
SAMOA HEALTH PROJECT

DEPARTMENT OF HEALTH



REVIEW OF INTERNATIONAL HEALTH
MANAGEMENT EXPERIENCES

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By

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INTRODUCTION

This literature review has been prepared by the Samoa Health Project for the Department of Health (DOH) in Samoa. The purpose of the review, is to provide with information on different health system management strategies that have been applied internationally. This document, provides a brief definition of the health system management strategy, its advantages and disadvantages, and a description of an example of its implementation in a country. A list of key references is also attached, and the full set of reference materials will be available to any one wishing fuller information on the option.



DECENTRALISATION OF HEALTH SYSTEMS

Definition

Decentralisation is the transfer of authority from central or national authorities to local government levels. There are four methods for transferring power:

- *Deconcentration* occurs when management functions are transferred to lower levels within the same bureaucratic unit.
- *Delegation* refers to the transfer of managerial responsibility to organisations that are not controlled by the central government.
- *Devolution* means that authority is transferred to provincial or municipal levels of government.
- *Privatisation* occurs when private organisations are given specific management functions that used to be the government responsibility.

Decentralisation of health services has had mixed results internationally. Often, this has been because critical issues have not been addressed in the planning phases. Critical questions to be answered in planning for decentralization include:

- What are the stated goals of the decentralisation initiative, e.g. reduce bureaucracy, cut costs, improve efficiency?
- How will it be implemented, by a constitutional law or by an administrative order more easily to change in the future?
- What programs or functions are being decentralised?
- To whom are these programs/functions being transferred?
- What impact will these changes have on service-related job?
- What new skills will managers need to develop?
- What are the estimated financial and human resource costs (e.g. new office posts, training)?
- Which monitoring and supervisory procedures should be implemented?
- Which effective linkages between central-local authorities should be in place?



Advantages and Disadvantages

Advantages:

- More responsive to local priorities.
- Increased responsiveness of health services, since local staff are more accountable.
- Greater involvement of local communities which in turn can increase community financing and control.
- Local decisions can be made more rapidly.
- More effective way of meeting local needs and targeting the poor.
- Reduces congestion at the central level so that national authorities can focus on policy-making, supervision and national priorities.

Disadvantages:

- When there is conflict between local and national priorities, local authorities may divert resources from national goals.
- Local politicians and interest groups have stronger influence on local decisions.
- Both local and central staff may lack the required new skills which will impact on health system performance.
- Decentralisation can be expensive - costs include training, new information systems and low productivity during the transition - and may be higher than the expected gains in efficiency.
- When the process is inadequately planned, it may lead to fragmentation of health services.
- Decentralisation of functions that are critical to the attainment of national health priorities, places their achievement at risk. Establishment of standards and monitoring processes is essential.
- It is difficult to ensure equity.



CASE STUDY: PAPUA NEW GUINEA

Prior to the independence, the PNG government structures, including the health system were highly centralised. Health programs were vertically administered from Port Moresby.

In 1977 the National Constitution created a new system of decentralised provincial governments. Nevertheless it was only in 1983 that the Department of Health eventually decentralised the political and administrative control of health services to provincial governments. Provinces were given the responsibility for primary health care facilities and programs, including supervision of aid posts, health centers, family health services, ambulances and disease control programs. They shared authority over provincial hospitals, malaria control and extension services with the National Department of Health. The Department in turn remained responsible for standards monitoring; pharmaceutical services; mental health and specialist services; medical training; hospitals services and disease control.

The decentralisation process was implemented after a political struggle of provincial health staff who held great expectations about the gains that would arise from decentralisation. The Department of Health was openly opposed to pass on power to local authorities. Instead of devoting time to plan, negotiate and build new health management skills, the Department focused on resisting the process. The process suffered from deficient planning; lack of management training; staff proliferation, poor information management and inadequate supervision. Local and central authorities were ill prepared to perform their new roles.

Not surprisingly, the gains of the decentralisation process came short of the expectations. Management difficulties were severe, in particular regarding provincial hospitals. National Authorities re-assumed responsibilities for some health services that had been decentralised to the provincial level. Provinces attempted to transfer some of their functions to the districts, but in most of the cases, administrative responsibility remained in the provincial level.

Decentralisation also did not equalise regional differences. On the contrary, regional inequality was widened. Health services were strengthened in provinces with qualified staff, financial resources and a political elite committed to the health system performance. In contrast, health coverage and quality service deteriorated in poor provinces that lacked resources and political support.



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CENTRALISED HEALTH SYSTEMS : PUBLIC INTEGRATED MODELS

Definition

Public integrated models were the backbone of health systems in Scandinavia, the former Soviet Union, Cuba and Costa Rica. Under these models, the government takes over full responsibility for the organisation, provision and financing of health care services. Hospitals are usually owned and run by the state. They are given fixed annual budgets to cover their running costs. Health staff, including doctors, specialists and nurses are employed on salary in the public sector.

The main features of public integrated models are as follows:

- The health system is financed through general taxation and managed by the government with the explicit goal of delivering health services to the entire population.
- Pyramidal hierarchy of administrative health authorities from the top at the national level through regions and districts. All component parts of the health system are managed by the Ministry of Health who enjoys strong supervisory powers. Hierarchical levels are clearly stated. Every organisational unit and employee of the health system knows his duties and responsibilities.
- Health resources and health care services are centrally planned by national health authorities. They are responsible for setting the health system goals and priorities. The decision on the total level of health expenditure is also responsibility of the government who allocates the system resources.
- Since health care delivery is a government responsibility, services are provided by public hospitals and health centres managed by the Health Minister. Hospitals are usually given annual global budgets to cover their running costs. Doctors, specialists, nurses and other health staff are employed on salary basis by the government.
- Private medical practice is subject to strict regulation. Public provision of health care services at reasonable costs is a common practice utilised to discourage private practitioners to increase their prices.
- There is no competition between health care providers since the government enjoys the monopoly of health care services. As a consequence, consumers have no freedom of choice.



Advantages and Disadvantages

Advantages:

- Under public integrated systems, the government enjoys greater powers to coordinate the provision of health services, which facilitates the achievement of national health goals and offers.
- Health authorities are more able to respond rapidly during crisis, such as an outbreak of cholera or postwar reconstruction, where strong coordination of health activities is required.
- A well run public integrated model leads to greater equity outcomes as it delivers adequate and equitable treatment for the entire population. For instance, the Cuban system is considered to rank number one in equity outcomes. This achievement is highly remarkable given the limited economic resources of the Cuban health system
- Since health care services are provided by government-run hospitals and health centres, the system faces reduced transaction costs. For instance, health authorities do not need to spend time writing, monitoring and supervising complex contracts with private health care providers.

Disadvantages:

- Bureaucracies are vulnerable to capture by vested interests and corruption. For instance there is evidence of 'under-the-table' payments from patients to public providers.
- Consumers lack freedom of choice and there is no competition between health care providers. As a consequence health providers (e.g. hospitals and doctors) face no incentives to improve efficiency, reduce costs and offer high quality health services.
- The system contains perverse financial incentives, since money does not follow the patient. When health providers perform well they will not receive more money. Good performers are likely to be rewarded with more patients and more work..
- Should rigid supervisory structures be in place, innovation will be discouraged and the system will suffer stagnation.



- In vertical integrated models organisational units of the health system are highly interdependent. A failure in one part of the structure may disrupt the performance of the entire system and prevent it to perform well.

CASE STUDY: CUBA

The Cuban health system is characterised by public monopoly of health care services. The government is fully responsible for organising, financing and providing health care. All services are available for free to everyone and they are delivered by salaried staff in public health facilities. The health system consists of three levels:

- The Ministry of Public Health, which controls, regulates and coordinates the entire system activities.
- Provincial public health offices, responsible for intermunicipal hospitals, blood banks, provincial health and epidemiology centers.
- Municipal health offices which oversee polyclinics, rural and local hospitals and social welfare institutions for the elderly and disabled.

A preventive health care orientation prevails in the Cuban health system, with family physicians as the backbone. Each physician delivers primary care and preventive services for 800 patients. Their main responsibilities include seeing each patient in their practice area at least twice a year and maintaining a record of preventive services and conditions for all their patients. Family physicians guarantee that the entire population receive preventive services which are appropriate for their age, sex and risk factors.

Government policy encourages utilisation of local primary care facilities within an organised system of consultation and referral. When hospitalisation is required, family physicians act as gatekeepers. They refer patients to local primary care services, provincial or national hospitals. Only during emergencies, patients may decide to bypass family doctor.

Although highly controversial, the centralised Cuban health system has accomplished impressive outcomes. These achievements are even more remarkable when taking into account the shortage of financial resources. The entire population is covered by the health system. Immunisation coverage rates have remained between 99% and 100% during the last decades. All women receive prenatal care and delivery by health staff and 70% of women use contraceptives. Unlike other developing countries, in Cuba no deaths occur for lack of medical care. The entire population is able to seek same-day care provided by the family physician, the cornerstone of the health system. Not surprisingly, infant mortality rate is only 7.2 per 1,000 and maternal mortality 2.15 per 10,000.



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MANAGED CARE

Definition

Managed care is a complicated system for organising the delivery of health services where health insurance and health care services management are combined in one organisation. Although there are different models of Managed Care, they share some common features:

- Health Management Organisations (HMOs) compete in the health market to provide people with health insurance and health care services. Every person has the right to choose the HMOs that will cover their health risks.
- In exchange of the insurance premium received, HMOs guarantee the delivery of a pre-established list of health services. This list is usually known as a health benefits package.
- Since health services are financed by the insurance premium, after paying a monthly premium there are virtually no additional costs for consumers. The insured population are not exposed to out-of-pocket expenses.
- HMOs act as purchasing agents of health services in the name of their insured population. People are relieved of searching health providers and contracting the provision of health services.
 - HMOs contract with a network or group of providers (e.g. doctors, hospitals and pharmacies) to deliver health services. HMOs and providers sign contracts and negotiate price, payment mechanisms and quality standards.
 - HMOs offer their customers a list of providers to choose from.
 - HMOs limit patients' choice of health providers. People cannot freely choose their doctors, they should be included in the HMO's list of providers.
- Most Managed Care models aim at guaranteeing that health insurance premiums are not risk related. That is, the healthy and young should not pay more than the sick and old to receive health services.
 - In order to do so, health premiums are funded from tax revenue or are paid by each individual according to his/her monthly income, usually a percentage of their salary.
 - There is a "sponsor", usually a government body, who pools health premiums from the entire population.



- Once premiums have been pooled, the sponsor pays to each insurer a risk-adjusted sum for each person.
- By pooling resources, the healthy and young subsidise the sick and old. With the surplus paid by the healthy and young who have a low risk-adjusted premium (they are not likely to require health care services) the sponsor will finance the deficit of the sick and old who have a high risk--adjusted premium (they are likely to require many health care services)

Advantages and Disadvantages

Advantages:

- Promote the use of cost-effective preventive care. The system encourages members to obtain preventive care, such as mammograms or annual physical examinations, as they do not have to pay additional costs.
- Maintain or improve quality standards of health services delivery. People demand their HMOs to deliver better services and HMOs have enough power to negotiate better quality standards with health providers.
- Control costs. HMOs do not have incentives to provide unnecessary health services. Their income is not related to delivered services. More inpatient care does not lead to higher income for HMOs. Furthermore, they face incentives to minimise costs of health services delivery to be profitable.
- HMOs monitor health suppliers, such as doctors and hospitals and implement mechanisms to prevent doctors to require unchecked and costly services.
- HMOs may enjoy economies of scale in the purchase or use of health inputs, due to the size of the insured population.
- People can access specialist at a lower cost. Specialist's tariffs are not negotiated individually but by HMOs in representation of their entire insured population. As they have market power, they can get good deals.

Disadvantages:

- Managed care systems are highly complex. This complexity may threaten the long-run financial sustainability of the health system. For instance if the risk-adjusted premium amount is set too high, HMOs are profitable but the system faces health cost explosion. On the other hand if the premium amount is set too low, HMOs reduce quality standards and may even face financial losses.



- Due to the system complexity, HMOs, health providers and the government face high transaction costs. They must devote time to write complex contracts and to monitor their implementation.
- Even though HMOs receive a risk-adjusted premium, under managed competition HMOs are likely to cream-skin the market. They tend to select low risk patients (the healthy and young) for whom the cost of health delivery is substantially lower.
- Managed care introduces competition and so there is no longer a single purchasing agency in the health sector. This situation may weaken the bargaining power of health services purchasers. As a consequence the system is likely to face rising costs of health care services.
- Managed care systems demand governments with strong regulatory and supervisory capabilities. Governments should design the financial characteristics of the system and supervise HMOs. When governments lack these capabilities, HMOs cream-skin the market and siphon off the system resources.

CASE STUDY: LATIN AMERICAN REFORMS

During the last decades, various developed countries, including the US, Netherlands and Israel, have implemented managed care systems, with mixed results. Only a few developing countries have followed the trend. South Africa along with Latin American countries, Chile, Peru and Colombia, have reformed their health systems to implement managed care.

By 1981 the Chilean government reformed its public-run health system and implemented a managed care model. The objective was offering consumer choices through a competitive health insurance market and expand the health system coverage. Public monopoly of the health system was abolished. Private Health Management Organisations (ISAPREs) were created to compete with the National Health Fund (FONASA) and to offer pre-paid health insurance to the population.

Competition has created many difficulties for both consumers and the government. Contracts to enrol HMOs are highly complex, people do not understand the implications and find difficult to choose the plan that best suits their needs. The system does not offer universal health benefits package. HMOs offer diverse packages to the population and impose restrictions regarding access to health care. They utilise exclusionary clauses (e.g. do not cover pre-existent conditions) and waiting periods.



In addition, there is evidence of cream-skimming practices amongst private HMOs. They target high income and low risk groups of the population. For instance, around 70% of the population enrolled by HMOs are less than 40 years old. In contrast, the National Health Fund has insured and delivered health services for the poor, the sick and the elderly. Making the things worse for the public institution, an increasing proportion of HMOs beneficiaries are receiving health services from the National Health Fund.

By the mid 1990s, the Chilean managed care reform was followed by Colombia and Peru. These countries attempted to address the Chilean model failures by introducing complex financial arrangements aimed at preventing HMOs to cream-skin the market. HMOs were not allowed to refuse enrolment applications. The government introduced an universal health benefit package to be delivered by all HMOs. Nevertheless, even under more tightly regulated environment, private HMOs have found their ways to cream-skin the market and refuse applications of high-risk individuals.



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INTERNAL MARKETS FOR HEALTH CARE - PROVIDER / PURCHASER SPLIT

Definition

Two of the most important functions of health systems, funding of health services and delivery of health care used to be performed by the same health authorities. For instance, as below discussed, in the UK prior to the 1980s, the National Health Services (NHS) authority used to both funding universal health care for every citizen and delivering health care services for the population.

The creation of internal markets for health care aims at splitting these functions – the financing and provision of health services. Financing usually remains under the control of a public agency, while the provision of health care services is contracted out to external private or public service providers. As a consequence, the role of health authorities is transformed from one of managing health care provision into one of purchasing health care services from different providers.

Internal markets create competition for health care services delivery. They offer choice of providers. They separate health purchasing agencies from health care providers. By introducing competition, internal markets are supposed to lead to health costs reduction and gains in efficiency. The purchaser/provider split seeks to prevent government purchasers from purchasing services from the public hospitals they managed at the expense of more efficient providers

Given the social relevance of health services, these internal markets are not free-markets. They are usually regulated by the government who retains certain powers, including, controlling market entry (e.g. clinical authorisation licenses); reviewing prices and setting minimum quality standards.

The potential efficiency gains derived from competition will never be achieved if governments lack ability to design, implement and monitor contracts. Particular attention is needed for the design of adequate payment mechanisms and incentives. For instance a fee-for-service mechanism provides suppliers with the best incentive to join the scheme. However, it will also create incentives for excessive and unnecessary treatments which increases health costs. On the other hand capitation payment is relatively easy to manage but gives the provider incentives to reduce quality and cream-skin the market.



Advantages and Disadvantages

Advantages:

- Competition between health care providers leads to gains in technical efficiency.
- Competition also ensures that they deliver the kinds of services that customers really want, which leads to higher levels of patient satisfaction.
- Improved accountability is also achieved. Health authorities seem to know better which services are getting from their financial resources. Similarly, providers (public and private) know what it is they are required to supply and at what level. Political interference may be reduced.
- The contractual process may promote transparency in trading and decentralisation of managerial responsibility both of which lead to increasing efficiency.
- Contractors may fill gaps temporary or permanent gaps in government capacity (e.g. targeting specific population groups).

Disadvantages:

- High contracting costs which include health staff time, accounting and legal fees, consultancy fees and travel costs. The most significant cost is usually health staff time.
- During the transition period health authorities also incur in substantial implementation costs such as setting up adequate information systems and staff training.
- Individuals responsible for making purchasing decisions may be subject to pressures from interest groups, including health care providers, which may affect the health system performance.
- When contracts are signed for short-term, e.g. one year, providers are usually reluctant to make costly investments, which may affect the quality of health services.
- In many developing countries, potential gains in efficiency from competition have not been realised because:
 - There are not enough potential providers to promote competition
 - Government purchasing agencies have not been able to adapt themselves to their new roles – from managers to regulators and supervisors
 - Health authorities lack capacity to negotiate, write, implement and monitor contracts



- There is no adequate information on the production costs

CASE STUDY: INTERNAL MARKETS IN THE UK

In 1946, Great Britain established the National Health Service (NHS), the pioneer of universal social health insurance. The system, financed mainly out of general taxation, aimed at providing health care to all British residents. The government monopolised the provision of both social health insurance and health care services delivery. Consumers had neither choice of insurer or provider. In regard to public hospitals, money did not follow the patient. Doctors were usually paid by salaries and hospitals by global budgets. As a result, the income level of providers did not depend upon the health services delivered.

During the 1980s there was evidence of increasing health costs and crisis in the funding of public hospitals. There were large variations in performance between individual hospitals and between general practitioners. By 1987 various hospitals reduced their staffing and beds which led to a resources shortage and service deficiencies. The quality of hospital out-patient consultations was no optimal. There were failures to meet consumers' needs and preferences, which was reflected in long waiting lists for elective surgery and long waiting times for appointments with specialists.

The Prime Minister Margaret Thatcher decided to introduce internal markets for health care in order to strengthen the delivery of health services. Competition between health care providers was implemented, although within strict government regulation. Government agencies invite both private as well as public providers to bid for health care services delivery.

There is a clear distinction between health authorities (purchasing agents) and health providers. District health authorities have no longer control upon public hospitals:

- District health authorities -not hospitals- receive financial resources to purchase health services for the population.
- Hospitals and community health services are managed by "health trusts" -not by district health authorities.
- These hospitals and community health services compete with private providers for financial resources allocated to health authorities.

The dispute over the costs and gains derived from these reforms in the UK is far from resolved. Internal markets seem to have succeed in reducing waiting lists and waiting time. On the other hand, regarding health cost containment, evidence seems to point out to increasing health expenditure in the system.



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HOSPITAL MANAGEMENT

Hospitals are large organisations, which require the combined effort of many different workers, including doctors, nurses, accountants, cleaners, receptionists and many others. For hospitals to carry out their functions, their staff members need to work together. Each worker has different skills, knowledge and responsibilities and it is their joined effort which makes possible the efficient delivery of health services.

Hospitals units also have competing responsibilities which may be in conflict, e.g. the financial unit is pushing for cutting off costs whilst doctors for increasing service quality. A number of management strategies have been applied internationally to improve hospital management. These include:

- Hospital Boards
- Chief Executive Officer
- Hospital Budgeting and Payment Mechanisms
- Cost Centre Management

Hospital Boards

Some countries have appointed Hospital Boards to provide guidance to hospital managers on higher level strategy issues. Members are usually prominent community members and are volunteers with diverse backgrounds and skills. Boards are expected to provide leadership, guidance and direction to hospital managers.

One of the most common mistakes made by Board members is focusing on day-to-day affairs and interfering with operational issues. In order to operate effectively, Boards must have a clear understanding of their roles. Their task is not to manage hospitals in detail –that is the hospital staff responsibility - but to provide strategic direction. This may involve the following types responsibilities:

- Developing the strategic plan that sets the long-run direction that the hospital will take.
- Supporting the leadership and growth of the organization.
- Providing financial and programmatic performance oversight.
- Maintaining community and government relations.
- Ensuring that high-quality services are provided.



The table below summarises the role of a Board, in comparison to that of hospital management.

BOARD RESPONSIBILITIES	HOSPITAL MANAGEMENT RESPONSIBILITIES
Strategic Planning	
<ul style="list-style-type: none"> ▪ Develop the hospital's strategic plan and make the long-run strategic decisions 	<ul style="list-style-type: none"> ▪ Help the board and recommend strategic options
<ul style="list-style-type: none"> ▪ Approve operational plan and budget according to strategic decisions 	<ul style="list-style-type: none"> ▪ Develop operational plan and budget for the Board consideration.
	<ul style="list-style-type: none"> ▪ Implement the strategic plan
Organisational management	
<ul style="list-style-type: none"> ▪ Hire and evaluate the CEO 	<ul style="list-style-type: none"> ▪ Organisational management
<ul style="list-style-type: none"> ▪ Identify new financial resources and contribute to fund raising 	<ul style="list-style-type: none"> ▪ Develop budgets; identify new financial resources and contribute to fund raising
Financial Oversight	
<ul style="list-style-type: none"> ▪ Approve format and frequency of financial reports 	<ul style="list-style-type: none"> ▪ Manage hospital financial resources
<ul style="list-style-type: none"> ▪ Analyse financial information and make recommendations 	<ul style="list-style-type: none"> ▪ Provide adequate information to the board
External Relations	
<ul style="list-style-type: none"> ▪ Ensure that government and community interests are met 	<ul style="list-style-type: none"> ▪ Ensure that clients needs are effectively addressed.

Chief Executive Officer

A Chief Executive Officer, CEO, is the general manager of the hospital. Hospital CEOs coordinate the activities of hospital departments, allocate financial resources and ensure that health services of high quality are efficiently delivered. A CEO may report to a Board or to a senior public servant, such as the Director General, or a Regional Manager (responsible for a number of facilities in a geographic area).

CEOs need to be able to see the hospital as a whole and an overall understanding of how the organisation interacts with the external environment.



Generally CEO responsibilities include:

- Asses the hospital environment. Predict changes that are likely to occur (e.g. technological advances or demographic changes) and their impact on the hospital performance.
- Formulate the hospital strategy. Identify those services that the hospital should provide and how they will be implemented.
- Develop organisational policies. These policies will guide the staff decision-making and so will help workers to properly carry out their functions.
- Design the organisational structure that must be in place to execute the strategic plan. They must choose the best service configuration that matches available resources.
- Lead the plan implementation. This requires emphasising the work to be done and the people who will be doing it.

To manage effectively, the CEO requires the ability to manage hospital resources: financial, physical and human. Human resources deserve particular attention, as it is the staff under the CEO's strategic direction who put into action the plan.

Hospital Budgeting and Payment Mechanisms

Hospitals consume around 50% to 80% of public sector health resources in developing countries. Financial management is an integral part of the overall hospital strategic management. In order to accomplish this task, hospital managers need to utilise planning, recording, monitoring and controlling the use of hospital financial resources to:

- Prepare a realistic and detailed budget for the strategic plan. The budget must contain essential information on projected expenses and income associated with planned activities;
- Calculate and analyse services costs;
- Project revenues, costs and profits;
- Monitor cash flows so that adequate cash will be available to cover all anticipated financial obligations each month;
- Prepare financial reports. Those necessary to analyse the hospital financial situation;
- Establish basic standards and controls of financial resources;



- Monitor the financial plan implementation by comparing obtained results against budget projections.

In order to improve hospitals efficiency, internationally different mechanisms to funding hospital services. They are described in the following table:

PAYMENT MECHANISM	STRENGTHS	WEAKNESSES
<p>Global Budget</p> <p>Hospitals receive a global amount covering the cost of all services provided in a given period.</p>	<ul style="list-style-type: none"> ▪ Central authority assures that total expenditure limit will not be breached. ▪ Incentives to increase efficiency 	<ul style="list-style-type: none"> ▪ Incentives to reduce the number of patients and services. ▪ No incentives to improve services quality.
<p>Capitation</p> <p>Hospitals receive a fixed amount per registered patient or population served.</p>	<ul style="list-style-type: none"> ▪ Facilitates prospective budgeting. ▪ Incentive to deliver preventive health services. 	<ul style="list-style-type: none"> ▪ If capitation amount is set too low the hospital will face resources shortage. ▪ Incentive to reject high-cost patients. ▪ Incentive to underservice patients.
<p>Fee for Service</p> <p>Hospitals sell their services and are paid by single acts or visits.</p>	<ul style="list-style-type: none"> ▪ Revenue linked to cost of health services delivered. 	<ul style="list-style-type: none"> ▪ Incentive to deliver unnecessary treatments. ▪ Administrative burden of processing claims.
<p>Per Case</p> <p>There is a standard table of average cost per diagnosed case. Hospitals are paid that average cost.</p>	<ul style="list-style-type: none"> ▪ Hospital's reward fairly tied to output. ▪ Incentives to minimise resources wastage. 	<ul style="list-style-type: none"> ▪ -Technical difficulty of forcing all cases into standard list. ▪ In order to receive higher payments, diagnosis may be misrepresented.



Hospital Cost Centre Management

The main goal of financial management is helping managers to make the best use of hospital financial resources. This means that hospital managers must have a clear understanding of the costs associated with all the hospital services. To address this, many hospitals have moved to cost centre management.

Cost centers are the hospital units which are responsible for providing services and therefore have the capacity to control their costs. Each cost center is assigned all direct and indirect costs associated to the services it provides. For instance, the maternity unit costs include their staff salary (direct costs) along with laundry costs (indirect costs).

The definition of which hospital units will be considered as cost centers is a managerial decision. However, the most common pattern is that hospital cost centers correspond to existing departments of the hospital. Managers can then track how individual departments use available resources.

Cost centers are usually classified according to the nature of their work:

- **Patient Care:** These cost centers are responsible for delivering health care services to patients. Examples include the intensive care unit, nursing department or ambulatory care center;
- **Intermediate:** These cost centers which are organised as separate departments, provide ancillary support services to patient care units. Examples of intermediate cost centers are the pharmacy and laboratory departments;
- **Overhead:** They provide overhead support services to both patient care and intermediate centers. Security, cleaning and finance departments are some examples of overhead cost centers.

Once cost centers are defined, financial managers need to decide how to allocate the cost of the services delivered by overhead and intermediate centers. Since each patient care unit utilises those services, their indirect costs must include such costs. For example cleaning services may be allocated to each patient care unit, according to its floor area, since the more spacious the department area, the more to clean. In regard to allocation of intermediate centers costs (e.g. laboratory and radiology), managers may ask the staff to track those services utilisation by department, and allocate those costs according to available information.

Although the aim is to allocate most of the hospital costs to final centers (patient care departments), some costs may not be associated with services provided by those centers. An example is the cost of teaching medical students.



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