

Response of the Orthodontic Society of Ireland  
to the Preliminary Report of the Competition Authority  
Competition in Professional Services  
Dentists December 2005

## ORTHODONTIC SOCIETY OF IRELAND

The Orthodontic Society of Ireland is a voluntary organization. It was established sixteen years ago and has developed into an active society. The majority (91%) of the registered orthodontists in Ireland are members of the society. The aims of the society are:

To advance the science and practice of orthodontics.

To encourage research and education in orthodontics.

To promote the highest standards in orthodontic practice.

To liaise with the European Orthodontic Society.

To represent its members within and outside the profession.

The Orthodontic Society of Ireland wishes to respond to the Preliminary Report of the Competition Authority. This report was sent to the OSI (Orthodontic Society of Ireland) on 15<sup>th</sup> December 2005. The CA(competition Authority) invited the OSI to respond to the report and requested that all submissions be returned by 28<sup>th</sup> February 2006. The officers of the society have done their best to meet this deadline and apologize if there has been an overrun on time. However the CA should appreciate that the only time available to the officers to prepare the response has been in the evenings after the days work is done. The OSI anticipates that the CA understands the pressure the short preparation time has put on the officers of the society. In preparing the report the OSI has limited the reply to those sections of the report specifically dealing with orthodontics.

## INTRODUCTION

As a broad concept competition is generally welcome as it benefits the consumer and we are all consumers. However the CA should bear the following in mind when attempting to increase competition.

- (1) The CA should not undermine the excellence of a service or profession.
- (2) That a level playing pitch of opportunity and exposure to patients be available to all providers.

Only then can competition be fair.

## TRAINING SPECIALISTS IN ORTHODONTICS

Orthodontics is a specialized branch of dentistry. Postgraduate training is required and graduates that complete a recognized postgraduate training course and pass the exams are eligible for registration on the specialist register with the Dental Council. To be eligible to participate in the training course a candidate must be a dentist with at least two years experience. There is an entry requirement of M.F.D./ M.F.D.S. of the Royal College of Surgeons. The programme is three years in length and is divided between a dental school(60%) and time in a regional unit(40%). Successful candidates obtain a Masters Degree from the University and a Royal College Membership in Orthodontics.

Orthodontics is a recognized specialty of Dentistry under the EU directives 78/686/EEC and 78/687/EEC and the training course must be three years long to conform to EU directives. The training course must also follow a recognized syllabus (e.g. 'ERASMUS' guidelines).In summary ,specialist orthodontists will have spent about 10 years in full time training before commencing practice.

Registration as a specialist in Ireland allows the candidate to be registered as a specialist in many other EU countries, and the reciprocal is that specialists from these EU countries may also be registered in Ireland as specialists. It is essential therefore, that the quality of Irish training programmes be equivalent in quality and length to those of other EU nations.

The Dental Council, which is the statutory body under the Dentists Act 1985 has established that specialist training in dentistry (including orthodontics) should be

provided by the three national postgraduate providers in dentistry. These are, the National University of Ireland Cork (NUIC) The Royal College of Surgeons in Ireland(RCSI),and The University of Dublin(TCD).

Any other bodies seeking to be involved in the training must collaborate with one of these three institutions. Some HSE areas that have a Consultant orthodontic service are collaborating with the three recognized bodies and have in the past applied to the Irish Committee for Specialist Training in Dentistry (ICSTD) for accreditation for orthodontic training courses. Successful courses have been developed and between 2002 and 2005 there were sixteen candidates trained in TCD alone.

## MANPOWER

The number of orthodontists in Ireland has almost quadrupled since 1992 and has increased by almost two thirds on the figure of 69 in 1998. There are currently one hundred and ten registered orthodontists in Ireland and it is projected that this figure will rise to one hundred and thirty nine by 2009 (1) At present 48.5% work in the public service/hospital service and 55% work in private practice. This information contradicts the CA's analysis (3.83) which states that 'it is becoming increasingly difficult to recruit and retain qualified orthodontic specialists in the public sector due to their high earning potential in the private sector'. The figures suggest that working in the public service is well accepted by the profession.

To train to specialist level in orthodontics is very expensive. It is stated by the CA (3.85) that in Ireland 'the education of orthodontists costs in the region of 50,000 per student per annum...' There are definite indications that a number of schools in the U.S.A., where competition is open, are discontinuing their orthodontic training programmes for cost reasons. The OSI recognizes the need for more properly trained orthodontists and supports the Dental Schools in Dublin and Cork in their efforts to provide recognized training posts.

In some quarters in Ireland there have been calls for 'less extensive training' and thereby less expensive training for orthodontists in the public sector –This seems to suggest that those patients with the greatest need for treatment, and who would most likely obtain their treatment via the HSE, should be treated to a lesser standard. This is not in accordance with principles that the HSE espouses, namely equality, equity and access to the same high standard of care for all who seek treatment within it.

The limited number of training places (3.83) is a result of a European wide effort to ensure that the quality of training is to a universally high standard. The aim is that orthodontic qualifications can be transferable across the Community allowing orthodontists from other EU countries to be recognized as specialists in Ireland. Such unrestricted movement of orthodontists into Ireland negates statements 3.81 and 3.83 of the CA report. In fact it is a very 'open' situation.

There are currently 28 Irish registrars in orthodontics in the U.K. who are due to complete their training in the next three years and they will be eligible to return to Ireland should they so wish.

## MARKET FOR ORTHODONTIC TREATMENT

It is very important that the CA understands that orthodontists do not engage in any service other than the provision of orthodontic treatment to a patient. They rely on the general dentist for referral of any patients who might require orthodontic treatment. Once such treatment is completed patients are returned to the referring dentist for their routine dental care. In section 2.28 of the CA report they say 'narrow relevant markets may exist within each of the groups....but for the purpose of this report it is not necessary or useful to determine this'. The OSI however, would feel that the narrowness or range of a market is of paramount importance when discussing the efficacy of a profession from a training and education point of view. The fact that orthodontists have a practice that is 'limited to orthodontics' must be accepted by the CA . It must be understood that the range of the service is truly limited.

It is acknowledged by the CA that the provision of orthodontic treatment in the private sector is not restricted to the specialist orthodontist(Fig.1,pg 13). So, the specialist orthodontist is limited to orthodontic treatment only and the general dentist is not.

In 'Barriers to Entry'(note2,pg25) few if any of the points raised are relevant to Dentistry in general or to Orthodontics in particular. Once a person has proved themselves qualified to practice as a dentist there are no restrictions on where they may set up or on what procedures they may perform. A general dentist is legally entitled to carry out orthodontic treatment and oral surgical procedures despite the fact that these are the only two specialties recognized by the Dental Council. This indicates the potential level of competition under existing regulations. The fact that most patients in the private sector

choose to be treated by specialists is surely an indication that they prefer to be treated by suitably trained dental professionals. While a dentist can offer any form of treatment to his or her patient most do not choose to do so because a) They are not trained specialists and b) They will not undertake any treatment outside their competence because this could give rise to litigation if things go wrong.

Orthodontic treatment can be performed on a patient at any age be they adult or child. However the ideal age for treatment falls between 10 and 16 years of age. The older patient can be treated but the range and scope of treatment is affected by biological factors and may need to have a surgical component to it. According to Proffit and White 1990 approximately 0.5% of the population cohort may require a surgical component. In fact the number of maxillofacial surgeons in this country who can perform such procedures is minimal. (At present there are 7 in Ireland and the need is for at least 25 with appropriate support staff.)

The CA believes that in the HSE all children are screened at the age of 12 to determine whether they require orthodontic treatment and are categorized according to their level of need (2.48). It is unclear whether this is in fact the reality of the situation - some HSE areas have very long lists waiting for assessment. (Table 9, pg 50). The generally accepted age for initial screening is earlier and this coupled with long delays is not at all ideal.

The HSE has a monopoly on patients up to the age of sixteen years ((0.9 million potential patients) thereby reducing the exposure of the private orthodontist to this 'ideal group'. Ideally the HSE should assess patients at this ideal age and then inform parents a) Whether the child is going to be offered treatment or not, and b) When the child is going to be given said treatment.

If they are not in a position to provide the patient with appropriate treatment at the ideal age the HSE should inform the patient promptly. The patient can then make an informed decision on whether to go privately or not for treatment. The OSI recognizes that this approach is adopted in most HSE areas and hopes that all HSE areas would follow suit.

The CA quotes the "Fourth Report- Review of Public Orthodontic Services, Joint Oireachtas Committee on Health and Children, June 2005" section 2.49 in the preliminary report. In its discussion on publicly funded orthodontic treatment it states that the number of patients on waiting lists vary across HSE areas. It further states that the true numbers of those requiring treatment could be much higher than official figures as it has been claimed that consultant orthodontists have been told not to include children on waiting lists who have no realistic chance of being seen due to the shortage of qualified orthodontists. This is indeed a very sweeping statement by the CA. The OSI would like to know the basis for this statement. The OSI would also like to know who made the claim

and who told the orthodontic consultants to omit some children from the lists???. Having read the Fourth Report and having failed to identify the particular reference anywhere in the report is worrying for the OSI. This inconsistency is a cause of concern and undermines the reliability of the research carried out by the CA.

It is worth noting that in some HSE areas non-specialists are employed in the delivery of the orthodontic service. The productivity of these areas is lower than in the areas that employ specialist orthodontists.

## DEMAND FOR ORTHODONTIC TREATMENT

The demand for orthodontic treatment is potentially limitless. In a study in Norway Helm (1990) found that two thirds of all adolescents would demand treatment if it was available free and immediately. It is unlikely that the demand for treatment in Ireland is any less than this.

This year (2006) will see the most favorable ratio yet of orthodontists to 12 year olds in Ireland, at 1:435. This compares to 1:2773 in 1980 and 1:890 in 1998. This information confirms that there is not a serious shortage of trained orthodontists in Ireland at present.

A total of 23,000 patients are undergoing treatment in the HSE at present and approximately 24,000 are being treated in private practice. So up to a potential 47,000 patients are undergoing orthodontic treatment in Ireland at any one time with approximately one half receiving treatment privately and one half in the HSE. The OSI believes these figures undermine the CA statement 3.87 which states 'There are serious problems in relation to the provision of public orthodontic treatment in Ireland ,which point to a shortage of trained orthodontists in Ireland'. The OSI strongly disagrees with this statement. It is not supported by the facts.

## PARA-PROFESSIONALS

It is very important to remember that if highly qualified personnel are replaced or substituted with less highly qualified personnel then the standard of the service will suffer in the long term. It is important that everyone in the delivery of dentistry realizes that highly trained personnel can be enhanced by good back up from auxiliaries.

The OSI is in favour of para-professionals and have been instrumental in the promotion of the establishment of the grade of auxiliary dental personnel called Orthodontic Therapist. The OSI believes that the orthodontic therapist will enhance the delivery of orthodontic service and improve productivity.

### Orthodontic Therapists

Orthodontic Therapists will undergo a years supervised training and will then work under the direction of the specialist in orthodontics. The job of the therapist will be to enhance the provision of service delivery. It will make treatment more efficient and more productive because the therapist will be able to carry out routine orthodontic procedures, all of which at present must be carried out by the trained specialist, as the delegation of such tasks was not legal up to now. The therapist is not a replacement for a specialist as is implied in statement 3.90 if the CA report. The therapist will be an important extension of the overall treatment provider team in orthodontics.

At present the training pathway for therapists is being formalized by the two dental schools and the OSI is very keen to have an input to this training as the members have extensive clinical expertise and well developed views on what is required of these auxiliaries. The OSI would also favour a 'grandfather' clause which would allow dental nurses working in orthodontic practices to be fast tracked and qualified as orthodontic therapists.

The OSI is concerned that this new grade of orthodontic therapist may be considered by the HSE as a substitute for the orthodontist. Be sure that it is not. Such therapists cannot work on their own and must be supervised at all times by the orthodontist. The orthodontic therapist rather should be seen as an auxiliary worker to the orthodontist and not a replacement for the orthodontist.

The CA believes the orthodontic therapist will 'reduce the cost of providing orthodontic treatment and reduce the requirement for more orthodontists...'3.96. There is some truth in the first half of this statement because increased productivity implies a more cost efficient service. However, that the CA believes the orthodontic therapist will reduce the requirement for more orthodontists is a misunderstanding on behalf of the CA. The specialist orthodontist treats the patient and has auxiliary support from the nursing staff, orthodontic therapist etc. How the presence of orthodontic therapists would reduce the

need for orthodontic specialists is a mystery unless the CA believes the orthodontic therapist will be doing the work of the orthodontist.

Having detailed the training pathway required to become an orthodontist it is unbelievable that the job description of orthodontist and orthodontic therapist could be so misunderstood. They are not interchangeable positions. Orthodontic therapists cannot work independently of an orthodontist. The orthodontic therapist can only work under direct supervision of an orthodontist.

Also, if (as the CA believes) “the orthodontic therapist will reduce the cost of providing orthodontic treatment” then the demand for orthodontics will surely increase. A direct effect of an increase in demand is an increased need for more specialized orthodontists. As previously mentioned the demand for orthodontic treatment is potentially limitless.

The OSI strongly believes it is imperative that the role of the orthodontic therapist is clearly understood thus avoiding misconceptions and inappropriate applications of the job description.

## ADVERTISING & CORPORATE MODEL

The qualification of Dental Surgeon is a statement in itself and those who have been conferred with it are identifiable as being of a certain standard of ability to provide a dental service to the public. It is not considered necessary to employ marketing techniques and methodology to further tempt the patient to attend the clinician. All clinicians are considered equal and if this is not the case patients would be unwise to assume one clinician is better than another on the basis of their advertisements. That they rely on their own reputation and skill and not a marketing ploy is a credit to the profession as a whole.

All advertising has to be controlled. The question arises as to who will decide what advertising is “decent, legal, honest and truthful” in relation to the delivery of dental care. One assumes that this would fall on the Dental Council. The public could be in a worse situation through false or misleading advertising.

The corporate model is an issue which may deserve further discussion. Whether it is allowed or not will not affect the standard of the service delivered-rather it would change the structure and delivery of a service. However, it would be important that corporate bodies would not be used as a shield to limit the responsibility of a dentist towards the patient.

## CONCLUSION

At the present time ,there is no shortage of trained orthodontists in Ireland

The numbers of orthodontists being trained in Ireland has been increasing steadily over the past number of years and is set to continue .

Contrary to the CA report we will not have to wait until 2009 to see the benefits of this increase in personnel, it is already here!

The creation of the new grade of orthodontic therapist is already in progress.

The OSI would like to have an input into the development of the training pathway for the orthodontic therapist.

## REFERENCES

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