

# Competition in Professional Services

# dentists

The Competition Authority is undertaking a study across a range of eight professions in the construction, legal and medical sectors of the Irish economy. The specific professions being reviewed are engineers, architects, dentists, optometrists, veterinary surgeons, medical practitioners, solicitors and barristers

October 2007



**The Competition Authority**  
An tÚdarás Iomaíochta





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# Glossary of Terms

## Central Statistics Office

The Central Statistics Office (CSO) is the State body responsible for compiling official Irish statistics across a number of fields, including demography, trade, the economy, the labour market, industry sectors and the environment.

## Clinical Dental Technician

A clinical dental technician is a dental technician who has undertaken further training to develop clinical skills required to fit and sell dentures directly to patients.

## Consumer Price Index

The Consumer Price Index (CPI) is a measure compiled by the CSO which shows the change in prices across a broad range of goods and services used by consumers. The index indicates how prices generally have changed by reference to a base year. The CPI can therefore be used as a reliable indicator of price inflation in the economy.

## Cosmetic Dentistry

Cosmetic dentistry encompasses forms of dentistry which improve the appearance of teeth and gums, such as laser whitening, but are not designed to prevent or cure dental maladies.

## Dental Council

The Dental Council is the State regulatory body for the dental profession in Ireland. It was established as a statutory body under the provisions of the Dentists Act 1985.

## Dental Hygienist

Dental hygienists are qualified to carry out a particular subset of dental treatments such as scaling, polishing and cleaning teeth, applying materials to the teeth and gums, administering local anaesthesia and giving advice in relation to oral health. The main role of dental hygienists is in the rehabilitation of patients who have suffered from gum disease, in the oral health maintenance of patients who have had advanced prosthodontic treatment and in the placement of fissure sealants.

## Dental Nurse

Dental nurses provide support to dentists. Their duties include the preparation of the surgery, setting out the appropriate instruments, receiving patients, assisting during operations, attending to instruments and to the general cleanliness of the surgery.

## Dental Technician

A dental technician constructs and repairs crowns, bridges and other dental appliances using prescriptions and impressions taken by a dentist.

## Dental Technicians Association of Ireland

The Dental Technicians Association of Ireland is the representative body for dental technicians.

## Dental Treatment Benefit Scheme

The Dental Treatment Benefit Scheme (DTBS) is a scheme run by the Department of Social and Family Affairs which provides dental services to insured workers and retired people who have the required number of Pay Related Social Insurance (PRSI) contributions. Under the Scheme, eligible persons receive free or subsidised dental treatment from dentists engaged in private practice.

### **Dental Treatment Services Scheme**

The Dental Treatment Services Scheme (DTSS) is a scheme for the provision of dental services to all medical card holders over the age of 16. Treatments available under the Scheme are free to the patient and include examination, x-rays, fillings, extractions, partial and full dentures, periodontal and root canal treatments.

### **Dentists Act 1985**

The Dentists Act 1985 details how the profession of dentistry in Ireland should be organised and regulated. It provides for the creation of a statutory Dental Council, and places a number of legal restrictions on the way in which dental services can be offered to the general public.

### **Denturist**

The terms “clinical dental technician” and “denturist” can be used interchangeably.

### **European Economic Area**

The Member States of the European Economic Area (EEA) are the 27 Member States of the European Union plus Iceland, Liechtenstein and Norway.

### **Endodontics**

The branch of dentistry concerned with the cause, diagnosis, prevention and treatment of diseases and injuries of the tooth root, dental pulp and surrounding tissue.

### **General Dental Council**

The General Dental Council is the regulator of the dental profession in the United Kingdom.

### **General Dental Practitioner**

The majority of dentists work in private practice as general dental practitioners offering a range of dental treatment services rather than specialising in particular fields of dentistry.

### **Health Service Executive**

The Health Service Executive (HSE) took over full operational responsibility for running the State's health and personal social services on January 1, 2005. The HSE's objective is to improve the patient healthcare experience and provide a better working environment for healthcare staff.

### **Higher Education Authority**

The Higher Education Authority (HEA) is the statutory planning and development body for higher education and research in Ireland. The HEA has wide advisory powers throughout the whole of the third-level education sector. In addition, it is the funding authority for the universities and a number of designated higher education institutions.

### **Irish Dental Association**

The Irish Dental Association, established in 1922, is the main representative body for general dental practitioners, specialists and State-employed dentists.

### **Irish Dental Hygienists Association**

The Irish Dental Hygienists Association is the national professional representative association for dental hygienists.

### **National Treatment Purchase Fund**

The National Treatment Purchase Fund was established by the Government in April 2002 as a means of reducing patient waiting lists by sourcing treatments for patients in Ireland, Northern Ireland and the United Kingdom.

## **Oral Surgery**

The branch of surgery which deals with the diagnosis and treatment of oral conditions of the jaw and mouth structures requiring surgical intervention.

## **Orthodontic Society of Ireland**

Founded in 1990, the Orthodontic Society of Ireland represents the interests of orthodontists.

## **Orthodontics**

The branch of dentistry concerned with the prevention and correction of irregularities of the teeth, bite and jaw.

## **Periodontics**

The branch of dentistry concerned with the diagnosis, treatment and prevention of diseases and disorders (infectious and inflammatory) of the gums and other structures around the teeth.

## **Prosthodontics**

The branch of dentistry involving the replacement of missing teeth and the associated soft and hard tissues by prostheses (crowns, bridges, dentures) which may be fixed or removable, or may be supported and retained by implants.

## **Register of Dentists**

Under the Dentists Act 1985, one of the main functions of the Dental Council is to establish, maintain and publish a Register of Dentists listing all dentists approved to practise in the State. The Dental Council also maintains and publishes the Register of Dental Hygienists, the Register of Dental Specialists and the Register of Dental Nurses.

## ***Regulating Better***

The Government White Paper designed to improve national competitiveness and policy implementation by ensuring that new regulations and legislation are more rigorously assessed in terms of their impacts, more accessible to all and better understood.

## EXECUTIVE SUMMARY

1. Competition in dental services is restricted and discouraged by an outdated system of regulation for dentists and related professions. The number of dentists and orthodontists being trained in Ireland has not kept pace with the growing demand for dental services. Consumers in Ireland do not have the benefits of the competition between dentists and a range of other qualified oral health professions that exists in other countries.
2. As a result, the prices consumers pay for dental services are not as competitive as they could be and consumers do not have the full range of information and options available to them to purchase appropriate dental services for their needs.
3. The price of private dental services in Ireland continues to rise at a rate above the general rate of health services inflation. Although 80% of the population of Ireland is entitled to a free examination and clean annually, only 44% of people in Ireland visit the dentist at least once a year.<sup>1</sup> Some consumers travel to other countries for certain dental services.<sup>2</sup>
4. The regulatory system governing the dental profession in Ireland urgently needs reform. This is because competition in dental services has been seriously undermined by inappropriate rules and regulations that promote an outdated model of delivering oral health services:
  - Consumers in Ireland have to visit a dentist for all their dental services (at least as an intermediary). In other countries, consumers can access basic dental services directly from other qualified oral health professionals - dental hygienists and clinical dental technicians;
  - Dentists are prevented from competing through normal methods of competition such as advertising prices and offering discounts;
  - The restrictions on advertising deny consumers access to basic information about the availability of dental services in their area which would help them to make informed decisions about their oral health;
  - Dentists are unable to promote awareness of their practices and their services and this discourages them from innovating. They are also at a competitive disadvantage vis-à-vis dentists in Northern Ireland and other countries who can advertise freely here;
  - Lack of transparency in prices reduces competitive pressure on dentists and discourages consumers from purchasing routine or preventive dental services;
  - Dentists traditionally work as sole practitioners, sometimes with other dentists as associates or as employees in their practices. Competition between corporate bodies of dentists would have many benefits for dentists and consumers, by improving their access to capital and business skills. These benefits include: cost savings, ability to afford locations that are more convenient for many consumers, flexible working arrangements, longer opening hours, and checks and balances on the quality of each dentist's services (put in place to maintain the corporate body's reputation).
5. The regulatory system also offers limited protection for consumers:
  - The Dental Council does not have strong powers to pursue those dental technicians practising dentistry illegally in Ireland;<sup>3</sup>

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1 "Poor Prescriptions", Combat Poverty Agency, June 2007.

2 See "Irish are top dental tourists", Sunday Business Post, 12<sup>th</sup> August 2007.

3 Dental technicians make dentures for sale to dentists and repair dentures for dentists and for members of the public. However, a number of dental technicians fit and sell new dentures directly to the public, thus practising dentistry illegally.



- The Council must wait until damage is done to a patient before it can act against a dentist. There are no regular checks on the standard of dental services provided by dentists.
6. Another problem is the lack of training of sufficient dentists and orthodontists to meet demand. In particular, the training of orthodontists in Ireland has been “stop-start” and this has led to a shortage of orthodontists in the public sector.
  7. In this report, the Competition Authority makes 12 recommendations to address the competition problems identified in the dental profession.<sup>4</sup> Implementing these recommendations will lead to a modern system of regulation to ensure:
    - that the health and safety of the public is protected;
    - that consumers are more aware of their options and the prices for dental services;
    - more choice for consumers regarding when, where, and from whom, they get dental services;
    - better use of the skills and very expensive training of dentists and orthodontists;
    - a sufficient supply of dentists, orthodontists and related professionals;
    - value for money in dentists’ services;
    - more consumers availing of dental services and thus better oral health in the population.

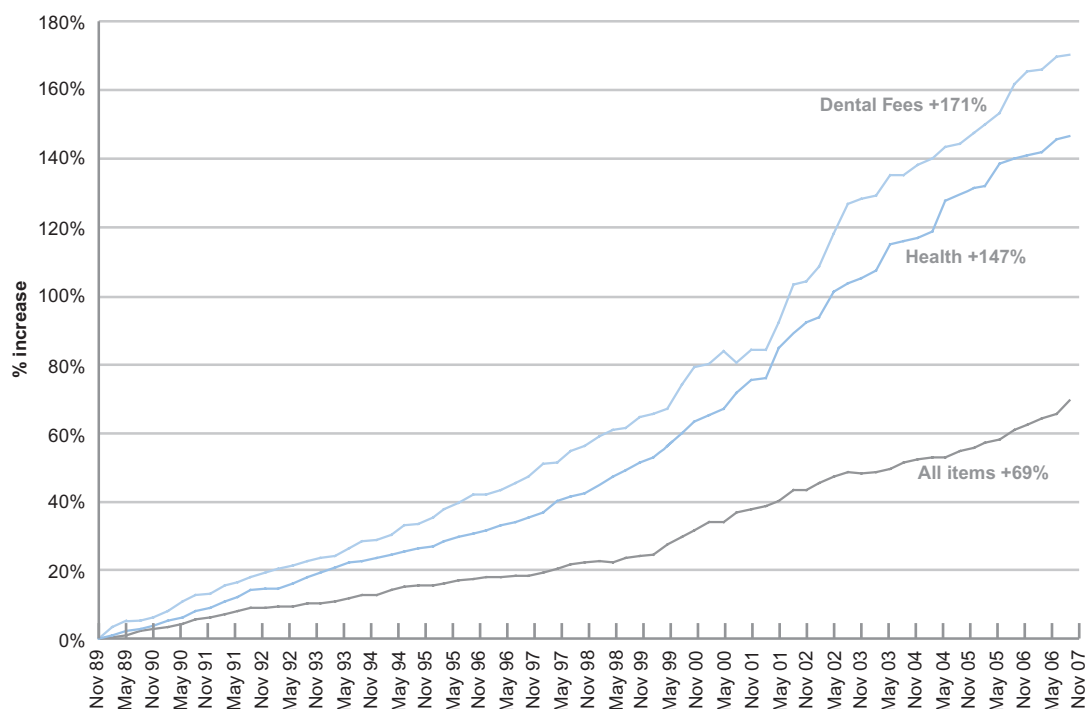
## Regulatory and Commercial Environment

8. Under the Dentists Act 1985, it is unlawful for a person to use the title “dentist” or “dental specialist”, or to provide dental services, without being registered by the Dental Council. The conduct and standards of dentists, and related oral healthcare professionals, are regulated by the Dental Council. Dentists often employ other qualified professionals, such as dental nurses and dental hygienists, to assist them and to provide basic dental services to their customers.
9. Most of the dentists working in Ireland practise in the private sector, offering their services direct to the public. However, the State subsidises dental services through a variety of schemes. In 2005, the State spent over €105 million on dentists’ services.
10. The price of private dental treatments has consistently increased above the general rate of inflation and above the rate of health inflation. Between 1990 and 2007, the Consumer Price Index (CPI) increased by 69%, health costs grew by 147% while dental services increased by 171%, according to data from the Central Statistics Office (CSO).

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<sup>4</sup> This report is not the only occasion that the Competition Authority has addressed competition issues in the dental profession. On 28<sup>th</sup> April 2005, the Competition Authority agreed settlement terms, without admission of liability, with the Irish Dental Association in a High Court action taken by the Competition Authority alleging a breach of the Competition Act 2002. The Competition Authority took this action following allegations of an attempt to frustrate price competition between dentists through a collective boycott of a private dental health insurance scheme being introduced in Ireland by Vhi DeCare.

## Inflation in Dental Services, Health and CPI (All items) (January 1990-May 2007)



Source: Central Statistics Office

11. It is unclear if dentists are allowed to offer their services under a corporate business structure. This uncertainty should be removed so that corporate dental bodies can evolve in Ireland and consumers can reap the benefits.
12. Allowing dentists to develop new ways to offer their services will make it easier for them to invest in their businesses, become more efficient and offer greater choice to consumers in terms of the convenience of the location and longer opening hours. Corporate dental groups will also be able to benefit from the economies and efficiencies deriving from shared costs and greater buying power.

## New Oral Healthcare Professions

13. Ireland is out of step with most other developed economies in not having a range of oral healthcare professions that can offer dental services directly to consumers.
14. In Ireland, only dentists can provide dentures directly to the public. *Clinical dental technicians* are permitted to fit and sell dentures to members of the public in many countries including the UK, Australia, Canada, Denmark, Finland, the Netherlands, New Zealand, Sweden and the USA.
15. There is provision in the Dentists Act 1985 for the establishment of a new oral healthcare profession that would be permitted to sell dentures in addition to dentists.<sup>5</sup> This provision was made on foot of a recommendation in the Restrictive Practices Commission's 1982 *"Report of Enquiry into the Statutory Restrictions on the Provision of Dental Prostheses"*. However, the Minister for Health and Children has not, to date, approved any proposals made by the Dental Council in this area. The impasse was due to disagreement over how to deal with dental

<sup>5</sup> See section 54(3) of the Dentists Act 1985.

technicians currently selling dentures illegally to the public. This issue has now been resolved and, at the time of writing, the Dental Council was expected to shortly submit new “proposals” to the Minister. Giving legal recognition to suitably trained clinical dental technicians will ensure the protection of consumers and promote greater choice for consumers in terms of where they can get their dentures legally.

16. The current system of regulation requires that consumers must go through a dentist before they can benefit from the services of a dental hygienist. In many other countries dental hygienists can offer a specific set of largely routine, preventive, dental services independently of dentists. This is the case in Sweden, Finland, Denmark, Norway, the USA, Canada, the Netherlands and Switzerland. The quality of dental care is protected in these countries, as dental hygienists are obliged to refer their patients to a dentist if they identify a problem that is beyond their scope of practice.
17. Dental hygienists in Ireland are not trained sufficiently to operate independently of dentists. The Competition Authority recommends the creation of a new oral healthcare profession of *advanced dental hygienist*, trained to offer services directly to the public independently of dentists. The creation of this new profession would give consumers more options for accessing dental hygiene services and promote competition in these services.

### Unnecessary Restrictions on Advertising

18. Competition between dentists is actively discouraged by the Dental Council's *Guidelines on Public Relations and Communications*. The restrictions placed on dentists go beyond what is necessary to protect the public from untruthful and inaccurate advertising. For example, it is forbidden to advertise even basic price lists, and new dental practices are limited to a maximum of six newspaper advertisements in their first year of practice advertising their existence. Allowing truthful, informative advertising will empower consumers to make more informed decisions about their oral health. It will also encourage dentists to compete on price, to offer new services and to deliver their services in new customer-focused ways.
19. The Dental Council's *Professional Behaviour and Dental Ethics* also limits competition by prohibiting price discounts and frustrates new dental practices by prohibiting the solicitation of patients by dentists.

### The Supply of Dentists and Orthodontists

20. Demand for general dental services has grown substantially over the past ten to fifteen years. Over this period, the number of training places for dentists has remained static and there are no plans to increase them. The limit on training places in Irish universities could lead to a serious shortage of dentists in the future and put further upward pressure on prices. While the introduction of new oral healthcare professions proposed in this report should minimise the effects of the shortage of dentists, by making better use of their skills and expertise, the number of training places should be reviewed by the Department of Health and Children to ensure a sufficient supply of dentists and other oral healthcare professionals in the long-term, so that consumers and the State get value for money in dental services.
21. The training of orthodontists in Ireland has been “stop-start” and this has led to a shortage of orthodontists in the public sector. At the time of writing, the course operated by the Cork University Dental School and Hospital, which commenced in 2006, is the only orthodontists’ training course available in Ireland, although the Dublin Dental School and Hospital intends to recommence training for specialist orthodontists in 2007.
22. A new oral healthcare professional called an *orthodontic therapist* was approved by the Dental Council in 2004. Orthodontic therapists would be trained to assist the work of the orthodontist. They would enable orthodontists to treat a greater number of patients and thereby potentially reduce the cost of orthodontic services. At the time of writing a number of issues remain to be resolved in relation to orthodontic therapists.

## Reform of Regulatory Structures

23. There is significant potential for conflicts of interest to arise from the current membership structure of the Dental Council. The Dental Council is almost entirely composed of members of the dental profession and those involved in the education of dentists. In principle, it is not necessary, proportionate or transparent for the governing body regulating a profession to be populated mainly by the profession being regulated.
24. The Competition Authority recommends that the composition of the Dental Council should be changed to include other groups. This will ensure that the composition of the Dental Council is consistent with best practice for regulators of professions in general and specifically with recent developments in other health professions. As the Dental Council will also have to regulate orthodontic therapists, clinical dental technicians and advanced dental hygienists, each of these oral healthcare professions should be represented on the Council. There should also be an appropriate number of consumer representatives, and a majority of the membership of the Council should come from outside the professions being regulated by the Council.
25. The Dental Council should be given powers to deal with fitness to practise issues relating to all groups of auxiliary dental workers regulated by it. The functions of the Dental Council should be clearly set out in the Dentists Act.

## Consumer Information

26. Consumers should be able to access clear, impartial information on oral healthcare issues, including their entitlements under the State dental schemes, and the different types of treatment available.

## Recommendations

Recommendation 1:		Introduce a new oral healthcare profession of clinical dental technician	
Details of Recommendation		Action By	
The Dental Council should, as a matter of urgency, finalise its draft Scheme for Clinical Dental Technicians and submit it to the Minister for Health and Children.  When the Scheme has been approved, the Dental Council should establish a Register of Clinical Dental Technicians. All eligible candidates should be registered without delay including clinical dental technicians who have appropriate qualifications from overseas.		Dental Council	
		December 2007	
		June 2008	

Recommendation 2:		Allow clinical dental technicians to be directly reimbursed under the State dental schemes	
Details of Recommendation		Action By	
The Health Service Executive and the Department of Social and Family Affairs should allow clinical dental technicians who are on the Register of Clinical Dental Technicians to be directly reimbursed under the Dental Treatment Services Scheme and the Dental Treatment Benefit Scheme, for the sale of dentures and for denture repairs.		Health Service Executive	
		Department of Social and Family Affairs	
		October 2008	



<b>Recommendation 3:</b>	
<b>Engage with training providers to establish courses in Clinical Dental Technology</b>	
<b>Details of Recommendation</b>	<b>Action By</b>
The Dental Council should engage with training providers to establish courses in clinical dental technology in Ireland.	Dental Council  October 2008

<b>Recommendation 4:</b>	
<b>Introduce a new oral healthcare profession of advanced dental hygienist who can operate independently of dentists</b>	
<b>Details of Recommendation</b>	<b>Action By</b>
The Dental Council should commit itself to the introduction of advanced dental hygienists within the shortest feasible timeframe. The Council should, in conjunction with the Dental Schools, identify any additional training necessary to enable advanced dental hygienists to operate on a stand-alone basis.	Dental Council  October 2009
The Minister for Health and Children should bring forward proposals to amend the Dentists Act 1985 to allow for the establishment of a new profession of advanced dental hygienist, who can operate independently of dentists. The Dental Council should be given powers to investigate complaints against advanced dental hygienists and apply appropriate sanctions.	Minister for Health and Children  October 2008
The Dental Council should submit a new Scheme for Advanced Dental Hygienists to the Minister for Health and Children. The Scheme should provide that hygienists are obliged to refer a patient to a dentist if they suspect that the patient requires treatment which they are unqualified to perform or which is beyond their scope of practice.	Dental Council  October 2009

<b>Recommendation 5:</b>	
<b>Allow advanced dental hygienists to be directly reimbursed for treatments provided under the State schemes</b>	
<b>Details of Recommendation</b>	<b>Action By</b>
The Health Service Executive and the Department of Social and Family Affairs should allow advanced dental hygienists who are on the Register of Advanced Dental Hygienists to be directly reimbursed under the Dental Treatment Services Scheme and the Dental Treatment Benefit Scheme for eligible dental treatments they provide.	Health Service Executive  Department of Social and Family Affairs  At the same time as the Register of Advanced Dental Hygienists is established

<b>Recommendation 6:</b>	<b>Review the number of training places for dentists and other oral healthcare professionals</b>
<b>Details of Recommendation</b>	<b>Action By</b>
<p>The Department of Health and Children should, in the context of the forthcoming National Oral Healthcare Policy:</p> <p>(a) assess the future manpower requirements for dentists and other oral healthcare professionals; and,</p> <p>(b) carry out a detailed review of the number of training places for dentists and other oral healthcare professionals, taking account of the effects of the other recommendations contained in this report, to determine whether the number of places for dentistry and other oral healthcare professionals needs to be increased and, if so, to what level.</p>	<p>Department of Health and Children</p> <p>October 2008</p>

<b>Recommendation 7:</b>	<b>Remove unnecessary restrictions on advertising</b>
<b>Details of Recommendation</b>	<b>Action By</b>
<p>The Dental Council should limit its restrictions on advertising to prohibiting advertising which is false or misleading.</p>	<p>Dental Council</p> <p>December 2007</p>

<b>Recommendation 8:</b>	<b>Remove the ban on discounts</b>
<b>Details of Recommendation</b>	<b>Action By</b>
<p>The Dental Council should amend its <i>"Professional Behaviour and Dental Ethics"</i> to remove the ban on discounting by dentists.</p>	<p>Dental Council</p> <p>December 2007</p>

<b>Recommendation 9:</b>	<b>Provide information to consumers on oral healthcare issues</b>
<b>Details of Recommendation</b>	<b>Action By</b>
<p>The Department of Health and Children should provide for the dissemination of information on oral healthcare issues to consumers as part of the National Oral Healthcare Strategy.</p>	<p>Department of Health and Children</p> <p>October 2008</p>

<b>Recommendation 10:</b>		<b>Explicitly permit corporate dental bodies</b>
<b>Details of Recommendation</b>	<b>Action By</b>	
<p>The Minister for Health and Children should bring forward legislation amending the Dentists Act 1985 to:</p> <ul style="list-style-type: none"> <li>(a) explicitly allow corporate bodies to engage in the business of dentistry; and,</li> <li>(b) require that all treatment carried out on patients is delivered by registered dentists or other appropriate registered oral healthcare professionals.</li> </ul>	<p>Minister for Health and Children</p> <p>October 2008</p>	

<b>Recommendation 11:</b>		<b>Amend the composition of the Dental Council</b>
<b>Details of Recommendation</b>	<b>Action By</b>	
<p>The Minister for Health and Children should bring forward legislation to amend the composition of the Dental Council. The revised legislation should provide that:</p> <ul style="list-style-type: none"> <li>(a) a majority of the membership of the Council should come from outside the professions being regulated by the Council; and,</li> <li>(b) each of the professions regulated by the Council should be represented on the Council.</li> </ul>	<p>Minister for Health and Children</p> <p>October 2008</p>	

<b>Recommendation 12:</b>		<b>Give the Dental Council power to deal with fitness to practise issues for all groups of dental workers regulated by it</b>
<b>Details of Recommendation</b>	<b>Action By</b>	
<p>The Minister for Health and Children should bring forward legislation to amend the Dentists Act 1985 to:</p> <ul style="list-style-type: none"> <li>(a) give the Dental Council the power to deal with fitness to practise issues relating to all groups of auxiliary dental workers regulated by it; and,</li> <li>(b) clearly set out the functions of the Dental Council.</li> </ul>	<p>Minister for Health and Children</p> <p>October 2008</p>	







# section 1



# 1. INTRODUCTION

- 1.1 Competition in the dental profession is not working in the best interests of consumers. This report contains 12 recommendations designed to maximise the benefits of competition for consumers of dental services.
- 1.2 The Competition Authority's recommendations are in line with reform of the dental profession that has taken place, or is taking place, in other countries, such as the United Kingdom.
- 1.3 The Competition Authority understands that the Department of Health and Children is currently preparing a National Oral Healthcare Policy and a new Dentists Bill. The recommendations in this report complement these developments and come with a proposed timetable for implementation. This timetable is based on the Competition Authority's experience of the timeframe involved in preparing legislation generally. The recommendations for legislative change – addressed to the Minister for Health and Children – envisage a Dentists Bill in 2008. This is an achievable timeframe. The recommendations to the Dental Council and others are given a tighter timeframe reflecting their ability to put changes into effect more quickly.
- 1.4 This report is not the only occasion on which the Competition Authority has addressed competition issues in the dental profession. On 28th April 2005, the Competition Authority agreed settlement terms, without admission of liability, with the Irish Dental Association in a High Court action taken by the Authority alleging a breach of the Competition Act 2002.<sup>6</sup> The Competition Authority took this action following allegations of an attempt to frustrate price competition between dentists through a collective boycott of a private dental insurance scheme being introduced in Ireland by Vhi DeCare.

## Background to the Report

- 1.5 The Competition Authority aims to ensure that competition works well for consumers. One of the Competition Authority's functions under section 30 of the Competition Act 2002 is to *"study and analyse any practice or method of competition affecting the supply and distribution of goods or the provision of services or any other matter relating to competition"*.
- 1.6 This report is part of a wider study of a number of professions. Following an OECD Report<sup>7</sup> in 2001, which suggested that competition in the professional services sector in Ireland could be stronger, the Competition Authority commenced a study of selected professions. The professions chosen were: engineers, architects, dentists, optometrists, veterinary surgeons, medical practitioners, solicitors and barristers.
- 1.7 The initial process of the study involved a research phase and report by Indecon International Economic Consultants. Their report, *Indecon's Assessment of Restrictions in the Supply of Professional Services*, was published in March 2003.<sup>8</sup>
- 1.8 The Competition Authority has published final reports on the engineering profession (December 2004), the architects' profession (March 2006), the optometry profession (June 2006) and the legal professions (December 2006).

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6 2005 521 P *The Competition Authority v. Irish Dental Association* (FH 2D). See [www.tca.ie/press/132.pdf](http://www.tca.ie/press/132.pdf) for full details of settlement terms.

7 OECD (2001) *Regulatory Reform in Ireland*.

8 See [www.tca.ie/professions.html](http://www.tca.ie/professions.html).

## The Consultation Process

- 1.9 The Competition Authority published its preliminary report on the dental profession in December 2005. The document presented preliminary analysis and recommendations designed to enhance competition to the benefit of consumers of dental services. The Competition Authority sought submissions on the facts, analysis and preliminary recommendations in the report from all interested parties.
- 1.10 The consultation was carried out publicly in the interests of fairness, consistency and transparency. The Competition Authority sought responses to the preliminary report in general and to its preliminary recommendations in particular. Respondents, in compiling their submissions, were asked to identify obstacles to the implementation of preliminary recommendations and also identify potential side effects, either positive or negative, that might arise.
- 1.11 Eleven parties provided responses and were consulted by the Competition Authority in the preparation of this final report.<sup>9</sup> In addition, the Competition Authority met a wide variety of interested parties in preparing the preliminary report and this final report.

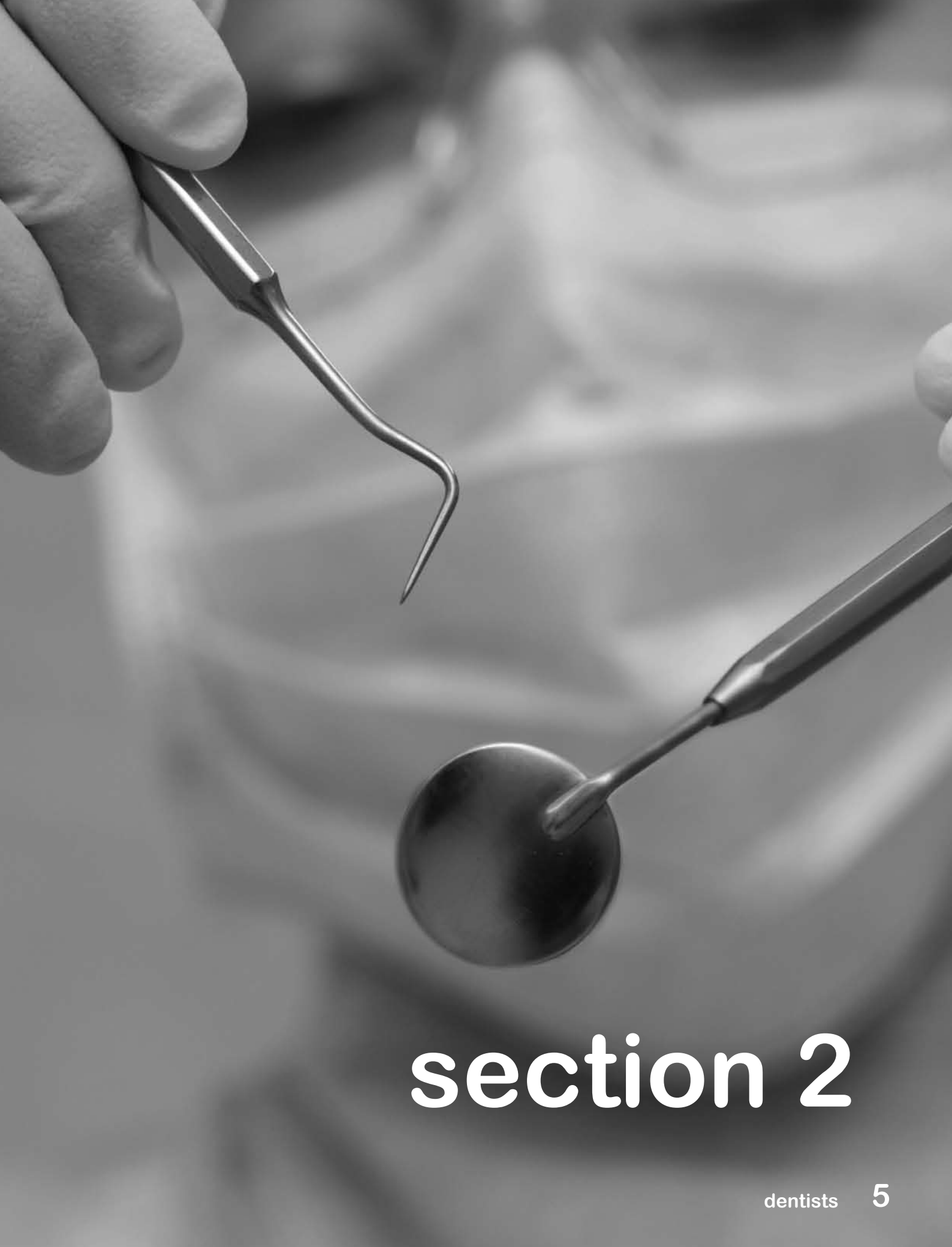
## Structure of the Report

- 1.12 The report contains a general overview of the dental profession, followed by a detailed examination of the restrictions limiting competition for dental services and the features of the profession which discourage competition.
- 1.13 The remainder of the report is structured as follows:
- Chapter 2 describes the dental profession in Ireland, including a description of the work of dentists and other oral healthcare professionals, the regulatory environment in which they operate, how dental services are supplied, who pays for them and how much they pay.
  - Chapter 3 analyses restrictions on offering dental services. The specific issues examined are restrictions on the sale of dentures, restrictions on dental hygienists, restrictions on the number of training places on undergraduate dentistry courses and restrictions on the supply of orthodontic services.
  - Chapter 4 deals with rules or practices which reduce competition and rivalry between dentists and the need for more information for consumers.
  - Chapter 5 deals with reform of regulatory structures, specifically in terms of the composition and functions of the Dental Council, in line with the principles of better regulation.
  - Chapter 6 provides an overall conclusion on competition in dental services.

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9 A list of submissions received is attached at Appendix 1.





# section 2



## 2. AN OVERVIEW OF THE DENTAL PROFESSION

### Summary

- 2.1 This chapter outlines the services provided by dentists<sup>10</sup>, and related oral healthcare professionals, and describes the regulatory and commercial environment in which they operate.
- 2.2 Dentists diagnose oral health problems and provide treatments for anomalies and diseases of the teeth, mouth, jaws and gums. Dentists work predominantly in the private sector, and offer their services directly to the public. Dentists often employ other qualified professionals - dental nurses and dental hygienists - to provide basic dental services to their customers. Orthodontists and oral surgeons are qualified dentists with additional specialist qualifications. Orthodontists provide orthodontic treatment, mainly to children, while oral surgeons perform oral surgery, typically on the basis of a referral from a dentist.
- 2.3 The conduct and standards of dentists, and related dental professions, are regulated under statute by the Dental Council. Under the Dentists Act 1985, it is unlawful for a person to use the title “dentist” or “dental specialist”, or to practise dentistry, without being registered by the Dental Council.
- 2.4 The State is the biggest purchaser of dental services, and in 2005 spent over €105 million on dentists’ services.<sup>11</sup> The State subsidises dental services through a variety of schemes. The vast majority of the population is eligible for some form of free/subsidised dental treatment under one of the State schemes.
- 2.5 Demand for dental services continues to rise. This is being driven by a growing population and higher incomes. The number of dentists providing their services in Ireland has risen consistently over the last 15 years.<sup>12</sup> However, the number of dentists trained in Ireland has not increased in line with demand and the undersupply of domestically-trained dentists has led to a reliance on immigration by foreign-trained dentists to the Irish market.
- 2.6 Dental prices have been increasing faster than general health inflation in Ireland over the past fifteen years.

### The Role and Functions of Dentists

- 2.7 The role of the dentist is to prevent, diagnose and treat anomalies and diseases of the teeth, mouth, jaws and associated tissues.<sup>13</sup>
- 2.8 Dental services range from routine preventive procedures (such as teeth cleaning) and simple restorative work (such as fillings), to more complex procedures (such as root canal treatment) and advanced restorative work (such as crowns and bridges). Dental treatments may be sought for the relief of pain, as a result of injury, or for purely cosmetic reasons.
- 2.9 Most dentists perform a similar range of routine dental treatments and can be classified as general dental practitioners. There are a small number of dentists who specialise in a particular area of dentistry (such as orthodontics, oral surgery, prosthodontics, periodontics or endodontics).<sup>14</sup> Dentists who work in general practice will sometimes refer a patient onwards to a dentist who specialises in a particular area of dentistry if the patient requires more advanced dental treatment.

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10 The terms “dentist” and “dental surgeon” are used interchangeably in this report.

11 This excludes the cost of providing tax relief on non-routine dental expenses. An accurate cost of this tax relief could not be obtained from the Revenue Commissioners.

12 At the end of 2006 there were 2,414 registered dentists. Source: the Dental Council.

13 Sources: (1) Definition of the practice of dentistry contained in Council Directive of 25th July 1978 concerning the coordination of provisions laid down by law, regulation or administrative action in respect of the activities of dental practitioners (78/687/EEC), and (2) response of the Dental Council to Competition Authority questionnaire, February 2002.

14 See Glossary of Terms for a description of these areas of dentistry.

2.10 The majority of dentists work in private practice, either alone or in partnerships with other dentists. A new model for the delivery of dental services with highly visible Main Street locations, longer opening hours and a strong brand identity, similar to the Specsavers model for optometry services, has recently begun to emerge in Ireland. Dentists who are employees of the State work in Health Service Executive (HSE) areas, the two university dental hospitals in Dublin and Cork, and the defence forces.<sup>15</sup> There were approximately 1,800 practising dentists in Ireland at the end of 2006.<sup>16</sup>

## Related and Overlapping Service Providers

2.11 There are two specialist areas of dentistry in Ireland that are legally recognised and protected – orthodontics and oral surgery.<sup>17</sup>

2.12 **Orthodontists** are dentists who have undertaken additional specialist postgraduate training in the field of orthodontics over a three year period. Orthodontists treat patients who have irregularities of the teeth, bite and jaw. There are currently 103 orthodontists in Ireland.<sup>18</sup> Approximately 50% of orthodontists work in private practice, with the rest employed in the HSE areas and in the dental hospitals, in many cases on a part-time basis.<sup>19</sup>

2.13 **Oral surgeons** are dentists who have undertaken additional specialist postgraduate training in the field of oral surgery over a three year period. Oral surgeons perform surgical procedures on patients under general anaesthetic. There are currently 35 oral surgeons in Ireland.<sup>20</sup> The majority of these work in private practice although some are employed in the HSE areas and in the dental hospitals, in some cases on a part-time basis.<sup>21</sup>

2.14 There are a number of other oral healthcare providers in Ireland - dental hygienists, dental nurses and dental technicians.

2.15 **Dental hygienists** are qualified to carry out a particular subset of dental treatments such as scaling, polishing and cleaning teeth, applying materials to the teeth and gums, administering block anaesthesia<sup>22</sup> and giving advice in relation to oral health. The main role of dental hygienists is in the rehabilitation of patients who have suffered from gum disease, in the oral health maintenance of patients who have had advanced prosthodontic treatment and in the placement of fissure sealants. Hygienists must work under the supervision of a dentist. Hygienists can only treat a patient who has been referred by a dentist and can only provide services prescribed by a dentist. There were 317 dental hygienists in Ireland at the end of 2006.<sup>23</sup> A total of 61.25 dental hygienists (whole-time equivalents) were employed by the Health Service Executive (HSE) at the end of June 2007.<sup>24</sup>

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15 At the end of June 2007 there were 4.2 Dental Surgeons (Clinical Grade 1), 221.85 Dental Surgeons (General), 32.89 Dental Surgeons (Principal), 63.77 Dental Surgeons (Senior) and 17.71 Dental Surgeons (Senior Administrative) giving a total of 340.42 whole-time equivalent dentists employed by the Health Service Executive. Source: Health Service Personnel Census. The Department of Defence employs its own dentists to treat members of the Defence Forces.

16 Source: Estimate from the Irish Dental Association.

17 To use the title "orthodontist" or "oral surgeon" a dentist must be on the Register of Dental Specialists, which is maintained by the Dental Council. Currently these are the only specialist areas of dentistry which are officially recognised, although the Dental Council has requested the Minister for Health and Children to officially recognise a number of other specialist areas.

18 Source: Dental Council's Register of Specialists as at end 2006.

19 At the end of June 2007, there were 11.87 Consultant Orthodontists and 40.14 Specialists in Orthodontics employed in the public sector, giving a total of 52.01 whole time equivalents. Source: Health Service Personnel Census.

20 Source: Dental Council's Register of Specialists as at end 2006.

21 At the end of June 2007, there were 2.18 Consultant Oral Surgeons and 4.45 Consultant Oral and Maxillo Facial Surgeons (whole-time equivalents) employed in the public sector. Source: Health Service Personnel Census.

22 Block anaesthesia is anaesthesia of an area supplied by a nerve produced by an anaesthetic agent applied to the nerve.

23 Source: Dental Council's Register of Dental Hygienists.

24 Source: Health Service Personnel Census.



2.16 The Minister for Health and Children recently approved a proposal from the Dental Council to expand the duties that can be carried out by dental hygienists.<sup>25</sup> Hygienists will now be permitted to:

- Administer block anaesthesia to patients provided that it is prescribed by the supervising dentist who must remain on the practice premises until the treatment is completed; and,
- Place temporary dressings and re-cement crowns with temporary cement when fillings or crowns are displaced by a hygienist in the course of his/her work.

2.17 Existing dental hygienists will require training before they will be able to carry out these additional duties. The Schools of Dental Hygiene in Dublin and Cork have agreed to adapt their training programmes so that newly qualified hygienists will be able to undertake these duties and to provide supplementary training courses for existing hygienists.

2.18 **Dental nurses** assist dentists and are involved in the preparation of surgeries for operative procedures, the sterilisation and disinfection of instruments and equipment, the reception and care of patients, the provision of chair-side assistance to the dentist and/or dental hygienist, dental radiography and clerical and administrative duties.<sup>26</sup> The exact number of dental nurses is unknown as registration is not mandatory. However, it is estimated that there are in excess of 2,000 persons carrying out dental nurse duties in Ireland.<sup>27</sup> There were 422 registered dental nurses in Ireland at the end of 2006.<sup>28</sup> A total of 95.19 dental nurses and 31.57 senior dental nurses (whole-time equivalents) were employed by the HSE at the end of June 2007.<sup>29</sup>

2.19 **Dental surgery assistants** work in dental practices but do not have any qualifications. At the end of June 2007 there were 464.96 Dental Surgery Assistants (whole-time equivalents) employed by the HSE.<sup>30</sup>

2.20 **Dental technicians** specialise in the manufacture and repair of dentures and other dental prosthetics. It is illegal for dental technicians to sell dentures directly to the public, but many do so.<sup>31</sup> As there is no legal title of dental technician and no register of these professionals in Ireland, there is no official data on the number working in the profession. It is estimated that there are around 250-300 dental technicians in Ireland.<sup>32</sup> At the end of June 2007 there were 5.0 dental technicians (whole-time equivalents) employed by the HSE.<sup>33</sup>

## Regulation of the Dental Profession

2.21 The Dental Council is the regulatory body responsible for the registration and control of persons engaged in the practice of dentistry in the State. The Dental Council was established under the Dentists Act 1985. The Council is responsible for the operation and enforcement of the provisions laid down in the Act. The general concern of the Dental Council is to promote high standards of professional education and professional conduct among dentists and to fulfil the functions assigned to it by the Act.

2.22 The Dental Council has a membership of 19 persons. The composition of the Council is dictated by the Dentists Act 1985 and is set out in Table 1 on the following page.

25 See [www.dentalcouncil.ie/news](http://www.dentalcouncil.ie/news) "New Duties for Dental Hygienists", 23rd March 2007.

26 To become a qualified dental nurse a student can take a one-year course at the Dublin Dental Hospital, or a two-year course at the University Dental School and Hospital, Cork.

27 Source: Dental Council.

28 Source: Dental Council's Register of Dental Nurses.

29 Source: Health Service Personnel Census.

30 Source: Health Service Personnel Census.

31 *Report of Enquiry into the Statutory Restrictions on the Provision of Dental Prostheses* (1982), Restrictive Practices Commission; Dental Council; Dental Technicians Association of Ireland; and other industry sources contacted by the Competition Authority in the preparation of this report. According to the Dental Council, a number of dental technicians have been prosecuted in Ireland for selling dentures directly to the public.

32 *Oral and Dental Specialisation in Ireland, April 2002*, commissioned by the Department of Health and Children, available at [www.dohc.ie](http://www.dohc.ie).

33 Source: Health Service Personnel Census.

**Table 1: Composition of the Dental Council**

Number of Members	Nominating Party	Occupation
7	Registered Dentists (by election)	Dentists
4	Minister for Health and Children	None specified but at least two must be non-dentists who represent the interests of the general public as consumers of dental services
2	University College Cork	None specified
2	University of Dublin	None specified
2	Medical Council	None specified
1	Royal College of Surgeons in Ireland	None specified
1	Minister for Education and Science	None specified

Source: Dentists Act 1985

2.23 The Dental Council is charged with the statutory protection of certain titles under the Dentists Act 1985 and maintains a number of registers. Registration must be renewed annually.

- Register of Dentists - those who wish to practise dentistry or use the title “dentist” must be on this Register.
- Register of Specialists - this is currently divided into two groups: orthodontists and oral surgeons. Those who wish to use the title “orthodontist” or “oral surgeon” must be on this Register.
- Register of Dental Hygienists - those who wish to use the title “dental hygienist” must be on this Register.
- Register of Dental Nurses - registration for dental nurses is voluntary. A person is not obliged to be registered with the Council in order to practise as a dental nurse.

2.24 The main functions assigned to the Dental Council under the Dentists Act 1985 are:

- To establish, maintain and publish a register of dentists, specialists, and other auxiliary dental workers (hygienists, nurses);
- To oversee dental education and training provided in the State's dental schools, including the standards required at examinations for primary qualifications and the suitability of postgraduate education and training;
- To investigate allegations of professional misconduct or unfitness to practise against a registered dentist and to take action. The Council has the power, subject in some instances to confirmation by the High Court, to advise, admonish, censure, suspend, attach conditions to registration or erase a dentist's name from the Register;
- To make, with the consent of the Minister for Health and Children, schemes<sup>34</sup> for the establishment of classes of auxiliary dental workers;

34 Section 53(1) of the Dentists Act 1985 gives the Dental Council the power to make schemes for classes of auxiliary dental workers who may undertake classes of dental work specified by the Council. Such schemes set out the training and qualifications required to become a member of each class of auxiliary dental worker, the nature of the work they may undertake, establish a register for each class and specify the title of the particular class. Such schemes must be approved by the Minister for Health and Children.

- To discharge the duties assigned to the Council pursuant to the provisions of EU Dental Directives; and
- To advise the dental profession and the public on all matters relating to the ethical conduct of dentists.

2.25 The Dentists Act 1985 provides that the Dental Council may carry out its functions through a number of statutory committees such as the Education and Training Committee, the Fitness to Practise Committee and the Auxiliary Dental Workers Committee.

2.26 The Council is self-funding, deriving most of its funds from the fees it charges to dentists, specialists, dental hygienists and dental nurses for registration and retention on the Registers.<sup>35</sup>

## Registration of Dentists

2.27 Inclusion on the Register of Dentists is available to:

- Graduates in dentistry from a university in Ireland;<sup>36</sup>
- Nationals of European Economic Area (EEA)<sup>37</sup> Member States who graduate within the EEA with a scheduled dental degree or diploma;
- Nationals of EEA Member States who qualify for registration under the provisions of Directive 2001/19/EC; and
- Dentists, not otherwise entitled to registration, who pass a special Dental Council Examination (see para 2.28).

2.28 Non-EEA nationals who have obtained their dentistry qualification from within the EEA, and EEA nationals who have obtained a dentistry qualification outside the EEA, do not have an automatic entitlement to registration in Ireland. Their training and professional experience are assessed on an individual basis by the Dental Council. They must pass a special examination set by the Dental Council. This examination is set to a standard equivalent to the final examinations on an Irish undergraduate dentistry course. The Dental Council has announced that it already has a full quota of applicants for the 2008 examination.<sup>38</sup>

2.29 The Dental Council does not operate a quota for the examination as such and until 2006 was able to accommodate all candidates for its examination for foreign-trained dentists. However, in 2007 the Council received 82 applications for the examination, possibly due to the temporary suspension of the UK General Dental Council's examination for foreign-trained dentists.<sup>39</sup> The Council decided to deal with this exceptionally high number by allowing half the applicants to take the examination in 2007 and half in 2008. This was because the Council uses the staff and facilities of the Dublin and Cork Dental Schools to run its examinations and it would not be possible to arrange the use of staff and facilities on two occasions in one year. While it is understandable that a once-off increase in the number of applicants caused difficulties for the Council it is not satisfactory that new candidates wishing to sit the examination will not be able to do so until 2009. The Council should investigate other options to enable it to cope with large numbers of candidates should the increase in numbers continue in the future.

35 Other sources of finance include rental income, examination fees, sales of registers and bank interest. The fees charged by the Council are subject to the approval of the Minister for Health and Children. Source: Dental Council's response to questionnaire February 2002.

36 The primary dental qualifications awarded in Ireland are: Bachelor of Dental Surgery of the National University of Ireland and Bachelor in Dental Science of the University of Dublin.

37 The European Economic Area is made up of the 27 Member States of the EU, Iceland, Liechtenstein and Norway.

38 See [www.dentalcouncil.ie/news](http://www.dentalcouncil.ie/news) "Examination for Non EEA Trained Dentists", 1<sup>st</sup> January 2007.

39 The General Dental Council has now commenced a new Overseas Registration Examination. It is expected that the first sittings of the examination will take place in September 2007.

2.30 The Dental Council can grant temporary registration to dentists who are not automatically eligible for full registration or are in Ireland temporarily to practise dentistry in supervised posts for training, teaching or research purposes. Dentists with temporary registration cannot work in private practice. Temporary registration is granted initially for up to one year but can be extended to a maximum of five years.

2.31 Table 2 gives details of the numbers who have applied for the Dental Council's examination for foreign-trained dentists for the period 2002-2007 inclusive.

**Table 2: Applications for Examination for Foreign-trained Dentists**

2002	2003	2004	2005	2006	2007
12	12	21	26	26	82 <sup>40</sup>

Source: Dental Council

## Registration of Dental Specialists

2.32 The Dental Council maintains a Register of Dental Specialists, which was established in 2000. Two specialist areas of dentistry are currently recognised by the Council – orthodontics and oral surgery.

2.33 Inclusion on the Register of Dental Specialists is available to:

- A registered dentist who, prior to the establishment of the Register, had, in the opinion of the Dental Council, completed specialist training in a specialty recognised by the Council;<sup>41</sup>
- A registered dentist who provides evidence of satisfactory completion of specialist training by a body recognised by the Dental Council;<sup>42</sup>
- A national of an EEA Member State who has been awarded a qualification in another Member State in a specialist area recognised by the Dental Council;<sup>43</sup> and
- A dentist who satisfies the Dental Council that he/she has completed a programme of training of a standard considered by the Council to be adequate, in a specialist area recognised by the Council.

## Registration of Dental Hygienists

2.34 Inclusion on the Register of Dental Hygienists is available to:

- A person who holds a qualification in dental hygiene awarded by an institution in Ireland approved by the Department of Education and Science, following a course of training approved by the Council;
- A person who holds the Certificate of Proficiency in Dental Hygiene awarded by the Central Examining Board for Dental Hygienists in the United Kingdom; or

40 As noted in para 2.29, the Dental Council was unable to deal with the exceptionally high number of applicants for the examination in 2007 and decided to allow 40 candidates to take the examination in 2007 with the remainder taking it in 2008.

41 Section 37 (1) of the Dentists Act 1985 states "The Council may, from time to time with the consent of the Minister, determine the specialties which it shall recognise for the purpose of specialist registration under this Act".

42 Section 37 (3) of the Dentists Act 1985 states "The Council shall from time to time determine, in relation to each specialty recognised by it, the body or bodies which the Council shall recognise in the State for the purpose of granting evidence of satisfactory completion of specialist training".

43 Under European law, the State is obliged to recognise specified specialist qualifications in oral surgery and orthodontics that are awarded in another EEA Member State to an EEA national.

- A person holding a qualification in dental hygiene obtained following an acceptable course of training and which in the opinion of the Council is equivalent to the qualifications specified above.<sup>44</sup>

## Registration of Nurses

2.35 Inclusion on the Register of Dental Nurses is available to:

- A person who holds a qualification in dental nursing awarded by the Dublin Dental Hospital/University of Dublin, the University Dental School & Hospital Cork/National University of Ireland Cork;
- A person who holds a qualification in dental nursing awarded by the National Examining Board for Dental Nurses in the United Kingdom;
- A person who holds a qualification in dental nursing which, in the opinion of the Council, is equivalent to that specified at (a) or (b) above; or
- A person who satisfies the Council that he/she has the requisite training and/or experience to enable him/her to carry out the duties of a dental nurse in a safe and efficient manner.<sup>45</sup>

## Representative Bodies

2.36 The professionals who provide dental services each have their own representative body which represents their interests and interacts with the Dental Council on their behalf.

- The professional representative body for dentists is the Irish Dental Association. This is a non-statutory body with over 1,300 members. The majority of dentists in Ireland are members of the Irish Dental Association, although membership is voluntary.<sup>46</sup>
- The Orthodontic Society of Ireland is the professional body representing orthodontists. It was founded in 1990 from what was formerly the Orthodontic Group of the Irish Dental Association.<sup>47</sup>
- The Irish Dental Hygienists Association is the professional association for dental hygienists.<sup>48</sup>
- The Dental Technicians Association of Ireland is the main representative body for dental technicians.
- The Irish Dental Nurses Association is the representative body for dental nurses.<sup>49</sup>

44 Dental Hygienists trained in the EEA are covered under the General System for the mutual recognition of professional qualifications. Under this system, an individual applies for recognition to the competent authority for the relevant profession in the host Member State. The competent authority will compare the professional education in the home Member State with that required in the host Member State. If there are significant differences in either length or content the competent authority may impose one of the following additional requirements: proof of experience in the practice of the profession concerned in the home Member State or the completion of an adaptation period or an aptitude test in the host Member State.

45 Persons granted registration under this provision are unlikely to have less than five years experience in carrying out the duties of a dental nurse, the majority of this experience having been obtained during the immediately preceding five years. Applicants are required to submit signed statements from their employing/supervising dentists attesting to their competence in chairside assisting, cross-infection control, sterilisation, patient management etc., and to submit verifiable evidence of their duration of employment in carrying out the duties of a dental nurse.

46 [www.dentist.ie](http://www.dentist.ie).

47 [www.orthodontics.ie](http://www.orthodontics.ie).

48 [www.irishdentalhygienists.com](http://www.irishdentalhygienists.com).

49 [www.idna-ireland.com](http://www.idna-ireland.com).

## Categories of Dental Services

2.37 There are three different types of dental services provided in Ireland:

- General dental services;
- Orthodontic services; and
- Oral surgery.

The latter two types of dental services are referred to collectively as “specialist” dental services. Figure 1 outlines the services provided by the various dental professionals and shows where these overlap.

**Figure 1: Suppliers of Dental Services in Ireland**

Service	General Dental Service Providers			Specialist Dental Service Providers	
	Dentist **	Dental Hygienist	Dental Technician	Orthodontist*	Oral Surgeon*
Preventive services	✓	✓			
Advice on oral health	✓	✓			
Fitting and selling dentures to the public	✓				
Denture repairs	✓		✓		
Routine treatments (e.g. fillings)	✓				
Complex treatments (e.g. crowns)	✓				
Orthodontic treatment				✓	
Oral surgery					✓

\* Orthodontists and oral surgeons are qualified to undertake the same range of dental treatments as dentists, although in practice, they only supply orthodontic treatment and oral surgery respectively.

\*\* Dentists are also qualified to perform orthodontic treatment and oral surgery. However, in practice they tend to refer patients who require specialist treatment of this nature to an orthodontist or oral surgeon as appropriate.

### General Dental Services

2.38 The suppliers of general dental services are dentists, dental hygienists and dental technicians. There is a degree of overlap in the range of treatments which these providers are qualified to perform; however, most dental treatments are reserved solely to dentists under the Dentists Act 1985, which defines what is regarded as the “practice of dentistry”.<sup>50</sup>

2.39 General dental services refers to a wide range of dental treatments from routine treatments, such as fillings, to more complex treatments, such as bridgework, as well as cosmetic procedures, such as tooth whitening. These are all provided by general dental practitioners. Some complex dental treatments are provided by general dental practitioners who limit their practice to a particular area of dentistry (e.g. periodontics or endodontics).<sup>51</sup>

50 The Dentists Act 1985 defines the practice of dentistry as “the performance of any operation and the giving of any treatment, advice, opinion or attendance which is usually performed or given by a dentist and includes the performance of any operation or the giving of any treatment, advice or attendance on or to any person preparatory to, for the purpose of, or in connection with, the fitting, insertion or fixing of artificial teeth”.

51 These dentists tend to use the phrase “Practice Limited to ...” to denote the area of dentistry in which they specialise. They cannot call themselves ‘specialists’ as, according to the Dental Council, this would breach the Dentists Act 1985.



2.40 Consumers tend to purchase routine dental treatments (e.g. check-up, scaling and polishing) and emergency dental services (e.g. acute pain, sports injury) locally. Consumers are unlikely to travel substantial distances to avail of price differences for these treatments, which may, in any case, be difficult to detect.<sup>52</sup>

2.41 People are more likely to travel further afield for irregular complex dental treatments. Such treatments are non-routine in nature and typically command high prices. Consumers are more likely, therefore, to shop around beyond their locality. Some consumers are willing to travel considerable distances to avail of price differences for complex dental treatments, for example to Northern Ireland and Hungary.<sup>53</sup>

#### *Specialist Dental Services – Orthodontics and Oral Surgery*

2.42 There are formally recognised dental specialists in the areas of orthodontics and oral surgery and *de facto* specialists in other areas including prosthodontics, periodontics and endodontics. While some specialists operate in the public sector, the majority are engaged in private practice. There are regional consultants in orthodontics and oral surgery and dental hospital-based consultants in a number of disciplines. Other than the dentists who are on the Register of Specialists (of which there were 138 at the end of 2006), there are approximately another 100 dentists operating practices limited to a particular aspect of dentistry. The remaining dentists operate as general dental practitioners.<sup>54</sup>

2.43 Due to the much smaller number of specialists compared to general dental practitioners, specialist dental treatments tend to be provided at a more regional level and in the major cities, with each specialist serving a much wider catchment area than a dentist. This is reflected in both private and public provision of specialist dental services.

2.44 Orthodontic treatment is rarely practised at general practitioner level and has been almost exclusively a treatment carried out by specialists.<sup>55</sup> As orthodontic treatment tends to involve a period of ongoing treatment, it is less likely that people will travel abroad to access treatment.

## **Demand for Dental Services**

#### *Demand for General Dental Services*

2.45 Demand for dental services comes from individual consumers, some of whom may be entitled to free or subsidised dental services under the State schemes. Consumers seek dental treatments for different reasons, including regular check-up, pain relief, sports injury, concerns regarding oral health and cosmetic reasons. Greater affluence has resulted in increased demand for cosmetic treatments.<sup>56</sup> The need for dental services increases as people retain more of their natural teeth due to improved oral healthcare awareness and fluoridation of water supplies.<sup>57</sup>

2.46 The table on the following page shows the average household expenditure on dentists' fees according to the Household Budget Surveys carried out in 1994/1995, 1999/2000 and 2004/2005. Over the period the average annual expenditure on dentists' fees per household increased by 133%. However, the cost of dental services increased by 94% in the same period, indicating that a significant proportion of the increase in expenditure was due to an increase in overall demand.<sup>58</sup>

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52 The Consumers Association of Ireland has found that dentists typically do not give price information over the phone, or advertise their prices. See *Consumer Choice*, May 2001 and September 2004.

53 *Foreign dentists take a bite out of Irish market*, Sunday Times, 4th September 2005. Accurate figures are not available on the numbers travelling outside the Republic to access dental treatments.

54 Source: Response of the Dental Council to Competition Authority questionnaire, February 2002.

55 Source: Response of the Dental Council to Competition Authority questionnaire, February 2002.

56 *Ibid.*

57 *Ibid.*

58 Source: CSO Household Budget Survey and CSO data on the cost of dental services for the period 1994-2005.

**Table 3: Average Annual Household Expenditure on Dental Services**

Dentists' fees	1994/1995 €/year	1999/2000 €/year	2004/2005 €/year
Urban households	57.44	79.04	153.92
Rural households	64.69	64.69	118.04
All households	60.06	73.94	140.40

Source: CSO Household Budget Surveys 1994/1995, 1999/2000 and 2004/2005. Yearly figures are estimates based on average weekly expenditure x 52.

2.47 The demand for various types of dental treatments has changed over time.<sup>59</sup> As the oral health of the general population improves, due largely to increased awareness of oral health issues, demand for dental treatment generally has increased. Tooth extractions and full dentures are less in demand, relatively speaking, while demand for restorative work (e.g. fillings) and cosmetic procedures (e.g. tooth whitening) has increased significantly, in line with rising incomes.

2.48 There are a number of ways in which the State has an impact on the demand for dental services. These include the number of medical cards, subsidisation of dental treatments through the Pay Related Social Insurance (PRSI) system and also the availability of tax-relief on non-routine dental treatments.<sup>60</sup>

2.49 While a significant proportion of the population is entitled, to some degree, to free or subsidised dental services, many potential customers do not qualify for treatment under any of the State schemes. While it is not possible to quantify exactly the number of people who are not entitled to dental services under any of the State schemes, it is likely to be in the order of 750,000 to 1 million. In the area of private dental services, two factors are worth noting which will impact on demand for these services:

- Tax relief is available on non-routine dental treatments, and
- Private dental insurance is now available.<sup>61</sup>

2.50 Children under 16 and certain groups with special needs (e.g. people with disabilities, people in long-term hospital care and people with Hepatitis C) are entitled to State-funded dental services by State-salaried dentists. There are approximately 920,000 children under 16 eligible for free general dental services.

2.51 Certain dental services are available free of charge to all medical cardholders over the age of 16 (and their dependents) under the Dental Treatment Services Scheme (DTSS) which is run by the Health Service Executive. Dental services under the scheme are provided by approximately 1,000 dentists working in private practice who have signed an agreement with the Health Service Executive to participate in the scheme.<sup>62</sup>

2.52 Under the Dental Treatment Benefit Scheme (DTBS) operated by the Department of Social and Family Affairs, certain dental treatments are available free of charge and others at a reduced rate to workers or retirees who have made a sufficient number of PRSI contributions. Depending on the nature of the dental treatment and the consumer's income, the State either pays the full cost of the treatment or, in other cases, pays a fixed contribution and then the consumer pays the balance (for some treatments this is fixed). Dental services under

<sup>59</sup> Based on enquires conducted by the Competition Authority in the preparation of this report.

<sup>60</sup> Non-routine dental procedures covered for tax relief are: crowns, veneers/rembrant type etched fillings, tip replacing, gold posts, gold inlays, endodontics – root canal treatment, periodontal treatment, orthodontic treatment, surgical removal of impacted wisdom teeth and bridgework. This list was obtained from the Revenue Commissioners.

<sup>61</sup> Private dental insurance was first provided in Ireland by Vhi DeCare Dental in 2004. At the time of writing, Vhi DeCare Dental remains the sole provider of private dental insurance in Ireland. Dental insurance from Vhi DeCare Dental is open to everyone, although Vhi Healthcare members get a 10% reduction on their premiums.

<sup>62</sup> Dentists in private practice are not obliged to participate in either the DTSS or the DTBS; however, the majority of dentists do. Dental treatments under the DTSS are also provided by State-employed dentists.

the scheme are provided by approximately 1,500 dentists working in private practice who have signed an agreement with the Department of Social and Family Affairs to participate in the scheme. The DTBS covers a broader range of dental treatments than the DTSS. Further information on the DTBS is provided in Appendix 3.

2.53 Around 900,000 people, or 23% of the total population, are eligible for treatment under the DTSS. About 1.66 million people qualify for treatment under the DTBS.<sup>63</sup> It is estimated that upwards of 400,000 people are eligible under both the DTSS and the DTBS.<sup>64</sup> Table 4 gives a breakdown of those covered by the various State dental schemes.

**Table 4: State-funded Dental Schemes**

Scheme	Operated by	Who is covered	Numbers covered <sup>65</sup>
Dental Treatment Benefit Scheme	Department of Social and Family Affairs	Eligible PRSI contributors and their dependent spouses <sup>66</sup>	1.66 million
Dental Treatment Services Scheme	Health Service Executive	Medical card holders and their dependants	0.9 million
Child health schemes	Health Service Executive	Children under 16 referred from (a) child oral health examinations, and (b) school oral health examinations	0.92 million <sup>67</sup>
Other schemes	Health Service Executive	Holders of a Health (Amendment) Act Card	1,700 <sup>68</sup>
Tax Relief	Revenue Commissioners	All taxpayers and their dependants	

Source: Department of Social and Family Affairs, Department of Health and Children

2.54 While upwards of 80% of the population are entitled to a limited degree of free/subsidised dental services, many potential consumers do not qualify for treatment under any of the State schemes.<sup>69</sup> There may also be many consumers who are unaware of their entitlements or fail to claim them, as evidenced by the low utilisation of the DTSS in particular.<sup>70</sup>

2.55 There are certain dental services which are available only on a wholly private basis, i.e. the consumer must pay the full cost. For example, the DTSS does not cover fissure sealants, and advanced restorative treatments such as crowns, bridges and veneers are excluded.<sup>71</sup> Services regarded as cosmetic dentistry, such as tooth whitening, are not subsidised under either the DTSS or the DTBS, nor is tax relief available for this type of treatment.

2.56 In 2005, the amount paid to dentists under the DTSS and the DTBS amounted to €55.4 million and €49.7 million respectively - a total of over €105 million.

63 Of the 2.4 million people paying PRSI, 1.66 million qualify for treatment under the DTBS, as they have accumulated a sufficient number of contributions. The majority of these people qualify in their own right (1.28 million) with the remainder being dependent spouses. Source: Treatment Benefit Section, Department of Social and Family Affairs.

64 Treatment Benefit Section, Department of Social and Family Affairs.

65 These figures are not cumulative.

66 Individuals paying PRSI Classes A, E, P and H who fulfil the qualifying conditions, and their dependent spouses, are eligible for treatment under the DTBS.

67 Number of children aged 15 and under in 2006, CSO.

68 Source: Department of Health and Children.

69 The following groups are not entitled to dental benefits under the DTBS: Employees who pay PRSI Class D (Public Service employees) and PRSI Class B (e.g. pre-1995 Civil Servants), and employees who have not built up the required number of PRSI contributions which varies by age.

70 Utilisation of the DTSS by eligible persons is only around 25%. Source: *Dental Treatment Services Scheme – Service Utilisation and Treatment Need*, Oral Health Services Research Centre, University College Cork, p. 85-86, 2005. Commissioned by the Department of Health and Children. Available at [www.dohc.ie/issues/dental\\_research/dtss.pdf?direct=1](http://www.dohc.ie/issues/dental_research/dtss.pdf?direct=1)

71 *Dental Treatment Services Scheme – Service Utilisation and Treatment Need*, Oral Health Services Research Centre, University College Cork, *op cit*.

**Table 5: Payments to Dentists under the State Schemes 2005**

Scheme	Total Amount Paid to Dentists	Average Amount Paid to each Participating Dentist
DTSS	€55.4 million	€59,230
DTBS	€49.7 million	€34,975

Source: Department of Social and Family Affairs; Primary Care Reimbursement Service.

### *Demand for Orthodontics*

2.57 There is a strong demand for orthodontic treatment in Ireland for children and, increasingly, for adults.<sup>72</sup> Tax relief is available on orthodontic treatment and it is also covered under private dental insurance policies.

2.58 Children in primary schools are screened at the age of 12 to determine whether they require orthodontic treatment and are categorised according to their level of need. Treatment is provided by the State, free of charge, on the basis of priority. Treatment takes an average of two years to complete.

2.59 Children who cannot avail of treatment publicly, either because the waiting list is too long or because they are considered to be low priority patients, can avail of private orthodontic treatment but must pay the full cost.

2.60 Demand for public orthodontic treatment is in some cases met by orthodontists working in the private sector. For instance, in 2002, the Minister for Health and Children provided funding of €5 million to the health boards to pay for orthodontic treatment from orthodontists working in the private sector for children on public waiting lists.<sup>73</sup>

2.61 There is a higher proportion of adult patients in the private practice caseload than in the public sector caseload. In addition, fewer patients of private orthodontists require extractions as part of their treatment (43% of private patients require extractions compared to 63% of publicly-treated patients).<sup>74</sup> This suggests that orthodontic treatment availed of privately is less complex and more cosmetic in nature, with the more complex cases being treated by the publicly-funded system.

## Supply of Dental Services

### *Supply of General Dental Services*

2.62 The number of dentists on the Register has increased from around 1,300 in 1990 to over 2,400 at the end of 2006.<sup>75</sup> However, the number of dentists trained in Ireland has not increased in line with demand and the undersupply of domestically-trained dentists has led to a reliance on immigration by foreign-trained dentists to the Irish market. The graph below shows the increase in the number of registered dentists in Ireland compared to the increase in population over the period 1990-2006.

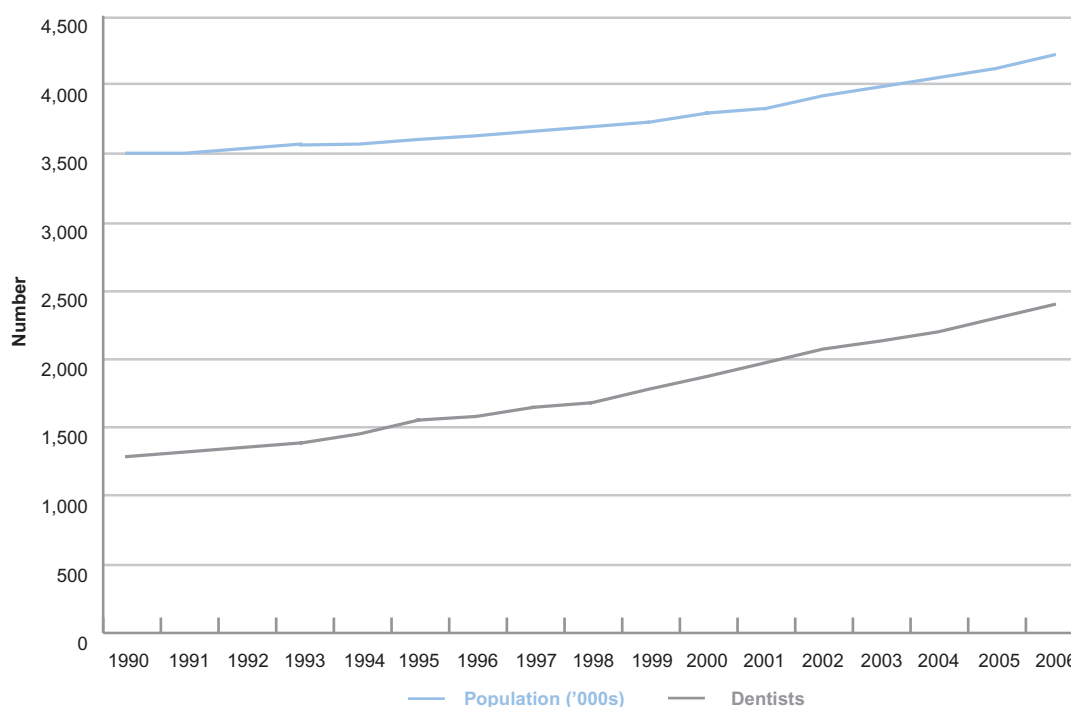
72 Private sector orthodontists treat a higher proportion of adult patients than the public sector. The average percentage of adults in the private caseload was 28% compared with 11.8% in the public sector caseload. Source: "The Orthodontic Workforce in Ireland: A Report by the Orthodontic Society of Ireland", February 2006.

73 This funding was provided through the National Treatment Purchase Fund.

74 Source: "The Orthodontic Workforce in Ireland: A Report by the Orthodontic Society of Ireland", February 2006.

75 The number of dentists on the Register is greater than the number of dentists in active practice. The Register includes a number of dentists who are retired, as well as some dentists who work abroad but continue to register in Ireland. The Register also includes dentists who practise exclusively as orthodontists and as oral surgeons rather than as general dental practitioners.

**Graph 1: Growth in Population and Number of Dentists 1990-2006**



Source: Register of Dentists, CSO population data.

2.63 Table 6 below shows the breakdown of where new registrants on the Register of Dentists obtained their qualifications. Of the 156 new registrants on the Register of Dentists in 2006, 74 graduated from either Dublin or Cork, 28 obtained their qualifications in the UK, 39 came from other EEA Member States, and 15 qualified in non-EEA Member States.

**Table 6: New Registrants on the Register of Dentists 2001-2006**

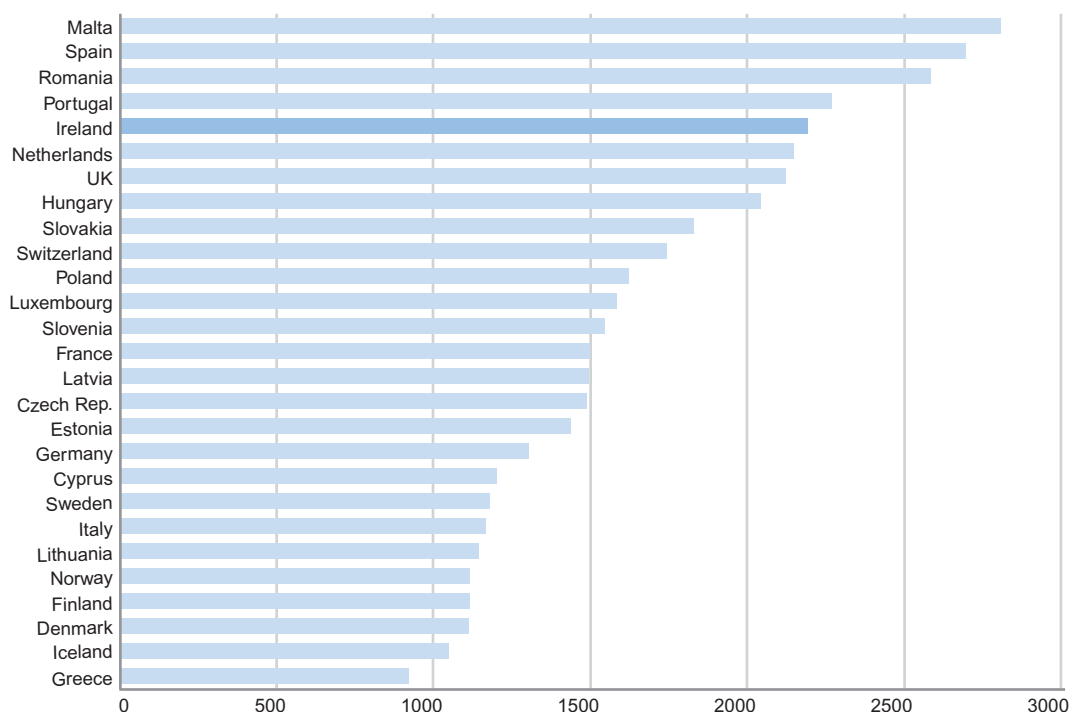
Where Qualified	2001	2002	2003	2004	2005	2006
Dublin	35	37	48	31	42	38
Cork	51	28	30	24	41	36
<b>National</b>	<b>86</b>	<b>65</b>	<b>78</b>	<b>55</b>	<b>83</b>	<b>74</b>
UK	44	35	29	18	35	28
New EU Member States <sup>76</sup>				22	21	21
Other EU/EEA	9	22	17	16	13	18
Non EU/EEA	14	7	11	17	13	15
<b>Total New Registrants</b>	<b>153</b>	<b>129</b>	<b>135</b>	<b>128</b>	<b>165</b>	<b>156</b>

Source: Dental Council

<sup>76</sup> The new EU Member States referred to in the table are Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovak Republic and Slovenia, all of whom joined the EU on 1<sup>st</sup> May 2004.

2.64 Graph 2 below shows the ratio of population to active dentists in EEA Member States in 2004. The average ratio of dentists to population in the EEA is around 1:1,625, while in Ireland this ratio rises to 1:2,165. This means that there are significantly less dentists in Ireland per head of population than is the case in most other EEA countries.

**Graph 2: Ratio of Population to Active Dentists in EEA Member States**



Source: Manual of Dental Practice, EU Dental Liaison Committee (2004).<sup>77</sup>

2.65 Dentists in private practice can operate as sole practitioners, in partnership with other dentists, or as employees. Most dental practices employ administrative staff and larger practices also tend to have dental hygienists or dental nurses on staff.

2.66 As the capital cost of setting up a new dental practice is high, the formation of associations, where dentists form larger groups, is now common.<sup>78</sup> An associate will enter into a contract with a principal (i.e. the dentist who is the owner of the practice) to contribute a percentage of his gross fee income for the use of premises, facilities, equipment and staff. This arrangement is neither one of partnership nor employment; each associate is regarded as a sole practitioner. The contribution can be as much as 50% of gross fees.<sup>79</sup>

2.67 A fairly recent phenomenon is the emergence of main street dental clinics which tend to have longer opening hours than traditional dental practices.<sup>80</sup>

2.68 There is a wide geographic spread of dental practices. They tend to be situated in main street environments in towns and small villages across the country, while in cities and larger towns they are often located in residential

<sup>77</sup> Source: *Manual of Dental Practice*, EU Dental Liaison Committee (2004). This report was undertaken by the Dental Public Health Unit in the University of Wales, College of Medicine, Cardiff. While simple population:dentist ratios are a relatively crude way of determining whether there is an under- or over-supply of dentists in a given area and there is no consensus on what the ideal ratio should be, it does provide a useful indication of how Ireland compares to other countries in a discussion of dental manpower issues.

<sup>78</sup> Office of the Revenue Commissioners (2001) Audit Instructions – Trade Profiles. [www.revenue.ie](http://www.revenue.ie).

<sup>79</sup> *Ibid.*

<sup>80</sup> Based on enquiries conducted by the Competition Authority in the preparation of this report.



areas, such as extensions to private dwellings. There are a higher number of dentists per head of population in the larger cities.<sup>81</sup>

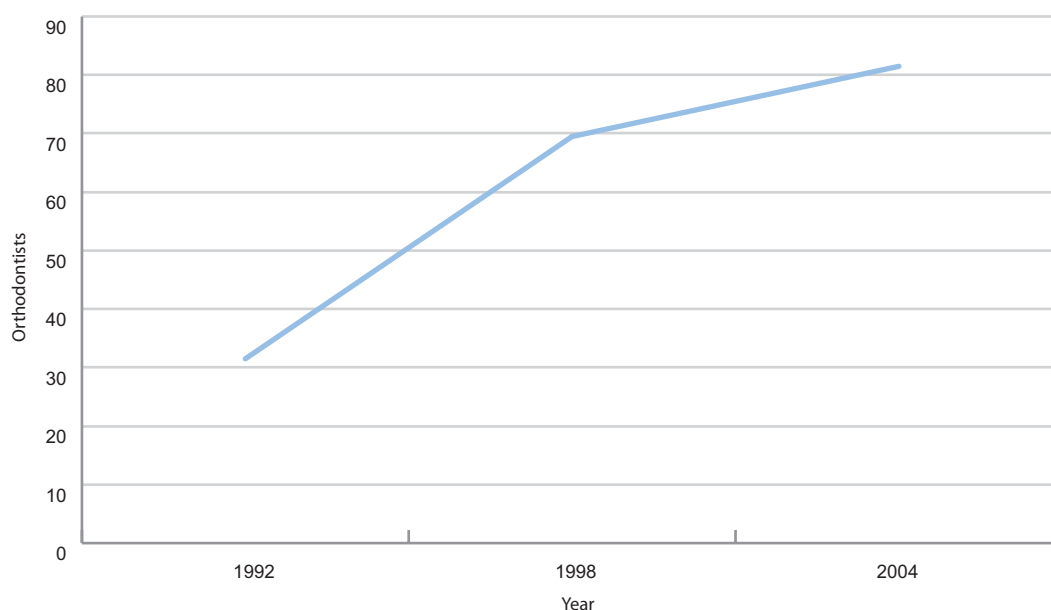
2.69 Dental hygienists provide dental services in a general dental surgery, although they typically work in their own separate treatment room. Dental hygienists are not permitted to operate their own practice independently of dentists. Dental technicians tend to have their own premises where they manufacture and repair dentures. Dental technicians are not permitted to sell dentures direct to the public, but many do so.<sup>82</sup>

#### *Supply of Orthodontic Services*

2.70 At the end of 2006, there were 103 registered orthodontists and 35 registered oral surgeons in Ireland. The growth in the number of orthodontists in Ireland in recent years is shown in Graph 3 below. Most of these specialists work in private practice, while some also work part-time in the Health Service Executive areas and in the two university dental hospitals.<sup>83</sup>

2.71 According to the Orthodontic Society of Ireland, there are 28 Irish specialist registrars in orthodontics training in the UK who are due to complete their training by 2009.<sup>84</sup>

**Graph 3: Number of Orthodontists in Ireland 1992-2004**



Sources: "Orthodontics in Europe 1992", Moss, J.P., European Journal of Orthodontics 1993, 15:393-401; "An update on orthodontic manpower in Ireland", Blake, M., Garvey, M.T., Healy, B., Journal of Orthodontics 2001, 28:93-96; Register of Orthodontists; Orthodontic Society of Ireland.

2.72 In 2006, the ratio of orthodontists to 12-year olds in Ireland was 1:435 compared to a ratio of 1:2773 in 1980 and 1:1890 in 1998.<sup>85</sup> This ratio may change in the coming years due to the rising number of births since the low of 47,929 in 1994.

81 Based on an analysis of the Register of Dentists.

82 Restrictive Practices Commission (1982) *Report of Enquiry into the Statutory Restrictions on the Provision of Dental Prostheses*; Dental Council; Dental Technicians Association of Ireland; and other industry sources contacted by the Competition Authority in the preparation of this report.

83 Approximately 55% of orthodontists work in private practice while 45% are employed in the public sector. Source: "The Orthodontic Workforce in Ireland: A Report by the Orthodontic Society of Ireland", February 2006.

84 *Ibid.*

85 Source: "The Orthodontic Workforce in Ireland: A Report by the Orthodontic Society of Ireland", February 2006.

2.73 The average waiting time to receive publicly funded orthodontic treatment is three years, but the numbers on waiting lists varies across different HSE areas.<sup>86</sup> The waiting time for private orthodontic treatment is 4-6 weeks.

## Dentists' Incomes

2.74 The main sources of income for dentists who work in private practice are:

- Fees from private patients;
- Reimbursements for services provided to patients under the two State dental schemes, the DTSS and DTBS (for dentists who participate in these schemes)<sup>87</sup> and
- Other sources such as locum fees and, in the case of a dentist who owns a dental practice, contributions from associates and hygienists for the use of facilities, equipment and staff.<sup>88</sup>

2.75 Owners of dental practices may receive profits in addition to salary income. According to the Revenue Commissioners, the following factors affect the profitability of dental practices:

- Ratio of private fees to payments under the State dental schemes;
- Location – whether it is an urban or rural practice;
- Socio-economic profile of the practice clientele;
- Degree of competition;
- Degree of specialisation, e.g. orthodontics, periodontics etc.;
- Fee charging policy and debt-collection procedures;
- Experience and age of the dental practitioner;
- Investment in technology, clinical equipment and training; and
- Contributions from associates and hygienists for the use of practice facilities.<sup>89</sup>

2.76 Dentists' incomes vary according to the number of years experience, as illustrated by Tables 8 and 9 on the following page.<sup>90</sup>

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86 Joint Oireachtas Committee on Health and Children (June 2005) *Fourth Report - Review of Public Orthodontic Services*.

87 Most dentists working in private practice participate in one or both of the two main State dental schemes. Dentists' earnings from services provided under these schemes vary from one dentist to another.

88 Revenue Commissioners (2005) *Audit Instructions – Trade Profiles*.

89 *Ibid*

90 Income figures used in this report were provided by the Revenue Commissioners. The Revenue Commissioners matched a large random sample from the Register of Dentists to the corresponding Revenue records for dentists' declared income from providing dental services and provided the Competition Authority with an anonymised version of the results. The income figures refer to individual dentists' gross earnings from dental services (whether as PAYE employee or self-employed sole trader) before tax, net of business expenses.

**Table 7: Dentists', Orthodontists' and Oral Surgeons' Income – 2002**

Category	Average Income	Median <sup>91</sup> Income	% with Income over €54,000	% with Income over €100,000
Dentists	€116,955	€96,355	80%	52%
Orthodontists	€280,307	€245,176	100%	77%
Oral Surgeons	€175,426	€91,076	100%	44%

Source: Revenue Commissioners

**Table 8: Dentists' Income by Years of Experience – 2002**

Experience (years) <sup>92</sup>	Average Income	Median Income	% with Income over €54,000	% with Income over €100,000
0-3	€16,309	€5,922	4%	4%
4-6	€55,505	€58,207	52%	2%
7-9	€92,304	€84,446	78%	35%
10-12	€101,289	€80,715	76%	35%
13+	€133,945	€114,648	92%	58%

Source: Revenue Commissioners

**Table 9: Orthodontists' Income by Years of Experience – 2002**

Experience (years) <sup>93</sup>	Average Income	Median Income	% with Income over €54,000	% with Income over €100,000
0-3	€60,109	€58,612	100%	77%
4-6	€107,039	€103,771	100%	100%
7-9	€150,508	€134,271	100%	100%
10-12	€432,876	€362,342	100%	100%
13+	€358,196	€381,784	100%	100%

Source: Revenue Commissioners

2.77 The public sector salary scales for dentists and orthodontists are set out below:

- Clinical Dental Surgeon (Grade 1) salary scale of €51,351 to €54,644 for an entry-level dentist;
- General Dental Surgeon salary scale of €59,187 to €87,445;
- Senior Dental Surgeon salary scale of €74,496 to €95,115;
- Specialist in Orthodontics €139,044;
- Consultant Orthodontist €172,841.<sup>94</sup>

91 The median income is the income level at which half of those in the profession are earning more and half are earning less.

92 Number of years experience relates to the number of years since the completion of a primary degree in dentistry.

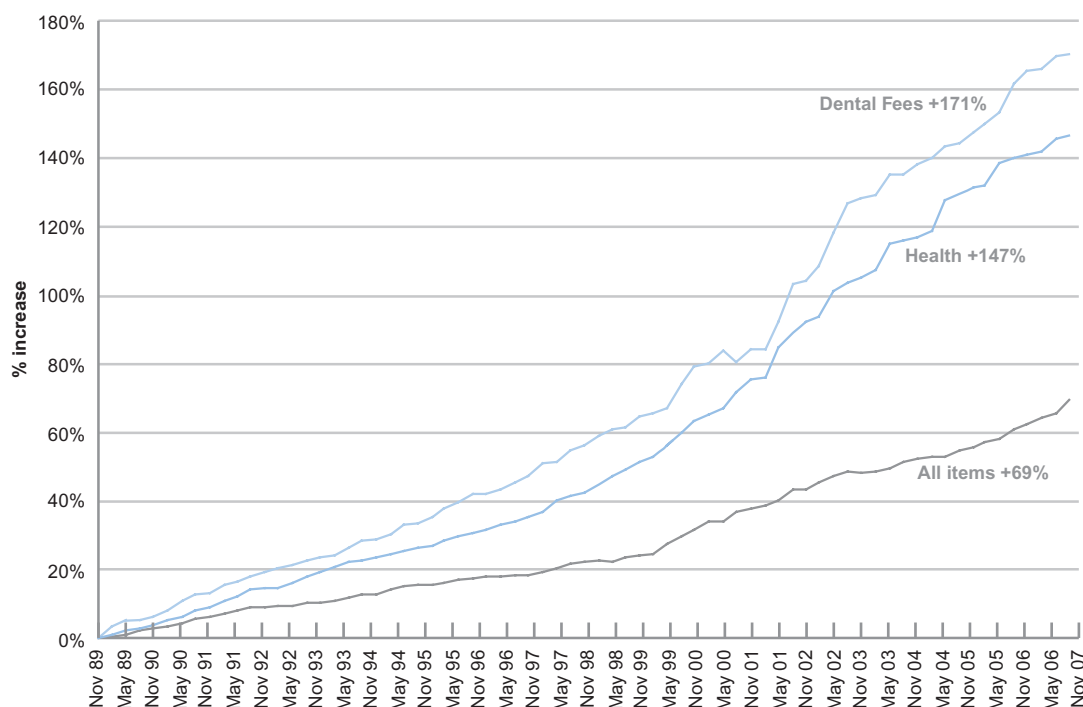
93 Number of years experience relates to the number of years since entry on the specialist register of orthodontists.

94 Source: Department of Health and Children Consolidated Salary Scales. Figures correct as at 1<sup>st</sup> June 2007. Available at [www.dohc.ie/publications/salary\\_scales\\_june07.html](http://www.dohc.ie/publications/salary_scales_june07.html).

## Price of Dental Services

2.78 The price of private dental treatments has consistently increased above the general rate of inflation over the last seventeen years and above the rate of inflation for health services over the same period. Between January 1990 and May 2007, the overall Consumer Price Index (which covers all items) increased by 69%, health costs grew by 147% while dental fees increased by 171%, according to data obtained from the Central Statistics Office.<sup>95</sup>

**Graph 4: Inflation in Dental Services, Health and CPI (All items) (January 1990-May 2007)**



Source: Central Statistics Office

2.79 The CSO is the most reliable and consistent source of accurate and unbiased data on private dental fees. The information compiled by the CSO in relation to dental fees covers four specific treatments on which information is collected from up to 30 dentists around the country every quarter. These are: scale and polish; tooth extraction under local anaesthetic; standard silver filling and a full set of dentures. While the CSO does not collect data from dentists on the price of every dental treatment, the four treatments they collect data on provide the most reliable guide to changes in the price of all private dental fees.<sup>96</sup>

## Fitness to Practise & Complaints

2.80 The Dental Council has a special committee, the Fitness to Practise Committee, for dealing with inquiries into the fitness of registered dentists to practise dentistry on the grounds of (a) alleged professional misconduct, or (b) alleged unfitness to practise by reason of physical or mental disability. The Committee reviews applications made by either a member of the public or the Dental Council itself for an inquiry. If the Committee is of the view that there is a prima facie cause for concern, an inquiry takes place. If it decides that there is not a case for holding an inquiry, it informs the Council, which has the right to direct the Committee to hold an inquiry.

<sup>95</sup> The most recent data available from the CSO at the time of publication was May 2007.

<sup>96</sup> The fact that many people are entitled to these services on a free/subsidised basis under the DTSS and the DTBS does not make the CSO data irrelevant as a significant section of the population can only access these services on a private basis.

2.81 The penalties available to the Council following an inquiry are: advice, admonishment, censure, attaching conditions to registration, suspension from the Register and erasure of name from the Register. The latter three sanctions cannot be implemented without prior High Court approval. The Dental Council has never deemed it necessary to suspend a dentist's registration or to erase a dentist's name from the Register. It has generally favoured the attaching of conditions to registration, thereby prohibiting the dentist concerned from carrying out a particular aspect of dentistry until he/she has taken an approved training course and demonstrated his/her competence in that aspect.

2.82 In addition to its statutory role to inquire into the fitness of a registered dentist to practise dentistry, the Dental Council's Fitness to Practise Committee deals with complaints against dentists and advises the complainant and the dentist concerned on possible means of resolution. Between 2000 and 2006, the Dental Council received over 360 complaints about dentists. The most frequent complaint is in relation to alleged unsatisfactory treatment as shown in the table below. The Dental Council does not have any disciplinary role in relation to auxiliary dental workers such as dental hygienists.

**Table 10: Number and Nature of Complaints to the Dental Council 2000-2006**

Nature of complaint	Number of complaints received
Alleged unsatisfactory treatment	145
Fees	45
Signs/advertisements	30
Attitude/manner of dentist	29
Infection Control	31
Failure to attend or treat	19
Failure to obtain consent	15
Access to records	11
Alleged over prescription	9
Dentists/dentist dispute	7
Failure to pay laboratory bills	4
Alleged racism	3
Alleged fraud	3
Alleged inappropriate questions	3
Alleged substance abuse	2
Alleged discourtesy or aggression	7
Inadequate emergency service	1
Alleged assault	1
Others	2
<b>Total</b>	<b>367</b>







# section 3



### 3. RESTRICTIONS ON OFFERING DENTAL SERVICES

#### Summary

- 3.1 In Ireland, consumers wishing to avail of dental services must either be treated by a dentist or visit a dentist for a referral for treatment by another oral healthcare provider. In other countries, consumers can access dental services directly from a range of qualified oral healthcare providers – dentists, dental hygienists and clinical dental technicians. The current regulatory system has not facilitated the emergence of these options in Ireland.
- 3.2 In Ireland, it is unlawful under the Dentists Act 1985 for a person to use the title “dentist” or to practise dentistry without being registered by the Dental Council. This is a proportionate restriction on the supply of dental services and is designed to protect the health and welfare of the general population. However, the regulatory system should be as fluid and responsive as possible to ensure that the right numbers of the different types of dental professional are in place to meet the demand for dental services and that unnecessary restrictions are not applied to competent professionals.
- 3.3 Given the high costs of training dentists, it is important that suitably qualified para-professionals are permitted to provide treatment for which they are appropriately trained, so that dentists can concentrate on providing the services that only they are qualified to provide. The Competition Authority is, therefore, recommending the creation of two new oral healthcare professions. Ireland should have suitably qualified *advanced dental hygienists* and *clinical dental technicians* providing their services – dental hygiene services and dentures, respectively – directly to the public. This will improve consumers’ access to quality dental services, and lead to improved oral healthcare in Ireland. It will also encourage competition in dental services, in terms of price and quality.
- 3.4 There is currently a shortage of training places in dentistry; this has been identified by Fás and acknowledged by the Irish Dental Association. Although the inflow of dentists from overseas has helped to limit the seriousness of the current skills shortage, this is not necessarily a sustainable situation. The limited number of training places for dentistry in Ireland reduces the supply of dentists and ultimately affects the price of dental services. This situation should be reviewed by the Department of Health and Children in the context of the forthcoming National Oral Healthcare Policy.
- 3.5 The limited number of training places in Ireland to study orthodontics and the fact that these training places have not been available on a consistent basis in recent years has led to a shortage of orthodontists and caused long waiting lists (averaging three years) for orthodontic services in the public sector. It also affects the price and availability of private orthodontic treatment. The commencement of training for specialist orthodontists in Cork from 2006 and Dublin from 2007 should increase the supply of orthodontists, although it is important that this training is provided on a consistent basis from now on. In addition, the upcoming introduction of a new dental profession of *orthodontic therapist* should contribute to lowering the cost, and increasing the availability, of orthodontic treatment.

#### Restrictions on the Supply of Dentures and Denture Related Services

##### Summary

- 3.6 In Ireland, only dentists are legally allowed to sell dentures to members of the public; however, dentures are also sold illegally by some dental technicians.<sup>97</sup> In many other countries, there are specialist professionals known as clinical dental technicians, who are fully trained and are legally permitted to make and fit dentures. Clinical dental technicians are legally recognised in a number of European countries – the UK, Denmark, Finland, the Netherlands, and parts of Switzerland – as well as Australia, Canada, New Zealand and the USA.

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<sup>97</sup> A dental technician constructs and repairs crowns, bridges and other dental appliances using prescriptions and impressions taken by a dentist. Dental technicians are not allowed to sell dentures directly to the public.

- 3.7 The exclusive right of dentists to sell dentures in Ireland has been debated extensively since the 1970s. The Restrictive Practices Commission, a predecessor of the Competition Authority, held an official public enquiry in 1982 on the restrictions on the provision of dentures. The Commission's report concluded that *"prohibiting the supply of dentures by non-dentists is a restrictive practice not justified by any advantages it may offer"*.<sup>98</sup> The report also found that the illegal sale of dentures by dental technicians was widespread in Ireland and recommended that the Dentists Act be amended to provide that the *"general prohibition on carrying on of dentistry by a non-dentist does not apply to the provision of dentures to a person of eighteen years of age or over provided it does not involve work being done on living tissue"*. Twenty-five years have passed since the publication of the Restrictive Practices Commission's Report but the situation has not changed.
- 3.8 Enabling provisions for a new grade of dental professional – clinical dental technicians – already exist in the Dentists Act 1985. The Dental Council has submitted a number of draft Schemes for Clinical Dental Technicians to the Minister for Health and Children. None of these Schemes were approved by the Minister. The impasse was due to disagreement over how to deal with dental technicians currently selling dentures illegally to the public. This issue has now been resolved and at the time of writing the Dental Council was expected to shortly submit a new Scheme to the Minister. Giving legal recognition to suitably trained clinical dental technicians will ensure the protection of consumers and promote greater choice for consumers in terms of where they can get their dentures legally. There are no training programmes in clinical dental technology in Ireland.
- 3.9 The delay in resolving this issue means that the illegal supply of dentures by dental technicians is going unchecked and the system is failing to protect consumers.
- 3.10 Consumers who require dentures should be free to choose from a range of suitably qualified providers when purchasing dentures. The Competition Authority recommends that the dentists' monopoly on the provision of dentures in Ireland should be ended as a matter of urgency, through the introduction of the profession of clinical dental technician, in line with the Restrictive Practices Commission's earlier findings and the intention behind the Dentists Act 1985.
- 3.11 Specifically, the Dental Council should finalise a new draft Scheme for Clinical Dental Technician and submit it to the Minister without delay.

#### *Nature of Restraint*

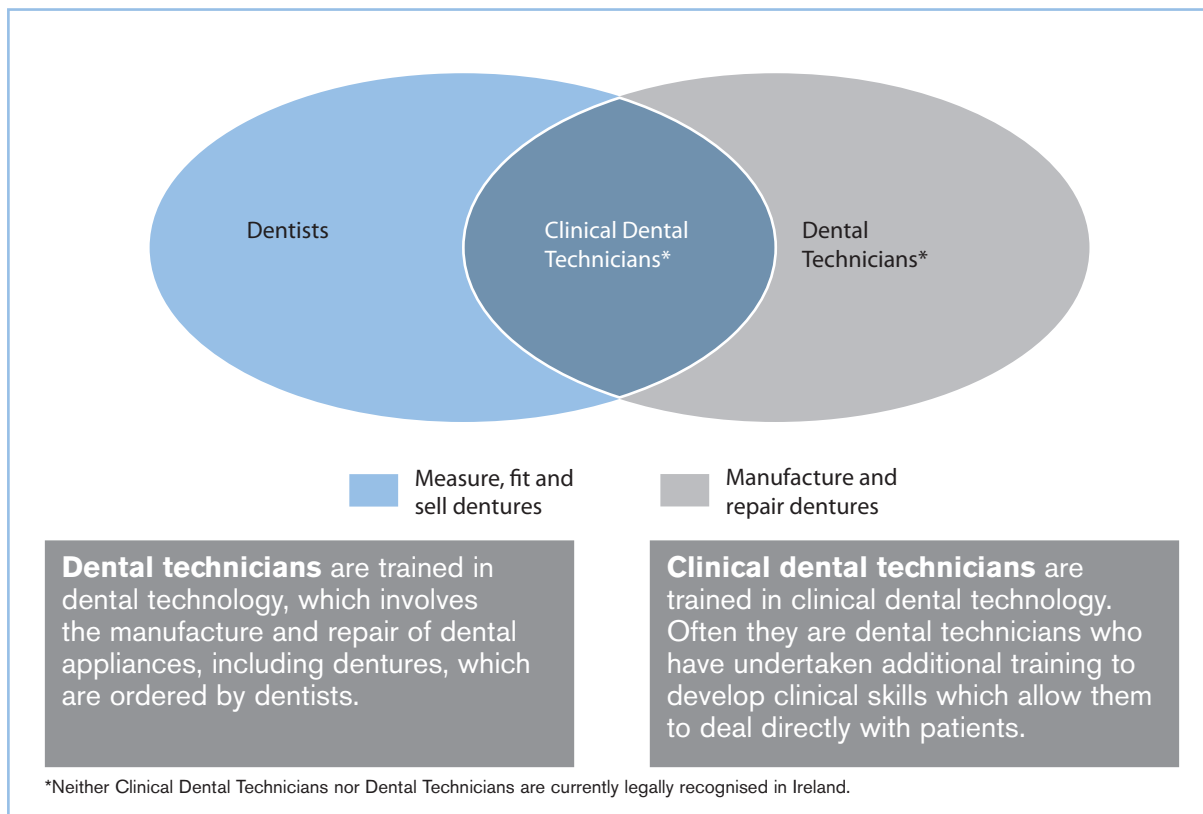
- 3.12 The sale of dentures directly to the public is not legally permitted by anyone other than a dentist. The sale of dentures falls within the definition of "practising dentistry"<sup>99</sup> which is reserved to dentists under section 51(1) of the Dentists Act 1985.
- 3.13 There is provision in the Dentists Act 1985<sup>100</sup> for the establishment of a new grade of dental professional who would be permitted to sell dentures, in addition to dentists. However, the Minister for Health and Children has not, to date, approved any proposals made by the Dental Council in this area.

<sup>98</sup> *Report of Enquiry into the Statutory Restrictions on the Provision of Dental Protheses*, Restrictive Practices Commission, 1982.

<sup>99</sup> As defined in section 2 of the Dentists Act 1985.

<sup>100</sup> Section 54(3) of the Dentists Act 1985.

**Figure 2: Providers of Dentures and Denture Services**



### *Effects of the Restraint*

3.14 Restricting the legal sale of dentures to dentists results in patients choosing to either:

- Purchase dentures from a dentist who orders them from a dental technician. Dentists charge patients a mark-up on the cost of dentures ordered from a dental technician;<sup>101</sup> or
- Purchase dentures directly from a dental technician who is providing this service illegally. Patients who go directly to dental technicians may do so because they feel they are getting better value for money and may not be aware that dental technicians dealing directly with the public are acting illegally and may not be trained.<sup>102</sup> As there is no register for dental technicians, such patients have no way of checking the qualifications of these dental technicians or of knowing whether a dental technician supplying dentures directly to the public has adequate training in cross-infection control.

3.15 Patients do not have the option of going either to a qualified clinical dental technician for a one-stop-shop service by someone who is trained to measure, make and fit dentures – or to a dentist. This choice is available to consumers in other countries.

101 This is known in economic literature as double marginalisation, as more than one mark-up is applied to a product.

102 While it may be the case that dental technicians do not charge less than dentists, the public perception appears to be that they do.

### *Rationale offered for the Restraint*

3.16 Both the Dental Council and the Irish Dental Association argue that only suitably trained and qualified persons should be permitted to sell dentures. They further argue that such persons must be registered with the Dental Council to ensure that patients are protected.

3.17 During the enquiry conducted by the Restrictive Practices Commission in the early 1980s, the Dental Council, and individual dentists who appeared before the Commission, argued that only dentists should be permitted to supply dentures directly to the public for the following reasons:

- Before being measured for dentures, a patient must receive a preliminary examination to check for oral or systemic diseases which could otherwise go undetected. Only a dentist is qualified to perform this examination.
- Poor quality dentures and/or badly designed or fitted dentures could affect the wearer's appearance and cause continual discomfort. They could also damage a patient's oral health through temporary or permanent damage to gums and potentially the loss of remaining teeth.
- Oral infections can be spread from one patient to another unless the person who carries out the dental work observes strict hygiene procedures.

3.18 During the 1982 enquiry, the Dental Council argued that the number of people requiring dentures was decreasing and, therefore, that setting up a Register of Clinical Dental Technicians, and designing and funding training programmes to meet a declining demand, would be a misallocation of resources. The Dental Council remains of the opinion that demand for dentures is falling. In September 2003, the Council stated:

*"Studies have conclusively shown that the demand for full dentures has fallen significantly in Ireland and this pattern is expected to continue. Where replacement teeth are required the demand will increasingly come from an ageing population. Partial dentures will be a treatment option but implants and bridges are expected to become items of treatment for which there will be greater demand."*<sup>103</sup>

### *Views of Interested Parties*

3.19 The Dental Council claimed that a decision of the High Court in a case taken by a dental technician, Mr Martin Kenny, against the Dental Council,<sup>104</sup> vindicated its position that a Register of Clinical Dental Technicians must only be open to those with proper training, as no amount of experience can substitute totally for training.<sup>105</sup> The Council also argued that, under the provisions of the Dentists Act 1985, it was required to determine the appropriate standards of training and qualifications for each class of Auxiliary Dental Worker established.

3.20 The Dental Council stated that it would be willing to provide an examination that would assess the competence of dental technicians who have experience in the provision of dentures to the public and have undertaken relevant training to become a clinical dental technician. The Council stated that it would re-submit its Scheme for Clinical Dental Technicians to the Minister for Health and Children with such a provision.

3.21 The Dental Council also stated that:

*"if a Register of Clinical Dental Technicians is established, the Council would ensure that foreign trained clinical dental technicians, with appropriate qualifications, would be admitted to registration without difficulty".*

<sup>103</sup> Source: Letter from the Dental Council to the Competition Authority, dated 15/09/2003.

<sup>104</sup> *Kenny M (trading as Denture Express) v The Dental Council and others*, 2004 IEHC 29.

<sup>105</sup> The Dental Council has furnished the Competition Authority with extracts from the judgement given by Mr Justice Gilligan, delivered on 27<sup>th</sup> February 2004: "It appears reasonable on the evidence adduced before me to come to a conclusion which I do that it would be irresponsible of the Dental Council to compromise in any way the quality of denturists' training given the public expectation of trust in healthcare professionals and the potential for harm to patients in a variety of ways.....I take the view that on the basis that the schemes as proposed by the Dental Council are rational and were proposed on the basis that the Dental Council considered it would be an abrogation of their responsibilities to the public in a matter of public health to provide a shortcut to recognition for those dental technicians currently practising as denturists. I find that the Dental Council did not act unreasonably or unfairly in proposing a scheme without a grandfather clause."

3.22 The Irish Dental Association supported the establishment of a clinical dental technician grade as it would result in a more efficient delivery of dental care to patients and would be beneficial in the public healthcare system. The Association *“supports the establishment of a training pathway for clinical dental technicians”*.

3.23 However, the Irish Dental Association argued that there was little international evidence to indicate that the claimed benefits of clinical dental technicians for consumers would materialise. The Association quoted a journal article that, six years after the introduction of clinical dental technicians in Ontario, questioned the claims that had been made by the clinical dental technicians associations that legalising the profession would lead to greater choice and improved access. The authors argued that these claims should be re-examined in light of actual experience.<sup>106</sup>

3.24 The Irish Dental Association raised other issues relating to patient protection which arise in the context of legalising clinical dental technicians:

- Only a dentist is trained to undertake a full assessment of a patient's oral condition.
- Consumers have a right to be informed of all available treatment options to ensure fully informed choice. There are a number of options now available to people with missing teeth – removable partial dentures, fixed partial dentures (i.e. bridges) and implants. Only a dentist is in a position to advise patients on all of their options – clinical dental technicians in other countries are not trained to do this. To make the decision as to what is most beneficial for a patient requires the clinician to be trained in all aspects of dentistry.
- While clinical dental technicians in other countries can make full dentures for members of the public, a patient must have a prescription from a dentist if they visit a clinical dental technician to get removable partial dentures. The Irish Dental Association argues that there is a sound clinical basis for this requirement, so that if clinical dental technicians are legalised in Ireland they should have to have a prescription from a dentist to make partial dentures for a patient.<sup>107</sup>

3.25 The Dublin Dental School and Hospital favoured allowing patients to visit clinical dental technicians for dentures. However, the School had a number of concerns:

- There should be no circumstances in which someone who has not had appropriate clinical training should be allowed to practise dentistry on patients. If an experienced dental technician wishes to become a clinical dental technician, they must first receive conversion training.
- Patients who visit a clinical dental technician may not be fully informed of all their treatment options. Clinical dental technicians are only trained in the provision of dentures; however, there are many other options available to patients with missing teeth.
- In other countries where clinical dental technicians are legalised, denture wearers are required to have a Certificate of Oral Health or a prescription for treatment from a dentist before visiting a clinical dental technician. The Dental School is very concerned that denture wearers continue to be seen by a dentist to ensure that underlying diseases such as oral cancer are detected at an early stage and sees a requirement for a Certificate of Oral Health as one means of achieving this.

3.26 The Dental Technicians Association pointed out that a number of Irish dental technicians had, or were currently in the process of gaining, a qualification in Clinical Dental Technology in the UK (from the Royal College of Surgeons, UK).

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<sup>106</sup> Abrams SH. Journal of the Canadian Dental Association, 1997;63(10):771-4.

<sup>107</sup> The Irish Dental Association refers to a journal article which highlights the health hazards associated with removable partial dentures, and argues against the expansion of clinical dental technicians' activities to partial dentures as this *“treatment repeatedly tests the knowledge and skills of the most experienced dentists”*; MacEntee MI, Journal of Prosthetic Dentistry, 1993;70(2):132-4.



3.27 On the issue of training, the Dental Technicians Association proposed that those dental technicians who were currently (illegally) selling dentures to members of the public should have their skills assessed by a panel from the Dublin Dental School and Hospital and the Cork University Dental School and Hospital. A training course should be set up to address any perceived shortfalls in their skills. This training course would have to take into account that the candidates are in full time employment.

3.28 The Dental Technicians Association did not support the idea of a Certificate of Oral Health as a means of protecting public health. It argued that qualified clinical dental technicians in other countries were trained to detect abnormalities in the oral cavity and were also required to refer the patient to a dentist if this was necessary. Requiring denture patients to get a Certificate of Oral Health from a dentist first would create a funnel effect resulting in a delay to services to the public.

3.29 The Dental Technicians Association claimed that there are long waiting lists at present for dentures among medical card holders.<sup>108</sup> It claimed that, if clinical dental technicians were legalised, patients would be able to see a clinical dental technician more quickly than a dentist.

#### *International Experience*

3.30 Clinical dental technicians are permitted to fit and sell dentures to members of the public, independently of dentists, in many countries including Australia, Canada, Denmark, Finland, the Netherlands, New Zealand, Sweden, the USA and most recently the UK.<sup>109</sup>

3.31 Until recently, the situation in the UK mirrored that in Ireland. Dental technicians were legally permitted only to manufacture dental appliances, although many practised illegally and sold such appliances directly to patients. The Office of Fair Trading recommended in 2003 that the sale of dentures should no longer be restricted to dentists.<sup>110</sup> As a result the legislation was changed and, since July 2006, clinical dental technicians have been legally recognised in the UK and the General Dental Council has established a new Register of Clinical Dental Technicians.<sup>111</sup> Clinical dental technicians are now allowed to sell dentures directly to the public and work in their own practices independently of dentists. Patients are not required to visit a dentist to get a referral to a clinical dental technician. Clinical dental technicians are, however, required to refer patients to a dentist if they themselves are not competent to carry out a particular procedure or if a condition is present that is beyond their scope of practice.

3.32 Training courses exist in most countries where clinical dental technology is legalised. However, in some countries these courses are provided on a distance learning basis.<sup>112</sup>

3.33 Training courses in clinical dental technology generally extend over a two or three year period. They are often taken on a part-time basis by people who already have a qualification in dental technology.

3.34 There are currently no clinical dental technology training programmes in the UK but the General Dental Council is working with training providers to develop such courses. There are a significant number of people working in the UK who hold qualifications in clinical dental technology from the George Brown College in Toronto. According to the General Dental Council, "[...]*the Faculty of General Dental Practice (FGDP) at the Royal College of Surgeons England is developing an accredited UK award for UK holders of qualifications from*

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108 No evidence is provided in the submission to support this claim.

109 In certain states in the USA and Australia, clinical dental technicians can provide full and partial dentures directly to the public. In Denmark, Finland and the Netherlands, clinical dental technicians can provide full dentures but patients who need partial dentures must first have a treatment plan from a dentist.

110 The Office of Fair Trading argued: "We believe that professionally trained staff should not be stopped from supplying services directly to the consumer that they are able to provide. This relaxation should expand the supply of dentistry services and offer greater choice both to consumers and to those working in the profession." *The private dentistry market in the UK*, March 2003.

111 The new legislation requires all persons working within dentistry, including dental technicians and clinical dental technicians, to be registered with the General Dental Council.

112 For example, the George Brown College in Toronto has special arrangements in place with dental universities in many countries whose students take its course on a distance learning basis.

*George Brown College, Canada.*<sup>113</sup> When in place, this will allow clinical dental technicians with George Brown qualifications to obtain a UK recognised Diploma in Clinical Dental Technology, after they have undertaken extra training in the UK in areas such as health and safety and UK legislation.<sup>114</sup>

- 3.35 International evidence indicates that when clinical dental technicians are legalised, the rate of inflation for denture-related treatments is lower than for other dental treatments which only dentists can provide. For example, six years after denturism was legalised in Oregon, the price of dentures stabilised. The rate of increase for dentures was substantially lower than the rate for all other dental treatments.<sup>115</sup>

#### *Analysis of the Competition Authority*

- 3.36 Imposing restrictions on the way various professional groups in dentistry can operate in order to protect the health and safety of the public is a valid objective. However, restricting the supply of dentures to dentists only is a disproportionate way of achieving this objective if there are other dental professionals who can be equally well trained to provide this narrow set of services. Clinical dental technicians receive the necessary training to provide dentures to members of the public and provide the same quality of care as dentists in the provision of denture services.
- 3.37 An efficient dental service involves making the best use of the oral healthcare resources available, particularly manpower resources. It takes longer and is more expensive to train a dentist than a clinical dental technician because dentists are trained across a broader range of areas. It is an inefficient use of the more advanced training and expertise of dentists to have them providing services which clinical dental technicians are equally well trained to perform. Better use of current and future oral healthcare resources could be achieved by introducing a profession of clinical dental technician and allowing dentists to focus on the provision of care which only they are qualified to perform.
- 3.38 In countries where clinical dental technicians are legally recognised, a qualification in clinical dental technology is required in order to be listed on the register, or to gain a licence to practise. As with dentists, training in hygiene protocols is an essential component of the training required to become a clinical dental technician. Training courses in clinical dental technology are shorter and less extensive than training courses for dentists as they only focus on a specific field of dentistry.
- 3.39 It may be appropriate for a patient who is having dentures fitted for the first time to visit a dentist for a preliminary examination to ensure that their gums and mouth are in good condition and they are aware of other options for treatment, such as implants or other restorative solutions, before dentures are fitted. However, existing denture wearers should not be obliged to visit a dentist before visiting a clinical dental technician. There is no evidence that denture wearers require a general dental check-up any more than other patients do. In other countries where clinical dental technicians are legally recognised, they are obliged to refer the patient to a dentist if a condition is present that is beyond their scope of practice. A clinical dental technician is also likely to recommend that their patients visit a dentist if they require dental treatment other than dentures.
- 3.40 The Dublin Dental School and Hospital supported a requirement that people visiting a clinical dental technician should first have a Certificate of Oral Health from a dentist on the grounds that people should continue to be examined by dentists to aid in the detection of diseases such as oral cancer which can be more successfully treated with an early diagnosis. A requirement for a Certificate of Oral Health before being treated by a clinical dental technician would be disproportionate and would have no impact on the significant numbers of Irish people (estimated at more than 50%) who do not attend a dentist on a regular basis. Other means of encouraging everyone, and not just those who are getting dentures, to have regular assessments of their oral health should be considered, such as an awareness campaign.<sup>116</sup>

113 [www.gdcuk.org/Our+work/Education/Training+course+providers/to+become+a+clinical+dental+technician.htm](http://www.gdcuk.org/Our+work/Education/Training+course+providers/to+become+a+clinical+dental+technician.htm).

114 [www.fgdp.org.uk/pdf/pr\\_jun\\_cdt\\_dip.pdf](http://www.fgdp.org.uk/pdf/pr_jun_cdt_dip.pdf).

115 Rosenstein, D.I. et al, *The effects of denturism on denture prices*, American Journal of Public Health, June 1985, Vol. 85 No. 6.

116 For example, the Dental Health Foundation recommends that adults have an annual dental check-up whether they have natural teeth or wear dentures in order to detect oral cancer at an early stage.

3.41 The Dental Council has argued that the number of people requiring dentures is falling as overall dental health in Ireland improves and people are less likely to lose their teeth. However, the reality is that dentures are still a common requirement amongst Irish people.

- Oral Health Surveys reveal that at least half a million people in Ireland wear some form of dentures, primarily in the 65+ year-old age cohort as demand for dentures is strongly correlated with age.<sup>117</sup>
- People are now living longer than previous generations.
- Tooth loss from accidents or sports injuries will mean that demand for partial dentures will continue even if the demand for full dentures falls as people retain more of their natural teeth due to improved oral hygiene.

3.42 The amount spent on dentures is actually growing on a yearly basis. In 2005, the State spent nearly €15 million on denture-related treatments provided by dentists to members of the public under the State schemes (dentists were paid over €13.6 million for the provision of dentures and an additional €1.2 million for denture repairs). Table 11 shows the fees paid to dentists in respect of the provision of dentures in 2004 and 2005 while Table 12 shows the numbers of denture related claims (excluding denture repairs) under the State schemes for those years.<sup>118</sup>

3.43 The amount spent by members of the public who obtain dentures on a private basis is unknown although information from the Household Budget Surveys for 1999/2000 and 2004/2005 indicates that, while overall denture related expenditure decreased during that period, expenditure on dentures increased by 26% from an annual average per household of €171 to an annual average of €216.<sup>119</sup>

3.44 Based on the number of denture claims and the size of the State's expenditure on dentures, the Dental Council's argument that demand for dentures is falling does not hold. Moreover, the longer the current situation continues, the more some consumers will continue to avail of services being provided illegally, and, thus without any protection, by dental technicians.

**Table 11: Fees Paid to Dentists by the State for the Provision of Dentures**

Scheme	2004	2005
Dental Treatment Services Scheme (Medical cards)	€10,872,853	€11,373,165
Dental Treatment Benefit Scheme (PRSI) <sup>120</sup>	€2,050,240	€2,299,394
<b>Total</b>	<b>€12,923,093*</b>	<b>€13,672,559*</b>

Source: Department of Social and Family Affairs; Primary Care Reimbursement Service. \* Excluding denture repairs.

**Table 12: Number of Denture Claims under the State Schemes**

Scheme	2004	2005
Dental Treatment Services Scheme (Medical cards)	37,135	37,710
Dental Treatment Benefit Scheme (PRSI)	18,208	19,812
<b>Total</b>	<b>55,343*</b>	<b>57,522*</b>

Source: Department of Social and Family Affairs; Primary Care Reimbursement Service. \*Excluding denture repairs.

117 Oral Health Surveys are carried out by the Oral Health Services Research Centre at the Cork University Dental School and Hospital. See Appendix 4 for how this estimate was calculated.

118 The figures in Table 11 do not reflect the total amount spent on dentures in Ireland in 2004 and 2005. The table excludes the amount spent by private patients on dentures, top-up fees by PRSI patients and also the cost to the State of Health Service Executive dentists who fit dentures to medical card holders in HSE clinics.

119 Average annual household expenditure on denture repairs decreased from €137.28 per household in 1999/2000 to €27.04 per household in 2004/2005.

120 This refers only to the amount paid by the Department of Social and Family Affairs and not individual contributions. Private PRSI patients pay a minimum of €1.5 million (€1.6 million if denture repairs are included) on top-up fees for denture treatments.

3.45 The Irish Dental Association points to research showing that the prices paid to dentists and clinical dental technicians are similar i.e. clinical dental technicians do not charge less than dentists and prices did not fall with their introduction.<sup>121</sup>

3.46 The fact that the research found that dentists and clinical dental technicians charged similar prices for providing the same service does not mean that the introduction of clinical dental technicians in other countries has not had a positive impact on prices. One would not expect dentists to be able to charge a different price for the same service in a competitive market. But dentists who have to compete with clinical dental technicians as well as other dentists are less likely to be able to increase their prices. Research into the effect of clinical dental technicians on prices shows that competition from clinical dental technicians has had a constraining effect on the prices charged by dentists (see para 3.35). It prevented the prices charged by dentists from increasing by more than they would have in the absence of competition from clinical dental technicians.

3.47 The Dental Council has submitted a number of proposals regarding the establishment of a profession of clinical dental technician. However, the Minister for Health and Children has not approved any of these proposals. The impasse was due to disagreement over how to deal with dental technicians currently selling dentures illegally to the public. This issue has now been resolved and at the time of writing the Dental Council was expected to shortly submit a new Scheme to the Minister.

3.48 The Competition Authority recommends that a Register of Clinical Dental Technicians should be established in Ireland as a matter of urgency. Establishing a Register of Clinical Dental Technicians who have the necessary skills and training to provide dentures to members of the public safely would improve competition in the sale of dentures and give the c. 500,000 denture wearers in Ireland greater choice as to where they get their dentures. Improving competition in the provision of dentures would have a beneficial impact on the price of dentures.

#### *Solution*

3.49 Clinical dental technicians should be legally recognised in Ireland as a matter of urgency and an associated register should be established.

3.50 The Dental Council should ensure that there are no unnecessary restrictions on clinical dental technicians who qualify overseas and wish to work in Ireland, to ensure an adequate supply of these professionals while new Irish-based courses in clinical dental technology come on stream.

3.51 A new draft Scheme for Clinical Dental Technicians should be finalised by the Dental Council and submitted to the Minister for Health and Children for approval.

3.52 When the Scheme has been approved by the Minister, the Dental Council should establish a Register of Clinical Dental Technicians. The Register should be open to those who have a recognised qualification in clinical dental technology obtained overseas (and in Ireland once training courses are established). All candidates who meet the registration criteria should be registered without unnecessary delay

3.53 The creation of a Register of Clinical Dental Technicians, who will be allowed to sell dentures direct to the public, will:

- Provide legal competition to dentists in the sale of dentures;
- Provide consumer protection, as buyers of dentures will be able to determine whether the provider they choose is a qualified professional and is registered with the Dental Council;

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121 A Canadian study found that patients paid similar costs for dentures made by either a dentist or a clinical dental technician. *Morin C, Lund JP, Sioufi C, Feine JS.* Journal of the Canadian Dental Association, 1998;64(3):205-8,210-2. In Ontario, six years after the introduction of clinical dental technicians, there appeared to be no substantial cost differential between the services provided by dentists and those provided by clinical dental technicians. *Abrams SH,* Journal of the Canadian Dental Association, 1997;63(10):771-4.

- Provide consumers with more choice of qualified professionals from whom to obtain dentures; and
- Have a beneficial impact on the price of dentures.

<b>Recommendation 1:</b>	
<b>Introduce a new oral healthcare profession of clinical dental technician</b>	
<b>Details of Recommendation</b>	<b>Action By</b>
The Dental Council should, as a matter of urgency, finalise its draft Scheme for Clinical Dental Technicians and submit it to the Minister for Health and Children.	Dental Council  December 2007
When the Scheme has been approved, the Dental Council should establish a Register of Clinical Dental Technicians. All eligible candidates should be registered without delay including clinical dental technicians who have appropriate qualifications from overseas.	June 2008

3.54 When the profession of clinical dental technician has been established, registered clinical dental technicians should be able to make claims for denture-related treatments provided under the State schemes. This will enable patients who are entitled to free or subsidised dentures under the State schemes to choose between the services of a registered clinical dental technician or a dentist.

<b>Recommendation 2:</b>	
<b>Allow clinical dental technicians to be directly reimbursed under the State dental schemes</b>	
<b>Details of Recommendation</b>	<b>Action By</b>
The Health Service Executive and the Department of Social and Family Affairs should allow clinical dental technicians who are on the Register of Clinical Dental Technicians to be directly reimbursed under the Dental Treatment Services Scheme and the Dental Treatment Benefit Scheme, for the sale of dentures and for denture repairs.	Health Service Executive  Department of Social and Family Affairs  October 2008

3.55 As there are no training courses in clinical dental technology in Ireland, the Dental Council will initially only be able to recognise overseas qualifications when a Register for Clinical Dental Technicians has been established. The Dental Council should engage with educational institutions, in particular the Dublin Dental School and Hospital and the Cork University Dental School and Hospital, to help establish:

- A full or part-time course in clinical dental technology;
- A full or part-time course in clinical dental technology which could be undertaken by those who already have a qualification in dental technology; and
- Modules to act as an add-on for those with an overseas qualification in clinical dental technology if that is considered necessary.

Recommendation 3: Engage with training providers to establish courses in Clinical Dental Technology	
Details of Recommendation	Action By
The Dental Council should engage with training providers to establish courses in clinical dental technology in Ireland.	Dental Council  October 2008

## Restrictions on the Supply of Dental Hygiene Services

### Summary

3.56 Dental hygienists are trained to provide preventive and corrective dental services to patients to improve their oral health. The conditions under which hygienists are permitted to work are laid down by the Dentists Act 1985 and reflect the level of training they receive. The Act dictates that hygienists are only allowed to treat patients when three conditions are met:<sup>122</sup>

- The patient must be examined by a dentist before a hygienist can perform any treatment;
- The dentist must indicate to the dental hygienist the course of treatment for the patient (i.e. provide a prescription); and
- The dental hygienist must carry out the treatments specified by the dentist under the dentist's supervision.

3.57 There are other countries where dental hygienists receive more training than they do in Ireland, allowing them to work independently of dentists. Dental hygienists in Sweden, Finland, Denmark, Norway, the Netherlands, and parts of Switzerland, as well as parts of Canada and the USA, do not need a referral from a dentist before they can treat patients. These hygienists are trained to draw up a treatment plan for the patient and carry out a range of treatments. Dental hygienists who receive this level of training are often referred to as advanced dental hygienists.

3.58 The experience from these countries shows that allowing *suitably qualified* dental hygienists to offer their services directly to the public, without the need for a referral and a prescription from a dentist, benefits consumers. Consumers have greater access to basic dental services, which leads to improved oral healthcare, while still maintaining a high level of consumer protection. The Competition Authority recommends the introduction of a new profession of *advanced dental hygienist*, trained to work independently of dentists. This would benefit consumers of dental services in Ireland in the same way that consumers in other countries where this profession exists have benefited.

3.59 Introducing advanced dental hygienists in Ireland will require an amendment to the Dentists Act 1985 and a new Scheme to be put in place by the Dental Council.<sup>123</sup> In addition, a new training programme will have to be designed for dental hygienists who wish to undertake further training to become advanced dental hygienists and thereby be qualified to practise independently.

### Nature of Restraint

3.60 Dental hygienists do not currently have the opportunity to undertake additional training in Ireland which would qualify them to work independently of dentists. The training dental hygienists currently receive is limited and means they can only carry out treatments on a patient “*under the supervision of a registered dentist*” and after a dentist has examined the patient and indicated the course of treatment.

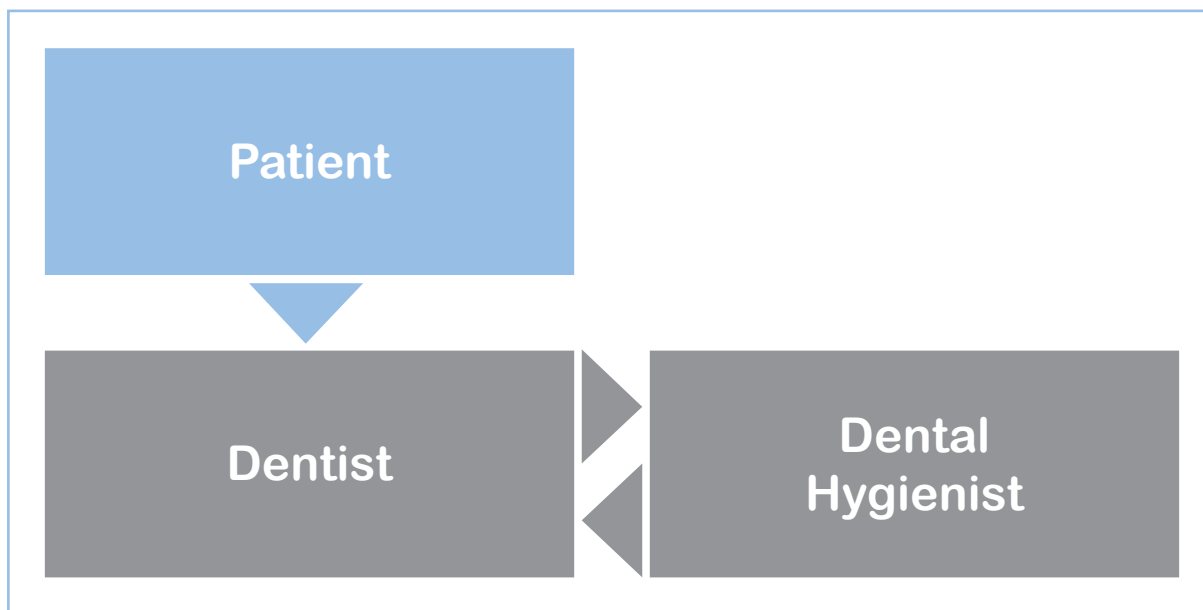
<sup>122</sup> See section 54(2) of the Dentists Act 1985. In the Dentists Act 1985, the term “auxiliary dental worker” refers to dental hygienists and other classes of dental worker established by the Dental Council.

<sup>123</sup> Allowing advanced dental hygienists to work independently of dentists would require a change to the Dentists Act excluding them from the provisions of section 54(2), similar to section 54(3) which relates to the profession of clinical dental technician.

3.61 As a result, dental hygienists have to operate under a number of restrictions:

- Hygienists must rely on referrals. They cannot treat patients unless the patient has a referral from a dentist; and
- Each hygienist must have a “supervising dentist”.

**Figure 3: Current Model for Delivering Dental Hygiene Services**



3.62 Hygienists cannot be directly reimbursed for treatments they provide to patients who are covered under the State dental schemes – these payments are made directly to their supervising dentist who has a contract with the relevant Government Department, even if the treatment in question was performed by a hygienist.<sup>124</sup>

3.63 The Dentists Act 1985 precludes the emergence of more qualified dental hygienists who are trained to operate independently of dentists.<sup>125</sup>

#### *Effects of the Restraint*

3.64 This restraint has a number of negative effects for consumers:

- Consumers have to see a dentist before they can see a hygienist – the dentist acts as a gatekeeper;
- Consumers' choice of oral healthcare providers is reduced, as patients do not have direct access to hygienists – they must visit a dentist first;
- It prevents the emergence of new ways of delivering dental hygiene services to consumers, such as stand-alone dental hygiene clinics or mobile dental hygiene clinics which could visit nursing homes, hospitals etc;
- It prevents the emergence of competition between dentists and dental hygienists;

<sup>124</sup> From contract document DTBS 1992 – “The contracting dentist undertakes to provide such treatment personally or by way of a substitute who is a registered dentist or registered dental hygienist and covered by appropriate medical protection insurance.”

<sup>125</sup> A fully independent hygienist is one whose training is sufficient to ensure that patients can visit them directly and do not need a referral from a dentist. These hygienists are capable of drawing up a treatment plan for the patient and carrying out this treatment, provided it is within their scope of practice.



- It keeps the price of preventive oral healthcare services artificially high, as experience from other countries shows that suitably qualified dental hygienists, who work independently of dentists, can provide these services to the same standard as dentists and slow the rate of price increases (see para 3.76);
- It reduces consumers' choice as to where they can access preventive oral healthcare services – since these can only be supplied at a traditional dental surgery by dentists and/or hygienists, other potential settings (e.g. stand-alone dental hygiene clinics) cannot emerge;
- It reduces consumers' access to hygienists, as hygienists can only treat the patients of their supervising dentist;
- It results in an inefficient use of the resources spent by the State in training dentists; and
- Ultimately it reduces the amount of preventive dental services purchased by the public, which goes against the promotion of good oral health.

#### *Rationale offered for the Restraint*

3.65 Dental hygienists are currently trained to provide dental services under the direction of a dentist and are not trained to work independently of a dentist. Dental hygienists are not qualified in the interpretation of x-rays and are not trained in the diagnosis of oral disease, including dental decay. The Irish Dental Association argues that these skills are essential in the treatment of gum disease. For this reason, the Irish Dental Association claims that the present “*complementary relationship*” that exists between dentists and hygienists must continue until such time as hygienists are trained in all of these areas.

#### *Views of Interested Parties*

3.66 The Irish Dental Hygienists Association stated that its members were not currently trained to operate independently of dentists but that they are in favour of having the option to train to such a level. The Association was also in favour of allowing dental hygienists to be reimbursed directly for treatments provided under the State schemes so as to allow advanced dental hygienists to offer their services directly to patients (once appropriately trained) and to operate on a stand-alone basis (i.e. in their own separate clinic) should they wish to do so.<sup>126</sup>

3.67 The Irish Dental Association indicated in its submission that it had “*no difficulty with any suitably trained dental auxiliary eligible for registration with the Dental Council providing services directly to the public*”. The Association would support the attainment of further skills by dental hygienists, as this would result in the efficient delivery of care to patients in practices with collaborative dental teams and would be beneficial in the public health care system.

3.68 The Irish Dental Association acknowledged that independent practice was permitted in a number of countries but pointed out that there were a variety of restrictions on the practice of dental hygienists in many of these countries.<sup>127</sup> For instance, in Canada and the USA, a patient who visited a dental hygienist must have been seen by a dentist within a certain timeframe and dental hygienists must be supervised when carrying out x-rays and administering local anaesthesia.

3.69 The Irish Dental Association argued that stand-alone practice by more qualified dental hygienists was unlikely to be feasible because the fees which the Departments pay under the State dental schemes were too low. At present, dentists are reimbursed approximately €30 for a scale and polish. If stand-alone dental hygienists were reimbursed the same fee, the Association asserted that they would not be able to operate on a viable basis.

<sup>126</sup> Views of the Irish Dental Hygienists Association expressed in discussions with the Competition Authority.

<sup>127</sup> Finland, the Netherlands, Switzerland, Denmark, Norway, Sweden, United Kingdom (in the near future), three states in the US and one province in Canada (British Columbia). Source: Kravitz AS, Treasurer ET, Manual of Dental Practice, EU DLC 2004.



3.70 The Irish Dental Association also referred to literature which indicated that few hygienists elect to work on their own, given the option. The Association pointed to a US study, which found that only 3.1% of hygienists were in some form of stand-alone practice.<sup>128</sup> A survey of 1,443 dental hygienists in Colorado revealed that only twenty hygienists elected to work on a stand-alone basis and in the Canadian province of British Columbia approximately twenty hygienists were in stand-alone practice.<sup>129</sup>

3.71 The Dublin Dental School and Hospital indicated that it was in favour of direct access by patients to dental hygienists, provided that patients continued to have access to a full range of oral health information and services, and not just isolated items of treatment. In particular, medical card holders should not be precluded from obtaining dental care from dentists and they should not be forced to see a hygienist if they would prefer to see a dentist.<sup>130</sup>

3.72 According to the Dublin Dental School and Hospital, training dental hygienists to diagnose and draw up a treatment plan would not be possible within the current 2 year programme and would require an additional one year's training. In Denmark, an additional 6 months was added to the training period before dental hygienists were permitted to operate independently and in Sweden an additional year was added.

#### *International Experience*

3.73 In many countries it has been determined that supervision or control of suitably qualified dental hygienists by dentists is not necessary and that there is no rationale for dentists' examining patients before they attend a dental hygienist.<sup>131</sup> Dental hygienists are permitted to work independently of dentists, set up their own private practice, and charge their patients directly, in Sweden, Finland, Denmark, Norway, the Netherlands, as well as parts of Canada, the USA and Switzerland.<sup>132</sup>

3.74 The general trend, in countries where hygienists are gaining increased responsibility in terms of less supervision by dentists and increased scope of practice, is that this has occurred in conjunction with an increase in the period of training required to become a dental hygienist. The period of training required is becoming longer and increasingly academic and curricula in many countries are being augmented and extended.<sup>133</sup> The average length of training for dental hygienists in other countries is three years. In Ireland, the current training course for dental hygienists extends over a two year period.

3.75 International studies have shown that independent dental hygienists:

- Deliver high quality, safe and effective care;
- Pose no additional risks to patients compared to dentists;<sup>134</sup>
- Have excellent diagnostic abilities for dental disease and frequently recognise treatment needs for which they refer their patients to alternative providers of dental care; and
- Make it easier for consumers to avail of oral healthcare services.<sup>135</sup>

128 Singer JL, Cohen L, LaBelle A., *Journal of Public Health Dentistry*, 1986;46(2):86-95.

129 Source: Dr J O'Keeffe, Editor in Chief, *Canadian Dental Journal*.

130 Submission of the Dublin Dental School and Hospital to the Competition Authority, February 2006.

131 Johnson (2003), *International profiles of dental hygiene 1987 to 2001: A 19-nation comparative study*, *International Journal of Dental Hygiene*.

132 Although many countries are relaxing rules on dental hygiene practice, many hygienists choose not to operate independently of dentists even though they are permitted to do so. On a global scale, most dental hygienists work in dentists' surgeries. This is for a number of reasons, including the costs and risks involved in setting up and running their own business and the greater flexibility in working arrangements possible when working as an employee compared to self-employment. Source: B Gatermann-Strobel & M Perno Goldie (2005) *Independent dental hygiene practice worldwide: a report of two meetings*, *International Journal of Dental Hygiene*.

133 Luciak-Donsberger (2004), *The study of dental hygiene at institutions of higher education in Europe*. This report was commissioned by the Federal Ministry of Education, Science and Culture, Vienna, Austria.

134 For instance, in the USA, professional liability insurance rates are the same irrespective of whether dental hygienists work under the supervision of a dentist or in independent practice. This implies that there are no additional risks when hygienists operate in independent practice. Source: *Health Care and Competition Law and Policy*, presentation by the American Dental Hygienist Association to the Federal Trade Commission. Available at [www.ftc.gov/ogc/healthcarehearings/docs/030610byrdtammi.pdf](http://www.ftc.gov/ogc/healthcarehearings/docs/030610byrdtammi.pdf).

135 Luciak-Donsberger & Aldenhoven (2004), *Dental hygiene in Australia: A Global Perspective*, *International Journal of Dental Hygiene*. This paper cites a number of sources which confirm these four statements.

3.76 Internationally, it has been found that dentists provide dental hygiene care to the public at a higher cost than dental hygienists. It has been estimated that the fees charged by independent dental hygiene practices could be significantly lower – in the order of 20% to 40% – than traditional dental practices.<sup>136</sup>

3.77 In many countries where independent hygiene practice is permitted, hygienists are obliged to refer their patients to a dentist if they suspect that the patient is suffering from a problem which they are unqualified to treat or which is beyond their scope of practice. Hygienists therefore play an important screening role. For instance, in Sweden, all children see a dental hygienist who then refers on children who need to also see a dentist.

#### *Analysis of the Competition Authority*

3.78 In its preliminary report, the Competition Authority recommended that dental hygienists be allowed to operate independently of dentists. The Competition Authority notes the consistent view expressed across all submissions that the training that dental hygienists currently receive does not adequately prepare them for independent practice.

3.79 Suitably trained independent hygienists would bring benefits, not just in the private sector, but also in the public sector. Independent practice opens up a wide range of options for oral healthcare in the public sector – for example, hygienists could play a screening role for children, residents of nursing homes, etc. In many countries where independent practice is permitted, hygienists often choose to work with a dentist. This is likely to happen in Ireland in many cases also.

3.80 Introducing a new profession of advanced dental hygienist would allow greater flexibility for hygienists. Hygienists would have the choice of seeking further training to equip them to practise on an independent basis or continuing to work as they do at present, under the supervision of a dentist.

3.81 The Irish Dental Association expressed concerns about the viability of stand-alone dental hygiene practices (see para 3.69 above). It should be left to hygienists or entrepreneurs to determine whether or not stand-alone practice would be feasible, whether there is a market for independent dental hygiene clinics, or indeed whether there are alternative ways of providing dental hygiene services, e.g. mobile or travelling practices.

3.82 The benefits of advanced dental hygienists are:

- Beneficial impact on fees;
- Greater consumer choice;
- Improved efficiency in the delivery of dental services;
- Improved public oral health; and
- A choice of practice options for dental hygienists.

These are discussed in more detail below.

#### Beneficial impact on fees

3.83 Based on international experience, one of the benefits to consumers of enabling the emergence of independent hygienists is that it has a beneficial impact on fees by putting dentists and independent dental hygienists in competition with one another in the provision of dental hygiene services.

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<sup>136</sup> American Dental Hygienist Association, *op cit*. Also, a study by the Alberta Dental Hygienists Association in Canada estimated that requiring dental hygienists to work under the supervision of dentists added approximately 25% to fees charged by dental hygienists based on an analysis of the contribution of hygienists to the revenues of dental practices. Luciak-Donsberger & Aldenhoven, *op cit*.

3.84 This is not to say that the prices charged by dental hygienists will necessarily be cheaper than those charged by dentists but that allowing dental hygienists to offer their services independently of dentists will lead to more competitive pressure and this will have a disciplining effect on prices.<sup>137</sup>

3.85 A hygienist setting up a stand-alone dental hygiene clinic is likely to face lower start-up costs compared to a dentist setting up a dental surgery, as a hygienist does not require the same level of investment in equipment, due to the narrower scope of practice involved. Indeed, in other countries, mobile dental hygienists visit people who may have difficulty in travelling to a dental surgery, e.g. people in hospitals or nursing homes, or who are house-bound. While it may not be possible for a hygienist to perform a full range of treatments in a mobile setting, it indicates that many treatments can be provided with a minimal amount of equipment.

#### Greater Consumer Choice

3.86 The introduction of advanced dental hygienists would enable consumers to choose from whom they obtain dental hygiene services – either a dentist or an appropriately trained dental hygienist. Provided particular steps are taken (see discussion on consumer protection below) both would be reliable and safe options. It should be a matter of choice for the consumer – and not a decision for a dentist – as to whether to visit a dentist or a dental hygienist for the same service. Many consumers are well-informed about their oral health and are in a position to determine whether they require the services of a dental hygienist or a dentist.

3.87 If a consumer requires a number of different dental treatments, for instance a routine clean and more complicated treatments such as crowns or bridges, a consumer may well prefer the convenience of visiting a dental surgery where all treatments can be performed at the same location, either by a dentist or by a dental team consisting of both a dentist and a hygienist. Given the experience in other countries where dental hygienists are allowed to practise independently, the option of a one-stop shop 'dental team' is likely to be attractive, both to consumers and members of the profession. Thus, stand-alone dental hygiene practices can be expected to exist side-by-side with traditional dental surgeries where the dental hygienist works with a dentist.

#### Improved Efficiency in the Delivery of Dental Services

3.88 An efficient dental service involves making the best use of the oral healthcare resources available, particularly manpower resources. It takes longer, and is more expensive, to train a dentist than a hygienist because dentists are trained across a broader range of areas than hygienists. It is an inefficient use of the more advanced training and expertise of dentists to have them performing basic oral healthcare services, which dental hygienists are equally well-trained to perform. Better use of current and future oral healthcare resources could be achieved by encouraging a shift in the provision of basic oral healthcare services from dentists to hygienists so that dentists can focus on the provision of more complex restorative care which only they are qualified to perform.

3.89 The efficiency of dental services in Ireland would be improved if preventive oral healthcare performed by more qualified dental hygienists became an additional entry point to oral health services along with dentists. This could have a particularly important impact in the public healthcare sector. For example, advanced dental hygienists could perform a screening role. An advanced dental hygienist could treat those who do not require treatment by a dentist and give them advice on oral healthcare. The advanced dental hygienist could then refer on to a dentist only those who require further treatment.

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137 An example of the impact on prices of removing restrictions on who can carry out specific types of work is the effect on the price of conveyancing services in the UK following the introduction of conveyancers who compete with solicitors in the provision of conveyancing services to the public. In the period 1989 to 1996 the average cost of conveying a £65,000 house had fallen by 25%. Source: Department for Constitutional Affairs: "Competition and Regulation in the Legal Services Market". A report following the consultation "In the Public Interest?", July 2003, Annex A paragraph 24.

### Improved public oral health

3.90 Oral health surveys in Ireland and abroad have found that cost is often a significant factor in a patient's choice of whether or not to avail of dental treatment.<sup>138</sup> It is universally accepted that prevention is better than cure and early treatment of oral health problems is preferable, for instance in the detection of oral cancer. If the public had access to routine preventive dental services at competitive prices from suitably qualified professionals, this would encourage them to purchase more preventive dental treatments.

3.91 Although an advanced dental hygienist would not be able to provide the complete range of oral treatments that a dentist can, it would be preferable, from a public health perspective, if consumers chose to visit a hygienist rather than a dentist, as opposed to visiting neither.

### A High Level of Consumer Protection

3.92 The benefits of independent dental hygiene practice can be achieved while still maintaining a high level of consumer protection. In such a scenario, there are a number of ways in which consumer welfare and safety would continue to be protected:

- Registration with the Dental Council would be mandatory in order to use the title "advanced dental hygienist". To achieve registration status, a person would have to have completed a period of training and have received a qualification deemed appropriate by the Dental Council;
- The training that advanced dental hygienists receive would have to be approved by the Dental Council. The Dental Council is responsible for accreditation of dental hygiene education programmes in the case of Irish-trained dental hygienists. This ensures that appropriate standards are in place for the training of hygienists and that the health of the public is protected. The Council also assesses the education obtained by dental hygienists from other countries who wish to register in Ireland, to ensure that they have received a satisfactory level of training;
- The Dental Council would be responsible for setting out the dental procedures which an advanced dental hygienist could perform, based on the training they receive, following an amendment of the Dentists Act 1985 to permit independent practice. It would be illegal for a hygienist to carry out any dental treatment beyond those determined by the Council.

3.93 Additional consumer protection measures should be taken when independent dental hygiene practice is introduced:

- As is the case with dentists, the Dental Council should be granted the power to investigate complaints against any registered dental hygienist or advanced dental hygienist and to apply sanctions, including the power to fine and/or strike a hygienist from the Register. The Dentists Act 1985 should be amended to give the Dental Council these powers;
- Advanced dental hygienists should be obliged to refer a patient to a dentist if they suspect that the patient is suffering from a problem which they are unqualified to treat or which is beyond their scope of practice. This is standard practice in countries where independent dental hygiene practice is permitted.

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<sup>138</sup> For example, Office of Fair Trading (2003), *Survey of consumers' experience of dental services*, and Oral Health Services Research Centre (1992), *Oral Health of Irish Adults 1989-1990*, a survey conducted by University College Cork.

### A choice of practice options for hygienists

3.94 Allowing advanced dental hygienists to train to work independently of dentists would provide them with a choice of practice options. For example, advanced dental hygienists could choose to work on a stand-alone basis in their own premises, establish a mobile dental hygiene practice or work with a dentist as part of a dental team.

### *Solution*

3.95 The Dental Council should propose a new profession of advanced dental hygienist, so that dental hygienists may become suitably qualified to offer services directly to the public independently of dentists.

3.96 As a first step, the Dental Council should, in conjunction with the Dental Schools, undertake a review of training. This review should determine whatever additions may be required to the current dental hygienist training courses to enable hygienists to practise safely on an independent basis. The aim should be that advanced dental hygienists are fully trained and competent to work independently, can draw up a treatment plan independently of a dentist, and can undertake dental work within their scope of practice.<sup>139</sup>

3.97 While the appropriate training courses are being devised and a Scheme for Advanced Dental Hygienists drawn up by the Dental Council, the Dentists Act 1985 should be amended to enable advanced dental hygienists to operate independently of dentists.

3.98 It may be necessary to include additional measures to ensure that consumers are protected. Firstly, the Dentists Act should be amended to grant the Dental Council power to investigate complaints against advanced dental hygienists and apply appropriate sanctions. Secondly, the Dental Council should require advanced dental hygienists to refer their patients to a dentist if they suspect that the patient requires treatment which they are unqualified to perform or which is beyond their scope of practice.

3.99 The introduction of a new profession of advanced dental hygienists, who are suitably qualified to work independently of dentists in the provision of routine oral healthcare services, will have a significant impact on competition and deliver considerable benefits to both consumers and the State:

- It will allow the emergence of new ways of providing preventive dental services to consumers;
- Stand-alone dental hygiene clinics may emerge where people can receive oral health care advice and basic teeth cleaning;
- Independent dental hygienists may commence mobile dental hygiene clinics and visit schools, hospitals etc.

3.100 It will also (without compromising the quality of dental care):

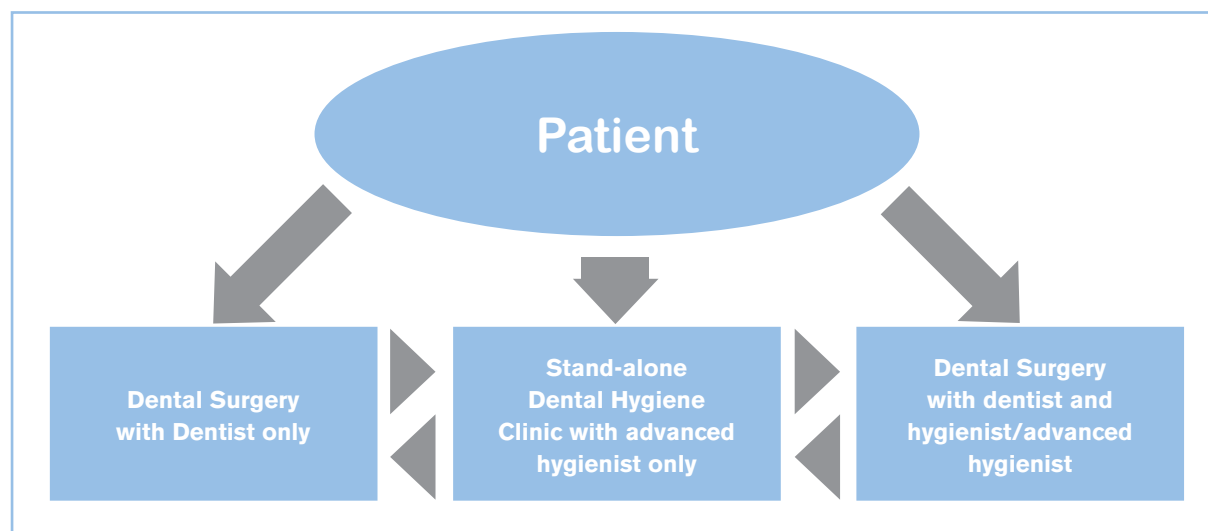
- Lead to a more efficient use of the respective skills and training of dentists and dental hygienists by making it more likely that consumers go to a hygienist for routine cleaning and to their dentist for other dental treatments;
- Allow greater consumer choice of oral healthcare providers;
- Put additional competitive pressure on the price of dental hygiene services;
- Encourage improved oral health.

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<sup>139</sup> The training review should also be used to identify any treatments which dental hygienists are currently trained to perform, but which are not currently permitted by the Dental Council's existing Scheme.

3.101 Given the experience in other countries, it is highly unlikely that all advanced dental hygienists will choose to work in stand-alone practices. Many are likely to remain working alongside dentists as part of a dental team. Stand-alone dental hygiene practices can be expected to exist side-by-side with traditional dental surgeries where both dentists and dental hygienists operate together.

**Figure 4: Recommended New Way of Delivering Dental Hygiene Services**



Recommendation 4:		Introduce a new oral healthcare profession of advanced dental hygienist who can operate independently of dentists
Details of Recommendation		Action By
<p>The Dental Council should commit itself to the introduction of advanced dental hygienists within the shortest feasible timeframe. The Council should, in conjunction with the Dental Schools, identify any additional training necessary to enable advanced dental hygienists to operate on a stand-alone basis.</p> <p>The Minister for Health and Children should bring forward proposals to amend the Dentists Act 1985 to allow for the establishment of a new profession of advanced dental hygienist, who can operate independently of dentists. The Dental Council should be given powers to investigate complaints against advanced dental hygienists and apply appropriate sanctions.</p> <p>The Dental Council should submit a new Scheme for Advanced Dental Hygienists to the Minister for Health and Children. The Scheme should provide that hygienists are obliged to refer a patient to a dentist if they suspect that the patient requires treatment which they are unqualified to perform or which is beyond their scope of practice.</p>		Dental Council
		October 2009
		Minister for Health and Children
		October 2008
		Dental Council
		October 2009

3.102 Hygienists working in the private sector are not currently permitted to claim directly for services provided under the State dental schemes. Instead, the claim is made by the hygienist's supervising dentist. The current dentists-only contract should be amended so that advanced dental hygienists also have contracts with the relevant State authorities, and can claim for treatments carried out under the State schemes.

3.103 Allowing advanced dental hygienists to be directly reimbursed for treatment provided under the State schemes will allow them to treat PRSI patients and medical card holders and claim reimbursements directly. Eligible patients will be able to choose whether to receive their free scale and polish treatment under the State schemes from a hygienist or from a dentist.

Recommendation 5:	
Allow advanced dental hygienists to be directly reimbursed for treatments provided under the State schemes	
Details of Recommendation	Action By
The Health Service Executive and the Department of Social and Family Affairs should allow advanced dental hygienists who are on the Register of Advanced Dental Hygienists to be directly reimbursed under the Dental Treatment Services Scheme and the Dental Treatment Benefit Scheme for eligible dental treatments they provide.	Health Service Executive  Department of Social and Family Affairs  At the same time as the Register of Advanced Dental Hygienists is established

## Restriction on the Number of Dental Training Places

### Summary

3.104 Demand for general dental services has grown substantially over the past ten to fifteen years. Over this period, the number of training places for dentists has remained static and there are no plans to increase them. The limited number of training places has led to a reliance on the entry of foreign-trained dentists to meet demand for dental services in Ireland. Over half the additions to the Register of Dentists in 2006 were trained outside the State.<sup>140</sup>

3.105 Despite the flow of qualified dentists into Ireland from overseas, the limit on training places in Irish universities could lead to a more serious shortage of dentists in the future and put further upward pressure on prices. While the other recommendations proposed in this report should minimise the effects of the shortage of dentists by making better use of their skills and expertise, the number of training places should be reviewed to ensure a sufficient supply of dentists in the long-term, so that consumers and the State get value for money in dental services.

3.106 There is no restriction on other institutions or private entities offering undergraduate courses in dentistry although such courses would have to meet the standards for recognition by the Dental Council in order for their graduates to be eligible for registration as dentists in Ireland. To date, no institution other than those already recognised has decided to offer an undergraduate course in dentistry and pursue recognition from the Dental Council.

### Nature of the Restraint

3.107 Two third-level institutions provide undergraduate degrees in dentistry in the State – Trinity College Dublin and University College Cork. Each school has the capacity to cater for about 40 new students each year, giving a total of 80 dentistry training places per year. Of the 80 places available each year, about 60 are available to Irish/EEA students with the remaining 20 reserved for non-EEA students.<sup>141</sup>

<sup>140</sup> See Table 6, Chapter 2.

<sup>141</sup> The reservation of training places for non-EEA students is a common feature of medical and dental education in Ireland. More than 50% of undergraduate medical training places are reserved for non-EEA students. These students pay high fees which provide an important source of income to third level institutions.

### *Effects of the Restraint*

3.108 The limited number of dental training places in Ireland results in:

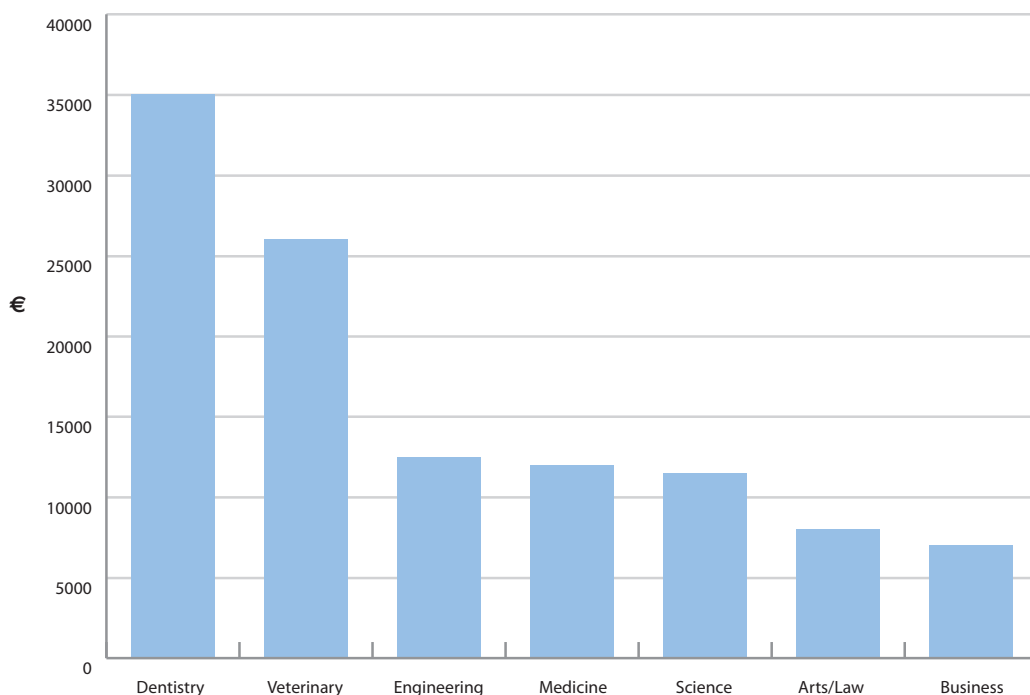
- Difficulties in recruiting dentists in both the private and public sectors;
- A dependence on foreign-trained dentists to meet the demand for dental services; and
- Ultimately, upward pressure on the price of dental services.

### *Rationale offered for the Restraint*

3.109 The number of places for undergraduate dentistry courses is, to a large extent, determined by the amount of funding available.<sup>142</sup> Dentistry is the most expensive undergraduate training course, costing around €35,000 per annum per student.<sup>143</sup> This is illustrated in Graph 5 below which shows the average cost of third-level education across a range of undergraduate degree programmes. Training for dental students is expensive due to the very high level of supervision involved, necessitating very low student-teacher ratios. Dental students get a high degree of hands-on experience as part of their training and it is important that they are adequately supervised while treating patients.

3.110 According to the dental schools in Dublin and Cork, it is not possible to increase the intake of dentistry students as the existing staff and physical resources of both colleges are currently operating at maximum capacity.

**Graph 5: Unit Cost of the Provision of Undergraduate Degree Programmes 2005/2006**



Source: Higher Education Authority<sup>144</sup>

<sup>142</sup> Funding for training courses in dentistry is provided by the Department of Education and Science and the Department of Health and Children.

<sup>143</sup> Based on data obtained from the Higher Education Authority.

<sup>144</sup> The figures used in this table are based on 2001/02 data which have been updated to indicative 2005/06 levels by using the fee increases that applied during the intervening years. These fee increases were as follows; 6% in 2002/03, 6.5% in 2003/04, 7% in 2004/05 and 7% in 2005/06. The figure for dentistry refers only to University College Cork. This is because the number of students funded through the core Higher Education Authority grant at the Dublin Dental School is very small so these are not included.



### Views of Interested Parties

3.111 The majority of submissions which commented on this issue agreed that there was a need to review the number of training places for dentistry in Ireland, with some submissions recommending that this should be done as soon as possible so that the findings of such a review would be available to inform educational strategies for the future.

3.112 Submissions suggested that the following issues should be covered by a review:

- Means of entry and training;
- Workforce planning in relation to all members of the dental team; and
- Funding issues around these places.

3.113 The Higher Education Authority (HEA), in its submission, agreed that there were concerns over the number of training places currently available in dentistry, but pointed out that it does not determine the number of places on third-level courses. The role of the HEA is to advise Government on skills needs in the economy and to support the higher education institutions in meeting those needs. The HEA does not specify a cap on the number of places provided – these decisions are made by the institutions themselves. The institutions make decisions regarding course provision on the basis of student demand and the economic demand for particular skills needs. The HEA notes that there are risks involved in increasing the number of places for a course (e.g. graduates may be unable to find employment, there is a cost to the State in providing courses) and they need to be considered.

### Analysis of the Competition Authority

3.114 The number of courses and places available in Ireland to study dentistry is a major determinant of the number of qualified dentists in Ireland. This, in turn, affects competition in dental services. There has been no change in the number of places available to study dentistry in Ireland despite growing demand from consumers for dental services. A formal review of the number of places available to study dentistry in Ireland has never been undertaken. Such a review is necessary to ensure that a sufficient number of dentists are being trained to meet the demand for dental services now and in the future. Reviews of this kind have been undertaken for other health-related professions such as medicine, pharmacy and health therapy courses. In each case, it was concluded that the number of places was inadequate.<sup>145</sup>

3.115 The Report of the Commission on the Points System (1999) recommended that there should be a regular review of places on healthcare-related courses with highly restricted availability.  
*“While the Commission recognises that manpower planning is an inexact science and that it can be very difficult to project, with any degree of accuracy, the long term or even the medium term needs of a specific profession, it nevertheless **considers that there should be a regular review of places on courses with capped numbers. The findings of such reviews should be in the public domain and the basis on which decisions are taken should be open and transparent. In undertaking such reviews, it will be important to ensure that no single interest group should have an overriding voice in fixing intake quotas.**”*<sup>146</sup>

3.116 In Ireland, undergraduate training of dentists is funded and provided entirely by the State at no cost to students. Private provision of training for dentists is not restricted although such courses would require recognition by the Dental Council and would have to compete for students with publicly-funded courses provided by the State. In a free market, the demand for dental services and, in turn, dentistry training and the supply of dentistry training

145 See *Current and Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists* (2001). Available at [www.dohc.ie/publications/pdf/baconrep.pdf?direct=1](http://www.dohc.ie/publications/pdf/baconrep.pdf?direct=1) and *Assessing Supply in Relation to Prospective Demand for Pharmacists in Ireland* (1999), [www.heai.ie/uploads/pdf/Pharm%20Report.pdf](http://www.heai.ie/uploads/pdf/Pharm%20Report.pdf), both commissioned by the Higher Education Authority.

146 See section 2.4, *Report of the Commission on the Points System* (1999), emphasis in original. Available at [www.education.ie/servlet/blobServlet/cps\\_point\\_comm\\_report99.rtf](http://www.education.ie/servlet/blobServlet/cps_point_comm_report99.rtf).

places, would balance themselves at the level of fees students were willing to pay for dental training. To ensure an appropriate supply of dentists, the State must estimate what would happen if market forces applied to the education sector. Limiting the supply of dentists beyond this level constrains competition in the market, raising the price of dental services. These costs are borne by both the State and by individuals. Training more dentists is an investment which, in the long term, will ensure that there is a sufficient supply of qualified dentists competing to supply dental services. This is supported by the Report of the Commission on the Points System, which stated:

*“The Commission accepts that in the case of some professional courses, especially those where the unit cost to the State is very high, there is a need to ensure that there are not too many students taking courses relative to the employment opportunities available. However, at the same time, **output from publicly funded third-level courses should not be less than the need for graduates from such courses.**”<sup>147</sup>*

3.117 A number of sources indicate that there is an under-supply of dentists in Ireland, which would imply that an expansion in the number of training places for dentists is required:

- (i) Prices for dental services are rising faster than the rate of health inflation, which itself is increasing at a significantly faster rate than overall inflation in the economy (see graph 4, chapter 2);
- (ii) The average ratio of dentists to population in the EEA is around 1:1,625, while in Ireland this ratio rises to 1:2,165 (see Graph 2, Chapter 2). This means that there are significantly less dentists in Ireland per head of population than is the case in most other EEA countries;
- (iii) Demand for dental care in Ireland has increased significantly in recent years and is forecast to continue growing in line with rising disposable incomes (see Table 3, Chapter 2).<sup>148</sup> At the same time, the number of training places for dentists has remained static;
- (iv) Although the entry of foreign-trained dentists has helped alleviate a severe shortage of dentists this inflow is unlikely to be sufficient in the longer term.<sup>149</sup> Forfás and the *Expert Group on Future Skills Needs* considered this issue in their submission to the Minister for Enterprise, Trade and Employment “*Skills Needs in the Irish Economy: The Role of Migration*” and listed a number of reasons why an exclusive reliance on immigration is not an ideal long-term solution to skills shortages in the healthcare professions:<sup>150</sup>
  - Rates of retention for immigrants are lower than those for their Irish-born colleagues, and some immigrants will wish to return home after a period of working in Ireland; and
  - The demand for many healthcare professionals throughout Europe is much greater than the supply from the resident labour force and competition for healthcare professionals will intensify as the European labour force ages. Consequently, there is no guarantee that Ireland will continue to attract healthcare professionals in the same volume as recent years;
- (v) Indecon’s survey of dentists found evidence of a shortage of qualified dentists, as the majority of dentists surveyed had experienced considerable difficulties in recent years when recruiting qualified dentists for their practices;<sup>151</sup>
- (vi) The Healthcare Skills Monitoring Report predicted that demand for dentists in 2015 would range from 2,249 to 2,782 depending on whether demand is determined only by population growth or whether

147 *Ibid*, emphasis added.

148 Based on market enquiries by the Competition Authority in the preparation of this report and economic literature on the demand for dental services.

149 See Table 6 in Chapter 2 which shows that in 2006 half of the new additions on the Register of Dentists obtained their qualifications overseas.

150 This report was prepared for the Department of Enterprise, Trade and Employment in 2005 and is available at [www.skillsireland.ie](http://www.skillsireland.ie).

151 See Table 10.15, “Indecon’s Assessment of Restrictions in the Supply of Professional Services”, March 2003. Available at [www.tca.ie/professions.html](http://www.tca.ie/professions.html).

demand will be determined by other factors such as changing demographics, increased demand for higher quality services and increased client expectations. The projected domestic supply of dentists in 2015 is 2,085 leading to a shortfall of between 164 and 696 dentists.<sup>152</sup>

3.118 The increased use of other oral healthcare professionals such as advanced dental hygienists and clinical dental technicians will reduce the reliance on dentists for certain dental services. Thus any review of manpower requirements in dentistry should take account of plans to introduce these professions and the effects of their introduction on the demand for dentists.

#### *Solution*

3.119 While the entry of foreign-trained dentists is driving the increase in the numbers on the Register of Dentists and helping to meet the demand for dental services in Ireland, it would be desirable, for the reasons set out in the *Report of the Expert Group on Future Skills Needs*, for Ireland to have sufficient training places to meet its own needs.<sup>153</sup>

3.120 The Department of Health and Children should conduct a review of the number of training places for dentists and other oral healthcare professionals in the context of the forthcoming National Oral Healthcare Policy.<sup>154</sup> In the event of a decision to increase the number of training places available, the question of expanding the provision by existing institutions or inviting tenders from other institutions to provide undergraduate training for dentists should be considered.

Recommendation 6:		Review the number of training places for dentists and other oral healthcare professionals
Details of Recommendation		Action By
The Department of Health and Children should, in the context of the forthcoming National Oral Healthcare Policy:		Department of Health and Children
(a) assess the future manpower requirements for dentists and other oral healthcare professionals; and,		October 2008
(b) carry out a detailed review of the number of training places for dentists and other oral healthcare professionals, taking account of the effects of the other recommendations contained in this report, to determine whether the number of places for dentistry and other oral healthcare professionals needs to be increased and, if so, to what level.		

## Restrictions on the Supply of Orthodontic Services

### *Summary*

3.121 Demand for orthodontic services has grown substantially over the past ten to fifteen years, notably among adults.<sup>155</sup> The supply of trained orthodontists has not kept pace with the increase in demand for their services. This has had a big impact on the availability of *publicly-funded* treatment. The practice of orthodontics in the private sector is lucrative and the public service has to compete with this high remuneration to recruit and retain orthodontists. A recent study found that 23% of orthodontists in the public sector intended to change to

152 See Table 4.5, *Healthcare Skills Monitoring Report*, Fás, August 2005.

153 See Appendix 2 for the growth in the number of dentists on the Register of Dentists.

154 See para 1.3, Chapter 1.

155 See "Orthodontics" at [www.rte.ie/tv/theafternoonshow/1091452.html](http://www.rte.ie/tv/theafternoonshow/1091452.html).

private practice in the future.<sup>156</sup> The average waiting time for publicly funded orthodontic treatment is up to 2 years for high priority patients and up to four years for medium priority patients.<sup>157</sup>

- 3.122 Private orthodontic treatment can cost several thousand euro depending on the complexity of the case, although in general the more complicated cases are treated by the public orthodontic service as they fulfil the eligibility criteria for treatment. The waiting time for the commencement of private orthodontic treatment is 4-6 weeks. Many orthodontists practising in Ireland have trained abroad, often at their own expense.
- 3.123 To use the title “orthodontist”, a dentist must complete a three-year postgraduate course in orthodontics. At the time of writing, the course operated by Cork University Dental School and Hospital, which commenced in 2006, is the only training course for orthodontists available in Ireland, although the Dublin Dental School and Hospital intends to recommence training for specialist orthodontists in 2007.
- 3.124 A new oral healthcare profession of *orthodontic therapist* was approved by the Dental Council in 2004. Orthodontic therapists will be trained to assist the work of the orthodontist. They will enable orthodontists to make better use of their expertise and skills by increasing the number of patients treated per orthodontist, thereby increasing the availability of orthodontic treatment and potentially reducing the cost. The Dublin and Cork Dental Schools have jointly developed a training programme for orthodontic therapists that has been approved by the Dental Council. However, at the time of writing, neither the Dublin nor the Cork Dental Schools have any plans to commence training of orthodontic therapists.

#### *Nature of the Restraint*

- 3.125 Currently, training places to study orthodontics in Ireland are extremely limited. All orthodontic training in Ireland is funded by the State, and has been provided on a “stop-start” basis. The 2006 Report of the Orthodontic Review Group provides an overview of orthodontic training in Ireland.<sup>158</sup> According to the report, the Dublin Dental School and Hospital trained 10 postgraduate students to specialist orthodontist level in the period 1989 to 1999 and five specialists completed training to consultant level, while 16 dentists completed specialist orthodontic training during the period 2000 to 2005. The Dublin Dental School and Hospital does not currently provide a training programme for orthodontists but will recommence training in 2007 with an annual intake of two students. The Cork University Dental School and Hospital commenced a three-year specialist training course for orthodontists in 2006. The Cork course will have an intake of four students every two years.
- 3.126 In addition to the training places provided in Ireland, the Irish health services sponsored training for 13 specialist orthodontists in the UK in the period 2002 to 2005. A further four postgraduate students commenced State-funded orthodontic training in the UK in 2005. However, the Orthodontic Review Group identified the following disadvantages to this option:
- Potential trainee orthodontists are not always in a position to move to the UK for a three year training period; and
  - The trainees involved do not treat any patients from the Irish health service orthodontic waiting list as they would if they were trained in an Irish setting.

156 Source: “*The Orthodontic Workforce in Ireland: A Report by the Orthodontic Society of Ireland*”, February 2006.

157 For details of average waiting times across the country see Appendix 5.

158 Published December 2006. Available at <http://hse.ie/en/Publications/HSEPublicationsNew/PCCCRReports/OrthodonticReport2007>.

### *Effects of the Restraint*

- 3.127 The number of qualified orthodontists in Ireland is affected by the number of training places available. This, in turn, affects the level of competition in the market for orthodontic services.
- 3.128 Increasing demand for orthodontic services has led to lucrative opportunities for orthodontists in the private sector. Consequently, it has become increasingly expensive for the HSE to recruit and retain qualified orthodontic specialists in the public sector, due to their high earning potential in the private sector. This has resulted in very long waiting lists for orthodontic assessment and treatment in the public sector, as shown in Appendix 5.
- 3.129 The ideal time for orthodontic treatment to begin is around the age of 12, when a child's permanent teeth have all erupted. If children cannot access treatment during this time, it can lead to more complicated and costly treatment being required at a later stage.

### *Rationale offered for the Restraint*

- 3.130 One of the reasons for the very small number of training places for orthodontics is the very high cost of training. Training a dentist to become an orthodontist costs in the region of €30,000 per student per annum, which covers fees and expenses. Students are also paid €58,389 per annum by the HSE for treating patients from the public orthodontic waiting lists during their period of training.<sup>159</sup>
- 3.131 According to the Chief Executive of the Dublin Dental School and Hospital, the number of orthodontic trainees accepted in Dublin is constrained by the limited number of consultant orthodontists available to supervise their highly specialised training.<sup>160</sup>

### *Views of Interested Parties*

- 3.132 According to the Irish Dental Association, the public service is unable to retain consultant and specialist orthodontists as the current level of remuneration is too low. The Association has recommended that the range of duties carried out by dental hygienists could be expanded to equip them with the necessary skills to assist in the provision of orthodontic treatment i.e. to act as orthodontic therapists.<sup>161</sup>
- 3.133 The Orthodontic Society says that there is no shortage of orthodontists in Ireland, and that the number of Irish orthodontists being trained has been increasing steadily over the past few years (see Graph 3, Chapter 2), many of whom accessed such training abroad at their own expense. The Society is supportive of the introduction of orthodontic therapists and wishes to be involved in developing training for orthodontic therapists. The Society does not, however, believe that the introduction of orthodontic therapists will reduce the cost of orthodontic treatment.
- 3.134 The Irish Dental Nurses Association considers that dental nurses with an additional year's training could qualify as orthodontic therapists, but points out that, without a statutory register of dental nurses, there could be registration problems with orthodontic therapists. Currently, registration by dental nurses is voluntary and dental nurses do not need a qualification unless they work in a hospital.

### *International Experience*

- 3.135 In other countries, including the UK and Sweden, a profession of orthodontic therapists has been introduced. Orthodontic therapists work under the direction of orthodontists and are trained to carry out elements of orthodontic procedures which are less complex and do not require the skills of a fully qualified orthodontist. This results in a more efficient utilisation of the skills and expertise of orthodontists.

159 Source: *Report of the Orthodontic Review Group*, HSE, December 2006.

160 *Orthodontic Accreditation System and System of Training for Orthodontics: Presentation*. Joint Oireachtas Committee on Health and Children, 26<sup>th</sup> June 2003. Available at: [www.oireachtas.ie/documents/committees/29thdail/jchc/jchc260603.rtf](http://www.oireachtas.ie/documents/committees/29thdail/jchc/jchc260603.rtf).

161 Submission by the Irish Dental Association to the Competition Authority (3<sup>rd</sup> November 2003) following the publication of the Indecon Report.

- 3.136 Access to publicly-funded orthodontic treatment in Ireland is limited. This is evident from the long waiting lists for both assessment and treatment across the country. This indicates a shortage of orthodontists in the public sector relative to the current level of demand, in spite of the growing number of orthodontists practicing in Ireland.
- 3.137 The Report of the Orthodontic Review Group recommended that the existing Department of Health and Children Guidelines for orthodontic treatment be replaced with new assessment criteria based on the *Index of Orthodontic Treatment Need* (IOTN), which is an internationally recognised assessment system.<sup>162</sup> In its report, the Review Group noted that implementation of these guidelines will result in more patients being eligible for public orthodontic treatment, thus adding to the existing waiting lists.<sup>163</sup>
- 3.138 The commencement of new training courses for orthodontists in Cork University Dental School and Hospital in 2006 and in the Dublin Dental School and Hospital in 2007 means that there are now Irish-based training courses for orthodontists after a break of some years. However, these courses will not have any significant impact on the provision of services for a number of years, when the new graduates start working. In the meantime, there are a number of Irish specialist registrars in orthodontics training in the UK who are due to complete their training in 2009, some of whom may decide to come back to work in Ireland.<sup>164</sup>
- 3.139 The introduction of orthodontic therapists in Ireland was suggested during the lifetime of the previous Government<sup>165</sup>, and the Dental Council drew up a Scheme for Orthodontic Therapists and submitted it to the Minister for Health and Children. The Scheme has been approved by the Minister. The Dublin and Cork Dental Schools have designed a training programme for orthodontic therapists which has been approved by the Dental Council.
- 3.140 A number of issues remain to be resolved in relation to orthodontic therapists, such as the appropriate ratio of orthodontic therapists to orthodontists, dedicated funding for the commencement of training and the terms and conditions of employment for public sector therapists.
- 3.141 Orthodontic therapists will be permitted to undertake cleaning and polishing of teeth, take impressions, bite registration and photographs. They will also be allowed to fit space maintainers, retainers and orthodontic headgear. The orthodontic therapist will only carry out work after the orthodontist has examined the patient and indicated the course of treatment to be provided. All treatment provided by the orthodontic therapist must be inspected and approved by the orthodontist before the patient leaves the premises.<sup>166</sup>
- 3.142 Training dental hygienists/dental nurses to become orthodontic therapists will be an efficient and effective means of increasing the supply of orthodontic services in Ireland, without necessarily requiring more orthodontists. However, this will only be the case if the ratio of orthodontic therapists to orthodontists is sufficient to allow a real improvement in the productivity of orthodontists. Training for orthodontic therapists should be designed to ensure that they are sufficiently skilled to work under the general supervision of an orthodontist rather than be directly supervised at all times. Ratios of orthodontic therapists to orthodontists vary from country to country. For example, the average ratio in the Netherlands is 4 orthodontic therapists to 1 orthodontist while in Germany the ratio is 12 orthodontic therapists to 1 orthodontist.<sup>167</sup>

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162 See page 20 of the *Report of the Orthodontic Review Group* for a brief description of IOTN.

163 The Department of Health and Children estimates that the adoption of the new assessment criteria will lead to an increase of approximately 12% in the numbers eligible for public orthodontic treatment.

164 Source: The Orthodontic Society of Ireland.

165 *Progress Report on the Implementation of an Agreed Programme for Government between Fianna Fáil and the Progressive Democrats* (August 2004).

166 Page 31, *Report of the Orthodontic Review Group*, December 2006.

167 Source: Department of Health and Children.

### *Solution*

- 3.143 The Competition Authority welcomes the establishment of the new oral healthcare profession of orthodontic therapist, with specific training to assist in the provision of orthodontic care, and who would be permitted to work without direct supervision. Submissions received following the publication of the preliminary report agreed that the introduction of orthodontic therapists would improve the productivity of orthodontists.
- 3.144 Establishing a profession of orthodontic therapist and facilitating dental hygienists or dental nurses who wish to upgrade their skills would:
- Provide a group of professionals who are trained to assist orthodontists in the provision of orthodontic treatment;
  - Increase the supply of professionals who are trained in the area of orthodontics, albeit to a much lower degree than orthodontists themselves;
  - Reduce the need for more orthodontists who are extremely expensive to train;
  - Reduce the waiting period for publicly-funded treatment; and
  - Ultimately increase access to both publicly-funded and privately-funded orthodontic treatment by enabling orthodontists to treat more patients.
- 3.145 The commencement of training for orthodontists in Cork in 2006 and the re-introduction of orthodontic training in Dublin from 2007 are welcome developments. However, these courses will only result in an average of four new specialist orthodontists per year. The number of training places for specialist orthodontists should be kept under review in the light of the needs of the public orthodontic service.
- 3.146 In its preliminary report the Competition Authority suggested a review of the number of orthodontic training places to ensure that there was an adequate supply of orthodontists to meet demand. The Orthodontic Review Group, which reported in December 2006, examined these issues in the context of its work.
- 3.147 The increase in training places for orthodontists and the finalisation of the outstanding issues relating to orthodontic therapists will increase the productivity of public and private orthodontic services. It remains to ensure that the appropriate numbers of orthodontists and orthodontic therapists are trained for the future. The Department of Health and Children should ensure that the ongoing manpower and training requirements for orthodontists and orthodontic therapists are reviewed as part of the implementation of Recommendation 6 above.





# section 4





## 4. RESTRICTIONS ON RIVALRY AND COMPETITION BETWEEN DENTISTS

### Summary

- 4.1 Competition between dentists is actively discouraged by the Dental Council's rules on how dentists can advertise their services. These rules are not proportionate to their aim of protecting the public from harm. For example, it is forbidden to advertise even basic price lists, and new dental practices are limited to a maximum of six press notices advertising their existence in their first year of practice. In addition, dentists are forbidden to offer their services at a discount.
- 4.2 These unnecessary restrictions should be removed as a matter of urgency. Allowing truthful, informative advertising will empower consumers to make informed decisions about their oral health. It will also encourage dentists to compete on price, to offer new services and to deliver their services in new customer-focused ways.
- 4.3 The Competition Authority understands that the Dental Council is currently updating its guidelines on advertising. Rather than amend the guidelines, they should be revoked entirely. The Dental Council should be concerned only with ethical behaviour and the clinical practice of dentistry and not with the economics of how dentists carry out their business. Similarly, the restriction on discounts should be removed.
- 4.4 To further assist consumers to make informed decisions and choose between competing dentists, independent information should be available to consumers on their entitlements under the State dental schemes and on the different types of treatments available.
- 4.5 There is some uncertainty surrounding the issue of whether corporate dental bodies are permitted to engage in the business, as opposed to the practice, of dentistry. This uncertainty should be resolved as a matter of urgency by amending the relevant section of the Dentists Act to permit corporate dental bodies to engage in the business of dentistry. The benefits of corporate dental bodies include cost savings, ability to operate from locations that are more convenient for many consumers, flexible working arrangements, longer opening hours, and checks and balances on the quality of each dentist's services (put in place to maintain the corporate body's reputation).

### Restrictions on Advertising

#### *Nature of the Restraint*

- 4.6 The Dental Council's *Guidelines on Public Relations and Communications* ("the Guidelines") are the rules by which the Council imposes restrictions on the manner in which dentists may advertise their services and promote their practices.<sup>168</sup>
- 4.7 Under the Dentists Act 1985, the Dental Council, following an inquiry by its Fitness to Practise Committee, has the power to impose sanctions, up to and including removal from the Register, on dentists who violate these rules. Where the Council decides to attach conditions to the continuing registration of a dentist, or to suspend or remove a dentist from the Register, the dentist has the right to appeal the decision to the High Court.<sup>169</sup>

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<sup>168</sup> Available at [www.dentalcouncil.ie](http://www.dentalcouncil.ie).

<sup>169</sup> See Part V of the Dentists Act 1985.

#### 4.8 According to the Guidelines:

- A dentist may only have two professional plates and one 'Dental Surgery' sign to indicate the location of his/her practice. The professional plates may not exceed 40cm x 30cm in size while the 'Dental Surgery' sign cannot exceed 75cm x 15cm in size. A dentist may only put a limited amount of information on a professional plate i.e. name, qualification, opening hours and phone number;
- A dentist is discouraged from appearances in press, radio, TV or other media *"where such publicity could result in his/her gaining a professional advantage"*;
- A dentist opening a new practice may only place a notice in the press six times in their first year of operation and these notices may not exceed a 5cm single column.

#### 4.9 The advertising of prices is not allowed in the Guidelines and it is explicitly stated that:

*"Advertising and canvassing beyond the guidelines set out in this document and any other overt promotional activities are strictly prohibited."*

#### 4.10 The Dental Council's *Professional Behaviour and Dental Ethics* prohibits the solicitation of new patients by dentists and price discounts.<sup>170</sup>

*"Overt advertising, canvassing, sponsoring, discounting or the payment of commission by a dentist for the purpose of obtaining patients is forbidden. Patients must not be canvassed from colleagues. Particular attention in this regard must be paid by those acting as locums, assistants or associates."*

#### *Effects of the Restraint*

#### 4.11 Advertising by dentists is limited almost exclusively to the most basic listing in directories (e.g. Golden Pages), which provides only the name, address and telephone contact for each dentist.

#### 4.12 The Dental Council's restrictions on advertising have a number of detrimental effects:

- They make shopping around unnecessarily awkward and time consuming. Consumers find it difficult to get useful information on the range and price of treatments provided by different dentists, and so are less informed about the options available to them and hindered in their efforts to choose the best option for them;
- They act as an unnecessary obstacle to dentists who wish to establish new dental practices. Advertising is an important way for new dental practices to make themselves known to potential customers/patients in their local area. The current restrictions on dentists who wish to set up a new practice severely constrain their ability to publicise their existence and therefore reduce the likelihood that consumers would be aware of a new dentist in their area. This protects the position of dentists already established in the locality;
- They reduce the incentives for dentists and dental practices to offer new or innovative ways of delivering dental services. Dentists who wish to differentiate themselves by making such investments are unable to use advertising to effectively promote their new services and facilities in an effort to attract new patients and recoup their investment;
- They limit price competition. It is extremely difficult for consumers to make price comparisons and shop around for the best value.<sup>171</sup> This allows dentists to charge more than they would in a more transparent competitive environment;

<sup>170</sup> Available at [www.dentalcouncil.ie](http://www.dentalcouncil.ie).

<sup>171</sup> A survey carried out by Indecon in 2002 revealed that the majority of consumers consider that there is virtually no, or very little, price competition among dentists in Ireland, and the public feel that they do not have access to adequate information on the fees charged by dentists.

- The cost to consumers for dental services is thus kept artificially high.

4.13 The advertising restrictions place Irish dentists at a competitive disadvantage to their counterparts in Northern Ireland and elsewhere, who can, and do, freely advertise their services in the Republic.

#### *Rationale offered for the Restraint*

4.14 The Dental Council asserted that *“tradition in dentistry as in allied professions has been to avoid advertising and to rely on word of mouth and quality of service to build a practice”*.<sup>172</sup> The Council also claimed that the advertising restrictions *“maintain the dignity and integrity of the dental profession as a caring profession committed to achieving optimum oral health for the public”*, and that they preserve: *“the essential trust in the dentist/patient relationship”*.

4.15 The Dental Council also stated that excessive advertising was bad for consumers because, if all dentists engaged in it, advertising would be self-cancelling and would simply lead to an increase in costs which would ultimately be passed on to consumers:

*“If one dentist overtly or excessively advertised it is almost certain, as has happened in other professions, that other dentists would follow in order to maintain a level playing pitch. Advertising costs money and the cost must be borne by the practice. Inevitably the quality of service will suffer or the cost of the service to the patient will increase.”*<sup>173</sup>

4.16 The Irish Dental Association states that the advertising regulations *“...ensure that patients are directed to the best qualified and most appropriate clinician for their requirements, rather than to the best marketing dentist, whose dental skills may not be appropriate to the needs of the patient.”*

4.17 While recognising the benefits of informative advertising (i.e. hours of business, services provided, range of fees displayed within the dental practice for such services, websites, etc.), the Irish Dental Association is of the view that *“advertising should be restricted in the profession in order to protect the public from unscrupulous claims by practitioners”* and that *“the public must be protected from claims being made by dental surgeons that are misleading, i.e. a dentist claiming that he/she is a specialist in a particular area of dentistry, when he/she does not hold a specialist qualification.”*<sup>174</sup>

#### *Views of Interested Parties*

4.18 A number of submissions addressed the question of restrictions on advertising for dentists. The Department of Health and Children would support a change in the current restrictions on advertising, although it considers that safeguards are required in relation to false and misleading claims.

4.19 The Dental Council recognises that the *Guidelines on Public Relations and Communications* that were drawn up by the Council in 1990 need to be *“changed significantly and updated”*. The Council notes that, under Section 66 of the Dentists Act 1985, the Council is required *“to give guidance of a general nature to the dental profession on matters relating to ethical conduct and behaviour”*.<sup>175</sup>

4.20 The Dental Council is, however, concerned about *“an advertising free-for-all where the only winners will be the advertising media and the only losers the patients”*. According to the Council, *“dentistry is unlike most professional services in that the client generally is not in a position to judge the necessity or the propriety of the treatment recommended or the quality of the treatment delivered”*.

<sup>172</sup> Dental Council submission to the Competition Authority, February 2002.

<sup>173</sup> *ibid.*

<sup>174</sup> Irish Dental Association submission to the Competition Authority, November 2003.

<sup>175</sup> Dental Council submission to the Competition Authority, February 2006.

4.21 The Dental Council is prepared to discuss the recommendation regarding advertising restrictions with the Competition Authority *"with a view to implementing changes that will not result in any diminution of the standard of dental care delivered in Ireland or in an increase in the cost to the consumer"*.

4.22 The Irish Dental Association supports informative advertising that is both accurate and truthful. According to the Association, if patients were better informed and educated about dental treatments generally, they would be in a position to better understand the treatment being recommended by their dentist.

4.23 The Irish Dental Association believes that, if the ban on advertising by dentists is removed, it is essential that:

- An information campaign is established to educate patients about dental procedures generally as well as their entitlements to free or subsidised dental procedures under the State schemes; and
- To protect the welfare of patients, the Dental Council must be empowered to take punitive action against dentists who engage in false, misleading and distasteful advertising which could bring the profession into disrepute.

4.24 The Irish Dental Association claims that advertising is not a significant factor in how a patient chooses a dentist. In a survey of 6,000 people in the UK, 1% chose a dentist because of an advertisement in the Yellow Pages and 1% because of an advertisement.<sup>176</sup>

4.25 The Irish Dental Association also claims that research has shown that advertising does not impact on prices or the volume of patients who go to a particular dental practice.<sup>177</sup>

4.26 The Orthodontic Society expressed the view that all advertising should be controlled and that it was a matter for the Dental Council to determine what advertising is decent, legal, honest and truthful. The Society considers that clinicians should rely solely on their reputation and skills and not on marketing ploys to attract patients.

#### *International Experience*

4.27 International experience has shown that advertising of professional healthcare services does not have a negative impact on the quality of care provided. Informative advertising of the services provided by healthcare professionals lowers prices. Evidence in support of the pro-competitive effects of advertising in markets for professional healthcare services dates back to studies in the 1970s.<sup>178</sup>

4.28 A study by the US Federal Trade Commission examined optometry services in different cities in the USA, classified in terms of their restrictions on advertising, and found that restrictions on advertising raised price without affecting quality.<sup>179</sup> The study provided compelling evidence that advertising posed no danger to the quality of healthcare services provided. Eye examinations were just as accurate and thorough, while the workmanship of glasses was of the same quality whether advertising restrictions were in place or not. The findings of this study have been corroborated in later work.<sup>180</sup>

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176 National Audit Office (UK) J9437uz00 2003.

177 Kwon IW, Safranski SR, Kim JH., Health Service Management Research, 1993;6(1):32-60.

178 Benham, Lee, *The Effects of Advertising on the price of Eyeglasses*, Journal of Law and Economics, Vol.15, No. 2, October 1972; Benham, Lee and Benham, *Regulating Through the Professions: A Perspective on Information Control*, Journal of Law and Economics, Vol. 18, No. 2, October 1975. Both studies examined optometry which was at the time one of the few professions in the USA with significant State to State variation in permissible advertising. Using data from a national survey of consumers it was found that advertising resulted in significantly lower prices. Other studies of the time reported similar findings.

179 Bond, Ronald S., et al, *Staff Report on Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry*, Federal Trade Commission Bureau of Economics, September 1980.

180 See Love, James H. and Frank H. Stephen, *Advertising, Price and Quality in Self-regulating Professions: A Survey*, International Journal of the Economics of Business, Vol. 3, 1996.

4.29 In its Report on Competition in Professional Services the European Commission said:

*“There is [...] an increasing body of empirical evidence which highlights the potentially negative effects of some advertising restrictions. This research suggests that advertising restrictions may under certain circumstances increase the fees for professional services without having a positive effect on the quality of those services. The implication of these findings is that advertising restrictions as such do not, necessarily, provide an appropriate response to asymmetry of information in professional services. Conversely, truthful and objective advertising may actually help consumers to overcome the asymmetry and to make more informed purchasing decisions.”<sup>181</sup>*

#### *Analysis of the Competition Authority*

4.30 The Dental Council asserts that consumers do not know what treatment they need or how to judge quality and so advertising by dentists ought to be restricted. It is true that, as dentists know more than patients about dental services and their effects, patients are vulnerable to *supplier induced demand*, a situation where a practitioner prescribes more services than are strictly necessary. However, this *information asymmetry* is common in relation to the supply of professional services, for example solicitors, electricians, financial intermediaries etc. and it is certainly not unique to the dental profession. Consumers of dental services are no more at risk from information asymmetries than consumers of these many other professional services.

4.31 The solution is to equip consumers with the information they need to reduce the information asymmetry between themselves and the dentist, and to make rational decisions. Truthful informative advertising helps to equip them for this.

4.32 Contrary to the Dental Council's assertion that allowing truthful advertising would lead to higher prices for consumers, or lower quality of care, international evidence shows that informative advertising lowers prices without lowering quality of care. In Ireland, in the case of optometry services for example, there is no evidence that the quality of eye care services in the State has fallen now that advertising has become a market feature. There is also no evidence that optometry professionals have any less integrity than dental professionals do. In any case, the quality of dental services in Ireland is already protected and regulated by the Council through the requirement to be fully qualified, and through its Code of Ethics for dentists.

4.33 Advertising is the lifeblood of competing businesses, including the supply of professional services, and is a straightforward and widely accepted facet of normal business behaviour.

4.34 The Irish Dental Association claims that the restrictions on advertising by dentists “ensures that patients are directed to the best qualified and most appropriate clinician for their requirements”. However, the current advertising restrictions mean that the customer has little or no information with which to determine who is the “best qualified and most appropriate clinician”. In fact, because the restrictions reduce the availability of information to consumers they are more likely to cause them to make poor decisions about their health and avail of fewer dental services. Moreover, advertising does not mean that consumers will all go to the best advertised dentist, as the evidence cited by the Irish Dental Association, in paragraphs 4.24 and 4.25 above, shows. Word of mouth, reputation and previous personal experience will always be the most valued source of information for consumers of professional services.

4.35 However, the Competition Authority agrees with the Dental Council and the Irish Dental Association that the public needs to be protected from unscrupulous practitioners, and in particular from misleading claims made by dentists. Misleading advertising frustrates the competitive process and is harmful to consumers, and this is why it is explicitly outlawed under consumer protection legislation. Dealing with misleading advertising under that legislation is a proportionate way of protecting the public while still allowing them the benefits of truthful advertising.

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181 European Commission (2004), *Report on Competition in Professional Services*. Available at <http://europa.eu/scadplus/leg/en/lvb/123015.htm>.

4.36 The Dental Council's restrictions on the manner in which dentists can advertise and promote their practices go far beyond what is necessary to protect the public from poor quality dental services and unscrupulous misinformation. They negatively affect consumers by limiting the information available to them on which they can base decisions about their oral health. Rather than protecting consumers, they protect dentists established in the profession, and should be abolished. They severely constrain normal competitive behaviour among dental practices, and make it unnecessarily difficult for dentists to establish new practices and/or offer their services in innovative ways. This reduces consumer choice.

4.37 The ban imposed by the Dental Council on price discounting by dentists is a serious and unnecessary interference in how dentists operate their businesses and should be abolished. It should be left to dentists themselves to determine the price structure of the services they offer to their patients. If a dentist is willing to offer his/her services at a discount, for example, where a patient is having a number of fillings or crowns, then the Dental Council should not prevent the patient from benefiting as it does at present.

#### *Solution*

4.38 The Dental Council should abolish the current anti-competitive restrictions on advertising. Truthful and accurate advertising of dental services is a useful means of providing important information to consumers.

4.39 Permitting informative truthful advertising by dentists will bring many important benefits:

- Patients will be empowered to make better informed decisions about their oral health;
- Consumers will be able to shop around for dental services and this will encourage price competition among dentists;
- It will encourage dentists to offer new and innovative ways of delivering dental services; and
- It will make it easier for dentists who wish to establish a new practice to promote their practice and inform local residents of the arrival of a new practice.

4.40 The ban on dentists offering discounts for their services should be removed. This would allow dentists the flexibility to offer more innovation in the services they provide to their patients.

4.41 It is vital that competition between dentists, and consumer information, is encouraged by the regulatory system. The restrictions on advertising and price discounts by dentists are contained in the Guidelines of the Dental Council, and not in the Dentists Act 1985 itself. They could, therefore, be removed by a decision of the Council.

Recommendation 7:		Remove unnecessary restrictions on advertising
Details of Recommendation		Action By
The Dental Council should limit its restrictions on advertising to prohibiting advertising which is false or misleading.		Dental Council December 2007

Recommendation 8:		Remove the ban on discounts
Details of Recommendation		Action By
The Dental Council should amend its <i>"Professional Behaviour and Dental Ethics"</i> to remove the ban on discounting by dentists.		Dental Council December 2007

4.42 Informed consumers make better decisions about the products and services which best suit their needs and desires. Without useful, accessible information, consumers are unable to accurately assess the merits of competing products. Consumers should be able to access clear, impartial information on oral healthcare issues, including their entitlements under the State dental schemes and the different types of treatment available.

4.43 The Department of Health and Children should provide for the dissemination of information on oral healthcare issues as part of the National Oral Healthcare Policy. Such information will assist consumers in comparing quotes from dentists and help them to ensure they are comparing like with like. This information could be disseminated through bodies such as the Health Service Executive or the Dental Health Foundation.

Recommendation 9: Provide information to consumers on oral healthcare issues	
Details of Recommendation	Action By
The Department of Health and Children should provide for the dissemination of information on oral healthcare issues to consumers as part of the National Oral Healthcare Strategy.	Department of Health and Children October 2008

## Restrictions on Business Models

4.44 In its preliminary report, the Competition Authority referred to the prohibition on the delivery of dental services in Ireland by a corporate body which is contained in section 52 of the Dentists Act 1985.

4.45 Section 52(1) states: *"It shall not be lawful for any body corporate to engage in the practice of dentistry<sup>182</sup> (other than the performance of the dental work referred to in section 51(2)(b)<sup>183</sup> of this Act)."*

4.46 The Dental Council told the Competition Authority in 2002 that: *"It is not lawful for any body corporate to engage in the practice of dentistry."*<sup>184</sup> However, in its submission on the Authority's preliminary report, the Council stated *"There does not appear to be any restriction on the business of dentistry in Ireland"*.<sup>185</sup> While the Dentists Act prohibits a body corporate engaging in the practice of dentistry, it appears permissible for bodies corporate to employ dentists for the purpose of engaging in the practice of dentistry, similar to the situation which applies to optometrists and pharmacists. However, the situation is unclear and the Competition Authority is aware of differing legal interpretations of the relevant section of the Dentists Act.

4.47 This uncertainty should be removed, to make it clear that dentists in Ireland are allowed to operate in a variety of business forms, as they do in 25 of the Member States of the European Economic Area.

4.48 In its preliminary report, the Competition Authority identified the following ways in which consumers would benefit from the emergence of corporate dental groups:

- They will have an opportunity to choose between a corporate dental group or a traditional dental practice, depending on which they consider is best suited to their needs;
- Dental services will become available in more convenient locations and for more hours of the day;
- The establishment of corporate dental groups is likely to lead to efficiency gains. In a competitive market,

<sup>182</sup> " 'practice of dentistry' means the performance of any operation and the giving of any treatment, advice, opinion or attendance which is usually performed or given by a dentist and includes the performance of any operation or the giving of any treatment, advice or attendance on or to any person preparatory to, for the purpose of, or in connection with, the fitting, insertion, or fixing of artificial teeth;" – section 2 of the Dentists Act 1985.

<sup>183</sup> This refers to activities by dentistry or medical students.

<sup>184</sup> Dental Council Submission to the Competition Authority, February 2002.

<sup>185</sup> Dental Council Submission to the Competition Authority, February 2006.



these gains will be passed on to consumers in the form of lower prices and access to better quality or state-of-the-art equipment.

- 4.49 Corporate dental groups will also be able to benefit from the economies and efficiencies deriving from shared costs and greater buying power. For example, a corporate dental group employing a number of dentists will be able to use its buying power to get a better deal on dental supplies than an individual dentist can. Similarly, corporate dental groups will be in a better position than dentists operating as sole traders to deal directly with insurance companies who may wish to provide dental insurance.
- 4.50 Corporate dental bodies will offer benefits to dentists by giving them more flexibility to choose between establishing their own practice or working on a full or part-time basis as an employee. The employment of non-dentists to oversee the administration of the business and seek value from new suppliers will allow dentists to concentrate on their clinical work.
- 4.51 Corporate dental bodies are likely to be successful in attracting patients who did not previously attend a dentist, as has occurred in the UK, thereby expanding the size of the market and contributing to the better oral health of the population.<sup>186</sup>
- 4.52 One of the concerns expressed about corporate dental groups is the danger that the dentist providing the treatment might hide behind the anonymity of a corporate body. The provision of services by a professional employee of a corporate body has not been an issue in other healthcare professions where corporate bodies are permitted, such as optometry and pharmacy. The clear solution is that it be clarified in law that, while only registered dentists can actually *practise* dentistry, i.e. carry out treatment on patients, corporate bodies can nonetheless engage in the *business* of dentistry. Mandatory recording of the dentist who provided the service (on a patient's record) would also address such concerns, as would a requirement that dentists have professional indemnity insurance.
- 4.53 The Competition Authority recommends that the current confusing situation be clarified through an amendment to the Dentists Act 1985 which will explicitly permit corporate bodies to engage in the business of dentistry.

Recommendation 10:		Explicitly permit corporate dental bodies
Details of Recommendation		Action By
The Minister for Health and Children should bring forward legislation amending the Dentists Act 1985 to:		Minister for Health and Children
(a) explicitly allow corporate bodies to engage in the business of dentistry, and		October 2008
(b) require that all treatment carried out on patients is delivered by registered dentists or other appropriate registered oral healthcare professionals.		

<sup>186</sup> This has been confirmed to the Competition Authority in discussions with representatives of Smiles who stated that more than 50% of their customers had not previously attended a dentist on a regular basis.



# section 5



## 5. REFORM OF REGULATORY STRUCTURES

### Summary

- 5.1 The Dental Council is composed mainly of members of the dental profession, and those involved in the education of dentists. It is not necessary, proportionate or transparent for a regulatory body to be run mainly by the profession being regulated.
- 5.2 In other health professions, the composition of regulatory bodies has been amended or set up so as to represent a broader range of interests than the profession being regulated. Indeed, an emerging trend is for a *majority* of the governing body of a statutory regulatory body for a profession to be composed of non-representatives of the profession being regulated.<sup>187</sup>
- 5.3 Consistent with this development, the composition of the Dental Council should be changed to include other interests, including representatives of the other oral healthcare professions regulated by the Council. This will ensure that the dental profession continues to be regulated in the interests of protecting consumers from harm, with regulations that are proportionate and that do not unnecessarily hinder competition between dentists.
- 5.4 The Dental Council should be given powers to deal with fitness to practice issues relating to all groups of auxiliary dental workers regulated by it. The Functions of the Dental Council should be clearly set out in the Dentists Act.

### Principles of Better Regulation

- 5.5 The Government White Paper Regulating Better sets out six principles of good regulation:<sup>188</sup>
  - Necessity – Is the regulation necessary? Can we reduce red tape in this area? Are the rules and the structures that govern this area still valid?
  - Effectiveness – Is the regulation properly targeted? Is it going to be properly complied with and enforced?
  - Proportionality – Are we satisfied that the advantages outweigh the disadvantages of the regulation? Is there a smarter way of achieving the same goal?
  - Transparency – Have we consulted with stakeholders prior to regulating? Is the regulation in this area clear and accessible to all? Is there good back-up explanatory material?
  - Accountability – Is it clear under the regulation precisely who is responsible to whom and for what? Is there an effective appeals process?
  - Consistency – Will the regulation give rise to anomalies and inconsistencies, given the other regulations already in place in this area? Are we applying best practice developed in one area when regulating other areas?
- 5.6 These principles should be borne in mind both in the context of reviewing existing regulations for the dental profession and any proposals for new regulations.

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187 See for example the Health and Social Care Professionals Act 2005, the Medical Practitioners Act 2007 and the Pharmacy Act 2007 all available at [www.oireachtas.ie](http://www.oireachtas.ie).

188 Department of the Taoiseach, January 2004. Available at [www.betterregulation.ie](http://www.betterregulation.ie).

## Composition and Functions of the Dental Council

- 5.7 The Dental Council is almost entirely composed of members of the dental profession and individuals involved in the education of dentists (see Table 1, Chapter 2). Only two of the 19 members are appointed to represent the interests of consumers. The Competition Authority is concerned that the current composition of the Dental Council creates the potential for a conflict of interest.
- 5.8 While it is important for a regulatory body to have access to expert professional advice on its governing Council, the need for such advice is not so great that the majority of members must come from the profession being regulated. A situation such as pertains in the Dental Council, where the vast majority of the members of the Council are practising dentists, raises issues regarding conflicts of interest between regulating for the protection of consumers on one hand and furthering the interests of the profession on the other.
- 5.9 The Competition Authority would recommend an approach similar to that adopted in recent legislation concerning Medical Practitioners, Pharmacists and Health and Social Care Professionals. In each case the legislation provided for a majority of the members of the governing Council to come from outside the profession being regulated as well as representatives of the professions being regulated.
- 5.10 Membership of the Dental Council should include representatives of each of the professions regulated by the Council as well as other groups with an interest in the dental profession such as those involved in dental education and consumers and the majority of the membership should come from outside the professions being regulated. The objectives of the Council should be clearly set out in legislation.
- 5.11 The reconstitution of the Dental Council along these lines would ensure that regulation of the profession was not dominated by representatives of the professions being regulated and would promote consumer-focused regulation, in line with the principles of better regulation and with best practice in this area.
- 5.12 The submissions received by the Competition Authority which considered the issue of regulatory reform were broadly supportive of these proposed changes. The Irish Dental Association suggested a number of other legislative changes in addition to those proposed by the Competition Authority.<sup>189</sup>

Recommendation 11:	
Amend the composition of the Dental Council	
Details of Recommendation	Action By
<p>The Minister for Health and Children should bring forward legislation to amend the composition of the Dental Council. The revised legislation should provide that:</p> <p>(a) a majority of the membership of the Council should come from outside the professions being regulated by the Council; and,</p> <p>(b) each of the professions regulated by the Council should be represented on the Council.</p>	<p>Minister for Health and Children</p> <p>October 2008</p>

- 5.13 The Dental Council should be given explicit powers to deal with fitness to practice issues relating to auxiliary dental workers regulated by it such as dental hygienists and other groups which it may regulate in the future.

<sup>189</sup> The IDA considers that legislation should also provide that the Department of Health and Children, the Department of Social and Family Affairs and the Dental Council should be obliged to (a) provide explanatory/information leaflets in relation to dental treatments and procedures (for example, a common misunderstanding by patients is in relation to fillings and crowns; there are many different types of fillings as there are a number of surfaces on each tooth; there are also many different types of crowns of different materials and quality); (b) keep consumers informed of their dental entitlements under the State schemes; and (c) educate consumers about the importance of prevention as this will reduce the necessity for more extensive dental work during their lifetime.

5.14 Modern regulatory statutes contain a list of the functions of the regulator, for example section 8(2) of the Health and Social Care Professionals Act 2005, section 7 of the Medical Practitioners Act 2007 and section 7 of the Pharmacy Act 2007. The Dentists Act 1985 should be amended to include a list of the functions of the Dental Council.

Recommendation 12:	Give the Dental Council power to deal with fitness to practise issues for all groups of dental workers regulated by it
Details of Recommendation	Action By
<p>The Minister for Health and Children should bring forward legislation to amend the Dentists Act 1985 to:</p> <p>(a) give the Dental Council the power to deal with fitness to practise issues relating to all groups of auxiliary dental workers regulated by it; and,</p> <p>(b) clearly set out the functions of the Dental Council.</p>	<p>Minister for Health and Children</p> <p>October 2008</p>



A black and white photograph showing a close-up of a dentist's face, partially obscured by a surgical mask. The dentist is wearing gloves and using a dental handpiece on a patient's teeth. The patient's mouth is open, and the handpiece is positioned over the upper teeth. The text "section 6" is overlaid in the center of the image.

# section 6





## 6. CONCLUSION

### Summary

- 6.1 Competition in dental services is restricted and discouraged by an outdated system of regulation for dentists and related professions. The number of dentists and orthodontists being trained in Ireland has not kept pace with the growing demand for dental services. Consumers in Ireland do not have the benefits of the competition between dentists and a range of other qualified oral health professionals that exists in other countries.
- 6.2 As a result, the prices consumers pay for dental services are not as competitive as they could be and consumers do not have an appropriate range of information and options available to them to purchase dental services appropriate to their needs.
- 6.3 In this report, the Competition Authority makes 12 recommendations to address the problems identified in the dental profession. Implementing these recommendations will help to ensure a modern system of regulation which protects the health and safety of the public, while at the same time encouraging value for money in dental services in a variety of convenient settings, thus promoting better oral health in the population at large.

### The System of Regulation

- 6.4 The Dentists Act 1985, and the rules made by the Dental Council under the Act, perpetuate an outdated model of delivering dental services. This model operates against competition in dental services and against the promotion of better oral health. Specifically:
  - Consumers in Ireland have to visit a dentist (at least as an intermediary) for all their dental services. In other countries, consumers can access basic dental services directly from other qualified oral health professionals, such as dental hygienists and clinical dental technicians. Consumers in Ireland do not have the benefits of such choices and of competition between these professions.
  - Dentists are prevented from competing through normal methods of competition such as advertising prices and offering discounts. This makes it difficult for consumers to shop around.
  - The restrictions on advertising deny consumers access to basic information about the availability of dental services in their area which would help them to make informed decisions about their oral health. Dentists are also unable to promote awareness of their practices and their services and this discourages them from innovating. They are also at a competitive disadvantage vis-à-vis dentists from outside the State who can advertise freely here.
  - Lack of transparency in prices reduces competitive pressure on dentists and also discourages consumers from purchasing dental services. This is in part because consumers often do not know what the final price will be but also because prices are higher than they would be in a fully competitive market.
  - Dentists traditionally work as sole practitioners, sometimes with other dentists as associates or as employees in their practices. Competition between corporate bodies of dentists would have many benefits for both dentists and consumers, by improving their access to capital and business skills. These benefits include cost savings, ability to operate from locations that are more convenient for many consumers, flexible working arrangements, longer opening hours, and checks and balances on the quality of each dentist's services (put in place to maintain the corporate body's reputation).

6.5 The regulatory system also offers limited protection for consumers:

- The Dental Council does not have strong powers to pursue those dental technicians practising dentistry illegally in Ireland;<sup>190</sup>
- There are no regular checks on the standard of dental services provided by dentists. The Dental Council cannot promote high standards of dental treatment through regular inspections. Rather, the Council must wait until damage is done to a patient before it can act against a dentist.

## The Supply of Dentists and Orthodontists

6.6 Another significant problem is the lack of training of enough dentists and orthodontists to meet demand. In particular, the training of orthodontists in Ireland has been “stop-start” and this has led to a significant shortage of orthodontists in the public sector.

6.7 A new oral healthcare profession called an *orthodontic therapist* was approved by the Dental Council in 2004. An orthodontic therapist will be trained to assist the work of the orthodontist, to make better use of their expertise and skills and thereby potentially reduce the cost of orthodontic services. However, at the time of writing, a number of issues remain to be resolved in relation to orthodontic therapists.

## The Way Forward

6.8 The Competition Authority makes 12 recommendations in this report to ensure a more efficient, effective and competitive market for meeting the demand for dental services in Ireland. The recommendations provide for:

- Two new oral healthcare professions to offer basic dental services direct to the public – *clinical dental technicians* to increase competition in the provision of dentures and *advanced dental hygienists* to increase competition in preventive dental treatments;
- Truthful, informative advertising of dental services;
- An independent source of useful information for consumers;
- A review of the number of training places for dentists in Ireland to ensure an adequate supply;
- Explicitly allowing corporate bodies to engage in the business of dentistry (with appropriate safeguards);
- Creating a balanced composition in the Dental Council to remove the risk of potential conflicts of interest in governance structures; and
- Amending the functions and powers of the Dental Council to provide for the better protection of consumers.

6.9 Implementing these recommendations will lead to a modern system of regulation to ensure:

- That the health and safety of the public is protected;
- That consumers are more aware of their options and the prices for dental services;
- More choice for consumers regarding when, where, and from whom, they access dental services;

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<sup>190</sup> Dental technicians make dentures for sale to dentists and repair dentures for dentists and for members of the public. However, a number of dental technicians fit and sell new dentures directly to the public, thus practising dentistry illegally.

- Better use of the skills and very expensive training of dentists and orthodontists;
- A sufficient supply of dentists and orthodontists;
- Value for money;
- More consumers availing of dental services and thus better oral health in the population at large.

6.10 Allowing corporate dental bodies, removing unnecessary advertising restrictions and giving consumers a choice of trained oral healthcare professionals may lead to the emergence of chains of dental clinics alongside traditional dental practices, as happened in optometry services in the early 1990s.





# appendices



## Appendix 1: Submissions in Response to Preliminary Report

Cork University Dental School and Hospital  
Dental Council  
Dental Technicians Association  
Dublin Dental School and Hospital  
Department of Health and Children  
Health Service Executive  
Higher Education Authority  
Irish Dental Association  
Irish Dental Hygienists Association  
Irish Dental Nurses Association  
Orthodontic Society of Ireland



## Appendix 2: Dental Council Registers of Dental Professionals

Year	Dentists <sup>191</sup>	Orthodontists	Oral Surgeons	Dental Hygienists	Dental Nurses <sup>192</sup>
1990	1,313	-	-	-	-
1991	1,348	-	-	-	-
1992	1,400	-	-	53	-
1993	1,433	-	-	63	-
1994	1,494	-	-	73	-
1995	1,568	-	-	91	-
1996	1,609	-	-	109	-
1997	1,671	-	-	122	-
1998	1,713	-	-	136	-
1999	1,794	-	-	156	-
2000	1,899	-	-	174	-
2001	2,006	-	-	204	-
2002	2,102	-	-	223	225
2003	2,171	87	27	249	303
2004	2,237	82	33	277	332
2005	2,327	90	28	292	397
2006	2,414	103	35	317	422

Source: Dental Council

191 This includes dental specialists, i.e. orthodontists and oral surgeons.

192 Registration is not mandatory for dental nurses.

## Appendix 3: Dental Treatment Benefit Scheme – Fee Schedule July 2007

Treatment Description	What the Department pays the Dentist	What the Consumer pays the Dentist	
	Subsidy	If Earnings under €60,000	If Earnings over €60,000
Oral Examination	€33.55	Free	Free
Prophylaxis	€31.50	Free	Free
Protracted Periodontal Treatment	€30.55	Balance	Balance
<b>Restorations</b>			
Simple/Compound Amalgam Filling	€33.95	(Private Fee less 15%) less Department's Contribution of €33.95	Balance
Composite Fillings on Anterior Teeth	€35.25	(Private Fee less 15%) less Department's Contribution of €35.25	Balance
Pin Retained Fillings	€30.55	Balance	Balance
Restoration of Incisal Angle or Tip	€30.55	Balance	Balance
<b>Exodontics</b>			
Extraction of a Tooth under Local Anaesthetic	€26.40	€13.65	Balance
Surgical Extractions	Fee to be determined on a time basis. €35.60 for each 15 minute unit* up to a maximum of 45 minutes – fee thereafter set in consultation with Dental Adviser.		
* The breakdown of the Fee for each 15 minute unit is:	€24.95	€10.65	Balance
<b>Prosthetics</b>			
Partial Acrylic Denture (From 1 - 11 Teeth)	€115.30	€115.30	Balance
Full Upper/Lower Denture	€157.25	€157.25	Balance
Full Upper & Lower Denture	€230.75	€230.75	Balance
<b>Relined Dentures</b>			
Complete Upper/Lower Denture	€62.90	€62.90	Balance
Complete Upper & Lower Denture	€104.80	€104.80	Balance
<b>Denture Repairs</b>			
- First Item of Repair	€23.10	€23.10	Balance
- Each Subsequent Item	€7.35	€7.35	Balance
- Maximum	€37.80	€37.80	Balance
<b>X-Rays</b>			
Extra-Oral			
- 1 Film	€17.60	€7.50	Balance
- 2 or More Films	€26.50	€11.45	Balance
Panoramic	€29.35	€12.70	Balance

Treatment Description	What the Department pays the Dentist	What the Consumer pays the Dentist	
	Subsidy	If Earnings under €60,000	If Earnings over €60,000
<b>Endodontics</b>			
Root Canal Therapy	€81.70	Balance	Balance
Apicectomy/Amputation of Roots	€81.70	Balance	Balance
<b>Miscellaneous</b>			
Biopsy - Excision of Soft Tissue	€14.20	Balance	Balance
Haemorrhage - Secondary	€14.20	Balance	Balance
Pulpotomy	€14.20	Balance	Balance
Dry Socket	€14.20	Balance	Balance
Abscess - Pre-Treatment and Incising	€14.20	Balance	Balance
Dressings	€14.20	Balance	Balance
Pericoronitis	€14.20	Balance	Balance
Other Miscellaneous items not specified in this schedule.	Fee determined in accordance with Clause 28(c) of the Dental Agreement.		
<b>Alternative Treatments</b>			
White Filling on a Back Tooth (4 - 8)	€33.95	Balance	Balance
Glass Ionomers	€33.95	Balance	Balance
Crown	€35.25	Balance	Balance
Porcelain Jacket Crown	€35.25	Balance	Balance
Partial Chrome Cobalt Denture or Bridge	€115.30	Balance	Balance
Full Upper/Lower Chrome Cobalt Denture	€157.25	Balance	Balance
Full Upper & Lower Chrome Cobalt Denture	€230.75	Balance	Balance

	Free to the consumer
	Price paid by the patient is: Private Fee - Subsidy = Balance
	Price to the patient is fixed by the State

Source: Department of Social and Family Affairs

Most people eligible under the PRSI scheme are in the <€60,000 p.a. income bracket. These people are entitled to one free Oral Examination and Scale and Polish per year. If they need a tooth extraction (under Local Anaesthetic or Surgical Extraction), X-rays or dentures (excluding chrome dentures), the price they pay the dentist is fixed by the Government.

For all other dental treatments covered by the Scheme, patients must pay the Private Fee minus the Department's contribution. In the case of fillings, an extra 15% is deducted from the Private Fee.

For example, if a dentist charged €100 for an amalgam filling, a DTBS patient would pay €100 - €15 (15%) - €33.95 (Department's contribution) = €51.05.

	Amalgam Filling	Crown	Partial bridge
Private Fee	€100.00	€600.00	€600.00
Less 15% (only applies to fillings)	€15.00	n/a	n/a
Less Government Subsidy	€33.95	€35.25	€115.30
Price charged by dentist to DTBS Patient	€51.05	€564.75	€484.70

This illustrates that in cases where the private dental fee charged by the dentist is high, the government subsidy only covers a small portion of this charge, and the amount paid by the consumer is significant.

## Appendix 4: Number Of Denture-Wearers

The Competition Authority has estimated that there are over 500,000 denture-wearers in Ireland. This is a conservative estimate, based on the following information.

A comprehensive Oral Health Survey was carried out in 2002 by the Oral Health Services Research Centre at University College Cork.<sup>193</sup> This survey found that 74% of 65+ year olds wear dentures, while dentures are less common among younger age groups (16% of 35-44 year olds and 1% of 16-24 year olds wear dentures).

Using population data obtained from the CSO (for the year 2002):

- There are about 322,600 65+ year olds who wear dentures (this is 74% of the total 65+ population of 436,000);
- There are approximately 90,000 35-44 year olds wearing dentures (16% of the total 35-44 population of 562,900); and
- There are approximately 6,400 16-24 year olds wearing dentures (1% of the total 16-24 population of 641,500).

This would give a total of around 419,000 denture wearers in Ireland.

However, the Oral Health Survey 2002 excluded 25-34 year olds and 45-64 year olds. The size of the population within each of these age groups is approximately 617,000 people and 832,000 people, respectively. Applying the percentage of denture wearers in nearby age groups to these population figures, it can be assumed that, at the minimum, there are 500,000 denture wearers in Ireland among the general population.

<sup>193</sup> The full report of the findings of this survey has not yet been published, however, the figures used in this report on denture-wearers were cited in *Oral Health of Adults with an Intellectual Disability in Residential Care in Ireland 2003*, April 2005, p.21, available at [www.dohc.ie](http://www.dohc.ie)

## Appendix 5: Waiting lists for Public Orthodontic Services

### HSE Orthodontic Waiting Lists for Assessment and Treatment at 30th September 2006

HSE Area	Assessment Waiting List		Treatment Waiting List			
	Patients	Average Waiting Time (Months)	Category A	Waiting Time (Months)	Category B	Waiting Time (Months)
South Western	142	3-6	468	<6	269	<12
East Coast	177	3	75	6-12	321	12-18
Midland	83	3	Nil	No waiting time	51	6
Northern	25	<3	8	<3	1279	<36
North Eastern	Nil	Nil	3	1.5-2	377	12-15
Mid Western	1017	24-36	Nil	No waiting time	786	24-36
North Western	1311	10	284	16	1086	29
Western	232	1	Nil	No waiting time	693	18
South Eastern	408	<5	Nil	No waiting time	622	18
Southern	3182	42-48	Nil	No waiting time	3685	42-48
<b>Total</b>	<b>6577</b>		<b>856</b>		<b>9169</b>	

Source: Reproduced from the Report of the Orthodontic Review Group, December 2006.

## Appendix 6: Explanatory Notes

### Explanatory Note 1: Barriers to Entry

Barriers to entry are direct or indirect restrictions on the ability of potential suppliers to offer their goods or services in a particular market. In professional services markets, such restrictions prevent efficient new professionals from offering further choice to buyers. Barriers to entry often serve to protect the established members of the profession from competition and the threat of competition. The resulting lack of competitive pressure can lead to serious adverse effects on customers, as established service providers may be able to charge higher prices, offer lower quality services and offer less choice. This protection may also mean less incentive for established members of the profession to innovate and to respond to the needs of their customers with new services and new ways of delivering professional services.

Entry barriers may arise naturally, because of the peculiar aspects of a market that make it difficult to successfully offer services such as difficulties in establishing a reputation. Entry barriers may also arise directly from actions taken by existing suppliers. For example, in professional services established members of the profession may make it difficult for their customers to switch to a new provider. Regulations limiting who may offer particular professional services create direct barriers to entry.

Markets for professional services tend to have regulatory barriers to entry. It is usually claimed that these barriers prevent a potential market failure arising from a perceived inability of buyers to evaluate the professional services. It is defended as necessary to ensure that practitioners offer a high quality service due to the potential inability of buyers to distinguish between a high quality service and a low quality service.

However, such regulatory barriers can operate to deny buyers choice and protect existing suppliers from any threat of competition without correcting any market failure. In particular, quantitative entry restrictions (where there are direct limits on the number of professionals who may supply a service) are likely to limit competition severely and hurt buyers without ensuring a high-quality service is provided. Quantitative limits can occur, for example, directly through regulations limiting the number of those who can practice, or indirectly through limitations on the educational opportunities for training in the area.

## Explanatory Note 2: Rivalry

To ensure that buyers benefit fully from competition, regulatory rules and practices should enable suppliers to compete freely. Activities that reduce buyers' ability to make informed decisions regarding the price, quality and specifications of the service that best suits their needs hinder the competitive process. Thus any barriers to buyers' ability to gain this type of information, such as advertising restrictions, are undesirable barriers to rivalry.

Advertising that is factual and accurate informs consumers of choices available to them, reduces search costs and facilitates competition in the marketplace. In addition, advertising reduces the information asymmetry between clients and service providers i.e. advertising builds up awareness of the options available. Advertising of prices allows buyers to make meaningful comparisons between service providers.

Professionals should always be free to organise the delivery of their services in different ways and to join and establish other professional organisations that compete with existing organisations in representing their interests or administering any self-regulation required within a profession.

Another type of barrier to rivalry is high switching costs, which prevent buyers from switching easily between different service providers. For example, a buyer may be locked in to a long-term contract with a certain provider which includes a penalty for opting out of the contract early.

## Explanatory Note 3: Advertising and Professional Services

Advertising provides consumers with information regarding both the availability and quality of services and, therefore, helps to reduce the costs incurred by consumers in the process of selecting the appropriate professional service provider (search costs). Any increase in search costs can lead consumers to reduce the extent to which they "shop around", thus reducing the intensity of competition in the marketplace. Therefore, so long as it is truthful and not designed to deceive, advertising plays an important role in facilitating the competitive process and benefiting consumers.

Furthermore, advertising restrictions can also work as barriers to the establishment of a new practice by a professional. For example, a professional who is setting up a new practice may be prevented from pursuing both on-going and one-off consumers. This acts in the interests of those who are established in the profession, and have built up a reputation based on word-of-mouth, to curb the effectiveness of new entrants' promotional efforts. Thus, advertising restrictions make it unnecessarily difficult for professionals who wish to open a new practice to establish themselves and also limit innovation in the delivery of professional services. Thus, any restrictions on advertising except those preventing untruthful or misleading adverts, are likely to limit competition.



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