Conundrums in health care reform: current experiences across the North Atlantic

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Abstract

Objective: To assist stakeholders (policy makers, dentists and patients) implementing the Patient Protection and Affordable Care Act of 2010 in the United States by providing information on conundrums arising from previous polices of the UK Labour government and emergent policies of the recently elected Coalition Government.
Methods: The authors provide a background to the development of National Health Service dental services contrasted with US provision. Considerations are given from the different perspectives of stakeholders involved (policy makers, dentists, and patients).
Conclusions: Policy makers must work under pressure for services to remain within boundaries of finite economic resources and what people are willing to pay for. The importance is stressed that they respond to public demands and workforce capability by clearly determining what the priorities should be, what services will be delivered, and defining responsibilities.

Introduction

Armed with an eclectic background in dental clinical care and dental academia, we offer some food for thought for policy makers, clinicians, and patients involved in the American and British debates about changes in dental care systems. Both governments are in the process of implementing health care reforms. In the United States, the Patient Protection and Affordable Care Act 2010 (PPACA) (1) seeks to expand government involvement in health care delivery, while the UK government seeks to reduce involvement by encouraging provider competition, thus "liberating" the National Health Service (NHS) (2). In implementing these reforms, some shared conundrums arise which face both countries and to a great extent hinge around costs.

The United States and UK are experiencing the financial consequences of economic downturn while under the perennial pressure of providing accessible health services of quality to the consumer and at a satisfactory cost to taxpayers and voters. Increasing access to dental care can lead to issues in managing demand. As demands rise, costs soar and decisions must be made about increasing access to dental care via state-funded mechanisms or reducing access by rationing of some form. Increasing workforce capacity to supply demand involves not only new recruitment but satisfactorily remunerating dentists. Their participation in state-funded schemes

will be limited if they perceive that it does not adequately recompense them while increasing their workload. A further consequence of the political promise to increase access is the need to manage expectations. Government will be expected to show what extra is being delivered and how increased spending of taxpayers' money is delivering a service of enduring quality.

With this in mind, we seek to consider the implementation of the reform policies from different perspectives of the stakeholders involved and the outcomes in terms of costs, effects on oral health and upon patient experience.

Background

The United States predominantly operates on a fee-for-service basis for private professional practices rendering services to patients in a decentralized system (3). An assortment of insurance schemes (administered by private companies, employers and/or the government, paid by employer contributions and employee premiums) and out-of-pocket payment by patients account collectively for most dental payments. The Federal government (the nation's largest health care insurer) finances the Medicaid program with Federal and state-level tax revenues (4). Increases in coverage and access to care are key aims of the PPACA (1), allowing for stand-alone dental plans and comprehensive insurance plans to include oral care for children. Some Federal funds have been appropriated to make operational the several provisions in PPACA, which strives overall to create a comprehensive systems approach to improving oral health (5). The approach aims to extend children's dental coverage in Medicaid and the Children's Health Insurance Program (CHIP), and seeks to increase participation in school-based dental sealant programs and national oral health surveillance systems in all US states. Prevention initiatives include a public education campaign promoting oral health and grants to investigate the effectiveness of research-based dental caries management provided by community-based dental professionals. A national commission will review oral health care workforce capacity, development and training. Stipends, loan repayments, and institutional grants will fund residency programs and training of a dental workforce committed to public health, and for caring for the underserved and those at risk. Expanding workforce capacity includes intentions to fund training of dental hygienists and alternative dental health care providers to deliver care programs in underserved communities. Some areas of the profession disagree with this initiative, while others view an opportunity work in tandem by supervising hygienists delivering less complex care allowing dentists to focus their skills on more complex treatments. Payments to dental professionals will be reviewed by the Medicaid and CHIP Payment and Access Commission (5). Although PPACA will not radically alter the current system of delivery, the overall intention of the PPACA is to increase coverage and access to dental care in the United States. Some PPCA provisions have been authorized and received an appropriation of funds. Others have not and without appropriation are unlikely to happen. Some provisions will not be operational until 2014 and, given the ongoing economic climate, may receive limited appropriation or none at all.

The UK operates a mix of public and private services. Oral health care in the NHS is universally available and financed from collective taxation (6). The NHS was established in 1948, and dentists were paid through a fee-for-item-based remuneration system administered by the central government. Large unmet need meant that demand exceeded predictions, threatening financial viability, so in 1952, co-payments were introduced (7). A new national contract in 1990 introduced a capitation payment system for children, and although the fee-for-item system persisted for adults, additional continuing care payments were introduced for adults "registered" with a dental office (8). Under financial pressure in the 1990s, the government reduced funding, leading dentists growing the private element of their practice and reducing their NHS commitment; most of them, however, maintained a mixed clientele (9). Access to NHS dental services became a high-profile political issue; NHS strategies for improvement (10) included the creation of dental access centers mainly staffed by salaried dentists. Alternative methods of delivery and remuneration (usually based on capitation) were pilot tested; despite such changes, there was recognition that radical change was required (11). Reforms in 2006 capped the NHS dental budget and returned management of contracts to local NHS bodies. Contracts radically changed to payment through a mix of cost and volume arrangements: past treatment activity and gross earnings by dentists were converted to units of dental activity (courses of treatment weighted by complexity) (12). Under this new approach, dentists had to meet agreed activity targets for specified monthly payments. The co-payment system also changed, moving from a complex system of charges for 400 individual items of treatment to only three charge bands based on complexity (13). The coalition government formed in 2010 has announced that they will introduce a new NHS dental contract based on patient registration and a capitation system of remuneration, together with incentives to ensure quality.

In summary, in the United States, dental care is delivered via decentralized systems dominated by private enterprise, while in the UK, it is essentially a public service controlled by central government. The UK has a policy of lifetime universal access to dental care provided by NHS dentists remunerated by the government. Patients contribute toward treatment through National Insurance contributions and taxes during their working life and co-payments to the dentist. Treatment is free for children under the age of 18, the unemployed, the

chronically sick, and those on low incomes. Fees for service in the United States are mainly paid for by employer-/employee-funded insurance schemes and out-of-pocket expenses. Once retired or unemployed, coverage via the schemes ends, so unless patients can afford private insurance or out-of-pocket fees, they are without cover, while in the UK, this is not so. The United States does operate the Medicaid welfare scheme, but dental cover for those over the age of 21 is optional. A prescribed minimum schedule of care is provided for those aged under 21 should their families qualify, but administration of Medicaid differs state by state, and patients must find a dentist who is willing to treat Medicaid beneficiaries.

The United States and UK are looking at revamping dental health programs and health care systems (1,5,11). Governments of both countries face a similar dynamic of opinion on delivery of care. At one pole, there is the social opinion desiring to expand care funded by universal collective taxation. At the other end, there is the individualistic opinion opposed to increased taxation and care systems dominated by the central government. While the current landscapes (late 2011) are in a state of flux in a great many dimensions, future programs and systems will likely need to incorporate and combine the perspectives of all main stakeholder groups involved. An initial discussion of three areas where this will be required is outlined in the next sections.

Policy

Oral health care policy may range from emergency access to clinical services to resolve pain, or universal access to preventive and rehabilitative care. Any program funded through taxation will always operate under political pressure to maintain public satisfaction and control expenditure. Government and administrators must make explicit the health care offer to the public in terms of what will be available to follow the mandate of programs while successfully balancing demand and costs of services. Systems need to adequately monitor and, where necessary, manage the type and amount of care provided; they must also demonstrate effectiveness in delivering health improvements. As the past 10 years have clearly shown in the UK, access to care is a sensitive political issue; because the evidence base for a substantial proportion of clinical dentistry is sparse (14), measurement of adequate quality services is complex. Another challenge for policy makers (in the United States and in the UK, and most likely anywhere) is the current financial climate and a requirement to contain the spiraling costs of health care. In the UK, research suggests that capitation tends to incentivize undertreatment (15). Pilot projects revealed a fall in clinical activity under capitation (16), resulting in a reduction in the total dental budget from fewer co-payment fees (17). At the same time, evaluations (18) of the pilot projects could not show increases in the provision of preventive care or substantive improvement in patients' oral health (at least in the short term). Dentists' personal remuneration was protected in these pilots and is not separated from co-payment fees in the 2006 contract.

The activity targets of the 2006 NHS contract were introduced to incentivize activity and maintain co-payment revenue; they resulted, however, in a different set of unplanned incentives leading to a decline in complex treatments such as endodontic therapies, and placement of crowns and bridges, while volumes of extractions increased (15,16). This experience raised significant concerns about a decline in the quality of care. It also illustrates the complexity of planning reforms of dental services and emphasizes the need for policy makers to have a very clear picture of what they are trying to achieve.

Knowing that the ultimate goal of the PPACA is to improve health status overall, a concerted set of actions have been laid out to enhance access and affordability (1). Access to dental care has been plagued by substantial problems for a considerable fraction of the American public. The PPACA propositions address the various dimensions of oral health at the community, family, and individual levels that should be supported with sufficient funding, and adopted to become long-standing features of dental programs (5). Wider-reaching actions to change the environment pertaining to social determinants of health were hinted at in PPACA but not fully developed.

In the UK, despite universal national insurance contributions, free-of-charge access to dental care was financially untenable as demand soared, costs spiraled, and a co-payment system had to be introduced. This in many ways helps allocate state funding toward necessary treatment. Remunerating dentists for their work has been problematic as capitation appeared to encourage dentists to register more patients but treat less, while fee-for-item incentivizes overtreatment. Governments are accountable to taxpayers and voters, consumers of health services, and must show that they spend wisely on quality care. A clear government statement on what consumers can expect to be available from their dental care system coupled with robust assessments to ensure quality would help show taxpayers and voters that they were receiving value for money in treatment and service.

Payment

A comprehensive approach to care was expected as an outcome of the 2006 NHS reforms (13), but the contract was implemented in one action, immediately replacing the fee-for-item system; it caused a measure of dissatisfaction among dental professionals (19). The fee-for-item mindset remains today, and it appears to influence dental professionals' approach to care by focusing on treatments that help them reach their activity targets as expeditiously as possible (15).

Such paradox raises concerns about how publicly funded systems can influence the complex balance between professional ethics and running a profitable small business. The ideal compensation system would obtain the best outcomes for patients and ensure that dental offices remain profitable. Careful thought is required to second-guess the effects of contractual incentives (both planned and unintended) so that policy makers get the expected product and taxpayers get value for money.

Because the financing of the oral health care systems in the Unites States is most likely to remain primarily funded by private entities for the foreseeable future, a direct extrapolation of the NHS experiences to the American scene is pointless. However, in the smaller context of the publicly funded oral health systems (which remains by and large the cornerstone of child access-to-care enhancement in PPACA), the NHS experiences highlight a variety of experiences to consider. Perhaps, the more complex facet of such smaller context for the United States is to address who is in charge of identifying the problems and of designing and negotiating strategies to solve those problems, and then having multiple players working in sync to attain defined goals over time.

Dentists have to make a living and, understandably, their participation in state-funded schemes will be limited unless it adequately recompenses them and does not place targets upon them which they perceive are difficult to achieve. Government can ensure that remuneration is acceptable and, at the same time, ensure that payment systems are prompt and efficient. In return, dentists would need to actively show that they are providing accessible care and treatment and a quality service to their patients.

Public need

The demands of the public (taxpayers, voters, and media) are ephemeral for the most part; but it is clear from the UK political issues of the late 1990s that a period of adjustment must ensue when publicly funded services contract. Case in point is access to clinical services. In the UK, there is a desire to move toward a more preventively oriented service system (12) However, public understanding of the "less is more" argument to pay for prevention at the expense of complex restorative treatment posed a tough problem: designing systems to collect co-payment revenues perceived by the public to be fair and justifiable. The activity targets of the 2006 contract incentivized quantifiable treatment activity that could be easily verified and limited financial risk to the NHS from reductions in co-payment revenue. Shifting costs to the consumer through increases in co-payment (a method of cost containment (20)) is always a contentious issue. Patients' contributions in the UK have been relatively low with many groups being exempt from charges. In the United States, Medicaid cost-containment approaches have been usually managed by positioning the eligibility bar higher or lower in relation to the Federal poverty level; thus, more or fewer individual households become eligible for specified services. (Certain population subgroups have traditionally been awarded special treatment.) CHIP also adopted private sector strategies such as co-payments, premium charges, and other limitations on services common in the private sector.

The experience in the UK is that increasing co-payments may restrict access, as those with less disposable income would feel the financial burden more acutely than affluent counterparts; the former may reduce the use of services accordingly (21,22). In any part of the world, the implicit assumption in programs is that patients would also seek assurances about value for their money, the quality of the care they receive, and the ensuing outcomes. Given the disparity in knowledge between dentists and patients, policy makers need to consider mechanisms to support patients to make informed choices about the dental services they wish to use. While both the United States and UK environments rely on expert groups and governmental agencies to protect the interests of the public as far as choices of services are concerned, PPACA provisions signify a major leap forward for the United States. They include initiatives to improve the quality of information supporting strategies to address epidemiologically important diseases – in particular dental caries; the creation of alternative workforce formulas as effective means to meet untreated disease, as well as efforts to examine the performance of such "emerging" formulas; and the expansion of health enhancement platforms such as school-focused clinical and health education centers.

Taxpayers, voters, and media must be convinced that increasing coverage and access to dental care will be costly, but a preventative focus on the long-term achievements in improving dental health would reduce treatment costs over time. They should expect that government shows investment in prevention, which has the desired outcomes of not only improving dental health but also improving the health behaviors of consumers of publicly funded services. In return for their increased financial contributions, the public should expect affirmation that publicly funded treatment is being provided to those disadvantaged, is necessary for well-being and is of a quality that endures.

Closing thoughts

In seeking to reform dental care systems, there are many issues to consider by government policy makers, dental professionals, and the public with the key issues centered around access, cost, and quality. It is crucial that policy makers respond to public demands and workforce capability by clearly determining what the priorities should be and what services will be delivered and defining responsibilities. A

further pressure is to remain within boundaries of finite economic resources and what people are willing to pay for.

Within the UK and the United States, there currently appears to exist a focus on prevention over invasive treatment. Given the current economic climate, hard questions need to be asked, for example, whether the provision of preventive dental services is in fact a more cost-effective use of taxpayer's money than services focused on treatment (23). It may be desirable to clearly and explicitly separate prevention and treatment; one approach to consider is to charge publicly funded programs with prevention and health promotion tasks, and leave a better defined mix of publicly and privately funded clinical services to focus on relief of pain and restoration of function. Making the compensation system clear and explicit is critical – whichever system is negotiated – so that incentives in fact produce the intended financial and behavioral outcomes.

Management costs of publicly funded services can be significant. While centralized monitoring and management may have "low" costs, they may not be sensitive to local needs, capacity, and competition. In the UK, local management of the dental programs has been criticized because of perceived insufficient capacity or expertise to adequately support this function (16). It is in general costly to build up this capacity (something the current UK government is acutely aware of (2)), and one is left wondering if attempting to develop and fund multiple local expertise resources in fact negates the prestige, experience, and know-how ascribable to dedicated bodies. Excellent examples of these in the United States would be the Centers for Disease Control and Prevention and the Agency for Health Research and Quality (24).

Herein lies a major conundrum, because of the current fragility of the economy, the private sector alone cannot solve problems in increasing accessible quality care however tempting it is to allow the market to sort itself out. This is a lesson from the United States that the UK can take heed of in considering shifts of policy emphasis toward private models of dental care provision. Shortage of disposable income may influence utilization at dental offices which are businesses after all and must remain profitable or they go to the wall and subsequently impact on accessibility. Too expensive dental care could have a negative impact on individual and overall oral health levels. The US policy makers may acknowledge that dental care cannot be given away as seen in the UK when a free-for-all caused demand to soar.

Increased government involvement and public funding is necessary to expand services, but, again, as learned from UK, government changes to remuneration systems can have unintended consequences which act as barriers to access. In return for remuneration from public funds, dentists may have to relinquish a degree of independence and be more flexible toward government. This may mean moving toward preventative initiatives rather than treatment, or vice versa depending on how the majority of taxpayers and voters influence government policy.

Expansion of workforce capacity to achieve improvements in overall oral health must come at a cost to taxpayers, and politicians need their approval of policies. Future improvements could impact upon the private sector however as increased capacity could reduce costs of treatment through increased competition to service healthier consumers.

Looking to the future, it will be an interesting exercise in social and professional values to consider and contrast how health care reforms in the United States and the UK are received and implemented, more importantly, what their outcomes are in terms of their costs, population oral health and disease, and patient experiences (15).

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