Office for Health Improvement & Disparities

Atlas of health variation in head and neck cancer in England

Dental access

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8. Dental access

Dental professionals have a key role in the early diagnosis of head and neck cancers.[88] Compared with general medical practitioners, dentists receive more training and are more likely to see patients with head and neck cancers. Dentists are well placed to provide preventative advice and identify signs and symptoms of head and neck cancer as part of a routine dental check-up.[61] Access to primary dental care is essential to ensure people receive timely and appropriate referrals.

In June 2024 40.3% of the adult population (18 years and over) accessed NHS dental care in the preceding 24 months.[89] Access levels to NHS dental care in England continue to be lower than pre-pandemic levels; this is a particular concern in rural and coastal areas and more deprived areas.[60 90] There are inequalities in access to dental services with NHS dental service data suggesting that people from some ethnic groups (black, Asian and minority ethnic groups) may find it more difficult to access NHS dental care.[23] Difficulties in accessing NHS dental services are also experienced by older people, people with disabilities, people with additional or complex needs including those with special educational needs and disabilities (SEND) and autism, people from vulnerable groups including refugees and asylum seekers; and people who are homeless.[23 91]

Primary care dentists can provide a mix of NHS and private dentistry.[91] All adults are eligible to check-ups and treatment at NHS rates with some groups entitled to free NHS treatment. Analysis has found that deprived areas are more likely to suffer from shortages of NHS dentists, which can lead to those entitled to free care unable to access it.[92] Recent surveys report that the cost of care influences the type and timing of care, which in turn may lead to worse oral health outcomes.[93]

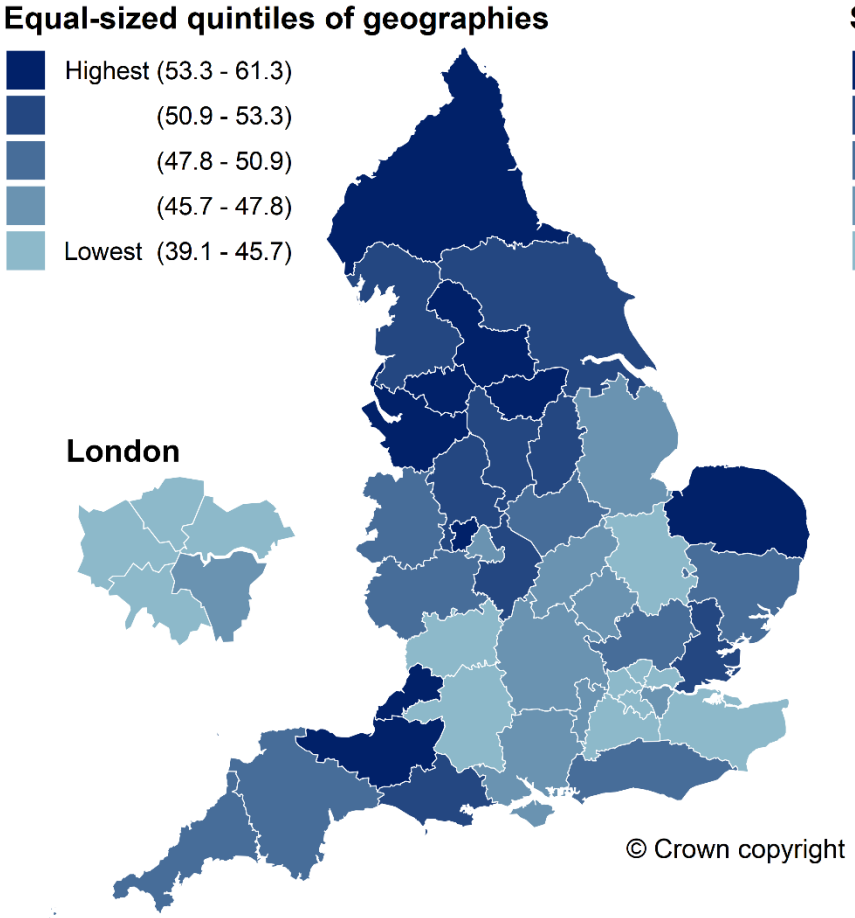
The Adult oral health survey 2021 results showed that those living in lower income households or in more deprived areas were less likely to report going to the dentist for regular check-ups, more likely to report only going to the dentist when having problems with their teeth, and more likely to report that the cost of dental care had affected the type of dental care or treatment they had received.[93]

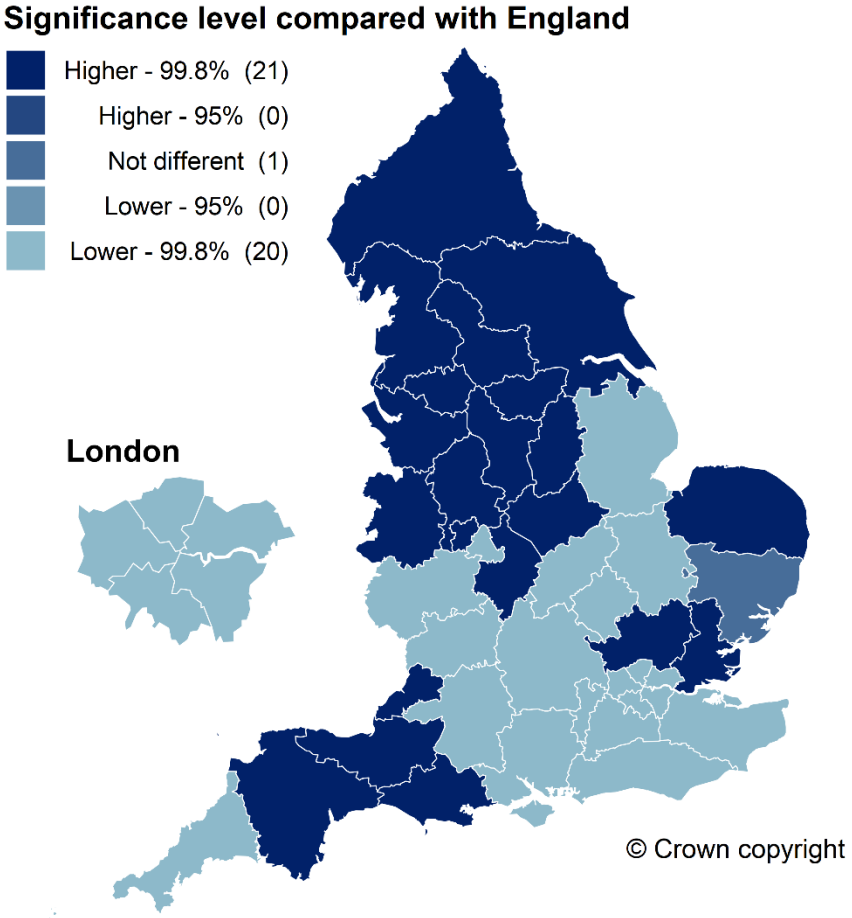
Analyses for this atlas presents data that is available on access to NHS dentistry. The indicators present measures of patients attending a dentist in the preceding 24 months, this is the maximum period between oral health reviews as recommended by National Institute for Health and Care Excellence (NICE).[94] No data is available on access to dental services provided on a private basis and the contribution of private dentistry to the diagnosis of head and neck cancer is unknown. This makes it difficult to fully gauge the true level of public demand for dental services or to measure inequalities in access that may exist.

8.1: Variation in percentage of people aged 18 to 69 years who attended an NHS dentist in the last 24 months

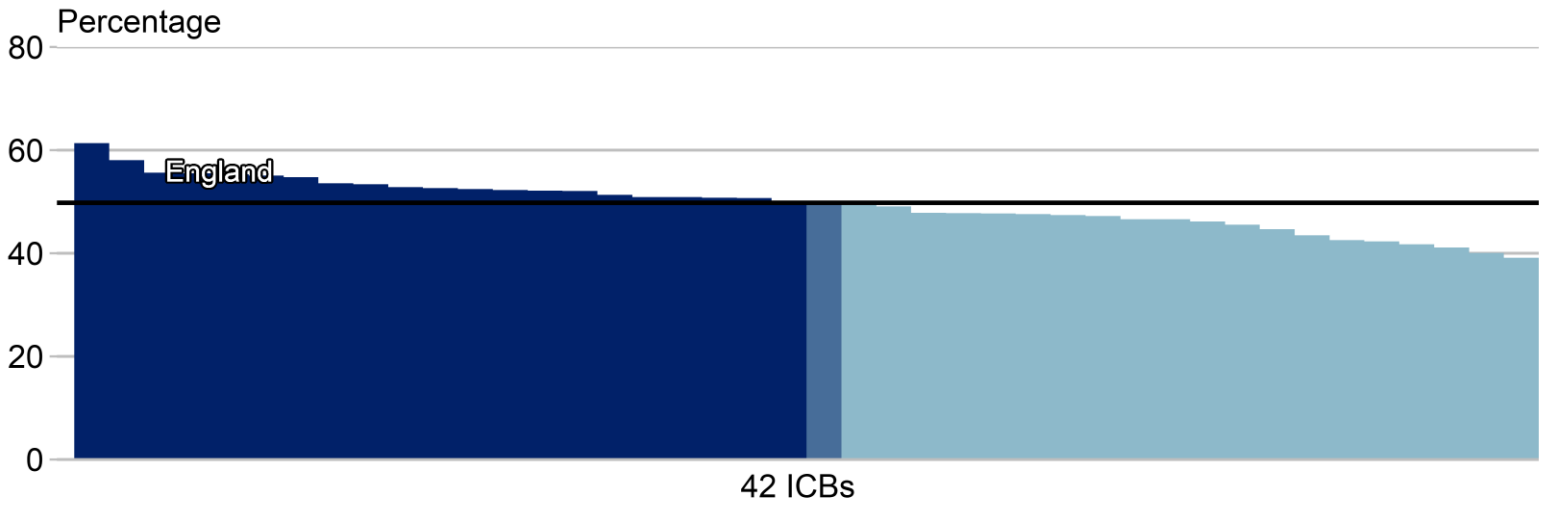
Map 8.1: Variation in percentage of people aged 18 to 69 years who attended an NHS dentist in the last 24 months by ICB (year ending December 2019)

Optimum value: high

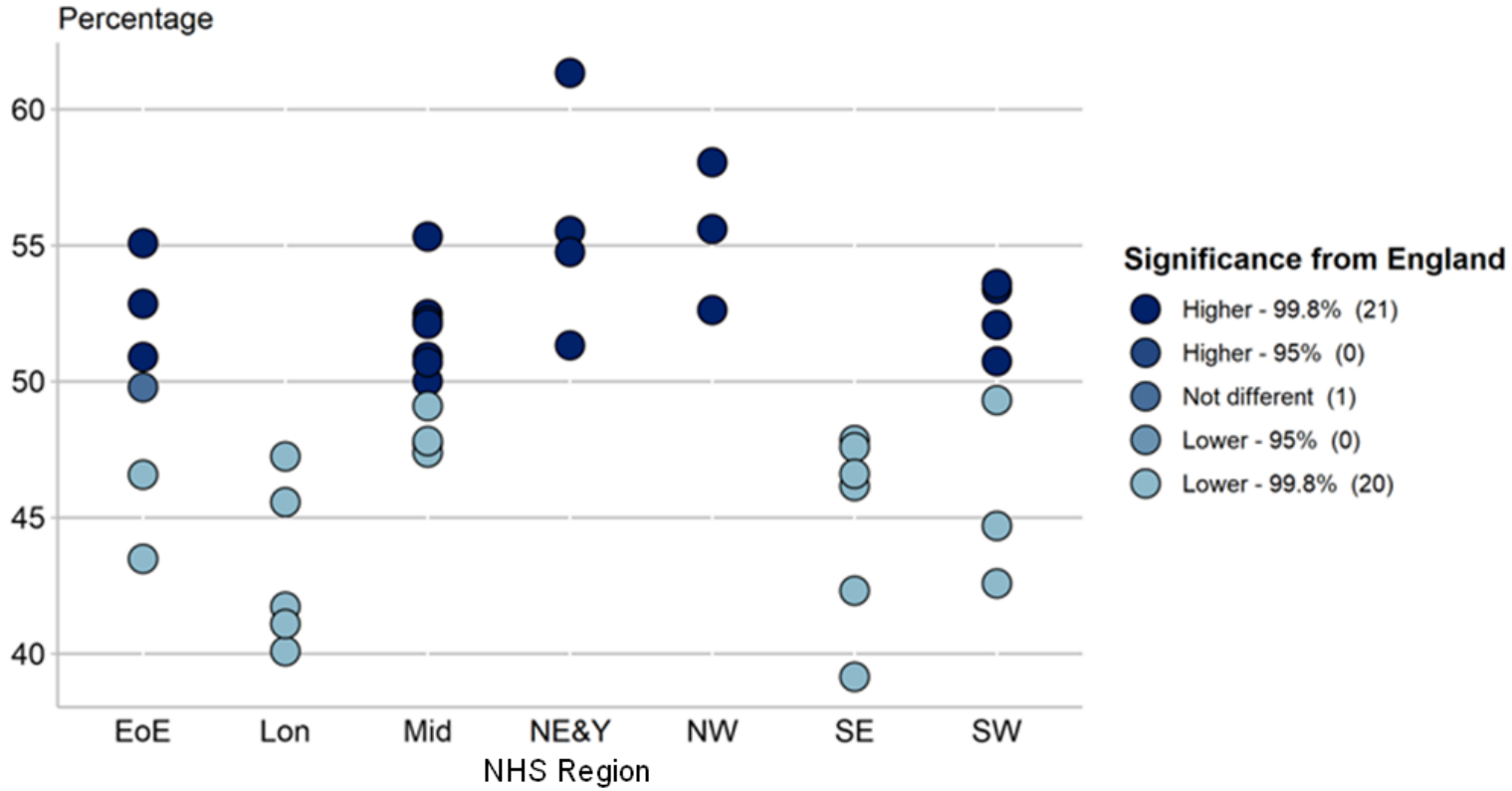




Bar chart 8.1: Variation in percentage of people aged 18 to 69 years who attended an NHS dentist in the last 24 months by ICB (year ending December 2019)



Regional dot plot 8.1: Variation in percentage of people aged 18 to 69 years who attended an NHS dentist in the last 24 months by ICB and region (year ending December 2019)



ICB values ranged from 39.1% to 61.3%, which is a 1.6-fold difference between ICBs. The England value was 49.8%.

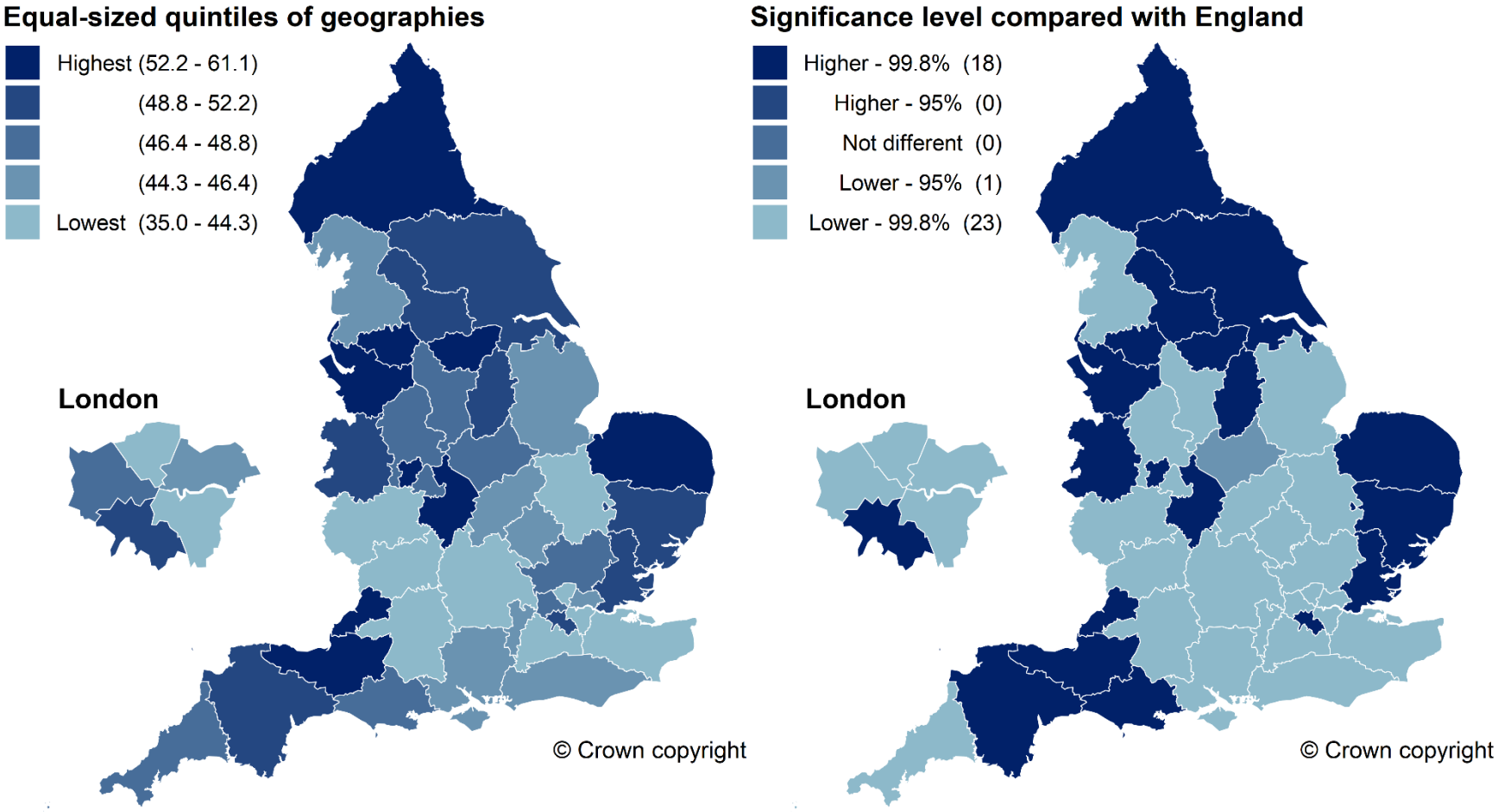
Of the 42 ICBs, 21 were statistically significantly higher than the England value (0 at the 95% confidence level and 21 at the 99.8% confidence level) and 20 were statistically significantly lower than the England value (0 at the 95% confidence level and 20 at the 99.8% confidence level).

The data showing the values for all ICBs is available in the head and neck cancer atlas data file.

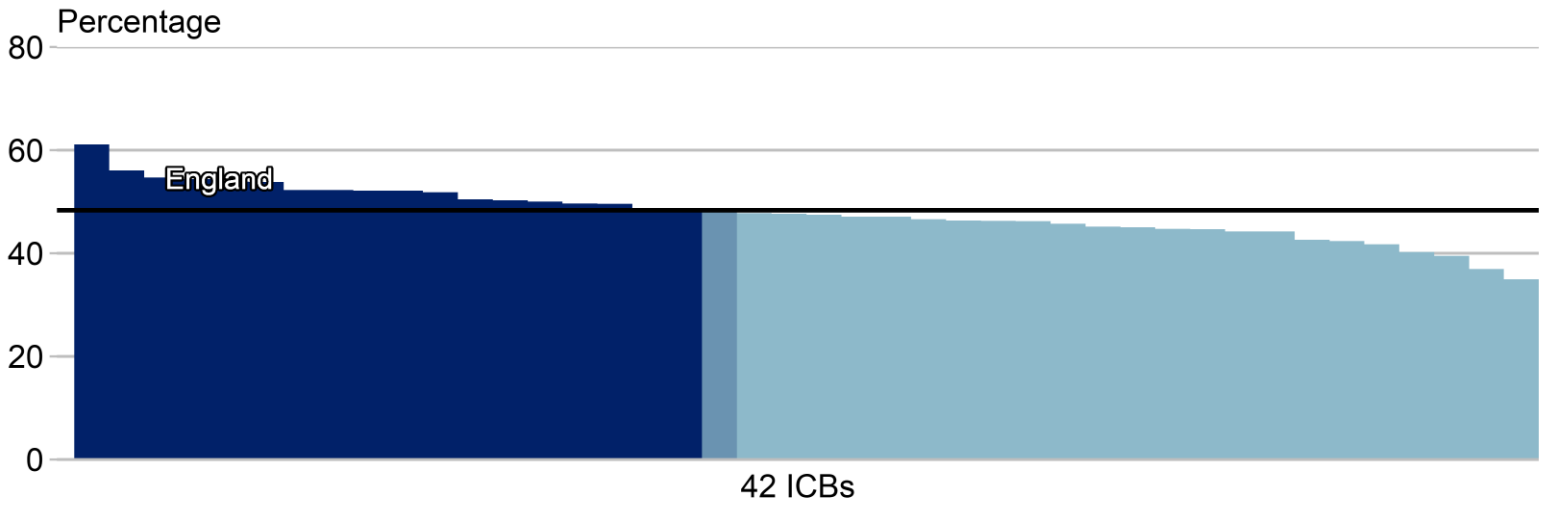
8.2: Variation in percentage of people aged 70 years and over who attended an NHS dentist in the last 24 months

Map 8.2: variation in percentage of people aged 70 years and over who attended an NHS dentist in the last 24 months by ICB (year ending December 2019)

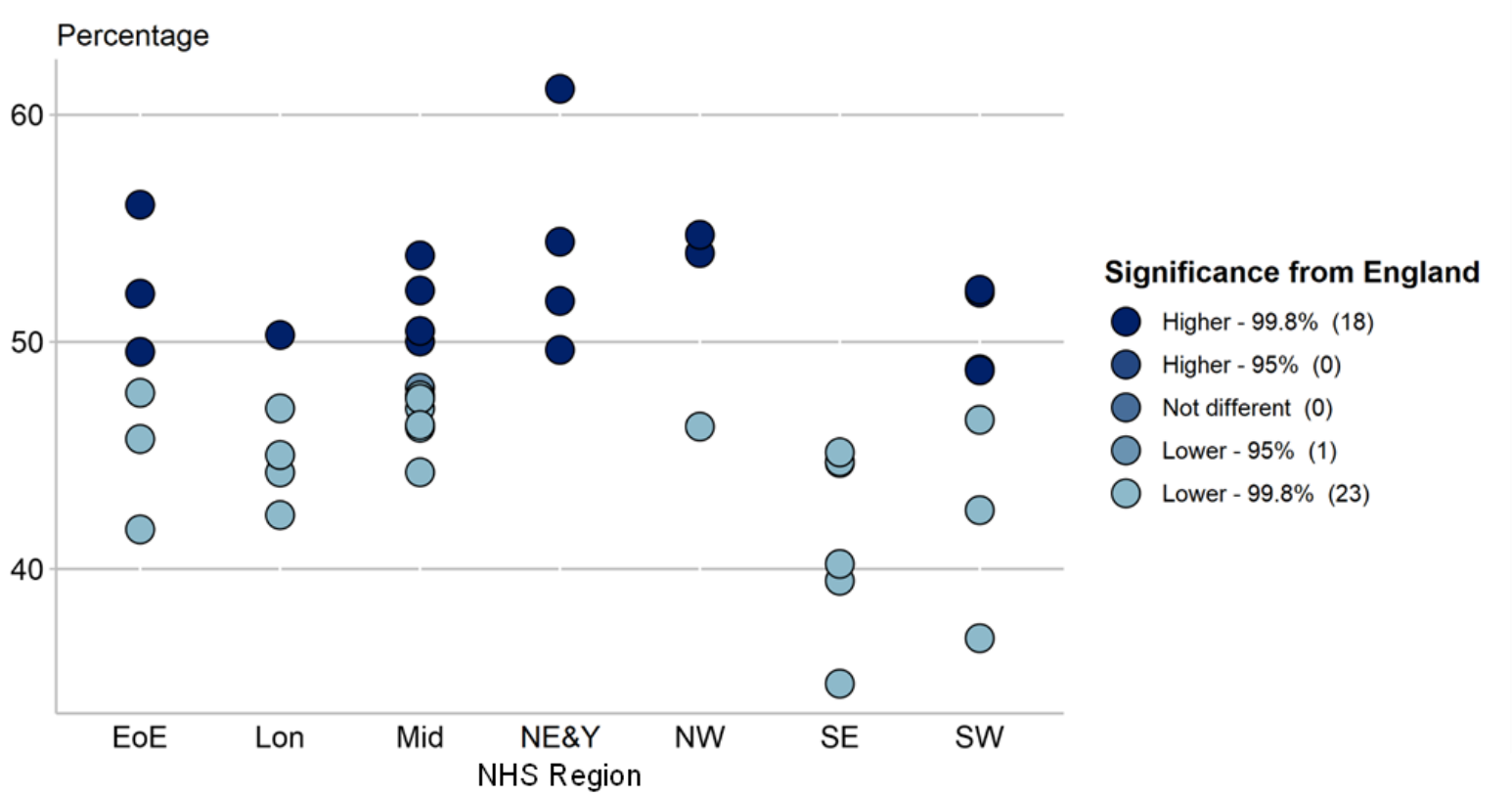
Optimum value: high



Bar chart 8.2: Variation in percentage of people aged 70 years and over who attended an NHS dentist in the last 24 months by ICB (year ending December 2019)



Regional dot plot 8.2: Variation in percentage of people aged 70 years and over who attended an NHS dentist in the last 24 months by ICB and region (year ending December 2019)



ICB values ranged from 35.0% to 61.1%, which is a 1.7-fold difference between ICBs. The England value was 48.3%.

Of the 42 ICBs, 18 were statistically significantly higher than the England value (0 at the 95% confidence level and 18 at the 99.8% confidence level) and 24 were statistically significantly lower than the England value (1 at the 95% confidence level and 23 at the 99.8% confidence level). The data showing the values for all ICBs is available in the head and neck cancer atlas data file.

Reasons for variation in dental access

There is regional variation in access to NHS dental services, Access to NHS dental services is lower in the 70 years and over age group compared with the younger age group.

No data are available on access to dentistry provided on a private basis. This affects the interpretation of variations in NHS dental access as a range of dental services are provided privately, outside of NHS contracts, and the proportion of services provided through the NHS varies considerably between areas. The amount of activity commissioned and delivered through NHS contracts does not indicate the overall availability or quality of dental services in an area.

Reasons for variation in access to NHS dental services include:

- individual and population factors such as:
    - the cost of dental services are unaffordable or perceived to be unaffordable
    - low priority of oral health among other health problems or daily difficulties especially for vulnerable population groups[23]
    - reduced health and oral health literacy affecting the ability to access or process information to improve oral health[23]
    - language and communication barriers for groups such as those from minority ethnic groups, refugees, migrants or those with hearing impairments[23]
    - lack knowledge of what services are available and how to make appointments[23]
    - dental fear and anxiety following previous dental treatment[23]
- health system factors such as:
    - lack of training for the dentistry workforce to meet the needs of more vulnerable groups[23]
    - reduced access to NHS primary dental practices:
        - the distribution of the NHS dental workforce is not aligned to the oral health needs of local populations[91]
        - increase in dentistry provided on a private basis[91]

- dental practices not taking on new NHS patients or having lengthy waiting lists to join their practice[23]

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