Becoming a Practice Owner: The Challenges facing UK Dentists

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About the BDA

The British Dental Association (BDA) is the professional association for dentists in the UK. It represents more than 23,000 dentists working in general practice, in community and hospital settings, in academia and research, and in the armed forces, and includes dental students.

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Abbreviations

BDA – British Dental Association
CODE - Confederation of Dental Employers
CQC – Care Quality Commission
DCP - Dental Care Professional
DH – Department of Health
GDC – General Dental Council
GDS – General Dental Services
LHB – Local Health Board
OFT – Office of Fair Trading
PCO – Primary Care Organisation
PCT – Primary Care Trust
UDA – Unit of Dental Activity
Summary

This report describes some of the findings from a programme of research and analysis carried out by the British Dental Association (BDA) to investigate how well the dentistry market is working in the UK.

As part of this research programme, the BDA conducted a survey of dental practice owners in the UK in order to explore their views and opinions on a variety of topics relating to the dental market, including:

- Competition
- Patient decision making
- Cost and fees for private treatment
- Patient complaints and redress.

Fieldwork for this survey took place between 15th and 28th November 2011. An online mode of administration was used (using SurveyMonkey). The survey population included all dental practice owners who were members of the BDA and for whom the BDA had current and reliable information. Of the 5396 individuals who were invited to participate in the survey, 1804 responses were received, giving a response rate of 33 per cent. Of these, 1723 were valid cases

As part of the survey, dental practice owners were asked about the challenges or barriers they faced in becoming an owner. This report presents a qualitative analysis of their responses to this question.

Key findings from the research

Around one-quarter of practice owners said that they had experienced barriers to either being or becoming a practice owner. The kinds of challenges they faced included:

Financial challenges

- Among respondents who gave information about the challenges they had experienced, almost half said that these barriers had been financial; in particular, they said that they had experienced difficulties in accessing loans or raising the capital needed to start-up, grow, or maintain a practice.
- Several respondents reported that the cost of borrowing had been a key barrier for them: interest rates and the bank charges associated with private financing were seen to be too high by some.
- Some of those who reported experiencing financial barriers pointed to difficulties with the lending policies of banks.
Regulation and paperwork
The next most commonly cited set of barriers related to ‘regulation and paperwork’ and ‘red tape’. Almost three out of ten of those who had experienced barriers pointed to difficulties in this area. In particular, there was evidence of a high level of frustration among these practice owners with the Care Quality Commission (CQC); for example, many expressed concern about the excessive administrative burden that the current regulatory regime places upon them.

Other challenges facing practice owners
Respondents identified a number of other challenges to becoming or being a practice owner, including:

- Almost one in five of those who said they had experienced barriers to becoming a dental practice owner cited difficulties in negotiating NHS contracts and a variety of other difficulties in their relationships with PCTs.
- Some 13 per cent pointed to the high costs involved.
- Around 12 per cent referred to difficulties linked to the local dental market; for example, some experienced difficulties in finding a practice or partnership to buy, either because there were none for sale or they had faced competition from other buyers or corporate dentists.
- Around one in ten referred to barriers associated with the planning system; such barriers include the legal costs or time involved in obtaining planning permission;
- Again, one in ten said that they had experienced staffing or employment-related difficulties.
- Finally, around six per cent cited more personal barriers; for example, some described how they had initially lacked the skills, business knowledge or experience to run a practice.

Newer versus more established dental practice owners
Newer (post-2006) practice owners were more likely to report experiencing barriers to becoming or being a practice owner compared with those who had set up their practice earlier (pre-2006). There were some differences in the types of barriers that owners described depending on whether they were relatively new owners (five years or less) or more established owners (more than five years or pre-2006); for example:

- Newer practice owners were more than twice as likely as more established owners to say they had experienced market barriers or difficulties in their relationships with PCTs or in negotiating NHS contracts.
- More established practice owners (pre-2006) were twice as likely (as newer owners) to identify planning and legal barriers as impediments to establishing a new practice. This suggests that this may have been more of a problem in the past than it is today.
- Newer (post-2006) owners were marginally less likely to say they had faced financial or cost barriers to starting up, compared with more established (pre-2006) owners.
1 Introduction and background

This report describes some of the findings from a national survey of dental practice owners which took place in November 2011. This survey was undertaken as part of a programme of research and analysis carried out by the British Dental Association (BDA) to investigate how well the UK dentistry market is working.

In September 2011, the Office of Fair Trading (OFT) announced its plan to conduct an investigation into the UK market for the provision of dental services (OFT, 2011). This report forms part of a wider contribution of evidence submitted by the BDA to the OFT investigation. Its evidence was based on a programme of research undertaken by the BDA between October and December 2011.

1.1 The OFT investigation of the UK Dentistry market

According to the OFT’s scoping document, the purpose of the investigation was

“to examine whether the UK dentistry market is working well for consumers. It will examine how dentistry services are sold and the extent to which there is access to accurate and impartial information to help make informed decisions. It will consider consumers’ ability to assess and act on the information that is provided, as well as the nature of competition between providers of dental services”. (OFT, 2011:3)

OFT (2010) define a market that is ‘working well’ in the following way:

“When markets are working well, firms compete to win business by achieving the lowest level of cost and prices, developing better products and services or exploiting their strengths, skills, and other advantages to meet consumers’ needs more effectively than their rivals. This process encourages innovation and provides consumers with increased choice. Competition is enhanced when consumers are empowered to shop around through access to readily available and accurate information about products and services.” (OFT, 2010:2)

That is, a healthy market is one that meets “consumers’ needs”. Competition between firms results in lower costs and better quality services or products for consumers. By contrast, OFT describe the consequences of a market that is not working well in the following way:

“Markets that are not working well can result in serious negative effects for consumers, businesses and the economy. For example, consumers may be unable to make informed choices about prospective purchases, businesses may be deterred from improving their products or entering the market and productivity in the sector may be undermined.” (OFT, 2010:2)
Here, then, a market that is not working well is one where there is limited competition between firms. When consumers are not well informed and where the choices available to them are limited, this can lead to poorer quality services and products.¹

When this line of thinking is applied to UK Dentistry, it suggests that better informed patients and consumers, together with higher levels of competition and choice, are likely to result in more affordable and better quality dental care for the UK population.

### 1.2 BDA response to OFT 2011/12

In response to the OFT investigation, the BDA submitted evidence which included relevant economic arguments, research, information, policy positions and recommendations (BDA, January 2012).² This submission was grounded in the findings from a programme of research and analysis carried out to address the question at the heart of the OFT investigation: how well is the UK dentistry market working?

This research programme sought to:

- examine the extent to which information about dental services is accessible and transparent to consumers, enabling them to make informed decisions about their care
- assess whether the UK dentistry market supports consumer switching
- identify whether current mechanisms for complaint and redress are effective
- assess levels of competition in the UK dentistry market and how this affects quality and cost
- assess the extent to which there are barriers to entry into and the expansion of NHS dentistry.

These objectives cluster around three main themes which were the focus of the research programme:

- Information and choice
- Competition
- Complaints.

The research sought to answer the following research questions:

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² The BDA’s submission to the Office of Fair Trading inquiry into the UK dentistry market can be found at: http://www.bda.org/dentists/policy-campaigns/research/oft/OFT.aspx (Accessed 18 July 2012)
• Is there sufficient transparency of information to enable consumers to make informed choices between dental practices, treatments, private and NHS provision, and different payment methods?
• Is this information provided in appropriate forms?
• Are effective mechanisms in place to support consumer switching? What barriers do consumers face when they want to switch dentists?
• How far are consumers aware of complaints procedures?
• How do practices compete – service, speed of appointments, etc.?
• How satisfied are patients with NHS and private dental care?
• What is the average price of common private treatment and is there a relationship between price and time taken?
• What are the barriers to entry into the UK NHS dental market?
• What are dentists’ attitudes to direct access to dental care professionals?

A mixed-method research design was used to investigate these questions (Bryman, 2006) with four main elements:

• A rapid search and review of the policy and research literature on the themes above.
• An in-depth qualitative case study of the dentistry market in the London Borough of Croydon, which included: three patient focus groups; eight semi-structured interviews with local practice owners; and five interviews with local stakeholders.
• A national survey of 1000 consumers of dental care (commissioned from GfK NOP).
• An online survey of BDA dental practice owners in the UK.

As part of the survey of dental practice owners, respondents were asked about the barriers or challenges they had faced in becoming a practice owner. This report presents a qualitative analysis of their responses to this question.

This first section gives the background to the report. Section 2 gives an account of the survey design and data collection. Section 3 presents a profile of respondents and their dental practices. Section 4 examines the barriers that respondents identified to being and becoming an owner of a dental practice in the UK.
2 Research design

This section describes the design, data collection, and outcomes of the survey of practice owners that took place in November 2011.

2.1 Aims and objectives

The aim of the survey was to investigate dental practice owners’ views about patient choice and competition within the UK dentistry market. In particular, the survey sought to explore the following questions relating to choice and competition from the perspective of practice owners in the UK:

- To what extent is information about dental services accessible and transparent to consumers, enabling them to make informed decisions about their care?
- How well does the UK dentistry market support consumer switching?
- How effective are current mechanisms for patient complaint and redress?
- What are the levels of competition in the UK dentistry market and how does this affect quality and cost?
- What are the barriers to entry into the UK dentistry market?

2.2 The survey population

The target population included all dental practice owners across all four UK countries: England, Scotland, Wales, and Northern Ireland. This included owners of practices that provide care to exclusively private or NHS patients, and provide a mixture of NHS and private dental care. The target population included corporate dentists, general and specialist dentists, but excluded NHS salaried and community dentists.

The effective survey population included all UK practice owners who were also members of the BDA and for whom the BDA had current and reliable information. Respondents were identified using the BDA database, CARE\(^3\).

2.3 The survey schedule

We designed a questionnaire to be administered online based on questions to meet our research objectives. Some of the questions were based on the questionnaire used in a postal survey of dental practice owners carried out in July 2002 in response to an OFT inquiry into private dentistry (BDA, July 2002). The final schedule included mixture of closed and open questions that explored the following themes:

- Patient choice, information and marketing
- Patient switching
- Experience and perceptions of competition

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\(^3\) CARE is a contact management system, used by not-for-profit organisations
• Attitudes toward ‘direct entry’ of hygienists
• Treatment charges
• Barriers to becoming a practice owner
• Patient complaints.

The questions were developed and refined through consultation with colleagues at the BDA and the Chair of the BDA Executive Board.

2.4 Data collection

The survey was conducted using an online mode of administration and via the online survey tool, SurveyMonkey[^4]. Data were collected between 15th and 28th November 2011. The data collection had to be completed within a two-week period so it was not possible to conduct such a large survey using telephone or postal methods. We therefore chose an online mode of administration because of its advantages in terms of cost and time.

A letter was composed explaining the purpose of the research, its rationale, what participation in the study would involve, and assuring respondents of confidentiality and anonymity (See Appendix I). On 15th November, all practice owners included in our survey population (see above) were sent an email with this letter and a link to the online questionnaire in SurveyMonkey. On 22nd November, a reminder letter was sent out to practice owners. The survey was closed on 28th November. Of the 5396 BDA members who were invited to participate, a total of 1804 participants responded. This gave us a response rate of 33 per cent.^5

2.5 Managing the data

Upon closure of the survey, the data were downloaded from SurveyMonkey and imported into SPSS. Once in SPSS, demographic data stored in CARE were appended to the dataset using the unique identifier. The first question of the survey was a filter question to ensure all participants were practice owners; 63 cases were identified not to be practice owners and were removed from the dataset. In addition, 18 cases were identified as having answered the filter question but not proceeding with the survey; these were removed from the data-set. Table 2.1 sets this out schematically.

<table>
<thead>
<tr>
<th>Table 2.1 Outcome of practice owner survey</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of those who responded to survey</td>
<td>1804</td>
</tr>
<tr>
<td>Of these:</td>
<td></td>
</tr>
<tr>
<td>Those who said that they were not practice owners</td>
<td>63</td>
</tr>
<tr>
<td>Those who identified themselves as practice owners, but did not go on to complete any other questions in the online survey</td>
<td>18</td>
</tr>
<tr>
<td>Total valid cases</td>
<td>1723</td>
</tr>
</tbody>
</table>

[^4]: http://www.surveymonkey.com/
[^5]: Completed at least one item in the online survey
Three attrition points were identified when assessing the data. At each of these points, there was a marked drop-off of respondents who did not go on to complete the remainder of the survey. At each of these points the remaining data were assigned as missing.

There were seven free-text variables, six of which were associated with an 'other' option on a multiple-response question\(^6\). The data collected for these questions were all coded and sorted into categories. Question 19 (see Appendix II) was an open question where respondents were asked about barriers to becoming a practice owner. A coding frame with 15 categories was developed from the responses to this question (see Appendix III). This then formed the basis for the analysis presented in Section 3.

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\(^6\) See Appendix II These were questions 16.7, 21, 24, 27, 30, 31, 34
3 About practice owners and their main practice

This section describes the demographic characteristics of respondents and profiles their practices.

3.1 Demographic characteristics of respondents

Table 3.1 shows the demographic characteristics of all respondents (N=1723). The majority of participants were aged over 45 years with an average age of 49.9 years and more than three out of every four respondents were male.

Table 3.1 Demographic profile of survey respondents

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Column percentages</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-34</td>
<td>4.3</td>
<td>74</td>
</tr>
<tr>
<td>35-44</td>
<td>22.5</td>
<td>385</td>
</tr>
<tr>
<td>45-54</td>
<td>45.8</td>
<td>783</td>
</tr>
<tr>
<td>55+</td>
<td>27.4</td>
<td>468</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>1710</td>
</tr>
<tr>
<td><strong>Mean age</strong></td>
<td>49.9 years</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>77.8</td>
<td>1333</td>
</tr>
<tr>
<td>Female</td>
<td>22.2</td>
<td>380</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>1713</td>
</tr>
<tr>
<td><strong>Country</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>84.2</td>
<td>1445</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>3.3</td>
<td>56</td>
</tr>
<tr>
<td>Scotland</td>
<td>8.7</td>
<td>149</td>
</tr>
<tr>
<td>Wales</td>
<td>3.9</td>
<td>67</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>1717</td>
</tr>
</tbody>
</table>

Base: All practice owners

7 ‘Main practice’ refers throughout to where the practice owner undertakes her or his largest number of clinical sessions each week.
Table 3.2 shows the sex and age composition of the sample and that almost six in ten respondents were men aged over 45 years.

**Table 3.2 Sex and age composition of respondents**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-34</td>
<td>3.4</td>
<td>0.9</td>
<td>4.3</td>
<td>74</td>
</tr>
<tr>
<td>35-44</td>
<td>15.7</td>
<td>6.8</td>
<td>22.5</td>
<td>383</td>
</tr>
<tr>
<td>45-54</td>
<td>35.2</td>
<td>10.6</td>
<td>45.8</td>
<td>782</td>
</tr>
<tr>
<td>55+</td>
<td>23.5</td>
<td>3.9</td>
<td>27.3</td>
<td>467</td>
</tr>
<tr>
<td>All</td>
<td>77.8</td>
<td>22.2</td>
<td>100.0</td>
<td>1706*</td>
</tr>
</tbody>
</table>

Base: All practice owners
*Missing N=17.

It was not possible for us to make a clear judgement about the representativeness of the respondents in relation to the broader population to which they belong (i.e. all UK practice owners who were BDA members). This was because data were not available on key variables related to the purpose of the study for the survey population in the BDA database system, CARE. Nonetheless, it has been possible for us to compare respondents with the wider population using demographic data stored in CARE – specifically, sex, age, and country.

The mean age of all practice owners included in the BDA system was 48.9 years (N=5485). By comparison, the average age of respondents in our survey was 49.9 years. Overall, then, respondents were marginally older than the wider population from which they were drawn. In addition, around 22 per cent (N=1187) and 78 per cent (4279) of the broader membership population were female and male respectively, which is close to the sex composition of respondents (Table 3.2).

---

8 This excludes a small number of cases which, according to their reported date of birth, meant they were under 25 years.
Table 3.3 compares the UK country where respondents are based with the population of practice owners stored in the CARE database.9

**Table 3.3 UK country where practice is located: survey population compared with respondents**

<table>
<thead>
<tr>
<th>Country</th>
<th>Survey population</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>83.9</td>
<td>84.2</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>3.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Scotland</td>
<td>7.8</td>
<td>8.7</td>
</tr>
<tr>
<td>Wales</td>
<td>4.6</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>Total %</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td><strong>Total N</strong></td>
<td>5485</td>
<td>1707*</td>
</tr>
</tbody>
</table>

Base: All practice owners
*Missing values=16

Table 3.3 shows that respondents were broadly representative of the survey population. However, Scottish practice owners were slightly overrepresented and Welsh practice owners marginally underrepresented among respondents.

---

9 See note 4
3.2 Characteristics of respondents’ practices

Respondents were asked how long they had been the owner of their current main practice. On average, practice owners had been the owner of their current (main) practice for 16 years, with the majority (86.6 per cent) being the owner for five or more years. Respondents were also asked a number of other questions about their main practice. Table 3.4 presents some key characteristics of respondents’ main practices.

Table 3.4 Characteristics of respondents’ main practices

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Column percentages</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you describe your main practice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practice</td>
<td>92.5</td>
<td>1589</td>
</tr>
<tr>
<td>Specialist practice</td>
<td>6.8</td>
<td>117</td>
</tr>
<tr>
<td>Other</td>
<td>0.7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>1718</td>
</tr>
<tr>
<td>Location of practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>25.6</td>
<td>440</td>
</tr>
<tr>
<td>Urban</td>
<td>74.4</td>
<td>1279</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>1719</td>
</tr>
<tr>
<td>Main practice owned by corporate body?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4.2</td>
<td>72</td>
</tr>
<tr>
<td>No</td>
<td>95.8</td>
<td>1631</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>1703</td>
</tr>
<tr>
<td>Number of dentists in main practice*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>20.9</td>
<td>356</td>
</tr>
<tr>
<td>2</td>
<td>25.2</td>
<td>429</td>
</tr>
<tr>
<td>3</td>
<td>19.2</td>
<td>327</td>
</tr>
<tr>
<td>4+</td>
<td>34.7</td>
<td>591</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>1703</td>
</tr>
<tr>
<td>Mean number of dentists in main practice</td>
<td>3.17 dentists per practice</td>
<td>1703</td>
</tr>
</tbody>
</table>

Base: all practice owners
*Includes the respondent

Table 3.4 shows that over two-thirds of practice owners reported that their main practice had three or fewer dentists, with around one-third reporting four or more. Less than one in twenty said that their main practice was corporately owned and three-quarters who said their main practice was based in urban areas.
Practice owners were also asked about the proportion of their patients they provide NHS care for (at their main practice). Table 3.5 shows the proportion of respondents who said that their main practice provided private, NHS, or a mixture of private and NHS care.

Table 3.5 Proportion of patients receiving NHS care at respondents’ main practices

<table>
<thead>
<tr>
<th>Proportion of patients that receive NHS care at main practice</th>
<th>Column percentages</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS only</td>
<td>7.0</td>
<td>116</td>
</tr>
<tr>
<td>75-99% NHS</td>
<td>33.3</td>
<td>550</td>
</tr>
<tr>
<td>25-74% NHS</td>
<td>17.6</td>
<td>291</td>
</tr>
<tr>
<td>1-24% NHS</td>
<td>20.5</td>
<td>338</td>
</tr>
<tr>
<td>Private only</td>
<td>20.8</td>
<td>344</td>
</tr>
<tr>
<td>Don’t know</td>
<td>*</td>
<td>3</td>
</tr>
<tr>
<td>Would prefer not to answer</td>
<td>0.6</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>1652</td>
</tr>
</tbody>
</table>

Base: All practice owners
*Less than 0.5%
'Missing cases N=71

Table 3.5 shows that around one in five practice owners described their main practice as fully private and only seven per cent as fully NHS, with the majority providing a mixture of NHS and private care.
Table 3.6 examines how the proportion of NHS care provided at respondents’ main practices varies across UK countries.

Table 3.6 Proportion of patients at respondents’ main practices receiving NHS care, by UK country

<table>
<thead>
<tr>
<th>Proportion of patients that receive NHS care at main practice</th>
<th>Column percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>England</td>
</tr>
<tr>
<td>NHS only</td>
<td>7.2</td>
</tr>
<tr>
<td>75-99% NHS</td>
<td>31.5</td>
</tr>
<tr>
<td>25-74% NHS</td>
<td>16.4</td>
</tr>
<tr>
<td>1-24% NHS</td>
<td>20.5</td>
</tr>
<tr>
<td>Private only</td>
<td>23.5</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0.9</td>
</tr>
<tr>
<td>Would prefer not to say</td>
<td>0.7</td>
</tr>
<tr>
<td>Total %</td>
<td>100.0</td>
</tr>
<tr>
<td>Base N</td>
<td>1382</td>
</tr>
</tbody>
</table>

Base: All practice owners
¹ Missing cases N=75

Table 3.6 shows some variation across UK countries in the proportion of NHS care provided at owners' main practices; for example, practices in England were far more likely to be wholly private than in the other three countries. In the other UK countries, mixed NHS and private care was more common than in England.

The next section gives a detailed account of the analysis of the data relating to the barriers to being and becoming a practice owner.
4 Challenges to becoming a practice owner

This section presents an analysis of the barriers or challenges that respondents faced when becoming a practice owner. It is important to note here that the survey did not ask about barriers experienced by respondents in relation to their current main practice, but about barriers they had experienced in becoming a practice owner.

4.1 Proportion who experienced barriers at current main practice

Around one-quarter of practice owners surveyed (23.8 per cent, N=395) reported that they had experienced some difficulties in becoming a practice owner. Of particular interest are those who had acquired a practice in the past five years. Table 4.1 shows the proportion of practice owners who said that they had experienced barriers to becoming a practice owner by proportion of NHS patients at current main practice and by how long they had been a practice owner.

Table 4.1 Proportion of practice owners who had experienced barriers, by number of years a practice owner and proportion of patients who receive NHS care at main practice

<table>
<thead>
<tr>
<th>Number of years owner of current practice</th>
<th>Experiencing barriers to becoming a practice owner?</th>
<th>Row percentages</th>
<th>Base N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Don’t know</td>
</tr>
<tr>
<td>5 years or less</td>
<td>47.7</td>
<td>47.3</td>
<td>5.0</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>20.1</td>
<td>77.4</td>
<td>2.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proportion of patients receiving NHS care</th>
<th>Experiencing barriers to becoming a practice owner?</th>
<th>Row percentages</th>
<th>Base N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Don’t know</td>
</tr>
<tr>
<td>NHS only</td>
<td>18.1</td>
<td>81.0</td>
<td>0.9</td>
</tr>
<tr>
<td>75-99% NHS</td>
<td>25.3</td>
<td>72.3</td>
<td>2.4</td>
</tr>
<tr>
<td>25-74% NHS</td>
<td>25.9</td>
<td>71.4</td>
<td>2.8</td>
</tr>
<tr>
<td>1-24% NHS</td>
<td>19.6</td>
<td>77.7</td>
<td>2.7</td>
</tr>
<tr>
<td>Private only</td>
<td>25.3</td>
<td>70.6</td>
<td>4.1</td>
</tr>
<tr>
<td>Don’t know/would prefer not to answer</td>
<td>30.8</td>
<td>69.2</td>
<td>0</td>
</tr>
<tr>
<td>All cases</td>
<td>23.8</td>
<td>73.5</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Base: All practice owners

*Missing N=63. The number of cases in this column do not always sum to the total because of variable missing data on the break variables.

Table 4.1 shows that almost half of those who had become an owner of their current practice more than five years ago were much less likely to report experiencing barriers to becoming a practice owner compared with those who had acquired their
practice more recently. Table 4.1 also shows how the likelihood of dental practice owners reporting barriers varies by the proportion of patients receiving NHS care at their main practice. Owners of practices that provide treatment to exclusively NHS patients or carry out a small amount of NHS work were only marginally more likely than other practice owners to report experiencing barriers to becoming a practice owner. However, as mentioned above, it is important to note that such barriers may not have been experienced in relation to their current main practice, but may relate to an earlier practice they had owned.

Table 4.2 further explores the relationship between number of years as a practice owner and barriers to becoming a practice owner. In April 2006, a new contract and PCT/LHB-led commissioning were introduced in England and Wales. This required practitioners to fulfil contracts to deliver a set number of Units of Dental Activity (UDAs) in a given time period. However, the arrangements in Northern Ireland and Scotland continued to be based on the existing system of capitation and fee-per-item payments. In order to explore the impact of these different arrangements, England and Wales, and Scotland and Northern Ireland have been aggregated in Table 4.2.

Table 4.2 Practice owners who had experienced barriers, by country and number of years a practice owner

<table>
<thead>
<tr>
<th>UK Country10</th>
<th>Number of years owner of current main practice</th>
<th>Experienced barriers to becoming a practice owner?</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
<th>Base N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Don’t know</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England/Wales</td>
<td>Less than 5 years</td>
<td>48.4</td>
<td>45.7</td>
<td>5.9</td>
<td>100.0</td>
<td>186</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than 5 years</td>
<td>19.5</td>
<td>78.2</td>
<td>2.4</td>
<td>100.0</td>
<td>1269</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>23.2</td>
<td>74.0</td>
<td>2.8</td>
<td>100.0</td>
<td>1455</td>
<td></td>
</tr>
<tr>
<td>Scotland/Northern Ireland</td>
<td>Less than 5 years</td>
<td>45.5</td>
<td>54.5</td>
<td>0</td>
<td>100.0</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than 5 years</td>
<td>25.6</td>
<td>71.4</td>
<td>3.0</td>
<td>100.0</td>
<td>168</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>28.9</td>
<td>68.7</td>
<td>2.5</td>
<td>100.0</td>
<td>201</td>
<td></td>
</tr>
<tr>
<td>All countries</td>
<td></td>
<td>23.8</td>
<td>73.5</td>
<td>2.7</td>
<td>100.0</td>
<td>1660*</td>
<td></td>
</tr>
</tbody>
</table>

Base: All practice owners
*Missing N=63. The number of cases in this column do not always sum to the total because of variable missing data on the break variables

Table 4.2 shows that newer practice owners (past five years or less) were more likely to say that they faced barriers than more established practice owners. Whilst the proportion of new practice owners who reported experiencing barriers is greater

10 See note 5
among more recent acquirers in all four UK countries, this pattern is slightly more pronounced in England and Wales.

### 4.2 Types of barriers experienced

All those who said that they had experienced barriers to becoming a practice owner (current main practice) were asked to describe the kinds of barriers or challenges they had experienced. Of the 395 cases who reported experiencing barriers, 18 gave no further information about these barriers. The remaining 377 respondents who did give information were free to report more than one barrier or difficulty they had experienced. The qualitative data collected in response to this question were then analysed thematically.\(^{11}\)

Interpretation of these data was complicated by the fact that it was sometimes unclear in the responses given whether practice owners were referring to barriers to becoming a practice owner or to barriers experienced in their current work as a dental practice owner. That is, their responses sometimes conflate three things: first, barriers to starting up; second, reflections on the kinds of barriers that exist to starting up among dentists starting up now; third, some respondents described more general difficulties with running their practice – and these were not necessarily barriers that they had experienced when they first became a dental practice owner. As far as possible in what follows and where the data supports it, an attempt has been made to differentiate between these.

Table 4.3 shows the results of this analysis and displays the range of barriers that respondents experienced.

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\(^{11}\) A coding framework was derived from the data and the data was then coded according to this framework (this coding framework with definitions of each category is included in Appendix III).
Table 4.3 Barriers to becoming a practice owner

<table>
<thead>
<tr>
<th>Type of barrier identified</th>
<th>Multiple responses included % of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial barriers – difficulties borrowing/raising capital to start or maintain a practice</td>
<td>45.1</td>
</tr>
<tr>
<td>Regulation/bureaucratic barriers to working as a practice owner</td>
<td>28.4</td>
</tr>
<tr>
<td>NHS/PCT – difficulties associated with NHS contracts or relationship with PCT</td>
<td>18.3</td>
</tr>
<tr>
<td>Costs of setting up or running a practice</td>
<td>12.7</td>
</tr>
<tr>
<td>Market barriers</td>
<td>12.2</td>
</tr>
<tr>
<td>Legal and planning barriers</td>
<td>10.9</td>
</tr>
<tr>
<td>Staffing and employment</td>
<td>9.3</td>
</tr>
<tr>
<td>Individual barriers</td>
<td>6.4</td>
</tr>
<tr>
<td>Discrimination</td>
<td>0.8</td>
</tr>
<tr>
<td>Other barriers</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>Base N</strong></td>
<td>*<em>377</em></td>
</tr>
</tbody>
</table>

Base: Practice owners who said that they had experienced barriers and who also gave information about those barriers
*Missing cases N=18

Table 4.3 shows that by far the most commonly cited barrier to becoming a practice owner related to financial issues and difficulties in borrowing or raising capital to start-up and maintain a practice. The next most common type of barrier cited relates to regulatory constraints, ‘red tape’ and bureaucracy; around three out of every ten said that they experienced barriers in this category. Finally, almost one in five cited barriers to do with negotiating NHS contracts and other difficulties in their relationships with PCTs.

There were some differences in the types of barriers described depending on whether respondents were relatively new owners of their main practice (five years or less) or more established (more than five years or pre-2006). Table 4.4 shows the frequency of each type of barrier by how long the respondent had been a practice owner.
As Table 4.4 shows, newer (post-2006) practice owners were far more likely to report experiencing barriers than those who had set up earlier (pre-2006). Table 4.4 shows that, among those who said they had experienced barriers, there were also differences in the kinds of barriers they identified depending on how long they had been an owner of their current practice.

On the one hand, newer (post-2006) practice owners were more than twice as likely as more established (pre-2006) owners to cite market barriers or difficulties in their relationships with PCTs or in negotiating NHS contracts (Table 4.4).

On the other hand, more established practice owners (pre-2006) were twice as likely (as newer owners) to identify planning and legal barriers as challenges to becoming a practice owner; this suggests perhaps that these kinds of barriers were more of a problem in the past than they are now. In addition, more established owners were more likely to cite financial barriers, the cost of setting up and running a practice, and bureaucratic barriers (Table 4.4). That is, newer (post-2006) owners were less likely
to say that they had faced financial or cost barriers than more established (pre-2006) owners (39.2 per cent compared with 50.4 per cent).

4.2.1 Financial barriers to becoming a practice owner

Table 4.3 showed that almost half of those who gave information about the barriers they had experienced said that these barriers had been financial. As one respondent put it, “many financial barriers made it difficult to set up practice”, whilst another commented that “finance is a massive barrier and raising capital”.

Setting up a new dental practice is an expensive undertaking, and some respondents commented on the scale of the borrowing involved; for example, one referred to “massive borrowings” and another described how they had found becoming a practice owner “financially difficult” and had “had to take out big loans”. One other owner commented that the “financial burden of borrowing to purchase the practice is high”.

The most commonly mentioned financial barrier cited by practice owners had to do with difficulties they encountered in raising the necessary finance to set up a practice and accessing private funding from banks; for example, they reported difficulties in “getting the funding set up with the bank” or obstacles to “borrowing the money to finance the practice”. Others reported that:

“Bank business loan finance not straightforward to dentists anymore”

“Unable to secure a loan”

“Loans are difficult to obtain”

“Securing bank finance was the major hurdle”

“Being able to raise favourable, competitive funding was initially a barrier”

As these examples illustrate, many respondents experienced difficulties accessing capital. In some cases, respondents said that the funding just was not available from banks, or that banks had been reticent to lend to them:

“Getting finance to get started - if family member had not loaned initial purchase price I would not have been able to get started. Difficult to get banks to lend to small businesses despite government & PM assuring us otherwise”

“Poor availability of funding from banks and other institutions”

“(Non) availability of finance”
“Financial loan difficult to come by”

“No one would lend me money”

“Currently, I know of several dentists attempting to purchase practices who are unable to raise the finance”

A few owners thought that these difficulties in accessing finance were linked to wider economic conditions:

“Credit crunch meant that bank finance was very difficult”

“Difficulty borrowing money in the current economic climate”

Several reported that the cost of borrowing had been a key barrier for them: interest rates and the bank charges associated with private financing were seen to be too high. For example, respondents pointed to “expensive funding”, “prohibitive banking charges”, “interest charges”, or the “initial costs associated with bank” as barriers to establishing their practice. Others reported that:

“Cash supply from the bank was moderately difficult to obtain at a reasonable rate”

“Getting finance at reasonable rates from a bank”

“Obtaining the finance to buy - as it was some years ago interest rates were very high”

“Deposits and interest rates quoted unaffordable”

The lending policies of banks, lending criteria, and the conditions attached to bank loans were also frequently cited as financial barriers; for example:

“Banks’ lending policies”

“Difficulties in obtaining bank funding. Bank changing conditions at last minute”

“Onerous conditions on loan from bank”

“Deposit - especially now as banks want 30% deposit for a squat practice”
“Big practices/corporates are preferred to single handed and more favoured”

For many dentists, starting a new dental business means taking on a high level of personal financial risk. The requirement to provide security against the loans required was cited as a barrier by some respondents, for example:

“Finance-high level security required”

“Raising money and having to put one’s house up as security for loan”

“Borrowing from bank - had to put a charge on home”

A small number of practice owners said that they had to use their home as security against the borrowing needed to set up a practice:

“[I] had to borrow the money to pay for the business from the bank and use own home as security. I remember it was quite a struggle when the children were little, to pay off the mortgage and the business loan at the same time. Dentists risk losing everything to buy their own business”

“Raising finance from the bank was problematic. We have recently constructed a purpose built practice. The bank was only willing to lend a proportion of the funding, and excluding the VAT. We had no option but to raise the remainder by increasing the mortgage on our private house. If we were not a 'husband and wife' team I don’t think we would have proceeded”

Other respondents felt that their individual circumstances or characteristics such as not being a home owner made it more difficult for them to access capital from banks:

“As a single woman, without owning my own home at the time it was difficult to get finance”

“It was difficult to get a bank account as a foreigner let alone a loan. We were in a catch 22 without a bank account no lease for a property and without a home address no bank account!!”

“Multiple medical tests to obtain life insurance to be able to get a mortgage to buy the building”

In particular, as the following excerpts illustrate, a few female owners felt that their gender had been a barrier to them accessing the necessary finance:
“As a female who had a young family and been an Associate for 11 years I found getting finance a real struggle”

“Obtaining loan from bank - felt it was because I was a woman as went to bank that the practice had been using”

“[Name of bank] wouldn't lend to me being a woman”

“Banks were reluctant to lend to a female”

Finally, one respondent felt that the financial process involved in setting up a dental practice is not well understood by government (e.g. “[the] need to borrow to finance these services is just not understood by either the state authorities nor [or] by patients”). A small number of respondents commented that banks or lenders have a limited grasp of dentistry and the dental market. One referred to a “lack of understanding of business of dentistry by the bank I approached”; another to a “failure of financial institutions to understand the market”. Finally, one respondent claimed that “banks lack of knowledge of dentistry”. Others expressed more specific concerns about lenders’ understanding of dental enterprises:

“Had difficulty trying to get a loan to relocate to better premises […] Banks saw business plan as a commercial venture rather than dental”

“Financial institutions did not understand the cash flow characteristics of a NHS specialist orthodontic practice start-up”

4.2.2 Regulatory and administrative barriers to working as a practice owner

The second most frequently cited barrier related to ‘regulation and paper work’, with almost three in ten of those who said that they had experienced barriers mentioning difficulties in this area (see Table 4.3). However, in many cases, respondents’ comments related to current difficulties in running their practice(s) - that is, barriers to being a practice owner rather than specifically barriers experienced in becoming one.

Many of those respondents who said they had experienced barriers cited bureaucracy, legal requirements, and (over)regulation as common difficulties. They described feeling overwhelmed by a “sea of red tape and regulation”, “bureaucracy”, “legislation”, and “paperwork, paperwork and paperwork”. Others alluded to “excessive overregulation”, “extreme legislative and regulatory burden”; “too much paperwork”; “too much regulation”, “red tape and over-regulation”; “too many rules and regulations”; “unbelievable amount of administration”; and “excessive red tape […] grossly excessive bureaucratic interference”.
Several respondents linked this excessive burden of ‘red tape’ and ‘paperwork’ to the requirement to meet external standards or compliance regulations (e.g. “Changing the practice to higher standards […] the never-ending paperwork”; or “Paper work involved additionally the numerous compliance requirements”). Many raised concerns about the Care Quality Commission\textsuperscript{12} (CQC) in particular (“CQC a barrier to remaining a practice owner”). Several participants simply referred to “CQC” as a barrier. Others pointed to the “CQC registration process”, “CQC compliance”, “burdensome regulations CQC” as barriers, or reported feeling burdened by,

\begin{quote}
"Managing the paperwork and protocols for CQC and HTML05"
\end{quote}

\begin{quote}
"Endless paperwork on governance /CQC etc."
\end{quote}

\begin{quote}
"Legal and regulative burdens such as HTM-0105 and clinical governance and CQC"
\end{quote}

\begin{quote}
"Dealing with CQC and clinical governance"
\end{quote}

The administrative burden involved in meeting CQC requirements led one respondent to question whether it is fit for purpose:

\begin{quote}
“CQC is onerous, and seems to be a paper exercise, which makes me question whether it is actually going to be effective at dealing with those substandard practices it is aimed at”
\end{quote}

Whilst many respondents referred to the CQC as a barrier in their work as practice owners, some referred to both the CQC and NHS organisations as barriers, fuelling negative perceptions of both.

There was a strong perception among a few respondents that the amount of paperwork and ‘red tape’ had increased over recent years; for example, they referred to: a “huge increase in paperwork”; a “huge increase in responsibility and administration”; a “continuous increase in bureaucracy + red tape”; an “increasing burden of paperwork, registration for more new bodies and increasing rules and regulations”. The following two respondents specifically linked this increase in bureaucracy and paperwork to the CQC:

\begin{quote}
“Increased pressure and regulations in an already highly regulated profession, including increased bureaucracy and costs have been a hindrance. CQC!”
\end{quote}

\textsuperscript{12} The Care Quality Commission is responsible for regulating health and social care services in England; for more information about the CQC, see http://www.cqc.org.uk/public/about-us
“Increasing regulation relating to CQC requirements”

A few other respondents pointed to the bureaucracy associated with running a business and employing staff:

“Red tape (both dental and employment law etc.)”

“Regulations - good and necessary but increasingly onerous employment law”

“Same with employment legislation. Too many rights in favour of staff and patients”

Practice owners were not only concerned about the extent of paperwork or the fact that it was perceived to be increasing. Many were critical of the current regulatory regime on other grounds; for example:

- A small number of respondents felt that the regulations and paperwork they were required to complete are ‘duplicated’; for example, one described the CQC as “another inflexible body which is doing the same job as the PCT, GDC and BDA”;
- One respondent felt that legislation is not tailored to small practices (e.g. “excessive legislation which is not tailored to small practices”);
- At least two respondents were unhappy with what they described as unwarranted “bureaucratic interference”;
- A few respondents felt that the regulations have an inadequate grounding in evidence (e.g. “Fussy regulations that have little evidence to support them”; “Some of these regulations are duplicated and some of them haven’t even been tested for their effectiveness”);
- One respondent expressed confusion with the regulations (e.g. “excessive paperwork [and] confusing regulations”) and another thought that they were inconsistent (e.g. “The implementation of CQC regulations […] are not evidence-based nor consistent”);
- A small number of respondents expressed negative views about legislation (e.g. “Regulation from too many authorities and too much useless legislation”; “Lots of unnecessary legislation which does not improve patient care. It actually hinders it”).

Other comments on this theme related to the impact of excessive regulation and bureaucracy on respondents’ work and on their dental practice. Several highlighted the negative financial implications of excessive regulation, with some singling out the CQC again. For example:

“CQC obligations a major cost”
“CQC - very time consuming without directly helping patients and costing me money!”

“The implementation of CQC regulation[s] has meant that I have had to finance all the changes myself”

“Keeping up with the on-going changes in the regulations means no end to paper work. This has an implication in terms of time and money. Some of these regulations are duplicated and some of them haven’t even been tested for their effectiveness”

The following excerpt illustrates the negative financial impact of meeting CQC requirements on a small practice:

“CQC costs and time required to comply utterly intolerable (totally unrealistic to compare a small practice with a hospital dept.). Costs to comply with latest X-infection requirements prohibitive for a small practice - no scientific justification. I want to provide the best possible for my patients, always have done, but how? MY POCKETS ARE NOW EMPTY!”

These negative cost implications of current regulatory practice led one respondent to conclude that the current regulatory regime is economically unsustainable (“Regulatory framework is financially more difficult than the market can support”).

Apart from the cost implications of regulation, respondents also mentioned some other negative effects of “excessive regulation”. The following excerpt illustrates a strongly felt concern that there is a risk that the high cost of meeting regulatory requirements may have a perversely negative impact on dental services, as well as on dentists’ morale:

“Nowadays the added cost burdens imposed by recent changes in statutory legislation add to the cost burden without any consideration of its effect on limiting availability of services by a willing profession whose need to borrow to finance these services is just not understood by either the state authorities nor by patients.”

One respondent’s experience of the CQC had been so negative that they had considered quitting as a practice owner (“CQC registration (this year) has almost made us quit”). And in the following excerpt another respondent expressed concern about the impact on a colleague’s workload, which, in this case, resulted in them leaving the practice:
“Complying with IG [Information Governance] regulations and then CQC meant that we had spent large amounts of time and money complying with what for the most part seemed a completely useless exercise and lead to member of staff departure from the practice as they found the work load impossible to cope with. The amount of red tape and unnecessary paperwork has added to our already high work load. I do not remember the last time I’ve actually had a lunch break in the last 2 years.”

Similarly, several respondents expressed frustration with the impact of regulation and ‘red tape’ on their clinical work and the amount of time they have available for treating patients:

“Extensive regulations reducing clinical time”

“A lot of paperwork, a lot of repeated paperwork and many people checking our business and we do not have time to treat patients or to do what we were trained to do”

“Over regulation - lack of coherence and nonsense talked about with x-infection control the massive amount of surgery time that has been lost to CQC paperwork”

“Too much red tape and paperwork distracting dentist from their patient care”

“Red tape and bureaucracy and over-regulation of general dental practices take up too much valuable time that could be better spent in providing a service for patients”

The above excerpts illustrate clearly how current regulatory practices may be having a negative impact on some practices – on the costs associated with running dental practices, on clinical care, and on dentists’ morale. In addition, there were a small number of respondents who highlighted the implications of excessive regulation and bureaucracy for their personal wellbeing. For example, one reported that they had experienced “stress from complying with so much regulation and at the same time working clinically”. Another referred to the “stress of paper work and dealing with PCT or CQC”.

Whilst most of the responses in this category related to concerns or barriers experienced whilst working as a practice owner, some respondents made specific comments relating to starting up or becoming a practice owner.

Some respondents felt that bureaucracy or ‘red tape’ had been one of the principle difficulties they faced when establishing their practice; for example, one described
how they had found the process of buying the second half of a practice “extremely involved with government red tape”, and another struggled with “ensuring compliance with regulations from start-up”. One respondent pointed to “CQC registration” as a barrier to starting up, and another expressed concern about the initial costs involved in meeting government regulations (e.g. “Setting up costs and paper work involved additionally the numerous compliance requirements”).

Bureaucratic barriers to starting up a practice were sometimes linked to NHS contracts and relationships with PCTs (discussed in the next section). For example, one respondent expressed concern about how long it had taken to validate their NHS contract (e.g. “Applications and time required to validate contracts with both CQC and PCTs. Both seem very slow and departments run by non-dentist[s] make it very difficult to communicate with [them]”).

4.2.3 Barriers associated with NHS contracts

The third most commonly cited barrier relates to the NHS and PCTs. Again, it was often unclear in respondents’ comments whether they were referring specifically to problems that they had experienced in establishing their practice or to on-going difficulties related to running their practice.

A few respondents pointed to contractual relations with the NHS as the main barrier to running their practice, citing, for example,

“Contract issues”

“Constant changes in the NHS contract”

“NHS contractual relations”

“Problems with the PCT wanting to change the contract”

As one respondent put it, the availability of new contracts “depends on the PCT wanting new services and having financial resources to fund it”. A key barrier to establishing a new practice then is the shortage of available contracts when PCTs do not have the necessary funding available.

A few other owners highlighted a dearth of available practices for sale or NHS contracts as key barriers to becoming a practice owner:

 “[The] availability of practices for sale has made it very difficult to become a practice owner. The new NHS contracts have effectively capped the number of practices (private start-ups are notoriously hard to do) so demand to purchase any that become available is much higher”
“All NHS contracts are held by existing contract holders and it is very hard/nearly impossible for anyone new to get a contract since 2006”

“Nowadays availability of an NHS contract could be problematic”

Indeed, several respondents reported difficulties in getting an NHS contract or said that contracts were unavailable (e.g. “Absence of NHS contracts”; “Can’t get a NHS contract”; “Securing NHS contract”; “If under NHS, new contracts not available”; “No access to NHS contract when I started”).

Several participants pointed to a lack of NHS funding as a barrier to developing and expanding their practice:

“No chance to expand a 100% NHS practice due to funding cuts”

“Limitations imposed by NHS funding”

“No help from NHS with regard to funding”

“Limitations imposed by NHS funding”

“Not being able to get NHS funding”

Another owner expressed the view that the current contract system and the limited funding available is a barrier to starting up in the current dentistry market:

“Not half as many as new dentists would [start up] due to the contract nature of NHS GDS now and (non) availability of finance. Fortunately, [I] started this practice as a squat under old contract.”

This shortage of funding was linked to a perception that the value of NHS contracts and UDA values are too low and that this represents a barrier to both starting and running a practice; for example, they said that:

“Contracts themselves poor value”

“Contract value very low to start a new practice”

“Poor value UDAs”

“Poor contract value/poor value”

“Small NHS contract value”
The following excerpt points to a barrier or constraint associated with the current system in that, because contract values are fixed by PCTs, this makes it difficult for practices to increase the supply of dental care in response to increasing demand from patients:

“Practices with a good contract value are hard to find. In the fee per item days, this wasn’t an issue as long as there was potential for growth. With the current contract, contract values are restricted by the PCT. This means that there may be a demand and a potential supply present, but due to a lack of funding the supply is not utilised.”

In establishing or running their practices, a few respondents alluded to difficulties in their relationship with PCTs in general, citing difficulties in their “dealing” or “discussions with the PCT”. One respondent expressed his frustration starkly in the following excerpt:

“I tried to set up an NHS practice when the new contract came into being. The PCT has been a horrific organisation to work with”

A small number of practice owners reported that they had found PCTs to be unreliable partners. For example, one expressed frustration that PCT staff had been “unsure of legislation”. Another felt generally let down by their local PCT (“Having bought an existing practice, had promises made by PCT only to be let down regularly”). Yet another said that difficulties in relations with the PCT had undermined his morale (“Low morale due to difficulties with PCT and lack of coordination”) and another had found dealing with the PCT stressful (“Stress of paper work and dealing with PCT or CQC”).

Often respondents highlighted difficulties in their relationships with PCTs in the context of negotiating NHS contracts, and identified problems at every stage of the process:

First, some respondents pointed to difficulties with the tendering process:

“Contract negotiations/tendering process with local PCT was extremely difficult”

“Had to go through the tendering process”

Another respondent described how, after going through with the purchase of a practice, the local PCT cancelled the NHS contract associated with his practice. This was because he had not been in a position to notify the PCT three months prior to the purchase date that he wished to take over the contract:
“I purchased my practice 5 years […] immediately after the purchase I was informed as a first communication by a stark letter from the PCT that all NHS contracts were cancelled due to the fact that I did not enter into negotiation 3 months prior to purchase with them about the existing contract. This was quite alarming as I was one of [number given] dentist[s] competing to buy the practice with a short list etcetera there was no 3 months’ notice that I would become the practice owner. They also indicated that they would take over and redistribute my existing patients to practices in my location.”

A few respondents referred to difficulties in negotiating the value of their contract (“Negotiating a UDA value”; “Negotiating UDA contract & contract value with PCT”). And one other respondent had found it difficult to obtain “a realistic contract from the PCT”.

Some practice owners were critical about the process involved in awarding NHS contracts. For example, one felt that the process had taken too long:

“Applications and time required to validate contracts with both CQC and PCT’s. Both seem very slow and departments run by non-dentist make it very difficult to communicate with”

Others found that PCTs had not always delivered on what had been agreed:

“Had difficulty converting residence to a dental surgery, had to go to the council for decision, the PCT promised but did not give the contract which was promised causing a lot of financial strain”

“[Name of NHS agency] let me down totally on the financing of a new NHS practice under the then new contract. Promises were never fulfilled”

“PCT verbally promised full contract for 2 dentists and then only gave us UDAs for 1 dentist”

A few respondents perceived some unfairness in the process of tendering and awarding contracts, with PCTs being seen to favour “corporates” or being unwilling to award contracts to younger owners:

“Competition with corporates - a PCT that favours corporates […] unfair competition”

“PCT unwilling to give contracts to young practice owners […] big practices/corporates are preferred to single handed and more favoured”
These views were echoed by others who pointed to the advantages that corporate dentists have in competing for tenders because of the resources they have at their disposal:

“Now it is extremely difficult to set up a new practice, corporate bodies have many advantages in that they have dedicated teams whose sole function is to buy/set up new practices. The tendering process is arduous and off-putting for individual practitioners.”

“Competitive tendering for single practitioners is burdensome and very stressful. Feel cannot compete that well with salaried service and corporates who have dedicated teams to place tenders.”

Some pointed to difficulties in transferring NHS contracts:

“PCT obstacles with no clear rules for transfer of ownership”

“PCT reluctance to transfer contracts”

“Difficulty in taking my own NHS contract to start my own practice”

“The PCT was very reluctant to transfer the PDS (Orthodontics) contract to me”

Whilst many alluded to difficulties they had experienced in their dealings with PCTs, a few felt that there had been a lack of support or help available from PCTs or other NHS organisations:

“No help/support from NHS”

“No help given from health service”

“No help or advice from PCTs”

“PCT poor attitudes. Poor PCT support”

Finally, another underlying theme in these accounts was a perceived imbalance of power between the NHS/PCTs and practice owners. Some expressed frustration with a system in which the NHS and PCTs are the dominant partners:

“Nowadays, it is a nightmare to keep running the practice. You cannot even sell your practice easily. The PCT has got all the power”
“The NHS can force to alter or take away our contract. So we can lose everything. The NHS has no risk!!!!!”

“PCT - an unaccountable body that has the power to interpret current guidance in any way they think fit leaving to vast differences in the power they exert over a practice depending on which PCT you are in. Also, the firm belief that they now ‘own’ the goodwill of a practice.”

4.2.4 Other barriers

Costs of setting up a practice

Some 13 per cent identified the costs involved in becoming a practice owner as a barrier (Table 4.3). Such respondents mostly referred to the high costs involved in setting up a practice, with some specifically referring to the cost of property or premises, equipment, and insurance.

Market barriers

Around 12 per cent of respondents who experienced barriers becoming an owner referred to difficulties linked to the dental market (Table 4.3); for example, they reported difficulties in finding a practice or partnership to buy either because there were none for sale or they experienced competition from other buyers. Others found it difficult to find appropriate premises in the right location. Finally, a few referred to barriers associated with the local dental market; for instance, one respondent described the market as ‘saturated’, and a few cited difficulties in attracting enough patients.

Legal barriers and planning permission

Around one in ten respondents referred to barriers associated with the planning system (Table 4.3). Such barriers included the legal costs involved or the time involved in obtaining planning permission.

Staffing and employment

Several respondents (almost one in ten) expressed difficulties with staffing or employment (Table 4.3). Again, it was sometimes unclear whether these barriers related to running their main practice or to difficulties experienced when starting up. Common concerns highlighted in this category included:

- Maternity leave;
- Employment law and regulation;
- Training of staff;
- Managing and dealing with staff;
- Difficulties with associate contracts.
Individual barriers
Around six per cent of those who had experienced barriers cited individual or personal difficulties (Table 4.3). For example, a few said that they had initially lacked the skills, business knowledge or experience to run a practice. Others said that they had lacked confidence or had found it difficult to adjust to the level of responsibility involved. Finally, two practice owners believed that being a woman had made becoming a practice owner more difficult, and one other cited racism as a barrier.
Appendix I Invitation letter to practice owners

30 October, 2011

Salutation,

OFT investigation - Practice owner survey

I am writing to invite you to participate in a survey we are currently conducting of practice owners. We are conducting this survey as part of the BDA’s response to the Office of Fair Trade’s (OFT) study into the UK dentistry market.

Last month, the (OFT) decided to undertake a market study into the market for the provision of dental services. They are aiming to assess how well the UK dentistry market is working for consumers. The OFT previously looked at the dental market in 2003, when they carried out a study into private dentistry. That report generated a number or recommendations and subsequently the GDC revised its guidance to dentists regarding choice, pricing of information and systems of redress.

The British Dental Association (BDA) plans to respond to the market study with a submission of evidence including relevant economic arguments, information, policy positions and recommendations. This will require that we conduct new research into the dental market and, as part of this research, we have decided to survey practice owners about their views and experiences. The survey will look to understand patient information, choice and methods of redress across the UK.

The findings from this survey will be invaluable for the BDA and the evidence submission to the OFT market study. Every response we receive helps to ensure the results are representative of all dentists.

You will shortly receive an email inviting you to participate in this survey. I would be most grateful if you would follow the link in the email and complete the questionnaire. It should take you no more than 10 minutes to answer the questions and all information gathered will be kept strictly confidential. I have also attached to this letter an information sheet which gives you more background to the research.

Due to the time restrictions placed upon us we would be grateful if you could complete the survey by the XXX November.

If you are interested the scope of the investigation and OFT press release they can be found by following this link (http://www.oft.gov.uk/OFTwork/markets-work/market-studies-further-info/current/dentistry/).

Thank you in advance for any assistance you are able to provide and for taking the time to participate. If you have any questions, comments or concerns regarding this
survey, please do not hesitate to contact Martin Kemp or Henry Edwards, BDA Research Unit, on 020 7653 4135 or at martin.kemp@bda.org.

Yours sincerely,

Dr Susie Sanderson
Chair of the BDA's Executive Board
Appendix II Practice owner survey schedule

BDA Practice Owner survey, November 2011

This survey is for practice owners assessing their perception of choice and competition in the UK dentistry market.

1. Are you a practice owner?
   Yes
   No

Section A. About your practice

In this first set of questions, we would like to ask you a few questions about your own practice.

2. How would you describe your main practice*?
   General practice
   Specialist practice
   Other

*‘Main practice’ refers to where you undertake the largest number of clinical sessions each week

3. How would you describe the location of your main practice?
   Rural
   Urban

4. How long have you been the owner of your current practice?
   [ ] years

5. Which of the following groups are you taking on as new patients in your practice?

   (Please select as many as apply)
   NHS children
   NHS exempt adults
   NHS non-exempt adults
   Private children
   Private adults

6. Is your practice owned by a corporate body?
   Yes
   No
7. Including yourself, how many dentists work in your main practice?

[     ] No. of dentists

8. Do you employ/engage any hygienists in your practice?

Yes
No

9. Which sets of patients does your hygienist(s) treat?

Private patients only
NHS patients only
Both NHS and private patients

10. Do you employ/engage any dually qualified hygienists/therapist in your practice?

Yes
No

11. Which sets of patients does your dually qualified hygienist/therapist(s) treat?

Private patients only
NHS patients only
Both NHS and private patients

12. Do you employ/engage any therapists in your practice?

Yes
No

13. Which sets of patients does your therapist(s) treat?

Private patients only
NHS patients only
Both NHS and private patients

Section B. Competition

The next set of questions relate to your perceptions and experience of the local dental market in the area where your practice is located.

14. Please read each of the statements below and indicate how strongly you agree or disagree with each statement

*The ‘dental market’ is defined as the market for the provision of dental services. This includes the dental services provided by both NHS and private practices in the UK.
<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) “The dental market in my area is working well”</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>b) “The dental market in my area is overcrowded”</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>c) “The prices charged for private services by my practice are influenced by competition with other practices”</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>d) “The quality of service my practice provides is influenced by competition with other practices”</td>
<td>[ ]</td>
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<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>e) “In my dental practice, I would not object if patients could directly access dental hygienists or dental therapists without first being examined by a dentist”</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>f) “Outside a dental owned practice, I would not object if patients could directly access dental hygienists or dental therapists without first being examined by a dentist”</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>g) “Patients should be able to directly access dental hygienists or dental therapists without first being examined by a dentist”</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</table>
15. Do you advertise your practice?

Yes (please specify below how you advertise your practice)
No

16. How do you advertise your practice?

(Please select as many as apply)

Newspaper adverts
TV/radio adverts
Leaflet/flyer
Internet
Signage
Yellow pages
Other (please specify):

17. How far ahead is the first available appointment with a dentist in your practice?

[ ] working days

18. How would you rate current levels of patient demand at your practice?

Very high demand
Moderately high demand
Neither high nor low demand
Moderately low demand
Very low demand
Don’t know

19. Did you experience any barriers or difficulties in becoming a practice owner?

Yes (please specify below)
No
Don’t know

Please tell us more about the barriers or difficulties that you experienced in the space below:
Section C. Patient decision-making

Next we would like to ask you some questions about patient decision-making.

Thinking about dental patients in general…

20. Please read each of the following statements and indicate how strongly you agree or disagree with each statement.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat agree</th>
<th>Strongly agree</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) &quot;Patients understand which treatments are available on the NHS&quot;</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>b) &quot;Patients understand what treatment(s) are available privately&quot;</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>c) &quot;Patients are well informed about the cost of their treatment before their treatment starts&quot;</td>
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<td>[ ]</td>
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<td>[ ]</td>
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</tr>
<tr>
<td>d) &quot;Patients are able to switch to another dentist freely&quot;</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Now, thinking about your own practice…

21. How are patients able to book an appointment at your practice?

(Please select as many as apply)

Telephone
Face-to-face
Email
Internet
Don’t know
Other (please specify)
22. Do you inform your patients of your fees or charges prior to treatment?

Always
Sometimes
Never
Would prefer not to say

23. What approximate proportion of your patients do you provide NHS care for?

100% (Exclusively NHS patients)
75-99%
50-74%
25-49%
1-24%
0% (Exclusively private patients)
Don’t know
Would prefer not to answer

Section D. Fees and charges

Now we would like to ask you some questions about the fees that you charge at your practice.

24. How do you set charges for private dental treatment in your practice?

(Please select as many as apply)

Use the BDA advice on private practice
Find out what other neighbouring practices are charging
Seek advice from an accountant
Based on NHS fees
Use an hourly rate for time taken, and then add the average laboratory fee
Charge what I feel is correct
Other (please specify below)

25. Please specify the average time (in minutes) it takes to perform the following treatments on an adult patient?

a) New patient examination
   [ _______ ] minutes
b) Normal recall examination
   [ _______ ] minutes
c) Simple scale and polish
   [ _______ ] minutes
d) Hygienist simple scale and polish (if appropriate)  
[ ] minutes  
e) Extraction (1 tooth)  
[ ] minutes  
f) Small composite filling  
[ ] minutes  
g) Large sized amalgam  
[ ] minutes  
h) Large posterior filling  
[ ] minutes  
i) Medium sized upper metal partial denture  
[ ] minutes  
j) Bonded molar crown  
[ ] minutes  
k) Veneer (per tooth)  
[ ] minutes  
l) Tooth whitening (both arches)  
[ ] minutes

26. Please tell us what private fees you would charge for the following items for an adult patient.

a) New patient examination  
[ ] (£)  
b) Normal recall examination  
[ ] (£)  
c) Simple scale and polish  
[ ] (£)  
d) Hygienist simple scale and polish (if appropriate)  
[ ] (£)  
e) Extraction (1 tooth)  
[ ] (£)  
f) Small composite filling
g) Large sized amalgam

h) Large posterior filling

i) Medium sized upper metal partial denture

j) Bonded molar crown

k) Veneer (per tooth)

l) Tooth whitening (both arches)

27. How do you communicate your private fees or charges to patients?

(Please select as many as apply)

Display charges in waiting room/reception
Display charges in the window
Display charges in surgery
Provide patient information leaflets
Discuss costs prior to treatment
Other (please specify)

28. Do all the dentists within your practice charge out at the same rate?

Yes
No
Not applicable
Don't know
Section E. Complaint and redress

The following section asks questions about the complaints and redress systems in your practice.

29. Does your practice have a written complaints procedure or policy that is available to patients?
   Yes
   No

30. What is your policy based on?

   (please select as many as apply)
   BDA guidance
   NHS requirements
   Own policy
   Other (please specify)

31. How do you communicate this policy to your patients?

   (please select as many as apply)
   Display policy in waiting room/reception
   Display policy in surgery
   Display on website
   Patient information leaflets
   Discuss with patients
   Other (please specify)

32. Has your practice received any complaints in the past two years?

   Yes
   No
   Don't know
   Would prefer not to say

33. How many complaints have you received in the past two years?

   [   ] no. of complaints
34. Which organisation(s) did your patients file complaints with?

(please select as many as apply)

Dealt with within the practice
PCT/Health Board/Local Health Board
Ombudsman
General Dental Council
Dental Complaints Service
Patient Advice and Liaison Services (PALS)
Would prefer not to say
Other (please specify below)

That was the last question! Thank you for sharing your views with us and for giving up your time to take part in this study

When you press ‘Done’ your answers will be submitted to us. Thank you
Appendix III Coding frame: barriers to becoming a practice owner

Barriers to starting up - Market factors
- Difficulties in finding a surgery/practice to buy (none for sale, difficulties finding premises etc.)
- Finding a partnership
- Competition with other buyers or Corporates
- Barriers to do with the local dental market (e.g. ‘saturated’)
- Wider economic/market conditions
- Difficulties in attracting/referring patients
- Finding the right location/localising the practice

Barriers to starting up - NHS
- NHS - General
  - Difficulties in getting an NHS contract – the ‘NHS Market’
  - Difficulties associated with NHS/PCT contracts, difficulties in working with PCTs

Barriers to starting up - legal/planning
- Legal barriers – high costs; time, etc.
- Getting planning permission

Barriers to starting up - costs
- High set up costs - generally
- High cost of equipment/premises
- Cost of property/surgery
- Getting insurance

Barriers to starting up - borrowing/raising capital
- Financial - general
  - Difficult in obtaining funding/obtaining private finance/capital – no financial value on goodwill, non-home owner, gender, etc.
  - Bank charges/interest rates on loans or conditions associated with bank loans

Barriers to starting up - regulation/bureaucracy
- Amount of paperwork/administration
- Rules and regulations/‘red tape’
- Impact of regulation: costs/work associated with ‘red tape’/over regulation/‘bureaucracy’ – meeting compliance conditions
- CQC/Central Government regulation
Barriers to starting up – staffing/employment
- Staffing/employment issues (e.g. maternity, employment law, regulation, training of staff, dealing with staff, etc.)
- Difficulties with associate contracts

Barriers to starting up – Individual barriers
- Lack of skills/knowledge/experience; especially in finance/financial management, business
- Personal barriers – e.g. confidence
- Too much responsibility; adjusting to responsibility

Discrimination
- Gender
- Race

Other
- Takes too much time
- Risks are too great
- Lack of support or advice
Bibliography


British Dental Association. 2010. Omnibus Survey


