An incremental approach to dental contracts? Really?

John Renshaw[1]

Key points

- Less money, more output and higher quality has never been a successful equation long-term in any contractual arrangement.
- Successive governments have wanted dentistry out of the NHS but have been unwilling to expose themselves to the potential public backlash.
- The most surprising fact is that there is still an NHS primary care dental service at all.

Abstract

A recent *British Dental Journal* article argued that the current general dental services contract could be modified incrementally to find a way of delivering NHS dental care within a set budget. Reaching any agreed position on the financing of dental care within the NHS requires that both parties (funders and service providers) feel content with the nuts and bolts of the agreement.

This article argues that the UK Government has deliberately constructed the current units of dental activity contract to persuade dentists to cease providing NHS dental care in a way that allows the Government to blame dentists for the failure of the service. The idea that the Government might want to negotiate a better deal for dentists is, in the opinion of the author, unforgivably naive.

Introduction

The paper published in the *British Dental Journal* (*BDJ*) by Harris and Foskett-Tharby[1] is deeply embedded in the kind of obscure management/academic language that seems to have the sole purpose of baffling its alleged audience.

The use of terms such as 'wicked problems' (?), 'stubborn', 'ethically deplorable', 'distributive justice', 'dyadic relationship' (meaning there are two parties – very clever, I'm sure) and 'taming strategies' is no more than a thick layer of academic fog. This may be very ego-pleasing for the authors, but to many of the readers of the *BDJ*, these expressions are no more than gobbledegook.

Communication between two parties is built on trust – simple clarity and honesty of expression form a bond between the communicator and the listener. The adoption of clever 'management speak' when talking to a large group of clinicians is entirely counter-productive. It undermines the listener's confidence in the communicator's honesty and leaves them unclear what exactly they are being told. The *BDJ* article talks at length about the period since 2021 and simply ignores the previous 73 years during which the confidence of the dental profession in the honesty and integrity of any government official has been eroded to ground zero level.

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Refereed Paper.
Submitted 6 December 2022
Accepted 7 December 2022
https://doi.org/10.1038/s41415-023-5511-8

Contracts and political reality

Any commercial contract (public service or private, it does not matter) that produces some form of recognisable product or output must focus inexorably on the same three components:

- The size of the financial pot that is made available by the buyer
- The number of units the buyer requires for that level of expenditure
- The qualities of the purchased unit that are required.

By beginning the discussions, the buyer (in this case, the commissioners within NHS England), by stating that the allocated budget is pre-determined (that is, already fixed) means the second and third areas of discussion are never going to be reached. This is what has been happening in negotiations between the NHS and dental care professionals ever since 1951.

Dental service funding in the NHS has been progressively decreasing as a percentage of total NHS funding available since 1951. Those in charge of the NHS were surprised, and alarmed, when they discovered back in 1948–1949 that the most common healthcare issues in the country were eyesight (glasses) and teeth (dentistry). The fact that this came as such a surprise speaks to the naivety and ignorance to be found among those allegedly in charge of the service.

The NHS total projected budget in 1948 was about £190 million. (The current figure is about £160,000 million, with a primary care dental spend of nearly £3,000 million and patient charge revenue of £856 million). The actual total amount spent on the whole NHS in 1948 was about £400 million. Not a good start!

Spending on eyes and teeth were blamed for the overspend, and a couple of years later (1952), patient charges for eye care and dental care were introduced, ostensibly to raise additional revenue, but in reality, the revenue

from charges was never great. The real motive in levying charges was to suppress demand for care and reduce costs that way.

Every year since then, the allocation of funds for dental care has been reduced (as a percentage of overall NHS funding), while at the same time, there have been regular calls for greater individual outputs and a raising of clinical standards. This pattern of fiscal abuse against the dental profession began a very, very long time before 2021.

This provides the backdrop: the political reality of how NHS dentistry is not valued by those in power.

The current contract

The author of this piece was Chairman of the British Dental Association (BDA) in the period leading up to the introduction of the units of dental activity (UDA) contract in 2006. The BDA was well aware of what was being proposed. The UDA was another step up in the Department of Health's fight against the cost of dental care in the NHS.

Any interested observer will remain astonished that NHS dental care is still available at all in 2022 after the UDA contract was introduced in the face of staunch opposition from the profession's representatives across the board. The NHS dental service has been failing for decades and has gone on failing ever more quickly since 2006.[2]

The number of dentists leaving the profession is terrifying, especially when the number of young graduates leaving is realised. These people are not just leaving the NHS and taking a private funding pathway, many are leaving dentistry altogether. That is a brutal measure of how good the UDA contract is for them.

If we were to suppose that the price of one UDA went up to £500 tomorrow, does NHS England really think there would still be a shortage of potential suppliers? You would have to fight your way to the front of the queue to get in. Talks about output targets and quality measures would be undertaken with sincerity and new ways of working would be happily discussed and agreed.

There are good people out there trying to find a way of working with the NHS and with their patients in a way that they feel is ethically sound. Having to explain to patients the ins and outs of the UDA payment system is an impossible task. The NHS dos not just abuse dentists, it abuses patients just as much.

An important historical note: political will

In the late 1990s, the author of this piece spent two years working with Alan Milburn, then Secretary of State for Health in Tony Blair's new government on what became known as *The NHS plan* (published 2000).[3] He was a senior figure in the profession back then and he made a genuine effort to help the new government deal with the mounting problems they faced on NHS performance and recurring funding issues.

The NHS budget back in 2000 was approximately £100 billion. Alan Milburn was very persuasive and managed to get the Cabinet to raise the NHS budget to an impressive £120 billion. If the same 20% increase could be found for dentistry, it would feel that every last bit of hard work would have been justified and things might indeed begin to improve.

Mr Milburn sought a meeting with the BDA's representative privately – this was presumed to be to tell him what the BDA could tell their members the new government had decided to add to the NHS dentistry budget.

The Secretary of State was there, along with his senior civil servant, Simon Stevens, who was an exceptionally talented thinker. He became Chief Executive Officer of the NHS for many years, later in his career.

The information received at that meeting was that the share of the new money pledged for the NHS that would be coming to dentistry was precisely 0% – nothing.

This was the most telling signal yet that the NHS really did not value dental services. The Department of Health seemed to regard NHS dentistry costs as out of control and largely provider-generated (they thought many NHS dentists were providing more care than was necessary in order to drive up profits).

If the reader doubts this analysis, it would be interesting to hear how the introduction of the UDA a few years later (2006) could be perceived in any other way. The UDA meant that if you provided one crown you receive a fee from the NHS. If you provided two crowns you would receive the same fee and no more. That looks like direct proof of their belief in provider-driven output. In the years since 2000, dental funding has been slowly eroded even more.

That fall in funding has not stopped the NHS asking for greater output (in patient numbers) and insisting on the adoption of more burdensome quality measures.

Reduce funding + demand greater output + raise quality standards

This is a simple demonstration of the way the NHS sees the relationship between the three elements in the contract that seem to matter so much to Harris and Foskett-Tharby.

Paying less for the service and ramping up output requirements while raising the so-called quality standards of the product is a recipe for failure. It cannot be seen any other way.

If it was the Government who introduced and have persisted with this contract for the last 16 years, it is impossible to believe they don't know what is happening.

It then becomes clear, to the author at least, that what can be seen in the UDA contract is a deliberate intention to reduce NHS dental output and costs, with the inevitable happening: dentists walking out of the NHS. From a political perspective, the public can then be encouraged to blame the 'greedy' dentists for what has been happening.

The NHS dental workforce (dentists, nurses, hygienists and therapists) is declining at a rapid rate as a result of the UDA contract, along with the reduced funding.[4] Despite the investments that have occurred in training, the workforce cannot deliver the outputs within the current NHS system. Instead, they have moved in the majority to an arrangement without the nonsensical quantity and quality measure.

Pretending that this is not deliberate policy is deceitful. Arguing that finessing a new contract by adopting an 'incremental approach to contract change' flies in the face of the evidence.

A patient perspective

Perhaps the wealth of argument over the rights and wrongs of the UDA have distracted us from what should matter most to a professional group. What impact is this current funding battle having on our patients?

Sadly, the damage is worrying and getting steadily worse. Colleagues report finding patients with accumulated problems that take longer to deal with. Patients very often report not being able to find anyone in their area willing to take on any new NHS patients. Children go untreated for years rather than months. The damage that takes place in that time may be repairable, but the damage has been done.

Stories like this are commonplace. A casual glance at social media will show any enquirer

what is happening. There is no secret around the failings of NHS dental care.

The same patients are finding problems obtaining access to NHS primary care medical services and cannot easily access hospital services; in an emergency, the crossing of fingers is just not good enough.

Pharmacists have not had an increase in dispensing fees for five years but the NHS wants them to take on more and more responsibility for NHS care.

The problems of NHS dental care are not isolated. They have become generic across the NHS. These are collective symptoms of a system failure brought on by cuts in funding that push professional staff into leaving the service for good.

The dental profession should always remain mindful of our purpose in life – to provide good quality dental care for patients in a timeframe that allows for the reduction of pain and the swift repair of damaged teeth and unhealthy soft tissues.

Conclusion

Of the three key elements in all contract negotiations, quantity and quality must always take a back seat while the financial boundaries remain set in stone. Until that government position is changed, the only incremental development that will occur in NHS primary dental care is the continued demise of the state system, albeit at a faster rate than previously.

History has much to tell us, but history did not start in 2021.

The author

John Renshaw has held several senior positions within the BDA over a long career in dental politics.

He was a member of the General Dental Services Committee from the 1980s until 2000. He was vice chair of that committee from 1994–2000.

He was a member of BDA Representative Body from 1985–2012 and Chairman of Finance from 1997–2000.

At a local level, he was Chairman of Yorkshire Branch from 1984–1999 and President on two occasions – 1983 and 2006. He was a senior local dental committee (LDC) member from 1984–2007 and was Chair of the LDC Conference in 1993.

Between 2000 and 2006, he was Chairman of the BDA Principle Executive Committee.

The key issue throughout these long years was about the relationship between the dental profession and the NHS and the most senior people were constantly taking part in negotiations about pay and conditions for dentists working within the NHS. That eventually led on to the introduction of the UDA contract in 2006. His great knowledge and experience in this area qualifies him to speak with considerable authority in the area of contracts, especially when dealing with the NHS.

In a long career in dental politics, he crossed swords with a number of Secretaries of State for Health – some of the better known – and longer lasting – examples are: Kenneth Clarke, Alan Milburn, Virginia Bottomley, Frank Dobson, Alan Johnson and Andrew Lansley.

In a very different context, the author had been pursuing a wide interest in understanding how the NHS works – not simply in dentistry – and he acted within the NHS at many important levels. This level of experience in the NHS and within the dental industry makes him a very unusually qualified person.

He was Chairman of the Department of Health Standing Dental Advisory Committee from 1997–1999 (he was a member of Standing Dental Advisory Committee from 1994–2005).

In 1999–2000, he was a key member of a task force created by Alan Milburn (then Secretary of State for Health) to re-organise the whole NHS. One important member of that review group was Simon Stevens, who went on to become Chief Executive of the NHS later.

At a more local level, the author was a member of his District Health Authority, with control of a good-sized hospital.

This led to him becoming a non-executive director of North Yorkshire Health Authority, with management control of four large hospitals and three smaller units. These were very unusual appointments at the time.

He was also a dental practice adviser to North Yorkshire Health Authority and then to Selby and York Primary Care Trust.

As part of his wider interest in healthcare management, the author was also a board member of a large charitable hospice for eight years.

Ethics declaration

The author declares that he has no conflicts of interest in relation to this article.

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