
Super-complaint on private dentistry: preliminary findings on the issues raised by the Consumers' Association

23 January 2002

I INTRODUCTION

On 25 October 2001 the Consumers' Association (CA) submitted a super-complaint to the Office of Fair Trading (OFT) about private dentistry, alleging that competition in this sector was ineffective and identifying a number of core problems worthy of further investigation. These are:

- (a) a lack of price transparency in the provision of private treatment;
- (b) a failure of competition in the provision of private treatment;
- (c) a failure of new entry to the market for private dental provision to bring down prices;
- (d) lack of a system for dealing with consumer complaints and offering suitable redress for private dental treatment;
- (e) the impact which the lack of access to NHS treatment is having on competition in the provision of private dental treatment;
- (f) a failure by dentists to comply with guidance produced by the British Dental Association.

2 FINDINGS FROM PRELIMINARY ENQUIRIES AND RESEARCH

Outlined below are the findings from our preliminary enquiries, analysis and research on each of the above mentioned points.

(a) Price transparency

Price transparency is essential to enable consumers to make rational choices between dentists and types of treatment on offer. It is a prerequisite for effective competition either between private dentists or between NHS and private treatments. We have considered the evidence provided by the CA's research and other survey evidence, including that provided to us by the Warwickshire Trading Standards Service (WTSS) and have concluded that there is a need for further investigation into the availability of price information for private dental treatment. The WTSS survey found that only two out of 20 dental practices provided a list of prices that was made available to private patients.

The British Dental Association (BDA) in a statement following the announcement of the super-complaint said, "the association has consistently advised dentists to give typical price indications as a guide to the general charging levels in a practice". We will gather further evidence to establish the extent to which this BDA advice is being followed.

(b) Competition

We agree that a wide variation in cost for seemingly comparable services in a market can indicate that charges levied are not governed by the prices charged by other suppliers or by the costs of doing business, and therefore that the market is not subject to effective competition. The extent of price dispersion shown by the CA's survey work provides grounds for further investigation.

(c) New entry

In many markets new entry imposes a competitive restraint on the behaviour of suppliers. However, reference is made in the CA's super-complaint to the entry of new high street dental chains and the fact that this has not resulted in a reduction of charges or greater price transparency in private dentistry. As part of our further investigation we will look closely at the constraints and incentives to provide new services.

While there has been some new entry into the sector, this has been at a time of growth in the demand for private dental treatment due, at least in part, to the difficulty in some areas of the country in obtaining NHS treatment. There has also been some growth in demand for cosmetic dentistry (such as tooth whitening) and this forms a larger part of

the work of some dental chains than general dentistry. Such chains may not therefore be in direct competition with other dentists in the same locality.

Despite some increase in the number of outlets operated by dental chains, a significant growth in supply of dental services by corporations has been prevented by dental legislation, which restricts entry to those corporations that were incorporated before 21 July 1955. As a result, there are only 27 dental corporations. The Department of Health (DoH) has indicated that it will abolish this manifest restriction on competition. We welcome this, as it will open the market to potential new service providers.

While the proportion of private dental treatment provided under capitation schemes¹ has increased (now accounting for almost one fifth of private dentistry), it is not clear whether this has improved competition. Such schemes are primarily concerned with the method and process of payment for treatment, rather than the provision itself. Capitation schemes may have had the effect of increasing the amount of private treatment, as dentists might have found it easier to get patients to switch from their previous arrangement, where they can offer this by means of a regular monthly payment. It is possible that capitation schemes could in future constrain dentists' fees through buyer power exercised by the providers of such schemes, and we will need to examine this issue further.

(d) Redress and complaints handling

Consumer access to user-friendly, inexpensive and timely redress mechanisms is a fundamental element of the government's consumer policy. Following a consultation exercise involving the General Dental Council (GDC), the BDA and the Dental Defence Union, the Department of Health now proposes to introduce a service for the investigation of complaints about private dentistry. This will be operated by the GDC. A change in legislation will be required. In considering competition in the provision of dental treatment we will consider the likely impact of the proposed complaints system. We currently have no comprehensive evidence about the frequency and resolution of complaints in the private dental sector, and we hope to gather this information during the course of our investigation.

¹ Capitation schemes are a type of dental insurance plan involving a scheme provider which collects regular monthly payments from individual dentists' patients registered under the scheme and makes payment to individual dentists for treatment undertaken.

(e) Access to NHS treatment

In principle, NHS treatments could act as constraint on the prices charged for private dentistry. This however depends on the patient having access to the appropriate NHS treatment. From the evidence that we have considered, in many areas of the country, reduced access to NHS treatment is likely to have decreased the competitive pressure on private dentistry. Where there are limited competitive pressures from NHS dentistry, effective competition between dentistry suppliers becomes all the more important for consumers.

The increasing demand for private dentistry results in part from many dentists no longer taking on new NHS patients and no longer treating adults on the NHS. A survey undertaken by the BDA in 1993 found that 75 per cent of dentists in the General Dental Service received at least three-quarters of their income from the NHS, and just twelve per cent received less than a quarter from that source. By 1999, those figures had changed to fifty eight per cent and eighteen per cent respectively. Such figures demonstrate the extent to which dentists are now spending their time providing private treatment.

The DoH strategy paper on dentistry, 'Modernising NHS Dentistry' (September 2000), stated that at that time approximately one third of Health Authorities reported serious problems in finding dentists for at least some of their residents. Research published in the *British Dental Journal* in February 2001 provided further evidence of access problems in some parts of the country. This research indicated wide regional variation in the proportion of private treatment. The median percentage of private patients was around 50 per cent in the south east and south west, 30 per cent in London, 20 per cent in the West Midlands and eastern counties and less than 10 per cent elsewhere.

The DoH advised us that there has been some improvement in the level of access to NHS dental treatment since the measures outlined in the strategy paper. The level of NHS provision as such is not a matter for the OFT. The fact that some patients are unable to obtain NHS treatment does nevertheless increase the importance of ensuring effective competition in private treatment. We will therefore examine thoroughly the impact of reduced access to NHS treatment on the supply of private dental treatment. What matters ultimately is the service that the consumer gets.

(f) Failure of guidance

The principal guidance to dentists is set out in the GDC's 'Maintaining Standards: Guidance to Dentists on Professional and Personal Conduct'. This guidance includes the need to keep patients advised on treatment plans, estimates and costs. The guidance is however recommended practice: it does not cover conduct that could lead to disciplinary action. We have discussed the guidance with the BDA who regard it as an essential working tool for its members. The BDA also issues its own complementary guidance.

Evidence we have collected supports the CA's observation that some dentists are not complying with aspects of this GDC guidance. For example, in a survey conducted by WTSS of participants receiving private treatment, half were not informed of the total cost of treatment before it was completed. The figure for NHS treatment was even higher. Almost two-thirds of those having mixed NHS/private treatment did not receive a written plan or estimate. However, most dentists questioned by WTSS stated that they gave clear information on costs and the treatment plans. Compliance by dentists with professional guidance will be examined as part of the proposed wider OFT investigation.

3 PROPOSED ACTION BY OFT

As stated in the covering letter we propose to use powers under section 2 of the Fair Trading Act 1973 to undertake a wider investigation into the market for private dental treatment. The OFT's Markets and Policy Initiatives Division will conduct the investigation drawing in support from across the OFT as necessary.

As part of this investigation, any practices that came to light that may require investigation under competition law would be referred to the OFT's Competition Enforcement Division. Also we will consider whether improved enforcement using existing consumer protection powers could help to overcome any problems that may be identified.

We will be consulting key players such as the GDC, BDA, and the DoH to see whether changes to existing guidance or its observance could be improved. We will also talk to bodies representing patients and others with an interest in this market.

Our investigation of the market for private dental treatment will look not only at the specific issues identified by the super-complaint, but also at wider issues. These include the structure of the market for dentistry, the factors which influence patients' choice of dentist and the source of patients' seeming reluctance to switch dentists, and whether this is a major factor inhibiting competition.

As to the research and other methods of data collection that our investigation will require, an important element will be a consumer survey to obtain information on how patients go about choosing a dentist, the information available to them in doing so and their experiences of private dental treatment.

At the end of the investigation we will produce a report presenting our findings, summarising the evidence on which this is based and, where relevant, making recommendations make the market for private dental treatment work better for consumers. This report will be published by the end of the year.

OFT
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