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COMMENTARY

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NHS dentistry in Britain: A long overdue check-up

Neil Lunt[1] | **Mark Exworthy**[2]

[1]Social Policy Group, School for Business and Society, University of York, York, UK

[2]Health Services Management Centre, University of Birmingham, Birmingham, UK

Correspondence
Neil Lunt, Social Policy, Social Policy Group, School for Business and Society, University of York, York, UK.
Email: neil.lunt@york.ac.uk

Abstract

There has been longstanding international fascination with the British National Health Service since it was established in 1948. The British population itself has offered enduring support for the principles and institutions of public provision. However, coverage of the NHS has typically been uneven in academic and policy debates. There is limited understanding of some darker corners of NHS provision resulting in a partial picture of public service provision. Public dentistry has been a Cinderella service in broader debates about the NHS and a check-up is overdue. We offer a long-term view of dentistry that assesses the current state of dental health policy, including its gradual decay. We examine the purpose of dentistry and the challenge of injecting fundamental National Health Service values (weighted capitation and a focus on need) into services and which necessitates redistribution and tackling shibboleths of NHS provision. Alongside political values and public attitudes, we examine the interests of professional stakeholders and how the combination of values, attitudes, and interests does not currently cohere into a sustainable policy. We explore how dentistry might recover purpose and respond to need. Discussion is prescient considering an acknowledged crisis in British dental care, including widespread public and media coverage, and with 2024 being a general election year with NHS provision a familiar battleground.

KEYWORDS

health care reform, politics, public health insurance

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Key Points

- Dentistry remains an overlooked and neglected corner in academic understanding and analysis of contemporary British healthcare and the NHS.
- Our succinct analysis of dentistry assesses the current state of dental health policy. It examines the purpose of dentistry and the challenge of injecting fundamental NHS values into services.
- It asks how dentistry might recover purpose and respond to need.

AN OVERDUE CHECK-UP OF NHS DENTISTRY AND THE DENTAL WORKFORCE

Since its establishment in 1948, there has been enduring international interest in the organization and delivery of the British National Health Service. Across decades, commentators have addressed what they see as the good (Beeson, 1974; Leatherman & Berwick, 2000), the bad (Light, 1998), and the very different (Enthoven, 2013) in British publicly funded healthcare delivery and reform. On their part, British authors have regularly updated overseas readers on the twists and turns of domestic health policy (Day & Klein, 1991; Potter & Porter, 1989).

However, coverage of NHS activity has typically been uneven. Richards' (1971) paper situated developments in British dentistry alongside elements of the US experience, but such interest is unusual, and dentistry has been a Cinderella service in broader debates about the NHS.

A dental follow-up is thus long overdue and so, our *Comment* assesses the past 50 years in this neglected corner of NHS activity and policy. Our reflection gives voice to previously unspoken compromises facing policymakers but which are increasingly being aired around public dentistry. This is timely considering the Dental Recovery Plan (Department of Health & Social Care, 2024) and 2024 being a general election year with NHS provision a battleground.

UNDERSTANDING BRITISH HEALTH POLICY—A LONG-TERM VIEW OF DENTISTRY

Although dentistry was brought into a national scheme after 1948, foundational NHS principles—centrally-funded and free at the point of delivery, universal, equitable, comprehensive, and high quality (Delamothe, 2008)—never fully fit the experience of British dentistry.

The new NHS did not own and operate dental facilities or employ dentists. Dentists remained independent “professional tradespeople” (Taylor-Gooby et al., 2000), did not receive subsidies for buildings and, unlike General Practitioners, could not be compelled to take on NHS patients. Dentists choose whether to generate income from private patients, NHS provision, or a combination of the two. Such a service mix may be offered within the same facility and even the same session, unlike healthcare which has separate private facilities, and private wards within public hospitals (Hancock et al., 1999).

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The government was never a single-payer for dental services. Soon after the establishment of the NHS, demand for dentures soared and charges were introduced in 1951 and 1952 (alongside those for prescriptions and spectacles), with exemptions for priority classes and children. In 1969, General Dental Services cost about 5% of the total NHS budget, and one-fifth of these NHS dental costs were met by charges (Richards, 1971).

National professional standards and regulation of the dental workforce (Gulabivala, 2018) had no equivalent framework for service access. Dentistry was never truly equitable, and despite commitments to a uniform and national system, freedom to practice saw a regional imbalance in the distribution of dentists that disadvantaged the north of England (Richards, 1971 p. 142). Areas of high social deprivation had relatively few dentists with no controls and few incentives on geographic location. Rather than workforce planning, policy relied on incentives—per capita, activity, fee-for-item, and mixes therein (Grytten, 2005). NHS dentistry adopted a fee-for-item reimbursement (Taylor-Gooby et al., 2000) and there were no limits on what private dentists could charge, thereby exacerbating the inverse care law (Tudor Hart, 1971).

Following the introduction of dental charges in 1951, there was relative policy stability up to 1990. With better dental health in the population, dentistry moved into a “drill and fill” phase, focused on more conservative, restorative treatments. Money followed activity in granularized fee-for-service reimbursement covering 400 different procedures. Cost containment was a problem and policy sought to address “overperformance” with a 7% fee cut in 1992/3 (Williams et al., 2023), creating animosity among dentists, a shift to private activity, and providing patients with little choice but to remain registered with their dentist (Taylor-Gooby et al., 2000; Tickle, 2012). At the start of the 1990s, 90% of dentists generated three-quarters of their income from NHS activity; this fell to only 60% of dentists generating three-quarters of their income from NHS activity by the end of the 1990s (Williams et al., 2023). Dentists who moved to the private sector justified it in terms of ensuring a quality service, spending more time with patients, having patients who value prevention, as well as financial benefits. Those who remained within the NHS identified their reasons as related to securing a reliable income, insufficient private demand, and access to an NHS pension (Taylor-Gooby et al., 2000).

A 2006 Contract reform introduced a “cost and volume arrangement” (Units of Dental Activity; UDA) to replace the granular fee-for-service arrangement. UDAs are financial values given to a course of treatment, based on historical levels, effectively capping the budget. Providers deliver a set number of UDAs and must stay within quotas (Tickle, 2012). Under the old NHS contract, dentists were paid for each item of treatment provided whereas with UDAs they are paid per course of treatment, irrespective of how many items such a course requires.

This “activity” approach incentivized volume over need and quality, and encouraged cream skimming (selecting healthier patients with less dental need), with a dramatic fall in the number of more complex procedures (Almutairi et al., 2022; Williams et al., 2023). Some dental work was delivered at a loss. There were also familiar criticisms of the system being bureaucratic and target-driven (Merry, 2024). Over 1000 dentists (out of 23,000 in 2012) did not sign up to the new arrangements and by 2012 there was a decrease in NHS use, particularly amongst patient groups with previously good access to dental care, and again consumers migrated to the private sector (Whittaker & Birch, 2012, p. 2515).

Unlike many other NHS professionals, dentists have a choice of where and how to work. In standard markets, reducing or removing price barriers improves supply and broadens access. However, in dentistry, it also depends on providers being able and willing to deliver services at rates reimbursed under the public system (Whittaker & Birch, 2012). Supply will only follow NHS funding if dentists do not compensate for reduced earnings opportunities in “over supplied [areas] by expanding privately funded service in those locations” (p. 2515).

The policy is strongly supply-driven, with changes in the balance of NHS and private activity reflecting the interests and preferences of dentists rather than a push for consumer choice amongst the public (Hancock et al., 1999). Supply is often geographically determined not least in the form of graduates from dental schools. Until 2001, by comparison the distribution of GPs was determined by the Medical Practices Committee who would sanction new practices only in areas that were under-served by GPs (Gooderham, 2021; Peckham & Exworthy, 2003, pp. 92–95). There are 12 dental schools in England, four in Scotland, one in Wales, and one in Northern Ireland. English dental schools are mainly concentrated in large cities such as London (3), Birmingham, and Manchester. NHS England (2022) reporting to the Review Body on Doctors' and Dentists' Remuneration: Fifty-First Report (2023) suggested geographical spread rather than the number of dentists is the problem.

CURRENT DENTAL POLICY DECAY

Covid-19 stretched dental services and generated a backlog with 13 million fewer treatments in 2021/2 than prepandemic (British Dental Journal, 2022). Devolution has added further complexity, and shaped four unique "national" NHS services with clear policy divergence, for example, Scottish NHS dental examinations are free of charge and the country has lower banding charges (Chestnutt, 2013; Greer, 2016).

Focusing on dental policy in England, there are around 11,000 dental provider practices and of that number, about three-quarters have contracts to provide NHS services. This public provision may be either a minor or major element of their overall practice income (and role) (Baird & Chikwira, 2023). Between 2010/11 to 2021/2, total funding for dentistry fell 8% in real terms (2021/22 prices) (Garratt, 2023).

The evidence base on the dental workforce is fairly poor. The headcount of registered dentists has increased but the actual FTE is unclear (General Dental Council, 2024). The NHS Long Term Workforce Plan (2023, p. 79) proposes dentists spend a greater proportion of their time delivering NHS activity; however, an increasing number of dentists per population doing NHS work does not address how much private activity they do, and what their NHS commitment is (including their FTE and role). We know little about the development of private practice, which is troubling given a growing proportion of young dentists are considering entering private practice. For patients, unlike other NHS services, there is no metric on waiting times and responsiveness of dentistry. There is little evidence on national dental needs, including who is seen and not seen.

Most recently, the NHS recouped £0.5b in dental charges (Garratt, 2023) and between 2014/15 to 2019/20 income from patient charges increased by 8% (Williams et al., 2023). In 2021/22, charges amounted for 20% of total NHS dentistry revenue. The lack of research post-2010 on the impact of dental charges in fiscal austerity is surprising. Dale et al. (2021, p. 2) conclude that there is "a likely relationship between increased NHS dental charges and reduced access to NHS dentistry; a relationship which is likely to affect poorer individuals and those with worse oral health disproportionately".

From 2010, so-called "blended contracts" (Steele Report, 2009) were piloted, involving payments for patients registered by the practice, rewards for quality, but also for activity. These have since ended and while there have been tweaks to the UDA (six bands of treatment now have different numbers of UDAs) (Baird & Chikwira, 2023), fundamental reform has not been forthcoming.

Dentists are deeply unhappy with the current contract which is said to reward those who meet government targets for treatments whereas dentists' priorities are patients and prevention. There is an echo of half a decade of policy drift: "Many dentists believe that some change in their remuneration system is desirable; however, what is not clear is what

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change should be made" (Richards, 1971, p. 151). Moves from NHS to private activity are about both job satisfaction and the nature of the contract (including targets) (Waitzman, 2019) and any reform must address both of these concerns.

The last decade has seen an increase in the number of patients experiencing difficulty accessing NHS dentists and a further drift to private activity (Health and Social Care Committee, 2023). In May 2022, the British Dental Association reported that 3000 dentists had stopped providing NHS dental services since the start of the pandemic (cited in the Health and Social Care Committee, 2023). A British Dental Association (2023) suggested that 50.3% of dentists in England have reduced their NHS commitments since the start of the pandemic. More worryingly, nearly three-quarters (74%) stated they intend to reduce, or further reduce their NHS work in the future (Williams et al., 2023). The pandemic accentuated the crisis of access; a 2022 survey found 90% of practices across the UK were not accepting new adult patients (cited in Health and Social Care Committee, 2023).

What does this mean for patients? There is evidence of a significant rise in the proportion of people who tried to get dental appointments within the last 2 years but were unsuccessful (NHS GP Patient Survey, 2022). Parts of the UK are "dental deserts," that is, geographical areas where no dentists are taking on new patients. Again, there is a familiar ring in an earlier analysis of Steele: "Access to care is a problem, but not a universal problem, as it tends to be concentrated in particular areas of the country" (Steele Report, 2009, p. 2). There is close to a threefold variation in areas with the least/most NHS dentists per population.

Access to NHS services and waiting times correlate strongly to patient satisfaction. Indeed, satisfaction (1998–2019) for publicly funded dental care *rose* following the 2008 economic downturn which coincided with increased use of publicly funded services (Almutairi et al., 2022). Recently, however, patient satisfaction with NHS dentistry dropped to a record low, driven by challenges in access (Morris et al., 2023).

The crisis is one of access but also widened geographic inequalities in oral health that impact particularly on older and deprived populations. Between April 2022 and May 2023, 30,000 children and 70,000 adults were admitted to A&E with tooth decay (Khan, 2024). The public portrayal of dentistry in the (new and social) media includes increasing mentions of travel abroad for dental treatments at affordable prices, and even those with more urgent needs resorting to DIY dentistry.

In short, it does seem that dentistry has moved *even further* from "foundational" NHS principles outlined earlier: centrally funded and free at the point of delivery, universal, equitable, comprehensive, and high-quality services.

RECOVERING PURPOSE AND RESPONDING TO NEED

Reports from Parliament and respected advocacy bodies detail the extent of the crisis (Health and Social Care Committee, 2023; Williams et al., 2023). The Dental Recovery Plan (DH&SC, 2024) was launched by the then Conservative government to help address the crisis. It includes, for example, an extra fee for dentists on top of the standard payment for seeing a patient who has not visited a dentist for 2 years. There will be an increased fee for patients needing complex work, and 240 dentists will be offered one-off payments of up to £20,000 for working in under-served areas for up to 3 years. Measures also include outreach dental teams visiting schools and nurseries, expansion of water fluoridation to support prevention, and mobile dental services in rural and coastal areas with poor dental coverage.

The Health and Social Care Committee (2023, para 13) suggested there is a need for "compelling incentives" to attract new and existing dentists to undertake NHS work. Responses from professional bodies suggest the proposed measures are unlikely to reverse

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longstanding system decay. The NHS Long Term Workforce Plan (2023) has also argued for increased dental training and recruitment, and potential lock-in (e.g., loan forgiveness) for those who train and remain in the NHS. However, there are many unanswered questions about the political and practical feasibility of such measures. Recruitment of dentists in competitive global markets is difficult which has not been helped by the UKs withdrawal from the European Union in 2016 and an end to cross-border mobility of EU dentists wishing to work in the United Kingdom.

What values should underpin any additional supply of dentists and dental services, for example, to ensure universalism and comprehensiveness? Back in 1971, Richards asked, "Should the state attempt to provide a complete service to some sections of the population or should it provide an incomplete service to all the population?" (p. 149). Such a question remains very current (Williams et al., 2023). If the NHS's role is to meet needs then such a goal must be matched by a need-based resource allocation and political will (Williams et al., 2023). However, "Historically, reimbursement had followed activity rather than patients' needs by virtue of the payment system" (Gulabivala, 2018, p. 10). The Health and Social Care Committee (2023) argues for a weighted capitation-based system to give financial incentives for seeing new patients and those with greater dental needs. A greater focus on need, for example, could entail a basic core for those unable to afford private treatment. Yet any redistribution of resources from those who currently have good access (irrespective of means) is likely to be unpopular. If the NHS's role is to reduce need then far more of a preventative focus is required, which again requires reprioritisation. Arguably, however, the current focus of dental provision is more about demand rather than need, and changing this is "a political decision with associated political risks" (see Tickle, 2012 p. 110 for an excellent overview). The nature of need has changed and patients with the lowest need are more likely to attend regularly, an example of the inverse care law (Tudor Hart, 1971).

Should the focus be on maintaining dental supply? As Tickle (2012, p. 113) notes, dentists (as with other practitioners) respond to contractual incentives and the business incentive may be stronger than professional values (also Le Grand, 1997). Tickle suggests "NHS dentistry is therefore, on a potential collision course between providing an expensive service for which there is strong public and professional support but dwindling need" (p. 113). There are professional assumptions about its role and an overvaluing of individual restorative practices to maintain high professional autonomy (Taylor-Gooby et al., 2000, pp. 380, 394) with current treatment dominated by high-tech, interventionist, and specialized methods not tackling underlying causes and inequalities (Appleby, 2016).

The overarching objectives for dentistry, the organization and delivery of its services, and how to share costs, remain contentious. There are calls for a dental service that is universal, comprehensive, and free of charge (Puntis, 2022). However, "Before the pandemic, out-of-pocket expenditure on dental practice was in the region of £4b (Nuffield Trust, 2024, p. 9). Few political parties would campaign to bring this cost into the public purse, even if greater charges were introduced as part and parcel of any change. At present, the NHS is funded to provide a basic service for half the population, expanding that will be expensive, and redistribution politically contentious.

Another option is a more limited offer. The Labour Party campaigned in 2019 to offer free checkup, scale, and polish with an anticipated cost of £450 million a year. This is a considerable distance from bringing all those paying privately back to a universal and comprehensive NHS (and abolishing charges). A more limited offer would go hand in hand with greater means-testing.

There are thus difficult decisions about who gets what, and at what cost, with the need for much greater spending, or a more limited NHS offer combined with means-testing the likely outcome (William et al., 2023, p. 3). The political sensitivities of NHS provision ensure

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discussion of public and private dentistry is not straightforward. The result is a steady decline in NHS dentistry and a policy marked by drift and lack of strategic overhaul (Williams et al., 2023, p. 48). The *de facto* policy is being made by dentists' drift to the private sector, something successive governments have been unwilling to prevent or address (Nuffield Trust, 2024). A full and frank discussion of how to improve NHS dentistry could be less a policy of drift, and more one of a health service being cut adrift from espoused values.

Injecting fundamental NHS values into the service (weighted capitation and a focus on need) is necessary but requires redistribution and tackling shibboleths of NHS provision. Policy-makers, professionals, and patients need some measure of consensus on what access means and implications for means-testing, comprehensiveness, universalism, and equity. The story of dentistry's decline and decay has been largely without public debate until 2024. There is also perhaps an implicit narrative in the challenges facing wider primary health care and concern it could take a similar trajectory. International watchers will undoubtedly benefit from more regular "check-ups" of NHS services, including dentistry, to better understand the health of UK public services.

There are increasingly explicit implications from this case-study of dentistry's decline and decay for the rest of the NHS. First, there is a need for a renewed debate about how NHS values (equity, etc.) are operationalized in different sectors and services, not just dentistry. Second, this links to the need for a modernized version of universalism of key public services. How can universalism operate in a society of burgeoning choice? Third, dentistry has been at the forefront of many policy changes (especially relating to its organisation and finance) and so might offer insights into how other services might also respond. General practice is perhaps more akin to this - the challenges of access and waiting times in general practice are redolent of those in dentistry. Fourth, this case-study provides lessons for comparative health policy analysis, both within the UK and internationally. As health is a devolved competency, there are lessons to be drawn from Scotland, Wales and Northern Ireland. Equally, there are lessons for other jurisdictions (perhaps with similar national health systems) as they also grapple with questions of access to care and universalism.

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ETHICS STATEMENT

The article is based on a review of existing academic and policy literature and does not involve primary collection. The piece was not subject to formal institutional ethics review.

ORCID

Neil Lunt http://orcid.org/0000-0002-4501-1999

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AUTHOR BIOGRAPHIES

Neil Lunt is a professor of social policy and associate dean (Internationalisation) School for Business and Society, University of York, UK.

Mark Exworthy is a professor of Health Policy and Management at the Health Services Management Centre, University of Birmingham, UK, and Co-Director of the MBA Clinical Leadership course.

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