27 August 2003

Dear Mr Thomson

Reference: Comments on Issues sought on the Consultation Document, Appliance Contractors

The British Healthcare Trades Association represents 90% of Appliance Contractors in Great Britain and whilst each member company has retained the right to comment on the consultation individually, the Members are in agreement to provide this collective response.

We welcome the opportunity to once again assist the Department of Health and Scottish Executive Health Department (SEHD) in addressing this issue, as we have done previously with FPN 498, The Touche Ross Report and when acting as members of the Advisory Group in the late 1990s. It is only disappointing that we did not receive sight of the later report by Tom Luce nor received any conclusions from the Advisory Committee itself.

Following our review of the Consultation Document, the BHTA, would like to take the opportunity to add clarity to a number of areas in the document which will improve the understanding of SEHD and therefore assist the consulted parties in reaching their conclusions with all the available information.

There are also a number of areas in the document where we seek clarification, on behalf of our Members, as we believe certain statements in the document to be ambiguous or potentially misleading to third parties and the consulted group. We have chosen to deal with these issues first in this document, prior to responding to the comments on the issues raised in the Consultation Document.

Areas requiring clarification and correction:

Paragraph 9
Unfortunately no reference was made here to the increasing number of patients requiring continence care. This is an area that Appliance Contractors have started to support since the change in clinical practice that led to the significant increase in the use of ISC for intermittent
catheterisation. NHS statistics show that 25% of females and 10% of males will require some level of support to maintain continence in their lifetime.

Paragraph. 11
We were unsure of the relevance of the statement regarding VAT; it only appears to complicate the issue and is surely not within the remit for the consulting group to consider and should be for the Board to discuss with the Scottish Parliament.

Paragraph. 12
The BHTA is not aware of circumstances outlined regarding deliberate cross border prescribing. However, Industry has recognised the Board's concern regarding the potential for so-called exploitation and will put forward a proposal for audited self-regulation in our response below.

Paragraph. 13
If paragraph 13 is intended to infer that Appliance Contractors can and do influence General Practitioners' prescribing practice, the BHTA on behalf of its Members would like to clarify that this is not a practice that Appliance Contractors become involved in, other than where specific assistance is requested by the prescriber.

Paragraph. 15
To assist the Department of Health and SEHD, we have carried out an independent internal survey to establish the current expenditure on Sponsorship in this area. We have included Stoma and Continence Care posts supported in the NHS together with Company Nurses directly involved with care of patients. In addition costs that are part of the sponsorship contract including IT support and Education have also been included. Please also note that a number of Companies are requested to supply free product to hospitals as part of their agreement.

The BHTA Industry estimate expenditure for sponsorship in the UK is currently £10.6 million and will increase to approximately £12 million next year, this is considerably higher than the £8 million stated in the document.

Paragraph. 17
We believe the Scottish Executive and consulted parties would have been better served by referencing the NHS guidelines to sponsorship and considering the contractual obligations of sponsors and Company Nurse providers to offer choice to patients, rather than raising questions over the integrity and ethics of NHS staff and clinicians in general.

Paragraph. 18
We request clarification of what the Board considers to be 'reasonable return' and on what basis it will calculate this. It is difficult to imagine how it is possible to consider what level of funding is required to sustain patient services and support, without a clear understanding of this.

Paragraph. 25
The BHTA were under the impression that the current initiatives regarding Nurse Prescribing were designed to address this issue.
Paragraph. 40
We fail to see the issue that is raised regarding the contractual option suggested, providing a more open replacement for sponsorship. It is clear that nurse sponsorship is conducted in an open contract forum, with a procedure that is both driven and regulated by the DH, SEHD and Welsh Assembly.

BHTA Comments on Issues sought on the Consultation Document

Objectives- Yes
We broadly agree with the objectives laid down in paragraph 18 of the document. However, as stated previously, we believe clarification is urgently required on what is considered by SEHD to be ‘reasonable return’ and how SEHD has derived this.

We also believe the second objective, relating to provisioning arrangements and prescriber knowledge should be achieved by the current revision in nurse prescribing and does not need further review by this Consultation Document.

Regarding the removal of exploitation in the system, about which SEHD seems to be concerned, we are not aware of significant levels of cross-border prescribing, other than demanded by patient mobility. We are however, in favour of the prevention of Agency Arrangements as we outline in the later commentary.

We fully endorse the intention to reduce disruption and administration cost wherever possible, but we feel a number of the proposals outlined in the document will fail to achieve this objective for either SEHD or Industry.

Revision of Arrangements- Yes
We believe that a revision of the arrangements is more likely to meet the objectives of the review, than the other options outlined in Annex B. However, we cannot agree with a number of the proposals put forward by SEHD and we see considerable disruption and extra cost in instigating certain of the revisions suggested.

Although we do not recommend the ‘Do Nothing’ option, we do believe there are aspects of the existing system that are robust and do not need to change. The system has served to fund extensive patient services over the years and there is a strong likelihood these services would suffer seriously if the system were radically changed. It is also important to note that demographic shift is likely to create a situation where more patients will require services of the kind offered by our Members and we would therefore want to explore opportunities with SEHD where additional funding would be available to support this increasing patient population.

We are also not in favour of local or national contracting for services, as we believe this will again restrict patient choice and lead to a considerable amount of increased administrative cost to both SEHD and Industry. There is also a reference to wanting to provide a more open system of contracting for Sponsorship. We believe the current arrangements to be entirely open and are effectively managed by the NHS or its representatives.
Service Standards- Yes

Our Members are strongly in favour of establishing service standards for Appliance Contractors. (Many members already exceed the service standards quoted, by providing, for instance: visitor centres, free-phone telephone help lines for patients, freepost services, samples of alternative products for patients having difficulties and replacement of products that are either defective or no longer appropriate because of a change in the patient’s stoma size.)

We are also prepared to instigate an Industry Self-Regulation Scheme under the review of a recognised Notified Body that will both ensure the maintenance of the service standards and operate an audit system that can remove many of the alleged exploitation opportunities so evidently of concern to SEHD.

In addition, the BHTA is currently consulting on a new Code of Practice for the industry, which is to be submitted for OFT approval. This will introduce a further element of management and policing of those companies that sign up to the Code. (A copy is included herewith for your interest/comment.)

The stated level of service standard is currently funded by a combination of reimbursement and remuneration, to fund this with a system of funding which consists of the current level of remuneration alone is unrealistic. Any consideration of change from SEHD must take the issue of total funding into account.

Our Members are also concerned that a system differentiating appliances that attract an additional service element would restrict valuable care and create confusion for both healthcare professionals and Appliance Contractors. Our Members have stated that many of the appliances supplied to patients, outside the classification of stoma and incontinence, are actually supplied to patients receiving the full range of support services. It would be fair to say that patients receive the service because the patient chooses to have their prescription dispensed by the Appliance Contractor, rather than the service relating to the specific product supplied.

We also believe the complexity of the range of products handled by the Appliance Contractor is lost by just considering the major Drug Tariff categories of Stoma, Incontinence, Dressings and Other Appliances. The largest increase in service provision in the last few years is in the area of Urology (categorised under Other Appliances). Here Intermittent Self Catheterisation, resulting from a change in Clinical practice, is an example where Appliance Contractors have assisted the NHS to improve patient care and save money.

It is also difficult to comprehend how Appliance Contractors could have the same remuneration system applied as for Pharmacies, when the pharmacy remuneration is based on an entirely different business, with a more complex system including a number of fees and allowances pertaining to their profession in general; their business is also supplemented by retail and OTC profit margin.

Remuneration System

The replacement of the current system of On-Cost is not considered to be necessary by our Members, as it still represents a system that has been effective and robust for many years. As mentioned earlier we believe a contracting option either locally or nationally is going to considerably increase administration and costs for both SEHD and Industry. Additionally a
mixed system of ‘contracting’ and ‘reimbursement and remuneration’ seems to offer the worst option of all, creating confusion and increased costs, thus totally defeating the final objective.

The BHTA members' preferred option is that the system should largely remain unchanged, with the exception of the implementation of an audited self-regulation scheme and the removal of agency agreements. However, we would welcome the opportunity to discuss the current arrangements regarding entry on the Pharmaceutical List for Appliance Contractors. We believe that the continuation of a dispensing ‘license’ for an Appliance Contractor and therefore their continued entry on the list of Contractors should be tied to a service provision model from those premises.

Our Members would also want to explore how additional levels of Remuneration could be made available, where services over and above the specified service standards are required by patients and endorsed by responsible healthcare professionals.

We reason that the current system is simple and well understood. If the concern regarding alleged exploitation can be removed by Industry self-regulation in the way outlined above, then continued funding would underpin the necessary support given to patients both directly and by sponsorship. We request the opportunity to discuss this further with SEHD, or its designated representatives.

However, if the system must change more dramatically, as suggested by SEHD, then any alternative proposal must supply the level of funding that can support current services, provide a reasonable return to Contractors and must not result in a diminution of services to patients.

Global Sum- No
The suggestion for the introduction of a Global Sum would represent an increase in administrative costs and introduce significant complexity to all parties including Pharmacy Contractors. It would require the creation of a body equivalent to the PSNC and require annual negotiation across a four party table including this new body with the Department of Health, Scottish Executive and the PSNC. We are aware of the complexity and administrative burden currently posed by the Pharmacy Global Sum; we fail to see the sense in complicating this system further.

The Department of Health and SEHD already exert a level of control to pricing of Appliances through the Drug Tariff, which affords a regulation system not seen in the registration, regulation and dispensing of Medicines.

The SEHD and the Department of Health have already exercised cost reduction measures over the last 4 to 5 years, by imposing annual price reviews with manufacturers below the current rate of inflation. This has resulted in a direct and adverse impact on the reimbursement of Appliance Contractors.

The figures quoted in the Consultation Document demonstrate a continual migration of patients from Pharmacies to Appliance Contractors, as patients avail themselves of the additional support services provided by Appliance Contractors. We also believe a Global Sum approach would operate to restrict the number of patients able to avail themselves of this much needed and valued support.
Discount Recovery- No
We believe there are a number of reasons why a Discount recovery system is inappropriate for Appliance Contractors. Although the Department may not have considered that there are differences between the operations of Pharmacies and Appliance Contractors, they are in fact quite clear.

Appliance Contractors effectively act as Wholesalers as well as Dispensing Contractors and carry many additional costs that do not fall into the cost structure of Pharmacy Contractors, these include: the working capital costs of significant stockholdings, warehousing costs, transport and stock write-offs. It is also a fact that most Appliance Contractors are specialist “single activity” operations that concentrate on patient support and would be unable to mitigate the effect of discount recovery via the retail margins available to Pharmacists on the many consumer lines they sell.

Agency Arrangements- Yes (these arrangements should be banned)
As mentioned previously, our Members are strongly in favour of changes to the terms of service that result in the Agency Arrangements being banned. The BHTA Code of Practice for Appliance Contractors specifically excludes companies who operate agency arrangements from membership.

As a general comment on the Consultation Document, we must state that we feel it gives an unreasonable view of contractors who are focussed on service provision to patients, whilst operating as commercial companies. We believe the references to fraud and influencing prescribing practice for gain, are unfounded and highly influential to readers of the Consultation Document.

In summary, Appliance Contractors have a level of expertise and knowledge gained over many years of dedicated patient service provision, their advice and support has directly saved money for the NHS. This has been achieved through direct and indirect support of healthcare specialists and the effective reduction of waste in the system.

It is a reality that for a number of years Remuneration and Reimbursement have been consolidated to provide funding for product and ancillary service support to patients, including direct nursing provision. Simply discounting one element of total funding is not dealing with this system in a realistic way. If the outcome is to remove considerable funding from Appliance Contractors, then it will significantly and irrevocably affect the level of service available to approximately 100,000 UK stoma patients and a similar number of patients requiring continence care.

Yours sincerely

Ray Coughlin
Director General