PERSPECTIVE

Equity or equality? An inside-out perspective

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Key points

- Looking at equality and diversity.
- Addressing inequalities in access to dental care.
- Discussing contract reform.

Dentistry in its current incarnation is neither freely accessible nor fit for purpose when it comes to equity or equality for our patients or our workforce. It seems the current *status quo* is for some NHS practices to keep their doors well and truly shut unless a patient is deemed profitable enough for them to be allowed on to the much coveted, but completely fabricated, 'registration' list. Alternatively, patients are asked if they would like to be placed on interminable waiting lists or be seen within the week, on a private basis. With treatment being driven by finances and not optimal long-term oral health outcomes, we see vulnerable patients, including those from the most deprived groups, unable to access dental services, potentially leading to late diagnoses of malignancies and overall poorer population oral health outcomes. Where's the social justice in that?

Oral health inequality is widening, with poor access to NHS dental services being a significant driver of oral health inequality. Ruth Freeman and colleagues categorised these stigmatised groups as hallmarks of social exclusion.[1] First described by general practitioner Julian Tudor Hart over 50 years ago, never before has the inverse care law been so significantly palpable in oral health: those who most need health and care services are those most likely to be under-served.[2]

The severe workforce crisis, patient backlog and inaccessibility has created an inequality which could takes years to bridge, if ever at all. It is frequently said that COVID-19 has shone a stark light on inequalities faced by individuals and marginalised groups and this was just as applicable to oral health outcomes. Unfortunately, the restoration of dental services post-COVID has not been equitable and we are at risk of exacerbating a widening inequality gap which we seem to be ignoring. If asked, no dental professional would say they wake up in the morning with the intention to be discriminatory; however, the profession is faced with a raft of disuniting decisions to make which results in dental care provision which is neither accessible nor equitable.

Are we not discriminating on a day-to-day basis by refusing to see patients on the NHS for fear of the dreaded 'high-needs' patient and the burden that will place upon our clinical time, materials, expertise and skills for a meagre three units of dental activity (UDAs)? Do we not panic that our slots will be overwhelmed with patients needing multiple extractions and root canal treatments at the expense of the well-maintained, aesthetically inclined, easy UDAs patient?

> 'We are at risk of exacerbating a widening inequality gap which we seem to be ignoring.'

Marginalised groups face a further burden of being more likely to experience bias and discrimination in healthcare. Discriminatory treatment selection was demonstrated in the Patel *et al.*[3] study, that showed the clinicians in the study were significantly more likely to extract teeth in Black patients and offer root canal treatment in white patients, highlighting that over 78% of participants displayed white bias in brief implicit association tests.

As the calls for dental system reform grow louder, the Department of Health and Social Care, in line with wider 'levelling up' ambitions, needs to decide on the ask: a little bit for everyone (equality) or more for the few (equity). As we head towards austerity 2.0, a cost-of-living crisis and a projected prolonged economic recession where pockets are being squeezed to impossible levels, does an oral healthcare provision that caters for all and ensures the most vulnerable are cared for seem like an achievable ambition? As more and more are unable to access timely healthcare, leading to costlier complex problems and rendering themselves more 'undesirable' to NHS practices, there will be many who simply cannot afford dental treatment and therefore are left in a frustrated endless limbo at best, or extreme, desperate pain at worst.

The only solution I see to this negative spiralling is immediate, significant, contractual change offering common sense remuneration and incentivising personalised preventative care to struggling patients for a minimal or zero tariff.

Incremental policy change has become the new approach in healthcare, which seems to be at odds with the clumsy, antiquated NHS dental system that doesn't consider new technological advances, evidence, the changing financial climate, or social patterns of behaviour.

As the wider NHS strives to ensure equitable access, excellent experience and optimal outcomes for all, we would do well to ask what NHS dentistry is doing to strive for the same ambition. ■

References

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