Can we remunerate for prevention? A public health perspective.

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Remunerating to deliver prevention in NHS dental contracts is important, as incentives are a substantive driver for clinical activity.[1] However, NHS dental contracts are also required to meet many other policy-objectives: reducing inequity, promoting access for regular and irregular attenders, service provision for both non-urgent and urgent patients, maintaining viability of NHS provision, cost-containment and value for the tax-payer.[1]

Dental service provision is a complex system with multiple incentives and counter-incentives producing both intended and unintended consequences. Fee-for-service remuneration often incentivises over-activity, whilst capitation can incentivise under-treatment, cream-skimming (seeing mainly low-risk patients) and does not necessarily promote prevention.[1] As such, a 'one size fits all' approach to designing a national contract using remuneration as a sole means of changing practitioners' behaviour, is too blunt an instrument and is unlikely to achieve the (often conflicting) policy goals.[1] Additionally, impact of the pandemic on dental service provision and workforce constraints cannot be solved through contract reform alone.

The underlying aim of down-stream activities delivered at a scale by practices is to contribute to population oral health, when midstream and upstream interventions can counter the impact of commercial and structural determinants of health and can better target inequity.[2] Incentives to promote down-stream activity need to align with the prevailing level of population health.

There is much to be done. Despite good examples of innovative practice, the widely endorsed Delivering Better Oral Health toolkit is still not implemented across all dental practices in the United Kingdom. Even when dental teams are encouraged to promote chairside prevention through a reduction in clinical activity targets, this does not always happen.[3] Equally, Dental Associates react to contractual incentives differently to Practice Owners, who take the capital risk.[2] Dental Therapists, Dental Hygienists and Dental Nurses can all provide effective prevention in practice but only when there are incentives and a culture to support their use.[4,5,6] Evidence-based prevention that aligns to the need and risk of a practice population should be seen as an essential part of delivering equitable healthcare and a measure of quality.

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