Key points

- Before the COVID-19 pandemic took hold the service was in tatters
- Current circumstances show how unsustainable it was
- Its future must now be in question
- Will it be revolution or evolution?

How much longer does NHS dentistry have left?

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Introduction

I keep hearing and reading this phrase from commentators, critics and anyone who cares to interject a conversation with their opinion. 'Now isn't the time to discuss [insert topic]. We've all got to rally and be united', or words to that effect. Echoes of wartime lexicon, insinuating that opinions should be placed on hold for the greater good.

Take GMB's Piers Morgan. Like him or loathe him, most of the criticism lavelled at him is that he's bullying guests on the programme, that he should be supporting the government rather than doing what he is doing – asking difficult questions at a time when it's more important than ever to do so. Deduct the suspiciously looking accounts and political bias, and you're left with the bare bones of a coherent defence.

And that is why, even now, it is right to ask how much longer NHS dentistry in England has left.

Pushed over the edge

Although March felt like it lasted 857 days, it's worth recalling where things were. Recruitment crisis, morale lower than ever, a remuneration model that was unsuitable and a contract few wanted when it was introduced, let alone 14 years later. Time was at a premium. Contract reform was painfully slow. Patients and the profession alike were being failed.

In 2017, this publication asked whether NHS dentistry was at tipping point. Questions were posed: were associates and dental practice owners reaching a stage that significant numbers were going to either give back their NHS contracts, spend more time on private dentistry and fail to meet their UDA targets or in other ways provide less NHS care? How many junior hospital dentists would walk away from hospital careers and opt for specialist private practice? The community dental services workforce was highlighted as ageing, would they increasingly opt to retire early or resign from part-time posts? Would all of this happen in sufficient numbers to start to create real workforce shortages and impact on access to NHS care?

In the intervening time, it would not be a stretch to say these things have all – to a certain degree – happened or are still happening, and the situation is worse than it was then. And, I'd hazard a guess that if such an article existed in 2014, it would show a similar pattern of stagnation, deep-rooted problems and growing resentment, with the 2017 article surmising the same outcomes. Contract reform sits at the top of that pile. Little wonder – it is approaching nine years since the Department of Health in England began piloting and prototyping new contractual arrangements in England. It has been a long and testing process, and only last October the BDA reported the end could be in sight, with a degree of certainty known about dates that were being committed to.[1]

Not quite. Further waves of prototypes were anticipated – although unconfirmed – to be taking place from April 2020. And that's not happening, which has prompted colleagues to ponder whether the pandemic will derail contact reform and kick it into the long grass for good.

Maybe. Maybe not. Whichever sentiment holds true, I go back to Chief Dental Officer for England, Sara Hurley, and an interview from 2015, in which she said: 'We all recognise the current care and remuneration model is unbalanced and there is a clear desire to shift our goals towards prevention. The legacy characteristics of remuneration based on activity may have stood our forefathers in good stead in the early years of NHS dentistry but they are clearly no longer applicable, it was a model of its time that has had its time.

'Acknowledging that the DH contract reform process commenced well before my arrival on the scene, I am fully aware of the various drivers and aspirations of all stakeholders. From my perspective, success will be a dental contract that improves access to care and, critically, a contract that recognises and facilitates the ability of the dental team to develop longer term relationships with patients in order to support an individual in taking charge of their health and preventing dental disease.'[2]

With that in mind, you would fully expect contract reform to be picked up once again.

At the heart of the matter

One of the more interesting observations from Dr Hurley's quote relates to access to care. In the 2017 article, it was suggested that if the UK's decision was to leave the EU and it led to fewer dentists from Europe practising in England, then there may well be a workforce crisis that would not be confined to dentistry.

That particular observation came to fruition. It may be too simplistic to suggest Brexit alone is the reason for the current workforce crisis, although there is no doubt the landscape in the UK has changed since

26 June 2016. The compounding factors surrounding dentistry don't entice people into the workforce – who wants to work in a target-driven profession with an over-bearing regulator and derisory pay rises? The postcode lottery of being able to access NHS treatment versus the recruitment crisis begins to sound more like 'which came first: the chicken or the egg' than sound government policy.

The constant narrative of dragging feet has created an NHS dental workforce lacking in motivation to such an extent it's on the verge of collapse, leading to pockets and hotspots around the UK severely lacking. Understandably for young dentists looking to launch their career alongside quality of life, urban areas have tended to be more popular. Alongside London devolving, more and more practices outside of the city are offering better remuneration and attractive golden hellos – some worth up to £20,000 – which theoretically means more and more candidates are considering a move from the capital.

Wrong.

BDA analysis of the government's last GP Survey indicates over 1.4 million adult patients have tried and failed to access care – with a further two million estimated to have not tried in the belief they would be unable to secure an appointment. With 130,000 reporting they are on waiting lists, and over 700,000 citing cost as a barrier, thus bringing a level of unmet need to over 4 million people.

Areas facing challenges have not previously experienced significant problems, with many of the worst affected areas in parts of London and the South East, including the overwhelming majority of London boroughs, Brighton, and parts of Kent and Surrey.

The government has acknowledged issues in a few hotspots with a history of access problems, such as West Yorkshire, Cumbria and Cornwall. Data also indicate lower success rates among patients attempting to secure an appointment for the first time, the young, and ethnic minorities.

The BDA claims these figures reflect the 'perfect storm' facing patients, as budget cuts, contract failure and staffing problems bite. NHS dentistry is operating on a budget that has remained largely static since 2010, but with patients contributing a greater share each year through increasing NHS charges. The current target-driven NHS contract funds care for little over half the population, and has prompted a collapse in morale within the workforce. Recruitment problems have become endemic, with BDA surveys indicating 75% of practices struggling to fill vacancies, and 59% of dentists stating their intentions to reduce or end NHS work. Problems are most severe among practices doing most NHS work.

If Dr Hurley judges the success of a dental contract as one that improves access to care, it's entirely reasonable to state success is not around the corner.

Broken beyond repair?

If the service was close to breaking point, has this time served to assess whether things are broken beyond repair and we carry on as we were, or whether there's a relationship left to salvage? I fear dentistry will simply resume as it was with all of the humdrum and campaign for change in the background. But, as with so many other areas, government lockdown gives us the time to reflect whether that will or should happen.

With many economists expecting a global recession, is NHS dentistry doomed, or is there one last lifeline?

Access is now the worst it has been for a decade, with just half of adults undergoing regular checks. Ten years on from the recession and austerity, the current economic climate does not bode well for the future of a service being funded on fumes and goodwill. In October last year, for the first time in a decade, dentists in England received an uplift close to inflation levels. The Department of Health and Social Care confirmed that the annual uplift for 2019/2020 of 2.42% would be backdated to April 2019.

Dentists have seen a 30% decrease in income across a 10-year period. In that time, successive years of wholly inadequate uplifts, which were below inflation, made them pay cuts in real terms. How does that possibly set them up for a period of inactivity and continued uncertainty? Research in America suggested general dentist visits declined slowly and steadily during the Great Recession, reaching a low of 38.4% in 2010, and have not shown significant signs of recovery.[3] Yes, their healthcare model differs substantially to ours, but the downward trend should serve as a warning.

Providing there is a service to return to, lessons from 2009 and 2010 show there may be an opportunity for NHS dentistry to recover.

In 2009, news stories emerged of dentists who left the NHS over the introduction of the 2006 contract to pursue fully private work returning to the NHS due to recession. With an estimated 5,500 general dental practitioners in purely private practice – an increase of 44% from when figures were first recorded in 2008/09 – and 3,000 purely private practices – an increase of 32% on 2009/10,[4] history could be about to repeat itself.

Perhaps not a total surprise, but an opportunity nonetheless. Consumers want the best deal they can, a theory particularly true during times of recession. As the economic downturn took hold, patients began to think twice about paying for private treatment if they could get it cheaper as an NHS patient. There were reports one private practice offered a package to which patients sign up for life membership that included one visit a year with a dentist, two visits a year with a hygienist, all necessary X-rays, preventive and dietary advice, UK and worldwide dental injury and emergency insurance, 10% reduction off all dental treatments (excluding referral for specialist treatment) and free teeth whitening, all for £19.99 a month.

Last year a report by LaingBuisson[5] suggested that while the high street dental sector forecast annual growth of 2%-2.5%

over the next three years, this was primarily down to expanding private care, particularly cosmetic treatments such as teeth whitening and straightening. The overall UK dental market is worth £7.1bn a year – NHS market share is at the £3.5bn mark and private sector at around £3.6bn – and there is very real reason to suggest this growth will not be seen in the private sector. Will patients be driven back to the NHS out of necessity? Will practices struggling to recruit prior to the pandemic be able to fill vacancies out of necessity? The last recession forced practitioners to add more strings to their bow, and so non-surgical facial aesthetics and a boom in cosmetic dentistry happened. Time will tell which way the pendulum swings, but if there's one thing we do know for certain about consumers, it's about getting the best deal.

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What happens next?

The million-dollar question, to which not even the cheating Who Wants To Be A Millionaire Major can cough up an answer to.

The real question is what do we want to happen, and how do we make it happen – are we to expect evolution, or is the time right for revolution?

It would be remiss of me not to highlight that while many of the problems at the heart of NHS dentistry have been present for a decade and beyond, there has still been little in the way of significant key-change improvements of any note. The need to improve the NHS dental contract is and has been a priority for all members of the profession, not simply BDA members or those working in the community, for years. The issue has spawned groups on social media calling for change and overhaul to the UDA system and echoing other areas of campaign work the BDA has undertaken. People are understandably frustrated with the lack of progress, so why would we expect NHS dentistry to alter its path once a degree of normality is resumed?

Let me state that this is not a slight towards the OCDO. Many friends have colleagues have been disillusioned with the chronic lack of leadership on display from that office throughout the pandemic, a reflection of the general feeling towards issues at the real heart of what is wrong in dentistry. Why would they expect things to be any different with those in charge remaining in post?

Perhaps it is because they have to be different. NHS dentistry cannot follow the same path. While some believe there will always be an NHS, you only need to look at the increased activity of privatisation. Dentistry does not escape this scrutiny.

Take patient charges and their annual increase, for example. In 2019 it was announced that patient charges would increase by an eye-watering 5% on the previous year's figures, increases that saw treatments stand at £22.70 for a routine checkup in Band A, a filling cost £62.10 in Band B and dentures cost £269.30 in Band C. These increases have served little more than providing cover for sustained cuts in state contributions to NHS dentistry. Net government expenditure on services in England has fallen by nearly £550 million in real terms since 2010, while charges levels have increased by over 30% to plug the gap.

Charges for complex NHS treatment over the past five years have increased 4 times faster in England than in Wales. Fees for treatments in Bands 2 and 3 have gone up by 23% since 2014/15 in England and are expected to rise by only 7% in the same period in Wales.

Nearly 1 in 5 patients have delayed treatment for reasons of cost, and studies show 380,000 patients with toothache are choosing to head to their GPs, who are not subject to charges but are unequipped to provide dental treatment. The BDA estimated these appointments cost the NHS over £20 million a year. Some 135,000 patients per year are attending A&E units with dental problems, and an increasing number are resorting to DIY dentistry.

It is not beyond the realms of possibility to come to the conclusion these data show a ramping up of NHS dentistry privatisation. How sustainable are these increases year-on-year? When do they start to mirror the charges of a scale and polish by a private dental hygienist? With the future as uncertain as it is, further increases would only serve to harm the chances of NHS dentistry surviving. And yet with every piece of evidence at hand to show what the government thinks of NHS dentistry, this could very well be an opening they pursue with vigour. It's like a scene from a film where a secondary character is fighting to keep afloat, only for the main character to come along with a lifejacket, appearing to be the hero, when in fact all they plan to do is loom over them with a knowing look that they do not intend to help them one little bit.

Looking ahead for the next five years if we do not see an improved and better remunerated contract in England and better terms and working conditions for employed NHS dentists we will get to a point that many more dentists will only work privately or will seek careers outside of dentistry. This would be a tipping point where the NHS is forced into action, maybe even offering some of the same financial and non-financial incentives that are currently being offered to general medical practitioners.

Perhaps, in the pursuit of wanting to end the uncertainty and assess what is to come, it is worth giving the last word to where we thought we would be now.

When asked what she hoped dental graduates starting out in 2015 would think of her upon graduating, Dr Hurley told me: 'I would hope that the graduates would acknowledge that we as a profession grasped all the opportunities to influence and shape the evolution of the NHS Dental Contact. For those electing to work in partnership with NHS England, it is seen as an attractive prospect within a viable reformed contract, enabled and managed through an agreed framework of national standards for commissioning and regulation.[2]

Her hope of a 'viable reformed contract' marks out the future with an asterisk, as does the notion of an 'attractive prospect'. NHS dentistry has neither and is unlikely to have either any time soon. Those responsible cannot hide behind the pandemic chaos to justify inaction.

If the dental contract were an organ, it would be a failing heart awaiting a new transplant. Without a new one, everything around it continues to fail. Without a new approach, it will continue to suffer. While it waits, NHS dentistry will continue to run out the sands of time, and it is in all our interests to ensure that time does not run out. ◆

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