Meeting Report

Countdown to Contract. Is NHS Orthodontics Finished?

The Specialist Practitioner Group of the British Orthodontic Society held its Practice Management Meeting at Guy's Hospital on Saturday 14 November. Orthodontic politics, speculating on the future of NHS orthodontics, was the subject for the meeting that attracted a record number of delegates.

The morning session consisted of four presentations. Professor David Gibbons, Consultant in Primary Care and Dental Public Health at Guys, started by setting the scene. He gave a resumé of the present structure of the NHS, thereby explaining the internal market, and how Health Authorities are responsible for purchasing effective quality services for prevention and treatment of disease in their population. The purchasers must determine the need and identify service requirement to meet the needs within the funds available. They then negotiate a contract with the provider. In summary, the whole idea of the internal market is to increase value for money by purchasing services for maximum health gain, clinical effectiveness, and appropriateness. However, problems arise because the purchaser, provider, and patient all have different priorities.

The new UK government are introducing Primary Care Groups, phasing out GP Fund Holders. These are to commission services for natural communities of about 100,000 people. They should all be set up by April 1999 and are led by local medical practitioners. They are to develop and provide primary care services, and implement health improvement programmes, working alongside secondary care and community health care services. Services will be commissioned in line with primary health improvement plans offering contracts running for 3 years to help continuity.

A dental version, PDS, gives dentistry an opportunity to be involved by negotiating local contracts and is intended to respond to local need. The first pilot started in October with local negotiation and, at present, no compulsion. A GDP may leave at anytime. It is generally felt to be the way things will go, especially for orthodontics, and we need to decide if this is a problem or an opportunity.

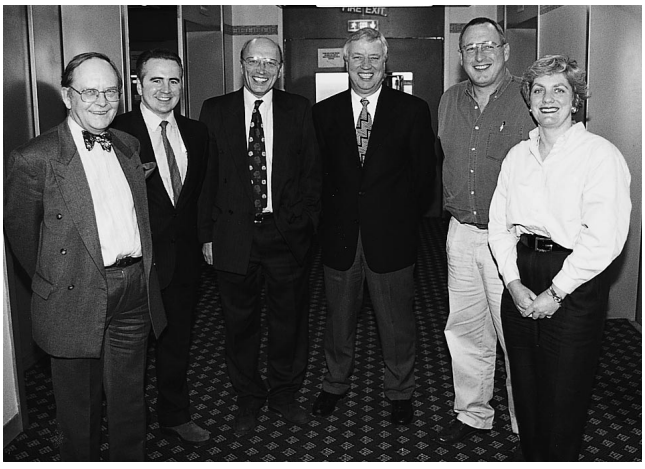
Unfortunately, the second speaker, who was to put the purchaser's point of view, failed to attend. We therefore moved swiftly onto Dr Chris Kettler, Specialist Orthodontic Practitioner, who put the provider's point of view. He is involved in one of the PDS pilots and took us carefully through his new contract. He explained the background to PDS, touching on historical NHS problems: the Schanshief and Bloomfield reports, the new contract; and the cut in fees in 1992. His local Consultant in Public Dental Health was instrumental in getting together with the local practitioners in his area to try and find a solution to local problems. These included: reduced manpower; long waiting lists; people in need being kept waiting; the general problem in NHS orthodontics of payment at the end of treatment; variable monthly payments; prior approval; sanctions on treatment; and timing of treatment. The result was their PDS contract: orthodontics is to be offered to under 18 years olds. It is a cost/volume contract, with a defined number of new cases starting each year from a defined IOTN scoring. More new screenings are to be undertaken and quality monitoring is to be carried out by the DPB at an increased rate. The funding will be paid to the practitioner in equal monthly instalments by the local health authority. The contract has the advantage for the Department of Health of being cash limited and prioritized. He summarized the advantages for the provider, but pointed out that income is fixed with no scope for increase in gross NHS income. The practitioner has also lost the protection of the nationally negotiated contract. Those patients who have no NHS qualification in this contract will either have no treatment or move into other geographical areas, the dental schools, or the private sector.

After a break for coffee, Professor Gibbons returned to the rostrum to provide an 'off-the-cuff' view from the purchaser. We are very grateful to him for filling in this gap in the programme. He started by explaining that the purchaser must first define oral health and also consider equity, i.e. the accessibility to services for the whole population. The contract must specify clinical and quality standards to safeguard against compromising service quality in the pursuit of a cost efficient service. Therefore, there is an argument for contracts not going to 'dabblers', but to 'centres of expertise'.

The final speaker of the morning was Dr John Renshaw for the BDA who started a dynamic presentation by announcing that 'the world is changing, ignore it if you like but it will sweep over you anyway. We have a responsibility to be aware if we are business people'. He went on to explain that the Minister of Health is not happy with the product he is buying. There are problems with the present contract. He spent time discussing contracting, who does the contract, and with whom. At present, GDS money is separate, but is likely to be swallowed up by the primary care group system. It would be looked after by local medical practitioners, who do not understand or care about orthodontics. The Oral Health Advisory Group hope that they will be able to persuade the primary care groups to set the dental money aside, but this is by no means guaranteed. It is important that we work together as a whole profession to ensure successful contracting for our incomes. To-date we have been protected by the national contract—now we must negotiate locally, and ensure we get it right or live with the consequences. We need to be prepared by knowing our market place, accurate unit cost, fixed overheads, variable costs, work flow, and capacity. We need to find out what constitutes a good contract and use professionals who understand our business to help us. We have a lot to offer—a top quality product at a sensible price for a person who wants it. Our skills are in high demand and compare favourably with the product available at hospital units.

We retired then for an enjoyable lunch and a chat. There

0301-228X/99/030000+00$02.00



Left to right: Dr C. Kettler, Dr R. Flanagan, Professor D. Gibbons, Dr J. Renshaw, Mr D. Ankerson, Dr S. Hill.

was an opportunity to browse around the Trade Exhibits, who always support this meeting so admirably.

The afternoon session started with an open discussion based on the mornings' presentations. This gave the delegates plenty of opportunity to ask questions of the speakers and expand on some of the subjects of the morning session. There was considerable interest in the PDS contract and Dr Kettler had to field quite a number of the questions. The audience obviously felt that this was where we would all be shortly.

The final speaker was Mr David Ankerson, a Business Consultant. He gave another stimulating presentation. He explained how business works emphasizing that we must understand our customers and the people who are paying us. Standing still is equivalent to going backwards. We must lead change or become a victim of it. We need to have absolute clarity about the market, our competitors, strengths, weaknesses, and our proposition. We must understand our resources, the capital required, our skills, time, and revenue costs. He discussed marketing at length and drew his presentation to a close by explaining competitive advantage—you have to be different to the other guy. The difference has a value; therefore, your service is one of choice by your customer that you can milk for all it is worth.

The meeting was certainly stimulating and gave us all a lot to think about. Our thanks go to Colin Wallis who organized the day. We all look forward to the next SPG Meeting—our Clinical Day to be held at the RSM on the 6 March 1999.

MOIRA BROWN