In the uproar following the 2006 dental contract, one of the main criticisms coming from all quarters was that no pilot studies had been carried out before it was rolled out - and that if it had been, surely it wouldn’t have been implemented in its current form.

By definition a ‘pilot’ is a small scale study designed to test a system for flaws before a full scale launch, in order to avoid costly mistakes.

As we all know, trials are currently taking place in preparation for the ‘New New Contract’; however, as these trials do not test the final version of the contract, is it correct to describe them as ‘pilots’? One might argue that by not field testing the final version of the new contract the current trials are dragged a long way away from the definition of a ‘pilot’ and simply do not test the most unpredictable variables of the lot: the human responses towards the incentives contained within the new contract and how this might skew clinical decision making.

The current trials aim to explore a range of facets such as a patient pathway, a quality and outcome framework, and methods of remuneration. As I simply don’t understand the first two, I will stick to examining the third aspect, remuneration, in this article; however, I promise to come back to you if I can manage to get my head around these in the future. The three remuneration models being tested are Type one - guaranteed income, Type two - a simulation of capitation and Type three - a simulation of capitation for routine treatment and guaranteed income identified for complex treatment.

At present the DoH has not confirmed whether it will or will not ‘pilot’ the final version of the contract prior to implementation but surely there is a good case for this to be piloted for a reasonable amount of time before we can judge its merits. Recently the DoH announced that it is to introduce another 25 pilot sites to the existing 70. The DoH claim that the extra sites will help fine-tune different parts of the new contract that will see dentists paid for the number of patients they care for, and the health results they produce, rather than the number of courses of treatment they perform.

I strongly support piloting the new dental contract, in New Dental Pilots: Practical or Pointless? Will the pilots tell us anything useful? asks Neel Kothari

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One of the most important things we need to decide upon before we can trial any form of change is the basis of what we are changing to. This is something we can only really do effectively if the government and the profession have a frank and open discussion about what is going to be provided in the new dental contract system.

Unfortunately, dentistry is expensive, has always been expensive and probably always will be expensive, but in light of this expense if the government funds a ‘core’ system then, no matter how we polish it, a core system is what we will get.

In my opinion what we really need to be discussing is how, in the face of a very limited budget, we can get dentists (myself included) to do more dentistry for less money in a way that is perceived to be fairer by all and incentivises the profession to want to do what is in patients’ best interests. Frankly it’s not in anyone’s interest if dentists get paid ridiculously high sums of money for carrying out a small filling and then a comparatively low sum of money for root treating a multi-rooted tooth. The skew in remuneration between ‘reward’ and ‘effort’ has effectively degraded the profession to many to consider NHS dentistry as a core service in all but name.

In 2008 the Health Select Committee (HSC) reported on the state of the dental sec-