Dear Sir/Madam,

The planned study will be incomplete without considering **how consumers are affected by the contract terms imposed on dental associates by surgeries:**

Background

Dental Associates (dentists) work as individual contractors for dental practices/surgeries. Accordingly, the jobs market for dental associates is close to perfect competition, as they compete for associate positions individually, have no effective union, and being self employed, have no employment rights - in short, they lack bargaining power in their dealings with surgeries. Consequently, dentists with decades of service at a surgery have experienced material changes to their job contract with just a month's notice - something that would be illegal had they been employees. This often occurs when a surgery changes hands.

Dental associates traditionally work full time at just one surgery, and this appears to be assumed in the CMA questionnaire. However, things have evolved in that today, a very large proportion of dental associates work part-time at multiple surgeries. The economic effect of this trend is to further reduce their bargaining power relative to their surgery.

About a third of dentists are paid up members of the British Dental Association (their trade body/ union). It offers members a free contract checking service that flags unusual and unfair terms in their member's contract, with appropriate commentary. However, their advice is that the surgery is most unlikely to negotiate contractual terms - particularly when it is part of a group. Accordingly, the main use of this service is where the dentist is considering a new position. In view of this service, the BDA is a rich source of information about contractual terms.

Dental surgeries have traditionally operated independently, but there is a trend for private equity groups, such as [✂] to buy surgeries or establish new ones. Currently. 12% of surgeries are part of equity groups, but such a trend has resulted in equity groups controlling 60% of vetinery services. It is exceptional for a dental surgery to agree any changes to their standard contract, and least likely where the surgery is part of a group. From the surgery's viewpoint, agreeing to exceptions for one dental associate would be hard to justify to the others, if they found out. Overall, dental surgeries already hold all the bargaining cards in their contractual dealings with associates.

Share of Fees

It was almost universal for dentists to be paid 50% of the fee paid by the customer for the particular treatment, in both NHS and private dentistry. Dentists are expected to pay any laboratory fees involved in the treatment from their share. However, the trend in recent years has been for the dental associate's share to diminish, and the surgery's share to increase correspondingly - [✂] has reduced it to 42.5%. For example, where the consumer pays £100, the dentist receives £50, whereas in the case of [✂] the dentist only receives £40, unless their charges are higher. Indeed, dental fees need to be increased by almost 18% to £117.64 for the dentist to still get £50.

In considering associate positions, a dentist considers not only the fee they will receive but also the quantity and type of work they will get at the surgery, as it is no use being paid a lot for a treatment if there are only one or two appointments a day, and they are idle most of the time.

It is relevant to consider whether this shift in remuneration to the surgery is justified - are surgeries facing more costly bureaucracy than their associates (who have to make notes and pay for their own professional indemnity), or has the cost of medical equipment increased? Do surgeries need more administrative staff than in the past, or can surgery groups afford more admin staff out of economies of scale? Yet some smaller surgeries still manage with just one receptionist, who may also act as a dental nurse. At the same time, dental associates also experience an increasing bureaucratic burden, so why should surgeries take a greater cut?

Unfair Contract Terms

The expertise of dental associates lies in their work, and they seldom have legal knowledge, as they believe their surgery should sort this out. Most are not members of their trade body -the British Dental Association, and therefore have no access to a legal helpline or similar, while solicitor charges are prohibitive. With their lack of bargaining power, they are easy prey for new owners.

Where a dental treatment has failed, it is customary for the dentist and surgery to share the cost of the refund in the same proportions as they were remunerated. However, [✂] has imposed 100% of the refund cost upon the dentist, even though the latter only received 42.5% of the fee! Failed treatments are not necessarily the result of poor workmanship, as the prospects of successful treatment may have been slim on account of the poor health of the tooth etc. Consequently, the dentist's annual earnings can only be preserved by increasing treatment fees by more than 18%. Additionally, tooth conservation is discouraged, by this, while more expensive and complicated treatments encouraged, despite the possibility of a successful cheaper treatment. As a result, consumer choice is restricted as it becomes harder for the patient to find a dentist to take the risk involved in conserving their tooth.