An incremental approach? An honest approach would be better

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Key points

- Presents an understanding of the contextual setting of the NHS general dental services contract.
- Provides a set of issues that need to be considered when taking forward contractual negotiations.
- Helps outline issues that need to be addressed.

Abstract

This paper argues that before continuing to search for a satisfactory contract for the provision of dental care through the NHS, it is not incrementalism that is necessary, but honesty.

Introduction

One of Hans Christian Andersen's best-known works is *The emperor's new clothes*.[1] It is a fairy story about how fraudsters offer their paymaster, an emperor, clothing, which they claim appears invisible only to those who are stupid.

As the supposed cloth is woven into a 'suit', the courtiers involved in overseeing its production continue the pretence of the suit's veracity. They do not wish to appear stupid to their master. Upon completion, the emperor goes for a walk wearing the suit. Initially the public also follow the pretence; they too do not wish to be seen as stupid, but eventually, a child speaks out, highlighting reality:

'But he hasn't got anything on', a little child said.

'Did you ever hear such innocent prattle?' said its father. And one person whispered to another what the child had said: 'he hasn't anything on. A child says he hasn't anything on'.

'But he hasn't got anything on!' the whole town cried out at last.

The emperor shivered, for he suspected they were right. But he thought, 'this procession has got to go on'. So, he walked more proudly than ever as his noblemen held high the train that wasn't there at all.

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A consensus of academic analyses of the fairy story, using today's parlance – a systematic review – concluded that the work was 'a standard metaphor for anything that smacks of pretentiousness, pomposity, social hypocrisy, collective denial, or hollow ostentatiousness'.[2]

The *British Dental Journal* Opinion article by Harris and Foskett-Tharby[3] suffers comparable failings for two reasons. First, there is a total lack of any recognition of the perilous state of NHS dental care provision in England. Second, the relatively short-term of the analyses chosen (post March 2021) is naive at best or deliberately misleading at worst.

The central thrust of their argument is that health policy reform should be incremental in nature and, rather than focusing on contract reform alone, should emphasis implementation and system reform in which: '…focus groups with frontline teams will continue to be key in staying true to this iterative and collaborative path to reform'.

The problem with this argument is that the two elements – incrementalism and contract reform – are two totally different issues. Incrementalism is process-related and indeed, one may ask when is something not incremental, while contract reform is objective. But even more importantly, their 'new' approach is set against the backdrop of a crumbling NHS general dental services (GDS) system in England, visible for all to see – a long-running problem that started long before the present contract issue. Yet the authors, courtiers in the NHS England palace, suggest that the path to enlightenment provided by six aims is within their grasp, following learning gained from prototypes. 'We' are ready to move forward. Dream on.

This paper, by contrast, argues that their arguments are deeply flawed. Until reality dawns within the NHS England palace and the courtiers acknowledge actual reality, progress towards a delivery system that is, the rather overused expression, 'world class', is and will remain a lost cause.

What exactly is meant by the dental care system?

The first question to ask is: what do the authors mean by a dental care system?

All dental care systems consist of a series of elements in which activities are linked. The population do not have the single option of the NHS GDS for their care. While in 1948 the state decided to allocate central funds to cover the costs of oral healthcare, less than five years later, co-payments were introduced (1952), albeit initially for one item only. Note co-payments were not introduced throughout the NHS. Co-payments are used for two purposes: to raise revenue and supress demand.

Subsequently, co-payments have been levied on a growing number of items of treatment and with the current contract, a patient co-payment for each course of treatment is based on three 'bands', broadly reflecting differences in the degree of service complexity, unless the patient is exempt.

This is important, as it provides the environment in which the GDS and, equally

importantly, other arrangements develop. Given the co-payment and banding arrangement, the alternative arrangements in which the state has no direct financial involvement – the non-NHS component – has become an integral part of care delivery and should feature in any discussions when exploring the role that the NHS England GDS system should play.

However, even the NHS oral healthcare element is not one single entity. It consists of a number of sectors, for example, the community dental service and hospital-trust-based services.

Changes in any of the contractual arrangements in any of the individual sectors that exist may impact on the other elements. Furthermore, even if all the aforementioned oral healthcare delivery sectors were used to define the boundary of the 'system', this would ignore possible impacts on other NHS care sectors: the growing attendances of patients at primary and secondary medical care centres seeking help with their dental problems being but one example.

These, however, are simply the care delivery structural components.

All care systems consist of a number of components whose functions can be categorised into three main elements:

- Delivery
- Finance
- Governance.

For delivery, aspects include what is delivered, where, and by whom. For finance, issues include obtaining resources (pooling, an issue which applies to both the NHS and non-state organised care plans) and their subsequent distribution. Governance is the framework through which authority and accountability for the system's performance is undertaken.

This creates the major problem which the authors have simply ignored – the starting point of any reform – the lack of definition of the boundaries of the system that they wish to see reformed.

There is no placement of the NHS GDS contract in the wider context, which in turn avoids the thorny issue of exactly what the 'system' is trying to achieve except in very nebulous terms.

The six aims which the authors refer to range from better outcomes to preventive dentistry and then on to access. There is no mention of the serious workforce problem which has arisen largely as a direct consequence of the current contract.

Take another example: 'care system resources', to which the authors refer in aim number six. They have to 'be affordable within NHS resources made available'. But what are they and how might they change? What exactly does the term mean? Do they include the costs of training and education, or recruitment from overseas to address failings in previous healthcare policies? Or indeed, costs that arose from the impact of the country's decision to redefine the relationship with the European Union? What exactly are the resources that have been made available (and indeed, for key reasons, went unspent in each year despite the problems)?

By concentrating on a single entity – the delivery of widgets in the NHS England GDS contract – the authors ignore the far larger set of activities which all have a bearing on the provision of oral healthcare and consequently, oral health in England.

Leaving aside for the moment the lack of clarity, the real challenge remains: where does the GDS contract fit into the delivery system? This is an NHS England contract through which an undefined element of what is in the majority elective care with a co-payment, which, in some circumstances, means that non-NHS care is less expensive and will be provided through a static agreement against a backdrop of everchanging elements. The authors suggest an 'incremental approach'!

Contract, what contract?

But first, 'the contract'. A contract is a legally enforced agreement between (at least) two parties. For the NHS GDS contract referred to, this is between NHS England and either an individual or a corporate structure. As Compagnucci *et al.*[4] wrote:

'Contract design is about bringing design and user-centricity into the world of contracting. It is not just about verbal content, it is also about communicating contracts so that they work better for their intended purpose and functions and for all audiences, whether consumers or organisations, commercial or technical'.

So, what then is the NHS England GDS contract trying to achieve? The authors remain silent on where it fits into either the wider NHS or the overall care delivery system that operates. For example, there is no discussion of whether the current levels of care provision through non-NHS arrangements are deemed satisfactory. In addition, the authors have also ignored the existing additional contracts within the delivery arrangements besides the NHS GDS contract, although the individuals have been included in the 'stakeholder' analyses.

These additional contracts include any agreements between practice principals and other staff: between primary and secondary care, and most importantly, between patient and the GDS. Indeed, with respect to the latter, it is remarkable that, at a time when those designing a contract have as an aim to see increased attendance, they increase the major barrier to it – patient co-payments. Not only is this totally counter-intuitive, but as highlighted above, ignores the very real impacts that have arisen in other aspects of the care system, namely primary and secondary medical care, where charges do not exist. Is this what the authors mean by 'leaving a mark'?

The authors fail to discuss why many current contracts have been returned and why there are problems with recruitment and retention of dental care providers, all in part a result of the current NHS England GDS agreement.

Furthermore, while highlighting discussion of 'stakeholder' engagements, there is nothing surrounding the actual terms of reference that each of the groups were given. Did the groups consider what care should be provided within the NHS? Were co-payment changes considered? What role would primary care practices play in undergraduate training? Were current governance structures appropriate?

The approach adopted

In their work, the authors' use of terminology should also be examined in detail, not least as it may help understand the approach outlined in the article. There are a number of words that stand out but for different reasons, two examples are worth highlighting.

First, that of 'efficiency'. Their scope in the use of the term efficiency would appear to be limited to cost alone, with reference to economic efficiency, namely obtaining the greatest health benefit from interventions using the available resources, or achieving a given health benefit in a way that minimises costs/resource use. The authors would be wise to note the comments from the Bristol Inquiry[5] concerning children's heart surgery:

'What marks out the NHS, is that successive governments have made claims of excellence which simply have not been realisable, given the funds allocated. Patients have been led to have high expectations, only to be disappointed too often. Those working in the NHS have become increasingly frustrated that they are unable to give patients the service which they joined the NHS to provide. They have found themselves

battered from all sides: taught what is the best, but expected to practise in circumstances in which "getting by" is prized as success, and make excellence very difficult to attain'.

Other possible meanings of efficiency are ignored. Nowhere are the dimensions of technical or allocative efficiency raised, yet for patient care are central.

The very reason for the use of a salaried service to exist alongside that of the GDS is to provide the opportunity for work of a technical or managerial difficulty that does not fit within the GDS to be provided.

While there is a recognition that the treatment is of value, it cannot be provided through the single arrangement known as the GDS under the current contract. An alternative supply arrangement is required. The authors could of course explore the issue of what factors could be changed that would allow the work to be carried out under a GDS contractual agreement. Again, how might financial arrangements, if that were the barrier, be modified to allow this to happen, if it was felt appropriate?

A second example of use of language are the references to a *cause célèbre* of the DH, that of 'supplier-induced demand'. The examples used to infer its existence are flawed. In the case of Birch's work,[6] the study involved 'testable predictions are generated which distinguish between the inducement and traditional approaches', that is, hypothetical scenarios.

For Grytten *et al.*:[7] 'the results reported that, in the short run, a reduction in the prevalence of dental diseases may not necessarily lead to a concurrent reduction in demand and utilisation of dental services' based on the number of teeth as a measure of dental disease, while in the work of Chalkley *et al.*,[8] the authors state 'our results suggest that the supply-side and demand-side of the market cannot safely be treated separately'.

Indeed, the only report ever undertaken to quantify supplier-induced demand in the NHS – the Schanschieff report[9] – highlighted minimal evidence to support the concept of supplier-induced demand and, where it did, suggested that a key factor was associated with 'outdated' treatment philosophies.

At no point is the measure of outcome from the NHS England GDS system discussed in any detail, yet it is of paramount importance. By selective use of such flawed material, the authors have exposed their hand. The profession is bad. Their underlying premise centres on dentists providing too many inappropriate interventions, although they are never actually defined, when trying to achieve an undefined goal.

Without ever using the actual distribution of claimed interventions and their adoption of a theoretic set of models, they wish to see an incremental change in the contract to stop waste. The actual evidence presented for such a statement, in particular through GDS arrangements, however, is non-existent. Furthermore, there is no discussion of the other care sectors and the level of such 'inappropriate' interventions. Does it exist?

In designing a contract, the measure of performance needs to be defined. Currently, it is units of dental activity (UDAs). It is the currency that links the purchaser of care, NHS England, to the provider, the contract holder. And woe betide a contract holder that falls below their contract value of 96%. By using the UDA, NHS England are accepting that it is the key measurement of intervention. The goal of the system is to provide 100% of UDAs each year.

The majority of systems across the world use a fee-per-item payment mechanism. What this allows is transparency for the payer, whether a third party or a patient, key for helping ensure good governance. What such systems in the vast majority do not have, indeed never have had, are the monitoring arrangements that existed within the NHS before the decision to abolish them with the introduction of the 2006 contract.

If ever an example of the utter crassness of policymaking within the dental sector existed, it was this change. The expertise, skills and foresight that had been built up over a period of more than 50 years were discarded. An arrangement which allowed not just an individual to be followed through the system, but a tooth surface. The value of such real-life data on longitudinal measures of outcomes, changes in policy decisions, such as co-payment levels, and most importantly, on helping define better practice to support the profession, have been lost.

Again, at no point are alternative arrangements offered. Indeed, it would have been useful for the authors to highlight where the pilot schemes were working (if at all) to stimulate stakeholders to 'incrementally' move forward. What all the references used highlight is simply that any incentive arrangement has the potential to create NHS England's perceived unwanted consequences but nothing about wanted consequences. And with the abolition of the dataset, an instrument for holding decision-makers to account is lost.

Finally, and perhaps most importantly, is the idea of honesty, an ominous example being the timeframe used. The authors highlight that 'NHS England took over contract reform in England in March 2021'. Are they insinuating that before that, any problems with its development are not their responsibility? In political terms, this is analogous to an approach taken by Pol Pot in Democratic Kampuchea and the concept of Year Zero, an approach in which the past is deemed irrelevant. When discussing various aspects of 'contract' reform, there have been a number of major changes before the present work, all of which had implications to how the present should be viewed. Not least the NHS GDS contract reform in the late 1990s set the context for subsequent reform discussions.

Any negotiation is divided usually into six phases: presenting the arguments; challenging and presenting counter arguments; sending signals about your negotiating position; putting possible bargains on the table; structuring an agreement; and documenting the agreement.

The above issues help identify the negotiating position of NHS England. They have suggested improving efficiency but in a single dimension based on a reduction in their signal of supplier-induced demand but which lacks a valid basis.

Solving the apparent conundrum

So how should contract reform move forward? While the authors go to considerable lengths to describe the problem of system reform as being 'wicked', their subsequent work is more about discussions with a range of providers. This raises the issue of control. The work of Periyakoil[10] may help. They wrote:

'Wicked problems require adaptive solutions that are tailored to work in the local setting and need to be implemented by a group of local stakeholders and champions who are well acculturated in their organisational culture'.

The critical issue is shifting developments away from the ideal of finding a complete solution to developments which have sustainability, that is, the ability to adapt to changing circumstances and have local ownership. It is not about a 'once and for all' fix, but an arrangement that can adapt to changing needs or impacts.

An example of this is when the authors state that one element of their approach is for 'the strategy to incentivise fewer, not more treatments per patient'. This approach is flawed. A strategy for health is about incentivising interventions that help the patient achieve their health goals. It is not necessarily fewer but the appropriate interventions. This approach also highlights their continued wish for total control for a centralised arrangement. It is about specifying which interventions should

be provided and that they know prevention is always better than treatment. As an aside, why is placing a restoration in a tooth classified as treatment, not prevention? Surely, the restoration is placed to prevent the tooth being lost.

This wish for total control is flawed. The authors must recognise the factors which can contribute to improving health and that oral health is a nebulous concept which can and will evolve depending upon the circumstances that individual patients find themselves in. It is about contract holders forming relationships with patients, adapting to their changing circumstances, and supporting their roles in a sustainable framework. It is about encouraging investment in practices to ensure high-quality patient experiences, acknowledging that the practice owners should receive a reward for the risks taken with ownership. It is local and it is, to some extent, unique to each practice.

It is also recognising what is needed to help support addressing the determinants of oral health, the vast majority of which lie outside the GDS. How can any contract support collaborative working across the differing care sectors? The existence of patient charges is a deterrent to good care and an incentive to inappropriate care. While emphasising access, a contract which potentially penalises the holder for decisions out of their control, for example, increases in patient co-payments acting as a key deterrent for individuals to attend, is simply wrong. Attendance for what the patient sees as a mouth ulcer at a medical practitioner who has little or no training will lead to, at minimum, a delay in diagnosis and most likely, poorer outcomes, all as there is no medical co-payment.

Solving the conundrum of improving health requires critical thinking. It involves the individual's ability to undertake the following: conceptualising; logical reasoning; applying strategy; analytical thinking; decision-making; and synthesising to solve any problem.

As Head[11] writes:

'While continuing to recognise the centrality of complexity and uncertainty, and the need for creative thinking, a broader approach would make better use of recent public policy literatures on such topics as problem framing, policy design, policy capacity and the contexts of policy implementation'.

Most importantly, however, is strengthening political will. This is the key role of the courtiers within the NHS England palace.

Strategies must include: limiting the scope of the contract to factors which the holders can control; promoting the success of existing collaborative arrangements where evidence of intraoral and extraoral healthcare sectors exists; promoting social entrepreneurship that generates creative solutions to the current arrangements; and harnessing the media to educate and motivate the public to address this pressing problem.

If improvements to the delivery of dental care are to be found (not least the over-arching principles of reducing oral health inequalities, sustainability and the public's experiences), clarity and reality on the role that the NHS GDS system dental services could play in the overall system needs to be provided.

Only then can the starting point that outlines the requirements of the NHS England GDS contract be made. It is worth noting that the GDS contract only defines one element of the care arrangements. Negotiations should define the arrangements that best meet the needs of the population and must be designed to cover those needs now, and estimates of what they will be going forward. And it must do so in conjunction with other delivery arrangements to ensure technical, allocative and cost efficiencies. Until then, the current shambles that engulfs NHS GDS care delivery in England will continue.

While this may not yet be acceptable to politicians, it is neither in the interests of the dental professions nor the public to allow the current situation to remain. Addressing the provision of dental care in England requires a degree of honesty and the willingness to challenge. A starting point for those involved would be to note Ham's[12] critique on reforming the NHS, who wrote:

'The reviews argued that the NHS needed to build a culture of learning and improvement, and to strengthen staff capabilities for improvement. Their core argument was that there had been too much reliance on reforms being led from the top down, and too little on equipping and supporting NHS organisations and staff to lead change and improvement. This included engaging clinicians much more effectively because of their central role in improving patient care'.

Conclusion

There needs to be an acceptance, not simply from March 2021, of the failings by those responsible for policy covering dental care provision, to articulate the reality of the system's shortcomings and why. Changes need to concentrate on developing three elements: trust, transparency and training.

However, perhaps of even greater importance, is to note a lesson from history. Those charged with establishing the most cost- and allocative-efficient care delivery arrangement found anywhere in the world did not adopt an incremental approach in 1948. They showed leadership, critical thinking and a political will.

Ethics declaration

The author declares no conflicts of interest.

The author acted as adviser to the House of Commons Health Committee in the inquiry into dental services.

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