Justice and NHS dental treatment – is injustice rife in NHS dentistry?

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IN BRIEF

- Discusses the relevance of justice in the provision of NHS dental care.
- Questions the relative roles of institutions and individuals in the initiation and perpetuation of injustice.
- Asks whether the current dental contract fosters a focus upon targets rather than improving oral health.
- Discusses whether targets lead to a loss of altruism and the ethical dilemma of target-centred care.

OPINION

In this article the issue of injustice in NHS dental care is examined using the philosophical principles of non-ideal theory. The causes for this injustice in this context are examined as well as how injustice may be perpetuated within the NHS dental system. The focus upon targets that the current system supports contributes in shifting the focus of healthcare provision from being patient-centred to that of financial gain. This leads to a drop in quality of care and to dissatisfaction within the dental workforce. This article aims to examine this perversity and how this further contributes to injustice.

INTRODUCTION

The Health and Social Care Act 2012 has caused a huge outcry from many healthcare groups and professional bodies. Despite the letter published in the *BDJ* from the British Society for the Study of Community Dentistry,[1] there has been little in the way of comment from the dental profession. One suspects this is because NHS dentistry already operates in a way that other services will change to when the new Act comes into effect. The majority of those involved in primary care dentistry act as private contractors to the NHS, providing NHS dental services in businesses owned and operated by private individuals. Over the last 20 years or so dental body corporates have been taking an ever greater share of the dental market and a few of these have become major stakeholders in NHS dentistry. In a report at the beginning of 2011 it was stated that corporate dentistry supplied 11.3% of NHS dental services in primary care. These companies are large organisations that hold large numbers of NHS dental contracts with great worth and their contribution should not be overlooked. This article is concerned with justice within the oral healthcare domain and questions whether there is an issue of injustice for patients within NHS dentistry or with the providers of such services, whether they are individual practitioners or large organisations.

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Accepted 21 February 2013
DOI: 10.1038/sj.bdj.2013.323
©British Dental Journal 2013; 214: 335–337

NON-IDEAL THEORY AND ITS BRANCHES

Justice may be examined through the concepts of ideal and non-ideal theory. An ideal theory of justice states the ideal scenario in which institutions are well organised, just and known for being so. It also states that individuals within such organisations both accept and comply fully with those requirements imposed upon them by such an institution. The perhaps obvious jump to non-ideal theory is the converse; that organisations may fail to be just and individuals within these institutions may not comply with rules and requirements. These ideas have been explored extensively by John Rawls in his book *A theory of justice*.[2] Rawls divides non-ideal theory into two separate (but not always distinct) branches. These consist of partial compliance theory and transitional theory.

It is these two areas where the branches divide; transitional theory discusses the institutions that are unjust and partial compliance theory concerns the individuals who do not comply. It is these two theories that will be discussed with reference to the current dental contract and the providers of dental services that will hopefully demonstrate to what extent the current NHS dental contract addresses issues of justice in oral healthcare. These two branches, as alluded to earlier, are not distinct and separate. Rawls states that individuals have to bring just institutions into existence and to a certain extent, institutions have to foster compliance within individuals. The discussion of the differences between the two branches is often academic as usually transitional theory and partial compliance theory will often apply together. Transitional theory tends to be more concerned with the reform of unjust institutions whereas partial compliance theory is more concerned with the punishment of those non-compliant individuals and restitution. The latter two themes seem to feature increasingly in dentistry with growing litigation and so-called self-regulation becoming ever more stringent and quick to find fault. This non-ideal theory may apply to both the relationship between the NHS (institution) and a provider (individual) and also to the relationship between a dental body corporate (institution) with its own internal culture and environment, as well as a practitioner (individual) working within it. Throughout this discussion, the term 'organisation' may apply to both large dental corporates and the institution of NHS dentistry.

PERVERSE RELATIONS

The verb pervert has many different connotations. In the context of this discussion, it may be defined as to 'change the

original form or meaning of something so that it is no longer what it should be.'[3] It has been argued that perversion in institutions (whether this refers to dental body corporates, other non-corporate dental practices or NHS dentistry) flourishes when people are used as means to an end. Rather than as individuals, people may be seen as instruments and commodities. This idea is explored by Long,[4] who considers this effect upon large corporate organisations. While this may apply to smaller dental practices, dental body corporates certainly fall into this remit and the environment of NHS dentistry is one where the corporate business ethos thrives. Perversion in this context can be described as seeking personal or individual gain and pleasure at the expense of the common good, often to the extent of not acknowledging the existence of others or recognising their rights.[5] Long's discussion on perversity is concerned with that behaviour displayed by institutions rather than individuals.[4] However, as alluded to by Rawls,[2] it is difficult to separate an institution and its members as in reality they are entwined. An individual's actions are influenced heavily by the culture within an institution and these actions in turn serve to reinforce this environment. This may be the same for either a constructive or destructive culture within an organisation. This idea of an organisation and its members being perverse may serve to explain how the culture within NHS dentistry may seem in a certain minority of institutions to be exploitive towards patients, staff and those who commission services. Some might feel that the sentiments of perversion are better suited to discussion of the criminal or distasteful. However, the purpose of the NHS dental services is to improve oral health. The current system may justifiably be accused of focusing practitioners on reaching units of dental activity (UDA) targets rather than achieving oral health promotion for patients. Many practitioners could report that providing they reach their UDA targets, there is no question on how these are reached. Dental clinicians are increasingly being seen as means to ends, rather than the professionals that they are. If this is the case, such an unjust system might be quite rightly described as perverse when such a discrepancy exists as that between the need for good oral healthcare and the treatment targets practitioners are instead forced to concentrate upon.

To consider non-ideal theory again; if an individual does not follow the unjust rules and regulations set out by an organisation, under partial compliance theory they are liable to be punished for their non-compliance, even though their actions in themselves may be morally sound. Similarly if a practitioner does not meet their UDA target due to such a target being unmanageable while providing ethical and high quality care, they will be punished financially by having to hand money back over to the NHS. This is the case regardless of the fact that the dentist in question may very well have been providing a superior service, which over a longitudinal basis will save the NHS money. This can be theoretically contrasted to the dentist in the practice along the road who reaches or even surpasses the same UDA target, but manages this through providing rushed and poor quality treatment. In reality, many might say that both dentists are victims of the system. If this is the case, then the system can only change by the individuals within it providing change. The dentist who provides poor quality dentistry in order to meet targets is in fact contributing to the perpetuation of such an unjust system.

THE DEATH OF ALTRUISM

Jos Welie discusses altruism as being an important moral competency for dentists.[6] Altruism is important because there is an inherent imbalance of power in the dentist-patient relationship. Not only does the dentist wield knowledge, the power to potentially cause pain makes patients almost universally feel at their professional's mercy. With the idea that professionals have started to become more like commodities than individuals, the ability to make money is now seemingly valued at a greater level than the intrinsic value of the work carried out. This has been discussed in the context of childcare.[7] A daycare nursery was sick of parents turning up late to pick up their children. Their solution was to place a fine on lateness each time a parent kept the staff waiting past normal opening hours. The result surprised the nursery; the incidence of lateness increased. This was because the parents stopped looking at the staff staying late as altruistic, instead looking at the fine as an extra payment. It left the parents with a sense of entitlement and acceptability that was not there before. When we take altruistic actions and make them into commodities to be bought and sold, we lose the sense of ethical obligation on either side of what can now be termed a commercial transaction. This acts as a powerful warning for those who believe the NHS dentistry should allow lateness or missed appointment charges to patients.

There is the risk with the loss of altruistic behaviour that healthcare becomes a solely money orientated venture. The idea that a patient can walk into the surgery, pay their money and make their choice is an increasingly poor interpretation of Kant's theory of autonomy.[8] It is important to distinguish this transactional behaviour from that where patients' choices and rights are actually respected. To say that their autonomy is being respected in providing a patient with anything they want, in the way they might be treated in a shop, is wrong. To do this is to treat them the same as one might treat a petulant child. Patients do not have the benefit of a dental education and therefore need to be guided down the road of treatment. Altruism helps in this task as putting patients before one's own interests is so important in providing the right treatment. If a patient is given treatment based on the clinician's own desires for financial gain there is a risk that they will leave the surgery with expensive and advanced treatment and with their basic treatment needs unfulfilled. The current UDA-based dental contract does not help to position practitioners' focus onto patients but more onto meeting targets and deadlines. There is an inherent injustice for those using the service when this occurs.

THE ETHICS OF TARGETS

Research has shown that organisations that are target driven fall into certain behaviours that are undesirable.[9] Three main features that have been found to be impacted upon are particularly prudent to NHS dentistry. These three features are tunnel vision, misrepresentation and gaming. Tunnel vision involves the concentration of focus and achievement in areas that are included in quality indication schemes

such as CQC outcomes or PCT vital signs. These areas are concentrated upon to the detriment of other aspects of the service that are either immeasurable or not likely to be scrutinised by outside regulation. These areas are, however, still important to the organisation's running in a proper manner. Misrepresentation is where data are manipulated to show that recorded behaviour differs from actual behaviour. Fissure sealants being claimed as band two treatments could be described as an example of misrepresentation that is common in NHS dentistry. Probably one of the most disliked aspects of the UDA contract from the viewpoint of the PCTs is that of gaming. Gaming can be defined as altering behaviour in order to obtain strategic advantage. The scope of this article is not to describe the various ways gaming takes place in the NHS, needless to say that most practitioners will be aware of these strategies and the vast majority are too scrupulous to attempt to benefit from them.[10] In these unsettled financial times funding for public services is evaporating at a rate that is both alarming and upsetting. It is understandable that those in charge of service commissioning need to be providing services on an ever tightening budget. What seems to be missing though is the point of it all. Iliffe describes how targets and financial pressures may be met, but the point of the service provided is missed.[11]

The issue of gaming is interesting as it raises an important question: why do highly respected professionals resort to such nefarious ways of playing the system? The answer is touched upon by Chris Ham who states that in disempowering front line staff and overloading organisations with targets innovation is stifled.[12] In addition, practitioners become cynical, disengaged with their work and morale becomes low. Perhaps more concerning is that practitioners have more mistrust in patients and suffer more anxiety.

INJUSTICE RE-VISITED

So to reconsider the two branches of non-ideal theory: transitional theory and partial compliance theory, which player is responsible for the portrait of injustice in the NHS dental system? The individual or the organisation? It has already been mentioned that the two are inextricably linked and separation is difficult. It is also an issue of causation, is it corrupt providers who have promoted injustice within the organisation of NHS dentistry or the broken institution forcing the individual to practice in a way that could be described as unjust? The diminution of funding for NHS dentistry and the inevitable loss of income this has meant has forced practitioners to take on more UDAs in order to maintain the same level of pay. This has meant quality has inevitably dropped in some practices. The focus on targets is also driven by the NHS, forcing those providing NHS care to concentrate on target provision primarily and then patient interests. It should be stressed that those dentists who compromise integrity for financial gain are in the minority, but those who get trapped into a culture of target-focused behaviour become increasingly drawn into provision of expensive treatment and non-treatment of dental disease. This links back to Iliffe's observation of those practitioners who focus on targets as missing the point.[11] Providing either a direct or indirect restoration into an unstable mouth is not treating dental disease – it is contributing to that individual's need for further restorative care in the future. This is surely the crux of the injustice present in the system. It seems that transitional theory trumps partial compliance theory in this discussion; the NHS dental contract makes injustice difficult to avoid, even encouraging it in some areas (for example the low recognition for prevention and anxiety management). It is, however, every practitioner's responsibility to make sure that he or she does not compromise his or her principles.

It is well lamented that the current UDA contract was not sufficiently consulted upon and perhaps this may be the reason for this injustice. In order to prevent this from reoccurring in future contracts the professional bodies within dentistry need to be far more aggressive and rigorous in their lobbying of the Department of Health for a contract that is suitable for both the needs of the profession and more importantly for patients. Another conclusion that can be drawn from this discussion is that organisations need to actively engage in quality control and management without infringing upon a practitioner's clinical autonomy. So long as target driven contracts are in place the potential for unjust target-driven behaviour needs to be kept in check. It may be a source of pride for organisations that they can boast that they achieve 100% of their NHS contract targets, but if these are not reached in a way that is both responsible, just and improves oral health, this achievement is pointless.

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