Author's response to reviews

Title: How to reform western care payment systems according to physicians, policy makers, healthcare executives and researchers: A discrete choice experiment

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Author's response to reviews: see over
Dear Editor,

We would like to thank you for your positive reply concerning the submission of our manuscript MS: 1382816611461104 entitled “How to reform western care payment systems according to physicians, policy makers, healthcare executives and researchers: A discrete choice experiment” to BMC Health Services Research (Section: Health policy, reform, governance and law). You asked us to revise our manuscript taking into account the comments and questions raised by the two reviewers. We have done so and you can find our replies to the comments and questions below.

We hope this revised version of the paper meets with your approval.

Sincerely,
Roselinde Kessels, Pieter Van Herck, Eline Dancet, Lieven Annemans and Walter Sermeus

Reply to the revisions requested by László Kalabay

Reply to Major Compulsory Revisions:

1. Authors analyze attitudes in several dimensions, i.e. stakeholder position, geographical region. Age, gender, seniority, form of physicians’ payment are also considered. Based on Table 2 a practicing doctor in a teaching hospital in the USA is the most frequent data supplier. Although the authors are aware of the consequences arising from selection bias, does the study have enough power to compare minor groups (less represented regions, stakeholder positions)?

   Reply: We agree that there is some unbalance in the representation of the respondent subgroups we investigated in the paper, namely stakeholder groups and geographical regions, but this unbalance is not dramatic. We were still able to compare the subgroups among each other, as shown by the significant p-values for various interaction effects involving combinations of attributes and the subgroups.

2. Did the form of physicians’ payment (Table 2, last row) significantly affect their choice in the performance domains?

   Reply: This is an interesting research question we omit to answer, and therefore, we added the following paragraph to the paper in a separate subsection of the results:

   “We compare stakeholders' choices based on the current payment systems in use to pay physicians (see Table 2 for the different payment forms). Because respondents could select more than one payment form, it is not surprising that we found no significant differences in evaluation of the care payment reform outcomes between most payment forms in use, including salary, fee for service, episode-based payment, capitation, evidence informed case rates and never event non reimbursement or warranty. There is, however, a significant effect from the use of a quality bonus or adjustment. Using such payment form, stakeholders pay less importance to the outcome effects in 'provider wellness' compared to not using this form (0.41, 0.35 and 0.73 times less for avoiding deterioration, improvement and preserving status quo).”
Reply to Minor Essential Revisions:

3. Eastern Europe is probably the most heterogeneous region in terms of health care systems, attitude of health policy makers, national income. Were there differences between Western and Eastern parts of this region?

Reply: A limitation of the study is that we treated Eastern Europe as a homogeneous region, whereas it is indeed probably the most heterogeneous one. We have not deepened the differences between different sub-regions of Eastern Europe, because in this case the sample size or power is too small for providing useful results. We added this specific limitation in the list of limitations in the discussion section of the paper (see second limitation).

Reply to revisions requested by Neeltje van den Berg:

Reply to Minor essential revisions:

Introduction:

1. Some more details to the referenced studies are needed especially with respect to the lines 57-62. The study considers stakeholders from different parts of the world. Are the referenced studies in the introduction also from different countries and do they consider different kinds of reimbursement systems?

Reply: To provide more clarity on this issue, we started line 57 with the following text: “The literature to date consists of about 130 effect studies of healthcare payment reform, with the majority taking place in the US (50%) and the UK (45%). The remaining studies are spread across Australia, Germany, the Netherlands, Spain and Italy. Studies in Canada and Eastern Europe are largely lacking. Results show that …”

Methods:

2. Why only physicians were included in the health care provider group? There are other important stakeholders, e.g. nurses.

Reply: This is indeed a limitation of our study which we added to the list of limitations in the discussion section of the paper (see third limitation).

3. Please explain more detailed how the different profiles were compiled.

Reply: In Section 2.2 we explained in detail how the different partial profiles were compiled. We also added all relevant bibliographic references about the methodological aspects of partial profile design construction.

4. The language of the questionnaire was English. Were all participating countries English-speaking countries? I don’t think so, because also countries in Eastern Europe were included. Please provide some more details here.

Reply: For sure, English as a language had an effect on the response rate of the questionnaire among the non-English speaking part of Europe. This involves some selection bias, which we recognized in the list of limitations in the discussion section of the paper (see fifth limitation). However, we reached enough participants from Eastern Europe to be able to make useful comparisons with other geographical areas.
Discussion:

5. The geographical areas of the stakeholders were included into the analysis, but a discussion about the possible causes of differences between these areas is lacking. Do you think the differences reflect rather cultural or political differences or maybe reflect differences between the healthcare systems?

Reply: In the fourth paragraph of the discussion section, we included a series of hypothetical factors explaining the differences between geographical areas: “Possible explanations are that Oceania is internally perceived as a high performer already, Canadian physicians focus more on conservative objectives for payment, and in Western Europe one does not feel sufficient pressure yet on cost containment. These hypothetical factors are likely to change during the following years and decades as a consequence of external pressure on health systems. In Eastern Europe and the US this seems to be already the case.”