

Dentistry

An OFT market study

May 2012

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1 EXECUTIVE SUMMARY

- 1.1 The OFT recognises that the dentistry market¹ is critical to ensuring good levels of oral health across the UK population.² Evidence gathered in this market study suggests that dental patients are largely satisfied with the services provided by their dentist. However, this market study has also identified a number of concerns which the OFT has with the current operation of the dental market.
- 1.2 The dentistry market in the UK has seen significant growth over recent years, with the value of the market rising by around 90 per cent between the period of 1999-2000 and 2009-10. The dentistry market is valued at an estimated £5.73 billion a year, with spending on NHS³ dental treatment accounting for approximately 58 per cent of the market value, and spending on private dental treatment accounting for the remaining 42 per cent.
- 1.3 In September 2011, the OFT launched this study into the dentistry market prompted by a significant level of complaints reported to Consumer Direct, concerns raised by stakeholders in relation to local pockets of concentration in the NHS dentistry sector, the OFT's significant concerns regarding potentially high barriers to entry and expansion into the dentistry market and regarding the continuing

¹ Throughout this report, references to the dentistry market encompass both NHS dental treatment and private dental treatment, across the UK, unless otherwise specified.

² According to research carried out in support of the WHO Global Oral Health Programme, England had a DMFT (mean number of decayed, missing and filled permanent teeth) of 0.7 in 2008-09. This is comparable with the best in Europe: Denmark 0.7 (2007) and Germany: 0.7 (2005), www.mah.se/CAPP/Country-Oral-Health-Profiles/EURO. In a separate survey in 2011, Scotland's DMFT was also assessed at 0.7, www.isdscotland.org/Health-Topics/Dental-Care/Publications/2011-11-29/2011-11-29-DentalNDIP-Report.pdf?64451235533.

³ References to the NHS in this report are intended to encompass the Northern Ireland Health Service, except where otherwise specified.

restrictions on dental patients' ability to access dental hygienists, dental therapists and clinical dental technicians.

Overview of key findings

- 1.4 A significant, core concern for the OFT is that **the existing NHS dental contract in England acts as a barrier to entry and expansion in the dentistry market**. Having a contract to provide NHS dental treatment is crucial to the commercial viability of most dental practices. In England, most NHS dental contracts were allocated to incumbent dental practices in 2006. The majority of these contracts are not time-limited and only a small volume of new contracts are put out to competitive tender each year. The effect of these factors has been to insulate dental practices with an NHS dental contract – which are profit-seeking businesses – from competition. Potential new, innovative dental practices trying to enter the dentistry market face limited opportunities, good practices offering higher quality services to patients face high barriers to expansion, and poor performing dental practices face more limited incentives to improve in order to retain and attract new patients. The Department of Health is already engaged in a process of reform of the current NHS dental contract, and the OFT hopes that the analysis and principles for reform set out in this report will assist the Department.
- 1.5 This market study has also identified a number of other significant concerns which contribute to the dentistry market not always working as well as it should. These are summarised below.
- 1.6 **Insufficient information for patients:** Dental patients often do not benefit from timely, clear and accurate information to make active, informed decisions regarding their choice of dentist and dental treatment. In particular:
- 39 per cent of NHS dental patients who had been to the dentist in the last two years reported that there were no leaflets or posters providing information on NHS charges at their dentist

- 56 per cent of dental practices that provide some private dental services do not display private fee information at the dental practice reception
 - 82 per cent of dental patients who recently received a course of dental treatment that incurred a charge did not receive a written treatment plan.
- 1.7 We are concerned that effective, timely, sufficient enforcement action against dentists and dental practices is not being prioritised and pursued by NHS commissioning bodies, the Care Quality Commission (CQC) and the General Dental Council (GDC), where dentists and dental practices have breached relevant regulations and/or standards which those bodies each have powers to enforce.
- 1.8 We are particularly concerned to find that **around 500,000 patients each year may be provided with inaccurate information by their dentist regarding their entitlement to receive particular dental treatments on the NHS**, and as a result be required to pay more to receive private dental treatment unnecessarily. Evidence gathered by the OFT suggests that NHS commissioning bodies and the GDC need to be far more proactive in identifying and pursuing formal, robust and timely enforcement action against such instances of misconduct where appropriate.
- 1.9 **Sale of dental payment plans:** Twenty per cent of dental patients who have joined a dental payment plan as a means of paying for private dental treatment stated that they felt that they were put under pressure by their dentist to sign up to the plan. As a result, such patients are denied the opportunity to make active, informed decisions regarding how they pay for their dental treatment and may receive poorer outcomes and value for money.
- 1.10 **Complaining and redress:** We are concerned that there are multiple different bodies with which a patient may need to deal, depending on their circumstances, if they have a complaint which is not resolved by their dental practice. The resulting complexity and costs impose unnecessary burdens on patients and dentists. For example, where a

complaint relates to a course of dental treatment which comprises both NHS and private dental treatment, the complaint must be split into separate aspects which follow different routes. Evidence also indicates that many dental patients do not receive adequate redress from their dentist when dental treatment fails.

- 1.11 **Restrictions on patients' ability to access dental care professionals directly:** Dental patients are currently unable to access dental hygienists, dental therapists and (except for patients without any teeth) clinical dental technicians without first receiving a referral from a dentist. We do not consider that there is any compelling, objective justification for the current restrictions. Further, we consider that these restrictions are likely to dampen competition in the dentistry market, reduce innovation, limit patient choice and lead to inefficient use of resources in the provision of dental treatment.
- 1.12 Although the OFT called for the GDC to end restrictions on direct patient access to such dental care professionals in 2003, the GDC has provided no compelling explanation for the delay in implementing the requisite reforms. The OFT considers this delay to be unjustified and calls on the GDC to act swiftly to address the concerns set out in this report.

Key recommendations and actions

- 1.13 The OFT has worked closely with many stakeholders in the dentistry market to identify, and, in many cases, to agree implementation of, a package of measures which we consider need to be pursued, many in the short term, to achieve a better functioning, more efficient dentistry market in the UK to the benefit of patients. These are summarised below.

Reform of the NHS dental contract in England to facilitate greater competition

- 1.14 In the OFT's view, it is vital that the Department of Health progresses the redesign of the NHS dental contract and, in doing so, that it ensures that the principles of patient choice and the facilitation of entry into the

dentistry market by new dental practices and expansion by higher performing dental practices are given due consideration when developing the new NHS dental contract. One option which the OFT would urge the Department of Health to consider is introducing a system in which 'any qualified provider' may deliver NHS services to dental patients and where NHS dental payments follow the patient.

- 1.15 The OFT strongly considers that the Department of Health must also, when redesigning the new NHS dental contract, bring an end to non-time-limited NHS dental contracts.
- 1.16 The OFT considers that the commissioning process for NHS dental contracts in England should also be streamlined and standardised to facilitate entry into the market by new dental practices. The OFT notes that it is hoped that the introduction of the NHS Commissioning Board, as the single body responsible for all NHS commissioning in England from April 2013, will lead to a single, more consistent approach across England.

Improved provision of information to facilitate active, informed patient choices

- 1.17 Appropriate, immediate steps should be taken to improve patient awareness of existing online tools which enable patients to find local dentists who provide NHS dental treatment, such as the NHS Choices website. We also strongly recommend that the content of these online tools be expanded significantly to improve their utility to patients. Further to OFT engagement with the NHS Business Services Authority and the Department of Health in the course of this market study, the introduction of some of these requisite changes is already being planned. The OFT is also pleased that the NHS Commissioning Board also appears committed to publishing accessible and clear quality information about dental practices to patients.
- 1.18 The OFT urges NHS commissioning bodies and regulators of dental practices, such as the CQC, to be far more proactive in ensuring that dental practices comply with existing rules which require them to display

NHS dental treatment prices and to provide patients with clear information about proposed dental treatment, including the cost, prior to receiving dental treatment.

- 1.19 We also call on the GDC to expand their professional standards to require that indicative prices of private dental treatment are consistently displayed. We are pleased that, further to OFT engagement during the course of the market study, the GDC has agreed to include such a requirement in proposed revised professional standards on which it will consult during 2012.
- 1.20 NHS commissioning bodies must also be far more proactive in identifying and taking robust, timely and regular enforcement action against dental practices that provide inaccurate information to patients regarding their entitlement to certain NHS dental treatments. We also urge the GDC to be more focused on taking more robust and timely disciplinary action against such instances of misconduct by dentists, where appropriate, to further deter future misconduct.

In relation to the sale of dental payment plans, the OFT calls on the British Dental Association (BDA) to develop a robust and effective code of practice to help ensure that dentists do not put pressure on patients when selling dental payment plans and thereby run the risk of non-compliance with consumer protection law. The OFT is pleased that the BDA has responded to the OFT's concern by agreeing to develop and publish such a code.

Improved patient access to redress and a simpler complaints system

- 1.21 The OFT calls on the GDC to expand their professional standards to provide that dentists must, with limited exceptions, remedy at no extra cost to the patient, any dental treatment, including private dental treatment, which they have provided and which fails within one year. This must be in addition to patients' existing statutory rights.

- 1.22 Further to engagement with the OFT during the course of this market study, IDH and Oasis – the two largest corporate dental groups in the UK – have voluntarily agreed that their dental practices will, in addition to the existing guarantee which applies to NHS dental treatment, also guarantee private dental treatment for at least one year. On the basis of the evidence gathered during this market study, the OFT can see no compelling reason why such a guarantee cannot be implemented across the dentistry market.
- 1.23 The OFT considers that the dental complaints system must be reformed to make it simpler, easier and less time consuming for dental patients and dentists to lodge and respond to complaints that have not been satisfactorily resolved at the dental practice level. The OFT strongly recommends that either a single body should be responsible for dealing with such complaints, or a single patient-facing portal for the reporting of such complaints should be developed to ensure a more effective, efficient and consistent complaints system. The OFT urges relevant bodies to engage constructively to facilitate such reform of the dental complaints system.

Direct patient access to dental care professionals

- 1.24 The OFT calls on the GDC to review and urgently remove restrictions on direct patient access to dental care professionals. The exact nature of how direct access is implemented is a matter for the GDC to decide, but the OFT calls on the GDC to implement appropriate changes without further delay and cost to both patients and the dental profession. The OFT is pleased that the GDC has recently initiated a review of these restrictions. The OFT will closely monitor the outcome of the GDC's review of direct access, and we will review our position and consider the appropriate course of action once the GDC has made a decision following the conclusion of its review in spring 2013.

Acknowledgements

- 1.25 The OFT has committed considerable resource throughout this market study to engage closely with patients, dental professionals and key

stakeholders. For example, we commissioned face-to-face interviews with over 3,400 adults across England, Scotland, Wales and Northern Ireland. We sent detailed information requests to, and received responses from, certain parties regarding issues of relevance to the study. We also commissioned extensive survey work among dentists and consulted a wide range of stakeholder groups representing patients, dental professionals, government and regulators.

- 1.26 We are grateful for all of these contributions and for the willingness of all parties to assist the market study team.

2 INTRODUCTION

The OFT's mission and powers

- 2.1 The OFT's mission is to make markets work well for consumers. The OFT has a broad interpretation of consumers, including both businesses and final consumers. Market studies are one of a number of tools at the OFT's disposal to address competition or consumer protection problems, alongside its enforcement and advocacy activities.⁴
- 2.2 Market studies involve the analysis of a particular market, or practices across a variety of goods and services, with the aim of identifying and addressing significant aspects of market failure, ranging from competition issues to consumer detriment and the effect of government regulations.
- 2.3 Possible outcomes of market studies include:
- future enforcement action by the OFT
 - a reference of the market to the CC
 - recommendations to the Government or regulators for changes in laws, regulations or policy
 - voluntary action by industry players to address any problems found
 - campaigns to promote consumer awareness, and
 - a clean bill of health.

⁴ Market studies are conducted under the OFT's general function in section 5 of the Enterprise Act 2002 (EA02), which includes the functions of obtaining information and conducting research. For more information on market studies, see: www.oft.gov.uk/OFTwork/markets-work/market-studies-further-info

Launch of the OFT market study into dentistry

2.4 In September 2011, the OFT launched a study into the dentistry market in the UK. The study was prompted by:

- The response to the OFT's market study into private dentistry in 2003.⁵ That report made three sets of recommendations, focused on:
 - improving patient information
 - resolving problems and improving complaints procedures and
 - reducing unnecessary restrictions on the business of dentistry.

Although some changes were implemented with a view to addressing these issues, the OFT was concerned that the issues raised in our report had not been fully addressed. The OFT was particularly concerned with the lack of effective action by the GDC to remove the restrictions on patients' direct access to dental care professionals.

- The results of surveys in England by consumer bodies and the Department of Health which raised concerns around patients' ability to access clear and transparent information on prices and treatment, particularly in situations where patients may receive mixed dental treatment – that is, involving both NHS and private funding within the same overall course of dental treatment.⁶

⁵ 'The private dentistry market in the UK' (OFT630), March 2003
www.offt.gov.uk/OFTwork/markets-work/private-dentistry

⁶ For example, Which? research into dentistry in 2010, and 'Dentistry Strategic Review', Department of Health, 2009,
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101153.pdf

- Concerns raised during the recent merger between two corporate dental groups⁷ over high levels of concentration in NHS dental services in some local areas.
- Consumer complaints to Consumer Direct.⁸

Scope and purpose of the study

2.5 For the purposes of this study, we define the dentistry market as the market for primary care dentistry, encompassing both NHS and private dental treatment, but excluding cosmetic treatments such as teeth whitening.⁹

2.6 In relation to issues affecting patients' ability to make active and informed decisions, and to drive competition between providers, the market study sought to:

- examine whether there was adequate provision of sufficiently transparent information to allow patients to make informed choices between:
 - dentists/dental practices
 - dental treatments, including private and NHS dental treatment
 - different payment methods

⁷ 'Completed joint venture between the Carlyle Group and Palamon Capital Partners LP for the acquisition of Integrated Dental Holdings Group and Associated Dental Practices', ME/4926/11, OFT, June 2011, www.offt.gov.uk/shared_offt/mergers_ea02/2011/IDH_decision.pdf.

⁸ Consumer Direct received a total of almost 2,500 complaints regarding the dentistry market over the period 2008–09 to 2010-11.

⁹ It should be noted that this is not an economic definition of the market, such as may be carried out for a merger analysis or in the context of competition law enforcement.

- examine whether mechanisms currently in place support patients who wish to change dentist
- consider whether current redress systems deliver effective outcomes for patients.

2.7 In relation to the supply of dentistry and the extent of competition between providers, the study sought to:

- consider the nature of competition between dental practices
- identify barriers to entry and expansion and their impact on competition between providers
- investigate professional regulations which restrict patients' ability to directly access certain dental care professionals.

Information gathering

2.8 Since the OFT launched the market study it has received representations from over 30 interested parties active across the dentistry market, including regulators, trade bodies, corporate dental groups, independent dentists, and patient representative bodies.

2.9 The OFT has committed considerable resource throughout this market study to engage closely with patients, dental professionals and key stakeholders. In particular, the OFT commissioned research which included:

- face-to-face surveys of over 3,400 adults across England, Wales, Scotland and Northern Ireland to explore patient experiences in the dentistry market
- eight focus groups with patients from a wide-range of geographic and socio-economic backgrounds across the UK to discuss certain aspects of patients' experiences in the dentistry market in greater depth

- eight in-depth interviews with patients who had recently changed dentist
- a survey of 250 dental practices in England, and a further 12 in-depth interviews, half of which had either entered the market or recently changed ownership over the past five years
- mystery shopping of 500 dental practices to explore the price and range of services offered by dental practices in different areas.

2.10 In addition, the OFT hosted two expert roundtable discussions which focused on:

- information provided to dental patients and complaining and redress in the dentistry market, and
- restrictions on direct access to dental hygienists, clinical dental technicians and dental therapists.

2.11 A record of these roundtable discussions and a full list of stakeholders that attended are at Annexes A and B.

Structure of the report

2.12 The remainder of this report is structured as follows:

- Chapter 3 provides an overview of the dentistry market in the UK
- Chapter 4 sets out our findings in relation to dental patients' ability to make active, informed choices regarding the dental practice they attend
- Chapter 5 sets out our findings regarding whether, when at the dentist, patients are provided with timely and accurate information regarding their dental treatment
- Chapter 6 sets out our findings in relation to the sale of dental payment plans by dentists

- Chapter 7 sets out our findings regarding whether patients obtain adequate redress when they experience problems with dental treatment and whether the current system for dealing with complaints about dentistry is sufficiently easy for patients and dentists to negotiate
- Chapter 8 sets out our findings in relation to the supply of dentistry in England, specifically the effect of the NHS dental contract as a barrier to entry and expansion in the dentistry market
- Chapter 9 sets out our findings regarding restrictions on direct patient access to dental hygienists, clinical dental technicians and dental therapists
- Chapter 10 sets out our recommendations, and actions which are already being taken, to improve the working of the dentistry market
- Chapter 11 sets out the OFT's proposed decision not to make a market investigation reference to the Competition Commission at this time and invites views on that provisional decision.

3 OVERVIEW OF THE DENTISTRY MARKET

Introduction

3.1 The dentistry market provides an essential service to millions of patients and is critical to ensuring the oral health of the UK population. The OFT's patient survey found that three quarters (75 per cent) of UK adults reported having a regular dentist and a similar proportion (76 per cent) reported having visited a dentist in the last two years. Almost all adults will visit the dentist at least once in their lives.¹⁰

NHS and private dentistry

3.2 Dental treatment in the UK can be either funded or part-funded by the NHS or privately funded by the patient (whether directly or through the use of a dental payment plan or insurance).

3.3 Where dentists provide NHS dental treatment, they are required to provide all proper and necessary dental care to maintain the patient's oral health under the terms of their NHS contract. This will not include treatments which are provided for cosmetic purposes.¹¹

3.4 NHS dental treatment may either be wholly funded by the NHS or may be part-funded by the NHS and part-funded by the patient. Specifically:

- Free NHS dental treatment is available for specified groups of patients who are exempt from payment, such as children, pregnant

¹⁰ The OFT's patient survey found that 96 per cent of all adults reported that they have been to a dentist for a check-up. Only four per cent reported that they had never visited a dentist.

¹¹ The OFT understands that there is no clear dividing line regarding whether a particular treatment is necessary or cosmetic. This is a clinical judgement made by the dentist, based on the circumstances of the individual patient.

women and individuals on certain benefits.¹² In addition, in Scotland all dental examinations are free.

- Patients not exempted from payment will pay a contribution towards the cost of NHS dental treatment.
- Patients on low incomes who do not fall into any of the specified groups of patients who are exempt from payment may be entitled to help with payments.

3.5 The OFT's survey found that the majority of dental patients receive NHS dental treatment. Sixty-six per cent of patients who had a regular dentist and had been to the dentist in the last two years reported that they received NHS dental treatment on their last visit. Twenty-three per cent reported that they had received private dental treatment and 10 per cent reported that they received a mix of private and NHS dental treatment. More patients in Scotland reported receiving NHS dental treatment (75 per cent), while fewer patients reported receiving NHS dental treatment in Northern Ireland (54 per cent). A full break down of the regional variations is at Table 3.1.

¹² See www.nhs.uk/chq/pages/1786.aspx?categoryid=74&subcategoryid=742 for the list of specified groups in England; <https://cfs.scot.nhs.uk/dental.php> for the groups in Scotland; www.nhsdirect.wales.nhs.uk/localservices/dentistfaq/#have_to_pay for the groups in Wales; and, www.hscbusiness.hscni.net/services/2068.htm for the groups in Northern Ireland.

Table 3.1: Proportions of patients whose most recent course of dental treatment was NHS, private or a mixture of NHS and private dental treatment by constituent countries of the UK

	per cent			
	NHS	Private	Mixed	Don't know
England	66	23	10	1
Scotland	75	8	16	1
Wales	61	26	11	2
Northern Ireland	54	38	9	-
United Kingdom	66	23	10	1

Source: OFT survey of 3,450 UK adults, November – December 2011.

Base: 2311 adults who have a regular dentist and have seen their dentists in the last two years.

Rows may not sum 100 per cent due to rounding.

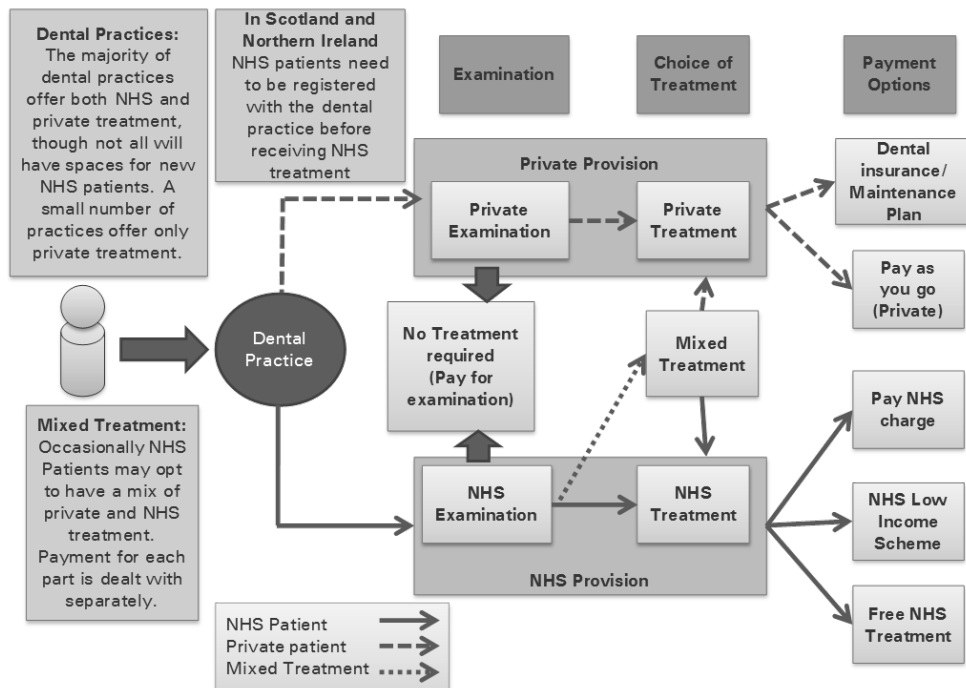
Patient choices in the dentistry market

3.6 Patients typically make a number of choices in the dentistry market, including:

- which dental practice/dentist they attend
- which particular dental treatment(s) to have
- whether to have NHS or private dental treatment, and
- how to pay for dental treatment.

3.7 A typical patient journey in relation to these key choices is set out in Figure 3.1 below.

Figure 3.1: Typical dental patient journey¹³



3.8 Chapters four to six below cover key aspects of the choices that patients face in the dentistry market.

Size and growth of the dentistry market

3.9 The UK dentistry market was valued at an estimated £5.73 billion a year in 2009-10. Spending on NHS dental treatment was £3.32 billion and accounted for approximately 58 per cent of the total dentistry market, with spending on private dental treatment totalling £2.4 billion and

¹³ Not including emergency treatment.

representing the remaining 42 per cent of the market.¹⁴

- 3.10 There are estimated to be 29,500 dentists practising in primary care settings in the UK, with the vast majority offering NHS dental treatment or a combination of NHS and private dental treatment. Fewer than 10 per cent of dentists (2,500) carry out private dental treatment only.¹⁵
- 3.11 Dental practices in the UK are typically either small or medium sized private businesses that are owned either by an individual or a partnership of dentists, or are owned by a corporate dental group (an incorporated company operating three or more dental practices). Prior to 2006 there were significant restrictions on the ownership of dental practices by corporate dental groups. Restrictions on corporate dentistry were relaxed in 2006. Since then the corporate dental sector has expanded and, in October 2010, was estimated to account for around 10 per cent of the dentistry market.¹⁶
- 3.12 The dentistry market has seen significant growth over recent years, growing by an estimated 46 per cent in real terms between 1999-2000 and 2009-10. The value of the private dentistry sector almost doubled between the period of 1999-2000 and 2009-10, rising from £1.21 billion to £2.4 billion. The value of the NHS dentistry sector also rose over the same period, up 83 per cent from £1.82 billion to £3.32 billion.¹⁷

¹⁴ *'Dentistry UK Market Report 2011'*, Laing and Buisson, page 4. The estimate that the dentistry market is valued at an estimated £5.73 billion a year is for 2009-10 and does not include cosmetic dentistry. The value of the dentistry market including cosmetic dentistry was estimated as £7.2 billion in 2010 according to *'The UK Dentistry Market Development'* Market and Business Development (2010).

¹⁵ Laing and Buisson, *ibid*, page 8.

¹⁶ Laing and Buisson, *ibid*, page 8.

¹⁷ All figures in this paragraph: Laing and Buisson (2011), *ibid*, p.4 - 6.

- 3.13 Rising disposable income, increased cosmetic consciousness, greater access to dental insurance plans and dental maintenance plans, as well as increased government funding for NHS dental services have been some of the factors driving growth in the dentistry market.
- 3.14 Recently the economic downturn has had an impact on dentistry. While growth in the market was running at around four per cent per annum from 2000 onwards, it slowed to one per cent in 2008-09 and two per cent in 2009-10.¹⁸ This appears mainly to be due to a softening of demand for private dentistry (as spending on private dentistry fell in real terms by four per cent and three per cent in 2008-09 and 2009-10 respectively).¹⁹ Over the next few years, the provision of NHS dental treatment may face increased pressure from cuts in public spending.
- 3.15 Successive Adult Dental Health Surveys²⁰ show that the oral health of UK adults has improved significantly over recent decades. For example, the proportion of adults in England who have no natural teeth has fallen from 28 per cent in 1978 to six per cent in 2009, and the proportion of adults in England with visible coronal caries has fallen from 46 per cent in 1998 to 28 per cent in 2009.²¹ Indeed, the UK is considered to have one of the highest standards of oral health in the world and, according to

¹⁸ Laing and Buisson, *ibid*, p.4.

¹⁹ Laing and Buisson, *ibid*, p.7.

²⁰ Adult Dental Health Surveys have been carried out every 10 years since 1968. The most recent survey results – for the 2009 survey – were published in March 2011 and are available at: www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/adult-dental-health-survey-2009--summary-report-and-thematic-series

²¹ 'Adult Dental Health Survey 2009 – First Release', p. 4 and p.13, www.dhsspsni.gov.uk/adultdentalhealthsurvey_2009_firstrelease.pdf

World Health Organisation measures, the best in Europe alongside Denmark and Germany.²²

- 3.16 As the oral health of the population continues to improve, the demand for restorative dentistry is expected to decline in the future with increasing emphasis on preventative dentistry.²³

Oversight and regulation of the dentistry market

- 3.17 The dental market has a complex regulatory structure with several bodies variously responsible for regulating different aspects of the provision of dentistry. The main regulators are outlined below.
- 3.18 In England, the Department of Health provides strategic leadership for public health, the NHS and social care. The Department has overall responsibility for the regulations that apply to dentists in England. In particular, it is responsible for the funding and policy underpinning NHS dental work in England.
- 3.19 Overall responsibility for public health, including dentistry, has been devolved to the other nations in the UK with responsibility for dental health falling to:
- Scotland: the Chief Dental Officer for Scotland as part of the Health and Social Care Directorate of the Scottish Government
 - Wales: the Chief Dental Officer for Wales as part of the Health and Social Care Department of the Welsh Government

²² According to research carried out in support of the WHO Global Oral Health Programme, England had a DMFT (mean number of decayed, missing and filled permanent teeth) of 0.7 in 2008-09. This is comparable with the best in Europe: Denmark 0.7 (2007) and Germany: 0.7 (2005), www.mah.se/CAPP/Country-Oral-Health-Profiles/EURO/. In a separate survey in 2011, Scotland's DMFT was also assessed at 0.7, www.isdscotland.org/Health-Topics/Dental-Care/Publications/2011-11-29/2011-11-29-DentalNDIP-Report.pdf?64451235533.

²³ Laing and Buisson, *ibid*, p.25.

- Northern Ireland: the Chief Dental Officer for Northern Ireland as part of the Department of Health, Social Services and Public Safety of the Northern Ireland Executive.

3.20 The GDC regulates dental professionals in the United Kingdom and defines the business of dentistry and who can perform it. All dentists, dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists must be registered with the GDC in order to work in the UK. The GDC publishes 'Standards for dental professionals' with which registered dental professionals must abide.

3.21 NHS commissioning bodies contract or enter into arrangements with NHS dental practices²⁴ to deliver an agreed level of primary dental care in their local area. Regulations²⁵ require that these contracts/arrangements include quality standard levels which, if breached, could be considered a breach of the contract/arrangement. The relevant NHS commissioning bodies are:

- Primary Care Trusts (PCTs) in England
- NHS Boards in Scotland
- Local Health Boards in Wales, and

²⁴ NHS commissioning bodies may contract with individual dentists, a partnership of dentists or corporate dental groups which include a mix of dentists and non dentists. References in this report to NHS dental contracts with 'dental practices' and with 'dentists' are intended to refer to, and to encompass, these scenarios.

²⁵ In England, The National Health Service (General Dental Services Contracts) Regulations 2005, www.legislation.gov.uk/uksi/2005/3361/contents/made. In Scotland, The National Health Service (General Dental Services) (Scotland) Regulations 2010, www.legislation.gov.uk/ssi/2010/208/contents/made. In Wales, The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006, www.legislation.gov.uk/wsi/2006/490/contents/made. In Northern Ireland, The General Dental Services Regulations (Northern Ireland) 1993.

- Health and Social Services Boards in Northern Ireland.
- 3.22 The CQC regulates primary dental care for both private and NHS services in England. The CQC is responsible for ensuring that the care and treatment provided by all dental practices in England meet government standards of quality and safety.
- 3.23 In Scotland, Wales and Northern Ireland, the local health boards listed at paragraph 3.21 above are responsible for inspecting NHS dental practices to ensure that they meet the standards set for quality and safety by the relevant national government.
- 3.24 Further, in Wales, Healthcare Inspectorate Wales is responsible for ensuring that the care and treatment provided by individual dentists that offer private dental treatment meet government national minimum standards for quality and safety. In Northern Ireland, the Regulation and Quality Improvement Authority is responsible for ensuring that the care and treatment provided by dental practices that offer private dental treatment meet the Department of Health, Social Services and Public Safety's minimum standards for care and treatment. In Scotland, there is currently no body which has responsibility for regulating private dental practices.

Reforms affecting the dentistry market in England

- 3.25 Under the Health and Social Care Act 2012, responsibility for commissioning and managing NHS dental contracts in England will move from local PCTs to the NHS Commissioning Board. The NHS Commissioning Board will take on its full statutory responsibilities in April 2013.
- 3.26 The Coalition Agreement set out an intention to 'introduce a new dentistry contract that will focus on achieving good dental health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren.' The Department of Health is responsible for developing the revised NHS dental contract in England and is planning to replace the existing contract with one based on registration, capitation

and quality.²⁶ Pilots with test contracts started in September 2011 and will run for 12 months in 70 practices in areas across England. The pilots are testing elements needed to design a new dental contract including weighted capitation, a new care pathway and a pilot Dental Quality and Outcomes Framework with the intention that dentists will be rewarded for maintaining and improving their patients' oral health. The Department of Health intends to use learning from the pilots to develop proposals for a new NHS dental contract, which is expected to be introduced no sooner than 2014.

²⁶ Details of the Department of Health's NHS dental contract proposals are available in The Departments' proposals for pilots publication (December 2010) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122660

4 PATIENT CHOICES: CHOOSING A DENTAL PRACTICE

Introduction

- 4.1 Well functioning, competitive markets are characterised by active, informed consumers. In the dentistry market, informed and active patients are more likely to search out and choose a dentist who provides high quality services, thus driving up standards of care in the market and leading to improved oral health.
- 4.2 The OFT's research has highlighted that, in general, patients prefer not to change dentists once they have found one with whom they are happy.²⁷ Where this results in the patient receiving good quality continuing care from a particular dentist, this can be of benefit to the patient in terms of improved long term oral health outcomes.²⁸ However, where patients remain with a dental practice because it is difficult to obtain information on the existence, costs and service quality of alternative providers, this will limit patients' ability to drive competition between dentists. In the long run, this can be expected to result in poorer outcomes for patients in terms of price, quality and/or choice.
- 4.3 This chapter sets out the OFT's findings regarding the extent to which dental patients have access to, and awareness of, sufficient information to help them to make active, informed choices between dentists and dental practices. The chapter considers the following aspects in turn:

²⁷ The OFT survey found that 40 per cent of all patients had been with their current dentist for 10 years or more, with more than half (58 per cent) having being with their current dentist for five years or more. The survey found that private patients demonstrated a higher degree of loyalty with just under half (49 per cent) of private patients being with their current dentist for 10 years or more, with over two thirds (69 per cent) being with their current dentist for five years or more.

²⁸ See '*NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele*', June 2009, p.56, www.dh.gov.uk/en/Healthcare/Primarycare/Dental/DH_094048.

- patients' awareness of local dental practices providing NHS dental treatment and how to find out about such practices
- patients' ability to find and compare prices charged for dental treatment by different dentists or dental practices
- patients' ability to compare the quality of service and patient satisfaction levels of different dental practices.

Patients' awareness of availability of local dental practices providing NHS dental treatment

4.4 To assess patients' awareness of local dental practices providing NHS dental treatment, we have considered:

- the sources of information available to patients
- patient awareness of those sources of information
- how patient awareness levels impact upon patient choices and competition between dental practices.

4.5 The OFT has found that websites exist that provide patients with quick and easy access to basic information on local dental practices which offer NHS dental treatment: namely, the NHS Choices website in England, the NHS 24 website in Scotland, the NHS Direct Wales website, and the Health & Social Care in Northern Ireland website.²⁹

4.6 However, public awareness of these websites appears to be very low and patients are therefore making limited use of such available information. For example, the OFT patient survey found that only seven per cent of patients in England who had been actively looking for a

²⁹ Patients without internet access can telephone NHS Direct, or its equivalent in the devolved nations, to obtain this information.

dentist who would provide NHS dental treatment had used NHS Choices to do so.³⁰

4.7 The poor awareness and low usage levels of such information in part likely reflects the quality of the information provided. NHS Choices has told the OFT that dental practices in England tend to be less active than, for example, GP practices in placing information on NHS Choices and in keeping that information up-to-date. This is considered to be partly due to that fact that many PCTs do not allow dental practices directly to add and edit their individual practice information on the site. As a result, information on NHS Choices about dental practices, including whether or not they are currently accepting new patients for NHS dental treatment, is less likely to be accurate, and therefore useful to patients, than if dental practices were permitted to update this information themselves.

4.8 Dental patients' lack of awareness of suitable information sources is having a negative impact on their propensity to switch between competing practices. For example, evidence from the OFT's patient survey and focus groups suggests that patients are discouraged and/or prevented from changing dentist, even where they are dissatisfied with their current dentist, by a perceived or real difficulty in finding a dentist who will provide NHS dental treatment to new patients.³¹ The OFT survey and focus groups found that:

- among patients who had actively been looking for an NHS dentist, almost half (46 per cent) said they had found the process of obtaining information on the availability of NHS dentists difficult
- of the small proportion of NHS patients who expressed some dissatisfaction with their current dentist, 28 per cent had not

³⁰ This figure is based on a relatively small sample size and should therefore only be considered as broadly indicative of the actual proportion.

³¹ ['The dentistry market: A research report by TNS-BMRB – Qualitative'](#), Chapter 3,

switched due to the perceived difficulty of finding a new dentist and/or of switching dentist

- 22 per cent of patients who had stayed with a dentist as a private patient when the dentist stopped providing NHS dental treatment only did so because they thought it too difficult and/or inconvenient to find a new NHS dentist
- some private patients would prefer to have an NHS dentist if one were available locally.³²

4.9 Evidence also suggests that the real or perceived difficulty of finding a dentist who will provide NHS dental treatment deters many potential patients from attending the dentist at all, or else narrows their options to considering only private dental treatment. The Department of Health's GP Patient Survey Dental Statistics for England found that 40 per cent of the 515,000 respondents to the survey had not tried to get an appointment with an NHS dentist in the last two years and, of these, 17 per cent stated the reason as being that they didn't think they would be able to get an NHS dentist.³³

4.10 In summary, the OFT finds that:

- although websites exist that enable patients to find local dental practices that provide NHS dental services, awareness of such sources is limited, probably due to inadequate publicity of the websites

³² Some private patients who took part in the OFT focus groups indicated that they would prefer to receive NHS dental treatment, but either there was not local NHS availability or they were not aware of it. The OFT survey also found that among patients who had changed dentist in the last three years and whose original dentist had been private, 40 per cent had sought to move to an NHS dentist, compared to 20 per cent who had sought another private dentist. The remaining 40 per cent either had no preference or were seeking an NHS dentist but were happy to accept a mixture of NHS and private treatment.

³³ 'GP Patient Survey Dental Statistics, January to March 2011, England', Department of Health, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_127417.

- further, there is scope to enrich scope to the information available to dental patients to the level seen for general practice patients by opening the contents to both dental practices and patients more systematically
- as a result, many patients face high 'search costs', which limits their propensity to identify alternative suppliers and, ultimately, to switch between competing dental practices.

Patients' ability to compare prices charged for dental treatment by different dentists and dental practices

4.11 The price charged for different services is one of the key pieces of information that is required to enable consumers to make an informed choice between suppliers. Where dentists display prices transparently, this helps patients to get a sense of the likely costs of dental treatment(s) and to make more informed comparisons of dentists, dental practices and alternative courses of dental treatment.

4.12 In this section we consider:

- existing requirements regarding the display of dental treatment prices
- the extent to which dental practices display dental treatment prices
- how the non-display of dental treatment prices impacts upon patient choices and competition between dental practices
- the potential for dental practices to display private dental treatment prices.

4.13 Dentists providing NHS dental treatment in England and Wales are required by NHS regulations to display prominently in their surgery

information on NHS dental prices (this information is provided by the PCT or Local Health Board respectively).^{34,35}

Box 4.1: NHS dental charges in England³⁶ and Wales³⁷ as at 1 April 2012

There are three NHS charge bands:

Band 1: £17.50 in England/£12 in Wales – includes an examination, diagnosis and advice. If necessary, it also includes X-rays, a scale and polish and planning for further treatment.

Band 2: £48 in England/£39 in Wales – includes all treatment covered by Band 1, plus additional treatment, such as fillings, root canal treatment and removing teeth (extractions).

Band 3: £209 in England/£117 in Wales – includes all treatment covered by Bands 1 and 2, plus more complex procedures, such as crowns, dentures and bridges.

³⁴ The National Health Service (General Dental Services Contracts) Regulations 2005, Schedule 3, paragraph 34, requires that NHS dentists prominently display such information on NHS charges as is supplied by the PCT. www.legislation.gov.uk/ukxi/2005/3361/contents/made. In practice, such information takes the form of a poster setting out the NHS charges.

³⁵ Similar requirements are placed on dentists: in Scotland, under The National Health Service (General Dental Services) (Scotland) Regulations 2010, Regulation 35, www.legislation.gov.uk/ssi/2010/208/contents/made; in Wales under The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 Regulation 35, Schedule 3, Part 5, www.legislation.gov.uk/wsi/2006/490/contents/made; and in Northern Ireland under the General Dental Services Regulations (Northern Ireland) 1993, Rule 31.

³⁶ NHS Dental charges for England from 1 April 2012
www.nhs.uk/nhsengland/aboutnhsservices/dentists/pages/nhs-dental-charges.aspx

³⁷ NHS dental charges for Wales from 1 April 2006
www.nhsdirect.wales.nhs.uk/localservices/dentistfaq/#cost

- 4.14 There is no specific requirement for dentists who provide private dental treatment in England and Wales to display their private dental treatment prices. The OFT's market study into private dentistry in 2003 recommended that the GDC's Standards for Dental Professionals should be expanded to require that dental practices provide indicative prices on a range of relevant dental services and that these should be clearly displayed to patients. This recommendation has not been implemented.
- 4.15 In Scotland, all dentists are required to abide by the standards set out in the National Standards for Dental Services published by the Scottish Government.³⁸ These standards notably cover dentists providing both private and NHS dental treatment and require the dentist to provide 'a guide to the range of charges for the services provided – in particular, initial consultation, treatments, investigations and prescriptions.'
- 4.16 In Northern Ireland, all dentists are required to abide by the standards set out in the Minimum Standards for Dental Care and Treatment published by the Department of Health, Social Services and Public Safety.³⁹ These standards cover dentists providing both private and NHS dental treatment and provide that 'where fees apply, there will be ... a guide to the range of charges for the services provided - in particular, initial consultation, treatments, investigations and prescriptions.'
- 4.17 A range of evidence indicates that a significant proportion of dental practices do not prominently display their dental treatment prices:
- The OFT's patient survey found that 39 per cent of patients who usually received NHS or mixed NHS/private dental treatment and who had been to the dentist in the last two years reported that there

³⁸ *'National Standards for Dental Services'*, Scottish Executive, www.nationalcarestandards.org/25.html

³⁹ *'Minimum Standards for Dental Care and Treatment'*, Department of Health, Social Services and Public Safety, www.dhsspsni.gov.uk/minimumstandardsfordentalcareandtreatment.pdf

were no leaflets or posters providing information on NHS charges at their dentist.⁴⁰

- Patient surveys carried out by the NHS⁴¹ indicate that around half of patients who recently received NHS dental treatment report that they did not see NHS dental treatment prices on display in their dental practice.
- Research carried out by Which? in 2010 found that only around one third of 40 practices that they visited, and which provided both NHS and private dental treatments, had private dental treatment prices on display. Among dental practices which only provided private dental treatment, only around one in 10 had prices on display. Fewer than half (14 of 33) of all practices visited which did not display prices gave price lists on request. The remainder provided information on some prices verbally.
- A survey carried out in 2011 for the BDA, and submitted by the BDA to the OFT, found that only 44 per cent of owners of dental practices that provide some private dental services reported that they displayed private fee information at the practice reception, while 10 per cent reported that they provide such information in the surgery.⁴²

4.18 The non-display of prices (NHS and/or private) by dentists means that patients and prospective patients are less able to make fully informed

⁴⁰ Forty eight per cent said that there were such leaflets or posters at their dentist. Twelve per cent did not know/couldn't remember.

⁴¹ Namely, the NHS Business Services Authority's 'Vital Signs' reports which provide measures to help Primary Care Trusts to monitor their contracts across four key areas; access, activity, quality and finance.

⁴² The survey of owners of BDA member practices in the UK was carried out on behalf of the BDA by GfK NOP in 2011. There were 1,723 valid responses to the survey.

decisions regarding their choice of dentist and the different dental treatment options available to them.

- 4.19 The OFT's survey indicates that, while there are a range of factors which patients take into account when choosing a dentist, only a very small proportion currently actively compare dentists' prices.⁴³ The OFT considers that a contributing factor to this appears to be the fact that prices are not commonly made readily available to patients and prospective patients to enable such price comparisons. Survey evidence submitted to the OFT indicates that over 31 per cent of the public would, in fact, like to be able to shop around for a new dentist and compare prices of dentists if the requisite information was available.⁴⁴
- 4.20 Further, people who do not currently regularly attend a dentist were particularly likely to want to be able to compare prices of dental treatment, with over 40 per cent of such 'non-attenders' saying that they would like to be able to compare prices.⁴⁵ The fact that 'non-attenders' are more likely than those who regularly attend the dentist to want to be able to compare prices and to shop around for dental treatment suggests that the obstacles to comparing prices that are currently faced by prospective patients may be a contributing factor to non-attendance at the dentist.
- 4.21 The OFT through its focus groups also found that patients would like to be able to compare prices for dental treatments. The OFT ascertained additionally that patients would like dentists to publish prices in a standard format that would aid comparison of different dentists' prices. The focus groups also indicated that many NHS patients are not aware that there are standardised NHS dental treatment prices, and that

⁴³ Only one per cent of NHS patients, and only two per cent of private patients, with a regular dentist said that they had chosen their dentist as the practice had competitive prices.

⁴⁴ Denplan submission to the OFT market study. Survey of 2,007 adults conducted by ICM on behalf of Denplan, in October 2011.

⁴⁵ Denplan submission to the OFT market study, *ibid*.

patients who previously suspected that they may have been overcharged are often reassured to find out that NHS prices are fixed. As such, the non-provision of prices could potentially also contribute to an undermining of patient trust in dentists.

- 4.22 Key stakeholders have informed us that dentists providing private dental treatment should be able to provide patients with single set prices for check-ups and for simple dental treatments, such as a scale and polish. However, stakeholders have informed the OFT that the large number of different dental treatments available and the different factors which can affect the cost – including the seniority of the dentist, the materials used, and the condition of the patient's oral health – can be an obstacle to providing patients with a single set price for some more complex private dental treatments. Stakeholders have suggested that, for such private dental treatments, a reasonable alternative is for dentists to display a minimum and maximum price for dental treatments.
- 4.23 The OFT notes that, in the Republic of Ireland, the Dental Council has introduced a mandatory requirement for dental practices to display the private dental treatment prices for certain key and common dental treatments. Details of this requirement are outlined in Box 4.2 below. This requirement was introduced in 2011 and, while a full evaluation of its impact has not yet been carried out, we strongly consider that the implementation of a similar system in the UK will improve price transparency and should be deployed across the dentistry market in the UK.

Box 4.2: Code of practice on display of private dental treatment prices in the Republic of Ireland

In 2011, the Dental Council of Ireland introduced a Code of Practice relating to the display of private prices in dental practices. The Code of Practice requires dentists to display the following fees prominently in the practice. The fees displayed must be accurate, transparent and inclusive of all costs.

Dentists must display a single fee only for the following treatments:

- Examination, Diagnosis and Treatment Plan
- Hygiene Treatment (Hygienist) - per visit
- Hygiene Treatment (Dentist) - per visit
- X-rays – Small
- X-rays - Large (OPG) ⁴⁶
- Prescription

Dentists must display fees for the following treatments and these may be displayed in the form of a range of fees. If displaying a range of fees both the minimum and maximum fee must be shown. It is not permitted to set a minimum price only for any treatment:

- Advanced Gum Treatment
- Restorations - White (composite resin)
- Restorations - Silver (amalgam)
- Acrylic-based Dentures
- Metal-based Dentures
- Root Canal Treatment
- Routine Extraction
- Surgical Extraction
- Core/Post Preparation
- Crowns

For all other treatments dentists should provide an estimate of the cost of that treatment and obtain patient agreement and consent before treatment commences.

4.24 In summary, the OFT finds that:

⁴⁶ An Orthopantomogram (OPG) is a panoramic scanning dental X-ray of the upper and lower jaw

- an unacceptable, significant proportion of dental practices do not currently display NHS dental treatment prices or make private dental treatment prices available in their practice premises
- as a result, patients face high 'search costs' with regard to the prices of alternative dental practices, thus limiting their propensity to identify alternative dentists with a view to potentially switching between alternative dental practices in search of better value for money and/or higher quality of service
- we strongly consider that dentists should be able to make a single set price available for check-ups and simple dental treatments, such as a scale and polish, and to provide minimum and maximum treatment prices for a range of other common dental treatments and urges all dental practices to make lists of private treatment prices available in their dental practices and on their websites.

Patients' ability to compare the quality of service and patient satisfaction levels of different dental practices

4.25 In the dentistry market it is often particularly difficult for patients to make informed assessments of the quality of dental treatment provided by different dentists and dental practices. Certain information asymmetries are inevitable in healthcare markets given that patients are unlikely to know more about their condition than a medical professional, nor able to navigate their choices effectively without expert advice. Clinical procedures are typically experience or credence services where quality may not be directly observable by the patient. As such, the availability of objective, standardised and up-to-date information regarding the quality of dental treatment, quality of service and patient satisfaction levels achieved by different providers would enable patients to make more active, informed decisions and to drive competition.

4.26 In this section we consider:

- the extent to which dental patients currently have access to such information regarding the quality of dental treatment, quality of service and patient satisfaction levels of individual dental practices
- how the lack of such information impacts upon patient choice and competition between dental practices
- the potential for such information to be made readily available to dental patients.

4.27 The OFT has found that there is currently an almost complete lack of information regarding the quality of dental treatment and service and patient satisfaction levels achieved by different dental practices. The OFT notes that this contrasts with the information which is available about GP practices. For services in England, NHS Choices provides summary scores achieved by individual GP practices in relation to the organisation of the practice and the clinical care provided in respect of a number of key health conditions. The information includes the GP practice's performance scores relative to the relevant PCT average and the national average.

4.28 In contrast, NHS Choices typically only includes basic information about the facilities of NHS dental practices. While there is the option for patients to provide feedback on their dental practice, this is not as yet widely used or promoted.

4.29 Similarly, NHS Direct Wales, NHS 24 in Scotland and the Health and Social Care website in Northern Ireland do not include indicators of quality of service or patient satisfaction levels relating to different dental practices. Nor do they currently include provision for patients to provide feedback on dental practices.

4.30 The OFT has, in previous research work, found that consumers often value the views of other consumers particularly highly, and the use of qualitative consumer reviews of experiences can make complex

decisions and comparisons easier.⁴⁷ Indeed, a number of participants at the OFT's patient focus groups indicated that they would like to be able to access patient reviews of dentists online in order to help them to make an informed choice of dentist.⁴⁸ However, in England, where NHS Choices provides such a facility, low levels of public awareness of this facility mean that it is not currently widely used.

4.31 The OFT's focus groups and in-depth interviews with dental patients suggested that some patients who were dissatisfied with their current dentist or dental practice were deterred from looking for a new dentist because they were concerned that switching could result in a change for the worse.⁴⁹ Published information about dental practices' quality of dental treatment, quality of service and patient satisfaction would likely go some way to addressing these patient concerns and encourage more switching.

4.32 In England and Wales, the NHS Business Services Authority currently carry out regular surveys of dental patients for the purpose of their 'Vital Signs' reports, which provide measures to help NHS commissioning bodies to monitor dental practices' performance in relation to the NHS dental contracts across four key areas: access, activity, quality and finance. Information gathered by the 'Vital Signs' surveys includes measures of:

- patient satisfaction with the dental treatment the patient received
- satisfaction with the time they had to wait for an appointment, and
- whether all the dental treatment they required was available at the practice.

⁴⁷ *'Empowering consumers of public services through choice-tools'* OFT1321, April 2011, www.of.gov.uk/shared_of/reports/consumer_protection/oft1321.pdf.

⁴⁸ *'The dentistry market: A research report by TNS-BMRB – Qualitative'*, Chapter 4

⁴⁹ *'The dentistry market: A research report by TNS-BMRB – Qualitative'*, Chapter 6, *ibid.*

- 4.33 This valuable database of information, which patients could potentially use to help make an informed choice of dentist, is not currently published so as to be accessible to patients.
- 4.34 Further, the OFT notes that the Department of Health is currently developing a Dental Quality and Outcomes Framework (DQOF) to monitor and measure the quality of the dental work carried out by dentists and the clinical outcomes they achieve under the planned new NHS dental contract for England. Under DQOF, quality is defined as covering three domains:
- clinical effectiveness
 - patient experience
 - safety.
- 4.35 The results of these quality measures would, if made publicly available, also provide dental patients with objective information which would help patients to make active, informed decisions regarding their choice of dental practice. The Department of Health is currently piloting DQOF alongside the pilots for the new NHS dental contract. Currently however, the OFT remains concerned that there is no published timetable for the national roll out of the new NHS dental contract and DQOF.
- 4.36 In summary, the OFT finds that:
- Dental patients do not have access to basic requisite information regarding the quality of dental treatment, quality of service and patient satisfaction levels of individual dental practices. This contrasts with the information currently available for GP practices.
 - As a result of the lack of information regarding dental practices' quality and patient satisfaction levels, patients face high 'search costs' which limits their propensity to identify alternative dentists and, ultimately, to switch between alternative dental practices offering more innovative and/or higher quality dental treatments and/or services.

- In England and Wales, considerable amounts of potentially valuable information regarding patient satisfaction with dental practices is collected but not yet currently made publicly available to patients to enable greater awareness and comparisons.
- New quality measures are being developed for dentists providing NHS dental treatment in England, the results of which, if made publicly available, would also likely help patients to make active, informed decisions regarding their choice of dental practice.

Conclusion

4.37 The OFT considers that patients' ability to make active, informed choices regarding which dentist and dental practice to visit is inhibited by:

- low public awareness of means of finding local dentists who will provide NHS dental treatment
- lack of consistent provision of dental practices' treatment prices, and
- the scarcity of objective, up-to-date information regarding the quality of service and patient satisfaction levels of individual dental practices.

4.38 As a result, dental practices' incentives to drive up both standards of care and quality of service continually in order to attract dental patients are dampened and patients are likely receive less positive outcomes, in terms of price, quality and/or choice.

4.39 The OFT has identified a number of recommendations which we consider must be prioritised, and in many cases implemented in the short term by the Department of Health, including: NHS choices; NHS commissioning bodies and the NHS Business Services Authority, and their devolved equivalents, the GDC, and dental practices, to help address these issues. These are set out in Chapter 10.

5 PATIENT CHOICES: TREATMENT OPTIONS

Introduction

- 5.1 Dental patients are entitled to receive clear, timely and accurate information about prospective dental treatment from their dentist. Without such information, patients are not able to provide their informed consent for dental treatment and are not able to make active, informed decisions about the dental treatment they receive.
- 5.2 This chapter sets out the OFT's findings in relation to whether dental patients consistently receive:
- adequate information regarding proposed dental treatment, including the cost of the dental treatment, from their dentist prior to the dental treatment being provided
 - accurate information from their dentist regarding which dental treatments they are entitled to receive on the NHS.

Provision of dental treatment information, including cost, prior to treatment being provided

- 5.3 In this section we consider:
- the extent to which dentists comply with requirements to provide patients with timely information about dental treatment the patient is to receive, including the cost, prior to the dental treatment being provided
 - how the lack of such timely provision of dental treatment information impacts upon patient choices and competition between dental practices
 - whether the bodies that have powers to enforce the timely provision of such treatment information by dentists are pursuing sufficiently robust enforcement, where appropriate.

- 5.4 Existing standards and regulations require dentists to provide NHS and private patients with relevant information on a proposed course of dental treatment, including the cost of the dental treatment, prior to the dental treatment being provided. However, the OFT's survey of dental patients indicates that a significant number of dentists are not meeting these standards.
- 5.5 The OFT's patient survey asked all patients who recently received a specific course of dental treatment (beyond a simple check-up) that would have incurred a charge⁵⁰ and who would be required to pay for the dental treatment⁵¹ what information they had received prior to receiving the dental treatment. The survey found that:
- 82 per cent of such patients reported that they did not receive a written treatment plan
 - 56 per cent of patients reported that they did not receive information (written or verbal) about the cost of the dental treatment⁵²
 - 12 per cent of patients did not receive any information about the dental treatment.
- 5.6 The OFT survey found that private dental patients were not significantly more or less likely than NHS dental patients to be provided with timely and adequate dental treatment information.⁵³

⁵⁰ That is, excluding patients who received treatment which would fall into the NHS Band 1 treatment category, since, on the NHS, the treatment would not incur an additional charge beyond that which was already payable by the patient for the check-up.

⁵¹ That is, excluding fee exempt NHS patients who are not required to pay for the treatment and patients who reported that they had a comprehensive dental payment plan or dental insurance which would cover the cost of their treatment.

⁵² The BDA submitted to the OFT results of a survey which found that 87 per cent of practice owners stated that they always made sure their patients were aware of charges before treatment. The OFT notes that, even if this is the case, this still leaves a significant proportion who do not do so.

- 5.7 An online survey by Which? in 2009 of 2,631 English residents found similar results to the OFT survey, with only 46 per cent of patients who paid for NHS dental treatment reporting that they were informed of the costs prior to dental treatment and only 33 per cent of patients reporting that they were given a treatment plan.⁵⁴
- 5.8 According to the OFT's survey results, the OFT estimates that each year there are:
- approximately 6.9 million instances where a UK adult receives dental treatment which incurs a charge (in some cases, amounting to hundreds of pounds) without having been given any information regarding the cost of the dental treatment.
 - approximately 1.5 million instances where a UK adult receives such dental treatment without receiving **any** prior information regarding

⁵³ Seventy-nine per cent of patients whose last course of treatment was private, compared to 84 per cent of patients whose last course of treatment was NHS, and 81 per cent of patients whose last course of treatment was a mix of NHS and private, reported that they did not receive a written treatment plan. Fifty-four per cent of private patients, compared to 61 per cent of NHS patients, and 57 per cent of mixed patients, reported that they did not receive information (written or verbal) about the cost of the treatment. Sixteen per cent of private patients, compared to 11 per cent of NHS patients and eight per cent of patients who received a mix of NHS and private treatment, reported that they did not receive any information at all about the dental treatment.

⁵⁴ '*Independent Review of NHS Dentistry, Which? Submission*', March 2009, www.which.co.uk/documents/pdf/independent-review-of-nhs-dentistry-which-response-178905.pdf

the dental treatment at all.⁵⁵

5.9 Without timely provision of relevant information regarding prospective dental treatment, including the cost, patients are not able to give informed consent to the dental treatment and are effectively denied an opportunity to make an informed decision regarding a range of potential options, including whether to:

- shop around for dental treatment from an alternative dental practice
- seek a second opinion from another dentist as to whether the dental treatment is required
- consider alternative courses of dental treatment
- have the dental treatment carried out on the NHS or privately.

5.10 Further, the OFT considers that the failure by many dental practices to provide patients with timely information on the cost of the dental treatment they are to receive could deter some patients from regular attendance at the dentist. In this context, the OFT notes that the Adult Dental Health Survey 2009 reported that uncertainty about cost had been highlighted in previous national dental surveys as a barrier to

⁵⁵ The estimates in this paragraph are based on analysis of the OFT survey results regarding patients' experience of information provided on their last visit to the dentist, in cases where the course of treatment went beyond a check-up, x-ray and scale and polish, and applied to a notional population of 49 million UK adults. The estimates assume that patients who reported that their last visit to the dentist took place within the previous six months visit the dentist on average twice a year, that those who reported having last visited within the previous year visit the dentist on average once a year, and that those who reported having last visited within the previous two years, visit the dentist on average once every two years. The estimates include some additional technical adjustments, such as the exclusion of patients who receive free NHS dental treatment and those who have a comprehensive dental payment plan or dental insurance.

attending.⁵⁶

- 5.11 Finally, consistent provision of written treatment information to patients should facilitate greater understanding among patients as to the dental treatment they have received. Such understanding should help the Department of Health and the NHS to detect, and ascertain the scale of, fraud involving dentists claiming NHS remuneration for dental treatment which they have not, in fact, carried out.⁵⁷
- 5.12 In England, NHS regulations provide that, with limited exceptions, a dentist who agrees to provide a course of NHS dental treatment shall at the time of the initial examination and assessment (the check-up) ensure that the patient is provided with a treatment plan which should include the NHS charge, if any.⁵⁸ Similar requirements are in place in Scotland,⁵⁹ Wales⁶⁰ and Northern Ireland.⁶¹

⁵⁶ 'Adult Dental Health Survey 2009', published by the NHS Information Centre and National Statistics, Chapter 8, p.11, www.ic.nhs.uk/webfiles/publications/007_Primary_Care/Dentistry/dentalsurvey09/AdultDentalHealthSurvey_2009_Theme8_Barriersandaccesstocare.pdf

⁵⁷ In May 2012, the Department of Health reported that dental fraud cost an estimated £70 million in 2009-10. One of the most common types of fraud was dentists submitting claims for more expensive treatment than was actually delivered. mediacentre.dh.gov.uk/2012/05/08/70-million-wasted-on-dental-fraud/

⁵⁸ The National Health Service (General Dental Services Contracts) Regulations 2005, paragraph 7(5) of Schedule 3 (treatment plans), www.legislation.gov.uk/uksi/2005/3361/contents/made

⁵⁹ The National Health Service (General Dental Services) (Scotland) Regulations 2010, Paragraph 4, Schedule 1, www.legislation.gov.uk/ssi/2010/208/contents/made.

⁶⁰ The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006, Para 7, Schedule 3, www.legislation.gov.uk/wsi/2006/490/contents/made.

⁶¹ The General Dental Services Regulations (Northern Ireland) 1993, Rule 4.

5.13 NHS commissioning bodies can take action for breach of contract against dentists who fail to comply with the above regulations. Effective action by NHS commissioning bodies relies on the commissioning body becoming aware of a potential breach by a dentist and being able to obtain robust evidence of a breach. Further, this only applies where a dentist provides NHS dental treatment, as NHS commissioning bodies do not have any powers or remit in relation to private dental treatment.

5.14 The GDC's 'Standards for Dental Professionals' provide that all dental professionals, whether providing either private and/or NHS dental treatment, shall give patients 'the information they need, in a way they can use, so that they can make decisions' including 'giving full information on proposed treatment and possible costs.'⁶² Further, the GDC has provided guidance⁶³ to dentists on their responsibility to ensure that they have received informed consent from the dental patient before proceeding with the proposed dental treatment. In particular, the guidance explains that:

'whenever a patient is returning for treatment following an examination or assessment, [you should] give them [the patient] a written treatment plan and cost estimate.

If, having agreed an estimate with the patient, you [the dentist] think that you will need to change the treatment plan, make sure you get the patient's consent to any further treatment and extra cost, and give the patient an amended written treatment plan and estimate.'

5.15 The GDC can take disciplinary action against dentists who fail to comply with the standards, when it becomes aware of an allegation

⁶² 'Standards for Dental Professionals', General Dental Council, [www.gdc-uk.org/Newsandpublications/Publications/Publications/StandardsforDentalProfessionals\[1\].pdf](http://www.gdc-uk.org/Newsandpublications/Publications/Publications/StandardsforDentalProfessionals[1].pdf)

⁶³ 'Principles of Patient Consent' General Dental Council, [www.gdc-uk.org/Newsandpublications/Publications/Publications/PatientConsent\[1\].pdf](http://www.gdc-uk.org/Newsandpublications/Publications/Publications/PatientConsent[1].pdf)

that a dental professional has failed to comply with this requirement. However, during 2010, the GDC's Professional Conduct Committee (PCC)⁶⁴ considered only 17 cases involving failure by a dental professional to obtain consent and/or explain treatment.⁶⁵

5.16 In England, the CQC is responsible for regulating and inspecting dental practices providing both NHS and private dental treatment. The CQC's Essential Standards for care facilities⁶⁶ comprise 28 outcomes which relate to regulations contained in the legislation governing the CQC's work. These include 'Outcome 3 – Fees' which requires that:

'People who use services.... who pay the provider for the services they receive:

- Know how much they are expected to pay, when and how.
- Know what the service will provide for the fee paid.'

5.17 However, CQC inspections of dental practices' compliance with the Essential Standards, currently focus on four or more of the 16 Essential Standards. Notably – and of concern to the OFT – Outcome 3 is not currently one of these 16 Essential Standards. As a result, dental

⁶⁴ The Professional Conduct Committee (PCC) is a statutory committee of the General Dental Council and is one of three practise committees. The PCC will consider whether an allegation referred to it amounts to misconduct and if this misconduct amounts to an impairment of the registrant's fitness to practise. The PCC may conclude that a dental professional's Fitness to Practise is not impaired and close the case, issue a reprimand to the dental professional, impose conditions on the dental professional for up to 36 months (immediate conditions can be applied if required), suspend the dental professional for up to 12 months (with or without a review) (immediate suspension if required), or erase the dental professional from the register of qualified professionals. See www.gdc-uk.org/Governanceandcorporate/Committees/Pages/Professional-conduct-committee.aspx

⁶⁵ In total, there were 224 cases (of any type) referred to a GDC Practice Committee during 2010.

⁶⁶ 'Essential standards of quality and safety', Care Quality Commission, www.cqc.org.uk/organisations-we-regulate/registered-services/guidance-meeting-standards.

practices are not routinely required by the CQC to show evidence that they meet this basic standard on transparency around fees.

- 5.18 In Scotland, Dental Reference Officers inspect, on behalf of NHS Boards, dentists which provide NHS dental treatment. The National Standards for Dental Services,⁶⁷ against which dentists are assessed, specify that dental treatment information, including cost, must be provided to patients before dental treatment is provided, but do not specify that this must be provided in writing. There is currently no provision for inspecting providers of private dental treatment in Scotland, although the Scottish Government are currently considering how best to regulate independent healthcare services, including providers of private dental treatment. The OFT is greatly concerned that dental practices in Scotland are not being inspected to ensure that dentists provide Scottish dental patients with a written document containing this basic level of information. The OFT encourages the Scottish Government to expedite its consideration of how to regulate independent healthcare services and ensure that the resultant regulator prioritises ensuring that Scottish dental patients are provided with written treatment plans in advance of receiving dental treatment as a basic standard on transparency around fees.
- 5.19 In Wales, inspections of individual dentists are carried out by the Dental Reference Service.⁶⁸ The Dental Reference Service's inspections of dentists providing private dental treatment include questions to monitor compliance with the requirement that 'Service users ... receive clear and accurate information about ... the costs of any treatment and services which they are required to pay for.'⁶⁹ The Dental Reference Service's

⁶⁷ 'National Standards for Dental Services', Scottish Executive, *ibid*.

⁶⁸ These inspections are undertaken on behalf of the Local Health Boards for dentists providing NHS dental treatment on behalf of Healthcare Inspectorate Wales for dentists providing private treatment.

⁶⁹ Standard 18 of the 'National Minimum Standards for Independent Health Care Services in Wales', www.hiw.org.uk/Documents/477/NMS%20IHC%20Services%20in%20Wales-e.pdf.

inspections of dentists providing NHS dental treatment do not, however, include such an assessment. Instead, monitoring of such dentists' provision of timely dental treatment information is achieved by way of an online survey, which it is compulsory for dentists to complete on an annual basis.

- 5.20 The OFT is concerned that dentists in Wales are not inspected to ensure that dentists provide Welsh dental patients with a written document containing this basic level of information. The OFT encourages the Dental Reference Service to revise its inspection routine to ensure that written treatment plans are provided to Welsh dental patients in advance of receiving dental treatment as a basic standard on transparency around fees.
- 5.21 In Northern Ireland, the delivery of private and NHS dental treatment is monitored by the Regulation and Quality Improvement Authority (RQIA) and the Health and Social Care Board (HSCB).⁷⁰ The RQIA is in the process of completing its register of dentists who offer private dental treatment in Northern Ireland. Once the registration process is completed, the RQIA and the HSCB will co-operate to carry out the physical inspections of dental practices in Northern Ireland. Inspectors from each organisation will inspect the full range of private and NHS dental treatments provided within a practice and share the relevant results and information. Each will inspect to ensure that dental practices abide by the standards set out in the Minimum Standards for Dental Care and Treatment.⁷¹ These standards specify that dental practices must provide patients with dental treatment information, including a verbal estimate of treatment cost, prior to the patient being provided with the

⁷⁰ The RQIA and the HSCB have developed a memorandum of understanding detailing how they will share information about inspections that they each carry out in order that any one dental practice can reasonably expect to have their procedures inspected by one body.

⁷¹ 'Minimum Standards for Dental Care and Treatment', Department of Health, Social Services and Public Safety, www.dhsspsni.gov.uk/minimumstandardsfordentalcareandtreatment.pdf

dental treatment and that patients may request a written estimate if they wish.

5.22 The OFT is concerned that dentists in Northern Ireland are not inspected to ensure that dentists provide Northern Irish dental patients with a written treatment plan containing this basic level of information. The OFT encourages the RQIA and the HSCB to revise its standards to ensure that written treatment plans are provided to Northern Irish dental patients in advance of receiving dental treatment as a basic standard on transparency around fees.

5.23 In summary, the OFT finds that:

- A significant proportion of dentists who provide NHS and/or private dental treatment are failing to provide dental patients with basic, requisite information about the dental treatment they are to receive, including the estimated cost, prior to providing the dental treatment to the patient.
- A significant proportion of dentists are failing to abide by the general legal and ethical principle that the dentist must get valid consent before starting treatment for a patient as described the GDC's principles of patient consent.
- This lack of timely provision of basic, requisite information significantly limits patients' ability to make active, informed decisions regarding the dental treatment options available to them and limits their ability to seek out alternative options and/or dentists on the basis of value for money, as well as potentially discouraging some patients from regular attendance.
- NHS commissioning bodies, the GDC and, in England, the CQC can all take enforcement action in relation to dental practices that fail to provide timely information about dental treatment, including the cost, and yet do not appear to have robust, sufficient enforcement programmes in place to identify and address instances of misconduct.

- In England, although the CQC undertakes inspections of dental practices providing NHS and/or private dental treatment, it does not routinely inspect for compliance with the requirement that 'People who use services... who pay the provider for the services they receive [should] know how much they are expected to pay, when and how [and] know what the service will provide for the fee paid.' Where inspections of dentists or dental practices are currently carried out in Scotland, Wales and Northern Ireland, they also do not routinely include an assessment of whether the dental practice provides timely treatment information, including cost, prior to dental treatment, except to the limited extent of dentists providing private dental treatment in Wales.

Provision to patients of inaccurate information regarding entitlement to NHS dental treatment

5.24 In this section, we consider:

- existing regulatory requirements on dentists to avoid providing inaccurate information to patients regarding their entitlement to NHS dental treatment
- evidence of some dentists providing inaccurate information to some patients regarding their entitlement to receive certain dental treatments on the NHS
- the financial detriment and potential harm to oral health which is likely to be caused to patients as a result of such inaccurate information
- the apparent and concerning lack of potential enforcement action against dentists who provide such inaccurate information.

- 5.25 NHS regulations require that dentists providing NHS dental treatment in England must provide their patients with 'all proper and necessary dental care and treatment' under the NHS⁷² and that dentists shall not
- 'with a view to obtaining the agreement of a patient to undergo services privately ... advise a patient that the services which are necessary in his case are not available from the contractor [the dentist/dental practice] under the [NHS] contract'⁷³
- 5.26 Accordingly, NHS advice to patients states that: 'All the treatment that your dentist believes is necessary to achieve and maintain good oral health is available on the NHS.... If your dentist says you need a particular type of treatment, you should not be asked to pay for it privately.'⁷⁴
- 5.27 Similar requirements are placed on NHS dentists in Wales,⁷⁵ Scotland,⁷⁶ and Northern Ireland.⁷⁷
- 5.28 However, it has, prior to this market study, been noted that some dentists contravene the above requirements by informing patients that certain necessary dental treatments cannot be obtained on the NHS. For

⁷² The National Health Service (General Dental Services Contracts) Regulations 2005, Part 5, paragraph 14, www.legislation.gov.uk/ukxi/2005/3361/contents/made

⁷³ The National Health Service (General Dental Services Contracts) Regulations 2005, *ibid*, Schedule 3, Part 2, Paragraph 10(3).

⁷⁴ 'NHS dental services', NHS Choices, www.nhs.uk/nhsengland/aboutnhservices/dentists/pages/nhs-dental-charges.aspx

⁷⁵ Under '*The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006*', *ibid*.

⁷⁶ Under '*The National Health Service (General Dental Services) (Scotland) Regulations 2010*', *ibid*.

⁷⁷ Under the General Dental Services Regulations (Northern Ireland) 1993.

example, the Steele Review of NHS dental services in England reported that:

'there are some clinical procedures where the [NHS] banding assigned to them is perceived as unrealistic when combined with a low UDA⁷⁸ rate [which determines the amount that the dentist will be remunerated for providing the dental treatment]. These procedures are simply not offered on the NHS by some dentists. This is a breach of contract, but most patients are unsure about their entitlement.'⁷⁹

- 5.29 To be clear, where a dentist tells a patient that a dental treatment, which in the patient's case is 'proper and necessary', is not available on the NHS, this will be a breach of the dentist's contract with the relevant NHS commissioning body.⁸⁰
- 5.30 The OFT's research confirms that some dentists appear to be misleading a minority of patients into taking private dental treatment by providing inaccurate information to patients regarding their entitlement to receive certain dental treatments on the NHS.

⁷⁸ Units of Dental Activity – see Paragraph 8.5

⁷⁹ 'NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele', June 2009, p.28, www.dh.gov.uk/en/Healthcare/Primarycare/Dental/DH_094048

⁸⁰ In England, NHS Primary Care Commissioning ('NHS PCC') has produced guidance to PCTs on how to monitor and enforce NHS dental contracts, including the handling of cases concerning the provision of misleading information regarding NHS dental services and the process for managing breaches of NHS dental contracts. See '*Handling Cases of Misleading Information about NHS Dental Services: PCT advice*', NHS Primary Care Commissioning, www.pcc.nhs.uk/uploads/Dentistry/june_2006/handling_cases_of_misleading_information_about_nhs_dental_services.pdf

- The OFT's survey results indicate that, each year, over 500,000 patients⁸¹ had been told by their dentist that they could not obtain one or more specific forms of dental treatment on the NHS. This figure only includes those patients who were told they could not receive, on the NHS, a dental treatment which is likely to have been **needed** by the patient, rather than one for which there may not have been a clinical need (such as, for example, white fillings, whitening treatments, veneers).⁸²
- Forty per cent of patients who reported that their last course of dental treatment comprised a mix of NHS and private dental treatment, said that they had some of the work carried out privately either because they were told by their dentist that they could not have the treatment on the NHS or because their dentist would not provide the dental treatment on the NHS.^{83,84}

5.31 Also of some significant concern is the OFT's findings from surveying PCTs. The OFT surveyed a small sample of PCTs across England, nine of the 12 PCTs that provided a response stated that the PCT was generally

⁸¹ The OFT's survey indicates that 2.4 per cent of the UK adult population have in the last two years been told by their dentist that they could not obtain one or more specific forms of treatment on the NHS, to which they are in fact likely to have been entitled (see paragraph 3.3). Since there are approximately 49m adults (18+) in the UK, this equates to approximately 1.18m UK adults (0.024 x 49m) in the last two years. This in turn equates to over 500,000 patients per year. The OFT considers this to be a conservative estimate since it is possible that some of the patients may have been given such inaccurate information more than once within the two year period.

⁸² The treatments which patients were told were not available on the NHS and which are included in the OFT's analysis are: bridges, crowns, root canal treatment, silver fillings, dentures, extractions, check-ups and x-rays.

⁸³ This does not include patients who stated that they had cosmetic work carried out which would not qualify for NHS dental treatment.

⁸⁴ Twenty-two per cent reported that their dentist would not provide the treatment on the NHS and 19 per cent stated that they were told that the treatment was not available on the NHS.

aware of the potential practice of dentists misleading patients regarding the availability of some dental treatments on the NHS in order to obtain the patient's agreement to have the dental treatment carried out privately.

- 5.32 The OFT's focus groups with dental patients indicate that most patients are not aware of their right to receive all of the dental treatment that they require to maintain their oral health on the NHS.⁸⁵ As a result, the majority of patients are not empowered to demand dental services to which they are fully entitled and/or to complain to an appropriate body if they do not receive the dental services to which they are fully entitled.
- 5.33 The provision of misleading information to a patient regarding their entitlement to NHS dental treatment has the clear potential to harm the patient's interests.
- 5.34 Firstly, a patient may incur financial detriment where he or she pays more to have a dental treatment carried out privately than would have been the case had the dental treatment been carried out on the NHS. In some cases, the difference between the cost of NHS and private dental treatment may be considerable. For example, in England, a root canal treatment will typically cost from around £360 to £475 per tooth when provided by a dentist privately,⁸⁶ but only £48 when provided by a dentist on the NHS.⁸⁷ Furthermore, around half of NHS patients are

⁸⁵ [The dentistry market: A research report by TNS-BMRB](#) – Qualitative, Chapter 4

⁸⁶ Indicative price range taken from '*Root canal Treatment: the costs and benefits*', Private Healthcare UK, www.privatehealth.co.uk/articles/july-2008/root-canal-treatment-the-costs-and-benefits.

⁸⁷ In Wales the cost is £39. In Scotland and Northern Ireland the price to the patient will be 80 per cent of the cost of the treatment, that is £37 - £78 in Scotland, and £36 - £77 in Northern Ireland.

exempt from NHS charges⁸⁸ and so, for these patients, the difference in cost between NHS and private dental treatment will be greater still.

5.35 Secondly, a patient may suffer harm to his or her oral health if, due to the greater cost of private dental treatment, he or she decides either to forgo the dental treatment altogether or to opt for a less expensive and less beneficial course of dental treatment (such as an extraction rather than a root treatment and crown).

5.36 With regard to the identification of, and enforcement action against, dentists engaging in such misconduct, the OFT's survey of a small sample of PCTs also found that:

- eight of the 12 PCTs had found that specific dentists with whom they contracted had engaged in providing inaccurate information to patients regarding their entitlement to NHS dental treatment
- however, only one of these PCTs reported that it had taken any formal action, namely through the issue to the dental practice of remedial notices and, ultimately, termination of the dental practices' NHS dental contract.

5.37 Two PCTs suggested that effective enforcement action against dentists who engage in this misconduct can be hampered by the element of subjectivity inherent in determining whether or not a particular dental treatment is proper and necessary for a particular patient. Key dentistry stakeholders at a roundtable discussion hosted by the OFT also raised this issue as a barrier to effective enforcement action. The OFT has not, however, been convinced that this is a compelling hurdle that should

⁸⁸ Patients do not have to pay for NHS dental treatment if, when the treatment starts, they are: aged under 18, under 19 and receiving full-time education, pregnant or have had a baby in the previous 12 months, staying in an NHS hospital and the treatment is carried out by the hospital dentist, an NHS hospital dental service outpatient. Patients also do not have to pay if, when the treatment starts they are: receiving certain benefits, named on a valid NHS tax credit exemption certificate, entitled to an NHS tax credit exemption certificate or named on a valid HC2 certificate.

prevent effective investigation and action against dentists engaged in this misconduct. We are surprised and disappointed by the low levels of formal enforcement activity especially when PCTs have evidence of this misconduct by dentists.

- 5.38 In addition to being a breach of NHS regulations, such practices are also likely to be a breach of the GDC's Standards for Dental Professionals. The GDC has recently completed three investigations of dentists who are alleged to have provided misleading information to patients regarding their entitlement to NHS dental treatment and PCC hearings of these cases are likely to be heard later in 2012.⁸⁹ However, despite OFT's estimate that there are possibly as many as 500,000 instances of patients being given inaccurate information by their dentists regarding their entitlement to receive a particular course of dental treatment on the NHS (see 5.30 above), the GDC appears to have a notable, and concerning low enforcement track record of pursuing instances of breaches, and so deterring future misconduct.
- 5.39 Finally, where the OFT becomes aware of a dentist persistently providing misleading information to patients regarding their entitlement to NHS dental treatment, and where relevant bodies, including the GDC and the relevant commissioning body, have failed to take effective remedial action, the OFT and other enforcers, such as local authority Trading Standards Services also have powers to take enforcement action, under consumer protection law, where appropriate.
- 5.40 In summary, the OFT finds that:

⁸⁹ Hearings are held once an allegation about a dental professional has been investigated and the GDC's Investigating Committee has decided there is a case. The case is then referred to one of the practice committees (such as the PCC), depending on the type of case, and a hearing is held. The GDC have a target to hold practice committee hearings within nine months of the Investigating Committee's decision.

- existing NHS regulations require dentists who provide NHS dental treatment to provide all proper and necessary dental treatment on the NHS
- some dentists provide inaccurate information to a small proportion of patients, amounting to an estimated 500,000 patients each year, regarding their right to receive certain dental treatments on the NHS
- as a result, such patients are likely to incur financial detriment, where they choose to have private dental treatment instead of NHS dental treatment, or may suffer harm to their oral health where they choose to forgo the dental treatment altogether or to opt for a less beneficial course of dental treatment
- although NHS commissioning bodies and the GDC have existing powers to take enforcement action against dentists who provide such inaccurate information to patients there is a concerning lack of robust, timely enforcement action against such dentists, particularly in the light of our estimate of as many as 500,000 instances of patients being affected by this misconduct each year.

Conclusion

5.41 The OFT considers that patients' ability to make active, informed choices regarding the dental treatment they receive is significantly restricted by:

- the failure by some dentists to provide basic, requisite information to dental patients regarding proposed dental treatment, including the cost, prior to the dental treatment being provided
- the provision to patients by some dentists of inaccurate information regarding their entitlement to receive certain dental treatments on the NHS in breach of both NHS regulation and GDC standards.
- a lack of consistent and effective enforcement by either NHS commissioning bodies, the CQC and inspectors of dentists in the devolved nations, or the GDC which would act as a deterrent to other dentists considering similar misconduct.

- 5.42 As a result, dental patients may receive less positive outcomes in terms of the dental treatment they receive and incur financial detriment. These practices may also result in some patients attending a dentist less frequently.
- 5.43 The OFT has identified a number of recommendations which we consider must be prioritised, and in many cases implemented in the short term by NHS commissioning bodies, the CQC and inspectors of dentists in the devolved nations, and the GDC, to help address these issues. These are set out in Chapter 10.

6 PATIENT CHOICES: DENTAL PAYMENT PLANS

Introduction

- 6.1 Patients who receive private dental treatment may be provided with the option by their dentist to sign up to a dental payment plan to spread the cost of the dental treatment they receive.
- 6.2 This chapter sets out the OFT's findings regarding the sale of dental payment plans and the potential for pressure being placed on dental patients to sign up to such plans. We have considered:
- how dental payment plans operate and evidence of alleged pressure selling of dental payment plans by dentists
 - how pressure selling of dental payment plans impacts upon patient choice and the outcomes that patients receive
 - the requirements of consumer protection legislation regarding the sale of products to consumers and their application to dentists and the sale of dental payment plans.

Dental payment plans

- 6.3 A dental payment plan is a contract (typically a monthly rolling contract) between a patient and a dentist/dental practice under which the patient pays a fixed monthly fee in return for a specified level of private dental care.
- 6.4 Dental payment plan revenues are valued at an estimated £481m per year and an estimated 2.7m UK patients are members of a dental payment plan.⁹⁰ The patient's monthly payment under a dental payment plan is typically between £13/month (for a patient with very good oral

⁹⁰ Laing and Buisson, *ibid*, p.97. Figures as at 31 December 2009 and exclude other ways in which patients may spread the cost of their dental treatment, such as insurance and health cash plans.

health, or for a patient signing up to a basic maintenance plan which includes check-ups and hygienist visits only) to £39/month (for a patient with poor oral health who signs up to a comprehensive plan which covers all necessary dental treatment).⁹¹

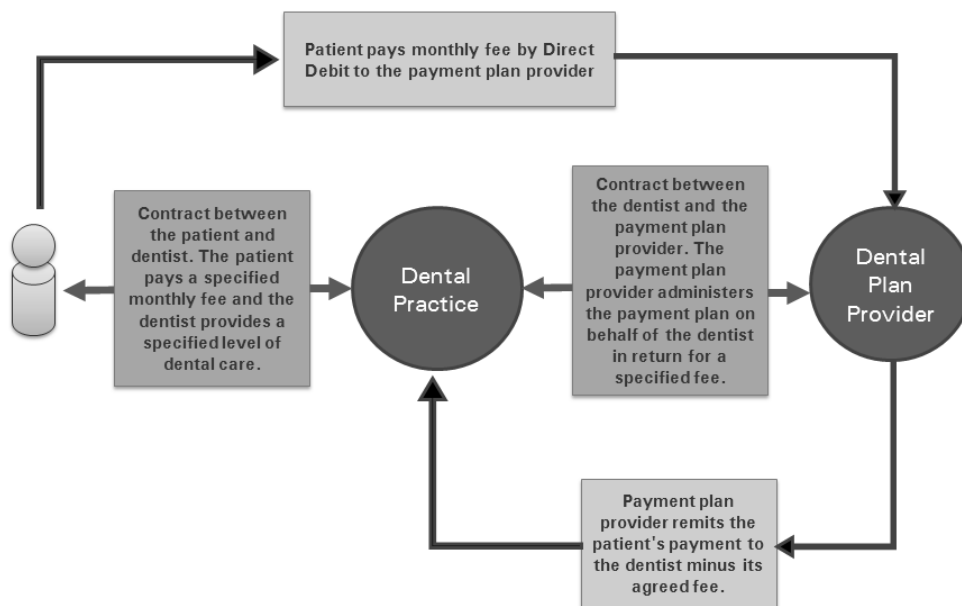
- 6.5 The OFT estimates that the three largest providers of dental payment plans – Denplan Limited, Practice Plan Limited and DPAS Limited – currently provide approximately 95 per cent of dental payment plans in the UK.⁹²
- 6.6 Dental payment plans are maintenance agreements which are not classed as insurance and are not, for the most part, regulated by the FSA.⁹³
- 6.7 Dental payment plans are sold to the patient in the dental practice, but typically a payment plan provider collects patients' fees and operates the administration of the plans on behalf of the dentist in exchange for an administration fee. See figure 6.1.

⁹¹ Figures derived from submissions to the OFT market study from Denplan, Practice Plan and DPAS.

⁹² Estimate based on submissions from Denplan, Practice Plan and DPAS and data from Laing and Buisson, *ibid*.

⁹³ Dental payment plans generally include an indemnity insurance element in respect of accidental and emergency dental trauma. This element of dental payment plans is regulated by the FSA.

Figure 6.1: Dental payment plans – typical relationship between dentist, patient and payment plan provider



Note: In the case of DPAS Limited, there is a contract between DPAS and the patient for the provision of the dental payment plan in return for a fee payable by the patient to DPAS.

6.8 Some dental payment plan providers charge dentists for the administration of payment plans on a sliding scale whereby a lower per-patient administration fee is charged as the number of patients that the dentist has signed up to the plan increases. This, and the guaranteed income that dentists receive from patients on dental payment plans, would appear to provide dentists with financial incentives to increase the number of their patients who sign up to a payment plan.

Alleged pressure on patients to sign-up to dental payment plans

6.9 A survey of private dental patients carried out by Which? in 2010,⁹⁴ the results of which were submitted to the OFT, found that a significant proportion (29 per cent) of patients with a dental payment plan reported

⁹⁴ Which? online survey of 499 patients with dental payment plans.

that they were required by their dentist to join the plan in order to continue receiving dental treatment from their dentist. The Which? survey also found that a further six per cent of patients considered that they were put under some form of pressure by their dentist to join the payment plan.

6.10 In order to further investigate the sale of dental payment plans, the OFT's patient survey asked patients about their experience in considering with their dentist whether to join a dental plan.⁹⁵ The survey found that:

- 20 per cent of patients⁹⁶ with a dental payment plan felt that they were put under pressure by their dentist to sign up to the plan; of which four percent felt they had been placed under 'a lot of pressure'⁹⁷
- the reasons given by these patients for feeling under pressure were that they had understood that 'being part of the plan was a condition of treatment' (54 per cent), a 'general feeling that I had to go along with it/hard sell' (39 per cent), and 'other' (seven per cent).⁹⁸

6.11 The OFT considers that because dentists often have a high degree of influence over patients' decisions, care must be taken by dentists to ensure that they are not at risk of unduly influencing patient decisions regarding whether or not to join a dental payment plan. If patients are

⁹⁵ The survey also asked the same question of patients with dental insurance. Only three per cent of patients with dental insurance reported that they had felt under pressure to take the product.

⁹⁶ This figure excludes a small number of patients who reported that they had a payment plan which covered NHS dental treatment only, since such payment plans are in fact not typically available.

⁹⁷ Ten per cent felt under 'some pressure', and six per cent felt under 'a little pressure'

⁹⁸ The figures in this paragraph are based on a small sample size and should therefore be considered as broadly indicative of actual proportions.

pressured into taking a dental payment plan, they are denied the opportunity to make a more considered and informed choice regarding whether they wish to choose to sign up to a proposed plan. As a result, patients may receive a less suitable product and/or less value for money than would have been the case in the absence of such pressure.

6.12 In this context, we note that among patients responding to the OFT survey who reported feeling under pressure to sign up to a dental payment plan:

- 34 per cent stated that, without such pressure, it is likely that they would not have joined any dental payment plan
- eight per cent of the other patients surveyed stated that it is likely that they would have joined a different dental payment plan or an alternative insurance scheme.^{99,100}

6.13 The Consumer Protection from Unfair Trading Regulations 2008 (the CPRs) protect consumers, including dental patients, from misleading or aggressive commercial practices. In order to comply with the requirements of the CPRs, dentists must take care to avoid any action by which a patient's freedom of choice could be significantly impaired. Amongst other things, this means not putting pressure on a patient to sign up to a dental payment plan, in a way which may significantly limit the patient's ability to make an informed decision about whether or not to sign up to the plan. Non compliance with the CPRs could result in enforcement action being taken by the Office of Fair Trading and/or local authority Trading Standards Services.

⁹⁹ Forty-three per cent said that, without the pressure, they would still have joined the same payment plan. Sixteen per cent responded 'Don't know'.

¹⁰⁰ The figures in this paragraph are based on a small sample size and should therefore be considered as broadly indicative of actual proportions.

Conclusion

- 6.14 The OFT considers it important that dental patients are able to make informed decisions regarding how they pay for private dental treatment and that dentists do not put undue and unacceptable pressure on patients to join a dental payment plan.
- 6.15 Details of actions which the OFT and relevant stakeholders have agreed to take to address the issue of potential pressure selling of dental payment plans are set out in Chapter 10.

7 COMPLAINING ABOUT DENTISTRY AND OBTAINING REDRESS

Introduction

7.1 Although the majority of patients surveyed by the OFT reported never having been unhappy with any aspect of the service offered by their current dentist, in those cases where unsatisfactory dental service is encountered, patients should, in OFTs view, be able to obtain appropriate redress and have access to a simple complaints system. This chapter sets out the OFT's findings regarding these issues.

Provision of appropriate redress by dental practices

7.2 In general, the first point of contact for dental patients who experience a problem with dental treatment they have received should be the dental practice.¹⁰¹ In this section, we consider:

- the extent to which patients appear to receive adequate redress from their dentist or dental practice when they experience problems with dental treatment
- the detriment that patients incur when problems with dental treatment are not resolved satisfactorily
- existing guarantees and statutory provisions relating to patient redress with regard to defective or faulty dental treatment
- the notable reluctance among many dental patients to complain about problems with dental treatment.

7.3 The OFT's analysis of dental patients' complaints to Consumer Direct¹⁰² between September 2008 and 31 August 2011 suggests that some

¹⁰¹ Patients who wish to complain about NHS dental treatment may, alternatively, choose to complain to the relevant PCT. The PCT may then refer the complaint to the dental practice.

dental practices may be poor at handling patients' complaints and/or providing appropriate redress:¹⁰³

- Approximately 60 per cent of those complaints from dental patients related to poor quality or defective dental treatment, for example a filling falling out or poorly fitted dentures.¹⁰⁴
- In over a quarter (26 per cent) of these complaints, the complainant explicitly stated that the poor dental treatment resulted in the patient being charged again by the dentist for further remedial dental treatment.¹⁰⁵

7.4 Where patients are required to pay again to have poor quality or defective work remedied, there is clear potential for these patients to incur significant financial detriment. Further, to the extent it occurs, poor complaints handling and inadequate provision of redress by dental practices¹⁰⁶ can also act to undermine patient confidence in individual dentists and the dental profession generally.

¹⁰² Consumer Direct was a government-funded consumer advice service which, until 31 March 2012, offered consumers information and advice on problems with goods and services, energy and post. From 1 April 2012, the functions of Consumer Direct have been subsumed within Citizens Advice.

¹⁰³ The OFT notes that complaints to Consumer Direct are allegations which may, or may not, have been resolved, and which may not be substantiated. The OFT has not assessed the genuineness of individual complaints, or investigated any individual complaint to assess its reliability.

¹⁰⁴ Between 1 September 2008 and 31 August 2011, 1,039 of 1,782 complaints to Consumer Direct about dentistry (excluding enquiries and weak complaints) related to poor quality or defective treatment.

¹⁰⁵ Between 1 September 2008 and 31 August 2011, 272 of 1,039 complaints to Consumer Direct about poor quality or defective treatment explicitly stated that the poor treatment resulted in the patient being charged by the dentist for further work to remedy the poor treatment.

¹⁰⁶ The number of complaints received by Consumer Direct and other complainant bodies are low compared to the number of dental treatments carried out in the UK.

- 7.5 The OFT notes that NHS dental treatment is guaranteed against failure for 12 months.¹⁰⁷ As such, a dentist should carry out any work needed to repair or re-do failed NHS dental treatment, such as a filling that falls out during that period, without any additional charge to the patient.
- 7.6 There is currently no equivalent standard guarantee against the failure of private dental treatment. This is an anomaly in the provision of dental treatment which does not appear to be justified. In OFT's view, dentists should, as a minimum, provide a similar level of guarantee to their private patients as is currently enjoyed by their NHS patients. In this respect, the OFT notes that:
- the OFT has not received any representations from stakeholders which has made a compelling case for not providing this level of guarantee to private patients
 - where this point has been discussed, stakeholders have, in principle, endorsed the suggestion of extending such a guarantee to private patients
 - the OFT has found that some dentists providing private dental treatment already provide guarantees, and these typically range from one year up to 10 years.
- 7.7 It is also worth noting that the OFT considers that dental patients' access to appropriate redress where problems with dental treatment are experienced would be improved by an increased public awareness of

¹⁰⁷ Dentists are required by regulations to provide guarantees for much of the dental work they carry out under the NHS. The regulations covering each nation are as follows: England - Regulation 11, Schedule 3, Part 2 of the National Health Service (General Dental Services Contracts) Regulations 2005; Scotland - Regulation 7, Part 2, Schedule 1 of the National Health Service (General Dental Services) (Scotland) Regulations 2010; Wales - Regulation 11, Schedule 3, Part 2 of the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006 and Northern Ireland - Regulation 7, Part 2, Schedule 2 of the General Dental Services Regulations (Northern Ireland) 1993.

patients' rights under the NHS guarantee and also under consumer protection legislation.

- 7.8 In relation to both NHS and private dental treatment, the Supply of Goods and Services Act 1982 requires that where a contract exists for the supply of a service, that service will be carried out with reasonable care and skill and that any materials or goods supplied as part of that service will be of satisfactory quality, fit for purpose and as described. If dental treatment is not carried out with necessary care and skill by a dentist and/or goods supplied (dentures, fillings, crowns etc) are not fit for purpose then this could be considered a breach of contract and the patient could assess whether to seek redress in the County Court in England, Wales and Northern Ireland and the Sheriff Court in Scotland.
- 7.9 However, it is of particular concern that the OFT focus groups and depth interviews undertaken with a sample of dental patients who had experienced problems with poor quality or defective dental treatment indicate that patients are commonly reluctant to complain about dental treatment.¹⁰⁸ The main reasons given were: fear that the dentist will seek retribution, fear of being 'de-registered', a perception that nothing will be achieved, and lack of time to go through the complex complaints process.
- 7.10 The OFT is also concerned that evidence gathered during the course of this market study, for example through analysis of complaints to Consumer Direct and patient focus groups, indicates that, in general, dental patients tend to have low awareness and understanding of their rights in the dentistry market. Previous OFT research into the drivers of business compliance with consumer law has found that informed consumers asserting their rights can have a significant impact on business behaviour and are a key driver of business compliance.¹⁰⁹

¹⁰⁸ ['The dentistry market: A research report by TNS-BMRB – Qualitative'](#), Chapter 6

¹⁰⁹ See www.oft.gov.uk/OFTwork/policy/drivers.

7.11 Accordingly, the OFT will, in partnership with organisations including Which?, Citizens Advice, and NHS Choices and devolved nation equivalents, develop and disseminate patient education materials targeted at improving dental patients' awareness and understanding of their rights to redress in the dentistry market and how to complain.

The dental complaints system

7.12 Where a patient complaint about dentistry is not adequately resolved by the relevant dental practice, then the patient may choose to refer their complaint to a relevant complaints body for further consideration. In this section, we consider:

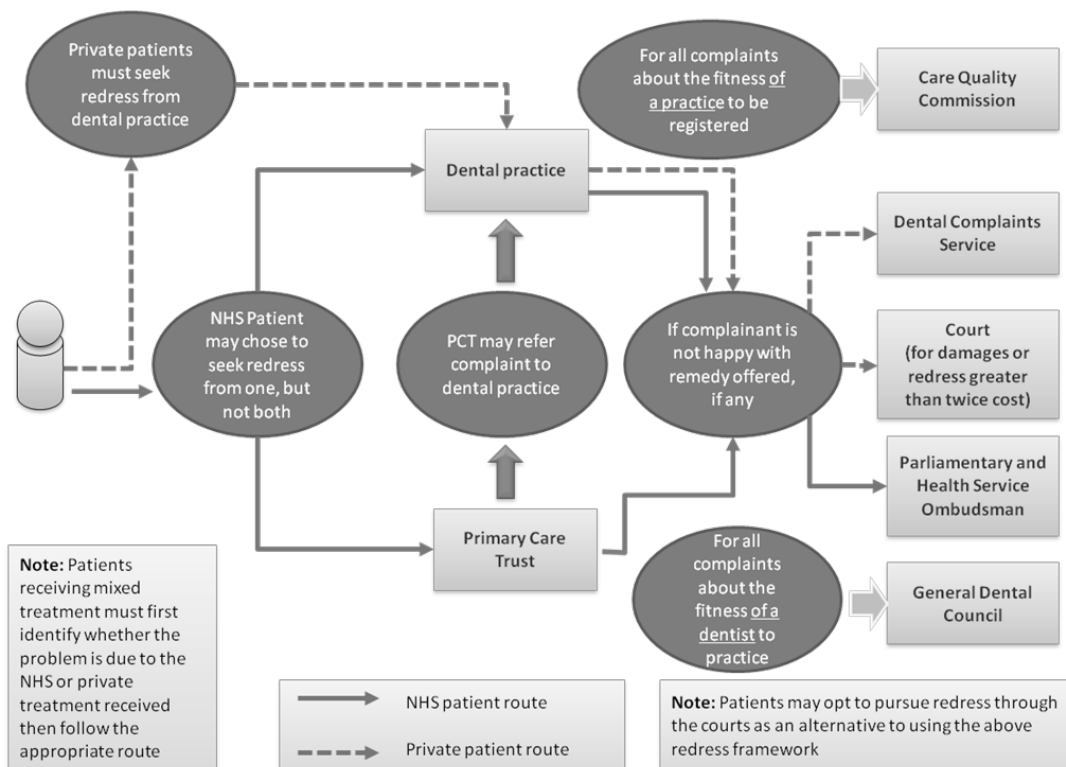
- the many bodies which are responsible for dealing with patient complaints about dentistry
- the impact on patients of the current complex system for dealing with complaints about dentistry
- the scope for a simplified, more streamlined complaints system.

7.13 The current system for escalating complaints beyond practice level is complex and potentially confusing for both patients and dentists. There are multiple bodies that deal with complaints about dental treatment which are not resolved at practice level:

- in England, PCTs and the Parliamentary and Health Service Ombudsman (PHSO) deal with complaints about NHS dental treatment
- in Scotland, NHS Boards and the Scottish Public Services Ombudsman deal with complaints about NHS dental treatment
- in Wales, Local Health Boards and the Public Service Ombudsman for Wales deal with complaints about NHS dental treatment

- in Northern Ireland, the Health and Social Care Board and Northern Ireland Ombudsman deal with complaints about NHS dental treatment.
- The Dental Complaints Service (DCS) deals with complaints about private dental treatment across the UK.

Figure 7.1: The dental complaints system (England)



Note: Alternatively, patients may choose to pursue their claim through the courts without using the dental complaints system.

7.14 In addition, the GDC deal with fitness to practise cases relating to NHS and private dentists.¹¹⁰

¹¹⁰ As part of the GDC's duty to protect the public, if a dentist or dental care professional falls seriously short of the professional standards expected of them, the GDC can either remove them from the Register of dental professionals who are authorised to practise in the UK, or restrict what they can do professionally. These powers cover all registered dentists and dental care professionals whether they are working in the NHS or in private practice.

- 7.15 The OFT notes that the PHSO has submitted to the OFT as part of this market study that it considers that complainants find the current complaints system complicated and unwieldy. The process of making a complaint about dental treatment can be particularly complex, and potentially confusing where a course of treatment comprises both NHS and private dental treatment, since different bodies are currently responsible for dealing with complaints about NHS and private dental treatment. In such cases, a single complaint has to be split into separate aspects and follow different routes.
- 7.16 The Independent Complaints Advocacy Service (ICAS)¹¹¹ has reported to the PHSO that patients complaining about dental treatment have expressed frustration to ICAS where they have had to deal with two separate bodies about a defective course of treatment which was part NHS and part private treatment.
- 7.17 The BDA and the PHSO have submitted to the OFT that, consistent with the OFT's vision for a reformed dentistry market, they also both consider that, in principle, a single complaints service would benefit patients and dentists through greater clarity about how to make a complaint and potential efficiency gains if patients and dentists only had to deal with a single complaint body,¹¹² regardless of the nature of the dental treatment in question.
- 7.18 The OFT recognises that there will be many hurdles to overcome for a single complaints service to be put in place, not least the introduction of regulation to implement these changes. In the meantime, the OFT

¹¹¹ The Independent Complaints Advocacy Service (ICAS) is a free, independent and confidential service offered to NHS patients, including dental patients, and their carers, who are unhappy with the service they have received. The ICAS offers dental patients, and their carers, help and advice in resolving their complaint, including supporting patients and their carers wishing to pursue a complaint about their NHS dental treatment or care.

¹¹² Save for instances of complaints about serious professional misconduct which would continue to be subject to disciplinary action by the GDC.

strongly recommends, supported by the BDA and the PHSO, that a single portal for patients to seek redress be introduced so that patients need only approach a single contact point to make a complaint. This contact point would then forward the complaint to the appropriate body, including the GDC for complaints of serious professional misconduct, for them to deal with.

Conclusion

- 7.19 The OFT considers that patients who receive private dental treatment should benefit, at a minimum, from the same one-year guarantee that currently applies to NHS dental treatment. This would help dental patients' understanding of their rights to redress, and their ability to obtain redress in appropriate cases.
- 7.20 The OFT also considers that action must be taken to raise dental patients' awareness of the redress available to them in the dentistry market, their rights in relation to making a complaint, and how they should go about making a complaint.
- 7.21 The OFT considers that the current fragmented and complex complaints system must be made simpler, clearer and more accessible and that patients and dentists should only have to deal with a single complaints body or portal. The OFT is pleased that stakeholders including the BDA and the PHSO agree with the OFT's view. The OFT considers that a single-complaints body or portal would be particularly appropriate for complaints about dentistry (compared to, for example, other health services) due to the fact that NHS and private dental treatments are often provided alongside one another, and sometimes within a single course of dental treatment.

The OFT has identified a number of recommendations which we consider must be prioritised, and in many cases implemented in the short term by the GDC and the dental complaints bodies, to help address these issues. These are set out in Chapter 10.

8 THE SUPPLY OF DENTISTRY

Introduction

- 8.1 As in any market, the ability of new dental practices to enter the dentistry market and for successful practices, offering higher quality dental services to patients, to expand is critical to driving greater efficiency, innovation and higher levels of service. If potential new entrants face significant difficulties in entering the market, incumbent dental practices have little incentive continually to be striving to innovate or improve their services in order retain and attract new patients. Similarly, if expansion in the market is restricted or distorted, this may prevent poorly performing practices from losing custom to better performing alternative dental practices.
- 8.2 The NHS dental contract is of critical importance to how well the dentistry market works for patients. The OFT strongly considers that the NHS dental contract in England acts as an unnecessary barrier to entry into the dentistry market for new innovative dental practices and the expansion of dental practices which provide high quality services to patients.
- 8.3 In the context of this chapter it is important to remember dental practices are profit seeking businesses and, for the dentistry market to work effectively, incumbent dental practices must face competitive pressures. The current non-time-limited NHS dental contract in England has the effect of insulating such practices from competition, as prices and volumes of dental treatment are fixed, and have been in many cases since 2006.
- 8.4 This chapter sets out our findings regarding key barriers to entry and expansion in the dentistry market in England and how these affect patient choice and competition. Specifically, the chapter considers:
- the importance of having a contract to provide NHS dental treatment ('an NHS dental contract') to potential market entry

- the allocation of NHS dental contracts and the different types of NHS dental contract
- the number of new NHS dental contracts that are issued for competitive tender and the tendering process
- buying into a practice as an alternative market entry route and the practice of NHS dental contracts being transferred to new dentists when dental practices are sold
- the impact of the existing NHS dental contract and tendering process on barriers to entry and expansion in the dentistry market and the detrimental effect on competition between practices.

The importance of the NHS dental contract to potential market entry

8.5 Currently, dental practices in England that wish to provide NHS dental services must have a contract with the local PCT. The contract specifies the total amount of dental treatment, defined by 'Units of Dental Activity' (UDAs), that the dental practice should deliver over a year and the price that the PCT will pay the practice for delivering each of those UDAs.

8.6 Having a contract to provide NHS dental treatment is of crucial importance to the ability of most potential new dental practices to enter the dentistry market, because the majority of patients prefer to have a dentist that offers NHS services. For example, the OFT patient survey found that:

- 75 per cent of patients without an existing dentist, and who would like a dentist, would prefer to have an NHS dentist
- only 12 per cent of patients without an existing dentist, and who would like a dentist, would prefer to have a private dentist.¹¹³

¹¹³ Eleven per cent said they had no preference, and two per cent did not know.

- 8.7 Indeed, the vast majority of existing dental practices have a contract to provide NHS dental services. A survey of dental practice owners by the BDA found that:
- 71 per cent of dental practices offer both NHS and private services and a further seven per cent offer NHS services only
 - only 21 per cent of dental practices only offer private dental services.¹¹⁴
- 8.8 According to Laing & Buisson, fewer than 10 per cent of dentists in the UK carry out private dental treatment only.¹¹⁵
- 8.9 Further, the SPA survey of dentists carried out for the OFT found that, of those dental practices that had tendered for an NHS contract and been successful:
- 50 per cent stated that without the NHS dental contract to provide NHS dental services, their practice would not have been nearly as good a commercial option or not a viable option at all
 - even among dental practices with a sizeable proportion of private only patients (over 10 per cent), 28 per cent said the practice would not have been nearly as good a commercial proposition, or not a viable option at all, without an NHS dental contract.
- 8.10 Follow up in-depth qualitative interviews conducted for the OFT with dental practice owners that recently entered the dentistry market also reflect the importance of access to an NHS dental contract for new, existing and expanding practices. For example:

¹¹⁴ The survey of owners of BDA member practices in the UK was carried out on behalf of the BDA by GfK NOP in 2011. There were 1,723 valid responses to the survey.

¹¹⁵ Laing & Buisson, *ibid*, page 8.

'It [having a contract to deliver NHS dental services] is just a lot more guaranteed business I suppose ... patients aren't going to leave NHS practices because they are in financial hardship. I suppose we were a little naïve; we didn't realise that it would be so much harder to be a private practice.'

Practice with small NHS dental contract, taken over by new owner (Independent)

Allocation and types of NHS dental contract

- 8.11 The majority of dental practices with an NHS dental contract had the contract allocated in 2006 with a set volume of work (defined by UDAs) to be delivered fixed by that contract according to the amount of dental treatment that the particular practice had delivered in the preceding 12 months. The result of this historic, fixed allocation is that dental practices are restricted in the extent to which they can now expand the NHS dental treatment they deliver to patients as dental treatment above the agreed volume in the contract is not paid for.
- 8.12 Moreover, the prices paid by PCTs to individual dental practices per UDA were also fixed in 2006. As a result, PCTs' payments to dental practices neither reflect the current quality of service that a dental practice delivers to patients nor provide scope for good dental practices, offering higher quality of dental services to patients, to attract and treat additional patients seeking NHS dental treatment.
- 8.13 In addition, the OFT is also concerned that potential new market entrants that wish to provide NHS dental treatment must either wait until a PCT puts a new NHS dental contract out to tender, or buy-out/go into partnership with a dentist with an existing NHS dental contract due to the inappropriately non-time-limited nature of existing NHS dental contracts.
- 8.14 NHS dental contracts in England mainly take one of two forms: Personal Dental Services contracts (PDS contracts) which are fixed term contracts usually lasting approximately five years, or General Dental Services

contracts (GDS contracts) which are rolling contracts with no fixed end date.

- 8.15 The majority of NHS dental contracts issued by PCTs are GDS contracts with absolutely no fixed end date. In England, approximately 73 per cent of NHS dental practices were on a GDS contract at the end of March 2010, and only 12 per cent were working under a PDS contract.¹¹⁶

The number of new dental contracts issued for tender

- 8.16 Due to the fact that the majority of NHS dental contracts in England were allocated in 2006 and are rolling contracts with no fixed end date, PCTs rarely issue new NHS dental contracts for competitive tender. In practice, they tend only to do so if:

- they identify a shortfall in the existing supply of NHS dental treatment compared with the estimated 'need' for dental services in that area
- a dentist with an existing dental contract dies, retires or decides to give up his contract in order to become a private dentist
- the PCT terminates a dental practice's contract, for example due to poor performance, and they need to reallocate the contract.¹¹⁷

- 8.17 The significant rarity with which new NHS dental contracts are put out to competitive tender creates a significant barrier to entry and expansion for dental practices and potential new dental practices. Submissions to the OFT in relation to a recent merger between two corporate dental groups suggest that, nationally, only five per cent of the total volume of

¹¹⁶ Laing and Buisson, *ibid*, p.129. A further seven per cent of dental practices were contracted to provide 'Trust-led Dental Services' to target groups, and nine per cent were working under a mixture of different contracts.

¹¹⁷ PCTs are also able to commission new NHS dental contracts to increase supply of NHS dentistry in a local area. However, PCTs can only do this if they have available funds.

NHS dental treatment (defined by UDAs) becomes available each year.¹¹⁸ The responses to an OFT information request indicate that volume is freed up mainly due to a dentist dying, retiring or moving into private practice. Terminating an NHS dental contract for poor performance is uncommon and PCTs on the whole prefer to resolve issues related to poor performance through discussion with the dental practice. Indeed, across PCTs surveyed by the OFT, each PCT had, on average, terminated only two contracts, for any reason, in the last five years.

- 8.18 Further, PCTs will only make new NHS dental contracts available for competitive tender if the total amount of additional UDAs being commissioned exceeds a specified amount, typically 13,000 UDAs. Where fewer new UDAs are to be commissioned, the additional UDAs are typically reallocated to existing dental practices that already deliver NHS dental services.
- 8.19 Additionally, the OFT understands that the barriers to entry and expansion identified are exacerbated because the competitive tendering of new NHS dental contracts can be lengthy and involve a substantial time lag between identifying 'need', signing contracts and getting these fully mobilised. This results in strong incentives for PCTs to issue new UDAs in a piecemeal way to incumbent dental practices, and thereby to avoid the competitive tendering process altogether.

The tendering process

- 8.20 The OFT considers that the way in which new NHS dental contracts are tendered can also raise undue barriers to entry into the dentistry market for some potential new entrants to the detriment of patients.
- 8.21 When new NHS dental contracts do come up for tender, those wishing to win the contract must undergo a lengthy and complex tendering process. This provides significant advantages to those existing practices

¹¹⁸ *'Completed joint venture between the Carlyle Group and Palamon Capital Partners LP for the acquisition of Integrated Dental Holdings Group and Associated Dental Practices'*, *ibid*, paragraph 77.

with previous experience of tendering for NHS dental contracts and with significant resources to devote to bidding for such new NHS dental contracts.

- 8.22 The OFT also understands that tender requirements for NHS dental contracts favour existing contract holders by specifying that applicants must demonstrate previous experience of delivering NHS dental services or previous experience of running a business. This is a particular problem for dentists who have not previously owned a practice. This was reflected in an in-depth qualitative interview with a practice owner that had sought to win an NHS dental contract:

'There was always somebody offering more and because I did not have a practice before, I was not a suitable buyer for them.'

Dental practice providing private dental treatment, started from scratch¹¹⁹

- 8.23 Further, the OFT survey of dental practice owners indicates that there is no clear, consistent single channel through which dentists hoping to enter the dentistry market typically find out about NHS dental contracts which may be available. The 30 respondents to an OFT survey who had tendered for an NHS dental contract reported that they had found out about the contract becoming available from a wide variety of means, including being contacted by the PCT, websites, word of mouth and from other dentists or contacts in the profession.
- 8.24 Finally, there appears to be little constructive feedback provided to failed bidders by PCTs. Although a small evidence base, the OFT's survey indicated that, of the eight respondents who had unsuccessfully bid for contracts, five indicated they either got 'not very much' or 'nothing at all' from the PCT in terms of feedback as to why their bid was

¹¹⁹ ['SPA Future Thinking Research on the Supply of UK Dentistry'](#), paragraph 5.4

unsuccessful.¹²⁰ This was also reflected in the qualitative interviews with practice owners:

'They [the PCT] just wrote an email to me saying that if anything comes up, they'll keep you updated but that was it.'

Dental practice providing private dental treatment, started from scratch¹²¹

Buying into an existing dental practice that has an NHS dental contract

8.25 An alternative way of entering the dentistry market and to gain a contract to supply NHS dental treatment is to buy a dental practice that already has an existing NHS dental contract or to buy out a partner in such a practice, for example when a partner wishes to retire. Buying, or buying into, an existing dental practice can also avoid difficulties around attracting new patients, as existing dental practices will tend to have an established patient list.¹²²

8.26 NHS contracts between dentists and PCTs currently contain the following clause which is in fact intended to prevent the transfer of the existing NHS dental contract when a practice is sold:

'The contractor shall not give, sell, assign or otherwise dispose of the benefits of any of its rights under this contract, save in accordance with the contract. The contract does not prohibit

¹²⁰ Two said 'A fair amount', four said 'Not very much', one said 'Nothing at all', and one 'Did not know'.

¹²¹ ['SPA Future Thinking Research on the Supply of UK Dentistry'](#), paragraph 5.13

¹²² When asked what makes it difficult for dentists to establish a practice of their own, 22 per cent of owners of dental practices that were taken over or bought into, and who think it is difficult for dentists to establish a practice of their own, cited attracting patients as a major challenge.

the contractor from sub-contracting its obligations arising under the contract where such sub-contracting is expressly permitted by the contract.¹²³

- 8.27 When a dental practice is sold, the seller and purchaser should contact the PCT, who can then choose whether to continue the contract, renegotiate the terms, or terminate the contract.¹²⁴ However, PCTs have discretion as to whether to apply these rules and the OFT understands that their application varies amongst PCTs.¹²⁵
- 8.28 The OFT is concerned that the current recourse to entering the market by buying, or buying into, a dental practice with an existing NHS dental contract has the effect of protecting incumbent dental practices from potential competition and transferring economic rents to dentists who happened to have had a dental practice in 2006 from later cohorts. This is important as dental practices are profit seeking businesses and for the market to work effectively practices must face competitive pressures. We understand that the sale of the 'goodwill' of holding an NHS 2006 dental contract by incumbents has had the effect of raising the price of their dental practices relative to their turnover,¹²⁶ thereby further raising barriers to entry into the dentistry market.

¹²³ Model General Dental Service Contract, Part 2, Clause 12; Model Personal Dental Service Contract, Part 2, Clause 12.

¹²⁴ See *'Briefing Paper: Termination of Dental Contracts and Sale of Goodwill'*, 2006, NHS Primary Care Contracting, www.pcc.nhs.uk/uploads/Dentistry/october_2006/goodwill_briefing_paper.pdf

¹²⁵ *'Completed joint venture between the Carlyle Group and Palamon Capital Partners LP for the acquisition of Integrated Dental Holdings Group and Associated Dental Practices'*, *ibid*, paragraph 75.

¹²⁶ According to recent results of the National Association of Specialist Dental Accountants and Lawyers (NASDAL) goodwill survey for the quarter ending 31 October 2011, NHS practices were, on average, valued at more than 120 per cent of their fee income, while private practices were mostly valued at less than 100 per cent of turnover. National Association of Specialist Dental Accountants and Lawyers press release: *'Practices with NHS contracts are highly prized*

8.29 In this context, stakeholders, including leading banks and the National Association of Specialist Dental Accountants and Lawyers, have submitted to the OFT that there has been a marked increase in the value of dental practices with large NHS dental contracts in recent years. The significant restrictions on the number of new NHS dental contracts that come up for tender set out above seem to be one of the factors that is driving up prices of dental practices.

Impact of barriers to entry and expansion created by NHS dental contracts and tendering processes

8.30 In view of the above, the OFT is concerned that the following factors raise barriers to entry and expansion in the dentistry market, preventing new and innovative dental practices from entering and/or existing dental practices which offer higher quality of dental services to patients:

- that the widespread award of non-time limited NHS dental contracts in 2006 to incumbent dental practices in England, resulting in few new NHS dental contracts being put out to competitive tender, insulates such practices from competition
- that tendering processes for new NHS dental contracts, where they become available, can be lengthy and complex and favour certain types of bidder

in the sales market', www.nasdal.org.uk/assets/press-releases/nhs%20practices%20hold%20value%20final.pdf. According to the Industry report 'The UK Dentistry Market Development' 2010, by Market and Business Development, turnover for dental practices varies significantly in the UK, but the most common size of practice has a turnover of between £100,000 to £250,000 per annum (p.50 paragraph 4.1). According to these estimates, on average, a dental practice could be sold for between £120,000 to £300,000 if it holds an NHS contract, plus the costs of any assets.

- the practice of NHS dental contracts effectively being bought and sold with dental practices, resulting in higher prices of dental practices.
- 8.31 The barriers to entry and expansion created by these factors are likely to result in a number of adverse outcomes for the operation of the dentistry market, which are described below.
- 8.32 **Lower levels of innovation:** The OFT has found that in those cases where new dentists have been able to break into the market, they are more innovative and offer a wider range of dental services to patients, such as, orthodontics, implants, dentures, and cosmetic dentistry compared with existing dental practices. The OFT's survey of dental practices found that 60 per cent of dental practices that had been set up in the last four years offered such specialist dental treatments, compared with only 43 per cent of dental practices where there had been no recent change in ownership.
- 8.33 New entrants are also more innovative in the way they communicate with their patients. Research carried out by SPA, on behalf of the OFT found that only 53 per cent of dental practices which had not experienced a recent change of ownership were using a website to inform and attract patients, compared to 86 per cent of dental practices established within the last four years.
- 8.34 **Supply cannot easily adjust to meet changes in demand:** Usually in well functioning markets, the supply-side automatically adjusts to meet changes in demand. However, due to the significant barriers to entry and expansion set out above, it is difficult in the dentistry market for dentists to change their location or to expand or contract to meet changes in demand by patients. In order for the supply of NHS dentistry in an area to expand, the relevant PCT must first identify that there is additional 'need' for extra dental services, and must also be willing and able to fund this need. This process, and the process of then tendering new NHS dental contracts, can be lengthy and complex. As a result, it is not possible for the supply of NHS dentistry to adjust quickly to meet changes in demand and to meet patient needs.

8.35 **Limited incentives to improve quality of services:** The OFT is concerned that the current contracting arrangements mean that the provision of higher quality dental service is not necessarily rewarded. Dental practices that provide a superior quality of dental service to patients are not incentivised to expand the provision of NHS dental services beyond their agreed UDA target as they will not receive additional payment. Further, there is no link between the level of payment per UDA and any objective quality measure which is monitored and assessed regularly. Instead, the quality of NHS dental services that are delivered by dental practices are 'performance managed', meaning action is only taken to prevent sub-standard services and misconduct. As noted above, in very few circumstances have dental contracts been terminated or reallocated for poor performance. Thus, dental practices face few incentives to improve the quality of the dental services they deliver to patients.

Summary and conclusion

8.36 In summary, the OFT finds that:

- gaining access to an NHS dental contract is extremely important to the success with which new dentists can enter the dentistry market or with which existing firms in the market can expand into new geographic areas
- significant, detrimental barriers to entry and expansion in the dentistry market are created by the fact that:
 - the majority of NHS dental contracts are not time-limited and were awarded to dental practices in 2006, resulting in few new NHS dental contracts being put out to competitive tender and practices being insulated from competition
 - tendering processes for new NHS dental contracts, where they become available, can be lengthy and complex and favour certain types of bidder
 - NHS dental contracts are often effectively bought and sold with dental practices, resulting in higher prices of dental practices

- The significant barriers to entry and expansion created by these factors are likely to dampen competition in the dentistry market leading to lower levels of innovation, potential local discrepancies between supply and demand and therefore inefficiencies which lead to reduced value for money, and limited incentives for dental practices continually to improve the quality of dental services offered to patients.

8.37 Dental practices are profit seeking businesses and therefore must face competitive pressures for the market to work effectively. It is therefore vital the Department of Health address the barriers to entry and expansion identified above as removing these will be critical to driving future improvements in the dentistry market.

8.38 The OFT considers that the Department of Health must take action in the short term to reduce barriers to entry and expansion in the dentistry market by bringing an end to non-time limited NHS dental contracts and by replacing such contracts with time limited contracts by 2014 or the time at which the new contract is introduced.

8.39 Priority should also be given to PCTs in the short term (and NHS Commissioning Board in due course) to ensure commissioning of dental contracts is more transparent to prospective market entrants.

8.40 The OFT has identified a number of recommendations which we consider must be prioritised, and in many cases implemented in the short term, by the Department of Health to help address these issues. These are set out in Chapter 10.

9 RESTRICTIONS ON DIRECT PATIENT ACCESS TO DENTAL CARE PROFESSIONALS

Introduction

- 9.1 Dental hygienists, dental therapists and clinical dental technicians – referred to collectively hereafter as Dental Care Professionals (DCPs)¹²⁷ – each perform an important role in the delivery of dental care to patients. However, GDC regulations currently prevent patients from accessing DCPs directly without first seeing a dentist and obtaining a referral.
- 9.2 The restrictions on direct patient access to DCPs is an issue that was considered by the OFT in the Private Dentistry Market Study in 2003.¹²⁸ The OFT raised concerns about the negative effect this was having on consumer choice and benefits as well as competition and innovation in the market more generally and recommended relaxation of these restrictions. The OFT is disappointed by the GDCs failure to remove such restrictions.
- 9.3 During the course of the market study, the OFT held a roundtable discussion on direct access with the representative bodies for dentists and DCPs,¹²⁹ the Department of Health, the General Dental Council and other health sector regulators. The OFT raised its significant concerns regarding the lack of reform relating to direct access for patients.

¹²⁷ In this report, we use the term Dental Care Professional or DCP to refer to dental hygienists, dental therapists and clinical dental technicians collectively. We recognise there are also other professions that form part of the dental team. For details of each profession and their scope of practice see: *'Scope of Practice'*, General Dental Council, [www.gdc-uk.org/Newsandpublications/Publications/Publications/ScopeofpracticeApril2009\[1\].pdf](http://www.gdc-uk.org/Newsandpublications/Publications/Publications/ScopeofpracticeApril2009[1].pdf).

¹²⁸ *'The Private Dentistry Market in the UK'*, OFT, *ibid*.

¹²⁹ Namely, the British Dental Association (BDA), the British Association of Clinical Dental Technology (BACDT), the Association of Denture Specialists (ADS), the Clinical Dental Technicians Association (CDTA), the British Society of Dental Hygiene and Therapy (BSDHT) and the British Association of Dental Therapists (BADT).

- 9.4 Overall, there was general agreement across the majority of attendees that direct patient access to DCPs could function in a similar way to the general practice setting in medical care where initial screening is carried out by the practice nurse. There was also general agreement for the need to incorporate safeguards into direct access such as DCPs having a duty to refer patients in cases where it is appropriate. Delegates also emphasised the importance of holistic care being provided to patients.¹³⁰
- 9.5 The OFT believes that the continued restrictions on direct patient access to DCPs is denying patients greater choice, competition and innovation which help to achieve better value for money and better quality of service as well as greater efficiency in the supply of dental services.
- 9.6 The GDC and the BDA have raised concerns around patient safety if patients are allowed direct access to DCPs. However, neither the GDC nor BDA have put forward a compelling, evidence based, justification for such restrictions to remain. The OFT has, during the course of this market study, considered objectively the concerns on patient safety, consulting widely with independent academic dental experts, the GDC, the Department of Health, professional representative bodies, experts in the field of general medical practice (where direct access is successfully in operation) and other liberalised dental jurisdictions.¹³¹
- 9.7 In this chapter we consider:
- the potential benefits that direct patient access to DCPs could deliver for patients and in relation to the provision of dental services more generally
 - how potential concerns around direct patient access to DCPs can be managed

¹³⁰ A summary of the roundtable discussion on direct access is at Annexe B.

¹³¹ Denmark, Ireland and Canada (Ontario and British Columbia)

- core principles which the OFT considers should guide the implementation of direct patient access to DCPs in the short term
- how similar models of direct access in overseas jurisdictions and in the general medical practice setting operate successfully
- potential models for how direct patient access to DCPs could be implemented in the UK, namely direct access within a general practice setting or direct access within an independent practice setting.

Dental Care Professionals (DCPs)

9.8 Dental hygienists specialise in preventative oral healthcare and carry out procedures such as scaling and polishing teeth, and applying topical fluoride and fissure sealants. Dental therapists carry out a similar role to hygienists but also carry out treatments such as teeth restoration and extracting primary teeth. Clinical Dental Technicians are primarily involved in the making and fitting of dental devices such as dentures, crowns, bridges, and dental braces.

Patient access to DCPs

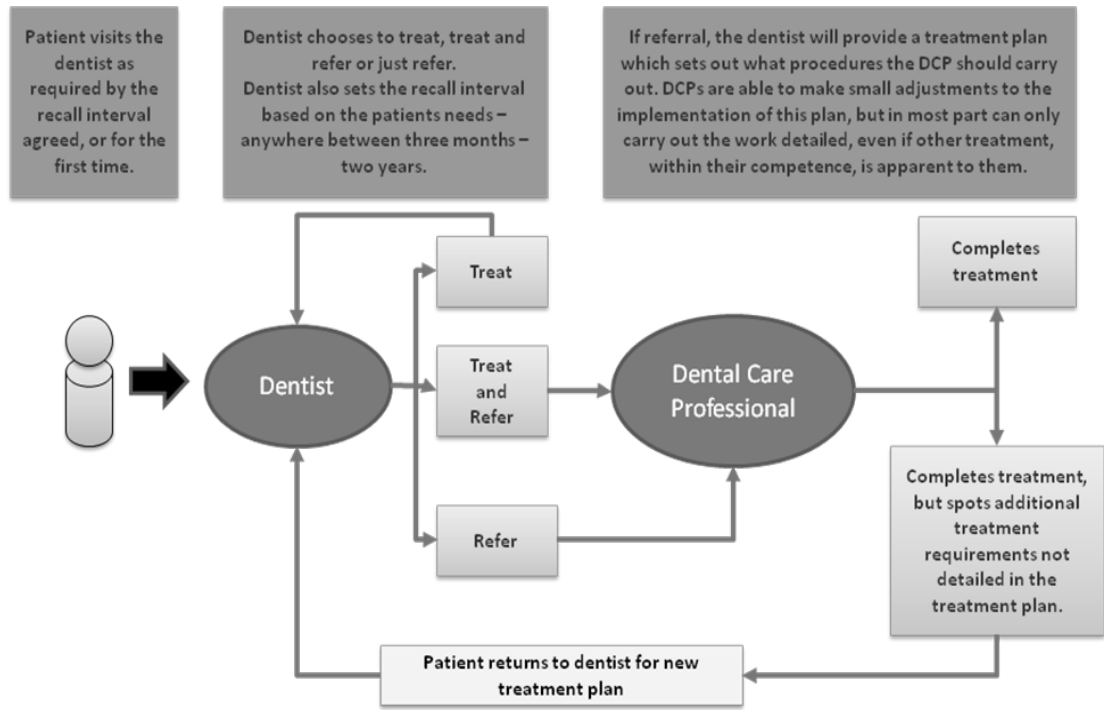
9.9 GDC regulations¹³² currently prevent patients from accessing DCPs directly.¹³³ This restriction is predicated on the belief that there is potential patient safety risks involved in seeing DCPs direct before the patient has seen a dentist. Patients must therefore see a dentist first, before engaging the services of a DCP. Having examined a patient, the dentist can either refer the patient to the appropriate DCP with a

¹³² 'Principles of dental team working', General Dental Council, www.gdc-uk.org/Newsandpublications/Publications/Publications/DentalTeamWorking.pdf

¹³³ An exception to this rule is that Clinical Dental Technicians are allowed direct access to patients who have no teeth.

treatment plan, or carry out any necessary treatment themselves that may also be within the DCP's scope of practice.

Figure 9.1: Typical patient journey between dentist and DCP



9.10 When OFT considered direct access in 2003, only dental hygienists and dental therapists were registered by the GDC. In 2006 this position changed with the amendment of legislation enabling the GDC to register all DCPs and regulate their activities, lending further support for the introduction of direct access. Since this time the GDC has not duly investigated and implemented liberalisation to a sufficient extent as the restriction remains in force.

9.11 Table 9.1 below shows the number of registrants for each category of DCP and dentist in the UK for 2011.

Table 9.1: Number of GDC registrants for dentists and DCPs as at December 2011

Dentist	Dental Hygienist	Dental Therapist	Clinical Dental Technician
39,307	5,968	1,800	226

Source: Figures submitted to the OFT market study by the GDC.

Potential benefits of direct access

- 9.12 There are a number of benefits that direct access may deliver for patients and in relation to the provision of dental services more generally. These are outlined below.
- 9.13 **Greater patient choice and access to treatment:** The ability to access DCPs directly would provide patients with greater choice as to which provider they engage for certain dental treatments, for example a scale and polish. At the present time, patients must see a dentist in order to access simple treatment which can be competently and effectively undertaken by DCPs within their scope of expertise. This, inevitably, restricts the patients' choice of treatment providers.
- 9.14 Further, a significant proportion of the UK population do not currently access dental treatment and this group tends to be the most deprived and experience higher levels of oral disease.¹³⁴ There are, therefore, a large number of potential patients whose oral and more general health might be at risk, and who do not access dental treatment. A key benefit of direct access would be the creation of additional pathways for such patients to access the dental care system.
- 9.15 **Greater competition in the dentistry market:** Direct patient access to DCPs would facilitate greater competition between DCPs and, where

¹³⁴ House of Commons Health Select Committee (2008), House of Commons Health Committee: Dental Services – Fifth Report Session 2007-08.

either a DCP or a dentist could provide a particular dental treatment, between DCPs and dentists. Removing dentists as the 'gatekeeper' would allow DCPs direct interaction with patients rather than relying on a referral from a dentist. This could open up new opportunities for DCPs to compete more vigorously for patients rather than rely on dentists to decide which DCP receives the referral, if indeed, a referral is made (a dentist is, of course, at liberty to carry out the dental treatment that could be carried by DCPs). Such competition could improve the incentives of dentists and DCPs continually to improve the quality, range and value for money of the various dental services they offer to the benefit of patients.

9.16 The fact that DCPs rely on dentists to refer patients to them effectively imposes significant barriers to entry and expansion for DCPs. Without a dentists' agreement (this may not be a formal agreement) to refer patients to it, it is even more difficult for a DCP to enter the market because successful entry will be wholly dependent on the dentists desire to refer patients to it, rather than any meaningful business strategy adopted by the DCP. Similarly, a DCPs ability to expand and take on more patients largely depends on the volume of referrals it receives from dentists, rather than directly depending on the quality of the service and treatment that the DCPs provide to patients, which again does not lead to optimal incentives focused on the patient experience.

9.17 **More efficient use of resources:** The general consensus among the very many academic dental experts with whom the OFT has spoken is that the current regulatory regime on direct access is leading to inefficiencies impacting across the dentistry market.¹³⁵

¹³⁵ The OFT has had detailed discussions with a number of academic experts from dental schools in England and Scotland, including Manchester, King's College London, Leeds, Newcastle, Kent, Surrey and Sussex Deanery and Glasgow. The consensus among these experts is that direct access can be implemented without compromise to patient safety and is necessary in order to make dental provision more efficient, effective and flexible for the patient, with benefits to be gained for the profession as a whole.

- 9.18 The current regulatory regime requires the dentist, the most expensive resource within a dental practice, to act as the gateway for a patient into all dental care. Relying solely on dentists to screen and refer patients is unlikely to be an efficient use of resources given that evidence shows that DCPs have the capability to screen and refer patients appropriately.¹³⁶ Moreover, given the significant costs involved in training dentists¹³⁷ and the high opportunity costs of dentists' time (in that there is a cost for dentists and the profession as a whole in carrying out some of the more basic dental treatments, which could easily be carried out by DCPs, when they could be focusing on more complex clinical work), this regime leads to concerning inefficiencies.
- 9.19 By way of further evidence of these inefficiencies, in England, around 55 per cent of patients who attend an NHS dentist for a check-up in fact only end up having a scale and polish.¹³⁸ As a result, many patients with relatively low levels of oral health needs are treated by the most expensive resource, the dentist, while high levels of need persist in patients who do not access dental treatment.
- 9.20 In contrast, in general medical practice, for example, patients can typically either make an appointment to see a nurse for minor dental treatments (and potentially receive a referral onwards as appropriate) or alternatively make an appointment to see a GP directly if the patient needs acute and/or less minor dental treatment.
- 9.21 **Development of new models of service:** Removal of restrictions on patients' direct access to DCPs could also enable the development of new, more efficient models of service in the dentistry market that may be more responsive to patients' needs, for example by reflecting

¹³⁶ See section below on evaluating risks of direct access and the competency of DCPs.

¹³⁷ Figures from the Department of Health show that the cost of training a dentist is around £200,000.

¹³⁸ House of Commons Health Select Committee (2008) House of Commons Health Committee: Dental Services – Fifth Report of Session 2007–08.

increasing focus on preventative dental care, as opposed to remedial dental treatments.

9.22 The Government's public health strategy identifies a clear need to focus on prevention rather than treatment and identifies the key to this strategy as the engagement of professionals across the service.¹³⁹ Medical Education England¹⁴⁰ recently carried out a review of the skills mix in dentistry and considers that the significant range of preventative procedures that are within the scope of DCPs makes this group fundamental to the Government's public health goals. One of the key recommendations of the skills mix review 2012 was that:

'There is a significant need to enable dental practitioners to:

- make best use of skill mix to improve care of patients; and
- promote different models of service delivery and organisation to maximise stability and sustainability of their practices.'¹⁴¹

Potential risks arising from direct access

9.23 The BDA continues to oppose the introduction of direct patient access reform and has submitted to the OFT that direct patient access to DCPs would introduce risks to patient safety because DCPs are not trained to diagnose significant early stage oral disease.

¹³⁹ *'Healthy lives, healthy people: our strategy for public health in England'*, Department of Health, 2010, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

¹⁴⁰ Medical Education England is an Independent Advisory Non-Departmental Public Body with a remit for medicine, dentistry, pharmacy and healthcare science. It provides independent expert advice on education and training and workforce planning for doctors, dentists, healthcare scientists and pharmacists.

¹⁴¹ *'A Review of Skill Mix in Dentistry'*, Medical Education England, www.mee.nhs.uk/pdf/Skill_Mix_in_Dentistry.pdf.

9.24 The OFT has not been persuaded by these submissions and considers the fundamental question around direct access to be in fact whether DCPs have the training and competency to screen patients effectively and to make appropriate referrals, rather than to themselves diagnose oral disease. Screening is the recognition of oral disease, whereas diagnosis concerns identification and classification of oral disease. Academic experts have confirmed that screening and diagnosis require different skill sets. Box 6.1 below provides definitions of screening and diagnosis which are supported by academic dental experts.

Box 9.1: Definition of screening and diagnosis

Screening – 'an assessment of the hard and soft tissues of the oral cavity to determine whether a patient has or is at risk of developing an oral disease, to distinguish between those that are healthy and those that need to be referred for further consultation with a dentist.'¹⁴²

Diagnosis – 'a detailed assessment of the hard and soft tissues of the oral cavity and head and neck by a primary care dentist in order to determine and classify the type and extent of disease the patient may present with'¹⁴³

9.25 Competency to screen is acquired by DCPs and dentists through a combination of educational training and clinical experience. There is broad consensus among the many academic dental experts with whom the OFT has discussed this issue that dental hygienists and dental

¹⁴² This definition was provided by Dr Paul Brocklehurst of the University of Manchester School of Dentistry using studies and definitions by other experts.

¹⁴³ Brocklehurst et al 2012 – Contained in a joint submission to OFT by Dr Paul Brocklehurst, Martin Tickle, Steve Birch and Bonnie Sibbald of the University of Manchester. See Annexe C.

therapists are entirely adequately trained to screen (but not diagnose) patients for oral disease and to make the appropriate referral.¹⁴⁴

DCP competency to screen

- 9.26 In terms of education and training, the learning outcomes required for GDC registration of DCPs clearly identify recognition of abnormalities in the oral cavity as a requisite learning outcome.¹⁴⁵ In addition, the GDC scope of practice document¹⁴⁶ also identifies recognition of abnormalities and the carrying out of oral cancer screening as being within the scope of practice of dental hygienists and dental therapists. Similarly, for clinical dental technicians, the GDC scope of practice document also identifies the recognition of abnormal oral mucosa and related underlying structures as being within the scope of practice of dental technicians. The DCPs in scope are therefore sufficiently able to screen for oral cancers or other oral abnormalities.
- 9.27 In addition, peer reviewed research,¹⁴⁷ both in the UK and abroad, has also established that dental hygienists and dental therapists are in practice entirely capable of screening for oral disease effectively and of making appropriate referrals thereafter.

¹⁴⁴ The evidence of the experts spoken to in relation to the training and skills of the current cohort of clinical dental technicians to screen patients was mixed. See paragraphs 9.31 and 9.32 for further discussion.

¹⁴⁵ 'Preparing for Practice: Dental Teams Outcome for Registration', GDC, www.gdc-uk.org/Newsandpublications/Publications/Publications/GDC%20Learning%20Outcomes.pdf

¹⁴⁶ The GDC scope of practice document describes what a dentists and each category of DCP is trained and competent to do. It describes the areas each dental category of professional has the knowledge, skills and experience to practise safely and effectively in the best interests of patients.

¹⁴⁷ 'Relative performance of different dental professional groups in screening occlusal caries', Dr Paul Brocklehurst (2012) et al, 'A systematic review on the use of role substitution in dentistry', Galloway (2003) et al, and 'Utilizing dental hygienists to undertake dental examination and referral in residential aged care facilities', M.S. Hopcraft (2005) et al.

Dental hygienists' and dental therapists' competency to screen

- 9.28 Dental hygienists and therapists are typically, though not exclusively, trained in dental schools.¹⁴⁸ All schools run BSc, FdSc or Diploma programmes. The education and training for hygienists and therapists is extensive and includes studying the recognition and identification of dental caries, periodontal disease and dentine hypersensitivity. St Bartholomew's Hospital and The London School of Medicine and Dentistry developed the first programme in dental hygiene and therapy in 1983, utilising a model of education and training that has been replicated across the UK as an effective method of dental education.
- 9.29 The GDC recognises that the current training for dental hygienists and dental therapists is sufficient to ensure that they can competently screen for the presence of oral cancers. Further, none of the independent academics we spoke to at the leading dental schools in the UK disputed this. In addition to oral cancer screening, recent research has been carried out by Dr Paul Brocklehurst at the University of Manchester School of Dentistry to ascertain the relative performance of different dental professional groups in screening for dental caries. Participants included final year dental students and final year dental hygienists, therapists and dental nurses. The research found that, with minimal training, the DCPs showed the potential to screen for occlusal caries to a similar standard as dentists, with the relative performance of the dental professional groups involved being almost identical.¹⁴⁹ These findings are

¹⁴⁸ Some schools undertake a training programme leading to registration as a dental hygienists or therapist with limited links to dental schools.

¹⁴⁹ *'Relative performance of different dental professional groups in screening for occlusal caries'*, P. Brocklehurst, J. Ashley, T. Walsh and M. Tickle, 2012, www.ncbi.nlm.nih.gov/pubmed/22390725.

also consistent with research carried out at Eastman Dental Hospital in 2003.¹⁵⁰

- 9.30 Research carried out in Australia in 2005 also confirmed the ability of dental hygienists safely and effectively to screen and refer patients during tests carried out in relation to residents of care homes.¹⁵¹

Clinical dental technicians' competency to screen

- 9.31 The GDC also recognises that the current training for CDTs ensures that they can competently screen for the presence of oral cancer, which the independent academic dental experts we spoke to did not dispute. However, the experts' views on screening other oral disease, such as occlusal caries, were more mixed. Professor Stephen Lambert-Humble (Kent, Surrey and Sussex (KSS) Deanery), the national lead dean for all DCP education and training, considered that CDTs are well suited for screening and referral but that all CDTs currently registered would need to undertake a further 'bolt-on' course in order to be able to do so effectively.
- 9.32 The KSS Deanery now offers a course which provides a qualification for CDTs which includes screening and referral of oral disease. This course has been quality assured by the GDC. The current tranche of CDTs will

¹⁵⁰ A systematic review undertaken on the use of role substitution in dentistry concluded that other members of the dental team such as dental hygienist, dental therapists and dental nurses could detect caries: *'The professionals complementary to dentistry: Systematic review and synthesis'*, Galloway, Gorham, Lambert, London: Eastman Dental Hospital, Dental Teams Unit, 2003.

¹⁵¹ *'Utilizing dental hygienists to undertake dental examination and referral in residential aged care facilities'*, M.S. Hopcraft, M.V. Morgan, J.G. Satur and F.A.C. Wright, 2005, www.ncbi.nlm.nih.gov/pubmed/21756266. The research results showed agreement between the dentist and hygienist on screening for oral disease and making referrals. The recommendation from the study was that there should be greater utilisation of hygienists in the provision of dental care to residents of aged care facilities, as this would represent a safe, efficient and effective use of health resources.

complete the course in June 2013.¹⁵² Those CDTs who qualify under this course will not require a bolt-on course for screening and referral.

Implementing direct access

9.33 Implementation of direct patient access to DCPs is within the remit of the GDC as the statutory regulator for dental professionals and the OFT considers that it must be investigated by the GDC as a matter of priority with a view to implementation in the short term. During the course of the OFT market study, the OFT has therefore welcomed the GDC setting up a working group¹⁵³ to consider the options for adopting direct access and to report to the GDC Council who would then take the necessary decisions regarding direct access in early 2013.

Core principles

9.34 There are a number of core principles which the OFT considers should guide the GDC in its consideration of the options for adopting direct access and which were also supported by many of the academic and other dental experts which we have spoken to. These are:

- that all dental professionals involved in dental care should act within their professional competencies, and if in doubt should ensure that they refer patients on to the most appropriate alternative member of the dental team
- that there are adequate safeguards and a clear clinical patient pathway (for example, ensuring that each professional seen by the patient is aware of dental treatment the patient has previously received)

¹⁵² The University of Lancashire (UCLAN) is also running a similar course. UCLAN is currently training the first cohort of students and only has provisional approval from the GDC. The GDC will inspect the UCLAN course over the next 18 months and give final approval at their final examination board once they have seen all the processes.

¹⁵³ The GDC 'Task and Finish Group'.

- patients should have real choice and flexibility over how they choose to engage with the dental healthcare system and reforms should be focused on benefitting patients and that clinical responsibility for the care of the patient is, at every step, clear
- that the approach ensures an appropriate, balance between patient safeguards and over regulation.

International models

9.35 The OFT considers that a number of models of patient access to dental services internationally can further inform the approach the GDC should follow in pursuing requisite reforms, as well as the general medical practice model which also serves as a relevant comparison.

9.36 Several international jurisdictions have liberalised access for patients to DCP equivalents. A summary of the models which have been considered by the OFT is set out in table 9.2 below for illustration. A more detailed summary of each model is contained in Annexe E.

Table 9.2: Summary of various international models on direct access

Country	Direct access model	Details	Safeguards	Potential concerns
Denmark	Direct access to all DCPs except dental laboratory technicians.	Highly liberalised regime since 1996 using light touch regulation. Hygienists play a screening role.	DCPs have a legally binding duty to refer. CDTs cannot see patient directly when signs of pathological lesions.	None reported. The approach is working well with no rise in complaints or problems with patient care according to the regulatory body in Denmark.

Country	Direct access model	Details	Safeguards	Potential concerns
Ireland	Direct access to CDTs for both partial and full dentures since 2008.	Irish Dental Council (IDC) engaged with the Government to introduce a full scheme of direct access to all DCPs in independent practice.	CDTs have an obligation to inform the patient if further treatment is required and to note this on the patient record	No complaints about CDTs have been received by the Irish Dental Council since implementation of direct access in 2008.
Canada - Ontario	Partial direct access to DCPs allowed subject to approval by the DCP's relevant college. Dental technologists rarely have direct access to patients and work on the basis of fabricating appliances based on a prescription from the dentist.	Hygienists who are authorised by the relevant college to self-initiate treatment have direct access. Those who do not have the authorisation need an order (treatment plan) from the dentist to carry out any treatment	Hygienists are required by law to make appropriate referrals to other members of the dental or medical team.	No major problems have been reported on patient safety and the system by the regulatory body in Ontario.
Canada – British Columbia	As in Ontario, each DCP is regulated by its relevant college. The system in British Columbia allows for partial access and the rules differ for each profession.	Patients can directly access hygienists provided the patient has seen a dentist in the past 365 days and the dentist has provided instructions. Patient can take these instructions to any hygienist.	DCPs have a duty to refer issues beyond their scope of practice to a dentist.	System works well without any major problems reported by the regulatory authority in British Columbia.

Source: Information and data obtained by the OFT from the relevant dental regulator of each jurisdiction.

- 9.37 The OFT notes that, within these jurisdictions, there has not been any apparent increase in complaints or concerns relating to patient safety arising from the introduction of direct access to DCP equivalents. Appropriate safeguards appear to have been developed both in a general dental practice setting and/or in independent DCP practices, and the referral systems which have evolved appear to operate effectively and are understood by the entire range of dental professionals involved.

The general medical practice model

- 9.38 The majority of the academic dental and other experts that we have engaged with during the course of this market study have agreed that the patient access options within a GP practice setting is a relevant comparator for considering patient access options for dentistry services.
- 9.39 In a GP practice, the triage system works from the 'bottom upwards'. That is, a practice nurse, who has direct access to patients, screens patients and may refer them to a doctor or to other medical team members. Practice nurses utilise clinical protocols (also known as decision trees) to aid their referral decisions and to help to ensure that they consistently follow a particular clinical pathway. The practice nurse only works within his/her scope of practice but is trained to screen and refer patients appropriately.
- 9.40 Academic experts in the field of general medical practice with whom we have engaged¹⁵⁴ have told us that this system works effectively, efficiently and is not likely to give rise to any additional costs. Further, the experts were of the view that this reformed system of access is helping to focus doctors' roles on more complex areas of clinical work while providing patients with multiple pathways to healthcare thereby

¹⁵⁴ Professor Bonnie Sibbald (University of Manchester), Mike Pringle (Royal College of General Practice), Sue Cross (Qualified Practitioner Nurse with extensive experience of working in General Practice).

offering patients greater choice and flexibility. Most general medical practices are now adopting this system and employing practice nurses.

Potential models for how direct access could be implemented

9.41 For illustrative purposes, set out in Annexe D, we have provided further detail on two possible models for how direct access for patients within the dentistry market could be implemented by the GDC with a view to improved value for money, greater efficiencies and improved patient choice and flexibility. The models reflect the considerable evidence and submissions during significant stakeholder engagement considered by the OFT in this market study.

Summary and conclusion

9.42 In summary, the OFT finds that:

- Direct patient access could facilitate greater patient choice and access to dental treatment by opening up multiple gateways into dental care as opposed to the single gateway through a dentist, currently available.
- Direct patient access could provide a basis for greater competition in the dentistry market with DCPs being able to compete directly with dentists and other DCPs rather than depending on dentists for referrals. A more liberal and open market will provide greater incentive for dentists and DCPs to continually to improve the quality through innovation, range and value for money of the various dental services they offer to the benefit of patients.
- More efficient use of resources within the dental team can be achieved through direct access. Under the current system patients with the least need are being treated by the most expensive and qualified resource in the dental team, the dentist. Direct access can rebalance the deployment of resources for certain dental treatments leaving dentists to focus on more complex procedures such as crowns, bridges and root canal treatment for the significant

proportion of the population that currently do not access dental care yet may have the highest incidence of oral disease.

- Evidence from academic research and international and other comparative models show no indication that risks to patient safety are likely to arise from carefully implemented direct patient access to DCPs. This is because the suggested model for direct access by academic dental experts is based on screening and referral which DCPs are qualified to undertake, not diagnosis which concerns BDA and GDC.
- A number of key stakeholders have agreed a set of core principles which could help guide the implementation of direct patient access to DCPs and there are two broad models for how direct access could be implemented in practice.

9.43 On the basis of evidence we have considered there is a clear and compelling case for the removal of current restrictions on direct access to DCPs, without further delay. Patients are losing out on potential benefits that direct access could bring. Furthermore, we see no evidence to suggest that patient safety will be at risk. In coming to this conclusion, we adopted an open and objective consideration of the evidence, consulting widely with academic dental experts and other key stakeholders on the concerns raised and therefore we can see no reasonable justification for their continuation.

9.44 Chapter 10 sets out the OFT's recommendation to the GDC regarding direct patient access to DCPs.

10 RECOMMENDATIONS AND ACTIONS

- 10.1 The OFT is concerned that dental patients' choices regarding the dental practice they attend, the dental treatment they receive, and how they pay for dental treatment are unduly restricted by the limited availability of clear, timely and accurate information about prices, quality, treatment options, and payment options. We are also concerned that, where patients experience problems with dental treatment, they often do not appear to receive appropriate redress from their dentist, and complaining about dental treatment can be unnecessarily confusing and complicated.
- 10.2 The NHS dental contract is of critical importance to how well the dentistry market works for patients. The OFT strongly considers that the current NHS dental contract in England acts as an unnecessary barrier to entry into the dentistry market for new, innovative dental practices which offer better services and improved value and to the expansion of dental practices which provide high quality services to patients. As a result, dental practices face weaker incentives to be efficient, innovative and to improve their quality of service.
- 10.3 The OFT strongly considers that current restrictions on direct patient access to DCPs are unjustified and are likely to dampen competition, reduce innovation and limit patient choice.
- 10.4 This chapter sets out a package of recommendations and actions which the OFT considers must be taken to address the problems we have identified in the dentistry market. The recommendations call for specific actions to be taken by the Department of Health, NHS commissioning bodies, the GDC, the CQC, the BDA, and other bodies. The OFT will closely monitor the progress that these bodies make in relation to the implementation of a number of the recommendations set out below.

Patients' awareness of availability of local dental practices providing NHS dental treatment

- 10.5 Public awareness of existing websites that enable patients to find local dental practices that provide NHS dental services is limited. As a result,

many patients face high search costs, which limits their propensity to identify alternative suppliers and, ultimately, to switch between competing dental practices.

10.6 The OFT strongly recommends that, in England, the Department of Health and NHS Choices implement appropriate low cost methods of improving patient awareness of NHS Choices as a means of finding local NHS dentists and as a source of patient reviews of dental practices. The OFT considers that such measures should include, for example:

- requiring NHS dentists who are not able to take on new NHS patients to refer such patients to NHS Choices
- including details of NHS Choices on the treatment plans which dentists are required to provide to patients and on posters which display NHS dental treatment prices.

10.7 The OFT recommends that the devolved administrations in Scotland, Wales, and Northern Ireland also consider similar measures to raise awareness of the NHS 24, NHS Direct Wales and Health & Social Care websites respectively.

10.8 In order to ensure that information on NHS Choices regarding whether individual dentists in England are currently accepting new NHS patients is accurate and up-to-date, the OFT also strongly recommends that dentists be given the ability to update this information themselves, rather than it being carried out by the relevant PCT.

10.9 On the basis of evidence gathered in the course of this market study, the OFT considers that these actions can, and should, be implemented in the short term.

Patients' ability to compare prices charged for dental treatment by different dentists and dental practices

10.10 The prices charged by different dental practices is one of the key pieces of information that patients require to be able to make an informed choice between dental practices. The OFT is concerned that evidence

gathered in the course of this market study indicates that dental practices commonly do not make dental treatment prices readily available to patients.

- 10.11 With regard to the display of private dental treatment prices, the OFT is pleased that further to discussions with the OFT, Integrated Dental Holdings (IDH) and Oasis – the two largest corporate dental groups in the UK¹⁵⁵ – have agreed to make lists of private dental treatment prices available in their dental practices and on their websites. The price lists provided by these dental groups will provide a single set price for the most common treatments, including examinations and x-rays.¹⁵⁶ For more complex treatments, price ranges will be provided.
- 10.12 The OFT strongly considers that similar action to improve price transparency should be taken across the dentistry market and urges other dental practices, both corporate and independent, to make lists of private dental treatment prices available in their dental practices and on their websites.
- 10.13 Further, the OFT strongly recommends that the GDC introduce a requirement for dentists to display NHS prices and private prices, as appropriate, prominently in their practices and, where they have one, on their website. The OFT is pleased to note that the GDC has agreed to introduce such a provision into its draft revised Standards for Dental Professionals and associated guidance. The GDC will consult on these during 2012, with a view to introducing new standards and guidance in early 2013. The principles which the OFT considers should apply to the display of private dental treatment prices in order to ensure that prices are meaningful and useful to patients are set out in Annexe F.

¹⁵⁵ By number of dentists and dental practices, according to Laing and Buisson, *ibid*.

¹⁵⁶ Some additional charges could apply when using specialists.

- 10.14 The OFT is pleased to note that the BDA has stated that it would support a requirement for dental practices to display standard indicative prices in their reception areas and on their websites.
- 10.15 In order to remedy the detriment arising from non-display of NHS dental treatment prices, the OFT considers that NHS commissioning bodies across the UK¹⁵⁷ must be proactive in identifying dental practices that breach NHS regulations by not displaying NHS prices prominently in the practice and that they take appropriate measures to bring such practices into compliance with the NHS regulations in the short term.
- 10.16 From April 2013, the NHS Commissioning Board will be responsible for enforcing contractual terms with NHS dentists in England, including ensuring that NHS prices are displayed in dental practices. The OFT is pleased to note that the NHS Commissioning Board Authority has agreed to monitor proactively dental practices' compliance with the display of NHS prices, for example, through the addition of relevant questions to the GP Patient Survey in England¹⁵⁸ and the monitoring of the results to identify dental practices that may be failing to display NHS prices.
- 10.17 The OFT considers that the Department of Health and Social Care in Scotland, the Department for Health, Social Services and Children in Wales, and the Department of Health, Social Services and Public Safety in Northern Ireland should consider similar potential measures to identify dental practices that fail to prominently display NHS dental treatment prices and to bring them into compliance as a matter of priority.

¹⁵⁷ Namely, Primary Care Trusts in England, NHS Boards in Scotland, Local Health Boards in Wales, and the Health and Social Care Board in Northern Ireland. In April 2013, Primary Care Trusts will be abolished and local commissioning of NHS dentistry in England will be held to account by the NHS Commissioning Board.

¹⁵⁸ The GP Patient Survey has been designed to give patients the opportunity to comment on their experience of their GP practice. The survey asks patients about a range of issues related to their local GP surgery and other local NHS services. See www.gp-patient.co.uk.

Patients' ability to compare the quality of service and patient satisfaction levels of different dental practices

- 10.18 Clear, meaningful measures of dentists' quality of service and patient satisfaction would, if made readily available to patients and prospective patients, enable patients to make more active, informed decisions regarding their choice of dentist.
- 10.19 The OFT is pleased that, further to discussions with the OFT, the Department of Health and the NHS Business Services Authority have now agreed to publish the results of NHS patient surveys and measures of patient satisfaction with dental practices on NHS Choices in order to help patients to make more informed choices of dentist.
- 10.20 The OFT considers that the devolved administrations for Scotland, Wales and Northern Ireland should consider similar steps to ensure that existing quality of service and satisfaction indicators for NHS dental practices are similarly made available. Further, the OFT considers that the devolved administrations should extend the content of the NHS 24, NHS Direct Wales and Health & Social Care websites to include patient reviews of dental practices.
- 10.21 The OFT strongly recommends that, in the longer term, the Department of Health publish summary scores of individual dental practices' clinical effectiveness, patient experience, and safety – as measured by the Dental Quality and Outcomes Framework – on NHS Choices as soon as possible and in a format which helps patients to make informed choices between different dental practices. The current publication of similar scores for GP practices on NHS Choices clearly demonstrates that such a step can be practically implemented.

Provision of dental treatment information, including cost, prior to treatment being provided

- 10.22 It is essential that patients are provided with clear information regarding proposed dental treatment, including the cost of the dental treatment, prior to receiving it. Without such information, patient choice is limited

and dentists are unable to obtain patients' informed consent to treatment. Evidence gathered in the course of this market study indicates that there is a clear and concerning gap between regulatory requirements regarding provision of such information and actual practice, to the detriment of patients. As such, there is an urgent need for more proactive monitoring of compliance with regulatory requirements and, where appropriate, enforcement action.

- 10.23 The OFT strongly recommends that the CQC expand the focus of its inspections of dental practices in England to routinely include assessment of whether dental practices provide patients with timely information on the dental treatment they are to receive, including the cost of the dental treatment. We do not consider that it is sufficient for the CQC to assess whether dental practices provide such information only in those cases where the CQC finds evidence that a dental practice does not provide the information. The OFT's research indicates that non provision by dentists of dental treatment information, including the cost of the dental treatment, is a widespread problem which, we consider, warrants more proactive monitoring and enforcement action.
- 10.24 The OFT considers that the inspections of dental practices which are currently carried out in Scotland, Wales and Northern Ireland should also be expanded to include, where they do not already, an assessment of whether dental practices provide patients with timely information on the dental treatment they are to receive, including the cost of the dental treatment in writing.
- 10.25 Specifically, the OFT recommends that inspections of dental practices should include an assessment of whether dental practices consistently provide patients with a written treatment plan which clearly and accurately sets out the dental treatment(s) to be provided, whether each element of the course of treatment is NHS or private dental treatment, and the cost of each individual element of the course of treatment.
- 10.26 The OFT is pleased that the Chief Dental Officer for Scotland has, further to engagement with the OFT, agreed to explore whether Dental Reference Officers in Scotland could be tasked with exploring these

issues in addition to their current responsibilities for inspecting, on behalf of NHS Boards, dentists who provide NHS dental treatment. We welcome such action and strongly recommend similar action across the rest of the UK.

- 10.27 In relation to Scotland, where there is currently no provision for the inspection of private dental provision, the OFT encourages the Scottish Government to expedite its consideration of how to regulate independent healthcare services and ensure that the resultant regulator prioritises ensuring that Scottish dental patients are provided with written treatment plans in advance of receiving dental treatment as outlined in paragraph 10.25 above.
- 10.28 In relation to the provision of NHS dental treatment, the OFT strongly recommends that NHS commissioning bodies are proactive in monitoring whether dental practices consistently provide patients with a treatment plan which includes the cost of the dental treatment at the time of the patients' initial check-up. Where an NHS commissioning body identifies a dental practice that does not consistently provide such information, the OFT strongly considers that the NHS commissioning body should take timely and robust enforcement action to bring the dental practice into compliance and to send a strong deterrent message to dental practices generally.
- 10.29 The OFT considers that it has reasonable grounds for suspecting that the widespread non-provision by dental practices of timely price information about dental treatment constitutes a feature of the dentistry market that prevents, restricts or distorts competition for the supply of dentistry services for the purposes of section 131 Enterprise Act 2002.¹⁵⁹ As such, the OFT could exercise its discretion to make a market investigation reference to the Competition Commission. However, we

¹⁵⁹ Section 131 of the Enterprise Act 2002 gives the OFT the power to make a market investigation reference to the Competition Commission if it has reasonable grounds for suspecting that any feature or combination of features of a market in the United Kingdom for goods or services prevents, restricts or distorts competition.

consider it would not be proportionate to make a market investigation reference at the present time.

- 10.30 Chapter 11 provides further details, and invites views, on the OFT's provisional decision not to make a market investigation reference at the present time.

Provision to patients of inaccurate information regarding entitlement to NHS dental treatment

- 10.31 Evidence gathered in the course of this market study indicates that around 500,000 dental patients each year may be provided with inaccurate information by their dentist regarding their entitlement to receive certain NHS dental treatments. As a result, such patients, where they opt for private dental treatment, are likely to incur considerable additional cost, or, where they choose to forgo the dental treatment altogether, are likely to experience poorer oral health outcomes.
- 10.32 The OFT calls for urgent action to address this issue and strongly recommends that NHS commissioning bodies across the UK (including, in due course, the NHS Commissioning Board in England) are far more proactive in identifying and taking robust and regular enforcement action against dental practices that provide inaccurate information to NHS patients regarding their entitlement to receive certain NHS dental treatments.
- 10.33 Specifically, the OFT strongly recommends that NHS commissioning bodies consistently and more actively apply appropriate sanctions against such dental practices, including the use of remedial notices, the withholding or deducting of monies otherwise payable under the NHS contract and, where appropriate, termination of the dental practice's NHS contract.
- 10.34 The OFT also notes that the Department of Health is currently developing a range of 'clinical pathways' which aim to provide clear guidance to dentists regarding the circumstances under which specific dental treatments should be provided on the NHS to patients. The OFT

urges the Department of Health to make certain that these clinical pathways help to ensure that potential breaches of the NHS dental contract by dentists can be more easily identified and proven.

- 10.35 The GDC considers that any mis-selling by dentists of private dental treatment to NHS patients through the provision of inaccurate information to the patient regarding their entitlement to receive NHS dental treatment may constitute misconduct which amounts to an impairment of the registrant's fitness to practise. However, only 17 cases of this type were considered by the relevant GDC Practice Committee during 2010. The OFT considers that the GDC must take more prompt, regular and robust disciplinary action against dentists who mislead patients regarding their entitlement to NHS dental treatment. Such disciplinary action should aim to send a strong deterrent message to dentists generally.
- 10.36 In order for the GDC to pursue a more rigorous enforcement programme, it is essential that NHS commissioning bodies, where they find that a dentist has provided inaccurate information to patients regarding their entitlement to NHS dental treatment, are proactive in sharing relevant information with the GDC.
- 10.37 Where the OFT becomes aware of a dentist persistently providing misleading information to patients regarding their entitlement to NHS dental treatment, and where relevant bodies, including the GDC and the relevant commissioning body, have failed to take effective remedial action, the OFT and other enforcers, such as local authority Trading Standards Services also have powers to take enforcement action, under consumer protection law, where appropriate.

Sale of dental payment plans

- 10.38 Dental patients who are put under pressure by their dentist to take a dental payment plan are denied the opportunity to make an active, informed choice regarding how they pay for their dental treatment. As a result, they may receive a less suitable product and/or poorer value for money than would have been the case in the absence of such pressure.

- 10.39 The OFT is pleased that, after engagement with the OFT, the BDA has agreed to work with dental plan providers to develop and publish a short code of practice for dentists on the sale of dental payment plans with a view to ensuring that dentists do not put undue pressure on patients to sign up to a payment plan.
- 10.40 In order to help the parties to develop a suitably robust code of practice, the OFT has worked with the BDA to provide clear advice on the necessary steps for dentists to take which the OFT considers would be likely to reduce the risk of dentists breaching the CPRs when selling payment plans. Such steps include, for example, not offering patients a view or opinion on what type of payment method – for example, a dental payment plan or fee-per-item – is most suitable for the patient or seeking to influence which payment method the patient chooses. The OFT's advice to the BDA and dental plan providers on steps that dentists can take that may reduce the risk of breaching the CPRs when selling dental payment plans is included at Annexe G.
- 10.41 The OFT is also pleased to note that, further to engagement with the OFT, the GDC recognises the concerns identified and has agreed to include a signpost to the prospective BDA code of practice from the GDC's revised guidance for dentists on compliance with its Standards for Dental Professionals. The GDC will consult on its revised guidance and standards during 2012 with a view to introducing these in early 2013.
- 10.42 Once the BDA code of practice and revised GDC standards and guidance are in place, we urge the GDC to ensure appropriate enforcement action is taken against pressure selling of dental payment plans by dentists.

Provision of appropriate redress by dental practices

- 10.43 It is essential that dental practices consistently provide appropriate redress to patients to whom they provide defective or faulty dental treatment. Without such redress, patients can experience considerable financial detriment where they are required to pay to have problems rectified.

- 10.44 On the basis of the evidence gathered during the course of this market study, the OFT can see no reason why the guarantee which applies to NHS dental treatment should not also apply to private dental treatment.
- 10.45 The OFT is pleased that, further to engagement with the OFT, IDH and Oasis – the two largest corporate dental groups in the UK¹⁶⁰ – have voluntarily agreed that their dental practices will provide patients with a one year guarantee against the failure of private dental treatment, thus matching the standard guarantee on NHS dental treatment.
- 10.46 The OFT recommends that the GDC, as part of their current review of their Standards for Dental Professionals, introduce a requirement that dentists should, in relation to private dental treatment they provide, match the current guarantee which applies to NHS dental treatment. The OFT is pleased to note that, further to engagement with the OFT, the GDC has agreed to include such a provision within the revised Standards for Dental Professionals on which it will consult during 2012 with a view to introducing in early 2013.

The dental complaints system

- 10.47 The fragmented and complex nature of the current system for dealing with dental complaints that are not resolved by dental practices imposes unnecessary burdens on patients and dentists.
- 10.48 In order to reform the dental complaints system to make it simpler, easier and less time consuming for patients and dentists, the OFT recommends that either a single body should be responsible for dealing with patient complaints which have not been satisfactorily resolved by a dental practice or, alternatively, a single patient-facing portal for the reporting of complaints should be developed.
- 10.49 Such a body or complaints portal should be developed so as to ensure that patients can simply and easily report any complaint not resolved at

¹⁶⁰ By number of dentists and dental practices, according to Laing and Buisson, *ibid*.

practice level once and to a single source, regardless of whether the dental treatment was carried out on the NHS or privately.

- 10.50 The OFT is pleased to note that, in England, the Parliamentary and Health Service Ombudsman has begun to explore the potential development of a single complaints portal and has undertaken some early discussion regarding this issue with other bodies. The OFT welcomes such action and urges relevant bodies to engage constructively to facilitate potential reform of the dental complaints system.

The NHS dental contract as a barrier to entry and expansion

- 10.51 Dental practices are profit-seeking businesses and, in order for the dentistry market to work effectively and efficiently, incumbent dental practices must face competitive pressures.
- 10.52 The widespread award of non-time-limited NHS dental contracts to incumbent dental practices in England in 2006 has had the effect of insulating such practices from competition. Opportunities for potential new innovative dental practices to enter the market are limited, good dental practices face high barriers to expansion and, as a result, poor performing dental practices face limited incentives to improve in order to retain and attract patients. This situation does not facilitate good patient outcomes or good value for money for the NHS.
- 10.53 The Department of Health is already engaged in a process of reform of the current NHS dental contract. In the OFT's view, it is vital that the Department of Health, in redesigning the NHS dental contract, gives due consideration to the principles of patient choice and the facilitation of entry into the dentistry market by new innovative dental practices and expansion of high performing dental practices.
- 10.54 A potential means of achieving this end, which the OFT urges the Department of Health to consider, is to facilitate a system in which 'any qualified provider' may enter the market and deliver NHS services to patients. NHS payments would follow the patient so that those dentists

who deliver higher quality services and attract new patients would receive greater compensation.

10.55 The OFT considers that the Department of Health, when redesigning the new NHS dental contract, must also take action to reduce barriers to entry and expansion in the dentistry market by bringing an end to non-time-limited NHS dental contracts and by replacing such contracts with time-limited contracts. The length of the contracts must balance far more the need to incentivise investment by dental practices with the need to facilitate potential entry and expansion in the market. The OFT report 'Commissioning and Competition in the Public Sector'¹⁶¹ provides guidance to commissioners and procurers of public services regarding how they may leverage competition to create open and contestable public services markets that create incentives for suppliers to increase efficiency, improve quality of service provision and innovate.

10.56 The OFT considers that it has reasonable grounds for suspecting that the barriers to entry and expansion created by the NHS dental contract in England constitute a feature of the dentistry market that prevents, restricts or distorts competition for the supply of dentistry services for the purposes of section 131 Enterprise Act 2002.¹⁶² As such, the OFT could exercise its discretion to make a market investigation reference to the Competition Commission. However, we consider it would not be proportionate to make a market investigation reference at the present time.

10.57 Chapter 11 provides further details, and invites views, on the OFT's provisional decision not to make a market investigation reference at the present time.

¹⁶¹ 'Commissioning and Competition in the Public Sector' (OFT1314), OFT, 2011, www.of.gov.uk/OFTwork/research/strategicresearch/commissioning-competition/.

¹⁶² Section 131 of the Enterprise Act 2002 gives the OFT the power to make a market investigation reference to the Competition Commission if it has reasonable grounds for suspecting that any feature or combination of features of a market in the United Kingdom for goods or services prevents, restricts or distorts competition.

Tendering of NHS dental contracts

- 10.58 Evidence gathered during the course of this market study indicates that tendering processes for new NHS dental contracts, where they become available, can be unnecessarily lengthy and complex and favour certain types of bidder. As a result, the tendering processes for NHS dental contracts can act as a further barrier to entry into the dentistry market.
- 10.59 The OFT recommends that, in the short term, the commissioning of dental services should be streamlined across PCTs (in due course, the NHS Commissioning Board) and priority should be given to ensuring that dental contracts are appropriately advertised to prospective market entrants. In addition, the tender and evaluation process should be transparent and constructive feedback should be provided to bidders.
- 10.60 The OFT is pleased to note that, further to engagement with the OFT, the NHS Commissioning Board Special Health Authority has agreed to implement a more streamlined procurement process for the commissioning of NHS dental contracts in England.

Direct patient access to dental care professionals

- 10.61 On the basis of evidence gathered in the course of this market study, the OFT does not believe there is any objective justification for the current restrictions on direct patient access to DCPs. We also do not recognise any objective justification for the lack of progress on this issue given the OFT's recommendation in 2003 that such restrictions should be brought to an end.
- 10.62 The OFT calls on the GDC to review and remove restrictions on direct patient access to DCPs urgently. The exact nature of how direct access is implemented is a matter for the GDC to decide, but the OFT calls on the GDC to implement appropriate changes without further delay and cost to both patients and the dental profession. The OFT will actively engage with, and contribute evidence to, the working group that the GDC has set up to consider direct access to DCPs. We understand that, further to consideration by the working group, the GDC expects to make

a decision regarding the restrictions on direct patient access to DCPs in March 2013. The OFT will closely monitor the GDC's progress and its decision.

- 10.63 The OFT considers that it has reasonable grounds for suspecting that the current restrictions on patient access to DCPs constitute a feature of the dentistry market that prevents, restricts or distorts competition for the supply of dentistry services for the purposes of section 131 Enterprise Act 2002.¹⁶³ As such, the OFT could exercise its discretion to make a market investigation reference to the Competition Commission. However, given that the GDC has formed a working group to consider the issue of direct access, we consider it would not be proportionate to make a market investigation reference at the present time.
- 10.64 The OFT will closely monitor the GDC review and, should the GDC not conclude, by spring 2013, that restrictions on direct patient access to DCPs should be lifted, we will review our position and consider the appropriate course of action to be taken.
- 10.65 Chapter 11 provides further details, and invites views, on the OFT's provisional decision not to make a market investigation reference at the present time.

Improving patients' awareness of their rights and increasing patient engagement

- 10.66 Evidence gathered by the OFT during the course of this market study indicates that, in general, dental patients tend to have low awareness and understanding of their rights in the dentistry market. Previous OFT research into the drivers of business compliance with consumer law has found that informed consumers asserting their rights can have a

¹⁶³ Section 131 of the Enterprise Act 2002 gives the OFT the power to make a market investigation reference to the Competition Commission if it has reasonable grounds for suspecting that any feature or combination of features of a market in the United Kingdom for goods or services prevents, restricts or distorts competition.

significant impact on business behaviour and are a key driver of business compliance.¹⁶⁴

10.67 To complement the actions to be taken by other bodies, as set out above, the OFT will, in partnership with organisations including Which?, Citizens Advice, and NHS Choices and devolved nation equivalents, develop and disseminate patient education materials targeted at improving dental patients' awareness and understanding of key features of the dentistry market. The education materials will focus on:

- how to find and choose an NHS dentist
- what information the dentist should provide
- entitlement to NHS dental treatment
- rights to redress and how to complain when things go wrong.

10.68 The patient education materials will be disseminated via the OFT's and partner organisations' communications channels from June 2012.

¹⁶⁴ See www.oft.gov.uk/OFTwork/policy/drivers.

11 CONSIDERATION OF A MARKET INVESTIGATION REFERENCE

11.1 This chapter sets out the reasons why the OFT considers that it would not be appropriate to make a market investigation reference regarding the dentistry market to the Competition Commission (CC) at the current time and invites views on this proposed decision.

The reference test and the OFT's discretion regarding whether to make a reference

11.2 In order to make a market investigation reference, the OFT must have reasonable grounds for suspecting that any feature, or combination of features, of a market in the UK for goods or services prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the UK or a part of the UK ('the reference test').¹⁶⁵ Where the reference test is met, the OFT has discretion as to whether in fact to make a reference.¹⁶⁶

11.3 The OFT has stated that it will only make a reference to the CC when the reference test and, in its view, each of the following criteria have been met:

- it would not be more appropriate to deal with the competition problems identified by applying the Competition Act 1998 or using other powers available to the OFT or, where appropriate, to sectoral regulators
- it would not be appropriate to address the problems identified by means of undertakings in lieu of a reference

¹⁶⁵ The reference test is set out under section 131 of the Enterprise Act 2002, available at www.legislation.gov.uk/ukpga/2002/40/section/131.

¹⁶⁶ See 'Market investigation references: Guidance about the making of references under Part 4 of the Enterprise Act', OFT (2006), available at: www.of.gov.uk/shared_of/business_leaflets/enterprise_act/of511.pdf.

- the scale of the suspected problem, in terms of its adverse effect on competition, is such that a reference would be an appropriate response to it
- there is a reasonable chance that appropriate remedies will be available.¹⁶⁷

Provisional decision not to make a market investigation reference

11.4 We consider that the following features of the dentistry market meet the reference test:

- dental practices not displaying NHS dental treatment prices or making private dental treatment prices available in their practices
- barriers to entry and expansion in the dentistry market in England created by the current NHS dental contract
- restrictions on direct patient access to DCPs.

11.5 However, having considered the features identified in this market study in the context of the above criteria, we do not think that a reference to the CC would be appropriate at the present time for the reasons set out below.

Dental practices not displaying NHS dental treatment prices or making private dental treatment prices available in their practices

11.6 The OFT must consider the scale of an identified feature in terms of its adverse effect on competition in determining if a reference would be an appropriate response.

¹⁶⁷ OFT (2006), *Ibid*, paragraph 2.1.

- 11.7 The OFT has stated that the persistence of the feature giving rise to adverse effects on competition will be relevant to the OFT's consideration of the scale of the problem.¹⁶⁸ In this context, in relation to dental practices not displaying NHS dental treatment prices or making private dental treatment prices available in their practices, we note that key bodies, namely the NHS Commissioning Board Special Health Authority and the GDC have agreed to take relevant action to improve the provision of price information relating to dental treatments to patients, as set out in Chapter 10, in order to address the OFT's concerns in the short term.
- 11.8 As such, the OFT does not consider that the scale and likely persistence of this feature of the dentistry market is sufficient for a market investigation reference to be proportionate at this point in time.
- 11.9 Further, in the context of availability of remedies, the OFT notes that the powers of both the OFT and the CC extend only as far as making recommendations to NHS commissioning bodies, and the GDC with regard to the enforcement of the existing requirements, or, to the Department of Health regarding any changes to the existing requirements.

Barriers to entry and expansion in the dentistry market in England created by the current NHS dental contract

- 11.10 In considering the persistence of the issues regarding barriers to entry and expansion in the dentistry market which result from the current NHS dental contract in England, we note that the existing NHS dental contract in England is being re-designed by the Department of Health and a new contract is likely to be introduced in the medium term. As such, the OFT does not consider that the scale and likely persistence of this feature of the dentistry market is sufficient for a market investigation reference to be proportionate at this point in time.

¹⁶⁸ OFT (2006), *Ibid*, paragraph 2.28.

- 11.11 Further, in the context of availability of remedies, the OFT notes that the powers of both the OFT and the CC extend only as far as making recommendations to the Department of Health regarding changes to the NHS dental contract.
- 11.12 As such, the OFT considers it more proportionate to use competition advocacy to engage with the Department of Health, to seek to ensure that the recommendations set out in Chapter 10 of this report, regarding reform of the NHS dental contract, are prioritised and considered in depth by the Department of Health. The OFT will monitor the progress made by the Department of Health in pursuing redesign of the NHS dental contracts in England closely.

Restrictions on direct patient access to DCPs

- 11.13 In considering the persistence of the issues regarding restrictions on direct patient access to DCPs which result from current GDC regulations, we consider that the restrictions can be relatively swiftly addressed by the GDC acting to implement the relevant recommendation set out in Chapter 10 of this report. In this context, the OFT notes that the GDC has now initiated a review of these restrictions which is due to conclude in spring 2013. The OFT will closely monitor the progress of this review and will review its position and consider the appropriate course of action to be taken once the GDC has made its decision.
- 11.14 Further, in the context of availability of remedies, the OFT notes that the powers of both the OFT and the CC extend only as far as making recommendations to the GDC regarding changes to the GDC regulations governing direct access or to the Department of Health regarding changes to the legal framework governing the operation of the GDC.
- 11.15 As such, the OFT does not consider that the scale and likely persistence of this feature of the dentistry market is sufficient for a market investigation reference to be proportionate at this point in time.

The UK dental market

11.16 We have also considered whether, taking all the features detailed above together, it would be a proportionate reference for a market investigation reference of the dentistry market at this point in time.

11.17 The OFT has noted that:

- in relation to dental practices not displaying NHS dental treatment prices or making private dental treatment prices available in their practices: the NHS Commissioning Board Special Health Authority and the GDC are taking action in order to address the OFT's concerns in the short term
- in relation to the barriers to entry and expansion in the dentistry market which result from the current NHS dental contract in England: the existing NHS dental contract in England is being re-designed and a new contract is likely to be introduced in the medium term
- In relation to the restrictions on direct patient access to DCPs which result from current GDC regulations: the GDC has now initiated a review of these restrictions which is due to conclude in spring 2013.

As such, the OFT does not consider that the scale and likely persistence of these features of the dentistry market is sufficient for a market investigation reference to be proportionate at this point in time.

11.18 In the context of availability of remedies, the OFT notes that the powers of both the OFT and the CC in these matters extend only as far as making recommendations to the relevant bodies (as detailed above).

11.19 As such, the OFT does not consider that the scale and likely persistence of these features of the dentistry market are sufficient for a market investigation reference to be proportionate at this point in time, and in relation to barriers to entry, we believe it to be more proportionate to use competition advocacy to engage with the Department of Health, to seek

to ensure that the recommendations set out in Chapter 10 of this report, regarding reform of the NHS dental contract, are prioritised and considered in depth by the Department of Health.

Conclusion and consultation on the OFT's provisional decision

- 11.20 In view of the factors set out above, the OFT has provisionally decided that it should not exercise its discretion to make a market investigation reference in relation to the dentistry market at the present time.
- 11.21 We are consulting on our provisional decision not to make a reference to the CC. Responses to the consultation must be made in writing and can be emailed to dentistry@oft.gsi.gov.uk by 5pm on 10 July 2012. Alternatively, they can be sent by post to:
- Dentistry Market Study Consultation (Floor 8C)
Office of Fair Trading
Fleetbank House
2-6 Salisbury Square
London EC4Y 8JX
- 11.22 We will consider any responses received and will publish our final decision on a market investigation reference in due course.