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## the editor's corner

A great deal of time has been spent in attempting to determine the dental needs, including the orthodontic needs, of the population of the United States. The Department of Health, Education, and Welfare has published three studies on this subject. The first two (*An Assessment of the Occlusion of the Teeth of Children 6-11 Years* and *An Assessment of the Occlusion of the Teeth of Youths 12-17 Years*) were presented and discussed in an article in JCO in December 1978. A third publication—*Basic Data on Dental Examination Findings of Persons 1-74 Years*—is dated May, 1979.

It is important for orthodontists to understand that population assessments of the severity of malocclusion have almost no relationship to the private practice of orthodontics. In a private practice, the need for orthodontic treatment is not determined by a scale of severity of malocclusion. It is determined by the need of the individual who owns the malocclusion. A person with a single upper central incisor in crossbite or a person with two upper central incisors at an angle of 90° to each other or a person with a large diastema between the upper central incisors all score close to zero on a Treatment Priority Index of Malocclusion. Yet, many individuals with such malocclusions frequently decide that it is important to them to correct the irregularities in terms of appearance, function, hygiene, and speech. They derive great satisfaction from having had orthodontic treatment, and even minor corrections can contribute greatly to an individual's self esteem, success, and happiness. And, he doesn't consult a scale



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of severity of malocclusion to help him decide.

Why, then, have so many indexes of malocclusion been developed? They do permit screening and profiling a population for malocclusion. They do permit speculation about manpower needs in orthodontics. A rather neat article on this subject appeared in the September 1977 issue of *AJO* as a report of the AAO Special Committee on the Availability of Orthodontic Services. The premise of the report was—based on a certain number of orthodontists, a certain number of case starts per orthodontist, and various degrees of utilization—through what level of severity of malocclusion (as determined by the HEW Tooth Priority Index) could the existing and projected cadre of practicing orthodontists treat children with malocclusion?

The value of the report was to anticipate some illogical conclusion on the part of government such as: "If X number of children are determined by the Treatment Priority Index as "needing" treatment and only half that number are getting treatment, we need twice as many orthodontists." Or, "If every child who needed treatment were suddenly eligible to receive it, there would not be enough orthodontists to handle the load."

The term "Treatment Priority Index" explains the utilization of indexes of severity of malocclusion. They are meant to be restrictive in deciding who may qualify for orthodontic treatment in a program funded with public or corporate money or in an insurance program whose basis requires less than 100% utilization. The orthodontist is restricted in his determination of the need for treatment by the cut-off point on the severity scale of measurements. Such screening may not even be considered by the sponsors to re-

quire an orthodontist to perform it.

There has been another use of a treatment priority index that is totally alien to a rational concept of orthodontic treatment. It is that a case which originally qualified on a basis of a severity scale and which has been treated to the cutoff point beyond which it originally qualified, if it presented in this condition it would no longer qualify. Therefore, the sponsor's obligation is at an end and the treatment must terminate at that point. Such decisions place an unfair burden on conscientious orthodontists who feel obligated to complete the case in spite of the termination of payment.

There has been some interest recently in trying to make an assessment of the need for orthodontic treatment in the adult population. Our thinking has been so conditioned by the neatness of the divisions of the gradations of severity of malocclusion, that often those who are involved in assessments of adult malocclusion fall into the trap of looking for a percentage of need. In reality, all that we can or should do is to take the number of adults — let us say in the 18 to 44 age group — subtract the number of this group which we can determine have probably received treatment as children (prior to age 18), subtract an estimation of those who have perfect occlusion (HEW says that 11% of the 12-17 group has "virtually classic normal occlusion." If we only knew what was meant by "virtually"), subtract those that are edentulous (HEW, May 1979 report), and the potential for orthodontic treatment lies somewhere in the remainder. It is a very large number, and certainly no one can tell you to subtract those with a very minor malocclusion. It may be minor to someone else, but major to the one that has it. □