**Can conditional health policies be justified? A policy analysis of the new NHS dental contract reforms.**

# Abstract

Conditional policies, which emphasise personal responsibility, are becoming increasingly common in healthcare. Although used widely internationally, they are relatively new within the UK health system where there have been concerns about whether they can be justified. New NHS dental contracts include the introduction of a conditional component that restricts certain patients from accessing a full range of treatment until they have complied with preventative action. A policy analysis of published documents on the NHS dental contract reforms from 2009-2016 was conducted to consider how conditionality is justified and whether its execution is likely to cause distributional effects. Contractualist, paternalistic and mutualist arguments that reflect notions of responsibility and obligation are used as justification within policy. Underlying these arguments is an emphasis on preserving the finite resources of a strained NHS. We argue that the proposed conditional component may differentially affect disadvantaged patients, who do not necessarily have access to the resources needed to meet the behavioural requirements. As such, the conditional component of the NHS dental contract reform has the potential to exacerbate oral health inequalities. Conditional health policies may challenge core NHS principles and, as is the case with any conditional policy, should be carefully considered to ensure they do not exacerbate health inequities.

# Keywords: health policy, conditionality, dental, responsibility, inequality

#  Introduction

 Conditional policies, where access to services are provided on the condition that the recipient behaves in a specified way (Standing 2011, Clasen and Clegg 2007), are increasingly prominent. Although conditional policies have been present in the USA, Australia and the UK for some time, it has only recently become introduced in healthcare. In the UK, this would appear to be a significant departure from the core values of the National Health Service (NHS), which stipulate that it should: a) meet the needs of everyone, b) be free at the point of delivery, and c) be based on clinical need, not ability to pay (Delamothe 2008). These founding principles were reiterated as recently as 2013 in the NHS Constitution, and remain at its core. It appears, therefore, to be contradictory to observe the recent embracing of conditional health policies. For example, some Clinical Commissioning Groups (CCGs) in England have restricted non-urgent surgeries to patients who are obese or smoke, unless they can demonstrate periods of cessation and dieting, albeit with some concern expressed in the national media (Campbell 2016). The values embodied in the NHS Constitution include two elements which are potentially in opposition – a commitment to a wider social duty to reduce inequality *and* a commitment to ‘providing the most effective, fair and sustainable use of finite resources’ (NHS England 2013). Examining whether conditional health policies conflict with patients’ right to care and are ethically justifiable is, therefore, relevant when making policy decisions at this difficult juncture.

We examine this area by undertaking a policy analysis of ongoing NHS dental contract reforms in England and Wales. Dental policies are rarely the subject of critical examination but reflect and reproduce wider discourses about health and society (Exley 2009). In examining the most recent phase of NHS dental contract reform, this paper aims to identify the way conditionality is rationalised and enacted in policy. We approach this by undertaking a textual analysis of recent dental policy documents, first to examine the rationale given for the policy, and then in a second part of the paper, how the policy operates in relation to its stated rationale and its likely distributional impact on different populations. Taken together this allows us to examine whether the arguments for introducing conditional health policies can be justified.

## Conditional Politics

 The principles of conditionality, namely no rights without responsibilities, have become a central tenet of modern policy (Dwyer 2004). Although access to social benefits has always been conditional to a point (Classen & Clegg 2007, p.171), in the UK, it was the Conservative party in the 1980s and 1990s and New Labour under Tony Blair when conditionality in social policy became prominent (Dwyer 2008). Conditional policies reflect the shifting notions of social citizenship or the relationship between the state and its citizens (Dwyer 2010). Rather than being legally entitled to benefits from the state, contemporary forms of social citizenship state that in order to access benefits individuals have a responsibility to contribute in socially responsible ways (Deacon 1994, Dwyer 2008). As New Labour increasingly made these links between rights and responsibility in a range of policy areas, conditionality became a more widely accepted approach in the UK.

Conditional health policies in the UK are not as widespread or accepted as they are in other social policy domains and in other countries. In the United States, health-related conditionality has featured within its market-based health system for many years (Rylko-Bauer and Farmer 2002). Market-based systems have a principle of optimising efficiency and focus on cost control, which tends to promote a commodification of products (health and health care), and as such, aligns easily with explicit rationing (Horton et al. 2014), often at the expense of viewing patients as ‘special, unique even’ (Harris and Holt 2013, p63). Growing conditional elements in UK health policy probably reflects an increasing demand for cost control and a move towards rationing care. With unremitting rises in financial pressure, conditionality offers the NHS a tool for organising and prioritising treatments and services (Grønning, Scambler, and Tjora 2012).

 Policy makers typically alter one, or a combination, of three levels of conditionality (Clasen & Clegg 2007). The first level is condition of category, where social benefits depend on being a member of a defined category (such as being unemployed). The second level is condition of circumstance, which refers to eligibility and entitlement criteria (such as duration of unemployment). The third level is condition of conduct referring to behavioural requirements (such as applying for jobs). As Clasen & Clegg (2007) note, there are levers for these three levels of conditionality that make the requirement of social benefits more or less restrictive (hard) or available (soft). Conditional policies can also be characterised into two broad types: those that provide additional benefits and support (incentive-based) or those that withdraw and sanction social benefits (punitive-based) to encourage ‘appropriate’ behaviours (Henman 2011).

Conditional Cash Transfers (CCT) programs are one example of the use of incentives. CCTs aim to reduce inequalities by making cash payments to families living in poverty on the condition that they attend health care appointments and other services. These CCTs have gained popularity following their successful use in improving access to services across a wide range of developing countries (Lagarde, Haines, and Palmer 2007). In the UK, the Sure Start Maternity Grant similarly gave women financial benefits in exchange for attending child health care appointments with professionals (Lund 1999). These sorts of programmes involve citizens receiving a reward they would not have otherwise received, in return for compliance (Dwyer 2008). On the other hand, job seekers and welfare claimants often face punitive forms of conditionality. Punitive conditionality results in the sanctioning of citizens by the state, through having expected entitlements withheld (Henman 2011).

 Conditional policies are often justified using contractualist, paternalistic, and mutualist arguments (Deacon 2004). Contractualist arguments draw on the notion of social justice and reciprocity that links to ideas of social citizenship. The central premise it that governments and individuals have a duty to each other. As such, conditional policies can be justified to act as a deterrent to abuse of the system. Paternalistic arguments suggest that conditional policies are in the best interest of the individual who would otherwise remain dependent (Deacon 1994). This argument treats individuals as unable to make the ‘right’ decisions independently and in need of correction through monitoring and intervention (Manji 2016). Critics suggest that there is a difference between offering and coercing people into undertaking activities that they may not otherwise choose (Voigt 2016), especially when policies ignore the wider social context of people’s lives. Mutualist arguments propose that conditional policies are necessary for the good of the majority and that individuals have responsibilities towards each other (Deacon 2004). This also relates to responsibilities towards a shared community resource, such as the NHS. Efficiency-oriented utilitarianism (Roberts & Reich 2002) further underlies recent conditional policies (Watts, Fitzgerald et al 2014).

Conditional policies vary in form and implementation (Deacon 2004) so it is important to assess each in turn. A number of authors have proposed criteria to assess if conditional policies are morally and ethically justified (c.f. Delamothe 2008, Krubiner & Merritt 2017, White 2000, Whitehead & Dahlgren 2006). Not all of the criteria are relevant to examining health conditionality in particular, but the most commonly occurring criteria in the literature are fairness and attainability. According to Whitehead and Dahlgren (2006, p.5), fairness in health represents ‘fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill’ (Whitehead and Dahlgren, 2006, p.5). While this means that action to reduce inequalities in health for *everyone* across the whole social gradient is legitimate, to eliminate inequities, proportionally more resources may be required to ‘level up’ the health of those who are most disadvantaged. Attainability relates to there being a fair opportunity for patients to be able to meet the demands placed on them that also respects patient autonomy (White 2000, Cookson & Dolan 2000). Conditional policies should also be evidence-based and assess any likely distributional impacts, such as risk and burdens that may result directly or indirectly from the introduction of a policy (Krubiner & Merritt 2017). In other words, conditional policies should not worsen disadvantage (Krubiner and Merritt 2016).

So far, many proposed conditional health policies in the UK have been called into question before implementation (Campbell 2016) making it difficult to explore how they are enacted in a particular institutional context (Harris and Holt 2013). In dentistry, however, a conditional health policy has been incorporated into reforms of contracts that govern the provision of NHS care in general dental practice. Plans for a new contract model were first put forward following an independent review of NHS dentistry in 2009 (Department of Health 2009), with pilots set up in 75 dental practices in 2011, followed by an announcement in 2015 that some of these would move forward to prototype testing (Department of Health 2015). The evolutionary nature of the reforms gives us the opportunity to explore how policy frames and implements conditionality in a health context where inequalities are a real concern.

## Oral health inequalities and the reform of NHS dentistry

Inequalities in oral health are reported the world over. In a wide range of cultural contexts, a socio-economic gradient in oral health shows poorer oral health at progressively lower levels of socio-economic status (Guarnizo-Herreño et al. 2013). Whilst poorer oral health among those at the lower end of the socio-economic gradient is attributed to unhealthy dietary patterns and inadequate tooth-brushing, receipt of dental care is also found to contribute, at least in part (Harris, Pennington, and Whitehead 2016). Poverty, however, is just one way that socio-economic disadvantage relates to poor oral health. Differences in education and occupation as well as a range of socio-psychological factors, such as social capital and sense of coherence, have also been associated with inequalities in oral health (Nicolau et al 2003). Therefore, when considering whether patients are able to procure services proportional to their need, the power distance and social relationship between the patient and dentist are likely to be important considerations, in addition to their ability to pay.

 Primary care dentistry in the UK is mainly delivered through independently owned general dental practices contracted to the NHS or through private practice where reimbursement is received either directly from patients or through third-party payers such as insurance companies. Although it is possible for practices to deliver both NHS and private care in the same premises, more than 85% of practices rely on some form of NHS income (British Dental Association 2013). Finding a way to reimburse dental practitioners fairly for NHS work, as levels of disease have declined, has been a struggle. Since the 1990s, there have been various models of NHS dental contract, all matched with subsequent unintended consequences (Harris et al. 2014). A remuneration system introduced in 2006 based on activity grouped into three bands of Units of Dental Activity (UDA) (House of Commons 2008) was widely recognised as failing to incentivise quality of care, particularly prevention (Department of Health 2009). The UDA system was also found to promote variation between dentists in terms of the advice and treatment offered to patients (Rooney 2014). This eventually prompted moves towards standardising care by means of care pathway commissioning (Harris and Bridgman 2010).

A process of piloting elements of a new contract, with care pathways at its heart, began in 2011. Prototype testing of the new dental contract is underway, with roll-out to all dental practices expected in the next few years (Department of Health 2015). The aims of the reforms are to focus on the delivery of long-term preventive care, and remunerating dental professionals based on quality of care, rather than treatment (Department of Health 2009). The iterative shaping of these new NHS dental contracting arrangements (Rooney 2014) provides us with the opportunity to explore how and why conditionality was included within the new system, and how it is justified in policy terms.

Care pathways are a quality improvement initiative designed to enforce the use of standardised processes and approaches known to deliver predictable outcomes (Rooney 2014, Department of Health 2011). The use of care pathways to guide practitioners in delivering evidence-based dental care was prompted by the Steele review (Department of Health 2009) and subsequently incorporated into the new NHS dental contract arrangements now being tested. Practitioners enter patient’s social (self-reported) and medical information into clinical software that uses an algorithm to sort patients into a traffic-light system (Red, Amber, Green, or RAG). This RAG allocation sets in motion recommended preventive care protocols. Patients categorised as ‘Green’ (healthy) can proceed with regular dental care along with reduced surveillance (up to biennial check-ups), while ‘Amber’ patients are also recommended to have a full range of dental treatment and up to annual check-ups.

For ‘Red’ patients, on the other hand (identified as having active disease requiring treatment), there is a ‘treatment lock’ meaning they are not entitled to advanced care within the NHS. Red patients are only entitled to ‘limited restorative work’ (fillings, extractions and acrylic dentures) until they have demonstrated that they are committed to improving their tooth-brushing, diet, and reducing their ‘risk’. The reasoning is that recurrent decay or periodontal problems can cause some restorations to fail (NHS Centre for Reviews and Dissemination 1999). To receive a full range of care (such as root canal treatment, crowns, bridges and cobalt-chrome dentures), as well as improving self-care, ‘Red’ patients must comply with preventative ‘interim care management’ (ICM) appointments. This requires multiple appointments and visits every three months; for oral health advice and preventive treatments such as fluoride varnish and scaling before they can revisit the dentist who will check compliance before proceeding with a full treatment plan.

In 2013, against a background of falling patient charge revenue in NHS dental practices piloting the reforms, a new category of patient charges was introduced (Band 1a, currently £20.60) for ‘Red’ patients receiving preventive treatments such as fluoride varnish and scaling in ICM appointments. UK Government guidance, however, recognises that some patients may agree to one or more ICM appointments and then ‘simply not turn up’ thereafter. In this case, protocol is that patients are offered a ‘check-up’ appointment some months later, but no further prevention visits, and no advanced restorative care if oral health remains sub-optimal.

As such, ‘Red’ patients at highest need are subject to a punitive conditional policy that restricts them from accessing full care until they comply with dental demands. This conditionality is not just based on patients’ ability to demonstrate increased skill and motivation to maintain their own oral health between appointments (e.g. improved tooth-brushing) but may involve the expense of additional dental visits to receive preventive care.

## Overview

This article aims to look at how the introduction of conditionality in the NHS dental reform is rationalised and enacted in policy. NHS dentistry is an interesting section of the health service uniquely positioned on the boundaries of public and private provision (Exley 2009) and has wider implications for other health services internationally. Firstly, we will explore the arguments made in the policy documents for introducing a conditional policy as part of the reforms. Secondly, we will examine how this may affect the provision of care to NHS patients and its potential distributional impact. To do so, we present a policy analysis of the publicly available documentary evidence on the reforms.

# Methods

What follows is a policy analysis of published documents on the NHS dental contract reforms. Policy documents published from 2009-2016 on the dental contract reforms were searched using the UK Government’s database ([www.gov.uk/government/publications](http://www.gov.uk/government/publications)) using the terms ‘dental contract\*’ and ‘dental reform\*’. There were 98 results in total but after title screening (59 documents excluded) and paper screening (25 documents excluded), eleven documents from the database were included in the analysis. Documents were excluded if they were about an unrelated topic or did not refer to the reforms. A search of other sources led to two further inclusions: the first a mass-media article outlining policy reforms, and the second, guidance produced for pilot practices published on NHS websites. Table 1 shows the thirteen included documents labelled A-M in chronological order.

[Insert Table 1 here]

The policy analysis approach draws on the methods by Fairclough and Fairclough (2012) which looks at how policy arguments comprise of an identified problem, or *claim for actions*, the specific *means* and desired *goals* proposed to achieve a proposed action, and contextualising *circumstances* and *values*. The analysis is not concerned with determining the validity of claims in the documents, but instead to explore the way in which arguments in the policy documents frame and justify conditionality. In doing so, we recognise that language and discourses are important ways in which policy formation gets enacted and influence how policies are interpreted by the public and policy-makers (Moon and Brown 2000). By looking at the reform documents over time, we can also show how the policy developed and was rationalised.

The documents were entered to qualitative analysis software NVivo 11 to systematically collate and code the information. Each of the documents was thematically coded using inductive codes and developed through constant comparison methods (Silverman 2013). To avoid selection bias in the analysis of the documents, we used NVivo for a series of text-mining queries to check the thematic analysis. The queries allowed us to explore the most frequently used words in and across the documents, in addition to a cluster analysis (Prior, Hughes, and Peckham 2012) that links related words and concepts together (see supplementary material). The resulting themes were organised into the policy analysis categories (outlined above) and collated into visual representations using the templates by Fairclough & Fairclough (2012).

# Findings

# Part One – How is conditionality justified?

## Framing the NHS dental contract reforms

[Insert Figure 1 here]

To examine the conditional component of the reform, it is important to look at the underlying arguments used in the policy documents to frame the reforms itself. There are four identified arguments used to highlight the central claim for action, that there is a need for a reform of NHS dental contracts, as can be seen in detail in Figure 1. Underlying all the arguments is the understanding that the NHS should provide access to fair and efficient services (*values*). The premise of the first, and most dominant, argument is:

There needs to be a move shift away from a treatment-based model to a ‘prevention-focused model’ (*goal 1*) (Document E, p.9) by focusing on delivering preventive care (*means-goal 1*) to better meet the changing needs of the population who ‘want a dental service that helps them maintain good oral health’ (*circumstances 1*) (Document C, p.4).

 The premise of the second argument, meanwhile, is that:

Patients experience inconsistent care across NHS dentistry (*circumstances* *2*) and that a clinical pathway approach should be introduced (*means-goal 2*) to deliver ‘the most effective evidence-based care’ (*goal 2*) (Document G, p7).

These two arguments focused on organisational and service level change, are consistent with the policy documents from the outset in the independent review (Document A) to the reform engagement exercise (Document L).

 The third and fourth arguments relate to each other and illustrate contractualist and mutualism justifications. The premise of the third argument is that:

Citizens have a duty to be well (*circumstances* *3*) and as such patients should use personalised information on their oral health (*means-goal* *3*) to ‘do their bit’ (Document F, p.18) and take responsibility for what ‘they as an individual can do to improve and maintain it’ (Document I, p.2) (*goal 3*).

This evokes contractualist ideals that citizens are obliged to contribute in socially responsible ways by maintaining their own oral health. In doing so, they are protecting the finite resources of the NHS further emphasised in the fourth argument:

 Under constrained economic conditions (*circumstances 4*) the NHS needs to be cost-effective (*goal 4*) by investing resources where ‘needs and benefits are greatest’ (*means-goal 4*) (Document A, p44).

These latter arguments often merge through claiming that patients have a responsibility to take care of their oral health and not to place unnecessary burdens on a constrained NHS. This focus on the individual responsibility becomes more prominent in the policy documents from 2012 (E-M).

## Framing conditionality in the NHS dental contract reforms

[Insert Figure 2 here]

 All of the documents discuss the conditional component in the NHS dental contract in some form (clinical guidance, feedback, practical approaches) under the framing arguments set out above. In four documents, however, additional justifications rationalise the conditional policy: the two earliest documents in 2009/10 (Document A and B) and later in 2011 (Document D) and 2015 (Document K) as presented in Figure 2. The framing of the conditional component varies over this period, with Document A and B, written by the same author, drawing on contractualist and mutualist arguments to emphasise the limits of patients’ rights in the reform to warn that:

Advanced treatment ‘represents a substantial cost to the taxpayer’ (*circumstances 1*) (Document A, p.57) and therefore should not be an automatic right (*means-goal 1)* so that NHS resources are used in a fair and efficient way (*goal 1*).

It claims that restricting entitlement to advanced dental care is the right thing to do because the NHS cannot afford expensive, avoidable treatment and patients should not be automatically entitled to make demands on this resource. To emphasise this point, financial terminologies such as *risk*, *benefit*, *cost*, *investment*, and *value* are used. Since this is the justification used in the independent review (Document A) and the BBC article (Document B) it could be said to be the public-facing rationale.

In Document D & K, the justification for conditionality suggests that restricting access to advanced care is in the best interest of the patient:

Treatment is more likely to fail if there is poor oral health (*circumstances 2*) so preventative care should take place before any advanced treatment (*means-goal* 2) to engage patients (*means-goal* 2) to ensure success (*goal 2*).

 This emphasises perceived positive consequences of conditionality suggesting that it will encourage patients to take control of ‘their own self-care responsibilities’ (Document A, p.41) by becoming ‘pro-active in their oral self-care’ (Document D, p.38). As such, ‘treatment is limited by what the patient is willing to accept and the advice s/he is willing to adhere to’ (Document M, p.4) The message emphasises individual behaviour as the cause of poor oral health, reinforcing that dental diseases ‘are almost entirely preventable’(Document I, p.10), downplaying structural causes and barriers.

The dental contract reforms and the conditional component draw on the contractualist, paternalistic, and mutualist arguments used in other social policies to frame conditionality. White (2000), in his review of how conditionality is rationalised within welfare reform in the UK and USA, found that the contractualist and paternalistic justification are commonly used. This is reflected in Documents A and B where the idea of a social contract between the state and individual is drawn; suggesting that in order to be entitled to care patients have an obligation to service providers and other taxpayers, such as in the following statement in the BBC article on the reforms:

‘If taxpayers are contributing to the NHS to provide costly and difficult treatment, asking the patient to provide a healthy mouth first seems a reasonable deal doesn’t it?’ (Document B, p.1)

 Paternalistic justifications are more likely when the primary level of conditionality is conduct as is the case here (Watts, Fitzpatrick et al 2014). A paternalistic justification for conditionality, White (2000) argues, depends on demonstrating that existing systems have failed. In particular, that there has been ‘some failure of autonomy – of rationality or self-discipline – on the part of the individual’ (White 2000, p.523). Conditionality, therefore, is a solution to individual and system failures, with the assumption that this approach will produce benefits for everyone.

So far, we have focused on looking how conditionality has been framed within wider arguments about the need for reform. Conditionality is positioned as a rational solution to tightening resources in the NHS and as necessary to encourage greater patient responsibility. It is important, however, to explore whether these arguments presented in the policy documents can be justified. In order to assess this, in the next part, we will look at how the conditional component might work in practice and any likely distributional effects. This will assess who is likely to be affected by its introduction and as such to what extent is the conditional component likely to increase or reduce oral health inequalities.

# Part Two – Examining the likely distributional effects

 [Insert Figure 3 here]

‘Red’ patients

There are two subject positions used to describe patients in the reforms. These are ‘willing/able’ patients who want regular attendance and adhere to self-care standards and those ‘unwilling/unable’ to accept the offer of continuing care. Here, we could argue that patients classified as ‘Green’ are the first subject position, whilst ‘Red’ patients represent the second position. ‘Red’ patients, those categorised as unwilling and unable, are positioned as in need of intervention for their own good. There have always been constructions of ‘good’ and ‘bad’ patients (Kelly and May 1982) and dentists are known to tacitly rate patients according to their ‘compliance, tractability, and likability’ (Rouse & Hamilton, 1991). In focusing on the individual as the site of change, the reforms reinforce a message that ‘there are not real material barriers to behaviour change but merely motivational ones’ (Voigt 2016, p.3).

‘Red’ patientsare often described as lacking both the correct behaviours and attitudes to receive care. These patients not only need advice to improve their oral health behaviours but also need help to ‘ensure cooperation, motivation, and aspirations are consistent’ (Document D, p.29) with that of their dentist. This becomes problematic when considering the makeup of this group, with an independent evaluation of the pilot reform stating that the patients in the unwilling/unable group are from ‘socially deprived areas’ (Document H, p.16). This group are characterised as ‘less invested in health’ (Document H, p.16) and as having ‘challenging lifestyles’ (Document H, p.4). Accordingly, the paternalistic argument is that this group of patients cannot be trusted to comply on their own and intervention is in their best interest since they are a group in most need of care. Maximising resources for this group could reduce inequalities and be considered fair *if* there is also fairness in opportunity and support to meet the demands of conditionality (Whitehead & Dahlgren 2006)*.*

## Compliance costs

The policy documents recognise that ‘Red’ patients may be more likely to come from deprived areas. This is because, in the main, poor oral health is usually a reflection of factors associated with poverty (Harris et al. 2011). ‘Red’ patients seeking NHS care, therefore, may be least able to buy into consumption practices around oral health and NHS treatment costs. Furthermore, under the reforms, this group of patients have additional compliance costs through the care pathway that requires multiple appointments. This may cause difficulties for patients since most dental appointments occur during working hours and may involve losing income in addition to travel costs. In addition, attending the compulsory prevention ICM appointments for ‘Red’ patients now carries an additional NHS charge, Band 1a, which is currently £20.60. Compliance costs for this group of patients, therefore, are likely to be higher than for patients in other groups. This means it is likely that ‘Red’ patients at the lower end of the socio-economic scale may drop out of routine care. This has already emerged as an issue in the independent evaluation of the pilot practices:

 ‘Those who are less interested in looking after their teeth and gums are more likely not to attend their ICM appointments, despite reminders from the practice’ (Document H, p6)

 In theory, ‘Red’ patients who are most vulnerable should be exempt from paying NHS dental charges, although eligibility for free dental care is complex (see NHS Choices 2014). Even if patients are exempt from NHS charges, they still face lost opportunity, care, and travel costs. These structural barriers are minimised in policy by stating that patients who fail to attend ICMs are simply not invested or interested in their oral health. However, we should be mindful that for some people investing in their health might come at the expense of other, more pressing, needs (Voigt 2016). Recent research shows that people living in poverty pay a premium on average of £490 per year on everyday essential services such as household bills (Davies, Finney, and Hartfree 2016). Attending ICM appointments, therefore, are more costly and may take lower priority for some groups of patients. Indeed, health researchers working in the USA have found that ‘those least likely to comply are usually those least able to comply’ (Rylko-Bauer and Farmer 2002, p483). For ‘Red’ patients compliance with the conditional requirements may not be attainable, and further suggests that the policy may not be fair. To assess this further, then, we examining whether there are exceptions to the rule.

## Overriding and opting out of conditionality

Policy documents introducing care pathways to the NHS dental remuneration system are careful to point out that despite standardising care, the new system should not replace ‘clinical autonomy or leave decisions solely to a computer algorithm’ (Document J, p.41). To reinforce this, supporting clinical computer systems have an override function to allow dentists to change the RAG rating and subsequent pathway leaving them free to ‘use their own clinical judgement about what is in the best interests of their patients’ (Document C, p.13). This override function, however, rests on dentists’ discretion and may lead to reduced transparency and accountability, and even a ‘cherry picking’ of patients (Harris et al. 2014). Who gets their RAG allocation overrode, and why, appears to be a relatively unregulated area. Practitioners express concerns that clinicians will tend to override the assessment system most often in order to reduce patient complaints; given that a supplementary element of the remuneration arrangements relies on patient satisfaction scores (Woodington 2015). Given that patients from poorer backgrounds are likely to be the least vocal in objections (Daniel, Burn, and Horarik 1999, Willems et al. 2005), there remains a subtle incentive for practitioners to give more care to those less in need.

 The override function is expected to ‘be minimal’ (Document E, p.15) but depend on discretion, and as some health researchers note ‘non-accountable discretion is a potent source of power’ (Grimen 2009, p18). Previous research has found that physicians are poor predictors of compliance and tend to rely on personal characteristics (Rylko-Bauer and Farmer 2002) and notions of deservingness (Sontag and Richardson 1997). Furthermore, discretion may depend on social information such as previous compliance even though past non-compliance does not necessarily predict adherence to a new regime that better meets the needs of the patient (Rylko-Bauer and Farmer 2002). The lack of transparency may mean that groups of patients seen as ‘unwilling/unable’ remain on the care pathways whilst groups seen as ‘willing/able’ have their care pathways overridden. Dentists, in deciding when to override the system, become involved in deciding which patients deserve to receive treatment. The conditional component of the reforms, then, may be selectively applied. There needs to be further evidence that the new reforms can mitigate these risks.

Lastly, it is worth noting that there is a way in which ‘Red’ patients can receive the full range of treatment immediately. They can go private. In choosing to purchase private care, patients also buy out of the associated obligation and responsibility. This displacing of need away from the NHS could be regarded as a successful outcome of conditionality (Watts, Fitzgerald et al 2014). However, while those who can afford to pay for care can escape; those who cannot afford to do so must comply or leave. The option of private treatment means that not all patients are required to comply – it does not have ‘universal application’ (White 2000). Those who leave may seek care at another practice, some may not receive treatment at all, and some may resort to self-treating (Armstrong and Ruiz del Arbol 2015). This displaces the problem to other NHS services and may have a negative impact on help-seeking.

# Discussion

Our study has sought to examine how the introduction of a conditional health policy within NHS dentistry is justified, and the potential distributional effects of its introduction.. The dental contract reform uses contractualist, paternalistic and mutualist arguments, underlined with efficiency-based utilitarianism, to justify policy changes. Health conditionality, therefore, is drawing on the same justifications as in wider social policy (Deacon 2004). The increased focus on efficiency, however, perhaps reflects the current economic climate in the UK following the introduction of austerity measures in the wake of the Global Financial Crisis in 2008. Austerity and efficiency have led to increased stigmatisation in public and political discourse in the UK between the ‘deserving’ and ‘undeserving’ poor in society (Hancock and Mooney, 2012). These discourses help to garner public support for increasingly punitive forms of welfare, such as the sanctioning of job seekers whilst reducing available support (Fletcher & Wright 2017). Within this broader context, it is perhaps unsurprising that we are seeing a rise of punitive conditional health policies.

The likely distributional effect of each conditional policy, whether incentive or punitive based, should be considered before implementation. In this case, the potential effects of conditionality within the NHS dental contract reforms challenge core NHS values. Disadvantaged patients are likely to be most affected by the policy, and least able to comply, therefore the policy cannot claim to be fair or attainable. By constraining ‘Red’ patients from accessing needed treatment the policy violates NHS principles to meet the needs of everyone and be based on clinical need (Delamothe 2008). Given that other research has shown conditional policies to have a disproportionate impact on lone mothers and migrant populations (Krubiner & Merritt 2016), it is likely that further distributional effects are possible. In its current form, the contract reforms cannot be said to be fulfilling NHS promises to reduce inequality (NHS England 2013). The policy analysis, whilst only including thirteen documents, reflect seven years of reforms and all relevant published materials available to the public. As evaluations emerge of its impact, further analysis will be important for future debates on conditional health policies. The current findings demonstrate that as the policy currently stands there are unintended burdens and consequences. Furthermore, there is a lack of transparency about who is subject to the conditional component since patients may opt-out of the care pathway by paying to go private or may have their treatment lock lifted by the discretion of a dentist. In policy areas where the public and private care blur – as is common in dentistry and increasingly in other areas of healthcare – conditional policies will increase inequalities as those with the financial resources will opt out. This is especially significant when conditionality is linked to the notion of healthcare as a commodity. As international critics state, a focus on economic concerns can lead to a system that ‘judges deservingness of healthcare by one’s ability to reduce one’s burden on the healthcare system’ (Horton et al. 2014, 476). There is the potential for the NHS dental reforms, in their current state, to prioritise the rationing of care through conditionalityc over core principles of need, access, and equality.

# Conclusion

While conditionality has crept into social policy across the world, in the UK this is a relatively uncharted area in healthcare and one that is particularly lacking in research evidence. Exploring the policy area of NHS dental contract reforms has allowed us to examine a potentially contentious political area. Conditional policies represent an ongoing struggle to find policy solutions to providing ‘fair, equitable and sustainable care with finite resources’ at the same time as trying to pay ‘particular attention to groups or sections of society where improvements in health have not kept pace’ (NHS England 2013). As conditional health policy become increasingly widespread, therefore, we should be fastidious in examining who is likely to be affected by their introduction.

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# Table and figure captions

Table 1. List of included documents in policy analysis

Figure 1. Framing to support the need to reform NHS dental contracts

Figure 2. Framing to support the introduction of a conditional element in the NHS dental contract reforms

Figure 3. Mapping the trajectory of patients classified as ‘red’ in the clinical care pathway

# Tables and figures

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| **Table 1. List of included documents in policy analysis** |
| **Reference** | **Year** | **Name** | **Description** |
| Document A | 2009 | Department of Health. 2009. NHS dental services in England: an independent review led by Professor Jimmy Steele. London. | Independent review and policy proposals |
| Document B | 2010 | Steele, J, Patients 'should look after teeth if they want care', in BBC News Online. 2010: http://www.bbc.co.uk/news/health-12042614 | Mass media article |
| Document C | 2010 | Department of Health, NHS dental contract: proposal for pilots December 2010. 2010, Department of Health: London | Outline of Stage 1 pilots |
| Document D | 2011 | Department of Health. 2011. Dental Contract Reform Pilots: Notes to support Care Pathway Approach. London: Department of Health. | Clinical guidance to dental professionals  |
| Document E | 2012 | Department of Health, Dental Contract Reform Programme: Proposals for stage 2 piloting. 2012, Department of Health: London. | Outline of pilots and contract changes for Stage 2 pilots |
| Document F | 2012 | Department of Health, NHS dental contract pilots: Early findings. 2012, Department of Health: London. | Progress report on pilot  |
| Document G | 2012 | Department of Health, NHS dental contract pilots: Care Pathway Review. 2012, Department of Health: London. | Progress report on care pathway approach |
| Document H | 2012 | ICM, Dental contract pilots evaluation: Research report for the Department of Health. 2012 | Independent pilot evaluation  |
| Document I | 2013 | Department of Health, Dental contract reform programme: early findings and opportunity to give feedback. 2013, Department of Health: London. | Progress update |
| Document J | 2014 | Department of Health, NHS dental contract pilots - Learning after first two years of piloting. 2014, Department of Health: London. | Progress report on pilot |
| Document K | 2015 | Department of Health. 2015. Dental Contract Reform: Prototypes. London: Department of Health. | Outline of prototypes  |
| Document L | 2015 | Department of Health, Dental contract reform engagement exercise: detailed findings. 2015, Department of Health: London. | Progress update for dental professionals |
| Document M | 2016 | Department of Health. 2016. Dental contract reform: Managing Patient Compliance and Motivation. London | Clinical guidance |





