



International
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World Hospitals and Health Services

The Official Journal of the International Hospital Federation

Managing the hospital revenue cycle & medical banking

- I Two HIMSS Task Forces Address Financial Pressing Issues in Healthcare
- I Medical Banking: A Transformative Model for Global Health
- I Trends in Health Financing: The Move from Passive to Strategic Purchasing in Middle- and Low-Income Countries
- I The Health Care Revenue Cycle Management in Brazil: Challenges that keep CEOs awoken
- I Four Ways Consumers are Demanding Changes in the Healthcare Payments Experience
- I The Third Party Administrators

Learning from health care delivery system

- I Universal health care in a mixed public-private system: the Australian experience
- I Learning from the USA Affordable Healthcare Act: The New York 2016 Hospital Executive Study Tour

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Henry Mintzberg

John Cleghorn Professor of Management Studies (Strategy and Organization); Faculty Director (International Masters for Health Leadership)
Policy and Management Overview

PROPOSED SPEAKERS



Jean-Louis Dennis

Chair on Governance and Transformation in Health Care Organizations and Systems
Health Innovation Forum



Brent Diverty

Vice President
Canadian Institute for Health Information (CIHI)

PROGRAM FACILITATOR



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This special issue of the World Hospitals and Health Services Journal (WHHSJ) is about managing the revenue cycle carefully (the flow of money between payers and providers) and the potential savings to both hospitals and payers from improvements in this area of financial management of healthcare institutions.

Global spending on healthcare reached more than US\$7 trillion dollars in 2015. In high income countries, 70 to 80 percent of this spending is mediated through some form of third party payment mechanism. In other words, someone other than the payer or the provider is involved in management of the flow of money between the two parties. At low-income levels, this ratio is reversed but 20 to 40 percent is still mediated through a third party transaction agent.

Considering the global commitment to the Sustainable Development Goals, among which Universal Health Coverage is a critical priority, it is expected that in both developed and emerging market countries, third party payment systems will increase dramatically during the next few years, while out of pocket payments will decrease.

Even a seemingly insignificantly small amount – such as a 0.1 percent loss or gain – translates into billions of dollars making this matter a priority for any service provider in the world.

As described by the contributing authors to this issue of the Journal, sometimes the gains and losses are due to clerical errors in billing or payment of bills. Sometimes, discrepancies are due to a misunderstanding about the rules about what can be billed and/or at what rates of reimbursement. Also, there are times it is because of deliberate profiteering, fraud, and corruption.

In the past, when hospitals relied on manual records, it would take many months before managers realized they were losing money for one of these reasons. However, with the advent of electronic billing and automated payment systems, information is available instantaneously. In addition to paying bills or collecting claims, the associated data can be used to analyze what is happening and corrective measure can be taken quickly when things go wrong. Due to the arbitrage of seemingly small price, differences can translate into huge gains or losses for providers and payers, not surprisingly, a whole industry of data analysts and advisory services now exist to help hospitals and payers manage the revenue cycle more efficiently than they could do on their own.

At the policy level, management of the revenue cycle has a couple of additional interesting dimensions. Should management of the revenue cycle be an “intelligent” function which would involve decisions about how resources are used and possibly even incentives to influence clinical decisions making and patient behavior? Or should management of the revenue cycle be more like a “dumb” ATM where you stick in the card and out comes the money, flawless in terms of errors and data security, but devoid of any intelligent function?

Countries approach this question in different ways. Many European countries that have social health insurance payment systems or government run purchasing or commissioning authorities, act as intelligent purchasers, not as passive ATMs. Even in the case of private health insurance schemes, that are not run by governments, there is an increasing tendency towards the “intelligent” purchaser model.

In US, however, where third party transaction companies are used to handle the revenue cycle management, the “straight thru processing” modus operandi is still the dominant model. The focus has been on speed, elimination of errors and data security. The “intelligent” function is left to hospital finance departments and insurers.

“Ours not to reason, ours but to do and die.” - Alfred Lord Tennyson

Although, not yet an “intelligent” purchaser, US transaction processing companies are increasingly going beyond straight claims processing by getting involved in contract management, auditing claim, big data analysis, quality metrics, portability across geographic locations, and even some rudimentary aspects of population health. Commercial banks do this better than any other group, leading to the concept of “medical banking.”

The International Hospital Federation is very excited to share with its readers’ insights from around the globe this important topic and we welcome feedback and experiences sharing from our community of members. To share your ideas and views, consider using the IHF hub to post your comments (https://www.ihf-fih.org/account_login) and create a discussion group to further exchange your practices and tips to enhance performance in managing the revenues cycle effectively.

Two HIMSS Task Forces Address Financial Pressing Issues in Healthcare



PAM JODOCK, B.S.
SENIOR DIRECTOR, HEALTH BUSINESS SOLUTIONS
HIMSS

ABSTRACT: Throughout the world the hospital sector faces critical challenges in managing the revenue cycle, from billing through a long chain of events which concludes with the final payment of services provided. This article discusses Revenue Cycle Management (RCM) in the USA today, as well as its possible implementation in other countries.

Revenue Cycle Management (RCM) as it exists today, is ill-equipped to handle the market forces currently impacting healthcare. Rapid growth in consumer payments, evolving payment models, an ever-changing regulatory environment and shifting consumer expectations have all contributed to challenges facing RCM. The current approach of bolting on new technologies and reworking internal processes will not be sufficient in addressing these challenges. On the contrary, said approach leads to an increase in complexity and costs for RCM processes at a time when healthcare delivery organizations are under unprecedented pressure to reduce administrative expenditure.

As individuals assume increasingly larger amounts of direct financial responsibility for their healthcare, they begin to view healthcare as more of a retail experience. As such, they may transfer expectations of a typical retail experience to their healthcare experience. In those situations where it is possible to do so, patients are increasingly researching their healthcare options before deciding where to go for care. They expect to be able to use their smartphone, for example, to determine the level of care available to them, through their healthcare plan provider network, with pricing and quality or patient satisfaction information at their fingertips, and to be able to use this and other information to compare providers in the same way they might compare producers of other products they would purchase online. In addition, they

expect their financial obligations to be addressed in a single bill or statement, just as they receive one consolidated bill for buying a vehicle or remodelling a room of their home, even though there may have been multiple parties involved in developing the final product.

Industry stakeholders have acknowledged the need for health plans and providers to share information with consumers in a more coordinated fashion to enable improved consumer financial activities. Perhaps more importantly, it has become very clear that linkage between healthcare financial and clinical systems is absolutely critical to re-engineering RCM and the patient financial experience in healthcare. These systems will need to be able to share information seamlessly, regardless of which system, module or version of a system is being used.

There are already a number of examples emerging across the industry, of significant efforts to improve components of the patient financial experience. However, even broader industry engagement in the envisioned goal, and commitment to the level of secure data sharing as well as interoperability is essential in order to develop an optimal, consumer-friendly revenue cycle and provide for the financial wellness of our healthcare delivery system.

The Work of HIMSS and Revenue Cycle Improvement: The vision of improving health with information technology has been the focus of HIMSS since its establishment in

1961. Today, as a global voice, convener and thought-leader, HIMSS advises stakeholders on IT best practices to improve the quality, safety, and cost-effectiveness of health and healthcare.

Since 2014, the HIMSS Revenue Cycle Improvement Task Force (RCI TF) has addressed the emerging dynamic of healthcare consumerism and the patient experience related to the provider's financial and administrative performance and service levels. The group consists of a broad cross-section of stakeholders, including representatives from provider organizations, financial institutions, payers, retail health care clinics, mobile technology providers, vendors and consultants. It has focused its energies on creating, socializing and encouraging the adoption of a vision for the next generation of revenue cycle management tools and processes that keep administrative cost containment, interoperability, and patient engagement front and centre.

The work of the RCI TF is underpinned by a specific set of Guiding Principles. The group agrees that task force recommendations must involve solutions that:

- are patient-focused;
- support transparency of information;
- reflect process driven, non-duplicative business practices;
- leverage existing and emerging technologies;
- demonstrate a sustainable return on investment;
- have standard-based architectures;
- are intuitive and include simplified user interfaces; and
- are designed with the full revenue cycle business process flow in mind.

The task force has applied these principles to the development of an overarching vision for the patient financial experience of the future. This vision was shared in a White Paper, "Rethinking Revenue Cycle Management." The vision was further articulated in an infographic that illustrated the task force's vision for a simple, pre-planned office visit.

To help the industry and consumers, in 2016 the task force conducted a gap analysis of the technical functionality required to execute their vision from the patient's perspective, and compared that functionality against what was known to exist at the time, to identify potential gaps. These gaps included not only technical functionality, but also the development of national standards and uniform operating rules to support initiatives, such as accurate patient matching and the ability to share complex data in a meaningful and actionable way.

The task force published its findings in a white paper, "A Roadmap to the Patient Financial Experience of the Future." Since then, the task force's original infographic has grown into a microsite that follows the patient through an entire episode of care, as if it were the Patient Financial Experience of the Future.

The task force recently conducted a similar gap analysis from the primary care provider's perspective with an update to the microsite, offering a view of what is happening behind

the scenes with the urgent care and hospital organizations, to facilitate the patient's seamless experience. Both are expected to be released in February 2017.

Finally, the task force has initiated a call for case studies illustrating technical solutions aimed at closing one or more of the identified gaps. The intention is to identify and celebrate work already underway that will eventually lead to the Patient Financial Experience of the Future, as envisioned by the HIMSS Revenue Cycle Task Force.

Separate and apart from the challenges facing RCM is the transition from fee-for-service to pay-for-value, which has been referred to as one of the greatest financial challenges currently facing the U.S. healthcare system¹. While a great deal of attention has been paid to clinical elements and payment methodologies associated with this change, little has been said about the administrative infrastructure required to support the move.

A 2016 HIMSS Cost Accounting survey and follow-up conversations with provider organizations participating in value-based payment models, indicate that while providers are willing to embrace this change (nearly fifty percent of respondents were participating in some form of alternative payment model), few feel that their organization is well-prepared to do so.

Specific concerns focus on:

- ability to gather and analyze cost data in a routine and automated fashion;
- knowledge of and response to internal and external factors affecting price;
- administrative burden of tracking and analyzing an overwhelming amount of quality and performance metrics for the many variations of the programs they are involved in; and
- the challenge of exchanging an unprecedented amount of clinical and financial data across the healthcare continuum between both associated and disparate providers: an information exchange which was never contemplated when developing existing revenue cycle and communication systems.

In national conversations regarding alternative payment models (APMs), an underlying assumption exists that business processes and IT systems will need to be modified or completely revamped to support new payment models. However there is little, if any industry conversation about how we ought to address those challenges. Healthcare providers and delivery systems are looking to the industry to help them develop a consistent approach to the terminology/ definitions, business processes and tools used to support these new payment models and to build the technical infrastructure necessary to facilitate the underlying activities. According to a McKesson study published in July 2016², providers identified the following as the ten most important health IT capabilities needed to support a successful move

¹ Brown, Bobbi and Jared Crapo. "The Key to Transitioning from Fee-for-Service to Value-Based Reimbursement." 2014. <https://www.healthcatalyst.com/hospital-transitioning-fee-for-service-value-based-reimbursements>

² "Road to Value-Based Reimbursement Success." McKesson. July 2016. <http://www.mckesson.com/blog/the-road-to-value-based-reimbursement-success/>

to APMs:

- Care coordination
- Standardizing clinical measures
- Integration of work flows
- Patient/member engagement
- Real-time data exchange
- Standardized pay technologies
- Predictive analytics
- Better business intelligence
- Clinical transformation teams
- Patient/member incentives

Formed in July 2016, the HIMSS Alternative Payment Model Infrastructure (APMI) Task Force encouraged the industry to address these concerns. Offered as a compliment to work developed at a national level by groups, such as the Health Care Payment Learning and Action Network and the Accountable Care Learning Collaborative, this task force is responsible for developing and socializing the administrative framework necessary to support an alternative payment model, including the technical functionality recommended for embedding in this infrastructure. Over the course of the next several months, the task force will be developing a set of toolkits focused on five primary components of an administrative infrastructure: Governance; Programme Administration and Operations; Information Management; Contracting; and Financial Services (Revenue Cycle Management).

The toolkits will be available in February, on a new HIMSS web page. Additional activities include the delivery of educational sessions, such as the HIMSS17 Pre-Conference Symposium, “Succeeding in a Value-Based World.” and the publication of thought leadership articles. To avoid duplication of effort, HIMSS will be sharing its work with other professional groups addressing APMs, and cross-promoting the work of those organizations. It is the goal of the HIMSS APMI Task Force to be a one stop, dependable go-to source for information, tools and resources, for those organizations looking to make the move from fee-for-service to pay-for-value.

Each of these task forces reports to the HIMSS Health Business Solutions Committee (HBS). Formerly known as HIMSS Medical Banking and Financial Systems Committee, HBS has expanded the original focus of the group on the relationships between healthcare institutions and the banking sector to include engagement of a broader array of stakeholders, all working together to identify and promote the use of health IT for the efficient, cost-effective execution of financial and administrative functions across the healthcare continuum. In addition to the Revenue Cycle Improvement and Alternative Payment Model Infrastructure Task Forces, the Committee is involved in:

- resolving, prior authorization, pain points between payers and providers;
- providing input to the HIMSS Government Relations team regarding the implication for healthcare IT of proposed policy positions, legislative proposals or administrative action; and

- overseeing the creation and distribution of one of HIMSS’s most successful newsletters, Business Edge.

The work of both HIMSS, RCI and APMI task forces will be on display at the 2017 HIMSS Conference & Exhibition - HIMSS17 - scheduled to take place in Orlando, Florida in February. Highlights include a pre-conference symposium, “Succeeding in a Value-Based World,” where attendees will gain an understanding of what administrative infrastructure issues their organization should be prepared to address when moving to an alternative payment model, and how early adopters are mitigating the challenges presented by these changes.

Visitors to the HIMSS Interoperability Showcase™ can visit the Patient Financial Experience of the Future, as members of the task force demonstrate the interoperability of solutions already in place. These solutions create a seamless information sharing experience for the patient, as he/she makes her way through a variety of healthcare settings involved in delivering a single episode of care. Both task forces will be delivering presentations at HIMSS Spot, a location designed for conversation, meetups and education sessions. On the exhibition floor, two additional RCI presentations in the Clinical and Business Intelligence Knowledge Centre include one focused on the use of predictive analytics for patient-centred financial discussions throughout the continuum of the revenue cycle, and the other delivering an overview of the task force’s latest gap analysis, conducted from the primary care provider’s point of view. Please check out the HIMSS17 website at www.himssconference.org for complete details.

The success of these efforts would not be nearly as impactful without the strategic relationships HIMSS enjoys with organizations, such as the International Hospital Federation (IHF). HIMSS is a premier associate member of the IHF. Health information systems are a crucial part of today’s modern hospitals, and HIMSS has appreciated the opportunity to collaborate with IHF in areas of shared interest.

For more information about how to get involved in HIMSS Health Business Solutions efforts, please contact Pam Jodock at pjodock@himss.org. To learn about HIMSS membership, please visit the HIMSS website at www.himss.org.

BIOGRAPHY

Pam Jodock B.S. is the Senior Director of Health Business Solutions for HIMSS and is responsible for the overall management and strategy development for HIMSS Health Business Solutions initiatives. She has over 30 years of healthcare experience and is a graduate of Eastern Oregon University with a BSc in Politics, Philosophy and Economics.

Medical Banking: A Transformative Model for Global Health



JOHN CASILLAS
CEO
BOARDTRUST, LLC

ABSTRACT: The convergence of technology, business processes, credit practices, and other resources within the nexus of healthcare and banking has yielded a new industry niche. This nascent market development was called “medical banking” by the author in 1996, who founded The Medical Banking Project in 2001, now unified with the global HIMSS organization (2009). In this article, the author expands upon an earlier work (*The Rise of the Bank Infomediary, Casillas, 2007*) to suggest that banks and financial institutions, teamed with healthcare firms, are working on multiple commercial fronts to develop inter-organizational systems. The primary focus areas include privacy and security, revenue cycle improvement, “health-wealth” programs, and a new micro-insurance area that is classified as an “advanced community care platform.”

Introduction. “Medical Banking” refers to a broad series of emerging best practices that have resulted from the convergence of banking and healthcare systems, with the purpose of improving healthcare costs and access. The linkage of banking and healthcare information technology systems to form inter-organizational systems (IOS), conforms to a business theory developed by Konsynski, Venkatraman and others¹. Prime examples of IOS that have emerged and differentiated into various commercial constructs are SABRE (the airline ticketing system), Baxter’s ASAP (medical supplies system), IVANS (the healthcare insurance system), and others. The application of IOS theory to healthcare and banking has resulted in the emergence of new business models throughout cross-industry platforms, along with cash management practices that are prevalent between commercial banking institutions and healthcare providers².

¹ Barret & Konsynski, Inter-organizational Information Sharing Systems, MIS Quarterly, 1982; Konsynski, Strategic Control in the Extended Enterprise, IBM Systems Journal, 1993; Bensauo & Venkatraman, Inter-organizational relationships and information technology: a conceptual synthesis and a research framework, 1996.

² The formation of The Medical Banking Project acted as a catalyst to deliver the first industry-recognized community in this area and critical thought leadership around emerging models. The central tenet of this movement is a social goal: to convert systemic administrative inefficiency in healthcare to charity care, measured at between \$11 billion to \$35 billion annually. Cost savings

The Medical Banking Project, acquired by HIMSS in 2009, spearheaded thought leadership in this area. Over time, a community of like-minded institutions grew, including commercial banks, healthcare providers, banking and healthcare information technology firms, healthcare strategists and consultants, governments, academia and others. Since that time, medical banking IOS formation has been occurring across multiple functional areas, including:

1. Payment and remittance management and processing
2. Health data transaction management beyond payments (claims, authorization, secondary billing and credit, etc.)

are absorbed into operating structure and can be used to advance mission (see independent survey by PNC Financial). Today, medical banking looks beyond costs savings to a whole new way to engage consumers and change health behavior. My work has been to both produce original content and to socialize it within government, commercial and academic venues. This has been successfully accomplished via testifying before NCVHS and ONC, advising HHS, OCR, OCC, HHS, FDIC and other agencies on policy issues, serving as a contracted author to analyze and define legal issues for LexisNexis (writing Chapter 8 of the LexisNexis 4 Volume “Health Care Law Treatise”) and socializing the core message among top banks and healthcare groups at thought leadership centers like Vanderbilt Center for Better Health, University of Minnesota’s Carson School of Management and others. HIMSS is now carrying the message to benefit domestic and global audiences. The social goals are being implemented across a wide range of regions and cultures.

3. Denial management and contract management
4. Business intelligence dashboards and analytics that gauge multiple areas of the revenue cycle and general enterprise metrics
5. Specialized credit programs that target consumers/patients
6. Card-based platforms that implement credit programs and link to a series of “account-based plans” like HSAs, FRA, etc.
7. Receivable financing and/or funding programs and services that emerge from tighter data access by credit-granting organizations (banks, leasing firms, etc.)
8. A growing array of legislation-based financing programs (i.e., ARRA/HITECH)
9. Adaptation of online banking platforms to accommodate an increasing array of consumer-focused health and lifestyle programs, tools and resources (“health-wealth” programs)
10. Utilization of bank branches to deliver lifestyle programs into the community
11. The use of mobile banking to speed up consumer adoption of digital health
12. Other areas

The emergence of medical banking as a strategy to linking bank-based investment, systems, infrastructure, processes and markets, for the optimisation of both consumer health and healthcare operations, heralds a new series of best practices. Developed in 1996, the concept evolved after the author conducted a survey of 120 community banks over a period of 15 months in 1994-95. In 2001, The Medical Banking Project used this research to launch a think tank and to perform targeted market and policy research. The Project oversaw the creation of other mission-critical assets like The Medical Banking Institute, a neutral, cross-industry forum that organized an advisory council of industry experts to oversee content. The Institute provided a venue to discuss policy issues and to showcase emerging practices. Today HIMSS, the global health information technology association and society, WEDI (Workgroup for Electronic Data Interchange), and other forums provide a meeting place for the medical banking community.

Importantly, policy issues have surfaced in the national and international forums, as a pretence for the development of medical banking market structures, focused on the patient’s right to privacy, security and confidentiality of health data. A need for guidance has emerged among policy makers with reference to commercial bank obligations, for health data access, use or storage in a product or service offered to healthcare clients.

An article focusing on privacy risks in lockbox settings was published in 2001 by the International Association of Privacy Professionals, inadvertently sparking an industry debate, where it emerged that some banks are impacted by HIPAA (Health Insurance and Portability Accountability Act implemented by the US Congress in 1996)³ through their

3 Casillas, The Implications of HIPAA on Bank Lockbox Services, IAPP, 2001.

operation of treasury management platforms. This finding heightened market debate around policy issues at the nexus of banking and healthcare⁴. A policy overview presented to the National Committee on Vital and Health Statistics found that as early as 1996, banking regulators recognized health data processing as a service that is “incidental to the business of banking”^{5, 6}, further highlighting the need for guidance in this area.

Today’s ongoing policy dialogue around medical banking offers a compelling sign that business models are continuing to evolve⁷. At issue is the movement of trillions of dollars in healthcare funds in an emerging digital business environment, increasingly impacted by governance privacy and confidentiality regulations. This cross-industry arena is essentially redefining the boundaries of banking and healthcare operations, much like what has happened in other industries (e.g., linking banking to airline reservation systems), to craft high-efficiency services that meet regulatory requirements in a commercially reasonable way. Market needs mean that new payment technologies and programs, supporting an increasing array of digital payment options and moving both funds and associated remittance data, are here to stay.

The stakes are high. Removing cost friction from healthcare payment systems, estimated at some \$11 to \$35 billion in the US alone, offers a fertile field for innovation and fee revenues, even as policy issues are retroactively resolved throughout the ecosystem.

Overview of Emerging Best Practices and Trends

Emerging areas of practice in medical banking may be classified into four areas:

1. Privacy and security
2. Revenue cycle improvement
3. Health-wealth programs
4. Advanced community care platforms

Privacy and Security

Across all banking systems, the privacy, security and confidentiality of data is mission critical. A bank or financial service company that cannot support the highest levels of data protection will risk reputational loss that could lead to systemic deposit withdrawal and business cessation. In general, for this reason, the banking industry has prioritized data protection and privacy over many generations, making it a core competency focus with significant capital

4 After setting the stage through the creation of policy roundtables (“The HIPAA Gang”), the author was invited a number of times to provide public testimony to the National Committee on Vital Health Statistics, as well as numerous policy advisory meetings with HHS, the Office of Civil Rights, National Governors Association and public meetings with participation or attendance by OCC, NACHA, ABA, Federal Reserve and US Treasury officials, the ideas have gained increasing traction.

5 <http://www.ncvhs.hhs.gov/meeting-calendar/agenda-of-the-may-6-7-2015-ncvhs-subcommittee-on-privacy-confidentiality-security-hearing/>

6 Indeed, the advancement of new EFT, ERA and denial management standards in the senate version of the health bill, now signed into law by the Obama Administration, represents this new and growing reality (Section 1104 of HR3590). The new health payment focus areas at WEDI, EHNAC, CAQH/CORE, NACHA, TAWPI, The Clearing House, SWIFT, Federal Reserve Bank of Atlanta and other forums are a direct result of MBProject’s socialization of medical banking subject matter and provide testimony to the fact that medical banking offers a dynamic model for improving healthcare.

7 <http://www.ncvhs.hhs.gov/wp-content/uploads/2013/12/2015-Ltr-to-Secy-1179-Privacy-REDACTED.pdf>

investment across all operating units.

Notably, leveraging systems designed to protect and privatize data within medical banking programs is a key area of emphasis. The implementation of programs that specifically comply with HIPAA's Privacy & Security Rules, as well as FACTA, Title V of GLB, PCI, Red Flag Rules and other regulatory areas, unique to banking and generally across multiple industries, is an area that has become increasingly visible in the banking community. Since privacy involves the input of most, if not all, areas of the bank, as well as the coordination of systems, processes and people across the enterprise across all product lines, the emergence of governance mechanisms that oversee and routinely audit (both internally and via third parties) is a discrete focus area within the medical banking build out. Compliance with regulations around health data protection has become a specialized area of focus within banking and financial services organizations⁸.

Importantly, because banks are heavily invested in digital access as well as management and identity solutions embedded within and across product lines, they may "hold the key" for digital health to flourish in practice. A previously written paper explores the scope of this probability in the healthcare marketplace⁹.

Revenue Cycle Improvement

Medical banking principles are fuelling investment in new platforms that impact the cash flow of healthcare organizations, including health plans and payers, providers and other actors in the healthcare value chain. The impact is manifesting itself in multiple ways. For example, the integration of new applications onto lockbox platforms creates efficiency for end users (hospitals, others). This includes the adaptation of lockbox transport platforms that manage the on-paper explanation of benefits, specialized technical features that support imaging, digitizing images as well as the creation and application of data files to automatically update patient accounting systems.

Lockbox platforms that perform these specialized tasks can also provide online archive and retrieval capabilities for all incoming payments and remittances, the ability to automatically link outgoing claims and remittances to support secondary billing programs (coordination of benefits), specialized patient fulfillment generation and payment programs that integrate online banking programs and automate workflows in denial management, contract management and business intelligence analytics. The momentum of this technology model lies in its ability to move up the value chain, augmenting workflow automation routines and eventually supporting enterprise-wide decision making for the healthcare provider. Moreover, the platform creates a critical lever for health plans that want to implement electronic payment and remittance programs with the provider community.

In addition to technology convergence, banks and other

8 See FSAP, an accreditation program overseeing banking compliance with healthcare regulations:
<https://www.ehnac.org/financial-services/>

9 <https://www.ncbi.nlm.nih.gov/pubmed/24377146>

groups are seeking to implement specialized credit facilities into the platform using data streams, such as the advance funding of healthcare claims (immediate payment of a submitted claim minus a discount to offset waiting time for full payment by a health plan). Lockbox specialization may also include logistical support to finance consumer debt. Once the primary insurer pays, based on the credit policy of a hospital, the patient-owing balance may be calculated. Given that the lockbox is the first point of capture for primary plan payments, it can drive business intelligence and logistics support for automating consumer payment options for patients, all the way through to serving up online/mobile presentation.

Beyond lockbox, there has been increased focus on executing payment of claims at points of service. This involves the "hotel method" (reserving prospective amounts owed in an account until charges are determined), bill estimation mechanisms, based on prior history and other factors, and other methods. In addition to executing funds transfers, these platforms are integrating both financial and healthcare information databases for an end-to-end, seamless claim process at point of service, or as soon as possible after treatment is rendered. These programs often link to card platforms that have been developed for financial payment purposes in the retail setting, adaptable to the healthcare setting.

Other medical banking inter-organizational systems are emerging in the marketplace and also fit within the category of "revenue cycle improvement." While they aren't documented here, one area bears mentioning – the use of electronic fund transfer systems to improve revenue cycle.

In healthcare, the movement of payment and data is critical for streamlining workflow routines, yet limitations of current financial networks, and other reasons (like system preparedness to use financial electronic data interchange), means that moving both funds and data may not be possible. The volume of electronic fund transfers that include electronic remittance advise using the CTX (corporate treasury exchange) transaction, for example, is low compared to all healthcare payments. Thus, one would expect that such transfers could happen more routinely to streamline the workflow in remittance management.

This results in greater emphasis on using the ACH network, or SWIFT, a global financial messaging system, for the implementation of "straight through processing" in healthcare. This type of processing delivers impressive value to the healthcare provider¹⁰. After the enactment of federal operating rules for electronic funds transfers in the US healthcare system¹¹, the ACH network is reporting increased use¹². Notably, the series of bi-lateral trade agreements across ACH participants that are required to implement this type of high value efficiency system may already be in place and used by other industries. Thus, it is quite possible to create a new program for healthcare payments that immediately delivers impressive value via an

10 <http://www.himss.org/measuring-roi-medical-banking-healthcare-revenue-cycle-hfma>

11 <http://www.caqh.org/core/operating-rules-mandate-efit-and-era>

12 http://www.ncvhs.hhs.gov/wp-content/uploads/2015/04/150506-HOLLAND_Testimony.pdf

improved healthcare financial network.

Health-Wealth Programs

Health-wealth programs may be defined as the creation of programs, tools and resources that link healthcare costs to the “financial health” of individuals, families and groups. For individuals, the adaptation of better lifestyle practices can impact lifetime healthcare expenditure for chronic disease or other illness categories, and this could result in greater access to investments used for purposes other than healthcare, in retirement age. So, for example, if a 23-year-old person that is obese lost X pounds, based on actuarial evidence, they may reduce lifetime healthcare spending and add more discretionary income at retirement. In short, better health often means access to greater wealth, or discretionary income.

Implementing this principle in everyday life is the basis for many employer-driven programs that seek to optimize human capital in the work environment (dealing with presenteeism, absenteeism). To support this objective, many employers implement resources, programs and tools that are available on a “health portal”, yet employers suggest that portal use remains low and is generally highest once per year when employees need to make a plan selection.

A potential solution to this is secure linkage of the health portal to the online banking platform, used by over 70 million households in the US, three to five times per week for financial management purposes. Linkage to the platform could help in training individuals to use health resources, much like banks who encourage the adoption of other consumer tools, like ATM, mobile banking, credit/debit cards and other banking instruments.

Some banks and financial technology companies have decided to take the path of increased “health-wealth” investments, via access to a health record on the online banking platform, or the integration of an electronic personal health record onto an health savings account (HSA) management platform. The inclusion of electronic record programs is portentous of a secure “home” for personalized health information – the online banking platform – making this a potential key growth area in medical banking.

Advanced Community Care Platforms

In some ways, community care platforms overlap the two preceding areas of revenue cycle improvement and health-wealth, yet in other ways the emergence of this area of practice far surpasses their scope. Advanced community care platforms offer a venue with a series of resources that could impact population health.

Particularly, banks are likely to become more involved in community-oriented platforms because this orientation towards investment in healthcare is synergistic with existing investment objectives in facilitating a healthy community. In turn, a strong and vibrant community delivers a greater return in terms of deposit growth.

However, should banks invest in communities in ways that do not directly show a return on investment? Are there

indirect ways to invest in the community, targeting better healthcare and lifestyle programs? Studies indicate that investments into community health programs generally increase the economic vitality of the community¹³. Investing in health-related programming makes good business sense for banks, who routinely invest in other areas (little league sponsors, school programs, charity causes in the community, street festivals, etc.). Adding health-related programming to the mix may offer more than good public relation returns; it may be a good business decision. At least that’s what some banks seem to think.

A pragmatic example of this is a south-eastern regional bank that teamed up with a major hospital management company to develop a series of programs offered at bank branches. The branches, designed for ease of customer use, offer forums on stress management and other issues. The hospital brand is strengthened, the bank gains good public relations capital and individuals attending are part of an audience for targeted bank messaging.

One group in Massachusetts is taking this a step further by creating integrated community programming, and an online coordination tool that links key stakeholders, including the bank, into an end-of-life planning continuum for the community. The application that coordinates disparate stakeholders, from banks to social workers, community clinics, lawyers and others, supports a community-wide programmatic approach. A key focal point is elderly care, to support planning in a manner that reduces stress during the last years of life, estimated to capture as much as 80% of the entire expenditure of an average person’s lifetime healthcare bill. The area of mid-year baby boomers caring for their aged parents is a growing trend.

Yet another example of this trend can be seen in a major bank that opened “Retirement Planning Centers” at bank branches, integrating HSA planning, reverse mortgage financing mechanisms for end of life care, and more.

Aggregation, coordination and better access to community health assets where banks are a primary stakeholder, are core concepts of the advanced community care platform. As an adoption incentive, the coordinated platform could implement revenue cycle management tools for users (care providers), health-wealth tools for consumers, card-based programs that track utilization across the community (emergency room, clinics, etc.) and other programs and resources.

Future Trends

The evolution of medical banking programs coupled with the emergence of digital tools in healthcare – from online applications to mobile or “mHealth”, and integration with telemedicine and other areas – will enable a new generation of programs that support the healthcare needs of underserved areas in the world. One group is integrating medical banking and micro-insurance to develop a sustainable model that aims to reach some 10% of the

¹³ http://www.pewtrusts.org/~media/assets/2014/01/01/hria_ppr_leveraging_multi_sector_investments_jan_2014.pdf?la=en

world's poor over a period of 20 years¹⁴. Access to health records, cutting-edge, evidence-based pharmaceutical and treatment information, community resources and funding at points of service where mobile phones can reach beyond hard-wired network infrastructures, are all factors which can help forge a global platform to improve health among many people groups.

In support of this idea, the geographic adaptation of bank-based platforms that serve multiple areas of the world, like treasury management, online banking, ATMs and other innovations, point the way forwards, identifying medical banking as an integral strategy used by the world groups (UN, World Bank, WHO) for meeting UN Millennium Development Goals. A document signed by eight global health agencies in Geneva stressed the importance of four key actions in which banking infrastructure can play a meaningful role – (1) increase levels of efficiency and investment in health information; (2) develop a common data architecture; (3) strengthen performance evaluation and monitoring; (4) increase data access and use¹⁵.

The globalization of locally viable business models requires implementation of legal, regulatory and technical models that are responsive to multiple regulatory authorities, within a self-sustaining business formula. Banks, in contrast to the cottage industry-driven nature of healthcare, have created efficient technology programs. Despite focus on administrative excellence, they could adapt to viable and more robust data transfer programs which offer remarkable potential, to increase the use of health information technologies around the world.

Along these lines, the next critical path issue for the facilitation and more widespread use of medical banking principles, practices and technologies in the marketplace, is the creation of a common platform of standards and best practices with a quasi-formal governance mechanism that is invested with some level of government authority to speed up the adoption of standards, particularly in data privacy and transaction standards. There is too much stop and go in the industry, fuelling the inefficient use of corporate resources. Beyond this, the potential creation of a technology harness, or the evolution of a preferred platform that can normalize data exchanges, could vastly improve innovation in health technology and medical banking. Too many vertical specializations of technology seem locked in a silos that could be “harvested” using an “omnibus” technology grid to deliver value across the entire ecosystem.

Today, some of the largest cause-based communities and commercial firms in the world are starting to understand the potential of medical banking in fostering creative innovation in healthcare¹⁶. The potential for international messaging systems like the SWIFT network, the adaptation of open

source communities like the Object Management Group (OMG), the Healthcare Services Specification Project, Eclipse, NetBean and OASIS communities and others, as well as the implementation of an open technical harness that can speed up critical mass adoption of technologies and business processes, for the creation of a new platform of much needed efficiency in healthcare. This effort, coupled with a governance mechanism that oversees the community in a neutral setting, where all can participate, can foster critical investment into an area that many agree is under-represented in budget planning today.

Today, academia, commerce and government are taking notice of the medical banking arena and including it in legislative initiatives, standards communities and pilot activities. According to Dr. Stephen Parente, a professor at the University of Minnesota's Carson School of Management, the adaptation of health information technology towards medical banking “is inevitable”¹⁷. As medical banking convergence flourishes due to market demands, the spread of best practices which impact both rich and poor, appears to be a well-placed stratagem for innovation in global health.

BIOGRAPHY

John Casillas is CEO of BoardTrust, LLC., a strategic advisory firm focused on improving global health. Prior to BoardTrust, John founded and sold two health data firms. In 2001, he founded The Medical Banking Project to define and socialize emerging digital practices at the nexus of banking and healthcare IT. US HHS, Disney, PwC, BNY Mellon, PNC Bank, Wells Fargo and other corporations, universities and associations joined the effort prior to acquisition by HIMSS in 2009. He is currently working to help build digital platforms for developing countries.

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¹⁴ BoardTrust website: <http://www.boardtrust.com/>; MIA website: <http://www.microrinsuranceacademy.org/>

¹⁵ http://www.who.int/healthinfo/H8_PLoS_Medicine.pdf

¹⁶ While the term “disruptive” is eschewed by conservative bankers the author believes it is truly required. We need to be clear – in healthcare, “disruptive” occurs when our system fails us, leading to preventable deaths (as reported by the Institute of Medicine). We must embrace disruptive technologies that act positively upon our healthcare system to truly change how we “do healthcare”.

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¹⁷ http://healthe-commerce.hslnetwork.com/Parente_banking_galley.pdf

Trends in Health Financing: The Move from Passive to Strategic Purchasing in Middle- and Low-Income Countries



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ABSTRACT: Strategic purchasing is not new, rather it first started in Western Europe in the 1960s, as an approach to improving health system responsiveness, as well as for the more effective matching of supply and demand. In the 1960s some Western European facilities were affected by empty beds, others by overcrowding. Doctors were not showing up for work, due to the establishment of dual practice. There were consumer queues, and complaints that providers were inhumane. There was a shift in purchasers in High Income Countries like Organization and Economic Cooperation for Development (OECD) countries, from paying for inputs to outputs and now outcomes. These challenges are yet to be overcome by non-OECD countries. In this article, we discuss the shift towards strategic purchasing in Middle Income Countries (MICs) and Lower Middle Income Countries (LMICs). There are successful models in both categories of emerging markets. The article begins with an overview of health funding, then focuses on the allocation of funds and strategic purchasing.

Purchasing and Health Financing

Health Care Financing refers to the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system... the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care” (WHO 2000).

Health care financing is much more than a matter of raising money for health. It is also about who is asked to pay, when they pay, and how the money raised is man-

aged and spent. At its simplest, health care financing is not unlike a family budget. Family budgets rely on income streams, families need to decide how to manage and pool their money, and families always want to spend money wisely. However, there are important differences such as the fact that 3rd parties can spend on behalf of individuals and families in health care financing. In addition, providers often respond in unexpected ways to services delivered. Furthermore, data on true diagnosis and optimal interventions for a given diagnosis may not be available.

The success of the financing process depends on the performance of these **three (3) important functions:** revenue collection, the pooling of resources, and pur-

chasing of services and interventions. Figure 1 provides a graphic overview of these 3 functions. They have also been described elsewhere (Gotrett et al, 2008) in some detail and presented in Figure 1.

In this article, revenue collection and pooling fund management is not discussed. Rather, focus is on the allocation and use of funds – in other words, how to get “more” value for existing health money (i.e. equity, efficiency and quality), rather than “more money” for health. One measure of value for money is the use of strategic purchasing for the more cost-effective services at the primary healthcare (PHC) level.

Passive and Strategic Purchasing

All allocations for healthcare are for purchasing. Historically, countries received line item budgets from the Minister of Finance for inputs such as salaries, infrastructure, utilities, pharmaceuticals, food, and so on. These line item budgets typically cannot be moved across lines flexibly to respond to demand or needs. Budgets would arrive late at the service level, and often too late to be fully spent. Funds would then remit back to the Ministry of Finance. This is termed “passive purchasing”. This still occurs today in parts of Asia (India, Bangladesh and Pakistan) and in many countries in Sub-Saharan Africa (e.g., Liberia, Nigeria, Mozambique). Line-item budgeting does offer strong administrative control, often valued by government-run providers. It assumes governments can track and understand the right combination to achieve outputs, but in reality, they cannot, for lack of an ability to provide accurate estimates respond in a timely manner to healthcare demands and monitor information. This is the reason why line-item budgeting and passive purchasing are being abandoned across the world. Furthermore, annual budgets from the Ministry of Finance, often subjected to political and stakeholder pressures, tend to move relative allocations to urban and tertiary facilities over time, away from PHC.

Increasingly, there is a marked difference across countries in terms of how they purchase. Countries, regardless of income, are constantly searching for ways to improve the performance of health systems, to provide “more health for money”. Strategic Purchasing is increasingly used by countries from a variety of income levels, from Germany, Ghana, Estonia to the Democratic Republic of Congo. Strategic Purchasing is understood as the allocation of financial resources to providers that shifts away from passive line item budgeting exercises reflecting last year’s inputs + inflation, to more demand-driven (or service-driven) approaches that encourage activities and outputs to improve equity of access, delivery efficiency, quality, financial protection and (ultimately) health outcomes as well as population gain.

In the WHO Health Systems Performance report of 2000, strategic purchasing was seen as a policy tool that should be embraced by low and middle-income countries as well (WHO 2000). International organizations such as WHO, the World Bank, the IMF and research universities have

reported on growing evidence that strategic purchasing improves efficiency (both technical and allocational), equity across population groups, and improved financial protection (see, for example, Gottret et al, 2008). The World Bank has funded strategic purchasing efforts in every region of the world through its lending programs. Countries utilize it as part of overall system reforms (Kosovo, Bahrain, Nigeria), or as part of special programs for population groups (HIV/AIDs in Indonesia), or parts of the sector (states or regions).

The Joint Learning Network (Table 1) of 27 (mostly low-income) countries shows how consistently countries are moving in some way or another towards strategic purchasing, including countries in Sub-Saharan Africa such as Ghana, Kenya, and Nigeria. However, effective purchasing requires a complex network of interventions and institutions (more below), so moving to strategic purchasing is often far from easily accomplished or straightforward. Indeed, countries may experience unintended consequences if it is introduced and implemented incorrectly or inharmoniously throughout actors. For example, it could lead to an increase in unnecessary admissions. The wrong mix of services may be reimbursed. Nevertheless, international organizations must stop passive purchasing (line-item budgeting) from increasingly moving to urban and tertiary funding, and help LMICs in their desire to move towards the more strategic purchasing of poorer PHC services.

The “How to” of Strategic Purchasing: Function and Sub-Functions

If Strategic Purchasing is a function, purchasers focus on core sub-functions (sometimes termed “policy levers”) at their disposal for health system performance improvement. These four (4) sub-functions are outlined below in Table 2 and described in more detail elsewhere (Preker and Langenbrunner, 2005).

Table 2: Policy Levers Related to the Uses of Financing and Strategic Purchasing

Core Policy Levers	<ul style="list-style-type: none"> - Knowledge of the population at risk. Demand or “Population Coverage” (for whom to buy)? - Supply or “Benefits Package” (what to buy, in which form, and what to exclude)? - “Contracting” (from whom, at what price to buy and how much to buy)? - Prices and incentive regime or “Provider Payment Systems” (at what price and how to pay)?¹
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Source: Preker and Langenbrunner, 2005.

Other Sub-Functions. Other aspects or sub-functions of strategic purchasing include:

- I Management and information systems (MIS): for the purchaser, communication and exchange between purchaser and provider;

¹ Arguably, price for services and payment method can be thought of as separate levers, with overall incentives imbedded in these levers.

- Quality, at several levels: quality assurance that services provided improve health, accreditation of providers for contracting. Purchasers increasingly tie payment to quality and outcomes;
- Autonomization of providers: providers must respond to market signals and incentives created by the purchaser, and need flexibility to respond to new inputs such as staff mix, equipment and appropriate tests and drugs;
- Performance monitoring and evaluation: strategic purchasing can have unintended consequences on services and quality. Furthermore, providers may attempt to “play on” the mix of incentives. Purchasers must identify and address issues early, supply feedback on best practices for providers managing care and expenditures, and patients on care seeking behaviors.

Overall, these sub-functions create a type of network of institutions and interventions. It is critical that countries put together a full network of cohesive and coordinating interventions. If not, the occurrence of aforementioned “unintended consequences” is probable. This tends to occur across all countries to some degree, but more often in MICs and LICs.

Best Practices: Strategic Purchasing

All high-income countries (HICs) have been engaging in strategic purchasing to some degree since the 1960s. The US progressed in the 1970s and 1980s, when health care costs began spiraling out of control, though the multiplicity of purchasers in the U.S. has limited its success.

An increasing number of MICs has also initiated strategic purchasing in the last 3 decades. Three countries which are typically perceived as best practice models include: Thailand, Turkey, and Estonia. These countries have worked to:

- Create purchaser-provider splits with new purchaser-based social insurance funds;
- Increase levels of pooling: in Thailand, 70% of the population is covered by one pool of funds (the universal health fund). In Estonia and Turkey, multiple funds have been merged to form a single payer model;
- Benefits packages based on explicit criteria related to cost-effectiveness, equity, patient preference and other factors;
- Contracting with both the public and private providers;
- Person-level MIS systems for payment and quality assurance systems;

- New provider payment models for PHC, hospitals and performance-based bonus pools, for “priority services” such as immunizations, family planning, prevention care, etc. Strategic purchasing often focuses resources and management attention on primary health care and “family health”;
- Accreditation mechanisms and quality assurance systems.

Best Practices: Case Studies in LICs Middle-Income Countries (MICs)

Strategic purchasing has been successful in a number of MICs, including Thailand (Balibanova, et al., 2013, Estonia (World Bank, 2015), and Turkey (Atun et al., 2013), as well as parts of rural and poor Argentina. “Plan Nacer” in Argentina utilized performance contracting and payment to improve health outcomes for the poor. During a 5-year pilot program, the number of prenatal visits increased, quality of care improved, probability of low birth weight was reduced by 23%, and probability of in-hospital neonatal death was reduced by 74%. For children under 6 years, Plan Nacer raised the likelihood of healthy baby checkups (Cortez and Romero, 2013).

Strategic Purchasing in Low Income Countries (LICs)

Low income countries face a formidable number of challenges, including scarce public allocations for health, large OOP payments, and reliance on donor support which is often provided in fragmented streams of funding. Donor support is waning in several countries, creating pressure for LICs to spend wisely, shifting focus to domestic financing and strategic purchasing. Nevertheless, there are some notable successes with LIC experience in strategic purchasing.

- A. **Kyrgyzstan**, in the 1990s was a small (5 million population) land-locked, mostly rural republic in central Asia. It underwent economic freefall following the break-up of the Soviet Union; income / capita fell to levels comparable to Burundi today. Kyrgyzstan responded to the fiscal crisis by catalyzing health systems transformation, with wide-ranging structural reforms, including PHC service delivery. This drove significant health improvements over 10 years (Balabanova, et al. 2013).

Many other LICs have embarked on strategic purchasing reforms. However, LICs often engage in one or more elements of strategic purchasing, while facing challenges in terms of capacity and political economy in the development of a full network of institutions and interventions necessary to achieving successful strategic purchasing.

- B. **Ghana** is one of very few African countries to take significant, large-scale steps towards demand-side financing for health. Focus has been on expanding

the enrolment of vulnerable groups (10% increase over the last 5 years), increasing access and utilization through new payment models.

- C. Guatemala.** *Programa de Extension de Cobertura* (PEC) is an example of how large-scale contracting to NGOs can rapidly scale up PHC in poor, rural, underserved areas. PEC served 4.3 million people, and was managed within the Ministry of Health, 75% funded by government revenues. PEC contracted ~68 local accredited NGOs for a PHC-focused benefits package. Contract renewal was conditional on NGOs meeting 28 targets concerning prenatal health, family planning, and vaccinations.

A difference-in-difference study showed an increase of 30 percentage points for DPT and Polio boosters, 14 percentage points for BCG, and 22 percentage points for Measles. Prenatal care provider choice shifted to doctors and nurses over other traditional midwives. Women receiving prenatal care from physicians or nurses increased by 24 percentage points. Treatment of children with symptoms of ARI by a health professional increased from 26.0% to 40.4%; Iron/folate for pregnant women from 21.7% to 73.0% (Avila et al. 2015; Crista et al, 2013; Pena et al., 2013).

Moving Forwards

Countries and the donor community will need to consider the “so what” in the existing landscape. LMIC interest in Strategic Purchasing will only grow over time, therefore it is crucial that best practices are spread and implemented. It is important to prevent the “harm” and risks from purchasing being “captured” by elites and tertiary care, or oversimplified into a one-size fits all approach. The challenge is that work is often isolated, but a larger “network” of interventions and institutions is necessary for real impact. This calls for:

- 1. Building Technical Capacity and the Evidence Base** to design and implement provider payment systems and other strategic purchasing levers, especially the availability of skills to analyze data for purchasing decisions. Part of this is a broader IT and health management information system (HMIS) issue. For example, can steps be taken in the interim preceding a fully operational HMIS in a country?
- 2. Creating Greater “Policy Coherence”:** The case studies show that many LIC are taking steps on individual elements of purchasing e.g. changing provider payment mechanisms; HTA capacity, introducing facility accreditation (often led by a NHI agency). But it would be productive to link these initiatives with a more coherent overall purchasing function so that, e.g., pooled funds are used to purchase a benefit package that is based on the evidence of cost-effectiveness, using a provider

payment mechanism that sends clearer incentives to providers, linkable to measures to improve quality (e.g., clinical guidelines, or accreditation) and equity (e.g., no extra billing permitted).

- 3. Building Institutional Relationships between the MOH and Purchaser,** which are often different and frayed, and sometimes conflicting, stalling the implementation of strategic purchasing. The relationship must extend to Ministers of Finance and above all for overall Governance. This can help to ensure that purchasing isn’t “captured” by tertiary care, but instead is targeted towards PHC, prevention, and promotion.

These areas highlight activities being explored by countries and donors, but are by no means exhaustive.

BIOGRAPHIES

John (“Jack”) Langenbrunner is a Senior Program Officer with the Foundation since September 2015. Jack is a Health Economist with experience in both research and operations. He was most recently an Advisor for Social Health Insurance in Indonesia from 2013 until mid-2015. Previously, he was a Lead Health Economist for the World Bank for 16 years, where he coordinated a Health Financing and Health Insurance Thematic Group within the Bank, and led the Bank’s Global Expert Team for Health Financing and Health Systems in 2011-2013.

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Figures and Tables

FIGURE 1: THREE HEALTH FINANCING FUNCTIONS

How: 1) revenues are collected; 2) funds are pooled; 3) services are purchased



Source: Authors' Own

TABLE 1: SUMMARY OF JLN COUNTRY EXPERIENCES IN HEALTH CARE FINANCING

#1 JLN Country	#2 Purchaser- Provider Split	#3 Population coverage and share of funds of insurance/purchasing agency	#4 Benefit Package (HTA capacity)	#5 Contracting (P=includes private sector contracting)	#6 Purchaser - and Payment models	#7 Scale of new model implementation	#8 Comments
UC total	4 of 5		4 of 5	4 of 5; 3 of 5 with private	Fee-for-service and RBF models	All small scale	
Ethiopia	✓	Community Based Health Insurance (CBHI) and formal sector insurance schemes	✓	✓	Fee-for-service	SS	
Liberia					PBF	SS	
Mali	✓	Mutuelles cover ~4% of the population	✓	✓	NHIF Fee-for-service	SS	
Senegal	✓	Mutuelles – 25-30% population coverage; 5% total govt health spending	✓	✓ (P)	IPMs, Fee-for-service Mutuelles PBF	SS	
Tanzania	✓	20% Coverage (2013) - Community Health Fund (CHF - 7.2%) and National Health Insurance Fund (NHIF - 12.8%)	✓	✓	MDH PBF CHF/NHIF	SS	Single national health insurance fund planned
LMIC	9 of 15		10 of 15		Wide range of models	Mix of small & large scale	
Bangladesh				Some contracting with NGOs	MOH Budget; salaries Case-based payment in maternity care voucher program	SS	National Health Insurance (NHI) under discussion
Egypt		National insurance agency: 55% population coverage; 22% of government health expenditure	✓		Budget; salaries		NHI (55% coverage) but no purchaser- provider split since the insurance agency also acts as the provider and pays traditional budgets
Ghana	✓	National Health Insurance Scheme (NHIS) 40% population coverage; 32% of government expenditure (new World Bank PER suggests higher)	✓	✓ (P)	NHIA Capitation (PHC) Case-based (outpatient specialty; inpatient) Fee-for-service (medicines; some services) Fee-for-service	SS-LS LS	National Health Insurance Scheme in the process of scaling up capitation (5 of 10 regions complete)
India	✓	Multiple govt-sponsored insurance schemes (e.g. Aarogya; RSBY; others); 45% population coverage	✓	✓ (P)	Schemes Case-based ("package rates")	LS	
Indonesia	✓	National health insurance with purchasing agency (BPJS): 52% pop coverage; 19% of govt health spending	✓	✓ (P)	BPJS Capitation (PHC) Case-based (other)	LS	
Kenya	✓	National Health Insurance Fund: 8% of govt health spending	✓	✓ (P)	NHIF Fee-for-service Capitation (PHC) Case-based (inpatient)	LS P	NHIF in the process of expanding pop coverage and benefits
Kosovo					Budget; salaries		
Moldova	✓	National Health Insurance Company (NHIC): >80% population coverage; 80% of govt health spending	✓	✓ (P)	NHIC Capitation (PHC) Case-based (other)	LS	PHC free regardless of insurance status
Mongolia	✓	Social Health Insurance Agency (SIGO): >80% population coverage; 30% of govt health spending	✓	✓ (P)	MDH Capitation (PHC) Case-based (other)	LS	Case-based payment NHI (>80% coverage) PHC paid through budget; free regardless of insurance status

#1 JLN Country	#2 Purchaser- Provider Split	#3 Population coverage and share of funds of insurance/purchasing agency	#4 Benefit Package (HTA capacity)	#5 Contracting (P=includes private sector contracting)	#6 Purchaser - and Payment models	#7 Scale of new model implementation	#8 Comments
LMIC	9 of 15		10 of 15		Wide range of models	Mix of small & large scale	
Morocco		Mandatory Medical Insurance (AMO) for the formal sector and the Medical Assistance Scheme (RAMED) for the poor – together 53% population coverage; 25% of govt health spending					From limited reports it does not seem that the public insurance schemes use any strategic purchasing approaches
Nigeria	✓	Public health insurance scheme for federal employees contracts further to HMOs to serve as the purchasers; ~5% pop coverage	✓	✓ (P)	HMOs Capitation Fee-for-service (referrals-secondary and tertiary care)	SS SS	
Philippines	✓	National health insurance PhilHealth: >80% population coverage; 41% govt health spending	✓	✓ (P)	PhilHealth Capitation (PHC) Case-based (other)	LS	
Sudan	Unclear	Public health insurance scheme for federal employees and some poor; ~8% population coverage			Unclear		Plans for national health insurance fund
Vietnam	✓	National health insurance (VSS purchasing agency) - 68% population coverage; 45% govt health spending	✓	✓ (P)	Fee-for-service Capitation (PHC) Case-based (inpatient)	LS SS SS	
Yemen					Budget; salaries		Small-scale community-based health insurance schemes (2012)
LMIC	2 of 6		3 of 6, 1 of 6 with HTA	2 of 6, 1 of 6 with private	4 of 6 are budget / salaries	Mix of small & large scale	
Bahrain				✓ (P)	MOH Budget; salaries (system-wide) Capitation (PHC)		NHI planned
Colombia	✓	96% population coverage by 3 public insurance schemes (EPS; EPC; IPS) 83% of govt health expenditure	✓		EPS Fee-for-service (outpatient specialty) Case-based (inpatient) Disease management programs	LS SS SS	The public insurers contract further with entities (EPS) that are selected by individuals and actually carry out the contracting and purchasing with health providers
Malaysia					MOH Budget; salaries		
Mexico		3 public insurance schemes: Social health insurance for formal sector employed, civil servant scheme, and subsidized Seguro Popular for the poor and informal sector-together nearly 100% pop coverage and 56% of govt health spending	✓ (HTA)		All purchaser s Budget; salaries		100% public insurance coverage but no purchaser-provider split since the insurance agencies also acts as the provider and pays traditional budgets
Namibia					Budget; salaries		
Peru	✓	ESALUD scheme for the formal sector and SIS public insurance scheme for the poor	✓	✓	SIS Capitation (PHC)	LS	

Legend for Table 1, summarizing JLN country experience:

#	Column Heading	Description
1	JLN Country	Country name
2	Purchaser-provider split	✓ = means that there is a separate public insurance or purchasing agency in the country that manages at least a portion of government health funding.
3	Population coverage and share of funds of insurance/purchasing agency	The percentage of the population covered and percentage of total government health expenditure and/or premiums that are channeled through a public insurance or purchasing agency. *Data mainly take from the WHO Global Health Expenditure Database with country-reported National Health Accounts (NHA) data.
4	Benefit package (Health Technology Assessment capacity - HTA)	✓ = means that entitlement to services is defined either as a benefits package or essential services package (typically legislated). (HTA) = means there is also a process in the country for explicit decision-making and priority-setting for adding new tools, services or benefits.
5	Contracting (P=includes private)	✓ = means that there is some explicit contracting mechanism through a public purchaser (either the Ministry of Health [MoH] or insurance/purchasing agency). (P) = the public purchaser also contracts with private health care providers.
6	Purchaser and Payment models	The payment models used by public purchasers are: <i>Input-based payment model:</i> <ul style="list-style-type: none"> • <i>Budget/salaries</i>—the purchaser uses traditional input-based line item budgets and salaries to pay health care providers <i>Output-based payment models:</i> <ul style="list-style-type: none"> • <i>Case-based</i>—a fixed payment for each case depending on the type of case (e.g. diagnosis). Typically for inpatient services, but some countries also use for outpatient; • <i>Capitation</i>—a fixed payment for a period of time to deliver a defined package of services (particularly primary care); • <i>Fee-for-service (FFS)</i>—payment for each service delivered, sometimes based on a defined fee schedule; • <i>Performance-based Financing (PBF)</i>—payment based on performance objectives.
7	Scale of new payment model implementation	P = new approaches are planned but have not been implemented; SS = new approaches are being piloted or implemented on a small scale; LS = new approaches are being implemented nationally or for all providers paid through the purchasing agency.
8	Comments	Additional context about the health system or strategic purchasing approaches.

The Health Care Revenue Cycle Management in Brazil: Challenges that keep CEOs awoken

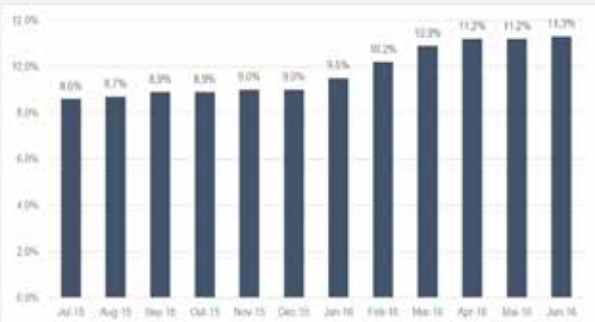


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ABSTRACT. Brazil's economic and political crisis had never been deeper, hardening the way companies deal on the market. Only those that are able to deal with tougher market conditions remain in the game, while facing increasingly difficult situations. A continuous rise in competition has shrunk prices and compressed margins, imposing necessary improvements to the way companies work in order to remain sustainable. The healthcare market is no exception, and if leaders identify improvement opportunities for the way their companies deal with Revenue Cycle Management, they will easily be one step ahead of competition.

Brazil is currently going through a deep recession. The country's growth rate has decelerated since the beginning of the decade, from an average annual growth of 4.5% between 2006 and 2010, to 2.1% between 2011 and 2014. In 2015, national GDP contracted by 3.8%. The economic as well as political crises have had a negative impact on investor and consumer confidence. The unemployment rate, which averaged 7.79 percent from 2012 until 2016, reached an all time high of 11.30 percent in June 2016 (exhibit 1).

EXHIBIT 1: UNEMPLOYMENT RATE IN BRAZIL



Source: Tradingeconomics.com

In addition to all this, the Brazilian Real reached an all-time high of 4.18 against the US\$ in September 2015 (Exhibit 2), resulting in a huge increase in costs, especially for imported goods.

These two economic factors have placed healthcare providers under considerable strain. On the one hand, an increased unemployment rate has reduced the eligible target population of healthcare providers

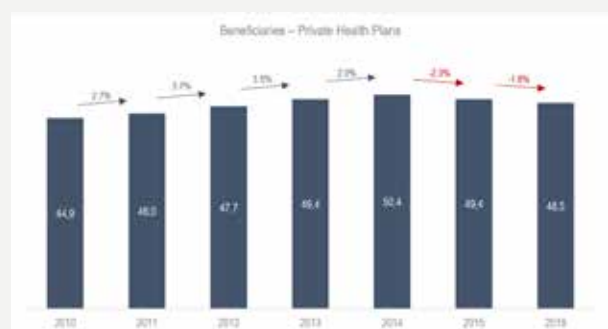
(Exhibit 3), strongly impacting their revenue streams.

EXHIBIT 2: BRAZILIAN REAL (BRL) EXCHANGE RATE



Source: World Economic Outlook 2016 - WEO 2016 Apr.

EXHIBIT 3: # OF LIVES – BENEFICIARIES OF PRIVATE HEALTHCARE PLANS IN BRAZIL



Source: Observatório ANAHP 2016

On the other hand, the exchange rate has almost doubled, and there has been a significant price increase of all goods tied to the US\$, hugely impacting associated costs.

A recent survey conducted in 2015 by Fundação Getulio Vargas (FGV) and the Sax Institute interviewed the CEOs of the largest and most important Hospitals in Brazil. Results show financial management as their top priority, especially in terms of cash flow and cost reduction (exhibit 4).

EXHIBIT 4: TOP PRIORITIES OF HOSPITAL CEOs IN BRAZIL



Source: Painel CEO's HOSPITAIS - 2015 Top Concerns – Setembro 2015

In addition, according to the American College of Healthcare Executives' (ACHE) annual survey, financial challenges remain top on the list of concerns for community hospital CEOs for at least the fourth year running.

From a 30,000-ft. perspective, given unprecedented pressure from a recent decrease in Hospital revenues and increased costs, it is clear that an improvement on RCM practice performance will play an important role in providers' financial health. There is considerable potential for improvement in several areas throughout the whole Services Delivery value chain within a Hospital. Here in particularly we shall focus on the so-called "Revenue cycle Management".

The Revenue Cycle Management and your Hospital day-to-day

Despite most people's belief that RCM starts when a patient is admitted to a service, the truth is it starts the moment a patient makes an appointment, and only ends when the patient's balance is zero. If we acknowledge that in between these two major events (shown in Figure 1), there are several intermediary processes that may either positively or negatively influence the

hospitals' ability to collect due payments, understanding the total revenue cycle is the first step toward achieving maximum revenue for your institution. It is also important to mention that "achieving maximum revenue" does not mean you are overcharging or trying to manipulate payers. It simply means that the way you have developed and implemented your processes, enables you to obtain payments from payers faster, with fewer, or even no errors.

Scheduling

Having in mind the "Detection" principle of the "Poka-yoke", which states that "The sooner an error is made visible, the faster and cheaper it is rectified", fool proof strategies to help the clinic/ hospital assistant (or the online service that will manage this activity), implemented to identify whether a person is eligible or not for a service, save a lot of money for institutions. Some examples of avoidable leakages through the implementation of said activities include:

- A. A "non-eligible" patient will not be allocated to a productive time slot;
- B. The whole assistance process will not even start, avoiding the occurrence of all rework-associated costs.

HOWEVER

Not even the most complete and reliable ERP will be able to avoid leakages in this process if the person in charge of scheduling is not aware of his/ her responsibility and the impact his/ her activity has on the overall process. Enablement sessions and close performance monitoring is key to controlling leakages at this phase.

Admission

"Shooting the messenger" refers to the act of blaming the bringer of bad news. Unfortunately, if the previous step fails, the front desk attendant shall be landed with blame. Usually, healthcare procedures require some preparation for patients, such as fasting, changes to his/ her daily routine, psychological stress depending on the procedure, and in case of refusal, frustration. In spite all this, if the patient fails to receive "bad news" in a timely manner, the institution is the one to suffer the consequences of the failure. If this occurs, important issues in the process will pop-up, for example:

- A. The continuity of care may be severely hindered;
- B. In case of partial invoicing, the payer will immediately deny the bill;

FIGURE 1: THE REVENUE MANAGEMENT CYCLE

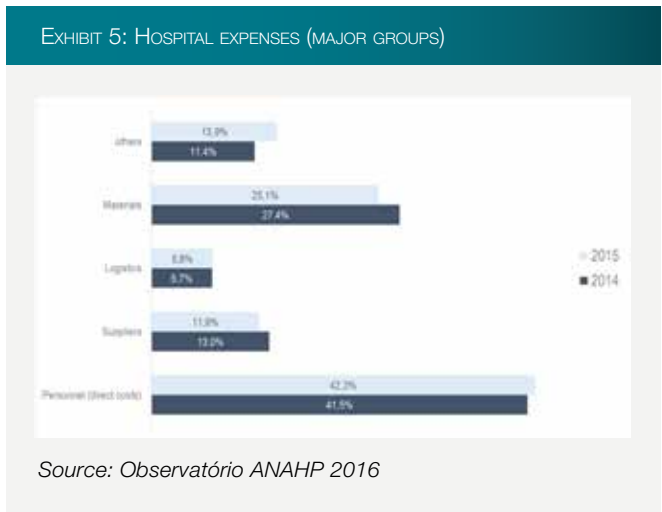


C. Judicialization, as the institution may be forced to provide care to safeguard patient care

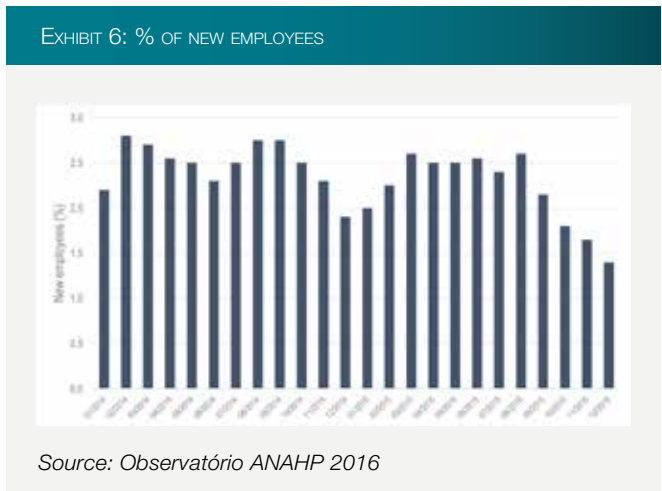
Closing the gap between these two initial processes is the key to avoiding some of the aforementioned consequences.

Assistance

Imagine that all barriers were lifted and only truly eligible patients were admitted to services. Besides the fact the daily routine of care providers is really stressful, current economics have imposed a necessary review on costs. According to ANAHP, 42% of costs in healthcare organizations are related to human resources (exhibit 5).



Considering the representativeness of this line on overall budget, a decrease on hospitals' capacity to admit new employees (Exhibit 6) naturally emerges.



With less professionals available to provide care, higher stress levels, absenteeism and rampant employee turn-over soon follow, with a significant increase in pressure on those employees responsible for providing care.

But what does all this have to do with RCM? A lot.

At this stage of the process, RCM depends entirely on the capacity of health care providers in performing "administrative"

tasks, parallel to patient care. Much has been done to facilitate care providers' lives, such as process automation, pharmacy logistics systems linked to patients' records, etc., but the final "hit the button" is still their responsibility. In view of the aforementioned, "Medical records missing information" leakage is one of the hardest to fight, but truly crucial, as the majority of leaks are usually found at this stage of the process.

Invoicing

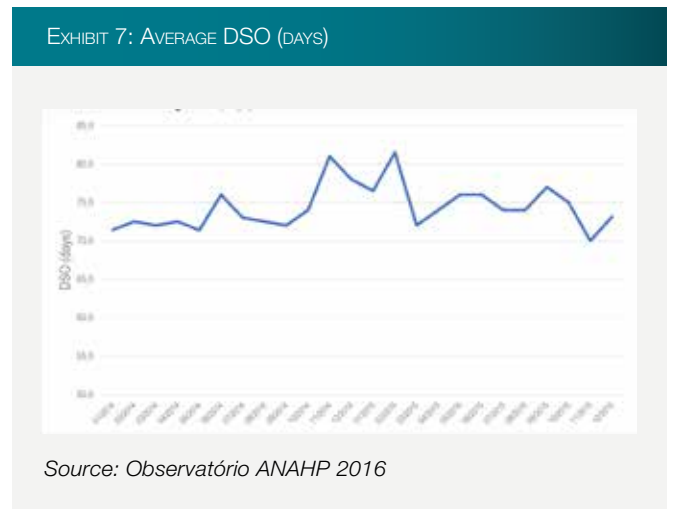
Let us imagine that the process has gone smoothly, with timely patient admittance, perfect procedures and discharge processes: now everything relies on the hospital's ability to invoice payers. Although Brazil has already implemented the TISS standard, with which all healthcare value chain players must comply, the implementation of such standards is still not complete. Therefore, often a lot of manual work is necessary to make the invoicing process work.

Broken processes, delays, understaffing, non-trained personnel are typical causes of leakages, in this case, denials. Was the specific procedure covered by a contract between the payer and the provider? How much time does the provider have before issuing the invoice? These and several other commercial conditions must be taken into account along the invoicing process. Any breach of this information flow will result in denials, hindering cash flow smoothness, fundamental for the financial sustainability of providers.

Although the rate of denials has remained stable at around 3.5% (in Jan/2014 3.46% and at the of 2015 this KPI reached 3.59%), in general, Brazil definitively requires solutions that make the process leaner and softer for providers and payers alike.

Remit Management

"Days to payment" is one of the most important KPI monitored by players in the Healthcare value chain, due its huge impact on cash flow. Currently in Brazil, a worrisome trend has emerged on the Market (exhibit 7), with DSO at around 75 days. In other words, shortening the time frame institutions get paid for services rendered is absolutely key to safeguarding their financial sustainability.



Conclusion

Although the implementation of an IT solution may address

the majority of aforementioned issues, the key is employee awareness of their importance in your organization. Once they know the impact of their daily activities on overall company results, rather than just making things right, they will strive to make things better.

BIOGRAPHY

Manuel Coelho is a professional with over 20 years of experience on the Latin American market in international companies, in the General Business Strategy and Marketing sector. In 2011 he founded Best Winds, a consultation company that has developed its strengths in three areas: Strategy, Organizational Development and Process Management. Having worked in several European countries (Portugal, Spain, Germany and Finland), Latin America (Mexico, Colombia, Venezuela and Argentina), Taiwan and North America, currently Manuel heads Best Winds in developing, implementing and monitoring clients' Business Strategy and Annual Plans.

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Four Ways Consumers Are Demanding Changes in the Healthcare Payments Experience



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ABSTRACT: Consumers in today's healthcare economy are more invested in their healthcare decisions. Experiences from innovators in other industries – such as clear payment communication and convenient, digital payment options – set expectations for the healthcare payment experience. However, healthcare payments have been slow to change, despite this evolution in the consumer's role, and continue to rely on disjointed, paper-based processes that leave consumers confused and frustrated. As a result, many consumers are demanding changes to the healthcare payments experience.

Introduction.

The consumer's role in healthcare payment processes has changed. With the increase in both consumer responsibilities as well as the number of high-deductible health plans, consumers are more invested in their healthcare decisions. Experiences from innovators in other industries – such as clear payment communication and convenient, digital payment options – set expectations for the healthcare payments experience.

However, healthcare payments have been slow to change, despite this evolution in the consumer's role, and continue to rely on disjointed, paper-based processes that leave consumers confused and frustrated. As a result, many consumers are demanding changes to the healthcare payments experience.

Here are four changes consumers want to see in their healthcare payment experience, and how providers can deliver:

1. 91% of consumers say it is important to know their payment responsibility prior to a provider visit

– *Consumer Healthcare Payments Survey 2015*

What this means: A rise in consumer payment responsibility has changed how consumers approach visits to providers. Consumers want to know upfront how much they will owe and then understand how to make payments. Questions like “how much is this going to cost?” and “what are my payment options?” have become common in the provider-consumer relationship.

What healthcare organizations can do: This consumer demand goes beyond providers making their retail prices available. The need is for consumers to understand an estimate of what they will actually pay, based on their benefit information, which can include variables like their deductible, co-payments and coinsurance. Healthcare organizations can deliver accurate estimates and a positive consumer experience by following best practices.

2. 76% of consumers reported that they were

confused by bills from their providers

– *Consumer Healthcare Payments Survey 2015*

What this means: Today's typical healthcare bill experience is confusing and frustrating. After a provider visit, a consumer receives an EOB from their health plan that looks like a bill including an amount they might owe, containing a bold disclaimer – “this is not a bill.” The confusion continues when the consumer receives a bill from their healthcare provider for their payment responsibility, which is often printed and mailed weeks or months after a visit and does not clearly indicate what is due or how to pay.

What healthcare organizations can do: Clearly communicate consumer payment responsibility. Healthcare organizations can leverage existing interaction points with consumers to create multiple communication touch points. For example, the scheduling process and all email communications are opportunities to explain consumer responsibility and discuss payment options. Formalize payment notification by automatically generating a printed letter to present at the time of service that explains payment responsibility. Anything healthcare organizations can do to set payment expectations and build trust with consumers will help facilitate payment conversations, improve the consumer experience and increase revenue.

3. 47% of consumers will switch providers based on their ability to understand cost upon scheduling, as well as the issuing of an comprehensive and easy-to-pay bill, using a preferred method.

– *Accenture 2014 Global Consumer Pulse Survey*

What this means: The impacts of consumers no longer putting up with the mysteries of healthcare costs are real. Consumers are more aware than ever as to how much they are spending on healthcare. Consumers also have previous experiences from innovators in other industries, like Uber and Amazon, where cost notification is clear and payment methods are convenient. These experiences have raised expectations from the healthcare payment experience.

What healthcare organizations can do: As new stakeholders in the healthcare payments industry, consumers want convenient, digital experiences to pay and manage their healthcare expenses. Healthcare organizations can deliver by offering digital experiences through online and mobile payment channels, eliminating paper from the process and by being transparent about costs.

4.64% of consumers reported being interested in using a new mobile payment system such as Apple Pay, Samsung Pay or Android Pay to make a healthcare payment.

– *Consumer Healthcare Payments Survey 2015*

What this means: According to Pew Research Center

Surveys, 64% of American adults have smart phones, and Forrester Research reports that the average consumer has 150-200 mobile moments a day. It is no surprise that the popularity of mobile systems is making its way into the healthcare payments industry.

What healthcare organizations can do: Both Apple Pay and Android Pay are available for healthcare payments. These payment options allow consumers to use their mobile devices to make payments without reaching for their credit card. Moreover, there is an added benefit: in many cases, new technology can introduce new security risks. With Apple Pay and other mobile payment systems, healthcare organizations can both improve the consumer experience and decrease the burdens of PCI Compliance.

To learn more about these and other trends impacting the healthcare payments industry, download the Trends in Healthcare Payments Annual Report: 2015.

BIOGRAPHY

Chris Seib is Co-Founder and Chief Technology Officer of InstaMed. Before founding InstaMed, Chris was an executive in Accenture's Health and Life Sciences practice. Additionally, Chris has been involved in strategic development efforts regarding government health initiatives, consumer-directed health plans and direct connectivity between providers and payers. Chris is a named inventor of multiple patents and patent applications held by InstaMed.

Reference

Accenture 2014 Global Consumer Pulse Survey. Trends in Healthcare Payments Annual Report: 2015

The Third Party Administrators



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ABSTRACT: This article is about health insurance-related and Third Party Administrator services in India. Health Insurance in India is still at an early stage: only about 14% of the entire population has taken out insurance. There is a large chunk of the population without any insurance coverage. Third Party Administrators (TPA's) are intermediary between Insurance companies, Hospitals (Providers) and Insured Parties (Corporate or Individual). Indian Health Insurance is growing at the rate of almost 30% per year. The government of India is launching a lot of schemes to cover the population, especially in rural parts of the country. Current market size is almost Rs 22000 Crores.

Introduction.

The Insurance Regulatory and Development Authority (IRDA) defines a Third Party Administrator (TPA) as 'an insurance intermediary licensed by the Authority who, either directly or indirectly, solicits or effects coverage of, underwrites, collects, charges an insured subject with a premium, or adjusts or settles claims regarding health insurance, except as an agent or broker or an insurer.' Basically, a TPA acts as a service integrator between the insurer, the insured and the health service provider.

The Insurance Regulatory and Development Bill, which was passed by parliament in January 2000, allowed the insurance sector to open out to private players. IRDA is the apex body that will ensure that the insurance sector operates in a manner that is consistent with consumer interests. The General Insurance Company was converted into India's national re-insurer in December 2000, and all the subsidiaries working under the GIC umbrella were restructured as independent insurance companies. Parliament cleared a bill on July 30th 2002, de-linking the four subsidiaries from GIC. A separate bill has been approved to make room for brokers, cooperatives and intermediaries in the sector.

TPAs were introduced as intermediaries to facilitate claims settlements between the insurer and the insured. Insurance companies have been searching for ways and means to align their management expenses, with specifications laid down by the IRDA. Insurers can now outsource

their administrative activities, including claims settlement, to TPAs, who offer such services at a cost. Given that TPAs are paid by the insurers, it is argued that policy holders should welcome such a move as they receive enhanced facilities at no extra cost. The other benefit of TPAs is that once a policy has been issued, insurance companies are required to pass on all the records to the TPA, and all information regarding the insured remains with the TPA. Lastly, the new system would be based on a cashless model, which is definitely an improvement on the previous system as far as consumers are concerned.

Ultimately, of course, the role of TPAs in the country must be measured against the basic parameters of a functional health sector, namely: are TPAs able to make healthcare more accessible and available to the population at large?

The Health Insurance Market

Health insurance premiums in India have risen from Rs 531 crore in 2000-01 to Rs 22,500 crore in 2015-16, which includes overseas medical policies. TPAs are being paid 4% of gross premium as commission. Based on a figure of over Rs 22,500 crore in premiums, this means that the total business for TPA's in India is approximately Rs 900 crore. However some business is being conducted without TPAs. There is a growth rate of approximately 30% on insurance premiums.

Given the current business of about Rs 900 crore, even

these 31 TPAs may seem too much. The market is already divided among some that have cornered major part of the business. However, while larger TPAs are more effective, in the case of pan-Indian operations, some of the smaller TPAs are also doing well in terms of quality of service, albeit in their limited areas of operation.

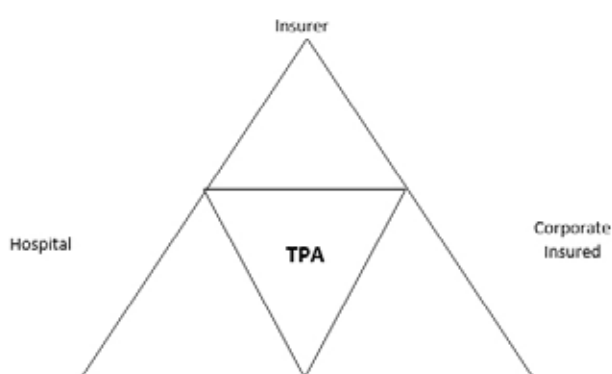
Critical success factors of TPA's depend on a fine balance of the following parameters:

- a. Share of total business
- b. Availability of capital and state-of-the-art infrastructure
- c. Geographic spread of operations

As on any market, unsuccessful players are expected to exit the business. In theory inefficient players, unable to satisfy their main customers, should exit the TPA market; this has not happened in India, however. The reason is that the TPA market is unlike any other: neither the entry nor the exit of TPAs from the market is free. As mentioned above, the entry of TPAs is based on a rationing of total business as opposed to natural entry, based on market considerations. Similarly, the exit of inefficient TPAs does not depend on market forces.

As mentioned here above, one of the main benefits of a TPA for customers is a cashless transaction at the time of service delivery. Clearly, this requires the TPAs to have sufficient working capital to make payments to the hospital. Given the cashless system of settlements being encouraged under the Mediclaim scheme, insurance companies are insisting on bank guarantees from TPAs. A new, single-window clearance system has emerged in the last three years, whereby the TPA adjudicates the claims and a batch file is forwarded to the Insurer window for direct remittance from the Insurers Bankers to the Insured's account (Retail Insured/ Corporate / Hospital).

Key Stake holders



Future of the TPA Market

There are 31 players on the market today and the number is growing. Significantly, Insurers have created their in-

house TPAs with an eye on improving customer satisfaction in the settlement process, without clearly understanding the root cause analysis of the grievance, namely the underwriting process and interpretation of clauses.

The Indian Healthcare market is growing at 30% CAGR and greater penetration of unchartered rural Indian territory markets will create considerable opportunities for all key stakeholders; technology will be a key factor for insured party satisfaction. The Health Insurance market, currently characterised by limited product choice, will be demographically driven, with the scrapping of a top-down approach.

Process

Insured (buys Insurance) Insurer (underwrites the proposal) TPA (for enrolment) TPA (Enrols & Issues ID Card issuing) Insured (in case of Claim) TPA (Adjudicates) Insurer (for Payment) Insurer (Settles the claims: Payment / denial)

Conclusion

TPA business though manpower and transaction-oriented work is still profitable. The challenges in this domain regard the constant upgrading of infrastructure in terms of IT systems, due to frequent process changes and incipient industries. The nomenclature of Third Party was conceived by policy makers with an intention of having an independent view on claims adjudication without any influence from the first (Insurer) and Second (Insured / Corporate / Hospitals) party. However, over the years, the regulator came to allow first parties to have In-house TPAs, and a rise in Insured party grievances is an indication of this over-step.

New systems have implemented few changes to TPA functioning during the last 14 years of co-existence with new Insurance companies. Ever-increasing penetration of the system requires an overall change in the dynamics in order to handle a volume of 18% penetration by 2020.

Is the Insurance Industry ready to embrace the new niche market? Only time can tell.

BIOGRAPHY

JE Prasad is a student of Economics with 38 years of experience in the field of Banking (14 years), the Healthcare Manufacturing industry (10 years) and Health care industry (last 14 years). He is based just outside Hyderabad in India. He maintains excellent working relations with Insurance Industry, Corporate world and the Medical hospital industry. He has travelled widely across India, Europe and other Asian countries. He likes to interact with people from all walks of life. Prasad is due to retire in the next couple of months and is looking forward to undertaking a couple of projects in the health-related industry.

Universal healthcare in a mixed public-private system: the Australian experience



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ABSTRACT: Australian governments and health service providers play a continual role in ensuring efficient healthcare budget use, which also concerns the meeting of goals within a universal health system, and ensuring compliance with relevant legislation and regulations. As is the case in most developed countries, there is substantial pressure on healthcare budgets, and this in turn places pressure on the capacity of governments to fund universal healthcare. The mixed public-private system in Australia has some imperfections including the fragmentation of care and limitations to fund use oversight, however overall, the system serves Australians relatively well. This article explores the Australian approach to a mixed public-private system and considers some of the complexities which arise as it seeks to support universal healthcare.

Introduction

Australians have enjoyed access to universal healthcare for more than 40 years, through a system “which achieves good results relatively efficiently. Health expenditure in Australia is about the same as the OECD average, at 8.8% of GDP. Life expectancy at birth is the sixth highest in the OECD, at 82.2 years.”¹

In common with many OECD countries, Australia's healthcare sector is facing challenges including an ageing population, a growing burden of chronic disease and a rise in healthcare service costs. A complex system of mixed public-private sector responsibilities for governance, funding and service delivery may lead to the fragmentation of care, as well as compromising oversight of the system.

¹ OECD 2015. OECD health policy overview: Health policy in Australia. p.1. Viewed 11 Jan 2017 at: < <https://www.oecd.org/australia/Health-Policy-in-Australia-December-2015.pdf> >

A mixed public-private system

While the development of policy responses to address these challenges may be complicated by the mixed public-private system, there is considerable support in Australia for a strong public healthcare sector, complemented by market competition and consumer choice through private sector healthcare services. Around 47% of Australians purchase private health insurance in addition to coverage available through the Australian government's universal Medicare program for primary healthcare and public hospitals.

Attempts by governments to reduce the public sector's role in healthcare service delivery caused substantial public backlash, particularly where voters believed this would lead to less accessible and affordable healthcare services. At the time of the 2016 Australian election, 60% of voters nominated health as the most important issue influencing their voting intention,

and 55% nominated investment in health and hospital services as the priority issue for the incoming government.²

Public-sector healthcare services are provided by the Australian, state, territory and local governments. Private-sector healthcare service providers include private hospitals and medical practitioners in private practices. In 2013–14, healthcare expenditure in Australia was estimated at \$AUD 155 billion—more than two-thirds of which came from federal, state, territory and local governments.³ Some of the \$AUD 105 billion spent by governments on health was transferred to the private sector including to private health insurers via subsidies (\$AUD 6 billion), private healthcare service providers including general practitioners and specialists (\$AUD 21 billion), pharmaceuticals (\$AUD 9 billion) and private hospitals and healthcare services (\$AUD 4.5 billion). Private health insurers contributed \$AUD 7 billion to expenditure in hospitals in 2013–14.⁴

Public hospitals

Public hospitals are funded largely by the eight state and territory governments (and indirectly via the federal government, which transfers some funds to the states and territories), with around 16% of funding from private health insurance. Funding from the federal government to the states and territories is calculated using an activity-based formula, with a national weighted average price being calculated annually by the Independent Hospital Pricing Authority. Data validation and linkage methodologies are employed to reconcile activity with funding, with the Administrator of the National Health Funding Pool as auditor. Work is currently underway to develop a methodology for excluding sentinel events, some hospital readmissions and specified hospital-acquired complications from the funding and pricing calculations. More details about the work of the Independent Hospital Pricing Authority are available at www.ihpa.gov.au.

The extent to which fraudulent activity or gaming of the system is at play in the public sector is unclear, however, there is considerable variation in the costs of hospital activity across Australia. According to the Australian Commission on Safety and Quality in Healthcare, this is “a result of an intricate interplay of factors, including differences in the health and socioeconomic status of populations and their access to healthcare, as well as differences between systems, services and clinicians. Patient and clinician preferences also play an important role. Some of this variation is warranted and some is unwarranted.”⁵

Private hospitals and health insurance

Services in Australia’s private hospitals are funded through public funding including Medicare, private health insurance

and out-of-pocket costs. While there is limited government regulation of pricing arrangements agreed between private health insurers and private hospitals, larger private health insurers generally enter into contractual arrangements with private hospitals to agree pricing of services. There has been considerable pressure in recent years from private health insurers on private hospitals to exclude payments for sentinel events as well as some hospital readmissions and hospital-acquired complications. With moves in the public hospital sector to incorporate these exclusions in funding and pricing methodologies, it is likely that these contractual arrangements will continue to be further developed. There is less opportunity for negotiating pricing with specialist medical providers and for consumables, coupled with limited vertical integration in the private sector.

A number of private health insurers, private hospital operators and suppliers of consumables have engaged in vigorous public debate about the extent to which payments are being gamed in recent years. A recent report by the now disbanded Private Health Insurance Administration Council noted:

“The competitiveness of the private health insurance industry can be enhanced or inhibited by the nature of competition along the supply chain within which private health insurance is nested. Some inputs insurers can control or influence to an extent (such as private hospital contracts), while there are other areas, such as prostheses devices and specialist fees, over which they have less control.”⁶

Also noteworthy is the impact of ‘gap payments’ charged by private hospital operators to insured patients, where their insurance product does not fully cover the cost of their private care. This has increased as private health insurers have introduced products with substantial exclusions on cover. In response to significant public concerns about the value of private health insurance products, the Australian government has instigated a review process, currently under way, to examine all aspects of private health insurance and provide the government with advice on reforms including:

- developing easy-to-understand health insurance categories
- developing standard definitions for medical procedures across all insurers for greater transparency and simplified billing
- ensuring private health insurance meets the specific needs of Australians living in rural and remote Australia.⁷

Primary healthcare and specialist services

Primary healthcare services in Australia are largely delivered by private sector providers, as are many specialist services. These are funded in part by Medicare, the cornerstone of Australia’s universal health system available to all Australians: in 2015–16, 84 percent of general practice services were fully funded by Medicare, with the remaining 16 percent required an out-of-pocket payment by the patient, with an

2 Murphy, K. 2016. Health and Medicare the most important issues for voters in federal election, poll finds. *The Guardian*. 26 July. Viewed 11 Jan 2017 at: < <https://www.theguardian.com/australia-news/2016/jul/26/health-and-medicare-the-most-important-issues-for-voters-in-federal-election-poll-finds> >

3 Australian Institute of Health and Welfare 2016. Australia’s health 2016. Australia’s health series no. 15. Cat. no. AUS 199. Canberra: AIHW. p.22

4 Australian Institute of Health and Welfare (AIHW). 2015. Health expenditure Australia 2013–14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.

5 Australian Commission on Safety and Quality in Healthcare. 2015. Australian Atlas of Healthcare Variation. p 12. Viewed 11 Jan 2017 at: < <https://www.safetyandquality.gov.au/atlas/> >

6 Private Health Insurance Administration Council. 2015. Competition in the Australian Private Health Insurance Market. p. 61. Viewed 11 Jan 2017 at: < http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Competition-in-the-Australian-PHI-market_June-2015.pdf >

7 <http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac>

average payment of \$AUD 33 per service. Annual growth in out-of-pocket payments was 6 percent, compared to an annual inflation rate of under 2 percent. Specialist services are less likely to be fully funded by Medicare (in 2015-16, 70 percent of specialist services required an out-of-pocket payment averaged at \$AUD 71, with out-of-pocket payments growing at a rate of 8 percent compared to the previous year).⁸ Out-of-pocket payments are a growing area of concern for health policy commentators in Australia who have noted the negative consequences for universal healthcare and associated impact on health inequalities. Likewise, moves to introduce compulsory co-payments have been very soundly rejected both by commentators and the electorate.

There is some limited evidence of fraud and misuse of Medicare funding⁹, both by service providers and through theft of individual Medicare numbers. Public reporting on this information is limited; however there are few prosecutions and limited revenue recouped from fraud investigations. For example, the Professional Services Review Agency (PSR), the body responsible for protecting the Australian government from having to meet the cost of services provided as a result of inappropriate practice, reported that during 2015 16 less than \$AUD3 million in Medicare benefits paid to practitioners was duly channelled for repayment and that, “fewer than 100 practitioners, out of around 85 000 whose services attract Medicare payments, are referred to PSR each year” for professional review.¹⁰

8 Commonwealth Department of Health. 2016. Annual Medicare Statistics 2015-16. Viewed 11 Jan 2017 at < [http://www.health.gov.au/internet/main/publishing.nsf/Content/34A89144DB4185EDCA257BF0001AFE29/\\$File/MBS%20Statistics%20Financial%20Year%202015-16%20external%2020160808.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/34A89144DB4185EDCA257BF0001AFE29/$File/MBS%20Statistics%20Financial%20Year%202015-16%20external%2020160808.pdf) >

9 Parnell, S. 2016. Health review: Medicare sweep for GP fraud rockets. In The Australian. April 27. Viewed 11 Jan 2017 at < <http://www.theaustralian.com.au/national-affairs/health/health-review-medicare-sweep-for-gp-fraud-rockets/news-story/337a21942a10e6822008fe12a221cfd2> >

10 Professional Services Review Agency. 2016. Annual Report 2015 16. Commonwealth of Australia.

Conclusion

Australian governments and healthcare service providers have a continual role in ensuring efficient healthcare budget use, which also concerns the meeting of goals within a universal health system, and ensuring compliance with relevant legislation and regulations. As is the case in most developed countries, there is substantial pressures on healthcare budgets, and this in turn places pressure on the capacity of governments to fund universal healthcare. The mixed public-private system in Australia has some imperfections including the fragmentation of care and limitations to fund use oversight, however overall, the system serves Australians relatively well.

BIOGRAPHY

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Learning from the USA Affordable Healthcare Act: The New York 2016 Hospital Executive Study Tour



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ABSTRACT: From June 27th to July 1st 2016, the International Hospital Federation (IHF) and Health Investment & Financing hosted a Hospital Executive Study Tour in New York City, NY, USA. The objective of the Hospital Executive Study Tour was to enable participants to learn how the US hospital sector addresses some of the key challenges and solutions in transforming the way hospital care is delivered in the 21st Century. The New York Study Tour was part of a series of premier events offered by the IHF. This Study Tour was a collaborative effort among regional members and partner organizations in hosting various events to allow an exchange of ideas, knowledge, experiences and best practices in the delivery of healthcare services, and in the leadership and management of their organizations.

Healthcare is the largest, fastest growing and most complex industry in the world. The American healthcare system accounts for almost \$3 trillion in annual expenditure, which is over 17% of its nation's Gross Domestic Product (GDP).

According to the Economist in the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), health sector annual growth is expected to increase at an average rate of 5.8% right through to 2020, well above stagnant GDP growth rates of the past decade (Keehan and Sisko et al 2016). By 2020, healthcare expenditure is expected to exceed \$4.5 trillion, and many other OECD countries are facing similar challenges.¹

Despite its size and growth trajectory, the healthcare industry in America is plagued with large-scale problems and inefficiencies that are prompting a massive transformation in how care is accessed, delivered, and reimbursed. Major changes

in the healthcare system already took place during the past eight years under the Obama Administration, with mixed results. The new Trump Administration has already pledged to "repeal and replace" Obamacare, making healthcare reform his major priority in the upcoming term.

The aforementioned healthcare challenges create opportunity for companies with innovative technologies and disruptive business process innovation ideas, which will help to control cost, improve health outcomes and patient satisfaction.

Facilities Visited and Executives Participating in the Study Tour

The Study Tour included visits to leading US policy makers, hospital managers and decision makers, Ivy League researchers, entrepreneurs, community leaders, and health financing experts. Organizations include the New York Department of Health, Mt. Sinai Medical Center and Health System, the Mailman School of Public Health at Columbia University, the Columbia University Medical Center, Wagner

¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2015.pdf>

School of Public Services, CityMD Urgent Care, New York Academy of Medicine, The Commonwealth Fund and other New York healthcare institutions in the New York Metropolitan area (see Annex 1 for a detailed agenda of the Study Tour).

The participants in the Study Tour included executives and leaders from Australia, Brazil, Canada, Finland, France, India, Spain, and the USA.

Highlights and Lessons Learned from Different Visits

Here follows a summary of some of the key highlights and lessons learned from the different visits during the study tour. For a comprehensive and detailed description of the study tour, please download a copy of the full report on the study tour at the following website: (<https://www.ihf-fih.org/activities?type=training§ion=study-tour>).

Day one

The Wagner School of Public Service (WSPS). The study tour opened with a visit to the Wagner School of Public Service, at New York University, with Professor Sherry Glied (Dean of the Wagner School). Professor Glied was formerly Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services (2010-12), and one of the main architects of the healthcare financing part of the Affordable Health Care Act.² She provided an overview of the history of the US Healthcare system and of recent efforts under the Obama Administration to expand insurance coverage to those without insurance (Weil 2017). Mexico, Turkey and America are the only OECD countries that currently do not provide universal healthcare coverage to all of their population.

Recent estimates indicate that 20 million people obtained healthcare insurance coverage because of the Affordable Care Act, the most historic reduction in the uninsured since the introduction of Medicaid and Medicare in 1965. Professor Glied also highlighted a number of other innovative reforms that were introduced under the reform, such as greater accountability for outcomes by healthcare providers and various cost containment measures in the complex public/private mix of healthcare delivery in America.

Major criticism of the reform includes escalating costs of insurance coverage, continued increases in healthcare expenditure, and increased regulation in the healthcare industry which makes it difficult for healthcare providers to focus on ensuring quality care for their patients.

The New York Medical Center (NYMC). This high level introductory review was followed by a presentation by Dr. Douglas Miller (Dean of Medicine for the New York Medical Center). Dr. Miller provided an overview of the implications for Universal Medical Centers after the implementation of the

² The **Patient Protection and Affordable Care Act (PPACA)**, commonly called the **Affordable Care Act (ACA)** and nicknamed **Obamacare**, is a United States federal statute enacted by President Barack Obama on March 23, 2010. **The Affordable Care Act was intended to increase health insurance quality and affordability, lower the uninsured rate by expanding insurance coverage and reduce the costs of healthcare.** Under the act, hospitals and primary physicians would transform their practices financially, technologically, and clinically to drive better health outcomes, lower costs, and improve their methods of distribution and accessibility. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and in 1965. <https://www.healthcare.gov/glossary/patient-protection-and-affordable-care-act/>

ACA to ultimately improve healthcare and service quality, and reduce per capital cost. He highlighted key challenges (both technical and financial) faced by university medical centers like NYMC, that often treat patients with much more complex and expensive medical conditions than non-academic healthcare facilities.

The New York City Department of Health and Mental Hygiene (NYC DHMH). During the site visit to the New York City Department of Health and Mental Hygiene, visiting executives had an opportunity to learn about a wide range of programs and interventions developed by the NYC DHMH to reduce the uninsured and increase access to care, at the Bureau of Primary Care Access and Planning (PCAP). The Bureau of PCAP creates and implements an impressive range of policy, program and research interventions that maximize health insurance coverage opportunities and increase access to affordable, high quality, and coordinated primary care, with a strong focus on vulnerable, underserved populations across Five Boroughs of New York.

Day Two

The Mount Sinai Health System and Health Network (MSHS). On the second day, the visiting hospital executives had an opportunity to learn about clinical excellence at Mount Sinai Health System and Health Network (MSHS).

Dr. Arthur Klein, the President of Mount Sinai Health Network, provided an overview of the health system and health network of Mount Sinai. Founded in 1852, Mt. Sinai is one of the oldest, largest and most prestigious non-profit hospitals in the United States. With over 55,000 staff members, the MSHS is one of the largest healthcare providers and single employers in New York City. The network includes several medical campuses and a large network of ambulatory clinics that span the five boroughs of New York City. It is very active in clinical research and is considered one of the top healthcare institutions in America.

Mt. Sinai was one of the first healthcare organizations in New York to embrace the spirit of the ACA by shifting its operations and funding to become an Accountable Care Organization (ACO), shifting to population-based funding and management incentivized to focus on health outcomes. Dr. Claudia Colgan, the Vice President for Care Coordination, offered insights into how population health at the MSHS had already been impacted by new incentives introduced under the ACA reforms affecting hospitals and healthcare networks.

Mt. Sinai is also active in the arena of international health and healthcare. The team met with Dr. Szabolcs Dorotovics (Vice President of the International Business Development at Mount Sinai Health) who discussed various partnership arrangements and opportunities for other countries to collaborate with Mt. Sinai.

The visiting executives also had an opportunity to visit several clinical departments, including the centers for breast cancer, cardiology, oncology, neurology, population health science, geriatrics, palliative care and urology, to understand how clinical departments at the MSHS are organized, and to examine the recent impact of healthcare reforms introduced

over the past few years.

Day Three

The Mailman School of Public Health at Columbia University. On the third day, visiting executives met with Professor Michael Sparer, the Chair at the Department of Health Policy and Management at Columbia Mailman School of Public Health, and Professor Larry Brown, former Chair at the Department of Health Policy and Management. They provided an in-depth analysis of the political reform process leading up to the ACA. They reviewed the long history of health reform, dilemmas public and private insurers are facing due to rising healthcare costs, and political conflicts over health policy.

They emphasized how American Federalism influences the politics and substance of the recently enacted Patient Protection and Affordable Care Act. They also reviewed issues around health insurance and healthcare delivery systems for low-income populations, and the ways in which inter-governmental relations influences policy, both in America and abroad.

They also discussed other topics, such as the expansion of Medicaid, different payment system reforms, private sector-led health reforms, the rise and fall of managed care, consumerism, value based purchasing and ACOs.

Ms. Ofra Weinberger, the Director of Licensing at Columbia Technology Ventures, provided insight into technology transfer from academic research labs and the commercialization of life science research at universities like Columbia University. She highlighted the challenges faced by academic institutions in translating bench research into commercial products that benefit patients and consumers. Columbia university is a major contributor to the life sciences both in the US and on a world-wide level.

The Jefferies Investment Bank. Visiting executives also had an opportunity to listen to staff at Jefferies Investment Bank, on how investors and capital markets view the health sector as a business opportunity. This includes investment opportunities in life science, medical technology, healthcare service delivery and a range of non-clinical service areas such health insurance and health information technology. The staff at the Jefferies Investment Bank also expressed their view on near and long-term investment opportunities as well as certain forces driving global healthcare trends.

Day Four

The New York Academy of Medicine and the Commonwealth Fund. The fourth day of the Executive Study Tour focused on health in the community. Dr. Anthony Shih, Executive Vice President at the New York Academy of Medicine, provided a comprehensive overview of the Academy and its mission to advance urban health and promote age-friendly cities through population health approaches and more effective urban health governance.

Ms. Robin Osborn, Vice President and Director at the International Program in Health Policy and Practice Innovations at the Commonwealth Fund, presented an in-depth review

of ways to measure the performance of healthcare systems at an international level and through cross-national comparisons. This provided visiting executives with an opportunity to review what they had seen during the week in New York, and compare American healthcare system with other OECD countries in a number of different dimensions.

The CityMD Urgent Care Clinics. The Study Tour ended with a fascinating presentation by Dr. Richard Park, CEO at CityMD, one of the new ambulatory walk-in clinic networks in New York. CityMD now provides an extensive network of walk-in clinics across New York that are focused on the delivery of ambulatory care in a friendly, dedicated medical facility, outside of a traditional emergency room setting. Urgent Care services are different from other urgent-care chains by being affordable, convenient, and most importantly, focusing on kindness and giving back to the community. They are a one-stop-shop for ambulatory urgent care, contributing to easing the load of crowded hospital emergency departments, a major problem in most OECD countries and many other cities in the USA.

Social activities

In addition to the academic program, the New York 2016 Executive Study Tour also included a wide range of social activities, excellent food, on- and off-Broadway entertainment for participants, providing them with a view of the vibrant social environment that make the “Big Apple” such a unique city.

Summary

Like most countries, improving healthcare in America is an ongoing challenge and endeavor, with close interplay between politics, policy, governance, socio-economic trends, and expectation/demand from the population. Over the last eight years, we have witnessed some radical changes in the healthcare system with positive and some negative implications. As foreseeable changes in the political landscape emerge, we can expect drastic changes in the healthcare industry and market.

The International Hospital Federation is committed to helping its members continue to learn from others. Another Hospital Executive Study Tour is planned for Montreal in mid-2017. For more information about this follow-up opportunity please go to www.executivestudyvisit.com.

BIOGRAPHY

Mr. Alexander S. Preker is President and CEO of the Health Investment & Financing Corporation and a member of the board of several of the companies in which the group has invested. He is a Founding Member of the New York Chapter of the Keiretsu Forum and an LLP with Keiretsu Capital. Mr. Preker is one of the Commissioners for the Global Commission on Pollution, Health and Development, a Member of the Board of the USA HealthCare Alliance, and the Chair of the External Advisory Committee for the World Hospitals and Health Services Journal of the International Hospital Federation. He is the Editor-in-

Chief for the World Scientific Series on Health Investment and Financing. He is an Executive Scholar and Adjunct Professor at Columbia University, New York University and Ichan School of Medicine at Mt. Sinai.

Katelyn Yoo is a Fellow at the International Hospital Federation and works as the Analyst in the Innovation and Analytics Centre (IAC) at Planned Parenthood of New York City. She previously worked at the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), UNICEF and Columbia University Mailman School of Public Health, engaged in research regarding disparity of policy and practice, monitoring, evaluation, and strategic management. She has a Master of Public Health Degree from the Department of Policy and Management at Columbia University and a Bachelor of Commerce and Economics from the University of Toronto.

Eric de Roodenbeke, PhD (1956) is a French national with extensive international experience in health systems and policies and a strong background in hospital management. Since June 2008 he is CEO of the International Hospital Federation. Prior to this, he worked at the World Health Organization and the World Bank for four years, leading various health intervention, educational, management and capacity-building programs, mostly in Africa. He was the Director of several French hospitals of different types for an overall period of 10 years. He has

also worked at the French Ministry of Foreign Affairs for 10 years, both at headquarters and in field projects in Africa.

Eric de Roodenbeke holds a Ph.D. in health economic; a Hospital Administration post graduate diploma and a University diploma in Public Health. He has taught on various masters programs as well as senior continuous education courses. He has published several books as well as various articles in professional journals.

References

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ANNEX 1 – DETAILED AGENDA

Mon Jun 27th Wagner School of Public Service, New York University, NYC

09:00 – 10:00 Overview of Study Tour - Eric De Roodenbeke & Alexander S. Preker

10:00 – 11:00 Affordable Health Care Act - Sherry Glied

11:00 – 12:00 Implications for University Medical Centers – Douglas Miller

15:00 – 17:30 Site Visit to New York City Department of Health & Mental Hygiene

Tue Jun 28th Ichan School of Medicine at Mt. Sinai, NYC

09:00 – 09:30 Introductions - Brian Nickerson & Alexander Preker

09:30 – 10:00 Overview of Mount Sinai Health System - Szabolcs Dorotovics

10:00 – 11:00 The Accountable Care Organizations (ACOs) – Claudia Colgan

11:30 – 12:30 Building Care Networks within a Health System - Arthur Klein

14:00 – 16:30 Site Visit to Mt Sinai Hospital Continuum

Wed Jun 29th Health Policy and Management Department, Mailman School, Columbia University, NYC

09:00 – 10:00 Introduction - Michael Sparer

10:00 – 11:00 Managing a Complex University Hospital Merger – Larry Brown

11:00 – 12:00 Technology Transfer – Ofra Weinberger

14:00 – 16:30 Site Visit to Columbia University Medical Center

16:30 – 17:30 Site Visit to Jeffries Investment Bank

Thu Jun 30th New York Academy of Medicine

09:00 – 09:30 Introduction- Eric de Roodenbeke & Alexander S. Preker

09:30 – 10:15 Urban Health and Age-Friendly Cities – Anthony Shih

10:15 – 12:00 Commonwealth Fund - Robin Osborn

14:30 – 17:00 Site Visits to CityMD – Richard Park

Medical banking and hospital revenue cycle 2016 Volume 52 Number 4

Résumés en Français

Deux groupes de travail de l'HIMSS s'occupent des problèmes de pression financière dans le secteur des soins de santé

Partout dans le monde, le secteur hospitalier est confronté à des défis critiques dans la gestion du cycle des revenus, de la facturation à travers une longue chaîne d'événements qui se termine par le paiement final des services fournis. Cet article traite de la gestion du cycle des revenus (GCR) aux États-Unis aujourd'hui, ainsi que de sa mise en œuvre possible dans d'autres pays.

Banque médicale : Un modèle de transformation pour la santé mondiale

La convergence de la technologie, des processus commerciaux, des pratiques en matière de crédit et des autres ressources en lien avec le secteur des soins de santé et du domaine bancaire est à l'origine d'une nouvelle niche de l'industrie. Le développement de ce marché émergent a été appelé « banque médicale » par l'auteur en 1996, qui a fondé le projet de banque médicale en 2001, maintenant unifié avec l'organisation globale HIMSS (2009). Dans cet article, l'auteur développe un travail antérieur (*L'ascension de la Banque Infomédiaire, Casillas, 2007*) pour suggérer que les banques et les institutions financières, en partenariat avec les entreprises de soins de santé, travaillent sur plusieurs fronts commerciaux pour développer des systèmes inter-organisationnels. Les domaines d'intervention principaux comprennent la protection de la vie privée et la sécurité, l'amélioration du cycle des recettes, les programmes «santé-richesse» et une nouvelle division de micro-assurance classée comme une «plateforme novatrice de soins communautaires».

Tendances dans le domaine du financement de la santé : Le passage de l'achat passif à celui stratégique dans les pays à revenu faible et moyen

Les achats stratégiques ne sont pas nouveaux, mais ils ont d'abord été lancés en Europe de l'ouest dans les années '60, en tant qu'approche visant à améliorer la réactivité du système de santé et à garantir une meilleure adéquation de l'offre et de la demande. Dans les années '60, certains établissements d'Europe occidentale ont été affectés par des lits vides, d'autres par le surpeuplement. Les médecins ne se présentaient pas au travail, en raison de la mise en place de doubles pratiques. Il y avait des files d'attente et les patients se plaignaient que les opérateurs étaient inhumains. Les acheteurs dans les pays à revenu élevé comme

les pays membres de l'organisation de coopération et de développement économique (OCDE) sont passés d'un système de paiement pour les intrants à un autre pour les extrants et maintenant les résultats. Ces défis doivent encore être surmontés par les pays non membres de l'OCDE. Dans cet article, nous discutons de la transition vers des achats stratégiques dans les pays à revenu intermédiaire (PRI) et les pays à revenu intermédiaire inférieur (PRII). Il existe des modèles qui ont eu du succès dans les deux catégories de marchés émergents. L'article commence par un aperçu du financement de la santé, puis se concentre sur l'allocation de fonds et les achats stratégiques.

La gestion du cycle des revenus engendrés par les soins de santé au Brésil : Les défis qui tiennent éveillés les chefs d'entreprise

La crise économique et politique du Brésil n'a jamais été aussi profonde, ayant comme conséquence de renforcer la manière avec laquelle les entreprises font des affaires sur le marché. Seuls ceux qui sont capables de faire face à des conditions de marché plus difficiles restent dans le coup, tout en affrontant des situations de plus en plus difficiles. Une hausse continue de la concurrence a réduit les prix et comprimé les marges, contraignant ainsi à des améliorations nécessaires au niveau du fonctionnement des entreprises pour garantir leur pérennité. Le marché des soins de santé ne fait pas exception, et si les dirigeants identifient des possibilités d'amélioration au niveau de la gestion du cycle des revenus par les entreprises, ils prendront facilement de l'avance sur la concurrence.

Quatre façons par l'intermédiaire desquelles les patients exigent des changements dans le cadre des paiements des soins de santé

Les patients dans le système de santé actuel sont plus investis dans les décisions inhérentes aux soins de santé les concernant. Les expériences provenant d'entreprises innovatrices dans d'autres industries - comme un système de communication clair et abordable pour les paiements et des options de paiement numériques pratiques - établissent des attentes pour l'expérience de paiement des soins de santé. Cependant, les paiements des soins de santé ont été lents à changer, en dépit de cette évolution dans le rôle du patient, et continuent à s'appuyer sur des processus disjointes sur papier qui laissent les patients confus et frustrés. Ceci a pour conséquence que de nombreux patients exigent des chan-

gements dans l'expérience de paiement des soins de santé.

Les administrateurs tiers

Cet article traite des services liés à l'assurance maladie et d'administrateur tiers en Inde. L'assurance maladie en Inde est encore à un stade précoce : seulement 14 % environ de la population entière a souscrit une assurance. Il y a une grande partie de la population qui n'est pas couverte par une assurance. Les administrateurs tiers (AT) sont des intermédiaires entre les compagnies d'assurance, les hôpitaux (fournisseurs) et les parties assurées (sociétés ou particuliers). L'assurance santé indienne progresse de près de 30 % par an. Le gouvernement indien lance de nombreux projets pour couvrir la population, en particulier dans les zones rurales du pays. La taille du marché actuel est de presque 220 milliards de roupies.

Assurance-maladie universelle dans un système mixte public-privé : l'expérience australienne

Les gouvernements australiens et les fournisseurs de services de santé jouent un rôle continu pour garantir une utilisation efficace du budget des soins de santé, qui concerne aussi l'atteinte des objectifs dans le cadre d'un système de santé universel, et le respect des lois et des réglementations en la matière. Comme c'est le cas dans la plupart des pays développés, les budgets des soins de santé subissent des pressions considérables, et ce phénomène accroît la pression qui s'exerce sur la capacité des gouvernements à financer des soins de santé universels. Le système mixte public-privé en Australie a plusieurs imperfections, notamment la fragmentation des soins et les limites dans la surveillance de l'utilisation des fonds, mais dans l'ensemble, le système répond relativement bien aux besoins des Australiens. Cet article explore l'approche australienne d'un système mixte public-privé et aborde certaines des complexités qui se présentent lorsqu'elle cherche à soutenir une assurance-maladie universelle.

Tirer des leçons de l'Obamacare : La tournée d'études pratiques dans les hôpitaux 2016 à New York

Du 27 juin au 1 juillet 2016, la Fédération Internationale des Hôpitaux (FIH) et la société HIF ont organisé une tournée d'études pratiques dans les hôpitaux à New York, aux États-Unis. La tournée d'études pratiques dans les hôpitaux avait pour objectif de permettre aux participants de savoir comment le secteur hospitalier américain aborde certains des principaux défis et les solutions pour transformer la manière de dispenser les soins hospitaliers au XXI^{ème} siècle. La tournée d'études organisée à New York faisait partie d'une série d'événements de premier plan proposés par l'IHF. Cette tournée d'études est le fruit d'un effort de collaboration entre les membres régionaux et les organisations partenaires pour accueillir différents événements visant à permettre un échange d'idées, de connaissances, d'expériences et de pratiques exemplaires dans le cadre de la prestation de services de santé ainsi que de l'encadrement et de la gestion de leurs organisations.

Medical banking and hospital revenue cycle 2016 Volume 52 Number 4

Resumen en Español

Dos equipos de trabajo HIMSS abordan urgentes cuestiones financieras de la Sanidad

En todo el mundo el sector hospitalario se enfrenta a retos críticos en la gestión del ciclo de ingresos, desde la facturación y a lo largo de una larga cadena de eventos que finaliza con el pago final de los servicios prestados. Este artículo trata la actual Gestión del Ciclo de Ingresos, Revenue Cycle Management (RCM), en EE.UU. así como su posible implementación en otros países.

Medical Banking (Bancarización Sanitaria): un Modelo de transformación para la Sanidad Global

La convergencia de tecnología, procesos empresariales, prácticas de crédito y otros recursos ha unido la sanidad con el sector bancario produciendo una nueva industria especializada. El desarrollo del mercado naciente fue denominado por su autor en 1996 como "medical banking" (banca- rización sanitaria), quien fundó el «Medical Banking Project» en 2001, actualmente unificado con la organización global HIMSS (2009). En este artículo, el autor amplía un trabajo anterior (*The Rise of the Bank Infomediary, Casillas, 2007*) sugiriendo que los bancos y las instituciones financieras, asociadas con firmas de asistencia sanitaria, están trabajando en múltiples frentes comerciales para desarrollar sistemas interinstitucionales. Las áreas de enfoque principal incluyen la privacidad y la seguridad, el mejoramiento del ciclo de ingresos, programas de "bienestar –salud" y una nueva área de micro seguros que se clasifica como una "plataforma de asistencia comunitaria de vanguardia".

Tendencias de la Financiación de la Sanidad: El cambio de Compras Pasivas a Estratégicas en Países con Ingresos Medios y Bajos

La compra estratégica no es nueva sino que comenzó ya en Europa Occidental en los años sesenta como un intento de optimizar la capacidad de respuesta del sistema sanitario y para ofrecer una correspondencia más efectiva entre oferta y demanda. En los años sesenta algunas estructuras de Europa Occidental se vieron afectadas por la presencia de camas vacías mientras que otras padecían el hacinamiento. Los médicos no se presentaban a trabajar, debido a la instauración de la doble práctica. Existían colas de consumidores y quejas sobre el trato inhumano de los proveedores. Hubo un cambio en los Compradores de los Países de Renta Alta como los países de la Organización de Cooperación y Desarrollo Económico (OECD), pagando por

aportes para gastos y ahora ven los resultados. Estos desafíos deben todavía ser superados por los países que no pertenecen a la OECD. En este artículo discutimos el cambio hacia la compra estratégica en Países de Renta Media (MICs) y Países de Renta Baja (LMICs) Existen exitosos modelos en ambas categorías de mercados en desarrollo. El artículo comienza con una vista panorámica sobre la financiación de la sanidad y luego se focaliza en la asignación de fondos y en las estrategias de compra.

La Gestión del Ciclo de Ingresos de la asistencia sanitaria en Brasil: desafíos que mantienen alerta a los Directores Generales

La crisis económica y política de Brasil nunca ha sido tan profunda, endureciendo el modo en que las compañías deben lidiar en el mercado. Sólo aquellos que han sido capaces de hacer frente a las severas condiciones del mercado han permanecido en el juego, afrontando situaciones cada vez más difíciles. El aumento continuo de la competencia ha disminuido los precios y reducido los márgenes, imponiendo mejoras necesarias en el modo de trabajo de las compañías para seguir siendo sostenibles. El mercado de la sanidad no es una excepción, y si los líderes identifican las oportunidades de mejora para que sus compañías aborden la Gestión del Ciclo de Ingresos, se encontrarán fácilmente un paso adelante con respecto a la competencia.

Cuatro modos que los Consumidores exigen se cambie en la Experiencia de Pago de la Asistencia Sanitaria

Los consumidores de la actual economía de asistencia sanitaria invierten más en sus decisiones sobre asistencia sanitaria. Experiencias de innovaciones en otras industrias - como comunicación de pago clara y conveniente, opciones de pago digital - crea expectativas respecto a la experiencia de pago en la asistencia sanitaria. En cualquier caso, los pagos de la asistencia sanitaria son de cambio lento, a pesar de la evolución del papel del consumidor, y sigue dependiendo de procesos basados en papel impreso, desarticulados, que dejan al consumidor confundido y frustrado. Como consecuencia, muchos consumidores están exigiendo cambios en la experiencia de pago de la asistencia sanitaria.

Los Administradores Externos

Este artículo trata sobre el seguro de salud relacionado con los Servicios de Administradores Externos en India El

Seguro de salud en la India sigue estando en una fase incipiente: solo el 14% de la población total tiene contratado un seguro. Un gran segmento de la población permanece aún sin cobertura de seguro. Los Administradores Externos (TPA's) son intermediarios entre las compañías de seguro, los Hospitales (Proveedores) y las Partes Aseguradas (Corporativa o Individual). Seguro de Salud de India está creciendo a niveles de casi un 30% por año. El gobierno de India está lanzando multitud de programas para dar cobertura a la población, especialmente en las zonas rurales del país. El tamaño actual del mercado ronda los 220.000 millones de rupias.

Asistencia sanitaria Universal en un sistema mixto privado-público: la experiencia australiana

Las autoridades australianas y los proveedores del servicio sanitario desempeñan un papel continuativo asegurando el uso eficiente del presupuesto de asistencia sanitaria, que, además incluye alcanzar los objetivos dentro de un sistema asistencial universal, y garantizan la conformidad con la legislación y las normativas vigentes. Como es el caso de muchos países desarrollados, existe una considerable presión sobre los presupuestos de sanidad y, a su vez una presión sobre la capacidad de las autoridades de financiar la asistencia sanitaria general. El sistema mixto público-privado en Australia tiene algunas imperfecciones incluyendo la fragmentación de la asistencia y las limitaciones del control de los fondos empleados, sin embargo, el sistema atiende en general a los australianos relativamente bien. Este artículo explora la propuesta australiana hacia un sistema mixto público-privado y considera algunas de las complicaciones que surgen cuando se busca sostener la asistencia sanitaria general.

Aprendiendo sobre la Ley de Asistencia Sanitaria Asequible en EE.UU.: Visita de Estudio de Directivos Hospitalarios a New York en 2016

Desde el 27 de junio al 1° de julio de 2016, la International Hospital Federation (IHF) y el Health Investment & Financing acogieron una Visita de estudio de Directivos Hospitalarios en la ciudad de New York, NY, EE.UU. El objetivo de la Visita de Estudio de Directivos Hospitalarios fue permitir a los participantes conocer cómo el sector hospitalario americano aborda algunos de los principales desafíos y sus soluciones transformando el modo en el cual la asistencia hospitalaria se realiza en el siglo XXI. La Visita de Estudio a New York formó parte de una serie de eventos principales ofrecidos por el IHF. Esta Visita de Estudio fue un esfuerzo de colaboración entre los miembros regionales y las organizaciones asociadas en la celebración de varios eventos para permitir un intercambio de ideas, conocimiento, experiencias y prácticas recomendadas para el suministro de servicios de asistencia sanitaria y el liderazgo y gestión de sus organizaciones.

中文摘要

两个 HIMSS 工作队解决医疗财政紧迫问题

全球各地的医疗部门面临着收入周期管理方面的严峻挑战——收入周期涵盖的范围，包括从计费开始、以所提供服务的最终付费告终的一系列相关活动在内。本文论述了美国当今的收入周期管理（RCM），以及在其他国家可能实施RCM的情况。

医疗银行：全球卫生变革模型

医疗保健和银行业在技术、业务流程、信贷实务和其他资源上的关联，创造了一个新的产业领域。这一新兴市场的发展，在本文作者1996年的著作中被称为“医疗银行”。作者在2001年建立了医疗银行项目，现已与全球HIMSS组织（2009年）整合。在本文中，作者在其早期著作（*The Rise of the Bank Infomediary, Casillas, 2007*）的基础上展开，提出：银行及金融机构正与健康卫生企业在多个商业前沿领域联手合作，以开发出跨组织的系统。合作主要针对隐私和安全、收入周期改进、“健康财富”计划，以及一个被列为“社区护理先进平台”的小额保险新领域。

卫生保健融资趋势：中等收入和低收入国家从被动转向战略性采购的行动

战略采购并不是一个新名词。在20世纪60年代，这一概念就在西欧萌芽，指的是用以提高卫生系统反应能力、同时更有效地匹配供需的一种方法。在1960年代西欧，有一些地方由于病床空置的局面导致设施也闲置不用；而另一些地方由于病人满为患，设施又供不应求。由于双重执业的影响，需要医生的时候，没有人手。顾客排起了长队，关于服务质量不佳的投诉也应接不暇。在组织和经济合作发展组织（经合组织，OECD）国家等高收入国家，顾客支付的对象发生了变化，从“输入”，到“输出”，到如今已经变为“效果”。而在这些国家之外，这些问题仍亟待解决。本文中，我们讨论了中等收入国家（MIC）和低中等收入国家（LMIC）向战略采购的转变。并提供了这两类新兴市场上的成功模式。文章以健康资金概述开头，然后侧重于讨论资金和战略采购的分配。

巴西的卫生保健收入周期管理：让CEO们时刻警醒的挑战

巴西正面临有史以来最严重的经济和政治危

机，这给企业的业务开展带来了阻力。只有那些有能力应对艰难的市场条件的企业，才能生存下来，迎接愈加激烈的状况的挑战。竞争持续上升，带来的是价格跌落、利润空间被压缩；企业不得不实施必要的改进，以谋求一席之地。卫生保健市场也不例外。如果领导者善于发现能让企业应对收入周期管理的改进机会，就能在竞争中轻松取得领先。

消费者要求医疗保健支付方式变革的四种方式

在当今的卫生保健经济中，消费者更多地是在为自己在卫生保健方面的决定买单。其他行业的创新者们的经验——如明确支付通信，以及方便的数字支付方式，都可为卫生保健行业所借鉴。然而，尽管消费者的角色在逐渐变革，卫生保健支付的演变还是非常缓慢，而且仍依赖于杂乱无章、基于纸面、陷消费者于困惑沮丧的流程。因此，许多消费者要求对卫生保健的支付方式进行改革。

第三方管理

本文的主题是印度的健康保险相关和第三方管理服务。印度的健康保险仍处于发展初期：所有人口中只有约14%已购买保险，还有大量的人口没有任何保险。第三方管理商（TPA）是保险公司、医院（供应商）和投保方（公司或个人）几者的中间机构。印度的医疗保险正以每年近30%的速度增长。印度政府正在启动涵盖全体人口——特别是农村地区人口的多种方案。目前的市场规模为近2200亿卢比。

公共-私营混合体制下的全民医疗：澳大利亚的经验

澳大利亚政府和卫生服务提供机构在确保医疗预算有效利用方面发挥了持续作用。这一点也关系到全民医疗体制下的目标达成，并确保符合有关法律和法规。与大多数其他的发达国家一样，澳大利亚在医疗预算方面也面临着较大的压力，继而给政府带来了提供全民医疗资金上的压力。澳大利亚的公共-私营混合体制有其不完善之处，包括分散的护理、资金使用监管的局限性等。但从总体上说，这一体制在澳大利亚运行的状况相对较好。本文探讨了澳大利亚公共-私营混合方式，以及在寻求该体制支撑起全民医保的道路上所遇到的一些状况。

《美国平价医疗法案》学习：纽约2016年医院行政考察

从2016年6月27日至 7月1日，国际医院联盟（IHF）和健康投资与金融（Health Investment & Financing）协会在美国纽约州纽约市主办了一次医院行政考察。此次考察的目的，是让参与者学习美国的医疗部门是如何解决在改变21世纪医疗护理提供方式时遇到的一些主要挑战和解决方案的。纽约考察是IHF组织的一系列主要活动的一部分。这次考察是区域成员和合作组织通过协作，主办的在提供医疗服务及他们的组织的领导和管理方面交换思想、知识、经验和最佳实践的各种活动之一。

IHF events calendar

2017

IHF

41st World Hospital Congress

November 7 – 9, Taipei, Taiwan

For more information, contact 2017congress@ihf-fih.org

2018

IHF

42nd World Hospital Congress

October 9 – 11, Brisbane, Australia

For more information, contact 2017congress@ihf-fih.org

2017

MEMBERS

AUSTRALIA

AHHA Think Tank

Discover the work the Deeble Institute for Health Policy Research and our partner universities are undertaking on a wide range of health policy topics

May 3, Brisbane

Australian Healthcare & Hospitals Association

<https://ahha.asn.au/events/think-tank-deeble-discovery>

Joint 2017 ACHSM/ACHS Asia-Pacific health leadership congress

The winds of change – adjust your sails

Wed – Fri Sep 29, Hilton Sydney, 488 George Street, Sydney NSW 2000, Australia

Australasian College of Health Service Management

<http://achsm.org.au/congress>

BRAZIL

5° CONAHP – (Congresso Nacional dos Hospitais Privados) Brazilian Private Hospitals Conference

The Hospital of Future: the future of hospitals

November 22 -24, Convention Center – Hotel Sheraton WTC - São Paulo, Brazil

Associação Nacional de Hospitais Privados

<http://www.conahp.org.br>

CANADA

2017 National Health Leadership Conference

Value-based healthcare: Embracing a patient and family-centered approach

June 12-13, Vancouver, British Columbia, Canada

HealthCareCAN

<http://www.nhlc-cnls.ca/>

Future conference dates:

June 4-5, 2018 – St. John's, Newfoundland

June 10-11, 2019 – Toronto, Ontario

June 15-16, 2020 – Edmonton, Alberta

<http://www.cchl-ccls.ca/site/nhlc#sthash.WXVnRcNi.dpuf>

GERMANY

Provision of Healthcare in the EU

May 19, Berlin

German Hospital Federation

<http://www.dkgev.de>; www.deutscherkrankenhaustag.de;

www.medica.de

European Hospital Conference

November 16, Düsseldorf Fairgrounds

German Hospital Federation

<http://www.dkgev.de>; www.deutscherkrankenhaustag.de;

www.medica.de

German Hospital Conference

November 13-16, Düsseldorf Fairgrounds

German Hospital Federation

<http://www.dkgev.de>; www.deutscherkrankenhaustag.de;

www.medica.de

HONG KONG

The Hong Kong Hospital Authority Convention 2017

The Hong Kong Hospital Authority's core values, viz. "People-centred Care", "Professional Service", "Committed Staff" and "Teamwork"

May 16-17, Hong Kong Convention and Exhibition Centre, Wanchai, Hong Kong

Hong Kong Hospital Authority

www.ha.org.hk/haconvention/hac2017

MEXICO

10th Directive Session

Creating the first Private Health System in Mexico

May 24 to 26, Grand Fiesta Americana. Coral Beach; Cancún, Quintana Roo, Mexico

Gerencia de Calidad y Análisis de Información

<http://www.cmh.mx/>

SWITZERLAND

H+ Congress 2017

Humanity and Technology: Digital Dynamics without boundaries? November 8, Kursaal Bern, Kornhausstrasse 3, 3000 Bern, Switzerland

H+ Les Hôpitaux de Suisse

www.hplus-kongress.ch

For further details contact the: IHF Partnerships and Project, International Hospital Federation, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: info@ihf-fih.org or visit the IHF website: <https://www.ihf-fih.org>

CALL FOR ABSTRACTS

Deadline for submission:
3rd March 2017



Theme: Patient-friendly and Smarter Healthcare

TRACKS

- Quality of Care and patient safety
- Capacity Building and innovation in Leadership and Management tools and practices
- Governance, Accountability and Ethics
- Financing and Universal Health Coverage
- Technology: acceptance by health professionals and changes in hospital organization
- Service Delivery: Innovations in delivery of Care and Hospital Services
- Organizing long term care for ageing and multi-chronic patients
- The challenges to access treatment: drug availability and price, physical access, cultural dimensions
- Resilience of hospitals to better face human (including IT security) and natural threats
- Patient as a stakeholder for healthcare service provision

IMPORTANT NOTES:

- ⇒ Abstracts can be oral or poster presentation.
- ⇒ Abstract should not be more than 300 words.
- ⇒ Abstracts must be in English.
- ⇒ Abstracts should address major issues of importance according to the 2017 Congress overarching theme : *Patient-friendly and smarter healthcare*



<http://congress.ihf-fih.org/>



For further information please contact:

Email: 2017congress@ihf-fih.org

Subject/Reference: [Abstract for 2017 WHC](#)

2017 IHF AWARDS

Deadline for submission:
2nd June 2017



Theme: Patient-friendly and Smarter Healthcare

AWARDS CATEGORIES

Category 1: IHF/ Dr Kwang Tae Kim Grand Award
Category 2: IHF Excellence Awards

- Excellence Award for Leadership and Management in healthcare
- Excellence Award for Quality & Safety and Patient-centered Care
- Excellence Award for Corporate Social Responsibility

Grab the chance to win an international recognition!



<http://congress.ihf-fih.org/>



Enquiries

Contact Email: 2017awards@ihf-fih.org

TRACKS

- Governance, leadership, management policies and practices;
- Quality service delivery in multiple areas at affordable costs;
- Culture of service to motivate healthcare professionals to excel;
- Innovations in healthcare delivery or process management;
- Quality and safety, ethical approaches and evidence-based practices in patient-centered care;
- Sustainable environment, energy conservation and green initiatives;
- Addressing inequalities in healthcare service delivery to the community;
- Advancing healthcare for emerging and developing nations