Cost Effectiveness: A Bargaining Chip?

William R. Laney, DMD, MS, Editorial Chairman

In the real world of providing patient health care, the bottom line has become cost. No area of treatment has complete immunity from the scalpel of the third party involved in the reimbursement for clinical procedures. Because of the many elective facets of dental restorative care, payors more and more look to the cost effectiveness of procedures and material systems in making support decisions.

Speaking at a health care management conference several years ago, Peter Boland, PhD, Berkeley, California, consultant and author of *The New Health Care Marketplace: A Guide to PDO's for Purchasers, Payors, and Providors,* suggested that the future selection of contract providers by purchasers of health care services will be based on those who are the most cost effective rather than the "cheapest." The assumption acknowledges the fact that high-quality care is not necessarily the most expensive; furthermore, it can often be less expensive. While a contract provider may offer lower prices up front, there is no guarantee that lower costs will prevail long term.

Doctor Boland has cited the attractiveness of preventive dentistry because of its cost effectiveness. If coverage of short-term needs only are emphasized, dental benefits will suffer over time. However, if the purchaser is concerned with total cost and the long-term cost, good cost-effective dental health care as a benefit is prudent.

A case in point is the dental prosthesis supported by predictable implant support. Edentulous patients with recurring problems of retention, stability, and malocclusion of conventional complete dentures pursuant to bone loss and lack of opportunity for base extension, prolong malfunction and discomfort until once again insurance-eligible for reline or remake. Partially edentulous patients with failing dentition and/or periodontal support may fear the edentulous state and continue with shortterm palliative care, oftentimes denying the inevitable. One cannot fault the regular seeking and provision of treatment to ameliorate discomfort and malfunction. However, if predictable long-term solutions to these common problems are available, even though more costly initially, their use may be financially more cost effective in the long run.

Perhaps more important than the pecuniary cost benefit is the biologic cost effectiveness of predictable implant therapy. Generally, when a cylindrical implant design is used and adequate crestal bone remains between implants, eventual failure should not result in significant bone loss at the implant site. Unless a chronic or complex pathologic problem is associated with a failing implant, the void remaining upon implant removal should fill without resultant defect. Seldom do all well-conceived and carefully placed implants fail in the same mouth. As integrated

implants remain in appropriate function, they in fact encourage bone retention and actually contribute to bone conservation.

While more than one restorative procedure or material system may be available for use on implant support, mismanagement of the prosthodontic phase of treatment can adversely affect the most reliable of implant modalities. When using a particular implant system, even through the slightest modification of accepted surgical or prosthodontic procedure, misuse or misapplication puts the patient at risk.

If these risks can be avoided, the one remaining element of success is controlled by the patient. At best, the prosthesis and its implant support are at the mercy of patient use and abuse. Any restorative system, regardless of design and material, will not survive neglect nor misuse indefinitely. However, when well-designed and fabricated prostheses are placed on predictable implant support in the mouths of caring patients, the result can be long lasting, provide comfort, and protect "that which remains" of the biologic foundation. What better value for the cost can one ask?