ISSN: 2577-2996

PROGRESS IN MEDICAL SCIENCES, 2023
VOL 7, NO. 3, PAGE 1 – 6
DOI: doi.org/10.47363/PMS/2023(7)E106

REVIEW ARTICLE

Open Access

Inclusive Healthcare Programs in an Exclusive Payor-Provider World

Gokul Ramadoss

USA

ABSTRACT

The purpose of this research is to determine how payer-provider integration influences health care business performance. The research examines whether integration reduces agency difficulties and encourages participants to collaborate for better outcomes. To collect data, the research study used secondary sources. We assessed the integrated hospital against its fee-for-service partner. The cost of occupational accidents dropped by 9% at an integrated hospital, occupational accidents cost 9% less. The main reason was an emphasis on careful treatment and speedier recovery. It focuses on Finnish workplace health initiatives. It provides preliminary evidence that the integration of payors and providers enhances operations. Vertical integration may arrange outcomes, but it requires careful analysis. Multiple approaches are combined. Strict change management is advised. The research shows that merging health care payors and providers not only benefits individuals but also minimizes care costs without compromising quality or client satisfaction. This is one of the few studies that examine payor-provider mergers in healthcare operations management over time. It advances knowledge of ways to boost operational efficiency.

ARTICLE HISTORY

Received May 11, 2023
Accepted May 18, 2023
Published May 25, 2023

KEYWORDS

Payor Provider, Healthcare System, Operations Management, Efficiency, Challenges

Introduction

Health care system process flows include patients, providers, and third-party payers [1]. Each class has distinct goals and value producers. Health care payers and providers have distinct aims and information. This implies that these actors have a variety of principal-agent interactions in which principals must delegate labor to autonomous agents [2]. Research on health care payment models suggests that the best model should benefit all system players [3]. This has been difficult due to the apparent imbalance of incentives, excellent patient care, low employer and insurer costs, and a big profit margin for the private healthcare provider are self-interested goals that can lead to agency problems like a moral hazard, which occurs when a care provider values highly incentivized treatments [4].

Theoretical Background

Operations and supply chain management (OSCM) research heavily relies on agency theory [5]. Researchers have examined adverse selection and moral hazard using agency theory. Negotiating result-based contracts is challenging because of information asymmetry, challenges in judging treatment outcomes, and the high costs associated with errors. Thus, health care agents typically receive FFS payments [6]. FFS payment arrangements are likely to persist since providers don't enjoy taking risks and don't want to be totally accountable for a patient's care, even while they bring agency issues like overtreatment and provider-induced demand. These issues might degrade the health care system if not managed [7]. Hospitals often use operations management to enhance their performance. Using diverse techniques to monitor clinical performance, exchanging and planning information in an integrated fashion, and delivering modular care and incorporating clients properly may enhance care quality and flow [8,9]. However, agency theory suggests improving health care procedures as a service system. This implies that agency theory examines comparable, higher-level decisions that impact service system actors' interactions. Better judgments might improve the service system.

Alignment of Issue

This investigation supports the premise that aligning objectives and incentives may manage agency issues at the system level [10]. The insurer and provider may merge when providing health care through insurance [11]. Vertical integration may help supply chains with agency issues [2]. Payors and providers may reduce costs and enhance treatment by sharing data, strategy planning, and financial incentives [12]. However, Crim noted that owning something doesn't guarantee that aims and values will coincide; additional social integration methods are required [13]. Patients may become less trusting when insurers and providers integrate, as they may not have the freedom to choose their providers, and systems may prioritize cost over appealing the US, where patients are consumers and a strong norm base protects their freedom of choice, these challenges often lead to customer dissatisfaction [14]. As a result, US "managed care" groups have struggled since

Contact: Gokul Ramadoss, USA

© 2023 The Authors. This is an open access article under the terms of the Creative Commons Attribution NonCommercial ShareAlike 4.0 (https://creativecommons.org/licenses/by-nc-sa/4.0/).

the 1990s. People believe that evil partnerships can deteriorate patient care and lead to a "managed care backlash" [15]. Vertical integration may help agencies overcome problems, even if managed and integrated care businesses have a poor reputation. Vertical integration has the potential to decrease random actions and improve the partial service system [7].

Research Question

This empirical study addresses the following research question, using data from a single non-US example to fill this knowledge gap:

- How does the ownership-based payer-provider combination affect agency problems and an insurance-based workplace health care system?

Research Objective

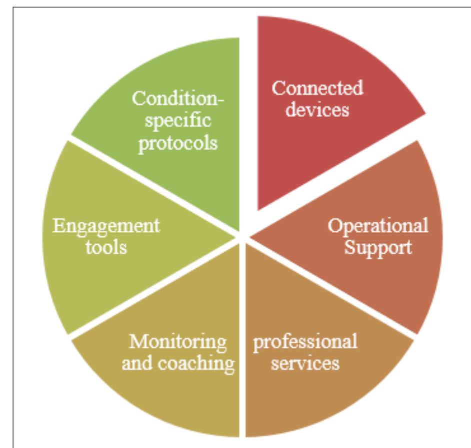
The research investigated why agencies have issues, proposed solutions (such as new methods of controlling the organization), and documented how Hospital applied them. To demonstrate how the system evolved and linked, many approaches and their sequences were documented.

- To discuss the ownership-based payer-provider combination affect agency problems and an insurance-based workplace health care system.

Literature Review

The Occupational Health Care System contains Various Participants with Diverse Purposes

Most wealthy nations provide health care through insurance. Patients, caregivers, and payers all influence service usage, provision, and payment in these systems [16]. Two-way contracts in health care may pose issues due to distinct aims and motives. A hospital may be both an owner and an agent for an insurance company, making it tougher to discover the optimal option. Additionally, participants may have both unique and shared incentives. The patient, employer, and insurance company all want the patient back to work immediately, but for different reasons. Doctors and hospitals don't enjoy taking chances; thus they don't care whether patients return to work fast or prices drop [17]. Doctors who make care decisions want to be paid more, while hospitals want to keep doctor rates low. Patients frequently lack the information to make smart medical decisions or obtain the finest treatment and are hesitant to take risks [18]. This leads individuals to choose the service provider with the greatest customer experience, not necessarily the best treatment. Therefore, individuals don't care about saving money on hospital or medical costs until they have to varied interests, uneven information availability, and varied risk choices produce agency difficulties at many levels in healthcare service systems, hurting system performance [19].



Health Care Agency Elimination

Lack of information may lead to moral hazard, which can result from overtreatment or doctor-induced demand [20,21]. Many initiatives have been made to integrate outcome-based contracts, FFS, and case rate payments have been a standard compensation method. They're simple to utilize and challenging to measure care effectiveness [22]. A capitated technique where care workers are paid the same for each consumer. Population-level objectives without improving patient care merely alter the level agency issues [23]. Along with contracts and compensation systems, there are frequently less formal techniques to avoid problems. Ethics and patient finances are agency issues [19]. Yet when the spotlight was on to the insurance company-health care provider relationship, the regulations Informal, and mutual trust-based organizations may no longer operate [24]. Those are difficult to assess and pay for, such mental health care. When these auxiliary professions assist a leader achieve objectives, direct hiring. Managerial intervention may eliminate undesirable agent behavior, illustrating why payors and providers should collaborate on health care. Another approach to standardize commercial agency interactions [14]. Self-enforcement and long-term relationships drive this hiring. To prevent self-serving behavior like overtreatment, two or more groups should have strong social relationships and confidence [1,8,25]. No matter what Relationship contracts offer certain benefits, but they're seldom utilized. Payments for health care reimbursement sometimes depend on measurable units, such as separate payments for care components [6,7,9]. Relational contracts are usually used for larger projects.

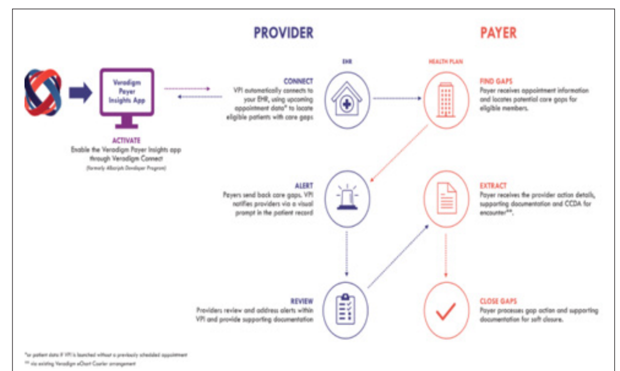


Figure 2: Health Care system components

Unified Health Services

In the 1990s, managed care demands and health-care reforms led to integrated delivery systems in the US. Vertical integration between hospitals, doctors, and insurers aligns incentives to increase treatment efficiency and efficacy [26]. Payor–provider mergers have been criticized for hurting competition, limiting consumers' provider options, and not improving quality [12]. Many ignore managed care because integrated delivery systems have a negative reputation. People don't always assume managed care backlash is driven by a reduction in medical quality, but by their perceptions and personal experiences of poor customer service (from cost savings) and less provider choice [16]. Because health care has grown more like a business, social disgrace might make consumers distrust the system, resulting in fewer patients and decreased revenues [18]. Customer and payor–provider awareness of successful treatment differs greatly. Customers fear they can't make smart judgments. Finally, vertical integration must be utilized to resolve agency concerns between payers and providers, as well as between patients and the integrated service system. Instead of limited optimization, problem-solving organizations require systematic governance.

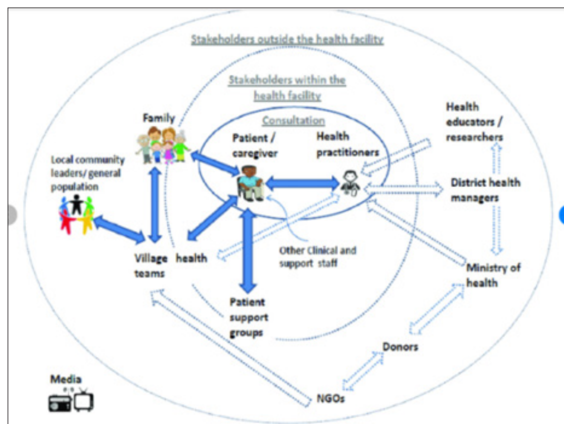
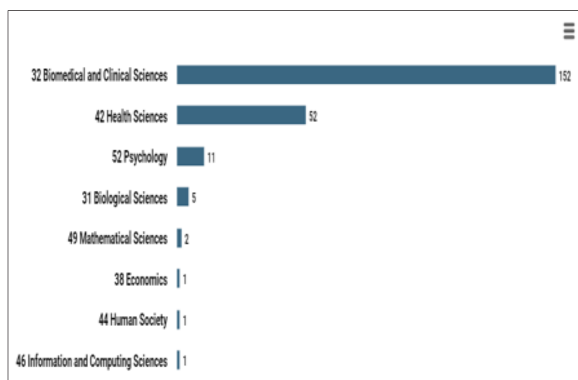


Figure 3: Category Distribution of Articles

Research Design and Methods

Secondary data analysis was used in this study. This research approach has been popular for studying a subject's historical progression from diverse perspectives. Secondary analysis reveals a study topic's limits, key authors, and fresh research avenues. Secondary analysis quantitatively analyzes items using a database. Due to its ability to explicitly demonstrate intellectual structure, we used secondary analysis for this work [15]. This technique and scientific mapping may be used to independently examine research article changes. Previous reviews have employed it well [16].



This research examines the most Inclusive Healthcare Programs in Exclusive Payor-Provider World concepts experts have discussed throughout the years and global interest in this topic. We picked articles to study and evaluate in two phases to satisfy research aims. This secondary analysis narrowed its search to "Payor-provider dynamics" and "health care equity". In the first stage of our investigation, we reviewed the selected publications using dimensions. We learnt about Inclusive Healthcare Programs in an Exclusive Payor-Provider World research's evolution by carefully categorizing and analyzing articles by year. This comprehensive investigation revealed academic interests and perspectives and highlighted how scientific inquiry has evolved. Our findings fit into the academic discourse by discovering patterns and trends in the literature. The figure 1 illustrates dimensions category distribution of articles. Biomedical and Clinical Sciences (32), Health Sciences (42), and Psychology (52), Biological Sciences (31), Mathematical Sciences (49), Economics (38), Human Society (44) and Information and Computing Sciences (46). Figure 2 depicts a thorough search approach used to examine the Inclusive Healthcare Programs in an Exclusive Payor-Provider World. This strategy combines various library characteristics to cover all literature thoroughly. The findings improved after narrowing articles by subject and relevance. This research began with 177 dimensions articles for literature analysis and summary.

We examined the complicated dynamics of academic discussion in Inclusive Healthcare Programs in an Exclusive Payor-Provider World using a novel analytic tool. Figure 4, we might examine co-authorship and phrase co-occurrence patterns. This cutting-edge technology helped us locate active talkers and worldwide collaborators. This indicated global expert connections. The multifaceted investigation revealed international and joint networks as well as major issues and concepts that are transforming intellectual life. By merging these perspectives, our study seeks to provide an Inclusive Healthcare Programs in an Exclusive Payor-Provider World utilizing the expertise of scholars and practitioners from across the globe.

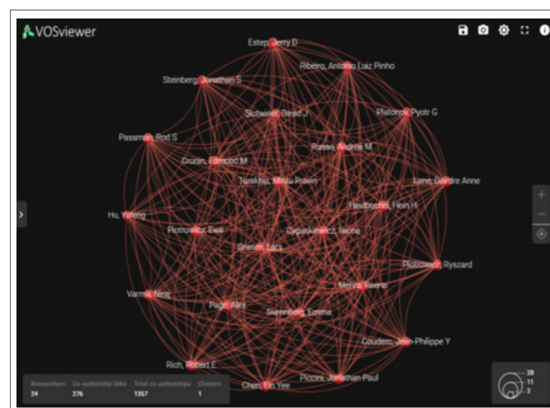


Figure 5: Co-Authorship and Phrase Co-Occurrence Patterns

Results

Healthcare firms assist clients with health issues. However, payers like Medicare, Medicaid, and commercial insurance companies pay provider expenses. Payers acquire claims from multiple providers, giving them a better picture of a patient's treatment. Payers typically coordinate patient treatment since healthcare is continually evolving. The payer's role has evolved to match pricing and quality of treatment to provide patients

the greatest outcomes at the lowest cost. Payers are often patients' initial healthcare step. They generally provide tools to assist clients pick a provider or customize treatment. Payers also keep members informed throughout their treatment. Payers are crucial to patients because they may supply health and fitness information that supports what their doctors say and helps them makes health choices.

Themes 1: Challenges do healthcare providers face in their relationships with payers

Working together isn't simple, even when both parties desire better patient outcomes and lower expenses. Payers and providers commonly have payment and care quality issues. Payers are blamed for patients' unpleasant experiences when they can't afford treatment due to provider issues. Others attribute payers' growing healthcare expenses on providers and their charges. Doctors distrust payers, making collaboration difficult [27]. The system pitted payers' and providers' financial interests against one other for decades. Doctors and patients must collaborate to make the payer-provider collaboration function. The insurer must work hard to regain provider confidence. Payers may provide physicians several tools. They may provide doctors with data and analysis to support their treatment plans. They assist clinicians manage patient risk with rapid, effective, and relevant data analytics [16]. Sharing patient-level data and information at the correct moment changes payer-provider relationships and builds a partnership to improve patient care. Many individuals also struggle with inconsistent data gathering, forms, tools, and other issues. CMS, commercial insurers, and other payers have varying quality data reporting standards. This makes quality reporting costly and time-consuming for healthcare providers. This difficulty is worsened by the demand for higher quality assessment and reporting data standards [15]. EHR systems must improve data collection, organization, and presentation to satisfy quality report requirements. Working with multiple forms of data, analyzing certain populations, and accessing data stored differently are some of these issues. Some risk-adjustment studies need specific data collection and analysis.

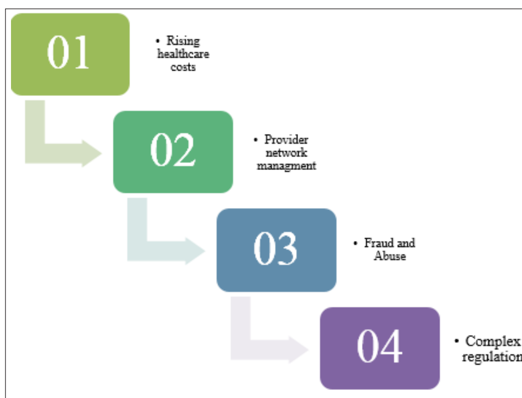


Figure 6: Challenges Do Healthcare

Themes 2: Improved payer-provider collaboration benefit patient outcomes

One good thing about value-based healthcare is that it creates a setting where funders and doctors are more likely to build relationships that are mutually useful and helpful. This better relationship between payers and providers helps people by letting providers focus on meeting their needs [9]. Overall, this is good for the population because a healthy population needs care less often, which lowers costs for customers and makes the system work better and more efficiently. Because most of these partnerships use data analytics tools, when payers and providers work together well, it also helps patients [19]. This is because records are necessary to find things like places that need more preventative care.

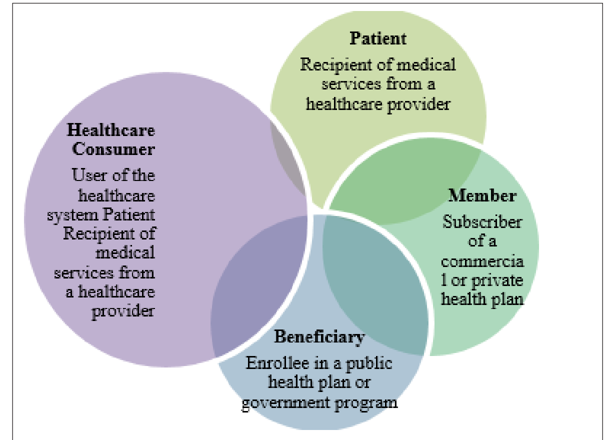


Figure 7: Payer-Provider Collaboration

Theme 3: Value-based care models affect payer-provider

Setting up strong and cooperative relationships between payers and providers is very important for the success of value-based care plans. Value-based care models and risk-sharing arrangements are being used more and more, but this often makes provider contracts more difficult to understand [21]. A new study says that this growing complexity is making agreement between payers and providers worse instead of better. The study found that only 11% of private payers had a lot of faith in the physician groups they worked with, and only 6% of doctors had a lot of faith in public payers [19]. Most customers and providers said they felt disconnected, which seemed to be linked to the lack of trust. Payers and providers don't have the same general goals for value-based care because they don't trust each other and talk to each other enough [23]. This makes it harder for their value-based care efforts to succeed.

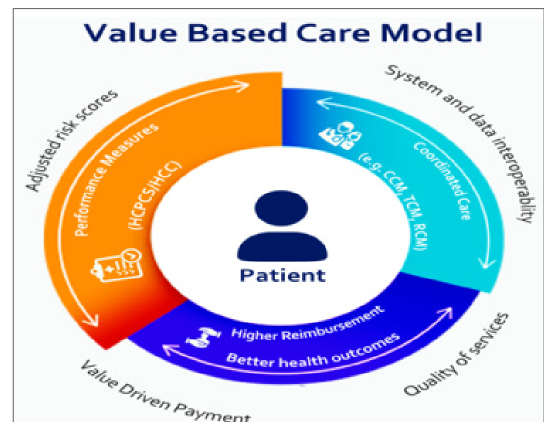


Figure 8: Value-Based Care Model

AI allows for personalized treatment regimens based on each patient's health data. Personalized healthcare is becoming increasingly crucial. Use more AI technologies like Machine Learning (ML) and Natural Language Processing (NLP) to predict patient outcomes, enhance diagnosis, and personalize treatment [15]. To effectively manage the health of particular populations, payers and providers must collaborate on socioeconomic determinants of health initiatives. Value-based agreements between patients and providers are growing as payers adopt value-based care models that need greater collaboration. Improved patient outcomes and low-cost treatment result from this transformation [18]. As funders assist physicians uncover treatment gaps and enhance community health, wellness and prevention will become increasingly significant [17]. More individuals use technologies that effortlessly communicate healthcare and claims data. This will streamline payer-provider negotiations and reduce claims disputes.

Figure 9: Payer-Provider Relationships in the Healthcare Industry

Discussion

This research investigated how integrating a health care payer and a provider may improve collaboration and workplace trauma treatment. This system-level aim assisted insurance, bosses, and injured workers in the health care system. It must carefully examine the change process phases to align stakeholders behind the new aim and simplify the hospital's infrastructure and everyday duties. Doctors and the integrated hospital worked better together toward similar objectives after integration. It also promoted conservative treatment procedures. Medical practitioners have been concerned to preserve their practice from structural changes that conflict with its aims and meanings. Their professional influence has mitigated new laws, regulations, and arrangements [19, 23,24]. This integrated system research found that managers may reduce and even exploit this professional authority by carefully choosing physicians, implementing evidence-based care regulations, and encouraging doctors to seek peer input when making medical choices. Despite the difficulty of aligning goals and practices some doctors kept doing what they were doing—this study suggests that informal solutions could help new care practices spread in hospitals that are still being built, where managers and professionals have more control over overall practices [9, 12,15]. Integration also led to mass-customized treatment chains, which allowed the insurer-owned hospital to fulfill each patient's demands and demonstrated its customer service. Studies on managed care plans and integrated systems show that consumers distrust them and have inferior experiences [22,27-30]. The research found that all layers of an integrated system should prioritize customer experience. This comprises strategic KPIs, marketing, customer interaction, and investments in new and improved working resources and procedures.

Conclusion

Joint care planning is difficult in many ways. First, physicians and health plans may have a history of distrust and limited data sharing. In these instances, establishing collaboration is essential. Some service firms may lack technical support as described below. Third, without a funder involvement strategy, a practice may struggle to standardize its professional practices and care administration. Fourth, the number of customers in a market influences how hard it is to establish standard quality measurements, financial incentives, and easy-to-use data. Finally, payer-provider collaborative care models may provide health care providers with the necessary skills to offer responsible care for Medicare and privately insured patients. We believe the current approach demonstrates appropriate care and risk-sharing. Sharing clinical quality and efficiency data, investing in care management, and utilizing an incentive-based financial plan may achieve this. Provider companies and health plans may benefit from the "Triple Aim" 7 of increasing public health, patient care, and cost.

Limitations and Future Research

Care provider and treatment decisions were made before the sickness and total expenditures totaled up that was based on the secondary data. Future research can do primary research in order to check the causation factors in the health care system. However, informed parties maintained they had no say in the patients' decisions; they were based on what the patients desired. The research also included academically necessary control elements to prevent missing cause bias. More controlled research is needed. This research did not analyze patients' effect on health-care decisions, despite their active role as decision-makers. A patient's attitude and objectives may determine whether to operate on their knee. While patient engagement was not monitored, new care master positions reduced information asymmetry as treatment chain transparency rose. Future research should clearly acknowledge the patient's agency in the entire treatment process to better understand agency difficulties at the patient-hospital interface.

References

[1] Acharya A, Singh SK, Pereira V, Singh P. Big data, knowledge co-creation and decision making in fashion industry. International Journal of Information Management. 2018; 42: 90-101.

[2] Ayatollahi H, Zeraatkar K. Factors influencing the success of knowledge management process in health care organisations: a literature review. Health Information & Libraries Journal. 2020; 37: 98-117.

[3] Bazyar M, Rashidian A, Sakha MA, Vaez Mahdavi MR, Doshmangir L. Combining health insurance funds in a fragmented context: what kind of challenges should be considered? BMC Health Services Research. 2020; 20: 1-14.

[4] Bolton RN, McColl-Kennedy JR, Cheung L, Gallan A, Orsingher C, et al. Customer experience challenges: bringing together digital, physical and social realms. Journal of Service Management. 2018; 29: 776-808.

[5] Edemekong PF, Annamaraju P, Haydel MJ. Health insurance portability and accountability act. 2018; Available at: https://

pubmed.ncbi.nlm.nih.gov/29763195/.

[6] Gafurova N, Babaev J. Review protecting the rights of the patient as a consumer of health services: International standards and national legislation. Journal of Critical Reviews. 2020; 7: 1.

[7] Fainman EZ, Kucukyazici B. Design of financial incentives and payment schemes in healthcare systems: A review. Socio-Economic Planning Sciences. 2020; 72: 100901.

[8] Crowley R, Daniel H, Cooney TG, Engel TS. Envisioning a better US health care system for all: coverage and cost of care. Annals of Internal Medicine. 2020; 172: S7-S32.

[9] Ho K, Lee RS. Equilibrium provider networks: Bargaining and exclusion in health care markets. American Economic Review. 2019; 109: 473-522.

[10] Luo J, Kaul A, Seo H. Winning us with trifles: Adverse selection in the use of philanthropy as insurance. Strategic Management Journal. 2018; 39: 2591-2617.

[11] Matinheikki J, Kauppi K, Brandon-Jones A, van Raaij EM. Making agency theory work for supply chain relationships: a systematic review across four disciplines. International Journal of Operations & Production Management. 2022; 42: 299-334.

[12] Molinari A. Healthcare Mergers and Acquisitions in an Era of Consolidation: Review of Health Insurance Mergers and a Call for Agency Collaboration in Antitrust Information. Pepperdine Law Review. 2018; 45: 405.

[13] Crim RB. Exploring Health Insurance Coverage and How it is Affecting Patients and Providers. 2021; Available at: https://egrove.olemiss.edu/cgi/viewcontent.cgi?article=2884&context=hon_thesis.

[14] Mrockova N. Corporate Bankruptcy Law in China: Principles, Limitations and Options for Reform. Bloomsbury Publishing. 2021.

[15] Mitzinneck BC, Besharov ML. Managing value tensions in collective social entrepreneurship: The role of temporal, structural, and collaborative compromise. Journal of Business Ethics. 2019; 159: 381-400.

[16] Peltokorpi A, Matinheikki J, Lehtinen J, Rajala R. Revisiting the unholy alliance of health-care operations: payor–provider integration of occupational health services. International Journal of Operations & Production Management. 2020; 40: 357-387.

[17] Russo Spena T, Cristina M. Practising innovation in the healthcare ecosystem: the agency of third-party actors. Journal of Business & Industrial Marketing 2020; 35: 390-403.

[18] Schmidt H. Equitable allocation of COVID-19 vaccines in the United States. Nature Medicine. 2021; 27: 1298-1307.

[19] Saghafian S, Song L, Newhouse J, Landrum MB, Hsu J. The impact of vertical integration on physician behavior and healthcare delivery: Evidence from gastroenterology practices. Management Science. 2023; 69: 7158-7179.

[20] Solheim-Kile E, Wald A. Extending the transactional view on public–private partnership projects: Role of relational and motivational aspects in goal alignment. Journal of Construction Engineering and Management. 2019; 145: 04019030.

[21] Stafford M, Steventon A, Thorlby R, Fisher R, Turton C, et al. Briefing: Understanding the health care needs of people with multiple health conditions. London: Health Foundation. 2018.

[22] Thompson FJ, Cantor JC, Houston R. Control versus administrative discretion in negotiating voluntary P4P networks: The case of medicaid accountable care organizations. Administration & Society. 2020; 52: 81-110.

[23] Garengo P, Sardi A. Performance measurement and management in the public sector: state of the art and research opportunities. International Journal of Productivity and Performance Management. 2021; 70: 1629-1654.

[24] Fainman EZ, Kucukyazici B. Design of financial incentives and payment schemes in healthcare systems: A review. Socio-Economic Planning Sciences. 2020; 72: 100901.

[25] Gong Y, Jia F, Brown S, Koh L. Supply chain learning of sustainability in multi-tier supply chains: A resource orchestration perspective. International Journal of Operations & Production Management. 2018; 38: 1061-1090.

[26] Bischoff WR. Economics of US Health Care Delivery. Foundations for Population Health in Community/Public Health Nursing-E-Book: Foundations for Population Health in Community/Public Health Nursing-E-Book. 2021; pp: 78.

[27] Moons K, Waeyenbergh G, Pintelon L. Measuring the logistics performance of internal hospital supply chains–a literature study. Omega 2019; 82: 205-217.

[28] Miller WL. The story of general practice and primary medical care transformation in the United States since 1981. Commissioned paper for the NASEM Consensus Report: Implementing High-Quality Primary Care Rebuilding the Foundation of Health Care. 2021; pp: 1-60.

[29] Lagarde M, Blaauw D. Overtreatment and benevolent provider moral hazard: evidence from South African doctors. Journal of Development Economics. 2022; 158: 102917.

[30] Xu Y, Li Q, Xue H, Pang H. Metal-organic frameworks for direct electrochemical applications. Coordination Chemistry Reviews. 2018; 376: 292-318.