Annexe E2

Type of basis of payment	Advantages	Disadvantages
Block	Gives providers the flexibility to spend the time necessary to meet each patient's individual	Harder to measure the effective delivery of the service.
DIOCK	<ul> <li>Gives greater flexibility to Providers (for example in allocating resources between different parts</li> </ul>	Difficulty for the Commissioners to recover payments in the event that the service fails to deliver appropriate numbers of treatments unless a collar is in place.
	<ul><li>of the service and covering overheads).</li><li>Offers certainty and stability to Providers to</li></ul>	There is a perverse incentive for the Provider to stop offering treatment (or make patients wait) when demand exceeds available funds.
	cover the costs of the service.	There is a perverse incentive for the Provider to restrict access to the service, in particular with regard to expensive elements.
		Limited incentive for Providers to cover staff shortages and other factors affecting the delivery of the service.
Activity <sup>1</sup>	The Provider is paid for the services that they deliver.	As tariffs are typically a flat rate, there is limited flexibility to adjust payment to match the time necessary to meet the individual patient needs without making the system unduly
	<ul> <li>Strong incentive for the Provider to remedy any problems affecting service delivery so that they</li> </ul>	complex.
	continue to receive payment.	Can provide perverse incentives with regard to the treatments offered (for example 'cherry picking' less complex patients or
	<ul> <li>Works particularly well with GA, sedation and domiciliary activity.</li> </ul>	unnecessary appointments in order to collect extra payment).
	<ul> <li>Incentive for the Provider to promote the service (and so increase demand).</li> </ul>	<ul> <li>Trusts have varying levels of overheads which are not always accurately paid for through a tariff (flat rate) system.</li> </ul>
		Lack of incentive to undertake preventive activity.
		Encourages unnecessary retention of patients within the service rather than discharge back to high street dentists.

<sup>&</sup>lt;sup>1</sup> Activity can be measured by Units of Dental Activity, courses of treatment, contacts etc.

Capitation	<ul> <li>Gives providers the flexibility to spend the time necessary to meet each patient's individual needs.</li> <li>Population-based activities (such as Epidemiology and Oral Health Promotion) benefit from a capitation approach to funding.</li> <li>More closely reflects population needs.</li> </ul>	<ul> <li>Difficult to accurately identify the numbers of patients requiring the CDS.</li> <li>Finding appropriate outcome measures to ensure effective delivery of the service.</li> <li>Difficulty for the Commissioners to recover payments in the event that the service fails to deliver appropriate numbers of treatments.</li> <li>Lack of incentive for the Provider to promote the service (and so increase demand).</li> </ul>
Mixed model  (includes elements of some or all of the above three types)	<ul> <li>Flexibility to use the appropriate type of payment most suited to each element of the service.</li> <li>In instances where the level of activity is variable or unknown (for example drop-in clinics for vulnerable people) a mixed model can provide better value for money by ensuring the provider can run a clinic regardless of numbers attending yet payments at least partially reflect the activity delivered .</li> <li>More incentive to devise flexible approaches (such as a block element with minimum and maximum levels of activity)</li> <li>Offers flexibility to provide appropriate payment for the most complex patients.</li> </ul>	Relatively more complex to administer and monitor than the other types.