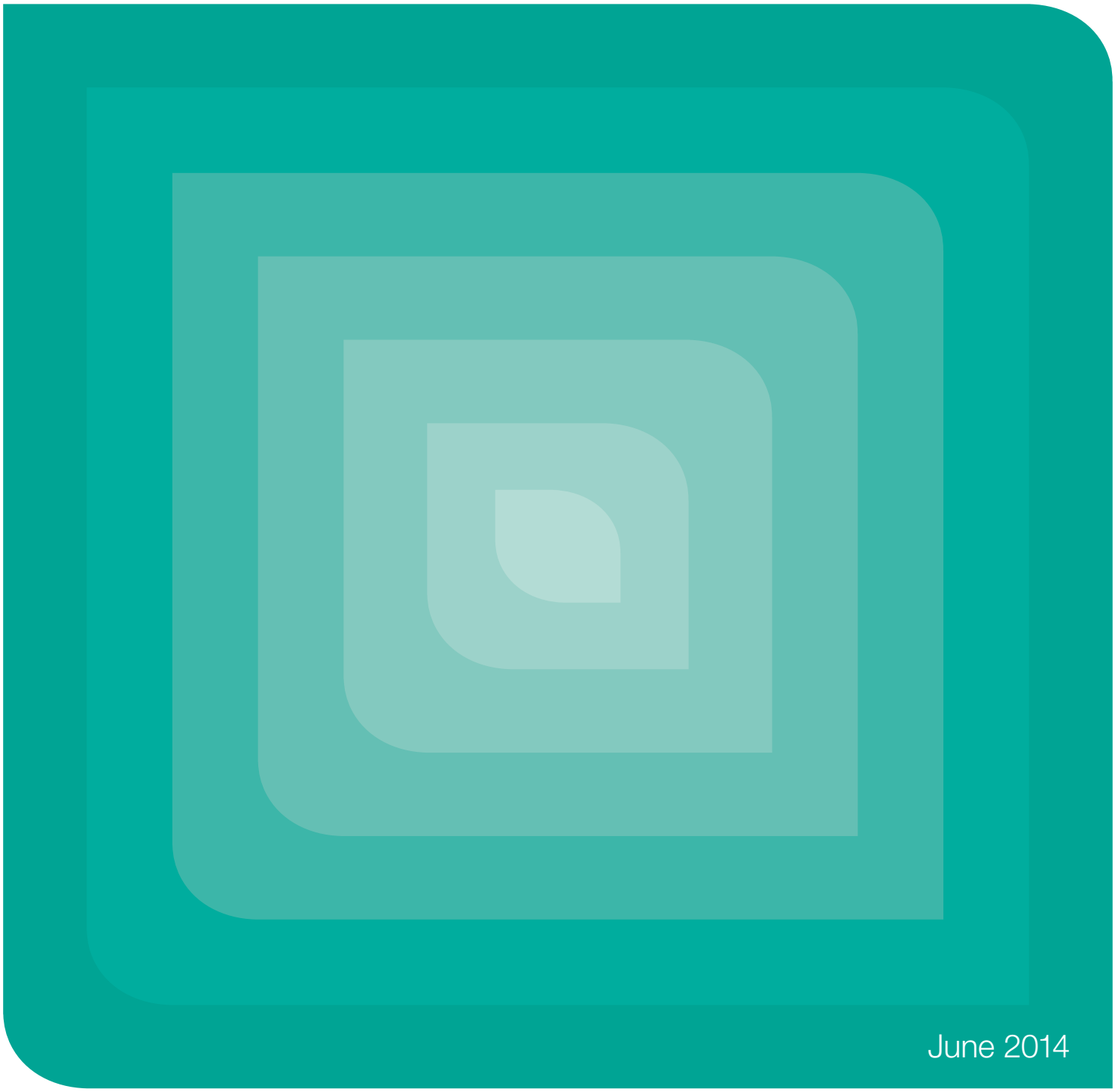
Department of Health

Dental Contract Reform: Engagement

Paper 4: The remuneration approach



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Purpose

The purpose of this paper is to consider the remuneration approach we are developing through the Dental Contract Reform programme. The paper covers:

1. The importance of developing a suitable remuneration model

2. Features of any new system

3. Remuneration based on quality and outcomes

4. Remuneration based on activity, capitation or a blend of capitation and activity

5. Next steps

There is an opportunity to feedback your comments at the end of this document.

1. The importance of developing a suitable remuneration model

One of the main challenges facing healthcare services is to ensure the provision of consistent, timely and evidence-based high quality care to all whilst making the best use of available resources to meet demands. Over the last 20 years, the NHS has increasingly adopted a pathway approach to care to address this challenge.

Adoption of the pathway approach in dentistry is an important step in meeting the goal set by ministers to increase access and improve oral health. A remuneration model needs to support the preventive pathway approach to care, reward appropriate levels of treatment and health outcomes as well as increasing access to dental services.

2. Features of any new system

There are a number of system features within which a reformed contract needs to be designed. These are listed in the overview document and repeated here also as they are important to bear in mind when considering a remuneration approach:

- Overall expenditure by the NHS on dentistry is not expected to alter as a result of these system changes
- The scope of NHS care is expected to remain unchanged
- It will be a commissioned system where contract remuneration remains capped
- There will be metrics for measuring delivery and there will be financial recovery where there is under-performance
- The current ability to flex the levels of service a practice offers by an agreed variation (temporary or permanent) to the levels of service specified will be retained. Any new remuneration system will have to have this capacity
- Patient charges will be expected to continue to raise a similar proportion of costs and the collection of charges is expected to remain with practices
- The system is expected to continue to allow for appropriate mixing of private and NHS care.

3. Remuneration based on quality and outcomes

An element of remuneration in any new contract will be based on quality and outcome measures in the shape of a Dental Quality and Outcomes Framework (DQOF).

We envisage that as in the pilots, practices will in the future be remunerated based on their relative performance against the DQOF. This mechanism means practices are rewarded for better performance whilst ensuring the total expenditure for commissioners and total income for providers as a whole remains unchanged.

In the pilots, 10% of contract value is effectively based on performance against the DQOF for which up to 1000 points can be achieved. The DQOF is designed, however, so that we expect the large majority of pilots to achieve at least 800 points meaning in the large majority of cases only 2% of contract value would be at risk. Where a pilot achieves less than 1000 points, any contract value deducted is entered into a notional national pool to be redistributed amongst pilots based on their relative performance. Pilots can be remunerated up to 102% of their contract value based on this additional payment.

In the pilots, there are DQOF indicators relating to the following areas:

- Patient safety – an indicator assessing whether practitioners are confirming whether there have been any changes to a patient's medical history at each oral health review
- Clinical effectiveness – indicators assessing whether patients' oral health has been maintained or improved between oral health reviews
- Patient experience - indicators assessing the views of patients on their experience of care provided
- Data quality – indicators assessing whether complete and timely data is being submitted by providers
- The future development of the DQOF indicators might also include clinical process measures, for example the proportion of groups of patients for whom preventive treatment is being provided; or measures relating to access, for example the number of different patients seen by a practice over a certain period
- Paper 3: The measurement of quality and outcomes provides further details on the ongoing development of the DQOF.

4. Remuneration based on activity, capitation or a blend of capitation and activity

Beyond the element of remuneration relating to quality and outcomes, the broad options that exist are whether the basis of remuneration is

- activity
- capitation
- some blend of activity and capitation.

Figure 1 — Approaches to remuneration

This document looks at the benefits and challenges associated with each broad option informed by our learning from the dental contract pilots.

Full activity

In this approach, providers are simply remunerated according to the amount of activity they deliver each year. The current units of dental activity (UDA) system is an example of an activity based approach as was the previous fee-for-service system where different payment tariffs existed for a long list of different activity items.

The benefits are:

- The system is relatively easy for commissioners and providers to understand and manage

The challenges are:

- A system based on activity can without intending to, give an incentive to providers to over-treat their existing patient base, which can lead to a reduction in access and inefficient use of resources
- A system based on activity is not an ideal fit with a preventive approach since it is difficult to remunerate preventive advice through activity
- A system based on activity does not align with the changing needs of the population where disease prevalence is reducing.

Full capitation

In this approach, providers are paid to care for a number of patients where the amount paid reflects the care needs of the population. In practice, a methodology is used to estimate the cost of care for each patient in the population (i.e. each patient on a capitated list) using key characteristics that are predictors of need or cost of care such as age, gender and deprivation status.

The benefits are:

- A capitation approach incentivises a provider to care for a certain number of patients and therefore can be used to increase access to their services (there is for example, no incentive to see patients for oral health assessments any sooner than clinically necessary)

- A capitation approach can create an implicit financial incentive for providers to deliver preventive care as this should reduce subsequent levels of treatment required.

The challenges are:

- The financial risk for providers and individual performers effectively having a single band payment for a particular cohort of patients where the needs of individual patients may vary significantly from the average for their patient cohort

- We do not yet have a sufficient understanding of whether weightings based simply on age, gender and deprivation status adequately predict care needs

- The risk of appropriate treatment not being delivered if we do not have sufficiently sophisticated outcome measures to mitigate this risk in the quality element of the remuneration model

- The risk that practices delivering a greater proportion of NHS treatment are disadvantaged in comparison to those delivering more private treatment (that could have been delivered on the NHS) to NHS patients – in theory this risk could be mitigated by adjusting capitation payments but this is likely to be logistically challenging

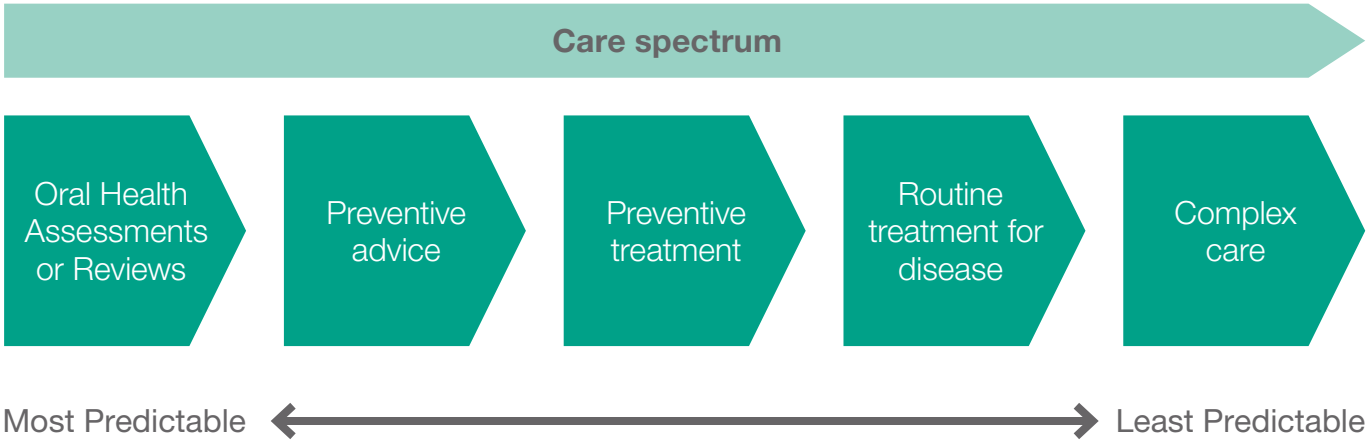
- The risk that patient charge revenue falls if treatment currently offered on the NHS starts to be offered privately, potentially at the same as or lower than the NHS charge.

Blended approach (part capitation and part activity)

In this approach, providers are remunerated based on a combination of the number of patients cared for and activity delivered.

One option for a blended approach would be for a capitation approach to be used to remunerate the first part of the care spectrum (i.e. care that is relatively speaking more predictable) whilst an activity-based approach could be used for the remainder of the care spectrum.

Figure 2 — Predictabilty of care



The benefits are:

- A blended approach seeks to harness the best features of a capitation approach and an activity approach in such a way that the negative aspects of each individual approach are reduced.

The challenges are:

- Any system which includes an element of activity may inadvertently incentivise providers to over-treat
- A blended approach introduces an additional challenge for providers in that they need to manage the delivery of two remuneration metrics - patient numbers and activity
- A blended approach introduces further complexity for providers in developing performer remuneration models that reflect the provider remuneration. The British Dental Association (BDA) are, however, developing models of performer remuneration which could be used in capitation and quality systems.

5. Next steps

Further work is necessary on the development of the DQOF that will be the basis of the element of remuneration relating to quality and outcomes in any new contractual system.

Beyond the element of remuneration relating to quality and outcomes, we think it most likely that remuneration will be based on a blend of activity payments and capitation. Further work is required to determine what element of the care spectrum is covered by capitation and it may be that the element of care covered by capitation increases over time. We need to construct a blend that offers us the right balance, neither over- or under- incentivising treatment and giving practitioners the flexibility to exercise clinical judgement and look after their patients in the way that best promotes their oral health.

We also need to ensure that any new remuneration system is fit for purpose for all parties. As well as ensuring the contract can be managed and delivered by commissioners and providers, we need to ensure that the contract can be aligned appropriately with performer remuneration and that the remuneration model does not have any adverse consequences for patients.

We hope this starts to inform the whole dental community of the future direction of contract reform, as we want you to be able to contribute to the further development of a new contract model.

Questions

We want to gather your views to inform further stages of the work. We have structured a series of questions to support you in providing comments. There is a free text box at the end of the section to pick up any other issues you would like to raise.

Please click on the button below to provide feedback.

Thank you for your contribution.

Question 1
What percentage of contract value do you think should be used for DQOF?

Question 2
We assume there will be an element of remuneration for quality and outcomes. Beyond this element, what are your views on the options for remuneration and how the challenges associated with them can be managed:

- Full activity
- Full capitation
- A blend of capitation and activity

Question 3
If a blend of capitation and activity is used, what elements of the care spectrum do you feel should be covered by capitation and why?

Question 4
What safeguards need to be in place to ensure that patients with high treatment needs are appropriately treated in any remuneration system?

Click here to feedback

This paper has been produced by the Dental Contract Reform programme

Any comments or queries on the papers should be made to the team via the online feedback mechanisms.

Feedback on the papers, sent via email, will not be considered as part of this engagement activity.

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