value for each year. The figure for 2023/24 is an in-year estimate, which assumes an 83% UDA delivery rate, and the figure for 2024/25 is modelled



reflecting a 90% UDA delivery target being met.

[10] NHS Dental Statistics for England, 2022-23, Annual Report - NHS Digital

Option B – increase charges by 4% (Preferred Option) (4%)

21. Table 6, below, show the patient charges by band for this option (final column). The reflected uplift in line with the GDP deflator, as previously mentioned, since the GDP deflator is a more accurate measure of inflation for the purposes of dental charges.

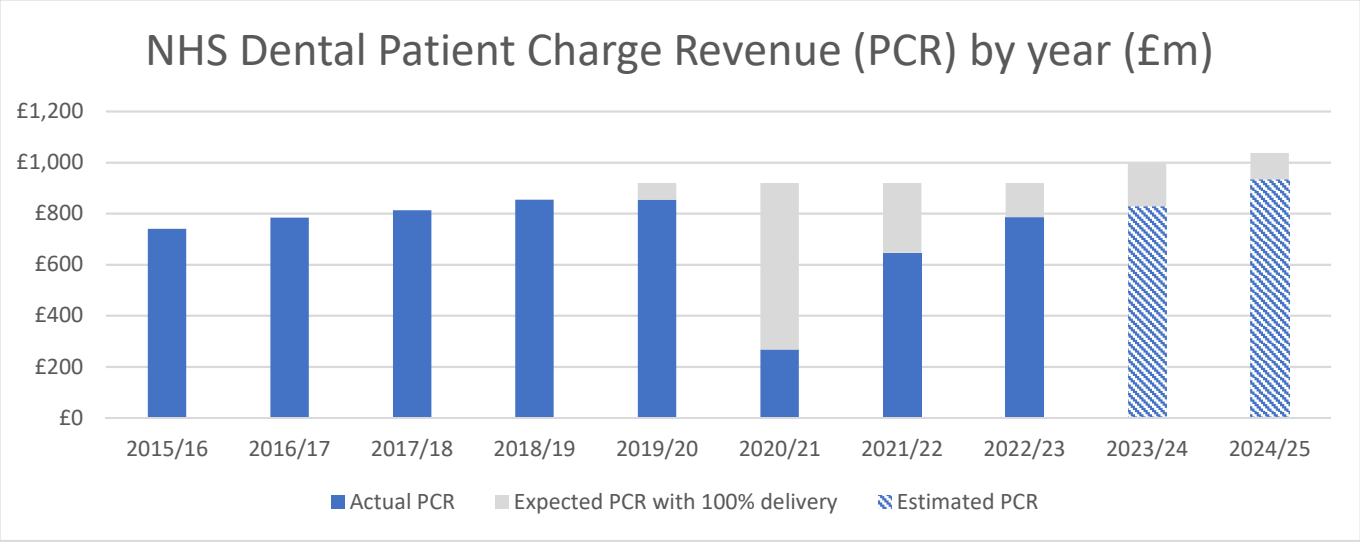
Table 6 – Option B, Patient Charges

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Actual	Actual	Actual	Actual	Actual	Actual (Uplift delayed and implemented in Dec 2020)	Actual	Actual	Actual	(Estimated)
Band 1	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80	£25.80	£26.80
Band 2	£51.30	£53.90	£56.30	£59.10	£62.10	£65.20	£65.20	£65.20	£70.70	£73.50
Band 3	£222.50	£233.70	£244.30	£256.50	£269.30	£282.80	£282.80	£282.80	£306.80	£319.10
Urgent	£18.80	£19.70	£20.60	£21.60	£22.70	£23.80	£23.80	£23.80	£25.80	£26.80
Uplift		5%	5%	5%	5%	5%	0%	0%	8.5%	4%

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 90% 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	2024/25
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	In-year estimate (based on 83% delivery)	Estimate based on 90% activity
Band 1	£220	£239	£249	£270	£278	£54	£165	£224	£247	£279
Band 2	£297	£312	£319	£334	£329	£107	£366	£307	£304	£343
Band 3	£221	£230	£234	£239	£234	£71	£189	£204	£220	£248
Urgent	£38	£41	£43	£46	£49	£52	£51	£51	£57	£64
Total	£777	£822	£846	£889	£891	£283	£671	£785	£828	£934



23. Patient charge revenue (PCR) for 2015/16 to 2022/23 has been calculated using annual published stats[11] and the patient charge value for each year. The figure for 2023/24 is an in-year estimate, which assumes an 83% delivery rate, and the figure for 2024/25 is modelled reflecting a 90% 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.
25. To calculate costs and benefits, a best estimate on the level of activity that will be delivered in 2024/25 has been set. The best estimate has been set as the mid-point between the low and high activity delivery rate. The low estimate assumes that 80% of activity will be delivered, in line with current activity levels, while the high estimate has been set as 100%, as this would assume that all commissioned dental activity is delivered.

Option A – no uplift to dental charges (Business as Usual) (0%)

Costs for Option A

Patients

26. As set out above, this option is expected to raise £898m of PCR in 2024/25. This cost falls on charge paying patients. NHS dental services delivered to children and adults exempt from charges are unaffected.

Option B – increase charges by 4% (Preferred Option) (4%)

Costs for Option B

Patients

27. As set out above, this option is expected to raise £934m of PCR in 2024/25 - £34.7m (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)

[11] NHS Dental Statistics for England, 2022-23, Annual Report - NHS Digital

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 because 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 and because it is considered to be a small cost compared to other costs and benefits.
29. There will be an additional administrative cost of uplifting patient charges. This includes costs such as media campaigning to promote awareness of changes to patient charges such as leaflets and posters. The estimated size of these costs is c. £25,000, based on producing the necessary number of posters and leaflets for NHS dental practices to advertise the charges associated with NHS dental treatment, the treatments provided and how help with costs can be sought. This cost estimate is based on the printing of posters and leaflets, their onward distribution to practices and the ability of practices to order more of these materials throughout the year. Given it is very small compared to other costs, it has not been included within the summary cost analysis.

Benefits

30. 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.
31. In line with evidence estimating NHS's opportunity costs which suggests the NHS can produce a Quality Adjusted Life Year (QALY) for £15,000 at the margin[12], then the increased revenue raised under this option could potentially result in the provision of 2,358 QALYs which would translate to a monetised societal benefit of £165m (discounted). A QALY has been monetised at £70,000 in line with latest update of the Green Book[13].

Section 5 – Analysis on the Impacts of Price Changes

32. The analysis set out above for Options A and B assumes that the total amount of NHS dentistry delivered is unaffected by patient charge increases. Recent data suggests that this assumption is reasonable, as, despite multiple patient charge uplifts in recent years, the overall uptake of NHS dental care has not reduced. However, there remains uncertainty about whether higher patient dental charges would lead to lower levels of NHS dentistry delivered in the future.

Impacts on Patients

33. There is limited research on the impact of patient charges on patient access to dental services in England, but economic theory plus 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 4% among those who are not exempt from charges. Current inflation levels are also expected to be putting pressure on peoples' incomes.
34. Increasing the patient charges, looked at in isolation, is a regressive policy. A regressive tax or policy is one which takes a higher percentage of a person's income who falls into a lower income group, i.e., those on lower incomes, pay more because of the tax or policy relative to their income. Increases to Patient Charges will have a greater impact on those on lower incomes as Patient Charges are the same for all non-exempt patients and thus would be a higher percentage of their income than a non-exempt patient on a higher income. However, the exemption criteria are there to protect children and those on the lowest incomes or entirely dependent on benefits.

[12] Claxton et al., 'Methods for the Estimation of the NICE Cost Effectiveness Threshold', CHE Research Paper 81 (2013) www.york.ac.uk/che/research/teehta/thresholds/

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

35. Increased costs could lead to some patients deferring 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. It is widely reported that missed band 1 appointments can lead to a rise in dental caries, periodontal disease, and tooth extractions. 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.

36. 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 £25.80 whereas Which? found that private providers charged between £40 and £130 for this service. For NHS dentistry, fitting crowns attracts a Band 3 charge of £306.80, whereas Which? found that private providers offered this service for £450 to £1,050[14].

37. Data shows that there has been an increase in recent years of patients choosing to receive private dental care. The GP Patient Survey (GPPS) shows that the proportion of patients who have not tried to get an NHS dental appointment in the last 2 years because they prefer to go to a private dentist has risen from 26% in 2019, to 28% in 2023[15]. There is currently no robust analysis to outline what might happen in the future on the movement between private and NHS provision.

    However, we do know that people on higher incomes are more likely to have private health

38. Some mitigation is provided through exemptions, as patients on lower incomes may fall into an exemption category. Those qualifying for income support, income related employment and support allowances, job-seeker's allowance, pension guarantee credit and universal credit are exempt from paying patient charges. There will, however, be a group of patients that are both in low-income groups and not exempt from patient charges.

Impacts on the NHS

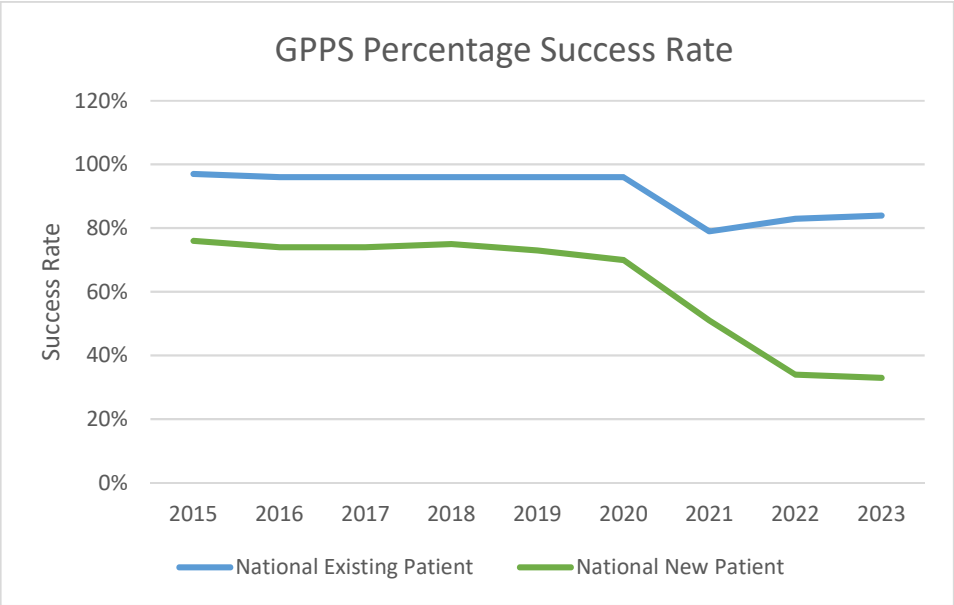
39. As discussed above, there is a potential risk that some patients may no longer be able to afford NHS dental care, however, this may not be apparent when looking at the NHS system as a whole. The GP Patient Survey (GPPS) results over time show that the success rate of patients getting an NHS dentist appointment has declined. The success rate for patients was 95% pre-pandemic, and this fell to 77% in 2023. This suggests that there has been a growing group of people who have wanted NHS dental care but have not been able to see an NHS dentist. 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.

Proportion of new and existing patients successfully getting a dentist appointment in the previous 24 months[16]

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

[15] Statistics » GP Patient Survey Dental Statistics (england.nhs.uk)

[16] Statistics » GP Patient Survey Dental Statistics (england.nhs.uk)



40. Additionally, due to the limited evidence, DHSC commissioned research from York University to help understand the impact of raising patient charges on demand for NHS dentistry.[17] 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.

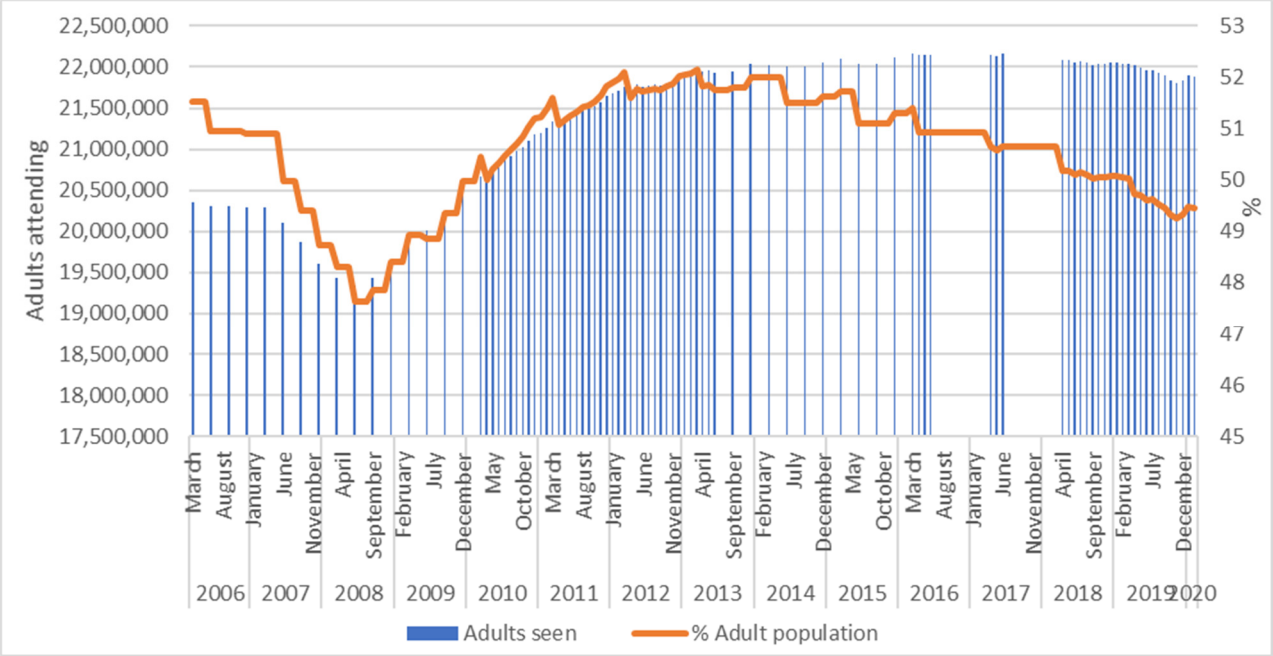
Number and percentage of adults reporting having visited a dentist in the previous 24 months (rolling total)[18]

17

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

18

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



41. 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.

42. 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[19]. This may be due in part to availability of NHS dentists or a lack of knowledge of exemptions.

43. 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.

44. 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.

45. Taking all the above evidence into consideration we feel that despite the increased pressures on household finances, current levels of increased levels of demand for NHS dentistry mean that increases to charges are unlikely to impact patient charge revenues to a large extent.

Dental System Reform and Plans to Recover and Reform NHS dentistry

46. The Dental System Reform[20] took effect by November 2022. This should allow a higher capacity of UDAs and will also change the balance of band treatments by introducing tiered bands 2a – 2c within band 2. This is 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 by shifting the treatment balance between the different bands. 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.

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

20 NHS England » First stage of dental reform

47. In February 2024, the Department for Health and Social Care and NHS England announced a plan to recover and reform NHS dentistry. These plans include deploying new mobile dental vans into areas where there are no NHS dental practices, introducing a New Patient Premium to encourage NHS dentists to see new patients, and offering a 'golden hello' to dentists who want to move to areas that persistently struggle to attract dentists into NHS work. These plans aim to increase the amount of NHS treatments delivered by dentists, and this will in turn likely lead to an increase in the total revenue received from patient charges. 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 businesses

48. The risks to patients and to the NHS as a whole have been outlined above, but there are also potential risks posed to individual dental 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 businesses delivering NHS contracts. 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.

49. The change in charges could also have two 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.

50. 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

51. As identified in section 5, evidence on the impact of increasing patient charges 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.

52. As part of this work, we have 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 dental sector. We would also need to consider cost of living pressures and pressures on other parts of the NHS caused by the uplifts, e.g., increased A&E dental care.

53. We are currently awaiting the results from the first stage of research that is currently being commissioned through NIHR. This first stage has been undertaken by PRU-Comm who are seeking to understand and draw conclusions from the literature and data currently available on unmet need in dentistry. It is hoped that this, alongside the future stages of work, will lead to a better understanding of NHS dental care as a whole, and how uplifted patient charges plays a part in this picture.

54. We are also currently exploring other research options to commission further work on NHS dentistry. However, it is important to note that there is continual monitoring of uplifts to patients charges, there has been systemic monitoring of performance management of contracts and through review of the system as a whole. This is to ensure that any adverse impact of the uplift is captured and noted to shape future policy and decision making.

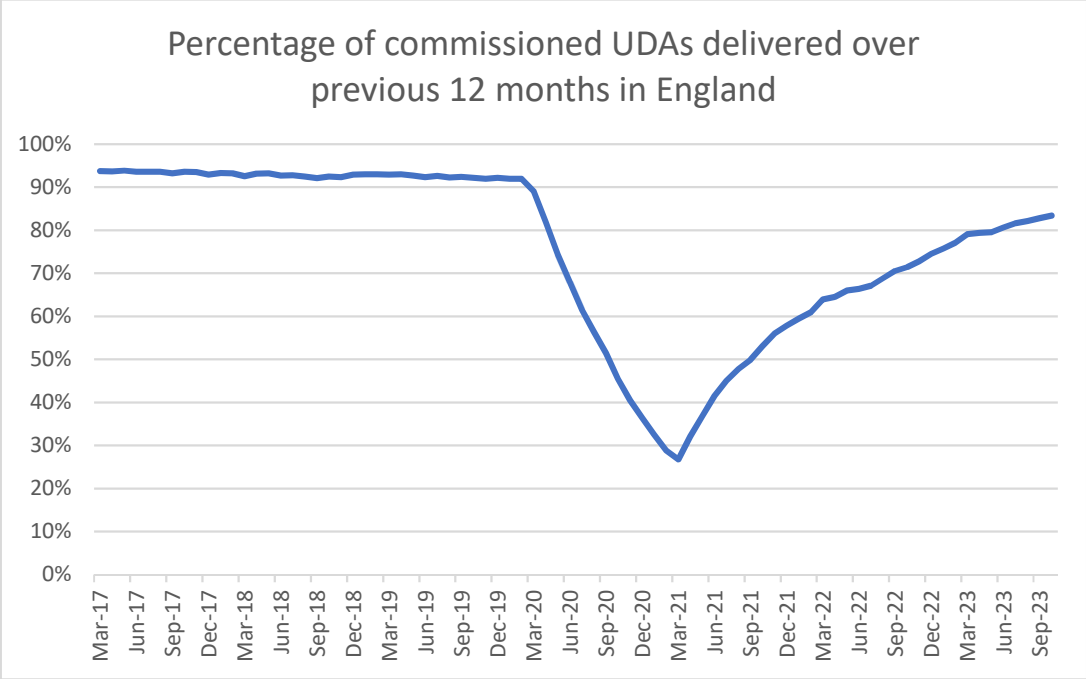
Section 7 - Summary of the Options

55. Table 8 sets out the net benefit of Option B (the preferred option) as compared to Option A (the Business as Usual option).

56. The best estimate of costs and benefits set out above assume that the activity delivery rate in 2024/25 will be 90%, (i.e., 90% of commissioned activity is delivered by NHS dentists). Table 8 also provides costs and benefits reflecting a lower activity delivery rate of 80% and a higher activity delivery rate of 100% in 2024/25 being achieved.

57. The decision to base the low estimate on 80% of UDA activity is derived from the current rolling average performance of NHS dentists in the 2023/24 financial year so far.

Percentage of commissioned UDAs delivered over previous 12 months in England, from March 2017 to October 2023[21]



58. The 12-month rolling UDA delivery rates seen in the graph above show that the trend of delivery rates has increased to just over 80% in 2023/24. It is therefore reasonable to set a low estimate of 80% for UDA delivery rates in 2024/25. The high estimate has been set as 100%, as this would assume that all commissioned dental activity is delivered. The best estimate has been set as the mid-point between the low and high activity delivery rate.

59. There are disparities between Integrated Care Boards (ICBs) in their performance against their UDA delivery targets, with the lowest activity levels in the South-West. In the 12 months to September 2023, the 12-month rolling UDA delivery rate for Somerset ICB was 58%, while this figure was 96% for North East London ICB.

Table 8 – Option B, Net Benefit, Full Year

[21] English Contractor Monthly General Dental and Orthodontic Contractual Dataset - Datasets - Open Data Portal BETA (nhsbsa.net)

	Discounted Low estimate (80% activity in 2024/25)	**Discounted Best estimate** (90% activity in 2024/25)	**Discounted High estimate** (100% activity in 2024/25)
Cost (Present Value[22])	£31m	£34.7m	£38.5m
Benefit (Present Value[23])	£147m	£165.1m	£183.4m
Net Present Value	£116m	£130.4m	£144.9m

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 previous years.

Equality

60. The Department of Health and Social Care has prepared an Equality Assessment for these regulations in addition to this impact assessment.
61. 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.
62. All children are excluded from charges as are adults who are pregnant or have had a baby in the last 12 months. 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.[24] More details of exemptions are given in Annex A. No changes are planned because of this uplift to the categories of patients eligible for help or to the help available.
63. 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.
64. 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.
65. As referenced in the risks above, one concern is a spill-over 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.

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

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

[24] 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.