

Survey of dental practices

Prepared by the Office of Fair Trading this survey report is supplementary information to OFT630 – The private dentistry market in the UK.

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PRACTICE SURVEY: SUMMARY

In many respects, the dental practices surveyed have characteristics of typical small businesses, with an average of eight staff – though individual practices were found to range from 1 person to 38 person operations – made up of about 2-3 dentists, and 5-6 others. This latter group commonly includes 1 or 2 qualified staff, usually nurses but often hygienists too. Comparisons with external data sources suggest that the practices that replied to our survey were a little larger than the national average.

Typical turnover was around £300k per year although some larger practices with turnover above £2 million per year and a small number under £100k per year were found in the sample. In the most recent two years, spending on new clinical and other equipment each year was of the order of five per cent of turnover, and for the most part the businesses appeared to have no problems in securing finance for their business needs.

Average prices for private treatment were at least double and sometimes treble the level for their NHS equivalent, and showed signs of considerable variability. Regardless of price levels, it is important for consumers to have ways of making comparisons in both price and quality to ensure they can identify good value for money. So information about prices and product are particularly important, but for a substantial proportion of practices, the provision of information to patients was poorly handled.

This was true for both general information, and for information specific to the patient and their course of treatment. Little information was reported to be on display at the practice for either private or NHS patients. It was encouraging that almost three-quarters of practices reported having a practice leaflet, but an examination of those submitted found that the contents were patchy. Generally good on the basics like location and opening hours, other issues like prices, payment arrangements, charges for broken appointments, and what to do in case of complaint were often absent.

For information specific to individual courses of treatment, a proportion of practices were content to rely on verbal communication about what was going to happen and about the cost of the treatment, rather than use written treatment plans. After completion of the treatment too many either present no invoice or only one that provided a total rather than itemised figure.

Encouragingly complaints were rare, although here again there was a marked preference to handle them by discussion rather than use more formal processes. Nevertheless most practices were able to report having some form of system for handling complaints, often modelled on the NHS procedure. Though most complaints appeared to be resolved satisfactorily, a small group seemed simply to grind to a halt without the complaint being withdrawn by the complainant on the one hand, and

without any redress or remedial action by the dentist on the other. While unjustified complaints will arise, these are potential cases of inadequate redress.

As a final stage, linear models were fitted to the data to see if any of the main characteristics of the practices could be seen to explain some of the price differences. Some factors did emerge as important, but the relative size of the differences were modest compared to the overall variability noted above. No link could be established between spending levels on new clinical and other equipment and prices.

1 BASIC INFORMATION: SIZE AND STRUCTURE OF THE SAMPLE

- 1.1 The questionnaire was sent to approximately 2,200 practices throughout the United Kingdom. The sample was clustered, drawn from randomly selected postcodes areas, with probability of selection proportional to the number of practice addresses in that post code area. Where returns are proportional to the number of practices, this type of population weighting produces data where simple sample means and statistics are unbiased estimators of the true population values. This analysis was prepared using 848 completed forms returned to OFT, representing about a 38 per cent response rate.
- 1.2 There can never be any guarantee that the study is free of non-response bias, that is a tendency for those who returned forms to hold different views to those who did not. There was no evidence of any particular bias in the responses from different parts of the country, although overall there appeared to be a degree of under representation from England and Wales and a degree of over representation from Scotland and Northern Ireland. On this basis, the results are unweighted
- 1.3 There was some evidence that the practices that completed and returned the questionnaire were a little larger than the national average, in terms of the number of dentists and the number of patients. This is discussed more fully in section 3, from paragraphs 3.3 onwards.
- 1.4 Not all the forms were completed in full. Where appropriate tables and chart indicate the number of responses included in the analysis. Of the 848 completed forms, 22 reported that they were dental bodies corporate, and 55 that the practice formed part of a group. There was no overlap between these two latter categories.

TABLE 1.1: SAMPLE STRUCTURE: DENTAL BODIES CORPORATE AND GROUP PRACTICES

	Number / %					
	Part of group		Others		All	
Dental body corporate	0	0%	22	3%	22	3%
Others	55	6%	771	91%	826	97%
All	55	6%	793	94%	848	100%

2 STAFFING

- 2.1 The average number of staff in the practices was just under eight, and again on average, made up of five full-time and three part-time staff. But practice size was highly variable and in this survey at a minimum included a number of single person operations, and at a maximum one practice employing 38 people in total.
- 2.2 Overall dentists made up 30 per cent of these staff, with other qualified staff – hygienists and nurses - making up 35 per cent and the remaining 35 per cent made up of unqualified support staff such as receptionists and cleaners. The dentists could be further subdivided into 55 per cent who owned the practice either outright or jointly, or were partners in the practice and 45 per cent working as associates or assistants. Results are summarised in table 2.1 below.

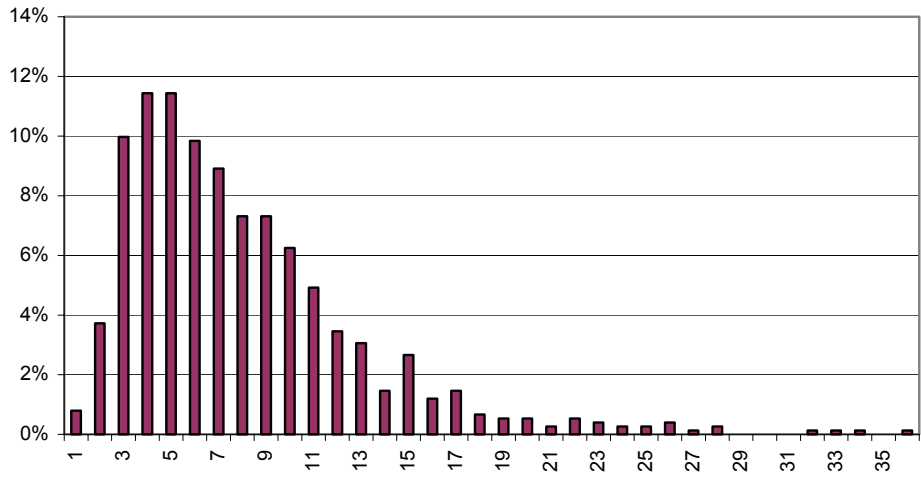
TABLE 2.1: STAFF NUMBERS

	Persons		
	Average	Minimum	Maximum
Dental staff	2.4	1	18
Other qualified staff, nurses, hygienists	2.8	0	15
Other non qualified staff	2.8	0	17
All staff	8.0	1	38
Of which:			
Full time	4.8	0	27
Part time	3.2	0	20

- 2.3 Independent data sources suggest that there may be about 11,000 dental practices in operation within the United Kingdom, and some 22,000 practitioners [*BDA Dental Business Trends Survey*, British Dental Association, 2001]. In nominal terms, it can be calculated that this provides for an average of two practitioners at each practice, although in reality as some dentists may work at more than one location the true figure may be slightly greater than two.
- 2.4 The distribution of practice size is shown below in chart 2.2. Note that while the average size is eight members of staff, the distribution is skewed and the

commonest size of practice is a little smaller than the average at four or five members of staff.

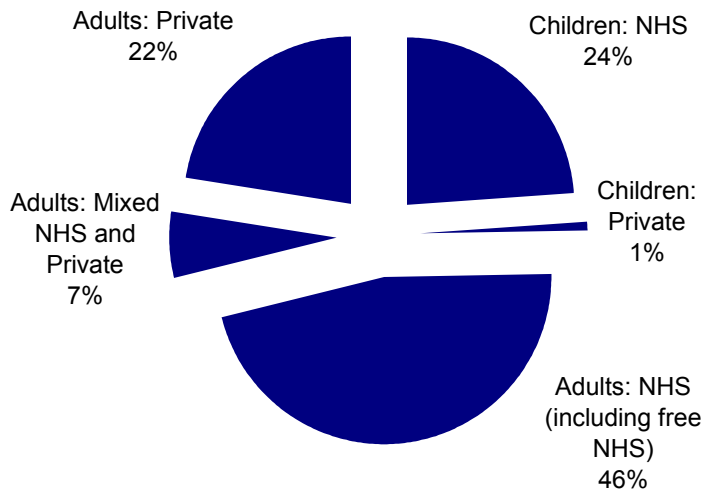
CHART 2.2: DISTRIBUTION OF PRACTICE SIZES: TOTAL STAFF NUMBERS



3 PATIENT NUMBERS

- 3.1 About 700 returns provided details of patient numbers, although a number limited the information provided to just the total number of registered patients so that about only 660 returns provided a detailed breakdown into types of patient. The average number of registered patients per practice based on totals was 4,009. The group providing full details was similar, averaging 3948.
- 3.2 The treatment of children as purely private patients is rare. In this sample, about 25 per cent of the registered patients were children, but only three per cent of the children - equivalent to one per cent of patients overall - were children registered for private treatment. Among the adults, patients registered for NHS treatment (including cases where the treatment was free) amounted to 46 per cent of all patients, but 62 per cent of adult patients. Those receiving purely private treatment made up 22 per cent of all patients but 30 per cent of adult patients. These results are illustrated in chart 3.1 below.

CHART 3.1: PRACTICE SURVEY: PATIENTS BY TYPE



- 3.3 To check the consistency of this survey with other sources, we make use of several results can derive the following average results. In our sample, the average number of dental practitioners was 2.42 overall treating an average of about 4,000 patients. From the survey results on the mix of patients, we can also estimate that on average each practice taking part had around 960 child NHS patients and 2,120 adult NHS patients. Full results are shown in table 3.1.

TABLE 3.1: PATIENTS PER PRACTICE: OFT PRACTICE SURVEY

Patient type	%	Per practice
Children: NHS	23.9	960
Children: Private treatment	0.7	28
Adults: NHS or mixed	53.0	2120
Adults: Private treatment	22.4	896
All	100.0	4000

3.4 As noted above in paragraph 2.3, independent data sources suggest that there may be about 11,000 dental practices in operation within the United Kingdom, and some 22,000 practitioners. Combining the first of these two estimates with figures from Department of Health and other devolved governments on NHS dental patients in continuing care provision in the UK we obtain the results presented below in table 3.2.

TABLE 3.2: PATIENTS PER PRACTICE: INDEPENDENT ESTIMATES

Patient type	Total (thousands) 1	Per practice 2
Children: Registered for NHS treatment	8,283	750
Adults: Registered for NHS treatment	20,469	1860

1 Estimate for year 2000: NHS dental patients in continuing care provision in the UK: Department of Health, Central Services Agency for Northern Ireland and ISD Scotland, the National Assembly for Wales

2 Based on estimates of 11,000 practices in the UK as above

3.5 A comparison of table 3.1 and 3.2 suggests that the practices providing returns to the OFT questionnaire were a little larger than the national average, in terms of both patient numbers and, as discussed in paragraph 2.3, the number of dentists at each practice.

3.6 In the OFT practice survey the number of dentists appeared to be about 20 per cent higher than expected, the number of children receiving NHS treatment

about 27 per cent higher, and the number of similar adults about 15 per cent higher. Under the assumption that similar ratios apply for private patients, sensible upper and lower limits for the estimates would suggest between 7.8 and 8.6 million adults registered for private treatment.

- 3.7 The Adult Dental Health Survey in 1998 provided estimates of the proportion of dentate adults, proportion attending for regular check ups, and the proportion that had private treatment at their last visit. Based on this and population estimates it can be estimated that about 4.3 million adults were then undergoing regular private treatment. Growth in expenditure between 1998 and 2002 amounted to 63 per cent in all or an average of about 13 per cent each year [MSI data survey]. To the extent that increased patient numbers has driven this growth, the 4.3 million could have grown to close to 7.0 million.
- 3.8 While exact figures are not available it appears that the number of adults undergoing regular private treatment in 2002 may be approaching 7 million. The total number of adults registered for private treatment may plausibly be between 7.8 and 8.6 million, although the source of these estimates does not indicate the extent to which some of these patients may be attending treatment only irregularly. In addition, practices estimated that about seven per cent of patients registered for NHS treatment chose on occasions to have some treatment done privately. On the same basis as the calculations above this is equivalent to about 2.5 million adults.

4 NEW PATIENTS

4.1 Among the practices in this survey, 18 per cent reported accepting no new patients of any kind at the time the survey was conducted. On the other hand 20 per cent reported accepting all types of new patients, regardless of age or payment system, that is including NHS patients qualifying for free treatment. The remaining 62 per cent reported accepting some types of new patient, but not others.

4.2 Overall acceptances levels were as shown in the table below. Clearly there was a higher proportion of practices accepting purely private patients than NHS. More practices reported being willing to take children for treatment under NHS where they were the children of private patients than were willing to take children under other circumstances.

TABLE 4.1: ACCEPTANCE LEVELS OF NEW PATIENTS: BY PATIENT TYPE: ALL PRACTICES

	Percent	
	No	Yes
Adults: Free NHS	51%	49%
Adults: NHS	59%	41%
Adults: Private	21%	79%
Children: Private	49%	51%
Children: PP Children for NHS	36%	64%
Other children	48%	52%

4.3 However, excluding those who were not accepting patients of any type, most show a clear willingness to accept new private patients, but the proportion accepting other patients is more moderate. Full information is given in table 4.2 below, where notably higher proportions are prepared to accept new adult patients for private treatment, than children either for private treatment or for NHS treatment where the parent is already private.

TABLE 4.2: ACCEPTANCE LEVELS OF NEW PATIENTS: BY PATIENT TYPE: LIMITED TO PRACTICES ACCEPTING SOME TYPES OF NEW PATIENT

	Percent	
	No	Yes
Q9: Adults: Free NHS	42%	58%
Q9: Adults: NHS	51%	49%
Q9: Adults: Private	9%	91%
Q9: Children: Private	39%	61%
Q9: Children: PP Children for NHS	26%	74%
Q9: Other children	38%	62%

4.4 Taking the responses in combination it was possible to identify those practices accepting only new private patients. Looking just at adult patients, and excluding practices not accepting any new patients, it was found that 39 per cent were restricting their acceptance of new adult patients to private treatment only. For children the situation was more complicated. Of practices accepting new patients of some type, 64 per cent would accept children generally. It was not found to be common to restrict the acceptance of children to those having purely private treatment. This was the case for just nine per cent of practices. The commonest form of selective behaviour was to accept children for NHS treatment only where the parent was already a private patient, but not accept children for NHS treatment more generally. This was found for 27 per cent of practices.

4.5 It was also apparent that the prevalence of selective acceptance was not uniform across the country. Within the local clusters used as part of the sampling, there was a greater degree of uniform behaviour than would be expected. Purely as example, some clusters in Scotland contained no practices selectively taking only adult private patients, and similar cases were also found in Northern Ireland and locations in northern England. Generally - though not invariably - certain clusters in the South contained more dentists exercising this option that would be consistent with a uniform 39 per cent across the country. This is certainly not to be interpreted in any way as collusion. However, it does confirm that different market conditions tend to apply in different areas.

- 4.6 Just 13 practices or about 1.5 per cent of the sample reported charging new patients a registration fee. The level of the fee was variable, from a minimum of £10 to a maximum of £60 and averaging just over £20 where charged. For private patients, it is a simple commercial choice for the dentist whether or not to charge registration fees. However, it should be noted that such fees are not permitted for NHS registrations.
- 4.7 Approximately half of practices indicated that they used advertising to attract new patients. Naturally some practices used more than one method. Overall, the most common approach was the use of directories, such as Yellow Pages or Thompson Local. Other forms of advertising were less commonly used. The use of the Internet had reached a surprising 14 per cent of practices, though its effectiveness is somewhat dependent on the degree to which the public might use this method to seek out information on dentists.
- 4.8 Some 40 or so descriptions of other methods were provided. Understandably these included some novel and ingenious ideas. Use of posters was not uncommon, sited variously in local supermarkets, doctors surgeries, health centres and elsewhere. Not surprisingly, a number emphasised the value of word of mouth to pass on their good reputation. Less common but interesting ideas included local radio, parish magazines, and sponsoring local sporting events. There were indications that not all use of newspapers involved paid-for advertisements, as there were some descriptions in this section of advertising features and articles.

TABLE 4.3: USE OF ADVERTISING TO ATTRACT NEW PATIENTS: METHODS USED

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

5 ABOUT THE PRACTICE: MAJOR ISSUES

5.1 About one quarter of practices reported having some form of recognised accreditation, including a small group (four per cent) reporting having more than one form of accreditation. In our sample, the most popular form was that provided by the British Dental Association, with about 12 per cent, with that provided by DENPLAN not far behind at 11 per cent, and those under BUPA just seven per cent of practices. Results are summarised below.

TABLE 5.1: ACCREDITATION BY TYPE OF SCHEME

Accreditation scheme	Percentage of practices	
	No	Yes
BDA	88%	12%
BUPA	93%	7%
DENPLAN	89%	11%

TABLE 5.2: ACCREDITATION MEMBERSHIP BY PRACTICE

	Percentage of practices
No membership of any accreditation scheme	76%
One form of accreditation	20%
Two forms of accreditation	3%
Three forms of accreditation	1%

5.2 In an open-ended question, practices were asked whether they had any particular philosophy or approach to dental treatment. Excluding 179 returns where no reply was given, five per cent of practices mentioned specialising to some degree in cosmetic treatment, 3.5 per cent in orthodontic treatment and one per cent in periodontic treatment. Around 7.5 per cent of practices reported a continued commitment to NHS provision, albeit sometimes commenting on the constraints of operating within the system. Full details are summarised in table 5.3 below.

TABLE 5.3: PRACTICE PHILOSOPHY OR APPROACH TO TREATMENT

Key features	% of practices mentioning this
Treatments	
Cosmetic	5.0
Orthodontic	3.5
Periodontic	1.0
Approach	
Mercury free	0.5
Pain free or pain minimisation	2.5
NHS commitment	7.5
General	
Education	3.0
Minimum intervention	13.0
Preventative	52.5

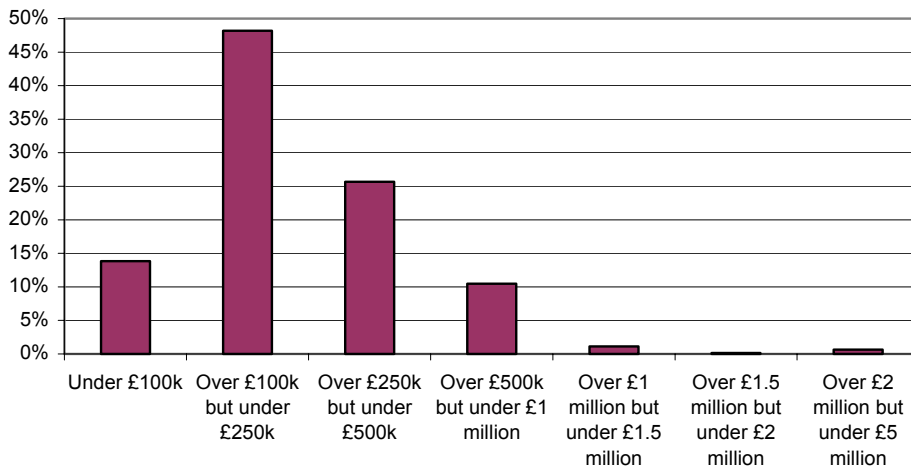
5.3 It was observed that where the practice indicated that minimum intervention, or a preventative approach formed part of the practice philosophy, the proportion of practices taking part in one form or other of capitation type payment plans was higher than otherwise. Table 5.4 summarises the link between these two features.

TABLE 5.4: PRACTICE PHILOSOPHY AND PARTICIPATION IN CAPITATION SCHEMES

Practice philosophy	No plan	Payment plan
Philosophy mentioned minimum intervention	31%	69%
Not mentioned	44%	56%
Philosophy mentioned preventative approach	32%	68%
Not mentioned	50%	50%

5.4 Excluding roughly five per cent of returns that failed to divulge practice turnover, the most common size of practice turnover fell between £100k and £250k. Only two per cent reported a turnover exceeding £1 million. Full results are illustrated in the chart below. Given the uncertainty in each band, such data do not allow the computation of an exact average turnover, but these results indicate an approximate figure in the region of £300k.

CHART 5.5: DISTRIBUTION OF PRACTICE TURNOVER

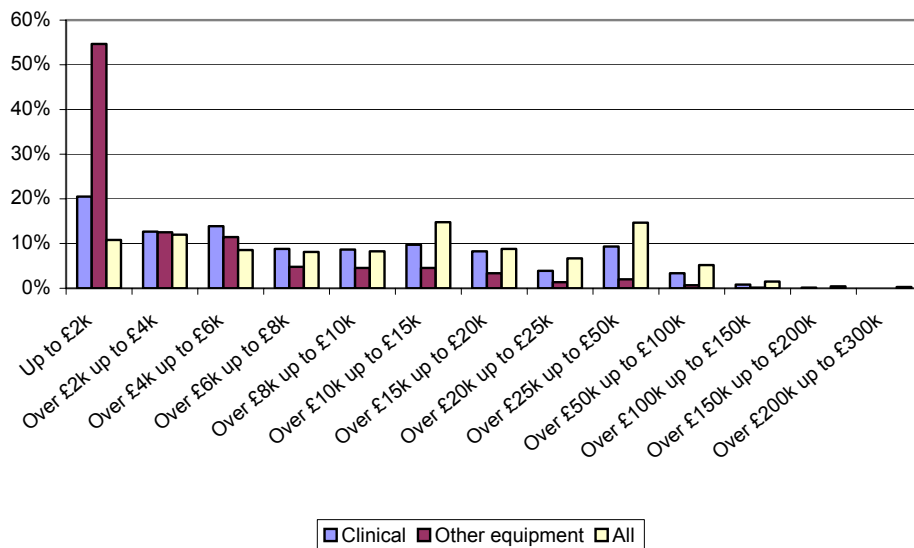


5.5 On average these practices reported spending about £19,000 in the most recent full year on the acquisition of new equipment, made up of a little under £14,000 on clinical equipment and a little over £5,000 on other equipment. Rather perplexingly, the corresponding figures for the previous year were closer to £13,000 made up of £9,500 on clinical equipment and the rest on other

items. This is a puzzling discrepancy, and with allowance for inflation there is no obvious reason why the most recent year should be very different to the previous one.

5.6 It remains possible that a degree of recall bias is present here: that is simply forgetting things that happened less recently. It is also possible that in completing the form, where an entry was made for the most recent year, some zeros were erroneously entered for the previous year where in fact blanks indicating no information were intended. This somewhat undermines the confidence that can be placed in these results, but taken at face value the range of spending was considerable, from zero or close to zero up to around £300,000. The reported distribution of spending for clinical equipment, other equipment and the sum of the two are shown in the following chart.

CHART 5.6: REPORTED SPENDING ON CLINICAL AND OTHER EQUIPMENT



5.7 A proportion of replies indicated that this level of recent spending was not typical – either higher or lower than normal - and explained why. Most of these explanations pointed out that certain types of spending was periodic but with intervals exceeding one or two years between major spending. While such explanations were accepted without reservation, no attempt was made to modify or replace the original data provided. Without a prolonged discussion of the statistical principles involved, such periodic spending should result in appropriate proportions of practices including such costs, without distorting or biasing the results. Combining the results with those in paragraph 5.4, we can conclude that such spending on new clinical and other equipment (roughly £16k

each year) amounts to a figure approximately five per cent of annual turnover (roughly £300k each year).

- 5.8 There was no strong evidence to suggest that practices faced major difficulties in securing finance to meet these spending needs. More than 60 per cent were able to meet the spending need from existing resources. Business bank loans and other commercial loans were also regularly employed to cover these needs, while personal loans were rather less common. Note that while collectively these sources sum to more than 100 per cent, this is entirely permissible since a practice is not only free to meet spending needs from more than one source, but may, of course, need to do so. Only 13 per cent of practices reported ever encountering any problems in obtaining capital to finance expansion or other business development needs.

TABLE 5.5: NORMAL METHODS EMPLOYED BY PRACTICES TO MEET SPENDING NEEDS

Method used	Percent	
	No	Yes
Existing resources	37%	63%
Personal bank loan	95%	5%
Business bank loan	59%	41%
Other commercial loan	73%	27%

- 5.9 Respondents were asked to describe the procedures they used to set prices for private treatments. The question was open ended and about 85 per cent of returns included some form of written description, though inevitably, some did not provide anything relevant to the question asked. This resulted in approaching 700 contributions to be analysed.
- 5.10 While there was considerably variation in the exact form of words chosen 77 per cent essentially described a method where fees were based on an hourly rate, plus the cost of materials and laboratory fees. Fewer descriptions went into detail about how the hourly fee was fixed, but where they did so, it was most commonly to generate a set level of earnings after meeting any other costs. Only a handful of comments mentioned taking into account market forces or competition.
- 5.11 There were a number of minority groups taking different approaches. Around seven per cent simply priced by reference to the corresponding NHS charge,

either by adding a fixed amount or by applying some fixed percentage increase, though this group often indicated too that the proportion of private work was small. Other minority groups relied on external guidance, using General dental practitioners associations (GDPA) recommended fee scales (2.5 per cent), BDA (one per cent) or that of Denplan (one per cent) or the practice accountant.

- 5.12 Despite the fairly common use of hourly rates, the resulting charges were not always fixed. Some practices used an average time to produce a set fee, others charging on a case by case basis and charging an amount specific to the time required to complete the treatment.

6 BUSINESS SIZE: LINKING STAFF, PATIENTS NUMBERS AND TURNOVER RESULTS

- 6.1 Understandably, there were strong associations between staff numbers, patient numbers and business turnover. Summary results are presented below in Table 6.1, showing that those practices with larger turnover also employ more dentists and treat larger numbers of patients.
- 6.2 These results are unsurprising, as is the finding that larger practices spend proportionately more on new dental and other equipment, as set out in table 6.2. It is, however, worth recording that practice size does not appear to exert any influence on problems in obtaining capital to finance expansion and other business needs. As recorded above in section 5.6, overall about 13 per cent of practices reported encountering problems at some time or other. This result was consistent across the different sizes of practice, and with no evidence to suggest that smaller practices had more problems. See table 6.3.

TABLE 6.1: AVERAGE NUMBER OF DENTISTS AND PATIENTS RELATED TO OVERALL LEVEL OF PRACTICE TURNOVER

Practice turnover	Count	Dentists		Patients	
		Mean	SE of Mean	Mean	SE of Mean
Under £100k	111	1.4	0.10	1600	130
Under £250k	387	1.8	0.05	2900	100
Under £500k	206	2.9	0.10	5000	190
Under £1 million	84	4.7	0.29	8300	520
Under £1.5 million	9	7.4	1.28	14700	2620

TABLE 6.2: TOTAL EXPENDITURE ON NEW DENTAL AND OTHER EQUIPMENT OVER MOST RECENT TWO YEARS: RELATED TO OVERALL LEVEL OF PRACTICE TURNOVER

Practice turnover	Count	Mean	Standard Error of Mean
Under £100k	111	£10,400	£2,000
Under £250k	387	£21,900	£1,200
Under £500k	206	£42,400	£3,100
Under £1 million	84	£56,100	£5,800
Under £1.5 million	9	£62,400	£17,700
All	803	£29,900	£1,300

TABLE 6.3: PRACTICES REPORTING EVER ENCOUNTERING PROBLEMS IN OBTAINING CAPITAL TO FINANCE EXPANSION OR OTHER BUSINESS DEVELOPMENT NEEDS

Practice turnover	Count	Percentage
Under £100k	111	13%
Under £250k	387	13%
Under £500k	206	14%
Others	99	13%
All	803	13%

7 PRACTICE BUSINESS: DAY TO DAY ISSUES

7.1 Private treatment prices were found, on average, to vary between twice and three times that of the comparable NHS fees. Comparisons are shown below.

TABLE 7.1: COMPARISON OF NHS AND PRIVATE TREATMENT COSTS

Treatment	NHS		Private	
	Code	Cost	Patient's contribution	Average treatment cost to patient
Examination: Existing patient	0101	£6.65	£5.32	£20.07
Radiographic: 1 small film	0201	£3.30	£2.64	£6.31
Scale and polish	1001	£10.45	£8.36	£23.91
Amalgam filling: 1 surface	1401	£7.05	£5.64	£28.15
Root filling: Molar	1501	£71.10	£56.88	£178.15
Extraction: Single tooth	2101	£6.55	£5.24	£37.10
Whitening for 12+ teeth	-	-	-	£246.45

7.2 The very highest and very lowest charges for private treatment tended to be linked to particular business circumstances. One example of a low price practice was a single dentist operating part time with a rather small patient list who indicated that he was approaching retirement and did not consider himself typical. Some high price practices made mention of acquiring and using the most advanced equipment available.

7.3 Note, however, that an analysis to investigate the influence that expenditure levels on new clinical and other equipment had on treatment costs did not reveal any relationship between the two. See section 12 below for full details. A useful measure of price variation – that avoids sensitivity to a few extreme and untypical results – is the range of prices excluding the most extreme five per cent of high and low prices, also beneficial in part to eliminate mistakes, erroneous data, and similar. Results of this measure of variability are shown in table 7.2.

TABLE 7.2: VARIABILITY IN PRIVATE TREATMENT COSTS

	Average	5 th percentile	95 th Percentile	Standard Error of average
Examination: Existing patient	£20.07	£9.50	£40.00	£0.53
Radiographic: 1 small film	£6.31	£3.00	£12.00	£0.13
Scale and polish	£23.91	£12.63	£40.00	£0.52
Amalgam filling: 1 surface	£28.15	£10.00	£54.25	£0.74
Root filling: Molar	£178.15	£85.00	£327.85	£3.35
Extraction: Single tooth	£37.10	£15.26	£75.00	£0.87
Whitening for 12+ teeth	£246.45	£120.00	£450.00	£7.47

7.4 In themselves, no significance can be attached to the differences between NHS and private treatment prices. The differences may reflect differences in quality of materials, time spent on the treatment, and other differences in the services provided. To the extent that variation in prices reflects differences in quality and service standards it is at the discretion of the consumer to consider value for money and choose accordingly.

7.5 However, the observed price levels and variability do raise justifiable concerns about the quality of information available to the patient about prices and services and the extent to which this allows the patient to correctly assess good value for money. Later sections consider the provision of information in more detail.

7.6 While price and high professional standards are perhaps the most important aspects of the way practices are run, there are others issues of relevance to the patient. The survey asked various questions about practice policy on hours of opening, policy on broken appointments and transfer of patient's records to other dentists.

7.7 Overall, appointments out of normal hours were found to be reasonable common. Weekend appointments were less commonly offered, and while some practices opened on Saturday mornings, very few on Saturday afternoons. A proportion of practices were only prepared to make these services available to their private patients, but many added comments to the effect that these were

normal working practices only, and that in the event of emergency special arrangements would often be made. A full description is set out in table 7.3.

TABLE 7.3: OFFER OF APPOINTMENTS OUT OF NORMAL HOURS

Offered to:-	Saturday		Weekdays	
	am	pm	early morning	evening
Not offered	61%	93%	41%	27%
All patients	24%	4%	45%	54%
Private patients only	15%	3%	13%	18%

7.8 When asked if they allowed transfer of patient’s records to other dentists, 52 per cent of practices reported that they would allow such transfer to any dentist and a further 15 per cent to another dentist in the same practice. However, when asked to supply information on charges for record transfer only 4 practices did so. Given that there is no reason to withhold such information should it be available, this is circumstantial evidence that record transfer is, in fact, a very rare event and that few practices could call on recent experience to provide an answer.

7.9 A very high proportion of practices reported charging patients for broken appointments, although it was also extremely common for this charge to be waived or not applied if the cancellation was with a suitable notification. Only seven per cent of practices reported compensating patients in turn for appointments that the dentist was unable to keep. Unfortunately many who reported charging or offering compensation did so did not provide companion data on the level of charges or compensation. Tentatively based on the 11 who did so, compensation levels were around £18 per instance, but this estimate must be with extreme caution, given the limited evidence. Information on charging for cancellation and compensation is presented below in table 7.4.

TABLE 7.4: BROKEN APPOINTMENTS AND NON ATTENDANCE: POLICY AND CHARGES

Policy on broken appointments	Percentage of practices	Charges	Based on: Observations
Always charge	7%	£22	26
If not cancelled with suitable notification	92%	£17	480
Do not charge	2%		

Policy on appointments broken or delayed by the dentist	Percentage of practices	Compensation	Based on: Observations
Offer compensation	7%	£18	11
Do not offer compensation	93%		

8 INFORMATION PROVIDED TO PATIENTS: GENERAL INFORMATION

8.1 Practices were asked to indicate the methods by which they provided information on prices for private treatment. Out of four possibilities, providing price information directly in response to telephone enquiries proved to be the most popular. Price displays within practices, and price leaflets were generally available in less than 40 per cent of practices. Looking at these methods as a group, 108 practices or about 13 per cent of the total did not report using any method.

TABLE 8.1: PROVISION OF INFORMATION ON PRICES FOR PRIVATE TREATMENT

Method	No	Yes
Display	67%	33%
Leaflet	61%	39%
Telephone	28%	72%
Other methods	59%	41%
At least one of the above methods	13%	87%

8.2 Nevertheless, this level of information provision was rather better than that provided for NHS patients, where comparable data was lower across each of the three main categories

TABLE 8.2: PROVISION OF INFORMATION ON PRICES: COMPARISON BETWEEN NHS AND FOR PRIVATE TREATMENT

Providing price information by the following methods:-	Percent of practices	
	NHS	Private
Display	21%	33%
Leaflet	15%	39%
Telephone	45%	72%

8.3 Looking at information more generally, it was encouragingly to find that some 75 per cent of practices reported having a practice leaflet. Practices with leaflets were requested to submit copies, and these were subject to an examination of their contents. In total 122 leaflets, and 12 price lists were included with returned questionnaires. This represents 14.4 per cent of practices, or about 1 in 7. The simple price lists provided equate to about 1.4 per cent of the sample.

8.4 Such leaflets appeared to be generally unavailable to non-registered patients, a finding that seems counter intuitive as making information available to people not currently registered might be considered a form of advertising and likely to attract additional patients. Only about half of practices made available information on complaints procedures, though in this instance the information for NHS patients was available in more practices than for private patients.

TABLE 8.3: PROVISION OF GENERAL INFORMATION

Method used by practice to provide general information	Percent	
	No	Yes
Practice leaflet	25%	75%
Leaflet for non-registered	86%	14%
NHS complaints	45%	55%
Own complaints	56%	44%

8.5 The information provided on each of the leaflets submitted was examined and categorised. In the table below, the level of information provided has been assessed, and placed into one of four categories depending on whether information was present or not, and, if present, whether it was general and non-specific, specific or specific and detailed.

TABLE 8.4: ANALYSIS OF PRACTICE LEAFLETS: INFORMATION PROVIDED

CATEGORY OF INFORMATION	% of leaflets				All
	Not present	General non-specific information	Specific information	Specific and detailed information	
Dental team information					
Qualifications	8%	43%	31%	17%	100%
Accreditation	89%	3%	7%	1%	100%
Specialisation	52%	23%	21%	4%	100%
Practice information					
Opening hours	11%	2%	14%	73%	100%
Location	2%	5%	56%	38%	100%
Awards	97%	2%	1%	1%	100%
Emergency treatment	16%	50%	30%	4%	100%
Details of treatment range	90%	2%	2%	5%	100%
Information on approach	89%	2%	3%	7%	100%
Complaints					
Process	74%	10%	4%	12%	100%
Who to complain to	76%	7%	6%	11%	100%
Time scale	88%	1%	2%	10%	100%
What happens if unresolved	87%	2%	1%	10%	100%

Costs

Cost of treatments	17%	42%	2%	39%	100%
Cost of initial examination	57%	3%	0%	39%	100%
Payment arrangements	52%	39%	7%	3%	100%
Charge for non-attendance	55%	39%	1%	5%	100%
Registration/admin charge	98%	0%	1%	2%	100%

8.6 Information on team qualifications was very common and in approaching half of cases providing a degree of detail. Accreditation was mentioned by 11 per cent of leaflets, and compared with other sections of the survey this appears to understate its prevalence, as 24 per cent of practices claimed to belong to at least one form of accreditation scheme.

8.7 Specialisation was mentioned on about half of all leaflets. In the absence of objective information on how common this is across practices, it would be unreasonable to comment on this further except to note that normally specific information is preferable to that of a general non-specific nature.

8.8 The provision of practice information was very good on basics, like opening hours and location, but much less good on other aspects like treatment range and approach. Little or no mention is made of awards, although this may be an issue that comes through at a personal level, and may be less important if specifics about the individuals in the dental team are adequately dealt with.

8.9 Given the potential importance to patients, information about emergency treatment proved slightly disappointing. Encouragingly, something was included in more than 80 per cent of leaflets, but disappointingly detail was thin and 50 per cent of leaflets contained only general non-specific information.

8.10 Another aspect of the leaflets that was generally poor was the provision of information about what to do in case of complaint, with between 75 per cent and 85 per cent failing to mention important aspects of the procedure. A small core of around 10 per cent to 15 per cent appeared to provide consistent specific information on each key aspect of the complaining process.

8.11 Results on the provision of costs were moderate, with around 40 per cent of leaflets providing specific and detailed information on treatments and examination costs, with a further 40 per cent or so provided some general even if non-specific information. Other aspects of costs were not so well handled,

however, and although about 50 per cent in total provided something on payment methods and charges for non-attendance, detail was limited and specific information present in only five per cent to 10 per cent of cases.

- 8.12 It would be unreasonable to criticise the very low level of information provided on registration charges for new patients. Such charges are reportedly rare - other survey results suggest only about 1.5 per cent of practices make such a charge. The one per cent to two per cent of leaflets that provided specific information on this might, optimistically, be seen as evidence that those who make such charges and have practice leaflets are prepared to record the fact.
- 8.13 Overall, the evidence points to practice leaflets being reasonably common with about 75 per cent of practices claiming to have such a leaflet, but generally the information content left something to be desired. Better in some places than others, for a number of important topics where complete and detailed information would be an advantage, comprehensive information was actually provided by all too few.

9 INFORMATION PROVIDED TO PATIENTS: TREATMENT SPECIFIC INFORMATION

9.1 Several questions were devoted to the provision of information to the individual patient and specific to a course of treatment rather than about the provision of information generally. For this it was noted initially that about six per cent of practices did not advise their patients in any way about the recommended course of treatment. This is hardly a high percentage but it is still rather higher than might be expected since this information is such a fundamental part of the transaction.

TABLE 9.1: ROUTINE PROVISION OF INFORMATION ABOUT TREATMENT

	No	Yes
Advice to patients about the recommended course of treatment	6%	94%
Of which:		
Written treatment plan only		4%
Verbal description only		24%
Both		72%
All being given information		100%

9.2 Where information was provided, it was still found to be the case that the information was provided only verbally in 24% of cases. However, where written treatment plans were not provided routinely by the practice, they were often provided in specific circumstances. The most common such instance was simply on request, although it was also often found in cases where the treatment was considered complicated. Any number of such exceptions can apply so the percentages do not sum to one hundred.

TABLE 9.2: WHERE WRITTEN TREATMENT PLANS ARE NOT ROUTINELY PROVIDED: SPECIFIC EXCEPTIONS

New patient	28%
Private treatment	20%
On request	57%
Complicated treatment	44%

9.3 Rather similar results were found about the advanced provision of estimated costs. While itemised and total costs were included on written treatment plans for around 60 per cent of patients in total, some 18 per cent were only provided with a verbal estimate, and in about 20 per cent of cases none of these methods were used. Again when examining the provision of an invoice, while some 33 per cent of practices provided itemised invoices, and a further 32 per cent an invoice with the total costs, 36 per cent did not normally provide an invoice, see tables 9.3 and 9.4 below.

9.4 Taking a general overview of these results, it is clear that at each stage a proportion of practices are either providing inadequate levels of information, or relying too heavily on verbal communications at the expense of providing clear written information. There is evidence of making greater efforts in special circumstances, but there is scope for patients to be disadvantaged if they have no clear idea in advance of what is going to happen and how much it is going to cost.

TABLE 9.3: IN ADVANCE OF THE WORK: INFORMATION ABOUT FINAL COSTS

Written treatment plan: Itemised costs	34%
Written treatment plan: Total costs	28%
Estimates given verbally	18%
None of the above	20%

TABLE 9.4: AFTER COMPLETION OF THE WORK: PROVISION OF AN INVOICE

Yes: providing itemised costs	33%
Yes: providing total costs	32%
Not normally provided	36%

- 9.5 Where estimated costs are provided in advance of the work, it is generally claimed that the estimates are suitable accurate and for 95 per cent of practices it is reported that these are usually within 10 per cent of the final outcome. Of the remainder, all but 3 practices felt that even if not always within 10 per cent, they were usually within 20 per cent of the final outcome. There is no evidence from this source to suggest that the patient cannot rely on any estimate being a reliable indicator of final costs.
- 9.6 One particular circumstance that might cause confusion for the patient is that when a course of treatment combines some elements that are NHS and some that are private. In these circumstances a sizeable majority of practices reported providing information on the division between the two sorts of treatment. An estimated 35 per cent of practices made the division clear by using both written and verbal description, with a further 21 per cent just providing written information and 16 per cent providing a verbal description only. Just 27 per cent reported not providing this information.
- 9.7 Further evidence of practices making greater efforts to provide information in potentially more complicated situations emerged when asked about treatments that might be considered optional. In these circumstances 91 per cent of practices reported making patients aware of any recommended treatment that might be considered discretionary.

10 ABOUT SERVICES PROVIDED

10.1 Patients registered for NHS are entitled to all the permitted treatments on the NHS, although some require special authority from the Dental Practice Board. However, the number of practices that said they would always provide the following treatments on the NHS were rather less than 100 per cent, as shown below in table 10.1. It may be reasonable to believe that those practices that reported providing such treatments “usually” or “rarely” might nevertheless provide in the appropriate circumstances. However, small percentages of practices reported never providing them – up to six per cent in the case of crowns and about four per cent in other cases.

TABLE 10.1: FOR NHS REGISTERED PATIENTS: TO WHAT EXTENT WOULD YOU UNDERTAKE THE FOLLOWING TREATMENTS UNDER NHS?

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

10.2 Dental payment plans for private treatment are becoming increasingly common. These include capitation schemes, insurance and other types of dental payment schemes. Among the practices taking part in this survey, 58 per cent reported being involved in at least one payment plan, and it was not uncommon for the practice to accept patients from two or more payment plans. One practice indicated it would accommodate any plan.

10.3 In this sample, the largest groups were Denplan and Hospital Savings Association, represented at 30 per cent and 21 per cent of practices respectively. But the number of schemes is considerable and there were three other schemes in the market with links to more than five per cent of practices and a number of other less widespread schemes too. The average number of plans per practice was 1.6 overall. Main results are in table 10.2.

TABLE 10.2: PRESENCE OF CAPITATION SCHEMES, INSURANCE AND OTHER DENTAL PAYMENT SCHEMES

Scheme	% of practice using
Denplan	30%
Hospital Savings Association	21%
Boots	8%
Cigna	7%
Densure	6%
Practice Plan	4%
Clinident	2%
DPAS	1%
Smilecare	1%
Highland Dental plan	-%
National Dental plan	-%
Other	4%

- Denotes less than half the least significant digit shown.

11 HANDLING COMPLAINTS

11.1 The questionnaire asked practices to describe in an open-ended way what procedures were normally employed for handling complaints about private treatment. Nearly 19 per cent did not provide any answer, but where an answer was provided roughly equal proportions reported either having some form of scheme or system, or went into greater detail by mentioning the actual steps or procedures. A percentage reported that complaints were rare or had never occurred. In the table below these are only separately identified where there was no mention of any scheme or contingency plans to handle complaints should the need arise.

TABLE 11.1: PRACTICE DESCRIPTIONS OF HANDLING COMPLAINTS ABOUT PRIVATE TREATMENT

Normal procedure:		
Handling complaints from private patients	Number	Percentage
No answer or no relevant information	157	19%
Answers describing schemes and systems	314	37%
Answers describing procedures	322	38%
No complaints but without mention of contingency plans	55	6%
	848	100%

11.2 Further detail on schemes and systems, and specific procedures are given in the table below. Systems based on NHS methods are still common, and were mentioned more frequently than proprietary schemes, but most common were in-house systems.

TABLE 11.2: PRACTICE DESCRIPTIONS OF HANDLING COMPLAINTS ABOUT PRIVATE TREATMENT: DETAIL

	No.	%	No.	%
Complaints handling: Schemes and systems	314	37%		
of which mentioning				
In-house systems			150	48%
Based on NHS			109	35%
Practice own system, scheme or procedure			102	32%
Denplan, BDA and other proprietry systems			18	6%
Complaints handling: Procedures	322	38%		
of which mentioning				
Discussion			145	45%
Asking for written description			94	29%
Meeting patient			33	10%
Acknowledgement			29	9%
Resolution			96	30%
Second opinion and other referrals			43	13%
Consideration and explanation			14	4%
Conciliation, rectification, refunds and correction			55	17%

11.3 It appears clear that at least three quarters – that is 37 per cent plus 38 per cent - of the practices were able to report either systems or procedures for handling complaints that would amount in effect to some form of formal complaints handling procedure.

11.4 When a patient approaches with a complaint about private treatment initially a large majority of practices (82 per cent) reported preferring to begin by discussing the problem rather than asking for the complaint to be put into

writing (18 per cent). Surprisingly only 30 per cent of practices initially provided advice on the normal procedures used for resolving complaints.

- 11.5 Overall 75 per cent of practices reported having not even a single complaint in the last 12 months, and a further 20 per cent reported somewhere between 1 and 4 complaints. The overall average was equivalent to only 0.7 complaints per practice per year, and combining this with the information on average practice size, is somewhat less than 2 complaints per 10,000 patients per year.
- 11.6 As a result, estimates of which types of complaint were most common can only be regarded as tentative. In most cases, the manager or practice owner completing the form will have relied on limited evidence on which to estimate such divisions. But while of somewhat limited value, the overall figures suggested that the main types of complaint are quite varied as shown below in table 11.3.

TABLE 11.3: RELATIVE FREQUENCY OF DIFFERENT TYPES OF COMPLAINT

Nature of complaint	Relative frequency
	%
Quality	18
Cost	23
Pain and discomfort	22
Cancellation charges	14
Administration	14
Other	8

- 11.7 While many practices reported that it was common or very common for the complaint to be withdrawn, many also reported that the most common outcome was free repair or replacement for the failed treatment. This, in combination with full or partial refunds, and sometimes further work to correct the problem, covered a very substantial proportion of the outcomes. Detailed results are given below.

TABLE 11.4: COMPLAINTS ABOUT PRIVATE TREATMENT: COMMON AND UNCOMMON OUTCOMES

Outcome	Very common	Common	Uncommon	Very uncommon
Withdrawn	61%	31%	6%	2%
Free repair or replacement	57%	31%	7%	5%
Partial refund	12%	23%	37%	29%
Full refund	24%	23%	22%	31%
Additional work	27%	40%	20%	12%
None of above	19%	19%	23%	39%

11.8 Nevertheless, instances in which no remedial work of any kind was undertaken, nor any refund paid, and where the complaint was not withdrawn but simply no further action taken by the complainant were judged to be very common by 19 per cent of practices and common by a further 19 per cent. This appears, at face value, to be unsatisfactory. The complaint does not appear to have been resolved satisfactorily, but nothing has been done to help or compensate the complainant. While all markets attract unjustified complaints, these are potentially cases of inadequate redress, that simply grind to a halt because the complainant has no reasonable way of taking the case further.

12 MORE ANALYSIS OF PRICES

- 12.1 Given the results presented earlier on price levels and their variability, it was considered important to examine any potential influences on price level apparent in the data. Linear additive models were therefore fitted to each of the five price variables for different types of treatment.
- 12.2 The factors that were considered are set out in full in the table below, along with the list of the different levels that were used in the model. The intention was to see if any differences in average price could be seen between different types of practice. In an effort to see if prices were in any way linked to spending levels on new clinical and other equipment, the total spend for the past two years on each of these items was included as a linear covariate, to reflect high and low spending practices.
- 12.3 The prices were analysed using an additive linear model. After checking for significant first order interactions and finding none, the model was reduced to a simple main-effects model. Some significant differences were found. Of the factors examined, few proved to have a consistently significant effect on prices. The exceptions to this pattern were found to be the acceptance of new patients, and to a somewhat lesser degree the turnover of the practice. One or two isolated tests proved significant at the five per cent level but not consistently so across all prices.
- 12.4 Some factors are therefore notable for their absence. The absence of any significant relationship between prices and spending on new capital and other equipment was one area where a possible link might be expected but no conclusive link found. A full description of the effects that were found to be significant is shown in table 12.2.

TABLE 12.1: PRICE ANALYSIS: FACTORS CONSIDERED AS POTENTIAL INFLUENCE

Factor	Number of levels	Levels in detail
Practice status	3	Conventional practice Body corporate Part of a group
Acceptance of new patients	4	Not accepting any patients Limited acceptance but including adults for NHS Limited acceptance: Adults for private treatment only Accepting all types
Turnover	6	Under £100k Under £250k Under £500k Under £1 million Under £1.5 million Under £2 million Under £5 million
Accreditation	2	Without accreditation With at least 1 type
Use of payment plan	2	Practice does not participate Participates in at least one form of payment plan
Spending	Covariate	Sum of spending in previous two years on new clinical and other equipment

TABLE 12.2: FACTORS HAVING SIGNIFICANT INFLUENCE ON PRICES: SUMMARY RESULTS

Treatment	Payment plan	Turnover	Acceptance of new patients	Practice type	Accreditation	Spending on new equipment
Examination	not sig	0.0000	0.0016	not sig	not sig	not sig
Film	not sig	not sig	0.0294	not sig	not sig	0.0403
Scale and polish	not sig	not sig	0.0017	not sig	not sig	not sig
Filling	not sig	0.0007	0.0000	not sig	not sig	not sig
Root filling	not sig	0.0000	0.0000	not sig	0.0439	not sig
Extraction	0.0383	0.0162	0.0000	0.0130	not sig	not sig

12.5 It is worth recording that the highest prices were found for practices that were limiting acceptance of new patients, and would only accept adults for private treatment. The other three types, those accepting no patients, or limited types but including adults for NHS or any and all types were usually rather closer together and with differences that would not prove significant on pair-wise comparison.

TABLE 12.3: PRICE DIFFERENCES: EXAMPLES TAKEN FROM ACCEPTANCE OF NEW PATIENTS

		Mean	Std Error
Examination	No new patients	£21.80	£2.30
Examination	Limited acceptance:	£19.30	£2.10
Examination	Limited acceptance: Private adults only	£24.60	£2.10
Examination	Accepting all types	£22.70	£2.00
Film	No new patients	£5.70	£0.50
Film	Limited acceptance:	£5.70	£0.50
Film	Limited acceptance: Private adults only	£6.60	£0.50
Film	Accepting all types	£5.90	£0.50
Scale and polish	No new patients	£21.90	£2.40
Scale and polish	Limited acceptance:	£22.10	£2.20
Scale and polish	Limited acceptance: Private adults only	£26.70	£2.20
Scale and polish	Accepting all types	£26.30	£2.10
Filling	No new patients	£23.90	£2.80
Filling	Limited acceptance:	£25.20	£2.60
Filling	Limited acceptance: Private adults only	£34.20	£2.50
Filling	Accepting all types	£27.80	£2.50
Root filling	No new patients	£171.00	£13.20
Root filling	Limited acceptance:	£176.50	£11.90
Root filling	Limited acceptance: Private adults only	£233.10	£11.70

Root filling	Accepting all types	£187.80	£11.60
Extraction	No new patients	£39.70	£3.80
Extraction	Limited acceptance:	£40.10	£3.40
Extraction	Limited acceptance: Private adults only	£51.10	£3.40
Extraction	Accepting all types	£42.40	£3.30

12.6 For completeness, results for the influence of turnover on prices are shown below. Results for the limited numbers of practices with very high turnover have large standard errors and not presented. Generally, there appears to be some slight association between increased practice turnover and price, but this was not found for all the treatments analysed – refer to the lack of significant effects listed in table 12.2 and the results for extraction costs where no consistent trend can be seen.

TABLE 12.4: PRICE DIFFERENCES: EXAMPLES TAKEN FROM PRACTICE TURNOVER

Treatment	Turnover	Mean	SE
Examination	Under £100k	£15.64	£1.99
Examination	Under £250k	£16.30	£1.63
Examination	Under£500k	£19.67	£1.67
Examination	Under£1 million	£18.55	£2.23
Filling	Under £100k	£23.40	£2.45
Filling	Under £250k	£22.10	£2.00
Filling	Under£500k	£26.08	£2.06
Filling	Under£1 million	£26.93	£2.75
Root filling	Under £100k	£155.89	£11.36
Root filling	Under £250k	£166.20	£9.31
Root filling	Under£500k	£179.79	£9.56

Root filling	Under£1 million	£190.47	£12.76
Extraction	Under £100k	£42.47	£3.27
Extraction	Under £250k	£38.45	£2.68
Extraction	Under£500k	£42.52	£2.75
Extraction	Under£1 million	£41.97	£3.67

