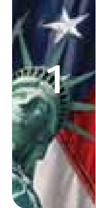


LAND OF THE FEE

At the end of 2010, a joint HFMA/ACCA study tour visited the US to take part in a workshop looking at improving healthcare value and to examine how US hospitals are facing up to the twin challenges of improving quality while reducing cost

FEE-PER-CASE payment systems in both the US and England offer perverse incentives to increase rather than decrease hospitalisation, *writes Sharon Cannaby*. But this is about to change as economic pressures hit home. Health reform, in both countries, will compel the move from fee-for-service to fee-for-value.

Value has been defined as quality of care divided by the cost of providing that care. But how do you measure quality? The Institute of Medicine (IOM) sums up poor quality in three words: under-use, over-use and misuse.

Under-use describes the occasions when a patient is not provided with the treatment they need. For example, all women over 40 in the US are recommended to have an annual breast examination, but in 2006 only 55% of women did so – a clear example of under-use.

Over-use equates to unnecessary treatment – a drug or procedure not recommended by evidence-based medicine. For example, there is a far greater rate of hospitalisation for residents aged over 65 in Miami compared with Minneapolis. This is shown by a difference in Medicare payments – which are significantly higher per Miami resident, probably due to a higher capacity of acute beds.

Misuse occurs when a patient is prescribed

DEFINING QUALITY

Geisinger and New York Presbyterian Hospital are two US organisations with a reputation for quality. Geisinger certainly gives the impression of being welcoming, clean, efficient and quiet. Its success appears to stem from having stable, focused leadership coupled with a strong culture of accountability embedded throughout. The chief executive meets all staff regularly to ensure consistency and clarity of message. Staff know how their role fits in the organisation and are all set clear objectives linked to incentive plans. For example, all clinicians are directly employed but about 20% of their pay depends on the achievement of set objectives.

Clinical leadership is at the heart of everything Geisinger does. No decision-making meeting takes place without at least one clinician present. And quality is literally the first item on the agenda of every board meeting.

It also makes innovative use of technology to manage quality and meet resource constraints (see pages 24 and 25 for examples).

Other US organisations have also put quality literally at the top of the board agenda. One chief financial officer told us every board meeting at his organisation begins with a report from the chief medical officer on the details of a particular harmful event within the hospital.

There is a big difference in reaction between the board receiving a paper report showing the number of adverse events over a set period and the board being told, for example, that Mr Smith, a 50-year-old married man with three children under the age of 18, was admitted to the hospital and died because he was given the wrong drug. Personalising the report brings home the seriousness of the issue, ensuring action is taken to avoid any recurrence. He said board members remembered individual cases – they didn't remember a table of statistics.

New York Presbyterian – the largest not-for-profit, non-sectarian hospital in the US with 2,353 beds – is very different to Geisinger. With a city-based population, it feels busier. Its strong focus on patient safety and quality was a major contributing factor in being ranked sixth in the US News Media Group's 2010/11 'best hospitals' assessment.

The hospital has also won awards for its patient safety 'Fridays' programme, for which more than 900 staff attend weekly training sessions on one potential clinical care safety issue (such as out of date medicines) and one potential environmental safety issue (such as refrigerator temperatures). These staff are then dispatched around the hospital to talk to staff and discuss recommended best practice.

The programme has produced impressive results, including improvements in: hand hygiene compliance from 70% to 96%; medication reconciliation compliance from 76% to 100%; and patient verification compliance from 78% to 100%.

The lessons from both Geisinger and New York Presbyterian suggest that to be a leading edge provider requires: strong top-down leadership; full clinical involvement in decision making; putting quality at the top of every agenda; total staff engagement; and an innovative spirit.

the wrong drug, when a procedure goes wrong and causes harm or when a patient acquires an infection. One study found that between 44,000 and 98,000 people die in US hospitals each year due to medical errors.

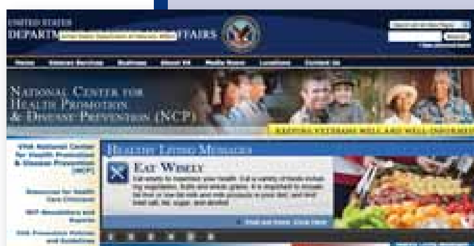
There is also a lack of consistency over the timescale for measuring quality. For patients it is a real-time issue; for clinicians the key point is when they complete a procedure; for hospitals the focus may be at discharge; for statisticians, focusing on mortality rates or life span, timescale is the rest of the patient's life. But there is now solid evidence that improving quality can reduce costs – for instance, by getting things 'right first time' and avoiding unnecessary readmissions.

There is significant potential. In Florida during 2004/05, for example, it was estimated that 61% of readmissions within 15 days were preventable. And about 9% of hospital costs in the US are estimated to relate to potentially preventable complications such as post-operative wound infections or pneumonia.

Health systems are now looking to find ways

MATURE RESPONSE

Responsibility for veterans' health rests with the US Department of Veteran Affairs (VA), which runs the largest integrated healthcare organisation in the US. It provides medical services for about 16 million veterans, has a budget in excess of $47bn, employs 239,000 staff and operates 1,400 hospitals, clinics, nursing homes and readjustment centres.



The Philadelphia VA Medical Center provides a full range of adult healthcare services and has 2,000 staff, 145 acute beds and a 135-bed nursing home. But with budgets set using Medicare prices – much lower than those paid by insurers – like all veteran hospitals, it faces challenges in delivering care.

Many aspects of its circumstances are similar to those in the NHS and there are areas the UK could learn from. For example, its unique population (average age 60) has led to highly specialised and nationally recognised programmes of care in areas such as hepatitis C and HIV, sleep medicine, behavioural medicine and neurodegenerative disorders.

The patient population is set to decrease, become younger and include more women. This will require modifications to existing premises. But matching demand to facilities will be aided by a new nationwide bed management system, which will detail occupancy numbers across all VA centres, enabling patients to travel quickly to be treated or be rapidly relocated.

Its MyHealtheVet system (left) is also impressive. Launched in 2003, a veteran's medical records can be accessed at any VA site in the US. It gives veterans secure, free, online access to personal medical records and can be used to access up-to-date health information, order repeat prescriptions, receive reminders, view lab results, communicate with VA healthcare providers and make or change appointments.

US healthcare reform: a guide

US healthcare reform is perhaps more accurately described as healthcare payment reform, *writes Mark Millar*. Its patchwork of healthcare systems means the single largest lever for governments to effect change is the funding mechanism – either directly through the publicly funded schemes or by laws and regulation around insurance requirements.

Healthcare reform has been President Obama's flagship policy and he achieved this in March 2010 when the *Patient protection and affordable care act* was signed into law along with the *Healthcare and education reconciliation act*. Numerous concessions were needed to get the legislation passed and there have been a number of subsequent legal challenges to it. The Republicans taking control of the House of Representatives at the beginning of 2011 (as opposed to the Democrat-controlled Senate) also increased speculation about whether the reforms, or aspects of them, could be repealed.

The fundamental challenges of healthcare in the US are well rehearsed:

- A spend of 17.3% of GDP on health in 2009 (compared with about 9% in the UK) is expected to grow to 19.6% in 2019.
- 50 million people are not covered by the public purse or insurers (19%).
- Pressures on health are increasing as the 'baby boomers' reach old age.

Aim of the reforms

Reform has two simple ambitions: to slow the increase in, if not decrease, health spend as a percentage of GDP; and reduce the numbers of uninsured. Today's healthcare coverage of the US non-elderly population (elderly population are funded through the Medicare system) is as follows:

Medicaid/child health insurance protection	40 million	15%
Employer insured	150 million	56%
Private insurance	27 million	10%
Uninsured	50 million	19%

The plan, set out in the 2010 acts, is to change this profile by introducing laws requiring employers and individuals to take out health insurance, with legal financial penalties being put in place for non-compliance. New state insurance exchanges will provide marketplaces for individuals to buy low-cost health insurance. Four levels of coverage must be offered, ranging from 60% to 90% coverage with the balance being a co-payment. State subsidies will be available to individuals on a sliding scale up to 400% of the poverty level.

In addition, the scope of Medicaid (the publicly funded healthcare programme for those on low income) will be increased to 133% of the national poverty line.

There are numerous other provisions to ensure coverage and to prevent insurance companies unreasonably declining or restricting cover. While the changes will be phased in, the expected change to the coverage profile by 2019, taking into account population growth is as follows:

Medicaid/child health insurance protection	51 million	18%
Employer insured	158 million	56%
Private insurance	25 million	9%
Insurance exchanges	24 million	9%
Uninsured	22 million	8%

There is a balance between the cost of insurance, through the exchanges and the levels of fines to be imposed for non-compliance. Observers believe the fines are still not sufficient to deter small firms and individuals from not complying. While the reforms are seen as dealing with key risks, they do leave 22 million people still not covered in nine years' time. The general view is that this represents good progress and that those remaining uncovered are likely to be, in the main, newly arrived immigrants or illegal workers.

Before examining the likely or potential costs of the changes, it is worth considering some facts on US healthcare spending:

to link financial rewards to the achievement of quality goals in order to encourage the elimination of waste such as this – although this is not a straightforward process.

As a move in this direction, some parts of the US have linked financial incentives to process measures, the delivery of which indicates that a patient has been put through the optimum pathway. This may not directly link to outcomes, but it links payment to measures that should give the best chance of the best outcome.

The scheme has been picked up by the NHS in the North West Strategic Health Authority's *Advancing quality* initiative, which offers small financial incentives to the best performing trusts in five high-volume areas; heart failure, heart bypass (CABG), heart attack (AMI), hip and knee surgery, and pneumonia.

So how does health reform fit in? The appointment of Don Berwick, former president and chief executive officer of the Institute for Healthcare Improvement (IHI), as administrator of the Centers for Medicare and Medicaid Services (CMS) should guarantee that quality is top of the reform agenda.

A CMS Center for Innovation is testing 'innovative payment and service delivery models' that will 'at the same time preserve or enhance the quality of care'. The centre will encourage the use of technology (including electronic patient records and remote monitoring of patients) to deliver high-quality healthcare that is closely aligned to patient needs.

> "There is now solid evidence that improving quality can reduce costs – for instance, by getting things right first time"

Fee-for-value moves

There is expected to be a gradual move towards fee-for-value payments and a corresponding decrease in average payment price. From 2013, the basic diagnosis-related group (DRG) rates paid to US hospitals through Medicare and Medicaid are expected to be reduced annually, equivalent to the amount that the organisation could earn from value-based incentive payments.

There is also a belief that the government will start adjusting payments based on patient satisfaction data. If so, health providers will need to ensure they have a good understanding of how their patients define quality.

Like Medicare and Medicaid, US insurance companies are also starting to link payments to quality – though at present this seems to be limited to refusal to pay providers for avoidable events such as treatment of bed sores. What is not known yet is whether this has had the impact of driving up quality or has simply encouraged the cross-subsidisation of services.

It is clear that finance staff will have a major role in delivering the quality agenda. They will be needed to make the financial case for quality improvement and to deliver robust cost information that helps clinicians hone pathways and eliminate unnecessary costs.

At present it remains an under-developed role in most organisations, but as in the UK, this will need to change. ■

Sharon Cannaby is head of health sector policy for ACCA

FLICKR

- The top 1% of earners account for 23% of all healthcare expenditure
- The top 5% of earners account for 49% of all healthcare expenditure
- The bottom 50% of earners account for 3% of all health expenditure
- Both Medicare and Medicaid are calculated as paying about 90% of the cost of providing care, while private payers pay 130% of the cost. In other words, private payers are subsidising Medicare and Medicaid patients.

Critics in the US, while grudgingly acknowledging that the plan will address some access issues, argue that it does nothing to tackle the twin goals of cost and quality. The free market insurance schemes will continue to offer benefits and premiums at a level the market will bear, given more affluent Americans' desire for choice and convenience at a price.

The Congressional Budget Office has confirmed a view that the cost of coverage from the public purse at $938bn by 2019 will be more than offset by 'funding' of $1,062bn, thus contributing to a net budget deficit reduction.

How do they arrive at this interesting calculation? The cost of increased coverage will be met by higher taxes and a squeeze on Medicare reimbursement rates. About 20% of the additional cost will be met by a Medicare tax of 0.9% on earned income over $200,000 and 3.8% on unearned income. A range of other measures mean that $569bn of the $1,062bn will be met through taxation. The balance will be met by squeezing Medicare reimbursement rates through routes linked to quality and efficiency.

Charges argument

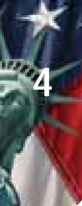
Healthcare providers believe they already subsidise Medicare/Medicaid patients (through higher charges to self-payers and insurance firms). Many say the changes will only increase this subsidy. Some argue self-payers will suffer a double hit as they are also the ones targeted with increased health taxes. And many claim that no one currently actually gets refused treatment and this is just a way of moving the money around to make things look better.

There may be some truth in that, but more taxation must mean more money in the system. The unknown is the impact on the insurance market and those funding the premiums.

The high transaction costs of charging on an individual basis – and the industry being centred around the authorisation of costs, billing, verification, disputes and payments – fuel costs in both public and private systems. It is worth bearing in mind that government bodies already pay 46% of healthcare costs under Medicare, Medicaid, state child health insurance, Veterans Administration and the Department of Defense.

There are plans, and variations on a theme, for seniors to top up their Medicare coverage, and a range of levels of co-payment apply across the board. In a discussion on simple solutions, I raised the idea of universal coverage paid for out of taxation with the option to buy increased benefits either directly or through an insurance scheme. But this was dismissed as resembling 'socialised medicine' – a total no-no to Americans. US colleagues said the answer to UK health issues was a $10 co-payment for visiting the GP. In many ways perhaps we were talking about the same thing.

• *Mark Millar is interim chief executive of Milton Keynes Hospital NHS FT*



Virtual reality for ITU

IN RESPONSE TO pressures to cut costs while improving quality, the Geisinger Health System (GHS), Pennsylvania, has invested heavily in telemedicine for its intensive treatment unit (ITU), *writes Phil Taylor*. Its experience may well be of interest to UK hospitals facing the same quality/cost challenge.

GHS is an integrated health service including provider facilities, a large physicians practice and managed care companies. It is, in effect, a vertically integrated system, with a single organisation collecting the funding and providing primary and secondary care. Unusually for the US – but similar to the UK – the physicians are directly employed rather than independent practitioners.

It serves a mainly rural population from a base in Danville, Pennsylvania. The Geisinger Medical Centre has about 400 beds, including 42 intensive care beds. There are a similar number of beds at two other campuses, including a 12-bed ITU, community facilities and three ambulatory surgery centres.

In a September 2010 speech to Congress, President Obama cited GHS as a model for the health industry. 'Even within our own country, a lot of places where we spend less on healthcare actually have higher quality than where we spend more,' he said. 'We have to ask why places like Geisinger Health System in rural Pennsylvania ... can offer high-quality care at costs well below average, but other places in America can't. We need to identify the best practices across the country, learn from them and replicate the success elsewhere.'

In the US, while hospital facilities overall have shrunk, critical care has continued to grow. Between 2000 and 2005 the number of general hospital beds fell by 4.2%, while critical

care beds increased by 6.5%. Over the same period, the number of hospital inpatient days rose by 5.1% compared with an increase in critical care inpatient days of 10.6%.

The demand for critical care services is linked to an ageing population and is expected to increase sharply after 2010, when the baby boomers hit 65. Demand is then likely to increase until 2030 before stabilising.

With severe shortages of critical care nurses and consultants, meeting this demand will be challenging. Workforce projections show a widening gap between the supply and demand for intensive care consultants. Currently 50% of US ITUs lack dedicated consultant coverage and only 26% were considered to have high-intensity coverage. In nursing, there is an anticipated shortage of at least a million nurses by 2020 (all nursing, not just ITU).

Evidence shows high-intensity ITU staffing reduces both hospital and ITU mortality and length of stay. Under a US intensive care standard, ITUs should be managed by consultants who are present during the day and provide clinical care exclusively in the ITU, and when not present return a call by pager within five minutes 95% of the time.

The GHS response to the pressures has been to invest in telemedicine – phase one for its in-house ITUs and phase two for surrounding hospitals. As with other hospital systems, recruitment of critical care consultants is a challenge for Geisinger – even though it is a major research and training facility. The move to e-ITU was motivated by a desire to improve quality and patient safety. Savings from reduced complications and length of stay (LOS) were not the main reasons. However, the business case shows it is a sound investment. The financial projections made were:

- Capital investment of $7m
- Internal rate of return of 29.1%
- Net present value of $168,000 over 10 years (using a 20% discount rate)
- Payback period of four years.

The development was planned over two phases. The planned bed coverage for telemedicine and cost/benefits are shown in the table below. The analysis shows cost benefit – cost savings through length of stay and variable cost reductions – as the main factor, rather than increases in income. These benefits are based on ITU LOS reductions of 15% at two of the existing units and 8% at the other.

Significant reductions in variable costs of 75% per day were also projected. Evidence that this level of saving had been made elsewhere was included in the business case.

The system chosen for Geisinger was already used across the US in more than 200 hospitals and the aggregate results were impressive (see table right). In individual hospitals, the results can be even more striking. One university hospital treating more than 2,800 patients in ITU over a three-year period achieved:

- ITU mortality reduction from 8.4% to3.1%
- Hospital mortality drop from 11.1% to 6%
- ITU LOS fall from 7.53 days to3.78 days.

In another case, a hospital showed a 53% reduction in ITU mortality over a 30-month

GEISINGER HEALTH SYSTEM: BED COVERAGE FOR TELEMEDICINE AND COSTS/BENEFITS

Beds	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
GHS site 1	42	49	49	49	49	49
GHS Site 2	12	25	25	25	25	25
Mobile	0	4	4	4	4	4
Outreach	0	0	35	40	45	50
Total	54	78	113	118	123	128

Costs/benefits ($000s)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Annual operating costs	(2,484)	(3,505)	(5,256)	(5,256)	(5,256)	(5,256)
Depreciation	(590)	(1,289)	(1,398)	(1,398)	(1,398)	(807)
Cost benefit	1,355	6,503	6,503	6,503	6,503	6,503
Revenue enhancement	67	324	324	324	324	324
Contracts for outreach	0	0	1,313	1,500	1,688	1,875
Contribution	**(1652)**	**2,033**	**1,485**	**1,672**	**1,860**	**2,638**
Capital investment	(5,902)	(1,086)				
Net cash flow	**(6,964)**	**2,236**	**2,883**	**3,070**	**3,258**	**3,445**

AGGREGATE RESULTS ACROSS SYSTEM USERS

	Baseline	Post eITU
Hospital mortality	12.9%	9.4%
Hospital LOS	12.77 days	11.14 days
ITU mortality	8.6%	6.3%
ITU LOS	4.35 days	3.63 days
Average ITU daily cost	$1,648	$1,141
Average cost/case	$10,444	$7,871
Average revenue/case	$17,276	$18,510
Average contribution/case	$6,832	$10,639
Contribution margin/month	$795,245	$1,319,236

period, saving an estimated 56 lives.

The business case for telemedicine in ITU at GHS cited similar evidence and was accepted in 2008. The model involves ITU consultants and nurses at a central monitoring station using visual and electronic monitoring to track care across a number of ITUs in several hospitals.

The central staff use remote control communications to see and hear activity around the patients and talk to bedside staff. Visual display units allow staff to view patients' vital signs fed from the bedside monitors, lab results and other systems, and to view the patient and clinical activity from the bedside camera. This allows them to advise clinicians.

The equipment was impressive. The bedside cameras give a clear view and can zoom in to great detail. Unlike the UK, the beds are mostly in single rooms, but the monitoring equipment at each bed is familiar except for the remotely operated video camera and voice system.

The central command centre is located away from the ITUs and is operated by highly experienced critical care consultants. It has a number of desks, each surrounded by the many monitoring screens. It is a quiet and calm environment away from the hustle and bustle of the operational units. When they or the bedside nurse have a problem, they discuss the patient details and provide advice, ensuring critical decisions are taken promptly.

It is too early to draw definitive conclusions from the Geisinger implementation, but the early results are better than anticipated in the business case for mortality and length of stay.

Could it work in the NHS? The number of intensive care beds in England has surged in recent years, from 2,240 in March 1999 to 3,662 in July 2010. Yet there are still shortages most winters. With similar interests in reducing mortality, length of stay and cost, it may be time for the NHS to examine the potential of telemedicine in intensive care. ■

• *Phil Taylor is a management consultant*

Electronic records: a competitive edge

THE FOCUS IN healthcare is shifting from delivering volume to delivering value or outcomes, *writes Sue Jacques*. One of the clear roles for the finance profession in this is to contribute to the development of meaningful outcome measures and look for ways to link funding to the delivery of these outcomes.

This is as important for governments in charge of policy as it is for commissioners, insurers and providers of healthcare, and quantification of such complex measures is reliant on effective data capture.

The importance has been underscored in the US with the introduction of federal incentives for the meaningful use of electronic patient records (EPRs) – this if nothing else has resulted in more widespread use of EPRs.

Four sites visited by the HFMA/ACCA study tour – Geisinger Health System, VA Philadelphia, New York Presbyterian and United Hospital System Kenosha – were very different in nature. But all four had forms of EPRs that were part of a strategic approach to securing and maintaining competitive advantage in a changing environment. EPRs were being exploited in three areas:

1. Decision support As medicine becomes more specialised and evidence-based, organisations are introducing pathways to ensure consistency in process and quality. But pathways can become disjointed, interrupted and even ignored – a result of non-elective pressures, for instance, resulting in patients being put into surgical beds, or staff shift patterns or increasing clinical policies.

The EPR systems in use could not only document events relating to a patient, but also prompt the clinician to do tasks. Where appropriate, the records even prohibited clinicians carrying out further action until they had done so. Any deviation was reportable in real time, enabling it to be reviewed by a senior decision maker. Clinicians will always need to be able to exercise judgement, but the EPR system's decision support functionality can support safer care.

2. Connecting with the customer – personalisation To the horror of my teenage daughters, I have no Facebook page, nor have I ever tweeted. Despite this, I wouldn't consider arranging my car insurance without going online to compare offers, nor would I restrict myself to the inconvenience of high-street banking. The organisations dealing with me online know a lot about me and use it to tailor their offerings to my needs. In return, I reward them with my business.

The power of this approach in healthcare was most evident at Geisinger. Members of its health plan, whether existing patients or not, have an account allowing them to transact with Geisinger online in a simple, personalised way, simplifying everything from booking an

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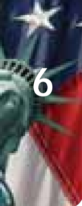

appointment to checking the results of a test.

As well as providing patient benefits, this approach to business creates exit barriers – if it's straightforward to deal with Geisinger, if GHS already knows everything about my health issues and allows these details to be shared (with my permission) between hospital and community health providers, why leave?

3. Patient centred costing The EPR system also provides the building blocks to allow finance leaders to shift from a cost-centred analysis of their business to a patient-centred analysis, broadening thinking about ways to streamline processes, improve care and save money.

Imagine being able to more accurately share variation in practice and cost with clinicians, linked directly to outcomes. Then imagine clinicians being able to do this for themselves, adjusting their practice in real time as needed. EPR supports patient level costing, enhancing cost attribution. US evidence shows they give:

- Access to richer and meaningful clinical, operational and financial data
- A common language and metrics for success across multiple clinical areas
- Stronger clinical accountability
- More ready identification of opportunities for improvement
- The ability to monitor progress and fine tune processes to drive success.

All of this would be helpful to us in the English NHS right now. And it will become even more vital when faced with the challenge of agreeing the cost of designated services and their inter relationships with the cost structures of other services.

In the US, business cases for EPR were rare – their introduction was a strategic top-level command, with operational return often not quantified. It was seen as a way to secure competitive advantage, at least in the short term, and had become mission critical.

In the NHS, the Department of Health, realising the power of the EPR, established the National Programme for IT and Connecting for Health.

Arguably such a centralist approach, at a time where the provider landscape was increasingly populated by more independent commercial orientated foundation trusts, had the potential to misfire. We now find ourselves (at least in the foundation trust sector) freer to do what we believe is right, constrained only by our imagination and the investment we can raise. Some will ask whether they can afford to invest in an EPR, others whether they can afford not to. As finance professionals we must help our organisations get that choice right. So where will your imagination take you? ■

• Sue Jacques is director of finance and deputy chief executive at County Durham and Darlington NHS FT

THE US CHALLENGE

The challenges in the US around healthcare reform are similar to those facing the NHS, *writes Tony Whitfield*. This is no surprise, given we face the same drivers – post-war baby boom demographic timebomb, advances in science and a widening affordability gap.

Through his healthcare reform, President Obama is attempting to create a system to deliver affordable healthcare for all – drawing both passionate support and opposition.

What is clear is that there is poor correlation in the US between government expenditure on health and patient outcomes. It appeared that where you lived mattered more than how much was spent. The reforms look to address this by creating a reimbursement system that is linked to outcomes rather than inputs.

The US HFMA is engaging with its membership to create a consensus on how the political ambition can be realised in practice. There were a range of views at an HFMA congress in Washington DC. Some believe current arrangements do not adequately reimburse for the required quality standards. Others claim cost and quality are so entwined that the pursuit of quality should reduce costs.

The US HFMA is trying to describe a value proposition for healthcare linked to existing work by leading academics such as Michael Porter, Don Berwick and Harvey Makadon.

The challenges in the US include:

- Misaligned financial incentives, with payments made on a cost-per-case basis rather than a population or outcome-based methodology. Patients share little of the financial burden.
- Institutions tend to operate largely in silos with an emphasis on many financial metrics that are often not linked to clinical care pathways or quality outcomes.
- Patients lack knowledge on where to seek care, often not understanding clinical outcomes, but vocal on service processes.
- There is a need for a fully integrated electronic patient record to support the optimum management of individual patients, but also using the data to make decisions around costs and quality on a population basis.

The leadership challenge for finance directors is to drive change that increases the value delivered for the payer. Increasingly, the chief financial officer will be leading a clinical change by partnering with doctors.

The Obama regime has made significant amounts of funding available to implement IT systems. The investment aims to ensure electronic patient records can enhance the reliability of care and offer clinicians a 'guiding hand' in management of individual patients – ensuring patients get the right treatment in the right order at the right time.

The investment also provides a huge efficiency opportunity. Existing systems have shown they can take out as much as 50% of marginal cost by avoiding duplication, and errors of omission and commission (not doing the right thing or doing the right thing wrongly).

But the systems also enable payers to see they are only paying for healthcare delivered against agreed standards, and not paying for sub-optimal treatment. The transparency enables commissioners and providers to engage in a fact-based debate on delivering high-quality care at a fair price.

We have had similar goals in the NHS. What is different in the US is that standards are the domain of payers, solutions the responsibility of the industry. For all the four institutions we visited, an EPR was as essential as having piped oxygen or electricity. I am convinced the NHS finance function needs to spend serious time understanding how an EPR could provide the platform for improving quality and productivity.

• Tony Whitfield is deputy chief executive and executive director of finance at Salford Royal NHS FT