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New Contracts for Specialist Orthodontic Practitioners?

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Abstract. *This paper discusses the possibility of new forms of contacting or commissioning emerging between UK Health Authorities (or other parties such as Primary Care Groups and Primary Care Trusts) and established providers of specialist orthodontic services.*

Index words: Commissioning, Contracting.

Throughout this paper, which is written specifically for the specialist orthodontic practitioner working within the U.K. NHS market, the words *contracting* and *commissioning* are interchangeable.

The key questions to be considered are as follows:

1. Who might be commissioning orthodontic services in the future?
2. Who will be providing orthodontic services in the future?
3. What is a contract, anyway?
4. What does a provider need?
5. What services can the provider sell?

Who Might be Commissioning Orthodontic Services in the Future?

The traditional place of the specialist orthodontic practitioner working within the main National Health Service (NHS) General Dental Service (GDS) framework may be a thing of the past. The familiar pattern of working has come in for very heavy criticism from all sides. The specialist practitioners have maintained that the NHS GDS fees paid are deplorable, but the amount of orthodontic work being carried out in the GDS has exploded over recent years. The traditional paymaster, the Department of Health (DoH), has regularly insinuated that too much treatment has been carried out, but has done precious little to control the flow of money into the pockets of specialist practitioners, preferring to avoid a confrontation. This established position may be about to change with the publication of a new strategy paper on Fraud in the NHS (4). At the same time as the Department of Health and the orthodontic practitioners have agreed to differ, patients and referring general dental practitioner colleagues have complained about poor availability, accessibility and long waiting times for orthodontic treatment to begin.

This whole scenario is unsatisfactory, everybody seems to be unhappy! This is, therefore, a recipe for substantial change in the foreseeable future. Perhaps the question that should be asked is, why has the current situation been allowed to go on for so long? The answer may have something to do with a mixture of political cowardice and a significant portion of indifference.

So, if change is inevitable, sooner rather than later, how might the orthodontic provider of the future be making a living? The chances are that he or she will still be carrying out orthodontic treatment on much the same patient group as now. What is at issue is how the treatment will be paid for and by whom.

The GDS will probably struggle on for a long time yet; after 50 years the old system is not going to disintegrate over night. What will emerge and begin to replace it are new forms of contracting organized on a more local basis. Orthodontists may well find themselves contracting with the local Health Authority (HA). Given the present changes, there may not be much of a Health Authority to talk to in future, so it may be the Primary Care groups (PCGs), emerging from 'The New NHS—Modern Dependable' (1), with whom they will be dealing. These groups, led by local General medical Practitioners, will not necessarily be sympathetic to the cause of orthodontics and especially the cost of providing it. The newly-formed PCGs will probably be converted within a couple of years into yet another, even more advanced life form—Primary Care Trusts (PCTs). They will have the responsibility of providing and developing the totality of primary care in their localities. This new melting pot is a challenge to all the various dental services and the orthodontic providers cannot afford to relax and take their eye off the ball!

Many PCGs have already agreed to have their relevant dental services effectively commissioned by groups of dentists called Oral Health Advisory Groups (OHAGs). These groups will advise PCGs on how best to organise and pay for dental services in their particular locality. For the moment, the GDS does not come into this new arrangement. OHAGs will be made up of general dental practitioners (GDPs), HAS, dental practice advisers, community dental services (CDS) representatives, hospital consultants, consultants in dental public health and Health Authority representatives (and maybe PCG representatives). Various others may be added/co-opted to create the full OHAG constitution. If services are to be determined by this group in the future, the local orthodontic practitioners need to get their act together so that they can play their part in this new decision making arena.

There is a possibility that orthodontics could become the subject of an 'arms length agency'. This popular arrangement (in other NHS situations) hands over the responsibility for the commissioning and provision of a service to a third party. The beauty of this approach is that the real commissioner can put the work out to tender and pass the

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management responsibility to someone else. A third party funder is not impossible to imagine, nor is it comfortable to contemplate. Having to deal with an organisation whose main purpose is to reduce costs, ma not be a welcome innovation.

Who Will be Providing Orthodontic Services in the Future?

The easy answer to this is obvious, the people who currently carry out treatment will surely be the ones who will be providing it in the future. Unfortunately, this is a very naïve and dangerous assumption. Given the high levels of dissatisfaction with the current arrangements, why would anyone want to perpetuate the existing set-up?

The treatment may well be provided by the same, trained professionals as before, but the contract will not necessarily be held by the,. The advent of the Personal Dental Services (PDS) (2) as a result of the Primary Care Act (1997) has shown that key providers can indeed create new contracting opportunities, but it would be dangerous to assume that the PDS will always work to the benefit of the practitioner. A 'free-standing contract' may have both advantages and disadvantages for the specialist orthodontic practitioner.

Would it be possible for the corporate bodies to establish a provider arm that deals solely with orthodontic treatment? Yes, it is possible but is it likely? Just stop for a moment and imagine the scenario—a sign above a major high street store in the centre of town saying 'Boots Dental Service Centre'. Underneath that, it may go on to say 'Quality NHS Orthodontic Care Available Here'. Would orthodontic practitioners feel able to compete with the marketing power of Boots the Chemist? A sobering thought!

Could the answer lie in more 'incorporation' and generic marketing by, say, 'BOS Yorkshire' or Berkshire Orthodontics Ltd? Would it be possible for a group of orthodontists to form a provider organisation to persuade the commissioners that they (BOS Yorks, etc.), and they alone can provide the quality and quantity of service that the local population need and deserve? Right now I would say the answer to that question is a resounding 'NO!', but the times they are a-changing and changing fast. This time next year, the first signs of such new arrangements may be emerging.

New answers to old problems are infinitely more attractive than going round the same tired old arguments over and over again. New alliances and new 'partnerships' will be needed in a new market place. There is strength in numbers. Commissioners will be looking for complete solutions to their problems not a diversity of little answers that have to be cobbled together somehow and then monitored separately.

What is a Contract Anyway?

Our comfortable familiarity with the GDS contract has led dentists into a false sense of security about contracts in general. The GDS contract is managed nationally and has evolved over fifty years. However, a contract is still a legally binding agreement. In health care circles, the contract usually concerns itself with the amount of work to be carried out (for example, a number of completed cases) and the amount of money to be paid for that set amount of work. The rest f the paperwork concerns itself with what happens when one or more of the conditions is not met by one party or the other. Once the contract is signed it has to be adhered to by both sides.

As long as everything goes according to plan the contract is never even looked at. It is only when things go wrong that someone pulls the contract out of the drawer and looks at what it says about the failure to achieve part of the agreement. Penalty clauses, for failure to deliver goods or services, are usually written in as part of the contract. The reason that penalties are in there is to give both parties leverage against the other. they cannot be ignored.

Where then are the problems likely to come from? For the service provider, there are many areas where things can go wrong. If the conditions in the contract are wrong to start with, they cannot be changed until the contract is due for revision—and there is no guarantee that they will be changed then, either. If a practitioner cannot deliver the contracted quantity of work, he is in trouble. If the other party is slow to pay, the provider may experience serious cash flow problems. If more work is completed than has been contracted for, there are no grounds for expecting to be paid extra unless it is in the contract. If insufficient work is completed a reduction in payment will probably be demanded. The man who holds the purse strings (the commissioner) has an infinitely more powerful weapon than the provider.

It follows that it would be a good idea to get it right—first time! The alternative is to refuse to sign until the terms and conditions are agreeable or sell the product and skills to another party. Getting it wrong implies real penalties and both parties to the contract carry some of the risk. A move out of the NHS and into the private sector and the opportunity that brings to deal directly with the general public is yet another attractive alternative.

What Does a Provider Need?

In this potential new environment, a provider will need to be armed with key skills and information. It is taken for granted that the orthodontic skills will be available but there will be an increasing need to demonstrate to contractors/commissioners that those skills are up to date and regularly refreshed. The consultation paper 'A First Class Service' (3) concerning quality in the NHS of the future makes the government's position abundantly clear. The days of payment in the NHS regardless of the outcome are coming to an end.

The orthodontist in the twenty-first century must know the market place in which he or she operates. The key players on the commissioning team must be identified and informed abut service priorities and patient needs in their locality. The availability of a service and the quantity of the service available locally are essential pieces of information. The other party in the negotiations is likely to know as much (and maybe more) about this side of the bargain as you do.

Each provider must know what his/her unit costs of treatment are. This means precise information about what can

be provided and at what price, what mark up is required and what the market will stand. The prices being charged by competitors are important, if you want more for your work than the market normally charges the arguments will have to be very persuasive. The main elements of practice cost are fixed overheads associated with buildings and staff wages, etc., and the variable costs are those associated with actual treatment.

The service provider of tomorrow will need to have workflow statistics at hand. An ability to take on extra work at short notice is important to take advantage of money becoming available to handle short-term waiting list pressures. Taking on extra work when it is impossible to deliver the goods is not a good idea. If you fail, you are unlikely to be offered this type of work again.

Any proposed new contract will need to pass through the hands of an accountant and a solicitor both of whom must understand your business intimately. An ordinary professional can only guide and assist, but could not give pertinent advice if they have no experience of this very special type of contract. If you seek advice from an individual you trust and have real confidence in, take the advice that is offered and stick to it. Too often, good advice is ignored to the ultimate cost of the individual concerned. 'If only I had listened . . .' goes the lament.

What Services Can the Provider Sell?

A qualified specialist orthodontic practitioner is in a very strong negotiating position. As a result of a great deal of hard work he or she possesses treatment skills that will be highly prized in twenty-first century Britain. The need for orthodontic treatment can only increase as decay rates fall and the population becomes more and more aware of its oral health status and appearance. The need for orthodontic treatment is readily converted into demand. The value that is placed on the appearance of the mouth by the general public increases exponentially. In America, where oral health concern is well ahead of Europe, orthodontics is a status symbol experience and a life style statement. Where America leads, Britain is usually not far behind. This is a very healthy situation for orthodontics and orthodontists.

Your competitors are the other providers of orthodontic services, your specialist practitioner colleagues, the hospital consultants and the community dental service practitioners. The last two have built in disadvantages in that the specialist practitioner does not have to deal with. The overheads of a small practice unit are much lower as are the waiting times—as a rule. Treatment times are generally shorter and the atmosphere is often more patient friendly. The ability of an independent orthodontic practice to respond flexibly to patient demand is infinitely greater than the hospital or Community Dental Service could manage. The quality of the end product should be just as good irrespective of where it is carried out. Peer review and clinical audit of treatment outcomes should demonstrate an ongoing commitment to top quality results for the patients who pass through the doors of the practice.

To sum up, the specialist practitioner must have a high quality product, flexibility of response to demand, and low unit costs. These are major weapons when the commissioning manager is sitting across the table. Armed with these weapons, the practitioner should be able to extract a good deal from the commissioner.

Conclusion

Knowledge, Information, Organisation, Preparation, Skills, and Flexibility are the Key Factors for Future Success

Armed with all these the specialist orthodontic practitioner can take on the world!

The specialist orthodontic practitioner group may well be facing a new contracting environment within a few years. Provided the people involved have carefully researched their financial situation and know their treatment capability, they will be in a strong position to become ever more powerful players in the future provision of orthodontic services within the NHS.

If specialist practitioners *get things right* they will do well, but preparation and knowledge are essential ingredients in making the change from the present unsatisfactory arrangement to a new and, hopefully, better model. Failure to understand the need for change will lead to long term disappointment for many and even disaster for some.

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