Features Section

Guest Editorial

In Pursuit Of Improvement Before Excellence

Many studies in recent years have not surprisingly found that the use of upper and lower fixed appliances bring about a greater reduction in malocclusion. However, it is surprising that the use of upper and lower fixed appliances in the General Dental Services in the UK is less than one third of all treatments. This is much lower than one would expect for a country of our size and wealth. Part of the explanation is arguably the British tradition of using removable appliances, which appears to be a part of our heritage. Whilst many other similar countries have adopted the use of fixed appliances more readily it is disappointing that upper and lower fixed appliances are used by specialist orthodontists in a relatively small proportion of their case-load (substantially lower than that reported in questionnaire response surveys).

However, when we use fixed appliances in the UK we are probably the most efficient and cost-effective when compared to countries of similar wealth. There are two very interesting points to note when upper and lower fixed appliances are used in the General Dental Services: Firstly, malocclusions are reduced on average by about 70 per cent and secondly the treatments are usually completed in 14 months. These treatments can be compared favourably with similar cases anywhere in the world. Considering these facts it is difficult to see why treatments take considerably longer in other countries in Europe (2 to 4 years). The reason for extended treatments in other countries is principally the result of the rule and regulations of remuneration systems. In some countries treatments can be paid for 4 years. In other words the remuneration system usually dictates the type and duration of treatment. In the UK the relatively low fees for upper and lower fixed appliance use dictates a higher turnover and higher case-load.

Nevertheless it is difficult to see why specialist practitioners do not use upper and lower fixed appliances more often. The recent article by Turbill, et al. (1998) demonstrates that greater use of upper and lower fixed appliances is associated with high earners. Therefore dual appliance use cannot be considered as a financial disincentive. It is well known that a high proportion of orthodontists consistently occupy the "Top 20" earners in dentistry as a whole.

So how can the use of upper and lower fixed appliances be encouraged.

- *Consumerism* It is well documented by the profession that upper and lower fixed appliances produce better outcomes than removable appliances and single arch fixed appliances. In addition, it has been documented that certain types of deviant occlusal traits are better treated than others. The consumer or patient is not always aware of these facts. With the advent of informed consent and shared decision making the consumer/patient should be made aware of the possible outcomes using different appliances. If the consumer/patient is not fully informed there may be grounds for litigation in that the patients malocclusion was not treated to its full potential. The risks of failure should also be explained.
- *Professionalism* It is important to train dentists and inform them on treatment outcomes considered as good and poor so that the referring dentist can make a informed judgement on the treatments being carried out by the orthodontist. The discerning dentist has the opportunity and obligation to refer his patients for the highest standard of care.
- *Change in remuneration* The fees for upper and lower fixed appliances are low compared to our competitors. A rise in fees could encourage greater use of fixed appliances. However it is difficult to consider fee increases that may boost the already existing high earnings of orthodontists. Although, it should be considered that low fees are associated with high turnover and higher fees with reduced case-load. There is obviously a need to establish a fee that is compatible with appropriate quick completion of treatments, good outcome and acceptable income for orthodontists.
- *Orthodontic auxiliaries* The introduction of orthodontic auxiliaries will undoubtedly tackle the shortage of qualified orthodontists in the UK and possibly provide the opportunity to substantially increase the proportion of upper and lower fixed appliance usage. However, auxiliaries can also substantially boost the orthodontistís turnover, which could easily double the orthodontic budget in five years. The setting of fees for fixed appliances cases will depend on the educational achievement of auxiliaries (which could be of degree status) and possible turnover and gross earnings per year. The setting of the appropriate fees should encourage greater use of dual arch appliance systems.
- *Reduction of administrative load* The administrative barriers to providing treatment should be minimalised. Currently, the prior approval arrangement does create a barrier for upper and lower fixed appliance usage.

It is difficult to see how the complex and conflicting interests can be resolved. Undoubtedly, the overall pot for orthodontic treatment will have to be increased. It is difficult to expect a substantial increase in funding within the NHS. Therefore, alternative sources of funding should be sought. The additional sources can only come from the expansion of the private funding sector through direct payments, "saver" and insurance schemes. I am sure that once the country starts to grow in financial terms the private sector will grow and will eventually become the dominant provider. This does not mean that the NHS

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budget will diminish but this will also expand to cover those individuals with severe handicapping malocclusions and those individuals who cannot afford to pay. It is within this environment that upper and lower fixed appliance usage should be allowed to dominate.

However, wherever orthodontic treatment is delivered, the Orthodontic Society should monitor its own members and reward those practitioners providing a high quality service by recognition, award and publication. It is only when we are moving quickly along the path of improvement that we can aim for and achieve excellence in orthodontics.

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E.A. Turbill, S. Richmond, and J.L. Wright,.
A critical assessment of high-earning orthdontists in the General Dental Services of England and Wales (1990–1991).
British Journal of Orthodontics, **25,** 47–53.