Author's response to reviews

Title: Pay for Performance: Will Dentistry Follow?

Authors:

Andreea Voinea-Griffin (avoineagriffin@yahoo.com)
Jeffrey L Fellows (jeffrey.fellows@kpchr.org)
D. Brad Rindal (donald.brad.rindal@healthpartners.com)
Andrei Barash (abarash@uab.edu)
Gregg H Gilbert (ghg@uab.edu)
Monika M Safford (msafford@uab.edu)

Version: 5 Date: 27 January 2010

Author's response to reviews: see over
January 27, 2010

Natalie Pafitis MSc
The BioMed Central Editorial Team

Dear Mrs. Pafitis,

We are pleased to submit our revised manuscript entitled “Pay for Performance: Will Dentistry Follow?” (MS: 1860499611304354). We are grateful for the thoughtful review given to our manuscript. We provide below our responses to the reviewer comments. To more easily identify all the changes made in the manuscript, we have provided a version that uses the “track changes” feature in the Microsoft Word.

Referee #1: Tim T. Newton

This is a fascinating paper which addresses an important public health problem - that is the impact of Pay for Performance on the behaviour of dentists.

Thank you for your feedback.

The paper is very much written on the basis of the American system of dentistry. The author(s) should acknowledge this limitation of the discussion and acknowledge that different systems might lead to different behavioural responses on the part of dentists. In particular what variables might be important (Eg the UK system of largely free at source dentistry with co-payments).

Thank you for your suggestion. We have now added the following statements to the Discussion session (pages 9-10): “A growing body of literature describes value purchasing programs and their implementation in various healthcare systems (Pink, 2006; Roland, 2004; Hill, 2009). Although provider incentives differ by healthcare system and P4P program, significant design and implementation obstacles exist in every country where P4P was implemented (McDonald, 200; Pink, 2006). Despite the focus of this analysis on the American system of dentistry, the factors influencing the P4P adoption exist in various degrees in other dental healthcare systems as well.” and “The structure of dental insurance is a major contributing factor in the implementation on any value-based plan. For example, in the United Kingdom, dental care is largely covered by the National Health Services (NHS). Due to NHS share in dental practice revenues, payment policy changes such as P4P, may
The authors are dealing with a number of topics, namely quality, structure of the care delivery system and incentive issues (although those covered in the present paper are largely financial). (...) While I would accept the overall premise made in the paper, it currently does little to add to the existing debate. The issues have been simplified.

The overall structure of the paper needs considerable modifications. (...) The overall theme that the paper is attempting to suggest is that, as performance is difficult to define, not least as the evidence base underpinning dentistry is limited, that the usage of ‘pay-for-performance’ arrangements should be adopted with caution.

Thank you for your suggestion. Since the current literature suggests that the successful P4P implementation depends on providers’ adoption and because providers are interested not only in the payment levels but also in quality of care, we analyzed the P4P from a quality improvement perspective. The reviewer’s point is well taken, because, as the literature suggests, quality in healthcare is not easily definable. This is why we adopted the classic Donabedian framework for quality (1966). Rather than reviewing a list of disparate topics influencing P4P, our intent is to present a solid theory-grounded approach to value-based purchasing in dentistry as related to quality of care.

First, one of the main problems of making comparisons across countries is the ability to transfer what are very contextualised policy decisions to another setting. The comparisons that the authors make are in the main from only two countries. However, the starting point for both systems is very different: the United Kingdom has a nationalised system based on universal coverage; the United States a privatised system in which access is a major problem and in addition at considerably greater costs than the UK. This makes the setting very different as the political impetus for change comes from a different base.
We agree with reviewer’s observation that policy decisions are highly contextualized and difficult to transfer. However, this paper does not attempt to compare policies across countries but to take advantage of the components of P4P related to quality of care as reflected in the existing literature. Our main examples are from the United Kingdom and the United States due to the wealth of published research and interest in P4P in the two countries. Although healthcare systems differ, highlighting current experiences and existing gaps relevant to P4P adoption, irrespective of the country, is important because: (a) dental services are not a catastrophic expense for patients and thus, not as influenced by third party payers as medicine; and (b) similar quality components related to P4P adoption in dentistry (i.e. lack of clinical guidelines) may be found in other countries as well. To clarify this issue, we included the following paragraph on pages 8-9: “A growing body of literature describes value purchasing programs and their implementation in various healthcare systems (Pink, 2006; Hill, 2009). Although provider incentives differ by healthcare system and P4P program, significant design and implementation obstacles exist in every country where P4P was implemented (McDonald, 2009; Pink, 2006). However, despite the focus of this analysis on the American system of dentistry, the factors influencing the P4P adoption exist in various degrees in other dental healthcare systems as well.”

The problems of the delivery system in the United States are also wider than rising costs and variable quality; they include access and payment for prescription drugs.

Thank you for your observation. We agree that the healthcare delivery system in the United States has numerous problems. There are numerous articles and a history of policy attempts to correct these issues. However, our paper covers a very narrow aspect of healthcare delivery: the aspects of quality related to value-based purchasing in dentistry. Our statement is “Rising costs and variable quality are two of the major challenges faced today by the United States (US) health care system.” (page 5), not because access and prescription drugs are not important issues of the US healthcare system, but due to the relevance of costs and quality to P4P programs. Moreover, we do not attempt to engage in a comprehensive discussion of the problems faced by the US healthcare system; thus, we state “two of the major challenges” rather than “the challenges” in our only reference to the whole healthcare system.

The second issue also centres on the transferability, namely that of measures of the qualities of care in medicine and dentistry. While I would totally support the authors comments on how the use of targets influences the manner in which providers respond (the reference used in the paper currently is limited and I have identified 3 which I would recommend), it is only part of the story.

Thank you, your suggestion is highly appreciated. We included the suggested references in the current version of the manuscript.

The question that arises is why were the targets set? I would argue that all care systems use financial incentives to steer performance.
The reviewer makes an excellent point in noting that all healthcare systems use financial incentives to steer performance. On page 5 of our revised manuscript we state that: “The so-called “pay-for-performance” (P4P) is in fact a group of value-based purchasing programs that attempt to link provider reimbursement to quality indicators, with the ultimate goal of improving the quality of healthcare”. Based on the reference suggested by the reviewer, we also include on page 7 the following: “A review on empirical literature found little evidence of the effectiveness of paying for quality in healthcare (Rosenthal, 2007)”. Thank you for your suggestion. Donabedian and quality experts do not deny the importance of structure and process indicators; they recommend that outcomes measures should be part of any quality-related program. Unlike in medicine, limited experience with incentive programs for dental care exists. We already published a detailed discussion about what we know about P4P programs in dentistry (Voinea-Griffin et al, “Pay for Performance in Dentistry: What We Know”. Journal for Healthcare Quality, Vol 32, No. 1, Jan/Feb 2010). The current manuscript highlights the paucity of outcomes indicators in dentistry (Table 3). Absent adequate research, the authors cannot suggest adequate outcomes measures, select those indicators to quality, or propose incentive arrangements to foster quality. The goal of the current manuscript is to define the problem, rather than to suggest solutions unsupported by research. To address the reviewer’s comment and eliminate any confusion, we added the following paragraph to the discussion section (page 20): “In conclusion, dentistry is not ready to follow primary care in implementing value-based purchasing programs. The key elements of a P4P program in general medicine have been identified and can be operationalized: clear objectives, definable units of assessment, valid performance indicators, analysis and interpretation of performance data, performance standards and financial rewards (Mannion, 2008). These elements have not been developed in dentistry yet. Future research should address the issues identified in this manuscript as well as demonstrate a link between financial rewards and performance improvement to foster the adoption of P4P for dental care.”

Third, while there are a considerable number of references used, many are dated and limited in their analyses given the topic. I would wish to see fewer and more pertinent references used. This could be achieved through the restructuring of the paper into three sections: namely remuneration options, issues surrounding the definition of the qualities of health care and the differences between general and dental health care. (…).It requires a rethink on the key elements that it is trying to convey. One of these is the need to make comparisons to alternative delivery systems; I think this detracts from the main message and as highlighted above, care systems are highly contextualised. A paper that addresses the key principles of remuneration, its links to the qualities of health care and a comparison of dentistry with general care limited to the Unites States would be my suggested starting point.
The reviewer’s point is well taken. In the previous version of this manuscript, 18 (21%) of references were dated prior to the year 2000. We addressed these issues by doing the following in the revised manuscript:

- We maintained 3 classic references (# 37, 81, 84 in the revised manuscript) due to their value to the field.
- Of the 6 references strictly related to dental care, we maintained 5. Reference #50 in the first manuscript was deleted. Given the limited attention given to this topic in dentistry, we could not replace these references with newer ones nor delete others without losing important information for the reader.
- 7 out of the remaining 9 references were deleted or changed to newer, more relevant references (# 2, 39, 40, 41, 60, 61, 68 from the first manuscript). Reference #57 in the current manuscript was retained because it illustrates that variations in dental care still exist, despite evidence and performance targets dating since 1990. Reference #73 was also maintained due to its very early definition of clinical guidelines by the Institute of Medicine; this reference also demonstrates how long ago clinical guidelines were promoted in public health.

The number of words in the main text increased from 3,861 in the initial manuscript to 4,139 in the current version.

Thank you very much for your consideration. Our manuscript has been considerably improved as a result of its peer review, and we are very appreciative. If we need to make additional revisions, we will be glad to do so.

With regards,

Andreea Voinea-Griffin, DDS, MBA, MSHA, FACHE