I was on a plane from Miami to Cancun with my wife for a few days getaway from work. I had a couple of books in my hands, pending readings from a recent programme just finished on managing healthcare delivery. One of the books, titled in red bold capital letters, ‘Who killed healthcare’, seemed radical, as if trying to draw attention to the subject; I wondered about the content. It was written by Regina Herzlinger, a professor at Harvard Business School and senior lecturer on healthcare topics. I started to read it immediately after take-off. In summary, Regina is at war – against hospitals and insurance companies for driving up the cost of healthcare, limiting access and charging unfair prices to uninsured patients and providing poor-quality services. Additionally, she mentions the government is micromanaging healthcare delivery by telling physicians how to practise medicine instead of performing a regulating role as in other industries. After one hour and fifteen minutes, the pilot started to descend and my wife was still sleeping; she was taking the vacation seriously. While looking out of the window to the intense blue waters of the coast of the Yucatan peninsula, I could not stop thinking about the book, it is not an extremist title after all – indeed healthcare is dying. According to a recent analysis by the Organization for Economic Cooperation and Development (OECD), the escalating cost of healthcare is becoming unsustainable for economies in some countries, including the US. The report states that a combination of reduced GDP due to the recent economic downturn and increased healthcare spending will force governments to cut budget deficits by increasing taxes or slashing expenses.

We are all in agreement that the current structure of the industry does not fulfill the basic needs of patients in terms of price and quality; or better to say, providers and payers fail to provide value to their customers. There are several areas where value is missing from the service proposition, and lack of cooperation between hospitals, physicians and insurance companies is making things worse.

Adding value
In other industries – such as hospitality, automotive, and computing – the driving force to success is satisfying the customer’s needs. Efforts and resources are centred on understanding their behaviours, likes and dislikes, trends, price elasticity, and other factors that allow companies to design products and services that match segmented markets. In healthcare, we are far from it; payers and providers shift costs from one to another, and, at the end, to the patient in the form of higher premiums or out-of-pocket expenses. In the worst scenarios, patients are faced with the challenge of denied coverage – either by failing to obtain insurance or not being authorised for a procedure. Reimbursement of hospital and physician services is very complex. There are curious differences between charges and payments, various payment methodologies, and countless codes that make it difficult to appreciate the benefits of the services received compared to the price paid for them. Anyone could easily perceive the value (benefits/price) of a Rolls Royce Phantom, a Mercedes Benz E class and a Toyota Corolla. For patients, on the other hand, it is difficult to almost impossible to differentiate one hospital versus the other. All of them provide the same general services; there is no data related to quality (benefits) and prices are usually unknown. Just imagine walking into a supermarket with no price tags on products. You approach the milk section and all of them are similar, just one brand and no difference between whole, reduced fat, low fat and skimmed milk; also there are no labels with information on calories, ingredients and other product information. Would you buy in this supermarket? Surely not! It is the same situation with hospital services and insurance products.

Healthcare is critical for any country; it improves the wellbeing of its citizens, giving them access to better quality of life and productivity. It also generates employment. By combining efforts, providers and payers may well change the future of health services. The following five strategies represent areas where value could be created for patients to help guarantee a sustainable industry:

1 Focus on the patient – Healthcare is about helping patients to get well and stay healthy. Providers and
time. Typically, strategy statements for insurance companies talk about access or cost. Best Doctors partners with physician specialists around the world, the best in their fields, to provide Interconsultation™ — a second medical opinion programme to ensure accurate diagnosis and treatment. In a review of 72 cases of cancer, treatment was changed in 40 per cent and diagnostic in 19 per cent of patients.

The benefit for the patient is clear; meanwhile, the insurer saves by not paying for unnecessary diagnostics, treatments or complications.

2 Bundled payments — A bundled payment includes hospital and professional fees for some or all services delivered to a patient for an episode of care for a specific condition over a defined period of time. This payment methodology provides a clear price to the payer for patient before receiving services. It avoids sending and processing multiple claims since the hospital issues one bill for the entire episode of care that includes all fees. Another important advantage is having the right incentives for hospitals and physicians to provide medically necessary services. In bundled payments, there is a clear description of services and their duration; therefore, efforts are converged on co-ordination of care to manage cases appropriately. UHealth, the University of Miami Health System, works with foreign governments using bundled payments, making it easier to refer patients for treatment abroad due to transparency of transactions.

3 Co-ordination of care and case management — Case managers at hospitals and insurance companies should collaborate in co-ordinating clinical care for patients, especially those with complex medical conditions. In the US, a typical Medicare patient sees seven physicians in four practices in a given year, impeding the ability of any one assigned provider to influence the overall quality of care for a given patient. The combined clinical co-ordination from payer and provider with access to the same medical information could lead to reasonable diagnostic testing and treatment consistency.

4 Administrative costs — A study by the American Hospital Association reported billing and insurance-related costs represent 10.8 per cent for hospitals, 13.9 per cent for physicians groups and 8.4 per cent for private insurers of total revenue. As mentioned before, bundled payments could represent important savings in claims processing. Electronic medical records and online communications between providers and payers can improve response time to authorise services. Hospital staff can access benefits information, and review copayments and deductibles, while insurance staff can access medical notes and diagnostic results, reducing waiting times for patients.

5 Preventive medicine — The value of preventive medicine is extremely obvious for the patient and payer. Providers also benefit because they are able to allocate limited resources to sicker patients. Any attempt to provide people with information and support on healthy lifestyle topics such as nutrition, physical activity, smoking cessation, and stress control reduces the risk of morbidity. Healthcare should be the business of wellness and not of sickness. For example, Aetna IntelliHealth™ in collaboration with Harvard Medical School provides valuable information and tools on their website for managing chronic diseases, fitness, weight management and mental health, amongst others.

Only by working together will hospitals, physicians and insurance companies be able to truly provide value to our main customer — the patient — by reducing the cost of care and improving quality.

Providers and payers should make a priority to satisfy patients’ needs. It is a simple statement but powerful enough to change the direction of the entire industry.

David Rivelis, senior vice president, CanAm Insurance/Active Care Management

“If the mitigation strategies [focus on the patient; bundled payments] are integrated into a network strategy, patient care can be maximised and insurer loss ratios can be manageable. Without implementing new strategies and cost containment paradigms, business as usual is not sustainable. The effect of ‘Obama Care’ on claims severity has not yet been fully realised. What we have seen until now is just the tip of the iceberg.”

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