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HEALTHCARE COST NEGOTIATION: A CASE STUDY OF SURGICAL SITE INFECTION

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Abstract

In the realm of healthcare research, adverse events represent significant financial and reputational risks to patients and hospitals. This article examines the complexities of a negotiation between a hospital and a health insurance company in Brazil, regarding a surgical site infection. The study sheds light on challenges and opportunities for cooperation in the cost management associated with adverse events through an examination of the bargaining process. The study highlights the complexities of stakeholder relationships, communication strategies, and contextual factors that influence negotiation outcomes, affecting the dynamics of healthcare negotiation, and influencing policy and decision-making in the Brazilian healthcare system.

Keywords:

Negotiation; Healthcare; Surgical site infection; Brazil

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1. INTRODUCTION

Adverse Events (AEs) related to healthcare comprise a group of incidents or complications that can result in damage to the patient's health. Today, especially in high-complexity hospitals (tertiary and quaternary), they are a clinical and economic challenge. This event

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may or may not be associated with failures in care processes or errors, which must be monitored by each institution and, in some cases, reported to ANVISA. According to RDC No. 36/2013, to characterize AE, some characteristics must be present: (a) Be associated with patient care; (b) Not be intentional. The main types of AEs are listed as follows: (c) Healthcare-associated infections (HAIs): surgical site infection (SSI), central venous catheter-associated bloodstream infection (BSI-CA), catheter-associated urinary tract infection (UTI-CA), ventilator-associated pneumonia (VAP); (d) In-hospital stays; (e) Pressure injuries or ulcers (LP); (f) Surgical events: surgery on the wrong patient or site, retention of foreign bodies (compresses, instruments); (g) Diagnostic failures (diagnostic error or delay); (h) Events related to medical devices, and finally, (i) Failures in the process of discharge and/or transition of care.

In this work, we will focus on AE: surgical site infection (SSI), as it is the type of AE that causes the most significant impact, as it prolongs the length of hospital stay and health care, uses a greater number of resources, and consequently, there is a significant increase in mortality. To get an idea of the impact, the Centers for Disease Control and Prevention (CDC), the government agency that regulates and monitors AEs in the United States, estimates an annual incidence of 2.5 percent (111,000/year cases) of SSI in different surgical specialties, according to data from the last decade. Between 2021 and 2022, the European Union monitored 662,309 procedures, resulting in 10,193 cases of SSI (1.5 percent).

In Brazil this scenario is even more challenging, because data from ANVISA, which monitors postpartum maternal infection, show an incidence of around 5 percent of SSI in cesarean deliveries, which is very high when compared to the international scenario, where we find two less than 1 percent. From an economic point of view, ISC generates direct or indirect costs between $5,000 and $20,000 for each case, impacting the financial health of both Health Operators and the service providers themselves.

In Brazil, there is no regulatory standard regarding the potential responsibility for additional costs generated, or the so-called Sharing of Costs or Risks arising from the EAS. This negotiation, when it occurs, takes place between the operator and the hospital, based on the registration of medical records, evidence, and possible contractual clauses, which are in force. In this context, we conducted this work, where a negotiation was initiated after the operator notified one of the hospitals where one of the authors works. Since it does not have a contractual clause that contemplates "discounts or allowances" in the account, it maintained the full collection of hospitalization costs. Finally, all names of real identities and companies were omitted for ethical and compliance purposes.

Negotiation is characterized as a communicative process aimed at achieving a mutual decision (Fisher, Ury & Patton, 1981, p. 20), attracting researchers' attention over past years (Dias, 2023; Dias, 2023a; Dias, 2023b; Dias et al., 2023; Navarro & Dias, 2024; Santos & Dias, 2024; Fisher, Ury & Patton, 1981; Kissinger, 1969; Lax & Sebenius, 1986; Raiffa, Richardson & Metcalfe, 2002; Rubin and Brown, 1975; Pruitt, 1981). The research domain has been examined in the following contexts: as a communication process (Acuff, 1993;

Salacuse, 2003, 2006; Shell, 2006), as conflict management (Zartman, 1988), as social interaction (Dias, 2016; Schatzki & Coffey, 1981), as decision-making (Bazerman & Moore, 1994), in relation to business negotiations (Dias, Toledo, Silva, et al., 2022; Dias, Lafraia, Schmitz et al., 2024; Dias, Pereira, Teles & Lafraia, 2023; Dias, Leitão, Batista & Medeiros, 2022; Santos & Dias, 2024; Dias, Pereira, Teles & Lafraia, 2023; Dias, 2023; Dias, Pereira, Vieira, et al., 2023), encompassing government negotiations (Navarro & Dias, 2024), retail business (Valente & Dias, 2023), software contract negotiations (Cunha & Dias, 2021; Dias, Nascimento et al., 2021), and complex military negotiations (Dias, Toledo, Silva, Santos et al., 2022; Dias, Pires et al., 2022; Dias, Almeida, Silva, Russo, et al., 2022). This research examines a Type II negotiation (Dias, 2020), as shown in Figure 1.

Figure 1 The Four-Type Negotiation Matrix
Source: Dias, 2020. Reprinted under permission.

2. RESEARCH METHODS

This research involves a multifaceted healthcare negotiation process between a hospital and an insurance provider in São Paulo, Southeastern Brazil, using a descriptive case study methodology. A case study is particularly suitable for this research as it facilitates the examination of a single occurrence within its natural context (Yin, 2018). The unit of analysis in this instance is the negotiation process, focusing on interactions and agreements among the diverse participants, as delineated by Saunders, Lewis, and Thornhill (2009). The analysis comprised the negotiation process to identify significant issues and concerns that developed throughout the discussion (Braun & Clarke, 2006).

3. BACKGROUND

This case describes the postoperative phase of a Total Hip Arthroplasty, a surgical procedure in which the hip joint is replaced with a prosthetic implant. During this procedure, the patient exhibited clinical symptoms on surgical site infection (SSI) on the fifth day after the surgery. Ultrasound and laboratory tests supported the diagnosis and indicate the severity of the situation. Because of this serious complication, the patient needs another surgery (debridement with drainage) and expensive antibiotics, which will keep them in the hospital for much longer and cost much more than the operator had planned. The hospital's billing

process is the same as usual, with no discounts or changes to the standard rates for medical care, medications, and materials. But the operator later tells the hospital that the infection is an Adverse Event (AE) according to ANVISA resolution, and at first refuses to pay the full bill. The operator wants a full re-examination and a 50 percent discount on the total bill because the costs of the Adverse Event were more than double what was originally planned.

4. NEGOTIATION ANALYSIS AND FOLLOW THROUGH

The Medical Accounts and Audits Department and the Health Insurance Company worked together on the analysis, but each had different priorities. The Medical Accounts department's main goals were to keep all of the hospital's money, avoid making decisions that could hurt relationships with other insurance companies, keep good relationships with both patients and insurers, and stress the hospital's commitment to safety and quality standards. A Zone of Possible Agreement (ZOPA) was set up, suggesting a 10–15 percent discount on the total bill for this particular Adverse Event (AE). However, the patient, who had been a client of the hospital for a long time, should not have to pay any extra private charges because of possible disallowances. It was made clear that future notifications would be handled on a case-by-case basis, using reference literature and best practices from around the world.

From the insurance company's point of view, the main interests were to share the costs of hospitalization to lessen the financial impact and to set a precedent for negotiating cost-sharing in future AEs (Fisher et al., 1981). The insurance company first offered a 50 percent discount, which started the negotiation. However, they said that the AE's ZOPA was 20-30 percent, which is what they thought it would be. This was a big change for the hospital, because in the past, the insurer had sent private bills to patients, which led to complaints and lawsuits with the National Supplementary Health Agency (ANS) and warnings to the insurer. The Quality and Safety department and the Intra-Hospital Infection Control Committee (CCIH) helped the Medical Accounts and Audits department do a thorough review of the patient's medical record. The parties put their best efforts on infection prevention issues and quantifying the costs directly attributable to the AE, considering the hospital's profit margin, employing SSI indicators to better understand the case. The hospital's representatives, including the department coordinator, a CCIH doctor, and a sales department representative, made the case to the insurance company during the meeting. They talked about possible risk factors, literature data, and the good outcome. They also looked at the current contract between the hospital and the insurance company, which did not include any discounts.

The hospital offered a 10% discount in good faith to keep the business relationship going. In response, the insurance company said that other providers and international practices (like those in the United States) usually offer discounts in these situations. They suggested a 30 percent discount. The head of the Medical Accounts and Audits department came up with a creative way to break the deadlock: a tiered negotiation model based on how bad the harm or complication was:

- AE without harm: the hospital pays for tests and evaluations

- Mild AE: 5% off starting the day the AE started - Moderate AE: 10% off
- Severe or catastrophic AE: 20% off

The Medical Accounts and Audits department would use this model on a case-by-case basis, but there would be no formal contract. If the parties can't come to an agreement, the insurer will completely deny the claim, the hospital may lose its accreditation for the procedure, and both sides will face serious consequences. The operator was well received because they got a discount within the ZOPA and, even though it wasn't official, they set up a way to negotiate for future events. The hospital still made a good profit from the negotiation, even with the discount, because the margin for this kind of procedure is usually 30 to 40 percent. The deal was made inside the ZOPA. The operator showed that they were in line with trends in both the national and international markets, and they always kept a good line of communication and negotiation open with this operator.

4. IMPLICATIONS AND DISCUSSION

As the Coordinator of the Medical Accounting and Auditing Sector at the time, the primary objective was to ensure that the most appropriate course of action was taken. Following a thorough technical analysis, it was acknowledged that, despite the absence of an identifiable "failure" in the process, the occurrence of such a complication was unexpected, notwithstanding the literature's reported incidence rate of 0.5 percent for this type of procedure. Moreover, the lack of identification of a "failure" did not necessarily imply its non-existence.

The primary goal was to develop a negotiation model that could be applied in similar cases. The focus was on fostering partnership and balance within the healthcare ecosystem, which encompasses the healthcare provider, hospital, patient, and other key stakeholders. In terms of practical implications, the study's results indicate that healthcare providers and insurers should formulate standardized protocols for managing Adverse Events (AEs), encompassing explicit directives for reporting, cost-sharing, and negotiation. A tiered negotiation model based on AE severity can help both parties reach mutually beneficial agreements. Good communication and cooperation between stakeholders can also reduce disagreements. Adding contractual clauses that explain how to share costs and negotiate for AE-related issues can also help prevent issues from escalating. Healthcare providers and insurers can better manage costs, maintain high-quality care, and foster strong relationships by implementing these strategies. The study enhances the negotiation research field by underscoring the significance of comprehending stakeholder priorities, pinpointing Zones of Possible Agreement (ZOPA), and employing innovative negotiation strategies to achieve mutually advantageous agreements, as articulated by Fisher, Ury, and Patton (1981) in their foundational work on principled negotiation. The study emphasizes the necessity for equilibrium within the healthcare ecosystem, which includes healthcare providers, hospitals, patients, and insurers, to facilitate efficient cost management and quality care, aligning with the principle of social interaction in negotiations (Schatzki & Coffey, 1981). The study elucidates the intricate dynamics of stakeholder interactions in healthcare by analyzing contextual factors that affect

negotiation outcomes, aligning with Lax and Sebenius's (1986) findings on the significance of comprehending the negotiation context. The study's emphasis on communication and collaboration among stakeholders reinforces the notion that negotiation constitutes a communication process (Acuff, 1993; Salacuse, 2003, 2006; Shell, 2006). This study pushes the understanding of negotiation dynamics into new perspectives, such aswithin the healthcare context. The results have implications for research on business negotiations (Dias & Teles, 2019; Dias, 2020a), underscoring the importance of innovative negotiation strategies and an understanding of stakeholder priorities. The tiered negotiation model proposed in this study applies to various contexts, including family business negotiations (Sartori et al., 2020; Dias, Lopes, & Teles, 2020). Additionally, the study's emphasis on communication and collaboration among stakeholders underscores the significance of trust in negotiations (Dias & Aylmer, 2019; Dias & Lopes, 2021). Role-play simulations of business negotiations (Dias, 2020b; Dias, Lopes, Cavalcanti, & Golfetto, 2020) can also benefit from the insights gained in this study, particularly regarding the comprehension of Zones of Possible Agreement (ZOPA) and innovative negotiation strategies. This research contributes to the expanding literature on negotiation theory and practice, with ramifications for multiple domains, including business and healthcare.

5. RESEARCH LIMITATIONS

This research is limited to the qualitative process, i.e. singles case study, and may not be replicable for other types of studies. In addition, the research is limited to the Brazilian healthcare system. Other countries or healthcare systems are not the scope of the present research and should be investigated in separate.

6. CONCLUSION

The study provides valuable understanding of the negotiation process between healthcare providers and insurers in the event of Adverse Events (AEs). The proposed multi-level negotiation framework offers a promising approach to cost-sharing negotiations, with a predilection for collaboration and balance in the healthcare environment. The findings call for effective communication, creative negotiation strategies, and formalized procedures for AE management. By instituting these measures, healthcare payers and providers can promote cost containment, maintain quality care, and preserve amicable relationships. The study's implications extend beyond the healthcare sector, contributing to the overall understanding of negotiation processes and informing research and practice in other contexts in the future.

6. FUTURE RESEARCH

In the future, researchers are encouraged to study the establishment of standardized protocols for Adverse Event (AE) management and cost-sharing negotiations, other types of negotiations, such as Types I, III, and IV, in quantitative studies, longitudinal investigations, for instance, to assess the enduring effects of tiered negotiation models.

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