

Alignment of interests in private practice

Is the CQC hungry to poke its nose into the 'fat cats' business?



News comment

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It has been interesting to see the early actions of the CQC that has been keen to start interviewing private practices who have, to date, been operating beyond the jurisdiction of PCTs – although, to labour the point, nevertheless under the full regulation of the GDC. I believe that the CQC has been quite open about their perception of the need to get right into independent practice, and there is a sense that they feel that the opportunity to poke their noses into these private businesses cannot come soon enough. This seems to mirror the attitude that exudes from the Department of Health and, indeed, the chief dental officer that, because it hitherto has operated outside the clutches of the state sector, something must be wrong with private practice. It is worth noting that, in 22 years of dealing with practices moving to the private sector, my experience is the overriding reason for conversion is to enable practices to spend more time with patients to produce a better outcome in a way that dentists feel is no longer possible for them under the NHS. It is not to

become 'fat cats' screwing money out of patients while letting them down. Indeed, the NASDA figures showing that average private principals earn less than NHS counterparts bear this out. Of course, in any walk of life, there will be the odd bad apple, but one should step back and consider the dynamics of private practice.

Whereas, under the NHS, patients effectively have to receive what is on offer and dentists get a ready supply of patients whatever the real standard of care, the patient/dentist relationship in private practice is totally different. This arrangement is, of course, subject to the natural circumstances of competition. If a practice charges too much, or misleads the patient regarding costs, the patient will go elsewhere. If a dentist provides unsatisfactory treatment, the patient will go elsewhere. If the practice surroundings are not attractive and welcoming, or if the practice does not display a good professionalism or approach, the patient will go elsewhere.

In private practice, if the patient isn't satisfied with the outcome of the dental 'encounter', the business is likely to lose that patient and suffer from adverse word-of-mouth publicity, and the fortunes of the practice will suffer. The earnings potential of the practice will diminish in a way that simply does not happen under the NHS. There is an alignment of interests between private patient and dentist, and I believe this provides a far better regulation to maximise patient outcome than the CQC ever will.