The Opportunity Cost in Health Care: Low Cost High Value

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Abstract

There is a need to innovate with new management tools to be disseminated both in the public health and in the private sector. The ways to contain health care expenditure, normally involve a decrease in the quality of services. Some of the measures are commonly adopted patient co-pay schemes, or practicing de-facto rationing, either by limiting the number of actual treatments provided in combination with long waiting lists, or carrying out consumer health campaigns focused on prevention, all with the aim of limiting the demand for public health services. Major industrialized countries have focused on reforming health care to cut costs rather than implementing policies to improve the health of their populations and thus stimulate national economic growth. Low cost-high value services are the answer firstly, to an individual's desire for personalized health care and secondly, to the inability of the western health care systems to respond to this change. Low Cost- High Value companies are new entries in those areas of the competitive system left vacant by the welfare state and they meet the patient's new needs to safeguard health with out of pocket payment. Often they are prime mover companies that launch innovations, invest in the development of new products and accept the risk of exploring unknown territory. The analysis of two case studies: Centro Medico Sant'Agostino and Odontosalute, highlights that the traditional health care business model and the low cost high value are significantly different in several points of their chain of values.)

Keywords: Health, low cost-high value, opportunity cost, case works, prime mover

Introduction

The purpose of this study is to analyze two companies that have chosen to operate in the field of low cost/high value health services, (Eisenhard, 1989). Companies operating in health services of the low cost/high value type are new entries in an area of the competitive system left

vacant by the shift of the welfare state from universal health care to a more selective system. However, this new course is not accompanied by new choices, even though the consumer/patients would like to see their needs met with a new range of options for which, despite their shrinking incomes, they are willing to pay out of pocket to safeguard their health. The patients pay directly for dental services, the counter drugs, diagnostic services and a majority of specialist visits. People are often encouraged to opt for paid services privately in order to ensure faster access at the cares (Fattore & Ferré, 2012). Many times these companies are first movers that introduce an innovation to the field, carrying the expense of developing a new product and the risks of exploring unknown territory. A possible answer to the needs of population who need to care are companies low cost high value. It is the long waiting time involved in public health services which leads people concerned with the cost of opportunity to turn to privately paid health services. These companies responding to the choices of the major industrialized countries have focused on health care reform to reduce costs, rather than implement policies to improve the health of their populations and stimulate national economic growth as well. The difficulties of the welfare state can not find an adequate response to the hoped-for recovery. In fact, the crisis of the creation of new jobs, inequality and the blocking of social mobility generate a terrible attack on two fronts at the Italian welfare. The first is in terms of funding, because fewer workers means less income to be taxed and less resources from which social services can be paid; the second on the demand side of performance, because it is the request of unemployed with no income, and the demand from those who work but still have insufficient income. It is the systemicity crisis enveloping the welfare which may explain the shocking numbers: Italians renounce at health services, especially those employed but in absolute poverty; so welfare is working contrarily to the original mission: instead of moderating, amplifying social inequalities (Censis, 2016). Furthermore there are many effects that derive from access to good health like increased productivity, since workers feel more physically and mentally more efficient and energetic or a decrease in the number of sick days and days off of work to care for family members who are ill, (Suhrcke & Martin McKee, 2005). Low Cost High Value companies are new entries in those areas of the competitive system left vacant by the welfare state and they meet the consumer/patient's new needs to safeguard health with out of pocket payment (Kachaner et al., 2010). Low cost health care providers, encouraged by the opening up of new market areas, particularly those in the lightweight care areas, are privileged correspondents of voluntary health care funds, while accredited private providers and the National Health Service itself often find it difficult to conform to the operating systems of company health funds which take into

consideration things like on-line appointments, short waiting lists and even pleasant environments, (Cinosi & Rizzo 2013)

Organization and Research Method

We want to prove that there is a new sector that stands between the public and private health care: the health care low cost high quality. The specific objective and the ultimate goal of the research that we resolved, is to be put in benchmarking, through the study of cases (Hartley, 1994), which may act as a guide for those who want to go down this road or want to improve their corporate policies in view of low cost high value in order to meet the requirements of good health. This work may act as a guide for those who want to go down this road or want to improve their corporate policies in view of low cost high value in order to meet the requirements of good health. According to Porter and Lee (2013), the value is defined as "health outcomes achieved that matter to patients relative to the cost of achieving those outcomes". In the research an analysis of changing economic and political choices in health care will be highlighted. Following Hibbard et al. (2012) we consider that achieving better health outcomes at lower cost is a major objective of many initiatives in health care.

The adoption of a descriptive research design, fieldwork and qualitative method is the default choice in the structuring of research and considered appropriate to achieving the objectives of the work. To define the business model for Low Cost High Value in health care providers, case studies are considered the most effective course to come up with answers to "how" and "why" questions when researchers have only limited control over events, but at the same time want to explore con-current trends with the aim of explaining certain phenomena and casual relationships. This is the reason why case studies and real stories are the research strategies that are most suitable to this kind of study. Yin (2003) suggested applying the logic of "literal e theoretical replication", which is based either on the identification of cases that will give similar results (literal replication) or which will give different results, but for predictable reasons (theoretical replication). The importance of this logic is that it allows for the extension or replication of the emerging theory. In our case we have chosen the "literal replication" analyzing two kinds of companies active in the low cost/high value sector to find their similarities. They are Italian companies working in northern Italy: the Centro Medico Santagostino Milan in Lombardy, and OdontoSalute Gemona in Friuli - Venezia Giulia. They are companies that have adopted the low cost/high quality philosophy by focusing on improving their organization and creating economies of scale to cut costs, thus making health services available to a wider range of consumers. Both companies adhere to the ethical code (Gazzola & Mella 2015) drawn up by the AssoLowcost and

so, while adopting different business strategies, they must follow similar parameters, (Wirtz, Iacovone & Lovelock, 2013)

The Opportunity Cost Choices in Health Care

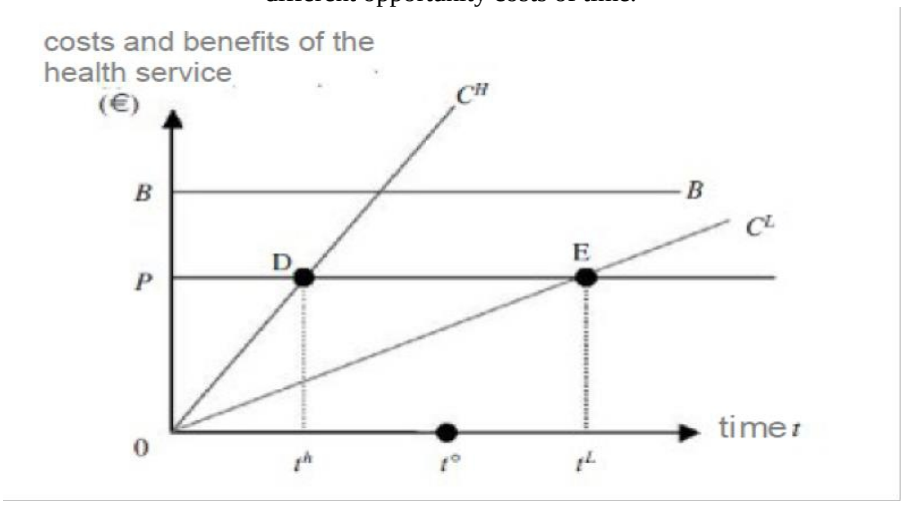
Major industrialized countries have focused on reforming health care to cut costs rather than implementing policies to improve the health of their populations and thus stimulate national economic growth.

Containing health care expenditure can be done in many ways, however they all involve a decrease in the quality of services. Some of the measures commonly adopted are patient co-pay schemes, or practicing de-facto rationing, either by limiting the number of actual treatments provided in combination with long waiting lists, or carrying out consumer health campaigns focused on prevention, all with the aim of limiting the demand for public health services. Resources are limited and the Italian National Health Service is struggling to deal with many problems like inadequate treatments due to insufficient staff and long waiting lists, mainly caused by lack of hospitals, inefficient bureaucracy, poor management and general dis-organization which all contribute to cost increases, (Querci, 2014 b).

It is important to define the difference in meaning between waiting lists and the lapse of time that occurs before a service is provided; the first refers to the number of patients in line while the second refers to the time patients must wait from the moment they join the line to the moment when they actually receive treatment, (Sanmartin et al., 2003). Striving to reach a point of balance between waiting lists and waiting time is rather complex since there is no direct benefit to be gained by increasing productivity; while this might lead to shorter waiting time it does not automatically shorten waiting lists which, on the contrary, might lengthen. This is due to the phenomena known as supply-induced demand where an increase in supply can lead to an increase in demand, generated by the perception that reduced waiting time means better quality. Therefore, it is waiting time that is an indicator of an excess of demand in relation to supply.

The private opportunity cost increases for as long as the waiting time increases, since it is impossible to carry out normal daily activities like work, housework and free time activities. Equally important is the time involved in obtaining treatment like waiting time, travel time and last, but not least, the anxiety and uncertainty involved in not knowing when treatment will be provided. It is therefore the long waiting time involved in public health services which leads people concerned with the cost of opportunity to turn to privately paid health services, (Rebba, 2009).

Figure 1 - Waiting times and choice between public and private: a comparison between two different opportunity costs of time.



Source: Rebba, 2009

Figure 1 highlights the difference between two inclined straight lines, CH and CL, where the first one refers to a subject H, with high cost-opportunity , and the second to a subject L, with low cost-opportunity. For both subjects it is initially hypothesized that the expected benefits from treatment B remain constant in time and are always above the price P. In general, an individual will choose free public health care when the expected waiting time is such that the cost-opportunity of the service is less than the price P of the service provided by private providers. As waiting time increases, the performance of the line, with reference to time cost-opportunity, overtakes the price P and in this case an individual might decide to turn to a private provider to obtain treatment.

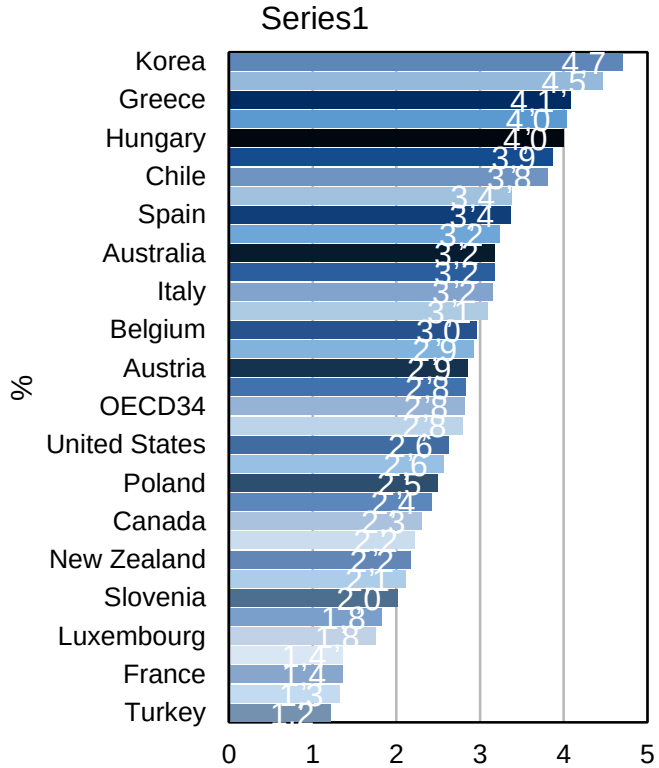
Subject H, with a high level of time cost-opportunity, will place a limit on the position assigned by the public health service, that is to say, if it is within the time limit th, however if waiting time shifts towards t°, his choice may immediately move towards private treatment at a price P. L, whose cost opportunity is lower, will turn to a private provider only if the waiting time of the public health provider is longer than tL. The choice in favour of paid health care does not necessarily imply that H has a higher income than L, but only that H might be self-employed with low income, so the impossibility of obtaining health care in a short time might lead to a loss of income, while L, with a higher income is drawn to the private sector because of the costs of anxiety. If H is not able to afford the payment of price P he will have to endure a reduction of efficiency caused by the loss of well-being as a consequence of having to stop working for the time t°.

The free Public Health System might manage to ration a specific health treatment through the practice of long waiting lists when there is a private alternative with no waiting lists and competitive prices, (Querci, 2014a). Who pays out-of-pocket health care often does so for the long waiting lists. This is due to the phenomena known as supply-induced demand where an increase in supply can lead to an increase in demand, generated by the perception that reduced waiting time means better quality. Therefore, it is waiting time that is an indicator of an excess of demand in relation to supply, (Boutsioli, 2010).

Reducing Waiting Time in Health Care

The OECD reports (2015) a general decline in health expenditure and the adoption of containment measures in Italy as a result of the economic crisis. Such containment measures exhort citizens to use the out of pocket private health care. The spending out of pocket in Italy (3.2%) is higher than the OECD average (2.8%), Figure 2 (Aceti & Squillace, 2016).

Figure 2 - Out of pocket medical spending as a share of final households consumption, 2013 (or nearest year)



Source: OECD, 2015

It is necessary to specify that the waiting time between public, private or the low cost high value healthcare is different. The comparison of the data CENSIS (2015) with the retail prices offered by the Low Cost High Value showed the cost of each day of waiting time for a medical examination. Every single day of waiting spared by purchasing private facilities rather than public ones will cost from € 4.2 to € 28, depending on the service. Cost and waiting time have inverse trends in the transition from public to private. Infact the increase of the cost in the private services corresponds to a decrease in waiting time and vice versa. Table 2 shows that a gynaecological examination costs € 30.7 in the public sector, while € 103.3 in the private, but with different waiting times. The waiting time is 5.4 days in private and 38.3 days in public sectors, and, compared to a cost of € 60, the waiting time of high to low-cost value is 7 days. The waiting time is the hidden cost that affects the choice of citizens to use the private sector, profit or non profit, (Table 1) (Querci & Gazzola, 2106).

Table 1 - Comparing costs between public health, private and low cost high value

Cost in euro (2015)	Public ticket*	Intramoenia*	Private*	Centro medico Santagostino low cost high value**	Odonto Salute low cost high value***
Specialist visits					
Before cardiological examination with Ecg	41.70	113.50	108.10	80.00	
gynecological examination	30.70	99.80	103.30	60.00	
orthopaedic examination,	31.70	101.90	103.60	60.00	
first eye examination	42.50	105.10	102.40	60.00	
Diagnostic examinations					
Full abdomen ultrasound	56.30	102.20	110.00	60.00	
Psa prostate specific antigen	13.80	19.30	18.80	13.80	
Laboratory analysis					
total cholesterol	4.90	7.60	7.30	1.70	
complete blood count	6.80	11.40	10.00	4.05	
Dental visits					
simple tooth extraction with anaesthesia	24.90	76.10	88.00		45.00
two-channel root canal	48.10	182.10	179.00		100.00

treatment					
tartar removal	16.40	55.10	88.00		40.00

source:*censis.it;**http://www.cmsantagostino.it;***http://www.odontosalute.it.

Private health Care, Low Cost High Value

This is mainly due to the shift from the National Health Service to the private sector and to the trends towards privatization occurring on a global scale. This has led to an attempt to overcome the economic downturn due to the privatization of assets and services, which used to be protected from commercialization, through the creation of new areas of market and the expansion of existing ones by increasing their profitability.

Long-term profitability is mainly guaranteed in the local public sector and in the social health services, due to their largely unvarying demand. The variety of companies that are involved in the health services system are the accredited private provider, the so-called" private to private" health care provider, among which there are those that adhere to the low-cost philosophy, and the foreign health care provider that caters to the medical tourism industry. There are also providers of many additional kinds of health insurance that can be complementary to, supplementary to, or duplicative of that of the National Health System.

Therefore the opening up of the market to a third kind of "lightweight" private health care, positioned between the public and the private sectors, as well as the inclusion in some national trade union agreements of voluntary health care funds, is one of the paths chosen to provide an alternative to national health systems. These national systems are in constant financial distress due to the imbalance between income and expenditure which results in ever increasing cuts in spending. Low-cost health care providers, encouraged by the opening up of new market areas (Pessina et al., 2011), particularly those in the lightweight care areas, are privileged correspondents of voluntary health care funds, while accredited private providers and the National Health Service itself often find it difficult to conform to the operating systems of company health funds which take into consideration things like on-line appointments, short waiting lists and even pleasant environments. Low cost high value companies have entered the market just at the moment when a new field is opening up and they offer advanced technology, good organization, pleasant accommodation and the ability to fulfil the demands of that new field. Their company mission is to provide low cost quality health care while at the same time meeting the commitment of company health funds to provide the required services to their members.

Health care companies in the low cost high value field share goals of long term economic viability, as well as that of total independence from the National Health Service. Prices of services are on average 30% lower than the price of private traditional health and sometimes inferior to the public ticket (Cinosi & Rizzo, 2013). Many times these companies are first movers that introduce an innovation to the field, carrying the expense of developing a new product and the risks of exploring unknown territory. The definition of first mover is ambiguous because, if a company moves into a consolidated market but takes advantage of certain technological gaps or sectors where there is a new demand, can it be considered a first mover? Can this be classified as the first move? There are no published answers to this question but from the data of the PIMS (Profit Impact of Market Strategy) it appears, for instance, that more than half of all the business units are "pioneers" among several competitors within the same market area (Querci, 2016)

The advantage of being first movers lies in the ability of the company to be in a pole-position to gain economically and this can be reached through several stages. In the first stage a particular advantage of the pioneer over its rivals can usually be attributed to some variable such as unique resources, or a particular foresight, or even just to a stroke of luck. Once this variable occurs, a series of mechanisms allow the company to take advantage of its position to increase the scope, or the length, of its profit as a first moverIt is important to bear in mind that in certain markets there is only room for a limited number of profitable enterprises so the first move is to select the most interesting niche sectors and then to put into effect those strategies that will limit the space available to further competitors (Lieberman & Montgomery, 1988). The next step is to pass from narrow and traditional skills to the wider and newer skills necessary, at the same time as the rules of the game are being re-written. R. Norman (2002) calls prime mover innovator/inventor those individuals that he considers "creators of sleeping assets markets". The prime mover transforms these assets into liquidity that can be advantageously employed in a different context. In this sense the prime mover makes all the players richer, leading others to identify untapped assets to be exploited, such as, in the realm of low cost high value health services, short waiting lists, comfortable accommodation and convenient geographical locations. They have a new approach as subjects capable of impacting on the outside environment. They are organizations that don't only understand the changing market but, in some ways, implement or direct the change itself (Norman, 2002) The prime mover has considerable advantages, among them technological leadership, learning curves, brand identification, as well as the opportunity to shift the switching expenses on to the client and the chance to exploit the positive effects generated by customer satisfaction. The leading company that is the first to invest in new technology,

particularly when this involves skills, will enjoy a preeminent position among its competitors, at least until they are able to reach the same levels of skills.

Case Study

The two cases studied, Centro Medico Sant'Agostino and OdontoSalute, though offering different types of goods and services, shared certain common elements like business strategies, the organization of their supply chains and customer satisfaction and orientation. The two companies are characterized by profit margins based on industrial production; dental prosthesis and specialties for the Centro Medico Sant'Agostino and dental care and prosthesis for OdontoSalute. The Table 2 compares their strong points.

Table 2 - Commercial strong points of the Centro Medico Santagostino, and the OdontoSalute

	Centro Medico SantAgostino	**OdontoSalute**
Born	2009	2008 (born like Progetto Dentale Apollonia (in June 2013 changed its name to OdontoSalute)
Their mission:	*"Health at the right price"*	*"With us a smile costs less"*
Market share:	Meets the growing consumer need for high quality specialized medicine that is economical and accessible.	Services at affordable prices to contrast medical tourism output by offering patients local care at fair prices and import patients from other countries
Price:	Prices are 30% to 40% below comparable market prices.	Prices are 30% to 40% below comparable market prices.
Customer satisfaction and orientation:	Patients seeking good health care with waiting lists of one week or less, in pleasant surroundings to get quality care with minimum stress	The strategies to contain costs benefit patients who are offered quality services at lower prices than those of the competition, with minimum waiting lists and easy access to care.
Location:	7 locations with 3 clinics that offer more than 30 specialties. In the center of Milan, the offices are easy to reach and cater to a vast and diverse socio-economic clientele.	21 locations, in north, center and south Italy, ample parking, near airports, and motorway exits, very diverse socio-economic clientele. seven clinics are owned by other franchise agreements

Type of goods and services:	Out-patient surgery furnishing careful and individual attention, aimed at supporting patients in every aspect of their care, especially the doctor/patient relationship, with plenty of time for dialogue, free consulting services and transportation, child care areas.	Highly specialized dental clinic with state of the art equipment. Provides medical tourism services for foreigners seeking treatment in Italy.

Source: author's elaboration

The cases analyzed (Eisenhard, 1989) are all in line with the parameters of the study, in fact they all adhere to the low cost/high value philosophy, all offer, either directly or indirectly, a variety of health services or medical prosthesis, they operate in different geographical areas and they are first movers. They are successful in the competitive market and are financially secure. They are providers for private care insurance policies, associations and company health care plans, or other organizations that could potentially become partners. In their performance, the two companies share a common organizational model, (Cinosi & Rizzo, 2013). For management and non-management personnel, paramedics and doctors, the two companies review performance, raise salaries and grant promotions on the basis of merit. Implementing organizational routines in the offices guarantees quality and efficiency and is useful when opening new branches or franchise ventures. Career and economic incentives are offered mainly to professional employees; at the OdontoSalute doctors are granted commissions on a percentage of the prosthetic work they perform, in the Centro Medico Santagostino, upward career mobility is the incentive. The IT systems are suitable and convenient for the type of business involved and, with cost control in mind, they use standard programs modified to suit specific demands. Branches are designed with functional features in mind, so as to provide efficient work environments and services.

If on one hand venues are designed with people in mind, taking into account hospitality and good use of space, on the other hand the layout is functional to containing costs. The OdontoSalute has come up with clinics that make the most of their investments by having 10 to 17 dentists' chairs that work for 6 days a week, in two shifts. In both centers it is possible to book on line. The Medical Center Santagostino website states that it maintains the waiting time within 3 days from the date of request for all visits.While Odontosalute informs the patients that at the entrance to the clinic, the customer is provided with a badge that 'counts' the waiting time.

Conclusion

In health care low cost/high value enterprises offer a satisfactory choice of quality services at substantially lower prices. In a society where welfare is suffering, and political choices are shifting towards multiple providers in health care, the volume of services and turnover of low cost/high value care, indicates that people consider it the answer to their demand for treatment at fair prices. Where the structure of the health services has had a gradual transformation from a network of professionals to a network of more industrialized services. These case studies are all virtuous examples whose aim is to increase economic turnover while safeguarding vulnerable consumers. The appearance of new private enterprises in the health market has a positive effect on the nation's revenues through the increase in income from taxation, the growth of job opportunities and real estate investments. However, the spread of the phenomena of low cost health care has increased the tendency to transform the health services market into one like many others, with the risk of generating negative consequences. In the comparison of Censis data (2015) with the retail prices offered by low-cost high value the cost of each day of time waiting for a medical examination evidence that their cost is competitive. These companies minimize the increase in the cost of private services with a decrease in the waiting time. The health services structures in low-cost high-value offer the services substantially characterized by the industrial logic. In fact they adhere to the low cost/high value philosophy, offering either directly or indirectly, a variety of health services or medical prosthesis, operating in different geographical areas and they are first movers. They also are providers for private care insurance policies, associations and company health care plans, or other organizations that could potentially become partners. (Carbone et al., 2010). OdontoSalute has 10 to 17 dental units that work for 6 days a week, in two shifts. The Centro Medico Santagostino offers dental care up to 10 pm. Large volumes of sales and narrow margins are the philosophy of all two companies and suppliers have had to conform to this same policy. It is particularly evident in health care that low cost/high value enterprises offer a satisfactory choice of quality services at substantially lower prices. In a society where welfare is suffering, and political choices are shifting towards multiple providers in health care, the volume of services and turnover of low cost/high value care, indicates that people consider it the answer to their demand for treatment at fair prices (Del Vecchio & Rappini, 2010).

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