IN BRIEF

- As of 1 April 2006, PCTs have the responsibility for commissioning a reasonable level of NHS dental services. PCTs should assess local needs and plan services accordingly.
- Traditionally dentists and orthodontists have set up practice where demand rather than need is greatest, which has led to inequalities in access to services.
- This paper describes orthodontic service use, which is in part related to access, across five geographically linked PCTs.
- Uptake of services was found to be related to deprivation and rurality.
- PCTs need to ensure that children from deprived and rural communities have adequate access to all primary care dental services to reduce inequalities.

VERIFIABLE CPD PAPER ONLINE

Inequality in uptake of orthodontics

Inequality in uptake of orthodontic services **C. S. Drugan,[1] S. Hamilton,[2] H. Naqvi[3] and J. R. Boyles[4]**

ABSTRACT

Objective
The purpose of this ecological study was to investigate the relationship between uptake of orthodontic services and factors that might influence receipt of care at a population level.

Method
The dental practice board supplied data on claims for courses of active orthodontic treatment from April 2001 to March 2002 for children from the former county of Avon. These data were analysed in relation to deprivation, living in an urban/rural setting and the proportion of the population from a black or minority ethnic group (BME).

Results
In Avon, children from deprived and rural areas were significantly less likely to be undergoing an active course of orthodontic treatment. Children from an area with a high proportion BME were significantly more likely to be undergoing treatment.

Conclusion
This research demonstrates that children from more deprived and rural communities in Avon are less likely to receive orthodontic treatment. This has important policy implications for primary care trusts that have a responsibility to ensure equal access to care for all of their children.

EDITOR'S SUMMARY

The premise and the content of, and the Commentary on, this paper exemplify the crossover there is in dentistry between biology on the one hand and social considerations on the other. Further, it serves to present several dilemmas associated with access to care and indeed attitude to care from the profession's viewpoint as well as from potential patients and in the case of orthodontics, their parents and carers.

In highlighting that children in the more deprived and rural communities in Avon are less likely to receive orthodontic treatment the authors also touch a nerve in terms of how these patients, when defined by social group rather than malocclusion, fare with regard to access in general. Lower socioeconomic groups and certainly those who live outside towns and cities worldwide have less uptake of dental services across the board, so these findings are perhaps not so surprising.

There are however, two elements here that I believe are of other significance. Firstly that malocclusion is a condition rather than a disease and therefore is viewed in a different light socially in terms of the need to treat it. Secondly, the authors suggest that one way of solving the problem might be for Primary Care Trusts (PCTs), under the new and current NHS regulations, to negotiate and contract for specialist services to provide appropriate care to these groups. How likely that is will depend on not only the will of a PCT to want to acknowledge the existence of the issue but also to commit specific funds in this field in preference to the many other calls on its cash and resources.

In his Commentary, Professor Jonathan Sandy doubts that this will happen and I find myself, albeit with disappointment, in agreement. However, the real question is how much we as a society *value* the correction of malocclusion as a health intervention or merely as an aesthetic nicety. Paradoxically it is something that the IOTN index, set up to grade severity and treatment need, both seeks to address and also neatly skirts around.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 202 issue 6.

Stephen Hancocks OBE,
Editor-in-Chief

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FULL PAPER DETAILS

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AUTHOR QUESTIONS AND ANSWERS

1. Why did you undertake this research?

There are known inequalities in accessing NHS treatment, particularly for those living in areas of relative deprivation, but there is little published evidence of this effect on access to orthodontic treatment. The core principles of the NHS are to provide quality care that meets the needs of everyone and that it will work with others to reduce health inequalities. (http://www.nhs.uk/England/AboutTheNhs/CorePrinciples.cmsx).

Locally, Bristol Primary Care Trust (PCT) has stated the aim to reduce inequalities – this research was deemed necessary to complete a needs assessment for oral health. It is in essence an equity profile in that it identifies the gap.

2. What would you like to do next in this area to follow on from this work?

From the research we can potentially recommend priorities for action and for securing changes in investment and service delivery etc. The PCT is commissioning orthodontic services within its fixed budget to ensure equity in service provision, reasonable waiting times and targeting treatment to those in most need. It is closely monitoring clinical activity and will review services to ensure these aims are met. A future equity audit will enable us to review the progress we have made towards our goal of reducing inequalities in all dental services.

COMMENT

This is an interesting paper, which seeks to find out whether certain groups of patients are less likely to receive orthodontic treatment and to develop a model to improve access if this is the case. Given the huge changes seen in Dentistry within the NHS over the last few years, it is slightly strange that orthodontics should be looked at rather than other inequalities which match social deprivation, such as caries experience. Indeed, it seems that they lacked some basic data on dental decay to prove associations in some areas.

The findings from the study may be anomalous to the UK as a whole. The data was collected from one area which is known to have one of the highest levels of orthodontic provision in the UK. Not surprisingly, the BME group who live in the inner city areas are more likely to have received care than those who live in rural areas and find it more difficult to access treatment. The reasons for uptake of orthodontic treatment are speculated on, including logistics and costs involved in attending. I would re-emphasise that the most alarming aspect of this paper is an inability to demonstrate a relationship between rates of uptake of care and other variables such as decay levels, registration rates and dentist to population ratio, simply because the data is not available. This is empirical if we are to understand basic dental disease rather than orthodontics, which has limited value in improving oral health.

Finally, this paper comes up with a model of care which might address the imbalance in favour of those communities that currently under-utilise existing services. They suggest it would be possible for the PCTs to contract with specialists or dentists with an interest in orthodontics to provide this care. Since the specialist practitioners are based within the city, this means they either develop satellite practices or work within a general dental practice in rural areas.

There is no doubt there is a need for data on provision of dental services. Orthodontics has traditionally been highly organised with regard to development of indices to measure need and outcome. I feel there is a more pressing need to deal with inequalities in basic dental service provision, rather than worrying about inequality of uptake in orthodontic services, where the PCTs have clearly signalled their intention to diminish this aspect of care.

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