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Draft CED Resolution

Corporate Dentistry in Europe

FOR APPROVAL – NOVEMBER 2018 GENERAL MEETING

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I - INTRODUCTION

The Council of European Dentists (CED) is a European not-for-profit association which represents over 340,000 dentists across Europe. The association was established in 1961 and is now composed of 32 national dental associations from 30 European countries.

The growth of corporate dentistry in Europe is a significant development as regards the provision of dental care and treatment. It has implications for oral health policy as well as carrying professional and commercial implications for dentists who are contracted by these organisations.

The CED is concerned that commercial interests which are driving the business model of such organisations may impact patient safety[1] overall, through a variety of factors including provision of care, treatment and employment conditions. Case studies in Spain and France have shown worrying examples of dental chains' disregard for patient safety, leaving patients without proper care and in some instances even harming them.

This paper details the CED concerns and position on the issue of corporate dentistry.

II – CORPORATE DENTISTRY AND MARKET DEVELOPMENT

Corporate dentistry refers to organisations that set up dental offices in a number of locations, which can be in the same country or across different countries, employ dentists and are usually run by investment companies, with a main interest in return on investment instead of delivering good dental care to patients. Often, these organisations are not headed by a dentist but by a non-dentist manager. Such organisations can include, but are not limited to, dental clinic chains, non-for profits, charities, social enterprises, and for-profit social enterprises.

Private equity firms interested in what they consider an investment opportunity have started to buy individual practices and smaller groups of practices to form chains in a number of countries. As a consequence, dental groups are expanding and opening offices in different countries in the EU, some employing up to 1000 dentists across a number of countries. Such companies have branches in Switzerland, Norway, Sweden, Denmark, Finland, Italy, Germany, Belgium, the Netherlands, France and the UK with the goal of establishing large dental chains in Europe.[2]

Across Europe, it appears that dental groups are most prevalent in Finland, where dental chains account for 35% of practices (in terms of numbers of dentists). Other countries with a large proportion of dental chains are the UK (24%) and Spain (25%).[3]

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[1] *Definition of patient safety: freedom, for a patient, from unnecessary harm or potential harm associated with healthcare;* Taken from the 2009 Council Recommendations on patient safety, including the prevention and control of healthcare associated infections

[2] Colosseum Dental, Management appointment at Colosseum Dental Group, 28 May 2018, http://www.colosseumdental.com/press/management-appointments-at-colosseum-dental-group-2/ / DentConnect, https://www.dentconnect.nl/?language=3

[3] KPMG, The dental chain opportunity, 2017: https://home.kpmg.com/xx/en/home/insights/2017/05/the-dental-chain-opportunity.html

III - CED CONCERN

Risk to the patients

The CED is primarily concerned about the safety of patients and the continuity of care offered to them. In this regard, the CED fears that the commercial drivers that are the foundation of the business model in corporate dentistry may, in fact, be detrimental to the health and well-being of patients.

A number of countries have already seen negative impacts on patients as a consequence of the methods employed by dental chains, where treatment decisions were taken on the basis of economic considerations. Worrying accounts from dental chains that were shut down in France and Spain reveal unethical practices and undue pressure on dentists to reach specific clinical targets, for example of quotas for placed implants. This has led to a string of court cases and caused great suffering to those patients that were mistreated and misled.[4]

In 2017, the Spanish dental chamber (Consejo General de Colegios de Odontólogos y Estomatólogos de España) reviewed the patient complaints that were received by the official Spanish dental associations and came to the conclusion that half of all patient complaints between 2013 to 2015 were related to dental chains even though they represented only 4 percent of dental practices in Spain then.

Some chains have resorted to aggressive marketing campaigns which misled patients. During such efforts, patients were confronted with inflated prices and deceptive discounts. The forced closure of a number of chains due to unethical behaviour and financial misconduct has left patients with unfinished treatments that were already paid for and led to great disruptions in the lives of these patients[5]. Through advertising and on-site pressure, such establishments may also push for treatments that are not medically necessary, thereby incurring additional costs for the respective healthcare systems and potential harm to the patient.

Risk to the workforce

It is evident that a business model that relies on large profits keeps pushing, and may sometimes overstep, the ethical boundaries regarding patients but also the treatment of its workforce. Complaints were made were dentists employed by dental chains who worked more than 12 hours a day, sometimes without being paid. Legal regulations regarding breaks and time off work were not respected. It has been recorded that absences due to anxiety and overload were extremely frequent. Clinical targets were also imposed on employed dentists[6].

[4] Natalie Huet, France's revolt of the toothless, 26 July 2016, Politico, https://www.politico.eu/article/revolt-of-the-angry-french-toothless-sans-dents-dentexia/

[5] See for example:

- Dentexia: https://www.politico.eu/article/revolt-of-the-angry-french-toothless-sans-dents-dentexia/;
- FunnyDent: https://www.abc.es/sociedad/abci-relatan-varios-clientes-estafa-funnydent-entre-porque-dolia-muela-y-sali-sin-media-boca-201602080716_noticia.html;
- iDental: https://elpais.com/ccaa/2018/08/03/madrid/1533318305_162005.html

[6] See examples above

Risk to the healthcare system

There is an inherent systemic risk to the provision of dental care where a chain or corporate entity providing dental care to a region or a large proportion of the population ceases its activities for whichever reason. Patients may be left without accessible care if the presence of the chain had previously led to a reduction of other dental practices in that area. Investors often apply the so-called buy and build strategy, where they buy – in this case - practices

(often pricing regular dentists out of the bid), then try to expand and sell at a profit after a few years. This runs contrary to the need for a long-term planning of healthcare systems.

IV - CED POSITION

While we recognise that the set-up of the dental practice may change in the future and that more reliable data is needed when it comes to dental chains, it is imperative that patient safety is safeguarded at all times. Therefore, the primary relationship in the delivery in dental care must always remain between the dentist and the patient who collaborate to develop strategies to ensure beneficial health outcomes. Financial considerations must not impact the treatment decisions taken in that setting.

The CED therefore calls for the following:

- Where legal persons established under private law are allowed to practice dentistry, these legal persons should only be founded and operated by dentists;
- Dentists, who are shareholders, should practice as dentists in the company;
- It should also be ensured that:
    - a) the company is run responsibly by a dentist; Chief executives have to be dentists;
    - b) the majority of the shares and voting rights are entitled to dentists;
    - c) third parties do not participate in the profits of the company;
- Corporate entities or investors must not hinder dentists from fulfilling their obligations as set out in the applicable code of ethics and national legislation;
- Corporate entities or investors must not have any influence on the treatment decisions taken by the dentist with the consent of the patient and must not be allowed to introduce clinical targets;
- Corporate entities or investors may not mislead patients through false advertisement, inflated prices or deceptive financing schemes.

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For adoption at the November 2018 General Meeting

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ANNEX – CASE STUDIES

Case Study 1: iDental – Spain

Context

iDental operated in Spain from 2014 until 2018. It had 26 centres with 100,000 square metres of facilities, all of which are currently closed, with approximately 2,500 employees, including dentists, nurses, assistants, hygienists, and receptionists. The investment fund Weston Hill acquired 100% of the company iDental for 25 million euros at the end of 2017, through the creation of an investment vehicle called Maxwell Capital.

iDental failed to comply with its obligations and clinical responsibilities, and its payment commitments to suppliers, employees, landlords, public administration and credit institutions. This resulted in the closure of all its clinics, non-payments and strikes of workers, and a flood of complaints filed by patients.

Business practices

The chain used advertising campaigns on social networks and in the media that misled patients on numerous topics, including their services and dental aid. iDental offered discounts on treatments costs ranging from 60-100% to patients in needs. However, these discounts were given on services with greatly inflated prices. Patients were time-pressured to take decisions or otherwise they would lose the so-called discounts.

Employer practices

iDental offered free postgraduate specialization that included a paid employment contract for young dentists (they now use the term IGD, International Global Dentist, Aula Zero). In fact, iDental offered the Master in Integrated Dentistry, Management and Implantology, with a duration of 3 years, accredited with 60 ECTS credits and endorsed by the University of Lleida and the University of Alicante. iDental subsidised 95% of the total cost of the degree to dentists working in their facilities, seemingly making it possible to reconcile work activity (paid salary) with specialised training.

However, none of these universities have a Faculty of Dentistry and are therefore neither in a position to offer these courses nor to endorse them. In addition, it has been found that the employed dentists worked more than 12 hours a day, sometimes without being paid. Legal regulations regarding breaks and time off work were not respected. It has been recorded that absences due to anxiety and overload were extremely frequent.

Complaints

From the outset, the number of patient complaints has been very high. It suggests that the centres were not complying with their obligations or with minimum standards.

The recipients of their services were people from a low-medium social class, who were duped by a supposed subsidy or reduction in the price of the treatments and now, due to the closure of the clinics, they have caused thousands of interrupted treatments with no dental attention. Furthermore, patients must continue to pay the loans that are financing their treatment.

The complaints include the following:

- The clinics refused to provide patients with their own medical records.
- A large number of professionals treated the same patient and therefore it was difficult to determine the responsible practitioner for the treatment.
- Non-compliance with clinical protocols, negligently carried out treatments and poorly sterilised instruments.
- Reaching informed consent was not possible due to inadequate or insufficient information.
- Inability to suspend loans that were provided to patients to fund their treatment which was subsequently interrupted after the closure of iDental.
- Poor cleaning of work boxes.
- No adequate invoices.
- Misleading/aggressive advertising referring to deceptive "subsidies".

Case Study 2: Dentexia – France

Context

Dentexia was a social enterprise that operated in France from 2012 until 2016. In its own words, its purpose was to promote access to dental care for all and especially for the poorest people. In fact, Dentexia focused on patients receiving universal medical coverage (CMU), which accounted for 2.8 million people in 2014.

In March 2016 a French court ordered the liquidation of Dentexia, which is believed to have accumulated 22 million Euro in debt during its four year existence.

The Health Ministry asked the French Government audit, evaluation and inspection office for health, social security, social protection, employment, work, community politics, professional structures and modernisation of the state (IGAS) to carry out an inquiry in the Dentexia case, which published a detailed report in July 2016.

Dentexia appeared legally as a non-for-profit association, but was in fact in business relations with a commercial company (selling or renting goods and services to the association): most of the profits thus went to the commercial entity.

Dentexia has also been sanctioned by the courts for unfair advertisement and competition practices towards private dentists. Following this jurisprudence, a decree was published in February 2018 in France, prohibiting advertisement by dental centres.

Business Practices

Dentexia required patients to pay for their care in advance, either through their own means or via a loan that was provided by Franfinance or Odotonlease. According to French law, such loans can be given upon receipt of a document certifying the (partial) execution of the treatment. According to the claimants, Dentexia signed such documents without the care having started. When Dentexia was closed down, there were unrealised treatments worth more than 1 million Euro in Marseille, 900.000 Euro in Lyon and several hundred thousand Euro in Paris.

Employer Practices

The IGAS report stated that instructions were given to salaried dentists:

- To reduce the number of sessions needed to remove teeth;
- To reduce the number of sessions needed to place implants and to therefore place more implants at a time;
- Not to explain to the patient what is being done during a session.

Patients were treated by different dentists and dentists moved between several centres. Due to this form of organisation, patients were not followed by the same dentist and treatment plans were not followed through.

Case Study 3: Funnydent - Spain

Context

Funnydent operated 9 clinics in Spain from 2012 until it closed down in January 2016 without any prior notice to patients or staff.

Funnydent also received a warning from the Spanish Ministry of Economics in 2014 regarding their misleading advertisement.

Business Practices

Patients were advised by commercial staff rather than by dentists which treatment they should consider. At the same time, they were promised stark discounts and given very limited time to take a decision before the discount would expire.

Patients had to pay for their treatment in advance, which meant that they could not change clinics even when they noticed that the situation in the clinics was not up to standards.

Employer Practices

Employees were reportedly not paid for the last months before the clinic closed down. A high turnover was reported in the practices, which meant that patients were often not cared for by the same dentist throughout their treatment.

Complaints

With the unannounced closure, many patients were left with unfinished treatments that were already paid for.

Case Study 4: Small Smiles Dental Centres[7]

Mission: 'to provide the highest quality dental care to low-income children in the Medicaid and (S)CHIP* populations.'

Operated: 70 clinics in 22 US states and the District of Columbia

[7] Source: E. O'Selmo (2018). Dental corporates abroad and the UK dental market. British Dental Journal 225(5). DOI: 10.1038/sj.bdj.2018.740

Parent Company: Church Street Health Management (CSHM) previously known as For Better Access (FORBA)

Owned by: Consortium of investment firms including Carlyle Group

Bought for: US$435 million in 2006

The US Senate examined the corporate practice of dentistry in the Medicaid program, primarily in the context of one company, Small Smiles. The Senate report was triggered by whistleblowing in late 2011 that initiated investigations by the Department of Justice (DOJ) and the Department of Health and Human Services Office of Inspector General (HHS OIG). Small Smiles was found to perform unnecessary treatments with the quality of care significantly below any recognised medical standard and cause serious trauma to paediatric patients with profit being placed ahead of patient care. The corporate structure of the dental management company appears to have negatively influenced treatment decisions by over-emphasising bottom-line financial considerations at the expense of providing appropriate high-quality, low-cost care. Small Smiles was the subject of a False Claims Act lawsuit and settled for US$24m with the US Justice Department with the DOJ settlement citing conduct from September 2006 – June 2010 including submitting Medicaid reimbursement claims for medically unnecessary pulpotomies, crowns, extractions, fillings, sealants, x-rays, anaesthesia and behaviour management; failing to meet professionally recognised standards of care and provision of care by unlicensed persons. CSHM, the largest dental management company in the US, entered into a Corporate Integrity Agreement (CIA)** with the Department of Health and Human Services, in order for Small Smiles to improve the quality of healthcare and to promote compliance to healthcare regulations. Small Smiles were required to institute compliance procedures and programs and submit to monitoring, by an Independent Monitor, including audits, site visits and changes to management. The company struggled to comply and repeatedly failed to meet basic quality and compliance standards. They continued carry out unnecessary treatment on children, administer anaesthesia inappropriately, provide care without proper consent and overcharge the Medicaid program. In February 2012 FORBA filed for bankruptcy protection before emerging under the name CSHM with the new ownership maintaining the previously held management services agreements that removed traditional ownership authority from dentists and limited their ability to exercise independent clinical judgment. In March 2012, due to CSHM's 'repeated and flagrant violation' of the CIA the HHS OIG recommended that CSHM be excluded from participation in Federal Health Programs. In 2014 it was announced that CSHM would no longer be allowed to use Medicaid or any other health programs of the federal government.

**The State Children's Health Insurance Plan was a program intended for children in families with too high an income to qualify for Medicaid but too low to afford private insurance*

***A CIA is an enforcement tool used by the HHS OIG to improve the quality of healthcare and to promote compliance to health care regulations*