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HEALTHCARE EXECUTIVE ALLIANCE SPECIAL EDITION ON E-LEARNING

Money Talks

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Costs, Costs, Costs!

Who Pays in Healthcare?

The nuances of the English language give "pay" and "cost" many meanings. When a person has no health insurance and no access to healthcare, what is the cost to their health? When the state pays for healthcare, when is "rationing" considered acceptable? Should non-smokers pay with their taxes to treat smokers' illnesses? The ethics of healthcare financing are considerable. When we contemplate healthcare finance, considerations of payment, cost, value for money, effectiveness, preventing fraud and waste are all in the mix.

One of the world's most successful investors, Warren Buffet, has compared healthcare costs to a tapeworm that is eating the American economy, and is "untenable over time" (valueinvestorsport.com 2010). The U.S. has been an outlier for many years in the percentage of GDP it spends on healthcare and yet still has millions of citizens who have no health insurance. Buffet advises tackling costs as the number one issue facing America, and observes that despite the huge expenditure, America has fewer doctors, nurses and beds per head of population than other countries that spend less on healthcare.

In developed and developing countries alike, a rapidly ageing population, advancing technology and competing demands are combining to create a 'perfect storm' of increased demand and less public funding. In the developed world, where infrastructure and services are widely available, the questions are around who pays and how to improve outcomes from spending. Are people willing to take out health insurance and increase spending from their own pocket? Will the move to more healthcare at home help the efficiency of the health service?

For the developing world, where governments are increasingly pursuing universal health coverage, out-of-pocket spending is already very high. Quality services may be unavailable or out of reach. The big questions are which models can expand access and be financially sustainable. What innovations can reduce costs and improve outcomes? What can developing countries learn from the mistakes of the developed world?

However healthcare is financed, every country is struggling to balance between increasing demand from an ageing population, increased costs and the need to optimise efficiency. The Chief Financial Officer (CFO) is a critical role in the healthcare enterprise. The introverted accountant stereotype is in the past, and the CFO needs to be a skilled communicator, able to challenge the CEO and the Board, whilst understanding clinical pathways with ease and evaluating and managing risks.

Individual health professionals and patients need to understand their responsibilities too. Is that test or imaging exam really necessary? Both patients and health professionals need to understand what is needed, and initiatives such as Choosing Wisely and appropriate use criteria are helpful here. Simple measures such as text message reminders about hospital appointments can save money overall: for example, missed first outpatient appointments cost the English National Health Service up to £225 million in 2012 to 2013 (UK Department of Health 2016). And such a measure may be preferable to overbooking appointments.

How can spending be reduced? With targets, or with nudges? The recently published results from a randomised controlled trial in the United States showed that including information on the costs of lab tests had a negligible effect on the ordering patterns of physicians (Sedrak et al. 2017). Studies on imaging have had similar results (eg Chien et al. 2017).

This issue of HealthManagement puts these critical questions under the microscope as experts from all walks of the healthcare sector world take an uncompromising look at what funding innovations are needed. With cooperation, collaboration and the courage to think outside the box, there is no reason for the future not to be bright. ■

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