Journal of Oral Research

EDITORIAL

DOI: *10.17126/joralres.2016.010*

Pay-for-performance? Let's take a look beyond the numbers in dentistry.

Performance is a central element in the delivery of health services, especially in public health, where resources seem to be always limited. Therefore, the design, implementation and evaluation of strategies to improve efficiency in public health is (or should be) a common practice. In dentistry the situation is no different. Furthermore, given our high morbidity indicators we must always improve efficiency in spending.

One of the strategies proposed to improve performance is precisely pay-for-performance (P4P). However, P4P does not simply imply paying a certain amount of money for achieving certain goals. A recent systematic review addresses the complex design that P4P programs involve and how variations in context or design can have an impact on results. The review concludes that there is no conclusive evidence regarding the implementation of P4P programs. It is also necessary that such programs be targeted to areas with low performance and be constantly evaluated. Finally, measurements and assessments should be consistent with the priorities of the system and adapted to changes in the context[1].

A number of P4P programs have been implemented in Chilean public dentistry, but little research has been conducted on their outcomes or results. Cornejo-Ovalle makes an assessment of the implementation of incentives for professionals who provide dental care to 6-year-old children, beneficiaries by the Explicit Health Guarantees System (GES). These incentives were paid as a bonus per performance according to the rate of dental discharge in this age group. The results are clearly positive, not only for improving discharge indicators, but also because their impact is greater in the lowest socioeconomic groups. Cornejo-Ovalle noted the need to further deepen and improve P4P strategies used in dentistry, adding new indicators and incentives. He places special emphasis on the inclusion of the rate of caries-free children within these indicators[2].

All this shows that P4P strategies are an option that should be considered in public health, but they need to be well designed, implemented and evaluated constantly. However, to implement them in Chilean public dentistry it is necessary to take into consideration other elements related to professional and local idiosyncrasies. Neglecting those and other relevant considerations could lead to programs with misleading results.

First, there is evidence that dentists consider their economic interests when they diagnose and treat patients. That is precisely the reason why P4P can have an impact on performance. However, the economic incentive may have an undesirable impact on the dentist's clinical practice. Naegele *et al.*[3] showed that there is a discrepancy between the diagnosis for dental treatment performed by salaried dentists and the treatment delivered by fee-for-service dentists. Patients who had less need of treatment (most of them) ended up receiving a longer and complex treatment. The opposite occurred in patients who were most in need of treatment. While it is possible to put forward several hypotheses for this discrepancy, it is very likely that economic incentives affect the clinical judgment of the dentist. In this case it is proposed that the fee-for-service dentists would provide more treatments than the necessary for their patients, to make dental practice more profitable. This would apply to the group of patients with low need for treatment, but we must not forget that the group with high need for dental care received less than the required treatment. This is very relevant in our context, given our high rates of oral disease. It may be that a large group of patients would receive fewer procedures than necessary before discharge. Or it could be that the group of patients most in need of treatment end up being neglected because delivering their treatment and achieving their discharge demand more effort and resources. Delving further into this point, a P4P program could increase levels of inequality, providing care for people with

fewer needs and discouraging the attention of those really in need.

Second, a scheme based on economic incentives could reinforce an instrumental vision of patients. In other words, it could make dentists consider patients as means rather than as ends. In a very interesting research, Alcota *et al.*[4] evaluated how the teaching of dentistry at a Chilean university contributed to a commitment to ethics and public responsibility. The results of this research are worrying, since the teaching of dentistry did not promote these values. On the contrary, there was an individualistic and dehumanized approach to patients. Given that the number of patients attending college clinics was limited, students had to compete for them. Then, patients were not seen as people with needs, but were reduced to a number of procedures necessary to meet certain requirements to pass clinical courses. If we extrapolate this to a P4P program, it is not difficult to think that many times patients will be reduced to procedures or discharges necessary to get high economic incentives at the end of the year. This again would increase the search for patients with less need for treatment, involving a more efficient use of the dentist's time to achieve his/her goal.

Third, we must consider the role of decisions made by patients about their own treatments. Although incentives of P4P programs are in line with health priorities, these might not be consistent with the beliefs or needs of the population. This could make patients opt for services or benefits that are "not necessary for them" and end up decreasing the desired efficiency[5]. In the case of local dentistry, patients may prefer to opt for simply cosmetic treatments instead of others that could help them recover their oral health integrally. Moreover, the imposition of "more efficient" treatments could end up disappointing the patients. This will happen especially in patients with fewer economic resources, as they have no other option but to make use of the oral health care delivered by public services.

It is clear that the design of P4P programs in dentistry should consider psychological and behavioral aspects of dentists and patients, it can never be simply reduced to numbers. As the same thing has happened with other interventions in dentistry, the greatest danger is to continue reinforcing the health paradox and not provide oral health to those who need it the most.

Finally, we must not forget that as the law of Campbell says *"the more any quantitative social indicator (or even some qualitative indicator) is used for social decision-making, the more subject it will be to corruption pressures and the more apt it will be to distort and corrupt the social processes it is intended to monitor".*

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