Pulling Teeth

Policy Exchange

Filling the gaps in dental provision

Gareth Lyon

Foreword by Rt Hon Sir Sajid Javid

Pulling Teeth

Filling the gaps in dental provision

Gareth Lyon

Foreword by Rt Hon Sir Sajid Javid

Policy Exchange

Policy Exchange is the UK's leading think tank. We are an independent, non-partisan educational charity whose mission is to develop and promote new policy ideas that will deliver better public services, a stronger society and a more dynamic economy.

Policy Exchange is committed to an evidence-based approach to policy development and retains copyright and full editorial control over all its written research. We work in partnership with academics and other experts and commission major studies involving thorough empirical research of alternative policy outcomes. We believe that the policy experience of other countries offers important lessons for government in the UK. We also believe that government has much to learn from business and the voluntary sector.

Registered charity no: 1096300.

Trustees
Karan Bilimoria, Alexander Downer, Andrew Feldman, David Harding, Patricia Hodgson, Greta Jones, David Ord, Daniel Posen, Andrew Roberts, William Salomon, Salma Shah, and Simon Wolfson.

About the Author

Gareth Lyon is Head of Health and Social Care at Policy Exchange.

Gareth has 20 years of experience in health care policy work. He has a record of achieving positive outcomes while engaging on Government policy working for some of the biggest healthcare companies as well as trade associations in social care, health, housing, education, engineering and digital advertising. He worked at Bupa for a number of years working several important policy initiatives on workplace health and healthcare system design including building a global network of companies, academics and health experts collaborating to improve health outcomes and drive innovation. He also led Bupa's engagement with the Competition and Markets Authority during their investigation into the UK private healthcare market. Gareth led policy and government relations for ARCO (Associated Retirement Community Operators) making the case for a new model of housing and care for older people in the UK, publishing policy reports making the economic, housing and health case for this new approach. At the Proprietary Association of Great Britain, he helped to shape the Government's self-care agenda and secured significant improvements in policy and regulation for over-the-counter medicines. At Novartis Gareth worked to expand access for UK patients to innovative medicines and treatments and worked on policy initiatives to tackle counterfeit medicines and animal rights extremism.

Acknowledgements

The author would like to thank the following people who have contributed ideas and insights into the development of this report or participated in interviews. Whilst their insights have informed this work, the output is wholly the responsibility of the author and does not reflect the views of the following:

- Stuart Carroll – Senior Fellow, Health & Social Care, Policy Exchange
- Professor Andrew Eder, Emeritus Professor at UCL and Specialist in Restorative Dentistry
- Iain Mansfield – Director of Research, Policy Exchange
- Zachary Marsh – Research Fellow, Policy Exchange
- Sean Phillips – Former Head of Health & Social Care, Policy Exchange
- Catherine Rutland – Director of Policy and Clinical Affairs Association of Dental Groups
- Ben Sweetman – Head of Data Analytics, Policy Exchange

© Policy Exchange 2025

Published by
Policy Exchange, 1 Old Queen Street, Westminster, London SW1H 9JA

www.policyexchange.org.uk

ISBN: 978-1-917201-84-1

Contents

Foreword

By ***Rt Hon Sir Sajid Javid****, Former Secretary of State for Health and Social Care*

As an MP, few topics filled my postbag quite like dentistry. From the frustration of families unable to find an NHS appointment to the stories of those in unnecessary pain, it was clear that this vital service was in urgent need of repair.

When I was Health and Social Care Secretary we made a start to those repairs. The measures I set in motion in 2022 were designed to stabilise the ship in the wake of the pandemic. It's heartening to see that NHS dental activity increased as a result. But we must be honest with ourselves: stabilisation is not the same as transformation. The government can, and must, go much further.

I am, and always have been, a free marketeer. I believe that choice and competition are essential to any well-functioning market. Yet, as it stands, the dental market does not perform efficiently.

The current contract, a legacy of the mid-2000s, is a case study in perverse incentives. Dentists are often paid the same for doing one filling as they are for doing six, because the system counts them as one course of treatment. This disincentivises taking on patients with higher needs - precisely the people who need our help the most. The current system offers little reward for the hard graft of prevention or oral health education. It encourages a focus on interventions - the old model of "drill and fill" - rather than preventing disease in the first place.

The price of this is paid by the taxpayer and the patient alike. The cost and workload for hospitals due to emergency dental admissions are staggering. In England alone, we see over 49,000 child admissions for tooth extractions and £81 million spent annually on tooth extractions.For adults, the figures are equally grim: 600,000 medical practice admissions and 135,000 A&E attendances every year. These crises result in £1.47 billion in secondary and community dental costs, to say nothing of the considerable pain and discomfort for patient, the vast majority of which is entirely avoidable.

One of my primary focuses as Health Secretary was tackling the health disparities that blight less well-off communities. It's unacceptable that in the UK, the poorer you are the greater the proportion of your life is spent in ill health. Dentistry is a case in point. Those with the greatest needs, often in our most deprived communities, are the least likely to easily secure an NHS dentist.

My plan for NHS reform, most of which I'm delighted has been picked up by the Labour government, had prevention and personalisation at its heart. This excellent report by Policy Exchange is a blue-print for embedding those principles at the heart of NHS dentistry. A voucher that people could use to pay for dental insurance or a capitation plan could fully cover a basic plan, or act as a co-payment towards a more extensive plan for others.

Such a system would empower patients, drive up standards through genuine competition, and finally break the deadlock of the current contract. It is a reform that aligns perfectly with a vision of a modern, responsive health service - one that prevents agony rather than just treating it, and one that serves the patient, not bureaucracy.

Endorsements

"The Association of Dental Groups welcomes new proposals to address the failing current system. There are a number of factors that have conspired over time to put dentistry in the state it is in today. We urgently need reform. That reform needs to include the prioritisation we should give to filling the gap in the workforce as well as addressing issues with the NHS contract, which currently does not cover dentists' costs. To address the workforce deficit which is prevalent in both the NHS and the Private sectors with over 2,700 job vacancies unfilled, we need to look at how we train UK dentists to fill the gap in the workforce in dental deserts in the long-term, as well in the short-term putting to work the trained international dentists who are ready to step up. The Overseas Registration Examination, which is run by the General Dental Council (GDC) needs reform to sort out the bottleneck of students queuing to take the exam, as does the GDC itself which last underwent reform during Maggie's time in 1984. We have to recognise that the dental landscape has changed significantly over the last 40 years, and thus the solutions to meet demands today must keep up."

Neil Carmichael, Executive Chair, Association of Dental Groups (ADG)

"We very much welcome this report by Policy Exchange. Dental health is a vital component of overall wellbeing, yet it's often overlooked in the context of primary care. In the UK, integrating oral health within the primary care model ensures early detection and prevention of dental disease, reducing the burden of complex treatments and hospital admissions. Poor oral health is linked to systemic conditions such as diabetes, cardiovascular disease, and respiratory infections, highlighting the need for coordinated care. By prioritising routine dental assessments, patient education, and timely referrals within primary care, we can promote lifelong oral health, improve quality of life, and enhance population health outcomes."

Ian Jones, Director, The Practice Managers Association (PMA)

"This proposal is a bold and timely contribution to the ongoing and increasingly urgent discussions about the future of NHS dentistry. A new direction is essential, as it is clear that NHS dentistry cannot continue on its current path. Widening access to care to improve oral health is a critical challenge that must be addressed. By enabling earlier diagnosis and intervention, there is an opportunity to avoid pain and disruption for patients and their families, while

easing the long-term burden on the NHS by preventing the need for more complex and costly treatments. As the report rightly emphasises, this applies not only to overall oral health but also to the early detection of oral cancers and other conditions where dentistry can play a vital role in early identification."

Professor Andrew Eder, Emeritus Professor at UCL and Specialist in Restorative Dentistry

"We are facing a growing oral health crisis: a quarter of adults now live with an unmet need for dentistry, and as few as one in ten people can secure an NHS appointment. As an MP, I hear week in, week out from constituents struggling to access basic dental care. For many families, what was once difficult has now become almost impossible. There is widespread dissatisfaction, and the current NHS dental contract is no longer fit for purpose.

I highly recommend this report from Policy Exchange. It sets out the scale of the challenges and offers sensible, patient-focused reforms that would expand access and ease pressure on the NHS. Ending the postcode lottery in dentistry and delivering equal access for all must be a priority. The report rightly exposes the broken system of price controls and subsidies that underpin the current contract. Its bold proposal to replace this failing model with a dedicated dental voucher would support basic care for patients, help more than 32 million people access dentistry, and make it economically viable for dentists to remain in the NHS long term.

Dental care is a vital foundation of effective primary care and is intrinsically linked to wider health outcomes. Improving access will also lead to fewer emergency admissions, reduce pressure on hospitals, and generate significant savings for the NHS. This report is a timely and valuable contribution to the long-neglected challenge of NHS dentistry, highlighting the need for a fairer and more sustainable funding model and the urgent need to end the unacceptable reality of dental deserts."

Joe Robertson MP, Member of the Health and Social Care Select Committee

"I welcome this report as a much needed reminder of the importance of improving NHS dentistry. Dental health has become a stark marker of inequality. Without ongoing care and access to that preventive care, children in less well-off families are more likely to suffer worsening dental problems.

As the report sets out, the contract is a major problem and too many families do not go to the dentist until it is too late and it is very expensive, so we need more of a focus on prevention to keep people out of A&E."

Lizzi Collinge MP, Member of Parliament for Morecambe and Lunesdale

"NHS dentistry faces real challenges and it's clear we need practical, workable solutions. Too many people still struggle to get an appointment, which puts pressure on patients and on the wider health service.

Policy Exchange's proposals would give patients greater control and improve access to dental care, helping to create a more responsive and effective system.

These ideas merit serious consideration and, if taken forward, could make a meaningful difference for patients across the country."

Greg Stafford MP, Member of the Health and Social Care Select Committee

"As someone who has relied on dental care since a cycling accident at the age of 16, I have come to deeply appreciate the services dentists provide. I have probably spent more time in dental surgeries since that accident than most people will in their entire lives, so I know just how important access to treatment is. I would not have been able to receive the care I needed without a combination of both NHS and private dental services, particularly the NHS in the first instance.

I welcome this report and the new ideas and proposals it brings to the debate. It is encouraging to see policy professionals and think tanks engage with an issue that affects so many, yet is often overlooked in wider political discourse."

Mark Sewards MP, Member of Parliament for Leeds South West and Morley

"This report makes plain one simple truth, that NHS dentistry has drifted far from the founding principles of the NHS to the point it has minimal resemblance to NHS service at all.

27 million adults and five million children have not accessed NHS dental treatment in the last two years. Whole communities, particularly rural areas, have been left completely shut off from NHS dentistry. People are forced to either pay for services or do them themselves. The report is clear, this is a systemic failure in how NHS dentistry is set up, with the fault lying with the deeply flawed NHS dental contract.

The report also exposes the flaws in the dental contract and how it pushes the provision of NHS dental services around wealthier parts of the country by fixing prices far below market rates.

Policy Exchange's proposed solution to the crisis, moving away from the irreparably broken NHS contract system to a funded voucher system, removing the distortions to ensure that people can secure insurance or treatment in a way that suits their needs and bringing the NHS dental system back to its original

principles, should be carefully considered by the Government."

Rt Hon David Davis MP, Member of Parliament for Goole and Pocklington

"People across the South-West are struggling to find a dentist and there is a huge backlog of unmet dental needs which has built up over many years. We need to address this – to make it easier for people to get a check-up and early treatment and to keep people out of emergency treatment in hospital.

I welcome the work Policy Exchange have done to profile the extent of dental needs across the country, and their bold proposals to expand access to more people."

Neil Duncan-Jordan MP, Member of Parliament for Poole

"I welcome this thoughtful contribution to the debate on NHS dentistry. Constituents frequently raise concerns about access to dental care, and it's clear the current system needs reform. This report offers constructive ideas to expand provision, improve patient choice, and encourage earlier treatment. I hope its proposals help drive forward much-needed improvements in dental services."

Andrew Rosindell MP, Member of Parliament for Romford

"We need to expand NHS dental support to far more people – millions of adults and children are missing out at the moment, meaning that their dental health is getting worse and opportunities to spot oral cancers early are being missed.

Policy Exchange propose some interesting solutions here which are worthy of serious consideration.

I'm delighted to see dental care getting the national profile it deserves and I hope that this acts as a spur to much needed reform."

Rosie Duffield MP, Member of Parliament for Canterbury

In Blackpool, the NHS dentistry crisis is a painful reality my constituents live with every day. Like half of the population here, and despite years of trying, I still don't have an NHS dentist. Blackpool residents are being left without basic care, forced into private treatment they can't afford, or simply going without. One-in-three five-year-olds here have tooth decay and parents are feeling helpless watching their children suffer with nowhere to turn. People in severe pain are resorting to A&E which is putting strain on vital hospital resources. It's a desperate situation that this report rightly shines a spotlight on. I welcome its proposals to tackle the root causes so that everyone, especially

the most vulnerable, can get timely, affordable dental care.

Chris Webb MP, Member of Parliament for Blackpool South

Executive Summary

Dentistry is different. It does not operate like any other part of the NHS and has not done so for nearly 75 years[1].

The NHS Constitution for England[2] opens by citing seven "Principles which guide the NHS." The first two of these are: "The NHS provides a comprehensive service, available to all" and "Access to NHS services is based on clinical need, not an individual's ability to pay."

Yet neither of these principles applies to the way in which dental services are provided in England.

Firstly, other than for children and people meeting certain criteria, people need to pay for NHS dental care.

Secondly, NHS dentistry, far from being available to all, is difficult or impossible to access for many people[3] and prospective patients, including children and those notionally eligible to receive free dental treatment, face a postcode lottery over whether it is available in their area at all including children and those notionally eligible to receive free dental treatment.

This paper proposes an end to the postcode lottery in dentistry in England: to give all adults an equal opportunity to access public support towards dental costs and to guarantee dental treatment for children.

This would turn the largely theoretical current provision into a flexible, usable and real benefit for millions more people and create a system in which there would be more incentives towards early diagnosis, prevention and treatment in dental care.

At the root of the many problems facing NHS dentistry in England is the broken system of price controls and subsidies which operate through the NHS Dental Contract.

"NHS dental practices" in England are in fact private contractors, rather than NHS bodies, and the difference between NHS and private dentistry is mostly one of cost and the level of services provided. Dentists providing NHS services are required to treat a certain pre-determined volume of patients at specified prices, supported by a level of centrally provided subsidy.

In the two years to the end of March 2024, 18 million adults and 6.6 million children accessed an NHS dentist in England. This equates to 40% of adults and 57% of children – meaning that **27 million adults and nearly 5 million children in England did not see an NHS dentist in that time.** Similarly, ONS data shows that only half of those over the age of 24 describe themselves as having an NHS dentist[4] (though this is no guarantee that they would be able to secure an appointment.)

Within these figures there is significant regional variation in the

1. https://dentistry.co.uk/2018/09/19/nhs-dentistry-throughout-years/
2. https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
3. https://www.bda.org/media-centre/dentists-97-of-new-patients-unable-to-access-nhs-care/
4. https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/experiencesofnhshealthcareservicesinengland/wave16/hisreferencetableswave16.xlsx DEN022 fields

provision of dentists and in access to care (with many so-called **'dental deserts'** particularly in the least well-off or most rural parts of the country.) **In some parts of England, as few as one in ten people can get an NHS dental appointment[5].** Meanwhile, those who can afford it are increasingly forced to turn to private provision; many others are foregoing dental care altogether. In recent years there has been **a rise in the number of people attempting risky "DIY dentistry" themselves[6].**

One result of people having to rely on private provision is that dentists, including those providing NHS services, are more likely to be found in those areas where there is more effective demand to sustain practices, that is where there are sufficient numbers of people with a high ability to pay.

As such, rather than a comprehensive services available to all, England has a system in which a fortunate minority of people are benefitting from price-capped and subsidised dental health while everyone else is required to fully fund their own dental care.

Perhaps the clearest departure from NHS principles comes in the fact that many people who pay for private dental treatment are doing so not from choice but from necessity - as they are unable to access NHS supported dental provision.

There is concern across the political spectrum about the need for far-reaching action to tackle dentistry. Two Health Select Committee investigations fifteen years apart in 2008[7] and 2023[8] have called for urgent reform. Both lamented the lack of progress made during the preceding period. The Government's most recent response[9] conceded many of the points made and the current Health Secretary has described the system as being **"at death's door,[10]"** whilst promising 700,000 more urgent care appointments to start to tackle the backlog – a figure which is nowhere near sufficient to address unmet demand[11].

More recently the Chancellor of the Exchequer has expressed concerns[12] about access to dentistry and a lack of consumer knowledge and difficulties in securing treatment for children through NHS supported dentistry – all of which are symptoms of the market distortion caused by the way in which NHS dentistry is delivered.

There is also widespread public dissatisfaction with dentistry[13]. Polling by Policy Exchange showed that improved access to NHS dentistry was the third highest priority amongst the British public, with 43% listing it as a priority – only behind 'shorter waiting times for operations' (56%) and 'better access to GPs' (48%).

Yet proposals so far are failing to address the fundamental flaws at the heart of the current system.

Attempts to incentivise dentists in England to take on more NHS work have run up against the reality that NHS dental contracts rely on requiring the delivery of dental services at a subsidised level still well below market rates. This is borne out by the figures. There are over 37,000 dentists in England but only 10,500 full time equivalent now providing NHS services.

This paper proposes moving away from the failing system of prices and subsidies and to replace them with a system in which **every adult**

5. https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/experiencesofnhshealthcareservicesinengland/wave16/hisreferencetableswave16.xlsx DEN029 fields
6. https://www.bda.org/media-centre/8-in-10-dentists-seeing-cases-of-diy-dentistry/
7. https://publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/289i.pdf
8. https://committees.parliament.uk/work/7140/nhs-dentistry/
9. https://committees.parliament.uk/publications/42564/documents/211641/default/
10. https://www.independent.co.uk/news/uk/wes-streeting-nhs-mps-british-dental-association-prostate-cancer-b2675140.html
11. https://www.gov.uk/government/news/dental-patients-to-benefit-from-700000-extra-urgent-appointments
12. https://www.thetimes.com/uk/healthcare/article/rachel-reeves-private-dentist-fees-vp9d8zdzr
13. https://policyexchange.org.uk/wp-content/uploads/A-Portrait-of-Modern-Britain-Health.pdf

in England would receive a dedicated voucher worth £150 they could use to pay for dental insurance/capitation plan[14], either fully paying for a basic plan or as a co-payment towards a more extensive plan. If they preferred, people would also have the option to take the voucher to any General Dental Council registered dental professional in the country towards the cost of clinical (non-cosmetic) dental treatment.

All registered dentists would be required to accept the vouchers under the terms of a revised General Dental Council (GDC) licence. They would also be required to accept children at current NHS England dental rates of reimbursement from the Department of Health and Social Care (DHSC) which would be indexed to inflation over time

As a contribution towards dental insurance or dental capitation plan this voucher would be enough to cover the whole annual premium for the most affordable offerings in the market. By using the voucher in this way people would be potentially covering themselves for substantial costs and taking the risks associated with the costs of the scheme away from themselves and the Government.

As an alternative, many may choose to take the voucher as a contribution towards dental costs if they expected to only need a check-up or routine treatment.

This reform would amount to a potential extension of NHS dental support in England to a further 27 million adults and 5 million children – 32 million people who are currently not benefitting from NHS dentistry in addition to maintaining a (more targeted) benefit for the minority (18 million adults and 6.9 million children) who currently are.

This proposal would also mean that more dentists would find it economically sustainable to provide services to more people, potentially leading them to extend their operating hours and to remain in the profession for longer.

There will also be significant, though harder to quantify savings in the wider NHS and at the DHSC, resulting from significant reductions in the administration cost of the scheme. There are also likely to be significant wider public health benefits. Far from being an 'optional' service, dental care is foundational to an effective primary care system**.** Oral and dental health is often a vital means of identifying other health conditions early on including many types of cancer[15] and there is a growing body of evidence that poor dental health can lead to a deterioration in overall health over time[16].

In particular, this would also result in a significant reduction in cost and workload for hospitals in emergency dental admissions – which currently include over 49,000 child admissions to hospital for tooth extractions in England[17] and 600,000 medical practice and 135,000 A&E admissions per year for adults[18]. These failure costs, largely due to a lack of early diagnosis and treatment result in £1.5bn in secondary and community dental costs and considerable pain and discomfort for patients – the vast majority of which is avoidable.

14. A dental capitation plan is a scheme whereby you regularly pay in to a dedicated account to cover the costs of dental treatment.
15. https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475
16. https://www.bupa.co.uk/newsroom/ourviews/dental-health
17. https://www.gov.uk/government/statistics/hospital-tooth-extractions-in-0-to-19-year-olds-2024/short-statistical-commentary-for-hospital-tooth-extractions-in-0-to-19-year-olds-2024
18. https://committees.parliament.uk/writtenevidence/117193/pdf/

Under the proposed new system the Government would no longer be dictating prices – and thereby keeping providers out of the market – instead all providers would be incentivised to compete on price and quality to attract customers in their local areas, as would insurers.

This paper proposes a more far-reaching reform to a system which is clearly broken and letting patients, dentists and the broader health system down. These proposals would incentivise better dental health and save the NHS money, promote patient choice and provider and insurer competition leading to a fairer and more even distribution of funding to those most in need. Attempts at reform have too often resembled the slow pain of pulling teeth – it is time for radical, corrective surgery on the NHS dental system.

Prescription: Recommendations

Our recommendations, based on our analysis of the fundamental problems of the current NHS dental contracting structure and its impact on supply, are:

Recommendation 1: To introduce a new annual Dental Voucher for all eligible adults in England initially worth £150 and linked to inflation over time to support the costs of dental insurance or a dental capitation plan or as a contribution towards clinical (non-cosmetic) dental treatment with any GDC registered dental professional and to amend the GDC licence to require that these vouchers by accepted by any registered dentist.

This would be supported by an increase in NHS England dental budget of £1.8 billion to be funded out of the £30.4 billion projected increase in the NHS budget up to 2029[19] or from reductions in NHS administrative spending recently set out by the Secretary of State[20].

Recommendation 2: To extend free dental treatment to all children in England at all dentists with reimbursement at current NHS reimbursement rates indexed to inflation over time and to amend the GDC licence so that children must be offered appointments at the current NHS rate.

19. https://www.england.nhs.uk/long-read/financial-performance-update-6/
20. https://www.gov.uk/government/news/billions-to-be-redirected-back-into-patient-care-with-nhs-reform

Opening-up: What is NHS Dentistry?

NHS general dentistry in England takes place in privately run general dental practice settings, provided predominantly by 'generalists.' In addition to this there is a smaller number of specialists working in a mixture of private clinics, primary care or hospital settings for advanced, emergency or specialist care.

Dental services in England are inspected by the Care Quality Commission as part of its role as the statutory regulator for the health and care services.

Dental professionals[21] are regulated by the General Dental Council.

Funding for NHS dental care in England comes from a combination of Government funding and patient contributions. The NHS spends £3.97 billion a year on dentistry and patients contribute a further £0.78 billion in charges[22]. Patients are charged for their dental treatments based on a tiered system known as NHS dental treatment bands, which vary depending on the complexity of the treatment, while others receive free treatment.

NHS England allocates funding to Integrated Care Boards based on the level of dental services provided in 2006 (when the current national dental contract model was introduced) rather than need, which inevitably has changed in patterns over time.

The Public Accounts Committee have estimated that, "at best, current funding and contractual arrangements are only sufficient for around half of the English population to see an NHS dentist over a two–year period[23]."

Free treatment

It is estimated that 5.4 million courses of free treatment were delivered by NHS England funding in 2023-2024[24].

"NHS dentists" in England should in theory be available for all who seek treatment but in practice are not required to take on children or free patients if they do not have capacity and many people struggle to find an NHS dentist with capacity[25].

In theory though, according to the NHS England website[26], you can get free NHS dental appointments and treatment if:

- you're aged under 18, or under 19 and in full-time education
- you're pregnant or have had a baby in the last 12 months
- you've had a stillbirth in the past 12 months
- you're getting treatment in an NHS hospital from a hospital dentist

21. The General Dental Council defines a dental professional as a person qualified to practise certain aspects of dental care. The term dental care professional (DCP) covers a number of titles that are eligible for GDC registration. Each title has its own qualifications and scope of practice https://www.gdc-uk.org/about-us/what-we-do/the-registers/types-of-registrants
22. https://www.nao.org.uk/wp-content/uploads/2024/11/Investigation-into-the-NHS-dental-recovery-plan-HC-308-1.pdf
23. https://committees.parliament.uk/publications/47347/documents/245396/default/ (p. 1)
24. https://www.bda.org/news-and-opinion/news/welfare-reform-has-pushed-millions-away-from-nhs-dentistry/
25. https://www.bbc.co.uk/news/uk-england-hereford-worcester-65122827
26. https://www.nhs.uk/nhs-services/dentists/who-can-get-free-nhs-dental-treatment/

(but you may still need to pay for dentures or bridges)
- you receive War Pension Scheme payments, or Armed Forces Compensation Scheme payments and the treatment is for your accepted disability

The same website also states that you can also get free NHS dental treatment if you or your partner receive certain benefits including:

- Income Support
- Income-based Jobseeker's Allowance
- Income-related Employment and Support Allowance
- Pension Credit Guarantee Credit
- Pension Credit Guarantee Credit with Savings Credit
- Universal Credit – but only if your income is below a certain amount

If you or your partner receive benefits that mean you can get free dental treatment from the NHS, your dependents aged under 20 can also get free dental treatment[27].

If you're not eligible for free NHS dental treatment and you're on a low income, you may still be able to get help with paying part of the cost from the NHS Low Income Scheme.

If you get help from the NHS Low Income Scheme, you'll get an HC3 certificate which will show how much you'll pay for dental treatment. You'll need to show your HC3 certificate to your dentist.

Paying for NHS dental treatment

Current NHS dental charges in England are set out in Appendix A.

A course of NHS dental treatment is defined as:

> *an examination of a patient, an assessment of their oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment; and the provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient.*[28]

Between 2014/15 and 2023/24 there was a 7% increase in real terms for Band 1 treatment charges and an 8% increase for Band 2 and Band 3 treatments. This compares to an 8% decrease in real terms in general NHS prescription charges[29].

The Government also reimburses dentists according to Units of Dental Activity (UDA)s delivered which vary but start at about £28 each with considerable regional variation. Band 1 treatments are valued by the Government at 1 UDA, Band 2 are valued between 3 and 7 UDAs and Band 3 are valued at 12 UDAs[30]. A typical dental practitioner may be allocated about 4000 UDAs a year[31].

Band 1 covers the most simple forms of dental treatment such as a check-up. **Band 2** includes more complicated treatment such as fillings.

27. https://www.nhs.uk/nhs-services/dentists/who-can-get-free-nhs-dental-treatment/
28. https://www.england.nhs.uk/wp-content/uploads/2018/08/PRN00241-Standard-General-Dental-Services-Contract-September-2023-version-2.pdf
29. https://www.nuffieldtrust.org.uk/sites/default/files/2024-01/Nuffield%20Trust%20-%20NHS%20dentistry%20policy%20briefing_WEB_Jan.pdf (p. 16)
30. https://faq.nhsbsa.nhs.uk/knowledgebase/article/KA-01976
31. https://ldc.org.uk/what-is-a-uda/

Band 3 are the most complicated treatments such as dentures and crowns.

Regulation

The General Dental Council[32] (GDC) is the UK-wide statutory regulator of more than 120,000 people working in dentistry including dentists, dental hygienists, dental technicians, dental nurses and dental therapists. It maintains a register of all practising dental professionals. The current legal basis of the GDC is the Dentists Act 1984[33]. Its primary purpose is to protect patient safety and maintain public confidence in the dental professions.

Dental insurance and dental capitation are regulated by the Financial Conduct Authority (FCA).

Finding a dentist

Dentists providing NHS services in England are not required to accept every patient and can turn people, including children, away if they believe they lack capacity.

The challenge people face in accessing an NHS dentist is not primarily due to a lack of dentists per se but instead due to a reluctance of dentists to operate under the NHS dental contract. Lord Darzi's independent investigation into the NHS in England[34] concluded that "there are enough dentists in England, just not enough dentists willing to do enough NHS work, which impacts provision for the poorest in society[35]."

Indeed, the GDC informed the most recent Health Select Committee Inquiry that the dental system in England is overstretched, with demand for services increasing, with evidence suggesting patients and dental professionals moving from NHS to private dental care[36].

GDC data also shows that 24,335 dentists performed NHS activity in 2022-23[37], approximately two thirds of those registered – meaning that one third of dentists in England were not undertaking any NHS work at all.

This significantly overstates the scale of dental capacity used by the NHS though, with dentists reducing the number of hours they work on NHS contracts[38]. NHS data shows that as of March 2024, the NHS estimated there were around 10,500 full time equivalent NHS dentists in England[39], and that there were around 2,700 full time equivalent vacancies for NHS dentists. Out of a registered population of over 21,500 dentists with NHS contracts this would suggest that less than half of their time is being spent on NHS work.

Overall, this would mean that out of over 37,000 dentists in England, less than a third of their full-time equivalent is being spent on NHS activity. This suggests a much broader issue with the model used to support NHS dentistry provision, especially when approximately 70,000 other dental professionals, including orthodontic therapists, dental therapists, dental technicians, dental nurses, dental hygienists and clinical dental technicians are factored in[40].

Efforts have been made over time to incentivise dentists to take on

32. https://www.gdc-uk.org/about-us
33. https://www.legislation.gov.uk/ukpga/1984/24
34. https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf
35. It should be noted that this conclusion is contested by large parts of the industry eg https://usercontent.one/wp/www.theadg.co.uk/wp-content/uploads/2025/06/Final-Creating-Dental-Oases-June-25-white-paper.pdf?media=1748871380 – but whilst recognising the contention that there may well be a need for more dentists in general to raise the UK up to the levels per head of population seen in some other countries it is also clearly true that a large proportion of dentists in England are now opting out of NHS dental work, thereby reducing effective supply and that steps can be taken to reduce the pressures driving many dentists out of the profession and out of NHS dentistry in particular.
36. https://committees.parliament.uk/writtenevidence/117220/pdf/
37. https://assets.publishing.service.gov.uk/media/676150ef26a2d1ff18253415/dhsc-annual-report-and-accounts-2023-2024-web-accessible.pdf
38. https://committees.parliament.uk/writtenevidence/117220/pdf
39. https://www.england.nhs.uk/statistics/statistical-work-areas/dental-workforce/
40. https://www.gdc-uk.org/docs/default-source/registration/registration-reports/registration-report---october-2025_a.pdf?sfvrsn=934ba260_1 although the aggregated numbers are over 77,000 some of these are duplicates due to individuals holding more than one registration.

NHS work – through reforms to the remuneration model for NHS work through national commissioning standards[41], to providing more local flexibility over funding[42], allowing above inflation increases in charges to patients[43] as well as exploring incentives for graduates to work for the NHS or for dentists in general to work in areas with less provision[44].

To an extent the NHS in England has been able to rely on altruistic motives on the part of dentists to cover this discrepancy, but as the GDC and Lord Darzi have demonstrated, a growing number of dentists are opting out.

Problems with the way that NHS dentistry in England is organised

The problems associated with NHS dentistry are well known, but are worth repeating:

The failures of the NHS dental contract model: It was the NHS dental contract introduced in 2006 which brought in payment for dentists via UDAs This system has been widely criticised as "not fit for purpose[45]". Dentists are paid the same for doing one filling or six fillings (since it can count as one course of treatment), which disincentivises taking on patients with higher needs[46] who require more work for the same pay. There is little reward for spending time on prevention or oral health education – the contract encourages a focus on interventions ("drill and fill") rather than stopping disease in the first place. As a result, many dentists find NHS work financially unviable or professionally unfulfilling, and may cap the number of NHS patients they see[47], ultimately leading to:

Loss of workforce from NHS provision: The number of dentists performing NHS work has not kept up with population needs, and raw headcounts obscure the issue of many dentists reducing their NHS commitment. Stress and burnout are high – in a BDA survey, 75% of NHS dental practice owners reported being *very or extremely stressed*, citing financial pressures and staffing issues[48]. Young dental graduates also often do a few years of NHS work then shift to focusing entirely on private practice. With an inability to incentivise providers to undertake NHS England dental work, the NHS does not have the supply to meet patient demand.

Financial pressures – masked by inconsistent and ineffective targeting. For over a decade, the NHS dental budget in England has been held at roughly the same level in nominal terms, not keeping pace with inflation. In real terms, spending is far below 2010 levels, yet population and needs have grown. The Public Accounts Committee found current funding and contracts are only sufficient for about 50% of the population to be seen in two years in line with the National Institute for Health and Care Excellence (NICE) advocated minimum.[49] Despite this shortfall in funding, the lack of supply caused by the restrictions of the NHS dental contract, such as pre-determining the number of UDAs to be delivered in a year and the unsustainable pricing structure, mean that the NHS in England has been unable to spend its full budget allocation for dentistry

41. https://www.england.nhs.uk/primary-care/dentistry/dental-commissioning/dental-specialties/#guides
42. https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-letter-delegation-of-nhse-direct-commissiong-functions-to-icbs.pdf
43. https://media.nhsbsa.nhs.uk/press-releases/c52e4da5-cf58-406c-b208-4335e5599319/nhs-dental-charges-from-1-april-2025
44. https://www.england.nhs.uk/long-read/dental-recruitment-incentive-scheme-2024-25/
45. https://lowdownnhs.info/topics/access/nhs-dentistry-where-did-it-all-go-wrong/
46. https://dentistry.co.uk/2016/05/24/nhs-dental-contract-what-are-the-problems/
47. https://patientplandirect.com/news/the-fake-economy-of-nhs-dentistry-a-costly-illusion/
48. https://committees.parliament.uk/writtenevidence/117203/html/#:~:text=3.5%20%25%20of%20NHS%20practice,%2C%20recruitment%2C%20and%20retention%20issues.
49. https://commonslibrary.parliament.uk/research-briefings/cbp-9597/

– with Integrated Care Boards (ICBs) having returned £400m underspend in 2022.[50] As things stand, the constraints imposed on supply by the NHS contract operate as a highly inconsistent but effective form of rationing ensuring that the shortfall in funding is not exposed. This creates:

A backlog for public health. Oral health problems untreated in primary care spill into other parts of the health system. 62% of all child teeth extractions take place in hospital[51] – highly concerning figures which reflect how decay prevention and routine dental care for children are failing in some areas contributing to the £1.47 billion the NHS in England spends every year in hospital and community dental care, the vast majority of which represents failure demand.

Preventable dental disease also results in adults attending GPs or A&E with dental pain, resulting in significant additional burdens on the parts of the system already under strain.

A lack of information or clarity for patients. There are well documented issues with the poor quality of online information about dental practices accepting NHS patients[52]. If practices do not update their status on the nhs.uk website within a 90-day period, then the practice status changes to 'no information supplied'. The official patient watchdog set up by the Government, Healthwatch England, cites NHS digital data from 2021 that showed over 3,000 practices were in this category. Recent changes to the dental contract have made explicit the need to update their information every 90 days, but it is not yet clear if this has improved the situation.

When combined with a widespread lack of understanding about what you are entitled to from NHS dentistry in England[53] it is clear that consumers are suffering a degree of detriment due to asymmetric information.

Despite the NHS principle of universality there is a de-facto three-tier system in dentistry in England:

1. those who pay privately, either because they have given up on the availability of NHS dentistry and are forced to, or because they choose to do so.
2. those able to access NHS dental care, and
3. those who have neither option, because NHS dental care is unavailable and they cannot afford to pay for private care.

Those with the greatest dental needs (often in poorer or rural communities) are the least likely to secure an NHS dentist – an example of the 'inverse care law' in action – whereby the availability of good medical care varies inversely with the need for it in the population served resulting in deteriorating oral health and risky self-treatment.

The scale of the shortfall in NHS dental provision, the wide variations in provision across the country and the extent of popular and political concern is set out in the following sections.

50. https://www.hsj.co.uk/finance-and-efficiency/nhse-set-for-400m-dentistry-underspend-despite-access-crisis/7034260.article
51. https://www.gov.uk/government/statistics/hospital-tooth-extractions-in-0-to-19-year-olds-2024/short-statistical-commentary-for-hospital-tooth-extractions-in-0-to-19-year-olds-2024
52. https://healthwatchgreenwich.co.uk/news/2024-02-02/our-position-nhs-dentistry#:~:text=Difficulties%20getting%20up%2Dto%2Ddate,fillings%20on%20a%20regular%20basis.
53. https://www.healthwatch.co.uk/blog/2024-11-20/what-people-want-nhs-dentistry

The Rot: The Scale of the Problem

> *"NHS England (NHSE) and Department of Health and Social Care (DHSC) do not yet know what that reform might look like or to what timescales it can be delivered. Further tweaks to the existing contractual arrangements will not be enough[54]."*
>
> **'Fixing NHS Dentistry', Public Accounts Committee** (March 2025)

In order to contextualise the extent to which current NHS dental provision in England is failing it should be noted that:

- 90% of general dental practices in England were not accepting new adult NHS patients at the time of the Health Select Committee report – though this number may have improved slightly since then as a result of incentives introduced, the difficulties with securing appointments once accepted as a patient would remain[55].
- In the two years to the end of March 2024, 18 million adults and 6.6 million children saw an NHS funded dentist. This equates to 40% of adults and 57% of children[56]. This means that:
- 60% of adults and 43% of children had not seen an NHS funded dentist in the 24 months to 31 March 2025 (equivalent to 27 million adults and 5 million children)[57] – the longest period of time in which it is recommended a person should see a dentist. Although not all of these people would necessarily have wished to see an NHS dentist in this time these figures clearly demonstrate that the current service is not universal and is a reasonable proxy for the number of people not benefitting from it.
- A study from 2022 found that 90% of NHS dental practices were not accepting new adult patients and 80% were not accepting new child patients[58].
- 1 in 10 people in Britain (10%) admit to attempting their own dental work. Of those who said they've performed DIY dentistry, most (56%) did so within the two years prior to being polled, 20% did so because they couldn't get a timely appointment, and 18% said they did so because they couldn't get registered with an NHS dentist[59].
- 8% admitted it's been more than a decade since they went to the dentist[60] - a real concern in the context of the NICE recommended

54. https://committees.parliament.uk/publications/47347/documents/245396/default/
55. https://committees.parliament.uk/publications/40901/documents/199172/default/
56. https://www.nhsbsa.nhs.uk/statistical-collections/dental-england/dental-statistics-england-202425
57. Policy Exchange calculation based on figures in: https://www.nhsbsa.nhs.uk/statistical-collections/dental-england/dental-statistics-england-202425
58. https://www.bbc.co.uk/mediacentre/ninety-percent-of-nhs-dental-practices-not-accepting-new-patients#:~:text=Over%20200%20practices%20that%20said,how%20benevolent%20you%20can%20be
59. https://yougov.co.uk/politics/articles/45450-one-ten-britons-have-performed-dentistry-themselve
60. https://yougov.co.uk/politics/articles/45450-one-ten-britons-have-performed-dentistry-themselve

two-yearly visit[61] and potentially representing a major undiagnosed dental health problem which is likely to amount to significantly higher costs over the long-term if unaddressed.

- Analysis of data published by the then Public Health England (PHE) in 2021, examining oral health inequalities, shows that current NHS dental provision, far from being a universal service, may actually correlate strongly to the ability of people or particular areas to pay: the most vulnerable and least well off people are more likely to live in "dental deserts[62]" where although notionally able to access subsidised NHS dental treatment, in reality they are often unable to access treatment at all.
- Children living in deprived areas are three and a half times as likely to have extractions due to tooth decay[63].

Wider health implications

Dentistry plays a vital role in the early detection of cancer, especially oral cancer. During regular dental checkups, dentists carefully examine the mouth, tongue, gums, cheeks, and throat for any unusual changes. Dentists are often the first to notice early warning signs that might otherwise go unnoticed. This makes routine dental visits not only important for maintaining oral health but also for potentially saving lives.

Dentists are trained to recognize subtle signs that could indicate cancer or precancerous conditions. These may include persistent mouth sores, red or white patches, unexplained bleeding, numbness, or swelling in the mouth or jaw. Even symptoms like loose teeth or difficulty swallowing can sometimes be linked to underlying cancers. When such symptoms are detected, the dentist can perform a screening or refer the patient to a specialist for further evaluation.

Oral cancer is a growing concern in the UK, with new cases of mouth cancer in the UK reaching 10,825 in 2023, an increase of 38% over a decade and by 133% over twenty years. The Oral Health Foundation listed late diagnoses and poor access to NHS dentistry as major challenges in this area[64].

In addition to detecting oral cancer, dentists can also identify signs of systemic cancers such as leukaemia or lymphoma, which sometimes first manifest in the mouth. They also play an important preventive role in public health education by educating patients about risk factors like tobacco use, excessive alcohol consumption, HPV infection, and poor oral hygiene.

The shortcomings of the dental health system in England, in particular, the lack of regular check-ups and early treatment is therefore having a significant impact on the wider health system, increasing avoidable cost and patient suffering.

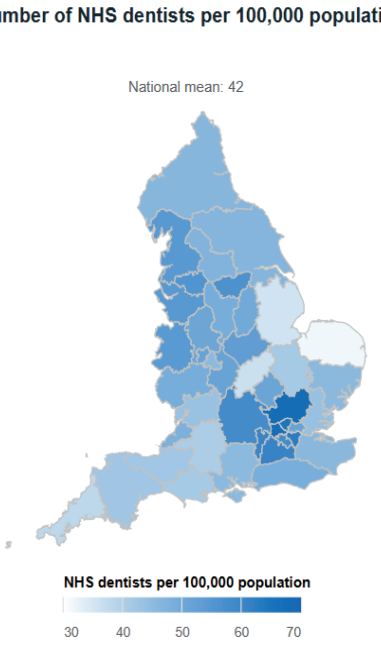
61. https://www.nice.org.uk/guidance/cg19/resources/dental-checks-intervals-between-oral-health-reviews-pdf-975274023877
62. https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england/inequalities-in-oral-health-in-england-summary
63. https://committees.parliament.uk/publications/40901/documents/199172/default/
64. https://www.dentalhealth.org/thestateofmouthcancer#:~:text=A%20summary%20of%20the%20key,identify%20mouth%20cancer%20cases%20sooner.

Cavities: Mapping England's 'Dental Deserts'

The failure of the current model of NHS dental contracting in England is more pronounced in some parts of the country than others. Two key figures which demonstrate this are as follows:

- More rural and more deprived areas in England generally had more shortages of NHS dentists than those in urban areas, with the top 10 council areas for shortages tending to have higher than average levels of deprivation or rurality[65].
- A 2022 study found that the prevalence of "dental deserts" in which it is not possible to access an NHS dentist was worst in the South-West of England, Yorkshire and the Humber, the North West and the East of England where 97-98% of practices were not accepting new adult NHS patients[66]. The levels of treatment provided varied significantly from 382 courses of treatment delivered per 1,000 people in Somerset ICB to 800 delivered per 1,000 people in South Yorkshire ICB in 2023–24[67].

The following map sourced from the NHS Business Services Authority[68] illustrates the degree of regional variation in the availability of NHS dentists.



65. https://www.local.gov.uk/about/news/nhs-dental-deserts-persist-rural-and-deprived-communities-lga-analysis
66. https://www.bbc.co.uk/mediacentre/ninety-percent-of-nhs-dental-practices-not-accepting-new-patients#:~:text=Over%20200%20practices%20that%20said,how%20benevolent%20you%20can%20be
67. https://publications.parliament.uk/pa/cm5901/cmselect/cmpubacc/648/report.html
68. https://nhsbsa-opendata.s3.eu-west-2.amazonaws.com/dental/dental_narrative_2024_25_v001.html

The Government itself acknowledges that:

> *"There are barriers to NHS care at individual, societal and policy level which include costs, lack of availability of services and services not commissioned to meet local needs.[69]"*

And

> *"The impacts of poor oral health disproportionally affect vulnerable and socially disadvantaged individuals and groups in society."*

And

> *"Reducing oral health inequalities is a matter of social justice and an ethical imperative."*

This points to the main and overriding problem – the system delivering NHS dentistry in England at the moment is incapable of matching effective demand with supply and all tweaks to public policy in recent years have proved ineffective in addressing this. A more fundamental rethink is needed and there are good reasons to believe that public opinion would support it.

69. https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england/inequalities-in-oral-health-in-england-summary

Bracing: Popular and Political Perceptions

Politicians and health bodies are very aware of public dissatisfaction with NHS dentistry in England. Complaints about a lack of NHS England dental provision fill MPs' postbags and those of NHSE itself.

There has been a growing volume of complaints about NHS dentistry in England since 2013. Despite accounting for approximately 1.5% of NHS spending.[70] the percentage of all complaints received by Healthwatch relating to dentistry rose from 5% up to 19% during the Covid period before returning to a still exceptionally high level at 14% in 2022[71].

Polling by Policy Exchange[72] has shown that improved access to NHS dentistry was the third highest priority amongst the British public, with 43% listing it as a priority – only behind 'shorter waiting times for operations' (56%) and 'better access to GPs' (48%).

Figures from the 2022 GP Patient survey cited by the BDA in the course of the Health Select Committee investigation indicate that self-reported patient unmet need has risen by every measure, equating to over 11 million people, or almost one in four of England's adult population. Nearly six million people reported trying and failing to get an appointment in the prior two years, and 3.6 million did not try because they thought they could not secure an appointment. Over one million adults are put-off by the cost of NHS dentistry[73].

70. https://dentistry.co.uk/2025/06/11/spending-review-what-does-the-dental-profession-think/#:~:text=this%20spending%20review.-,1.5%25%20in%202023%2F24.
71. https://committees.parliament.uk/writtenevidence/117223/pdf/
72. https://policyexchange.org.uk/wp-content/uploads/A-Portrait-of-Modern-Britain-Health.pdf
73. https://committees.parliament.uk/writtenevidence/117203/pdf/

Figure 1 - National Priorities: 'Which of the following changes to the NHS would be most important to you?' You may select up to three. (%)

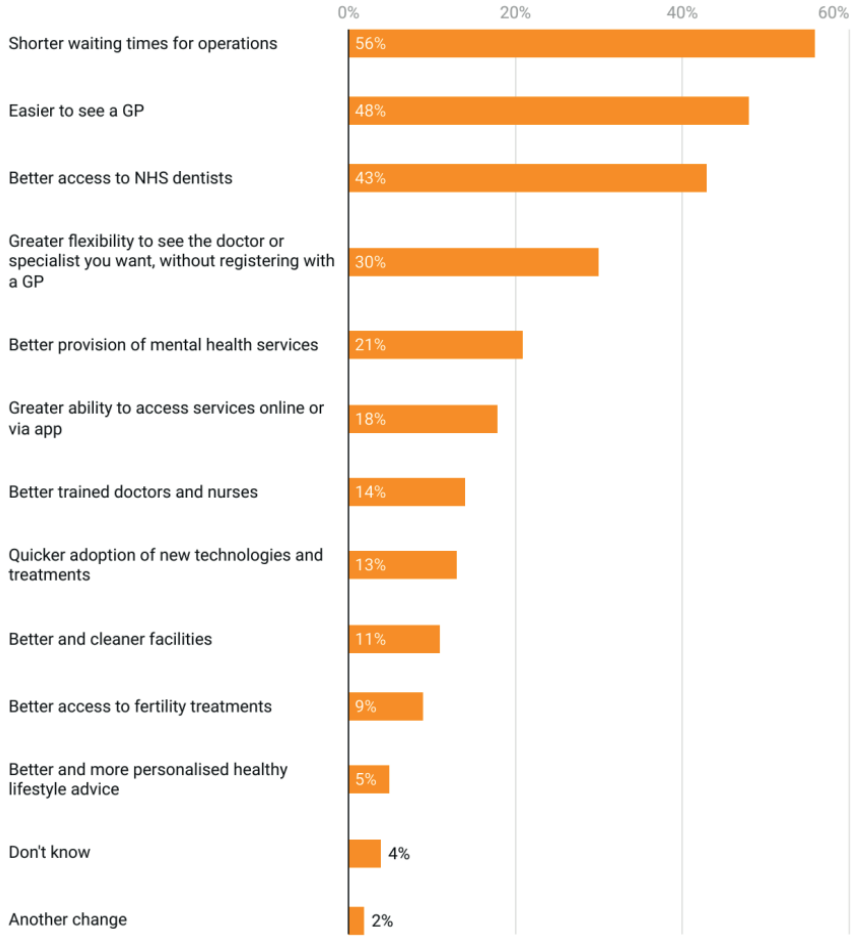
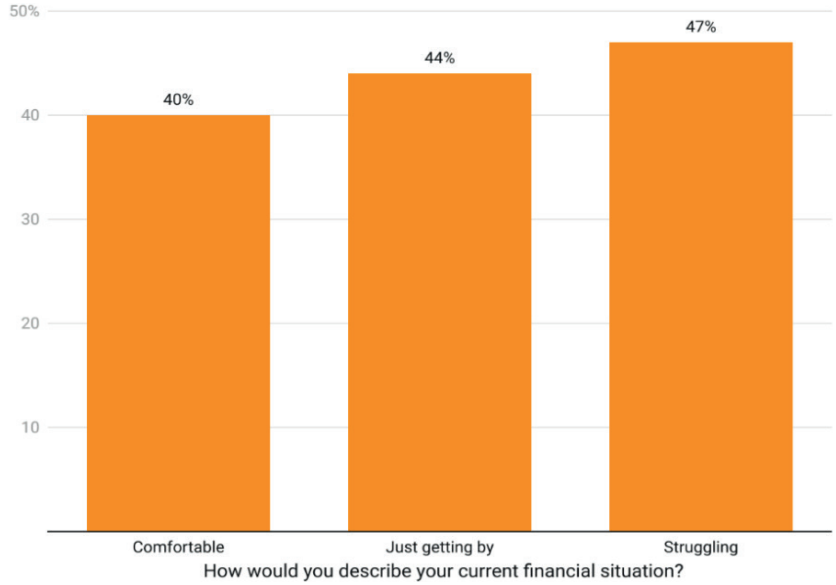


Figure 2 - Importance of improved NHS Dentistry by self-reported income: "which of the following changes to the NHS would be most important to you? "Better access to NHS dentists". (%)[74]



74. https://policyexchange.org.uk/wp-content/uploads/A-Portrait-of-Modern-Britain-Health.pdf

There is long-term and cross-party recognition of the crisis in NHS dentistry

NHS dentistry is – according to the Health Secretary – at "death's door"[75]. Whilst the Health Select Committee has recently concluded[76] that:

> *"NHS dentistry is facing a crisis of access, resulting in a decline in oral health. The Government needs to undertake urgent and fundamental reform if people are to receive the dental and oral healthcare they need. It is frustrating to have to return to recommendations made by our predecessor Committee fifteen years ago that still haven't been implemented."*

More recently the Chancellor of the Exchequer has expressed concerns[77] about access to dentistry and a lack of consumer knowledge and difficulties in securing treatment for children through NHS supported dentistry – all of which are symptoms of the market distortion caused by the way in which NHS dentistry is delivered.

While scepticism has been expressed in dentistry about the value of an investigation into a market in which the Government plays such a substantial role in determining prices and revenues[78] there is ongoing recognition in the sector of the scale of the issues with NHS dentistry and their impact on oral health[79] and an appetite for reform.

There have been numerous attempts to tweak the system and to address these problems but always within the context of the NHS England dental contract, rather than considering more fundamental alternatives.

The Practice Managers Association (PMA) have also confirmed to Policy Exchange that amongst their members there are considerable concerns about the way in which NHS funded dentistry works in England. Concerns include that the remuneration model is not financially sustainable, that people in their areas are not seeing a dentist often enough and that the restrictions in the NHS England dental contract are contributing to stress and burnout amongst dentists. The PMA also confirmed that there would be significant interest amongst their members in moving to a new funding model.

75. https://www.independent.co.uk/news/uk/wes-streeting-nhs-mps-british-dental-association-prostate-cancer-b2675140.html
76. https://committees.parliament.uk/publications/40901/documents/199172/default/
77. https://www.thetimes.com/uk/healthcare/article/rachel-reeves-private-dentist-fees-vp9d8zdzr
78. https://www.bda.org/news-and-opinion/news/chancellor-s-call-for-inquiry-into-private-dentistry-utterly-perverse/
79. https://dentistry.co.uk/2025/11/19/government-orders-investigation-into-costs-and-practices-of-private-dentistry/

Pulling Teeth: Policy background

Timeline

Year	Policy Development
1948	**Establishment of the NHS and the General Dental Service (GDS)** • The National Health Service Act (1946) led to the creation of NHS dental services, initially providing free dental care. • Dentists operated as independent contractors. • 94% coverage[80]. • Rapid reduction in prices paid after early surge in demand.
1950s	**Introduction of Patient Charges** • Due to the high demand and costs, charges were introduced for dental treatments. • 1951: Charges introduced for dentures. • 1952: Charges introduced for other treatments.
1990	**Revised Dental Contract** • Introduced registration for adult patients. • Introduced capitation payments for treating children up to 16. • Aimed to promote preventive care. • Clawback of profits.
1990s	**Due to overspending on the dental budget, in the early 1990's there was a reduction in the fees paid to dentists for treatments.**
2006	**New NHS England General Dental Service contract** • Shifted from "fee per item" to "units of dental activity" (UDAs). • This changed how dentists were remunerated, moving

80. https://dentistry.co.uk/2018/09/19/nhs-dentistry-throughout-years/

	away from a system that heavily incentivised individual treatments. • Personal Dental Service contract added in 2008 to cover certain services based on a performance metrics. • Intended as a temporary solution – remains in place 20 years later.
2020s	• Commissioning of NHS dental services was transferred from NHS England regions to integrated care boards. • Succession of incremental measures and subsidies to incentivise more dentists in England to provide NHS dentistry and to allow some dentists to increase provision.

In the early days of the NHS, despite provider concerns about price complexity, fees reimbursed by the NHS for dental treatment were sufficiently generous that by the end of 1949 94% of dentists registered to provide NHS services[81] and in its first year, NHS dentistry outspent general practice. This resulted in rapid reform leading to significant reductions in fees for top-earning dentists.

Further changes took place in 1951 with the introduction of charges for dentures (leading to the resignation of the then Health Minister Nye Bevan MP[82]) and the following year to dental services.

Because of concerns about the spiralling costs of dentistry and in an effort to promote preventive care, a requirement for people to register with a dentist was introduced in the Revised Dental Contract in 1990. This reform, reductions in dental fees and clawbacks saw a significant fall in the percentage of dentists undertaking NHS work over the following decade.

In a bid to address some of the challenges around provision, and intended initially as a short-term measure, the Government in 2006 introduced the NHS dental contract in England which removed the requirement to register, and which moved away from the increasingly complex fee-per-item system to a payment by Units of Dental Activity (UDA). With relatively minor adjustments this has remained the basis of NHS dentistry ever since.

The NHS Dental Contract in England

Under the current NHS dental contract in England, introduced in 2006, dental providers are required to agree in advance to complete a set amount of dental activity per year for the NHS, measured in Units of Dental Activity at the prices set out earlier in the paper. Commissioners can then 'claw back' money from providers that under-deliver. Providers have little scope to provide more activity, even if they have the capacity and time to do so[83].

The NHS dental contract in England has been criticised by professionals, unions, and the Government. Dental groups have argued it is inflexible

81. https://dentistry.co.uk/2018/09/19/nhs-dentistry-throughout-years/
82. https://www.nationalarchives.gov.uk/education/resources/fifties-britain/aneurin-bevan-resigns/
83. https://www.legislation.gov.uk/uksi/2005/3361/contents/made

and does not fairly reward dentists for seeing more complex and time-consuming patients[84].

As part of a series of reforms announced in July 2022, the Government said they would allow high performing practices to provide up to 110% of their agreed activity[85].

Up until 2023, NHS England was responsible for commissioning dental care services. However, in April 2023, the responsibility for commissioning was delegated to England's 42 Integrated Care Boards (ICBs). These organisations are responsible for allocating budgets, setting priorities, and contracting dental providers to deliver services that cater to the oral health needs of their local populations.

In May 2023, the Government introduced legislation enabling commissioners to amend dental contracts where practices do not deliver agreed activity over three consecutive "non-COVID-19 years" and to move the activity to another provider[86].

The Public Accounts Committee found that Government's Dental Recovery Plan announced in 2024 had not succeeded in delivering the 1.5 million additional courses of treatment DHSC had hoped it would and estimated that 3% fewer patients saw an NHS dentist since March 2024 while recruitment incentives had a disappointing impact and some of the initiatives have now been abandoned[87].

The trend of reducing dentist participation in NHS dentistry in England, thereby reducing availability to patients and the continued failure of modifications to the contract structure, is clear. It has proved consistently difficult to balance set prices, volumes and subsidies in a way which both controls costs and ensures adequate availability of dental services. There is clearly a case for more far-reaching reform of NHS dentistry in England.

84. https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/964/report.html
85. https://questions-statements.parliament.uk/written-statements/detail/2022-07-19/hcws223
86. https://www.legislation.gov.uk/uksi/2023/554/introduction/made
87. https://committees.parliament.uk/publications/47347/documents/245396/default/

Checking Up: Approaches in Other Countries[88]

In most other comparable countries, including in countries with comprehensive public health systems in which healthcare is largely free at the point of use, dental treatment is covered at least in part by a system of co-payment and/or dental insurance for adults. Very few jurisdictions attempt to both subsidise dental costs and to control dental prices.

It is standard practice for some degree of free provision to be available for children (of differing ages) but much less usual for free dentistry to be provided to other groups.

Some degree of subsidy and/ or incentives to take out dental insurance is however found in most systems.

In most comparable countries, dentists are private providers, but there are a few examples of state or regional government provided services.

Country	Commentary
Australia 	• Roughly half of the Australian population buys private supplementary insurance to pay for dental care and other health services. There are financial incentives to encourage this with the Australian federal government working in partnership with states and territories to provide rebate towards some costs and imposing a tax penalty for higher earners that do not purchase private insurance. • Dental providers are predominantly independently owned and able to determine their own prices, though there is a limited network of dentists managed at a state level alongside other health services. • Children's dental care is funded by the Australian federal government. • The latest available data shows that 53% of adults in Australia visit a dentist each year[89].

88. https://www.commonwealthfund.org/international-health-policy-center/countries

89. https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/patient-experience

Canada 	• Approximately two-thirds of the population have private health insurance which covers dental care with contributions towards premiums usually being made by employers, unions and other organisations. • The remaining population is covered by dental provision to targeted groups including those on low incomes. This is run at a provincial level with some variations between local policies. • The vast majority of dental services are privately run and able to determine their own prices though provinces publish guide price lists which are not enforceable. • The latest available data shows that 65.7% of adults in Canada visit a dentist each year[90].
Denmark 	• Dental services for children under 18 are fully funded by local government. • A combination of funding sources, including a public subsidy of up to 60%, insurance payments and out-of-pocket expenses fund adult dental care. • The majority of dentists in Denmark are private businesses and able to determine their own prices for most services (though standard prices for basic diagnostics are agreed by the dental trade association and government), though some are employed or funded by regional government. • The latest available data shows that 60% of adults in Denmark visit a dentist each year[91].
France 	• The majority of the French population have supplementary health insurance (mutuelle or complémentaire santé) which includes dental insurance, which supplements limited and specified dental reimbursement rates under Statutory Health Insurance. Together with out-of-pocket payments these provides the overwhelming majority of dental funding in the country. • This insurance has significantly grown in popularity in recent years, with an accompanying decline in out-of-pocket contributions. • Free dental care is however provided for the very lowest earners.

90. https://www150.statcan.gc.ca/n1/pub/82-003-x/2024004/article/00001-eng.htm

91. https://www.dental-tribune.com/news/irregular-dental-visits-and-deteriorating-periodontal-health-in-denmark/#:~:text=In%20the%20study%2C%20the%20researchers,the%20disease%2C%E2%80%9D%20he%20added.

	• Although most dentists operate within the public healthcare system, they are free to determine their own prices above government tariffs and to charge accordingly. • The latest available data shows that 64% of adults in France visit a dentist each year[92].
Germany 	• Preventive dental care and check-ups are covered by Statutory Health Insurance in order to encourage prevention, early treatment and diagnosis and there is a co-payment system including out-of-pocket contributions for other dental treatment. • Germany has a mixed model of dental provision, with many operators working within statutory criteria and charges while others offer purely private services. • Germany has one of the highest rates of adult dental visits – with the latest available data showing that 82.2% of adults in Germany visit a dentist each year[93].
Israel 	• In order to reduce health inequalities, National Health Insurance has recently been extended to cover the cost of dental care for children under the age of 18 and for adults over the age of 75. • Dental care for all other age groups is excluded from the NHI but a limited degree of preventive dental support is available. • Out-of-pocket contributions are a major source of funding for dentistry with 22.5% of all out-of-pocket healthcare expenditure being for dental services. • Most dental clinics are privately operated and able to determine their own prices. • The latest available data shows that 47.2% of adults in Israel visit a dentist each year[94].
Italy 	• Dental funding is generally not covered by public health insurance, except for children through age 16 and certain other groups considered vulnerable or in severe financial circumstances or in emergencies. • Dental care is one of the biggest out-of-pocket health costs. • The vast majority of dentists are private providers and able to determine their own prices.

92. https://www.lek.com/sites/default/files/insights/pdf-attachments/2181-French-Dental-Care-Investment.pdf
93. https://pmc.ncbi.nlm.nih.gov/articles/PMC10812290/#:~:text=Introduction,high%20educational%20level%20(87.0%20%25)
94. https://link.springer.com/article/10.1186/s13584-019-0312-x

	• The latest available data shows that 37.9% of adults in Italy visit a dentist each year[95].
Japan 	• All Statutory Health Insurance plans must include dental care in their standard package and the government has a long-standing ambition of increasing dental treatment and prevention. • The Central Social Insurance Medical Council sets prices on a per-item basis for dental treatment which most of the country's private dental providers adhere to. • The latest available data shows that 52.9% of adults in Japan visit a dentist each year[96].
Netherlands 	• The Netherlands has a compulsory insurance-based system for all citizens over 18 but dental cover is not part of the basic plan.[22] • Dental services are instead funded out of additional voluntary insurances which about 84% of adults choose to sign-up to. • Children up to 18 receive check-ups and basic dental care, free of charge. • While dentists in the Netherlands are mostly private practitioners, their fees are regulated by the Dutch Healthcare Authority (NZa) and the same throughout the country.[25] • The latest available data shows that about 80% of adults in the Netherlands visit the dentist every year[97].
New Zealand 	• The publicly funded health system covers dental costs for school children but not for adults, although there has been considerable political debate in New Zealand about extending dental care. • There is however some support for emergency dental care in hospitals, but co-payments are usual. • The vast majority of dentists are private providers and able to determine their own prices. • The latest available data shows that 49% of adults in New Zealand visit the dentist every year[98].

95. https://www.istat.it/wp-content/uploads/2015/07/EN_Dental_care_2013_1.pdf
96. https://pmc.ncbi.nlm.nih.gov/articles/PMC9518108/
97. https://pmc.ncbi.nlm.nih.gov/articles/PMC11066141/
98. https://roadmap.nzda.org.nz/roadmap-sections/5-workforce#:~:text=The%202022/23%20New%20Zealand,and%201.8%25%20respectively%20in%202024.

Norway 	• Parliament regularly reviews which health services are covered by public health insurance but currently they include dental care for children up to age 19, for people with chronic diseases, for nursing home residents, and for other prioritized groups, as well as partial dental coverage for young adults ages 19 and 20 and dental braces for children. There is some limited dental support available for young people aged 19-24. • The vast majority of dentists are private providers and able to determine their own prices. • The latest available data shows that 77% of adults over 20 in Norway visit the dentist every year[99].
Singapore 	• Most dental services are privately provided and paid for out-of-pocket, often using Medisave funds. • Publicly owned dental clinics offer basic dental services at subsidised rates for older people and those on government support schemes while private providers have more freedom over the prices they charge. • The latest available data shows that 53.9% of adults in Singapore visit the dentist each year but that 60% did not use their government dental subsidies[100]. • Singapore's dental system is very well regarded and has a strong focus on prevention.
Sweden 	• There is significant regional variation in the dental support provided – though most schemes cover funding for dental care for young people up to the age of 23. There is also a limited national subsidy available for adults. • Dental care is one of the largest areas for out-of-pocket health spending and only 13% of adults in Sweden have private dental insurance. • There is a mix of private and public (local government owned) providers, but all are free to set their own prices. • The latest available data shows that 54.8% of adults in Sweden visit a dentist each year[101].

99. https://www.sciencedirect.com/science/article/pii/S0020653921001362#:~:text=-Supplementary%20analyses%20using%20survey%20data,regular%20checkups%20every%202%20years

100. The oral health landscape in Singapore: A commentary on key features, challenges and future policies - PubMed

101. https://pmc.ncbi.nlm.nih.gov/articles/PMC6706393/

Switzerland 	• Compulsory Health Insurance does not cover dental care for adults, but children have funding for check-ups provided through government funding but not for more extensive treatment. • There is a uniform pricing structure in place with points awarded according to complexity of dental activity – but dental providers are free to determine their own charges for each point. • The latest available data shows that 80% of adults in Switzerland visit the dentist each year[102].
Taiwan 	• National Health Insurance covers basic dental care but not orthodontics and prosthodontics. • The vast majority of providers are private. They tend to charge within NHI determined rates for basic dental care but are free to set their own charges for more complex treatment. • The latest available data shows that 43.2% of people over the age of 15 in Taiwan visit the dentist each year[103].
United States 	• While there are a small number of state and federal funding programmes the overwhelming majority of dental funding in the US is private. • Most dental services are paid out-of-pocket or through private dental insurance – dental insurance is valued by many employers. • Dentists are private enterprises and able to determine their own prices. • The latest available data shows that 65.5% of adults in the USA visit the dentist each year[104]. • Dentists are in the main private companies and there is a strong ethos of quality and innovation.

102. https://pmc.ncbi.nlm.nih.gov/articles/PMC11758681/
103. https://pmc.ncbi.nlm.nih.gov/articles/PMC11725083/
104. https://www.cdc.gov/nchs/fastats/dental.htm

Filling the Gaps: An Alternative Approach

Instead of seeking further tweaks to a system of NHS funded dentistry in England which has consistently failed – and which successive attempts to modify have also failed – we propose a new approach which will deliver increased choice and access for patients, more certainty for dentists, savings to the wider health system and improved dental health.

Fundamentally, the policy proposed here would make sure that NHS dental support in England was available to everyone, not just the lucky few – providing financial support towards dental care for adults and extending dental care to far more children.

Crucially, the new market based approach would unlock dental supply across the country and allow everyone to be able to access dental services at a rate which was commercially sustainable in their area.

Rather than a complex system of Government payments to dentists by Units of Dental Activity within agreed volumes, subsidising controlled and commercially unsustainable prices, we are proposing an alternative which replicates some of the focus on prevention seen in several of the jurisdictions examined above and which recognises the reality and necessity of price variation.

We are proposing introducing a "dental voucher" for adults in England initially worth £150 a year and linked to inflation over time which people would have the option of using towards dental insurance or a dental capitation plan with any Financial Conduct Authority (FCA) registered dental insurer – using all or part of the voucher in that year.

If people prefer, they could also have the option of taking their voucher to any GDC registered dental professional to use towards any clinical (non-cosmetic) dental services they choose.

GDC regulations would also be updated to require that dental professionals must accept these vouchers at their full value.

Dentists would no longer be required to adopt a set of centrally directed prices and would instead be free to adapt pricing according to local market conditions.

This would both lead to an increase in the hours of dental services provided by current dentists and help to reduce movement out of the profession to career breaks, early retirements or career changes.

Crucially, this would mean that the large number of dentists currently not providing dental services to NHS funded patients in England would immediately start to do so and that the "dental deserts" discussed earlier

would be significantly eroded.

Figure 3 – Source MoneySavingExpert (Information sourced from the price comparison website MoneySavingExpert based solely on those policies which include private dental cover, not just NHS England price-controlled services[105].)

SimplyHealth ***Covers:*** *NHS and private treatment.*	£11.55	- £45 for check-ups (100% per claim) - £35 for scale and polish (75% per claim) - £200 for dental treatments (75% per claim) - £500 for dental emergency visits (100% per claim)	3 month qualifying period for treatment, dental accident and emergency.
Boots (Private Dental Plan - Level 1) ***Covers:*** *NHS and private treatment.*	£16.77	- Routine dental treatment, up to £750 - Emergency dental treatment, up to £1,000	3 months *(i)*
WPA (Level 2) ***Covers:*** *NHS and private treatment.*	£17.30	- £250 for general treatment, ie: examinations, x-rays, scale/polish, fillings, canals, etc. (75% per claim, max two claims) - £1,000 dental emergency (75% per claim, max two claims)	30 days
SimplyHealth ***Covers:*** *NHS and private treatment.*	£18.90	- £75 for check-ups (100% per claim) - £65 for scale and polish (75% per claim) - £400 for dental treatments (75% per claim) - £500 for dental emergency visits (100% per claim)	3 month qualifying period for treatment, dental accident and emergency.

As Figure 3 shows, the suggested annual value of a dental voucher would be mid-way between the two most affordable dental insurance policies in the market which cover non-NHS price controlled providers – more than enough to entirely cover the premiums for the lowest cost dental insurance currently in the market (currently £138.60 a year) as well as covering approximately 75% of the second best value (£201.24 a year).[106] In addition, from Policy Exchange's conversations with the industry, we are very confident that new products would be released by the insurers at this price level to cater for increased demand at this level in future.

Allowing patients to use their voucher towards dental insurance products or dental capitation plans, would work out a financially

105. https://www.moneysavingexpert.com/insurance/dental-insurance/ Data from November 2025

106. https://www.moneysavingexpert.com/insurance/dental-insurance/ Data from November 2025

advantageous choice for the NHS in England, effectively outsourcing the risks of treatment, as well as providing greater peace of mind and a greater sense of benefit to each user.

It is worth recalling that most people under existing NHS England dental arrangements, even if they were lucky enough to access a dentist providing NHS funded dentistry, would need to contribute financially to their dental care. With the proposed voucher, the situation changes as set out in the scenarios below. In each case we have adopted prices from two major private dental providers for the treatments. We have not modelled any new products or made any assumptions about existing products rebalancing their benefits more towards private treatment as would inevitably follow from the proposed policy change.

A summary of the scenarios and financial outcomes is set out in Figure 4 with more detailed explanations below. In each scenario the costs quoted for the people taking out insurance include the costs of their insurance policies.

Figure 4 – Situations and financial outcomes summary[107]

	Status quo without access to NHS supported dentistry	Status quo with access to NHS funded dentistry	Person using voucher directly towards dental treatment	Person vou towards cost ins pol
Check-up and light treatment	£126.50	£54.80	No cost	£35
Check-up and fillings	£401.50	£130.10	£251.50	£11
Multiple dental health issues and more extensive treatment	£1058.50	£484.20	£908.50	£76

Scenario 1 – Check-up and light treatment

In a situation where someone went for a check-up and needed only light treatment such as a scale and polish they would face the following financial outcomes:

- In the status quo, adults without access to NHS treatment would pay private rates. An average check-up would cost £55.50 privately and a scale and polish £71 – so costs would be **£126.50 for a check-up and a scale and polish.**
- In the status quo if they were able to access NHS subsidised treatment the cost would be **£54.80** for a check-up and scale and polish (two sets of Band 1 treatment.)
- If the voucher was introduced and they chose to take it directly to a dental practice for treatment they would face **no costs** – the £126.50 they would otherwise have paid would be covered in full

107. NB – All prices and policies correct as of November 2025. The data for the NHS price list is source from the NHS website article: 'How much does dental treatment cost'https://www.nhs.uk/nhs-services/dentists/how-much-nhs-dental-treatment-costs/ . The data for private dental prices are sources from two of the market leaders – MyDentist https://www.mydentist.co.uk/patient-information/myoptions-private-dental-care and Bupa Dental https://www.thenaturaldentist.co.uk/pdf/bank-pricelist.pdf. Insurance prices are sourced from the price comparison website MoneySavingExpert based solely on those policies which include private dental cover, not just NHS England price-controlled services.

by the cost of the voucher, leaving £23.50 of the voucher unspent.

- If the voucher was introduced and they used it towards the lowest cost dental insurance policies such as that in line one above[108] £45 in check-up costs and £35 in scale and polish treatments would be covered – leaving £46.50 in costs. Because the insurance cost only £138.60 they would have £11.40 still to spend which could then be deducted – leaving **£35.10 to pay**.
- If the voucher was introduced and they used it towards a more mid-priced insurance product such as the last in Figure 3[109] the check-up costs would be covered as £53.25 of the scale and polish costs, leaving only £17.75 owing. They would only need to pay the additional cost of the insurance over that of the voucher – in this case £76.80 – for a total of **£94.55 to pay**.

Scenario 2 – Check-up and fillings

In a situation where someone ended up going for a check-up and needed a both a scale and polish and two fillings they would face the following financial outcomes:

n using cher s lowest surance licy	Person using voucher towards more mid-priced insurance policy
5.10	£94.55
7.60	£143.80
7.10	£606.55

- In the status quo, adults without access to NHS treatment would pay private rates. An average check-up would cost on average £55.50 privately, £71 for the scale and polish and each filling £137.50 – so costs would be **£401.50 for a check-up, scale and polish and a two fillings.**
- In the status quo if they were able to access NHS subsidised treatment the cost would be £27.40 for the check-up, £27.40 for the scale and polish and £75.30 for the fillings (as two fillings count as one NHS course of treatment – so two Band 1 and one Band 2 treatment) for a total cost of **£130.10**.
- If the voucher was introduced and they chose to take it directly to a dental practice for treatment they would face costs of **£251.50** – that is the situation of someone in the cost of private treatment as set out above minus the £150 voucher.
- If the voucher was introduced and they used it towards the lowest cost dental insurance policies[110] £45 in check-up costs and £35 in scale and polish treatments would be covered as would up to 75% of the cost of the fillings (£192.50) leaving £129 in costs Because the insurance cost only £138.60 they would have £11.40 still to spend which could then be deducted – leaving **£117.60 to pay**.
- If the voucher was introduced and they used it towards a more mid-priced insurance product such as the last one in Figure 3[111] 75% of the cost of dental treatment would be covered (£259.50) as would £75 in check-up costs – leaving £67 owing and they would also need to cover the additional cost of the insurance over that of the voucher – in this case £76.80 – leaving a total of **£143.80 to pay.**

108. https://www.simplyhealth.co.uk/dental-plan
109. https://www.boots.com/insurance/dental-insurance
110. https://www.simplyhealth.co.uk/dental-plan
111. https://www.simplyhealth.co.uk/dental-plan

Scenario 3 – Multiple dental health issues and more extensive treatment

In a situation where someone had more extensive dental issues ended up going for two check-ups and needed more extensive dental work such as a crown, a filling and a scale-and-polish they would face the following financial outcomes:

- In the status quo, adults without access to NHS treatment would pay private rates. Each check-up would cost on average £55.50 privately, resulting in £111 in costs, the scale and polish would cost £71, and the filling would cost £137.50 and the average cost of the crown would be £739 for a total cost of **£1058.50**.
- In the status quo if they were able to access NHS subsidised treatment the cost would be £27.40 for each of the check-ups, resulting in £54.80 in costs, £27.40 for the scale and polish, £75.30 for the filling and £326.70 for the crown (Three Band 1, one Band 2 and one Band 3 treatment) for a total cost of **£484.20.**
- If the voucher was introduced and they chose to take it directly to a dental practice for treatment they would face costs of **£908.50** – that is the situation of someone in the cost of private treatment as set out above minus the £150 voucher.
- If the voucher was introduced and they used it towards the lowest cost dental insurance policies[112] £45 in check-up costs would be covered as would £35 for the scale and polish and up to £200 of the cost of the crown and fillings. Because the insurance cost only £138.60 they would have £11.40 still to spend which could then be deducted – leaving **£767.10 to pay**.
- If the voucher was introduced and they used it towards a more mid-priced insurance product such as the last in Figure 3[113] £400 towards the cost of the dental treatment would be covered, £53.25 towards the scale and polish and £75 towards the check-ups – leaving £529.75 to pay – plus the additional cost of the insurance over that of the voucher – in this case £76.80, leaving a total of **£606.55 to pay.**

It should also be noted that both insurance policies modelled would make a significant contribution towards emergency dental treatment costs and that in some cases the treatment costs outlined might be covered by this if the patient was in pain.

From the above it can be noted that:

- Inevitably, in every case the majority of people who are currently not covered by NHS England funded dentistry would be better off with our proposed vouchers.
- People whose dental needs extend to check-ups, or who need basic hygienist support and cleaning or fillings would be better off with

112. https://www.simplyhealth.co.uk/dental-plan
113. https://www.simplyhealth.co.uk/dental-plan

the voucher used as a means to pay directly for treatment or to pay for the cheapest insurance policy. For example, this option could be taken up by many younger people, people who are aware that they already have good dental health or people on lower incomes.
- They would be even better off than the minority of people currently able to access NHS dental support.
- People who need more complex treatment such as crowns would be better off if they chose one of the insurance policies, particularly the more expensive of those modelled, ultimately arriving at a situation where they were hundreds of pounds better off than many people relying on private provision in the status quo.

People could supplement their vouchers to pay for more expensive insurance or dental capitation plans than those modelled which would cover even more care if they were prepared to do so.

While some people would be better off with the voucher being used towards treatment rather than insurance or towards dental capitation plans, it is likely that many would seek a higher degree of security and would opt towards a form of insurance or capitation to cover them for the higher and more concerning costs.

However, the flexibility of options built into the voucher model means that people would be in a position to choose the dental support option which they felt was most suitable to their individual circumstances.

Children

Currently NHS contracted dentists in England are currently not required to accept children and many children struggle to access a dentist.

Our proposal is to introduce an additional requirement in revised GDC Fitness To Practice Regulations that all GDC registered dentists in England must offer appointments to children in line with required NHS England pay rates. This would ensure that all children would be able to see a dentist.

In relation to funding for children's dentistry it is proposed to retain current NHS England reimbursement arrangements, indexed to inflation over time.

Funding and financial implications (See calculations in Appendix B)

Currently, the NHS ringfenced dental budget for England (net of patient charges) is £3.97 billion[114] and including £0.78 billion of patient income comes to £4.75 billion.

The plan set out here – in which it is proposed to move away from fixed prices and subsidies for NHS dentistry in England– DHSC would be foregoing the £0.78 billion recouped in current patient charges.

As such, the remaining budget is **£3.97 billion.**

Policy Exchange has modelled that the proposed £150 voucher would require £4.05 billion in funding, but that in order to allow

114. https://www.nao.org.uk/wp-content/uploads/2024/11/Investigation-into-the-NHS-dental-recovery-plan-HC-308-1.pdf

sufficient funding for the expanded children's dental care treatment which would follow from the far wider availability the proposed reforms achieve and for the remaining community and hospital dental care needed to cover extreme cases and emergencies.

Policy Exchange estimates[115] that the current cost to the NHS or children's dental services in England is £0.7 billion. This currently provides for 57% of children over a two-year period. **Removing the current restrictions preventing children accessing dental care would surely lead to an increase in uptake – we have factored in a substantial increase to 80% of all children receiving dental care over that period and would assume that the cost would increase to £0.98 billion.**

There would be an additional funding requirement of £1.8 billion to be funded out of the £30.4 billion projected increase in the NHS budget up to 2029[116] or from redirecting recent savings from NHS administration recently announced by the Secretary of State[117].

In the context of the Public Accounts Committee view that current dental funding is only sufficient for 50% of the population, this proposal also represents a very moderate increase for a very significant increase in coverage[118].

These figures would be met within the overall budget outlined above and would in themselves represent a very substantial public policy win for health in terms of prevention and children's wider health.

Advantages of the proposed voucher system

The public policy advantages of this are as follows:

- **Universality** – under the proposed system for NHS funded dentistry everyone would be able to access NHS dental support, returning the system to its guiding principles and ending the postcode lottery in NHS dental support.
- **True free child dental care** – the proposed system would make the theoretical position of children always being able to benefit from free childcare a reality by significantly increasing the number of dentists available to them and making sure that they had a genuine entitlement to be seen by a dentist.
- **Flexibility** – giving people two options over how to use their voucher means that people would have the flexibility to choose the form of dental care which best suits their dental meets and personal situation.
- **Patient led** – rather than a top-down managed system in which administrators attempt to apportion capacity such as "units of dental activity" in advance, the proposed system would see funding following the patient and ensure that there was always an incentive for providers to take on more work and to make themselves more attractive to customers.
- **Innovation** – ending the system of price controls and subsidies and creating a guaranteed market for dental services would

115. Based on an analysis of courses of treatment in https://www.nhsbsa.nhs.uk/statistical-collections/dental-england/dental-statistics-england-202324
116. https://www.england.nhs.uk/long-read/financial-performance-update-6/
117. https://www.gov.uk/government/news/billions-to-be-redirected-back-into-patient-care-with-nhs-reform
118. https://committees.parliament.uk/work/8828/fixing-nhs-dentistry/

be very likely to lead to innovation by dentists and insurers in creating new finance options, plans and service offerings suitable to different customers.

- **Expanded provision** – because of these incentives and the removal of many of the factors which have damaged morale, caused burnout and generally discouraged dentists under the NHS dental contract in England, there would be likely to be a significant reduction in attrition in the profession to early retirement, reduced hours and career breaks. The proposed system would also allow those in receipt of NHS dental support in England to access the increasing number of dentists who would otherwise only providing services to private patients.
- **A bias towards prevention, early diagnosis and early treatment** – because of the option to use the voucher towards the costs of dental treatment and thus to avoid costs associated with check-ups or low-level hygienist support entirely, it is likely that people who are currently reluctant to see a dentist at all would start to do so more often. In addition, many of the insurance and capitation policies available provide support towards regular check-ups and early low-level treatment in a way which the current arrangements for NHS dentistry in England do not. This means not just earlier, less costly treatment and more of an opportunity for dental insurers to incentivise prevention, but also a significant increase in early diagnosis both of dental problems and in other conditions often detected early by dentists in check-ups such as certain types of oral cancer and systemic cancers.
- **Benefits to secondary care** – because of the above hospitals would make significant savings in time and funding for emergency care but also be able to engage earlier on other conditions which were detected. This would also be a significant human benefit to people in terms of reduced pain and suffering.
- **A self-managing system** – creating a clear patient-led incentive such as the one proposed would create a whole secondary set of aligned and dynamic market incentives around pay and conditions for people working in dentistry and more effective local demand in all parts of the country, thereby allowing the profession to respond more dynamically, responding more effectively to current and future demand trends, both saving administrative time and effort and creating a more efficient self-governing system.

Conclusion

NHS dentistry as it is currently structured in England is not delivering for the majority of people, and there is no reason to believe that incremental adjustments to the current system are any more likely to succeed than those witnessed over the past twenty years.

Imposing prices, quotas, subsidies and restrictive contracts have resulted in many dentists declining to undertake NHS work or to reduce the amount of time they spend providing it on the terms and at the price point imposed by the NHS in England, resulting in many dentists choosing to cater entirely to private payers. Any attempts to impose a price lower than market rates are bound to come up against this problem. Certainly, many dentists are finding it increasingly unsustainable to carry out NHS work under the current system and the pressures of the NHS dental contract system in England are contributing to stress and a loss of people from the profession.

The result has been that people find it harder to get appointments with NHS funded dentists, especially in the many "dental deserts."

There is a significant postcode lottery, and large parts of the population do not get either the routine or emergency dental care they need and turn to either dangerous DIY dentistry or end up in A&E with significant and avoidable costs to the NHS.

It is time to return to first principles and to seek a system which gives patients more opportunity to access dental care and which properly incentivises dentists to provide it.

Rather than seeking to manage both supply and demand of dentistry, the Government should end the postcode lottery and instead enable more people to be able to access dentistry on terms (and in locations) which suit them and in a way whereby the same support is available to everyone and not dependent on the luck of where they happen to live.

England is something of an outlier internationally in how public dental services are provided and funded. Insurance models are by far the most popular means of provision, but in countries where there is a political commitment to subsidising dentistry this is not generally done through a price-capping system but through subsidies.

The recommendations set out in this report could potentially benefit an additional 32 million people who are not currently accessing NHS dental services in England as well as securing more targeted support for those who are.

As well as making dentistry more affordable for far more people, increasing the supply of dental provision for more people and incentivising

earlier diagnosis, prevention and treatment and thus achieving a much-needed increase in dental health, there would also be substantial cost and time savings for the broader NHS resulting from improved public health education and early diagnosis of cancers.

There will also be significant savings in the NHS and at the DHSC resulting from significant reductions in the administration cost of the scheme.

Ultimately, the proposals set out in this report are a way of reshaping NHS dentistry in England to be a universal benefit available to all, and of ending the current postcode lottery. It would likely lead to an overall increase in dental health and would leave England with a dental system much closer to the most successful models around the world.

Appendix A – NHS Dental Treatment Costs in England [Reproduced from NHS Website]

The costs of NHS Treatment in England are set out on the NHS website (correct as of November 2025) are as follows:

NHS dental treatment costs in England[119]

NHS dental treatment costs

If you pay for NHS dental treatment, the cost depends on what treatment the dental healthcare professional thinks you need.

The dental professional should tell you how much it will cost before they start any treatment.

Dental treatments are grouped into 3 bands, and each band has a different cost.

If you need a mix of treatments from different bands, you'll pay for the cost of the highest band of treatment you're having.

If you need a mix of treatments from the same band, you'll only pay the band charge once.

Band 1: £27.40

Band 1 can include:

- examination, assessment and advice (a routine dental appointment)
- X-rays, if clinically needed
- putting fluoride on the surface of your teeth
- simple management of gum disease, such as scaling (a thorough clean of your teeth and gums), if clinically needed
- moulds of your teeth, for example to see how your teeth bite together
- minimal adjustments to false teeth (dentures) or orthodontic appliances, such as braces – for example, smoothing rough parts or tightening clasps

Gum treatment including scaling

If your dental healthcare professional says scaling is clinically needed, you can get it on the NHS. It can be done by a hygienist or dental therapist.

Scaling is usually included in Band 1 (£27.40), but extensive treatment,

119. https://www.nhs.uk/nhs-services/dentists/how-much-will-i-pay-for-nhs-dental-treatment/

or treatment for complex gum problems may be charged as a Band 2 (£75.30) treatment.

If the dentist says scaling is not clinically necessary, you'll have to pay for it privately.

Band 2: £75.30

Band 2 treatment includes all items in Band 1, plus it may include:

- fillings
- root canal treatment to treat an infection or inflammation in the centre of your tooth
- removing teeth (extraction) and other oral surgery procedures
- sealant to fill small holes or grooves in your teeth
- adding to your false teeth (dentures), such as adding a clasp or a tooth, or making extensive adjustments, such as relining and rebasing
- a bite-raising appliance to correct your bite (does not include a laboratory-made appliance)
- extensive management of gum disease

White fillings

White fillings are available on the NHS when clinically necessary. For example, if you need a filling in your front teeth, you may be given a white filling.

If the filling is needed in one of your back teeth, a more effective option may be a silver-coloured (amalgam) filling.

Your dentist should explain your options to you. If you'd prefer a white filling, your dentist will be able to advise you about private costs and the risks and benefits.

Root canal treatment

Your dentist should be able to provide root canal treatment, but if you need more complex treatment, they may refer you to another service.

You may be offered the option to get root canal treatment privately as an alternative to getting it on the NHS.

It's your choice whether you have private treatment or are referred to an NHS specialist service, where available.

Wisdom tooth removal

Wisdom teeth can be removed on the NHS when clinically necessary.

Your dentist may be able to remove them or may refer you to a specialist service.

You may also choose to be referred for private wisdom tooth removal.

Find out more about wisdom tooth removal.

Band 3: £326.70

Band 3 treatment includes all items in Bands 1 and 2, plus it may include:

- a type of cap that covers your real tooth (crown)
- restoring damaged teeth with inlays and onlays
- false teeth (dentures) made from plastic or metal
- a fixed replacement for a missing tooth or teeth (bridge)
- orthodontic treatment, such as braces, to improve the appearance, position and function of your teeth
- other custom-made appliances, not including sports guards

Crowns and bridges

You may be offered a metal-coloured crown on a back tooth.

You could discuss alternative options which may be available privately with your dentist, as well as the risks, benefits and costs.

Crowns may need to be replaced in the future.

Orthodontics

Your dentist or orthodontist will decide if you need orthodontic treatment using a standard assessment method. If orthodontic treatment is clinically necessary, you can get it on the NHS.

Your dentist or orthodontist will be able to discuss alternative options if you or your child are not eligible for NHS-funded orthodontic treatment.

Urgent dental treatment: £27.40

You may have urgent treatment at an urgent or emergency dental appointment.

Urgent treatment can include:

- examination, assessment and advice
- X-rays
- dressing of teeth (a temporary filling)
- emergency partial root canal treatment, for example, pulpectomy or vital pulpotomy
- management of a knocked-out tooth or any necessary treatment needed for an injury
- refixing inlays, crowns and bridges
- removing up to 2 teeth
- aftercare, including treatment for infections
- adjustment and alteration of false teeth (dentures) or orthodontic appliances, such as braces
- urgent treatment for severe conditions that come on suddenly, such as ulcers and herpetic lesions
- treatment of sensitive teeth which affects parts of the tooth called the cementum or dentine
- draining a dental abscess and treating any infection
- 1 urgent filling (routine and non-urgent fillings are a band 2 treatment)

You may need further dental treatment after your urgent appointment,

which may have additional costs.

Cost of further treatment

If you have dental treatment but need further treatment within 2 months, you do not have to pay extra if the further treatment is included in the same band, or a lower band.

If you need further treatment in a higher band, you'll have to pay the higher band fee.

You'll have to pay for any further treatment after 2 months has passed.

Dental treatments available for free

You do not need to pay if:

- you're having stitches removed
- your dentist has to stop bleeding from your mouth – for example, after a tooth extraction
- your false teeth (dentures) need to be repaired – but if they cannot be repaired you'll have to pay for new ones

Appendix B – Financial Methodology

The calculations and assumptions made in relation to the financial requirements of this report's proposed voucher for adults and extension of children's dental care are as follows:

1. Funding requirement for adult general dentistry (voucher scheme)

Figure 5 - Current system

Current NHS dentistry budget	£3.97 billion
Patient income	£0.78 billion
Children's dentistry funding requirement	(£0.7 billion)
Secondary dental funding costs	(£1.47 billion)
Adult general dentistry	(£2.58 billion)

Figure 6 - Proposed new system

New NHS dentistry budget	£5.77 billion
Children's dentistry funding requirement	(£0.98 billion)
Secondary dental funding costs	(£0.74 billion)
Funding requirement for voucher	(£4.05 billion)

As the above figures demonstrate, a net £1.8 billion will be required for the new system (including allowing for the loss of patient income). Further detail on each of the costs associated with Children's dentistry, secondary dentistry and the voucher funding requirements is set out below.

It is recommended that this budget requirement be financed out of projected NHS revenue budget increases of £30.4 billion by 2029 or from administrative savings recently announced by the Secretary of State[120].

2. Calculating take-up and usage rates

Determining take-up

- NHS statistics suggest that in England there are 45 million adults eligible for NHS dental support[121].

120. https://www.gov.uk/government/news/billions-to-be-redirected-back-into-patient-care-with-nhs-reform
121. https://www.nhsbsa.nhs.uk/statistical-collections/dental-england/dental-statistics-england-202425

- NICE guidance is that a person has a dental check-up at least once every two years – though currently the majority of people in England do not do so[122].
- Because of the differences in funding models and culture there will inevitably be a degree of uncertainty when modelling how much take-up there would be of the new NHS dental vouchers in England, but it is a safe assumption that it would be significantly higher than the 40% of adults who are currently accessing NHS supported dentistry in England over a two-year period.
- The analysis of dental systems in comparable countries earlier in this report included data on the annual use of dental services by adults as set out in Figure 5.

Figure 7 - Annual visits in other countries

Country	Percentage of adults visiting a dentist every year
Australia	53%
Canada	65.7%
Denmark	60%
France	64%
Germany	82.2%
Israel	47.2%
Italy	37.9%
Japan	52.9%
Netherlands	80%
New Zealand	49%
Norway	77%
Singapore	53.9%
Sweden	54.8%
Switzerland	80%
Taiwan	43.2%
United States	65.5%

- These figures are for dental visits, which is not an exact comparator for take-up of the proposed voucher but is the best available proxy. The mean visit rate amongst these countries stands at: 60.39%.
- There is not a significantly higher take up levels in countries where there is an element of public funding or compulsory social insurance funding towards dental care such as Denmark, Germany, France, Sweden and Taiwan – the average of which stands at 60.84%.
- There are a variety of other factors which influence the likelihood of dental visits. In the all of the top three countries with the highest levels of dental visits (Germany, The Netherlands, Norway and Switzerland) there is a strong culture of prevention in healthcare generally and a long-ingrained understanding that dental health is

122. Policy Exchange calculation based on figures in: https://www.nhsbsa.nhs.uk/statistical-collections/dental-england/dental-statistics-england-202425

a core part of health and hygiene. In addition, in the Netherlands high levels of uptake of supplementary health insurance (which often includes dental cover and is often actively promoted alongside compulsory basic health insurance which does not) has helped to increase the numbers of visits.

- The mean visit rate amongst the top half of these countries stands at **71.8%**.

Figure 8 - Take-up levels of other benefits

Benefit	Take-up
Attendance Allowance[123]	68.6%
Broadband social tariff[124]	10%
Carer's Allowance[125]	65%
Child Benefit[126]	88%
Council Tax Support[127]	62%
Free Bus Passes for older people[128]	73%
Free School Meals[129]	87%
Free TV licences[130]	74%
Healthy Start[131]	64%
Housing Benefit for Pensioners[132]	79%
Pension Credit[133]	65%
Universal Credit[134]	77%
Warm Home Discount[135]	41%
Water social tariffs[136]	35%

- It is also possible to gain insight into potential take-up rates by analysis of the take-up of other benefits in the UK as set out in Figure 6.
- The mean for these benefits is just over 63.47% but there is a very significant variety in circumstances and delivery mechanisms employed for each of these benefits.
- Two of these benefits which represent purely a ringfenced benefit (ie which are not tied to a financial payment) and which may therefore represent the closest approximations to the voucher are Free TV Licences (74%) and Free Bus Passes for older people (73%) – the average of these two benefits is **73.5%**.
- In addition, the mean take-up rate amongst the top half of these benefits is **76.94%.**
- Based on these figures as well as those above in relation to dental visit rates in other countries these calculations have adopted for take-up rate at **75%.**
- This would be a combination of people using the full value of the voucher towards dental insurance premium contributions or dental capitation plans and others who use only part of the value towards dental care.

123. https://policyinpractice.co.uk/wp-content/uploads/2024/10/Unclaimed-Attendance-Allowance_report-by-Policy-in-Practice-for-MSE_Dec23_compressed.pdf
124. https://policyinpractice.co.uk/wp-content/uploads/2025/09/MO25-24bnUnclaimed-PolicyinPractice-Sept25.pdf
125. https://policyinpractice.co.uk/wp-content/uploads/2025/09/MO25-24bnUnclaimed-PolicyinPractice-Sept25.pdf
126. https://www.gov.uk/government/statistics/child-benefit-statistics-annual-release-august-2024/child-benefit-statistics-annual-release-data-at-august-2024#:~:text=Figure%204:%20The%20percentage%20of,May%202014%20to%20May%202024&text=Key%20points%20to%20note%20from,effect%20in%20pushing%20down%20claims
127. https://policyinpractice.co.uk/wp-content/uploads/2025/09/MO25-24bnUnclaimed-PolicyinPractice-Sept25.pdf
128. https://assets.publishing.service.gov.uk/media/61816cd3e90e0719764890b8/concessionary-travel-statistics-year-ending-march-2021.pdf (latest available data)
129. Estimate of additional children claiming Free School Meals following expansion of eligibility, Reporting year 2025 - Explore education statistics - GOV.UK
130. https://policyinpractice.co.uk/wp-content/uploads/2025/09/MO25-24bnUnclaimed-PolicyinPractice-Sept25.pdf
131. https://policyinpractice.co.uk/wp-content/uploads/2025/09/MO25-24bnUnclaimed-PolicyinPractice-Sept25.pdf
132. https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/reports-and-briefings/money-matters/benefit-take-up-briefing-may-2024-.pdf
133. https://policyinpractice.co.uk/wp-content/uploads/2025/09/MO25-24bnUnclaimed-PolicyinPractice-Sept25.pdf
134. https://policyinpractice.co.uk/wp-content/uploads/2025/09/MO25-24bnUnclaimed-PolicyinPractice-Sept25.pdf
135. https://policyinpractice.co.uk/wp-content/uploads/2025/09/MO25-24bnUnclaimed-PolicyinPractice-Sept25.pdf
136. https://policyinpractice.co.uk/wp-content/uploads/2025/09/MO25-24bnUnclaimed-PolicyinPractice-Sept25.pdf

- These calculations therefore are for the voucher is used by 33.75 million adults (i.e. 75% of those eligible)

Usage rate

- The calculations behind this policy are also worked on the basis of an 80% usage rate amongst those who do take it up (i.e. 20% on average of a voucher goes unspent because some people are not using the full value either towards insurance capitation or treatment.)
- This would reflect the circumstances in which either someone uses the voucher directly towards only minor dental treatment – e.g. one or two check-ups a year, or those in which someone employs the voucher towards the cheaper dental insurance policy and assumes a higher take up at the of the higher voucher value utilisation options.

Figure 9 – Voucher usage rates

Usage	Percentage of voucher used
Payment towards one check-up - £55.50 average spend	37%
Payment towards two check-ups - £111 average spend	72%
Payment towards lowest cost dental insurance - £138.60	92.4%
Payment towards more expensive dental insurance	100%

As such the impact on costs is as follows:

Figure 10 – Voucher funding requirements

Eligible adult population	45 million
Of which take up the voucher (75%)	33.75 million
Value of voucher	£150
Of which used on average (80%)	£120
Total cost of scheme	£4.05 billion

3. Savings from secondary dentistry provision

NHS hospital and community dental costs, that is mostly the failure demand caused by the lack of available dental diagnosis and treatment earlier, stand at £1.47 billion in England.[137]

As such the calculations behind this proposal have modelled for a 50% reduction in these costs to **£0.74 billion** because of avoiding failure demand through earlier diagnosis, prevention and treatment and also in recognition of the significant contributions which would be made under

137. https://www.nao.org.uk/wp-content/uploads/2024/11/Investigation-into-the-NHS-dental-recovery-plan-HC-308-1.pdf

many dental insurance policies towards dental treatment costs in accidents or emergencies.

This will ensure that provision is still in place for exceptional circumstances which require hospital or emergency treatment.

4. Children's dentistry

Policy Exchange estimates[138] that the current cost to the NHS or children's dental services is £0.7 billion. This currently provides for 57% of children over a two-year period. **Removing the current restrictions preventing children accessing dental care would surely lead to an increase in uptake – accordingly the calculations behind this proposal have factored in a substantial increase to 80% of all children receiving dental care and would assume that the cost would increase to £0.98 billion.**

138. Based on an analysis of courses of treatment in https://www.nhsbsa.nhs.uk/statistical-collections/dental-england/dental-statistics-england-202324

£10.00
ISBN: 978-1-917201-84-1

Policy Exchange
1 Old Queen Street
Westminster
London SW1H 9JA

www.policyexchange.org.uk