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THE EDITOR'S CORNER

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Don't McMuff It

You may have noticed that McDonald's reduced the price of the Big Mac from $1.99 to $.55, and that the huge reduction in price didn't work. McDonald's experienced an additional 6% loss in sales. One would have to conclude that the product has lost its appeal. In fact, people might now assume that it was overpriced at $1.99. Orthodontists who might be inclined to reduce their fees, take note.

It has long been our contention that reducing orthodontic fees is counterproductive. For one thing, people would probably be unaware there had been a fee decrease even if it were substantial–from $3,500 to $3,000 or even $2,500. In that case, the reduction would have no effect other than to reduce income or to make it necessary to increase the case load by 16-25% just to stay even. Most of the time, however, when orthodontists consider reducing their fees, it is in response to a downturn in referrals and case acceptance. While it might actually be more productive to increase fees than to reduce them in such a situation, that is not usually considered a viable option.

It has been recognized time and again that people will willingly agree to a fair fee–almost regardless of its size–when they are convinced of the value of the service. The orthodontist's job is to make people aware of the value of the service and make the financial arrangements flexible enough, and then people will pay the fee. Basically, the orthodontist and staff must be sure they are turning out a high-quality product in both treatment and patient care. Then they must make their patients, referrers, and prospective patients aware of that quality.

So if you are tempted to reduce your fees because you are experiencing a lull in referrals and new patient case acceptance, take a day off and run an audit on your practice. Ask your staff if they think your fees are too high. If they say "yes", you've got a problem–and not necessarily because your fees really are too high. If your staff doesn't think the treatment they are performing is worth the fee you are charging, then you have not takenthe time to indoctrinate your staff as dedicated professionals. Another possibility is that you do not have the right staff. A third is that they may be right.

In any event, the solution to the fix you are in is highly complex. It could involve basic questions of management–staff management, office management, patient management, treatment management. You probably could use a management consultant.

Having said that, we must recognize that there are a number of collateral issues affecting orthodontic practice today. There are areas in the country where the patient base is co-opted by managed care and other third-party programs, creating an environment in which traditional practice building is impossible because both prospective patients and referring dentists are tied up by those programs. Some orthodontists in such areas do find ways to cope with the competition and conduct highly successful traditional practices. Whether this is made possible by a shift in the predominant referral base from dentists to patients remains to be documented. Some orthodontists accept a smaller traditional practice and, perhaps, a lower living standard. And some move to areas not yet invaded by such programs. Those who depend on the managed-care and other third-party organizations seem to be increasingly unhappy with arrangements they find it impossible to refuse.

I am not sure that we can learn much useful information from the experience of physicians. The

metaphor of sheep being led to the slaughter seems to describe the pattern of medical practice in recent years. A great many physicians appear to be in a bind: They can't live with their arrangements, but they can't live without them. At this late date, out of desperation, many physicians are turning to management consortiums to gain more clout in offering comprehensive medical care to HMOs and similar health-care organizations.

If a physicians' management company could corner a major percentage of GPs and specialists and include one or more hospitals in its affiliation within an area, then it would stand a chance of controlling the supply side of the equation, just as the HMOs in some areas control the demand side–the patients. Whether this would actually be an improvement in the doctors' bargaining position remains to be seen, because no physicians' management organization is yet big enough to compete with even the smallest HMOs–and there may be a trend toward consolidation of HMOs. Moreover, physicians seem to be accepting capitation as a workable basis of operation. It is doubtful that capitation will be the salvation of American medicine. It certainly has little application in general dentistry and none in orthodontics. □