DOWNLOAD PDF ORGANISATION AND FUNDING OF HEALTH CARE SERVICES

Chapter 1 : Publicly funded health care - Wikipedia

Key points: Financial balance is essential for all health organisations Funding Health Services. There are five main ways to fund health services, each of which have advantages and disadvantages.

This has raised questions about the sustainability of its funding model. The way that health care is funded varies between different countries. Here we explain the main models used to finance health care: We outline how each model works in its purest form, while recognising that most countries typically pay for health care using a combination of methods. We also cover user charges. Although no European or OECD Organisation for Economic Co-operation and Development country relies on user charges as a primary source of health care funding, all countries incorporate at least some element of user charging into the funding mix. We do not consider how social care is funded; in England, health and social care are funded separately, while the definition of social care varies between countries, making comparisons difficult. How is the NHS in England currently funded? Exemption arrangements are in place that cover many patients, including those aged under 16 or 60 and over, as well as recipients of specific state benefits. The exemptions in place resulted in 90 per cent of all prescription items in England being dispensed free of charge last year Health and Social Care Information Centre The relative contribution from each of these sources of finance â€" general taxation, National Insurance and user charges â€" has fluctuated over the years see Commission on the Future of Health and Social Care in England b. For example, the proportion of income from user charges, from a high of 5 per cent in remained at 1. Across the UK, private health insurance policies are held by Most of these are corporate subscriptions, offered to employees as part of their overall remuneration package LaingBuisson Taxation Tax revenues are collected to fund health care. How does it work in principle? Tax-funded models typically seek to pool risk across large populations and make health services available on a universal basis. Taxes vary according to: How is this model applied in practice? Australia, Canada, New Zealand and the Nordic countries are some of the other countries that rely mainly on general taxation to fund health care. However, no country relies on general taxation alone; they may also have user charges or elements of private insurance. For example, in Canada, about 70 per cent of health spending is publicly funded though taxation, with the remaining 30 per cent largely accounted for by out-of-pocket spending costs borne directly by patients In Sweden, for example, public funding for health care comes from both central and local taxation. This is because universal Medicare coverage is limited to medically necessary hospital and physician services. So, for example, there is almost no public coverage for dental care. Arguments for and against taxation The pros and cons of this model vary depending on the taxes used to raise funding, but some general implications are as follows. For It is generally considered to be equitable: Exactly how equitable these models are depends on whether the wider tax system is progressive or regressive see box. General taxes are an efficient way of raising money, with low administration costs relative to the amount of money they raise. There are strong incentives in tax-funded models to control spending. This is because in these systems, the process by which the spending level is determined is a political one that forces governments to weigh trade-offs between health and other areas of public spend. The ability to control spending in this way brings with it both benefits and disadvantages. For example, complaints of underfunding are common in tax-funded systems Savedoff Against As spending on health care tends to rise over time, health services can consume an increasing proportion of public spending. To pay for this, governments can either divert funds away from other areas of public spending or raise taxes, which can be unpopular, and particularly difficult during an economic downturn. Some argue that these decisions politicise the process and can make health budgets less predictable from year to year, although others see this as an advantage as it introduces a degree of accountability not present in other models. The television licence fee is one example. In the former, the dedicated tax funds all health care spending, in the latter it funds only part of the overall expenditure. Proponents of hypothecated taxes often argue that: However, those against this form of tax argue that: Finance ministries across the world,

including HM Treasury, may resist hypothecated taxes, mainly because they reduce flexibility in deciding on spending priorities that will change over time. For a discussion of the arguments for and against funding the NHS through hypothecated taxation see Layard and Appleby A regressive tax on incomes is one in which the average rate of tax falls as income rises â€" ie, the percentage of your income taken in tax falls as you become richer Progressive: A progressive tax on incomes is one in which the average rate of tax rises as income rises â€" ie, the percentage of your income taken in tax rises as you become richer Private health insurance PHI Individuals or employers on their behalf take out health care insurance policies from private organisations. Policy-holders contribute on a regular basis. The level of contribution is based on their risk of requiring health care, which can be assessed in several ways: Contributions are collected by private insurers. The benefits package may vary between insurers, enabling people to choose according to their means, needs and preferences. The use of private insurance varies greatly. Broadly speaking, there are five different ways in which private insurance can be used: In some countries eg, Switzerland PHI is mandatory. However, as with tax-funded models and social health insurance, countries that use PHI as a dominant form also rely on other sources of funding for example, see box on US. Most plans require members to cover some of their care costs through co-payments and other charges. There are also two major publicly funded health insurance programmes: However, significant gaps in coverage remain. In , 15 per cent of adults between the ages of 19 and 64 were uninsured Kaiser Family Foundation The Affordable Care Act also known as ObamaCare sought to address this problem, by providing affordable cover for those who did not qualify for Medicaid. By , the proportion of the population with no form of health care cover had fallen to 10 per cent. This form of PHI does not exempt people from paying into the publicly funded health system. Government incentives to encourage take-up of PHI In Australia, government reforms were introduced in the s to encourage take-up of private health insurance â€" including a 30 per cent rebate for premiums and income tax surcharges for those on higher incomes without private cover. While enrolment to private health insurance schemes increased, the reforms did not achieve their aim of easing financial and demand pressures in the public system and have been criticised for disproportionately benefiting higher earners and diverting government funds away from the public system Robertson et al Recently, the scale of tax relief has been reduced. In the UK, tax relief for private medical insurance was introduced for those over the age of 60 in , aimed at reducing pressure on the NHS and helping those who had insurance as part of their employment package to continue it after retirement. It proved poor value for money and was abolished in by the incoming Labour government Commission on the Future of Health and Social Care in England b. For example, in France complementary insurance is held by approximately 85 per cent of the population to cover the cost of statutory user charges. In Canada, for example, private supplementary health insurance provides coverage for the cost of prescription drugs only medication administered in hospital is covered by public funding , dental care, optical care and other goods and services not covered by the public system. In Germany, for instance, people who earn over a certain amount can choose to purchase private health insurance instead of social health insurance. However, this type of opt-out needs to be carefully managed to ensure the statutory scheme remains equitable and financially viable. Arguments for and against using private health insurance as the primary source of financing For Proponents of private health insurance argue that it promotes choice for users, encourages competition and drives up standards of care. Competition can in theory also drive down premium prices between competing insurance companies; however, Switzerland and the US, which both use PHI as the primary source of financing, spend more on health than the UK. It is also often argued that private health insurance reduces the burden on public finances by taking some people out of the state system. Against A pure unregulated private health insurance market is inequitable as it is based on risk selection. This means that insurers can deny cover or charge very high premiums to those who are deemed more likely to use health care services, such as those with pre-existing medical conditions or older people, leaving a proportion of the population uninsured and therefore forced to pay for their own care. There are a variety of failures in health care insurance markets such as asymmetric information and market power , so when private health insurance is used as a primary source of

funding it tends to be heavily regulated. As those on low incomes tend to have a higher need for health care, they are also more likely to have higher premiums, which may act as a further barrier to access Van Doorslaer et al This model tends to incur high management and administrative costs due to the resource required to assess risk, set premiums, design benefit packages and assess claims. Employer-based PHI schemes can make employees with higher health risks less likely to move to new employers and less able to work as self-employed or in smaller firms, leading some to argue that it makes countries less competitive in a global market. Social health insurance SHI What is it? Typically, employees and employers pay contributions to cover a defined package of services Wagstaff This system was introduced under Chancellor Bismarck in 19th century Germany. In classic social insurance models, members normally employees contribute a proportion of their salary, with the level of contribution related to income rather than risk of illness. Employee contributions are typically matched by employers. For example, in Germany, the basic flat social health insurance contribution rate in amounts to There may be a single fund or several funds covering different sectors of the population and these are usually publicly run. In some countries, privately run insurers can compete; where this happens, mechanisms may exist to pool risks and costs between funds. Members may or may not have a choice of which fund they join. The defined package of health benefits may also vary between funds, but there is usually a standard regulated basic package. The way that social health insurance schemes operate varies widely from one country to another. In most countries, the statutory scheme does not raise sufficient funds and is subsidised by other means see below. France also requires co-payments at the point of access that are capped. Co-payments also apply in Germany â€" eg, for each day of an inpatient stay â€" and are capped at 2 per cent of household income, or less for certain groups that meet the criteria Robertson et al As social health insurance is often based on employment, countries operating this model have to find ways including general taxation and other sources such as statutory pension funds to provide cover for those not in employment. For example, the Japanese health insurance scheme has several options to ensure universal cover is provided: Arguments for and against social health insurance SHI For Ensuring equity and universal access based on clinical need is a principal objective of SHI systems, and a major benefit is that payment is not related to risk. This means it does not discriminate against those who are older or have pre-existing medical conditions. Properly designed, SHI can provide comprehensive cover to all, in a similar way to tax-funded systems. Compared to private insurance, SHI is generally considered to be more efficient as it allows pooling of resources and risk across a group of people. Social insurance funds can be kept separate from other government-mandated taxes and charges, so like hypothecated tax models see box on hypothecated taxes , they potentially give more transparency and provide increased certainty about funding levels for health in the medium term. Because SHI contributions are raised purely for health, beneficiaries may be more willing to contribute the rates needed to provide comprehensive coverage.

Chapter 2 : WHO | Health systems financing

Figure 1: the mechanisms for funding local agencies, or purchasers of health services, 2 In some countries, government funds intended for local agencies may flow through intermediate organizations, such as independent insurance agencies.

Private Medical Insurance Social Insurance, sometimes, compulsory in law Note that in most countries all five systems are used - the difference is which ones are dominant. General taxation is regarded as being highly efficient, delivering strong cost containment It forces prioritisation through what are typically overall cash-limited health care budgets set by the government and allows trade off of spend on health care with other public health priorities such as education or reducing poverty Ensures universal access to services irrespective of ability to pay Low administrative costs Tax financing can help individuals in difficult times when they are less able to afford out-of-pocket payments or private insurance Because it draws revenue from a wide base, it helps to minimize distortions in particular sectors of the economy. The government has both a strong incentive and the capacity to control costs which could result in poor services Because the service is free at the point of use it can encourage overuse and high expectations Reliance on general tax financing can leave a health system vulnerable in times of economic and fiscal difficulties. The degree of individual choice tends to be relatively limited. The current National Insurance scheme was started by Lloyd George in as a form of hypothecated taxation. The best example of a hypothecated tax is the use of tobacco tax for anti-tobacco work in California. The electorate are generally willing to pay if they can see what they are getting for their money There is an identifiable link between the money paid and the service received The scheme is progressive so that those who earn more pay more Nobody is excluded from the service because they cannot pay - service is still free at the point of delivery Allows preventive services to be funded. Because the service is free it can encourage over-use. Over-use may be exacerbated if people want to get back what they have paid in In time it may not increase funding if contribution from general taxation is withdrawn as hypothecated tax increases May require a separate and complicated and costly administration Difficult to resist demands for further fragmentation of general taxation e. Can help to encourage a more responsible use of resources by limiting wasteful and unnecessary activity because people think before spending their own money on health care People do not spend money on food or heating while in hospital, so charges do not penalise people if they are used as top-up. People who most need service cannot afford to pay inverse care law Many people will cover themselves with private insurance leaving those who cannot afford charges doubly disadvantaged Where full user charges exist the proportion of GDP spent on health is high. There tend to be a large number of exemptions requiring funding from general taxation e. People with stigmatising conditions, or those who lack insight into their health problems psychotic mental illness may be deterred from seeking help. Preventive services may lose out in funding terms to curative services. Private Medical Insurance Definition: Weighting of premiums according to use means that there is a deterrent effect on demand The costs of every aspect of care are made more explicit Insurance companies may manage care to ensure only effective forms of treatment are used. Those who need insurance most often cannot afford it, e. People generally have to pay for services then make a claim afterwards, and re-imbursement may not be complete. Funding of health services tends to be removed from the political arena A system of payment and retrospective claim may limit demand Payment by employers may act as incentive to health and safety if they are penalised for ill health Non-profit making so all money paid in goes on either administration or health care. As with tax-financed systems, access to health services is typically universal or near universal and not based on ability to pay. May not limit demand as there is an element of getting value for the contribution paid May deter employers from taking on sick or disabled employees A high proportion of demand is not covered elderly, unemployed, chronically sick, children and therefore substantial amount of state underwriting remains Claims scheme may be complicated and deter genuinely sick from seeking help, particularly in conditions such as psychotic mental illness 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. This may lead to economic distortions and disincentives as the revenue base is more concentrated on employment. Social insurance systems can also be vulnerable to periods of economic downturn which can result in reduced revenues into the sickness funds Social insurance is not as progressive as general taxation and may be regressive if the sickest groups have to pay highest premiums Responsibility for funding preventive and public health services is unclear High earners may be allowed to opt out in favour of private schemes which depletes the social insurance scheme of funds Patients may shop around and see several doctors until they get what they want, increasing demand without increasing benefit. NHS budget statements usually have three sections: The system pays for activity not results e. The aim is to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for casemix. The central idea is that the NHS will be a fixed price for a particular operation of treatment wherever the care is provided i.

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Grant announcements from AHRQ for supporting research to improve the quality, effectiveness, accessibility, and cost effectiveness of health care Research Policies Policies and procedures, agency requests, and notices published in the Federal Register and NIH Guide.

The basics, however, remain the same--universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay. Under the Constitution Act, , the provinces were responsible for establishing, maintaining and managing hospitals, asylums, charities and charitable institutions, and the federal government was given jurisdiction over marine hospitals and quarantine. The federal government was also given powers to tax and borrow, and to spend such money as long as this did not infringe on provincial powers. The federal department of Agriculture covered federal health responsibilities from until , when the department of Health was created. Over the years the responsibilities of both levels of government have changed. In , the government of Saskatchewan introduced a province-wide, universal hospital care plan. By , both British Columbia and Alberta had similar plans. The federal government passed the Hospital Insurance and Diagnostic Services Act in , which offered to reimburse, or cost share, one-half of provincial and territorial costs for specified hospital and diagnostic services. This Act provided for publicly administered universal coverage for a specific set of services under uniform terms and conditions. Four years later, all the provinces and territories had agreed to provide publicly funded inpatient hospital and diagnostic services. The federal government passed the Medical Care Act in , which offered to reimburse, or cost share, one-half of provincial and territorial costs for medical services provided by a doctor outside hospitals. Within six years, all the provinces and territories had universal physician services insurance plans. In , under the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, cost sharing was replaced with a block fund, in this case, a combination of cash payments and tax points. A block fund is a sum of money provided from one level of government to another for a specific purpose. With a transfer of tax points, the federal government reduces its tax rates and provincial and territorial governments simultaneously raise their tax rates by an equivalent amount. This new funding arrangement meant that the provincial and territorial governments had the flexibility to invest health care funding according to their needs and priorities. Federal transfers for post-secondary education were also added to the health transfer. In , federal legislation, the Canada Health Act, was passed. This legislation replaced the federal hospital and medical insurance acts, and consolidated their principles by establishing criteria on portability, accessibility, universality, comprehensiveness, and public administration. Federal legislation passed in consolidated federal cash and tax transfers in support of health care and post-secondary education with federal transfers in support of social services and social assistance into a single block funding mechanism, the Canada Health and Social Transfer CHST , beginning in fiscal year An agreement on health reached in by the federal, provincial and territorial government leaders or first ministers set out key reforms in primary health care, pharmaceuticals management, health information and communications technology, and health equipment and infrastructure. At the same time, the federal government increased cash transfers in support of health. In , the first ministers agreed on the Accord on Health Care Renewal, which provided for structural change to the health care system to support access, quality and long-term sustainability. The Accord committed governments to work toward targeted reforms in areas such as accelerated primary health care renewal; supporting information technology e. Under the Accord, federal government cash transfers in support of health care were increased, and the CHST was split into the Canada Health Transfer for health and the Canada Social Transfer for post-secondary education, social services and social assistance, effective April The federal, provincial and territorial governments committed to a health care renewal plan that included work toward reforms in key areas such as: To support the Plan, the federal government increased health care cash transfers including annual increases to the Canada Health Transfer from until to provide predictable growth in federal funding. In spring , all provinces and

territories publicly committed to establishing a Patient Wait Times Guarantee in one priority clinical area by and to undertaking pilot projects to test guarantees and inform their implementation. A Patient Wait Times Guarantee is the offer of alternative care options e. For more detail on the history of our health care system, refer to the resources at the end of this brochure: The provincial and territorial governments have most of the responsibility for delivering health and other social services. The federal government is also responsible for some delivery of services for certain groups of people. Publicly funded health care is financed with general revenue raised through federal, provincial and territorial taxation, such as personal and corporate taxes, sales taxes, payroll levies and other revenue. Provinces may also charge a health premium on their residents to help pay for publicly funded health care services, but non-payment of a premium must not limit access to medically necessary health services. There is more to health than the health care system. The responsibility for public health, which includes sanitation, infectious diseases and related education, is shared between the three orders of government: First Nations people living on reserves; Inuit; serving members of the Canadian Forces; eligible veterans; inmates in federal penitentiaries; and some groups of refugee claimants. The Canada Health Act establishes criteria and conditions for health insurance plans that must be met by provinces and territories in order for them to receive full federal cash transfers in support of health. The Act also discourages extra-billing and user fees. Extra-billing is the billing of an insured health service by a medical practitioner in an amount greater than the amount paid or to be paid for that service by the provincial or territorial health insurance plan. A user charge is any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health insurance plan and is not payable by the plan. The federal government provides cash and tax transfers to the provinces and territories in support of health through the Canada Health Transfer. To support the costs of publicly funded services, including health care, the federal government also provides Equalization payments to less prosperous provinces and territorial financing to the territories. Direct federal delivery of services to First Nations people and Inuit includes primary care and emergency services on remote and isolated reserves where no provincial or territorial services are readily available; community-based health programs both on reserves and in Inuit communities; and a non-insured health benefits program drug, dental and ancillary health services for First Nations people and Inuit no matter where they live in Canada. In general, these services are provided at nursing stations, health centres, in-patient treatment centres, and through community health promotion programs. Increasingly, both orders of government and Aboriginal organizations are working together to integrate the delivery of these services with the provincial and territorial systems. The federal government is also responsible for health protection and regulation e. It also provides support for health promotion and health research. In addition, the federal government has instituted health-related tax measures, including tax credits for medical expenses, disability, caregivers and infirm dependants; tax rebates to public institutions for health services; and deductions for private health insurance premiums for the self-employed. The five Canada Health Act principles provide for: The provincial and territorial plans must be administered and operated on a non profit basis by a public authority accountable to the provincial or territorial government. The provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners and dentists working within a hospital setting. The provincial and territorial plans must entitle all insured persons to health insurance coverage on uniform terms and conditions. The provincial and territorial plans must provide all insured persons reasonable access to medically necessary hospital and physician services without financial or other barriers. The provincial and territorial plans must cover all insured persons when they move to another province or territory within Canada and when they travel abroad. The provinces and territories have some limits on coverage for services provided outside Canada, and may require prior approval for non-emergency services delivered outside their jurisdiction. The provincial and territorial governments fund these services with assistance from federal cash and tax transfers. Medically necessary services are not defined in the Canada Health Act. It is up to the provincial and territorial health insurance plans, in consultation with their respective physician colleges or groups, to determine which services are medically necessary for health insurance

purposes. If it is determined that a service is medically necessary, the full cost of the service must be covered by the public health insurance plan to be in compliance with the Act. If a service is not considered to be medically required, the province or territory need not cover it through its health insurance plan. The roles of the provincial and territorial governments in health care include: Most provincial and territorial governments offer and fund supplementary benefits for certain groups e. Although the provinces and territories provide these additional benefits for certain groups of people, supplementary health services are largely financed privately. Individuals and families who do not qualify for publicly funded coverage may pay these costs directly out-of-pocket , be covered under an employment-based group insurance plan or buy private insurance. Under most provincial and territorial laws, private insurers are restricted from offering coverage that duplicates that of the publicly funded plans, but they can compete in the supplementary coverage market. Health Expenditures Within the publicly funded health care system, health expenditures vary across the provinces and territories. Footnote 1 In , publicly funded health expenditures accounted for seven out of every 10 dollars spent on health care. The remaining three out of every 10 dollars came from private sources and covered the costs of supplementary services such as drugs, dental care and vision care. Canadian Institute for Health Information. National Health Expenditure Trends, - How health care dollars are spent has changed significantly over the last three decades. On average, the share of total health expenditures paid to hospitals and physicians has declined, while spending on drugs has greatly increased. Known to Canadians as "medicare," the system provides access to a broad range of health services. What Happens First Primary Health Care Services When Canadians need health care, they most often turn to primary health care services, which are the first point of contact with the health care system. In general, primary health care serves a dual function. First, it provides direct provision of first-contact health care services. Primary health care services are increasingly comprehensive, and may include prevention and treatment of common diseases and injuries; basic emergency services; referrals to and coordination with other levels of care, such as hospital and specialist care; primary mental health care; palliative and end-of-life care; health promotion; healthy child development; primary maternity care; and rehabilitation services. Doctors in private practice are generally paid through fee-for-service schedules that itemize each service and pay a fee to the doctor for each service rendered. These are negotiated between each provincial and territorial government and the medical professions in their respective jurisdictions. Those in other practice settings, such as clinics, community health centres and group practices, are more likely to be paid through an alternative payment scheme, such as salaries or a blended payment e. Nurses and other health professionals are generally paid salaries that are negotiated between their unions and their employers. When necessary, patients who require further diagnosis or treatment are referred to other health care services, such as diagnostic testing, and health care professionals, such as physician specialists, nurse practitioners, and allied health professionals health care professionals other than physicians and nurses. Health care providers may be regulated through professional colleges or other bodies or non-regulated, unionized or non-unionized, employed, self-employed or volunteer. Most doctors work in independent or group practices, and are not employed by the government. Some work in community health centres, hospital-based group practices, primary health care teams or are affiliated with hospital out-patient departments. Nurses are primarily employed in acute care institutions hospitals ; however, they also provide community health care, including home care and public health services. Most dentists work in independent practices; in general, their services are not covered under the publicly funded health care system, except where in-hospital dental surgery is required. Allied health professionals include: Hospitals are generally funded through annual, global budgets that set overall expenditure targets or limits as opposed to fee-for-service arrangements negotiated with the provincial and territorial ministries of health, or with a regional health authority or board. Although global funding continues to be the principal approach for hospital reimbursement in Canada, a number of provinces have been experimenting with supplementary funding approaches. Secondary health care services may also be provided in the home or community and in institutions mostly long-term and chronic care. Referrals to home, community, or institutional care can be made by doctors,

hospitals, community agencies, families and patients themselves. Patient needs are assessed by medical professionals, and services are coordinated to provide continuity of care. Care is provided by a range of formal, informal often family and volunteer caregivers. For the most part, home and continuing care services are not covered by the Canada Health Act; however, all the provinces and territories provide and pay for certain home and continuing care services. Regulation of these programs varies, as does the range of services. The federal department of Veterans Affairs Canada provides home care services to certain veterans when such services are not available through their province or territory. In addition, the federal government provides home care services to First Nations people living on reserves and to Inuit in certain communities.

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Health financing systems are critical for reaching universal health coverage. Health financing levers to move closer to universal health coverage lie in three interrelated areas: raising funds for health; reducing financial barriers to access through prepayment and subsequent pooling of funds in.

Organizational Structure of the Health Care System The Australian Health System - overview The Australian Health System consists of a mix of public and private sector health services and a range of funding and regulatory mechanisms. Service providers include private medical practitioners, other health professionals, public and private hospitals, clinics and other government and non-government agencies. Funding for services is provided by the Federal Government, State, Territory and Local governments, health insurers, individuals and a range of other sources. Medicare and the PBS cover all Australians, subsidising payments for out-patient private medical services and prescription medicines. Under Medicare, the Federal and State Governments also jointly fund public hospital services which are provided free of charge to Australians treated as public patients in a shared ward. The Federal Government also provides subsidies to Australians who choose to take out private health insurance through a national rebate scheme. The rebate is not means tested, so any Australian who has an appropriate level of private health insurance cover with a registered health fund is eligible for Government-funded reduction in the cost of their premiums. The objective of the system is to deliver a balance of public and private health services to provide all Australians, regardless of their personal circumstances, with free or low-cost access to universal care. Primary, Specialty and Hospital Care National Primary Health Care Strategy The Government is developing a strategy with advice from a specially commissioned external reference group and in consultation with State and Territory Governments for delivery in mid Its focus is tackling the health challenges of the 21st century and ensuring access to care. Priorities include better rewarding prevention, promoting evidence-based management of chronic disease, supporting patient management of chronic conditions, supporting the role of GPs in health care, addressing the needs for access to other health professionals and encouraging greater focus on multidisciplinary care. The strategy will also consider ways to reduce processing red tape and simplifying the Medicare Schedule. In-hospital services covered On admission to public hospitals patients can choose to be treated as a public or a private patient. Public patients are entitled to free medical and allied health care from doctors chosen by the hospital. Private patients are entitled to choose their treating doctor. The fees charged by the chosen treating doctor are funded partly by Medicare and the balance by the patient some or all of which may be covered by private health insurance. Full coverage for all treatment, care and after-care in a public hospital by a treating doctor or specialist nominated by the hospital. Outstanding costs for treatment, hospital accommodation, theatre fees and medicines will apply, but some or all of the balance may be covered by Private Health Insurance. Consultation fees for doctors, including specialists Tests and examinations by doctors needed to treat illnesses, including X-rays and pathology tests Coverage for a limited number of other specified health care services provided outside of hospitals, such as eye tests performed by optometrists and some services from Mental Health professionals Most surgical and other therapeutic procedures performed by doctors Limited surgical procedures performed by approved dentists Services not covered by Medicare Medicare does not cover the following services: Prostheses for private hospital procedures Medicines outside the subsidy covered by the PBS Medical and hospital costs incurred overseas Medical costs for which someone else is responsibleâ€”ie: Today, insurers are able to provide benefits for medical services provided as a substitute for hospital treatment or as part of a chronic disease management program. Visits to general practitioners which are covered by Medicare can not be covered by insurers. Under Community Rating, insurers are required to charge customers the same premiums irrespective of age, gender, health status or claims history. The insurance risk is therefore borne across all customers in the sector. This is very different to many private health insurance schemes globally, which tend to price on the basis of individual risk. The rebate can be claimed by registering to

receive a premium reduction from a private health insurer or by claiming the rebate directly from the Federal Government through Medicare Australia or as a refundable tax offset at the end of the income year. There are some exceptions. This loading ceases to apply once a person has had hospital cover for a period of ten continuous years. In late the Federal Government increased the income thresholds for the Medicare Levy Surcharge for the first time since it was first introduced. The new thresholds apply to the financial year. PHIAC is a Government statutory authority and the prudential regulator for the private health insurance industry. It supervises compliance by private health insurers with the PHI Act in relation to the management and operation of health benefits funds and seeks to promote industry conduct in the best interests of insured members. The Private Health Insurance Ombudsman PHIO is an independent Government agency that deals with inquiries and complaints about any aspect of private health insurance and provides and publishes independent information about private health insurance and the performance of health funds. Private health insurers are also subject to regulatory frameworks and obligations imposed by a range of other legislation. Premium Review Process Private health insurers are required to apply to the Federal Minister for Health and Ageing to increase their premiums at least 60 days prior to the date that the change is to take effect. Insurers who wish to change their premiums are required to submit an application in the approved form to the Department of Health and Ageing DoHA , the application includes not only the new rate and amount of the increase for each product but also detailed information regarding the reasons for the increase. Although insurers are free to make an application at any time this generally happens once a year. Insurers usually increase their premiums on 1 April each year with applications are due to DoHA in mid December each year. The Minister just announced that for the next premium review round applications will be due on 20 November which is around a month earlier than previous years. Advice in relation to the each application is then provided to the Minister who makes the decision whether to approve the increase sought. The Minister must approve the increase sought unless the Minister is satisfied that the increase would be contrary to the public interest. Community Rating It is a condition of registration that an Australian health fund ensures its rules and actions are consistent with the Community Rating Principle and that it does not undertake any activities which promote improper discrimination between policyholders, insurers or consumers. The Community Rating Principle aims to remove barriers to access for private health insurance by keeping it affordable, available and of value to everyone including the elderly and chronically ill. It prevents discrimination of contributors on the basis of matters such as their health status, age other than age at entry under Lifetime Health Cover , race, sex, sexuality or claims history. A Risk Equalisation Scheme has been developed to support the Community Rating Principle and operates to average out the cost of hospital, hospital-substitute claims and some components of chronic disease management program benefits, for specified ages across the industry. Australian Hospital Statistics Between and , the former Liberal Government introduced a range of policy initiatives to increase participation in Private Health Insurance including a government-funded rebate for premiums, the Medicare Levy Surcharge and Lifetime Health Cover. While the new Government has enacted changes to the MLS threshold levels as part of its first budget, it continues to publicly maintain a commitment to existing incentives, particularly the rebate, for the sector. Immediately post election, the Prime Minister signaled his priorities as revolutionising education, acting on climate change, improving fairness and balance in the workplace, maintaining a strong economy and fixing hospitals. Since that time the Government has announced a range of reviews and committees to determine forward directions in key policy areas. The Australian Health sector is one of the areas they are reviewing. Integrate new technology into the provision of health care and better manage patient information. Implementing a national drugs strategy to prevent the onset of use, intervene early and minimise the harm caused by legal and illegal drugs. Denticare The Commission has recommended the establishment of a Medicare type system for dental services. The system would be funded by an increase in the Medicare Levy of 0. Australians would opt to use the public dental system or to enroll in a private insurance dental plan. Governance Reform The Commission has put forward a number of options regarding long term governance reform for the health system. One of the options is the introduction of a

compulsory social insurance system, which would be a tax funded community insurance scheme under which there would be multiple competing health plans for people to choose from, which would be required to cover a mandatory set of services including hospital, medical, pharmaceutical, allied health and aged care. Data collection The collection of public and private hospital episode data nationally. Electronic Health record The development of a person-controlled electronic personal health record. National Preventative Health Taskforce This taskforce was established in April to develop strategies to tackle health challenges posed by tobacco, alcohol and obesity and develop a National Preventative Health Strategy by June National Primary Health Care Strategy The Government is developing a strategy with advice from a specially commissioned external reference group and in consultation with State and Territory Governments for delivery in mid The arrangement will include a performance and assessment framework to support public reporting against milestones and measures.

Chapter 5 : Care Continuum Alliance / Australia - Health Care System Structure and Organization

Previous Reporting Data. The table reflects the planned use of Prevention and Public Health Fund resources in fiscal year Information reported includes name of the agency receiving funds, the activity to be supported, and the program or activity funding level.

Health care system Most developed countries have partially or fully publicly funded health systems. Most western industrial countries have a system of social insurance based on the principle of social solidarity that covers eligible people from bearing the direct burden of most health care expenditure, funded by taxation during their working life. Among countries with significant public funding of healthcare there are many different approaches to the funding and provision of medical services. Systems may be funded from general government revenues as in Canada or through a government social security system as in Australia , France , Belgium , Japan and Germany with a separate budget and hypothecated taxes or contributions. The proportion of the cost of care covered also differs: Services provided by public systems vary. For example, the Belgian government pays the bulk of the fees for dental and eye care, while the Australian government covers eye care but not dental care. Publicly funded medicine may be administered and provided by the government, as in the Nordic countries , Portugal , Spain , and Italy ; in some systems, though, medicine is publicly funded but most hospital providers are private entities, as in Canada. The organization providing public health insurance is not necessarily a public administration, and its budget may be isolated from the main state budget. Some systems do not provide universal healthcare or restrict coverage to public health facilities. Some countries, such as Germany, have multiple public insurance organizations linked by a common legal framework. Some, such as the Netherlands , allow private for-profit insurers to participate. Two-tier healthcare Almost every major country that has a publicly funded healthcare system also has a parallel private system for patients who hold private medical insurance or themselves pay for treatment. From the inception of the NHS model , public hospitals in the United Kingdom have included "amenity beds" which would typically be siderooms fitted more comfortably, and private wards in some hospitals where for a fee more amenities are provided. Patients using these beds are in an NHS hospital for surgical treatment, and operations are generally carried out in the same operating theatres as NHS work and by the same personnel but the hospital and the physician receive funding from an insurance company or the patient. These amenity beds do not exist in all publicly funded systems, such as in Spain. The NHS also pays for private hospitals to take on surgical cases under contract. Health system and Health care reform Many countries are seeking the right balance of public and private insurance, public subsidies, and out-of-pocket payments. Many OECD countries have implemented reforms to achieve policy goals of ensuring access to health care, improving the quality of health care and health outcomes, allocating an appropriate level of public sector other resources to healthcare but at the same time ensuring that services are provided in a cost-efficient and cost-effective manner microeconomic efficiency. A range of measures, such as better payment methods, have improved the microeconomic incentives facing providers. However, introducing improved incentives through a more competitive environment among providers and insurers has proved difficult.

Chapter 6 : Health care - Wikipedia

Health services research is a "multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviors affect access to health care, the quality and cost of health care, and ultimately, our health and well-being." i.

Due to the complexities of health care services and systems, investigating and interpreting the use, costs, quality, accessibility, delivery, organization, financing, and outcomes of health care services is key to informing government officials, insurers, providers, consumers, and others making decisions about health-related issues. Health services researchers examine the access to care, health care costs and processes, and the outcomes of health services for individuals and populations. The field of health services research HSR is relied on by decisionmakers and the public to be the primary source of information on how well health systems in the United States and other countries are meeting this challenge. This was expanded upon in by AcademyHealth, the professional organization of the HSR field, with the following definition, which broadly describes the scope of HSR: Health services research is the multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviors affect access to health care, the quality and cost of health care, and ultimately our health and well-being. Its research domains are individuals, families, organizations, institutions, communities, and populations. These include changes in Medicare and Medicaid coverage, disparities in access and utilization of care, innovations in private health insurance e. As new diagnostic and treatment technologies are introduced, HSR examines their impact on patient outcomes of care and health care costs. The definition of HSR also highlights the importance of examining the contribution of services to the health of individuals and broader populations. These reports tell us that the American quality of care is inconsistent and could be substantially improved. For example, HSR methods have been developed to describe doctor-patient communication patterns and examine their impact on patient adherence, satisfaction, and outcomes of care. Prospective payment of hospitals, nursing homes, and home health care by Medicare became possible with the development of robust case-mix measurement systems. History of Health Services Research The history of HSR is generally considered to have begun in the s and s with the first funding of grants for health services research focused on the impact of hospital organizations. Public Health Services to address concerns with access to health services, quality of care, and costs. The Center funded demonstration projects to measure quality and investigator-initiated research grants. In , Congress created the Agency for Health Care Policy and Research and broadened its mission to focus attention on variations in medical practice, patient outcomes of care, and the dissemination of evidence-based guidelines for the treatment of common disorders. AHRQ provides Federal leadership for the field, investing in methods for quality measurement, development of patient safety methods, and health information technology e. The diversification of funding comes, in part, from the recognition that HSR is important in managing health care systems, such as the Veterans Health Administration, and provides essential information on the translation of scientific discoveries into clinical practice in American communities, such as those funded by National Institutes of Health. Funding by private foundations has a significant role and complements Federal funding. Other private funding sources include the health care industry, for example, pharmaceutical companies, health insurers, and health care systems. Goals for Health Services and Patient Outcomes The goal of health services is to protect and improve the health of individuals and populations. In a landmark report, Crossing the Quality Chasm: Patients should not be harmed by health care services that are intended to help them. Subsequent research has found medical errors common across all health care settings. Effective care is based on scientific evidence that treatment will increase the likelihood of desired health outcomes. Evidence comes from laboratory experiments, clinical research usually randomized controlled trials , epidemiological studies, and outcomes research. The availability and strength of evidence varies by disorder and treatment. Failure to provide timely care can deny people critically needed

services or allow health conditions to progress and outcomes to worsen. Health care needs to be organized to meet the needs of patients in a timely manner. Health care services should be personalized for each patient, care should be coordinated, family and friends on whom the patient relies should be involved, and care should provide physical comfort and emotional support. The health care system should benefit all people. The evidence is strong and convincing that the current system fails to accomplish this goal. The IOM report, Unequal Treatment, 32 documented pervasive differences in the care received by racial and ethnic minorities. The findings were that racial and ethnic minorities are receiving poorer quality of care than the majority population, even after accounting for differences in access to health services. Crossing the Quality Chasm concludes that for the American health care system to attain these goals, transformational changes are needed. Evaluating the Quality of Health Care HSR evaluation of quality of care has proven to be an inexact science and complex, even though its definition is relatively simple: The goal of quality care is to increase the likelihood of achieving desired health outcomes, as expressed by the patient. The complexity in measuring quality comes from gaps in our knowledge regarding which services, for which patients, will actually improve the likelihood of desired health outcomes. Also, patients need not have the same desired health outcomes and therefore might not receive the same care for an identical health problem, further complicating the measurement of quality of care. Quality measurement has advanced substantially, but it remains early in its development. The conceptual framework widely applied in evaluating quality comes from years of research and the insightful analysis of Avedis Donabedian. This model is applied in the evaluation of health services and the accreditation of health care providers and organizations. Seminal research about variation in the quality of care patients received brought to focus the need to monitor and improve the quality of health care. Wennberg and Gittelsohn 34 , 35 found wide variation in practice patterns among community physicians, surgical procedures, and hospitals. Brook and colleagues 36 found that a small number of physicians were responsible for a large number of improperly administered injections. This was the precursor to research on the appropriateness of procedures and services under specific circumstances 36 , 37 as well as the development of practice guidelines and standards for quality care. The challenge is determining whether there is a direct relationship between rates of utilization, variations in appropriateness, and quality of care. One of the challenges in understanding quality, how to measure it, and how to improve it is the influence of physical, socioeconomic, and work environments. Income, race, and genderâ€”as well as individuals within society and organizationsâ€”influence health and risks to health. The structure, process, and outcome dimensions of quality are influenced by both internal and external factors. Structure of Health Care The structure of health care broadly includes the facilities e. Structural characteristics are expected to influence the quality of health care services. One component in the accreditation of health care facilities e. The structural resources of health care facilities and organizations are the foundation upon which quality health care services are provided. Process of Care The interactions between the health care providers and patients over time comprise the process of health care. The process of care may be examined from multiple perspectives: Examining the time sequence of health care services provides insights into the timeliness of care, organizational responsiveness, and efficiency. Linking services to a specific patient complaint or diagnosis provides insights into the natural history of problem presentation and the subsequent processes of care, including diagnosis, treatment, management, and recovery. Examining the natural history of a presenting health complaint across patients will reveal variations in patterns of care. For example, presenting complaints for some patients never resolve into a specific diagnosis. An initial diagnosis may change as more information is obtained. Patients may suffer complications in the treatment process. Also, the process of care may provide insights into outcomes of care e. Generally it is not possible to examine the process of care and determine how fully the patient has recovered prior health status by the end of the episode of treatment. For this reason, special investigations are needed to assess outcomes of care. Evaluation of the process of care can be done by applying the six goals for health care quality. Was care timely and not delayed or denied? Were the diagnosis and treatments provided consistent with scientific evidence and best professional practice? Was the care patient centered? Were

services provided efficiently? Was the care provided equitable? Answers to these questions can help us understand if the process of care needs improvement and where quality improvement efforts should be directed. Outcomes of Care The value of health care services lies in their capacity to improve health outcomes for individuals and populations. Health outcomes are broadly conceptualized to include clinical measures of disease progression, patient-reported health status or functional status, satisfaction with health status or quality of life, satisfaction with services, and the costs of health services. Historically, quality assessment has emphasized clinical outcomes, for example, disease-specific measures. However, disease-specific measures may not tell us much about how well the patient is able to function and whether or not desired health outcomes have been achieved. HSR has developed valid and robust standardized questionnaires to obtain patient-reported information on these dimensions of health outcomes. As these are more widely applied, we are learning about the extent to which health care services are improving health. Public Health Perspective on Health Services Another perspective on health care services comes from the field of public health in which preventive health services are conceptualized at three levels: Primary prevention seeks to prevent disease or delay its onset. Examples of primary prevention include immunizations against infectious disease; smoking prevention or cessation; and promotion of regular exercise, weight control, and a balanced diet. Secondary prevention includes the range of interventions that can reduce the impact of disease morbidity once it occurs and slow its progression. With the increasing burden of chronic diseases, much of the health care provided is directed at secondary prevention. Tertiary prevention is directed at rehabilitation for disabilities resulting from disease and injury. The goal of tertiary prevention is to return individuals to the highest state of functioning physical, mental, and social possible. The public health framework expands the structure, process, and outcome conceptual model by identifying the role and value of health services at three stages: Methodologies and Data Sources Used in Health Services Research The interdisciplinary character of HSR draws on methods and data sources common to the many disciplines that form the intellectual underpinnings of the field. This section discusses the measurement of effectiveness and efficacy of health services and some of the methods and data sources used to understand effectiveness. Effectiveness is one of the six goals of health services. Effectiveness is interrelated with the other five goals, and some of these interrelationships are discussed. Efficacy and Effectiveness An important distinction is made between efficacy and effectiveness of health services. Efficacy is generally established using randomized controlled trial RCT methods to test whether or not clinical interventions make a difference in clinical outcomes. A good example is the series of studies required for Food and Drug Administration approval of a new drug before it is certified as safe and efficacious and allowed to be used in the United States. Efficacy research is generally done with highly select groups of patients where the impact of the drug can be validly measured and results are not confounded by the presence of comorbid conditions and their treatments. The efficacy question is: What impact does a clinical intervention have under ideal conditions? In contrast, effectiveness research is undertaken in community settings and generally includes the full range of individuals who would be prescribed the clinical intervention. Many of these individuals will have multiple health problems and be taking multiple medications, unlike those who were recruited to the RCT. Effectiveness research is seeking to answer the question:

Chapter 7 : Primary health care services funding and contracting | Ministry of Health NZ

Diagram outlining the relationships between funding and contracting for primary health care services. Downloads Primary health care: funding and contracting diagram (pdf, 1 MB).

To view this licence, visit nationalarchives. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned. This publication is available at https: Locally, clinical commissioning groups â€" made up of doctors, nurses and other professionals â€" will buy services for patients, while local councils formally take on their new roles in promoting public health. Health and wellbeing boards will bring together local organisations to work in partnership and Healthwatch will provide a powerful voice for patients and local communities. We lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve. The new and changing health and care organisations work together with the Department to achieve this common purpose. We enable health and social care bodies to deliver services according to national priorities and work with other parts of government to achieve this. We set objectives and budgets and hold the system to account on behalf of the Secretary of State. The Secretary of State for Health has ultimate responsibility for ensuring the whole system works together to meet the needs of patients and the public and reflect their experiences. However, some important underlying changes are being made to how the health and care system is run. This means better care for patients, designed with knowledge of local services and commissioned in response to their needs. They will involve people and community organisations, including elected representatives, in deciding what services the community needs â€" this will inform CCGs and local authorities when they commission services. Local Healthwatch, which are represented on health and wellbeing boards, give patients and communities a voice in decisions that affect them. Local healthwatch will report their views and concerns to Healthwatch England so that issues can also be raised at a national level. Local authorities commission care and support services and have a new responsibility to protect and improve health and wellbeing. They use their knowledge of their communities to tackle challenges such as smoking, alcohol and drug misuse and obesity. Working together with health and care providers, community groups and other agencies, they prevent ill health by encouraging people to live healthier lives. How health and care organisations will work together nationally NHS England supports NHS services nationally and ensures that money spent on NHS services provides the best possible care for patients. It funds local clinical commissioning groups to commission services for their communities and ensures that they do this effectively. Some specialist services will continue to be commissioned by NHS England centrally where this is most efficient. Working with leading health specialists, NHS England brings together expertise to ensure national standards are consistently in place across the country. Public Health England provides national leadership and expert services to support public health and works with local government, the NHS and other key partners to respond to health protection emergencies. Health Education England makes sure the healthcare workforce has the right skills and training to improve the care patients receive. It supports a network of Local Education and Training Boards that plan education and training of the workforce to meet local and national needs. The National Institute for Health and Care Excellence NICE provides guidance to help health and social care professionals deliver the best possible care for patients based on the best available evidence. NICE involves patients, carers and the public in the development of its guidance and other products. The National Institute for Health Research NIHR and its clinical research networks form a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public. The Health and Social Care Information Centre supports the health and care system by collecting, analysing and publishing national data and statistical information and will deliver national IT systems and services to support health and care providers. The NHS Business Services Authority carries out a range of support services to the NHS, patients and the public, including payments for community

pharmacists filling prescriptions and dentists carrying out NHS treatment. How the interests of people using health and care services are protected As the new system brings more freedom for those who plan, commission and provide services, new and existing health and care regulators will safeguard the interests of patients and the wider public. The Care Quality Commission CQC measures whether services meet national standards of quality and safety, ensuring that people are treated with dignity and respect. Healthwatch England works as part of the CQC. Monitor protects and promotes the interests of people using health services by making sure that NHS services are effective and offer value for money. Licensing providers of health care will be one of the main tools Monitor will use to do this. The Health Research Authority works to protect and promote the interests of patients and the public in health research. The Medicines and Healthcare Products Regulatory Agency makes sure that medicines and medical devices work and are safe to use. The Human Tissue Authority regulates human tissue, such as donated organs, to ensure it is used safely and ethically, and with proper consent. The Human Fertilisation and Embryology Authority regulates fertility treatment and the use of embryos in research. Most health and social care professionals must be registered with one of the independent regulators, such as the General Medical Council , who help protect patients and public by ensuring that professional standards are met. Contents Is this page useful?

Chapter 8 : The Role of Nonprofits in Health Care: A Trends Summary - Non Profit News | Nonprofit Quarte

national health care policies and, in particular, will be of use to health policy-makers and advisers, who are under increasing pressure to rationalize the structure and funding of their health systems.

Medical train "Therapist Matvei Mudrov" in Khabarovsk , Russia [7] Primary care refers to the work of health professionals who act as a first point of consultation for all patients within the health care system. Another professional would be a licensed independent practitioner such as a physiotherapist , or a non-physician primary care provider such as a physician assistant or nurse practitioner. Depending on the locality, health system organization the patient may see another health care professional first, such as a pharmacist or nurse. Depending on the nature of the health condition, patients may be referred for secondary or tertiary care. Primary care is often used as the term for the health care services that play a role in the local community. It can be provided in different settings, such as Urgent care centers which provide same day appointments or services on a walk-in basis. Primary care involves the widest scope of health care, including all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health , and patients with all types of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Consequently, a primary care practitioner must possess a wide breadth of knowledge in many areas. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same practitioner for routine check-ups and preventive care , health education , and every time they require an initial consultation about a new health problem. Primary care also includes many basic maternal and child health care services, such as family planning services and vaccinations. Physicians in this model bill patients directly for services, either on a pre-paid monthly, quarterly, or annual basis, or bill for each service in the office. Examples of direct primary care practices include Foundation Health in Colorado and Qliance in Washington. In context of global population aging , with increasing numbers of older adults at greater risk of chronic non-communicable diseases , rapidly increasing demand for primary care services is expected in both developed and developing countries. This care is often found in a hospital emergency department. Secondary care also includes skilled attendance during childbirth , intensive care , and medical imaging services. The term "secondary care" is sometimes used synonymously with "hospital care. Some primary care services are delivered within hospitals. Depending on the organization and policies of the national health system, patients may be required to see a primary care provider for a referral before they can access secondary care. Physiotherapists are both primary and secondary care providers that do not require a referral. In the United States, which operates under a mixed market health care system, some physicians might voluntarily limit their practice to secondary care by requiring patients to see a primary care provider first. This restriction may be imposed under the terms of the payment agreements in private or group health insurance plans. In other cases, medical specialists may see patients without a referral, and patients may decide whether self-referral is preferred. In the United Kingdom and Canada, patient self-referral to a medical specialist for secondary care is rare as prior referral from another physician either a primary care physician or another specialist is considered necessary, regardless of whether the funding is from private insurance schemes or national health insurance.

Chapter 9 : Canada's Health Care System - www.nxgvision.com

In Canada, for example, private supplementary health insurance provides coverage for the cost of prescription drugs (only medication administered in hospital is covered by public funding), dental care, optical care and other goods and services not covered by the public system.

Despite the antipathy that many public sector health care providers feel toward managed care, those providers are actually striving toward the same ends using similar means as managed care organizations MCOs. Many substance abuse treatment providers have been working within a managed care framework for decades, that is, looking at utilization data and developing a continuum of care. Substance abuse treatment providers, particularly those who use case management, have historically recognized the importance of connecting disparate services to meet the needs of clients. More than half the States are currently in the process of adopting some form of managed care to provide behavioral health care services, and more than one-third have received Federal waivers to implement Medicaid managed behavioral health programs, with other waivers planned or pending. Some experts predict that many substance abuse programs, already accustomed to scarcity of resources, will make a smooth transition to a managed care environment. However, many programs, particularly those that operate the least like businesses, may find this an extremely challenging time. The need to be accountable for outcomes, particularly in the face of a tax-conscious public, will undoubtedly increase in the managed care era. To adapt to the world of managed care, treatment programs must assess how their services are currently delivered and identify which elements should be preserved and which should be modified. They also must have a firm grasp on how changes in Federal and State reforms will affect their current and future funding mechanisms. Funding Case Management in a Managed Care World Despite the promise of case management as an important adjunct to substance abuse services, it will not survive without empirical data that support its efficacy. Key decisionmakers must believe that case management is an integral component of treatment service before they will incorporate it into the funding structure. It is also true for people who receive services through Medicare HMOs. See Chapter 4 for a discussion of program evaluation and measuring outcomes. For example, clients with long-term or chronic conditions may be required to move from residential facilities to the community before some treatment providers believe they are ready. In this scenario, case management can prove its value by providing the clients with wraparound or supportive services to aid in a successful transition. As another example, outreach case management can help in the area of relapse prevention and aftercare and thus avert the need for high-cost services like inpatient treatment. Managed care tools - clinical pathways, standardized assessments, and treatment protocols - can work well in a case management context. The challenge then lies in tailoring services to the unique needs of each consumer and avoiding "cookie cutter" services. The true test is to develop a comprehensive case management system within a managed care framework with the inherent flexibility and resources necessary to eventually show tangible savings. Only then will an MCO be able to clearly justify case management as a reimbursable service. The decision to include case management in the array of treatment services usually rests with a primary funding source or at the program level. As many traditional public sector providers overhaul their delivery systems to participate in managed care, they must recognize the importance of case management as a key element of effective treatment and communicate that to the funding source. If the primary source of funding usually a State agency expects or requires specific outcomes that go beyond sobriety or cost containment, then a program administrator must develop ways to measure those outcomes. To undertake scientifically valid outcomes studies is beyond the reach of most treatment programs. Providers can, however, increase the chances of having case management activities reimbursed if they measure everything that helps the client, such as consumer-run support groups, drop-in centers, or "Compeer" programs, in which volunteers help clients maintain sobriety and manage other aspects of their lives. Funding Models The multiple players involved in funding public substance abuse treatment have posed complex and ongoing problems for program

administrators. Case management services are no exception and have traditionally been funded through a variety of sources as well. These include Block grants from Federal agencies Medicaid, which included options that allow for non-medical services e. Integration of funding streams has emerged as a strategy to meld services and provide continuity of care. Some States, in fact, have used Medicaid managed care initiatives as the catalyst for blending funding streams, particularly in full capitation models. As States gain more freedom to allocate Medicaid dollars as they see fit, the prospect of increased flexibility in services offered at the program level improves. Managed care is frequently used as a vehicle for integrating funding streams and for fostering collaboration among health care providers. For example, many managed care organizations establish or will only contract with integrated provider networks that Offer a full range of services Extend coverage over a wider geographical or population area thus increasing the number of potential enrollees and sharing the financial risk among more providers Maximize efficiencies in areas like management information systems When providers are organized in such a manner, administrative service organizations are engaged to handle a wide range of business duties for the network. Blended funding approaches, especially those that give providers the necessary freedom to make clinical decisions while still holding them fiscally accountable, can preserve and support the case management function as an integral facet of modern substance abuse treatment. Substance abuse treatment services are treated in different ways depending on which overarching health care delivery model is implemented by the State or by the managed care organization s contracted to provide behavioral healthcare. The two models currently prevailing are the carve-in model and the carve-out model. Carve-in models The carve-in model integrates physical e. Although the purchaser of services may elect a carve-in approach, frequently the MCO may elect to carve out behavioral health care by contracts with managed care organizations. This is because behavioral health care tends to be the most expensive cost center of treatment within an integrated, managed care model of treatment. The carve-in model generally appeals to providers because many individuals with mental illness and substance abuse problems also have serious physical health problems. Integrating the two also underscores the notion that since body and brain are part of the same system, mental illness and substance abuse are bona fide health problems. However, in such a model, case management is often administrative in nature and involves clinical oversight and activities such as utilization review and prior authorization procedures. The primary care physician functions as the case manager or gatekeeper who assesses the range of services the client needs and, ideally, refers him to network providers who offer specialty services. This model for behavioral health care has two major drawbacks. First, primary care physicians may underdiagnose substance abuse problems, especially in populations such as women in whom depression is often diagnosed but seldom tied to substance abuse and the elderly. Lack of knowledge or the desire to hold down costs also may lead to underutilization of services, with consumers denied access to needed care. Second, since the course and overall treatment costs of behavioral health problems are less predictable than many physical health problems, the ability to establish firm enrollment or capitated rates is difficult. If rates are too low, the problem of inadequately treating or excluding those most in need of costly or long-term care e. When services are subcontracted, skimming may become a problem. In this situation, the opportunity exists to cost-shift "difficult" clients to subcontractors who receive only a percentage of the capitated rate. Carve-out models In carve-out arrangements, behavioral health care is considered distinct from other physical problems and is handled either as a separate contract or is intentionally excluded from a managed care plan. If behavioral health care is carved out and handled as a separate managed care account, it is possible to develop capitation or enrollment fees specifically tailored to this population. Carve-outs also provide States with a mechanism to monitor and control the use of substance abuse or mental health funds and some assurance that those problems are being addressed. Ideally, carve-out managed care organizations will have expertise in substance abuse services or will work jointly with providers who possess that expertise. Case management in a carve-out model is likely to remain a service function, particularly if the responsibility for behavioral health care is delegated to the public sector. Given the trends in behavioral health care, the public sector might be advised to learn from the example of the proprietary, more precise matching of clients and

service packages through management information capabilities, some aspects of utilization review procedures, and the development of clinical pathways. These efforts also help providers use their resources wisely and ensure that appropriate and cost-effective services are available to individual consumers. Unfortunately, this method lacks integration with the physical medicine side of treatment, which can lead to ineffective case management and duplication of services by the behavioral health provider and the primary care physician. Preparing a Program for Managed Care To adjust their current operations to meet new demands, programs need to assess their systems, appraise their readiness to operate in a managed care environment, and position themselves and their case management services in a competitive market by identifying market niches and preparing for increased staff licensing and accreditation. Systems Assessment As discussed in Chapter 1, case management assumes different forms depending on its setting and organizational context. Before integrating with managed care, program directors and administrators need to understand how case management is practiced in their program. Administrators must identify potential buyers of case management services and must stay abreast of plans to integrate Medicaid with public funds and efforts to secure private vendors to manage public behavioral health care services. With the blending of systems via managed Medicaid and Medicare, providers are now forced to compete directly with each other. Eventually, all services now delivered by traditional community providers will be delivered within a managed care framework. Currently, many public sector providers of services to people under Medicaid managed care guidelines for managed care companies are providing administrative and clinical case management services for a "fixed," "blended," or "bundled" rate. That rate is a small piece of the pie that comprises the total per-member capitation payment the provider receives and usually is not assigned a specific dollar value. What is the program doing? As a first step in organizational assessment, administrators must clearly define the case management model s being used in the program. At the agency level, community needs and available resources must be reviewed. Often case management services are subsumed under the general category of "the costs of doing business. Case management must be scrutinized both as a stand-alone activity and as part of a total package of services potentially available to consumers. The importance of auditing the costs and revenues associated with various services cannot be over-emphasized, particularly if a system is moving toward a capitated or shared-risk paradigm. Case management, whether a direct service or administrative function, must add value and provide cost benefit to justify its inclusion in the total array of services. Clinical case management must demonstrate direct or indirect benefits above those that consumers can expect from traditional services. The gatekeeping function in administrative-level case management limits the discretion and treatment planning authority of a substance abuse professional. Offsetting this disadvantage, ideally, are two systemwide advantages: Who is paying for case management? Reimbursement for the case management aspects of treatment may come from one or all of the following sources: Private managed-care organizations MCOs Private payers such as corporate employee assistance programs, foundations, and grant funding Volunteer and local sources Courts and criminal justice funding Social service providers e. Such knowledge will help design a case management program and will also help in advocacy efforts to shape State policy on funding streams. How does the program model fit within the system? What specific activities are considered case management and are they reimbursable? If they are reimbursable, are there limits on the number of billable units per consumer? Is there a finite pool of funds available on a fee-for-service basis? Given the melding of clinical and fiscal functions at the provider level, it is also critical to consider who benefits from case management and who does not. What is a reasonable length of time to offer services to a consumer? It is imperative that program staff grapple with these questions to best allocate available resources. Readiness Review In some cases, conversion to managed care must be accomplished in as little as six months after the enactment of legislation or by corporate decree, so providers must assess their readiness to make this transition rapidly and effectively. Tools and surveys can help administrators do a readiness review by providing a clear picture of what models they are using and how they fit in the changing environment. This and similar tools can help agencies evaluate their current operations within each of the following areas Program services and structure.