

**Competition** in the economy  
 vigorous competition drives productivity growth, innovation and value for all  
**innovation**  
 productivity  
 economy



productivity  
 growth, innovation and value for all in the economy

# Competition in Professional Services

## Dentists

### Preliminary Report

December 2005



**The Competition Authority**  
 An tÚdarás Iomaíochta



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## **GLOSSARY OF TERMS**

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### **Central Statistics Office**

The Central Statistics Office (CSO) is the state body which is 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 Central Statistics Office 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 which are not designed to prevent or cure dental maladies.

### **Dental Council**

The Dental Council, or in Irish, An Chomhairle Fiaclóireachta, 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.

### **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 that 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 cardholders over the age of 16. Treatments available under the Scheme include examination, x-rays, fillings, extractions, partial and full dentures, periodontal treatment and root canal treatments, and are free to the patient.

### **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 25 Member States of the European Union plus Iceland, Liechtenstein, Switzerland 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 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 (IDA), 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 that require 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 (infections 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 practice 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

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1. The dental profession in Ireland is hindered by numerous layers of unnecessary laws and regulations. Competition is not working well for consumers of dental services, i.e. individual patients and the State. The prices of dental services in Ireland have been consistently rising beyond the general rate of health inflation. Some consumers have even opted to travel to other countries for certain dental services. This is not surprising when competition is actively discouraged. For example the Dental Council bans dentists from offering discounts to consumers and it is illegal for suitably qualified professionals to offer basic dental services directly to consumers.
2. This Report is not the only occasion that the Competition Authority has addressed competition issues in the dental profession. On 28th April 2005, the Competition Authority accepted settlement terms offered by the Irish Dental Association in a High Court action taken by the Authority alleging a breach of the Competition Act 2002.<sup>1</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.
3. The rules governing the dental profession in Ireland urgently need to be modernised. This is because competition in dental services has been seriously restricted by unnecessary laws and regulations that do not apply to dentists in most other countries. In particular, the Dentists Act 1985 and the rules imposed by the Dental Council prevent consumers from benefiting from active competition in the following ways:
  - Healthcare professionals, such as dental hygienists and clinical dental technicians, are prevented from offering basic dental services directly to consumers;
  - Dentists are discouraged from attracting customers through normal methods of competition including price discounting and advertising;
  - Restrictions on informative advertising prevent consumers from getting access to basic information which would help them to make more informed decisions about their health;
  - Consumers are unnecessarily limited in their choice of provider of dental services; and,
  - There are unnecessary obstacles put in the way of dentists trying to offer new services to consumers, or to deliver their services in new ways.
4. Another significant problem in the Irish dental profession is the shortage of trained orthodontists. In the face of growing demand, this shortage has led to long waiting lists for orthodontic treatment for public sector patients (averaging 3 years) and high prices for private patients.

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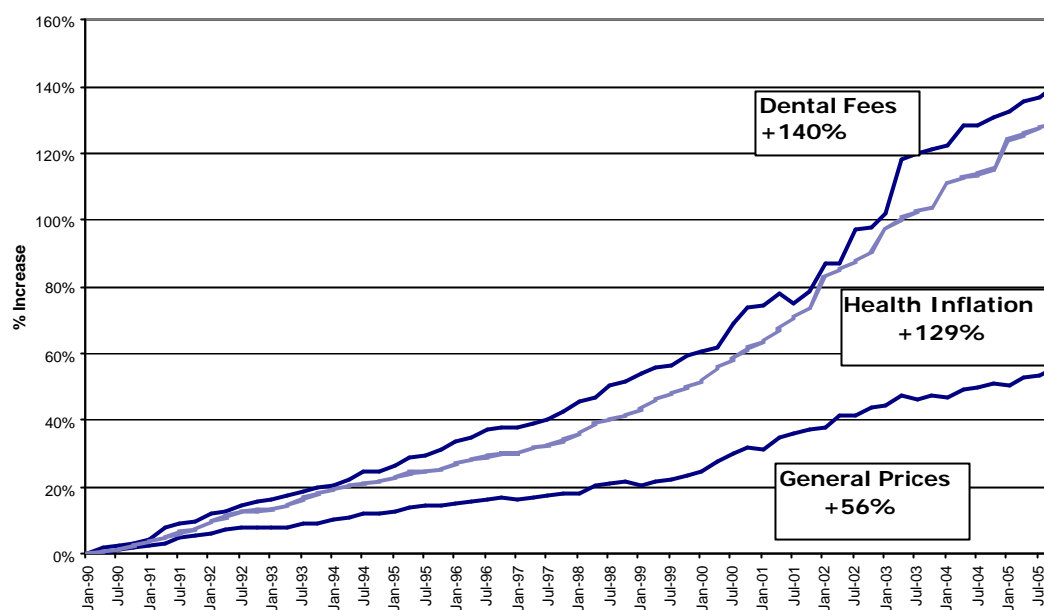
<sup>1</sup> 2005 521 P *The Competition Authority v. Irish Dental Association* (FH 2D). This settlement was agreed without an admission of liability by the Irish Dental Association. See [www.tca.ie/press/132.pdf](http://www.tca.ie/press/132.pdf) for full details of settlement terms.

5. The increase in the number of orthodontic training places in Ireland from 2006 should help alleviate some of the difficulties experienced by consumers of orthodontic services. However the impact of this change will not be felt until at least 2009, when the first group of new graduates start working. Recognition of a new dental profession of "orthodontic therapist" should also contribute to lowering the cost and increasing the availability of orthodontic treatment.
6. In this report, the Competition Authority makes 13 recommendations designed to address the competition problems identified in the dental profession. The implementation of these recommendations will lead to a modern system of regulation which ensures:
  - More choice for consumers on how, and from whom, they can access dental services;
  - Better use of dentists' skills and training;
  - Better access to dental care for consumers in Ireland; and,
  - Pressure to lower prices.

## **Regulatory and Commercial Environment**

7. The conduct and standards of dentists, and related dental professions, are regulated by the Dental Council. Dentists often employ other qualified professionals, such as dental nurses and dental hygienists, to provide basic dental services to their customers. Under the Dentists Act 1985, it is unlawful for a person to use the title "dentist" or "orthodontist", or to provide dental services, without being registered by the Dental Council.
8. Most of the approximately 1,750 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 2004, the State spent over €100 million on dentists' services.
9. The price of dental treatments has consistently increased above the general rate of inflation and above the rate of health inflation. Between 1990 and 2004, the Consumer Price Index increased by 56%, health inflation grew by 129% while dental fees increased by 140%, according to data from the Central Statistics Office (CSO).

## Inflation in Dental Prices, Health Inflation and General Inflation



Source: Central Statistics Office

## Restrictions on Dental Services

10. Ireland is out of step with most other developed economies in preventing certain oral healthcare professions from offering services to consumers they are qualified to provide. The Dental Council's rules insist that consumers must go through a dentist before they can benefit from the services of a dental hygienist. Dental hygienists must also operate in the same premises as dentists. In many other countries dental hygienists can work independently of dentists to offer a specific set of routine dental services. 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. This Competition Authority proposes that dental hygienists be allowed to operate independently of dentists.

11. The Competition Authority proposes that legal recognition be given to two professions which already exist in practice, dental technicians and clinical dental technicians. These recommendations are similar to those originally made by the Restrictive Practices Commission more than 20 years ago in its 1982 "*Report of Enquiry into the Statutory Restrictions on the Provision of Dental Prostheses*". Current regulations make it illegal for anyone other than dentists to sell dentures to members of the public. 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 and the USA. In 2006 clinical dental technicians will also be legally recognised in the UK. Giving legal recognition to suitably trained dental technicians and clinical dental technicians will ensure protection of consumers and promote greater choice for consumers in terms of where they can get their dentures.
12. 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 advertising their existence to a maximum of six newspaper advertisements in their first year of practice. 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.
13. Dentists are also unnecessarily limited in the type of business model they can use to deliver dental services. Irish dentists can only operate as sole traders or in partnership with other dentists and are not permitted to own or be employed in companies. This is in contrast with other healthcare professions in Ireland, such as optometrists and pharmacists, who can provide their services to consumers through a variety of business models. Irish dentists are also more restricted than in most other developed economies; for example, in 25 of the 29 members of the European Economic Area dentists have greater choice in how they offer their services to consumers. Also, recent changes to the UK Dentists Act 1984, supported by the UK's General Dental Council, have removed former restrictions on the number of corporate dental groups permitted to practise. The Irish restrictions are unnecessary to protect the public, as all dental services can be traced back to the dentist who provided them. Allowing dentists to develop new ways to offer their services would make it easier for them to invest in their businesses, become more efficient, and offer greater choice to consumers in terms of where and how they access dental services.

14. 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. It has presided over a number of serious and unnecessary restrictions on competition for decades. 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. The Competition Authority recommends that the composition of the Dental Council should be changed to include other stakeholders. 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.
15. In order to ensure that Ireland has an adequate long-term supply of qualified dentists, the Higher Education Authority should conduct a review of the number of dentist training places in Ireland. This review should take place once the other recommendations of the Competition Authority on the dental profession have been implemented. The impact of these recommendations will lead to a more efficient use of the skills and training of dentists, thereby influencing the number of qualified dentists required to meet the demand for dental services in Ireland.
16. The implementation of the Competition Authority's recommendations will lead to a modern system of regulation for the dental profession. This will ensure that the health and safety of the public is protected, while at the same time encouraging value for money and choice in dental services. The implementation of these recommendations will empower consumers to make informed choices about their oral health and to obtain dental services from a wider range of qualified professionals. Allowing competition between dentists and related professions will also maintain downward pressure on the price of dental services, saving money for both consumers and the State.

## Preliminary Recommendations

**Preliminary Recommendation 1: Allow dental hygienists to operate independently**

Details of Recommendation	Action By
<p>The Dental Council should amend the Scheme for Dental Hygienists to:</p> <p>(a) Remove the requirement for hygienists to operate under the general supervision of a dentist; and</p> <p>(b) Include a provision 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> <p>The amended Scheme should be submitted to the Minister for Health and Children for approval.</p>	<p>Dental Council</p> <p>December 2006</p>

**Preliminary Recommendation 2: Allow dental hygienists to be directly reimbursed for treatments provided under the State schemes**

Details of Recommendation	Action By
<p>The Health Service Executive and the Department of Social and Family Affairs should enable dental hygienists to be directly reimbursed for dental treatments provided under the State schemes.</p>	<p>Health Service Executive</p> <p>Department of Social and Family Affairs</p> <p>December 2006</p>

**Preliminary Recommendation 3: Officially recognise the profession of Dental Technician**

Details of Recommendation	Action By
<p>The Dental Council should amend the current proposed Scheme for the establishment of a Dental Technician grade and include a grandfather clause for experienced technicians currently working in the industry who do not have formal qualifications. The revised Scheme should be submitted to the Minister for Health and Children for approval.</p>	<p>Dental Council December 2006</p>

**Preliminary Recommendation 4: Ensure that foreign qualified dental technicians can work in Ireland without unnecessary difficulty**

Details of Recommendation	Action By
<p>The Dental Council should ensure that dental technicians who have obtained appropriate qualifications overseas are eligible for registration, without unnecessary difficulty, on the Register of Dental Technicians.</p>	<p>Dental Council December 2006</p>

**Preliminary Recommendation 5: Allow dental technicians to be eligible for reimbursement under the State dental schemes**

Details of Recommendation	Action By
<p>The Health Service Executive and the Department of Social and Family Affairs should enable dental technicians to be eligible for reimbursement under the Dental Treatment Services Scheme and the Dental Treatment Benefit Scheme, for denture repairs.</p>	<p>Health Service Executive Department of Social and Family Affairs December 2006</p>

**Preliminary Recommendation 6: Officially recognise the profession of Clinical Dental Technician**

Details of Recommendation	Action By
The Dental Council should amend the current proposed Scheme for the establishment of a Clinical Dental Technician grade and include an examination route for experienced dental technicians. The revised Scheme should be submitted to the Minister for Health and Children for approval.	Dental Council December 2006

**Preliminary Recommendation 7: Ensure that foreign qualified clinical dental technicians can work in Ireland without unnecessary difficulty**

Details of Recommendation	Action By
The Dental Council should ensure that clinical dental technicians who have obtained appropriate qualifications overseas are eligible for registration, without unnecessary difficulty, on the Register of Clinical Dental Technicians.	Dental Council December 2006

**Preliminary Recommendation 8: Allow clinical dental technicians to be eligible for reimbursement under the State dental schemes**

Details of Recommendation	Action By
The Health Service Executive and the Department of Social and Family Affairs should enable clinical dental technicians to be eligible for reimbursement 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 December 2006

**Preliminary Recommendation 9: Review the number of training places for dentists**

Details of Recommendation	Action By
The Higher Education Authority should undertake a detailed review of the number of dentistry training places to determine whether the number of places for dentistry needs to be increased, and, if so, to what level.	Higher Education Authority December 2007

**Preliminary Recommendation 10: Remove unnecessary restrictions on advertising**

Details of Recommendation	Action By
<p>(a) The Dental Council should remove its restrictions on advertising with the exception of prohibiting advertising which is false or misleading.</p> <p>(b) The Minister for Health and Children should bring forward legislation to amend the Dentists Act 1985 to limit the powers of the Dental Council in relation to advertising. The powers of the Council should be limited to ensuring that advertising by dentists is not false or misleading.</p>	<p>Dental Council December 2006</p> <p>Minister for Health and Children December 2006</p>

**Preliminary Recommendation 11: Allow dentists to offer their services as limited companies**

Details of Recommendation	Action By
The Minister for Health and Children should bring forward legislation to amend Section 52 of the Dentists Act 1985 and remove the prohibition on corporate bodies in the delivery of dental services.	Minister for Health and Children December 2006

**Preliminary Recommendation 12: Change 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, as set out in the Dentists Act 1985. The revised legislation should provide for a Dental Council that is representative of a large number of stakeholders, none of whom should be in a majority.</p>	<p>Minister for Health and Children December 2006</p>

**Preliminary Recommendation 13: Set out the functions of the Dental Council in legislation.**

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) Set out the functions of the Dental Council, and</p> <p>(b) Specify that one of the functions of the Dental Council is the promotion of competition and consumer focused regulation in the dental profession.</p>	<p>Minister for Health and Children December 2006</p>

## 1. INTRODUCTION

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### Background to the Report on Dentists

- 1.1 The purpose of this Report on the dental profession is to identify any regulations or practices that may restrict competition within the dental profession; to evaluate any consumer benefits claimed to exist from any such restrictions; and to consider whether the restrictions are proportionate to any benefits.
- 1.2 The Competition Authority works 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*".
- 1.3 This Report is part of a wider study of a number of professions. Following an OECD Report in 2001<sup>2</sup>, 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.
- 1.4 The initial process of the study involved a research phase and report by Indecon International Economic Consultants. This Report, *Indecon's Assessment of Restrictions in the Supply of Professional Services*<sup>3</sup>, was published in March 2003.
- 1.5 The Competition Authority published a Preliminary Report on the engineering profession in August 2003 and a Final Report in December 2004. Preliminary Reports on architects, the legal professions, and optometrists were published in November 2003, February 2005 and December 2005 respectively.
- 1.6 In its assessment of dental services, Indecon identified six areas or restrictions which merited further scrutiny in relation to their potential impact on competition:
  - The absence of registration status for suitably qualified denturists and dental technicians;
  - The transfer arrangements in relation to dentists from non-European Union countries wishing to practise in Ireland;
  - The limitation on the number of places available for study at Irish schools of dentistry;
  - The restrictions placed on advertising by dentists;
  - The restriction that dental hygienists must work under the supervision of dentists; and
  - The prohibition on the practice of dentistry by corporate bodies.

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<sup>2</sup> *Regulatory Reform in Ireland*, OECD, 2001.

<sup>3</sup> See <http://www.tca.ie/professions.html>

## The Consultation Process

1.7 This Preliminary Report proposes changes to regulations and practices designed to enhance competition to the benefit of buyers of dental services. The Competition Authority seeks submissions on the facts, analysis and preliminary recommendations in this Report from all interested parties, including:

- Dentists and allied professionals;
- Professional representative bodies;
- Consumers of dental services, such as Government Departments and agencies, dental insurance companies, private companies and members of the public; and,
- Any other member of the public or organisation that has contact with, or an interest in, the dental profession.

1.8 The consultation is being carried out publicly in the interests of fairness, consistency and transparency. The responses will inform the Competition Authority's thinking in the compilation of its Final Report on the dental profession which will be published in 2006.

1.9 The Competition Authority is seeking responses to the Report in general and to certain recommendations in particular. Respondents, in compiling their submissions, should give consideration to the general questions below and, as far as possible, structure their submissions accordingly.

- Is the Report's analysis at any stage based on erroneous or incomplete factual information? If so, how does this affect the recommendations?
- Are there any major obstacles to the timely implementation of the recommendations?
- Could the recommendations have any unintended negative consequences for competition?
- Are the recommendations addressed in each case to the appropriate party?
- Are the recommendations fit-for-purpose? Will they solve the problems they address?
- Will the recommendations facilitate adherence to the precepts of *Regulating Better*<sup>4</sup> – transparency, consistency, accountability, proportionality, effectiveness and necessity?
- Have any obvious recommendations which would benefit competition been omitted?

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<sup>4</sup> *Regulating Better* – A Government White Paper setting out six principles of Better Regulation, Department of An Taoiseach. See <http://www.betterregulation.ie/index.asp>

- 1.10 Following this consultation process, the Competition Authority will publish a Final Report on the dental profession. Additionally, the Competition Authority reserves the right to take any legal action it considers necessary under the provisions of the Competition Act 2002.
- 1.11 If you intend making a submission, please indicate anything in your response that you consider to be a business secret.
- 1.12 Where possible, submissions should be provided electronically to: [jmcd@tca.ie](mailto:jmcd@tca.ie). Hard copy submissions can be sent to:
- Jacinta McDonnell,  
The Competition Authority,  
Parnell House,  
14 Parnell Square,  
Dublin 1.
- 1.13 Submissions must be received by the Competition Authority by the 28th of February 2006.

## **The Competition Act 2002**

- 1.14 Restrictive behaviour on the part of suppliers of professional services, and certain rules, decisions and practices of their representative associations, may breach section 4, and potentially section 5, of the Competition Act 2002. While this Preliminary Report highlights some restrictions and practices that the Competition Authority believes have the potential to restrict competition, the Authority recommends that professional associations engage in self-assessment of their rules, decisions and practices, to ensure that they do not breach the Act.
- 1.15 The maximum fines and penalties for breaches of the Competition Act 2002 are as follows:
- Criminal (on indictment in the Circuit Criminal Court) - €4 million or 10% of turnover, whichever is the greater and/or up to five years in prison;
  - Criminal (summary in the District Court) - €3,000 and/or up to six months in prison;
  - Civil Action (by the Competition Authority) – None; and
  - Civil Action (by injured parties) - Damages at the discretion of the Court.

### **Note 1: The Competition Act 2002**

Section 4 of the Competition Act 2002 prohibits *“all agreements between undertakings, decisions by associations of undertakings and concerted practices which have as their object or effect the prevention, restriction or distortion of competition in trade in any goods or services in the State or in any part of the State”* including *“those which –*

- (a) Directly or indirectly fix purchase or selling prices or any other trading conditions;*
- (b) Limit or control production, markets, technical development or investment;*
- (c) Share markets or sources of supply;*
- (d) Apply dissimilar conditions to equivalent transactions with other trading parties thereby placing them at a competitive disadvantage;*
- (e) Make the conclusion of contracts subject to acceptance by the other parties of supplementary obligations which by their nature or according to commercial usage have no connection with the subject of such contracts.”*

Section 5 of the Competition Act 2002 prohibits *“any abuse by one or more undertakings of a dominant position in trade for any goods or services in the State or in any part of the State”* including

- “(a) directly or indirectly imposing unfair purchase or selling prices or other unfair trading conditions,*
- (b) limiting production, markets or technical development to the prejudice of consumers,*
- (c) applying dissimilar conditions to equivalent transactions with other trading parties, thereby placing them at a competitive disadvantage,*
- (d) making the conclusion of contracts subject to the acceptance by other parties of supplementary obligations which by their nature or according to commercial usage have no connection with the subject of such contracts.”*

### **Structure of the Report**

1.16 The Report contains a general overview of the dental profession, followed by a detailed examination of the restrictions which limit competition in dental services.

1.17 The remainder of the Report is structured as follows:

- Chapter 2 gives an overview of the dental profession in Ireland, including a description of what dentists and other dental professionals do, 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 dental hygienists, restrictions on the sale of dentures, 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. The rules examined are those relating to advertising by dentists and business models for dental practices.
  - 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 draws conclusions on competition in dental services.
- 1.18 The Report concludes with a number of Appendices with additional information.



## **2. AN OVERVIEW OF THE DENTAL PROFESSION**

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### **Summary**

- 2.1 This chapter outlines the services provided by dentists, and related oral healthcare professions, 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, jaw and gums. Dentists work predominantly in the private sector, and offer their services direct 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 "specialist", or to provide dental services, without being registered by the Dental Council.
- 2.4 The State is the biggest purchaser of dental services, and in 2004, spent over €100 million on dentists' services. 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 Dental prices have been increasing faster than general health inflation in Ireland over the past fifteen years.

### **The Role and Functions of Dentists**

- 2.6 The role of the dentist is to prevent, diagnose and treat anomalies and diseases of the teeth, mouth, jaws and associated tissues.<sup>5</sup>
- 2.7 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, bridges and dentures). Dental treatments may be sought for the relief of pain, as a result of injury, or for purely cosmetic reasons.

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<sup>5</sup> Based on the definition of the practice of dentistry contained in Council Directive of 25 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).

- 2.8 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>6</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. A small number of dentists limit their practice to cosmetic procedures only.<sup>7</sup>
- 2.9 The majority of dentists work in private practice, either alone or in partnerships with other dentists. 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>8</sup> There were approximately 1,750 practising dentists in Ireland at the end of 2004. Table 1 below provides an estimate of the number of dentists working in the public and private sectors.

### *Related and Overlapping Service Providers*

- 2.10 There are a number of auxiliary dental professions in Ireland - dental hygienists, dental nurses and dental technicians.
- 2.11 **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. Hygienists can only treat a patient who has been referred from a dentist and can only provide services prescribed by a dentist. There were 277 dental hygienists in Ireland at the end of 2004, of whom 56 were employed in the Health Service Executive (HSE) areas.<sup>9</sup>
- 2.12 **Dental nurses** operate under the direct supervision of a dentist 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>10</sup> There were 332 dental nurses in Ireland at the end of 2004, of whom 87 were employed in the HSE areas.<sup>11</sup>
- 2.13 **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>12</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 and, at the end of 2004, there were 6 employed in the HSE areas.<sup>13</sup>

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<sup>6</sup> See Glossary of Terms for a description of these areas of dentistry.

<sup>7</sup> Based on market enquires conducted by the Competition Authority in the preparation of this Report.

<sup>8</sup> The Department of Defence employs its own dentists to treat members of the Defence Forces.

<sup>9</sup> Dental Council's Register of Dental Hygienists; Employment statistics for 2004 obtained from the Department of Health and Children, available at [www.dohc.ie](http://www.dohc.ie)

<sup>10</sup> 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.

<sup>11</sup> Dental Council's Register of Dental Nurses; Employment statistics for 2004 obtained from the Department of Health and Children, available at [www.dohc.ie](http://www.dohc.ie)

<sup>12</sup> *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

2.14 There are two specialist areas of dentistry in Ireland that are legally recognised and protected – orthodontics and oral surgery.<sup>14</sup>

- **Orthodontists** are dentists who have undertaken 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 82 orthodontists in Ireland.<sup>15</sup> Most orthodontists work in private practice, and some are employed in the HSE areas and in the dental hospitals, in many cases on a part-time basis.<sup>16</sup>
- **Oral surgeons** are dentists who have undertaken 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 33 oral surgeons in Ireland.<sup>17</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>18</sup>

**Table 1: Estimated Number of Dental Professionals Working in Private Practice and the Public Sector (2005)**

Profession	Setting		
	Private	Public	Total
Dentists	1,400	350	1,750
Orthodontists	45	37	82
Oral Surgeons	27	6	33
Dental Hygienists	221	56	277
Dental Nurses	245	87	332
Dental Technicians	c. 250-300	6	c. 250-300

Source: Dental Council, Employment statistics for 2004 obtained from the Department of Health and Children, Estimates of the Competition Authority.

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other industry sources contacted by the Competition Authority in the preparation of this Report. No dental technician has ever been prosecuted for selling dentures directly to members of the public.

<sup>13</sup> *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); Employment statistics for 2004 obtained from the Department of Health and Children, available at [www.dohc.ie](http://www.dohc.ie)

<sup>14</sup> 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.

<sup>15</sup> Dental Council's Register of Specialists.

<sup>16</sup> At the end of 2004, there were 12 Consultant Orthodontists and 25 Specialists in Orthodontics employed in the public sector, giving a total of 37, according to employment statistics for 2004 obtained from the Department of Health and Children, available at [www.dohc.ie](http://www.dohc.ie)

<sup>17</sup> Dental Council's Register of Specialists.

<sup>18</sup> At the end of 2004, there were 3 Consultant Oral Surgeons and 3 Consultant Oral and Maxillo Facial Surgeons employed in the public sector, according to employment statistics for 2004 obtained from the Department of Health and Children, available at [www.dohc.ie](http://www.dohc.ie)

## Regulation of Dentists

- 2.15 Regulation of the dental profession in Ireland is the responsibility of the Dental Council, established under the Dentists Act 1985. The Council is responsible for the operation and enforcement of the provisions laid down in the Act.
- 2.16 The Dental Council has a membership of 19 persons. The composition of the Council is dictated by the Dentists Act and is set out below.

**Table 2: 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

- 2.17 The Dental Council is charged with the statutory protection of the title "dentist" under the Dentists Act 1985 and maintains a Register of Dentists. Those who wish to practise dentistry or use the title "dentist" must be registered with the Dental Council.
- 2.18 Registration with the Dental Council is also required use the title "specialist" or to operate as a dental hygienist. The Dental Council maintains a Register of Dental Nurses; however, registration is voluntary as dental nurses are not obliged to have their names entered on the Register to work in this profession.
- 2.19 The main functions assigned to the Dental Council under the Dentists Act 1985 are:
- To establish, maintain and publish a Register of Dentists.
  - 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 against a registered dentist of professional misconduct or unfitness to practise 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 for the establishment of classes of auxiliary dental workers.
- To discharge the duties assigned to the Council pursuant to the provisions of EU Dental Directives.
- To advise the dental profession and the public on all matters relating to the ethical conduct of dentists.

2.20 The Council is self-funding through receipt of income generated from fees charged to dentists, specialists, dental hygienists and dental nurses for registration and retention on the Registers.

### *Registration of Dentists*

2.21 Upon application to the Dental Council, registration in the Register of Dentists is granted to:

- Graduates of the undergraduate dentistry course at University College Cork and Trinity College Dublin;<sup>19</sup> and,
- Nationals of a European Union (EU) Member State who have been awarded a qualification in dentistry in an EU Member State.<sup>20</sup>

2.22 Non-European Economic Area (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 prove that they are proficient in English and pass a special examination set by the Dental Council. This examination is set to a standard equivalent to final examinations on an Irish undergraduate dentistry course.

2.23 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 5 years.

### *Registration of Specialists*

2.24 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.

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<sup>19</sup> 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.

<sup>20</sup> The State is obliged to recognise these qualifications under European law. This mutual recognition covers specified dental qualifications from the EEA Member States.

2.25 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>21</sup>
- A registered dentist who provides evidence of satisfactory completion of specialist training by a body recognised by the Dental Council;<sup>22</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>23</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.

### *Representative Bodies*

2.26 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 1,200 members. The majority of dentists are members of the Irish Dental Association although membership is voluntary.
- The Irish Dental Hygienists' Association is the professional association for dental hygienists.
- 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.
- The Dental Technicians Association of Ireland is the main representative body for dental technicians.

## **Relevant Markets for Dental Services**

2.27 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.

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<sup>21</sup> 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."

<sup>22</sup> 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."

<sup>23</sup> 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.

2.28 Narrow relevant markets may exist within each of these groups of dental services but, for the purpose of this Report, it is not necessary or useful to determine this.

**Figure 1: Who can supply 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.

### *General Dental Services*

2.29 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>24</sup>

<sup>24</sup> The treatments which a dental hygienist is qualified to perform are: scaling, polishing and cleaning teeth, applying prophylactic materials to the teeth and gums and giving advice in relation to oral health – all of which must be prescribed by a dentist. The services which a dental technician can offer are the manufacture of dentures (which have been ordered by a dentist) and denture repairs. Many dental technicians also sell dentures directly to members of the public, although this is illegal.

- 2.30 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>25</sup>
- 2.31 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, which may, in any case, be difficult to detect.<sup>26</sup>
- 2.32 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>27</sup>

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

- 2.33 Suppliers of orthodontic services are dentists who have undertaken specialist postgraduate training in orthodontists, over a minimum of three years, and are registered in the Dental Council's Register of Specialists.<sup>28</sup>
- 2.34 Suppliers of oral surgery services are dentists who have undertaken specialist postgraduate training in oral surgery, over a minimum of three years, and are registered in the Dental Council's Register of Specialists.
- 2.35 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.

### **Demand for Dental Services**

- 2.36 An important distinction can be drawn between public dental services and private dental services. In this Report, public dental services refer to those that are provided to the consumer free of charge by the State while private dental services are those for which the consumer pays in part or in whole.

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<sup>25</sup> 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.

<sup>26</sup> 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.

<sup>27</sup> *Foreign dentists take a bite out of Irish market*, Sunday Times, 4<sup>th</sup> September 2005. Accurate figures are not available on the numbers travelling outside the Republic to access dental treatments.

<sup>28</sup> Dentists receive training in orthodontics as part of their undergraduate study, and in some cases, where orthodontic treatment is of a relatively simple nature, this is provided by general dental practitioners or by State-employed dentists in the Health Service Executive. This is the exception rather than the norm however as most orthodontic treatment is provided by orthodontists. Source: *Oral and Dental Specialisation in Ireland*, April 2002, *op cit*.

## *Demand for General Dental Services*

- 2.37 Demand for dental services comes from individual consumers and is affected by socio-economic factors.<sup>29</sup> Consumers seek dental treatments for different reasons, including regular check-up, pain relief, sports injury, concerns regarding oral health and cosmetic reasons.
- 2.38 The demand for various types of dental treatments has changed over time.<sup>30</sup> As the oral health of the general population improves, due largely to water fluoridation and 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 and orthodontic work) has increased significantly, in line with rising incomes.
- 2.39 There are a number of ways in which the State impacts 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>31</sup>
- 2.40 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 0.9 million children under 16 eligible for free general dental services.
- 2.41 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 Department of Health and Children. Dental services under the scheme are provided by approximately 900 dentists working in private practice who have signed an agreement with the Health Service Executive to participate in the scheme.<sup>32</sup>
- 2.42 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 capped). Dental services under the scheme are provided by approximately 1,300 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.

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<sup>29</sup> Based on a review of economic literature analysing demand for dental services.

<sup>30</sup> Based on enquires conducted by the Competition Authority in the preparation of this Report.

<sup>31</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. Source: Revenue Commissioners.

<sup>32</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.

2.43 Around 0.9 million 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>33</sup> It is estimated that upwards of 0.4 million people are eligible under both the DTSS and the DTBS.<sup>34</sup>

**Table 3: State Funded Dental Schemes**

Scheme	Operated by	Who is covered	Numbers covered
Dental Treatment Benefit Scheme	Department of Social and Family Affairs	Eligible PRSI contributors and their dependent spouses <sup>35</sup>	1.66 million
Dental Treatment Services Scheme	Health Service Executive	Medical card holders and their dependents	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	0.89 million <sup>36</sup>
Other schemes	Health Service Executive	Holders of a Health (Amendment) Act Card	1,700 <sup>37</sup>
Tax Relief	Revenue Commissioners	All PAYE workers and their dependents	

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

2.44 While upwards of 75% of the population are entitled to some degree of free/subsidised dental services, many potential consumers do not qualify for treatment under any of the State schemes.<sup>38</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>39</sup>

<sup>33</sup> Of the 2.4 million people paying PRSI, 1.7 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.

<sup>34</sup> Treatment Benefit Section, Department of Social and Family Affairs.

<sup>35</sup> 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.

<sup>36</sup> Number of children aged 15 and under, Census 2002.

<sup>37</sup> Source: Department of Health and Children.

<sup>38</sup> 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.

<sup>39</sup> 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, Commissioned by the Department of Health and Children. Available at [www.dohc.ie](http://www.dohc.ie)

- 2.45 There are certain dental services which can only be accessed through the private dental sector. The DTSS does not cover certain dental treatments; for example fissure sealants, and advanced restorative treatments such as crowns, bridges and veneers are excluded.<sup>40</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.
- 2.46 In 2004, the amount paid to dentists under the DTSS and the DTBS amounted to €53.7 million and €45.8 million respectively - a total of almost €100 million.

**Table 4: Payments to Dentists under the State Schemes 2004**

Scheme	Total Amount Paid to Dentists	Average Amount Paid per Participating Dentist
DTSS	€53.7 million	€59,230
DTBS	€45.8 million	€34,975

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

#### *Demand for Orthodontics*

- 2.47 There is a strong demand for orthodontic treatment in Ireland among children and, increasingly, among adults.<sup>41</sup> Tax relief is available on orthodontic treatment and it is also covered under dental insurance policies.
- 2.48 Children 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, free of charge, on the basis of priority.
- 2.49 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>42</sup> Treatment takes an average of two years to complete. The true numbers of those requiring treatment could be much higher than the official figures, as it has been claimed that consultant orthodontists have been told not to include children on the waiting lists who had no realistic chance of being seen due to the shortage of qualified orthodontists.<sup>43</sup>
- 2.50 Children who cannot avail of treatment publicly, either because the waiting list is too long or they are considered to be low priority patients, can avail of private orthodontic treatment but must pay the full cost.

<sup>40</sup> *Dental Treatment Services Scheme – Service Utilisation and Treatment Need*, Oral Health Services Research Centre, University College Cork, *op cit*.

<sup>41</sup> Based on market enquires conducted by the Competition Authority in the preparation of this Report.

<sup>42</sup> *Fourth Report - Review of Public Orthodontic Services*, Joint Oireachtas Committee on Health and Children, June 2005.

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

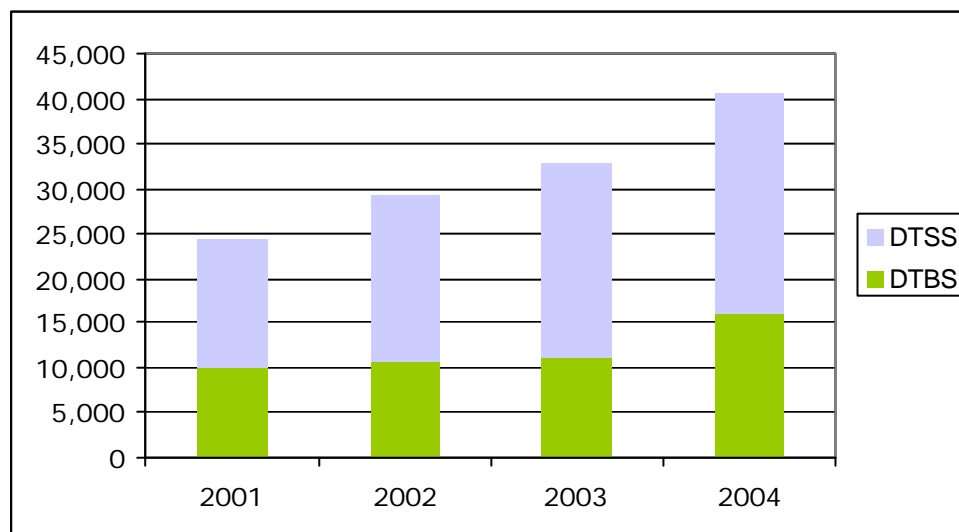
2.51 Demand for public orthodontic treatment is in some cases met by orthodontists working in the private sector. In 2002, the Minister for Health and Children provided funding of €5 million to the health boards to pay for children on public waiting lists to receive orthodontic treatment from orthodontists working in the private sector, rather than State-salaried orthodontists.<sup>44</sup>

### *Demand for Oral Surgery*

2.52 Patients who require oral surgery are generally referred from their dentist to an oral surgeon. Tax relief is available for this treatment.

2.53 As orthodontic treatment often requires tooth extractions where there is a problem with spacing or overcrowding of teeth, demand for oral surgery is likely to be closely related to demand for orthodontic treatment.<sup>45</sup> The graph below shows that the number of surgical extractions provided under the Dental Treatment Services Scheme and the Dental Treatment Benefit Scheme has increased significantly over the last four years.<sup>46</sup>

**Graph 1: Number of Surgical Extractions Provided Under the State Dental Schemes 2001-2004**



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

## **Supply of Dental Services**

### *Supply of General Dental Services*

2.54 There are currently over 2,200 dentists on the Dental Council's Register of Dentists. The graph below indicates how the number of dentists on the Register has increased over the last fifteen years, from around 1,300 in 1990 to around 2,200 at the end of 2004.<sup>47</sup>

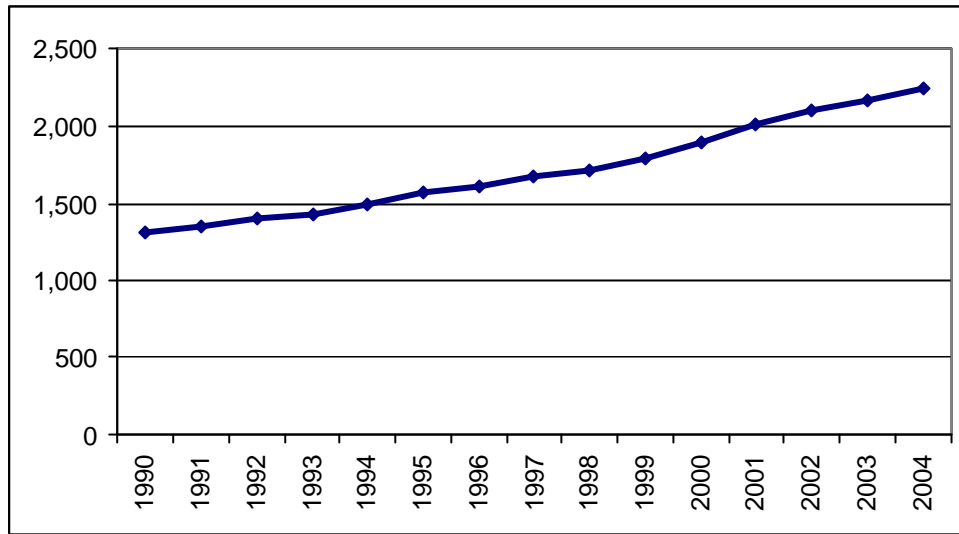
<sup>44</sup> This funding was provided through the National Treatment Purchase Fund.

<sup>45</sup> According to a report commissioned by the Department of Health and Children, 98% of oral surgery patients in the North Eastern Health Board Region required surgery as part of orthodontic treatment. Source: *Oral and Dental Specialisation in Ireland*, April 2002, p. 50, *op cit*.

<sup>46</sup> Changes in the eligibility criteria under the State dental schemes affect the number of treatments provided.

<sup>47</sup> The number of dentists on the Register overstates 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

**Graph 2: Number of Registered Dentists in Ireland 1990-2004**



Source: Dental Council

2.55 Table 5 below shows the breakdown of where new registrants on the Register of Dentists obtained their qualifications. Of the 128 new registrants on the Register of Dentists in 2004, 55 graduated from either Dublin or Cork, 18 obtained their qualifications in the UK, 38 came from other EEA Member States, and 17 qualified in non-EEA Member States.

**Table 5: New Registrants on the Register of Dentists 2001-2004**

Where Qualified	2001	2002	2003	2004
Dublin	35	37	48	31
Cork	51	28	30	24
<b>National</b>	<b>86</b>	<b>65</b>	<b>78</b>	<b>55</b>
UK	44	35	29	18
New EU Member States				22
Other EU/EEA	9	22	17	16
Non EU/EEA	14	7	11	17
<b>Total New Registrants</b>	<b>153</b>	<b>129</b>	<b>135</b>	<b>128</b>

Source: Dental Council

2.56 Dentists in private practice can operate as either sole practitioners or with other dentists in partnerships. It is illegal to establish a corporate dental group in Ireland.<sup>48</sup> Most dental practices employ administrative staff and larger practices also tend to have dental hygienists or dental nurses on staff.

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but continue to register in Ireland. The Register also includes dentists who practise exclusively as orthodontists and as oral surgeons rather than general dental practitioners (currently around 100 in total).

<sup>48</sup> Section 54 of the Dentists Act 1985.

- 2.57 As the capital cost of setting up a new practice is high, the formation of associations, where dentists form larger groups, is now common.<sup>49</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>50</sup>
- 2.58 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 large cities they are often located in residential areas, such as extensions to private dwellings. There are a higher number of dentists per head of population in the large cities.<sup>51</sup>
- 2.59 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>52</sup>
- 2.60 A fairly recent phenomenon is the emergence of dental clinics which specialise in cosmetic procedures, primarily tooth whitening.<sup>53</sup>

### *Supply of Orthodontic Services and Oral Surgery*

- 2.61 There are currently 82 registered orthodontists and 33 registered oral surgeons in Ireland. 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.

## **Dentists' Incomes**

- 2.62 Within the public sector, the salary for a newly qualified dentist starts at approximately €45,000 per annum. A dentist who has been promoted to Consultant level earns upwards of €145,000 a year, while a Specialist in Orthodontics earns upwards of €120,000 a year.
- 2.63 Most dentists working in private practice participate in one or both of the two main State dental schemes – the Dental Treatment Services Scheme (DTSS) and the Dental Treatment Benefit Scheme (DTBS). Dentists' earnings from services provided under these schemes vary from one dentist to another.
- In 2004, the 1,310 dentists participating in the DTBS earned a total of €45.8 million. 962 dentists earned less than €50,000 from the scheme, 305 dentists earned between €50,000 and €100,000 and 43 dentists earned over €100,000.

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<sup>49</sup> *Audit Instructions – Trade Profiles*, Office of the Revenue Commissioners, December 2001. Available at [www.revenue.ie](http://www.revenue.ie)

<sup>50</sup> *Ibid.*

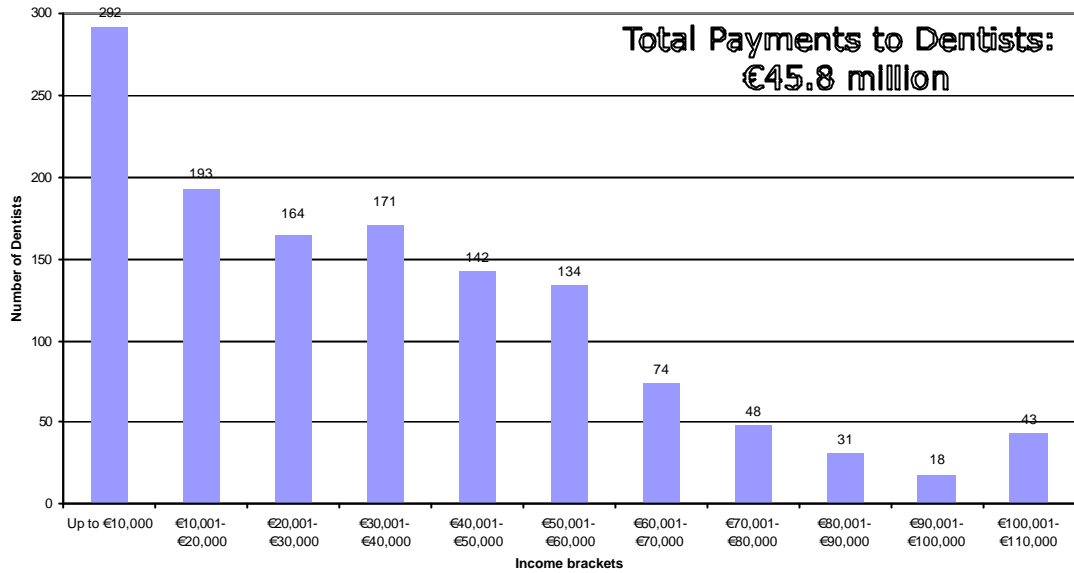
<sup>51</sup> Based on an analysis of the Register of Dentists.

<sup>52</sup> *Report of Enquiry into the Statutory Restrictions on the Provision of Dental Protheses* (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.

<sup>53</sup> Based on enquiries conducted by the Competition Authority in the preparation of this Report.

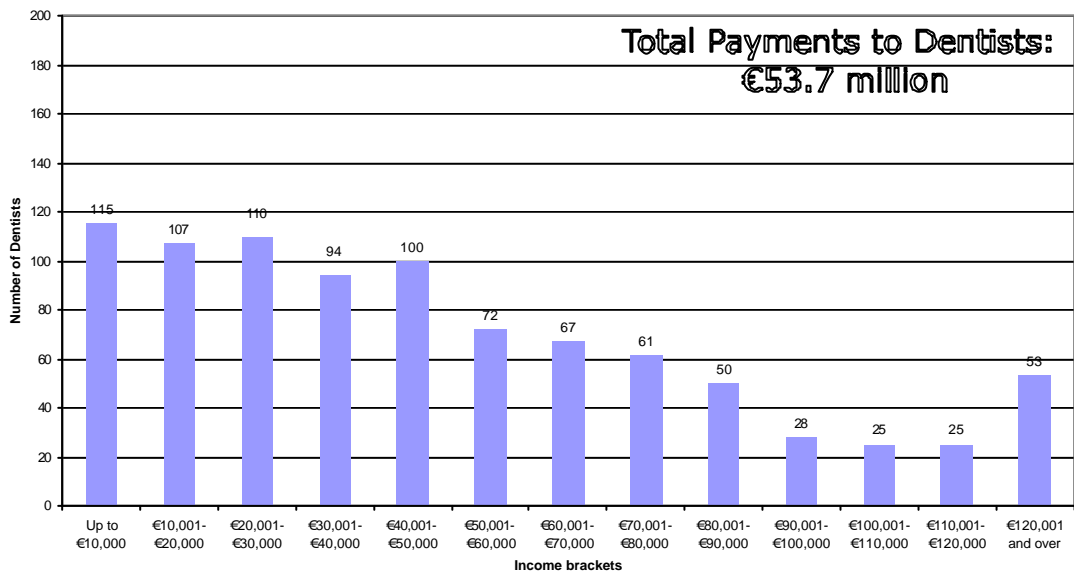
- In 2004, the 907 participating in the DTSS earned a total of €53.7 million. 526 dentists earned less than €50,000 from the scheme, 278 dentists earned between €50,000 and €100,000 and 103 dentists earned over €100,000.

**Graph 3: Payments to 1,310 Dentists Participating in the DTBS 2004**



Source: Department of Social and Family Affairs

**Graph 4: Payments to 907 Dentists Participating in the DTSS 2004**



Source: Primary Care Reimbursement Service, Department of Health and Children

- 2.64 The main sources of income of 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;
  - 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>54</sup>
- 2.65 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>55</sup>

## Prices of Dental Services

- 2.66 The price of dental treatments has consistently increased above the general rate of inflation over the last fifteen years and above the rate of inflation for health services over the same period. Between January 1990 and October 2005, the Consumer Price Index increased by 56%, health inflation grew by 129% while dental fees increased by 140%, according to data from the Central Statistics Office.<sup>56</sup>

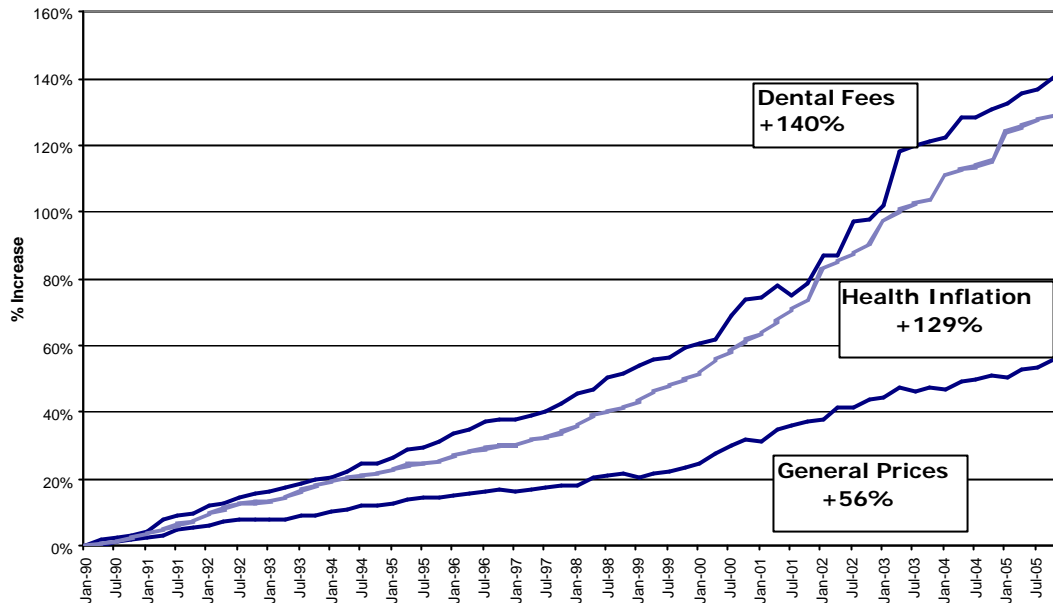
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<sup>54</sup> *Audit Instructions – Trade Profiles*, Revenue Commissioners, December 2001.

<sup>55</sup> *ibid*

<sup>56</sup> 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. The most recent data available from the CSO at the time of publication was October 2005.

**Graph 5: Inflation in Dental Prices, Health Inflation and General Inflation (January 1990-October 2005)**



Source: Central Statistics Office

2.67 There is a very limited amount of accurate information available on private dental fees. The Consumers Association of Ireland has conducted a number of surveys of dental fees in the Republic and Northern Ireland. However, given the small sample size (mainly due to the difficulties encountered by the Association in obtaining fee information over the phone) the results cannot be relied on as providing an accurate picture of fees being charged by dentists to private patients.<sup>57</sup> The table below shows some of the results of the survey conducted in September 2004.

**Table 6: Price Survey of Tooth Extractions and Fillings (September 2004)**

Location	Tooth Extraction	Filling
<b>Republic of Ireland</b>		
Dublin	€70 to €130	€70 to €130
Cork	€50 to €70	€50 to €80
Galway	€65 to €250	€60 to €120
Limerick	€50 to €120	€50 to €150
<b>Northern Ireland</b>		
Co. Down	€45 to €90	€30 to €105
Belfast	€37 to €180	€30 to €150

Source: *Choice magazine*, Consumers Association of Ireland

<sup>57</sup> See *Consumer Choice*, Consumers Association of Ireland, May 2001, September 2004.

2.68 The only comprehensive survey of dental prices completed to date that the Competition Authority is aware of was undertaken nearly five years ago by the Irish Dental Association.<sup>58</sup> This survey was undertaken again in March 2003 in the same manner. The results of the 2003 survey were not made available to the Competition Authority but, according to the Irish Dental Association, dental fees increased by an average of 10% over this two-year period.<sup>59</sup>

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<sup>58</sup> In March 2001, the Irish Dental Association surveyed 675 general dental practitioners who participated in the DTBS which were used to produce average prices for a range of dental services. 298 surveys were completed and returned anonymously to the Irish Dental Association.

<sup>59</sup> Source: Department of Social and Family Affairs.

### **3. RESTRICTIONS ON OFFERING DENTAL SERVICES**

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#### **Summary**

- 3.1 The rules imposed by the Dental Council on the practice of dentistry prevent certain oral healthcare professions from offering directly to the public the dental services that they are qualified to provide. This has kept the prices of these services artificially high. The Dental Council should amend its regulation of oral healthcare professions to allow suitably qualified dental hygienists and clinical dental technicians to provide their services directly to the public. This will give consumers access to quality dental services at lower prices, and lead to improved oral healthcare in Ireland.
- 3.2 There is currently a shortage of training places in dentistry which has been acknowledged by a number of different sources. Although the flow of dentists from overseas has helped limit the seriousness of the current skills shortage, this is not necessarily a sustainable situation. The limited number of places to study dentistry in Ireland reduces the supply of dentists and ultimately impacts on the price of dental services. This situation should be reviewed by the Higher Education Authority.
- 3.3 The limited number of training places in Ireland to study orthodontics impacts on the price of orthodontic treatment and has caused long waiting lists (averaging three years) for orthodontic services in the public sector. In 2006, the number of orthodontic training places in Ireland will be increased. However, the impact of this change will not be felt until at least 2009, when the first group of graduates start working. Recognition of a new dental profession of "orthodontic therapist" should help contribute to lowering the cost and increasing the availability of orthodontic treatment.

#### **Note 2: 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 buyers, 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 successful entry difficult, 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 supplied. In other words, restricting who may offer the professional services 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 practise, or indirectly through limitations on the educational opportunities for training in the area.

## Restrictions on Dental Hygienists

### Summary

3.4 Dental hygienists are trained to provide preventive dental services to members of the public. In Ireland they are only allowed to provide these services under the supervision of a dentist and following referral by a dentist. Experience from other countries shows that these restrictions are unnecessary. Allowing dental hygienists to offer their services directly to the public, without the need for a referral from a dentist, would give consumers greater access to basic dental services at lower prices, and lead to improved oral healthcare in Ireland.

### Nature of Restraint

3.5 According to rules laid down by the Dental Council, dental hygienists may only carry out dental treatment under the supervision of a dentist, and patients must be referred to them by a dentist.<sup>60</sup> When working in private practice, hygienists must be employed by a dentist and cannot set up their own independent dental hygiene practice. Hygienists cannot charge patients directly for their services nor can they be directly reimbursed for the treatments they provide to patients under the State dental schemes – these payments are made directly to the supervising dentist. The range of treatments which a hygienist can perform is determined by the Dental Council.<sup>61</sup>

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<sup>60</sup> These rules are contained in the Dental Council's *Scheme for the establishment of a class of auxiliary dental worker to be known as dental hygienist* (1992).

<sup>61</sup> A dental hygienist is permitted to carry out the following dental work:

- (i) cleaning and polishing of teeth;
- (ii) scaling of teeth (i.e. the removal of tartar, deposits, accretions and stains from those parts of the teeth that are exposed or which are directly beneath the free margins of the gums, including the application of medicaments thereto);
- (iii) the application to the teeth and/or gums of appropriate prophylactic materials including solutions, gels and sealants;
- (iv) giving of advice in relation to oral health.

Following an amendment to the Scheme by the Dental Council which was approved by the Minister for Health and Children, a dental hygienist who has successfully completed an approved course may administer local infiltration anaesthesia to patients, provided that the supervising dentist remains on the practice premises until the patient has been discharged.

Source: Dental Council's *Scheme for the establishment of a class of auxiliary dental worker to be known as dental hygienist*.

### *Effects of the Restraint*

3.6 The restrictive environment in which dental hygienists must practise in Ireland negatively impacts on consumers of oral healthcare by:

- Preventing the emergence of competition between dentists and dental hygienists for routine preventive dental services;
- Keeping the price of preventive oral healthcare services artificially high, as dental hygienists can provide these services to the same standard as dentists but at a lower cost;
- Reducing consumers' choice of oral healthcare providers, as patients do not have direct access to hygienists - they must have a referral from a dentist, and all treatments must be prescribed by a dentist;
- Reducing consumers' choice of 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. dental hygiene clinics) cannot emerge;
- Reducing consumers' access to hygienists, as hygienists can only treat the patients of their supervising dentist; and
- Reducing the amount of preventive dental services purchased by the public, which goes against the promotion of good dental health.

### *Rationale offered for the Restraint*

3.7 According to the Irish Dental Association, dental hygienists are currently educated to provide dental services under the direction of a dentist and they are not trained to work independently of a dentist. Dental hygienists are not qualified in the interpretation of x-rays, are unable to administer the full range of local anaesthetic injections 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 comprehensive 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.<sup>62</sup>

3.8 The Irish Dental Association also claims that there is no evidence that dental prices would fall if dental hygienists were able to work independently of dentists.<sup>63</sup>

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<sup>62</sup> Submission by the Irish Dental Association to the Competition Authority (3<sup>rd</sup> November 2003) following the publication of the Indecon Report.

<sup>63</sup> *ibid*

## International Experience

- 3.9 Independent dental hygienists exist in many countries, where it has been determined that supervision or control of dental hygienists by dentists is not necessary and that there is no rationale for dentists' examining patients before they attend a dental hygienist.<sup>64</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 certain parts of Canada, the USA and Switzerland.<sup>65</sup>
- 3.10 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>66</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>67</sup>
- 3.11 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>68</sup>
- 3.12 The general trend in Europe, the USA and Canada is that the level of supervision of hygienists by dentists is decreasing while the scope of practice of hygienists and the range of practice settings where they can operate is increasing.<sup>69</sup> In some cases, this increased responsibility has occurred in conjunction with an increase in the period of training required to become a dental hygienist.<sup>70</sup>

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<sup>64</sup> *International profiles of dental hygiene 1987 to 2001: A 19-nation comparative study*, Johnson, International Journal of Dental Hygiene (2003).

<sup>65</sup> 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: *Independent dental hygiene practice worldwide: a report of two meetings*, International Journal of Dental Hygiene (2005).

<sup>66</sup> For instance, in the USA, professional liability insurance rates do not change relative to whether or not 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 <http://www.ftc.gov/ogc/healthcarehearings/docs/030610byrdtammi.pdf>

<sup>67</sup> *Dental hygiene in Australia: A Global Perspective*, Luciak-Donsberger & Aldenhoven, International Journal of Dental Hygiene (2004). This paper cites a number of sources which confirm these four statements.

<sup>68</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*.

<sup>69</sup> Johnson, *op cit*.

<sup>70</sup> The period of training to become a dental hygienist is becoming longer and increasingly academic, and curricula in many countries are being augmented and extended. Source: *The study of dental*

- 3.13 In many countries where independent hygiene practice is permitted, hygienists are obliged to refer their patients to a dentist if they suspect the patient is suffering from a problem which they are unqualified to treat or which is beyond their scope of practice.

#### *Analysis of the Competition Authority*

- 3.14 The prohibition on independent dental hygienists protects dentists from competition in the provision of routine preventive oral healthcare. Dentists have a clear financial incentive to oppose the introduction of independent dental hygienists because hygienists working for dentists generate revenues for dental practices. As hygienists cannot set up their own practice, the supervising dentist benefits directly from these revenues.
- 3.15 The Dental Council's rules do not state that dental hygienists must work under the *direct* supervision of a dentist.<sup>71</sup> This implies that the Dental Council regards hygienists to be competent to work unsupervised in their own treatment room, given the narrow range of treatments they can perform. If hygienists are deemed competent to perform these treatments unsupervised,<sup>72</sup> the rationale for requiring hygienists to work alongside a dentist in a dental surgery is unclear. It may be argued that it is in the best interests of the patient to have a dentist on the premises while a dental hygienist is treating a patient in case the immediate intervention of a dentist is required. However, it would appear that, given the current limited scope of practice of hygienists in Ireland, in practice this scenario would rarely arise.

#### **Consumer Choice**

- 3.16 Consumers should be free to choose their own healthcare provider from a range of reliable and competent options.
- 3.17 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. For example, a consumer may wish to have their teeth cleaned by a hygienist every six months or annually. These consumers should not be forced to visit a dentist if they wish to avail only of the services of a hygienist, particularly if they also have to pay the dentist a consultation fee.
- 3.18 If a consumer requires a number of different treatments, some of which are routine and some more complicated, he/she may 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 combination of a dentist and a hygienist. Given the experience in other countries, the option of a one-stop shop 'dental team' is likely to be attractive, both to members of the profession and to consumers, even if dental hygienists are allowed to practice independently. Thus, independent dental hygiene practices can be expected to exist side-by-side with traditional dental surgeries.

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*hygiene at institutions of higher education in Europe*, Luciak-Donsberger. This report was commissioned by the Federal Ministry of Education, Science and Culture, Vienna, Austria. The average length of training for dental hygienists in other countries is three years, compared to two years in Ireland. This is reflected in the narrower range of treatments which hygienists in Ireland are permitted to perform compared to those in other countries.

<sup>71</sup> It is only in the case of local anaesthesia that the Dental Council specifically states that a dentist is required to be on the premises in the interest of patient safety.

<sup>72</sup> With the exception of local anaesthesia.

### Efficiency in the Delivery of Dental Services

- 3.19 Preventive oral healthcare performed by dental hygienists should be viewed as an entry point to other oral health services rather than requiring referral from a dentist.
- 3.20 It is an inefficient use of the training and expertise of dentists to have them performing basic preventive oral healthcare services which dental hygienists are equally well trained to perform. Better use of current and future oral health resources could be achieved by shifting the provision of oral hygiene services from dentists to hygienists so that dentists, who receive more advanced and more expensive training, use their skills mainly in the provision of complex restorative care rather than routine preventive treatments.

### Lower Costs

- 3.21 Based on international experience, enabling hygienists to work independently would lower the cost of oral healthcare to both consumers and the State.<sup>73</sup>
- 3.22 If dentists and dental hygienists were in competition with one another in the provision of routine preventive dental services, it is likely that the Department of Health and Children and the Department of Social and Family Affairs would be able to set lower reimbursement fees for those treatments that hygienists are qualified to perform. The savings to the State could be substantial given the significant amount spent on routine oral health services. It has been estimated in other countries that fees charged by independent dental hygienists are between 20% to 40% lower than those of dentists. In 2004, €15.7 million was spent by the State on teeth scaling and polishing, a treatment which hygienists are trained to perform, therefore the savings to the State of permitting dental hygienists to work independently could be in the region of €3.14 million to €6.28 million for this treatment alone.<sup>74</sup>

**Table 7: Potential Savings to the State on Scaling and Polishing Treatments**

State Expenditure on Scaling and Polishing in 2004	Savings in 2004 if prices 20% lower	Savings in 2004 if prices 40% lower
€15.7 million	€3.14 million	€6.28 million

Source: Competition Authority estimates based on data from the Primary Care Reimbursement Service and potential savings of independent hygienists estimated from international studies.

<sup>73</sup> A hygienist setting up a 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 as a dentist, due to their narrower scope of practice.

<sup>74</sup> In 2004, €11.1 million was spent on teeth scaling and polishing under the DTBS and €4.6 million was spent under the DTSS.

## Oral Health of the Population

3.23 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>75</sup> From a public health perspective, prevention is better than cure and early treatment of oral health problems is preferable. If the public had access to routine preventive dental services at lower prices, this would encourage them to purchase more preventive dental treatments. The overall effect would be that more people would receive professional advice about oral hygiene and taking care of their teeth on a regular basis, reducing the incidence of serious dental problems requiring expensive restorative treatment.

## Consumer Protection

3.24 A less restrictive environment for dental hygiene practice would not raise consumer protection issues as there are a number of ways in which consumer welfare and safety would continue to be protected:

- Dental hygienists are trained, within a limited range of treatments, to the same standard as dentists;
- Registration with the Dental Council is mandatory in order to use the title "dental hygienist". To achieve registration status one must have completed a period of training and received a qualification deemed appropriate 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 hygienists receive 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 has set out the dental procedures which a hygienist can perform, based on the training they receive, and it is illegal for a hygienist to carry out any dental treatment beyond those determined by the Council; and
- The Dental Council has the power to investigate complaints against any registered dental hygienist and apply sanctions, including the power to fine and/or strike a hygienist from the Register.

3.25 In countries where independent dental 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. This additional safeguard could easily be put in place in Ireland by the Dental Council.

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<sup>75</sup> For example, *Survey of consumers' experience of dental services*, Office of Fair Trading, March 2003 and *Oral Health of Irish Adults 1989-1990*, a survey conducted by the Oral Health Services Research Centre University College Cork.

### *Proposed Solution*

- 3.26 Dental hygienists should be recognised as primary care providers. The Dental Council should amend the current Scheme for Dental Hygienists to permit them to set up their own practice independently of dentists and provide a specified range of routine treatments which their qualifications and training enable them to perform.
- 3.27 Patients should be able to visit an independent hygienist without requiring a referral from a dentist. Hygienists should be required 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.
- 3.28 Hygienists working in the private sector should be permitted to charge clients directly for their services, and to make direct claims for services provided under State dental schemes, regardless of whether they work independently or in a dental surgery alongside a dentist.

**Preliminary Recommendation 1: Allow dental hygienists to operate independently**

<b>Details of Recommendation</b>	<b>Action By</b>
<p>The Dental Council should amend the Scheme for Dental Hygienists to:</p> <p>(a) Remove the requirement for hygienists to operate under the general supervision of a dentist; and</p> <p>(b) Include a provision 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> <p>The amended Scheme should be submitted to the Minister for Health and Children for approval.</p>	<p>Dental Council</p> <p>December 2006</p>

**Preliminary Recommendation 2: Allow 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 enable dental hygienists to be directly reimbursed for dental treatments provided under the State schemes.	Health Service Executive Department of Social and Family Affairs December 2006

*Effects of the Solution*

3.29 Implementing these recommendations will allow dental hygienists to compete with dentists in the delivery of routine oral healthcare services and deliver considerable benefits to both consumers and the State. Empirical evidence from other countries indicates that allowing dental hygienists to offer their services directly to members of the public:

- Reduces the cost of preventive oral healthcare services;
- Allows greater consumer choice of oral healthcare providers;
- Increases the availability of these services;
- Does not compromise the quality of dental care provided; and
- Improves the general dental health of the population.

3.30 Implementing these recommendations will also lead to a more efficient use of the skills and training of both dentists and dental hygienists.

## Restrictions on the Sale of Dentures

### Summary

- 3.31 Unjustified restrictions on who is allowed to provide dentures have been in place for decades. The lack of official status for those working in this area of dentistry has been debated extensively since the 1970s. The Restrictive Practices Commission, a predecessor of the Competition Authority, held an official public enquiry into the issue in 1982 and published a Report highlighting the negative implications for consumers.<sup>76</sup> Over twenty years have passed since the publication of the Restrictive Practices Commission's Report, yet dental technicians still operate in an uncertain legal environment. There is still no official recognition for auxiliary dental professionals who would be qualified to sell dentures directly to the public (i.e. clinical dental technicians), to do so legally.<sup>77</sup>
- 3.32 Consumers who require dentures should be free to choose where they purchase their dentures from a range of suitable and safe options. This is the case in other countries where clinical dental technicians are legally recognised including Australia, Canada, Denmark, Finland, the Netherlands, New Zealand, Sweden and the USA. Clinical dental technicians will also be legally recognised in the UK as of 2006.
- 3.33 The Dentists Act 1985 provides that the Dental Council may establish new "grades" of auxiliary dental professionals with an associated register. Any such scheme must be approved by the Minister for Health and Children. While a number of schemes have been proposed by the Dental Council for the establishment of a dental technician "grade" of dental profession<sup>78</sup>, none has been approved by the Minister.
- 3.34 Despite the Dental Council's reservations about the necessity for a Clinical Dental Technician grade, it has also submitted a proposal for the establishment of such a grade, following a request from the Minister.<sup>79</sup> Under the proposed Scheme, clinical dental technicians would be permitted to supply and fit dentures to members of the public. This scheme was rejected by the Minister primarily because it did not include a mechanism (or "grandfather clause")<sup>80</sup> for recognising the experience of dental technicians who currently work in the industry and who, in many cases, already sell dentures directly to the public (illegally).<sup>81</sup>

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<sup>76</sup> *Report of Enquiry into the Statutory Restrictions on the Provision of Dental Protheses*, Restrictive Practices Commission, 1982.

<sup>77</sup> The reader should be aware of the distinction between "dental technician", "clinical dental technician" and "denturist" – see Glossary of Terms. The terms "clinical dental technician" and "denturist" can be used interchangeably.

<sup>78</sup> *"The scheme for dental technicians was proposed by the Dental Council because it saw this grade, which historically has been poorly trained and disorganised, as needing an impetus that would raise the esteem of members and enhance the status of the grade in general. As the science of dentistry continues to evolve the demands on dental technicians are ever increasing. Well trained and highly skilled dental technicians are now required and this requirement will increase in the future to meet the dental laboratory aspects of complex treatments such as implantology and advanced prosthodontics."* Source: letter from the Dental Council to the Competition Authority dated 15/09/2003.

<sup>79</sup> *"The Council is not convinced that this grade, which would be permitted to provide full and partial dentures directly to the public, is the best way forward."* Source: letter from the Dental Council to the Competition Authority dated 15/09/2003.

<sup>80</sup> A "grandfather clause" is a provision exempting persons or other entities already engaged in an activity from rules or legislation affecting this activity.

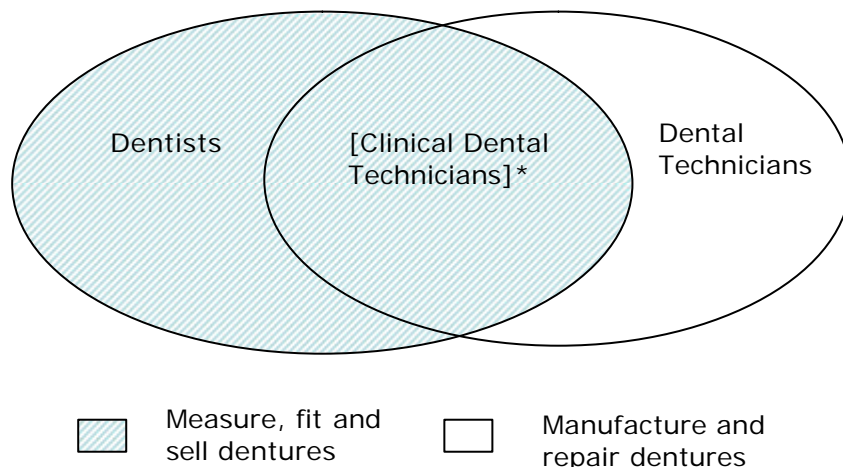
<sup>81</sup> In 2004, Mr Martin Kenny, a dental technician, took an unsuccessful case to the High Court against the Minister for Health and Children for refusing to approve this scheme. The case is now under appeal. Cf *Kenny v The Dental Council* High Court (Gilligan J), 27 February 2004.

3.35 To remedy this situation, the Competition Authority proposes that:

- A Register of Dental Technicians should be established which would recognise both formal qualifications in dental technology and experience in the manufacture and repair of dentures, and
- A Register of Clinical Dental Technicians should be established for those who have a qualification in clinical dental technology. Individuals who have sufficient experience of fitting dentures directly to members of the public, and successfully pass a clinical examination, should also be eligible for entry on this Register.

3.36 Creating these new classes of auxiliary dental professions will give people with dentures a choice of qualified, and appropriately regulated, professionals from whom they can purchase the dental services they require. Clinical dental technicians will provide competition to dentists for the range of services they are qualified to provide, thus putting downward pressure on the prices of these dental services.

**Figure 2: Providers of dentures and denture services**



\*This category of provider is not currently legally recognised in Ireland.

**Dental technicians** specialise in the manufacture of dental appliances, including dentures, which are ordered by dentists. Consumers can visit a dental technician if they require denture repairs.

**Clinical dental technicians** are qualified dental technicians who have undertaken further training to develop clinical skills which allow them to deal directly with patients. They are entitled to sell dentures directly to members of the public. This grade is not officially recognised in Ireland.

### *Nature of Restraint*

3.37 By law only a dentist is allowed to measure, fit and sell dentures to members of the public.<sup>82</sup> Qualified “clinical dental technicians”, who manufacture dentures and sell them directly to the public, exist in other countries but are not legally recognised in Ireland. There are dental technicians in Ireland who specialise in the manufacture and repair of dentures, many of whom illegally sell dentures directly to the public. However, they are unable to acquire appropriate clinical training in Ireland as the grade of clinical dental technician does not exist here nor is the sale of dentures directly to the public permitted by anyone other than a dentist.

### *Effects of the Restraint*

3.38 Restricting the sale of dentures to dentists prevents the emergence of competition between dentists and qualified clinical dental technicians in the supply of dentures. As a result, patients in Ireland pay more for their dentures than is necessary and have less choice.

3.39 By law, anyone who requires dentures must visit a dentist. The dentist examines the patient, takes measurements and sends an order for a set of dentures to a dental laboratory. The dentures are manufactured by a dental technician who sends them back to the dentist. The dentist then fits the patient with the dentures. Patients do not have the choice of going directly to a clinical dental technician – for a one-stop-shop service of measurement, manufacture and fitting of dentures - as is the case in other countries.

3.40 The lack of clinical dental technicians in Ireland means that price competition and choice in the legal sale of dentures to the public is limited to competition between dentists. Dentists place a mark-up on the prices which they pay dental technicians for dentures.<sup>83</sup>

### *Rationale offered for the Restraint*

3.41 Both the Dental Council and the Irish Dental Association argue that only suitably trained and qualified persons should be permitted to practise dentistry and that these persons must be registered with the Dental Council. They cite the need at all times to ensure that the patient is protected in the delivery of dental services.

3.42 During the enquiry conducted by the Restrictive Practices Commission in the early 1980s, the following arguments were made by dentists who appeared before the Commission and the Dental Council, for continuing to prevent suitably trained dental technicians from supplying their services directly to the public:

- Dentists claimed that the preliminary examination of a patient by a dentist before he/she was measured for dentures was extremely important as it often led to the early diagnosis of oral or systemic diseases and thus increased the possibility of successful treatment. It was claimed that only a dentist was qualified to perform this examination.

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<sup>82</sup> Under the Dentists Act 1985, this is considered to be “practising dentistry” which is reserved to registered dentists.

<sup>83</sup> This is known in economic literature as double marginalisation, as more than one mark-up is applied to a product. As discussed later, in most cases this mark-up is paid for by the State as a significant proportion of dentures are provided under the State dental schemes.

- Dentists pointed to the dangers which might result from poor quality dentures or inexpert work in their production. They claimed that inexpertly designed or fitted dentures could potentially lead to the loss of remaining teeth and to temporary or even permanent damage to gums, which, in extreme cases, could make it impossible for the patient to use dentures at all. Ill-fitting dentures could also cause continual discomfort, impairment of function and disimprovement to the wearer's appearance.
- Dentists claimed that dentures should only be provided by dentists, due to the dangers which might result from carelessness in hygiene procedures. Oral infections could be spread from one patient to another unless the person who carries out the work observes strict hygiene procedures.

3.43 During the Restrictive Practices Commission enquiry in 1982, the Dental Council argued that the number of people requiring dentures was decreasing and, therefore, setting up a Register of Clinical Dental Technicians, and associated training programmes, to meet a declining demand would be a misallocation of resources. In September 2003 the Dental 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 aging 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>84</sup>

### *International Experience*

- 3.44 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 and the USA.<sup>85</sup>
- 3.45 Clinical dental technicians will be legally recognised in the UK in 2006, following a recent change in legislation.<sup>86</sup> They will be allowed to sell dentures directly to the public and work in their own practices independently of dentists. This followed a recommendation by the Office of Fair Trading in 2002.<sup>87</sup> The General Dental Council will establish a new Register of Clinical Dental Technicians as well as a Register of Dental Technicians. As yet there are no Clinical Dental Technology training programmes in the UK but the General Dental Council is currently working with training providers to develop such courses. Patients will not be required to visit a dentist in the first instance. Clinical dental technicians will only need 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.

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<sup>84</sup> Source: Letter from the Dental Council to the Competition Authority, dated 15/09/2003.

<sup>85</sup> 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.

<sup>86</sup> The current situation in the UK mirrors the Irish situation, where dental technicians can only legally manufacture dental appliances but cannot fit them for patients, and clinical dental technicians are

## *Analysis of the Competition Authority*

- 3.46 The protection of the health and safety of the public is a valid objective but requiring all dentures to be supplied by dentists is a disproportionate way of achieving this objective. Clinical dental technicians are trained to provide the same quality of care as dentists, for a certain limited set of services. Recognising the auxiliary dental profession of clinical dental technician in Ireland would provide competition in the sale of dentures from other appropriately qualified professionals and give the circa 500,000 denture wearers in Ireland more choice.<sup>88</sup> It would also put downward pressure on the prices of dentures.
- 3.47 For a patient who is having dentures fitted for the first time, it may be appropriate for them to visit a dentist for a preliminary examination to ensure that their gums and mouth are in good condition before dentures are fitted. However, denture wearers should not be obliged to visit a dentist if they wish to order a replacement set of dentures as there is no evidence that they require a general dental check-up any more than other patients. 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.
- 3.48 It should be mandatory for individuals who wish to be included on a new Register of Clinical Dental Technicians to be suitably trained. The qualifications necessary to become a clinical dental technician are less extensive than those of a dentist; however international experience has proven their ability to provide dentures to a standard at least equivalent to that of dentists. As clinical dental technicians specialise in this area, undertake a higher number of training hours than do dentists in fitting dentures, and are likely to fit a higher number of dentures than a dentist would on a day-to-day basis, it is possible they provide a higher quality service than dentists given their greater experience and specialisation.
- 3.49 There is no evidence that clinical dental technicians are less careful than dentists in observing hygiene standards. Training in hygiene protocols is an essential component of the training received as part of courses in Clinical Dental Technology in other countries.
- 3.50 The Dental Council claims that the number of people requiring dentures is decreasing. While overall dental health in Ireland is improving, evidence from the results of various Oral Health Surveys reveals that:<sup>89</sup>
- At least half a million people in Ireland wear some form of dentures, primarily accounted for by 65+ year olds, as demand for dentures is strongly correlated with age;<sup>90</sup>

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not legally recognised. An amendment to the Dentists Act 1984 (a "Section 60 Order") was approved by the Scottish and UK Parliaments in June-July 2005. The new legislation will require all persons working within dentistry, including dental technicians and clinical dental technicians, to be registered with the General Dental Council. The provisions of the Order should come into effect in 2006. These changes were triggered by a report by the Nuffield Foundation in 1993 entitled *Report on the education and training of personnel auxiliary to dentistry*, and accelerated by the publication of an Office of Fair Trading report published in 2002 entitled *The Private Dentistry Market in the UK*.

<sup>87</sup> 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." p. 11.

<sup>88</sup> See Appendix 2 for how this estimate of the number of denture wearers in Ireland was calculated.

<sup>89</sup> Oral Health Surveys are carried out by the Oral Health Services Research Centre at the Dental School, University College Cork.

- People are now living longer than previous generations; and
- Even if the demand for full dentures falls as people retain more of their natural teeth, there will continue to be a demand for partial dentures, some of which comes from cases of tooth loss arising from sports injuries or accidents.

3.51 The current prohibition on a profession of qualified clinical dental technicians who can legally sell dentures directly to the public protects a significant source of revenue to dentists from competition. Just under €13 million was spent on approximately 55,000 denture-related claims under the two State funded schemes in 2004.<sup>91</sup>

**Table 8: State Expenditure on Dentures in 2004**

<b>Scheme</b>	<b>Number of Denture Claims</b>	<b>Expenditure</b>	<b>Average Claim</b>
Dental Treatment Service Scheme	37,135	€10,872,853	€292.79
Dental Treatment Benefit Scheme	18,208	€2,050,240	€112.60 <sup>92</sup>
<b>Total</b>	<b>55,343</b>	<b>€12,923,093</b>	<b>€233.51</b>

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

3.52 A clinical dental technician is likely to face lower start-up and overhead costs compared to a dentist setting up a dental surgery, as he/she does not require the same level of investment in equipment as a dentist, due to the clinical dental technician's narrower scope of practice. Thus, clinical dental technicians' costs should be lower than those of dentists.

<sup>90</sup> See Appendix 2 for how this estimate was calculated.

<sup>91</sup> An additional €1 million was spent on 25,811 denture repairs under the State schemes. Dental technicians compete with dentists in the provision of denture repairs; however, only dentists are eligible for reimbursements under the State schemes. Denture-related claims accounted for nearly a quarter of the total amount spent on the DTSS in 2004. The figure of €13 million is not reflective of the total amount spent on dentures in Ireland in 2004, as it excludes the amount spent by private patients on dentures and also the cost to the State of Health Service Executive (HSE) dentists who fit dentures to medical cardholders in HSE clinics.

<sup>92</sup> This refers only to the amount paid by the Department of Social and Family Affairs, and not individual contributions. See Chapter 2 for more details on how the DTBS operates.

### *Proposed Solution*

- 3.53 Both dental technicians and clinical dental technicians should be legally recognised in Ireland as a matter of urgency.
- 3.54 The Dental Council should submit an amended Scheme for the creation of the grade of dental technician. This should provide for the immediate registration (i.e. "grandfathering"<sup>93</sup>) of self-taught experienced dental technicians, as has been proposed in the UK. This could be achieved by allowing a transition period (for example two years) during which current dental technicians who do not have formal training but who have gained a specified amount of experience could have their names included on the Register. This route should only be available for those who prove that they had worked, for example, seven out of the last ten years in the profession, as the General Dental Council intends to do in the UK. After the transition period, only dental technicians with recognised training or qualifications should be eligible for entry on the Register. As registered dental technicians will only be permitted to sell the dentures they manufacture to informed buyers, that is, dentists or clinical dental technicians, no additional safeguards are needed to protect the public.
- 3.55 The qualifications required for entry onto the Register of Clinical Dental Technicians should be (a) those required for dental technicians (thus including initially those who are self-taught experienced practitioners), plus (b) additional clinical training. In addition, the Dental Council should amend the current proposed scheme to include a route of entry for dental technicians who do not have formal qualifications in clinical dental technology but perform to a satisfactory standard in an examination set by the Dental Council. This will enable those dental technicians who currently practise in Ireland to a high clinical standard to continue to do so, thus ensuring that patients are protected and do not have to switch from their preferred provider unnecessarily.
- 3.56 The Dental Council should ensure that there are no unnecessary restrictions on dental technicians and clinical dental technicians who qualify overseas and wish to work in Ireland, to ensure an adequate supply of these professions while new Irish-based courses come on stream.
- 3.57 Dental technicians and clinical dental technicians should be eligible for reimbursement for services provided under the State dental schemes.
- 3.58 The Dental Council should engage with any educational institutions interested in offering a course in Clinical Dental Technology in Ireland which would equip dental technicians with the necessary clinical training to provide dentures directly to the public.

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<sup>93</sup> A "grandfather clause" is a provision exempting persons or other entities already engaged in an activity from rules or legislation affecting this activity.

**Preliminary Recommendation 3: Officially recognise the profession of Dental Technician**

Details of Recommendation	Action By
<p>The Dental Council should amend the current proposed Scheme for the establishment of a Dental Technician grade and include a grandfather clause for experienced technicians currently working in the industry who do not have formal qualifications. The revised Scheme should be submitted to the Minister for Health and Children for approval.</p>	<p>Dental Council December 2006</p>

**Preliminary Recommendation 4: Ensure that foreign qualified dental technicians can work in Ireland without unnecessary difficulty**

Details of Recommendation	Action By
<p>The Dental Council should ensure that dental technicians who have obtained appropriate qualifications overseas are eligible for registration, without unnecessary difficulty, on the Register of Dental Technicians.</p>	<p>Dental Council December 2006</p>

**Preliminary Recommendation 5: Allow dental technicians to be eligible for reimbursement under the State dental schemes**

Details of Recommendation	Action By
<p>The Health Service Executive and the Department of Social and Family Affairs should enable dental technicians to be eligible for reimbursement under the Dental Treatment Services Scheme and the Dental Treatment Benefit Scheme, for denture repairs.</p>	<p>Health Service Executive Department of Social and Family Affairs December 2006</p>

**Preliminary Recommendation 6: Officially recognise the profession of Clinical Dental Technician**

Details of Recommendation	Action By
The Dental Council should amend the current proposed Scheme for the establishment of a Clinical Dental Technician grade and include an examination route for experienced dental technicians. The revised Scheme should be submitted to the Minister for Health and Children for approval.	Dental Council December 2006

**Preliminary Recommendation 7: Ensure that foreign qualified clinical dental technicians can work in Ireland without unnecessary difficulty**

Details of Recommendation	Action By
The Dental Council should ensure that clinical dental technicians who have obtained appropriate qualifications overseas are eligible for registration, without unnecessary difficulty, on the Register of Clinical Dental Technicians.	Dental Council December 2006

**Preliminary Recommendation 8: Allow clinical dental technicians to be eligible for reimbursement under the State dental schemes**

Details of Recommendation	Action By
The Health Service Executive and the Department of Social and Family Affairs should enable clinical dental technicians to be eligible for reimbursement 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 December 2006

### *Effects of the Solution*

- 3.59 The creation of a register of dental technicians will give professionals who currently work as dental technicians legal recognition and provide consumer protection.
- 3.60 The creation of a register of clinical dental technicians, who will be allowed to sell dentures direct to the public, will provide competition to dentists in the sale of dentures.
- 3.61 Buyers of dentures will have more choice for the same or a better quality service than currently exists, provided by qualified professionals.
- 3.62 There will be downward pressure on the price of dentures.

## **Restriction on the Number of Dental Training Places**

### *Summary*

- 3.63 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 the number of places. The limited number of training places has led to a reliance on immigration and foreign trained dentists to meet the demands for dental services in Ireland. Over half of the additions to the Register of Dentists in 2004 were trained outside the State (see Table 5, Chapter 2). Despite this flow of qualified dentists into Ireland, the limit on training places here is putting upward pressure on prices and could lead to a more serious shortage of dentists in the future. While the other recommendations proposed in this Report should help address the shortage of dentists by making better use of their skills and expertise, the number of training places should be reviewed by the Higher Education Authority to ensure a sufficient supply of dentists in the long-term, so that consumers and the State get value for money in dental services.
- 3.64 To protect the health and welfare of the general population, the State often puts in place rules and regulations governing who can supply certain services. Sometimes the rules go beyond what is necessary to protect the public and prevent qualified people from providing their services. When this happens, consumers have a smaller pool of suppliers to choose from and frequently pay higher prices as a result.
- 3.65 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 law is designed to ensure that members of the public are always treated by properly qualified persons. It is a proportionate restriction on the supply of dental services. Ordinary consumers are not likely to be able to evaluate the services on offer, either before or after they have bought them, and there is an immediate danger to their oral health if they receive inappropriate dental services.

### *Nature of the Restraint*

3.66 There are only two third-level institutions which provide undergraduate degrees in dentistry in the State - Trinity College Dublin and University College Cork. The number of places available on these courses for Irish and European Economic Area applicants is effectively capped at around 60 per annum.<sup>94</sup>

### *Effects of the Restraint*

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

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

### *Rationale offered for the Restraint*

3.68 The number of places for undergraduate dentistry courses is, to a large extent, determined by costs. Dentistry is the most expensive undergraduate training course, at approximately €35,000 per annum per student.<sup>95</sup> This is due to the low student-teacher ratios and the necessity for dental students to have hands-on experience of treating patients as part of their training, to a greater extent than is the case with medical training for doctors, for example. Graph 6 below shows the average cost of third-level education across a range of undergraduate degree programmes and it is clear that dental education is significantly more costly than other courses.

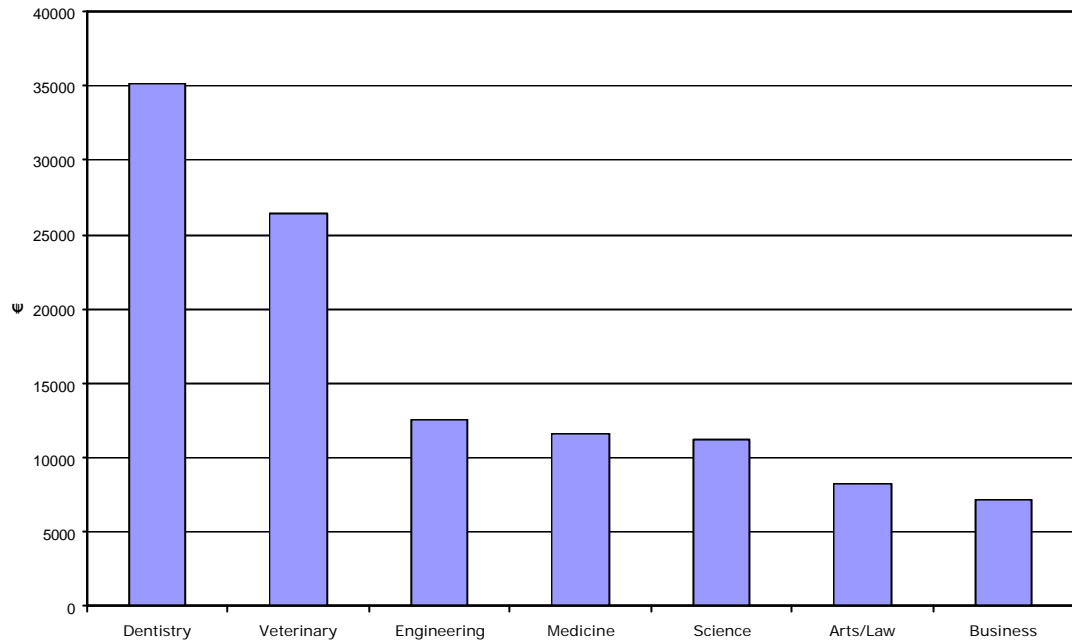
3.69 According to the dental schools in Dublin and Cork, it is not possible to take in additional dentistry students as the existing staff and physical resources of both colleges are currently operating at maximum capacity.

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<sup>94</sup> Each school has a maximum capacity of approximately 80 places per annum for new students. Of the 80 places available each year, about 60 are filled by Irish/EEA students with the remainder reserved for non-EEA students.

<sup>95</sup> Based on data obtained from the Higher Education Authority.

**Graph 6: Unit Cost of the Provision of Undergraduate Degree Programmes (2005/06)**



Source: Higher Education Authority<sup>96</sup>

### *Analysis of the Competition Authority*

- 3.70 The number of courses and places available in Ireland to study dentistry determines to a large extent the number of qualified dentists in Ireland. This in turn affects competition in dental services, including price competition. The number of places available to study dentistry in Ireland has remained unchanged over the last ten years despite growing demand from consumers for dental services. A number of factors indicate that this has led to a shortage of dentists in Ireland. A formal review of the number of places to study dentistry in Ireland is needed to ensure that a sufficient number of dentists are trained to meet the demand for dental services.
- 3.71 In Ireland, third level education is funded primarily by the State. In a free market, the demand for dental services and dentistry training and the supply of dentistry training 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, and these costs are borne by both the State and by individuals. Training more dentists is an investment which, in the long-term, will reduce the cost to the State of delivering dental services by ensuring that there is a sufficient supply of qualified dentists to meet the demand for dental services. This is supported by the *Report of the Commission on the Points System (1999)*, which stated:

<sup>96</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: 2002/03 - 6%, 2003/04 - 6.5%, 2004/05 - 7% and 2005/06 - 7%. 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.

*“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>97</sup>*

- 3.72 The number of places available to study dentistry in Ireland has remained unchanged over the last ten years, despite growing demand from consumers for dental services. A formal review of the number of places to study dentistry in Ireland to ensure that a sufficient number of dentists are trained to meet the demand for dental services has never been conducted. Reviews of this kind have been undertaken for other health-related courses such as medicine, pharmacy and health therapy courses, and in each case, it was concluded that the current number of places was inadequate.<sup>98</sup> Excess demand for third level places in Ireland generally has led to calls for the reintroduction of third level fees.<sup>99</sup>
- 3.73 In 1999, the Commission on the Points System recommended that there should be a regular review of places on healthcare-related courses with highly restricted availability, but, to date, no such review has been undertaken in the case of dentistry.<sup>100</sup>

*“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.**”*

- 3.74 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 5, Chapter 2).

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<sup>97</sup> Available at [http://www.education.ie/servlet/blobServlet/cps\\_point\\_comm\\_report99.rtf](http://www.education.ie/servlet/blobServlet/cps_point_comm_report99.rtf)

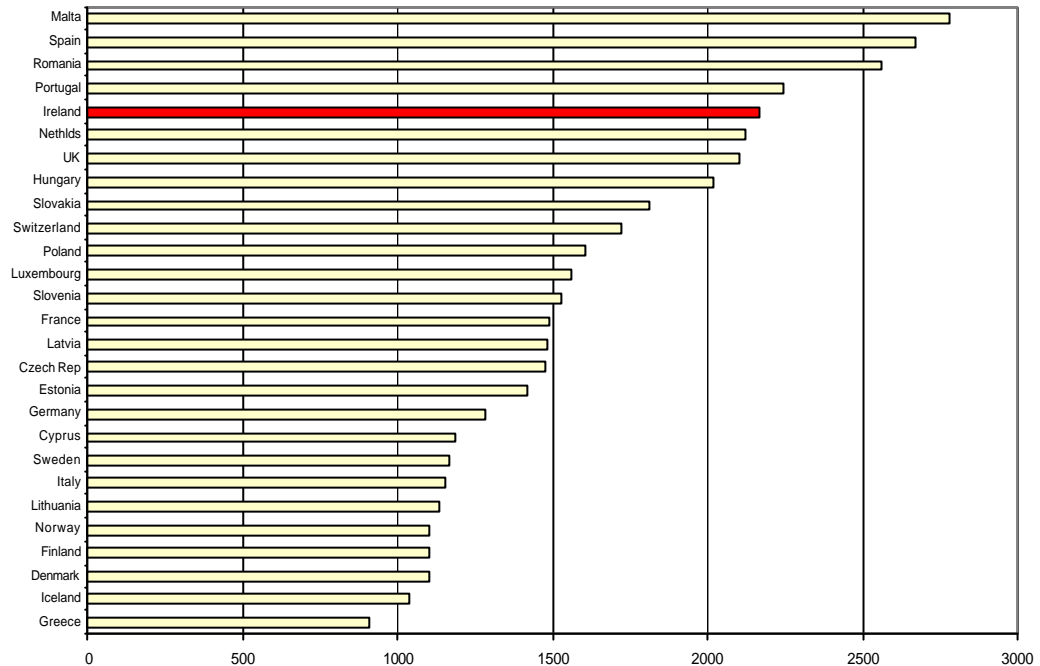
<sup>98</sup> See *Current and Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists* (2001) and *Assessing Supply in Relation to Prospective Demand for Pharmacists in Ireland* (1999), both commissioned by the Higher Education Authority.

<sup>99</sup> *Review of Higher Education Policy in Ireland*, OECD; *Education at a Glance*, OECD, 2005; *The Competitiveness Challenge 2005*, National Competitiveness Council, 2005, p. 53.

<sup>100</sup> *Report of the Commission on the Points System* (1999), Emphasis in original.

- (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. This means that there are significantly less dentists in Ireland per head of population than is the case in most other EEA countries.<sup>101</sup>

**Graph 7: Ratio of Population to Active Dentists in EEA Member States**



Source: *Manual Of Dental Practice*, EU Dental Liaison Committee (2004).

- (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.<sup>102</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>103</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”*<sup>104</sup> 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>101</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>102</sup> Based on market enquiries by the Competition Authority in the preparation of this Report and economic literature on the demand for dental services.

<sup>103</sup> See Table 5 in Chapter 2 which shows that in 2004 more than half of the new additions on the Register of Dentists obtained their qualifications overseas.

<sup>104</sup> 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)

- 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.

*Proposed Solution*

- 3.75 While the entry of foreign-trained dentists is driving the increase in the numbers on the register 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>105</sup>
- 3.76 The recommendations proposed by the Competition Authority in this Report will encourage more price competition in dental services and a more efficient use of the skills and training of dentists, for example by allowing dental hygienists and clinical dental technicians to compete in the market for dental services.
- 3.77 Following the implementation of the recommendations in this Report, the Higher Education Authority, which is the statutory body with responsibility for furthering the development of higher education, should conduct a review of the number of training places for dentists under section 6 of the Higher Education Authority Act, 1971 which requires the Higher Education Authority to "maintain a continuous review of the demand and need for higher education".

**Preliminary Recommendation 9: Review the number of training places for dentists**

<b>Details of Recommendation</b>	<b>Action By</b>
The Higher Education Authority should undertake a detailed review of the number of dentistry training places to determine whether the number of places for dentistry needs to be increased, and, if so, to what level.	Higher Education Authority December 2007

<sup>105</sup> See Appendix 1 for the growth in the number of dentists on the Register of Dentists.

### *Effects of the Solution*

- 3.78 A comprehensive review of the number of dentistry training places by the Higher Education Authority following the implementation of the other recommendations contained in this Report would quantify the extent of the shortage in the number of training places for dentists and the additional places that are needed, if any, to ensure a sufficient supply of dentists to meet the demand for dental services in Ireland in the longer term.

## **Restrictions on the Supply of Orthodontic Services**

### *Summary*

- 3.79 Demand for specialist orthodontic services has grown substantially over the past ten to fifteen years. The average waiting list for public orthodontic treatment is three years. There are currently a very limited number of training places to study orthodontics in Ireland, with approximately six graduates each year. The number of training places for orthodontists will increase by a further six places when a new course commences in Cork Dental School in 2006. The Competition Authority supports the legal recognition of a new auxiliary dental profession of "orthodontic therapist", to work alongside orthodontists. This will help reduce the cost of orthodontic services.

### *Nature of the Restraint*

- 3.80 Completion of a three-year postgraduate course in orthodontics is a pre-requisite for anyone who wishes to use the title "orthodontist". Currently, the only course on offer is in Dublin with six training places per year. A new course is due to commence in Cork Dental School in September 2006, initially offering six places.<sup>106</sup> As the course runs over three years, the first group of orthodontists from Cork will graduate in mid-2009.

### *Effects of the Restraint*

- 3.81 The number of courses and places available in Ireland to study orthodontics largely determines the number of qualified orthodontists in Ireland. This in turn affects competition in the market for orthodontic services, including price competition.
- 3.82 The limited number of training places has, together with increasing demand for these services, led to a shortage of orthodontists in the private sector, which has led to higher prices.
- 3.83 Simultaneously, it is becoming increasingly difficult to recruit and retain qualified orthodontic specialists in the public sector due to their high earning potential in the private sector. This results in long waiting lists for orthodontic assessment and treatment.<sup>107</sup> The average waiting list for public orthodontic treatment is three years and treatment takes an average of two years to complete.<sup>108</sup>

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<sup>106</sup> Source: Cork Dental School and Hospital. This is provided it receives approval from the Irish Committee for Higher Training in Dentistry which is responsible for postgraduate dentistry training in Ireland.

<sup>107</sup> The difficulties in meeting the demand for orthodontic treatment required by children have been extensively documented by the Joint Oireachtas Committee on Health and Children.

<sup>108</sup> According to information sent to the Department of Health and Children by the Chief Officers of the Health Service Executive.

3.84 The ideal time for orthodontic treatment is around the age of 12 when a child's permanent teeth have all erupted. If children cannot access treatment during this time, this can potentially lead to more complicated and costly treatment being required at a later stage.

**Table 9: Waiting Lists for Publicly Funded Orthodontic Treatment and Assessment by HSE Area at December 2004**

HSE Area	Waiting list for Treatment				Waiting List for Assessment	
	High Priority Patients	Months	Lower Priority Patients	Months	Patients	Months
South Western	619	12	254	24	403	3-6
East Coast	33	<6	167	<18	121	<3
Northern	97	<18	2,466	<36	135	3-6
Midland	0	n/a	312	12	173	4
Mid Western	0	n/a	730	24-36	2,896	24-36
North Eastern	8	1.5-2	276	18	0	n/a
North Western	179	8	1,191	24.5	2,557	10.5
South Eastern	0	n/a	675	18	236	2-2.5
Southern	0	n/a	3,362	42-48	2,853	n/a
Western	0	n/a	730	33	633	12
<b>Total</b>	<b>936</b>		<b>10,163</b>		<b>10,007</b>	

Source: *Fourth Report - Review of Public Orthodontic Services*, Joint Oireachtas Committee on Health and Children, June 2005, p. 43

#### *Rationale offered for the Restraint*

- 3.85 The small number of places for postgraduate courses in orthodontics is, to a large extent, due to the extremely high cost. The education of orthodontists costs in the region of €50,000 per student per annum which covers fees and expenses, with a further €50,000 per student per annum which the HSE pays to students as a salary for treating patients during their period of training.<sup>109</sup>
- 3.86 According to the Chief Executive of the Dublin Dental Hospital, the number of orthodontic trainees accepted each year in Dublin is constrained by the limited number of consultant orthodontists to supervise their highly specialised training.<sup>110</sup>

#### *Analysis of the Competition Authority*

- 3.87 There are serious problems in relation to the provision of public orthodontic treatment in Ireland, which point to a shortage of trained orthodontists in Ireland.
- 3.88 The effects of increasing the number of orthodontic training places in Ireland with the new course in Cork Dental School will not be known for a number of years, when the new graduates start working.

<sup>109</sup> *Fourth Report - Review of Public Orthodontic Services*, Joint Oireachtas Committee on Health and Children, June 2005.

<sup>110</sup> *Orthodontic Accreditation System and System of Training for Orthodontics: Presentation*. Joint Oireachtas Committee on Health and Children, 26 June 2003. Available at: <http://www.oireachtas.ie/documents/committees29thdail/jchc/jchc260603.rtf>

- 3.89 In other countries, including the UK and Sweden, a profession of orthodontic therapist 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.
- 3.90 The training of orthodontic therapists would be an efficient and effective means of improving the supply of orthodontic services in Ireland, compared to training more orthodontists.
- 3.91 The establishment of a new auxiliary dental profession grade of orthodontic therapist was suggested in the *Progress Report on the Implementation of an Agreed Programme for Government between Fianna Fáil and the Progressive Democrats* (August 2004).
- 3.92 The Dental Council has submitted a Scheme for Orthodontic Therapists to be established; however, it has not, to date, been approved by the Minister for Health and Children.
- 3.93 The Irish Dental Association has recommended that the range of duties of dental hygienists could be expanded to equip them with the necessary skills to assist in the provision of orthodontic treatment.<sup>111</sup>

#### *Proposed Solution*

- 3.94 The Competition Authority supports the introduction of a grade of orthodontic therapist. The Dental Council should liaise with any appropriate educational institutions who are interested in providing training courses which would enable dental hygienists to upgrade their skills to the level of an orthodontic therapist.
- 3.95 Once the new profession of orthodontic therapist is up and running, and the graduates of the new course at Cork Dental School enter the workforce, the Higher Education Authority should consider undertaking a review of the number of orthodontic training places to ensure that there is an adequate supply of these professionals to meet demand.

#### *Effects of the Solution*

- 3.96 Enabling dental hygienists to upgrade their skills to become orthodontic therapists who are trained to assist orthodontists in the provision of orthodontic treatment would reduce the cost of providing orthodontic treatment and reduce the requirement for more orthodontists who are extremely expensive to train. This would ultimately increase access to both publicly-funded and privately-funded orthodontic treatment.

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<sup>111</sup> Submission by the Irish Dental Association to the Competition Authority (3<sup>rd</sup> November 2003) following the publication of the Indecon Report.



## 4. RESTRICTIONS ON RIVALRY AND COMPETITION BETWEEN DENTISTS

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### Summary

- 4.1 Competition between dentists is actively discouraged by the Dental Council's *Guidelines on Public Relations and Communications*. The Guidelines 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 advertising their existence to a maximum of six press notices in their first year of practice. 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.
- 4.2 Dentists are also unnecessarily limited in the type of business model they can use to deliver dental services. In contrast with other healthcare professions in Ireland, such as optometrists and pharmacists, dentists are not permitted to be owners or employees of dentistry companies. Ireland is out of step with the vast majority of its European neighbours in this regard. These restrictions are unnecessary to protect the public, as all dental services can be traced back to the dentist who provided them. Allowing dentists to develop new organisational forms for delivering their services would enable them to invest in their businesses, become more efficient, and offer greater choice to consumers in terms of how they access dental services.
- 4.3 On 28th April 2005, the Competition Authority accepted settlement terms offered by the Irish Dental Association in a High Court action taken by the Authority alleging a breach of the Competition Act 2002.<sup>112</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.

#### **Note 3: 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 hinders the competitive process. Thus any barriers to buyers' ability to gain this type of information, such as advertising restrictions, are undesirable barriers to rivalry.

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<sup>112</sup> 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.

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<sup>113</sup> 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 also 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 into a long-term contract with a certain provider which includes a penalty for opting out of the contract early.

Along with entry by new professionals, the other main force ensuring competition in any market for professional services is rivalry. Rivalry refers to the process whereby suppliers operating in a market compete for buyers via price, quality as well as innovative products and services. This incentive to attract buyers can, in a well-functioning market, lead to each member of a profession offering high quality at lower prices, and a higher degree of innovation in the profession as a whole, with corresponding gains for buyers.

## Restrictions on Advertising

### *Summary*

- 4.4 The Dental Council's restrictions on the manner in which dentists can advertise and promote their practices are unnecessary and do not benefit consumers. 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 customer choice.
- 4.5 Restrictions on truthful advertising negatively affect consumers by limiting the information available to them on which they can base decisions about their oral health. Consumers should be afforded greater awareness of the range of dental services on offer, where they are available and at what price.
- 4.6 The Dental Council should remove the current anti-competitive restrictions on advertising. Truthful and accurate advertising of dental services is a useful means of providing information to consumers. Removing unnecessary restrictions on advertising will empower consumers to make informed choices about their oral health and lead to more competition between dentists, in terms of lower prices and more customer focused delivery of services.

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<sup>113</sup> Information asymmetry is a condition in which at least some relevant information is known to some but not all the parties involved. Information asymmetry causes markets to become inefficient, since all market participants do not have access to the information they need for their decision making processes.

### *Nature of the Restraint*

4.7 The Dental Council's *Guidelines on Public Relations and Communications* ("the Guidelines")<sup>114</sup> impose major restrictions on the manner in which dentists may advertise their services and promote their practices. The Council has the power to impose sanctions on dentists who violate these rules, including the power to strike a dentist from the Register. 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 – 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 and these notices may not exceed a 5cm single column.

4.8 It is implicit from the Guidelines that the advertising of dental **fees and charges** is prohibited. The advertising of **prices** is not mentioned 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."*

4.9 The Dental Council's *Professional Behaviour and Dental Ethics*<sup>115</sup> prohibits the **solicitation** of new patients by dentists and **price discounts**.

*"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*

4.10 The Dental Council's advertising restrictions severely distort competition between dentists in the following ways:

- The extremely basic level of advertising undertaken by dentists (primarily in phone directories) is of limited use to consumers;
- It is difficult for consumers to make informed decisions;
- Dentists who wish to establish a new practice are severely constrained in how they can promote their practice;

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<sup>114</sup> Available at [www.dentalcouncil.ie](http://www.dentalcouncil.ie)

<sup>115</sup> Available at [www.dentalcouncil.ie](http://www.dentalcouncil.ie)

- Dentists are discouraged from offering new or innovative ways of delivering dental services as they cannot inform consumers when they do so;
  - Price competition is restricted; and
  - The cost to consumers for dental services is thus kept artificially high.
- 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 restrictions on advertising make shopping around unnecessarily awkward and time consuming.<sup>116</sup> Members of the public 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.
- 4.13 The restrictions on advertising in the dentistry profession have a number of detrimental effects:
- 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>117</sup> This allows dentists to charge more than they would in a more transparent competitive environment.
- 4.14 The advertising restrictions place Irish dentists at a competitive disadvantage to their counterparts in Northern Ireland, who can, and do, freely advertise their services in the Republic.

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<sup>116</sup> This is known in competition economics as high search costs.

<sup>117</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.

### *Rationale offered for the Restraint*

4.15 The Dental Council asserts that the *"tradition"* in dentistry has been to avoid advertising and to rely on word-of-mouth and quality of service to build dental practices. The Dental Council claims 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 preserve the essential trust in the dentist/patient relationship.<sup>118</sup>

4.16 The Dental Council also states that excessive advertising is bad for consumers because if all dentists engage in it, advertising will be self-cancelling and will simply lead to an increase in costs which will ultimately be passed on to consumers:

*"if one dentist overtly or excessively advertised it is almost certain, as has happened in other professions, then 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>119</sup>

4.17 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."*

4.18 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>120</sup>

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<sup>118</sup> Dental Council submission to the Competition Authority, February 2002.

<sup>119</sup> *ibid*

<sup>120</sup> Irish Dental Association submission to the Competition Authority, November 2003.

### *International Experience*

- 4.19 International experience has shown that advertising of professional healthcare services does not have a negative impact on the quality of care provided. A study by the US Federal Trade Commission<sup>121</sup> 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. 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>122</sup>
- 4.20 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>123</sup>

### *Analysis of the Competition Authority*

- 4.21 The restrictions imposed by the Dental Council on advertising by dentists go far beyond what is necessary to protect the public from poor quality dental services and unscrupulous misinformation. In fact, the restrictions promote high prices and less informed choices by patients.
- 4.22 International evidence shows that informative advertising lowers prices without lowering quality of care. In Ireland, in the case of optometry services, there is no evidence that the quality of eye care services in the State has fallen now that advertising has become a market feature. In any case, the quality of dental services in Ireland is already protected and regulated by the Dental Council through the requirement to be fully qualified and through its Code of Ethics for dentists.
- 4.23 Misleading advertising frustrates the competitive process and is harmful to consumers, which is why it is explicitly outlawed under consumer protection legislation. Truthful advertising, on the other hand, benefits consumers by providing them with the information they need to make rational decisions. If patients are not aware of the dental services available to them, or how to avail of them (i.e. the location and cost), then they are not in a position to take appropriate care of their oral health.

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<sup>121</sup> 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.

<sup>122</sup> 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.

<sup>123</sup> 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.

- 4.24 In addition, truthful informative advertising can play an important role in reducing the information asymmetry which exists between the general public and service providers. 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. Advertising allows patients to better inform themselves about dental services, thus reducing their reliance on the dentist when making decisions regarding their oral health care.
- 4.25 The Irish Dental Association claims that the restriction on advertising by dentists “ensures that patients are directed to the best qualified and most appropriate clinician for their requirements”. In fact, because the restrictions reduce the availability of information to customers, and push up the prices of dental services, they are more likely to cause customers to make poor decisions about their health and avail of a lower level of dental services.

**Note 4: 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 market place. 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 is likely to limit competition.

*Proposed Solution*

- 4.26 It is vital that competition between dentists, and consumer information, is encouraged by the regulatory system. The restrictions on advertising by dentists are not contained in the Dentists Act 1985 but are contained in the Guidelines of the Dental Council. These restrictions could be removed by a decision of the Council. However, in the spirit of better regulation, the Dentists Act 1985 should be amended to ensure that the power of the Dental Council is limited to ensuring that advertising by dentists is not false or misleading.

**Preliminary Recommendation 10: Remove unnecessary restrictions on advertising**

Details of Recommendation	Action By
<p>(a) The Dental Council should remove its restrictions on advertising with the exception of prohibiting advertising which is false or misleading.</p> <p>(b) The Minister for Health and Children should bring forward legislation to amend the Dentists Act 1985 to limit the powers of the Dental Council in relation to advertising. The powers of the Council should be limited to ensuring that advertising by dentists is not false or misleading.</p>	<p>Dental Council December 2006</p> <p>Minister for Health and Children December 2006</p>

*Effects of the Solution*

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

- Patients will be empowered to make better informed decisions;
- Consumers will be able to shop around for dental services;
- There will be downward pressure on the price of dental services;
- It will encourage dentists to offer new and innovative ways of delivering dental services;
- 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; and
- Price competition between dentists will be promoted.

## Restrictions on Business Models

### *Summary*

4.28 In Ireland, dentists are unnecessarily limited in the type of business model they can use to deliver dental services. Specifically, they are prohibited from owning, or being employed by companies. Ireland is out of step with the vast majority of its European neighbours in this regard. Requiring dentists to operate a particular business model does not protect the health and safety of the public. Other professions in Ireland operate through a variety of business models, such as optometrists, pharmacists, architects and engineers. There is no evidence that professionals working in companies provide a lower quality of service than professionals working as sole traders. Removing these unnecessary restrictions would enable dentists to compete and offer their services in new, innovative ways and give consumers more choice in terms of how they access dental services.

### *Nature of the Restraint*

4.29 It is illegal under Section 52 of the Dentists Act 1985 to set up a corporate body to deliver dental services in Ireland. Private dental practitioners are limited to providing their services as sole traders, in partnership with other dentists, or in associations (whereby a dentist who owns a dental practice allows other dentists to use his/her facilities and equipment).

### *Effects of the Restraint*

4.30 The restriction on organisational structure specified in the Dentists Act 1985 unnecessarily limits the ways in which dentists can offer their services and compete for consumers of dental services. In particular, it puts unnecessary limitations on dentists' ability to invest in their practices, and on their ability to become more efficient in the delivery of dental services.

4.31 Irish consumers have less variety and choice of dental service providers than their European counterparts.

### *Rationale offered for the Restraint*

4.32 The Irish Dental Association believes that corporate dental bodies imply a "*lack of continuity in the provision of dental care by the same dental practitioner*" and that the "*freedom of clinical choice [is] removed from the practitioner in treatment decisions, materials, laboratories, referral of patients for specialist services etc*", leading to poor patient care.<sup>124</sup>

4.33 The Irish Dental Association has expressed concerns that corporate bodies are motivated primarily by profit while healthcare professionals, organised as sole traders or group practices, prioritise the well-being and health of their patients.<sup>125</sup>

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<sup>124</sup> Submission from the Irish Dental Association to the Competition Authority, 3<sup>rd</sup> November 2003.

<sup>125</sup> *Ibid.*

4.34 The Irish Dental Association argues that

*“there is no evidence that the presence of Corporate Bodies has reduced the cost of the supply of dental services in any other country, e.g. UK, USA and Canada”* and that

*“the introduction of Corporate Bodies may in fact eliminate competition that already exists within the market. The best type of competition is to have a number of sole traders operating in a local area, all competing with each other.”<sup>126</sup>*

### *International Experience*

- 4.35 Ireland is out of step with its European neighbours by imposing restrictions on dentists forming companies. Corporate dental groups are permitted in almost every EEA country. Ireland, Germany, Luxembourg and Malta are the only exceptions.<sup>127</sup>
- 4.36 In certain EEA countries only dentists are permitted to own dental companies,<sup>128</sup> while, in others, non-dentists may wholly or partly own a dental company, but at least one dentist must be employed by that company.<sup>129</sup>
- 4.37 In the UK, corporate dental groups, or dental bodies corporate as they are known, are well-established. These groups own chains of dental practices where dentists work as salaried employees or on a self-employed basis, depending on the company's policy. Most of these dental chains provide both public and private dental treatments. Some dental groups have acquired existing practices while, in other cases, they have established new practices. Many dental practices that are part of corporate chains are now situated on the high street. Some dental groups offer a wider range of opening hours than traditional dental surgeries, so that customers can attend outside the normal working day, and have introduced new dental treatments, for example cosmetic procedures. Due to the innovations of dental bodies corporate, many have been successful in attracting patients who did not previously attend a dentist, thereby expanding the size of the market and contributing to the better oral health of the public.<sup>130</sup>
- 4.38 Dental bodies corporate were originally prevented from engaging in dentistry by the UK Dentists Act 1956; however, those in existence when the legislation was introduced were allowed to remain. There are currently 28 dental bodies corporate permitted to engage in dentistry in the UK. The restriction on the number of corporate dental bodies in the UK is currently being revoked.<sup>131</sup> This initiative was proposed by the UK Department of Health and the General Dental Council fully supports moves to open up opportunities for dental care to be provided in a corporate setting.

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<sup>126</sup> *ibid.*

<sup>127</sup> Source: *Manual Of Dental Practice*, European Union Dental Liaison Committee, May 2004. This report was undertaken by the Dental Public Health Unit in the University of Wales, College of Medicine, Cardiff, United Kingdom.

<sup>128</sup> These are Austria, France, Iceland, Italy, Norway and Switzerland.

<sup>129</sup> These are Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, Greece, Hungary, Latvia, Lithuania, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and United Kingdom.

<sup>130</sup> Source: *The Private Dentistry Market in the UK*, Office of Fair Trading, March 2003.

<sup>131</sup> Legislative changes have been agreed but have not yet taken effect. See the UK Dentists Act 1984 (Amendment) Order 2005 (S.I. 2005/2011).

- 4.39 Under the new system in the UK, a number of measures will be put in place to protect patient safety. A majority of the directors of a dental body corporate will have to be registered with the General Dental Council as dentists or professionals complementary to dentistry. It will be an offence for a person whose name is currently erased or suspended from a statutory register<sup>132</sup> to sit on the Board of a dental body corporate, and the General Dental Council's Professional Conduct Committee will have the power to impose a financial penalty of up to £50,000 on a dental body corporate if found guilty of such an offence.

#### *Analysis of the Competition Authority*

- 4.40 Patient safety and quality of care are valid objectives, and certain restrictions on the organisational form of a business which is involved in the provision of healthcare services are necessary to protect the welfare and safety of patients. There is no evidence, however, that a restriction on dentists forming companies is necessary to protect patients. Indeed, Ireland is unusual in having this restriction. Other professions in Ireland, for example optometrists and pharmacists, work in a variety of business models without any ill-effects on the health and safety of consumers.
- 4.41 The Irish Dental Association argues that corporate dental bodies should continue to be prohibited to ensure "*continuity*" in the provision of dental care and that, under the current system, consumers are more likely to be treated by the same dentist when they require dental treatment. This argument implies that consumers always visit the same dentist, which, in reality, is not the case. Moreover, there is no evidence to suggest that consumers are worse off if they see a number of different dentists. Currently, consumers can switch dentists if they move home or job or their dentist retires or moves to a different location. Furthermore, dentists are required to keep records of their patients and any treatments which are carried out.<sup>133</sup> Continuity of care is no more important in dental services than in pharmacy or optometry services. If the same restrictions were applied to those professions as exist in the dental profession, the familiar chains, such as Boots, Unicare or Specsavers, would not exist and consumers would have less choice.
- 4.42 Health professionals who work in corporate settings can be held responsible for their work in the same way as those who work independently. Concerns about patient welfare and safety can be addressed by:
- Regulations on record keeping to ensure that all treatments can be traced back to a particular dental practitioner;
  - Monitoring and enforcement of quality and safety standards that are applicable to all types of dental practice; and,
  - Maintaining an effective complaints system for patients if they encounter a problem with a dental practice or practitioner.

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<sup>132</sup> These are: The General Chiropractic Council; The General Dental Council; The General Medical Council; The General Optical Council; The Health Professions Council; The Nursing and Midwifery Council; The General Osteopathic Council; The Royal Pharmaceutical Society of Great Britain; The Pharmaceutical Society of Northern Ireland.

<sup>133</sup> "*Dentists have a duty to maintain adequate and accurate records of all matters relating to their treatment of patients. These records should be kept in a secure location and retained for a reasonable period, not likely to be less than ten years, before being destroyed.*" Source: *Professional Behaviour and Dental Ethics* published by the Dental Council, available at [www.dentalcouncil.ie](http://www.dentalcouncil.ie)

- 4.43 The Irish Dental Association claims that *"the best type of competition is to have a number of sole traders operating in a local area, all competing with each other."*<sup>134</sup> Economic and competition policy literature points to the increased likelihood of collusive behaviour arising in markets where all suppliers are of the same size and share similar characteristics.<sup>135</sup> Private dental services have already been the subject of a High Court action by the Competition Authority<sup>136</sup> following allegations of anti-competitive behaviour by dentists. Having a variety of dental practices, in terms of their size, location, personnel, corporate structure and so on, gives consumers more opportunities to purchase their dental services from the dental practice that best meets their needs. It is also more likely to promote competition between dentists compared to the current situation whereby all dentists in private practice work as self-employed sole-traders or in partnerships.
- 4.44 Corporate dental bodies will introduce new and innovative ways of delivering dental services. Dental practices that are part of corporate chains are more likely to have access to the capital required to invest in new services and new ways of delivering services, such as locating in prime rent locations. Corporate dental practices have the personnel to offer longer opening hours. They can also spread the cost of advertising across a larger number of dentists.
- 4.45 Enabling the establishment of corporate dental groups may lead to the emergence of larger dental practices and create efficiency gains by making better use of the skills and expertise of dentists. Having non-dental staff undertake business management and other administrative tasks, which are currently undertaken by dentists, would enable dentists to spend more time performing dental treatments.

### *Proposed Solution*

- 4.46 There are adequate safeguards currently in place to protect patients. Dentists are required to keep patient records for a ten year period and the Dental Council investigates complaints of poor or inappropriate treatments. This means that, regardless of the way in which dental services are offered, a consumer can make a complaint to the Dental Council and every dental treatment is traceable back to an individual dentist who is personally responsible for their work.
- 4.47 Subject to all treatments being carried out by appropriately qualified persons, consumers should be able to choose from whom they wish to purchase dental services and dentists should have the freedom to decide how best to provide their services to consumers. Irish consumers should have the option to purchase dental services from a chain or franchise dental clinic, as is the case in other countries. Both dentists and non-dentists should be permitted to own corporate dental practices.

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<sup>134</sup> Submission of the Irish Dental Association, *Op.cit.*

<sup>135</sup> See *The Competition Authority - Notice in Respect of Guidelines for Merger Analysis*, available at [http://www.tca.ie/decisions/notices/n\\_02\\_004.pdf](http://www.tca.ie/decisions/notices/n_02_004.pdf)

<sup>136</sup> 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.

**Preliminary Recommendation 11: Allow dentists to offer their services as limited companies**

<b>Details of Recommendation</b>	<b>Action By</b>
The Minister for Health and Children should bring forward legislation to amend Section 52 of the Dentists Act 1985 and remove the prohibition on corporate bodies in the delivery of dental services.	Minister for Health and Children December 2006

*Effects of the Solution*

- 4.48 Consumers will benefit from the emergence of corporate dental groups in the following ways:
- They will have the opportunity to choose between a corporate dental group or an independent dental practice depending on which they consider is best suited to their needs.
  - Dental services will become available in more locations and for more hours of the day.
  - Enabling the establishment of corporate dental groups is likely to lead to the creation of efficiency gains by making better use of the skills and expertise of dentists. In a competitive market, these gains will be passed on to consumers in the form of lower prices.
- 4.49 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.



## **REFORM OF REGULATORY STRUCTURES**

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### *Summary*

- 5.1 The Dental Council has put in place a number of unnecessary restrictions on competition, as evidenced in Chapters 3 and 4 above. The Dental Council is mainly composed 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 stakeholders 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>137</sup>
- 5.3 To be consistent with this development, the composition of the Dental Council should be changed to include other stakeholders. 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 do not unnecessarily hinder competition between dentists.

### *Principles of Better Regulation*

- 5.4 The Government White Paper *Regulating Better* sets out six principles of good regulation:
- Necessity,
  - Effectiveness,
  - Proportionality,
  - Transparency,
  - Accountability, and
  - Consistency.
- 5.5 These principles should be borne in mind both in the context of new regulations and in reviewing existing regulations.

### *Composition and Functions of the Dental Council*

- 5.6 The Dental Council is almost entirely composed of members of the dental profession and individuals involved in the education of dentists (see Table 2, Chapter 2). Only two of the 19 members are required 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.

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<sup>137</sup> See for example the Health and Social Care Professions Bill 2004, available at [www.oireachtas.ie](http://www.oireachtas.ie)

5.7 While it is important for a regulatory body to have access to expert professional advice on its Council, the need for such advice is not so great that the majority of members must come from the profession being regulated. The Competition Authority would urge an approach similar to that envisaged for the proposed Health and Social Care Professionals Council<sup>138</sup> which provides for a majority of its members to be outside the professions being regulated.

5.8 Members of the Dental Council should be broadly representative of a large number of stakeholders with an interest in the dental profession, such as: auxiliary dental professions, suppliers and consumers.

**Preliminary Recommendation 12: Change the composition of the Dental Council**

Details of Recommendation	Action By
The Minister for Health and Children should bring forward legislation to amend the composition of the Dental Council, as set out in the Dentists Act 1985. The revised legislation should provide for a Dental Council that is representative of a large number of stakeholders, none of whom should be in a majority.	Minister for Health and Children December 2006

5.9 Regulatory bodies should have clear objectives, one of which should be the promotion and encouragement of competition in the profession or market they regulate.

**Preliminary Recommendation 13: Set out the functions of the Dental Council in legislation.**

Details of Recommendation	Action By
The Minister for Health and Children should bring forward legislation to amend the Dentists Act 1985 to:  (a) Set out the functions of the Dental Council, and  (b) Specify that one of the functions of the Dental Council is the promotion of competition and consumer focused regulation in the dental profession.	Minister for Health and Children December 2006

<sup>138</sup> Proposed in the Health and Social Care Professions Bill 2004, available at [www.oireachtas.ie](http://www.oireachtas.ie)

- 5.10 Clearly enshrining the functions of the Dental Council in legislation would impose a statutory obligation on the Council to promote competition in the professions regulated by it. The reconstitution of the Dental Council to make it representative of a broader group of stakeholders would ensure that regulation of the profession is not influenced by vested interests and would promote consumer-focused regulation, in line with the principles of better regulation.



## 5. CONCLUSION

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- 6.1 Competition is not working well for buyers of dental services. This is because competition in dental services has been seriously restricted by unnecessary laws and regulations. In particular, the Dentists Act 1985 and the rules imposed by the Dental Council, the statutory body charged with regulating dental services, prevent consumers from benefiting from active competition in the following ways:
- Healthcare professionals, such as dental hygienists and clinical dental technicians, are prevented from offering basic dental services directly to consumers;
  - Dentists are discouraged from attracting customers through normal methods of competition including price discounting and advertising;
  - Restrictions on informative advertising prevent consumers from getting access to basic information which would help them to make more informed decisions about their health;
  - Consumers are unnecessarily limited in their choice of provider of dental services; and,
  - There are unnecessary obstacles put in the way of dentists trying to offer new services to consumers, or to deliver their services in new ways.
- 6.2 The effect of these restrictions on competition has been to push up the price of dental services in Ireland, beyond the general rate of health inflation in Ireland, and drive some consumers to travel to other countries for certain dental services.
- 6.3 The effects of the shortage of trained orthodontists in Ireland have been well documented, in terms of extremely long waiting lists (averaging three years) for public sector treatment and high private sector prices. The increase in the number of training places in Ireland for orthodontists in 2006 should help alleviate some of these difficulties, but not for at least another three years, when the first group of graduates enter the workforce.
- 6.4 In this Report, the Competition Authority makes 13 recommendations designed to remedy the competition problems identified above. They include:
- Allowing related dental professionals to offer services they are qualified to provide direct to the public;
  - The creation of a new grade of “clinical dental technician” to increase competition in the provision of dentures;
  - The creation of the new grade of “orthodontic therapist” to reduce the cost of orthodontic services;
  - Reviewing the number of training places for dentists in Ireland;
  - Allowing truthful, informative advertising of dental services;

- Allowing dentists to provide their services through a variety of business models; and
- Altering the composition and functions of the Dental Council to ensure that non-dentist stakeholders are represented in sufficient number, to remove the risk of potential conflicts of interest in governance structures.

6.5 The implementation of the Competition Authority's recommendations will improve competition by leading to a modern system of regulation in the dental profession which ensures that the health and safety of the public is protected, while at the same time encouraging value for money in dental services. The new system will empower consumers to make informed choices about their oral health and to obtain dental services from a wider range of qualified professionals, in a number of different ways. It will also lead to more efficient use of Ireland's human capital by allowing for a better fit of the level of training required for each dental service provided. Allowing competition between dentists and related professions will also maintain downward pressure on the price of dental services, saving money for both consumers and the State.

## 6. APPENDICES

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### Appendix 1: Dental Council Registers of Dental Professions in Ireland

Year	Dentists <sup>139</sup>	Dental Specialists	Dental Hygienists	Dental Nurses
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	34	174	-
2001	2,006	75	204	-
2002	2,102	89	223	225
2003	2,171	100	249	303
2004	2,237	101	277	332

Source: Dental Council

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<sup>139</sup> This includes Dental Specialists, i.e. orthodontists and oral surgeons.



## Appendix 2: Number of Denture Wearers in Ireland

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>140</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 (15% 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 gives a total of around 419,000 denture wearers in Ireland.

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.

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<sup>140</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)

