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MANAGING THE MEDICAL SERVICES QUALITY IN MARKETING ACTIVITIES OF OHI FUND AND MEDICAL ORGANIZATIONS IN THE REPUBLIC OF KAZAKHSTAN

Abstract. The present article contains the description of the content analysis of the Republic of Kazakhstan Public Health Ministry issued statutory and regulatory acts on implementation of the quality management system over the period of health care organizations work with the Obligatory Health Insurance Fund since 2018. The issue is relevant because of the need to improve efficiency of the marketing interaction of the Obligatory Health Insurance Fund (OHIF) with medical organizations (MO) in achievement of the goals and objectives set in the Governmental programs for improvement of availability and quality of medical services in new conditions of the health care market players interaction. The objective of this study is to analyze the legislative and statutory acts on health care services quality management and the role of the OHI Fund in interaction with medical organizations. The methods of content-analysis of the Republic of Kazakhstan Public Health Ministry issued legislative and statutory acts, the Law on the Obligatory Health Insurance (OHI) in the Republic of Kazakhstan, orders for procurement of medical services and expert opinion on the primary medical documentation were used. The results of assessment of the expert examination of inpatient medical records revealed the deed for revision of many aspects effective in the medical services quality control system adopted in the Republic of Kazakhstan as a part of transfer from quality control to quality management. The conducted expert examination of the legislative and statutory acts and inpatient records allowed us to make a conclusion that the expert activity on the part of the internal audit service, depart-ment's head, deputy head of a medical organization is far from being sufficient in the conditions of heightened requirements to the medical services quality. Medical organizations need to use total analysis, i.e. they need to analyze all aspects of medical services quality (structure and process) and not only the final result in the form of the patients' complaints or mortality. This requires involvement by the process owners (doctors, paramedical personnel) in the quality management process in order for them to monitor the process indicators in the course of their pro-fessional duties discharge. It is exactly the stages of structure and process analysis where the defect prevention mechanisms are used.

Key words: medical services quality management, social marketing, obligatory health insurance fund, expert assessment, defects.

Urgency of the issue: the issue is relevant because of the need to improve efficiency of the marketing interaction of the Obligatory Health Insurance Fund (OHIF) with medical organizations (MO) in achievement of the goals and objectives set in the Governmental programs for improvement of availability and quality of medical services in new conditions of the health care market players interaction [1]. It is well-known that starting from 2018 the medical organizations rendering the guaranteed scope of free medical services (GSFMS) shall transfer to a new more rigid format of work, i.e. conclusion of agreements with OHIF for GSFMS services and observance of the GSFMS requirements to the health care services quality. In accordance with the legislative and statutory framework adopted over the period of 2015 through 2017, OHIF was determined as the sole operator and the buyer of medical services since

2018 [2-3]. In our opinion, efficiency of achievement of the set tasks and objectives is possible subject only to implementation of the social marketing methods and tools in the MO activity including the MOs such as cancer detection centre, cardiologic centers, outpatient hospitals, etc. [2-3]. According to F. Kotler's definition, social marketing is a social process aimed at satisfaction of desires and needs of individuals and legal entities by means of free competitive exchange of services and goods of certain value for consumers [4-5]. Implementation of new public health care system - obligatory social health insurance system, will be completed in 2020.

Objective: Analysis of the legislative and statutory acts (over the period of 2015-2017) and OSHIF requirements to medical services quality and development of recommendations on transfer from medical services quality control to quality management at the level of medical organizations.

Research Methods. Content-analysis of the legislative-and-statutory documentation (LSD) on implementation of the OSHIS in the Republic of Kazakhstan; analysis of the OHI Fund's requirements at the stages of the MOs activity quality control; analysis of the medical services procurement agreement's provisions; analysis of the LSD in the system of the governmental control of medical services quality; analysis of the MO Accreditation Guidance's; analysis of the standard organizational procedures for medical services quality management. We also used the method of expert estimate of the inpatient records from several medical organizations and analyzed the treatment guidelines (CHD and breast cancer) in accordance with the quality control check-lists of the OSHI Fund.

Results and Discussion. The conducted content analysis of the LSD on contractual obligations observance revealed that requirements to medical organizations (MO) will be heightened starting from the new year. Firstly, the competitive environment will be strengthened in the medical services market since more than 1500 providers are registered in the register of medical organizations under the OHIF, among which more than 45% are private medical organizations. Secondly, new Medical Services Procurement Rules and the Rules of selection of the guaranteed scope of free medical services provider and reimbursement of the provider's costs have been approved [6-7]. OHIF shall conduct monitoring of fulfillment by the medical organizations of the corresponding contractual obligations both in terms of quality and scope of medical services rendered to the consumers; it shall also process the complaints and applications filed by the citizens and medical organizations on the issue of medical services rendering and the OHIF shall also conduct monitoring of the services procurement contract conditions by means of field inspections of medical organizations.

The first stage of quality control will be carried out by the Fund based on the relevant standard compliance indicators (for example: accreditation). The control will be carried out on a monthly basis prior to payment. The second stage of the control will be carried out after conclusion of the contract and shall include a number of criteria, examination of the scope, quality of treatment cases, examination of pharmaceuticals prescription, examination and monitoring of the end results of a medical organization's activity. Quality assessment parameters using the OHIF's scheme shall include: patient safety assurance, clinical efficiency, economic efficiency and achievement of the target values. Based on the results of inspections, the OHIF will be forming a database of medical organizations with positive and negative ratings that will influence contracts conclusion for the next year.

Expert part of control is aimed at control against the check-lists to the Rendered Medical Services Quality and Scope Monitoring Results Report (the criteria of outpatient care are specified).

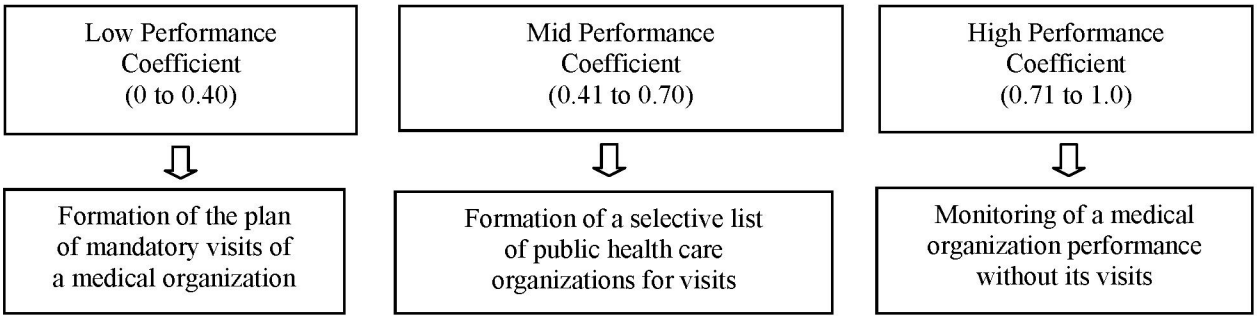
1) History taking quality assessment results (5 criteria);
2) Clinical diagnosis correctness and accuracy assessment results (7 criteria);
3) Detected iatrogenies and the results of iatrogenies assessment (6 criteria);
4) Diagnostics quality assessment results (6 criteria);
5) Professional specialists' advice timeliness and quality assessment results (6 criteria);
6) Dispensary care activities quality assessment results (10 criteria);
7) Results of assessment of quality of preventive activities for children of the age up to 5 years (10 criteria);
8) Results of assessment of quality of preventive activities for pregnant women (8 criteria);
9) Health care activity quality assessment results;
10) Treatment and preventive activities achieved results assessment results (6 criteria);
11) Treatment outcome assessment results (5 criteria);

12) Medical documentation keeping quality results (10 criteria);

13) Results of assessment of medical card data input into automated information system (AIS) correctness (6 criteria).

This control will be used to detect the defects in the diagnostic and treatment process. Given below are the deduction percentages applicable to confirmed detection of defects. In addition to the quality control, defects in the rendered medical services will be determined and subdivided into three groups with detailed description of detected defects (excess of the established clinical and diagnostic services (KDU) timeout, patients' complaints, ungrounded deviations of treatment and diagnostic activities from the standards from public health care activity; failure to observe the preventive medical examination standards, immunologic prophylaxis, events of non-provision or occasional provision of pharmaceuticals and healthcare products (HCP) for free provision of population within the framework of GSFMS at the outpatient level with certain diseases; ungrounded referral for hospitalization with deduction percentage of 0.10% to 0.50% depending on the defect code. The most severe defects are the detected defects with the following codes: 3.1-3.4. The events of ungrounded rendering (appreciation, increase, deviation) of medical services in the form of consulting and diagnostic aid shall be subject to deduction of 50% to 100% of the total cost of services.

In assessment of the risks related to activity carried out by the medical organizations (suppliers), the OHIF will subdivide the medical organizations into groups based on the risk zones and will prepare plans of mandatory visits of medical organizations. Given below is the scheme:



Expert analysis of the primary medical documentation of the Almaty health care stationary organizations: totally, 30 inpatient records were examined in the course of expert examination and retrospective analysis was conducted for the period of 2016-2017. We used the criteria of the check-lists annexed to the Expert Examination Report:

1) History taking quality assessment results (5 criteria);

2) Clinical diagnosis correctness and accuracy assessment results (7 criteria);

3) Diagnostics quality assessment results (6 criteria);

4) Professional specialists' advice timeliness and quality assessment results (6 criteria).

The Results of Expert Examination and Treatment Defects Detection:

1. The inpatient record cards examination revealed that the handwriting of physicians was illegible especially on the treatment sheets (80% of the inpatient record cards).

2. There were many defects on the treatment sheets, namely: weight and height of patients was not specified, there were no dosage calculation data for the prescribed superpotent drugs; dates and time of injections and intravenous interventions were not specified (90% of inpatient record cards).

3. Observation sheet defects: negligent keeping; diagnosis is specified in an abbreviated form in violation of the diagnosis wording requirements (80% of all cards).

4. Informed consent of a patient - in abbreviated form (50%).

5. Upon primary documentation drawing-up - inpatient record card, information on the patient's complaints was incomplete and of improper quality, life and disease history data collection is improper, daily patient examination log data and almost all inpatient record card data is the computer template text (90% of cards).

6. The final diagnosis: almost in all cards (80% of the inpatient record cards) wording does not meet the requirements of MKB-10. The final diagnosis establishing time violation (65% inpatient record cards).

7. Patient admission diagnosis, diagnosis after examination by attending physician, diagnosis after examination by the head of the corresponding department is established with violation of the requirements of ICD-10 requirements, and the wording of such diagnoses to 70% is of a template form and is challenged.

8. Violations were also found in the treatment protocol as regards the time of a patient staying in a hospital - up to 35% of cases.

9. It was noted that in many inpatient record cards the routine patient examination and questioning wording is of a template form and the same is true is for collection of life and disease history data collection.

Conclusion:

1. Due to the increasingly greater role of medical aid quality control by the OHIF, the Committee for Medical and Pharmaceutical Activity Control under the RK Public Health Ministry establishes new requirements to the medical organizations. It is necessary to reorganize the internal audit service and to subdivide its functions into clinical audit an organizational issues audit. In our opinion, clinical audit applies directly to the process owners (doctors and paramedical personnel) and heads of departments, while organizational issues audit is the responsibility of the head and deputy head.

2. Taking into account the results of the analysis of observance of the OHIF's requirements and those of medical services procurement contracts conducted by us, we can say that only the end result control carried out at the current moment everywhere at the level of medical organizations by the internal audit service will be insufficient since it is focused on the end result (patients' complaints, etc.), i.e. quality analysis at the medical organization level misses out the most important stages of treatment and diagnostic process and the structure and the very process are not analyzed. The analysis of scientific data that we have conducted allows us to make a conclusion that it is exactly the stages of structure and process analysis where the defect prevention mechanisms are used. The clinical audit shall be carried out in accordance with the A. Donabedian triad (structure, process and result analysis).

3. Only the internal audit service employees are involved in the quality examination process and not the process owners (doctors, paramedic personnel). Therefore, it is necessary to develop common approaches and algorithms of transfer from the clinical processes (complaints, mortality) end results control and medical services quality control with development of process analysis indicators, process initial indicators and intermediary process indicators that shall be determined for prevention of treatment and diagnostic process defects. Only involvement by the process owners in the clinical audit process can help to reduce the number of defects and thus to preserve the volume of a medical organization financing and to avoid penal sanctions on the part of the OHIF.

Practical Recommendations:

1. Contract fulfillment monitoring shall be carried out on a permanent basis in a medical organization using the first and second stage quality control indicators as the basis upon conclusion of a contract and indicators of defects in the rendered medical services;

2. Internal audit service operation shall be revised to abandon the end result based control concept and to transfer to development of the process cards preventing and adjusting activities at the level of treatment and diagnostic processes, i.e. monthly analysis and monitoring shall be carried out on a monthly basis for the indicators specified in the Reports on the Results of Quality and Scope Monitoring against the Check-Lists;

3. Training and seminars on expert examination indicators, defects, and development of preventive and corrective actions shall be arranged for doctors and paramedic personnel;

4. Timely identification of defects in treatment and diagnostic process shall be ensured and prevention documents system shall be developed;

5. It is necessary to transfer from quality control to quality management based on integrated assessment of medical services quality by the A. Donabedian's scheme and to analyze the processes based on the three components (structure, process and result) in daily activity of doctors;

6. Seminars and training shall be carried out on keeping the medical documentation, correct diagnosis establishing in accordance with ICD-10 requirements.

7. The status of the treatment and diagnostic processes owner shall be granted to the doctors in the process management and analysis and work on treatment protocols standardization shall be commenced. For the purpose of the Protocols adaptation, it is necessary to develop the process cards based on the treatment protocols not violating the protocols' requirements approved by the Republic of Kazakhstan Ministry of Public Health since medical services quality improvement is possible only through standardization of medical services rendering processes.

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ҚАЗАҚСТАН РЕСПУБЛИКАСЫНЫҢ МЕДИЦИНАЛЫҚ ҚОРЫ МЕДИЦИНАЛЫҚ ҰЙЫМДАРЫНЫҢ МАРКЕТИНГІ ҚЫЗМЕТІНДЕГІ МЕДИЦИНАЛЫҚ ҚЫЗМЕТТЕРДІ САПАСЫН БАСҚАРУ

Аннотация. Мақалада заңнамалық және нормативтік мазмұны талдау 2018 жылы міндетті әлеуметтік медициналық сақтандыру жүйесінің іргетасы медициналық ұйымдардың кезеңінде сапаны басқарудың жүзеге асыру үшін Қазақстан Республикасы Денсаулық сақтау министрлігі әрекет етеді. Медициналық қызметтер нарығына қатысушылардың өзара іс-қимыл, жаңа жағдайында медициналық қызметтердің қол жетімділігі мен сапасын арттыру үшін мемлекеттік бағдарламасы мақсаттары мен міндеттеріне қол жеткізу міндетті медициналық сақтандыруға және әлеуметтік денсаулық сақтау ұйымдарының маркетингтік өзара іс-қимыл қорының тиімділігін арттыру қажеттілігіне байланысты проблемалар өзектілігі. Зерттеудің мақсаты медициналық қызмет сапасын басқару бойынша заңнамалық және нормативтік актілерді талдау және Медициналық сақтандыру қорының медициналық ұйымдармен өзара әрекеттесудегі ролі болып табылады. Заңнамалық және нормативтік актілерді талдау әдістемесі, медициналық құжаттардың сараптамалық бағасы пайдаланылды. ауруханаға науқастарды медициналық жазбаларды сараптама нәтижелері сапасын басқару үшін бақылау қозғалатын медициналық ұйымдарда медициналық қызметтердің сапасын бақылау Қазақстан жүйесінде жұмыс істейтін көптеген аспектілерін қайта қарау қажеттігін көрсетті. Медициналық қызметтің сапасына қойылатын талаптарды арттырудың жаңа жағдайларында медициналық ұйымның ішкі аудит қызметі сапаны басқару үшін жеткіліксіз. Медициналық ұйымдар толық талдау жасауға көшу керек, яғни. Сіз науқастардың шағымдары түрінде, немесе өлімі денсаулық сақтау қызметтеріне (құрылымы және технологиялық) сапасы ғана емес, түпкі нәтижеге барлық аспектілерін талдау қажет. Ол үшін кәсіптік міндеттерді орындаған кезде процесстің көрсеткіштерін қадағалау үшін процестің иелерін (дәрігерлерді, медбикелерді) сапа менеджментіне тарту қажет. Медициналық қызметтегі ақаулардың алдын-алу механизмдері құрылымы мен процесін талдау сатысында тұр.

Түйін сөздер: медициналық қызмет сапасын басқару, әлеуметтік маркетинг, міндетті медициналық сақтандыру, сараптамалық бағалау, кемшіліктер.

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УПРАВЛЕНИЕ КАЧЕСТВОМ МЕДИЦИНСКИХ УСЛУГ В МАРКЕТИНГОВОЙ ДЕЯТЕЛЬНОСТИ ФОНДА ОМС И МЕДИЦИНСКИХ ОРГАНИЗАЦИЙ В РЕСПУБЛИКЕ КАЗАХСТАН

Аннотация. В статье проведен контент анализ законодательно-нормативных актов МЗРК по внедрению системы управления качеством в период работы медицинских организаций с Фондом обязательного социального медицинского страхования с 2018 года. Актуальность проблемы обусловлена необходимостью повышения эффективности маркетингового взаимодействия Фонда обязательного медицинского социального страхования (ФОМС) и медицинских организаций (МО) в достижении поставленных в Государственных программах целей и задач по повышению доступности и качества медицинских услуг в новых условиях взаимодействия участников рынка медицинских услуг. Цель исследования – анализ законодательно-нормативных актов по управлению качеством медицинских услуг и роли Фонда ОМС при взаимодействии с медицинскими организациями. Использованы методы контент анализа законодательно-нормативных актов МЗ РК, Закона об ОСМС в РК, Приказы по закупу медицинских услуг, экспертная оценка первичной медицинской документации. Результаты исследования экспертной оценки медицинских карт стационарных больных показали необходимость пересмотра многих аспектов действующей в РК системы контроля качества медицинских услуг в медицинских организациях в плане перехода от контроля к управлению качеством. Проведенная нами экспертная оценка НПА и карт стационарного больного позволяет сделать заключение, что экспертная деятельность только со стороны Службы внутреннего аудита, заведующего отделением, заместителя руководителя медицинской организации в новых условиях повышения требований в качеству медицинских услуг крайне недостаточно. Медицинским организациям необходимо перейти к тотальному анализу, т.е. нужно анализировать все аспекты качества медицинских услуг (структуру и процесс), а не только конечный результат в виде жалоб пациентов или же летальности. Для этого необходимо вовлечь в управление качеством владельцев процесса (врачей, средний медицинский персонал), чтобы они при выполнении профессиональных обязанностей осуществляли мониторинг индикаторов процесса. Именно на этапах анализа структуры и процесса заложены механизмы предупреждения дефектов лечебной деятельности.

Ключевые слова: управление качеством медицинских услуг, социальный маркетинг, фонд обязательного медицинского страхования, экспертная оценка, дефекты.