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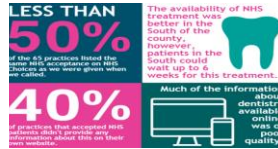
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## **Content page**

|                          |                 |
|--------------------------|-----------------|
| <b>Cover Page .....</b>  | <b>Page 1</b>   |
| <b>Content Page.....</b> | <b>Page 2</b>   |
| <b>Element 1 .....</b>   | <b>Page 3</b>   |
| <b>Element 2 .....</b>   | <b>Page 4,5</b> |
| <b>Reference .....</b>   | <b>Page 6</b>   |

# NHS Dentistry Services: Addressing Oral Health Inequalities in the UK

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## Public Health Relevance / Problem

Oral health is a core public-health issue because untreated dental disease causes pain, infection and impaired nutrition, and is linked with wider systemic risks, especially for people with diabetes and cardiovascular disease (periodontitis is independently associated with both) (Heber Isac Arbildo-Vega et al., 2024). Socio-economic inequalities persist: children in the most deprived communities still experience roughly double the decay of their least-deprived peers in England, with marked ethnic disparities despite modest overall improvements (Mathew, 2025). Access barriers have widened since the pandemic, with NHS dentistry widely reported as difficult to obtain and unmet need rising, exacerbating oral health inequities and shifting demand to urgent and emergency care (Lunt and Exworthy, 2024). Evidence also shows that pandemic disruptions amplified existing inequalities, particularly for vulnerable groups who already faced poorer oral health and barriers to care. Given these burdens and links to systemic disease, equitable access to timely NHS dentistry is essential to protect population wellbeing and reduce avoidable downstream costs across the health system (Watt, 2023).

## Chosen Health Service: NHS Dentistry Services

NHS dentistry is delivered primarily in general dental practice within the UK's primary-care framework, supported by community dental services (CDS) for patients with additional needs and urgent dental care hubs for unplanned problems (Doughty et al., 2022). Core functions span prevention (assessment, fluoride advice, risk-based recall), diagnosis (clinical and radiographic), and restorative treatments, alongside oral-health promotion in community settings to reduce disease and inequalities. CDS clinics and targeted outreach play a critical role for people experiencing social exclusion (for example homelessness, addiction or complex disability), offering flexible models and tailored access pathways where mainstream services are difficult to navigate (Paisi et al., 2024). Care teams include dentists, dental nurses, hygienists and therapists working under NHS contracts that aim to balance prevention and treatment, with referral links to hospital dental specialties for complex cases. Increasingly, digital tools (electronic records, remote triage, and image-based consultation) are used to support continuity and risk-based decision-making across settings (Scheerman et al., 2024).



## Evidence from Literature

Preventive approaches demonstrate strong value: umbrella evidence confirms periodontitis is associated with cardiovascular disease, supporting prevention and periodontal management as a public-health priority (Heber Isac Arbildo-Vega et al., 2024). Clinical and mechanistic reviews link periodontal disease with worsened glycaemic control and increased cardiometabolic risk, underscoring the need to integrate oral health into chronic-disease pathways. At the service level, national and local studies show targeted community models and CDS outreach improve access and acceptability for excluded groups, reducing unmet need through flexible appointments, trauma-informed care and links with homelessness and addiction support (Paisi et al., 2020). Mapping work across England indicates diverse delivery models serving socially excluded adults, but also highlights structural barriers (funding, workforce, continuity) limiting scale-up and sustainability. On the technology front, a 2024 umbrella review finds teledentistry can enhance triage accuracy, reduce travel/time costs and support prevention and follow-up where access is constrained, although standards and interoperability remain uneven. Post-pandemic analyses further document persistent access gaps and rising unmet need in NHS dentistry, indicating that modest contractual adjustments have not resolved systemic capacity problems (Scheerman et al., 2024).

## Critical Discussion

**Advantages:** NHS dentistry offers a universal entry point for prevention and restorative care, with evidence that proactive periodontal management supports wider cardiometabolic health and reduces downstream risk, aligning oral health with long-term public-health goals. Targeted community and CDS provision improves equity by reaching groups who face structural exclusion, demonstrating high acceptability and feasibility when services are co-designed with partners. Digital modalities (remote triage, asynchronous image sharing) can extend reach, maintain continuity and support risk-based recall, particularly in rural or underserved areas (Scheerman et al., 2024).

**Disadvantages:** Persistent access constraints and workforce pressures limit timely care, driving unmet need and widening inequalities despite policy attention since COVID-19. Children in deprived communities still experience disproportionately high decay, signalling that universal offers have not fully addressed the social gradient. Evidence from service mapping shows fragmentation, unstable funding and limited integration with wider health and social care, which hinder continuity for people with complex needs. Finally, pandemic-era disruption exacerbated backlogs and disrupted prevention, reinforcing the need for resilient pathways that protect routine care during system shocks (Stennett and Tsakos, 2022).

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## Addressing Shortfalls / Recommendations

**Funding and Contracts:** Align remuneration with prevention and complexity (periodontal management, high-need patients), rewarding quality and outcomes to reduce long-term cardiometabolic risk and hospital burden.

**Workforce and Equity:** Expand recruitment/retention and deploy skill-mix (hygienists/therapists) in high-need localities, supported by CDS partnerships to reach people facing social exclusion (Gallagher, Lim and Harper, 2013).

**Community and Schools:** Scale targeted early-years and school programmes in deprived areas to close the persistent decay gap.

**Digital Infrastructure:** Standardise teledentistry protocols and interoperable records to support triage, recall and shared care, particularly for rural and mobility-limited patients.

**System Resilience:** Embed contingency planning so prevention and routine care continue through shocks, with integrated pathways across primary, community and hospital services.



## Element 2

**Discuss the origin of the National Health Service (NHS) exploring the historical context and key principles that led to its establishment. Critically examine the current structure of the NHS and it's functioning.**

When we look at modern British history, The National Health Service (NHS) is significantly one of the most important social policy achievements. Its creation in 1948 reflected a convergence of historical forces, ideological commitments, and developing understandings of public responsibility for health. In the early twentieth century, significant disparities in healthcare access were clear, with services split among voluntary hospitals, charities, and municipal bodies. When we talk about quality and capacity, the services were uneven. This left significant sections of the population without adequate medical care. What further reinforced concerns about national health were the poor living condition, lack of coordinated planning and widespread poverty. During the Second World War, these issues became particularly evident when the government introduced centralised Emergency Medical Services to manage wartime casualties. This temporary coordination demonstrated the benefits of national planning and highlighted the limitations of the existing patchwork of local services (Timmins, 2018). As such, the war experience created both practical and political momentum for a comprehensive, state-led system.

A primary intellectual driver of post-war welfare reform was the Beveridge Report of 1942. Beveridge proposed a system of social insurance and universal welfare provision targeted at eliminating the “five giants” of want, disease, ignorance, squalor, and idleness (Beveridge, 1942). Even though the report did not outright outline a national health service, it provided a compelling rationale for collective solutions to social need and helped shape public expectations for state intervention. Building on this context, Aneurin Bevan, the Labour government's Minister of Health, developed the blueprint for a fully nationalised health service. Aneurin's vision was centred on universality, comprehensiveness, and care-free at the point of use, funded through general taxation and administratively unified under central government responsibility (Bevan, 1952). The NHS was established on 5 July 1948. This was despite political and professional opposition, particularly from elements of the medical profession concerned about losing autonomy, its founding principles became emblematic of Britain's broader commitment to social welfare and equality (Ham, 2020).

However, the contemporary NHS differs significantly from Bevan's original centralised model. Since the 1980s, governments have pursued reforms to improve efficiency, accountability, and responsiveness. Market-oriented changes introduced under the National Health Service and Community Care Act 1990 created an internal market by separating purchasers from providers, encouraging competition in service delivery (Le Grand, 2003). Over the years, there more expansion on the principles of NHS trusts, increased the role of commissioning, and opened the door to private-sector involvement. The Health and Social Care Act 2012 constituted one of the most extensive reorganisations, establishing NHS England and transferring commissioning responsibilities to Clinical Commissioning Groups (CCGs). Critics argue that these reforms fragmented decision-making and complicated accountability structures (Timmins, 2018).

Within the current NHS structure, national bodies, regional systems, and locally managed providers are all combined. In 2022, Integrated Care Systems (ICSs) was introduced. The ICS represents a shift away from competition toward collaboration. ICSs brings together

local authorities, NHS organisations, and voluntary-sector partners to improve population health, reduce inequalities, and coordinate services across geographical areas (NHS England, 2022). While the collaborative approach offers potential for integrated, preventive care, concerns remain about inconsistent system capabilities and the complexity of governance.

In terms of functioning, the NHS continues to face significant pressures. Demand has risen due to demographic change, an ageing population, and the increasing prevalence of chronic conditions. Meanwhile, workforce shortages, long waiting times, and funding constraints have strained service delivery (The King's Fund, 2023). Public confidence in universal access remains strong, yet debate persists over whether reforms have encouraged creeping privatisation or whether the system primarily suffers from chronic underinvestment and insufficient long-term planning.

To conclude, the NHS emerged from a unique historical context shaped by wartime experience, public health need, and social-democratic ideals. While its founding principles remain central to its identity, decades of reform have reshaped its structure in attempts to balance equity, efficiency, and local autonomy. Despite recent initiatives aimed at promoting integration, ongoing financial and workforce challenges continue to test the system's ability to uphold its original commitment to universal, high-quality care.

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