

The New Contract – Time to raise your prices.

I for one have been looking with some trepidation at the introduction of the 'New Contract' for NHS dental services beginning in April. The regulations for both General Dental Services (GDS) and Personal Dental Services (PDS) were laid before Parliament in December and came into force on 1 January 2006. The regulations regarding the new three-banded system of patient charges come into force on 1 April.

My trepidation is largely based on my experience of PDS, which under its present guise has for us meant almost suspension of dental laboratory work from practices that have operated this system so far. (see graph)

For arrangements after 1 April, the DoH has introduced a system Units of Dental Activity (UDA) that the BDA calls 'Target Driven'.

Essentially dentists will be measured on the UDAs they achieve. Their historic practice will have been analysed and contracts will be awarded to dentists based on their historic data and translated into UDAs. The value of a UDA will depend on the type and complexity of work undertaken before, and the number of UDAs to deliver over the year will be based on past performance. Dentists will have to accumulate within 5% of their target UDAs or be in breach of their contract.

I believe the UDA value can range from less than £20 to over £50 and the number to achieve each year can be very different from dentist to dentist. The number of UDAs for each type of treatment is listed in the table on p6, including the patient cost.

So the new currency in NHS dentistry is the UDA. We have seen the range of patient fees but do not confuse these with the value of what the dentist is being paid.

If a dentist fits a crown the patient will pay £189 contribution to the NHS (for fee paying patients). An average UDA value of £25 will mean a dentist is paid £300 for a single bonded NP crown (12UDAs x £25), compare this with the fee under the old SDR - the dentist received a fee £103.55

Again, if the dentist fits a three tooth partial denture the equation under the new system is the same: a dentist is paid £300 for a denture (12UDAs x £25), compare this with the fee under the old SDR - the dentist received a fee £61.85.

Now I am sure the dentist will be complaining he has to find the laboratory fee out of this money, he did under the old system. It makes good economic sense to do simple, single laboratory-involved work under the new contract and don't be pressured with the price. Ask the dentist how much his UDA value is and you will be able to calculate the payment. One dentist has told me his UDA value is almost £50.

There are some negatives, one being multiple work. The dentist receives 12 UDAs for one crown or a 6-unit bridge; or a single three-tooth partial or Part/Part multibar CoCr dentures. Maybe we could create a scale of charges, say £80 for one crown and then say £40 for each additional crown on the same patient. **Simply not charging enough for the laboratory work makes no economic sense.**

The other big negative is the 'what if?' What if dentists do not collect enough money from fee paying patients? Many patients will not be happy to see the amount they pay for one crown rise from £82.84 to £189. So if dentists only do more expensive treatment on exempt patients this will mean the expected income from patients will be far less than expected. The PCTs who now administer the budgets will be given

their budget minus the expected patient contribution. If this fails to materialise, the PCT will be left out of pocket and have to take money from other services to make up the shortfall.

Now, as if we don't have enough to contend with, the potential problem of cheap overseas work has taken an uncomfortable turn for the worse. This is now a time when dental laboratories need to know who their friends are. **Many companies we have supported as customers need to understand that our loyalty and custom is not without an expectation of support.**

Denplan has sent out an offer to their dentists offering overseas work for as little as £59 for crowns. It was always my understanding that under Denplan, dentists calculated the laboratory bill separately for patients, so I do not understand why this would be attractive to their patients (am I missing something here?).

The DLA has worked closely with Denplan for many years on promoting good laboratory practice for their Denplan dentists with DAMAS etc so it surprises me they should take this stance encouraging UK dentists to send their work overseas where it does not have to satisfy the same Directives and Standards that UK work does. Is this in the patients' best interest?

Dentsply announced to the Cal-Lab Group at the Chicago Mid-Winter meeting that it had set up a dental laboratory in China. Its aim is to sub-contract work from its US lab customers and have this work made at its Chinese facility. Dentsply is the largest dental manufacturer and supplier in the world. A lab-owner at the meeting commented that as more work was sub-contracted, the laboratories would reduce their staff until presumably they ceased to be a manufacturer and became just a retailer for Dentsply. At this point Dentsply would then deal directly with the dentist, as it would have no need for all these retailers. Remember this as you place your next order!