The Role of Clinical Guidelines in Controlling Expenditures for Dental Care

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There is a general consensus within Canadian society on the need to control inflationary expenditures for health care while maintaining or improving the quality of services provided, whether the initiatives to do so are national, provincial or local in scope. Controlling costs should be of particular concern to dentists, because their growing dependence on payments from third-party benefits cannot continue indefinitely. These resources depend on annual premiums levied from employers (in lieu of salary increments), governments (through taxes) or individuals, and as such they can never be sufficient to cover unlimited demands for service. Some form of rationalization is therefore inevitable. Moreover, attaining these seemingly incompatible strategic objectives of controlling expenditures and improving quality is essential if we are to avoid the widespread introduction of U.S.-style health care reforms (e.g., preferred provider and managed care options).

Before examining more closely some of the ways in which expenditures for dental care might be controlled, we wish first to dispel the unfounded myth that cutbacks in administrative and management overhead will mitigate the need for other economies. Even if such overhead were drastically reduced, significant constraints on the rising expenditures of third-party insurers would still be required. In this context, trimming operating costs makes economic sense, and the concomitant introduction of such modern management tools as provider profiling (e.g., as a means to identify "outliers" for subsequent auditing) would greatly augment the impact of doing so.

In considering ways to trim operating costs, third-party insurers should focus on developing strategies to address the general causes of inflationary expenditures for dental care. These causes include the following:

- general economic inflation,
- number of patients eligible for third-party benefits,
- inflation of professional service fees, and
- volumes and intensities of services eligible for third-party benefits.

The first 2 of these determinants are difficult to control because they are primarily dependent on political factors. Similarly, strategies to control professional service fees may be unsuccessful because of the potential that such measures will be countered by "balanced billing" and other practices. Targeting service volumes and intensities is thus the most logical strategic approach to reducing inflationary trends in third-party expenditures, particularly those related to the wastage of scarce resources. Even so, this approach may founder on controversies about the relative merits of services as viewed from the perspective of patients or their dentists, unless the changes are supported by clinical guidelines.

The classification of services as "appropriate" or "inappropriate" entails both bad news and good news. The bad news is that because continuing to provide inappropriate services (those with low merit and high cost) wastes scarce third-party resources, benefits for such services should be denied. The good news is that such service reductions may both constrain increasing costs for third-party benefits and improve the overall quality of services derived from the payments that *are* made. Therefore, third-party insurers should focus on strategies to transfer resources (benefits) from overused but low-merit services to those that are underused but that have higher merits. The potential advantages of these changes can be illustrated by an abstract example in which 500 dental patients are eligible for third-party benefits. Of this group, 250 patients are eligible to receive service A (e.g., replacement of a functional but large amalgam with a crown), which provides 5 units of merit at a cost of $1,000 per patient (for a total of 1,250 units of merit at a total cost of $250,000), and the other 250 are eligible for service B (e.g., application of sealants or topical fluoride in children of the appropriate age group), which provides 50 units of merit at $100 per patient (for a total of

12,500 units of merit at a total cost of $25,000). If the provision of service A to the first group is prevented, $250,000 will be saved at a loss of 1,250 units of merit. If service B is then supplied to the second group of 250 patients, the cost will be $25,000 and the service will yield 12,500 units of merit. Transferring resources from service A to service B would lead to a cut in total expenditures by a factor of 10 (from $250,000 to $25,000), with a concomitant increase in quality by a factor of 10 (from 1,250 to 12,500 units of merit).

The potential advantages of such strategic changes can be appreciated if the entire populations eligible for third-party benefits are considered, rather than specific subsets of patients. Given that all those eligible for benefits have paid premiums to a common resource pool in one way or another (e.g., through personal discretionary funds, taxes or employer payments), they are equitably entitled to these limited resources to maximize their oral health. Determining the degree to which this strategic objective (maximization of oral health) is achieved, rather than examining the limited experiences of individual patients, is one way to evaluate the overall quality of service provided by the benefit plan.

The success of such strategic changes also depends on a consensus that shifting resources from one service to another will markedly improve overall oral health in those eligible for benefits, despite the minor hardships experienced by subsets of individuals who are denied payments for services they consider necessary. (The frustration of this group is unlikely to be mollified by the fact that they can obtain such services by using their own discretionary resources.) However, the need for these changes in approach will be better appreciated if it is made clear that more patients would experience "harm" if such resource transfers did not occur. This is a typical zero-sum situation, in which resources are limited and hence the resources allocated to one patient group cannot also be allocated to another.

Strategic changes of this magnitude are complicated by the obligations of health care providers to offer the best possible services to their patients. This means that the differential merits of specific services must be realistically factored in to decisions regarding the eligibility of services for third-party benefits, since all are not equally meritorious. The most difficult challenge is to persuade patients to have realistic expectations of their dental services, since few have sufficient knowledge to define their specific needs or to differentiate the quality of their outcomes. The providers must therefore accept some "gatekeeper" responsibilities in this regard and thereby reduce the inappropriate use of scarce third-party resources. If providers systematically limit the provision of services eligible for third-party benefits, they just might avoid the need for further rationalization.

The best way to encourage the changes outlined above would be to link third-party benefits to specific clinical guidelines. Third-party insurers would then be obligated to ensure that they are fully informed of the attributes of specific services relative to alternatives (or relative to no service at all if there are no alternatives). The profession must accept its responsibility to develop such guidelines. If it fails to do so, there is a danger that such guidelines will be unilaterally developed and imposed by third-party insurers. To match accepted standards of accountability, third-party insurers must also demand satisfactory data on service outcomes to justify continued eligibility of services for benefit payments. Individual patients may be expected to express variable degrees of satisfaction with providers' decisions about their service needs, but third-party insurers are obligated to ensure that the services eligible for benefits are as effective as possible. Current information is insufficient to meet these obligations. It is imperative that the profession develop clinical guidelines backed by documented outcome data to allow the provision of needs-based dental coverage under third-party structures. ◆

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