Summary of: Are restrictive NHS contracts of benefit in addressing health inequalities? An ecological evaluation of their value in the North East of England

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FULL PAPER DETAILS

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Aim To determine if restrictive NHS contracts are of benefit in addressing health inequalities in oral health, by using an ecological approach based upon an area measure of material deprivation. **Methods** Postcodes of patients seen under all the restrictive contracts (49) within the North East of England were identified and matched to lower super output areas. The deprivation scores were identified for each area using the Index of Multiple Deprivation 2007. The proportion of patients within each area was calculated and divided into deciles for England, from the most to the least deprived areas. **Results** 33,341 postcodes were identifiable from datasets supplied for the study in the North East; a further 4% were invalid. There was inequity in the distribution of patients, with proportionately more patients from the least deprived deciles and less patients from the more deprived deciles seen under the contracts. However, many thousands of patients identified lived in the most deprived areas. **Conclusions** Restrictive contracts may be of benefit in addressing health inequalities. PCTs need to carefully consider the impact of ending restrictive contracts on their local populations.

EDITOR'S SUMMARY

Access as a term to express an ability to obtain dental care is much overused, sometime maligned and often misunderstood. Indeed there can be few single words that have reached the status of having an entire *BDJ* editorial devoted to them.[1] All manner of schemes and removal of potential barriers can be devised in order to make access apparently less difficult but ultimately a service will only be used if the patients targeted by the plan wish to make use of it.

This is a fundamental truth which is emphasised by the research published here. The premise of creating 'restrictive NHS dental contracts', which are limited to various clearly defined patient groups who are potentially at risk of reduced access, was that it would save such patients suffering from health inequality. However, in attempting to influence the pattern of attendance in such a way it seems that contracts of this nature tend to benefit the least deprived and least needy sections of the community disproportionally. In essence, the better off, the better educated and the better informed learn to access services perceived as beneficial more readily than those in lower socio-economic groups, as defined in this instance by postcoding.

The authors conclude that despite this somewhat skewed uptake of services there may be value in restrictive contracts, and they caution that commissioning authorities should not abandon such measures without careful consideration of their local circumstances and the likely effects. Certainly more patients from areas defined as deprived were seen by dentists holding these contracts but that is hardly surprising given the places in which they were deliberately geographically sited. The lessons to be learned, or perhaps more correctly, reinforced, are not only that good commissioning requires very precise knowledge of the population to be served and the needs of that population, but also that human nature, a quality not amenable to being confined by balance sheets or neat scheming, will always supersede the best efforts of any planning process.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 207 issue 8.

1. Smith M. Divided by a common tongue – 'Access'. *Br Dent J* 2009; **206:** 185.

Stephen Hancocks,
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IN BRIEF
- Restrictive dental contracts in the North East provided the majority of their dental care to residents of the more affluent lower super output areas.
- However, restrictive dental contracts did provide some dental care to residents of the most deprived lower super output areas.
- Commissioners should carefully consider the impact of ending restrictive contracts on access to dental services for their local populations.

RESEARCH

COMMENT

This paper investigates how restricted contracts are addressing dental health inequalities in the North East. These are NHS dental contracts that are restricted to children and exempt adults only. The hypothesis here, and the view sometimes put forward by the profession, has been that such contractual arrangements could make an important contribution to ensuring access to care for needy sections of the population.

Epidemiologists divide up the population nationally into tenths according to the levels of deprivation ascribed to the areas in which they live. This study divided the population of the North East according to these ten categories of deprivation and a higher proportion of the population were in the deprived categories compared with the national average.

Among the patients seen by dentists on these restricted contracts, more were from areas of deprivation. This is no surprise. That is where most of the exempt patients will live. However, when this patient group of children and exempt adults is calculated as a ratio of the resident population groups, the situation looks rather different. The most affluent population has a higher proportion of its population seen under these restricted contracts.

Although there may be some pockets of deprivation within affluent areas, there is limited scope for this in such small areas (the local super output area – LSOA) as are used here. Some inaccuracy may also be introduced here because the LSOA, used as a proxy unit for population, may have a range of population values from 1,000-1,800 with a mean of 1,500, but this surely averages out over the whole North East region.

The authors are to be congratulated on pointing out what appears to be an illustration of the inverse care law.[1] From information presented here, the least deprived and least needy sections of the population appear to have had relatively more benefit from restricted contracts in the North East.

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1. Hart T J. The inverse care law. *Lancet* 1971; **1:** 405-412.

AUTHOR QUESTIONS AND ANSWERS

1. Why did you undertake this research?

We were interested to understand the population served by practices operating under restrictive NHS dental contracts, and to understand the potential impact on dental access for the local population of any changes to these restrictive contracts.

2. What would you like to do next in this area to follow on from this work?

There is an implication that placing a practice within a specific area will ensure that the practice will provide dental care to that local population. It is clear from this research that practices with restrictive contracts do not wholly serve their local populations, but provide care for a mixed population group.

It would be interesting to understand whether dental practices with full NHS contracts have practice populations which are a reflection of their locality population.