Home assignment

- Describe a situation in health care that demonstrate the discrepancy between WANTS and INSUFICIENT RESOURCES
- Describe if / how a doctor (medical professionals) could decrease the contradiction between wants of a patient and the limited economical resources to satisfy its.

Opportunity cost

Within a fixed budget constraint, if the healthcare system spends more on one thing, it has to do less of something else

Source: Peter Littlejohns, The Challenge of Health Care in Europe: "value for money"

Test – Physicians and Sociaty – Ethics manual, chapter 3

Process of change in healthcare

J. Barzdins

Exaples of the fundamental changes in HC:

1. decreased role of classic hospital based medicine
2. increased role of primary care
3. increased pressure on health professionals while taking care for patients to think also about efficient use of limited resources

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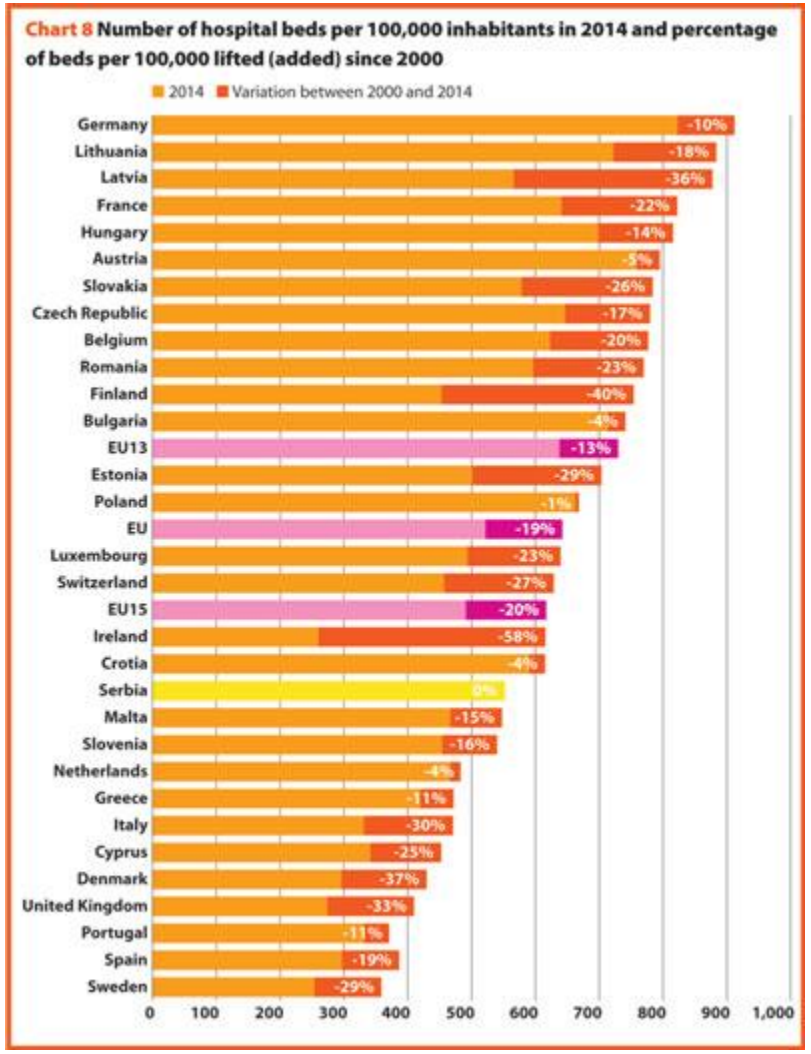
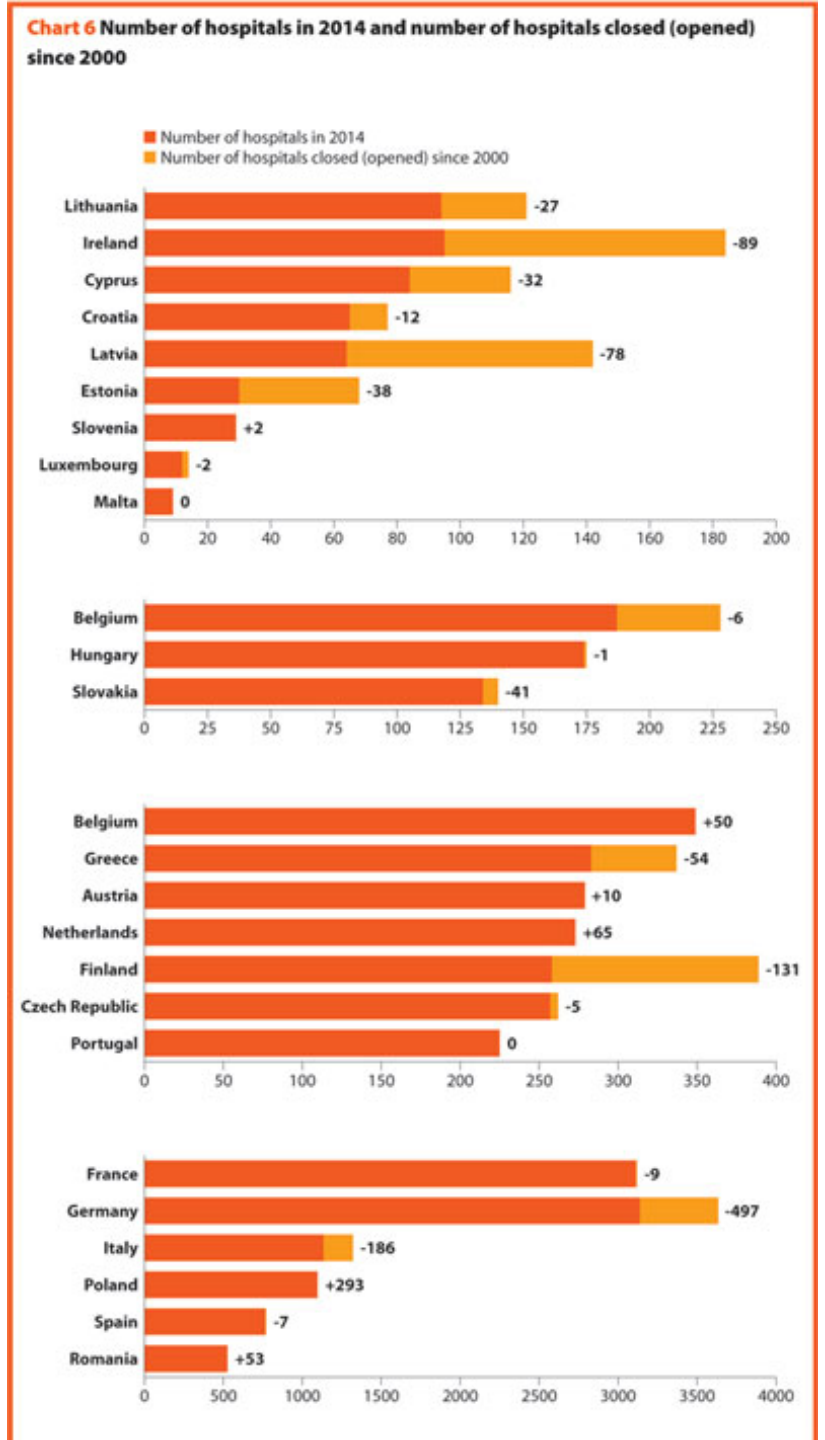
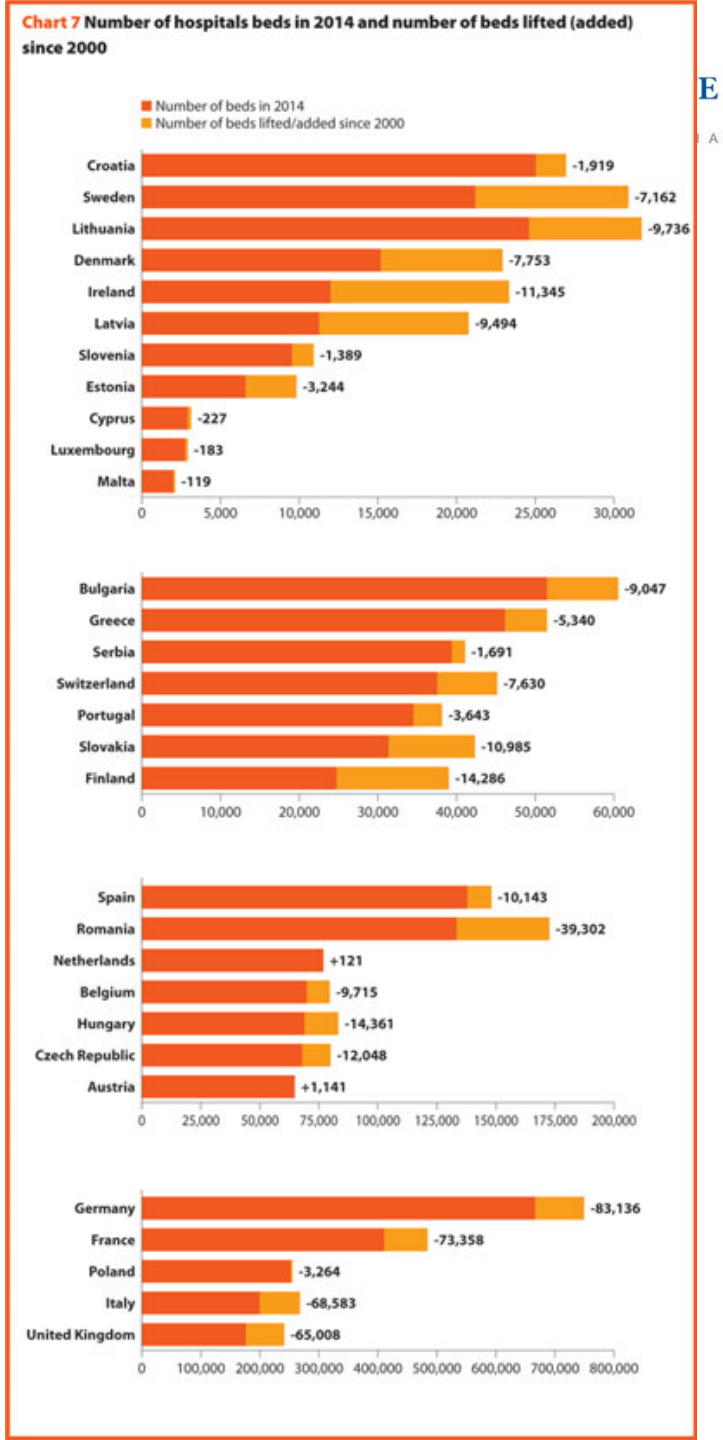
Decrease of hospitals' volumes in Europe







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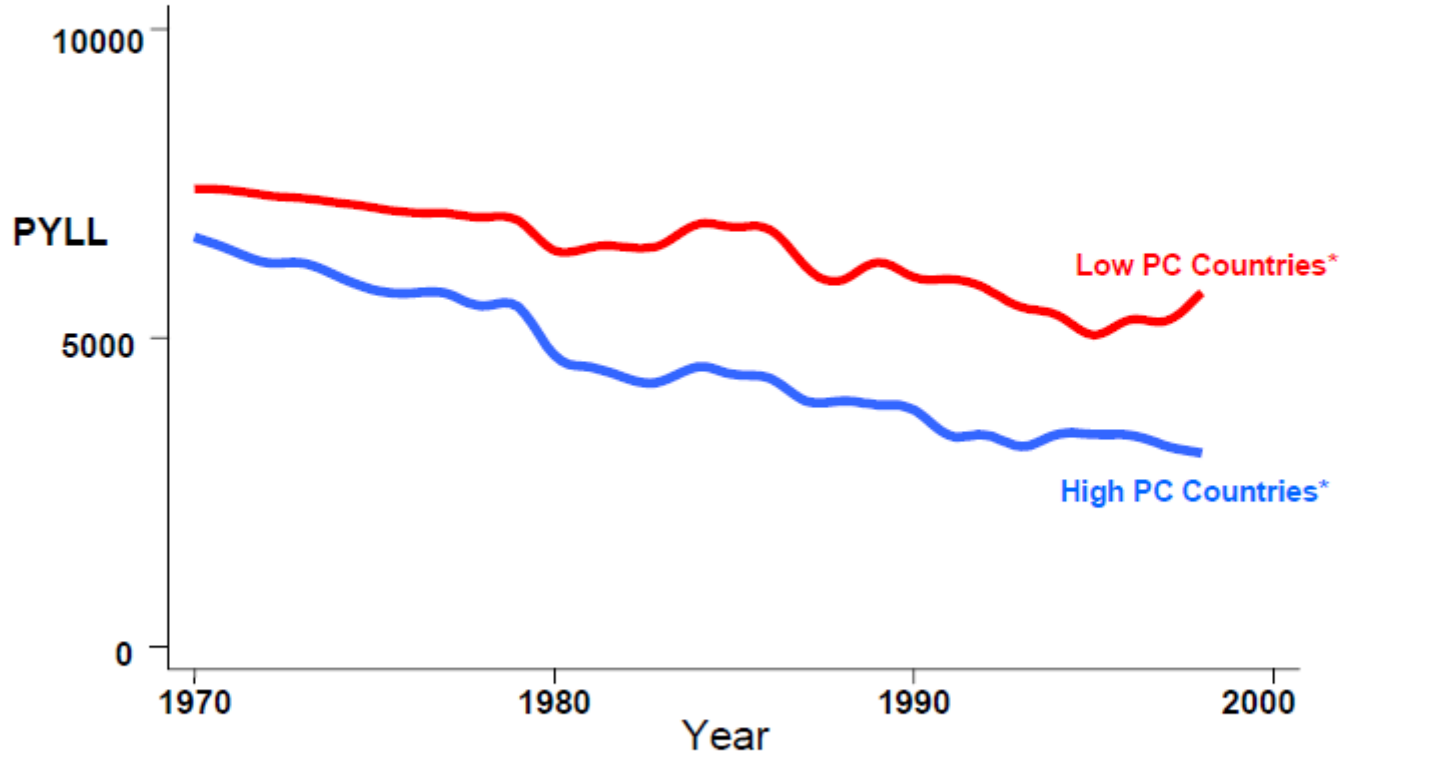
Primary Care Strength and Premature Mortality in 18 OECD Countries



*Predicted PYLL (both genders) estimated by fixed effects, using pooled cross-sectional time series design. Analysis controlled for GDP, percent elderly, doctors/capita, average income (ppp), alcohol and tobacco use. R^2(within)=0.77.

Source: Macinko et al, Health Serv Res 2003; 38:831-65.

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The systemic role of primary healthcare (General practitioners (Family doctors), community nurses)

- Gate keepers (and fundholders) – prevent overuse of secondary care (in particular unnecessary patients in emergency rooms).
- First contact to avoid unnecessary specialist visits.
- Health educator, consultant in healthcare system
- Person-focus over time avoids disease focused care (makes care more effective).
- Comprehensiveness avoids referrals for common needs (makes care more efficient).
- Coordination avoids duplication and conflicting interventions (makes care less dangerous).

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20% - 50% of resourses in healthcare are wasted and do not bring value to clients[1, 2]

1. Health Research Institute, “The price of excess. Identifying waste in healthcare spending,” 2008. PWC
2. The World Health Report, “Health Systems Financing. The path to universal coverage,” 2010. WHO

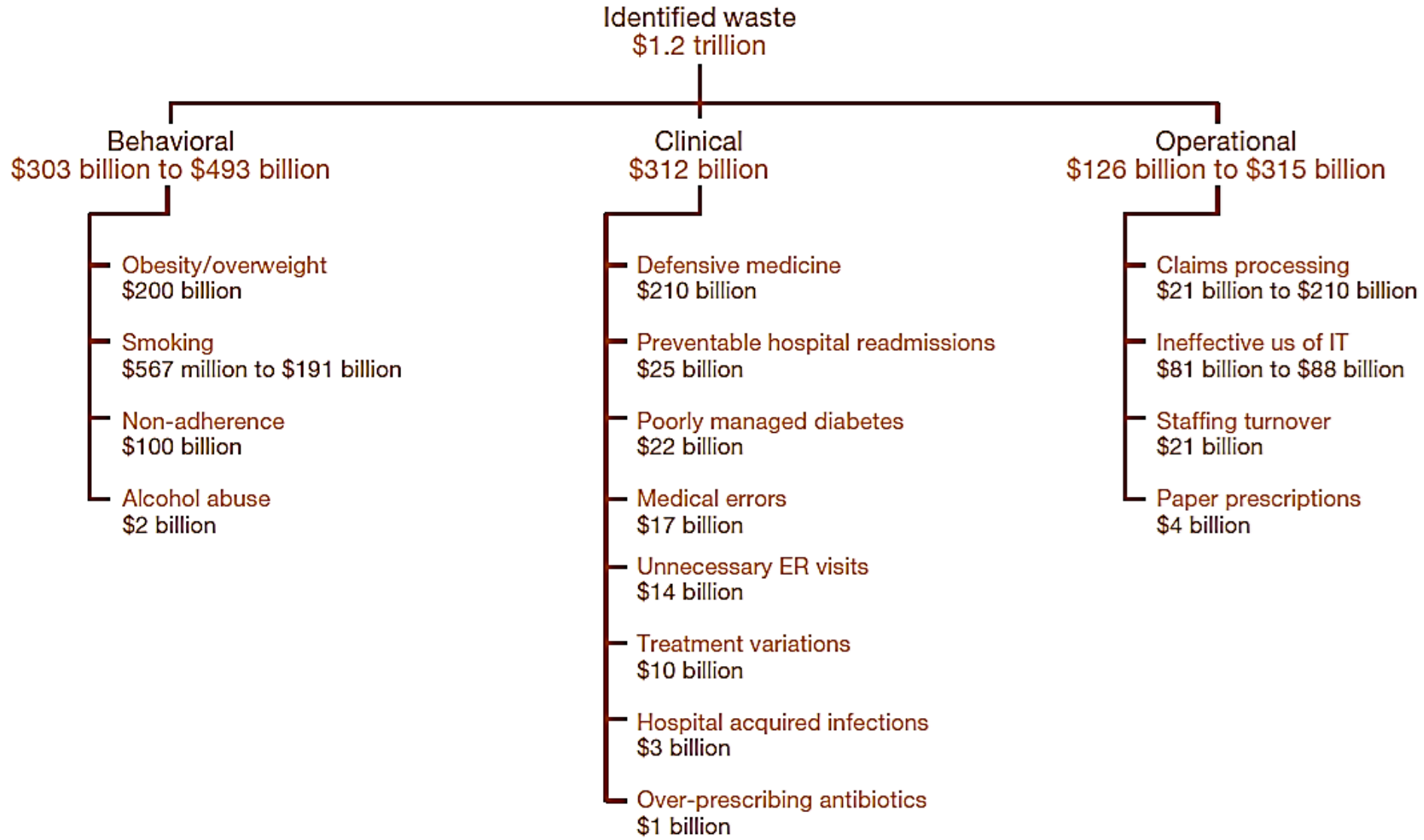
How resourses are wasted[1]

- **Behavioral -** where individual behaviors are shown to lead to health problems, and have potential opportunities for earlier, non-medical interventions.
- **Operational -** where administrative or other business processes appear to add costs without creating value.
- **Clinical -** where medical care itself is considered inappropriate, entailing overuse, misuse or under-use of particular interventions, missed opportunities for earlier interventions, and overt errors leading to quality problems for the patient, plus cost and rework.

1. Health Research Institute, “The price of excess. Identifying waste in healthcare spending,” 2008. PWC

USA example

Exhibit 3: Identifying waste in healthcare spending



PricewaterhouseCoopers' Health Research Institute
*The price of excess: Identifying waste in healthcare spending

USA: Wasteful spending in the health system has been calculated at up to $1.2 trillion of the $2.2 trillion spent nationally, more than half of all health spending.

Specifics of change in healthcare

Unique nature of healthcare organizations

- Dependent from environment
- Unique culture
- Autonomous professionals
- Multiple power and authority structures
- Different values for professional and administrators
- Ambiguity of goals
- Traditions

There are multiple stakeholders

- Doctors of different specialisation, nurses, allied health professionals
- Managers
- Bureaucrats
- Politicians
- Advocacy groups
- The Media

- Patients, relatives

Tensions between Different Key Groups

- **Politicians** – political leaders with a short term focus and usually politically biased
- **Bureaucrats** – Responsible for policy development and its implementation but do they lead?
- **Clinicians** – Access clinical resources and accountable for delivering quality patient outcomes. Lead clinical innovation and service delivery
- **Managers** Aaccountable for the organisational performance

The Way Healthcare is Delivered

Issues:

- Fragmentation and duplication of services
- Lack of integration across the health continuum
- Emphasis on hospital care
- Meeting the needs of our increasing older populations
- The need to develop new models of care

The Way Healthcare is delivered is changing

- Development of new models of care that prioritize primary care
- Integrating care and how it is delivered across the organizations (hospital / ambulatory care / home care ..)
- Growing recognition of need for clinical leadership for organisational change and evolution

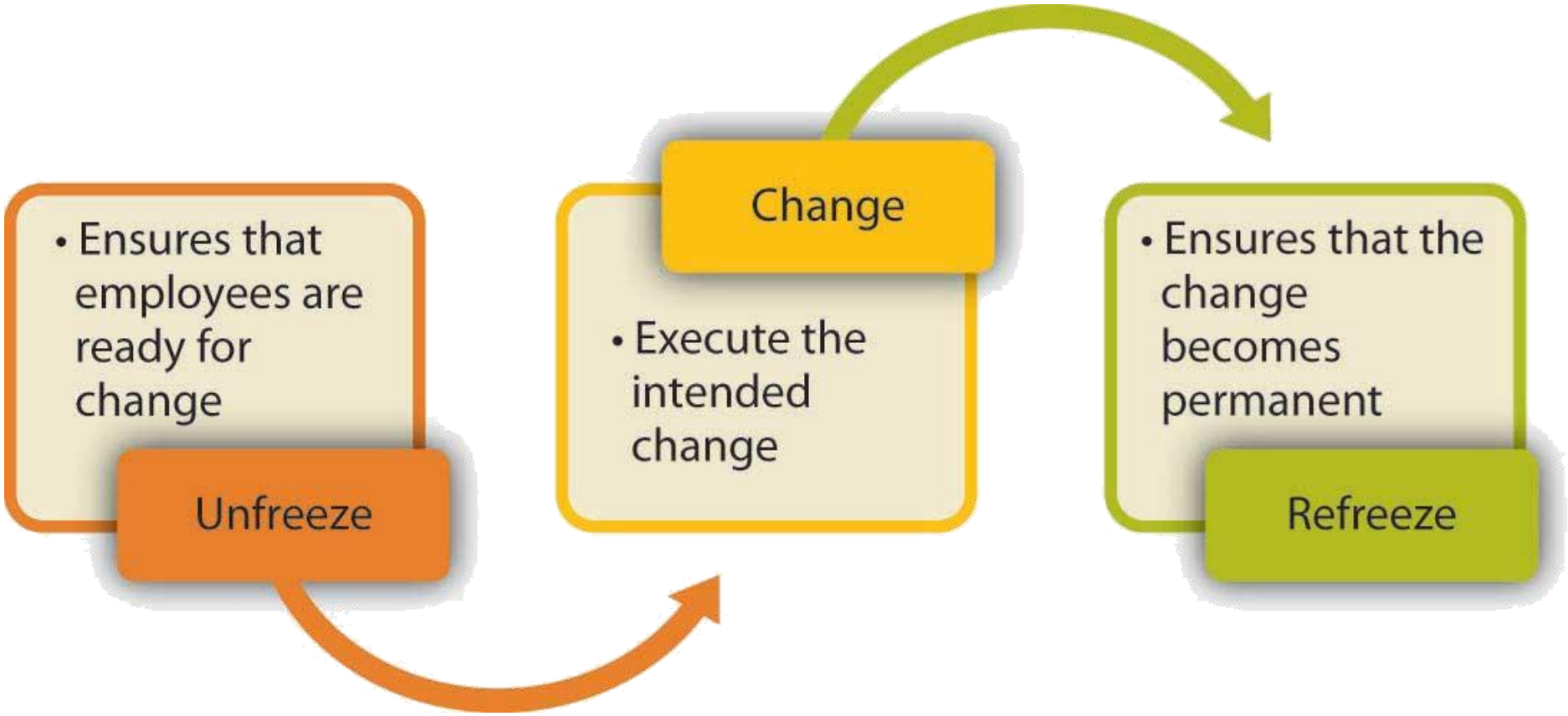
Theories of Change

1. Managed change
2. evolutionary,
3. life cycle,
4. dialectical,
5. cultural.

Scientific management or planned change

- Change occurs because leaders, change agents, and others see the necessity of change.
- It is assumed that organizations are purposeful and adaptive.
- Organizations proceed through distinct stages, and it is the leaders' role to effectively manage the transition from one stable state to another

Kurt Lewin model



Principles of planned change

(1) develop and focus on the vision, mission, and outcomes of the institution;

(2) creative and supportive leadership;

(3) implement systematic individual development;

(4) make data-driven decisions based on facts;

(5) ensure collaboration;

(6) delegate decision-making;

(7) proactively plan change.

Alternative models of change process

Evolutionary theories

- The main assumption underlying evolutionary theories is that change happens because the environment demands change for survival
- ...people have only a minor impact on the nature and direction of the change process
- Change is seen as inherent to biological systems; all organizations are constantly changing.
- Management role: observation of the external environment, analysis of the organizational system, and creation of structures and new organizing principles to respond to the environment.

Life Cycle changes

- Life-cycle models evolved from studies of child development and focus on stages of organizational growth, maturity, and decline
- Change does not occur because people see the necessity of or even want change; it occurs because it is a natural progression that cannot be stopped or altered
- Management role: is to assists members of the organization to grow (through training and motivational techniques)

Dialectical changes

- Change is created through the interaction of opposing forces.
- Predominant change processes are bargaining, deals, influencing, usage of social movements
- Progress and rationality are not necessarily part of this theory of change; dialectical conflict does not necessarily produce a “better” organization
- Organizations are perceived as political entities in which dominant coalitions manipulate their power to preserve the status quo and maintain their privilege.

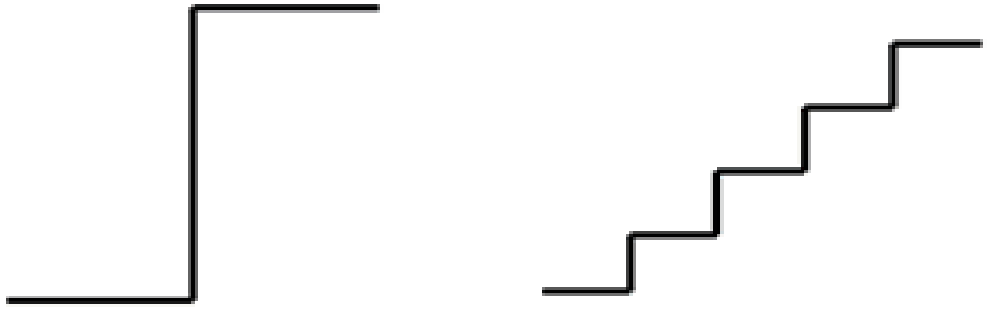
Skills needed to create political change:

- agenda-setting,
- networking and forming coalitions
- bargaining and negotiation.

Cultural changes model

- Cultural models emphasis on irrationality
- Change within an organization alterates of values, beliefs, myths, and rituals
- Change tends to be nonlinear, irrational, nonpredictable, often long-term and seemingly unmanageable

Revolution vs Evolution



Step change
Occurs rapidly

Incremental change
Change occurs over a period of time in incremental stages

- Change is anevitable. You can postpone but not avoid it
- Action and reaction / force and counterforce
- Setting priorities – change requires resources

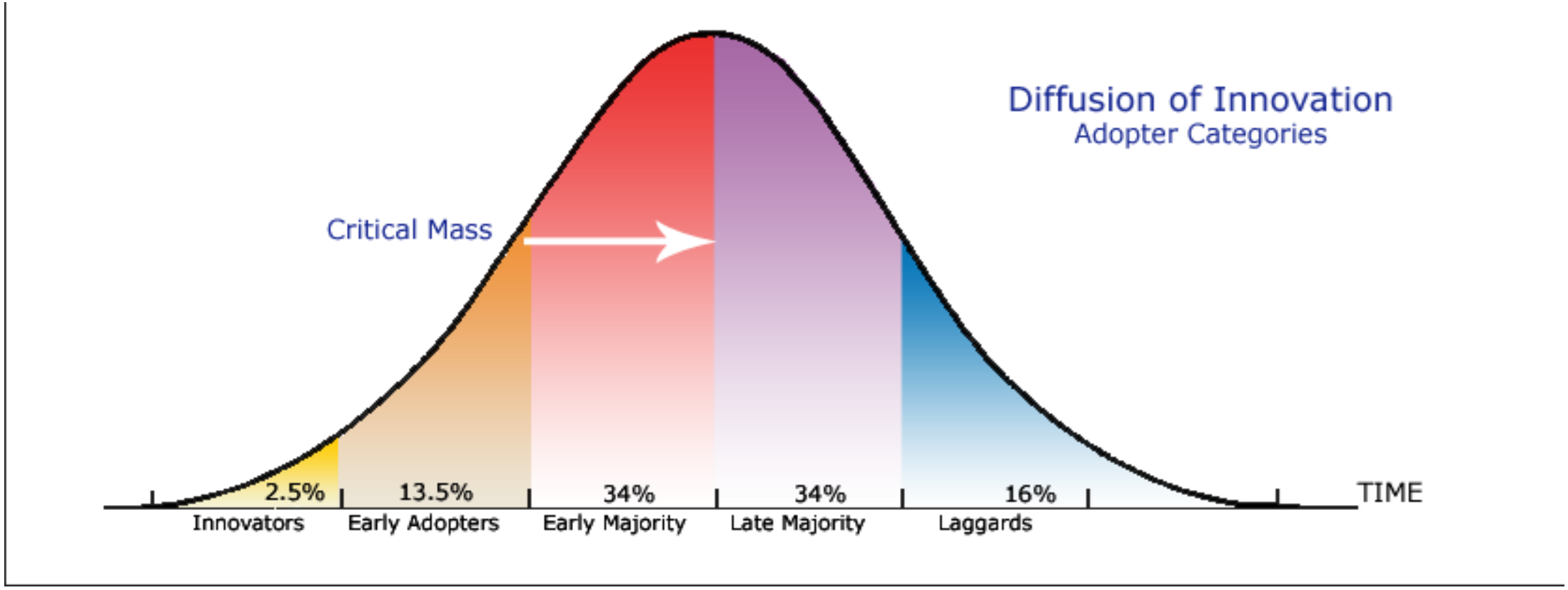
Evolutionary development is sucess if:

- Top management has a clear vision and mission for organisaton (top level of goals)
- Big goals, vision of organization shares great proportion of employes
- The change is not pushed from the top, but rather starts from bottom
- New management culture

Change in healthcare

- Increasingly difficult
- In all countries, is politically sensitive subject
- The asymmetry of information, opportunities for demagogy
- Doctor's independent nature of the profession
- Inconsistencies in the Public Interest
- Preference of evolutionary development

Types of individual adaptation to changes, innovations

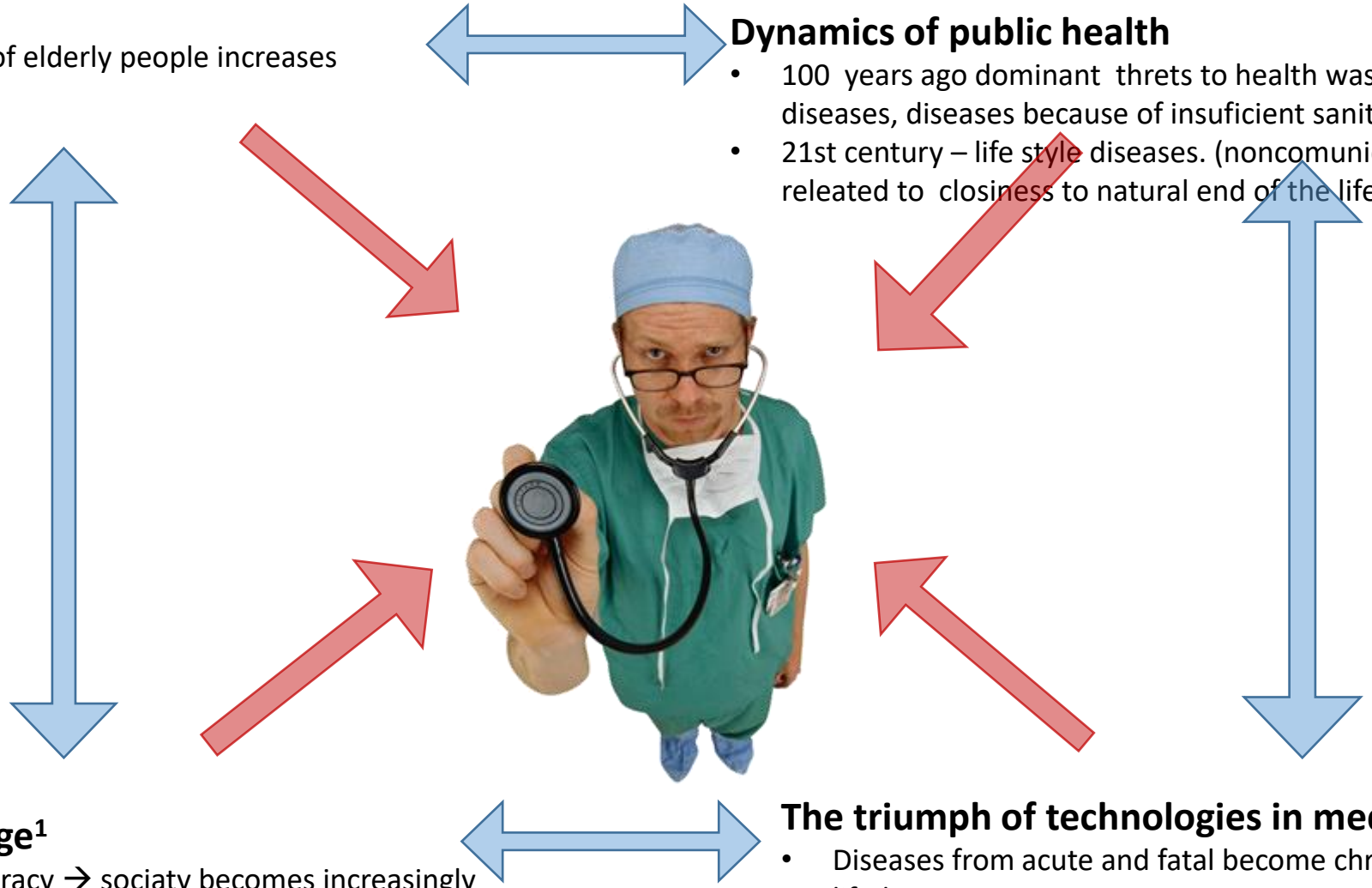


Demografic tendencies

- We live longer
- The proportion of elderly people increases

Dynamics of public health

- 100 years ago dominant threts to health was comunicable diseases, diseases because of insuficient sanity and nutrition, ijuries
- 21st century – life style diseases. (noncomunicable, chronic, releated to closiness to natural end of the life)



Power of knowledge[1]

- Increased health literacy → sociaty becomes increasingly demanding, healthcare becomes increasingly service oriented - consumerism
- However assimetry of informtion remains [2]

The triumph of technologies in medicine [1]

- Diseases from acute and fatal become chronic and managable life-long
- Decreased lenghts of treatment
- Incresed possibilities for outpatientand home treatment

1. A. Constant, S. Petersen, C. Mallory, and J. Major, “Research Synthesis on Cost Drivers in the Health Sector and Proposed Policy Options,” Canadian Health Services Research Foundation, Ottawa, 2011.
2. U. Schneider, “Asymmetric Information and the Demand for Health Care – the Case of Double Moral Hazard.” 2003.

More intensive usage of **existing** technologies – e.g. more lab. Tests, more frequent diagnostic imaging etc

Introducing **new** approaches, technologies, treatments

Regarding the increase in health costs the professional choices of health professionals is 3,8 times grater contributor than general aging[1]

1. B. Dormont and M. Grignon, "Health expenditure growth: reassessing the threat of ageing," *Health Economics*, vol. 963, pp. 947-963, 2006.

“physicians ***can*** induce demand for their services, they ***sometimes do*** induce demand…”

(Hurley & Labelle, Health Economics, 1005, p420).

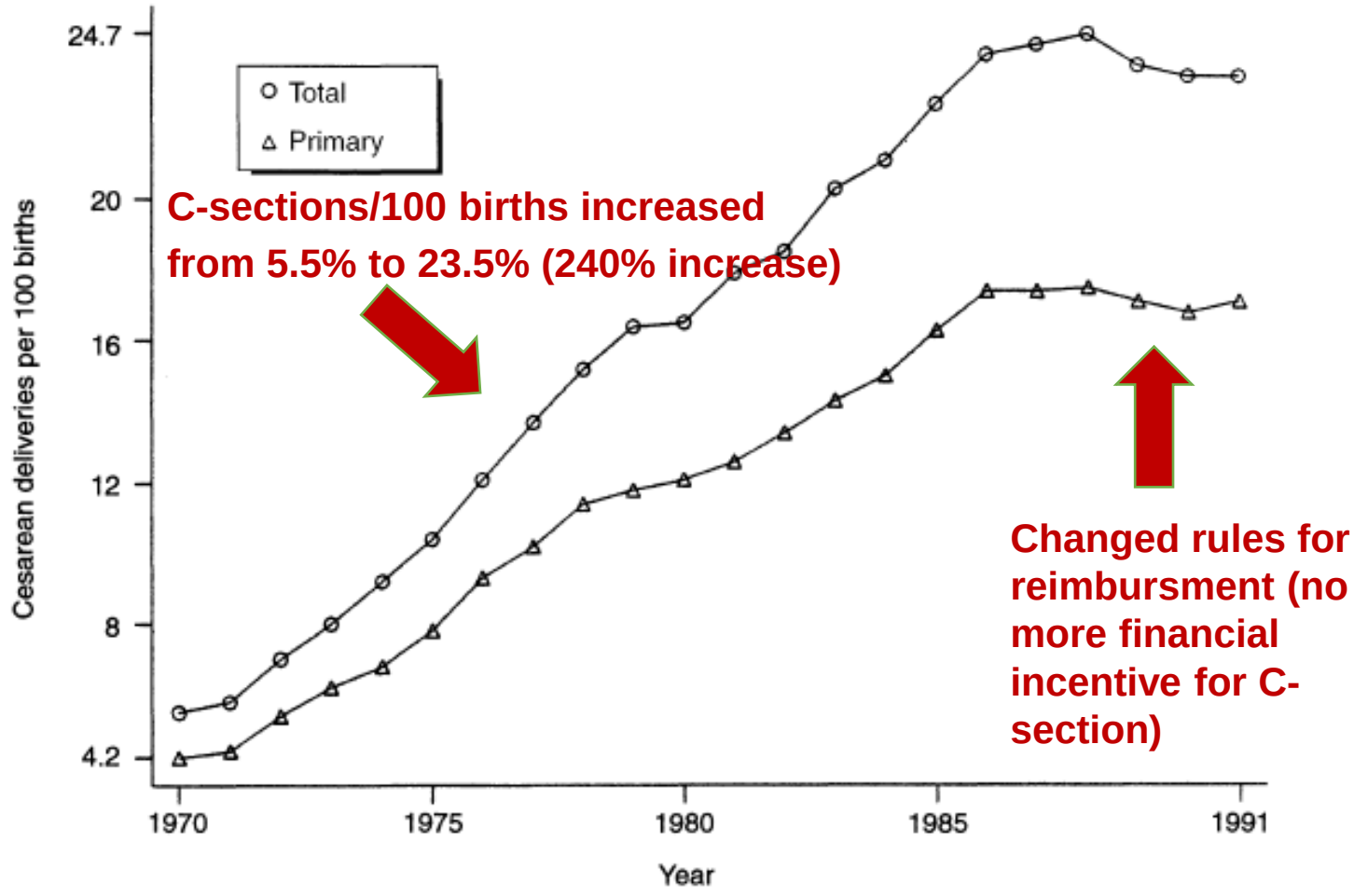
Caesarean Section Delivery US from 1970

- Fertility in US ↓, fall in demand for obs/gyn services
- 13.5% decline in births → 6.75% decline in income
- What happened?

*Gruber J, Owings M, Physician Financial Incentives and Cesarean Section Delivery. RAND Journal of Economics, 1996; 27(1): 99-123.

FIGURE 1

CESAREAN DELIVERIES IN THE UNITED STATES



C-sections/100 births increased from 5.5% to 23.5% (240% increase)

Changed rules for reimbursment (no more financial incentive for C-section)

Forms of payments used in organisation of health care

- Increasing income is a factor in anyone's motivation – even health professionals!
- Different ways of payment to doctors (and HC institutions) are in use
  - Fee-for-service - is a payment model where services used in managing patient are idividually accounted and paid for separately
  - Fixed salary - The amount of remuneration is based on the preplanned amounts of health care services to be provided.
  - Capitation payment (fixed sum for each individual belonging to particular General Practiotioner praxis) Capitation is a payment arrangement for health care service providers.

Asessment to 6.11

- Describe some positive and some negative aspects for each of the payment shemes:
  - For patient
  - For health care provider