Dental Workforce Issues in the United Kingdom

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The purpose of this article is to discuss some of the issues we are facing within the United Kingdom with regard to the dental workforce. It is a very personal view influenced by the projects I have worked on over the last two years. This overview will look at what is happening in the UK in terms of population demographics and dental treatment patterns, and I will pose some questions as to how the issues might be addressed. There have been several reports on this subject published in the UK, and I will briefly review this work. I will then try to set the information in the European context and look at the female perspective on what is happening.

Demographic and Oral Health Changes

The Government Actuary has predicted that the population of the UK is set to increase from 59.2 million in 1998 to 63.6 million in 2021 and just under 65 million in 2040. It is predicted that 50 percent of this growth will be from inward migration. It is not known and is very hard to predict what the oral health of those migrating will be. There will be a reduction in the number of people aged under sixteen and an increase in those aged over sixteen with a particular increase in those aged over sixty-five. There has been a very dramatic improvement in the oral health of the population over the last thirty years and correspondingly marked changes in the treatment provided. For example, data from the Scottish Dental Practice Board shows a reduction in the mean number of extractions per practitioner from over twenty-five to around five per week. In contrast, the national Adult Dental Health Survey found that in the ten years from 1988 to 1998 the proportion of the population with one or more crowns increased from 26 to 34 percent.

In summary, therefore, it can be seen that the population is increasing and aging. At the same time there are more people with more teeth and the treatment patterns are changing. It is also important to note that there are important variations both in disease levels and in treatment patterns according to levels of deprivation.

How Many Dentists Do We Need?

The problem of accessing dental services has become more acute and is an issue of importance to politicians because they are receiving correspondence from the public on the issue. Thus, Scotland, Wales, and England have all sought to answer the question “How many dentists do we need?” We must also ask: should we be looking at dentists, or should we be looking at other types of personnel?

In trying to answer these and other questions, two very useful reports were published in Scotland. They identified factors that were or would influence the demand of the public for treatment and the factors influencing the supply of the dental workforce. The factors they listed as influencing demand were:

- increased demand for all health services,
- increasing proportion of elderly,
- increasing number with natural teeth,
- increased number of retained natural teeth,
- increasing number of complex treatments,
- increasing public expectations,
- increasing proportion of children with untreated decay,
- reduction in oral disease, and
- technological changes.

The authors of these reports concluded that most, but not all, of these factors would increase the
demand for dentistry. Those factors that were likely to influence supply were:
• predicted decline in numbers of registered dentists,
• increased early retirements,
• increased part-time working, in non-National Health Service working,
• increased proportion of women,
• reduction of UK dental graduates,
• loss of dental workforce to other countries,
• overseas graduates,
• increase in those from EU,
• working time directives, conditions of service,
• dissatisfaction with working conditions,
• lack of Professions Complementary to Dentistry (PCDs), and
• requirements of clinical governance and lifelong learning.

Again the conclusion was that most of the factors were acting to reduce supply. Similar work in Wales and in England also reported that there was likely to be an increase in demand and a reduction in supply leading to increases in problems of gaining access to dental services.

Within the UK, the profession has shown a marked feminization with at least 50 percent of dental students being female. It has been reported that women work fewer hours and work fewer days than men and have a lower output. What has not been investigated is whether women’s working pattern is more appropriate. This is an area that requires more detailed research. Younger men are also choosing to work fewer hours, and from both groups there is a demand for more salaried (employed) positions rather than former generations that were happy to own and run their own practices.

How to Increase Supply

At the most basic level, there are several ways in which the situation might be improved. Various methods might be used to increase the number of dentists either by training more, acting to delay retirement, or trying to import dentists from overseas. Similarly, action might be taken to increase the number of hygienists and therapists, but due to the existing small numbers, this would have to be by training more. Productivity might be increased but with most of the factors operating to reduce productivity, it is unlikely that this might be achieved except by increasing working hours and there are barriers to doing this. Alternatively, it might be possible to move to a more evidence-based approach by identifying and reducing any treatment shown to be unnecessary or ineffective. Finally, attempts might be made to reduce demand. England through its program of planned change, “Options for Change,” is attempting to achieve this by introducing alternative methods of working based upon clinical pathways. Wales is looking to similar reforms but is also looking to increase the number of dental students. This must of course be set against a background of decreasing numbers of young people, which may cause difficulties.

Potential Problems

These plans are designed to keep as many dentists as possible working within the National Health Service (NHS). It is not yet clear what incentives there are for practitioners to remain within the NHS. It is possible that, if practitioners feel that their practice is being restricted, they may move into private practice. This might further increase demand and reduce supply, making the workforce situation more difficult than even anticipated.

At first sight, the enlargement of the European Union and the ability of dentists to move freely from one country to another to practice might be seen to be a solution, but it is very unclear whether this is the case. Several other countries in Europe are facing similar problems, but many have considerable resistance to professions complementary to dentistry. In particular, several European countries are facing an aging workforce.

If the situation is to be resolved by increasing the number of dental students, there is another problem. The age profile of dental school staff is such that many will retire in the next ten years, and the staff are not there to replace them. Some schools have plans to move considerable amounts of teaching to primary care-based academic units. Others have discussed opening a new school, but with schools already having problems recruiting academic staff, it is hard to see where they will come from.
Conclusions

Within the UK there appears to be a generalized shortage of both dentists and the whole dental team. Increases in numbers of personnel or changes in the working pattern would be necessary to meet demand. There are plans to try to achieve both of these aims. Workforce planning is complex and, in my opinion, there is no one way of doing it. Workforce planning needs to be an ongoing process and should be amenable to being changed.

REFERENCES