DO WE WANT TO MEASURE ORAL HEALTH OUTCOMES?

"You can't manage what you can't measure". Peter Drucker

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The implementation of Results-based financing and reimbursement models involves a significant transformation in the provision of care and financial management of the entire process. For the proper implementation and adoption of these models, literacy, education and information dissemination will play a critical role.

In addition, an appropriate information and communication technology (ICT) infrastructure, analyses and methods to predict the use and costs inherent in each of the procedures, regardless of their nature, is essential.

Our reality

In essence, two sources of funding for oral health care are prevalent in Portugal:

- Private, through:

• out of the pocket payments, the vast majority, with freedom of choice by the user;

• and in share, e.g. health insurance, ADSE (government employee and dependents) and health subsystems, with some degree of freedom of choice on the part of users.

- Public, through the State budget, in the context:

• the National Health Service (NHS) and Regional Health Services of the Azores and Madeira, without freedom of choice of the provider by the user;

• the 'Dental Voucher' to provide care to predefined groups of the population in the private clinical practice of adherent dentists, with freedom of choice of the provider;

• and Social Security, in this case for disadvantaged groups at risk and low-income elderly population, for rehabilitation procedures through dental prosthesis and some basic treatments, upon prior approval.

Expenditure on out of the pocket payments by citizens in the context of the provision of oral health care is one of the most relevant in Portugal with regard to direct payment; although the Portuguese NHS is theoretically universal, general and biased free, accessibility is very limited and conditioned on access to various areas of health, namely and here in particular the area of oral health.

These out of the pocket payments, made by private individuals, are already very close to 40% of the total health expenditure in Portugal, including the pills, analyses and auxiliary means of diagnosis, medical devices, prostheses and treatments of dental medicine, visual health, among several other headings.

How are payments for clinical procedures made by people and families?

In the area of oral health primarily through two strands:

• FFS (fee-for-service). Ex: conventional private practice, ADSE, Insurance and Health Plans;

• By Capitation. Ex: in Portugal the Dental Voucher 'Cheque Dentista' or Health Insurance Plafonds, with limits, usually annual, fixed for providers.

And will the fundamental question of the evaluation of the Results arising from the procedures carried out be linked to the form of payment?

It's consensual. Note that:
• payments FFS reward quantity overall, but not the quality or efficiency of clinical care; often lead to overtreatment;

• capitation payments often become disconnected from the actual needs of patients/users, which arise or evolve over time; lead to undertreatment.

So what will be the most efficient way to fund dental care?

All have advantages and disadvantages. Payment FFS is our culture, the norm, our *mantra*. It tends to induce treatment.

As such governments, subsystems and insurance companies have introduced "blind" rules to reduce over-service, without safeguarding quality and good clinical practice, as appropriate monitoring mechanisms have costly implementation, requiring human capacity and additional infrastructure to measure and monitor the use (or possible use) of services.

In another context, at the level of primary health care of the NHS, payments by act were replaced by capitation mechanisms and by some form of payment for "occurrence or type of episode", such as the designated homogeneous diagnostic groups in NHS hospitals.

The capitation Dental Voucher involves the payment of a fixed amount per person registered with a provider or institution for a certain period of time, with previously defined services and procedures. However, cost control has been done in this program, erroneously, at the expense of approaches and practices that tend to avoid preventive procedures, devices, tests, materials and rehabilitation treatments, more expensive and consumers of more time and human resources, to the detriment of a careful assessment of the health gains obtained.

At this stage, it is considered that for a reality such as the Portuguese, diversifying payment and reimbursement models by adding payment modalities by Value/ Results obtained will be healthier and allows testing acceptance by all stakeholders involved, providers, citizens, financiers and regulators.

But how can we then evaluate the essentials? The clinical results arising from different models?

A prior and personalized assessment of individual and collective risk resulting from existing pathologies, general health status, behavioral habits and other influencing factors is essential. To do so, funders, State, Public and Private Insurance must be made available to pay for this assessment.

The introduction of value-based reimbursement, depending on the calculated risk and the Results obtained, serves as a lever to better align providers' incentives for quality healthcare delivery.

Aligning reimbursement with the amount in this way rewards providers for efficiency in achieving good Results, while blaming for their reverse, penalizing the provision of lower quality care.

The value-based repayment concept is part of a radically different payment approach: grouped payments.

In a bundle payment system, providers are paid per pathology line of a customer throughout the entire service cycle, i.e. all services, procedures, tests, medications and devices used to treat a patient.

Let's look at a generic example of a Value Chain applied to "Surgical Extraction of Impacted Wisdom Tooth in Ambulatory Surgery Center" and the phases to be taken into account:

1. Integration of care throughout the Organization. E.g. screening, risk analysis planning and operationalization and follow up;

2. Multidisciplinary communication. Ex: Receptionist, Dental Assistant, Dentist, Oral Hygienist, Dental Prosthetic Technician, Assistant Physician, Nutritionist;

3. Information sharing on a technology platform. Ex: Dental Medicine computer Program with a high degree of interoperability;

4. Bundle payment Ex: allocation of 3 to 5 levels of payment resulting from previous risk analysis, due to morbidities, age, patient profile, tooth location, proximity to nerve and vascular structures, among other factors;

5. Measurement:
a) Costs. E.g. mapping and recording of all costs and time units affected by all actors, and
b) Results. Ex: due to alveolitis (inflammation and postoperative infection, pain, swelling, impediment of masticatory activity, limitation of movement);

6. Expansion of best practices and services of excellence. Ex: attribution of a Results and Quality index to professionals and reference units of oral surgery in this line of procedure;

7. Recognized Social Value. Ex: evaluation through public funding of this procedure, which is so often disabling masticatory functions, causing pain, headache and repeated infections.

In conclusion, to achieve a value-based delivery system, it is necessary to follow a series of mutually reinforcing steps:

• Evaluate the individual and collective risk arising from the pathologies in question, the general health status of users, behavioral habits, and other competing factors;

• Measure and disseminate health outcomes for all providers and all medical conditions. These results will not only boost healthcare providers and insurers to improve effectiveness and efficiency but will also help patients and funders choose the best teams of providers for their medical circumstances. Results should be measured throughout the entire treatment cycle of a medical condition, not separately for each intervention. The results are inherently multidimensional, including not only the direct impact of the intervention, but also the degree of health or recovery achieved, the time required for recovery, treatment discomfort and sustainability of recovery;

• Radically re-examine how to organize the provision of treatment and rehabilitation services, but also prevention, well-being, screening and routine health maintenance.

The model of providing health services in which providers are reimbursed in a dignified and tangible manner based on patient health outcomes, quality and cost of care (payment for performance) is understood as a value-based health model.

What do patients want, what do they really care about?

Results. Easy to understand, identify, feel, evaluate and compare. ■