Submission to the Competition Authority

regarding

Competition in Professional Services – Dentists

Preliminary Report, December 2005

February 2006

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1. PRELIMINARY COMMENT:

1.1 In advance of addressing each recommendation, the Association wishes to record its disappointment regarding the manner in which the Competition Authority published this Preliminary Report last December with a Press Release containing figures that were very misleading to the general public which has in turn contributed to the false perception that access to dental services is expensive. For the vast majority of the population, routine dental treatment is either free or subsidised.

1.2 The statement by the Competition Authority that *'the prices of dental services in Ireland have been consistently rising beyond the general rate of health inflation'* is not reflective of the vast majority of professional fees paid to dentists.

1.3 The Central Statistics Office conducts a survey of 30 dentists every quarter in relation to the professional fees charged for the following treatment items:

- Dentures
- Scale & Polish
- Filling
- Extraction (LA)

This survey does not reflect the fact that these treatment items are most often provided under the State Schemes nor does it take any account of the fact that the vast majority of General Dental Practitioners participate in the Dental Treatment Benefit Scheme (DTBS) and the Dental Treatment Services Scheme (DTSS), which has set fees in respect of the above items. The increase in professional fees payable to dentists during the period 1992 – 2005 under the DTBS was approximately 68%. The professional fee increases paid during this period were 61% less than health inflation and only 12% in excess of general price inflation.

1.4 The introduction of the Dental Treatment Services Scheme in 1994 has also taken a cohort of the population out of the private dental market into a publicly funded market where fixed professional fees are paid by the State on behalf of eligible patients to dentists for professional dental services.

1.5 Paragraph 2 of the Executive Summary is also very misleading. The terms of the settlement which the IDA agreed to was in the context of no admission of liability. This should be stated in paragraph 2 in the interest of balance and accuracy for the reader.

1.6 Paragraph 2.28, Figure 1 of the main document is also incorrect as dentists are also qualified and trained to provide both orthodontic treatment and oral surgery. This is a fundamental error.

1.7 Paragraph 2.53 is also grossly misleading as the graph represents surgical extractions provided under the State Schemes only. The vast majority of specialist oral surgeons do not participate in these Schemes.

1.8 Perhaps in any future Press Release in relation to the Dental Profession, the Competition Authority would try to ensure context, accuracy and balance in its statements to the general public and remind them of their entitlements to high quality routine dental services under the State schemes.

2. COMPETITION AUTHORITY RECOMMENDATIONS:

2.1 The Irish Dental Association welcomes any accurate review of professional dental services in Ireland.

2.2 Further to the recent publication of the Preliminary Report on Competition in Professional Services – Dentists, the Irish Dental Association would like to submit the following comments in relation to the recommendations contained in the Preliminary Report. The views submitted by the Association in relation to each recommendation are guided by the principle of ensuring the welfare of the patient in the first instance, which is of paramount importance in any healthcare setting.

3. PRELIMINARY RECOMMENDATIONS:

(1) Allow dental hygienists to operate independently
(2) Allow dental hygienists to be directly reimbursed for treatments provided under the State schemes

3.1 As outlined in our submission of October 2003, the IDA has no difficulty with any suitably trained dental auxiliary eligible for registration with the Dental Council providing services directly to the public. The Irish Dental Association would support the attainment of further skills by dental hygienists as this would result in the efficient delivery of care to patients in practices with collaborative dental teams and would be beneficial in the public health care system.

However, there is little evidence to indicate that the benefits as suggested by the Competition Authority would accrue.

3.2 In advance of enabling dental hygienists to provide dental services directly to the public, it is essential that the training needs of dental hygienists are reviewed to ensure that they will be qualified to recognise dental disease and other pathological lesions. More extensive training may be required in treating medically compromised patients and managing medical emergencies. Education in pharmacology would also have to be to the same standard as dentists if dental hygienists are to prescribe or administer drugs.

Unidentified dental disease may only come to light after a period of many years and therefore the competence of a dental hygienist in providing their services may not necessarily arise for a prolonged period of time, perhaps after significant damage has been done, if left undiagnosed by a dental hygienist. If dental hygienists are enabled to provide their services directly to the public, their training needs must be reviewed in order to ensure that the public is protected.

3.3 The statement made in paragraph 3.4 that *'allowing dental hygienists to offer their services directly to the public……would give consumers greater access to basic dental services at lower prices…'* cannot be substantiated. An extensive search of the literature is inconclusive in this regard and there is no evidence to suggest that this will be the case. Two research papers that statistically compare prices found no differences between dentists and dental hygienists in non-traditional or independent practice. (Bower EM, J Dent Hyg.1990; 64(3):144 -9 and Brown LJ, House DR, Nash KD. The economic aspect of unsupervised private dental hygiene practice and its impact on access to care. Dental Health Policy Analysis Series. Chicago: American Dental Association, Health Policy Resources Center, 2005.)

In fact the reality is that the fee charged by dental hygienists for a simple scale and polishing is already in excess of the professional fee payable to dentists under the State schemes.

3.4 The statement made in paragraph 3.5 is also incorrect, i.e. *'…hygienists must be employed by a dentist…'*. According to the Revenue Commissioners, dental hygienists are regarded as independent sole traders.

In relation to paragraph 3.9, evidence from the available literature indicates that few hygienists elect to work independently given the option. In a US study only 3.1% of hygienists were in some form of independent practice. (Singer JL, Cohen L, LaBelle A. J Public Health Dent. 1986;46(2):86-95) A survey of 1,443 dental hygienists in Colorado revealed that only 20 hygienists elected to work independently of dentists. The authors conclude that independent hygiene practice is very limited because that practice model does not offer a more efficient model for the delivery of preventive dental services over traditional dental hygiene practice. In addition, the model does not generate substantial economic incentives for dental hygienists to undertake the business risk of opening an independent practice. It was also noted that the location of the independent practices were primarily in areas with incomes substantially above the average.

3.5 The following table illustrates the practice of Dental Hygienists throughout Europe:

Country	Practice Permitted
Belgium	Dental hygiene practice not permitted
Estonia	Dental hygiene practice not permitted
France	Dental hygiene practice not permitted
Greece	Dental hygiene practice not permitted
Luxembourg	Dental hygiene practice not permitted
Romania	Dental hygiene practice not permitted
Austria	Dental hygiene practice not permitted. No training of Hygienists. Foreign hygienists permitted to work under the supervision of a dentist as a prophylaxis assistant.
Germany	Dental hygiene practice not permitted. No training of Hygienists. Foreign hygienists permitted to work under the supervision of a dentist as a prophylaxis assistant.
Cyprus	Hygienist must work under supervision of a dentist
Czech Republic	Hygienist must work under supervision of a dentist
Hungary	Hygienist must work under supervision of a dentist
Iceland	Hygienist must work under supervision of a dentist
Ireland	Hygienist must work to the prescription

	and under the supervision of a dentist. The dentist must be present when local anaesthetic is being delivered and while the same patient remains in the practice.
Italy	Hygienist must work to the prescription of a dentist. Dentist must be present in the practice.
Latvia	Hygienist must work under the prescription of a dentist.
Lithuania	Hygienist must work under supervision of a dentist
Malta	Hygienist must work under the prescription of a dentist.
Poland	Hygienist cannot work without the presence of a dentist.
Portugal	Hygienist must work under the direction and prescription of a dentist.
Slovakia	Hygienist cannot work without the presence of a dentist and must be employed by a dentist
Spain	Hygienist can only undertake prophylaxis under the prescription of a dentist. The dentist must be present in the practice.
Finland	Independent Practice Permitted but only to the prescription of a dentist
Holland	Independent Practice Permitted but only to the prescription of a dentist
Switzerland	Independent Practice Permitted but only to the prescription of a dentist
Denmark	Independent Practice Permitted if registered.
Norway	Independent Practice Permitted
Sweden	Independent Practice Permitted
United Kingdom	Independent Practice Permitted (in the near future)

Source: Kravitz AS, Treasurer ET, Manual of Dental Practice, EU DLC 2004

3.6 In Canada and the USA, there are a variety of restrictions on the practice of dental hygienists including the requirement for supervision of x-rays and the administration of local anaesthesia and the patient being seen by a dentist within a certain timeframe. In the USA, dental hygienists can work almost independently in three states only and in Canada, independent practice is only permitted in one Canadian province, i.e. British Columbia, where approximately twenty hygienists are in independent practice. (Source: Dr J O'Keeefe, Editor in Chief, Canadian Dental Journal - pers com)

3.7 The IDA has a general overall concern about the Competition Authority using material that is not evidence based to substantiate their view point. For example, reference 66 attributed to Ms Tammi Bird is merely a statement to the United States Federal Trade Commission (FTC) by a dental hygienist and is not evidence based nor does it offer references, scientific evidence or statistical support for this statement.

3.8 In relation to paragraph 3.14, the IDA does not oppose the introduction of independent dental hygienists and is unaware of any representations made to the contrary. There is no reference in this paragraph to any dentist having opposed the introduction of independent hygienists. The paragraph as written is suggestive to the reader that in some way dentists in Ireland have been actively opposing their introduction.

3.9 Paragraph 3.15 describes the issue regarding dental hygienists working under the direct supervision of a dentist. It is the understanding of the IDA that hygienists are required to work under the supervision and to the prescription of a dentist who has examined the patient, but not under the direct supervision of a dentist. A dentist must only be present in the building when local anaesthesia in being delivered and that patient is under treatment. Should a medical emergency arise as a consequence of local anaesthesia, since dental hygienists are not trained or permitted to prescribe or administer (excluding local anaesthetics and applying medicaments to teeth) drugs, a dentist must be present.

Oral cancer is increasing and Ireland has a higher rate of this disease than Great Britain, with upwards of four hundred cases per annum. The majority of oral cancer is first detected by general dentists and currently routine examination of the oral cavity by a dentist is the only method of early detection. **Since the prognosis of oral cancer is poor with late diagnosis it is an absolute imperative that any dental professional that examines the oral cavity is trained to recognise malignant and pre-malignant lesions in the oral cavity to the same standard as a dentist.**

3.10 Paragraph 3.19 states: *'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'*. Until such time as dental hygienists are appropriately trained, the IDA fundamentally disagrees with this statement. A questionnaire survey of 84.3% of US dental hygienists in independent practice revealed that 90% of their patients were in need of dental/hygiene services with approximately one in four requiring only hygiene services. (Singer et al. op. cit.) This finding would suggest that since 75% of patients required more than dental hygiene services and that independent hygiene practice is not an efficient entry point to other oral health services.

3.11 The conclusion drawn in paragraph 3.22 is unsubstantiated. It is interesting to note that the Competition Authority did not use the figures in the report for the Austrian Federal Ministry of Education, Science and Culture by Lusiak-Donsberger which is referred to in paragraph 3.12. In this report, at section 7.2.3, the author calculates the weekly earnings in 2000 by a prophylaxis assistant based on a fee of €110 for a prophylaxis (a scale and polish) in Austria. In paragraph 3.22 the Competition Authority suggest that dental hygienists in independent practice in Ireland could undertake a scale and polish for what amounts to €80 - €90 less than the 2000 Austrian fee.

Furthermore, under the current DTBS contract, dental hygienists are permitted to provide services under the scheme upon referral from a dentist. However, many hygienists are unable to provide services for a simple scale and polish under this scheme as the fee set is too low and uneconomical.

The statement in paragraph 3.23 that *'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'*. The fact that 80% of the population is entitled to a free examination and scale and polish on an annual basis needs to be highlighted on a regular basis as cost is not an issue.

3.12 The Irish Dental Association is supportive of the points made in paragraph 3.24 and 3.25.

3.13 With regard to the recommendation to enable dental hygienists to be directly reimbursed for dental treatments provided under the State schemes, as already indicated, many dental hygienists are unable to provide services for a simple scale and polish under the DTBS scheme as the fee set is too low and uneconomical.

(3) Officially recognise the profession of Dental Technician
(4) Ensure that foreign qualified dental technicians can work in Ireland without unnecessary difficulty
(5) Allow dental technicians to be eligible for reimbursement under the State dental schemes
(6) Officially recognise the profession of Clinical Dental Technician
(7) Ensure that foreign qualified clinical dental technicians can work in Ireland without unnecessary difficulty
(8) Allow clinical dental technicians to be eligible for reimbursement under the State dental schemes

3.14 The structure of the Competition Authority's report becomes confused when it comes to the restrictions on the sale of dentures and should only concern itself with the issue of Clinical Dental Technicians.

Dental technicians have trained for a longtime in Ireland gaining UK City and Guild or now BTEC qualifications through four years in-service training. There is

now a three-year Diploma in Dental Technology in Trinity College, Dublin. Dental technicians that have undergone formal education will have been trained in all areas of dental technology. Dental technology covers the fabrication of all forms of prostheses and removable orthodontic appliances to the prescription of a dentist. It does not involve any clinical work except on occasions in the assistance of determining shades for ceramic restorations. Dental technicians work in dental laboratories and as their career develops many choose to specialise in specific areas. The main areas of specialisation are fixed prostheses (crowns and bridges), removable prostheses (dentures) and removable orthodontic appliances. Within these areas some may specialise further and become dental ceramists who only work at dental ceramics, specialists in dentures requiring metal castings or specialists who only undertake acrylic work for dentures.

The confusion for the Competition Authority arises from the fact that some dental technicians in Ireland, who specialise in the fabrication of removable prostheses i.e. dentures, have for years have been operating as illegal 'denturists' supplying dentures directly to the public. In reality there are two separate groups, namely the traditional laboratory based dental technicians and those dental technicians who are currently illegally supplying dentures to the public or would like to in the future.

3.15 As outlined in our submission of October 2003, the IDA has no difficulty with any suitably trained dental auxiliary eligible for registration with the Dental Council providing services directly to the public. Currently, neither dental technicians nor clinical dental technicians are trained to a standard to enable them to provide services directly to the public. The IDA understands that the Dental Council has had for some years past a proposal for the suitable training of clinical dental technicians to provide services directly to the public, but that the Department of Health & Children has failed to act on this proposal.

The Irish Dental Association would support the establishment of a training pathway for clinical dental technicians, as this would result in the efficient delivery of care to patients in practices with collaborative dental teams and would also be beneficial in the public health care system. However, there is little evidence to indicate that the benefits, as suggested by the Competition Authority, would accrue.

3.16 Clinical dental technicians currently exist in Finland, Denmark, Netherlands and Switzerland and will be introduced shortly in the United Kingdom. It is important to note that clinical dental technicians in these countries can only make complete dentures for supply directly to the public. Partial dentures must be made to the prescription of a dentist. There is a sound clinical basis for only allowing clinical dental technicians to make partial dentures to the prescription of a dentist. A paper entitled **'Biological sequelae of tooth replacement with removable partial dentures: a case for caution'**, reviews the health hazards associated with removable partial dentures, and presents the biologic arguments against the

expansion of ‘denturist’(clinical dental technicians) activities to treatment that repeatedly tests the knowledge and skills of the most experienced dentists. (MacEntee MI. J Prosthet Dent. 1993:70(2):132-4)

Only a dentist is trained to undertake full assessment of a patient’s oral condition and then to advise of the most appropriate treatment. Where there are missing teeth, the first option is not always to restore missing teeth because fixed (bridges) or removable partial dentures have an effect on the adjacent teeth. For partial dentures using cast metal frameworks tooth preparation is required to increase the retention of dentures and to provide rest seats to protect the underlying tissues from loading when the denture is in function. Removable partial dentures may also be retained by the use of precision attachments that are incorporated in crowns or are attached to teeth using bonding techniques. Overdentures require the preparation of teeth and endodontic treatment. The consensus from research is that removable partial dentures are more detrimental to oral health than fixed partial dentures i.e. bridges. The other option now available is to replace teeth with implants. To make the decision as to what is most beneficial for a patient requires the clinician to be trained in all aspects of dentistry. Thus it is appropriate that the responsibility for the prescribing of removable partial dentures lies with dentists. This conclusion is supported by limiting the prescribing of clinical dental technicians to complete dentures in those European countries where they are permitted or are pending introduction i.e. UK. Partial dentures can be made to the prescription of a dentist in these countries.

Mandibular implant supported complete dentures should be considered in treatment planning in the patient with an edentulous mandible. (Doundoulakis JH, Eckert SE, Lindquist CC, Jeffcoat MK. J Am Dent Assoc.2003;134(11):1455-8). However it would be impossible (due their lack of training) for a clinical dental technician to provide this advice and requires a major input by a dentist. The Competition Authority no doubt agrees that consumers have a right to be informed of all available treatment options to ensure fully informed choice.

3.17 A number of spurious conclusions are drawn by the Competition Authority with regard to the ability of dental technicians and clinical dental technicians to provide services directly to the public:

‘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’.
‘…patients in Ireland pay more for their dentures than is necessary…’
‘Dentists place a mark-up on the prices which they pay dental technicians for dentures’.
‘Clinical dental technicians are trained to provide the same quality of care as dentists, for a certain limited set of services’.

The statements above made by the Competition Authority must be considered with reference to the issue of patient safety as highlighted in the Kenny v Dental Council High Court case. The observations on the clinical practice in this legal case should also be kept in mind before declaring in paragraph 3.55 *'this will enable those dental technicians who currently practice in Ireland to a high clinical standard to continue to do so'* or at 3.49 *'there is no evidence that clinical dental technicians are less careful than dentists in observing hygiene standards'*.

Extracts from the court transcript clearly demonstrate the concern in relation to patient welfare as follows: *"The plaintiff* (dental technician Kenny) *stated that he makes dentures and fits them in the patients' mouths. He uses his barber's chair with no artificial light and no mirror and does not put any instruments in the patients' mouths. In certain circumstances he would send patients on to a dentist. He accepted that he kept no records of patients but he would know what they had previously got done on their return. The plaintiff was asked what questions he would ask of persons who may be infected, for example, with Hepatitis C and he stated "I am not qualified to ask patients any questions"***.**

The following was the view of Professor O'Connell in this regard: "*Professor O'Connell gave evidence that he is a specialist in prosthodontics and outlined in great detail the necessity for appropriate education and training before a person could deal directly with members of the public for the purpose of fitting artificial teeth. He particularly emphasised the fact that in 90% of cases an adjoining tooth will require change to take as partial denture. He also emphasised the significance of cross infection control and the importance of sterilisation particularly in respect of bleeding. His overview of the plaintiff's practice is that it is dreadfully inadequate and unsafe particularly in respect of the risk of cross infection. In particular he took the view that the plaintiff's patients should be advised of the risk they have undergone and should go for testing (against the risk of infection). He took the view that having regard to the plaintiff's method of treatment using a barber's chair, no instruments, and with no artificial light it is not possible to carry out even a cursory examination of the patient's mouth. He was very critical of the plaintiff not keeping a patient history and emphasised the necessity to ascertain the patient's medical status"*.

3.18 It is astounding that despite the fact that the Competition Authority has confirmed that it has been made aware that there are dental technicians **illegally** providing dentures directly to the public, combined with the findings in the recent Kenny V Dental Council High Court case, particularly from a health and safety point of view, that the Competition Authority has not expressed any concern about the welfare of patients in this regard. This confirms the view of the IDA that the Competition Authority has approached their review of the dental profession from an economic point of view and has had little to no regard for the welfare of patients.

3.19 The comment in paragraph 3.48 that *'it is possible they (clinical dental technicians) provide a higher quality service than dentists given their greater experience and specialisation'* is not supported by dental research. A study of 410 edentulous patients found that while the patients paid similar costs for dentures made by either a dentist or a 'denturist', those treated by 'denturists' seem more dissatisfied with their mandibular prostheses than those treated by dentists. (Morin C, Lund JP, Sioufi C, Feine JS. J Can Dent Assoc. 1998:64(3):205-8,210-2)

3.20 It should also be noted that where there are illegal operators providing denture services directly to the public in Ireland, their fees for this service are in excess of the professional fee payable to dentists for the same service under the DTBS and the DTSS despite the inadequate clinical circumstances of their provision as evidenced above in the Kenny v Dental Council case.

3.21 Paragraph 3.36 stating that the creation of clinical dental technicians, *'thus putting downward pressure on the prices of these dental services'* is completely unsubstantiated by any evidence based literature. A review of the research literature which enables evidence based conclusions to be made reveals that the evidence is absolutely contrary to the Competition Authority's claims.

In Ontario six years after the introduction of 'denturists' there appeared to be no substantial cost differential between the services provided by dentists and 'denturists'. This paper also stated that the 'denturist' association's claims of greater choice and improved access may also be questionable, and should be re-examined in light of these findings. (Abrams SH. J Can Dent Assoc. 1997:63(10):771-4).

A study of two birth cohorts (65 to 69 years old) using the universal dental plan in Ontario over two periods of six years revealed differences between dentists and 'denturists'. The inflation adjusted expenditures increased by 19% mainly as a result of increases in 'denturists' expenditures (33%) while dentists expenditures increased by only 4%. It was concluded that the differences in plan expenditures per patient between the birth cohorts and dentists and 'denturists', along with the high continuity of care for dentists' patients, have important implications for planning and administering dental plans for the elderly. (Lewis DW, Thompson GW. AM J Public Health.1995:85(10):1408-11).

In Canada, where up to a quarter of a million treatments were reviewed, it was found that there was no economic benefit from the introduction of clinical dental technicians ('denturists'). The replacement of dentures over a fourteen year period was 22% by 'denturists' – three times more than dentists. (Lewis DW, Thompson GW, Folkins A. J Prosthet Dent. 1995;7493):264-9)

(9) Review the number of training places for dentists

3.22 There is no doubt that there is an imminent acute shortage of dentists in Ireland. The IDA supports the need to review the number of training places available in dentistry. As indicated in our submission of October 2003, the Royal College of Surgeons in Ireland (RCSI) undertook a feasibility study for the establishment of a second dental school in Dublin. The results of this study should be sought from the RCSI to assist in the review of training places for dentists.

3.23 With regard to the supply of Orthodontists, the current difficulty that exists in the public service arises from the inability of the service to retain Consultant and Specialist Orthodontists in the service. The Irish Dental Association is in the process of making submissions to the Review Body on Higher Remuneration in this regard.

3.23 It is difficult to understand why dental practitioners registered in other EU states (250,000 in total), where it has been suggested fee structures are significantly lower, do not take advantage of the opportunity to locate in the Republic of Ireland. There are no barriers to the establishment of a dental practice in the Republic of Ireland. This particularly applies to dentists in Northern Ireland who could commute to work from their homes outside of the State. The IDA concludes that this is likely to be explained by the additional costs associated with establishing and operating a dental practice in the Republic of Ireland when compared with other lower cost economies.

(10) Remove unnecessary restrictions on advertising

3.24 As stated in our submission of October 2003, the IDA supports the need for informative advertising that is both accurate and truthful. In removing any ban on advertising, it is essential that at the same time an information campaign is established to educate patients about dental procedures generally as well as free or subsidised entitlements to dental procedures under the State schemes.

3.25 The statement by the Competition Authority that *'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 teeth and avail of a lower level of dental services'*. Supporting evidence for this statement would be welcome. If patients were better informed and educated about dental treatments generally, it is likely that they would be in a position to better understand the treatment that is being recommended by their General Practitioner.

3.26 Advertising in dentistry is not a significant factor in patients choosing a dentist. In a survey of 6,000 people in the UK, 1% chose a dentist because of an advertisement in the Yellow Pages and 1% because of an advertisement. (National Audit Office (UK) J9437uz00 2003).

3.27 It has also been shown that advertising does not impact on prices or practice volume. (Kwon IW, Safranski SR, Kim JH. Health Service Manage Res.1993;6(1):32-60)

3.28 The provision of dental services to patients is about the welfare of patients. In the proposed removal of any ban on advertising, it is essential that the Dental Council is empowered to take punitive action against dentists who engage in false, misleading and distasteful advertising which could bring the profession into disrepute.

3.29 The Irish Dental Association is in the process of drafting a Code of Practice for Dentists who wish to advertise to ensure that advertisements are accurate, truthful and tasteful.

(11) Allow dentists to offer their services as limited companies

3.30 In relation to the establishment of corporate bodies, the IDA issues a caution in relation to the desire for corporate bodies, motivated primarily by profit versus healthcare professionals who prioritise the well-being and health of their patients whilst at the same time earning a living. There are serious ethical questions with regard to corporate bodies concerning clinical freedom of dentists in their employ.

3.31 Where a dental surgeon is an employee of a corporate body, their freedom of clinical choice may be eroded thereby causing a decrease in the quality of treatment provided. It is essential that any new arrangements for dentists to establish their business ensure high standards and quality of treatment are maintained.

3.32 The statement by the Competition Authority that: *'continuity of care is no more important in dental services than in pharmacy or optometry services'*. This statement displays a lack of understanding by the Competition Authority in relation to the provision of dental services. For example, the best outcome for a patient undergoing orthodontic treatment is very much dependent upon continuity of care by the same Orthodontist/Dentist, as appropriate. (Stenvic A., University of Oslo)

(12) Change the composition of the Dental Council

3.33 The Irish Dental Association has no difficulty with this proposal.

A newly composed Dental Council recently took up office in November 2005. The Minister for Health & Children has the ability to appoint up to four representatives, of whom two must be non-dentists. It is interesting to note that despite the published view of the Competition Authority in relation to the composition of the Dental Council and in particular the number of dentists

appointed to the Council, the Minister recently (February 2006) proceeded to appoint a dentist to one of these posts.

(13) Set out the functions of the Dental Council in legislation

3.34 The Irish Dental Association has no difficulty with this proposal. However, we would go further in seeking that the following functions also be set out in legislation:

(a) Compelling the DoHC/DSFA/Dental Council to provide explanatory/information leaflets in relation to dental treatments and procedures. For example, a common misunderstanding by patients is in relation to fillings and crowns. There are many different types of fillings as there are a number of surfaces on each tooth. There are also many different types of crowns of different materials and quality.

(b) Compelling the DoHC/DSFA/Dental Council to keep consumers abreast of their dental entitlements under the state schemes

(c) Compelling the DoHC/DSFA/Dental Council to educate consumers about the importance of prevention as this will reduce the necessity for more extensive dental work during their lifetime.

4. CONCLUSION:

4.1 The implementation of many of the Competition Authority's recommendations are supported by the Irish Dental Association but only where there are safeguards in place to ensure the prioritisation of patient welfare and the protection of the public, i.e. ensuring suitably trained personnel to provide dental services thereby maintaining the high standards of treatments that continue in Ireland, empowering the Dental Council to take punitive action against dentists or other personnel that provide services illegally or make false claims about their abilities.

4.2 The IDA does not believe that enabling dental auxiliaries to provide dental services directly to the public will necessarily mean a downward pressure on prices for the reasons already referred to above. There is very little evidence based research in the Report and some of the reference material quoted is erroneous.

4.3 As stated from the outset, the Irish Dental Association welcomes any accurate review of professional dental services in Ireland. It is the view of the Association that a more in-depth analysis needs to be conducted in order to substantiate the views of the Competition Authority.

Irish Dental Association
28th February 2006