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Financial Sustainability And Business Model: Case Study For A Network Of Medical Clinics

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Abstract:
This study analyzed the financial performance of a network of medical clinics during the period between 2021 and 2022, focusing on the investigation and comparison of assistance costs and revenues before and after the organization's accreditation with supplementary health operators in 2022 when it adopted the capitation remuneration model as the main source of revenue. The research employed a quantitative approach and followed a descriptive research methodology, using the case study as a technical procedure. To gain an in-depth understanding of the subject, a documentary review was conducted, consulting internal documents and the company's database. To assess financial performance, the loss ratio was used, which in the context of an organization accredited to supplementary health whose source of revenue is the capitation model, is important to evaluate financial sustainability and cost management effectiveness as the health organization receives a fixed amount per member per month, regardless of the medical services members use, linking loss costs with revenues generated by the health operator. The results of this research revealed that the capitation model did not bring benefits to this specific organization due to a lack of adequate monitoring of primary care and assistance costs, resulting in a loss ratio of 127%, considered high when the expected is 75%.

Key Word*: Capitation; Supplementary Health; Loss Ratio.*

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I. Introduction

The Federal Constitution of 1988, in its Article 6, ensures that all Brazilians have the right to health. This is the fundamental idea that guides health policies in Brazil. Therefore, it is the responsibility of the State to manage and regulate the necessary structure to meet the demands and needs that enable this objective. The first paragraph of Article 199 of the Federal Constitution allows private companies to enter the health sector in a complementary way to the public sector. As a result, Brazil currently has a mixed health system: public and private. Public health is represented by the Unified Health System (SUS), a complex national network with public financing and its own assistance and structure. However, it can also make use of contracted or private services for support (CAETANO; PRADO; PIETROBON, 2008).

The private health system has two subsystems: the classical liberal and the supplementary health. The liberal model consists of private services where professionals are autonomous, responsible for acquiring their clients and can establish their remuneration, funding, and administration independently. Supplementary health is financed by health insurance companies, and its management is private but regulated by an institution associated with the Ministry of Health, the National Supplementary Health Agency (ANS) (CAETANO; PRADO; PIETROBON, 2008). The activities carried out by health insurance and health insurance companies provide medical and dental assistance to beneficiaries who choose this type of coverage.

The services provided by supplementary health are offered through individuals or establishments accredited to their plans, usually hospitals, clinics, and laboratories (ANS, 2021). Companies that become accredited to supplementary health as service providers to insurers face the challenge of maintaining effective cost management in relation to the pricing of medical services, service availability, and volume of care to ensure the sustainability of the business without sacrificing efficiency and excellence in service. In this sense, it is essential to highlight the differences between the payment models that insurers use to remunerate their providers and accredited service networks. The most common forms of remuneration by these financiers are payments for services rendered (fee for service), capitation, and service packages.

In the fee-for-service model, medical service providers are compensated based on the specific services they perform for patients. Each service has a predetermined value, typically listed in a schedule of procedures and prices negotiated between the insurer and the providers. When a patient receives a particular medical service, the provider sends an invoice to the insurer, which pays for the service according to the established value in the schedule. This means that providers are rewarded for each procedure performed, encouraging a high quantity of services. However, this system can create an incentive for unnecessary procedures, which may increase costs (ANS, 2019).

In the Capitation model, service providers are compensated per enrolled patient, regardless of the specific medical services provided to each patient. The insurer pays a fixed amount per patient for a specified period, usually monthly or annually (DA SILVA, 2023). This places more responsibility on service providers to manage the health of their patients effectively, as they need to provide all necessary care within the agreed-upon amount. The risk of this model is that providers may be incentivized to cut back on care to increase their profits, which can compromise the quality of healthcare (ESCRIVÃO; KOYAMA, 2007).

On the other hand, in the third model, insurers offer compensation for packages of specific care at a fixed price. These packages may include a combination of consultations, exams, treatments, and other services. In the hospital sector, payment for packages is more common in certain types of procedures, such as outpatient surgeries and short-term hospitalizations (ESCRIVÃO; KOYAMA, 2007).

In Brazil, the most common model of compensation in supplementary health is the Fee For Service. This payment format has a table containing values for items and procedures, and the determining factor for the amount to be paid is the quantity of service or procedure performed. Although it is the subject of various criticisms and distortions, FFS is used as a payment method in outpatient care in several EU countries, often in combination with Capitation and other performance-based models (ANS, 2019).

Capitation-based compensation has been used in countries such as Spain, Portugal, and Switzerland. Its advantage lies in revenue predictability, while its difficulty is in managing costs effectively to ensure profit and necessary care for all beneficiaries. This involves managing service utilization effectively, eliminating excessive tests and procedures, encouraging preventive measures, and promoting health, thus ensuring consistent medical attention. Such control is necessary since compensation is based on fixed prices according to the number of people included in the contract for a specified period, regardless of the type and quantity of services and exams provided (ANS, 2019).

Each of these models has its advantages and disadvantages, and health insurance providers may choose to use a combination of them to control costs and encourage the quality of care. The choice of compensation model will depend on the insurer's strategy, market characteristics, and goals for quality and efficiency. Based on this information, this study aimed to investigate the financial sustainability of an organization accredited to supplementary health in São Paulo with a focus on primary care. The focus was on the challenge of maintaining profits for those who become accredited to supplementary health. Financial sustainability of a company refers to its ability to maintain a healthy and stable financial performance in the long term, ensuring its survival, growth, and ability to meet its financial obligations over time (SOUZA, 2020). It involves responsible and effective management of the company's financial resources to ensure its continuity and prosperity in the future.

Given that the financial sustainability of a company is a critical concept for its longevity and long-term success, it refers to the company's ability to maintain financial health and continue operating effectively while ensuring its growth and contribution to society. The present study aimed to analyze the financial performance of the mentioned organization from 2021 to 2022. More specifically, it investigated and compared the costs and healthcare revenues before and after the accreditation of this company in supplementary health, which adopted the capitation model as the main source of revenue in 2022. With the obtained results, the goal is to provide an overview of resource management and identify whether the capitation compensation system has brought positive results for this network of clinics.

II. Material And Methods

This study was conducted through the application of applied research, aimed at solving identified problems for the practical application of solutions (GIL, 2022). A quantitative approach was employed, presenting results in numerical form, generating information that can be quantified for analysis (GIL, 2022). A descriptive research approach was used to understand the issues in the study area. Descriptive research, according to Gil (2022), describes characteristics of a specific event. As a technical procedure, a case study was adopted, intending to describe the situation in the context of the ongoing investigation.

The presented study took place in a network of medical clinics focused on primary care compensated by capitation, located in São Paulo from 2021 to 2022. These clinics had primary and secondary care services in high-traffic areas, with an average of 2,000 visits per month and patients ranging from 0 to 90 years old. The company started as a startup in 2017 with the goal of introducing innovative health solutions. By 2021 and

2022, it had approximately 9 medical clinics in São Paulo, providing primary and secondary care services in high-traffic areas, with around 5,000 visits per month and patients aged 0 to 90 years.

As observed, the capitation payment model is based on the number of patients, not on individual services provided. Therefore, it is desirable for the provider to implement rigorous monitoring and evaluation mechanisms regarding the quality of services and financial balance. This is because service providers face financial risks due to the fixed nature of payments per patient. If the actual healthcare costs exceed the capitation payments received, providers may face financial difficulties. Additionally, variability in patients' healthcare needs can lead to imbalances between required resources and payments received. Another challenge is determining the right amount to receive per patient, as defining an appropriate capitation value involves considering factors such as the health of the served population, average medical costs, care needs, and other demographic factors.

To obtain a clear and accurate picture of the study object, a documentary review was conducted through consultations of internal documents and company reports from which financial data were extracted for the study. The collected information corresponds to the period from 2021 to 2022 and was obtained from the company's database, extracted from the Tasy Philips ERP - Health Management System. By accessing internal documents and reports, the quantity of consultations and internally performed exams was obtained, disaggregated by age group and health insurance provider, using the Microsoft Office Excel 365 program.

Additionally, an internal survey in the company's files was conducted to obtain revenue values, separated by source: private and health insurance. Costs related to medical payment transfers, laboratory costs, supplies, and performed exams were also collected directly from the invoices sent by service providers for payment. After obtaining this information, it was analyzed and separated by health insurance provider through tabulation in the Microsoft Office Excel 365 program. Finally, the quantity and value paid for each beneficiary were also collected, according to numbers provided by the health insurance provider through indicators of the Microsoft Power BI system, separated by age group and average monthly utilization. To better illustrate the results in the graphs, abbreviations such as "K" for thousands and "M" for millions were used. Following the proposed objective, the recommendations of Pires (2008) were followed. According to the author, within supplementary health, the connection between expenses and revenue can be measured by the loss ratio. A loss ratio is a metric used to assess the relationship between claims costs and revenues generated by an organization, usually in an insurance or supplementary health context (TEIXERA et. al., 2023). This index is widely applied in the insurance and health industry to measure the effectiveness of cost management and to help determine whether an organization is spending more on claims than it receives in revenue. The Loss Ratio is calculated according to expression 1:

$$\text{Loss ratio} = \frac{Total\ Claims\ or\ Losses}{Total\ Premiums\ or\ Revenues} \text{x}100 \qquad (1)$$

The "assistance costs," also known as "loss costs," include all medical expenses related to patient care. The "assistance revenue" or "capitation revenue" is the amount the organization receives for each enrolled member. The purpose of the loss ratio is to indicate whether the utilization of health resources covers administrative expenses and generates a profit margin that makes the business viable. Its calculation is based on comparing the actual costs of losses (medical expenses incurred to treat patients) with the revenues obtained through capitation payments (LIMA; SOUZA, 2019).

If the loss ratio is less than 100%, it means that the organization spent less on losses than it received in capitation revenue, which may indicate efficiency in cost management. On the other hand, if the loss ratio is equal to or greater than 100%, it indicates that the organization spent more on losses than it received in capitation revenue, suggesting that its costs exceed its fixed revenue. An acceptable loss ratio is up to 75%, meaning that costs represent up to 75% of revenue.

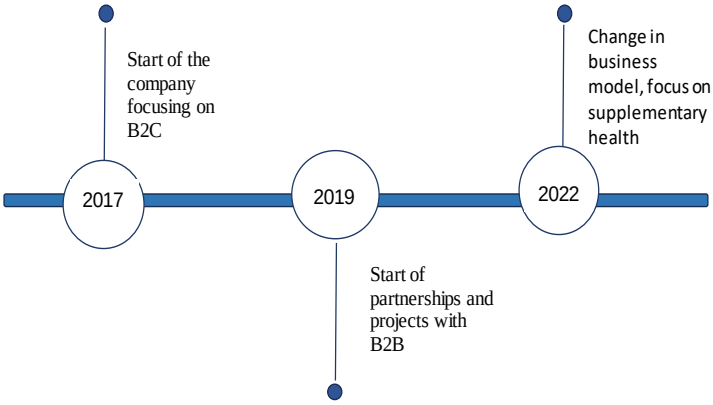
In the context of an organization accredited to supplementary health whose source of revenue is the capitation model, the application of the loss ratio is important to assess financial sustainability and the effectiveness of cost management. The healthcare organization receives a fixed amount per member (usually per month) from a supplementary health entity, regardless of the medical services members use (PAIVA et al., 2021). This means that the organization takes on the responsibility of providing effective healthcare within this fixed budget.

Thus, if the loss ratio is high, it may signal the need to control costs, improve operational efficiency, and ensure that medical care is provided effectively and economically (LEITE et al., 2022). Based on the results obtained from the loss ratio, the organization can take measures to adjust its services, review contracts with healthcare providers, implement care management programs, and adopt strategies to improve cost-effectiveness (PACHECO, 2023).

III. Result

Since the beginning of its operations in 2017, the company aimed to minimize the gap between the public and private healthcare systems in Brazil. It proposed an option for those who do not wish to wait for specialized medical care in the public healthcare system (SUS), which can take months, without incurring the high costs associated with general health insurance plans. With the premise of being an affordable healthcare network providing quality services, it offered in-person consultations at its own clinics in the city of São Paulo, with a significant presence in busy shopping centers. Additionally, it reached customers throughout Brazil via telemedicine, highlighting a Business-to-Consumer (B2C) business model. Below, Figure 1 illustrates the timeline milestones of changes in the business plan.

Figure 1: Timeline of changes in the company's business plan.



Source: Original data from the research.

Having B2C as the focus of the business model until then, the need for rapid changes in the company's strategy became evident as a precaution amid market uncertainties, the departure of some investors, and a decrease in investments.

It was identified that the initial model would not be sustainable due to the inconsistency of appointments, irregular cash flow entries, and the high cost of healthcare expenses and customer acquisition. As a result of this situation, in mid-2020, the company sought a way to streamline its operations and found the B2B business model to expand its services. In the Business-to-Business (B2B) model, the company establishes commercial relationships with other businesses, instead of directly serving end consumers (SOARES-SILVA et al., 2022). This can involve partnerships where health benefits, customized packages, discounts, or specific services for employees are provided. Thus, the company began to establish the B2B2C mixed business model, operating with both modes simultaneously (FIGUEIREDO-FILHO, 2021).

During this period, the company sought partnerships, but mostly they were short-term, aimed at operating only during the pandemic period, with short contracts or focused only on Covid testing or telemedicine services, which would only sustain demand as long as the pandemic lasted. It was also during the pandemic, throughout 2021, that the company began to provide primary health care to its own employees, supporting them through a program with family doctors. The success of this type of care, the structure set up with doctors, systems focused on primary health, and the effort to strengthen relations with supplementary health led the company to seek health insurance companies aligned with primary care.

This goal was achieved in late 2021 with the formalization of a contract with a health insurance company, establishing a business model where the clinic network was responsible for serving all beneficiaries of a specific plan, with a focus on primary and secondary care as needed by primary care physicians, and remunerated by capitation. In early 2022, the appointments began.

The term "primary health" refers to basic health care or primary health care. It is the first level of care within the health system and is essential for promoting population health, preventing diseases, offering initial treatment, and directing patients to more specialized levels of care when necessary (COSTA et al., 2022). Primary health is the foundation of the Unified Health System (SUS), and in the country, it is offered free of charge to the entire population (PAIM, 2020; GADELHA, 2022). In Brazil, primary health care is provided by family health teams, composed of doctors, nurses, and nursing technicians.

This strategy of investing in preventive health services and fundamental care can result in various advantages. Some of the possible advantages include:

• Long-term cost reduction;
• Health promotion and disease prevention;

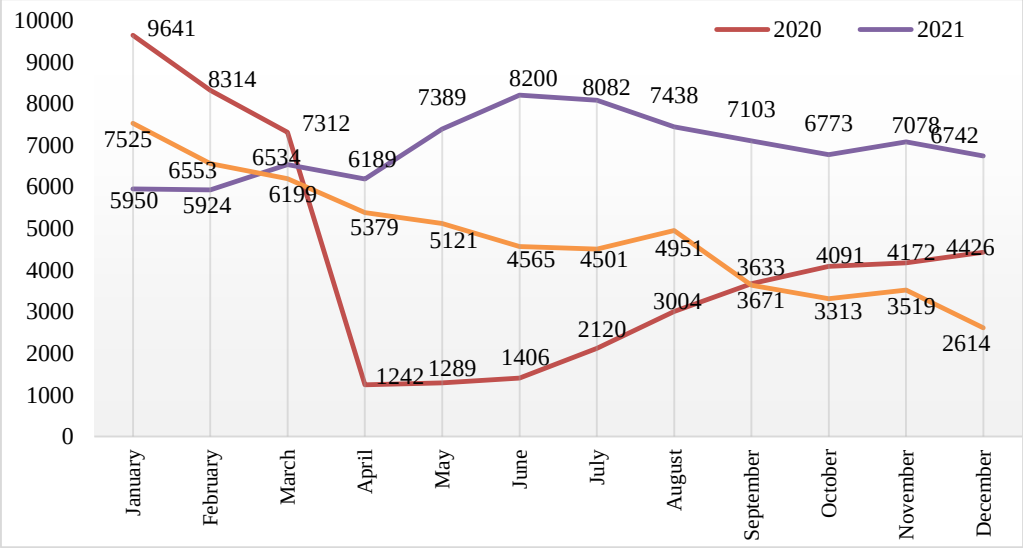
• Appropriate referral of patients to specialized services when necessary, alleviating pressure on hospitals and secondary care services.

The advantage of the capitation remuneration model is the existence of a fixed cash flow, based on the number of beneficiaries enrolled in the plan served and not on the volume of services provided. Health insurance companies are adopting the capitation model due to shared risk, leading to a focus on primary care, improving service levels, and reducing loss ratios in emergency care, where insurers incur higher costs. This results in a health management approach centered around family doctors, reducing unnecessary tests and expensive specialist doctor visits (ANS, 2019). The model requires robust indicators and continuous monitoring for better patient health tracking and minimization of healthcare costs.

With the inclusion of supplementary health services, the company sought accreditation with other health insurance providers for secondary care, such as services provided by specialist doctors like rheumatologists, orthopedists, gynecologists, and others, but with remuneration based on a fee-for-service model.

These changes led the company to make a shift in its business model, focusing predominantly on the supplementary health sector. However, it continued to serve businesses and end customers only when requested, without further investments in customer acquisition initiatives. The underlying purpose of this change was to achieve a balance between revenues and expenses, with a focus on the supplementary health sector, basing its sustainability on the Capitation model. Figure 2 below presents the total monthly service numbers from 2020 to 2022:

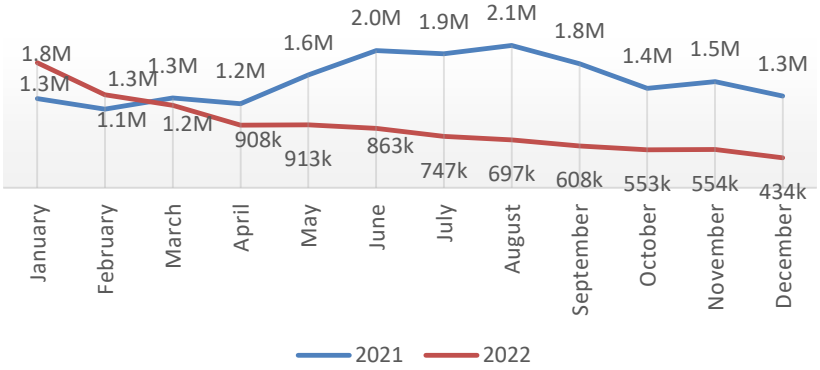
Figure 2: Total monthly appointments between 2020 and 2022.



Source: Original research data.

As seen in Figure 2, there is a variation in the number of appointments between the years 2020 and 2022, totaling 50,688 in 2020, 83,402 appointments in 2021, and 57,873 in 2022. When observing the monthly numbers, there is fluctuation in appointments over the years. The numbers vary significantly from month to month, with fluctuations that may indicate inconsistency in demands for health services. We note that appointments are lower in the month of (December), and there are other months where appointments are higher; this may be related to seasonal trends, holidays, or changes in the health conditions of the population. The data for 2020 shows the total appointments below the other years, which is due to the period of the COVID-19 pandemic, where there was quarantine, lockdown, and medical visits were marked only in emergency cases. The data for 2021 shows a significant increase in appointments throughout the months, a period when the population resumed seeking health services shortly after the period of major restrictions, and it was the beginning of B2B appointments. The initial months of 2022 (January to March) show relatively higher numbers, indicating a possible recovery or resumption of appointments after the company's accreditation to supplementary health. Figure 3 demonstrates the total monthly revenue for the years 2021 to 2022.

Figure 3: Total revenue through B2C, B2B, and supplementary for the years 2021 and 2022.

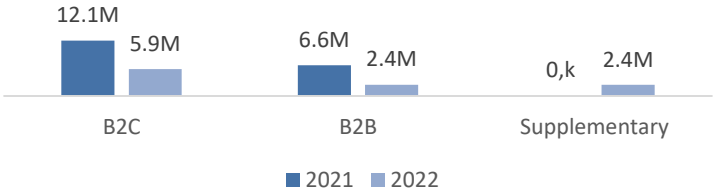


Source: Original research data.

According to Figure 3, revenue showed an upward trajectory in 2021, followed by a decline in 2022. The increase in revenues in 2021 can be attributed to the resumption of demand for outpatient services and the partnerships established in the B2B model for corporate services and the large-scale execution of Covid-19 tests. However, in 2022, there was a gradual decline in revenues. In this year, the company chose to reformulate its business model, focusing exclusively on the supplementary health sector, although it still served the B2B and B2C segments only on demand. It is worth noting that the company decided not to continue marketing efforts for the acquisition of new clients, and throughout 2022, some clinics were closed.

Figure 4, presented below, details the total amount of revenues, categorized according to the different sources of income.

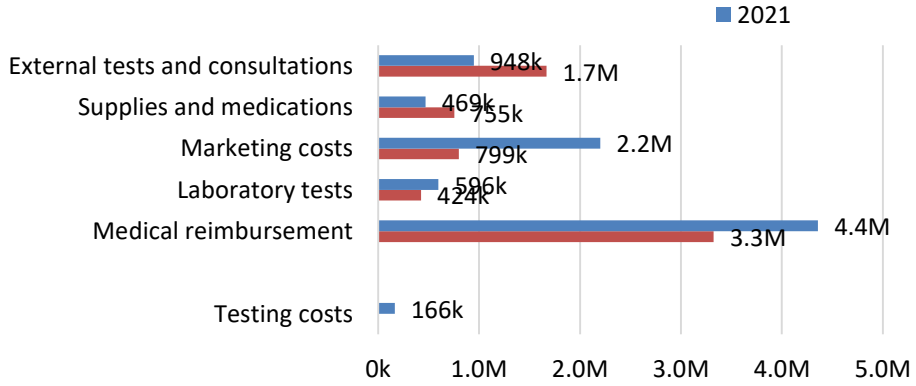
Figure 4: Total revenue through B2C, B2B, and supplementary for the years 2021 and 2022.



Source: Original research data.

Figure 4 illustrates that the majority of revenue was generated by the B2C segment in both 2021 and 2022. In 2021, there was a significant increase in B2B segment revenues due to substantial partnerships for providing services and COVID-19 testing to companies. However, these partnerships and projects were of a one-time nature, resulting in a reduction in revenues in the subsequent year. In contrast, in 2022, the figure highlights the entry of revenues from supplementary health. Figure 5 provides a representation of the assistance costs compared between the years 2021 and 2022:

Figure 5: Medical operation assistance values for the years 2021 and 2022.



Source: Original research data.

The data presented in Figure 5 provides a clear representation of the total healthcare costs in the years 2021 and 2022. It can be observed that in 2021, the total costs were evidently higher than in 2022, mainly due to marketing expenses necessary for patient acquisition, while in 2022, the highest costs were concentrated in medical fees, exams, and external consultations. The increase in costs for exams and external consultations in 2022 is directly related to the entry into the supplementary health sector, particularly the primary care contract. In this context, the company is responsible for providing care in all specialties of consultations and exams agreed upon in the contract. If a specialty is not available internally in the clinic, partnerships need to be established to refer patients, leading to an increase in costs. In 2021, costs related to exams and external consultations were also identified, resulting from partnerships established with other clinics and hospitals for surgeries and exams not covered by the clinic. No testing costs were found in 2022. Table 1 below brings the analysis of the 2022 appointments:

Table 1: Appointments conducted in 2022 separated by health plan.

Months	Appointments			
	B2C	B2B	Capitation	Fee for service
January	5740	751	671	353
February	5002	337	736	612
March	4337	106	877	840
April	3225	78	1100	960
May	2857	62	1080	1065
June	2477	73	1014	1000
July	2311	55	1107	931
August	2440	40	1601	825
September	1659	38	1302	672
October	1420	39	1123	597
November	1513	34	1398	575
December	1012	36	1302	490

Source: Original research data.

Table 1 shows that, among the 57,873 appointments that occurred in 2022, 59% corresponded to patients in the B2C model, 3% to B2B patients, 23% to Capitation model patients, and 15% to Fee for Service model patients. Upon analyzing these samples, it was noticed that the highest volumes of appointments for B2C and B2B patients occurred in the months from January to March. In the case of the Fee for Service model, there was an increase in the number of appointments starting from February, followed by a decline from September. On the other hand, the Capitation model showed an increase in the number of appointments starting from March.

Based on the presented data, Table 2 below details the total value of revenues and expenses related to the Capitation model in the year 2022:

Table 2: Capitation Revenues and Expenses 2022.

Months	Capitation Revenue	Capitation Costs
January	R$ 50.841,50	R$ 156.133,14
February	R$ 75.101,04	R$ 212.716,34
March	R$ 98.544,11	R$ 155.341,27
April	R$ 122.287,95	R$ 158.705,70
May	R$ 150.400,90	R$ 198.393,27
June	R$ 161.942,70	R$ 189.060,03
July	R$ 176.939,33	R$ 195.380,76
August	R$ 187.286,97	R$ 259.542,89
September	R$ 198.088,73	R$ 244.646,66
October	R$ 206.303,25	R$ 255.834,38
November	R$ 243.934,51	R$ 245.986,18
December	R$ 258.952,88	R$ 174.202,73

Source: Original research data.

Table 2 provides a comparison of values for revenues and healthcare costs related to the capitation contract. It is observed that healthcare costs are higher from January to November, with a significant increase in the first three months of the year. This phenomenon is attributed to the fact that the health insurer began marketing the plan with a focus on primary care at the end of 2021, resulting in some sporadic visits during that period. However, in 2022, the plan's utilization became more substantial.

Given that the remuneration in this contract is based on the number of patients included in the plan, rather than the quantity of services provided, costs increase as more visits and tests become necessary. Additionally, costs also rise when specialties and tests not offered by the clinic need to be referred to external partners, as illustrated in the data related to external exams and consultations in Figure 5. Below, in Table 3, the totals of patients included in the plan and visits conducted throughout the year 2022 are presented:

Tabela 3: Total patients monthly included in the contract and total appointments carried out during 2022.

Months	Patients included in the plan	Appointments
January	682	671
February	987	736
March	1290	877
April	1600	1100
May	1952	1014
June	2107	1107
July	2322	1601
August	2465	1302
September	2612	1123
October	2724	1398
November	2879	1302
December	3036	1014

Source: Original research data.

Table 3 shows the total number of patients enrolled in the plan and the total number of appointments made, illustrating the monthly amount transferred to the clinic as indicated in Table 2. As observed, as more patients join the plan, the amount transferred to the clinic increases, and it is noted that the increase in the number of appointments in relation to the number of patients included in the plan results in higher healthcare expenses. For an accurate assessment of healthcare costs coverage by the amount transferred by the operator, considering the attainment of a profit margin, we performed the calculation of the loss ratio:

$$\text{Loss ratio} = \frac{\text{R\$2.445,943}}{\text{R\$1.930,624}} \text{x} 100 \qquad (2)$$

The obtained result was 127%, indicating that the organization spent more on claims than it received in capitation revenues. This scenario suggests that its costs exceed its fixed revenue. It is worth noting that an acceptable loss ratio typically ranges up to 75%. This result is specific to the analysis conducted on this network, as mentioned earlier. It is important to emphasize that the Capitation model, while widely accepted and used in European countries, has a relatively recent adoption in Brazil, where no previous studies have been identified so far addressing health clinics with a similar contract and remuneration format.

IV. Conclusion

Based on the presented study, it can be concluded that the gross profit in 2021, obtained from the difference between revenues and healthcare expenses, surpassed the results obtained in 2022. However, the model in question is not sustainable as it depends on a constant frequency of appointments to ensure revenue generation, an aspect that proved to be highly seasonal, along with the high cost per patient acquisition. It is also concluded that the introduction of supplementary health through the "Capitation" model did not yield positive results, especially considering the performance of the loss ratio, which exceeded the recommended margin value to ensure the profitability of the business model. A lack of managerial control to adequately monitor the new business model was identified. The absence of monitoring and analysis of referrals for external exams and consultations resulted in unnecessary costs, even when many specialties could have been handled internally at the clinic's facilities. Additionally, a lack of monitoring in relation to primary care was observed, leading to consultations by specialists when issues could have been resolved within the scope of primary care.

The loss ratio was an essential tool to evaluate the financial sustainability of the organization, helping to identify whether the organization is effectively managing its costs and providing quality healthcare within the available resources. This index has proven to be a commonly used tool in health insurance and is usually adopted to measure the proportion of medical expenses claimed in relation to premium revenues.

It was observed that the healthcare organization needs to closely monitor its healthcare costs, including the model of payment for medical, administrative, and infrastructure fees, to ensure that these costs do not exceed the revenues received per enrolled patient. Additionally, it was noticed that the capitation model encourages the pursuit of efficiency and continuous process improvement to provide care within the fixed budget.

Therefore, it is recommended that the organization maintains a close partnership with the primary healthcare team, conducting periodic follow-ups, continuous analysis of operational data, and maintaining strict control over healthcare expenses. Furthermore, it is advisable for the organization to negotiate advantageous agreements with healthcare service providers to optimize the use of available resources. It is also crucial to maintain a diversification in the service mix, establishing differentiated contracts in the supplementary health area, which will ensure continuous revenue sources, in addition to maintaining the continuity of service in the B2C and B2B segments.

Despite the managerial contributions of this research to the studied organization, the results are limited to a case study, although this is a valuable research approach as it allows for an in-depth analysis of a phenomenon within its real context. Due to the unique and specific nature of each case, the results may not be applicable to other situations or contexts. Unlike controlled experiments, where independent variables can be manipulated and controlled, case studies generally do not offer the same experimental control capability, which limits an explanatory analysis of cause-and-effect relationships to descriptive analyses.

Given the limitation of analyzed data, access to all costs, and the singularity of each case study, for future studies, it is suggested to investigate different cases. To achieve statistical representativeness and generalization capability, new studies should increase the number of studied objects and establish a control group to obtain meaningful comparisons. Despite these limitations, the studies have proven valuable to the literature, especially for exploring the complex phenomenon in-depth related to the financial sustainability of an organization accredited to supplementary health.

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