

Capitation-based pilots – whither the outcome?



The skinny on dentistry

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The new NHS pilots will be based on the model of dentist remuneration largely (80%) derived from capitation, with the remainder being evenly split between patient registration and 'quality'.

The concept of capitation as a funding method for dentistry raises a degree of controversy. Just as remuneration wholly based on fee per item work may encourage over-treatment, capitation gives rise to the possibility of supervised neglect, i.e. remuneration without the proper dental care.

This latter situation is exacerbated by the absence of a single valid objective measure of dental care – one dentist's ethical non-interventionist 'wait and see' approach may appear to another as a prima facie case of neglect.

It is difficult to evaluate patient outcome under capitation fairly in a 'snapshot' review, however well annotated the patient records, as the heart of the concept is one of continuing care.

The success of capitation is also dependent on it being properly managed and, most importantly, properly funded. Under-funding inevitably leads either to neglect or to a diminution in dentist earnings. Arrangements where time allocation according to patient needs is not properly managed lead to chaos.

Despite these misgivings, capitation can work extremely well in the private sector, where the opportunity for proper funding and patient-centric time management exists.

As an ongoing contract between dentist and patient, where the dentist's livelihood depends on the continued patient goodwill, capitation should optimise patient outcome as dentist and patient interests are very much aligned.

The control over the delivery of care in an ongoing relationship is relatively self-regulated by the satisfaction of the fee-paying patient, who can always take their custom elsewhere.

However, in the state sector, this situation of checks and balances simply does not exist. Funding may well diminish, as patient contributions are likely to reduce significantly, thus contracting the overall pot available.

A situation where so much of dentist remuneration is based on non-interventionist care for patients who feel they have no choice of dentist, and who have little understanding of the care they receive, and where the outcome is hard to objectively analyse in a snapshot review, represents a huge gamble with the nation's oral health.

While many dentists will ethically try to make the new system work, without proper funding and management either their patients' oral health or their remuneration will suffer. Of course, there will also be those dentists who will do well, and whose costs will drop significantly at the expense of patient outcome.

A cynic might think that the decision to do away with the DRO team leaving the CQC inspectorate's expertise wholly in the realms of regulatory box-ticking rather than carrying any clinical depth whatsoever may have something to do with this.

If the regulatory inspectorate is in no position to judge clinical outcome, then where can any evidence of state-sponsored supervised neglect be uncovered?

All part of a blind dogma to increase access without regard to improving patient outcome.