ADMINISTRATIVE MEDICINE
Part I Examination

16 December 2002
Paper IB

Key Points for Question 7

1. Assessment of needs
   - Epidemiology of cardiovascular diseases
   - Risk factors for cardiovascular diseases
   - Defining and measuring the outcomes

2. Cost-effectiveness of interventions
   - Assessment of evidence
   - Efficacy, effectiveness and cost-effectiveness
   - Evidence of primary and secondary prevention
   - Evidence of primary and secondary care treatments

3. Cost-benefits of programs
   - Marginal analysis of costs and benefits
   - Program budgeting and planning
   - Prioritization of interventional programs
   - Maximizing health gain

Key Points for Question 8

Advantages and disadvantages of the following mechanisms for funding health services:-

(a) General taxation

- Refers to general taxation revenues, incorporating both direct and indirect tax receipts, collected by government.

- It is widely regarded as being highly efficient from a macroeconomic perspective, delivering strong cost containment and forcing prioritisation through what are typically overall cash-limited health care budgets set by the government. Under tax financing, the government has both a strong incentive and the capacity to control costs.

- An efficient way of funding health care from a microeconomic perspective, it typically involves low administrative costs. Because it

draws revenue from a wide base, it helps to minimize distortions in particular sectors of the economy.

- A reliance on general tax financing can leave a health system vulnerable in times of economic and fiscal difficulties. For example, a sharp slowdown in the economy can result in lower tax revenues and pressure to reduce public spending, including on health care. However, this is not a feature which is specific to tax financing, and tax financing can help individuals in difficult times when they are less able to afford out-of-pocket payments or private insurance. Adverse economic developments are likely to put pressure on resources available for health care spending (and indeed other goods and services) whether health care is financed by general taxation or social insurance, or indeed through private insurance or out-of-pocket payments.

- It ensures universal access to services irrespective of ability to pay, with minimum separation between an individual's financial contributions and their utilization of health care services. This is the key requirement of an equitable financing system – access based on clinical need and not ability to pay. The financial contributions made are related to ability to pay as defined by the country's tax system.

- The degree of individual choice available to patients tends to be relatively limited under tax financing.

(b) Social insurance

- In social insurance systems, employer and/or employee earnings-related contributions are usually paid to and managed by social insurance or 'sickness' funds.

- A criticism of traditional social insurance systems is that these sickness funds face little incentive to seek to contain the payments they make to health care providers because of their ability to raise contribution rates. As a result, many argue that cost control under traditional social insurance models has been weak and resulted in inefficient use of resource. The existence in some countries of multiple sickness funds and the greater fragmentation in health care purchasing involved in these systems can also result in relatively high administration and transaction costs.

- Sharply rising costs and emerging deficits in social insurance funds in recent years have led several countries to introduce reforms to their social insurance systems. These have involved moving towards financing arrangements where they can exert greater control on the overall level of health spending. For example, in 1997 Germany attempted to limit increases in social insurance premiums by imposing greater competitive pressures on the sickness funds and extra co-payments on the members of sickness funds which decided to increase premiums. And in France, there has been a shift in the balance of

funding from social insurance towards taxation, with the French parliament being given the power to set a global budget for health care.

- Social insurance contributions are raised from a narrower base than general taxation, with the costs falling mainly on employers and employees rather than the wider group of taxpayers.

- Social insurance contributions may lead to economic distortions and disincentives because the revenue base is more concentrated, i.e. on employment.

- Like tax-financed systems, social insurance systems can be vulnerable to periods of economic downturn which can result in reduced revenues into the sickness funds.

- As with tax-financed systems, access to health services is typically universal or near universal and not based on ability to pay.

- There is little scope for expression of individual choice under social insurance models. Some countries allow higher income earners to opt out of social insurance schemes (itself raising equity issues) and some allow scope to choose between individual sickness funds, but there is little choice between contribution rates and benefits available within schemes. Together with an increasing tendency for governments to cap expenditure levels of social insurance funds, there appears to be little difference in terms of individual choice between tax and social insurance financing.

(c) Private insurance

- Refers to private medical insurance taken out by individuals or, for example, by employers on their behalf.

- The nature and coverage of private insurance differ significantly across countries. In some countries (for example the US) private insurance is relied on by a majority of the population as their sole means of cover. In other countries, private insurance is largely taken out by higher income groups, either in place of social insurance (for example, Germany) or in addition to cover provided by the government (for example, the UK). Finally, in some countries (for example, France) private insurance is taken out widely by the population for the specific purpose of covering their liabilities for user charges within the health system.

- Systems which rely on private medical insurance tend to exhibit poor cost control, with spending largely demand led, an absence of global budgets and the fragmented commissioning of health care services.

- Management and administration costs are also high under private insurance, including the costs which are required in assessing risk, setting premiums and assessing claims.

- With private insurance, the level of access to health services is determined by the level of insurance cover which an individual can afford to purchase, and contributions are based not on ability to pay but on an individual's health risk rating as assessed by the insurer. It will usually be the poorer, older and less healthy in society who are considered by private insurers to have the greatest health risk and therefore face the highest insurance premiums. Access depends on ability to pay and the lowest income earners tend to pay more.

- This can result in a situation, as in the US, whereby a significant proportion of the population has no access to health services other than the last resort of the emergency room, either because they cannot afford the insurance premiums or because private insurers refuse to insure them because they are deemed to risky.

- For those who can afford to take out private medical insurance, choice is likely to be greater than under public financing, with choice of both the insurer and the type of care package and range of benefits which it offers.

(d) User charges

- Refers to fees and charges paid by patients for the use of particular health services, in either the public or private sector.

- Patients may be required to pay for all or part of the cost of a particular publicly-provided service through user charges. In addition, individuals are increasingly choosing to pay privately for specific interventions as and when they need them. An efficiency argument in favour of such charges is that they can help to encourage the responsible use of resources by limiting wasteful and unnecessary activity and contain the total amount of health expenditure which the government has to finance publicly.

- However, user charges may discourage people from seeking treatment including preventive care, or direct them to other areas of a health system where charges are not levied. In such circumstances, activity may be diverted to more costly parts of the system or delayed to a point at which treatment is more expensive.

- User charges relate access much more directly to ability to pay than either general taxation or social insurance.

- Where user charges are levied on what are clearly regarded as clinically necessary services, they are regarded as inequitable unless accompanied by adequate exemptions to ensure that those with a

clinical need are not discouraged or prevented from receiving treatment. In addition, in cases where user charges payments are designed to increase efficiency by discouraging wasteful use of resources, e.g. unnecessary visits to a GP, such charges are most likely to achieve the aim by discouraging use among the less well off in society – the charge is much less likely to change the behaviour of those who can easily afford the payment. User charges may therefore increase inequalities in access to health care.

Key Points for Question 9

1. Principles of priority setting
   - Ethical principles
   - Societal values
   - Economic principles
   - Evidence-based decision making
   - Implicit or explicit approaches
   - Policy versus bed-side decision making

2. Criteria for priority setting
   - Epidemiological basis
   - Measuring outcomes or deliverables
   - Efficacy and effectiveness
   - Cost-effectiveness of programs or interventions
   - Balancing risks and benefits
   - Maximizing utility
   - Assessment of political impacts

Key Points for Question 10

Health care as an industry shows the following characteristics:

a. It involves a series of complex steps that may span over a variable length of time
b. It usually involves personnel from different disciplines working as a coordinated team
c. It is both human resource and technology dependent
d. It always carries some uncertainty regarding the outcome of the care process
e. There is a significant knowledge imbalance between the patient and the care provider
f. Inter-personal interaction plays a very important part in the care process
g. Patients consider the quality of health care a vital issue as poor quality care can lead to devastating results
h. It is always expensive irrespective of who pays for the care

Culture of quality is of utmost importance to the success and sustainability of a health care organization.

The first step to engender a culture of quality is to secure the strong support from the governing body. *Quality should be a prominent theme in the vision and mission statement of the organization.* A *quality policy* should be promulgated with the endorsement of the governing board. *Quality indicators should also be constituents of the annual plan goals, and their results regularly presented and discussed in governing board meetings.*

The senior management team must also express explicit commitment to the pursuit of quality as a central business strategy. Senior managers and executives must agree on the meaning and components of quality health care for the corporation

It is important that *all staff members understand and share the same quality mission*. The importance and meaning of quality health care should be clearly spelt out to all staff members. A series of *communication processes* via different channels and forums should be conducted. *Training sessions* for the use of *quality improvement tools* should be arranged and provided to staff. Since there are a myriad of quality approaches and tools, it is desirable if *the whole organization adopts the same set of quality language and methodologies.*

For quality to become an ingrained element of the working culture of the organization, it should be *emphasized continuously*. The ideas of *benchmarking with best practice* and *continuous quality improvement (CQI)* should become innate concepts of all staff members. *Staff should be recognized for high quality care, and success quality improvement stories should be shared within the organization.*

The concept of quality should not be limited to those processes involving direct patient care. As mentioned above health care is a complex process involving many steps and different disciplines. *The same quality requirement should also apply to all processes involving internal customers, showing to staff that internal customers carry the same weight as external customers.* The result is *total quality* for the organization.

Quality is not just making good things better. In some instances it merges into the domains of *risk management*. For example poor documentation of clinical information and procedures can result in clinical risks to patients as well as medico-legal risks to the organization. Also undesirable health care quality is a common source of patient complaints. Thus *good management of public complaints should be part of the organizational quality drive*. All these should be communicated within the organization.

The emphasis of the organization on quality should also be made known to the public. *The public should be encouraged to feedback on high quality care as well as shortfalls*. Regular *satisfaction surveys* and *focused group meetings* with members of the public should be conducted to collect valuable ideas for further quality improvement. *Suggestion boxes* should be provided at convenient sites for use by staff members and the public.

For the culture of quality to take root and blossom, it requires *shared understanding and commitment of all members of the organization.* Quality should never be viewed as a management fad. Many professional staff members may take this skeptical attitude. They should be shown that quality care could lead to better health outcome for their patients, a goal in line with their professional aspirations. *Quality should also not be equated with injection of more resources or acquisition of state of the art technologies.* Indeed an essential element of quality is to eliminate wrong doings *(quality wastes)* that can be costly to the organization, and to many patients *high touch care* is more important to them than *high tech care*.

When the concept of *doing the right things right for the first time* becomes a well-accepted dogma among all staff members, one can say that a culture of quality is engendered in the organization. But this will always take some time to achieve, and my personal experience showed the whole transformation might require a couple of years. Thus we should not aim at just short term results, although we need short term successes to booster the momentum of change.