

# **The private dentistry market in the UK**

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## FOREWORD

This report concludes our study into the market for private dentistry, which we initiated following a super-complaint from the Consumers' Association. This is a rapidly developing market, currently worth over £1 billion annually.

Perhaps in part because of its recent growth, we found that the market is in some respects not working well for consumers. For example:

- consumers do not generally have basic information – eg about prices – to make properly informed choices
- in the event that problems arise, ways of seeking redress are often inadequate
- there appear to be some unnecessary regulatory restrictions on how dental services can be provided.

We recommend change on two fronts.

First, the supply of private dentistry needs to be more consumer-oriented. In particular, dentists should do more to inform and explain to consumers their options for treatment and their costs. Better and more effective self-regulation should help to achieve this and reassure consumers that standards are being met. In turn the Office of Fair Trading will produce guidance to help consumers get the information they need to make good decisions.

Second, the way that services are provided should be liberalised, subject of course to the maintenance of proper safeguards on service quality. Lifting regulatory restrictions on some of the professions and the organisations that may practice the business of dentistry would allow the public to be served in new and more innovative ways. Some deregulatory change to this end is already in hand; we think it should go further.

We are therefore making recommendations to achieve better self-regulation by dental professionals and the General Dental Council, and we are recommending some measures of deregulation to the Government. The result should be a market that serves consumers better.

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# 1 SUMMARY AND CONCLUSIONS

## Introduction

- 1.1 This market investigation was undertaken in response to a super-complaint from the Consumers' Association in October 2001<sup>1</sup>. The Consumers' Association highlighted six problem areas: a lack of price transparency, a failure of competition, little impact from new entrants to the market to trigger greater competition, the absence of a complaints system, a reduction in competition because of problems with access to NHS dentistry, and a failure to comply with professional guidance.
- 1.2 Our preliminary study of the market concluded that there were strong grounds to investigate further. On 23 January 2002 we announced a market investigation under section 2 of the Fair Trading Act 1973. Our work sought to examine:
- the nature and structure of the market and whether this works well for consumers
  - the impact of the regulatory framework
  - the level of consumer information and choice, and
  - consumer complaints and redress procedures.
- 1.3 In carrying out this investigation we:
- consulted widely with dental professionals, key organisations including the General Dental Council (GDC), trade and professional organisations, consumer groups, the Department of Health (DH), and the devolved administrations in Northern Ireland, Scotland and Wales
  - carried out surveys of consumers (2000 interviews), dental practices (850 replies) and undertook a 'mystery shop' of 750 dental practices
  - commissioned a report on the evaluation of the role of clinical decision making in the need and demand for dentistry from Professor Elizabeth Kay, at the University of Manchester Dental School, and
  - undertook an international study looking at how markets for dental services operate in some other countries, particularly the Netherlands.

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<sup>1</sup>Super-complaints enable designated consumer bodies to refer feature(s) of markets that are, or appear to be, significantly harming consumers' interests to the OFT for fast-track consideration. Chapter 2 explains this in more detail.

## Findings

- 1.4 The UK market for private dentistry is expanding rapidly. It grew by over 60 per cent between 1997 and 2001 and is currently valued at over £1 billion, a real terms increase of nearly 50 per cent. Around seven million UK consumers regularly receive private dental treatment. Most private dentistry is provided by dental practices that also provide National Health Service (NHS) treatment. Only around 200 of the UK's 11,000 practices provide no NHS treatment at all.
- 1.5 The rapid growth in the market reflects both the demand for services not otherwise available through the NHS (such as teeth whitening) and the availability of NHS treatment itself. The availability of NHS dentistry has also been influenced by the attractiveness of private dentistry to dentists in areas where the growth of incomes has enabled them to have a higher proportion of private patients and reduce the extent of their involvement in NHS provision. We anticipate that demand for private dentistry will continue to grow.
- 1.6 Our work suggests the market is not working well for consumers. In part, this reflects its very rapid growth from a small market: neither consumers nor practitioners have fully adjusted to the changes inherent in the switch from NHS to privately provided dentistry. This lack of adjustment is partly responsible for some of the problems in the market. The most significant of these are:
- consumers lack information necessary to make informed choices
  - should things go wrong, procedures for dealing with complaints are often inadequate
  - regulations may impose unnecessary restrictions on the business of dentistry.
- 1.7 In addition we examined whether consumers experience any unnecessary difficulties in changing dentists. We have reason to think that consumers rarely take copies of their dental records with them when they change dentists. It would be advantageous to them if they did so.
- 1.8 It is in the nature of a professional service such as dentistry that the supplier is more knowledgeable than the typical consumer, most obviously in relation to dentistry as a science and a clinical activity. This does not diminish the consumer's need for basic market information. In dentistry there is, however, an information gap which shows itself in a number of ways. It is difficult to get information about the differing price and quality of services offered by various dental practices. It is not always clear to consumers what services are available

under the NHS. Furthermore, it is difficult for consumers to judge the quality of treatment received, and there is a lack of universal quality assurance procedures.

- 1.9 Without this information consumers can find it difficult to make informed choices in selecting a dental practice, in making decisions about proposed treatment and payment options, and in judging the quality of service provided.
- 1.10 Most, if not all, of this information should be provided as a matter of course by dentists. Indeed, the GDC, the statutory regulatory body for dentistry, states in its guidance<sup>2</sup> that dentists should provide adequate information to patients on treatment and other costs. This includes:
- ensuring that the cost of initial consultation and of probable costs of treatment are made clear before treatment (with written plans particularly for extensive or expensive treatment)
  - explaining proposed treatment and any alternatives, and obtaining appropriate consent from patients
  - ensuring that patients receive an itemised account of their treatment
  - not giving incorrect information to persuade patients to accept private treatment and ensuring that patients know whether they are being charged under the NHS or privately.
- 1.11 However, it is clear from our work that the guidance in relation to these points is not generally adhered to. Our consultations and surveys show that compliance with the guidance is not routinely monitored, and that many dental practices are not following it. Furthermore, there are additional areas of concern and potential improvements that are not currently covered by the guidance.
- 1.12 Secondly, where consumers are unhappy with the service they have received or believe it to be of poor quality, their ability to complain and seek redress is limited. Unlike the NHS, there is no universal complaints procedure for private dentistry. While many practices do have their own complaints procedures, they are seldom well publicised. This can lead to dissatisfied consumers while leaving dentists unaware of the possible need to change their practices and procedures.
- 1.13 Thirdly, there are regulatory restrictions on the supply of dentistry services, both for professionals complementary to dentistry (PCDs) and corporate dental bodies. PCDs include dental therapists, dental hygienists, and dental

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<sup>2</sup> *Maintaining Standards: Guidance to Dentists on Professional and Personal Conduct*, General Dental Council, 2001

technicians. Certain PCDs can provide some dental services otherwise undertaken by dentists. For example, hygienists can do scaling and polishing, therapists can do simple fillings, however, at present, they are accessible only through the dentist, and the consumer pays the dentist for all services received. PCDs may not carry out what is known as, 'the business of dentistry', that is, they may not charge consumers directly for their services. Corporate dental groups face continuing restrictions on their choice of directors, staffing and activities<sup>3</sup>. Taken together, these various restrictions limit choice, competition and the potential to develop and deliver innovative and better services.

- 1.14 Consumers rarely change dentists. However, should they wish to do so, in addition to the lack of readily available basic information on price and quality, there can be further obstacles, for example in relation to the ease of transfer of copies of their dental records<sup>4</sup>. It can be helpful to the new dentist and the patient if the dental records and radiographs are available. Not all consumers and dentists may know that consumers have the right under the Data Protection Act 1998 to gain copies of dental records and radiographs.

## **Proposed remedies**

### **Improving consumer information**

- 1.15 Consumers need better information if they are to be in a position to make properly informed choices about which dentists and treatments will best meet their needs.
- 1.16 Markets work best when consumers are well placed to help themselves. Dental services, like other professional services, are naturally complex. This makes the provision of basic information to consumers all the more important.
- 1.17 The basic information that consumers need includes:
- the cost, if any, of registering with a practice and having an initial examination
  - the prices for proposed treatments
  - what is available under the NHS, and

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<sup>3</sup> Corporate dental bodies cannot carry on any other business other than dentistry or an ancillary business; the majority of directors must be registered dentists; and all its operating staff must be registered dentists or dental auxiliaries.

<sup>4</sup> The OFT Practice Survey found that only 52 per cent of practices reported they would allow the transfer of patient records to any dentist and a further 15 per cent to another dentist in the same practice. However, when asked to supply information on charges for record transfer only four practices did so.

- an itemised bill.

1.18 In addition to this basic information, the consumer needs to know what the treatment involves and whether there are other options. Here the consumer must rely more on the professional advice of the dentist, in the confidence that professional standards exist and are being adhered to.

1.19 **To promote the provision of this information we are making recommendations for regulation and self-regulation to be strengthened and broadened.** Firstly, the **standards promoted in professional guidance need to be monitored and enforced.** This will provide reassurance to consumers. Secondly, the **professional standards should, in our view, be expanded** to require that dental practices:

- provide indicative prices on a range of relevant services and that these are clearly displayed to consumers
- include itemised costing details in written treatment plans
- display prominently details of what services are available under the NHS and what services the practice provides privately
- refer existing patients who want NHS treatment to the relevant body (this might be the local Primary Care Trust, Health and Social Services Board, Local Health Board, Local Health Authority or NHS Direct) if they stop offering NHS treatment.

1.20 As a complementary measure we will, with the assistance of the health departments and key organisations, undertake a consumer awareness campaign so that consumers of private dental services know what information they need and have a right to expect. This will include examples of the kind of basic information mentioned above. It will also advise consumers that, when choosing a dentist or a treatment, there may be benefits from, for example:

- looking to see whether a dental practice has achieved a dental accreditation
- seeking a second opinion if very expensive or extensive treatment is proposed
- asking about the practice's complaints procedure.

#### **Resolving problems: complaints and redress**

1.21 Consumers have a right to expect their complaints to be taken seriously and for there to be a system to both register and resolve complaints.

- 1.22 The GDC's guidance, *Maintaining Standards*, states that practices should try to resolve complaints within the practice. The GDC endorses the guidance produced by a professional trade body, the British Dental Association, on the handling of complaints.
- 1.23 Consumers would benefit if they knew that all dental practices had a proper in-house complaints procedure of this kind. This should be straightforward, thorough, effective, speedy and confidential. **We recommend that each practice has a complaints procedure and that patients are made fully aware of this when they register with the practice.**
- 1.24 **Where problems cannot be addressed at practice level, we recommend that an independent complaints procedure is instituted.** This would enable consumers of private dentistry to have access to a complaints procedure which is independent of practices, just as consumers of NHS dentistry already have. The DH/GDC is in the process of instituting a complaints procedure for private dentistry that is independent of practices. We support the general principle and urge that such a procedure should be introduced in the near future.

#### **Helping consumers to change dentists**

- 1.25 When consumers change dentist copies of patients' dental records are often not passed on to the new dentist, perhaps resulting in the need for repeat exposure to x-rays. We believe it would help both consumers and dentists if records and radiographs were routinely transferred. **To this end we will highlight consumers' rights under the Data Protection Act 1998 to gain copies of dental records and radiographs.** Under the Act consumers are entitled to access to personal data including their dental records. The Act limits the charges that can be made for making copies. We will highlight further details about this in our consumer campaign.

#### **Lifting unnecessary restrictions on the business of dentistry**

- 1.26 In addition to maintaining a register of dentists, the GDC maintains a roll of dental auxiliaries (dental therapists and dental hygienists). These therapists and hygienists can perform certain dental procedures, for example scaling and polishing. However, dental technicians may only manufacture dental appliances; they cannot fit them for patients. The GDC are considering relaxing this restriction for clinical dental technicians once they have the power to enroll additional classes of PCD. At present, none of these PCDs may charge consumers directly for their services (ie engage in the business of dentistry). The GDC has also been considering proposals to relax this restriction, subject to necessary safeguards to protect consumers' health and safety.

- 1.27 **We support amendment of section 41 of the Dentists Act 1984 to allow selected registered Professionals Complementary to Dentistry to carry out the business of dentistry.** We believe that professionally trained staff should not be stopped from supplying services directly to the consumer that they are able to provide. This relaxation should expand the supply of dentistry services and offer greater choice both to consumers and to those working in the profession.
- 1.28 At present, under the Dentists Act 1984 there is a restriction on the number of corporate bodies which can carry out the business of dentistry, thereby limiting the number of corporate dental chains that can operate in the market. The DH are proposing to remove this restriction and we welcome this initiative. However, there are other restrictions that the DH are not proposing to lift concerning: limiting the business the company can undertake to dentistry or an ancillary business, requiring the majority of directors to be registered dentists, and requiring the operating staff to be registered dentists or dental auxiliaries. Having reviewed the arguments put forward by the DH, we are not persuaded that the retention of these restrictions, at least in their current form, is a necessary or proportionate way to safeguard patients. Preserving them will limit the range and type of businesses which can enter the market, to the potential detriment of consumers
- 1.29 **We therefore recommend that the Department of Health reconsiders the case for restrictions on dental corporate bodies specified in section 43 of the Dentists Act 1984.** It should consider whether in their current form they are the least restrictive way to protect patients.
- 1.30 Our recommendations should be seen as a whole. Measures to improve consumer information, to make self-regulation work effectively, and to lift unnecessary regulation should make the private dental market work better for consumers.

## 2 INTRODUCTION

2.1 This market investigation, which was announced on 23 January 2002<sup>5</sup>, has been carried out under section 2 of the Fair Trading Act 1973. It follows a preliminary investigation of the market, which concluded that there were strong grounds to investigate further.

2.2 The initial investigation was undertaken in response to a super-complaint from the Consumers' Association in October 2001<sup>6</sup>. The Consumers' Association highlighted six problem areas: a lack of price transparency, a failure of competition, little impact from new entrants to the market to trigger greater competition, the absence of a complaints system, a reduction in competition because of problems with access to NHS dentistry, and a failure to comply with professional guidance.

2.3 Our investigation has sought to examine:

- the nature and structure of the market and whether this works well for consumers
- the impact of the regulatory framework
- the level of consumer information and choice, and
- consumer complaints and redress procedures.

2.4 In carrying out this investigation, we have:

- consulted widely with dental professionals and key organisations including the GDC, trade and professional organisations, consumer groups, the DH, and the devolved administrations in Northern Ireland, Scotland and Wales
- carried out surveys of 2000 consumers and 2200 dental practices and undertaken a 'mystery shop' of 750 dental practices, and
- commissioned a report on the evaluation of the role of clinical decision making in the need and demand for dentistry from Professor Elizabeth Kay, at the University of Manchester Dental School and undertaken an

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<sup>5</sup> *OFT launches major investigation into private dentistry: Response to Consumers' Association 'super-complaint'*, OFT Press Notice, PN04/02.

<sup>6</sup> A super-complaint is a new fast-track procedure under the Enterprise Act 2002, where a designated consumer body makes a complaint to the OFT that a feature, or combination of features, of a market in the United Kingdom for goods or services is or appears to be significantly harming the interests of consumers (section 11 Enterprise Act, 2002). Prior to the Enterprise Act coming into force, the OFT agreed to consider super-complaints and respond within 90 days. Any investigations undertaken as a result of a super-complaint are currently initiated under section 2 of the Fair Trading Act 1973.

international study, looking at how markets for dental services operate in some other countries, particularly the Netherlands.

- 2.5 Whilst our remit was to examine private dentistry, since most dental practices carry out both private and NHS work it was necessary to take the latter into account in our investigation.
- 2.6 We understand that some dentists use the term 'independent' to imply a form of so-called 'affordable' dentistry. However, we use the term private dentistry to cover all forms of dentistry that are not provided under the NHS. We also understand that some readers may find the use of the term 'consumer' rather than 'patient' strange. Where we are referring to the financial and commercial aspects of dentistry we use the term 'consumer', where we are mainly referring to the clinical aspects of dentistry we use the term 'patient'.
- 2.7 The following chapters provide background on dentistry in the UK, outline the evidence and problems we found in the market for private dentistry and propose remedies. Chapter 3 outlines the structure of the market and the regulations that underlie it, Chapter 4 examines how the market for private dentistry works and Chapter 5 proposes a variety of remedies which aim to make the market work better for the public.
- 2.8 Details of our methodology, research, relevant legislation, proposed reforms, a glossary and a list of acronyms can be found in the annexes to this report.

## 3 HOW DENTISTRY IS PROVIDED IN THE UK

### The development of private dentistry in the UK

- 3.1 Although our remit was to examine private dentistry, this can only be understood in the context of National Health Service (NHS) dentistry, as most dental practices provide both. Most dentists are independent contractors who choose to undertake varying levels of NHS dentistry or none.
- 3.2 Since NHS dental services were introduced in 1948, the majority of dentistry in the UK has been supplied by General Dental Practitioners (GDPs) who are independent contractors. Private dental treatment was a small proportion of total dental provision until the early 1990s<sup>7</sup>. A fee level dispute at this time, following the introduction of a new NHS contract with dentists, is generally thought to be the main trigger of the expansion of private practice.

#### NHS dentistry

- Almost half of all NHS patients are currently entitled to free treatment
- Non-exempt NHS patients pay 80 per cent of the cost, up to a maximum of £366
- The NHS list includes over 300 different treatments

- 3.3 Initially the full cost of NHS dental provision was met by the taxpayer. Charges to meet a part of the cost of NHS treatment (other than for exempt patients) were introduced in 1951 and the proportion that patients have to pay has subsequently increased. Just over half of NHS patients must now pay 80 per cent of the cost of treatment up to a maximum of £366<sup>8</sup>. Individual dentists recover the rest of the cost of treatment (according to amounts set by government) from the Dental Practice Board (DPB) and in Scotland, from the Common Services Agency on behalf of the Scottish Dental Practice Board.
- 3.4 Following an annual recommendation by the Doctors' and Dentists' Review Body (DDRB) on a percentage increase to gross fees, Government sets the NHS

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<sup>7</sup> The Report of the Review Body on Doctors' and Dentists' Remuneration for 2002 refers to an estimate for the private dental market in 1993 of £200 million. This was provided to the Review Body by the British Dental Association.

<sup>8</sup> The maximum patient charge in Wales is £354. The maximum charge for patients in England, Northern Ireland and Scotland will increase to £372 from 1 April 2003.

fee scale accordingly.<sup>9</sup> In recommending an annual increase in gross fees, the DDRB aims to provide dentists with a reasonable level of income from their NHS work, varying according to their NHS commitment. The charge made to patients for each item of NHS treatment is 80 per cent of the dentist’s fee and is the same for all dentists no matter where they work. Government meets the remaining 20 per cent. Examples of current patient charges for common types of treatment are as follows:

TABLE 3.1: CURRENT CHARGES FOR TYPICAL NHS TREATMENTS

Treatment	NHS charge
Clinical examination, advice, charting & report	£5.32
Scale & polish	£8.36
Amalgam filling (medium size)	£11.04
Composite or synthetic resin filling	£10.64
Bonded crown – full or jacket crown in alloy of fine gold/precious metal	£84.00
Extraction – one tooth	£9.52

Source: Department of Health

3.5 Almost half of all NHS patients are entitled to free NHS treatment. In England, Northern Ireland and Scotland these include:

- all those under 18 years of age<sup>10</sup>
- those under 19 in full-time education
- women who are either pregnant or have borne a child in the previous 12 months
- people, and their partners, receiving Income Support, Minimum Income Guarantee, Job Seeker’s Allowance, Working Families’ Tax Credit or Disabled Person’s Tax Credit at the full rate or reduced by £72.20 or less
- families with a certificate for full help with the cost of NHS services.

In addition to the above, in Wales dental examinations are free for those under 25 years of age and for those over 60.

3.6 NHS patients are registered with a dentist for 15 months and registration lapses if patients do not attend at least once during this period. This can result in a subsequent refusal to renew the NHS registration. In certain areas, the patient

<sup>9</sup> Dentists’ fees are set out in the Statement of Dental Remuneration which can be found at [www.doh.gov.uk/sdr](http://www.doh.gov.uk/sdr).

<sup>10</sup> The government pays for the treatment of children through capitation payments (a set amount per child registered with the practice).

may find it difficult to register for NHS treatment elsewhere<sup>11</sup>. According to their terms of service, dentists can de-register patients at any time if they so choose, with normally three months' notice<sup>12</sup>.

- 3.7 The NHS list includes over 300 different treatments (items of service<sup>13</sup>) which dentists are obliged to provide to their NHS registered patients. Cosmetic treatments are not included on the NHS list. The fixed price of each item of NHS treatment means that, to achieve a certain level of net income, the dentist must set limits on the time and materials used for each patient. Dentists carrying out treatment on the NHS receive the same amount of payment for each treatment, however long they spend with the patient. There is also an impact on the capital invested in equipment, as such investment must be funded from these fees together with other NHS income. (The fees dentists receive for treatment account for only about 70 per cent of dentists' gross NHS income, with the balance including such items as payments for continuing care and pension contributions.)
- 3.8 By contrast with the constraints on practitioners working under the NHS, higher private dental fees can allow the dentist to spend more time with the patient if they wish to do so and to increase the quality of service they provide in this way. Part of these higher fees are needed to cover the 30 per cent of NHS income not coming from payments for individual items of service.
- 3.9 Practices undertaking a higher proportion of private work will be better placed to invest systematically in equipment than practices earning largely through NHS treatment. Government made available a modernisation fund of £35 million for improvements to practices, including the purchase of equipment, for significantly committed NHS dentists in the financial year 2001/02.
- 3.10 Many dentists providing only private treatment to adult patients continue to provide NHS treatment to children (particularly whose parents go privately) and/or adult patients receiving state benefits which qualify them for free NHS treatment<sup>14</sup>.

<sup>11</sup> According to the Department of Health strategy document, *Modernising NHS Dentistry- Implementing the NHS Plan*, 'about a third of Health Authorities have reported serious availability problems'. The government has since taken steps to improve access to NHS dentistry.

<sup>12</sup> See [www.nhs.uk/localnhservices/dental/dentistry\\_leaflet.asp](http://www.nhs.uk/localnhservices/dental/dentistry_leaflet.asp)

<sup>13</sup> See [www.dpb.nhs.uk/other/publications\\_sdr.shtml](http://www.dpb.nhs.uk/other/publications_sdr.shtml)

<sup>14</sup> See Table 3.12.

## The growth of private dentistry

- Around seven million adults regularly attend for private treatment
- Expenditure on private dentistry has grown by around 13 per cent per year

- 3.11 Private dentistry could potentially offer a higher quality service and allow dentists to spend more time with patients. The dentists who responded to a survey of private practice undertaken by the British Dental Association (BDA) stated that most of them took up more private work so that they could spend longer with each patient.<sup>15</sup>
- 3.12 Private dentistry also offers treatments not available on the NHS. Cosmetic dentistry, such as teeth whitening, is excluded from the NHS list of treatments. This has provided an area of growth for private dentistry, as increasing incomes combined with greater promotion and consumer awareness of these types of treatment have increased demand.
- 3.13 Moreover, innovative treatments are perhaps more likely to be used first in private dentistry. The development of new techniques, such as ozone treatment for early tooth decay (requiring no anaesthetic, no drilling and filling), may further expand the demand for private dentistry<sup>16</sup>.
- 3.14 The BDA survey of dentists' private practice showed that for 1127 dentists the most common private services were for composite fillings (265 respondents) and for bonded crowns on back teeth (202 respondents) (the latter are not generally available under the NHS<sup>17</sup>). Table 3.2 summarises the responses to this question.

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<sup>15</sup> Evidence from the British Dental Association, 2002.

<sup>16</sup> Whether dentists providing mainly NHS treatment will purchase such technology is not known. However, its use could significantly reduce the use of some traditional techniques.

<sup>17</sup> Dental treatments that do not appear in the Statement of Dental remuneration may be provided in certain circumstances if approved by the relevant NHS dental payment organisation.

TABLE 3.2: MOST COMMON PRIVATE TREATMENTS<sup>18</sup>

Treatments	Number of times stated by respondents (total 1127)	As a percentage of all responses %
Composite fillings	265	23.5
Bonded crowns	202	17.9
Examinations	190	16.8
Teeth whitening	24	2
Other (for example veneers, dentures, periodontal treatment)	446	39.6

Source: BDA Private Practice Survey 2002

3.15 Currently, the NHS provides a level of care that aims to ensure that all consumers have access to a set level of service at a predetermined (and subsidised) fee. Predominantly private practitioners tend to have a different focus from NHS providers: sometimes specialising in cosmetic dentistry, having longer opening hours, a greater number of high street practices, different materials or a greater length of time spent by the dentist or dental team with each patient. Consumers can choose the type of service and accompanying cost depending on their own preferences from this range of services.

### Size of the market

#### Numbers of dentate people

- 87 per cent of UK adults have some natural teeth (70 per cent in 1970)
- 30 per cent of 16 to 24 year olds have had no restoration (nine per cent in 1978)
- 59 per cent of adults with natural teeth have regular check-ups

3.16 The most recent Adult Dental Health Survey (ADHS) was in 1998<sup>19</sup>. It showed that 87 per cent of adults in the UK had some natural teeth; the remaining 13 per cent had lost all their teeth. There has been a marked improvement in the retention of natural teeth, with the proportion without any teeth having been 30 per cent in 1978 and 21 per cent in 1988. However, the proportion of adults

<sup>18</sup> Based on 1127 responses.

<sup>19</sup> *Adult Dental Health Survey: Oral Health in the United Kingdom 1998*, Office for National Statistics.

without any natural teeth was still somewhat higher in Scotland and Wales in 1998 (at 17 and 18 per cent respectively) than the rest of the UK.

- 3.17 The ADHS found that the proportion of 16-24 year olds with no restored teeth increased from nine per cent in 1978, to 13 per cent in 1988 to 30 per cent in 1998. Moreover, adults under 45 on average had fewer restored teeth (12 teeth or more) in 1998 than in 1988. Conversely, in 1998, older age groups were more likely to have their teeth restored. Those with restored teeth may need maintenance of their fillings. Although dental health has improved in the population overall, there remain some geographical pockets of poor health.

### **Market volumes**

- 3.18 Over time more people are visiting the dentist. The proportion of adults with natural teeth who report going to the dentist for regular check-ups has been increasing to 59 per cent in 1998, compared with 50 per cent in 1988 and 43 per cent in 1978. There were no significant differences between parts of the UK in the proportion of adults attending the dentist for a regular check-up. While some patients prefer to be registered with a dentist and regularly attend for check-ups, others prefer to go only when they feel pain or discomfort. Those without any natural teeth may visit a dentist for new dentures or soft tissue examinations (eg to be examined for oral cancer)<sup>20</sup>.

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<sup>20</sup> *Scientific Basis of Dental Health Education: A Policy Document*. 'The period between oral examinations must be flexible and based on professional assessment of the risk from oral disease. The maximum period between oral health examinations for everyone, irrespective of age or dental condition, should be one year'. Leviners, 4th edition, London: Health Education Authority 1996. NICE is currently examining recall intervals.

- 3.19 Although more people attended for check-ups, the number of adult dental patients in NHS continuing care provision<sup>21</sup> in the UK declined by 14 per cent between 1995 and 2000, from nearly 23.8 million in 1995 to nearly 20.5 million in 2000. The Department of Health (DH) say that the main reason for this was the shortening of the registration period in 1996<sup>22</sup>. The effect of this was to remove from dentists' registers patients who continued to be registered but who had in practice ceased to visit the dentist. It also meant that once they had ceased to be registered, some dentists would not take such patients back on their register or only take them back as private patients.
- 3.20 The data shows a small decline of five per cent (comparing 1995 and 2000) in the number of children receiving continuing care provision under the NHS, from just over 8.7 million to nearly 8.3 million. However, the previous registration period was shorter than for adults. Allowing for the change in the registration period, DH figures for Great Britain indicate an increase of around two per cent in the number of registered children between April 1995 and April 2000<sup>23</sup>.

TABLE 3.3: NUMBER OF NHS DENTAL PATIENTS IN CONTINUING CARE PROVISION IN THE UK 1995 TO 2000 (THOUSANDS)<sup>24</sup>

	1995	1996	1997	1998	1999	2000
<b>Adults</b>	23,794	23,424	23,394	20,286	20,295	20,469
<b>Children</b>	8,724	8,721	8,868	8,178	8,267	8,283
<b>Total</b>	32,518	32,145	32,262	28,464	28,562	28,752

Sources: Department of Health, Central Services Agency for Northern Ireland, ISD Scotland, and the Welsh Assembly Government

- 3.21 With the exception of Northern Ireland, the proportion of adults who received wholly private treatment tripled between 1988 and 1998.

<sup>21</sup> Continuing care payments are received by dentists on a monthly basis for patients who are registered for NHS treatment with them. Registration lasts for 15 months. It includes provision of emergency cover and continuing care payments are paid whether the patient attends for a check-up or treatment or not at all. Once a patient does attend, the registration is extended for a further 15 months.

<sup>22</sup> Prior to 1996, the registration period for adults was 24 months and children's registration lasted until the end of the calendar year following attendance. Comparison of the numbers registered before December 1997 with those after is affected by the change in the period and the point in the year when the old registration figures were calculated.

<sup>23</sup> Trend data on the number of children receiving continuing care provision under the NHS was subject to a break between 1997 and 1998 due to the changes in the registration period and the point in the year when the figures were calculated.

<sup>24</sup> The registration data for individual countries from which the figures are compiled relates to different months during each year for Northern Ireland and Scotland compared with England and Wales.

TABLE 3.4: PROPORTION OF ADULTS WHO RECEIVED WHOLLY PRIVATE TREATMENT IN 1988 AND 1998 BY COUNTRY AND REGION

	1988	1998
<b>Country</b>		
England	6	19
Wales	5	17
Scotland	4	14
Northern Ireland	7	10
<b>English region</b>		
South	6	24
Midlands	7	18
North	4	9

Source: Adult Dental Health Survey 1998 (Office for National Statistics)

3.22 A survey commissioned by the Office of Manpower Economics on behalf of the Review Body on Doctors' and Dentists' Remuneration and carried out in March 2000 asked GPs about the number of patients that they would expect to examine or treat in a week. The average number of total patients was 123.4 of which an average of 98.4 (80 per cent) were General Dental Services (NHS) patients. This gives an average of 25 private patients per week, or 20 per cent of the total. This is broadly consistent with ADHS figures.

3.23 Based on the results of the ADHS there were an estimated 4.3 million adult patients attending regularly for private treatment in 1998. As shown below in Table 3.6, expenditure on private dental care is growing at about 13 per cent each year. This growth combines that caused by increases in patient numbers with that caused by increases in the amount spent by individuals. On this basis it can be estimated that - as an upper limit - the number of adults now attending for regular private dental treatment is likely to be approaching seven million.<sup>25</sup>

3.24 This estimate is broadly consistent with estimates derived from the OFT Practice Survey. These suggest that there are between 7.8 and 8.6 million receiving private treatment.<sup>26</sup> However, these are total registrations and not all these patients will be attending on a regular basis. In addition, practices

<sup>25</sup> OFT estimate from ADHS figures.

<sup>26</sup> Comparison with external data sources suggests that the practices that replied to the OFT survey were, on average, a little larger than the national average. Due allowance has been made for this in arriving at the estimates above.

estimated that a proportion of patients under the NHS, equivalent to 2.8 million patients, sometimes chose to have certain treatments privately.

3.25 The results of a BDA Dental Business Trends Survey are reported in Table 3.5. This survey indicated that for the UK as a whole in 2001, 67 per cent of adult patients regularly received NHS treatment, 25 per cent regularly received private treatment on a fee-per-item basis and eight per cent regularly received treatment through private dental schemes. Given the NHS patient numbers set out in Table 3.3, this would suggest a figure as high as ten million for the number of patients receiving private treatment, either through a scheme or paid for on a fee-per-item basis.

3.26 The following table also shows that the proportion of NHS adult patients in the South was much lower than in the North, while only a very small proportion of child patients in the UK (six per cent) received private treatment.

TABLE 3.5: PATIENT MIX FOR ADULT AND CHILD PATIENTS IN 2001 (%)

	NHS	Private (non-scheme)	Members of scheme
<b>Adult</b>			
UK	67	25	8
North	75	18	7
South	53	37	10
<b>Child</b>			
UK	94	5	1
North	99	1	0
South	88	10	2

Source: BDA Dental Business Trends Survey 2001

#### Value of markets

- Private market exceeds £1 billion
- Spending on private dentistry grew by 64 per cent between 1997 and 2001

3.27 In 2000/2001, total expenditure in the UK on dental treatment<sup>27</sup> was estimated at about £2.9 billion<sup>28</sup>. Nearly two-thirds of this total was accounted for by

<sup>27</sup> Excluding expenditure on the Community Dental Service, the Personal Dental Service and the Hospital Dental Service.

<sup>28</sup> Figure calculated by OFT from NHS expenditure figure and MSI figure for expenditure on private dentistry. The UK Dental Care Market Sector Report 2003 published by Laing & Buisson estimated the total UK dental market in 2001/2002 at £3.7 billion. This, however, included estimated expenditure on private dentistry of £1.9 billion. This estimate is significantly higher than estimates from other sources for 2000/2001.

gross expenditure on NHS dental treatment of £1.88<sup>29</sup> billion and just over one-third on private treatment with an estimated expenditure of £1.05 billion.<sup>30</sup>

3.28 An MSI data survey<sup>31</sup> estimated growth in expenditure on private dental treatment of 64 per cent between the year to March 1997 and the year to March 2001 from £640 million to £1.05 billion; a real terms increase of nearly 50 per cent<sup>32</sup>. Expenditure on the NHS General Dental Service increased by 17 per cent in nominal terms over the same period.

3.29 Table 3.6 gives MSI estimates for expenditure on private dentistry for each of the years 1996/1997 to 2000/2001 with comparable figures for NHS expenditure over the same period.

TABLE 3.6: UK EXPENDITURE ON PRIVATE AND NHS (GDS) DENTAL CARE  
1996/1997 TO 2000/2001

	Expenditure (£bn)	
	NHS <sup>33</sup>	Private
<b>1996/1997</b>	1.60	0.64
<b>1997/1998</b>	1.64	0.73
<b>1998/1999</b>	1.75	0.84
<b>1999/2000</b>	1.80	0.94
<b>2000/2001</b>	1.88	1.05

Source: MSI, Department of Health, Central Services Agency Northern Ireland, Scottish Health Service, Welsh Assembly Government

3.30 Further evidence on the extent of private work, by value, compared with NHS, is provided by a BDA survey for 2001<sup>34</sup>, the results of which are shown in Table 3.7. This survey found that 62 per cent of GDPs derived three quarters or more of their income from NHS work. On average 24 per cent of dentists earned less than a quarter of their income from NHS work. 36 per cent of dentists in the South derive less than a quarter of their income from NHS work, compared with only 15 per cent in the North<sup>35</sup>.

<sup>29</sup> Department of Health statistics.

<sup>30</sup> *MSI Data survey*, February 2002. No figures for actual expenditure exist.

<sup>31</sup> *Ibid.*

<sup>32</sup> Using a general price deflator.

<sup>33</sup> Gross expenditure before deducting patient charges.

<sup>34</sup> *Dental Business Trends Survey*, British Dental Association, 2001.

<sup>35</sup> The North/South divide runs from the Bristol Channel diagonally across to the Wash in the East of England.

TABLE 3.7: DISTRIBUTION OF PERCENTAGE OF INCOME EARNED FROM THE NHS

	Percentage of income earned from the NHS			
	0-24%	25-49%	50-74%	75%-100%
Percentage of all respondents	24	8	6	62
Percentage of respondents from North	15	5	5	75
Percentage of respondents from South	36	12	8	44

Source: BDA Dental Business Trends Survey 2001

### Types of private provision

- There are about 11,000 dental practices in total
- About 210 practices are totally private

3.31 There is no official figure for the number of dental practices in the UK. The BDA's estimate is around 11,000<sup>36</sup>. This number includes both traditional practices and those that are owned by corporate groups.

#### Traditional dental practices

3.32 Small independent dental practices normally obtain finance for investment by means of a bank loan. Alternatively, items of capital equipment can be financed by hire purchase or leased. The typically low level of risk relating to lending to dentists makes it attractive business for the banks. This is also the usual means by which dentists buy into a practice for the first time. Commercial mortgages are available to purchase the freehold or leasehold premises of a dental practice.

3.33 Very few dental practices offer no NHS treatment at all. Many of the practices that are predominantly private still offer NHS treatment to (at the least) children of their private patients. One estimate puts the number of dental practices that provide no NHS dental care at 210<sup>37</sup> (approximately two per cent of the estimated total number of practices in the UK).

3.34 Some GDPs have switched to offering only private treatment to adult patients, or to registering new patients only for private treatment while continuing to give NHS treatment to existing patients. GDPs also provide a mix of NHS and private treatment to some patients where they can not or are not prepared to undertake particular treatments on the NHS. Were these treatments on the NHS list, this

<sup>36</sup> BDA evidence to OFT.

<sup>37</sup> *Growth in the Private Dental Market*, Kravitz, A S & Patel, D, British Dental Journal (in press).

would breach their NHS Terms of Service which require them to offer all treatments on the NHS list to NHS-registered patients.

- 3.35 The NHS contract permits dentists to undertake NHS and private work as part of the same course of treatment but not on the same tooth. Both the ADHS and the OFT consumer survey showed that in practice the proportion of known mixed treatment is very low. According to the ADHS, only two per cent of respondents reported having had mixed treatment on the last occasion, and four per cent of respondents to the OFT consumer survey reported mixed treatment.

### **Corporate dental groups**

- 3.36 In addition to individual dental practices, which generally operate with self-employed dentists, there can be up to 27 corporate dental groups<sup>38</sup> which own chains of practices for whom dentists may work as salaried employees or may work on a self-employed basis depending on the company's policy. These dental chains provide varying levels of NHS and private dental treatment. Some corporate dental groups have established high street practices and concentrate mainly on private dentistry (providing NHS treatment only for children) while others have acquired existing practices and continue to provide both NHS and private treatment.
- 3.37 For the businesses concerned corporate status is usually attractive because of:
- greater access to sources of capital
  - quality levels can be translated into greater brand awareness (as branding is linked to quality levels)
  - economies of scale particularly in relation to purchasing, and
  - limited liability protecting shareholders' personal assets.
- 3.38 A further attraction of dentistry for at least some of those corporates that have entered the sector may be the potential to increase the size of the UK dental market. This growth would come from new patients who currently do not visit the dentist and from the promotion of certain treatments, for example cosmetic ones.
- 3.39 According to Denplan (the largest provider of dental capitation plans), the corporates have around 400 practices between them, with 1,500 dentists and five million regular patients<sup>39</sup>. It has been suggested that, by turnover,

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<sup>38</sup> Not all of these may be active at any one time.

<sup>39</sup> Denplan estimate that on the basis that only half of the population regularly attend the dentist, corporates constitute 15 per cent of the entire dental market.

corporates have 5 per cent of the total market<sup>40</sup>. Table 3.8 gives a list of the largest corporate groups with details of their dental chains as at February 2003. The practices of major operators<sup>41</sup> increased by nearly 60 per cent from 251 in January 2001 to 396 in February 2003<sup>42</sup>. The number of dentists they employed had increased by 45 per cent from 1046 to 1516 over the same period. As a relatively recent entrant, Boots Dentalcare, has significantly increased its presence in the market and to date has established 54 outlets throughout the UK. This compares with only six outlets at January 2001<sup>43</sup>. Oasis has also significantly increased the number of practices it owns. Other chains have also been expanding too.

TABLE 3.8: MAJOR CORPORATE DENTAL GROUPS WITH NUMBERS OF PRACTICES AT 1 FEBRUARY 2003

Company	Number of practices	Number of dentists
Integrated Dental Holdings (IDH)	122	497
Whitecross (owned by IDH)	21	120
Oasis	126	510
Boots Healthcare	54	150
J D Hull	32	138
Associated Dental Practices (ADP)	26	77
BUPA Wellness	15	24

Source: Laing & Buisson, *Healthcare Market News*, February 2003

3.40 The Dentists Act 1984 places a number of restrictions on corporate bodies offering dental services. For example a corporate body may not practise the business of dentistry unless it was doing so on 21 July 1955. This effectively prevents entry by any new corporate dental bodies, other than by acquisition of an existing corporate. This restriction is being revoked. A fuller description of the restrictions on corporate dental bodies can be found in paragraph 4.79.

### Methods of payment

3.41 There are three main methods of paying for private dental treatment: fee-per-item, capitation and insurance.

<sup>40</sup> *Innovation in UK Dental Service Delivery*, Dan Richardson, 2002 (EMBA Management Report).

<sup>41</sup> As defined by Lang and Buisson. See Table 3.8.

<sup>42</sup> *Healthcare Market News*, Laing & Buisson.

<sup>43</sup> *Ibid.*

- 3.42 The majority of private dental treatment is paid for directly by the patient to the individual dental practice, on a 'fee-per-item' basis. Most practices ask patients to settle their bill at each stage of treatment. Patients with health cash plans, which in return for regular payments contribute towards dental and other health costs, can reclaim part of the cost of their dental treatment under the plan.
- 3.43 Capitation schemes are another common method of payment for private treatment. These schemes provide for fixed regular monthly payments according to the anticipated level of treatment required (following an initial examination) thus enabling patients to budget for the cost of treatment. Some dentists operate their own capitation schemes for private patients having regular treatment. Alternatively, they may subscribe to an externally operated capitation scheme. Different charging bands reflect differing levels of anticipated treatment. An advantage is that the cost over the contracted period does not vary with the level of treatment, other than for the cost of certain expensive items excluded from cover, such as dental appliances (including crowns and dentures).
- 3.44 Denplan, with 1.1 million registered patients, has a significant share of those dentists and patients using dental capitation schemes. Average monthly payments by patients to Denplan in 2002 were £15.18. The number of patients with other capitation schemes combined is estimated (by Denplan) to be about 200,000. Payments (by the scheme providers) to dentists under capitation schemes amounted in 2001 to some £170 million<sup>44</sup>.
- 3.45 In addition, many private health insurers offer dental insurance products. Dental insurers in the UK include CIGNA, NDP, BUPA and PPP healthcare. Patients with dental insurance can use any dentist for treatment, the cost of which will be covered up to a set financial limit. Some companies provide employees with dental insurance as part of their remuneration package or alternatively negotiate a low cost plan on behalf of employees who then decide whether or not to take this up.
- 3.46 Among the practices responding to the practice survey carried out by the OFT, 58 per cent reported being involved in at least one form of capitation, insurance based or other form of payment system, and it was not uncommon for practices to accept patients from two or more payment systems. The largest groups were Denplan (used by 30 per cent of practices) and the Hospital Savings Association (used by 21 per cent). Table 3.9 summarises the responses.

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<sup>44</sup> OFT estimate from industry figures.

TABLE 3.9: PRESENCE OF CAPITATION SCHEMES, INSURANCE AND OTHER DENTAL PAYMENT SYSTEMS

System	Proportion of practices using system
Denplan	30%
Hospital Savings Association	21%
Boots	8%
CIGNA	7%
Densure	6%
Practice Plan	4%
Clinident	2%
Others	6%

Source: OFT Practice Survey (See annexe C)

### Dental workforce

- 22,000 General Dental Practitioners
- Over 4000 dental hygienists
- Over 500 therapists
- 10,000 laboratory technicians

3.47 As well as General Dental Practitioners (GDPs), there are a substantial number of dentistry workers in professions complementary to dentistry (PCDs), including dental hygienists, dental therapists, and dental technicians. As set out below, these three groups of PCDs account for some 15,000 dental professionals in the UK <sup>45</sup>.

#### Dentists

3.48 There are currently approximately 22,000 GDPs in the UK<sup>46</sup>. The number of people obtaining dentistry qualifications in the UK to some extent limits the supply of dentists in the UK, although there is some potential for qualified dentists to come to work here from overseas. The majority of GDPs in the UK work as self-employed principal or associate dentists in small dental practices. After serving a post-qualification probationary period dentists will normally be employed as an associate in a practice before becoming a principal. This is done

<sup>45</sup> In addition, there are a number of dental nurses, receptionists and other staff members.

<sup>46</sup> *BDA Dental Business Trends Survey*, British Dental Association, 2001.

generally by buying into an existing practice. There are also some assistant dentists working as employees of practices.

- 3.49 In England, as of September 2002, around 1000 dentists were employed within the Personal Dental Service (PDS) to provide only NHS treatment, some of which is done through Dental Access Centres (DACs).<sup>47</sup> There are about a hundred PDS pilots of which almost half are DACs. DACs were set up to provide treatment to patients who have not registered for regular treatment and to meet the needs of areas where patients were having particular difficulty in getting access to NHS dentistry.
- 3.50 Other dentists employed in state dentistry work for the Hospital Dental Service (HDS) and the Community Dental Service (CDS). In England 2184 dentists were employed in the HDS at the end of September 2001 (1457 whole time equivalent) and 1348 (1018 whole time equivalent) were employed in the CDS. In Northern Ireland there were 68 dentists employed by the HDS at the end of February 2003 and 79 dentists were working in the CDS. In Scotland there were 341 dentists working in the HDS at the end of February 2003, and 293 dentists employed in the CDS. In Scotland, salaried GDS dentists and joint Community Dental Service/GDS salaried dentists have been employed for many years by a number of NHS Boards and, since November 1999, by NHS primary Trusts also to offer general dental services to the general population. The numbers of such posts are increasing. In Wales there were 203 dentists in the HDS and approximately 106 working in the CDS end of February 2003.

### **Dental hygienists**

- 3.51 There were 4317 dental hygienists on the General Dental Council's (GDC) Rolls of Dental Auxiliaries at 31 December 2002. Some were dual registered as dental therapists and not all are currently practising. A large majority of them work in more than one dental practice. While, recently, there has been some increase in the number of procedures that can be undertaken by hygienists, this can only be done on the instruction of a dentist, and patients cannot be charged directly by hygienists.
- 3.52 Dental hygienists are permitted (after a registered dentist has examined a patient and indicated in writing the course of treatment) to carry out a number

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<sup>47</sup> 341 of those working in the PDS at September 2002 were also working in the General Dental Service. Some were also working in the Community Dental Service (CDS). In Scotland a Remote Practice Allowance has been introduced, and abated according to the level of NHS commitment. In Wales the Community Dental Service/GDS salaried interface posts, that predated the PDS in England, have been made permanent.

of procedures. Under the direction of a dentist, a hygienist can undertake the following procedures<sup>48</sup>:

- clean and polish teeth
- scale teeth
- apply prophylactic materials
- remove excess cement
- take impressions
- place temporary dressings in teeth or replace crowns with temporary cement in emergencies
- perform the above treatments on patients under conscious sedation (on the condition that a dentist remains in the room for the duration of the work)
- administer local infiltration anaesthesia or inferior dental nerve block anaesthesia (under the direct personal supervision of a registered dentist).

#### **Dental therapists**

3.53 In the past only the CDS and HDS have been permitted to employ dental therapists. However, since July 2002, therapists have been able to work in the General Dental Service (GDS). There were 507 therapists on the GDC's Rolls of Dental Auxiliaries at 31 December 2002.

3.54 Dental therapists undergo a period of training similar to but shorter than that of dentists. Much of the work that hygienists, and more particularly therapists, are allowed to carry out overlaps with that of dentists. Under the direction of a registered dentist (and after the dentist has examined a patient and indicated in writing the course of treatment), therapists can undertake the same range of treatments as hygienists. In addition they are permitted to<sup>49</sup>:

- extract deciduous teeth
- undertake simple fillings
- restore primary teeth by means of pulp therapy and by the placement of pre-formed crowns.

#### **Dental technicians**

3.55 Appliances such as crowns, bridges and dentures are usually made by dental technicians and not by dentists. Dental practices generally contract with

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<sup>48</sup> These are set out in the Dental Auxiliaries Regulations 1986 (as amended) SI 1986/887.

<sup>49</sup> These are also set out in the Dental Auxiliaries Regulations.

external dental laboratories for dental appliances. There are, according to a survey by the Dental Laboratories Association<sup>50</sup>, around 2700 dental laboratory premises in the UK employing approximately 10,000 laboratory technicians. All dental laboratories must register with the Medical Devices Agency, an executive agency of the DH. Some laboratories have accreditation from the Dental Appliance Manufacturers Audit Scheme (DAMAS).

- 3.56 The estimated size of the UK dental laboratory sector at the end of 2001 was approximately £285 million to £290 million, of which private work accounted for around £75 million to £80 million (about seven per cent of the overall private dentistry market)<sup>51</sup>.
- 3.57 There are various types of dental technician (see glossary, annexe K). In the UK they are not required to have qualifications but some do undertake training<sup>52</sup>. A number travel abroad to gain qualifications in denturism (the manufacture and fitting of dental prosthesis) even though its practice is illegal in the UK. Dental technicians are by law not permitted to undertake the fitting of appliances, including dentures, which can only be carried out by a dentist. Some countries have clinical dental technicians (or denturists) who are permitted to undertake the fitting of appliances (see annexe E).
- 3.58 There is understood to be some illegal provision of such services in the UK by individual technicians. A 1994 survey by the Association for Denture Prosthesis (now the Clinical Dental Technicians Association)<sup>53</sup> found that 39.5 per cent of dental technicians at some time, and probably regularly, undertake unauthorised work directly with dental patients.

### Practice size

- Average number of registered patients per practice is over 4,000

- 3.59 75 per cent of practices' turnovers fell between £100,000 and £500,000 annually
- 3.60 The OFT Practice Survey<sup>54</sup> found that the average number of registered patients per practice was a little over 4,000. For those respondents who provided a

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<sup>50</sup> *UK Dental Laboratory Industry Survey Report 2001/2002*, Dental Laboratories Association.

<sup>51</sup> *Ibid.*

<sup>52</sup> The Clinical Dental Technicians Association have advised that 98 technicians will have received qualifications by April 2003.

<sup>53</sup> *A survey of Denture supply in relation to unauthorised provision by Dental Technicians*, Association for Denture Prosthesis, 1994.

<sup>54</sup> About 700 returns provided details of patient numbers. Comparison with external data sources suggests that the practices that replied to the OFT survey were, on average, a little larger than the national average.

detailed breakdown of their patients by type<sup>55</sup>, adult patients receiving NHS treatment were the largest group (46 per cent of the total). Children receiving NHS treatment amounted to 24 per cent of the total, adult private patients 22 per cent, adults receiving mixed NHS and private treatment seven per cent and children receiving private treatment only one per cent. (Of the adult patients 70 per cent were registered for NHS treatment, including those receiving free treatment.)

3.61 The average number of staff in the practices responding to our practice survey was just under eight, and again on average, was made up of five full-time and three part-time staff. Practice size was highly variable and in this survey 0.8 per cent were single person operations, while one practice employed 38 people in total.

TABLE 3.10: STAFF NUMBERS

	Average	Minimum	Maximum
		Persons	
Dentists	2.4	1	18
Other qualified staff, nurses <sup>56</sup> , hygienists, therapists	2.8	0	15
Other non-qualified staff	2.8	0	17
All staff	8.0	1	38
<b>Of which:</b>			
Full time	4.8	0	27
Part time	3.2	0	20

Source: OFT Practice Survey (annexe C)

3.62 Overall dentists made up 30 per cent of these staff, with other qualified staff (hygienists, therapists and nurses) a further 35 per cent, and the remaining 35 per cent were unqualified support staff, such as receptionists and cleaners. Of the dentists just over half (55 per cent) owned the practice (outright or jointly) or were partners in the practice, and the rest (45 per cent) worked as associates or assistants.

3.63 For 75 per cent of the respondents to our Practice Survey, practice turnover was in the range of £100,000 to £500,000 annually<sup>57</sup>. Only two per cent reported a turnover exceeding £1 million.

<sup>55</sup> 660

<sup>56</sup> Dental nurses are not required to have formal qualifications.

<sup>57</sup> These figures relate to the most recent year for which practices had available data.

## Competition for new patients

### Advertising

3.64 The most significant factors in the choice of dentist are use by other family members or recommendation<sup>58</sup>. Only half of the practices responding to our practice survey indicated that they used advertising to attract new patients. Overall the most common approach was the use of directories, such as Yellow Pages or Thomson Local. Other forms of advertising were less commonly used. The internet was used by 14 per cent of practices for advertising purposes. Table 3.11 sets out the advertising methods used and the proportion of practices using these methods.

TABLE 3.11: DO DENTISTS USE ADVERTISING TO ATTRACT NEW PATIENTS?

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<b>Do you use any form of advertising to attract new patients?</b>	
No	49%
Yes	51%
<b>Of those using advertising, methods used:</b>	
Directories	46%
Magazines	7%
Direct mail	6%
Internet or web site	14%
Newspapers	10%
Other	17%

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Source: OFT Practice Survey

### Acceptance of new patients

3.65 A small percentage of practices are not accepting any new patients. Of those that are accepting new patients, roughly half are accepting NHS patients. These results emerge clearly from both the BDA Dental Business Trends Survey and our own survey of practices.<sup>59</sup>

3.66 The results of these surveys are summarised in Table 3.12. The proportion of practices not accepting new NHS adult patients lies between 40 per cent (OFT Practice Survey) and 44 per cent (BDA), while the proportion of practices not

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<sup>58</sup> OFT Practice Survey.

<sup>59</sup> While the results of these surveys are not entirely consistent, even allowing for the limited sample size in both surveys (on the basis of which each survey should only be relied on to within plus or minus 4%), these key results emerge clearly in both.

taking on any new patients at all lies between 11 per cent (BDA) and 19 per cent (OFT). While patients registered for NHS treatment may in some circumstances be offered and agree to receive private treatment, the converse generally does not apply.

3.67 Both the OFT and BDA surveys showed a high proportion of practices, 53 per cent and 34 per cent respectively, not taking on adults exempt from NHS charges as specified in paragraph 3.5. Finally, the OFT practice survey established that among the 72 per cent of practices accepting children for NHS treatment, for an estimated 29 per cent of this group (21 per cent among children overall) acceptance for NHS treatment is dependent on parents being private patients.

TABLE 3.12: ACCEPTANCE OF NEW PATIENTS (% OF PRACTICES WHO ARE ACCEPTING NEW PATIENTS, BY TYPE OF PATIENT)

Type of patient	Accepting new NHS patients		Accepting only new private patients		Not accepting any new patients	
	OFT	BDA	OFT <sup>60</sup>	BDA	OFT	BDA
<b>Adults</b>						
UK	40	44	41	45	19	11
North		55		36		9
South		30		59		11
<b>Exempt adults</b>						
UK	48	59	N/A <sup>61</sup>	7	52	34
North		68		5		27
South		49		11		40
<b>Children</b>						
UK	72 <sup>62</sup>	83	7	7	21	10
North		88		2		10
South		78		13		9

Source: OFT Practice Survey and BDA Dental Business Trends Survey 2001

<sup>60</sup> Secondary estimate. Derived by subtracting the per cent accepting NHS patients from the total per cent accepting private patients.

<sup>61</sup> Not asked in OFT survey.

<sup>62</sup> For an estimated 29 per cent of this group (21 per cent among all children) acceptance for NHS treatment is dependent on parents being private patients.

## Regulatory framework

### NHS

- 3.68 Primary Care Trusts (PCTs) arrange with local dentists to provide dental treatment to NHS-registered patients in England. Health and Social Services Boards do the same in Northern Ireland, NHS Boards do so in Scotland and Local Health Authorities do so in Wales. (PCTs have recently replaced local health authorities in England.) Dentists can agree to undertake varying levels of NHS treatment with the vast majority of dentists having some NHS patients.
- 3.69 Payment of dentists and auditing of NHS dental treatment is undertaken centrally for England and Wales by the NHS Dental Practice Board (DPB)<sup>63</sup>. Dental care provided under the NHS is subject to random inspection by the DPB's Dental Reference Service (DRS). They examine 90,000 patients per year<sup>64</sup>. 65 dentists are employed by the service to undertake the inspections. There are no comparable procedures for the inspection of private dental treatment.
- 3.70 In Northern Ireland the equivalent of the DPB is the Central Services Agency and the equivalent of the DRS is the Referral Dental Services (RDS). The RDS aims to examine four patients per dentist per year. In addition, dental officers from the Central Services Agency examine some 800 patients each year prior to treatment.
- 3.71 In Scotland the equivalents are the Common Services Agency, Scottish Dental Practice Board and the Scottish Dental Reference Service (SDRS). The SDRS also aims to examine four patients per dentist per year.

### General Dental Council

- 3.72 The business of dentistry is regulated by the Dentists Act 1984. The Act covers the constitution and general duties of the GDC; dental education; registration of the dental profession; professional conduct and fitness to practise (poor performance, fraud and misconduct); visiting European Economic Area practitioners; restrictions on the practise of dentistry and on carrying on the business of dentistry; and dental auxiliaries.
- 3.73 The GDC is the registration and regulatory body for the dental profession throughout the UK. The GDC maintains the Dentists Register (for dentists) and the Rolls of Dental Auxiliaries (for hygienists and therapists). Only those

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<sup>63</sup> Changes to the existing arrangements are proposed in the recently published Health and Social Care (Community Health and Standards) Bill.

<sup>64</sup> DPB statistic.

registered or enrolled may practise. At present other staff working in dental practices are not required to be registered, and are not required to have any formal qualifications.

3.74 The GDC has powers to discipline dentists on grounds of serious professional misconduct, and auxiliaries on grounds of misconduct. The GDC has also published guidance<sup>65</sup> on best practice for dentists. Non-adherence does not necessarily lead to disciplinary action. Summarised below are points from the guidance of particular relevance to this investigation (see also annexe G).

- A dentist should not, for example, demand or receive fees for which there is no entitlement nor persuade a patient to accept private treatment by giving incorrect information (paragraph 2.3).
- As a member of a caring profession, a dentist has a responsibility to put the interests of patients first. The professional relationship between dentist and patient relies on trust and the assumption that a dentist will act in the best interests of the patient. Abuses of this professional relationship may lead to a charge of serious professional misconduct (paragraph 3.1).
- A patient is entitled to a referral for a second opinion at any time and the dentist is under an obligation to accede to the request and to do so promptly (paragraph 3.3).
- It is the responsibility of a dentist to explain clearly to the patient the nature of the contract and in particular whether the patient is being accepted for treatment under a particular scheme, including the NHS, or under some other arrangement (paragraph 3.6).
- The charge for an initial consultation and the probable cost of the subsequent treatment must be made clear to the patient at the outset. A written treatment plan and estimate will avoid misunderstandings and should always be provided for extensive or expensive courses of treatment (paragraph 3.6).
- Patients are entitled to an itemised account of treatment received and should normally be provided with one (paragraph 3.6).
- A dentist must explain to the patient the treatment proposed, the risks involved and alternative treatments and ensure that appropriate consent is obtained (paragraph 3.7).

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<sup>65</sup> *Maintaining Standards: Guidance to Dentists on Professional and Personal Conduct*, General Dental Council, 2001.

- 3.75 The GDC is currently made up of 60 members. Six of these are lay members appointed by the Privy Council, three are doctors nominated by the General Medical Council (for educational matters only) and one is a dental auxiliary. The rest of the Council is comprised of dentists. (The composition will change in April 2003, see annexe H.) The GDC is funded by the Annual Retention Fee (ARF) paid by dentists and PCDs. This is set by the Privy Council after consultation between the GDC and the Department of Health (DH).
- 3.76 While dentists undertake the majority of work, dental hygienists and dental therapists can carry out set areas of work as specified in the Dental Auxiliaries Regulations 1986 (amended in 1991, 1996, 1999 and 2002). In addition, dental technicians manufacture and supply dental appliances.

### **What is already changing**

- 3.77 A number of important initiatives are under consideration or in progress that will have consequences for the delivery of private dentistry. Much of the current government focus is on improved delivery of NHS dentistry, particularly in light of the Prime Minister's pledge on guaranteed access to NHS dentistry for all<sup>66</sup>. In August 2002 the Department of Health published *NHS Dentistry: Options for Change* as the first stage in reforming NHS dentistry. Shortly after this, the Audit Commission published their report examining whether NHS dental services provided value for money for taxpayers<sup>67</sup>. In August 2000, the Scottish Executive Health Department published its Action Plan for Dental Services in Scotland, aimed at identifying and addressing the specific oral health needs of, and dental services available to, the people of Scotland.
- 3.78 The government has proposed the formation of a UK Council for the Regulation of Healthcare Professions to co-ordinate and act as a forum for the regulators of all health services. Additionally, there is some rationalisation of existing healthcare bodies.
- 3.79 The government is also amending the Dentists Act 1984. Of particular note are the following:
- changes to the constitution and possibly the remit of the GDC
  - the registration of certain professionals complementary to dentistry, and
  - the introduction of a complaints procedure for private patients.

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<sup>66</sup> Labour Party Conference, September 1999.

<sup>67</sup> *Primary dental care services in England and Wales*, Audit Commission, 2002.

- 3.80 The DH has consulted on an amendment to the legislation to remove a restriction on the number of corporate dental bodies. It is not proposed to remove other restrictions on corporate dental bodies, details of which are given in paragraph 4.79.
- 3.81 The GDC is also considering an expanded role for all professionals complementary to dentistry. These all come under the broad umbrella of the government's aims to modernise the regulation of healthcare. (For further details refer to annexes H and I.)

## 4 HOW THE MARKET FOR DENTAL SERVICES WORKS

### Introduction

4.1 The market for private dentistry is a rapidly developing and growing market offering consumers greater choice in terms of quality, range of treatments and materials. However we concluded that the market overall is not working well for consumers. There are practical ways to make it work better. In this chapter we consider in detail three main issues:

- consumers lack the information necessary to make informed choices
- should things go wrong, procedures for dealing with complaints are inadequate, and
- regulations impose unnecessary restrictions on the business of dentistry.

In addition we examined whether consumers experience any undue difficulties in changing dentists.

4.2 First, consumers often lack basic information about price and quality of services offered by different dental practices; what services are available on the NHS; what treatment is required and whether treatment options exist; the expected price and quality of specific proposed treatments; and the quality of treatment actually received. Without this information, consumers find it difficult to make informed decisions about which dental practice to choose, what services to buy and how to pay for them, and to assess the quality of the work undertaken. For the dentist, on the other hand, consumers' lack of information and understanding presents an opportunity for over-treatment and/or overcharging which their professional standards, integrity and the need to protect their reputation may address in some but not all cases. More generally, the market may give weak incentives to provide value for money.

4.3 Second, even when consumers have good grounds to believe that they have received poor quality service, their ability to complain and seek redress is limited. There is no universal complaints procedure for private dentistry, only those provided by some practices and capitation plan providers. Where practices do have complaints procedures, they are rarely well publicised. These limitations may also weaken the incentives faced by dentists to provide acceptable levels of quality to their consumers.

4.4 Finally, there are restrictions on the supply of dentistry services, both for professionals complementary to dentistry (PCDs) and corporate dental bodies. Certain PCDs (dental therapists, dental hygienists, and dental technicians) could

provide some dental services otherwise undertaken by dentists but, at present, the consumer pays the dentist for all the services received. There are also continuing restrictions on the directors, staffing and activities of corporate dental groups. These various restrictions limit choice, competition and the potential development for innovative services.

- 4.5 In this section, we describe in detail the evidence of each on these points, and their implications for the functioning of the market.
- 4.6 Chapter 5 goes on to consider ways in which these various problems in the market might be addressed.

### **Consumers lack sufficient information to make informed choices**

- 4.7 In the private dentistry market, consumers generally have insufficient information about:
- price and quality levels of different dental practices
  - what services are available on the NHS
  - what treatment they require and whether treatment options exist
  - the expected price and quality level of specific proposed treatments, and
  - the quality of treatment actually received.
- 4.8 Each of these is discussed in turn below. Without this information, consumers are poorly placed to make informed choices in selecting a dental practice, in making decisions about proposed treatment and payment options, and in judging the quality of service provided. This in turn can reduce the incentives faced by dentists to provide value for money for their consumers.
- 4.9 In respect of professional expertise, limited consumer information is of course inherent in the nature of the service. We expect dentists to know more than consumers about a patient's dental needs and how to provide for these needs with an appropriate service. However, the inevitable information gap in respect of professional expertise does not explain or justify the apparent lack of basic information for consumers. This may be partly a result of the historical background of the private dentistry market, particularly its relatively recent emergence, and the previous experience of both dentists and consumers under the public sector NHS structure. Insufficient information about price and quality levels of different dental practices

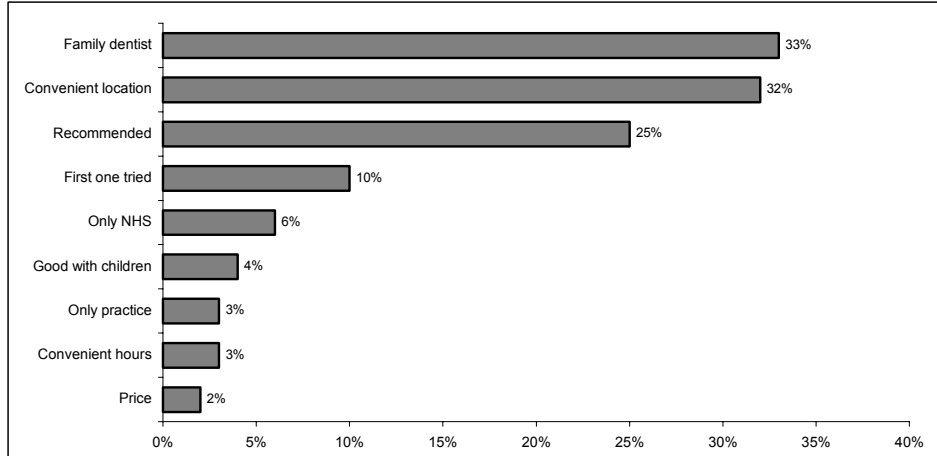
- 4.10 Under the NHS, charges to patients for each item of treatment are set by the government and are the same for all dentists, regardless of location. Therefore consumers who are used to receiving NHS dentistry have little experience of choosing a dentist on the basis of price.
- 4.11 However, even when consumers do wish to take prices into account when choosing a dental practice, our investigation has found that there is little information readily available to guide them. The OFT Mystery Shop found that only about half of the 749 practices surveyed had available information leaflets about the practice and only a third of these leaflets contained any information about charges.<sup>68</sup> Six per cent displayed a list of typical charges (non-leaflet, eg notices on the wall or desk). Taking into account all available forms of published information (websites, leaflets and notices) it was found that only 21 per cent of practices published their charges. Overall, responses to the OFT Practice Survey claimed rather better levels of information provision. Price displays for private treatment and price leaflets were each reported to be available in approaching 40 per cent of practices. But while 19 per cent of practices indicated that they provided both, this left 47 per cent of practices that admitted providing neither.
- 4.12 Given the lack of available information on prices and consumers' relative inexperience in choosing practices on the basis of price, it is perhaps unsurprising that little weight is given to price in choosing a dentist. As shown in figure 4.1, only two per cent of respondents to the OFT Consumer Survey gave price as a reason for their choice of dentist.<sup>69</sup>

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<sup>68</sup> OFT Mystery Shop, see annexe C.

<sup>69</sup> OFT Consumer Survey.

FIGURE 4.1: REASONS GIVEN FOR CHOOSING CURRENT DENTIST<sup>70</sup>



Source: OFT Consumer Survey (see annexe C).

4.13 However, the lack of information on prices can have serious implications for consumers, given that we observed a very wide range of prices. To avoid placing excessive emphasis on the most extreme prices, the measure of price range shown in table 4.1 below is that covering 90 per cent of reported prices, excluding the five per cent of lowest and highest prices. On this basis, for specific private treatments it was found that, prices:<sup>71</sup>

- for examinations were between £9.50 and £40
- for an amalgam filling on a single surface were between £10 and £54.25, and
- for a single tooth extraction were between £15.26 and £75.

In other words, we found that prices can vary by a factor of about four.

<sup>70</sup> The reasons given are not mutually exclusive and people questioned sometimes gave more than one reason for choosing their current dentist.

<sup>71</sup> OFT Practice Survey, see annexe C.

TABLE 4.1: VARIABILITY IN PRIVATE TREATMENT COSTS: PRICE RANGE COVERING 90 PER CENT OF REPORTED PRICES

	Average	5 <sup>th</sup> percentile <sup>72</sup>	95 <sup>th</sup> percentile <sup>73</sup>
Examination: Existing patient	£20.07	£9.50	£40.00
Radiographic: 1 small film	£6.31	£3.00	£12.00
Scale and polish	£23.91	£12.63	£40.00
Amalgam filling: 1 surface	£28.15	£10.00	£54.25
Root filling: Molar	£178.15	£85.00	£327.85
Extraction: Single tooth	£37.10	£15.26	£75.00
Whitening for 12+ teeth	£246.45	£120.00	£450.00

Source: OFT Dental Practice Survey

- 4.14 Price differences may not in themselves be a cause for concern, since they may reflect differences in quality. However, it is far from obvious that this is true for such wide ranges. Moreover, the lack of price information could result in consumers, being unaware, paying far more for their dental treatment from one dentist than they would from another without any justifiable difference in the quality of service received.
- 4.15 Quality is a further aspect of service delivery that is hard to assess in advance of choosing a dentist. Quality of private dentistry services can include a variety of elements, from clinical quality, materials or equipment used, and waiting times, to the amenity of surroundings and additional non-clinical services.
- 4.16 For NHS treatment, there are formal quality inspection processes in place, to check that the work done is clinically sound and cost effective. These include in-mouth inspections.<sup>74</sup> By contrast, there is no formal monitoring of quality standards in place for private dentistry.
- 4.17 One possible method of quality assessment is accreditation. Accreditation schemes should ensure that a practice meets certain set standards and may

<sup>72</sup> 5 per cent of reported prices were less than this figure, and 95 per cent greater.

<sup>73</sup> 95 per cent of reported prices were less than this figure, and 5 per cent greater.

<sup>74</sup> See paragraph 3.69.

include annual inspections. Where dental practices and dental treatment standards are subject to inspection, this should help keep the standard of dental treatment high. However, accreditation schemes can only signal quality standards effectively to consumers provided that they are widely adopted and publicised. This would give reassurance to consumers that they should obtain the level of quality care they expect before they purchase services.

- 4.18 However, a minority of practices currently have dental accreditations. The OFT Practice Survey showed that just 24 per cent of practices had membership of an accreditation scheme, although some were members of more than one.<sup>75</sup> Some practices advertise their achievement of the BDA's Good Practice standard, which is a self-audit tool and does not use inspections. From the 749 private or mixed dental practices surveyed in the mystery shop,<sup>76</sup> 17 per cent had achieved Denplan Excel accreditation and 14 per cent had achieved the BDA's Good Practice standard.
- 4.19 The results of the OFT Consumer Survey (see figure 4.1 above) suggest that the primary way in which consumers gauge quality is through recommendations from others. Still, recommendations were only given as a reason for choice of dentist by 25 per cent of respondents.<sup>77</sup> Moreover, since it is often naturally hard for consumers to judge the quality of the treatment they have received (see below), recommendations by other consumers are not ideal as an indicator of all aspects of quality.

#### **Insufficient information about what services are available on the NHS**

- 4.20 Evidence from the BDA Dental Business Trends Survey 2001<sup>78</sup> shows that those dentists with lower commitment to the NHS (less than 75 per cent of their income being derived from NHS work) are substantially more likely to earn income of over £70,000 before tax than those who have a higher NHS commitment. The interpretation of this result requires a degree of caution, as the comparison was not adjusted for practice size, or other factors that might also influence income. However, it appears to confirm what one would expect, that private dentistry is attractive for dentists, since they are likely to earn higher income if they increase the proportion of private work that they carry out.

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<sup>75</sup> OFT Practice Survey.

<sup>76</sup> OFT Mystery Shop.

<sup>77</sup> OFT Consumer Survey.

<sup>78</sup> Published February 2002.

- 4.21 If dentists do earn more from private dentistry, this means that dentists may have an incentive to encourage patients to have private treatment, even where there is an acceptable NHS alternative.
- 4.22 The NHS Terms of Service specify that where patients are registered for NHS treatment, and require a procedure which is available under the NHS, their dental practice must provide this as NHS dental treatment. However, a significant proportion of respondents to the OFT practice survey (which was anonymous) admitted that they would not always provide all permitted treatments under the NHS.<sup>79</sup> As is shown in Table 4.2, this is particularly the case for time-consuming and difficult procedures such as root canals and crowns.

TABLE 4.2: IS NHS TREATMENT AVAILABLE TO NHS REGISTERED PATIENTS? (% OF RESPONDENTS)

	Always	Usually	Rarely	Never
<b>Simple filling</b>	87%	8%	1%	4%
<b>White filling</b>	82%	12%	2%	4%
<b>Root canal filling</b>	67%	23%	5%	4%
<b>Crown</b>	58%	26%	11%	6%

Source: OFT Dental Practice Survey

- 4.23 The British Endodontic Society said: ‘Increasing numbers of dentists do not feel able to provide endodontic treatment according to the terms of the NHS contract for professional and ethical reasons associated with financial constraints on good clinical practice.’
- 4.24 An adviser with Dental Protection and the Chairman of the BDA’s Student Committee, Len D’Cruz, stated:
- ‘One of patients’ biggest concerns is the confusion over what is available under the NHS. Some practices have selectively withdrawn items so certain treatments such as chrome dentures, full dentures, molar root canal treatments, wisdom teeth extractions and crowns are not provided to patients on the NHS. While there are sound business reasons why practitioners do not offer these time-consuming and expensive items on the NHS this is a breach of practitioners’ Terms of Service if these items are required to secure oral health

<sup>79</sup> OFT Practice Survey.

and requested by the patient. This is often the source of disgruntled patients and complaints.<sup>80</sup>

- 4.25 We also received a complaint about a dental practice that advertised NHS services, but allegedly, only offered check-ups under the NHS and not treatment. Such behaviour is not only in breach of the NHS Terms of Service but may also breach the Control of Misleading Advertisements Regulations 1988 (see annexe F).
- 4.26 As well as consumers being unaware of whether or not particular treatments are available on the NHS, there is also considerable potential for confusion amongst patients as to whether a treatment was NHS or private even after the event. The blurring of the line between NHS treatment and private treatment is acknowledged in *NHS Dentistry: Options for Change*.<sup>81</sup> Such confusion is partly due to the lack of understanding of the NHS fee charging system whereby non-exempt patients have to pay 80 per cent of the cost of their treatment. Therefore many NHS patients are accustomed to paying something for their dental treatment at the point of delivery.
- 4.27 The issue of patient confusion has been highlighted by the National Association of Citizens Advice Bureaux (NACAB<sup>82</sup>). GDC guidance states that, 'It is the responsibility of a dentist to explain clearly to the patient...whether the patient is being accepted for treatment under a particular scheme, including NHS, or under some other arrangement.'<sup>83</sup> When accepting patients for NHS treatment, dentists must ensure completion of form FP17DC<sup>84</sup> (or, in Scotland, form GP17). Patients are also required to sign form FP17DC (or, in Scotland, form GP17) when treatment is completed to say that they agree to pay the NHS charge, including for mixed NHS/private treatment. The NACAB informed us that 'If a client has been receiving NHS treatment, s/he should be given a form (FP17DC (or, in Scotland, form GP17)) to sign to agree to begin private treatment. However CAB evidence suggests this does not always happen, and it is not clear how this requirement is policed.' NHS patients may well not know that they should be asked to sign a form FP17DC (or, in Scotland, form GP17), and, in any case, they may not appreciate what it is they are signing. If a patient is not asked to complete the form, they may believe that they are receiving NHS care but are in fact paying for private treatment.

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<sup>80</sup> *bda news*, October 2002, Vol 15, No 10, p40

<sup>81</sup> *NHS Dentistry: Options for Change*, Department of Health, 2002, p12.

<sup>82</sup> The new name for the National Association of Citizens Advice Bureaux is Citizens Advice.

<sup>83</sup> *Maintaining Standards: Guidance to Dentists on Professional and Personal Conduct*, General Dental Council, 2001, paragraph 3.6.

<sup>84</sup> NHS Dental Care Acceptance Form.

- 4.28 To remedy this confusion between private and NHS treatment, *Options for Change* recommends the use of clinical pathways<sup>85</sup> particularly when mixing NHS and private treatment. A dentist would determine whether or not a treatment was necessary by using established NHS clinical pathways<sup>86</sup>. Private treatment would be defined by reference to what falls outside these pathways, for instance cosmetic, optional items. A NHS dentist would be a dentist who had contracted to provide a defined range of services to an agreed population within a range of clinical protocols defined by a clinical pathway.
- 4.29 If consumers have poor information about what treatments are available under the NHS, or even whether or not a given treatment has been done under the NHS, this makes it difficult for consumers to make informed choices between NHS and private treatments.

#### **Insufficient information about what treatment is required**

- 4.30 Consumers are clearly not in a position to make judgements about what particular treatment they need. Dentists know more about a patient's dental needs than the ordinary patient. This asymmetry of information between patient and dentist means that consumers tend to place substantial trust in their dentist.
- 4.31 These factors mean that, for many people, feeling comfortable with their dentist is of particular importance. Two-thirds of those respondents to the OFT Consumer Survey who stayed with their existing dentist when he or she switched from NHS to private provision said they did so because of personal confidence in the dentist.<sup>87</sup>
- 4.32 While this personal confidence will often be deserved, the asymmetry of information between consumer and dentist can mean that, when payment is on a fee-per-item basis, dentists may have an incentive to over-treat; that is, to provide more, or higher quality, treatment than the patient strictly needs and the patient ends up paying more than is necessary. This propensity for a supplier to determine the 'demand' of its customer is known as 'supplier-induced demand', and is a well-known characteristic of healthcare markets.
- 4.33 With supplier-induced demand, the risk of over-treatment is increased by the fact that consumers are often captive in the dentist's chair when the required

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<sup>85</sup> *Options for Change*, Department of Health, 2002, paragraph 2.17

<sup>86</sup> Clinical pathways establish clinical protocols and are built on evidence and best practice. Dentists would record their clinical interventions via clinical pathways and note the outcome. Clinical pathways would ensure that dentists provide treatment which is driven by need and supported by evidence.

<sup>87</sup> OFT Consumer Survey.

treatment is discussed. At this point, consumers may have to absorb complex information and make important decisions. If consumers had greater opportunity to think about their treatment options or the options were explained in, what for some may be, a less intimidating environment, then they would be better placed to make decisions on whether they needed the treatment and, if so, which option they would prefer. Under these circumstances the scope for dentists to induce unnecessary demand and hence over-treat would be limited.

- 4.34 As previously discussed, dentists face an incentive for over-treatment. There is some evidence which is consistent with over-treatment, but this is not conclusive. There are substantial differences between dentists in terms of treatment philosophy, with no absolute 'right' level of treatment for any particular consumer. The paper written by Professor Kay of the University of Manchester describes how there are a range of needs for dental treatment and within this range there may be needs that only the consumer or only the dentist can identify, or even some that neither can identify but another dentist might.<sup>88</sup>
- 4.35 This explains some of the variation in approach between dentists. Some dentists tend towards a minimum-intervention approach while others may prefer to treat recognised problems early. There is no clear-cut 'right' level of treatment for any particular patient, and consequently the concepts of under and over-treatment are difficult to assess.
- 4.36 Despite this uncertainty over what the 'right' amount of treatment is, the asymmetry between dentist and patient could be ameliorated if more information were provided to consumers. There is existing GDC guidance that 'dentists should explain proposed treatment and any alternatives and obtain appropriate consent from patients'<sup>89</sup>. Nevertheless, the OFT consumer survey found that on their last occasion of treatment only 34 per cent of respondents were told what the treatment would involve, 26 per cent whether or not the treatment was essential and only 12 per cent whether there were any alternatives. Somewhat better information was provided to private patients, with respectively 37 per cent told what the treatment would involve, 37 per cent whether or not the treatment was essential and 21 per cent whether there were any alternatives. A high proportion of patients (71 per cent in 1998<sup>90</sup>) would like to know more about what the dentist is going to do and why.

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<sup>88</sup> *Need and demand for dental treatment: Evaluation of the role of clinical decision making*, Kay, E, 2002.

<sup>89</sup> *Maintaining Standards: Guidance to Dentists on Professional and Personal Conduct*, General Dental Council, 2001, paragraph 3.7.

<sup>90</sup> *Adult Dental Health Survey: Oral Health in the United Kingdom 1998*, Office for National Statistics.

- 4.37 Moreover, a number of studies have provided indicative evidence of over-treatment occurring in dentistry in the UK. Demos<sup>91</sup> examined this issue by comparing treatment levels under different payment systems. As discussed in Chapter 3, there are a variety of payment schemes available for private dentistry. These can affect dentists' incentives when treating patients, with fee-per-item providing incentives for over-treatment which do not exist under capitation schemes. The Demos report says 'the incentives from fee-per-item payments are to maximise the production of items of service that attracted the highest fee levels. There may be an incentive to over-treat.'
- 4.38 Demos also examined whether capitation schemes may lead to under-treatment. However, they found the evidence for capitation leading to under-treatment less conclusive than that for fee-per-item leading to over-treatment.<sup>92</sup>
- 4.39 Further evidence on this issue, albeit for NHS treatment, is presented by Chalkley and Tilley (2002).<sup>93</sup> Using treatment data for Scotland, Chalkley and Tilley found clear evidence of self-employed, fee-per-item dentists influencing the amount of treatment received by that category of NHS consumers who are exempt from payment. The authors found that self-employed dentists provide 15-20 per cent (by value) more treatment to exempt patients (those who do not have to pay any of the cost of their treatment, see paragraph 3.5) than their flat-salaried employed counterparts do.
- 4.40 The issue of unnecessary treatment was also raised by the Audit Commission (AC) in their recent audit of NHS dentistry.<sup>94</sup> They pointed out that that many commentators believe that far too many scale and polish procedures are being carried out. In 2001-2002, 11 per cent of GDS expenditure was spent on scale and polish. The AC stress that 'according to the scientific evidence, straightforward 'scaling and polishing' does not keep most people's teeth and gums healthy'. The AC also points out that 'there is great variation between dentists in how often they carry out a scale and polish, far more than can be explained by variation in true clinical need.' That said, the provision of scale and

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<sup>91</sup> *Open wide: Futures for dentistry in 2010*, Perri 6 with Jupp, B & Bentley, T, Demos, 1996, pp 56-62.

<sup>92</sup> Of course, a further explanation for these results may be that fee-per-item schemes may be more attractive than capitation schemes for dentists who prefer to intervene early where there are potential problems. Dentists who prefer a minimum-intervention approach to treatment may be more likely to use capitation schemes since they get a better reward than they would do under fee-per-item. Demos did not test for this possibility.

<sup>93</sup> *Treatment Intensity and Provider Remuneration: Dentists in the British National Health Service*, Chalkley, M & Tilley, C, Dundee Discussion Papers in Economics, 2002.

<sup>94</sup> *Primary dental care services in England and Wales*, Audit Commission, 2002, p31. See Annex I for further details.

polishing in some cases could, of course, be due to consumers' demands and therefore not necessarily induced by dentists.

- 4.41 While none of these studies provides conclusive evidence of over-treatment, it is clear that dentists who are paid on a fee-per-item basis will have an incentive towards over-treatment (whether or not they act on it). We therefore consider possible remedies to address this concern in Chapter 5.

#### **Insufficient information about the expected price and quality of specific proposed treatments**

- 4.42 Consumers lack sufficient information on their own needs and on the prices and values of possible treatments to make informed choices. In order for consumers to make an informed choice about appropriate treatment, the dentist needs to provide information about the nature of the treatment proposed, what it will cost, whether it is essential, and whether there are any alternatives to the treatment.
- 4.43 Despite GDC guidance that, 'a written plan and estimate will avoid misunderstandings and should always be provided for extensive or expensive courses of treatment',<sup>95</sup> survey evidence shows that this is not widely followed.
- 4.44 The OFT Consumer Survey showed that, on the last occasion they had treatment, just 47 per cent of private patients were told the overall price of the treatment in advance.<sup>96</sup> Only 14 per cent of those having private treatment had been provided with a written treatment plan.
- 4.45 Moreover, many patients are not even clear what they have paid for after treatment. GDC guidance states that 'Patients are entitled to an itemised account of treatment received and should normally be provided with one.'<sup>97</sup> IT software is available that can readily and easily provide itemised treatment plans and invoices.
- 4.46 Nevertheless, the OFT Consumer Survey found that only 52 per cent of private patients received an invoice when it came to paying for treatment. Of those

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<sup>95</sup> *Maintaining Standards: Guidance to Dentists on Professional and Personal Conduct*, General Dental Council, 2001, paragraph 3.6.

<sup>96</sup> OFT Consumer Survey.

<sup>97</sup> General Dental Council, *Maintaining Standards: Guidance to Dentists on Professional and Personal Conduct*, 2001, paragraph 3.6.

<sup>99</sup> *The Relationship between Change of Dentist and Treatment Received in the General Dental Service*, Davies, J A, *British Dental Journal*, 1984. This found that out of a sample of 116 frequent attenders (for dental care), the 60 people who had changed dentist at least once during the five years of the study, received, on average, twice as many restorations as those

private patients who received an invoice, 42 per cent of these showed only the overall charge while 31 per cent gave detailed itemised information on treatment and materials.

- 4.47 Poor price transparency may encourage potentially unnecessary treatment, or treatment that is of higher or lower quality than the consumer would wish, since it limits the consumer's ability to judge the cost of treatment, and so make an informed purchase choice.

#### **Insufficient information about quality of service received**

- 4.48 Even after treatment has been received, consumers may still be unable properly to judge the quality of the service provided or of the materials used. On the one hand, if consumers consider a lack of pain to be an indication of good quality, then they could easily be misled. Just because a consumer is without pain does not necessarily mean that the treatment was of a good standard, not least because there may be remaining problems that do not cause pain but are nevertheless detrimental to the consumer's oral health.
- 4.49 On the other hand, even where consumers are unhappy with the service they have received, this may not reflect bad practice on the part of the dentist. It may be due to misaligned expectations on the part of the consumer or further underlying problems that reveal themselves in the course of treatment.
- 4.50 This inability of consumers to judge quality of treatment means that dentists may have an incentive to provide a poorer quality of treatment or materials they charge for (in so far as that goes undetected), and may limit their incentive to provide high quality treatments. The OFT is not in a position to make judgements about the quality of service provided in practice, and since there is currently no system for evaluating the quality of treatment provided privately, it is not possible to determine the extent of this problem. However, we have been informed that some dentists may be acting on this incentive to supply lower quality service.
- 4.51 The Dental Law Company informed us of an extreme case where a patient suffered an allergic reaction to a new nickel post crown that her dentist had claimed was made of gold. This was despite the patient making the dentist aware of her nickel allergy prior to treatment. Not only was this clinically unacceptable but also an instance of a consumer being cheated. Had it not been for the patient's allergy, the deception may never have come to light.

#### **Changing dental practices**

- 4.52 We examined whether there were significant barriers to consumers changing dental practices (switching). While consumer switching behaviour is often desirable to encourage competition, we recognise that there may be issues concerning continuity of healthcare which would have an impact on the desirability of frequently changing practice. That said, there is certain information with which consumers would be better equipped should they wish to change dental practice.
- 4.53 As we know from our consumer survey, people seldom change dentists (only 16 per cent ever had). This means that dentists do not have to compete very hard to retain customers. An obvious barrier to switching is the trust relationship that the dentist often develops with their patient (see paragraph 4.30 to 4.31).
- 4.54 There is some evidence that people who switch dentists receive more treatment than customers who do not.<sup>99</sup> However, there are a variety of possible reasons for this:
- people who switch are high-treatment patients
  - people who switch do so because they are not being treated well/sufficiently/have not been able to get convenient appointments
  - dentists tend to give more treatment to new patients to 'prove their worth'
  - dentists take action that would have been unnecessary had they been aware of the patient's full dental history.
- 4.55 When changing practices it can be helpful for the new dentist and their patient to have a copy of the patient's dental records. Records and radiographs are however the property of an individual dentist. Our investigation found that the transfer of copies of records and radiographs is not common. Our practice survey found that 52 per cent of practices said that they would allow for the transfer of records to another practice if the patient wished. However, when asked to supply information on charges for transferring/copying records only four practices did so. Under the Data Protection Act 1998 (DPA), consumers are legally entitled to access to personal data, including their dental records. The DPA limits the amount that patients can be charged for this service.<sup>100</sup>
- 4.56 In addition, if consumers choose to change dentist, they may need to have an initial examination and may be charged a registration fee by the dentist.

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<sup>100</sup> The maximum that patients can be charged is £50 for access to manual or manual and automated records, and £10 for access to automated records.

Registration fees are less common than initial examination fees and should never be charged for NHS registrations. The OFT Mystery Shop found that only 27 per cent of practices surveyed charge registration fees.

- 4.57 These factors may act as a deterrent to consumers considering changing dentists. It also means that, when customers do switch, the new dentist does not know their dental history, which may lead to a lower quality of service, unnecessary exposure to repeated radiographs<sup>101</sup> and possible repeated treatment or over-treatment.

#### **Information shortage as it affects different groups of consumers**

- 4.58 Information shortage can affect some consumers more than others. Our review of the literature and discussions with relevant organisations indicated that there are indeed vulnerable groups due to factors such as low income, social deprivation, genetic disposition to particular diseases, diet, poor attendance by parents and English as a second language. More attention may need to be paid in future to the needs of these groups if the market for private dentistry continues to grow at a high rate.

#### **Complaints and redress procedures are inadequate should things go wrong**

- 4.59 As discussed in the previous section, consumers are often unaware whether or not they have received the expected quality of service. In addition, even when it is obvious to consumers that they have received poor quality service, their ability to complain and seek redress is limited. This lack of redress can lead to dissatisfied consumers while leaving dentists unaware of the possible need to change their behaviour.
- 4.60 There is no universal complaints procedure for private dentistry that exists independently of individual practices. The GDC has a remit to look only at cases of serious professional misconduct,<sup>102</sup> which could lead to permanent exclusion of the dentist from the dental register. Currently, complaints which fall short of this must be made directly to the dental practice involved. Complainants then

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<sup>101</sup> The Ionising Radiation (Medical Exposure) Regulations 2000 requires that radiation doses to patients are optimised so that they are as low as reasonably practicable.

<sup>102</sup> Serious professional misconduct covers a variety of issues which are not specifically outlined in *Maintaining Standards*. This says, 'It is not possible to be explicit as to what constitutes serious professional misconduct. However, it has been broadly defined as '...conduct connected with the profession in which the dentist concerned has fallen short, by omission or commission, of the standards of conduct expected among dentists and that such falling short as is established should be serious.'

do not have any further avenue if they are not satisfied with the response, other than to seek redress through the courts.<sup>103</sup>

- 4.61 This situation is far from ideal, for a variety of reasons. First, while most practices reported having some sort of procedure for handling complaints about private treatment, they are seldom well publicised. The OFT Mystery Shop found that only 22 per cent of practices made details of their complaints procedure readily available before patients register. The OFT Practice Survey found that when initially approached by a patient with a complaint, only 30 per cent of practices provided advice on the normal procedures used for resolving complaints. In response to our consumer survey, only 16 per cent of private patients claimed to be aware of the procedures for making a complaint with their dentist.
- 4.62 Secondly, consumers may prefer not to complain to their own dentist in view of the personal nature of their relationship and their future treatment. As there is no universal complaints procedure independent of practices, some consumers may not choose to pursue a complaint. Our own consumer survey did not investigate the reasons for non-complaint. However, a dental trade publication reported a survey by Desoutter Consulting on private dental treatment, which found that: 'there was a great reluctance to complain directly to the practice for fear of retribution at the next visit. Dentists were not perceived as very approachable, mainly due to the fact that they were always doing the talking and yet would not discuss the costs of any treatment'.<sup>104</sup>
- 4.63 Thirdly, sometimes complaints are not satisfactorily resolved at practice level. We asked dentists about actions that a practice would take to address a complaint. While 57 per cent said they very commonly offered free repair or replacement and 31 per cent said they did so commonly, many complaints appeared not to have been resolved satisfactorily. Instances in which no remedial work was undertaken, nor any refund paid, were judged to be very common by 19 per cent of practices and common by a further 19 per cent. In these cases, the complaint was not withdrawn but no further action was taken by the complainant.
- 4.64 The OFT Consumer Survey also provided some information about consumer satisfaction with the outcome of complaints. Due to the limited number of actual complaints, and the fact that the complaint could have occurred up to five years before the interview, the complaints cannot be reliably divided into those about NHS treatment and those about private treatment. Nevertheless,

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<sup>103</sup> Dentists may be prepared against such litigation through dental defence unions.

<sup>104</sup> *Patients dissatisfied with private care, Dentistry*, 30 October 2002.

overall consumer satisfaction was poor, with nearly half of those who complained not at all satisfied with either the way the complaint was dealt with (47 per cent) or the overall outcome (46 per cent) of the complaint.

### **Regulations impose unnecessary restrictions on the business of dentistry**

- 4.65 There are continuing regulatory restrictions on two types of possible entrant to the dentistry market. Firstly, there are a variety of professionals complementary to dentistry (PCDs) who would be in a position to provide certain services in competition with dentists, but who consumers can only gain access to through dentists. This limits the freedom of PCDs to offer services to the public, and restricts competition and choice in the market.
- 4.66 Secondly, there are continuing restrictions on the number, staffing and activities of corporate dental groups. Such groups provide a different business model, and tend to have a slightly different focus from that of more traditional dental practices. Depending on the needs of consumers, they have the potential to innovate, increase competition and offer better services to the public.

### Professionals complementary to dentistry

- 4.67 Dental hygienists and dental therapists undertake some types of work also undertaken by dentists. However, they are not legally permitted to charge patients directly for their services.<sup>105</sup>
- 4.68 The effect of this prohibition on hygienists and therapists undertaking 'the business of dentistry' is that dentists act as gatekeepers to consumers requiring their services. Dentists therefore determine both the amount of work they can undertake and the price charged to customers for their services. Patients of dentists that do not have PCDs in their practice<sup>106</sup> have effectively no access to PCDs.
- 4.69 As gatekeepers, dentists essentially determine which of their own and which of the PCDs' services are offered to patients and the standard of quality of these services. This is another means by which dentists, as the supplier, determine the demand for their services rather than by patients making choices on the advice of both dentists and PCDs.
- 4.70 A consequence of these restrictions is that a substantial proportion of the scarce time of dentists may be spent on tasks that could perfectly well be carried out by PCDs.
- 4.71 In the case of dental technicians, the law limits them to designing and constructing dental appliances and they are not permitted to undertake their fitting nor to charge patients directly.<sup>107</sup> Trade associations have, however, told us that some technicians are defying the law and providing appliances directly to customers. This has been affirmed in other reports:
- 'Substantial hidden savings are already being made by the unauthorised supply of dentures by dental technicians.'<sup>108</sup>
- 4.72 In the EU there is also evidence that dental technicians can perform useful work for consumers, since, 'In many member states, 'Denturists'<sup>109</sup> work unofficially or illegally and fit patients with dentures.'<sup>110</sup>

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<sup>105</sup> Sections 40-41 Dentists Act 1984.

<sup>106</sup> For example in our practice survey, where relevant data on staff numbers were provided, 54 per cent of practices reported employing no hygienists, 30 per cent employing one hygienist, and 16 per cent employing two or more (not necessarily full time equivalents).

<sup>107</sup> Dental Auxiliaries Regulations 1986 (as amended) SI 1986/887.

<sup>108</sup> *Private, National Health or both: A view of the economics of denture supply by non-dentists*, Association for Denture Prosthesis, 1994.

<sup>109</sup> Dental technicians who are permitted by law to manufacture and fit dental prosthesis.

- 4.73 In considering what further changes in the law might be appropriate in the UK to allow PCDs to compete with dentists and allow more efficient use of dentists' time, it is useful to consider what has happened in other countries. The international research that we have undertaken shows that some countries do allow certain PCDs to perform certain treatments independently and to charge consumers directly. In Denmark hygienists have a screening role in some public dental clinics and are authorised to work independently of a dentist and charge for their services in the private sector. Finland and Sweden have also legalised the independent practice of hygienists in the private sector.
- 4.74 In seven of the eleven countries we studied (Australia, Canada, Denmark, Finland, New Zealand, Sweden and the USA), denturists are permitted to work independently of dentists and to charge their patients directly. The type of work they are permitted to perform varies from country to country.<sup>111</sup>

#### **Corporate dental groups**

- 4.75 The OFT has no view on which methods of business organisation are best for the provision of dental services. However, we are concerned that there should be no undue restrictions on forms of business organisation.
- 4.76 New and existing corporate bodies are likely to have or bring in directors with business skills gained from other markets. This can facilitate alternative working methods to those followed by traditional dental practices, including the services on offer to consumers, which may be consistently promoted across a corporate chain. Some dental professionals may find this attractive as they may be freed from many of the administrative burdens and therefore become able to spend more time using their professional dental expertise. In addition corporate bodies offer alternative sources of capital and risk bearing.
- 4.77 Some practices, particularly those that are part of corporate chains, are now situated on the High Street, making it easier for some customers to attend in the course of other activities. Some of these practices also offer a wider range of opening hours so that customers can attend outside the normal working day. Certain corporates have been particularly successful in attracting patients who did not previously attend a dentist due to these differences from traditional dental practices. In 1998 41 per cent of dentate adults did not attend regular check-ups. There is therefore the potential for significant further growth in the market and consequent benefits to health.

<sup>110</sup> *An Opinion for the Legal Committee to the position of Denturists (unofficial translation from German)*, European Parliament Committee for the Environment, Public Health and Consumer Protection, 1984.

<sup>111</sup> See annexe E for further information and other PCD comparisons.

- 4.78 Where corporates adopt certain elements of good business and customer practice that may not currently exist comprehensively across the profession this may, over time, encourage independent practices to improve levels of service in order to compete more effectively. Opening hours, accessibility and better provision of clear price information are examples of where the presence of corporates may lead to a change in existing practice by other dentists, depending on the wishes of consumers. However, the impact has so far been constrained by restrictions on corporate bodies.
- 4.79 The DH has consulted on amendments to the Dentists Act 1984 to lift one of the restrictions on dental bodies corporate. Currently, a corporate body is prohibited from practising dentistry unless it is exempted by virtue of meeting all the following criteria:
- the body corporate was carrying on the business of dentistry on 21 July 1955 (unless the limited exception in Section 43 (2) of the Act applies)
  - it is not carrying on any business other than dentistry, or some business ancillary to the business of dentistry (unless the limited exception in Section 43 (2) applies)
  - a majority of its directors are registered dentists, and
  - its entire operating staff are either registered dentists or dental auxiliaries.
- 4.80 Section 43 (2) exempts societies registered under the Industrial and Provident Societies Act 1965 or the Industrial and Provident Societies Act (Northern Ireland) 1969. It also permits corporate bodies to merge or reconfigure and continue the business of dentistry.
- 4.81 The DH is proposing to revoke only the first of these restrictions, because the DH and the GDC regard the remaining restrictions as important for patient safety. In particular DH are concerned that as non-dentists on the board of a corporate body are not subject to the GDC ethical standards and disciplinary action, where a corporate body had a majority of lay directors, commercial decisions may be made that are incompatible with ethical requirements and patient safety.
- 4.82 It is undoubtedly desirable to have some dentists on the board of a corporate body involved in dentistry, to ensure that professional considerations are fully taken into account in decision making. However, it is not clear to us why this needs to be a majority of the board members. We believe that in practice non-dental members of a board would have every incentive to operate in a way that

would not put the company's dental employees at risk of GDC sanctions. Doing so would lose custom, attract bad publicity and discourage many dental staff from wishing to work for it in these circumstances.

- 4.83 Ethical standards are important across a wide range of economic activity, not just the professions. One method of ensuring ethical standards are maintained would be to give a director or group of directors on the board a particular role in this regard. This approach has been recommended recently in reports on the provision of audit services, as a means of ensuring adherence to ethical standards in this area.<sup>112</sup> Corporate dental bodies are also subject to general company law which is applicable to companies in all sectors and should provide protection against general malpractice.
- 4.84 DH also expressed concern that removing the second restriction, allowing corporate bodies to have other business interests, may in certain circumstances result in commercial pressures to operate the dentistry business in a way which benefits their other business interests but which may not be compatible with ethical requirements. Should this restriction be relaxed it is therefore important to include safeguards to prevent a conflict of interest where there is a danger that this might arise. Only a small number of business activities are likely to produce even the potential for conflict with the provision of dentistry services.
- 4.85 We welcome the prospective removal of the first of the restrictions on corporate bodies undertaking dentistry. However, we urge the DH to look again at the other restrictions, in the light of the analysis in this report. In reviewing these restrictions it should consider whether in their current form they go beyond what is strictly necessary to protect the safety of patients.
- 4.86 It would be for the customer given potentially a greater choice of corporates to decide whether a corporate rather than an independent practice provided a better service for their particular circumstances. This is the kind of free choice that suppliers and consumers have for most goods and services. At present, regulation prescribes the answer for dentistry. Liberalisation would give businesses the freedom to serve customers in new and potentially better ways. We are neutral as regards the corporate form, but in favour of unrestricted freedom for providers to adopt what they judge to be the best way of running their business to serve consumers, subject of course to other means of ensuring

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<sup>112</sup> See for example *Audit committees: combined code guidance*: a report and proposed guidance by an FRC-appointed group chaired by Sir Robert Smith. Submitted to the Financial Reporting Council in December 2002 and published in January 2003. And *Review of the role and effectiveness of non-executive directors*, Derek Higgs, published by the Department of Trade and Industry, January 2003.

that proper standards are adhered to in the operation of the company as a whole. To the extent that removing these restrictions leads to larger practices it may also bring efficiency gains by enabling more non-dental staff to be employed to undertake business management and other non dental work which is currently undertaken by dentists. This would reduce the amount of time that trained dentists have to spend on non-dental matters giving them more time to spend on dentistry.

- 4.87 Thus the limited availability of dentists and other dental professionals is a reason for, not against, liberalisation. Removal of restrictions should promote best use of scarce professional skills.

### **Competition law**

- 4.88 Regardless of corporate structure, all dentists should be aware of competition law and how it applies to them. During our investigation, in addition to the issues outlined above, we found some evidence of co-ordination between dental practices in certain areas, including an agreement between practices to refuse to register new patients under the NHS. These cases may reflect a lack of understanding among dentists about UK competition law and how it applies to them. While insufficient evidence was obtained to conclude that an anti-competitive agreement existed in these specific cases, the OFT will continue to conduct investigations in the private dentistry market if it has reasonable grounds to suspect an infringement of the Competition Act 1998. However, these cases may also reflect a lack of understanding among dentists about UK competition law and how it applies to them (see annexe F for more details).

### **Next Steps**

- 4.89 We have outlined above the main factors which prevent the market for private dentistry from functioning as effectively as it might and have referred to proposed changes that should have at least some impact. It is necessary in the next chapter to consider ways in which the existing problems with the market might be remedied.

## 5 PROPOSED REMEDIES

5.1 The previous chapter examined the characteristics of the market for dentistry services, and identified the underlying problems that impact on how this market works for consumers. The most significant of these are:

- consumers lack the information necessary to make informed choices
- should things go wrong, procedures for dealing with complaints are inadequate
- regulations impose unnecessary restrictions on the business of dentistry, both in terms of the use of professional staff and in the way in which services are provided.

5.2 In addition we considered whether the low rate at which consumers change (switch) dentist was an important factor in this market. This raised a number of other issues, in particular consumers' access to their dental records when changing dental practice (which we deal with below as an aspect of improving consumer information).

5.3 In this chapter, we propose a variety of remedies which are designed to address these problems.

### **Improving consumer information**

5.4 If they are to be able to make informed choices at every stage in the process of choosing a dental practice and making decisions about cost and treatment, consumers need better information.

5.5 Markets work best when consumers are well placed to help themselves. Dental services, like other professional services, are naturally complex. This makes the provision of basic information to consumers all the more important. However, given the nature of dentistry, many consumers are not in a position to know what to ask and what the information supplied means. They may need help and guidance in doing so.

5.6 There is a clear role for the profession here, one which builds upon the GDC's existing guidance for dentists on professional and personal conduct. We also see a role for the OFT in raising consumer awareness.

## Improved monitoring and enforcement

- 5.7 With regard to patient information, the GDC's existing guidance, *Maintaining Standards*, requires that:
- patients are not persuaded to accept private treatment by being given incorrect information
  - dentists explain clearly whether patients are being accepted for treatment privately or under the NHS
  - patients know what the charge for an initial consultation is and the probable cost of subsequent treatment
  - dentists provide a written treatment plan and estimate
  - patients receive an itemised account of treatment received
  - dentists explain the treatment proposed, the risks involved and alternative treatments and ensure that appropriate consent is obtained.
- 5.8 However, it is clear from our work that these things often do not happen. Our consultations and surveys suggest that compliance with the guidance is not monitored, and that many dental practices are not following it comprehensively. Furthermore, there are additional areas of concern that are not currently covered by the guidance. **We therefore recommend that the system of regulation and self-regulation be both strengthened and broadened.**
- 5.9 Firstly, to ensure that dental practices follow existing guidance on standards and that compliance is monitored. **We recommend monitoring and enforcement of the standards promoted in appropriate professional guidance for dentists and professionals complementary to dentistry.** At present the Dentists' Act 1984 is being amended and there may be opportunity for this recommendation to be reflected in the amendments.
- 5.10 In addition, to ensure that consumers' information needs are well met, **we recommend that the areas covered by the GDC's standards be expanded** to include the following:
- that dental practices should provide **indicative prices** on a range of relevant services and that these are clearly displayed to consumers
  - that written treatment plans should also include itemised costing details

- that dental practices should **display prominently details of what services are available under the NHS** and what services the practice provides privately, and
  - that practices which stop offering NHS treatment to existing patients should **refer them to a relevant body to assist them in finding a new dentist who will treat them under the NHS** (this might be the local Primary Care Trust, Health and Social Services Board, Local Health Board, Local Health Authority or NHS Direct).
- 5.11 Indicative price lists would enable consumers to compare prices and services offered by dental practices. This price information may increase consumer awareness of price differences (which may be substantial) and help consumers decide whether to change. This information will also help those consumers seeking a dentist who are currently without one in taking price into account in their choice.
- 5.12 Indicative price lists should be easy to produce and will be helpful to staff when explaining prices to potential customers. To be effective, lists need only cover a selection of the most common treatments: it can be explained that these are guide prices (and that the cost will depend on the particular needs of the patient and the work required). The GDC and others should not, however, set or publish particular prices centrally as this may contravene the Competition Act 1998 (see annexe F and the OFT's *Guidance to Trade Associations, Professions and Self-Regulating Bodies, Competition Act Guideline* - OFT 408). Itemised costing on treatment plans would enable consumers properly to consider specific treatment options and their prices. This would also enable them to check whether they had been charged the amount indicated prior to the treatment and give an indication of what they might expect to pay for a similar treatment in the future.
- 5.13 Dental practices already have information from the DH about what procedures are available under the NHS and in what circumstances. By making this information easily available to consumers, potential misunderstandings can be avoided (eg consumers believing that a certain procedure is not available under the NHS when, in practice, it is).
- 5.14 For those consumers who wish to continue receiving NHS treatment after their practice stops providing it, information about how they can find NHS dentistry elsewhere would show what choices are available. This would reduce the risk that patients may feel pressurised into accepting private treatment at their existing practice, without realising that there are other options.

- 5.15 Some steps are already being taken by the GDC to extend the scope of regulation and to improve the efficiency and effectiveness of existing procedures. We welcome the GDC development programme for the modernisation of professional regulation in dentistry. This expands the GDC's role from being primarily a registration body, with powers to take action only in extreme cases, to one which has a more active role in addressing poor performance (see annexe H). The GDC has introduced Continuing Professional Development (CPD) and is considering the introduction of new procedures for the revalidation and fitness to practise of dentists and PCDs. The intention of these GDC initiatives is that once registered, dental professionals continue to remain fit for registration and where this is not the case action can be promptly taken to address deficiencies and thus protect the public.
- 5.16 However, it is important that consideration is also given to the financial and commercial dealings of dental professionals when tackling poor levels of service, particularly in relation to consumer information (eg the provision of price information). As such matters often overlap with clinical issues, the two need to be addressed together. This can be seen with regard to the provision of treatment plans. These plans provide consumers with important information about the treatment proposed and its price. They are also an essential part of the clinical imperative to gain informed consent.
- 5.17 We have no strong view on whether the GDC would be the most appropriate body to monitor and enforce the standards. This is a matter for the Secretaries of State for Health Scotland, Wales and Northern Ireland to decide in consultation with their health departments. However, we note that in other areas of private healthcare the National Care Standards Commission (NCSC) (soon to become the Commission for Healthcare Audit and Inspection) already has expertise in the setting, monitoring and enforcing of standards (in conjunction with the appropriate professional body, such as, for medical care, the General Medical Council).
- 5.18 The NCSC's remit covers both clinical and consumer standards. Their involvement in the regulation of private dentistry could therefore help to meet our concerns about how dental practices behave towards consumers.
- 5.19 There may additionally be a role for the Dental Reference Service in England and Wales (or the body which succeeds it under proposals outlined in the Health and Social Care (Community Health and Standards) Bill), the Referral Dental Services in Northern Ireland, and the Scottish Dental Reference Service, which perform inspections for the NHS. Their remits could be extended to cover private dentistry.

- 5.20 In Northern Ireland, proposals are being considered for a Health and Personal Social Services Regulation and Improvement Authority, which might have a remit to include private dentistry. At present, only general anaesthesia and sedation are proposed to be included with regard to private dentistry.
- 5.21 In Scotland, NHS Quality Improvement Scotland (the former Clinical Standards Board for Scotland) and the Scottish Executive are working on the development of unified standards for both private and NHS dentistry.
- 5.22 The arrangements for the monitoring of quality assurance in private dentistry in Wales are currently under review.

#### **Consumer awareness campaign**

- 5.23 To help ensure that consumers gain the information they need, the OFT, with the assistance of the health departments and key organisations, will undertake a consumer awareness campaign. This will publicise what information the GDC says dental practices should already provide to patients. Of particular importance is price transparency. It will also advise consumers that, when choosing a dentist or a treatment, there may be benefits from:
- looking to see whether a practice has achieved a dental accreditation
  - seeking a second opinion if very expensive or extensive treatment is proposed
  - requesting a cooling off period to think about the proposed treatment (particularly relevant to cosmetic treatment)
  - asking if the dental practice charges a registration fee, and
  - asking about the practice's complaints procedure.
- 5.24 Accreditation schemes indicate that dental practices have achieved certain standards of care and service. Second opinions can help consumers to compare proposed treatments and thus be better able to decide which course of action is right for them. Cooling-off procedures (where practicable) can allow consumers time to consider proposed treatment and, if they consider it appropriate, seek a second opinion or alternative provider of that treatment.

#### **Helping consumers to change dentists**

- 5.25 Moreover, better information would help consumers feel more confident about seeking out and choosing a new dental practice. Consumer switching behaviour (changing suppliers) can help markets to work better for consumers by encouraging competition. Greater competition can lead to the provision of a

greater range of services and prices. However, consumers rarely change dentists.

- 5.26 When consumers do change practices, it can be helpful for the new dentist to receive a copy of the patient's dental records and radiographs. Without these the dentist must work without the benefit of the patient's dental history and the patient may have to undergo another x-ray. We think it would help both consumers and dentists if records and radiographs were routinely transferred. **To this end we will highlight consumers' rights under the Data Protection Act 1998 to obtain copies of dental records and radiographs.** Under the Act consumers are entitled to access to personal data including their dental records. The Act limits the charges that can be made for making copies. We will highlight further details about this and about registration fees in our consumer campaign.

### **Resolving problems: complaints and redress**

- 5.27 Consumers need recourse to an inexpensive, effective and speedy complaints system should things go wrong. They have a right to expect their complaints to be taken seriously and for there to be a system to both register and resolve them.
- 5.28 The GDC's guidance, *Maintaining Standards*, states that every effort should be made to resolve complaints within the dental practice. It also endorses the BDA's guidance on the handling of complaints; who advise that procedures should be straight forward, thorough, effective, speedy and confidential.
- 5.29 Consumers would benefit if they knew that all dental practices had such a formal in-house complaints procedure. **We recommend that each dental practice has a complaints procedure and that patients are made fully aware of this when they register with the practice.**
- 5.30 **We recommend that an independent complaints procedure is instituted where problems cannot be addressed at practice level.** This would enable consumers of private dentistry with unresolved complaints to have access to a complaints procedure which is independent of practices, just as consumers of NHS dentistry already have. The DH/GDC is in the process of instituting a complaints procedure for private dentistry which is independent of practices and will deal with those complaints that are not dealt with by the dental practice to the consumer's satisfaction. Such a procedure should in our view be introduced in the near future.

- 5.31 Knowing that such a procedure exists should reassure consumers and help dental practices to focus on maintaining good standards of service.

## **Reducing unnecessary restrictions on the business of dentistry**

### **Professionals complementary to dentistry**

- 5.32 Currently, dental therapists and dental hygienists can practise certain aspects of dentistry but dental technicians cannot. The GDC is considering relaxing this restriction for dental technicians<sup>116</sup>. At present, none of these Professionals Complementary to Dentistry (PCDs) can charge consumers directly for their services. The GDC has been considering proposals to relax this restriction, subject to necessary safeguards to protect patients' health and safety.
- 5.33 The Health and Social Care (Community Health and Standards) Bill<sup>117</sup> includes proposals to allow new categories of people and organisations to enter into General Dental Service (GDS) and Personal Dental Service (PDS) contracts. The following would be eligible:
- a dental practitioner
  - a dental corporation
  - two or more persons in partnership where at least one is a dentist and any partner who is not a dentist is a health care professional<sup>118</sup> or an NHS employee including employees of independent contractors.
- 5.34 Although GDS contracts concern the provision of NHS dentistry, the effect of this is that PCDs could become engaged in the business of dentistry working alongside dentists. It would not, however, enable them to operate independently. So there would continue to be restrictions on how PCD services are supplied and on the potential for competition to dentists from PCDs in those areas of dentistry where PCDs are competent to practise.
- 5.35 **We support amendment of section 41 of the Dentists Act 1984 to allow selected registered Professionals Complementary to Dentistry (PCDs) to carry out the business of dentistry.** This would of course be subject to appropriate safeguards. We believe this will expand the supply of dentistry services and ways of delivering these services, will offer greater choice both to consumers and to those working in the profession, and should enhance competition.

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<sup>116</sup> This will be subject to new arrangements for registration

<sup>117</sup> This is subject to parliamentary approval.

<sup>118</sup> Defined in s25(3) of *NHS Reform & Health Care Professions Act 2002*

## Corporate dental bodies

- 5.36 Currently, a corporate body is prohibited from practising dentistry unless it meets the following conditions:
- the body corporate was carrying on the business of dentistry on 21 July 1955 (unless the limited exception in Section 43 (2) of the Act applies)
  - it is not carrying on any business other than dentistry, or some business ancillary to the business of dentistry (unless the limited exception in Section 43 (2) applies)
  - a majority of its directors are registered dentists, and
  - its entire operating staff is either registered dentists or dental auxiliaries.
- 5.37 The GDC and DH have also consulted on lifting the restriction on the total number of corporate dental bodies that arises from the current requirement that the corporate body was carrying on the business of dentistry in 1955.<sup>119</sup> Changes are planned through amendments to legislation. However, there are no plans to change the remaining restrictions on bodies corporate, because the DH and the GDC regards them as important for patient safety.
- 5.38 The DH is proposing only to remove the first constraint. Arguments for retaining the remaining restrictions focus on the concern that the directors of corporate dental bodies may come under pressure to put the welfare and safety of patients at risk in pursuit of commercial advantage. The concerns outlined to us by DH were summarised in Chapter 4. However, while all agree that there is a need to ensure that corporate bodies adhere to ethical and professional standards in their dental operations in the interest of patient welfare and safety, we ask whether this objective could be achieved by other, less restrictive, means.
- 5.39 Concerns about patient welfare and safety should be addressed directly by improved monitoring and enforcement of standards that would be applicable to all types of dental practice and by providing improved means for patients to seek redress when something goes wrong. Dentists have the same personal and professional responsibility to the GDC for complying with its standards whatever corporate form they work in. Preserving the remaining restrictions specified in the Dentists Act 1984 would limit the freedom to offer new forms of supply, competition and customer service. **We therefore welcome the**

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<sup>119</sup> However these companies can be bought or sold allowing new entrants into the market but not allowing any increase in the total number.

**proposed removal of the first of the restrictions on corporate dental bodies under the Dentists Act 1984, outlined above, but recommend that the DH reconsiders the case for the remaining restrictions.** In doing so it should consider whether these go beyond what is necessary to protect the welfare and safety of patients and whether the same objectives could be achieved by other less restrictive means.

### **Further proposals**

5.40 Implementation of the various recommendations outlined above should widen the opportunities for the supply of dental services, help consumers and improve competition in the market for dentistry. Effective competition in dentistry is however also dependent on dentists adhering to the Competition Act 1998 (CA98) (see annexe F for more details). We will continue to highlight this issue and inform dental practices of the provisions of the Act.

# ANNEXES

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## A STAKEHOLDERS CONSULTED

### Consumer organisations

Consumers' Association  
General Consumer Council for Northern Ireland  
Institute of Consumer Affairs  
National Association of Citizens Advice Bureaux  
National Consumer Council  
National Consumer Federation  
National Federation of Consumer Groups  
Oxford Consumers Group  
Scottish Consumer Council  
Welsh Consumer Council

### UK dental organisations and companies

American Dental Society of Europe  
Association of Basic Science Teachers in Dentistry  
Association of British Health Care Industries  
Association of Consultants and Specialists in Restorative Dentistry  
Association of Community Health Councils for England and Wales  
Association of Dental Anaesthetists  
Association of Dental Hospitals of the UK

Association of Dental Implantology

Association of Dental Surgeons

Association of Thames Dental Advisers

Boots Dentalcare

British Association for the Study of Community Dentistry

British Association of Dental Nurses

British Association of Dental Therapists

British Association of Teachers of Conservative Dentistry

British Dental Association

British Dental Guild

British Dental Health Foundation

British Dental Hygienists' Association

British Dental Hygienists' Tutors Group

British Dental Laser Association

British Dental Practice Managers Association

British Dental Students' Association

British Dental Trade Association

British Endodontic Society

British Homeopathic Dental Association

British Orthodontic Society

British Society for Behavioural Science in Dentistry

British Society for Dental Research

British Society for Disability and Oral Health

British Society for General Dental Surgery

British Society for Mercury Free Dentistry

British Society for Oral Medicine

British Society for Restorative Dentistry

British Society for the Study of Prosthetic Dentistry

British Society of Dental & Maxillofacial Radiology

British Society of Gerontology

British Society of Paediatric Dentistry

British Society of Periodontology

Clinical Dental Technicians Association

Committee on Vocational Training for England and Wales

Confederation of Dental Employers Council of Deans of Dental Schools

Denplan Limited

Dentaid

Dental Anxiety & Phobia Association

Dental Care Association

Dental Defence Union

Dental Laboratories Association Limited

Dental Practice Board

Dental Protection Limited

Dental System Suppliers Association

Dental Technicians Education and Training Advisory Board Limited

Dental Vocational Training Authority

Dentists' Media Group

European Union of Dentists (UK)

Faculty of General Dental Practitioners (UK)

FDI World Dental Federation

FHS Appeal Authority

General Dental Council

General Dental Practitioners' Association

Help for Health Trust

Institute of Health Promotion and Education

International Federation of Dental Hygienists

Integrated Dental Holdings

Lindsay Society for the History of Dentistry

London Dental Fellowship

Medical and Dental Defence Union of Scotland

Muslim Doctors and Dentists Association

National Advice Centre for Postgraduate Dental Education

National Association of Postgraduate Medical Education

National Centre for Transcultural Oral Health

National Dental Health Education Group

National Radiological Protection Board

Oasis Healthcare plc

Oral Health Promotion Research Group

Orthodontic Technicians Association

Patients Association (The)

Royal College of Surgeons of Edinburgh

Royal College of Surgeons of England

Royal Odontochirurgical Society of Scotland

Society for the Advancement of Anaesthesia in Dentistry

University Dental Hospital of Manchester

University of Wales College of Medicine

Women in Dentistry

### **Overseas dental organisations**

American Dental Assistants Association

American Dental Association

Association of Finnish Denturists

Australian Dental Association Incorporated

Australian Dental Prosthetists Association

Canadian Dental Assistants Association

Canadian Dental Association

Danish Dental Association

Dental Council of New Zealand

Dental Industry Association of Canada

Denturist Association of Canada

Denturist Association of Maine

Dutch Dental Association (NMT)

Finnish Dental Association

Finnish Dental Society

International Association for Disability and Oral Health, Sweden

International Federation of Denturists, Belgium

International Federation of Denturists, Canada  
International Federation of Denturists, Denmark  
International Federation of Denturists, Netherlands  
International Federation of Denturists, USA  
Irish Dental Association  
National Dental Association, Belgium  
National Denturist Association USA  
Norwegian Dental Association  
Organisatie van Nederlandse Tandprotheticci  
Swedish Dental Association

#### **Local and national government organisations**

LACOTS  
Trading Standards Institute  
Chief Dental Officer, England  
Chief Dental Officer, Department of Health, Social Services and Public Safety  
Northern Ireland  
Chief Dental Officer, Scottish Executive  
Chief Dental Officer, Health Professional Group, Welsh Assembly Government  
Department of Health  
Eastern Health and Social Services Board  
Northern Health and Social Services Council  
Southern Health and Social Services Council  
Western Health and Social Services Council  
Qualifications and Curriculum Authority

## Others

Age Concern

Commission for Racial Equality

London Health Observatory

## **B METHODOLOGY**

- B.1 The investigation team consulted a variety of individuals and organisations during a seven-month consultation period. In addition to this we carried out a number of surveys, as well as commissioning and reviewing existing research into the dental market.
- B.2 Among the individuals and organisations consulted were: individual dentists, trade and professional organisations, consumer organisations, the General Dental Council (GDC), dental academics, various healthcare organisations and other government departments.
- B.3 These included:
- 110 UK dental, consumer and government organisations and individual dentists (of which 52 responded)
  - 27 overseas dental organisations (12 responded) in 11 countries
  - The Consumers' Association (CA) and the National Consumers Council (NCC)
  - Chief Dental Officer, England; Chief Dental Officer Department of Health, Social Services and Public Safety Northern Ireland; Chief Dental Officer Scottish Executive; and Chief Dental Officer, Health Group, Welsh Assembly Government
  - Department of Health (DH), Audit Commission (AC), Commission for Health Improvement (CHI), National Care Standards Commission (NCSC), NHS Dental Reference Service, and Medical Devices Agency.
- B.4 The team also visited a number of dental practices, dental laboratories and a Personal Dental Services (PDS) Dental Access Centre. A member of the team also attended the 2002 BDA Conference. To complement this consultation we reviewed existing research and carried out new research, and monitored the dental press. We also made comparisons with other professions and markets.
- B.5 In considering possible remedies, the team held a number of facilitated sessions bringing in specific expertise from other parts of the OFT and where appropriate, external experts. These sessions enabled the team to look broadly at the issues and possible remedies, before focusing on the key concerns and practicable ways forward.

## Consumer survey methodology

- B.6 The market research company, Ipsos, was commissioned to conduct a consumer survey of people chosen at random throughout the UK. Based on a UK weekly, nationally and regionally representative omnibus survey, the consumer survey produced more than 3,800 successful interviews with adults aged 18 years or more.
- B.7 The contractor was required to obtain authoritative results on three key issues affecting consumers, namely choice of dentist, information relating to treatment and payment, and complaints. To this effect the contractor was provided with a detailed brief and, for guidance, a draft questionnaire.
- B.8 The following list, though by no means exhaustive, highlights several of the detailed issues that the contractor was asked to consider:
- to establish what information was available to patients wanting NHS treatment and/or private treatment about the services offered and the prices charged by different dentists
  - to establish if patients were aware of the existing information on dental services and prices and if they used it to shop around when choosing a dentist
  - what proportion of patients whose dentist had ceased to provide NHS treatment attempted to move to another NHS dentist
  - to examine patients' general approach to choosing and changing dentists
  - to determine whether dentists routinely advised patients about the nature of treatment before it took place, including advising on different options where they exist and advice about how necessary the treatment was
  - whether patients were told precisely what treatment was on the NHS and what treatment they had to pay for privately, and whether patients were given itemised invoices showing precisely what treatment they had received
  - to measure patients' level of confidence in their dentist, and their view on both quality of treatment, information and advice
  - to measure the frequency with which patients felt they had had cause for complaint, separately on grounds of cost, quality and other aspects of service and the extent to which they took action about the complaint

- to measure patients' experience of attempting to complain about private treatment and the extent to which they judged their case was fairly handled.

### **Dental practice survey methodology**

- B.9 The OFT conducted its own survey by writing to 2,200 dental practices, located in randomly selected postcodes throughout Great Britain and Northern Ireland, to provide us with an insight into how practices operate as businesses, as well as the amount of private treatment they carry out. We received 850 responses.
- B.10 The survey form asked questions about staffing and patients; about running the practice as a business covering both major and day-to-day business issues; about the information and services provided to patients including; and about complaints and complaint handling.
- B.11 While some of these issues were common to the OFT's other evidence gathering and research, other issues were particular to this group of stakeholders. Such issues covered:
- practices' use of advertising to attract new patients
  - practices' approaches or philosophies towards dental treatment
  - practice owners' experiences of obtaining capital to finance modernisation, expansion or other business development needs
  - practices' involvement in dental payment plans
  - practices' participation in accreditation schemes.

### **Mystery shopping methodology**

- B.12 The OFT commissioned the market research company FDS International to carry out a mystery shopping exercise of 750 private and mixed (private/NHS) dental practices in the UK. In the case of mixed dental practices, information gathering only applied to the private services provided.
- B.13 The sampling frame used for this research was obtained from The Business Database. From their total of 9,985 Dental Practices, a fully representative list of 5,000 was supplied to FDS, who selected 750 at random.
- B.14 The mystery shop examined the availability of information, including information relating to prices and complaints procedures in both private and mixed dental practices in the UK. It sought to establish the following:

- what sort of information was provided about the practice and its dental services in the form of leaflets, notices and in other ways (eg on web sites)
- whether information was provided about the dental team and their specific roles
- whether the practices had any dental or general accreditation, or Investors in People (IIP) or any awards, and how widely publicised these were
- if there was a registration charge for new patients, whether these charges were displayed or shoppers had to request them, as well as how much they were
- how much was charged for an initial examination and treatment plan
- whether there were details of the practice's procedures for handling complaints on display or in leaflets and if so, how comprehensive these details were.

## C OFT SURVEY RESEARCH

### Key findings from surveys

#### Introduction

- C.1 The three surveys provided a considerable volume of evidence. Whilst the results were not fully consistent, with one exception that is explained in detail below, such inconsistencies do not amount to conflicting evidence. This is best illustrated by examples.
- C.2 In the survey of practitioners, a detailed examination of practice leaflets concluded that 40 per cent of leaflets provided detailed and specific information on prices. In the mystery shopping exercise the estimate was closer to 30 per cent. Another example of a disparity was practice leaflets, where around three-quarters of practices reported having such a leaflet, but the mystery shopping exercise could find leaflets for just over half the practices visited.
- C.3 In some circumstances conclusions necessarily have to be broad. In the above example, we cannot claim that the actual prevalence of practice leaflets is known. It is reasonable to conclude that practice leaflets, while probably more common than not, are by no means universal and that there is still scope for information provision to be improved by increased use. Similarly, there is considerable scope for increased use of leaflets to provide information on prices, which is certainly absent in more than half of cases.

#### Broad conclusions

- C.4 Provision of information to the patient was generally poor. This was apparent at all stages, from consumers seeking information on which to make informed decisions about changing dentists, through to final invoices after treatment. Information was often limited and all too often completely absent.
- C.5 Consumers change dentists rarely and then more commonly where circumstances dictate, for example after a house move or to avoid going private, rather than as a purchasing decision, for example because of lack of confidence in their existing dentist or to seek a dentist in a more convenient location.
- C.6 Dentists seem to face little competitive pressure. Around one in ten practices, perhaps more, are not accepting new patients, and about half reported they did not use advertisements to attract new patients. Where advertising was used, it often amounted to no more than entries in directories like Yellow pages. When

describing the methods used to set prices, very few practices reported giving consideration to what other practices charge.

- C.7 Complaints are rare, and many practices reported as few as two or less per year. The consumer survey revealed that consumers complain more frequently, but that complaints were still at low levels. Some six per cent of consumers reported ever having some reason to complain. Only half of these actually resulted in a formal complaint.
- C.8 When consumers do complain their satisfaction with both the way that the complaint was dealt with and with the final outcome were low. Overall, 46 per cent were not at all satisfied with the way the complaint was handled and a similar 46 per cent were not satisfied with the final outcome.

### **Key findings from the consumer survey**

#### *Introduction*

- C.9 This study surveyed consumers who had received private, NHS and mixed treatment. Some parts of the questionnaire included views from people who did not use dentists regularly, or only sought treatment when needed. Where appropriate, questions were specific to the type of treatment.

#### *Information consumers receive about prices and proposed treatment*

- C.10 Around 30 per cent of consumers said they had received no advice prior to treatment. About one third of respondents were given information about what the treatment involved. One third were given information on price and a little under a third were given an idea of how long the treatment would take.
- C.11 Just over 25 per cent were informed of whether the treatment was essential, 14 per cent of whether the treatment was available on the NHS, 12 per cent were given alternatives, and only seven per cent were given written treatment plans.
- C.12 Over half of the consumers had not received an invoice. Of those who did, in over half the cases the invoice only showed the total charge. Roughly 30 per cent received some itemised information, with about 20 per cent receiving detailed information. Looking at just those consumers who were treated privately, 73 per cent received invoices, 42 per cent showing the total charge and 31 per cent detailed information.

### *Complaints*

- C.13 Complaints were not common, with only six per cent of consumers stating that they had ever had cause to complain, of which half actually did so. Of those who had ever had cause to complain, this had not happened frequently, with an average of only 1.3 reasons to complain in the last five years.
- C.14 Of those who had cause to complain over 25 per cent said that this was about bad treatment and more than 10 per cent cited incompetence. A variety of other reasons were given, though each individually covered less than 10 per cent of cases. These other reasons included the treatment causing severe pain or infection, over-charging, poor service, attitude, treatment not needed and inappropriate treatment.
- C.15 There was a low level of satisfaction with the handling of complaints, with approaching half of complainants saying they were not at all satisfied with either the way the complaint was handled or with the overall outcome.

### *Consumer access to dental services*

- C.16 Nearly 60 per cent of respondents were not aware of any sources of information regarding dental practices in their area. Those who were aware of information most commonly cited word of mouth as the source (22 per cent), followed by Yellow Pages (nine per cent).
- C.17 Around 11 per cent of consumers said that they were not registered with a dentist because they could not find one that offered NHS treatment. Among those registered, 81 per cent were registered for NHS treatment and 19 per cent for private. Most of those registered privately lived in Greater London and the Southeast. The Southwest region also had a significantly higher proportion of privately registered patients than some other regions.
- C.18 The many people surveyed (41 per cent) had received no treatment in the last year. Of those who had received some attention, the majority (30 per cent) only had a check up. Private patients were more likely to receive check ups with some treatment to follow or to receive a 'scale and polish' treatment than NHS patients. Crowns and radiographs (x-rays) were also more common among private patients but fillings were more common for NHS patients.
- C.19 Describing their last treatment, 73 per cent said it was NHS, 22 per cent private and four per cent a combination of the two. Of those who received a combination of NHS and private treatment, 59 per cent said that this was because the treatment was not available on the NHS. A further 13 per cent

from this group said that the dentist was not prepared to do the work on the NHS or suggested that the work would be inferior.

#### *Factors influencing consumer choice*

- C.20 Just over one third of consumers chose their dentist because s/he was their family dentist. Another third made the choice on convenience of location and about a quarter went by recommendation.
- C.21 The top three features sought in a dentist and their practice were competence (65 per cent), quality of work (60 per cent), and cleanliness (55 per cent). Also significant were friendliness, availability of NHS treatment and understanding. Value for money came further down the list of priorities (31 per cent).
- C.22 The chief reasons for choosing private treatment were personal preference (38 per cent) and that the patient could no longer receive NHS treatment but wanted to stay with the practice they were registered with (29 per cent). A further 15 per cent said that there was no NHS alternative and nine per cent said that there were treatments and services not available under the NHS.

#### *Changing dentist*

- C.23 A large majority of consumers (79 per cent) said that they had never changed dentists nor even considered doing so and a further five per cent had thought about it but not done so.
- C.24 For both NHS and private patients, the main reason for changing dentist was moving home (30 per cent), followed by lack of confidence in the dentist's ability (18 per cent), more convenient location (17 per cent), and avoiding going private (15 per cent). For private only patients, the fourth most popular reason was replaced by 'looking for lower prices.'

### **Key findings from the dental practice survey**

#### *Introduction*

- C.25 This survey covered all types of practice: private, NHS and mixed. The sample was based on randomly selected postcodes. The questionnaire was sent to 2200 practices and 850 replies were received. Compared to surveys conducted by the BDA, our returns showed a slight bias towards being smaller and closed to new patients, but good agreement on considerations about patient numbers and mix of NHS and private patients.

*Information consumers receive about prices and proposed treatment*

- C.26 We asked dental practices about how they provided patients with information about prices for private treatment. 72 per cent of practices said that they did this by telephone and around 40 per cent said that they put price information in a leaflet. Just over 30 per cent said that they displayed prices in the practice. However, 13 per cent of dental practices told us that they gave consumers no information on prices.
- C.27 Some 75 per cent of practices reported having a practice leaflet and of these about 15 per cent of the total survey sample sent examples of their leaflets. After examining the leaflets to assess their contents, it was found that just under 40 per cent contained specific and detailed information on the cost of treatments, but around 40 per cent contained only general non-specific information on costs and approaching 20 per cent contained no cost information at all.
- C.28 Six per cent of practices stated that they did not give advice to patients about the recommended course of treatment. Of the 94 per cent that do give advice, 24 per cent only do so verbally. Similarly, 18 per cent of practices said that they only gave verbal estimates of costs and 20 per cent said that they did not estimate costs at all.
- C.29 Once the treatment was complete only 33 per cent of practices reported providing itemised invoices and 36 per cent do not provide an invoice at all.

*Information consumers receive about services and treatments available*

- C.30 From our sample of leaflets, 80 per cent of practices included some information on emergency treatment but half of them contained only general, non-specific information on the subject.
- C.31 About half of the practices reported using no form of advertising to attract new patients. Where advertising was used, it often amounted to no more than entries in directories like Yellow Pages.

*Complaints and quality assurance*

- C.32 Only about half of the practice leaflets made reference to what consumers should do if they had a complaint. Even when a complaint is actually made only 30 per cent of practices said that they would immediately provide advice on complaints procedures.
- C.33 Some 75 per cent of practices reported having received no complaints in the last year and the overall average worked out at 0.7 complaints per practice per

year. The most common outcome was either for the response to be withdrawn, or for the provision of free repair or replacement for the failed treatment.

- C.34 However, cases where no remedial work of any kind was undertaken, nor any refund paid, and where the complaint was not withdrawn but the complainant took no further action were judged to be very common by 19 per cent of practices and common by a further 19 per cent.
- C.35 Approximately a quarter (24 per cent) of practices reported having one (or more) accreditation schemes. In our survey the most common form of accreditation was that provided by the British Dental Association at 12 per cent of practices, followed by Denplan at 11 per cent and BUPA at seven per cent. We observed a degree of duplication with four per cent of practices having accreditation under two or more schemes.

#### *Consumer access to dental services*

- C.36 In our survey around 18 per cent of practices were not accepting any new patients, with about 20 per cent prepared to accept any new patient and 62 per cent accepting some types of patient. Of those accepting new patients, 39 per cent limited acceptance to adult private patients and 27 per cent to children of their private patients for NHS treatment. There were marked differences across the UK with generally more practices accepting NHS patients in the North than the South.
- C.37 NHS registered patients are entitled to all the treatments permitted on the NHS, although some treatments require special authority from the Dental Practice Board. However, the number of practices that said they would always provide the following treatments on the NHS were: 87 per cent simple filling, 58 per cent crown, 82 per cent white filling, 67 per cent root canal filling. Small percentages of practices reported never providing these treatments - up to six per cent in the case of crowns and about four per cent in other cases.

#### *Levels of investment*

- C.38 More than 60 per cent were able to meet the spending need from existing resources. Business bank loans and other commercial loans were also regularly employed to cover these needs, while personal loans were rather less common. Only 13 per cent of practices reported ever encountering any problems in obtaining capital to finance expansion, spending on equipment or other business development needs.

### *Range of services provided*

- C.39 About three-quarters of all practices offered some extended opening hours. Most commonly this took the form of early morning appointments, closely followed by late evening. Weekend opening was less common, and although 40 per cent opened on Saturday mornings only seven per cent did so on Saturday afternoons. Only a small proportion of practices restricted their Saturday, early morning or evening appointments to private patients (18 per cent, 13 per cent and 18 per cent respectively). These results refer to routine openings and some practices emphasised that special circumstances would apply to genuine emergencies.

### *Factors influencing consumer choice*

- C.40 The transfer of copies of their dental records and radiographs can help consumers to ensure continuity of treatment. Although over half of the practices reported that they would allow such transfers, only four practices actually provided information on charges for doing so. This may mean that records are rarely transferred in reality.

### *Procedures for setting prices*

- C.41 Dentists were asked how they set their prices in an open-ended question and about 85 per cent provided some form of answer. 73 per cent stated that their fees were set based on an hourly rate plus the costs of materials and laboratory fees. Not all mentioned how the hourly rate was set but where mentioned it was normally to provide a set level of earning after any other additional costs were met.

### *Dental philosophies*

- C.42 In an open-ended question practices were asked to describe whether they had a particular philosophy or approach to dental treatment. Excluding 179 returns where no reply was given, five per cent of practices mentioned some degree of specialisation in cosmetic treatment, 3.5 per cent orthodontic treatment and one per cent periodontic treatment. Just 0.5 per cent of practices reported providing mercury-free treatment, with 2.5 per cent considering that they prioritised a pain-free or pain minimisation approach. Around 7.5 per cent of practices reported a continued commitment to NHS provision, albeit sometimes commenting on the constraints of operating within the system.
- C.43 On more general issues, three per cent emphasised the importance their practice placed on education, 13 per cent on a minimum intervention approach and 52.5 per cent on a preventative approach.

- C.44 Practices that mentioned either a minimum intervention approach or a preventative approach were also more likely to be part of a capitation scheme. Of those mentioning minimum intervention, 69 per cent were part of a capitation scheme, compared with 56 per cent among those making no mention. Of those mentioning a preventative approach 69 per cent were also part of a capitation scheme, compared to 50 per cent of those not mentioning this.

#### **Key findings from the mystery shopping exercise**

##### *Introduction*

- C.45 The mystery shop surveyed dental practices that provided either private treatment only or both private and NHS treatment. The information gathered relates only to private treatment.

##### *Information consumers receive about prices, services and treatments available*

- C.46 An estimated 27 per cent of practices charged for registering new patients. The most common price was £30 but the observed range was from £5 to £95. Most practices (74 per cent) charged for initial examinations and treatment plans. The average price is £31 and the range is from £5 to £175. Private only dentists charged a higher price on average at £44, compared to £26 at mixed practices.
- C.47 Prices for a scale and polish ranged from £8 to £150 with an average of £27, although 12 per cent of practices would not provide a price stating that it varies according to the state of the patient's teeth.
- C.48 Shoppers were able to find leaflets at over half of the practices. The availability varied according to the size of the dental team, and larger practices (those with three or more dentists) were more likely to have leaflets. 62 per cent of the private only practices had leaflets compared to 51 per cent in the mixed practices.
- C.49 The amount of information contained in the leaflets was varied. One in five shoppers found most of the things they needed to know and one in five felt that a lot of information was included. The most frequent assessment, made in about half of all cases, was that the leaflets contained just a few of things shoppers wanted to know. Practices that had web sites generally had more informative leaflets.

- C.50 The most frequent information available from leaflets related to opening hours, the size and qualifications of the dental team and the range of treatments available. Only 30 per cent of the leaflets contained information on charges.
- C.51 In two out of three practices there were signs, notices or certificates on display giving information. The types of information most likely to be on show - each noticed by one in three shoppers - were lists of the dental team, their qualifications and opening hours. Very few practices (six per cent) display notices that show information related to charges.
- C.52 It was established that 14 per cent of practices had a web site. Shoppers became aware of the web site mainly by asking or from a leaflet, though a smaller proportion noticed the web site address displayed in the practice. The information available at such web sites had a lot in common with practice leaflets. Again the most frequently available information concerned the range of treatments available, opening hours and details of the dental team. Some 16 per cent of sites referred to charges.
- C.53 Overall, approximately 20 per cent of practices had neither a leaflet nor any information on display in the practice. Bringing together the three sources of published information (leaflets, notices and web sites) just one in five practices (21 per cent) gave some indication of charges. If shoppers actually asked for information (by telephone or in person) more information was provided on charges (87 per cent) though some variation in its quantity and quality was noted.

#### *Complaints and quality assurance*

- C.54 Only one in ten practices produced information on their procedure for handling complaints in any of the three sources of published information. Where information was given there was some detail about who to contact, a few practices described their own procedures and a very few gave expected response times to complaints.
- C.55 One in three practices were accredited by a recognised scheme and a few had more than one. Practices with dental accreditation tended to be the larger ones (three or more in the dental team).

#### *Range of services provided*

- C.56 Cosmetic dentistry, hygiene treatments and professional tooth whitening were available in a majority of practices. Checks for mouth cancers were less common and second opinions were rare. Practices with dentistry accreditation were more likely to offer all these services.

- C.57 Nearly three in four practices offered emergency treatments. Roughly 40 per cent of practices had emergency numbers available to the public through leaflets, web sites or on display at the practice.
- C.58 The most common time to open was 9am and the last appointments were generally between 5 and 6pm. Only one in three practices opened on Saturdays. Most frequently, it was necessary to ask for information about opening times (58 per cent).

*Conflicting evidence*

- C.59 In the practice survey only 1.5 per cent of the sample reported charging a registration fee, but the mystery shopping exercise found this for 27 per cent of practices visited. The true prevalence of this practice remains unclear. It should be noted that such fees are not permitted for NHS registrations.

## D RESEARCH ON APPROACHES TO TREATMENT

- D.1 During the course of this investigation, we came across numerous references to different approaches to dentistry; ‘minimum intervention’, ‘preventative’ and ‘conservative’ were terms frequently used. There is a general expectation that as the overall oral health of the nation improves, along with advances in the understanding of oral disease and the technology available to dentists, there will be a corresponding reduction in the demand for intervention. In order to determine how this may impact on the overall need for dentistry in the UK the OFT commissioned research by Professor Elizabeth Kay at the University of Manchester Dental Hospital.
- D.2 The key message from her paper, *Need and Demand for Dental Treatment- Evaluation of the role of clinical decision making*, is that dental needs reflect not only dentists’ views about their patients’ needs but also what patients consider to be their needs. Patient perceptions of their own state of health may differ from that of the dentists’ professional view. Thus, while the consumers’ needs may be reflected in the decisions made, dentists tend to continue to define health in terms of disease, rather than in terms of well-being. Quality care is provided by the dentist who chooses the optimal treatment for each patient, taking into account their ‘lifestyles, needs, attitudes and wishes’.
- D.3 The paper casts doubt upon simplistic assumptions about different types of approach (ie one being favoured over another) and the concepts of under and over-treatment. The existence of this variation between dentists means that patients may wish to compare the information provided by different dentists, and to ask questions, with a view to ascertaining whether one dentist is likely to meet their individual needs better than another. We have been informed that once a treatment has been undertaken on a tooth this will, of itself, create an on-going care and monitoring requirement with the likelihood of further interventions. A patient may therefore like to have the choice of a dentist who uses other methods of intervention where possible, or delays this until absolutely necessary.
- D.4 Professor Kay’s report is available on the OFT website [www.offt.gov.uk](http://www.offt.gov.uk). Her key findings are presented in more detail below.

### Definitions of need and demand for dental care

- D.5 In communicating options and the attendant risk to consumers, the labels that dentists may attach to their approach may not be helpful. The appropriateness/ inappropriateness of various approaches, in any given patient depends on:

- **The patients' future disease risk**  
This is assessed by the dentist, based on knowledge of the patient and their likely future behaviours, or may be derived from evidence (but this is often sparse), or may be a subjective view based on the dentist's previous experiences.
- **The value or utility of the process and outcome to the patient.**  
This value is usually derived implicitly rather than explicitly, but is ultimately for the patient to decide. Good clinical decision-making weights the value of the outcome by the chances of achieving it. Utilising purely economic grounds is not viable, as the value of the product is completely a function of the individual receiving the treatment.

### **Intervention thresholds and variations between dentists**

- D.6 Professor Kay's work supports the argument that there is variation between dentists in the view they take as to when intervention is appropriate and when not. The paper narrows this down to the practice scale where it is noted that even in ideal situations different dentists will favour different options. This suggests that there is no consensus about which treatments produce the most effective type of care.
- D.7 These views question the concepts of under or over-treatment; the boundaries of what may be justified may contain a wide range of different approaches. Dentistry is about taking actions that increase the probability of events/outcomes that the patient regards as favourable. Given the unpredictability of human nature, action may well go beyond what is strictly necessary to maintain oral health and it could be inappropriate for an external authority to judge whether over or under-treatment occurs.

### **Risk communication**

- D.8 Communication of risk to individuals is extremely problematic. The calculation of risk is the remit of the profession, who must derive their estimates from research evidence, from practice audit, and when nothing else is available, from experience, empirical knowledge of the diseases in question, and from knowledge of 'accepted best practice'.
- D.9 Satisfaction with treatment and the likelihood of complaints are largely dependent on the communication skills of the practitioner.

## **Evaluating oral health outcomes**

D.10 The basis on which patients can make informed dental choices on economic grounds is not in fact that different from many other markets. Even with information there are risks attached to the outcomes of all decisions by consumers. Consumers can, however, still make decisions on economic grounds based on the information they have and their assessment of the probabilities of the outcomes. The utility that they expect to derive from improved oral health is also a factor that they will consider when making decisions about paying for dentalcare.

## E INTERNATIONAL RESEARCH

### General comparisons

- E.1 The object of our international research was to gain insight into how dentistry and dental markets operate in other countries. We reviewed existing research and supplemented this information by contacting various national and international dentistry organisations in 11 countries, as well as academics in both the Netherlands and Norway. The countries we consulted were chosen either because their dental system is predominately private or because the dentistry market has been liberalised with regard to PCDs.
- E.2 To give us a comparative framework, the consultation letter requested information on the following:
- whether dentists are registered or regulated by a special organisation,
  - if prices for private treatments are set by an organisation, or whether dentists themselves decide on their fees,
  - if dentists are required to provide patients with a treatment plan and/or an estimate of the cost,
  - whether dental records can be transferred between dentists,
  - if there is a complaints system for dissatisfied private patients,
  - whether PCDs are permitted to work independently of a dentist and charge patients directly, and whether there are any restrictions on their work,
  - if they continue to work under the supervision of a dentist, whether there will be any changes to the law in the near future.
- E.3 We consulted 27 organisations and received a total of 12 responses, which contributed to this brief study.

### Australia

- E.4 The majority of dentistry in Australia is private, with a small proportion of state funded dentistry provided for pensioners. All dentists and denturists must be registered by the state or territory board. There are no recommended fee scales, as this would contravene Australian competition law. Dental records are often transferred between practitioners at the request of the patient. Each state or

territory board has a complaints procedure involving the Health Departments, Dental Boards and Australian Dental Association to varying degrees.

- E.5 Denturists are authorised to work independently of dentists as part of their private practice, and are permitted to provide both full and partial dentures in most states. All other complementary professionals have to work under the supervision of a dentist.

### **Belgium**

- E.6 In Belgium national insurance covers approximately 85 per cent of the population. Treatments available under national insurance and the levels of reimbursement are reviewed every other year. Private dentists deliver most of the care for both children and adults, since public dentistry services are only available in university dental school clinics.
- E.7 The majority of dentists in Belgium adhere to a fee scale for private treatments, which is agreed by a commission in the Office of National Health Assurances. The dentists who choose not to follow this scale set their own fees.
- E.8 All dentists are required to register with the Medical Commission in the province in which they intend to practice. Private patients can complain to the Flemish Dentist Organisation, and if they are not satisfied with their judgement they can resort to the judicial system.
- E.9 There are very few dental hygienists and therapists operating in Belgium. There has been formal training for denturists since 1973, however they are still not permitted to work independently of dentists. Recently, illegal denturists have requested to be legalised, and dental technicians have called for paramedic status.

### **Canada**

- E.10 The market for dentistry in Canada is almost entirely private. Dentistry is a self-regulating profession. All dentists must be registered with the Dental Regulatory Authority (DRA) for the province in which they practice. The principal remit of each DRA is to protect the public; however, they also set standards, discipline their members, administer a complaints procedure and initiate quality assurance schemes. Individual dentists set their fee scales, which are in fact limited by the levels of compensation that public and private insurance companies will pay out. Dentists are obliged to transfer dental records at the request of the patient.
- E.11 In most provinces denturists are able to work independently but they are only allowed to make and fit removable prosthesis. Hygienists are on the whole self-

regulating, although they still have to work under the auspices of a dentist or to prescription and can not charge the public directly.

### **Denmark**

- E.12 Dentalcare is free for all those under 18 years of age and is provided by dentists in public school clinics. Approximately 30 per cent of dentists (who are government salaried) work in these public clinics. Most adults receive private dentalcare, of which a percentage is reimbursed, depending on the age of the patient and the nature of the treatment. Some one million Danes have private health insurance to cover the cost of treatments not included under the public system. The private system is funded by social and private insurance, as well as funds from general taxation, and by direct payment. There is a general system for complaints regarding healthcare, and patients are able to request valuations of any treatment they are unsatisfied with.
- E.13 Hygienists have a screening role in some of these public dental clinics and are authorised to work independently of a dentist in the private sector. If they are self-employed, they remain responsible for the patient's well-being and can charge them directly; if this is not the case then the dentist is accountable. Dental laboratory technicians are not permitted to work independently. However, clinical dental technicians are allowed to provide dentures to the public and receive payment, as long as the patient has no pathological lesions.
- E.14 There are specific rules that oblige dentists and clinical dental technicians to cooperate when caring for patients. According to the Vice President of the International Federation of Denturists, these are very effective. A 1999 survey revealed that clinical dental technicians were making and fitting 75 to 80 per cent of all removable dentures.

### **Finland**

- E.15 Oral healthcare is provided equally between the public and private sectors. Most adult dentalcare is provided privately and those born after 1956 receive subsidised treatment in private practices.
- E.16 It is mainly dentists and denturists who provide private dental services. Both dentists and denturists must be registered with the Office of Healthcare Legal Protection and are obliged to take out comprehensive patient insurance. Any complaints are dealt with by either the county healthcare official or by the consumer authorities.

E.17 In Finland denturists are legal and they receive specialist training. However, denturists can only work independently of a dentist in certain circumstances. They can fit full dentures if the patient is edentulous, but partial dentures have to be made by the order of a dentist. Dental technicians can take money directly from the patient, although the dentist remains legally responsible for their work. Hygienists are also authorised to work independently of dentists in the private sector.

### **Ireland**

E.18 The majority of dentists and hygienists practise privately. All PCDs must be supervised by a dentist, and the situation regarding dental technicians has not changed despite an enquiry by Restrictive Practices Commission (now the Irish Competition Authority). The 1982 report on the 'Statutory Restrictions on the provision of Dental Prosthesis' concluded that limiting the supply of dentures by non-dentists was indeed a restrictive practice.

E.19 The Commission recommended that the relevant section of the Irish Dentists Act be 'amended so as to provide that the general prohibition on the carrying on of dentistry by a non-dentist does not apply to the provision to a person of eighteen years of age or over provided it does not involve work being done on living tissue<sup>120</sup>.' The Commission also emphasised that the practice of denturism should not continue to be prohibited by law.

E.20 These recommendations were never implemented, apparently due to resistance from the Irish Dental Council. However, the Irish Association for Denture Prosthesis continue to petition the Competition Authority, Dental Council and Department of Health for the legalisation of denturism.

### **Netherlands**

E.21 All dentists practise privately, however, 90 per cent of dentists are also contracted to a public dental scheme. The national healthcare scheme is financed by both employers and employees, and is for those in the low-income bracket. Approximately 63 per cent of the population are insured under this, while those who can afford it subscribe to private health insurance to supplement the cost of treatment. In the Netherlands maximum fees for private dentistry are set nationally, and regulated by the government.

E.22 The Health Care Professions Act introduced in 1997 impacted upon dentistry in that it made registration compulsory, revised the disciplinary code and

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<sup>120</sup> *Statutory Restrictions on the provision of Dental Prosthesis*, Restrictive Practices Commission, 1982, p47

introduced formal quality assurance procedures. The Dutch Health Inspectorate is the organisation responsible for policing quality and makes occasional visits to dental practices. Should a practice not comply with their standards, they have the authority to issue warnings and initiate disciplinary procedures. Patients with complaints can take these to one of the regional medical disciplinary boards or to the Dutch Dental Association, if the dentist in question is a member of their organisation.

- E.23 Hygienists are permitted to work independently of dentists and charge their patients, although the majority still work within the dentists' practices and charge the patient via the dentist (since all work they carry out must be referred by them.) They are, therefore, accountable for the work they carry out. Denturists can fit full dentures if the patient is edentulous, but partial dentures can only be made by the order of the dentist. They are also authorised to take money directly from the public. (See paragraphs E.35 to 50 for the case study on the liberalisation of hygienists in the Netherlands.)

#### **New Zealand**

- E.24 Dentistry in New Zealand is almost entirely privately funded. There is some limited state-funded dentistry for children up to the age of 18 years, and through hospital dental departments. There is no set fee scale in New Zealand, as the Commerce Act outlaws collusion or any similar behaviour that may restrict competition. The transfer of records at the patients' request is commonplace.
- E.25 It is the Office of the Health and Disability Commissioner that deals with complaints regarding dentists in the first instance. If they feel it is necessary the complaint can be passed to the Director of Proceedings for prosecution, before the Complaints Review Tribunal or the Dentist Disciplinary Tribunal. The former can fine dentists, while the latter may strike them off the register, suspend or restrict their practising. The trade body, the New Zealand Dental Association, also has a complaints officer in each regional branch.
- E.26 The proposed Health Practitioners Competency Bill will mean that dental therapists will not have to be overseen by a dentist. If it comes into force, therapists will be registered and they will also be permitted to work in the private sector. At present, hygienists are required to work under the direct supervision of a dentist, who must be on the premises. Hygienists will be registered under the Health Practitioners Competency Bill, and their trade body is petitioning for them to be allowed to work under the supervision of a dentist who is not on the premises. Clinical dental technicians can work directly to the

public, but a dentist or clinical dental technician must oversee dental technicians.

### **Norway**

- E.27 In 1996 the dental fee system in Norway changed from one where fees were determined largely through negotiation with the Ministry of Social Affairs and Health, to an entirely private system with fees being determined by market forces.
- E.28 Dentalcare is still free for those under 18 years of age, while 19 to 20 year olds pay 25 per cent of the charges. There are no subsidies to reimburse the cost of private care. Under the Dental Price Information Act, dentists are required to provide patients with comprehensive price information and to advertise their range of treatments widely. Dentists are expected to record the diagnosis and discussion of treatment options in the patient's records. If the cost of the treatment exceeds a given amount, then the patient should be given a written estimate.
- E.29 Hygienists have been allowed to practise independently of a dentist and charge the public directly for their services since the beginning of 2001. However, unlike in Sweden and Finland, denturism remains illegal.
- E.30 Most dentists practise in the public sector in Sweden. The public dental service offers free care for children up to 19 years and only care deemed 'appropriate and necessary to adults'. The latter is financed by state dental insurance, and by fees paid by patients.
- E.31 Charges are regulated by the government, and are comparable in both the public and private sectors. The costs of all types of treatments in the public dental service are reimbursed, as long as they are necessary to patients' oral health. Complex and costly courses of treatment are refunded on the condition that an expert has approved them prior to treatment. Hygienists can work independently and accept payment from the patient. They are legally accountable for their work, unless a dentist has delegated it.

### **United States**

- E.32 The dental market in the United States is mainly private, with a small percentage of public funded dentistry. Prices for private treatment are not set by a particular body, as this could constitute price fixing, which is against state and federal law. Dental records are frequently transferred between dentists at the request of a patient.

- E.33 Patients who are unhappy with their treatment can complain to the complaints officer of the dental or denturist regulatory board. In some states, dentists and PCDs are registered and regulated by the same board, in other states they are separate.
- E.34 Denturists receive extensive formal training, and are therefore the only PCDs that are legally recognised. Denturists can work independently of dentists and charge directly for their services. In most states denturists are not restricted in the services that they can provide (ie full and partial dentures) and are permitted to own denturist and dental practices. As the President of the National Denturist Federation USA stated: 'Denturists are trained stand-alone practitioners who are in direct competition with dentistry for that market which is referred to as Removable Oral Prosthetics.'

TABLE E.1: SHOWING LEGAL STATUS OF PROFESSIONALS COMPLEMENTARY TO DENTISTRY IN VARIOUS COUNTRIES<sup>121</sup>

Country	Clinical Dental Technician (Denturist)	Dental Technician	Dental Hygienist	Dental Therapist	Dental Nurse	Proposed Changes
Australia	Permitted to work independently (full and partial dentures in most states)	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	Some states are examining the scope of work denturists can carry out
Belgium	N/A *	Not permitted to work independently	N/A	N/A	Not permitted to work independently	Denturists wish to be legalised; dental technicians want paramedic status
Canada	Permitted to work independently (only removable prosthesis)	Not permitted to work independently	Not permitted to work independently, but in Alberta, British Columbia & Ontario can charge patients directly	Not permitted to work independently	Not permitted to work independently	None we are aware of
Denmark	Permitted to work independently (only removable prosthesis & if patient has no pathological lesions)	Not permitted to work independently	Permitted to work independently only in private sector & screen in public clinics	Not permitted to work independently	Not permitted to work independently	None we are aware of
Finland	Permitted to work independently (only if patient is edentulous)	Permitted to charge public directly, but still work to dentist	Permitted to work independently only in private sector	Not permitted to work independently	Not permitted to work independently	None we are aware of

<sup>121</sup> The information provided here is based on that supplied by overseas organisations. The OFT is not responsible for any inaccuracies in its content. Before relying on this material you are advised to carry out your own checks to ensure its accuracy.

Ireland	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	Irish Association for Denture Prosthesis still petitioning for legalisation of denturism, following recommendations in 1982 Restrictive Practices Commission report
Netherlands	Permitted to work independently (only if patient is edentulous)	Not permitted to work independently	Permitted to work independently	Not permitted to work independently	Not permitted to work independently	None we are aware of
New Zealand	Permitted to work independently	Must be supervised by dentist or denturist	Not permitted to work independently	Not permitted to work independently	N/A	Proposed Health Practitioners Competency Bill means dental therapists can work independently in the private sector, and hygienists will be registered
Norway	N/A	Not permitted to work independently	Permitted to work independently	N/A	Not permitted to work independently	None we are aware of
Sweden	N/A	Not permitted to work independently	Permitted to work independently	Not permitted to work independently	Not permitted to work independently	None we are aware of
United Kingdom	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	GDC may consider some PCDs undertaking the business of dentistry in the future

United States	Permitted to work independently (full and partial dentures in most states)	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	Not permitted to work independently	Some states are examining the scope of work denturists can carry out
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**\*Not applicable as this category of PCD does not exist in the country in question**

## **CASE STUDY: liberalisation of dental hygienists in the Netherlands**

- E.35 In November 1993 the Dutch Parliament passed the Individual Health Care Professions Act with a view to promoting and monitoring high standards of professional practice among individual care providers. While the Act is based on the notion that a patient must have the option of accessing the care provider of his or her choice, it recognises that patients need protection against professional carelessness and incompetence. The Act therefore reserved certain procedures for only those that are regarded as competent to carry out such work.
- E.36 The Act opened up the practise of medicine, giving people more freedom to choose the care provider they want. Consequently dental hygienists and denturists, among others, were entitled to serve the patients needs directly and set up their own practice if they so wished.

### **What can hygienists do under the Act?**

- E.37 The Act entitles dental hygienists to work independently in the area of prevention (eg oral hygiene, fluoride application) and check-ups. With the passing of the second segment of the Individual Health Care Professions Act in 1997, hygienists have been at liberty to administer local anaesthetic without supervision from a dentist. These fall outside the group of 'excluded procedures' which includes fillings, operative procedures and radiographs, which are reserved for the dentist. However under the supervision of a dentist, dental hygienist are allowed to perform these procedures. Apparently there are plans to allow dental hygienists to carry out small filings independently. From this year onwards, elementary restorative dentistry will be included into the education for dental hygienists.

### **Competitive progress**

In spite of these liberalising reforms there has been little competitive progress in terms of greater choice and lower prices for consumers. The chief reason for this appears to be significant manpower shortages which has hindered direct competition between dentists and hygienists, thus allowing dentists to continue in their role as gatekeeper and also, has deterred the government from relaxing price restrictions.

### **Dentist still acting as the gatekeeper**

- E.38 The Netherlands health-care market is strongly liberalised in the sense that anyone can provide any type of care, subject to the strict safeguard rules.

Dental hygienists can work within those rules. However, currently it is estimated that only around 20-25 per cent of dental hygienists work in their own practice without supervision by a dentist, although this proportion is growing. These independents do have the legal right to actively seek customers but, in practice, most rely on referral from dentists. Most hygienists operate in-house with their work (mainly preventative and initial periodontal treatment in nature) referred to them by dentists. Consequently a majority still bill the patient via the dentist.

### **Weak price competition**

- E.39 The government imposes an effective ceiling on fee per item prices charged by both private and public dentists<sup>122</sup>. There appears to have been convergence around this maximum which has not been helped by the acute shortage of dentists and hygienists that apparently prevails. Consequently, there is only weak price competition between dentists.
- E.40 Hygienists are exempt from this ceiling and instead they set their own fee on a remuneration per hour basis. However, since a large majority of dental hygienists still operate under the aegis of the dentist, hygienists almost invariably set rates equivalent to what the dentist would have charged had s/he carried out the work. This pressure to charge at the maximum level is reinforced by the hygienist having to bill the patient via the dentist. Hygienists' rates have therefore also converged around the maximum price level.
- E.41 Where hygienists operate in their own practice without supervision, they can bill their patient or insurance company directly and will perhaps have more freedom to price competitively. There are no official figures on the tariffs under these circumstances.

### **Quality control**

- E.42 All healthcare professionals including hygienists are subject to quality control via the Individual Healthcare Professions Act. The Act regulates the criteria for registration, education, the right to execute specified treatments etc. The Health Inspectorate monitors quality, albeit to a limited degree, checking if conditions for good practice are being met, and intervening in cases of poor treatment or hygiene control.

### **Manpower shortages**

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<sup>122</sup> Health Care Charges Act 1980: As a result of changes to this law it was no longer possible to fix a charge that was not accepted by the Central Council for Health Care Charges.

E.43 In spite of efforts to liberalise the market and promote consumer choice, labour supply problems are currently dissuading the government from repealing the maximum fee system. They fear that relaxing the maximum price scheme will result in excessive prices. According to the WHO<sup>123</sup> there is one dentist to every 2,200 patients and one hygienist to every 10,380. These are high patient numbers compared to other European countries.

#### **Recent changes/debates**

E.44 In 1997 an internal report was co-written by the Ministry of Health and the Ministry of Economic Affairs on how to increase competition within the healthcare field. This exercise was carried out mainly in response to European legislation on competition which was thought to be at odds with centrally arranged fee systems. It is now believed however that the Healthcare Charges Act may be waived from this legislation. In this report recommendations were made to end mandatory referral between dentists and dental hygienists, and to train dental hygienists to execute limited restorative treatment (small fillings) and preferably for a lower fee. However, this approach has been shelved due to the critical shortage in dental manpower in the Netherlands. Furthermore, the government believed it would undermine its objective to stimulate co-operation between health professionals within the various fields of healthcare which it thinks bestows benefits to consumers.

E.45 Last year an independent study was carried out into the effects of introducing market-like elements in several healthcare fields. Unlike physiotherapy and midwifery, it was decided that dentistry market conditions were not yet favourable for introducing free competition.

E.46 In January 2002 the Health Minister presented a report to Parliament containing recommendations for addressing the labour supply problem. Consequently, output from dental faculties will increase from 260 to 300 students per year and from 210 to 300 in dental hygienists schools. The Dutch Society for Dentists has been trying to encourage Belgian and German dentists to practise in the Netherlands, with little success to date. However, South African dentists who do not have to contend with the language barrier have shown greater interest.

#### **The cooperative model**

E.47 The report submitted to Parliament in January 2002 firmly endorsed the team concept that is, tighter co-operation between dentists, dental hygienists,

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<sup>123</sup> WHO Oral Health Country/Area Profile Programme: the CAPP

denturists and dental nurses. The government believes that the dental team approach will utilise available manpower more effectively, while simultaneously delivering customised care to patients. In anticipation of this, dental hygienists will be trained and educated to cover a wide array of day-to-day dental care (both preventive and restorative). By the hygienists taking charge of the regular 'volume' care, the dentist, says the government, will have more time to manage the team and/or practise more advanced dentistry.

### **Conclusion**

- E.48 The impact of liberalising the dental hygienist market in terms of price competition between dentists and hygienists has been negligible. Former plans to bring the dental hygienists within reach of government regulation and the Healthcare Charges Act have not been implemented. However, hygienists are indirectly subject to the Act via payment to the dentist and claims from the insurance companies.
- E.49 The official line is that because of the acute shortages of dental personnel in the Netherlands, the Government is reluctant to liberalise the fee system for fear of provoking price hikes. They do not believe that market conditions are right for such tariff liberalisation.
- E.50 However, once the smoothing of labour supply problems takes place the changes that have taken place to date will strengthen the case for further de-regulation and competition between dental professionals.

### **What we can learn:**

- primarily, that without adequate labour supply, liberalisation of PCDs is a necessary but not sufficient condition to ensure competition develops
- dental hygienists are capable of operating independently and without supervision from dentists as evidenced by the growing proportion of Dutch hygienists that are doing just this. With adequate quality measures there is no reason why PCDs should not compete with dentists
- the Netherlands have recognised the need to promote true consumer choice and restructure the supply-side to meet demand more effectively
- in principle, at least, the Dutch government have recognised the benefits that would be delivered from a more market-driven dental system. The independent study, that was carried out in 2001, into the effects of greater liberalisation of several health-care systems, concluded that while the dental market was not yet ready for this, other health markets were.

## **F COMPETITION AND CONSUMER PROTECTION LEGISLATION AS APPLIED TO DENTISTRY**

### **Competition legislation**

- F.1 The principal competition statutes are currently the Competition Act 1998 (CA98) and the Fair Trading Act 1973 (FTA) (to be superseded by the Enterprise Act 2002) that has been retained to deal with scale or complex monopolies. The Enterprise Act 2002 received Royal Assent in November 2002 and it will come into force in the course of 2003. The Act makes a number of significant reforms to competition law and consumer law enforcement in the UK. The new provisions will work alongside the CA98 and various pieces of consumer legislation but will largely replace the FTA.
- F.2 It is the CA98 that is most likely to apply to actions in the dentistry market and it contains two prohibitions. The Chapter I prohibition applies to agreements between undertakings, decisions by associations of undertakings or concerted practices which may affect trade within the UK or any part of it and which have as their object or effect the prevention, restriction or distortion of competition within the UK. The Chapter II prohibition applies to conduct on the part of one or more undertakings that amounts to the abuse of a dominant position in a market and which may affect trade within the UK or any part of it.
- F.3 These two prohibitions are modelled on European Community competition law and are applied consistently with it<sup>124</sup>. The OFT has powers to investigate and to take enforcement action against infringements of the prohibitions. Enforcement action could take the form of directions to bring the infringement of either the Chapter I or Chapter II to an end. The Director General also has the power to impose financial penalties of up to 10 per cent of turnover in the UK of an undertaking that has infringed either prohibition. The Director General intends to use this power to ensure that penalties have the necessary deterrent effect to prevent the occurrence and repetition of infringements.

### **Consumer legislation**

- F.4 The Supply of Goods and Services Act 1982 stipulates that services should be carried out with reasonable care and skill, within a reasonable time (where the time to be taken is not agreed) and where no price has been agreed, for a reasonable charge to be made. This legislation can be used in cases where the treatment received was claimed to be substandard.

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<sup>124</sup> See CA98 Section 60.

- F.5 It is also a criminal offence under the Trade Descriptions Act 1968 to apply false trade descriptions to goods and make a false statement as to the provision of services. In a recent high profile case, a dentist was fined £3000 plus costs for contravening this Act<sup>125</sup>. The dentist in question had not carried out some of the work specified on the treatment plan and the patient became suspicious after seeking a second opinion.
- F.6 To comply with the Consumer Credit Act 1974 a business carrying out certain activities in the field of credit and hiring must have a consumer credit licence issued by the OFT. Even if businesses (including dentists) are not going to offer credit themselves, the introduction of clients to someone who will, is likely to need a category C licence. The OFT can refuse or revoke a licence if it decides that someone is not fit.
- F.7 The Control of Misleading Advertisements Regulations 1988 implement EC Directive 84/450 to prevent the publication of misleading advertisements. The 1988 Regulations were amended in 2000 to implement Directive 97/55 and prevent unacceptable comparative advertising. The Regulations cover both advertisements to consumers and to businesses.
- F.8 All cases referred to the OFT by the regulatory body, the Advertising Standards Agency, for further action must be handled quickly to limit consumer detriment, as we can act only to stop the publication of the advertisement, not to punish those who have benefited from its publication. In the first instance we will seek voluntary undertakings from those involved in the publication of the advertisement.
- F.9 Further information on any of this legislation can be obtained from the OFT's website [www.offt.gov.uk](http://www.offt.gov.uk) or from the Public Liaison Unit on 020 7211 8000.

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<sup>125</sup> *Dentist fined for charging for work not done, Dentistry*, 30 October 2002

## G EXISTING GUIDANCE ON STANDARDS

### GDC guidance

G.1 **The GDC's guidance is advisory and not mandatory.** There is no statutory backing for this guidance and therefore no measures are being taken to enforce it directly. Infringement is not automatically a matter for investigation and possible censure. Currently, only if a dental professional's behaviour is indicative of serious professional misconduct will the GDC investigate. The guidance is contained in *Maintaining Standards: Guidance to Dentists on Professional and Personal Conduct* (first published November 1997 and revised in parts in 1998, 1999, 2000). It includes guidance on the following:

#### **Explaining treatment and costs (paragraph 3.6)**

- G.2 'It is the responsibility of a dentist to explain clearly to the patient the nature of the contract and in particular whether the patient is being accepted for treatment under a particular scheme, including the NHS, or some other arrangement.
- G.3 The charge for an initial consultation and the probable cost of the subsequent treatment must be made clear to the patient at the outset.
- G.4 A written treatment plan and estimate will avoid misunderstandings and should always be provided for extensive or expensive courses of treatment. A dentist who obtains the patient's agreement to these terms in writing is better placed to refute an allegation that a patient has been misled with regard to the nature of the contract or the type or cost of treatment provided.
- G.5 If it becomes apparent to the dentist, after the estimate has been agreed, that a modified treatment plan will become necessary the Council would expect the dentist to discuss this with the patient; obtain the patient's consent to the further treatment and additional cost; and provide a written, amended estimate before proceeding further.
- G.6 Patients are entitled to an itemised account of treatment received and should normally be provided with one.'

#### **Handling complaints (paragraph 3.13)**

- G.7 'If a patient has cause to complain about the service provided, every effort should be made to resolve the matter at practice level. The complaint may relate

to the treatment provided or some other matter such as the payment of fees or the attitude of a member of the dental team.

- G.8 The Council endorses the detailed guidance on handling complaints which has been issued by the NHS Executive and the British Dental Association and would expect compliance.'
- G.9 Other relevant sections of the guidance cover '**Misleading Claims**' (paragraph 4.6) and '**Promoting the Practice**' (section 7). The latter section reflects the British Code of Advertising Practice in saying 'a dentist may only use publicity or advertising material which is legal, decent honest and truthful and has regard for professional propriety.'

## **Other guidance**

### **Advice on clinical matters**

- G.10 There are four Health Departments in the UK responsible for policy development, planning and the funding of the NHS in England, Wales, Scotland and Northern Ireland. Each Department has a Chief Dental Officer who heads the dental profession and contributes to policies on improving oral health and the provision of hospital, community and general dental services.
- G.11 Academic institutions, the dental defence unions and professional organisations also give advice on clinical matters. However, the existence and dissemination of guidance and standards remains piecemeal.

### **Advice on non-clinical matters**

- G.12 **The Faculty of General Dental Practitioners** has produced guidelines on subjects such as good practice in clinical examination and record keeping.

## **Guidance from professional and trade associations**

### **British Dental Association (BDA)**

- G.13 The BDA advises its members on matters concerning the running of their practices. The BDA Advisory Service produces useful advice on subjects such as ethics in dentistry, marketing in dentistry, mixing NHS and private care, changing the balance of the practice, fee setting in private practice and handling complaints. **The advice is not mandatory, although the BDA encourages members to follow best practice.**
- G.14 In 2001 they launched the pilot BDA Best Practice Scheme. This is a voluntary, practical self-audit tool to help practices comply with current accepted

standards of good practice. It does not rely on initial one-off inspections but requires a continuous commitment to good practice. Once a practice has achieved the required standard, membership lasts for three years. A team of experienced dentists will randomly visit some member practices.

- G.15 The scheme covers work systems, treatment decisions, comfort, health and safety, infection control, mouth cancer checks, individual training, practice training, patient feedback and public protection. By November 2002, 231 practices had achieved the standard and 530 are in the process of applying for it.

#### **General Dental Practitioners' Association (GDPA)**

- G.16 In the GDPA's Private Fee Guide and the GDPA Journals advice is given to dentists about the importance of communicating with patients by doing the following:

- making clear from the outset the basis for treatment, ie private or NHS
- giving information about the diagnosis
- giving information about treatment options available
- giving information on risks, benefits and prognosis of options
- giving information on anticipated cost and length of treatment
- giving information on the consequences of refusal of treatment
- giving an opportunity for the patient to ask questions
- ensuring that the patient has understood and agreed to the treatment.

#### **Confederation of Dental Employers (CODE)**

- G.17 CODE represents practice owners even if they do not have employees. It produces a handbook of dental practice management with advice on subjects such as contracts, legal issues and dealing with complaints.

#### **Dental Laboratory Association (DLA)**

- G.18 The DLA represents dental laboratory owners. Some laboratories participate in third party accreditation schemes such as ISO 9002 (as per some dental clinics). In 1998 the DLA launched the Dental Appliance Manufacturers Audit Scheme (DAMAS). It is based on ISO 9002 and meets the requirements of the

Medical Devices Directive and Medical Devices Regulations. The DLA also gives general business and health and safety advice.

### **Guidance from companies**

#### **Denplan**

- G.19 Denplan is the major provider of capitation based dental payment plans in the UK. Dentists joining Denplan must agree to participation in the company's complaints scheme. It is backed by independent arbitration and is operated on Denplan's behalf by the Chartered Institute of Arbitrators.
- G.20 Denplan member dentists adhere to a code of practice and a quality programme which incorporate advice given by the BDA and other professional and statutory authorities. Provisions exist for the termination of membership by an independent professional and lay panel.
- G.21 In 2001 Denplan launched its Excel accreditation scheme for practices with high, current professional standards. Excel practices are subject to annual inspections.

#### **Dental bodies corporate**

- G.22 We have received details from some of the largest dental bodies corporate of their quality assurance procedures and their complaints systems.

#### **Individual practices or practice groups**

- G.23 Some practices have developed their own guidance on how the practice should be run and on customer service. Individual dental professionals may participate in local practice groups.

## H PROPOSED REFORMS TO THE DENTISTS ACT AND THE GDC WITH POTENTIAL IMPACT ON PRIVATE DENTISTRY

H.1 This is not the full list of reforms, and only refers to those directly relevant to private dentistry. For the complete list of reforms please refer to the GDC's *Implementing change: A programme for the modernisation of professional regulation in dentistry*.

H.2 'It is clear from the Kennedy Report<sup>126</sup> and the experience of professional regulation in recent years that there are weaknesses in the current arrangements which need to be addressed by reforms to the individual regulatory bodies, together with stronger and more effective co-ordination of their work and clearer and more robust accountability mechanisms<sup>127</sup>.'

H.3 The following paragraphs are the GDC's response to this concern.

### **Introduction of continuing professional development (CPD)**

H.4 CPD is already being made mandatory for dentists and PCDs. Practitioners can choose subjects for study from a given menu. The choice should reflect the individual's development needs but there is no monitoring of this. To remain registered, dental professionals have to complete 250 hours of CPD every five years.

### **Reform of fitness to practise procedures (subject to revision)**

H.5 The GDC has sought reform of its existing conduct and health procedures in the second of the Dental Orders made under the Health Act 1999. Key elements include:

- a more robust and integrated approach to the initial investigation and management of complaints,
- separation of the 'hearings function' from the main business of the Council,

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<sup>126</sup> *Learning from Bristol: the Department of Health's Response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*, Department of Health, 2002

<sup>127</sup> *Modernising Regulation in the Health Professions Consultation Document*, Department of Health, 2001

- a more comprehensive range of options for protecting the public and, where appropriate, providing a remedial framework for the registrant, including the introduction of performance procedures to deal with registrants whose performance has deteriorated,
- new powers to impose interim orders affecting registration, in serious and urgent cases, upholding public confidence without pre-judging the outcome of allegations,
- a proportionate and flexible approach to the difficult question of restoration to the register following erasure.<sup>128</sup>

H.6 The GDC is recruiting an independent Appointing Body to recruit and select members of a new Fitness to Practise Panel (FTPP).

### **Introduction of re-validation**

H.7 The GDC are considering the introduction of re-validation systems, beyond the requirement for CPD. If they decide to go ahead the very earliest implementation date is 2004 and a change in legislation would be required.

H.8 They suggest that revalidation should be based upon, 'existing or forthcoming local quality assurance mechanisms - for example, the training programmes of Royal Colleges, the assessment systems of Postgraduate Deans, and employers' appraisal systems.' They also state that, 'where appropriate, the system should be consistent with the principles of other systems being developed for healthcare professionals.'<sup>128</sup>

### **Introduction of complaints procedure for private dentistry**

H.9 The GDC has proposed that they institute a complaints procedure for private dental treatment. Currently, the NHS has a procedure but there is none for private dentistry. The GDC planned to seek legislation for 2003.

### **Lifting of restrictions on dental bodies corporate**

H.10 The DH has consulted on amendments to the Dentists Act 1984 to lift one of the restrictions on dental bodies corporate. Currently, a corporate body is prohibited from practising dentistry unless it is exempted under the following:

- the body corporate was carrying on the business of dentistry on 21 July 1955 (unless the limited exception in Section 43 (2) of the Act applies)

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<sup>128</sup> *Revalidation*, Anthony Townsend- Chief Executive and Registrar, General Dental Council, April 2002

- it is not carrying on any business other than dentistry, or some business ancillary to the business of dentistry (unless the limited exception in Section 43 (2) applies)
- a majority of its directors are registered dentists, and
- its entire operating staff are either registered dentists or dental auxiliaries.

H.11 Section 43 (2) exempts societies registered under the Industrial and Provident Societies Act 1965 or the Industrial and Provident Societies Act (Northern Ireland) 1969. It also permits corporate bodies to merge or reconfigure and continue the business of dentistry.

H.12 **The DH is proposing to revoke only the first of these restrictions.**

### **Registration of dental technicians and dental nurses**

H.13 The GDC are proposing to start a register for certain dental technicians, orthodontic therapists and dental nurses. Work on drafting legislative reform was in progress in early 2002 and the target for registration of the first new PCDs is autumn 2003.

### **Roles of dental therapists and dental hygienists**

H.14 The 1986 Dental Auxiliaries Regulations were amended in 2002 to allow for major extensions to the roles of dental therapists and dental hygienists.

H.15 Effectively, in 2002, the GDC decided to postpone a decision on allowing any of the PCDs to practise the business of dentistry (charge patients directly) until the newly constituted Council wishes to review the circumstances.

### **Changes in the organisation of the GDC**

H.16 The statutory framework has already been changed to allow a greater proportion of non-dentist representation on the GDC. The new composition will total 29 members, 15 of which will be dentists elected by their peers, 4 will be PCDs elected by their peers, and 10 will be lay members appointed by the Privy Council (whom could include other health professionals not eligible for registration with the GDC). Elections in autumn 2002 allow for members to take office in early 2003.

# I SUMMARY OF PROPOSED CHANGES TO NHS DENTISTRY AND PRIVATE CARE WITH POTENTIAL IMPACT ON PRIVATE DENTISTRY

## DH'S Modernising Dentistry Project

I.1 In *Options for Change*<sup>129</sup> the DH has published details of a number of proposals that it is considering to modernise dentistry in England. It covers:

- a new deal for patients - national standards
- systems of delivery of dentalcare
- education, training and development of the dental team.

### *A new deal for patients - National Standards*

I.2 The paper states that to ensure that there is **trust between practitioners and patients**:

- there needs to be **evidence-based care** and treatment
- **transparent and accurate information**
- **minimal intervention** should be practised where possible
- care should be **centred on prevention** and based where possible on lifelong care rather than being episodic or reactive
- patients should be confident that they are giving **informed consent** to treatment
- patients should have **clear communication** about dentalcare and treatment that is being carried out or necessary, whether it is private or NHS
- treatment options should be explained and **written information on costs** given on estimates, treatment plans and receipts
- clear **guidance on treatment costs** should be readily available, widely publicised and clearly displayed at dental practices

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<sup>129</sup> *NHS Dentistry: Options for Change*, Department of Health, 2002

- patients' **clinical records should be transferable** between dentists and there should be common notation for dental records.

## Systems of delivery of dentalcare

### Integration of NHS services

- I.3 *Options for Change* proposes that primary care dentistry as it currently exists (community dental services, personal dental services, and general dental services) needs to be integrated. **NHS dentistry needs to be fully integrated** with the rest of NHS primary care provision. It is suggested that one way to achieve this would be to initiate multi-surgery health centres in some geographical areas from which dental, medical, other community services and pharmacy services could be provided for the locality.

### New methods of remuneration

- I.4 The paper also states that independent contractors who deliver NHS dental services will have to be paid differently if change is to be effected. **For general dental practitioners, a menu of options is suggested**, in which they can contract with the NHS. Options might include long term cost and volume contracting with case mix taken into account, sessional payments, or a greater element of salaried employment as well as combinations of these. The DH is using demonstration sites and **pilots to test some of these new ways of organising NHS dentistry**.
- I.5 The DH believes that **clinical pathways**, as are now adopted across much of medical practice, should be developed and **applied in NHS dentistry**. They would be built on available evidence and best practice. Dentists would then record their clinical interventions and note the outcomes, rather than receiving a fee for each intervention.
- I.6 It was also stressed that private dentistry was essential in order to meet the public's growing demand for the type of dentistry and service it provides. The DH said that **private dentistry contributes to patient choice, provides dentists with options and independence and delivers those treatments that the government does not wish to finance**.
- I.7 **Capitation payments are being considered** as an alternative remuneration system to item of service, without moving to a salaried system. The DH observes that some private schemes, and at least one PDS pilot, are based on capitation and appear to be working well. They say that if this kind of arrangement were to be

implemented, the items that fall outside the capitation scheme could be negotiated according to need. The NHS/private boundary

- I.8 **The DH say that the current position, whereby dentists can mix private and NHS items of treatment within the same course, is known to cause confusion** amongst patients. The situation is further complicated by some dentists not being prepared to carry out certain treatments for the NHS fees set out in the Statement of Dental Remuneration.
- I.9 *Options for Change* looks at the possibility of disengaging the provision of treatment from the fee per item remuneration system so that it would be possible to develop contractual arrangements directly between the NHS and dentists. If the treatment is clinically necessary - for example within the clinical pathway - and if a suitable monitoring system assures quality as part of clinical governance, then, it is believed, it should be possible to reduce the reliance on item of service within the fee scale.
- I.10 The paper suggests that if payment were broadly separated from the detail of treatment in this way, then **private treatment would be defined by reference to what falls outside the NHS clinical pathway, such as cosmetic, optional terms**. In this context an 'NHS dentist' would be a dentist who had contracted to provide a defined range of services to an agreed population within a range of clinical protocols defined by a clinical pathway, with other arrangements for dealing with exceptionally high cost treatments. This would need to be monitored at PCT rather than national level to reflect local needs and priorities.
- I.11 The DH states that any dentist working within these arrangements would retain their right to provide private treatment. The protocols within the clinical pathway would define the NHS/private boundary. The objective would be to introduce clarity into the system for patients and clear demarcation boundaries for clinicians.

#### **Dental bodies corporate**

- I.12 Some corporate bodies have been primarily interested in private dentistry and have concentrated themselves in areas where this is likely to succeed. The paper suggests the possibility that groups of dentists may co-operate to form new corporate bodies, very different from those in existence at present, and offers an opportunity for the NHS. **PCTs could tender the dental services to new corporate bodies, which in effect could then become the dental network managers for an area.**

## Education, training and development of the dental team

- I.13 *Options for Changes* states that the **dental degree programme should be reviewed** in terms of its length and content as to whether it best prepares dentists for working in practice and meeting the needs of patients. The **one year vocational training for dentists wanting to run practices supplying NHS dentistry also needs to be reviewed**, according to the paper, **as does the training for PCDs**.
- I.14 The DH acknowledges the role of the specialist practitioner in the provision of dental care in the primary care sector. They find that the training is too similar to that for consultants and that a radical review is required. The **DH want a greater role for specialist practitioners** and therefore to increase the number of courses and to give bursaries to offset the loss of income training entails. The DH would seek partnership with the Dental Colleges to ensure quality control when increasing the number of training courses.

## Scottish action plan for dental services

- I.15 Targets and initiatives have been developed and grouped under the headings of Oral health/public health, Prevention and registration, Service availability and access, Quality and standards, Responsive services and Infrastructure resource. An Implementation Support Group was formed to monitor progress in respect of recommendations contained therein. With regard to future implementation, the group has agreed to set strategic high level targets around which NHS Boards could innovatively develop their own action plans, aimed at addressing particular issues. Each Board is now required to account for primary care NHS dental provision under the Performance Assessment Framework PAF). The revised PAF, which issued on 1 November 2002, contained a new target of 'progress in relation to the implementation of the Dental Action Plan'.

## NHS workforce review

- I.16 The DH expects to complete the Dental Workforce Review and to report to Ministers early in 2003. The Review's recommendations will be of two types:
- developing and improving workforce planning for the whole dental team, and
  - measures that address how the gap between demand and supply might be closed.
- I.17 Clearly, the review will have an **impact on the numbers of training places for dental professionals and on the policies regarding admission of practitioners**

**from overseas.** If the overall supply of dentists is kept artificially low there will be insufficient numbers of dentists to compete with one another.

### **Audit Commission (AC) Investigation into Primary Dental Care Services In England And Wales**

- I.18 This short investigation was launched at the end of 2001. It was restricted to the provision of NHS dentistry and complements our investigation. The key research themes were access to NHS dentistry, deprivation and poor dental health, the rate of modernisation and standards of care. The original proposal included evaluation of the spread of private practice and how this interacts with access to NHS dentistry. This was one of the areas of concern raised in the original Consumers' Association super-complaint. Due to time constraints the Audit Commission did not examine this question.
- I.19 The Audit Commission made twenty-eight recommendations for changes to NHS dentistry. The key messages were that **access to NHS dentistry is patchy across England and Wales, health inequalities are not being tackled, some NHS funds are being wasted, the rate of change is too slow and that patients should be empowered.**
- I.20 **The Audit Commission calls for fundamental reform with greater emphasis on prevention, changing the way the NHS remunerates dentists and national standards.** In responding to the report the DH pointed out that several of the Audit Commissions recommendations are included in the Modernising Dentistry agenda.
- I.21 **Medium to long-term changes to NHS dentistry, particularly greater promotion of oral health will have an impact on demand for dentistry.** Whether creating a better climate for dentists to provide services for the NHS will reverse the general move towards private provision is not possible to predict. A particular concern shared by our investigation was the **confusion in many patients' minds between whether they were paying for private or NHS care.**
- I.22 Other recommendations relevant to our investigation are as follows:
- a more scientific approach to recall intervals and the scrapping of the 15 month rule, for re-registering patients (see also paragraph I.22 below)
  - the call for greater consumer awareness
  - greater use of PCDs

- more up to date information from NHS Direct on dentists taking NHS patients
- encourage dentists to provide better information, both in the practice and directly to the patients including written estimates and treatment plans in advance
- foster greater investment by individual dentists in clinical audit, CPD and other aspects of clinical governance.

### **National Institute for Clinical Excellence (NICE)**

- I.23 NICE is a special health authority and forms part of the NHS. It provides guidance in England and Wales for healthcare professionals and patients and their carers, to inform their decisions about treatment and healthcare. Its guidance assists health professionals to provide effective treatments, and helps protect patients from care that is not effective.
- I.24 NICE undertakes technology appraisals to review the clinical and cost effectiveness of technologies. These are referred by the Secretary of State for Health and the Welsh Assembly Government. In Scotland, the Health Technology Board provides technology appraisals and the Scottish Intercollegiate Guidelines Network produces clinical guidelines. The Northern Ireland Executive was in the process of deciding who will develop guidance for the NHS in Northern Ireland.
- I.25 **NICE is considering the six-month recall period for dental appointments.**

### **Council for the Regulation of Healthcare Professions (CRHP)**

- I.26 The NHS Plan (July 2000) proposed the formation of a UK Council for the Regulation of Healthcare Professions to co-ordinate and act as a forum for the regulators of all health services. As such, it will oversee both the General Dental Council and the General Medical Council (GMC).
- I.27 Following government rationalisation of regulatory authorities in healthcare a number of new bodies have been formed through the merger of many others. **Although they regulate NHS dentistry and private medicine, none of these bodies (described below) cover private dentistry (except for general anaesthesia).**

## National Clinical Assessment Authority (NCAA)

- I.28 The National Clinical Assessment Authority (NCAA) is a special health authority set up in April 2001 as one of the central elements of the NHS' modernisation plans to ensure the high quality of healthcare. They provide a support service to health authorities and hospital and community trusts that are faced with concerns over the performance of an individual NHS doctor acting as a 'rapid response unit'. NCAA makes recommendations to health authorities when to suspend, retain or dismiss. It underpins the GMC's mandatory revalidation process.
- I.29 The **GDC called for the NCAA to expand its role as part of their proposals for revalidation.**<sup>130</sup> NCAA have limited resources, they may help complement quality assurance schemes but would not be seen as a principal means for improving quality.

## Commission for Healthcare Audit and Inspection (CHAI)

- I.30 The Commission for Healthcare Audit and Inspection will replace and broaden the role of the Commission for Health Improvement (CHI) and it will encompass the part of the National Care Standards Commission (NCSC) which licenses and regulates independent and voluntary healthcare and the part of the Audit Commission (AC) that is concerned with value for money health studies.
- I.31 CHI was created in order to improve the quality of the care that NHS patients receive. Although CHI works closely with the Department of Health, it is an independent body.
- I.32 CHI carries out clinical governance reviews of the NHS, investigates serious service failures in the NHS, undertakes studies of NHS national service frameworks, and publishes advice and guidance on clinical governance. At present, only NHS funded care is under the remit of CHI.
- I.33 The National Care Standards Commission (NCSC) (similarly, the Scottish Commission For The Regulation Of Care and the Care Standards Inspectorate For Wales) is an independent public body, which was established by the Care Standards Act 2000. It is responsible for the regulation of social care and independent and voluntary healthcare services in England.
- I.34 The role of the Commission is to ensure that the minimum standards and regulations stipulated by the Government are adhered to. **Exclusively private**

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<sup>130</sup> *Revalidation*, Anthony Townsend - Chief Executive and Registrar, General Dental Council, April 2002

**doctors and the majority of independent healthcare establishments fall under the jurisdiction of the NCSC, who license and register them, but private dentistry is not included except for general anaesthesia.**

- I.35 Subject to legislation, CHAI will be fully operational from 2004, with a period of shadow running prior to that.

#### **Scotland**

- I.36 The Regulation of Care (Scotland) Act 2001 established The Care Commission, an independent body with responsibility for regulating care services throughout Scotland. It is responsible for regulating independent healthcare services including dental practices providing private treatments. NHS Quality Improvement Scotland (the former Clinical Standards Board for Scotland) and the Scottish Executive are currently working on the development of unified standards for both private and NHS dentistry

#### **Wales**

- I.37 The Care Standards Inspectorate for Wales is the new comprehensive care regulator for Wales. Created by the Care Standards Act 2000, the Inspectorate is only charged with regulating general anaesthesia in the private dental sector.

#### **Northern Ireland**

- I.38 There is no equivalent of these bodies in Northern Ireland. A network of local authorities regulate social services.

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## K FURTHER INFORMATION

### Glossary

Clinical Dental Technicians	Clinical Dental Technicians are technically trained as Dental Technicians and have post-technician training in sciences, clinical skills, and interpersonal skills. They have the skills and knowledge necessary to provide a removable appliance service directly to the community, although this remains illegal in the UK.
Community Dental Service	The Community Dental Service (CDS) provides dental care for patients unable to access general dental services such as those with special needs and some specialist services. In particular, the CDS looks after young children who need special help, as well as elderly and housebound people, and patients with mental or physical disabilities. Dentists work in health centres, clinics and hospitals.
Cosmetic Dentistry	Cosmetic dentistry includes a variety of dental treatments aimed at improving the appearance of the teeth, using bleaching, bonding, veneers, reshaping, orthodontics, or implants.
Deciduous Teeth	Primary or baby teeth which are normally lost as adult teeth come through.
Dental Hygienist*	A professional who specialises in cleaning teeth and gum treatments under the direction of a dentist, and provides guidance on oral health programs.
Dental Technician*	Dental technicians are healthcare professionals whose scope of work includes the design, construction, repair or alteration of dental prosthetic, restorative and orthodontic appliances or devices. They either work in commercial dental laboratories, the hospital and community services or general dental practice.
Dental Therapist*	A professional who may extract deciduous teeth, undertake simple fillings and scale teeth under the direction of a dentist.
Dentate	Having one or more teeth.
Denturist	Dental technicians who are permitted by law to manufacture and fit dentures (prostheses technically includes crown and bridge). This group of dental

	professionals does not exist in the UK.
Edentulous	Having no teeth.
Endodontics (root canal treatment)	The branch of restorative dentistry concerned with the diagnosis and treatment of injuries and diseases of the pulp, root and tissues surrounding the tip of the root of the tooth.
General Dental Practitioner	'High street' dentists who provide services to the GDS as independent professional contractors. They generally provide services through local practices. They may work privately, for the NHS or a mixture of both.
General Dental Services	The main service through which National Health dental treatment is provided. Additional dental services are provided through the Hospital Dental Service and the Community Dental Service.
Inferior dental nerve block anaesthesia	A method of anaesthesia which anaesthetises the teeth of the lower jaw.
Local infiltration anaesthesia	A method of anaesthesia which places the anaesthetic as close to the root tip of the tooth as possible.
Maxillofacial Prosthetist & Technician (MPT)	A professional who provides a technical and scientific and advisory service to patients for their rehabilitation by restoration using implants, splints and prosthesis.
Orthodontics	Orthodontics is that area of dentistry concerned with the correction of malformations or misalignments of the teeth and jaws.
Personal Dental Services	Personal Dental Services agreements is the term in the 1997 Primary Care Act for local commissioning in primary care dentistry. It began with a first wave of 15 pilots in October 1998, a second wave of 24 pilots in October 1999 and a third wave for October 2000. Pilots are developed by Health Authorities and now PCTs working with dentists locally. They are led by local priority setting and are intended to respond to local need and the views of patients.
Professionals Complementary to Dentistry (PCDs)	The collective noun for non-dentist professionals who are involved in the provision of dental care, this includes technicians, hygienists, therapists, and dental nurses.

Pulp Therapy	Treatment to save a tooth by treating the pulp, especially used to treat deciduous teeth in preference to extraction.
Restorative Dentistry	Any treatment that involves the restoration of a tooth (e.g. fillings, root canal treatment, crowns) or treatment that replaces a missing tooth (e.g. bridgework, implants or denture work).
Technologist	A professional qualified to construct, to the prescription of a dentist, oral prostheses and related appliances, who has undertaken training approved by the Dental Technicians Association.

\* NB- These are the tasks they are allowed to undertake in the UK.

## Acronyms

AC	Audit Commission
ADHS	Adult Dental Health Survey
ARF	Annual Retention Fee
BDA	British Dental Association
CA	Consumers' Association
CAB	Citizens Advice Bureaux
CA98	Competition Act 1998
CAPP	Country Area Profile Programme
CHAI	Commission for Healthcare Audit and Inspection
CHI	Commission for Health Improvement
CODE	Confederation of Dental Employers
CPD	Continuing Professional Development
CRHP	Council for the Regulation of Healthcare Professionals
DAMAS	Dental Appliance Manufacturers Audit Scheme
DH	Department of Health
DLA	Dental Laboratory Association
DPB	Dental Practice Board
FTA	Fair Trading Act 1973
FTPP	Fitness to Practice Panel
GDC	General Dental Council
GDP	General Dental Practitioner
GDPA	General Dental Practitioners Association
GDS	General Dental Service

GMC	General Medical Council
NACAB	National Association of Citizens Advice Bureaux
NCAA	National Clinical Assessment Authority
NCSC	National Care Standards Commission
NHS	National Health Service
NICE	National Institute for Clinical Excellence
OFT	Office of Fair Trading
ONS	Office for National Statistics
PCD	Professionals Complementary to Dentistry
PCT	Primary Care Trust
PDS	Personal Dental Service
WHO	World Health Organisation















