Community Dental Health (2009) **26,** 66–68

doi:10.1922/CDH_2545-Batchelor03

Editorial

NHS dental care and the issues of public service ethos, governance, accountability and probity

"Every penny of public spending needs watching and safeguarding by independent regulators and through much more transparency otherwise taxpayers and voters will turn away" (Richards, 2009).

The current furor over the United Kingdom's Members of Parliament (MPs) expenses raises a number of issues, not least of which concerns the nature of and arrangements for allocating funds for a public service. The timing of the malfeasance could not be much worse as the reform of public services is high on the Government's agenda. As with the NHS dental care system, the Cabinet Office (2008) has suggested that the characteristics of a world-class public service involves four elements: excellent outcomes, personalised approaches, being fair and equitable, and; good value for money.

While few, if any, would disagree with the goals, the terms themselves lack definition. The publication continues in this vein. It acknowledges that, "all governments have a responsibility to ensure that taxpayers' spending achieves value for money" and "clear accountabilities are established so that each part of the system knows what is expected of them". Again all very laudable but, perhaps not surprisingly, there remains a lack of detail in both what the terms actually mean and crucially, how this is to be achieved. A further issue is that there is a tacit assumption about what is meant by a public service; that it is unambiguous and that the boundaries between public and private sectors are clear.

The public ethos

Flynn (2007) argues that the "public service" is one in which the finance is derived in the majority from taxation, rather than by direct payment by individual customers. This suggests that it is not the ownership of the service that is important but the way it which it operates. The majority of dental care is provided by individuals who work in privately owned premises but provide care under some form of contractual agreement; the state subsidising the care to varying degrees.

A further distinction of a "public service" is this idea of a public good, that the role is not simply based on commercial profit, that there are additional motives behind working for a "public service" instead of opting for the alternative (Bovaird and Löffler, 2003). This is known as the "public ethos". With the introduction of 'market-type' mechanisms in the public sector a conflict arises between commercial profit and the public good to a greater extent than previous arrangements. The Public Administration Select Committee (2002) concluded that "The (Public Service) ethos needs protecting and, where necessary reinforcing in these circumstances. The private sector can be a useful servant for public services, if properly supervised; what it can never be is their master."

McRae (2005) argues the public-sector ethos involves people trying to do things well in areas that could not be carried out by the private sector. He went on to add "(the) public sector has aped the private sector without understanding that you have to do this thoughtfully and carefully". He stated that individuals who work in the public sector, when faced with the danger of being set inappropriate targets and incentives, would become cynical and "will tick the boxes and meet their targets because that is what their political masters require them to do". This would appear to be an all too common failing within the NHS.

The need for governance

Irrespective of where the boundaries between public and private lie, a system of governance is required. The Independent Commission on Good Governance in Public Services (2004) defines governance as "the leadership, direction and control of public service organizations to ensure that they achieve their agreed aims and objectives and in doing so serve the public's best interests". This requires sound decision-making processes to exist. Morrell (2006) suggests that if clarity in the principles underpinning effective decision-making does not exist, the moral uncertainties and inconsistencies that arise "could be far more damaging to the standing of the NHS as a national institution than inefficiency or mismanagement". Indeed, for all the rhetoric about devolved decision making in the NHS, while the detailed administration and management of individual units does indeed occur at a local level, the service is held to account through a centralized policy and financial framework.

For governance in the public sector, government has relied on the use of targets and performance indicators. The underlying theory is that desired results are specified in advance, and using a monitoring system, some assessment of performance is made against the specification and feedback is given. This sounds all very worthy but as Bevan and Hood (2006) have pointed out two assumptions are made. First, the measurement problems are unimportant, that the part on which performance is measured can adequately represent performance as a whole, and that distribution of performance does not matter. Second, that this method of governance is not vulnerable to manipulation by agents for their own advantages, "gaming". The authors conclude that the above two assumptions made are not justifiable. Thus, the extent to which the "improvements" reported in the

NHS were genuine was not known as they could have been offset by "gaming" that resulted in reductions in performance that were not captured by targets.

These failings in themselves are not an argument for abandoning targets as part of any governance arrangement but to suggest, as McRae also identified, that more thought must be given to both the mechanism through which they are set and the system of monitoring.

The importance of accountability

Whatever the details of the arrangements that exist, a governance arrangement creates the concept of accountability. Accountability refers to the fact that decision makers do not enjoy unlimited autonomy but have to justify their actions to stakeholders. Stakeholders therefore must be able to evaluate the actions of the decision makers and to sanction them if their performance is poor (Held and Koening-Archibugi, 2004).

As Smith and Hague (1971) have highlighted, the key issue in accountability is how does one allow actors sufficient autonomy to allow them to achieve their tasks while at the same time ensuring that an adequate degree of control remains. Scott (2000) argued that the traditional mechanisms of accountability to Parliament and to the courts are problematic because of the nature of the state and highlights the fragmentation of responsibility that has occurred with the shift from direct provision of public services towards oversight of public services by others.

Brinkerhoff (2004) has suggested that accountability has three purposes. First, it exists to reduce abuse, second, to help ensure compliance with procedures and standards, and third, to improve performance and learning. He goes on to identify three categories in which accountability should exist: financial, performance, and political. By applying the above categories to a health delivery system, a picture of what the accountability issues are emerges and where gaps, contradictions and conflicts may lie. For example, he states that "tackling corruption in the health sector is not likely to be sustainable without some degree of political/accountability, which creates and strengthens the incentives for health policymakers to respond to citizens' needs and demands".

Probity

The term probity has begun to appear in a growing number of documents that are of relevance to health professions. For example, the General Medical Council (2006) and the Royal College of Surgeons (2009) both suggest that professionals should positively declare any actual or potential conflict of interests; demonstrate honesty and integrity, and; have identical standards and performance in both NHS and non-NHS sectors. This is however a very limited view of probity.

Probity is a far larger concept and for a public funded dental care system consists of four elements: the accuracy of claims submitted for payment; the quality of diagnosis and treatment planning; the quality of treatment provided, and; the compliance of contract holders with the terms of service. Furthermore, it should be regarded as a living entity. The contract defining the relationship between the purchaser of care and the provider is continually modified. As the data gained through the probity arrangements are analysed, the risks associated with the existing financial and care arrangements become apparent. There is a need to adjust the contractual agreements through which care is provided to handle the identified risks, particularly if the public ethos of continual improvement is to exist.

With the introduction of the dental contract in April 2006, two fundamental changes occurred that affected the probity arrangements. First, probity assessment no longer consisted of claims based around items of treatment but of Units of Dental Activity (UDAs). A UDA is a nebulous product that contains any number of differing interventions or treatments yet continues to form the central pillar for both the financial and performance elements of accountability. Second, a shift in accountability occurred in which responsibility moved from a national structure, the former Dental Practice Board, to over 150 Primary Care Trusts or Local Health Boards. The assumption here is that in each of these organisations there is an individual and associated support that can capture, interrogate and interpret whatever data are available in a meaningful manner. This assumption has been challenged.

The nature of the current dental contract when compared to its predecessor is such that, at best, there has been no improvement in accountability. Far from improving matters, the present contract through which dental services using public funds are provided in England and Wales has seen a substantial reduction in levels of probity. As Taylor, the former Chief Executive of the Dental Practice Board stated in his oral evidence to the Health Committee (2008) when commenting on the present dental contract "it is impossible to check whether individual treatments had been carried out, or had been carried out to the right standard. It had also become impossible to check whether the treatment given had been necessary".

Summary

A decision by any government to intervene in dental care requires that accountability arrangements exist and that the public has faith in them. Such arrangements require a range of governance mechanisms that in turn create routes of accountability. If accountability is to have meaning an appropriate probity system is necessary.

Existing probity arrangements in the NHS dental care system are far from ideal: the checks on claims are far less vigorous than under the previous contractual agreement. While the Dental Reference Service continues to refine its probity activities there are few, if any, assessments of the quality of diagnosis and treatment planning let alone the quality of the treatment provided, along with financial shortfalls. The nature of the contract introduced in April 2006 means that, even with compliance, its use as a quality assurance mechanism is substantially weaker.

To address these shortfalls requires improvements in the governance arrangements a key element of which is clarity in accountability. Accountability provides an understanding of how a delivery system works, the pressures and incentives facing its actors and allows for better reform design and implementation. If a public dental service is to have excellent outcomes, be fair and

equitable and offer value for money the present failings must be addressed.

As has been identified in other public services:

"…certain assumptions appear to be based on a belief that these standards were general throughout the public sector and would be maintained or adapted during periods of change. Little attention was given to what compromises the standards, how they are perceived and implemented across the public sector and who monitors or polices them, particularly in times of change." (Doig, 1995)

The development of improved probity arrangements and a suitable contract through which the service delivered is specified would be a starting point. Perhaps then both the public and the profession can begin to strengthen their faith in a delivery system and improve their trust in the political system. This in turn will help give rise to a modern and dependable care system, something the present government has been attempting and failing to achieve for over 10 years.

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