Reflection from Northern Ireland

A new primary dental care contract in Northern Ireland has been implemented which follows the same direction as proposals outlined in the Steele Review. Simon Reid reports on the latest developments...

There's an old joke often re-counted here about a lost traveller stopping to ask for directions from an old farmer somewhere in rural Ireland. The farmer listens carefully to where the traveller wants to go, pauses to think and then says, "Well, if you're heading there, you wouldn't want to be starting from here!"

Having been heavily involved in the development and negotiation of a new Primary Dental Care Contract (PDCC) in Northern Ireland since late 2006, our work and proposals in the Steele Review are heading in the same direction.

Up until the 2006, the new dental contract was introduced in England and Wales, while Northern Ireland and Scotland had taken the existing GDS model and then made regional adjustments to bring it within their legislation. Most of the framework and regulations were carried across and there were obvious resource advantages for Northern Ireland and Scotland in 'piggy-backing' in this way. Other components were added to or modified in the GDS contract to suit both countries' individual needs. Both these parts of the UK have continued to use their regionally adjusted GDS systems.

Need for reform

From Northern Ireland's perspective, the work in England on the modernisation of dentistry with the Options for Change Agenda, led to the realisation that our current GDS system needed reform. The drive for change began with our Oral Health Strategy in 2004 and Primary Dental Care Strategy in 2006, which have led to the development of a bespoke contract to meet our specific public dental health needs. In November 2006, negotiations began between the Department of Health, Social Services & Public Safety (Northern Ireland) and the Dental Practice Committee of the Northern Ireland Branch of the British Dental Association.

By developing our new contract, having reflected on the original GDS, the PDS model and the 2006 contract, it could be said that our work parallels the Steele Review process. I accept that we have had the benefit, as have those in Scotland, of watching the Steele Review process. We do not derive pleasure from this, but rather have reflected on your experiences and used these considerations whilst planning and developing our own contract model.

A blended approach

One of the earliest steps we took in 2007 was to commission Professor Ciaran O'Neill, a dental economist formerly of Queen's University Belfast, to carry out a global review of primary dental care remuneration systems and the current GDS model. Ciaran subsequently reported that the best approach was a blended model that would maximise the advantages of the different remuneration methods. We were already operating a de facto blended system (approximately one third of dentists' earnings was from non-item of service), but he recommended that we should develop the blend towards a 'predominant' equity and efficacy of care. We also recognised the earlier recommendations from a regional perspective we are pleased with the tremendous similarities with the independent-led Steele review. From a Northern Ireland perspective we are pleased with the recommendations of the Steele Review. We have continued to use their regionally adjusted GDS systems.

Review, while not defining a list of treatments, suggests a similar approach for routine care and "advanced/high-skill treatments" through proposals that not all practitioners may provide these.

Improving access

We believe that local commissioning of care is the key to improving access, but it is also important to make the contract more effective for GDPs. Our aim is to increase practitioner commitment by recognising that a mixed economy and the clearly defined range of clinically and cost-effective treatments, as 'Essential Dental Services' for those requiring urgent care but not long-term patient care and preventive measures by using a Patient Care Pathway and with associated registration.

Registration simplified

We propose an enhanced capitation payment for registration via the Patient Care Payment to cover the 'full medical journey' through the Patient Care Pathway. As such, it is more representative of patient-care needs than the original concept and banding of registration and continuing care payments under GDS arrangements. DHSSPSNI is currently developing a weighted capitation formula to calculate a patient-specific payment dependent on patient need and truly reflecting expected workload.

We now note that the Steele review recommends registration and payment for the continuing care of patients.

Effective communication

We propose to have clear and open communication between patients, practitioners and commissioners. The aim is to ensure that all understand their own responsibilities while being fully aware of what to expect from the other parties in this relationship. The aim is to correct past market failures of what Professor Steele calls the, 'lack of transparency' and what Professor O'Neill describes as, 'Asymmetric information' in our model there will be key roles for the commissioners to produce a, "simple and transparent" system that is, "easily accessible and understandable" for patients. Such a system could be achieved by primarily using web-based information. Equally we must communicate effectively with practitioners and facilitate them to adjust their practice to the new and different 'philosophy' of our new contract.

Data and administration

Our proposals are to have a simplified system of administration and reporting with practice-based data sets and minimum data sets for reporting to reduce the administrative burden. There has been some criticism of the 2006 contract resulting in reduced data capabilities for the BSA and the Steele Review proposes the development of a common set of indicators. An effective data capability can inform weighted capitation systems. We also concur that data reporting should be carried out electronically and we hope to develop an 'IT-lite' system for simplified reporting, which could also be linked into existing integrated practice management systems for those practices that are fully computerised.

From a Northern Ireland perspective we are pleased with the independently-led Steele review which appears to support many of our current proposals. We hope that our colleagues in the rest of the UK can now reflect on our work and be reassured by the tremendous similarities with the findings and recommendations of the Steele Review.

Current work is ongoing and further structural changes are currently under discussion including the development of a common remuneration methodology for both England and Scotland, to provide greater efficiency and equity of access to dental care, whilst also facilitating regular payments for improved practice cashflow. Importantly, quality of care will also be recognised and rewarded.

A core range of treatments

A key process has been to consider existing GDS 'items' and 'open access items' what we call "Essential Dental Services" that should be available under the new contract. These are the treatments that we consider are the most cost effective and are evidence-based using a hierarchy of evidence.

We have defined and listed this range; but also have a process to allow opportunity for equality of access to care in exceptional cases where clinical necessity is proven, the "Exceptional Treatments". The Steele Review recommends registration and payment for the continuing care of patients.

From Northern Ireland perspective we are pleased with the independently-led Steele review which appears to support many of our current proposals. We hope that our colleagues in the rest of the UK can now reflect on our work and be reassured by the tremendous similarities with the findings and recommendations of the Steele Review.

We currently are undergoing great structural changes here following a review of public administration in health and social care, but are continuing to develop our new contract and are actively working towards pilot testing. Local commissioning groups have been set up and with the establishment of a single health and social care board (regional equivalent of PCT), there is a huge opportunity to develop effective local commissioning arrangements. We await with interest the results of the work that will follow on from the Steele Review and we in turn, will be able to reflect on those findings.

About the author

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