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

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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 to 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.

1. 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 contradictory, therefore, 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 dieting and cessation, 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.

1.1. Conditional politics

The principles of conditionality, namely no rights without responsibilities, have become a central tenet of modern policy (Dwyer, 2004).

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Although access to social benefits has always been conditional to a point (Clasen and 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 et al., 2012).

Policy makers typically alter one, or a combination, of three levels of conditionality (Clasen and 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 and 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 et al., 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, 2017). 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 and Reich, 2002) further underlies recent conditional policies (Watts 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 and Merritt, 2016; White, 2000, Whitehead and 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 and 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 and Merritt, 2016). 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.

1.2. 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 et al., 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