EFOSA
European Federation of Orthodontic Specialists Associations
Federation Europeenne des Associations de Specialistes en Orthodontie

June, 2010
Issue 4

The EFOSA Quality News

Editorial

Academic faculty participation in QA activity was also limited. Faculty often assume that meaningful quality process demands excessive efforts and time unrewarded with career advancement, promotion, or monetary compensation.

In addition, unstructured QA leads to duplication of data and loss of educational opportunity.

A reorganized CQI format could stimulate enthusiastic participation of faculty and residents, and has generated in the 90's conferences and grand rounds pertinent to orthodontic care, outcome research, and cost containment. This was performed by the EuroQual program.

Quality : The message to our patients is loud and clear : offering and providing top quality at a fair price

Continuous quality improvement (CQI) is necessary in maintaining and improving the quality of medical care delivered. However, quality assurance (QA) in the past was performed superficially to meet requirements of Commissions on Accreditation of Health Care Organizations and other regulatory agencies.

Academic faculty should play leadership roles in the CQI process and include teaching models. Improved and increased academic faculty participation could be realized, when educational values, research activities, and cost analysis are incorporated into the CQI process.

Is CQI open to enhance faculty participation and interest in quality improvement however ?

Grading the quality of interest en actif participation should be one of the goals of the state of the art of modern orthodontic practice

In striving, dear I use this word, to improve the quality of patient care, today's academic orthodontic departments face special problems. Factors that are inherent in the department-s broader academic mission and in the organization of a major teaching hospital can compromise practice efficiency, reduce ease of access, and undermine cost competitiveness.

However, the same environment also provides the opportunity to exploit areas of unique clinical expertise, create value-added services, and develop regional approaches to service-line integration and disease management strategies.

A major challenge for the academic department is to validate the quality and efficiency of its current services while assuming a leadership role in the development of new approaches to quality improvement. This challenge must be met without losing sight of the department's equally important parallel commitments to research and education.

However, QM/CQI is increasingly being used by Government, Companies and the health care providers industry to improve their operations and profitability. This is probably the main reason why the specialist in orthodontics is reluctant to participate in the ESAS program !

The experiences with Euroqual, despite all the efforts that were made, unfortunately also were to the benefit of the reduction and cutting of the orthodontic fee in many countries once the final reports were available .

A further economical recession is not wanted. General practitioners provide far more orthodontic care then we believe and commercial actions and companies support them. The number of attractive coarses are rising rapidly and they are open to every one.

Perhaps the quality of "the specialist" is at stake ? **ESAS** can help to prevent this happenning !

Interim editor: Bart Vande Vannet

EFOSA: www.efosa.eu
ESAS: www.esas.nu

		population (milllion inhabitants)	% orthodontists per 100000 inhabitants	% registered ESAS orthodontists per 100000 inhabitants
(SE)	Sweden	9	2,7	0,36
(NL)	The Netherlands	16,3	1,5	0,18
(AT)	Austria	8,3	0,7	0,04
(IE)	Ireland	4,3	2,7	0,14
(LU)	Luxemburg	0,5	4,0	0,20
(DK)	Denemark	5,4	2,7	0,13
(BE)	Belgium	10,6	3,8	0,17
TK	Turkye	76,8	0,8	0,03
NW	Norway	4,7	5,7	0,17
(IT)	Italy	59,1	0,9	0,02
(SK)	Slowak Rep.	5,4	3,7	0,09
(EL)	Greece	11,2	2,5	0,05
(EE)	Estonia	1,3	4,0	0,08
(FI)	Finland	5,3	3,1	0,06
(UK)	United Kingdom	60,9	3,1	0,04
(ES)	Spain	44,5	1,1	0,01
(CZ)	Czech Rep.	10,3	3,1	0,04
(DE)	Germany	82,3	2,6	0,03

Table 1

Number of times mentioned as used for ESAS			
Treatment Process	**4**	**TP**	**22%**
Treatment Outcome	**5**	**TO**	**28%**
Patient Satisfaction	**6**	**PS**	**33%**
	3	PAR	17%
	3	IOTN	17%
	3	ICON	17%

Table 2

ESAS may not be not known, but certainly still is in an early developing stage. Statistics from these small numbers are hardly indicative. Much more promotion is needed to help ESAS reach a state for useful comparison. Since ESAS offers a special section for postgraduate students too, teaching institutions should participate and make ESAS a standard for future orthodontists.

The tabel to the left shows the number of orthodontists (source EFOSA) per 100.000 inhabitants and the percentage of the ESAS registered orthodontists per 100.000 inhabitants.

The table on the next page shows the top 5 of the registered users varies from 5% of registered uses in Luxemburg to 13 % registered users in Sweden.

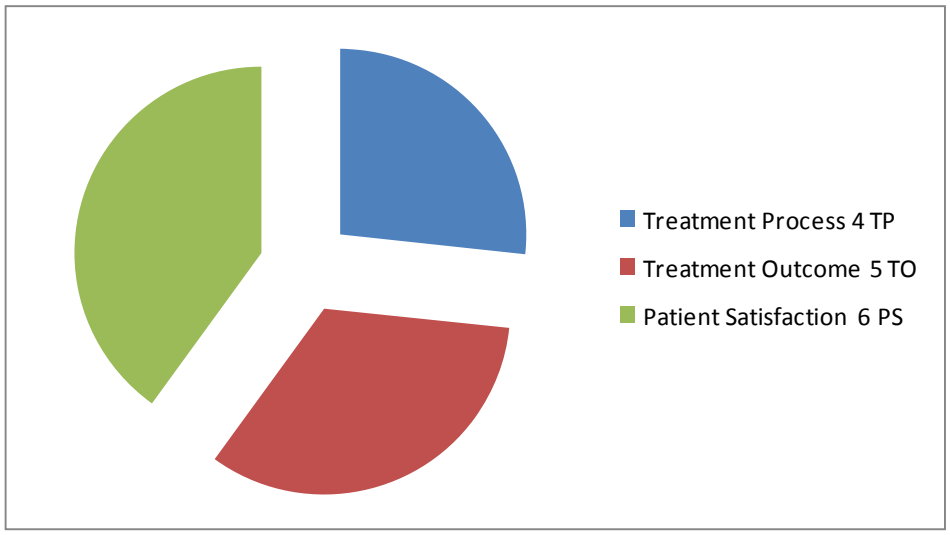
ESAS is mainly used for PS, on second place TO and in third place TP.

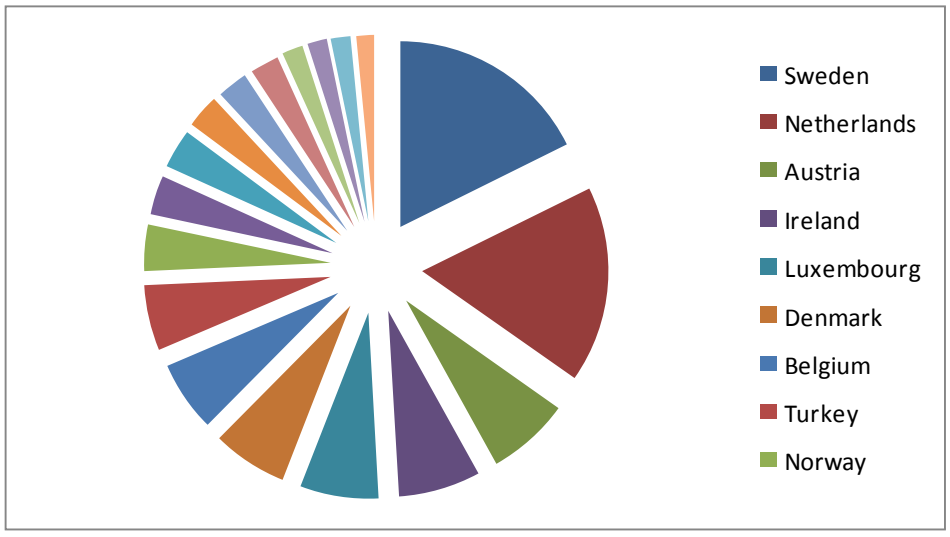
However the number of completed patients shows a large variability. In the UK there are relative less users (1.3.%) but they are very active. The Netherlands combine a high percentage of registered users (12.5%) with a high activity. Belgium shows a reasenable amount of registered users (4.5% within the top10) who are very active (within top 5).
Luxemburg shows however that the degree of activity has to be relativated and that one user can give a wrong picture.

“TOP 5 of users”

1. Sweden
2. The Netherlands
3. Austria
4. Ireland
5. Luxembourg

	Orthodontist registered as user	total number orthodontists	Patients introduced	Patients completed for 1 or more part	Used parts							% of orthodontists registered as user	activity
Sweden	**32**	**247**	**12**	**9**	**TP**	**TO**	**PS**	**PAR**	**IOTN**	**ICON**		**13,0%**	0,38
Netherlands	**30**	**240**	**47**	**5**			**PS**	**PAR**				**12,5%**	1,57
Austria	**3**	**57**										**5,3%**	0,00
Ireland	**6**	**115**										**5,2%**	0,00
Luxembourg	**1**	**20**	**14**	**1**	**TP**	**TO**	**PS**		**IOTN**			**5,0%**	14,00
Denmark	7	147	1	1		TO						4,8%	0,14
Belgium	18	400	20					PAR		ICON		4,5%	1,11
Turkey	24	576	1									4,2%	0,04
Norway	8	269	1	1			PS					3,0%	0,13
Italy	13	517	1									2,5%	0,08
Slovak Rep.	5	200	1									2,5%	0,20
Greece	6	280										2,1%	0,00
Estonia	1	52										1,9%	0,00
Finland	3	164										1,8%	0,00
UK	25	1861	18	3	TP	TO	PS		IOTN			1,3%	0,72
Spain	6	484										1,2%	0,00
Czech Rep.	4	323										1,2%	0,00
Germany	24	2133	5	5	TP	TO	PS			ICON		1,1%	0,21
Netherlands	3		35	2			PS						
Turkey	9		1										





Within this survey we noticed that not all parts of the program are registered and that the indeces PAR, IOTN, ICON are not very popular amongst the registered users. On the other hand we can state that allmost all countries (n=20) participate in the program, so it is not not known. Some countries are not represented in the statistics (Poland, Switserland, …). Perhaps more reports should be made for further stimulation.

The quality and the improvement of quality however is not improved by taking part to a quality measurement system. It only indicates the estimated position amongst peers.

One of the tasks of EFOSA in the European orthodontic field remains the promotion of the quality of care.

It was a challenge for me to make this edition of the Quality news as a guest editor and informing Europe over the status of the ESAS program. I hope this tradition can continue its way in the future.