The Provision Of Medical Services In A Healthcare Organization

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Abstract

The provision of medical services requires timely access to personal medical services that achieve the best possible health outcomes. Economic constraints, regional disabilities, and personal constraints are all factors to consider when accessing health care. Restrictions on medical services adversely affect access to health care, treatment effectiveness, and overall outcomes. An organization created to meet the health needs of a particular population is called a health system (Feldstein, 2015). According to the World Health Organization (WHO), a functioning health system has a well-managed funding mechanism. The system also has well-trained and well-paid staff. To supplement this functionality, it consists of reliable data on which decision-making and policies are based to properly manage a medical facility. A well-functioning health system can make a significant contribution to a country's economic growth, development, and industrialization. Healthcare has traditionally been seen as an important factor in promoting the general physical and mental health and well-being of people around the world. The following section discusses the provision of medical services in a healthcare organization.

Characteristics of the Healthcare System that have shaped the role of the Physician

Two components of healthcare systems that have shaped the role of physicians are physicians who have the legal authority to provide specific services and patients or insurance companies that lack the information needed to make medical decisions (Glick & Greenberg, 2017). Patients rely on physicians for diagnosis and treatment and often have little knowledge of the competencies of the physicians or specialists to whom they are referred. Due to a lack of awareness, the patient has a unique interaction with the doctor (Majda et al., 2021). As a result, the physician takes on the role of the patient's agent.

How does this lead to the provider being the patient's agent?

The main contribution of the documents of the medical economy is an agency connection (Yuryev & Sokolova, 2017). When a doctor is a perfect patient institution, it refers to a combination of financial technologies for paying for medical services and preferences provided by a patient's medical requirements, considering global attitudes and medical requirements (Majda et al., 2021). Previously, traditional insurance had a paid doctor based on the most common type of health care and a fee. Therefore, physicians are subject to physical responsibility or at risk of using hospitals and medical services. The number and type of services prescribed on behalf of the patient will depend on the patient's value for the additional treatment and the patient's treatment costs for that treatment. As long as the value exceeds the cost, the doctor will prescribe it (Glick & Greenberg, 2017). Doctors ignore the costs to society and insurance companies, focusing on the cost and benefits of services to their patients because of the insurance and the doctor's position as a patient advocate. Doctors will prescribe what is technically the best possible care, no matter how small the benefit to the patient or how expensive the insurance company may be.

The Effects of physician's income on Medical Services

The reduction in physicians' salaries increases the likelihood of them refusing to admit new Medicaid patients (Majda et al., 2021). As professional income and regulations change, physicians are less likely to admit Medicaid patients without insurance (Feldstein, 2015). A decline in physicians' income has the tendency to prevent physicians from admitting Medicaid patients. These changes, however, do not have an effect on decision-making regarding the provision of charity care services. The physicians' payment involves different financial transactional ways, such as the proportion of payment and time of payment. These circumstances can subsequently influence their behaviours towards patient services, hence causing inconsistencies in the quality of service.

To reverse the effects, policymakers are supposed to raise the rates of medical reimbursement schemes and authorize subsidies to organizations that are willing to allow physicians to provide charity care (Yuryev & Sokolova, 2017). Charity care implies that physicians offer services to uninsured, poor or low-income patients who do not have the capacity to settle their medical bills (Glick & Greenberg, 2017). This approach will ensure that both physicians and patients are fully aware of their healthcare costs and can institute plans for all medical services offered under their professionalism.

The forces currently limit supplier-induced demand

Inadequate monitoring of a physician's performance can pave the way for the development of SID (Supply Induced Demand). Medical symptoms have not been studied and carefully monitored (Yuryev & Sokolova, 2017). This monitoring is done when doctors prescribe the wrong medical services. Physicians are said to act as caregivers and decision-makers in the health care system, putting the interests of physicians ahead of those of patients. The current force that affects SID is medical complexity. Keep in mind that the more difficult and uncertain the service, the more likely it is that demand will be triggered.

Another force that is currently influencing SIDs in hospitals is the lack of robust monitoring systems for ethical issues in medical schools (Yuryev & Sokolova, 2017). Supervision of health and medical personnel in universities is not well carried out. Often, the emphasis is on what the doctor prescribes rather than on the correctness of the prescription (Feldstein, 2015). On the other hand, the school system plays an important role in the development of SID. Modern requirements are another reason for SIDs. Changes in disease patterns, patient lifestyles, and technologies have significantly altered healthcare needs in recent years. SID is associated with dynamic change, requirements development, demographic change, and a wide range of tastes.

The impacts of MCOs on the physician as the patient's agent

Medicaid managed care organizations (MCOs) are responsible for making health care accessible to enrollees and implementing quality improvement plans (Majda et al., 2021). MCO contracts may include affordable treatments that are not covered by the state plans of members of this policy, but the costs of these services may not be considered when determining payment rates. States may require the MCO to participate in welfare initiatives and require a compliance plan. They may also offer a fee or a subscription to achieve certain qualifications or access (Yuryev & Sokolova, 2017). MCO contracts may include cost-effective treatments not covered by state plans for those enrolled in this policy, but the costs of these services are not considered when determining payment rates. MCOs can provide services in addition to those offered by state schemes, thus improving customer access to MCOs.

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