The future of mixed dental practices and capitation

Dr Catherine Rutland, Clinical Director, Denplan, discusses the issues facing mixed dental practices and issues relating to capitation

We talk a lot about dentistry in terms of NHS and private practices. Naturally, this is a consequence of dental services in the UK largely being delivered from those practices delivering the NHS General Dental Services contract or providing wholly private treatments. Indeed, as figures from the National Audit Office (NAO) show, there are 5.3 NHS dentists to every 10,000 patients in England¹ with 12,500 dental practices – consisting of 8,500 independent practices, 2,500 owned by small groups of dentists and 1,500 corporate operators.² In terms of overall share of practices, this equates to what Denplan estimates as 40% wholly NHS or mostly NHS practices delivering the GDS contract and 15% wholly private practices. However, this leaves an entire community of dental practices across the UK which is often overlooked in discussions about dentistry – the 30% that are independent mixed dental practices.

As Clinical Director at Denplan, I am privileged to work with 6,600 of our member dentists who are serving 1.4 million patients; a large proportion of these member dentists operate in largely mixed practices, combining a majority of private patients, either paying fee per item or through a capitation product, with some NHS patients. They are often independently owned, high-street practices, with longstanding relationships with the families that use their services routinely. Their mixed patient base puts them in a different position to either wholly private or wholly NHS practices, and whilst there has always been a concern that there is a misunderstanding about the way

that they operate, this has been highlighted in the last year.

Despite the significant position they hold within the dental sector, mixed practices are often little understood by policy makers and left out of the wider public health discourse as demonstrated by the notable exclusion from the Department of Health and Social Care's *Integration and Innovation* white paper.³ This fact is underlined by Denplan's recent *The Future of Dentistry* white paper. Our research showed that the overwhelming majority of dentists we surveyed expressed concerns about the government's understanding of, responsiveness to, and support for the private and mixed dental sector.⁴ This lack of understanding of the sector means poor policy decision and outcomes in areas such as in England last June when mixed and private practices were given no advance notice for re-opening.

Mixed dental practices, like their private counterparts, perform a vital role in maintaining oral and general health in society alongside NHS dentists. While there are a wide range of reasons why dentists want to take up mixed dental practice, one of the leading reasons is the focus on patient care that is allowed outside of the constraints of the NHS dental contract.

In addition to this, mixed practices compliment NHS dental service provision by offering patients access to treatments outside of the NHS contract. If we are to truly pursue a preventive approach to oral health, as envisioned by the recent DHSC white paper, then mixed practices must form a key part of how we address the nation's oral and wider health. On a whole host of health

issues – from mouth cancer to diabetes and heart disease – mixed dental practices are well placed to deliver the preventive oral and wider health measures necessary in the emerging future healthcare landscape.

Further to the exclusion of considering using all forms of practices for the delivery of preventive healthcare, the lack of proper understanding of the importance of private dentistry in the oral healthcare of the nation has also impacted the regulation of mixed practices with a failure to properly understand their business model. While during the pandemic new guidelines and regulations were required to be developed at pace, there was nonetheless an assumption on the part of policy makers that any mixed practice delivering a NHS contract – no matter how small that contract may be – should be expected to have all aspects of their practice to fully abide by directives issued by the Chief Dental Officers (CDOs) of England, Scotland, Wales and Northern Ireland.

The unfortunate consequence of this is that it has created an extra unnecessary barrier to patients accessing dental care during the disruptive period of the pandemic, as mixed practices felt compelled to delay or excessively restrict the resumption of services for fear of falling afoul of unclear guidance and regulations. This meant that many mixed practices were unable to see as many patients as they would prefer as they were held to a regulatory standard customised to NHS practices, despite mixed practices tending to have a range of patient care differences to their NHS colleagues – including fewer patients seen per day, appointment scheduling that limits the need for waiting

rooms and more time offered for routine appointments.

As mixed and NHS practices are so different in terms of patient numbers, treatments provided and workload flexibility, it seems a shame to lose any benefits this creates, especially for patient access at a time when it is so needed. Therefore, any better understanding of mixed and private dentistry on the part of policy makers simply must result in an improved and tailored approach to the regulation of mixed practices.

Another area of interest to many of our mixed dental practice members is the issue of capitation. To those of you who have not been involved in capitation, it is the provision of care with a fixed monthly cost to cover clinically necessary treatment. Dependent on the system there may be certain exclusions, which should be clearly communicated to patients.

As many readers will be aware, the current mechanism for funding the delivery of dental treatments and controlling costs is carried out under the jurisdiction relevant General Dental Services contract, mainly based on activity. Another consideration to replace activity-based contracts is capitation. In place for GPs since 1948, capitation was first proposed as a system for dentists in the BDA-commissioned Tattersall Report of 1964 but took another almost 30 years to be adopted as a scheme to deliver NHS dental contracts.⁵ For some dentists the hybrid capitation system, registration and fee for item NHS contract, introduced in 1990 worked well. However, it swiftly led to clawback and caused many people to consider their NHS commitment.

Indeed, as Hill *et al.*, have stated, public funded oral health service systems are complex and governments wrestle to align financial incentives for health care professionals with policy goals.⁶ At a time of growing strain on NHS dental services, due to a combination of increased patient need and pandemic treatment backlog, the current contract model, regardless of jurisdiction, is proving to be very challenging for mixed dental practices.

Even before the COVID-19 pandemic, mixed practices struggled to deliver dental treatments under the current system and remain financially profitable. This isn't purely a question of money, the majority of our member dentists who operate mixed dental practices desperately want to continue to deliver NHS treatment alongside their private practice out of their deep commitment to their patients' wellbeing and wider community health. Many practitioners in

mixed practice would agree that their private income provides the funding to improve their practices, with the subsequent benefit to their NHS patients. However, several issues with this situation put the long-term viability of this dual existence into doubt.

In each jurisdiction there is now consideration of changing existing payment models and contracts. In England, the reform of the GDS contract and payment system has been promised – but as yet undelivered – since 2011. Pilots, and then prototypes have been trialled, but the wider rollout of reforms is postponed on an annual basis. The two blended prototypes being trialled in England and Wales, centred on preventive pathways, offer a positive shift in policy that has proved generally popular with dentists and patients.⁷ However, without further reform to the proposed capitation system, to make it more flexible, more mixed practices may reluctantly opt to become fully private.

Many dental practitioners will be all too familiar with the potential difficulties and concerns raised about capitation schemes, be they state or privately funded. From personal experience in practice and my learnings from speaking to many people in the years I have worked for Denplan, I know that if capitation is to work there are several themes to consider. At the heart of this is adequate funding, placing patients in the correct risk category, and reviewing this regularly, and having enough patients on a scheme. The benefits then become the regular monthly income for the practice and the spreading of costs for patients, whilst encouraging regular attendance and prevention.

As levels of tooth decay have declined in recent decades and general oral health has improved,⁸ the activity-based approach to delivering NHS treatment is less practical and the capitation model of payment per patient becomes more attractive. However, flexibility is the key to making capitation work for mixed practices. If prevention is to be at the heart of the future of dentistry, however mixed practices are funded, there needs to be remuneration for practitioners and their teams to have the time to provide prevention advice and be at the core of all they do. Moving away from an activity paid mindset, for both patients and the profession, will be a shift. Of course, I cannot finish without saying that for many of our members, their practices are working in this way, with prevention at the core, and funded by capitation and have shown for many years how well it can work. ♦

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Author bio

After qualifying as a dentist from Leeds University in 1992 and doing a year as a House Officer, Catherine worked as a Senior House Officer in Newcastle before settling into general dental practice. Catherine joined Denplan part-time in 2010 and was promoted to her current position in 2019. She has 19 years' experience as a joint partner in a private dental practice in Berkshire, and completed a Masters in Medical Ethics and Law from King's College London in 2013. She is also a certified member of the Institute of Risk Management and completed a Level 7 Certificate in Leadership Mentoring and Coaching in 2016.

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