IN BRIEF

- A group of UK general practitioners was approached for their strategies on fee setting.
- Dentists charge by hourly rate or fee-for-item according to the item of treatment.
- Clinical time spent is the most important factor in setting fees.
- The proportion of private treatment provided by a practice is a factor in whether fee-for-item or hourly rate is most used for fee setting.

Factors affecting fee setting for private treatment in general dental practice

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Objective To examine how pricing policies were contrived in general dental practice in terms of fee-for-item and hourly rate and how these were affected by specialist status and the level of private care provided in a practice.

Design A postal questionnaire.

Subjects Members of the British Society for General Dental Surgery working in dental practice.

Results Out of 160 eligible members, responses were received from 124 members (78%). Fifty-seven respondents claimed to specialise in one or more fields of dentistry. The majority of respondents consulted fellow colleagues or partners for advice on fee setting. A minority took external advice. The charging method varied according to the item of treatment with fee-for-item used predominantly for items such as a new patient examination, and hourly rate used more for items such as a direct composite restoration. Seventy-one respondents stated that their practice was 80–100% private treatment and these practitioners were significantly more likely to charge by hourly rate than fee-for-item for many items of treatment. Specialist status did not have any effect on charging method. The most important factors related to the setting of fees-for-item or hourly rate were clinical time spent, practice overheads and laboratory costs.

Conclusions This project has taken the views of a large group of experienced general dental practitioners, many of whom work purely in the private sector. The most important factors affecting fee setting were clinical time, practice overheads and laboratory costs. The method of charging was most affected by the proportion of private treatment provided by the practice.

General dental practitioners in the UK work either under the publicly funded National Health Service (NHS) scheme, under private contract or a mixture of both. Under the NHS scheme, dentists are paid mainly according to a fee-for-item of service basis. Many

practitioners feel that the models of pricing under the NHS do not reflect the true cost of providing care. Some items of treatment are not available under the NHS payment scheme. Such considerations have resulted in many dental practitioners opting to provide a proportion of or even all their treatment privately.

Under private contract, dentists can themselves determine both the levels of prices that they charge and also the pricing model, either on a fee-for-item basis or on a time basis by hourly rate. There are no enforced guidelines but the British Dental Association does produce an advice booklet entitled *Fee setting in private dental practice*. This has sections on setting fees, raising fees, differential fee scales, mixing NHS and private treatments and capitation schemes.¹

The 2003 Office of Fair Trading report² on private dentistry in the UK has brought into focus both the level of fees and the method by which they are calculated. It is clear that pricing structures should be transparent so that patients know how they are being charged and at what level. There has been little research into how dentists set both the method of charging and the level of fees.

LITERATURE REVIEW

There is very little literature that deals directly with the pricing policies of dentists in the UK. The literature on this subject is mainly from the USA. It concentrates mainly on business management and economics in relation to dentistry and covers areas such as methods of evaluating dental care costs,³ patient-friendly financial options,⁴ dental insurance plans⁵ and local competition.⁶

Having flexible payment options ensures that the patients have more choice in the methods of payment available. This can positively increase patient willingness to proceed with a proposed treatment.

The number of dentists in an area may affect charges for treatment due to increased competition. When considering a major expenditure, patients are more likely to seek a second opinion before committing themselves. A study into the relationship between the price of services, quality of care and patient time costs for general dental practice found that price of services and quality of care were positively correlated to each other.⁷ Shorter waits for a new patient appointment were associated with higher prices. The implication of such findings is that if the price of services is constrained, then the quality of care provided by the dentist may also be reduced.

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AIMS AND OBJECTIVES

The aims of this study were to examine how the pricing policies in this sector of treatment are contrived. The objectives were to determine:

- Who practitioners sought advice from in fee setting
- What type of charging method (hourly rate or fee-for-item) was more used
- Factors involved in calculating rates
- The effect of specialist status on fee setting and charging method
- The effect of the proportion of private treatment provided in a practice on the determination of costs

METHOD

A questionnaire was developed, piloted and distributed to general dental practitioners in the Greater Manchester area. The results of this study were interesting but limited by the number of dentists who were in wholly or mainly private practice. The Independent Practitioner's Group of the British Dental Association was approached for help but access to their mailing list of members was denied due to the constraints of the Data Protection Act. Subsequently, the British Society for General Dental Surgery (BSGDS) was approached for permission to sample its members for their opinions. BSGDS members are all holders of the diploma of Membership in General Dental Surgery (MGDS) from one of the UK Royal Colleges. This qualification denotes the achievement of a high standard of clinical skill and practice management^{8,9} and MGDS holders have therefore proved themselves to be in the upper echelons of general dental practice. From the BSGDS membership list, any member who stated that he/she was retired, in the armed forces or in hospital or university practice was excluded from the sample as ineligible. A postal questionnaire was developed and sent to all apparently eligible BSGDS members using Dillman's Total Design Method.¹⁰ One follow-up mailing was made to non-responders and an incentive was offered for returning the questionnaire.

RESULTS

A total of 182 questionnaires were sent out and 146 replies were received (80% response). Twenty-two subjects were deemed ineligible, 19 of whom were either recently retired or not in dental practice. Three questionnaires were returned as the subjects were not at the address provided.

Out of an eligible sample of 160, there were 124 usable responses, giving an overall response rate of 78% (Table 1). The response rate for male and female subjects was similar but the number of female subjects was low, only 9 in total. There was a significant difference in the response rate by year of graduation (chi-squared = 7.94, $P < 0.02$). Those qualified between 1970 and 1980 had the highest rate of return and those qualified after 1980 the lowest.

Fifty-seven respondents (46%) claimed to specialise in one or more fields of dentistry (Table 2). The questionnaire did not ask whether they were on the GDC specialist register. The most common specialist fields quoted were fixed and removable prosthodontics and general restorative dentistry, followed by periodontics, endodontics and implantology. Two respondents claimed to specialise in the area of occlusion and temporomandibular joint disorders.

When asked if they consulted anyone when deciding on pricing regimens, 102 respondents (82%) said they did. Some gave multiple answers but the most popular choice was fellow colleagues either within or without the practice (Table 3). Few claimed to use the BDA or GDPA fee guides.

Respondents were asked what method of charging they used for thirteen items of treatment ranging from a new patient history and examination to full upper and lower dentures. The options were FFI (fee-for-item), HR (hourly rate) or a mix of both. There was also a

Table 1 Response rate by gender and year of graduation

	Response	No response
All	124 (78%)	36 (22%)
Male	117 (77%)	34 (23%)
Female	7 (78%)	2 (22%)
Qualified 1943–1969	45 (78%)	13 (22%)
Qualified 1970–1980	59 (86%)	10 (14%)
Qualified 1981–2000	20 (61%)	13 (39%)

Table 2 Clinical areas of the 57 respondents who claimed to be a specialist (some respondents noted more than one specialist area)

Clinical area	Number
Fixed/removable prosthodontics	20
General restorative dentistry	20
Periodontics	11
Endodontics	11
Implantology	7
Oral surgery/surgical dentistry	6
Orthodontics/paediatric dentistry	6

Table 3 Sources of advice on pricing and charges ($n = 102$)

Source	Number
Fellow colleagues/partners	67
Accountant	27
Private health care insurers	25
In-house research	18
Financial consultant	9
BDA/GDPA fee guide	7

Table 4 Charging method by item of treatment

Charging method	New patient examination	Direct anterior composite	Metal–ceramic crown
Fee-for-item (FFI)	72 (59%)	48 (40%)	70 (57%)
Hourly rate (HR)	29 (24%)	46 (38%)	16 (13%)
Mixture of FFI and HR	18 (15%)	20 (16%)	29 (24%)
Treatment not provided	3 (2%)	7 (6%)	7 (6%)

column if the dentist did not provide a particular item of treatment. Three illustrations are given in Table 4. Fee-for-item is predominant for a new patient history and examination but nearly a quarter of respondents charge for this on an hourly rate. For the placement of a direct anterior composite restoration, the percentage of respondents using fee-for-item and hourly rate is similar. The percentage using hourly rate alone for a metal ceramic crown is the lowest with nearly a quarter using a mixture of charging methods.

Respondents were asked to estimate what percentage of the treatment provided in their practice was under private contract. The options were 0–20%, 21–50%, 51–80% and 80–100%. Seventy-one respondents (57%) stated that their practice was 80–100% private treatment. There were significant differences in the charging methods used by these practitioners for some items of treatment. They were more likely to charge by hourly rate than fee-for-item for a history and examination, scaling, direct amalgam and composite restorations and endodontic treatment. Table 5 shows that the percentage of dentists in mainly private practice who

Table 5 Charging method (FFI, HR or a mixture) for a new patient examination, a direct composite restoration and a metal-ceramic crown by the proportion of private treatment provided at the practice (< 80% v > 80%).						
	New patient examination		Direct posterior composite		Metal-ceramic crown	
	< 80%	> 80%	< 80%	> 80%	< 80%	> 80%
FFI	35 (66%)	37 (54%)	25 (47%)	16 (23%)	34 (64%)	36 (52%)
HR	6 (11%)	23 (33%)	8 (15%)	40 (58%)	3 (6%)	13 (19%)
Mixture	10 (19%)	8 (12%)	16 (30%)	10 (15%)	12 (23%)	17 (25%)
Not provided	2 (4%)	1 (1%)	4 (8%)	3 (4%)	4 (7%)	3 (4%)
<i>P</i> < 0.05			<i>P</i> < 0.001		NS	

Table 6 Factors affecting the hourly rate charged in order of importance			
Factor	Very important	Important	Not important
Practice overheads	93 (77%)	24 (20%)	4 (3%)
Dentist specialisation	55 (47%)	44 (37%)	19 (16%)
Ownership of the practice	23 (20%)	34 (29%)	59 (51%)
Rates of other dentists in the area	22 (19%)	50 (43%)	45 (38%)

charge by hourly rate for a new patient examination is three times greater than dentists in practices with less than 80% private work. For the placement of a direct posterior composite restoration the difference is even more marked. Fifty-eight per cent of mainly private dentists charge by hourly rate compared with 15% of the others. For metal ceramic crowns the trend was the same but the difference was not statistically significant.

In calculating their hourly rate, dentists were asked to rate the importance of four factors as very important, important, or not important (Table 6). Practice overheads had the highest rating of very important followed by the degree of the dentist's specialisation. Ownership of the practice and comparison with other dentists in the area were rated as less important.

An open question asked respondents how they calculated their fees per item. A number of factors were raised by the 118 respondents who replied (Fig. 1). Many quoted more than one factor. Factors relating to the dentist's hourly rate, the laboratory costs and the clinical time spent were the most mentioned items followed by material costs. Ten respondents mentioned the degree of difficulty of the procedure or the patient to treat as a factor that was costed in. Nine respondents based their fees on NHS fee rates and eight mentioned the fees charged by other practitioners in the area – 'the market rate'.

Respondents were asked to rate the importance of various factors when determining the fee for a metal-ceramic crown in a molar tooth (Table 7). Clinical time used and laboratory costs were always important for the vast majority of respondents. The dentist's experience and degree of specialism was the next most highly rated followed by the cost of the materials and equipment used. Patient factors such as the degree of patient co-operation were sometimes important for over half of the respondents but competition from other practitioners in the area and the time of the appointment were not rated as important.

The final open question asked which single factor was the most important (Fig. 2). Clinical time spent was stated by 43 (37%) of those who responded to be the most important. Maintaining profit or net income was mentioned by 13 respondents and laboratory

Table 7 Factors affecting the setting of a fee for a metal-ceramic crown by level of importance				
Factor	Always important	Sometimes important	Rarely important	Never important
Dentist clinical time	104 (90%)	8 (7%)	3 (3%)	0
Laboratory costs	97 (84%)	14 (12%)	3 (3%)	1 (1%)
Clinician's experience or specialisation	60 (54%)	28 (25%)	16 (14%)	7 (6%)
Material costs	42 (38%)	37 (33%)	24 (21%)	9 (8%)
Patient anxiety or co-operation	10 (9%)	58 (51%)	24 (21%)	21 (19%)
Local competition	6 (5%)	6 (5%)	38 (33%)	65 (57%)
Time of day of the appointment	3 (3%)	11 (10%)	31 (27%)	68 (60%)

Fig. 1 Factors in calculating fees per item (n = 118, multiple responses given)

Fig. 2 The single most important factor in determining fee-for-item charges ($n = 116$)

costs by 12 respondents. Eleven respondents mentioned that fee setting was influenced by patient factors including the acceptability of fees, the 'reasonableness' of fees, and the patient's willingness to pay a certain level of fees. The quality of work, clinical standards, and the dentist's skill and experience were also mentioned.

DISCUSSION

Because most general dental practitioners in the UK work mainly under NHS regulations where the fees are set on a national basis, this study was aimed at a group of dentists who were more oriented towards private or independent practice. This was not a random sample of dentists and therefore the results cannot be claimed to be representative of all dentists in the UK. However, it is the first time that such a large group of experienced practitioners has been approached in the UK for their views on fee setting and charging methods. Because of the constraints of the Data Protection Act, access to lists of dentists and in particular organisations is severely restricted. Assurances were given to the Council of the BSGDS that all information gained would be kept totally confidential and that the list of members would be destroyed once the research had been completed.

Less than half the respondents claimed to specialise in a particular area of dentistry. This is not surprising as the MGDS is not a specialist examination. Indeed, it has been said that any competent, mature general dental practitioner should be able to pass the examination provided they prepare thoroughly.¹¹

The different charging methods for different items of treatment reflects the predictability of the procedure but also a desire for clarity in patient charges. With a new patient examination, a dentist has no clue in advance of the complexity of the case and therefore how long the examination and treatment planning will take. However, new patients will always want to have an exact idea of how much this stage will cost. It is therefore a compromise with the dentist estimating the time to be spent and therefore quoting an exact fee in the majority of cases. Once the patient has been examined, it is easier for the dentist to predict treatment times and therefore costs. With direct restorations, such as anterior composite, more dentists charged on an hourly rate than for a metal-ceramic crown. However, this does not stop the dentist from quoting a fee for a composite restoration in advance, it is just that the fee is calculated in a different way and may vary from one restoration to another, depending on the size and complexity. With a metal-ceramic crown, the procedure is more predictable and there is therefore likely to be less variability from one crown to the next, in the same patient.

The finding that dentists who were predominantly private tended to use an hourly rate for calculating fees rather than fee-for-item, is probably a reflection of greater experience of private practice and therefore the times and costs applying. It might also be

argued that these practices are run on more exact business lines with more precise calculation of practice expenses.

Despite the plethora of financial advice available from various sources, the majority of respondents did not use any external or non-dental help in calculating their fees or hourly rate. The survey's non-responders were more likely to have graduated between 1981 and 2000. It is possible that these more recent graduates may have different and perhaps more modern attitudes to the financial aspects of dental practice.

The Office of Fair Trading has just reported on their investigation into private dentistry prompted by the 'super-complaint' brought by the Consumers Association. One of the conclusions of their report was that consumers should have more information on fees and charges. This should not only be a list of guide prices for the range of treatments provided but also the method by which the patient is being charged. The more transparent the fee structure is, the smaller the chance of misunderstanding or dispute between dentists and patients.

CONCLUSIONS

This project has taken the views of a large group of general dental practitioners, many of whom work purely in the private sector. The most important factors affecting fee setting were clinical time, practice overheads and laboratory costs. The method of charging was most affected by the proportion of private treatment provided by the practice.

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