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...

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Having been heavily involved in the development and negotiation of a new Primary Dental Care Contract (PDCC) in Northern Ireland since late 2006, our current GDS system needed reform and to grow 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 (NI) 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 how the 2006 contract was rolled out in England and Wales and the challenges times as it was bedded in. 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 health 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 between fee for service and capitation and equity of care. We also recognised the earlier recommendations from the Options for Change and the modernisation of dentistry led to the realisation that with the OfC, GDS systems with the current GDS system, and which had been developed in an attempt to reduce the ‘treadmill effect’ and facilitate 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 consult with practitioners and the GDS model, what we call “Essential 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 model and negotiation with practice has 20 year’s experience in general dentistry and is currently a dental officer with the Business Services Organisation in Belfast and has been seconded part-time to the Department of Health, Social Services & Public Safety (NI) and the Dental Practice Committee of the Northern Ireland Branch of the British Dental Association.

We propose to have clear and open communication between practitioners, patients and commissioners. The aim is to ensure that all understand their own responsibilities whilst 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 “complexity of knowledge” and what Professor O’Neill describes as, “Asymmetric information”. In our model there will be a key duty 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 philosophies of our new contract.

Registration simplified
We propose an enhanced capitation payment for registration via the Patient Care Payment to cover the patient 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 payment under GDS arrangements. DHSSPNI 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 whilst 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 “complexity of knowledge” and what Professor O’Neill describes as, “Asymmetric information”.

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Key items of common ground between the Steele Recommendations and the draft N. Ireland PDCC model

- Staged pathway
- Registration for continuing care
- Age banding
- Prevention care
- Evidence-based guidelines
- Essential services/quality/activity payments
- Proposed development of quality measures
- Defined data set
- Proposed range of restorative treatment
- Weighted capitation formula

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 are reassured by the tremendous similarities with the findings and recommendations of the Steele Review.

Currently we 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 piloting. 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 an opportunity to develop effective local commissioning arrangements. We await with interest the result 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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