Moving goal posts

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EDITORIAL

The first three years of the new contract of 2006 are about to come to an end, an end to the beginning of a new era in dentistry. The negative predictions of the fortune-tellers pre April 2006 do not seem to have materialised to the extent predicted. Although not perfect many dentists say that they would not like to return to the old contract now that they have experienced the new contract. However, the new system is open to abuse just as much as any system would be and clearly rules and regulations need to evolve for effective management and probity.

Since April 2006 the stakeholders involved in the provision of general dental services are no longer just dentists and their patients, now we have primary care organisations managing services so as to satisfy community need. This new stakeholder has direct influence on those practitioners providing National Health Services but also indirect influence on those in independent practice as 'competitors' in an open marketplace. To date primary care organisations have been criticised for continuing to 'contract' as opposed to 'commission' services in appropriate directions. Therefore, primary care organisations have the difficult task of managing services in the direction of improving oral health while ensuring probity.

The term 'gaming' has appeared in the narrative surrounding the management of the new contract by primary care organisations. This is where individual dentists maximise opportunities to generate Units of Dental Activity (UDAs) perhaps in situations where there is no harm but no clear benefit to the patient. Here 'grey areas' loosely defined in the regulations are interpreted and acted upon by dentists in the direction of benefit to the dentist rather than the patient or health service.

Developing rules and regulations to address 'gaming' need careful consideration so as to avoid a knee-jerk reaction that would create other service delivery problems. One such example is the allocation of UDAs for the treatment of urgent problems. How many UDAs should be generated by a new patient attending a dental practice urgently because of a painful tooth? An assessment of the problem, a radiograph to aid diagnosis and an extraction; according to the Dental Practice Board test period (October 2004 to September 2005) would have generated 3 UDAs towards the performance target required in the first and subsequent two years of the new contract. Contract managers now imply that the exact same situation and treatment should generate only 1.2 UDAs. This means that a dentist would now have to deal with almost three identical situations to generate the same number of units. How does this encourage a dentist to care for the sub-section of the community most likely to be in the situation of symptomatic attendance – the deprived?

'Like for like' and 'high trust' are two values on which the new contract were founded. The above scenario does little to develop trust as like in the new is not like in the old if this implication is made explicit. The implied goal posts have moved in the direction of increasing the likelihood of social inequality if dentists have to undertake more treatments for those with the greatest need so as to maintain a status quo.

The converse of the above is also observed in the context of recall attendance. NICE guidelines on recall attendance state that recall attendance should be according to disease risk with low-risk patients attending less frequently than high-risk patients. Here the number of 'recall examinations' remains constant but the number of patients cared for increases if low-risk patients who had been attending for six-monthly recalls make appropriate annual or bi-annual appointments. Here dentists are not expected to increase their workload, just reschedule it.

The majority of dentists will want to behave professionally in an 'optimum' fashion. The Chief Dental Officer of England has been explicit in his opinion regarding the need for 'new ways of working' from general dental practitioners in that they engage with their communities to improve oral health. The application of the NICE guidelines on recalling of patients is integral to this. Other desirable changes surround the taking of radiographs and routine scaling and polishing.

Moral Hazard is the risk that one party to a contract can change their behaviour to the detriment of the other party once the contract has been concluded. Health service managers in primary care organisations obviously want to see service providers operate effectively without dentists demonstrating immoral hazard but they must also own the responsibility of being morally just themselves. Inadvertently creating rules and regulations that are morally unjust could be putting community health at risk with a resultant increase in social inequalities in oral health.

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