equal access to NHS dental services. This does also mean that we do not want to go down the path of separating NHS dentistry into two parts, for those people who cannot afford private dentistry and for those people who cannot access NHS dentistry, we firmly would like to give everybody a sense that they do have access to NHS dentistry.

Secondly, we want a service centered around patients. We want to move away from an NHS designed from the centre and then handed out to public and move towards a service designed around the public’s needs.

The next principle is that we should, wherever possible, seek to maximise beneficial health outcomes. Where dentistry is concerned like other areas in the NHS I want us wherever possible to move away from a service that is focused on inputs, ratios, processes and procedures and into a service that is orientated on outcomes.

The last of the principles I will try to apply is to do with the working professionals within the NHS. The NHS is an organisation based on 1.3 million personnel, the great majority of whom are health professionals and should be treated like professionals. All of you have [addressing the audience] professional judgements, professional competencies and qualifications often acquired over a considerable period of time with a considerable amount of effort on your part and we should respect this and try and deliver the best possible service by recognising in every walk of life the best way of achieving any outcome is to have a positive engagement with the staff who are trying to deliver it. This is not done by competing or by making life more difficult for staff. Managing to deliver an outcome is about managing with and through people who work in the service.

The history of the current NHS contract

If we go back to the point at which there were PDS pilots and dentistry was contemplating what the new contract would look like (not the one we currently have), I had met with many dentists involved with PDS pilots and it seemed to me on the face of it the new contract was designed to be based on the experience of the PDS pilots.

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So why did all of this happen?

I think this rather an interesting question and I don’t pretend that I have any special knowledge of this, but I have talked to plenty of people who do, including many dentists involved with PDS pilots and those involved with subsequent discussions with the DoH about the new contract. The conclusion they have reached was that it didn’t happen for a very simple reason: finance. When the Audit Commission came in and looked at the PDS pilots, they concluded that if you actually concentrate on capitation and delivering better health outcomes for patients, the net outcome is that you do fewer procedures. This reduces the capacity to charge patients, which relates to a shortfall on patient charge revenue. Based on second hand information this shortfall in finances eventually led to the PDS pilots being torpedoed.

 Dentists now share along with GPs in the results of a government that has become completely obsessed with being able to tell the public that they are going to have increased access to services, and that access seems to be the only measure that matters. I’m not saying that access doesn’t matter, but I certainly do resist the proposition that access is the only measure that matters. Introducing the new dental contract allowed PCTs to have control over the dental budget and was aimed to allow PCTs to go out and buy more access.

In the short run this did precisely the opposite, as 1,000+ dentists said we really don’t want to go down the path of this new contract. Dentists will understand about some of the perverseities of the new contract probably better than I do. I find it very strange when you go around the country and ask dentists ‘how much are UDA’s worth here?’ and you get very different results in different parts of the country and sometimes you can have very different parts within the same PCT area.

It is also very perverse how the UDA structure creates a powerful incentive to pull a tooth out rather than carry out proper root canal work as well as many other perverse incentives. Understandably so, wherever you look in the NHS and beyond, if you create a structure of financial incentives you should not be surprised if people behave in perverse ways.

From the public’s point of view this has not delivered; we are still in a position where overall the public’s access to NHS dentistry is less now than it was just prior to when the new contract was introduced.