

# Research paper on benefits of strategic management in healthcare organizations

[Economics](#), [Insurance](#)



**ASSIGN  
BUSTER**

## Introduction

Tremendous change is being witnessed in the relationships between patients, physicians, and managed care facilities with the advent of managed care. Patient-physician relationships are changing, which were once based on the following Cs:

- Choosing the physician by the patient;
- Providing competence;
- Communication between patient and physician;
- Compassion;
- Continuity of care and;
- Absence of conflict of care on the part of the provider (Emanuel & Dobler).

There are three stages involved in strategic management. They are the strategic thinking, strategic planning, and the managing of strategic momentum. There are a number of benefits associated with strategic management in a healthcare organization. They are:

- Binding the organization together as a whole with a common goal and focus;
- Facilitating improvement of financial positions in a majority of cases;
- Providing consistency in decision making;
- Providing self concept, guidance and particular goals;
- Facilitating managers to analyze the present and think about the future;
- Aiding managers to engage in communication both horizontally and vertically;
- Facilitating establishment of coordination within the organization; and

- Aiding in the implementation of innovation and change within the organization.

## **Ethics in the HealthCare System**

If the required ethical standards are implemented, then managed healthcare can provide effective results and work admirably well. Following ethics provides a scenario for long-standing patient-physician relationships, with a population-based approach encouraged and used. Ethical standards, when applied, allow one to obtain results of outcome management studies and implement the most recent of treatment methods while rejecting unproven inefficient diagnoses. The older staff-model HMOs are the best of models where academic pursuits, team building, and collegial interactions were all appreciated and encouraged to take place. Patient-physician relationships were considered prime in these models.

## **Ethics for Physicians Dealing with Managed Care**

It is a significant fact that physicians are wholly responsible for patients, their decisions, and their behavior. In dealing with a managed care organization, the following need to be understood and followed:

- The physician of the patient must always work for the good of the patient and not intend or do any harm;
- Patients interests and rights are prime to the doctor;
- Patients need to be treated with respect, care and as one would treat their family or friend.
- The doctor is the wholly responsible person. In times of conflict with the patient, he must approach the managed care administration and allow for

another physician to take his place in treating the patient.

- Facts of the conflicts need to be documented well and appropriate confirmatory letters should be sent to both the managed care facility and the patient.

In a recent report, the AMA states, " It is essential that the profession and society now act to ensure that managed care techniques are implemented in a way that protects patients and the integrity of the patient-physician relationship."

## **The Social Contract**

Professional autonomy or the freedom to set their own professional standards - this social contract will be endowed on physicians who abide by the Code of Medical Ethics. After a year of its founding, the AMA had set up committees to establish standards on medical sciences, practical medicine, medical education, medical literature, surgery, obstetrics, and publications. Standing committees on anatomy, physiology, chemistry, material medical, vital statistics, forensic medicine, hygiene, and sanitary measures soon followed.

## **Insurance System in the United States**

This section in the paper deals with the management of healthcare systems in the United States. The United States can be called the most technologically advanced in the world and spends the most in terms of healthcare costs per person. Despite this scenario, the United States lags behind many countries when considering providing even the basic health care measures. There is also no universal coverage thus, not allowing about

one-sixth of the population with access even to basic healthcare. Public health is indicated most effectively by two aspects: life expectancy and infant mortality. Data suggest that the US is not amongst the forerunners when assessed based on these two aspects. It ranked the 12th amongst 24 industrialized nations for infant mortality and, in 1960, life expectancy dropped from 16th to 19th place for males and 13th to 17th place for females (World Health Organization, 2000). Thus, the scenario portraying the healthcare statistics is not satisfying enough for an advanced country such as the United States.

A bimodal distribution of healthcare exists in the United States and, hence, this inherent problems in the system are not easily noticeable to the common man. There are two groups of people in the United States. One is the higher socio-economic group who are granted high-quality preventative care. The other group is the population having a low socio-economic background such that services are limited to them and they exhibit life expectancy and birth mortality much lower than the groups in the other countries.

Thus, the scenario that exists is the one in which the US pays more for access to health services than other countries - but, only a smaller fraction of the people benefit from this. The main highlight of the American healthcare system is that the responsiveness to crises situations is outstanding. The confidentiality, the transparency, the autonomy and respect with which the doctors approach the patient are also noteworthy. However, all these advantages would pale down if the entire population in the US is not benefitted by the availability and access to good healthcare.

Uninsurance and underinsurance are two major problems existing in the US healthcare delivery system. What happens in the case of uninsured patients is that they cannot afford healthcare when an accident occurs. They are not able to get even primary care assistance and their illnesses get exacerbated due to this. They are majorly diagnosed with late-stage colorectal, breast and prostate cancers, which would have been treatable if they had access to proper healthcare in the initial stages itself. The other existing problem is underinsurance where the patient's doctor-recommends services are not allowed by the administrator.

Most often the quality of treatment is not satisfying to the patient. This is because of the existing system of employer-based insurance system. The employee is the person who gets the service and who does not pay directly. The insurance company finds itself no incentives to offer better services. The scenario is also characterized by the employer's plan to purchase the cheapest assistance or services. The insurance companies seek to cover fewer people, but healthier people so they tend to benefit. The patient is not bothered about the money involved as he does not pay directly.

The change that is most warranted in this situation is the shift from an employer-based insurance system to a system where the patient chooses the service he wants. Individuals in this case are held responsible for seeking good treatment and managed care facilities are held responsible for the service they offer to the client base. Health insurance in the US must be similar to the auto insurance and should be made mandatory. Otherwise, individuals who do not possess coverage become a public burden.

## **Incremental Proposals to Enhance Healthcare Delivery**

Uninsurance, according to politicians, can be dealt and rectified by the introduction of tax credits and medical savings accounts. The major problem underlying implementation of tax credits is the fact that most of the uninsured do not earn that high enough to pay taxes. Another hurdle that needs to be addressed in the case of tax credits is that they need to cover the full cost of the premium. It was estimated that individual policies amounted to \$2, 542 annually and family coverage is approximately \$6, 740. Thus, credits of \$1, 000 for individual members and \$2, 000 for families are not the likely solutions to help health insurance situation for the poor in America ([www. consumerreports. org](http://www.consumerreports.org)).

Another suggestion would be the implementation of medical savings accounts or MSAs. These are insurance policies linked to savings accounts. Four years back, the Congress sanctioned the offering of about 750, 000 MSAs on a trial basis by insurance companies. These were aimed at the people who were self employed or in small companies. However, by the end of 1999, the insurance companies managed to sell about 45, 000 of these accounts only. This is because the MSAs are preferred by younger and wealthier people (Grossman & Valtin, 1999). This policy is not the appropriate solution, as in the long run, it will help only healthier people benefit. Thus, these tax credits and MSAs function as mere band-aids to the severe problems underlying the healthcare system in the US.

## Single Payer Insurance

One good solution to this health insurance problem is the implementation of single payer health insurance, a system by the PNHP (Physicians for a National Health Program). All of the uninsured would be covered by the administrative savings of having a single government insurance plan. In addition, the underinsured also benefit by gaining complete care. Though this policy seems lucrative and effective, it has not still come to the public eye. The program by the PNHP would offer medical services such as home care, long-term treatment, mental health services, prescription drugs, preventive care, and medical supplies to all US citizens based on need and requirement rather than their ability to pay ([www. pnhp. org](http://www.pnhp.org)).

There would no more hospital billing. Rather, there will be annual payments from the government that covers fundamental operating expenses.

Marketing and hospital expenditure and expansion for the hospital would d be covered by a separate budget (Himmelstein & Woolhandler, 1989). Three reimbursement options would be present for physicians: hire-for service, salaried positions within group practices, and salaried hospital positions. The program would be financed by the federal government through a public sector at the regional and state levels. A net tax of \$2 per pack on cigarettes would be levied as part of the financing. The net result is that it allows 95 percent of the population to pay lesser for hospital and medical treatments. The savings under the single payer mode would cover the underinsured and uninsured peoples of America (World Health Organization, 2000).



## Conclusion

Physicians have long since being adherent to ethical commitments and numerous accomplishments have emerged from such commitments. Despite this long successful history, there are some hurdles in implementing Quality improvement (QI) projects.

QI has evolved from an individual to a professional to a systematic activity. There are ongoing tensions in the medical profession between balancing humility and pride from accomplishments. Admitting that quality problems exist is the first step in implementing QI, but this is done seldom so, as there is always the aspect of personal shame and threat of lawsuits (Woolhandler, Himmelstein, & Lewontin, 1993).

Professional, social obligations and those towards patients need to be balanced and a number of questions are seen arising in this scenario. Many physicians still do not agree to the social role or aspect for the medical professional and are not part of professional association involved in setting up quality standards. Another barrier is that the field of medicine is becoming complex by the day with the physicians trained to the minimum to manage such changes.

It should be noted that it is high time physicians stood up to the challenges. Both common sense and ethical standpoints highlight this fact. Ethics in the medical profession has been prevalent since the Hippocratic era where physicians need to admit to error and commit themselves in implementing quality improvements. By taking the Hippocratic Oath seriously, physicians can improve patient care tremendously. These should not be recognized by the physicians as external, burdensome and risky. Rather, they must be

recognized as an integral part of providing routine patient care. Given the scenario of a complex medical system in place, the physician and the government must endeavor to undertake renewed and reinforced leadership in their roles.

## References

- Emanuel E. J. & Dobler, N. N, (1995), Preserving the physician-patient relationship in the era of managed care. JAMA, 273(4), 323-39.
- World Health Organization (2000) Healthy Life Expectancy Rankings Based on the World Health Organization's Disability Adjusted Life Expectancy doi: <http://www.nt.who.int/whosis/statistics/dale/dale.cfm?path=statistics,dale&language=English>
- “ Second Class Medicine” and “ In Congress Two Plans for the Uninsured. But Will They Work?” DOI: [http:// www. consumerreports. org /Special/ConsumerInterest/ Reports/ 0009med0. htm](http://www.consumerreports.org/Special/ConsumerInterest/Reports/0009med0.htm)
- “ Rationing—the Bitter Pill.” From Grossman D, Valtin, H, editors.(1999) Great Issues for Medicine in the Twenty-First Century: Ethical and Social Issues Arising Out of Advances in the Biomedical Sciences, New York: New York Academy of the Sciences.
- “ Basic Information” Physicians for a National Health Plan. DOI: [http://www. pnhp. org/basicinfo. html](http://www.pnhp.org/basicinfo.html)
- Himmelstein, D. U. & Woolhandler, S. (1989) A National Health Program for the United States: A Physicians' Proposal. New England Journal of Medicine 320: 102-108.
- Woolhandler, S., Himmelstein, D. U., & Lewontin, J. P. (1993), Administrative

Costs in U. S. Hospitals. New England Journal of Medicine, 329, 400–403.

- World Health Organization (2000) The World Health Report 2000. DOI:

<http://filestore.who.int/whr/2000/en/pdf/StatisticalAnnex.pdf>