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BUSINESS RISK MANAGEMENT IN HEALTH CARE ORGANIZATIONS FINANCED FROM THE BUDGET

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Abstract

In contemporary business conditions, where health care organizations operate as a part of the public sector, the management of these entities needs to be concentrated specifically and to a greater extent on the risk management policy, as a way of a deliberate, timely and responsible response to the possible dangers and challenges, in order to execute the entrusted public authority and satisfy the general interest. Risk management includes identification, monitoring and control of the potential dangers that could adversely affect the stability (continuity) of public functioning and/or the efficient realization of the targeted function of a health care organization, as well as the adoption of alternative solutions that would help avoid or neutralize their adverse impact. The dominance of the non-profit compared to the profit goals of business operations, where the priorities lie within the stability of the business activity, responsible and rational use of limited (and usually scarce) public funds, as well as the efficient satisfaction of public needs in the field of health care, clearly indicates that risk management in health care organizations requires a different orientation compared to the market-oriented business entities. In other words, the risk management in health care organizations requires a significantly changed way of defining, interpreting and measuring the risk factors, as well as changed ways and possibilities, that is, restrictions related to responding to the selected factors and/or characteristics of risk. If one adds to this the specificity of the output in health care, in terms of its importance, immeasurability, ways of manifestation, consequences that may arise, etc., risk management becomes a very complex problem, because in addition to achieving their own goals, health care organizations must carry out the activities of public interest, entrusted to them by the state.

Key words: health care organization, business risk, public interest, performance measures.

УПРАВЉАЊЕ РИЗИКОМ ПОСЛОВАЊА ЗДРАВСТВЕНИХ ОРГАНИЗАЦИЈА ЧИЈЕ СЕ ПОСЛОВАЊЕ ФИНАНСИРА ИЗ БУЏЕТСКИХ СРЕДСТАВА

Апстракт

У условима савременог пословања, у којима као део јавног сектора послују и здравствене организације, све више се јавља потреба менаџмента ових ентитета да се посебно усредсреде на политику управљања ризиком као начином осмишљеног, благовременог и одговорног реаговања на евентуалне опасности и изазове ради извршења поверених јавних овлашћења и задовољења општих интереса. Управљање ризиком подразумева идентификовање, праћење и контролу испољавања дејства потенцијалних опасности које могу негативно утицати на стабилност (континуитет) јавног деловања и/или ефикасну реализацију циљне функције здравствене организације, као и на усвајање алтернативних решења којим ће се избећи или неутралисати њихов неповољан утицај. Доминантност непрофитних, у односу на профитне циљеве пословања, где су приоритети стабилност пословног деловања, одговорна и рационална потрошња ограничених (по правилу увек недовољних јавних средстава), као и ефикасно задовољење јавних потреба из области здравља, јасно указује да управљање ризиком здравствених ентитета захтева другачију оријентацију у односу на тржишно оријентисане ентитете. Другим речима, управљање ризиком здравствених организација захтева битно измењен начин дефинисања, тумачења и мерења фактора ризика, као и промену начина и могућности, односно ограничења реаговања на изабране факторе и/или обележја ризичности. Дода ли се томе специфичност учинка у здравству, у смислу његовог значаја, немерљивости, начина испољавања, последица које могу настати и сл., управљање ризиком остварења учинака постаје врло комплексан проблем јер треба остварити циљеве не само здравствених организација већ и извршити активност од јавног интереса које јој је поверила држава.

Кључне речи: здравствена организација, ризик пословања, јавни интерес, управљање ризиком, мере перформанси.

INTRODUCTION

A designed, responsible and justified response to the changes in a health care organization includes a well-formulated strategy and its implementation, as well as a constant improvement and development of business. When it comes to health care organizations, the management should, within the strategy framework, continually improve the operating processes and procedures, set higher working standards, meet the higher quality needs of end-users (patients), better motivate their employees and promote a good working atmosphere, etc. In the long run, those business improvements should ensure the continuity and stability of the business activity, and increase quality and safety (security) of health care, while maintaining a rational spending of public funds during the execution of the delegated authorities and accountability. These are the primary

interests of not only a health care organization (as an independent business entity), but also the state as its founder and financier.

In achieving public (common) interest and responsibilities in the new dynamic business conditions, business risk management in health care organizations assumes a greater importance. Risk management in health care organizations is not only the need, but also an obligation of the management to timely identify the potential dangers that may cause and/or adversely affect the performance and efficient achievement of the established target tasks. An adequate and timely response to the challenges and risks of the business should lead to the necessary adaptation to the changes in order to ensure a reasonable assurance that the objectives of the health care organizations will be achieved in a satisfactory manner. From a broader point of view, risk management should enable a health care organization, as a business entity, to maximize its performance, that is, the health benefits and/or to minimize the business losses (COSO framework) that may arise as a result of the lack of funds, maladjustment or excess spending in the realization of a health care activity. Certainly, the dominant influence of non-profitability and public interest on the formation of the target functions of a health care entity leads to significant modifications in the meaning of success, and thus the concept of risk, which also causes changes in the interpretation of the concept of financing, and finally their interrelationship: the risk-investments.

By recognizing the importance of maintaining the stability and continuity of the health care activity, profit, as a target, is replaced with the demand for safety, security and access to health care, which is why the purpose of financing (investments), based on the market reasons, changes for non-profit, more humane reasons. In this sense, those expressions such as financing, placement and investing are replaced with the expressions assigning, giving or gifting. As a consequence of the above said, the risk-investment relation in the case of a health care organization has its "non-profit" interpretation, and that is an acceptable rate risk – a sure rate of return, where the sure rate of return is primarily linked to the health care performance, that is, its features, adaptability, intensity and time of manifestation. As a result of risk management, the management of a health care organization should ensure business continuity, including an improvement in the operations, such as, for example, expansion and/or development of business programs, increasing the efficiency of operational activities, etc. However, unlike the economic sector, the changes in business operations of health care organizations can not relate to the changes of the activities or the market, or to a fundamental change in the way and dynamics of work, assortment, customers, funding structure, etc. This is because the subject, that is, the method of work, as well as the end-users, are directly defined by the very forming of the organization, which significantly restricts the possibility of the business changes in relation to

the economy entities. Significantly limited rights and the in the business opportunities, while respecting the maintenance of the public health function and common interests, is characteristic for all the entities engaged in satisfying the public demand, that is, the needs of the common interest, which, as such, constitute the public sector.

1. BUSINESS RISK MANAGEMENT IN HEALTH CARE ORGANIZATIONS

Understanding the business objectives and business success in the primary, non-profit manner, requires that the health care organization's management significantly adjust their risk management policy and, in accordance with a specific public function it carries out, define the following: what constitutes a risk; what are the relevant risk factors; when and how do different types of risk affect the business operations (especially high-risk and specific factors); how risk is expressed and measured; what are the risk norms; when and how big deviations from the established norms (reference value) can be allowed; how to ensure fairness, consistency and transparency of risk management, taking into account the legal, professional and business frameworks, etc.? Irrespective of the individual characteristics of certain types of risk, the general characteristic and specificity of interpretation of the risk of the health care organizations business operations also refers to the fact that the negative consequences of the possible business failures are not only borne by the health care organization as an independent business entity, but the society as well, that is, the general public and community, in which case the negative effects are much more serious.

The public significance of the functioning of health care organization, same as for all the public sector entities, underlines the importance and/or responsibility of risk management, especially in terms of its control and supervision. Risk management as a result of the implementation of policy of monitoring and control of the potential adverse events, as well as identifying the ways to prevent them, meaning a planned and thought out response to the identified challenges (optional response system/alternative decision-making), should ensure the protection of the long-term interests of both the health care organizations and society as a whole. In this way, risk management actually represents a segment of the strategic management. The link between strategy (as concretization of a development policy) and the goals, that is, the expected benefits, as well as the performance measures (in terms of the ways of expressing the target characteristics of the expected benefits), implies the suppression of all the risk elements that may jeopardize the effective execution of the above mentioned management categories. The business strategy and performance measurement system should be complemented by the health care organization's business objectives, given that the business goals are the concretization of the business strategy, same

as the performance measurement system is a material and/or nominal concretization of the health care organization's business objectives. Accordingly, the efficient implementation of the development strategy and an efficient achievement of the business goals, as well as an efficient execution of the performance measurement system, include business risk management (Novićević, Milojević, p. 381). In this context, the implementation of the development strategies, the realization of the target function and the execution of the established performance measures of a health care organization require the establishment and development of the risk management system. The risk management system comprises avoiding and/or using the challenges in order to carry out the business objectives and performance measures, as well as to implement the development strategy in the interest of all the stakeholders. Broadly speaking, the successful risk management is related to meeting the need for "balance" (James, 2003, p. 14), where the characteristic of balance or equilibrium is observed in relation to:

- the potential risks and expected benefits (*principle of justification*);
- the costs incurred by risk management and resultant monetary and non-monetary effects which should be higher than the investment (*principle of materiality*);
- the "balanced" appreciation of risks and interests of all parties involved (*principle of relevancy*).

When it comes to goals and/or interests, in terms of considering the needs of all the stakeholders of a health care organization, in order to protect the key stakeholders, the risk management system should be established in such a way to meet the requirement of the protection of the heterogeneous, often conflicting demands. As the basis for the formulation of the matrix of the so-called key risks, the balanced performance measurement system (Balanced Score Card – BSC) is most commonly used, based on which, and starting from the requirements of the key stakeholders (above all: state, employees, management and customers/patients), the risks/threats with the highest degree of probability are defined.

Practically, by using the BSC system that allows for the appreciation of all the relevant perspectives of successfulness of the health care organization's business operations and their mutual coherence, the matrix of the so-called key risks can be created, as potential danger and/or hindering factors. Starting from the demands of all the stakeholders and taking into account the different perspectives of viewing the successfulness, the risk factors in the health care organization's business operations can be grouped into four categories, namely:

- ***within the financial perspective***, the following risks can be identified: insolvency, untimely payment, misuse of funds, insufficiency of the inflow by sources of funding, etc.;

- ***within the end-user's (patient's) perspective***, the following risks can be identified: unavailability of health care offer, inadequacy or insecurity of medical treatments, untimely health care, etc;
- ***within the perspective of internal processes***, such as treatment procedures, therapies and the like, the following risks can be identified: obsolescence of equipment and methods of treatment, incompatibility of procedures and medical treatments, insufficient capacities, etc.;
- ***within the perspective of learning and*** growth that is related to the acquisition of knowledge and skills not only in the field of medicine, but also information technology and other related fields, the following risks can be identified: non-competitiveness, obsolescence, limited offer, intensity, quality, etc.

The expected target benefits defined through the performance measurement system as their verification and quantification, should allow for an effective, efficient and responsible spending of public resources (Novićević B., Milojević R., p. 379), which in its final phase should be manifested in the satisfaction of the created demand for public services in accordance with the interests of all parties. The above stated suggests the conclusion that risk management, in order to implement all the relevant perspectives of successfulness, should be carried out through a continuous monitoring and protection of the rights and interests of the end-user (patients), as well as through an efficiency and rationality of the public resources spending, which is achieved by:

1. establishing a business performance monitoring system (data collection, monitoring and evaluation of achievements);
2. establishing relevant mechanisms of identifying the presence of problems and delays – potential risks;
3. estimating the significance of a problem as the basis for determining the level of the priority of response;
4. defining the ways of responding to the changes that occurred; and
5. applying higher standards of health care services.

As a result of the improved solutions and their implementation in practice, different types of benefits for health care organizations are achieved, such as (Gapenski, 2004, p. 287):

- ***a higher level of competitiveness*** (market share, degree of customer loyalty, competitive advantage, evaluation of possible changes or redirections, etc.);
- ***a more stable and more certain funding sources*** (participation of public funds in financing, representation of subsidized programs, participation of grants, the level of market engagement, customer loyalty, etc.);

- ***improvement of the relationship with the patient*** (degree of satisfying the needs, application of individual (custom) access to treatment, quality of work, level of achieved standards, work professionalism and work discipline, etc.);
- ***preservation of liquidity demand*** (by creating pricing policy, procurement, borrowing costs, etc.).

The business improvements of the health care organizations should serve to achieve long-term objectives, which, unlike the market-oriented subjects, refer to: a high level of standardization of health outcomes (reducing the variations of the results in circumstances of equal material, financial and human resources (Department of Health and Human Services, 2011)); a minimization of the variations in the costs of health care services (the consistency of the costs of health care services in relation to the accepted standards); an increase in the safety and security of the procedures and methods of treatment (a reduction of the procedures and medical treatment risk); decreasing the waiting times for health care services; an increase of the customers' satisfaction (not only by solving the health problems, but also by experiencing the feeling of pleasure, safety, attention, kindness, etc.); an improvement in the patients' rights (the right to information, the right to choice, etc.), an increase in the employees' satisfaction and higher work motivation; rationalization of the operating costs, that is, an improved efficiency of spending from all the funding sources (Ministry of Health, 2009), etc.

2. PROGRAMS AS THE BASIS OF RISK ASSESMENT IN HEALTH CARE ORGANIZATIONS

Taking into account the specific area of work of health care organizations, which is characterized by a high level of heterogeneity, even within the same fields of health and medicine branches, risk management is based on the application of the program approach of management. Risk management on a program basis means that, depending on the nature and/or subject of the health care to which the program relates, the mechanisms of the risk factors control, the level of tolerable risk, the measures of protection from the consequences of risks, as well as the development of an alternative plan of action are defined in greater detail. Consideration of the risks on a program basis, in the case of health care organizations, is acceptable for the following reasons:

- *firstly*, the implementation of the program is always linked to the satisfaction of a specific health need (which has its own priority or importance of satisfying/execution, specific indicators of success, as well as specific risks and potential threats); and
- *secondly*, each project has a business, and often an organizational and economic autonomy (independence), which also carries its

own distinctive risks and associated significance at the level of the organization as an entity.

Depending on the type of health programs, a distinction is made between the programs that relate to the processes and procedures of immediate medical treatment and programs that support them, in terms of primary and secondary (auxiliary) programs, the difference between the independent and dependent programs, as well as the difference between the programs of strategic and operational importance. All of the above mentioned elements, that is, characteristics that determine a specific program, define the type and elements of its risk, where under the elements and/or characteristics of risks, one considers its importance (degree of manifestation), possibility of action or impact, way of response, expected consequences (especially negative), the degree of engagement of the subjects in the program (for example, population or an individual), etc.

Taking into account the program orientation of the business risk, identification, assessment and measuring of the relevant risk factors are primarily implemented on a program basis, where the risk elements of each separate program is viewed in relation to the level of (Gapenski L.C, 2004):

- *achievement of the objectives of the health care program as a business unit* – stand-alone risk*;*
- compatibility of a stand-alone health care program within the organization as a system – ***corporate risk***;
- *satisfying the interests of the external users and the general public* – market risk.

In this regard, a consideration of the overall risk on a program basis is observed in a segmented manner, according to various aspects of the manifestations of the risk factors, as well as in relation to the level of the involved entities to which the consequences of the risk refer, in the sense of importance and exposure to the possible negative outcomes.

2.1. Stand-Alone Program Risk

The risk of a stand-alone health program represents the risk of the successfulness of implementation of a specific program, where the program is seen as an autonomous, isolated business unit. The management of a health care organization is especially interested in this type of risk. The management, based on the monitoring and control of risk factors, manages the program in an effort to maximize positive outcomes. In this case, risk management includes defining critical success factors, assessment of the certainty of their occurrence, as well as consideration of alternative actions. In this sense, it is necessary to define the objective, whose efficient realization means success, then define the critical success factors and

identify potential risks with the associated percentage of certainty of occurrence (probability), and finally, define the response options or alternatives that would eliminate the risk factors and/or hold them under control. All of the above mentioned elements of risk management are in the function of a timely action and adaptation in order to "preserve" the efficient realization of the target values.

Let's suppose, for example, that the success of a recovery during the rehabilitation process is significantly influenced by the factor of care delivered to the patient, which is affected by the professionalism of the motivated employees. If the qualification structure and number of employees are an externally defined value for the management of a health care organization[1], then the intensity of the care for a patient is controlled by the element of motivation, by the means of: the stability and regularity of salaries, rewards, incentives, bonuses, additional payments, etc., based on the assumption that the motivation is primarily conditioned by the level of income. Sensitivity analysis determines the degree or the effect of the impact of changes in certain variables to the target value. Based on that, using the comparison method in relation to the basic (reference) case, it is determined which variable is the one, which control and risk management, contribute the most to the stability or improvement of the execution of target indicators. For this purpose, the so-called scenario analysis is used, which simulates the conditions of target values in relation to the change of the controlled variable, and which can have poor, expected or best value in certain probability percentages.

In this regard, if in the observed case the level of income of the employees is the variable and uncertain value (conditioned, for example, by the certainty of income, the level of inflation, the changes in the coefficients or the amount of labour costs, etc.), then the management should anticipate alternative options of response in order to maintain, and even increase the employees' incomes (the so-called additional injection for stability and improvement of a critical factor). In this way, the target level of incentive income/reward is maintained, as a precondition for a satisfactory motivation of employees, which actually maintains a satisfactory level of health care (the success of the realization of the target indicators), which is equivalent to the business successfulness in its entirety. Generally speaking, risk management will be efficient if the risk is displayed as a set of possible outcomes with a lesser or greater probability of occurrence (depending on

[1] In order to control risk management, the object of the analysis are relevant, materially significant risk factors, as the risk factors that cumulativelly fulfill three conditions, namely: that they can be influenced by the management; that these factors significantly affect the change of the target value; that the additional costs caused by their control and/or changes do not exceed the total benefits that arise on that basis.

the external and internal factors on which the management has a different influence) and if the alternatives are defined in each of the possible cases/situations.

2.2. System Risk

System risk represents the compliance risk of certain health care programs at the level of a health care organization as a business system, as a set of synchronized, mutually dependent and conditioned program contents. In this context, success is seen as the maximization of the total of the realized values of all programs at the level of the aggregated, that is, integrated value, which implies a high level of synchronization, coordination and harmonization of business actions. In this regard, the management should be engaged in the management and system risk control, which include the risks arising from: the occurrence of "bottlenecks", technological and personnel incompatibilities, organizational failures, downtime, disharmony, unused capacities, etc.

System risk management requires the management's special or additional "care" for the programs whose risk rate is above the average at the entity level, as well as the special concern if the risk level of the organization's business is above the average in the industry or in comparison to similar organizations. The issue of quantification of the system risk is also present in health care organizations, regardless of whether the system risk is a reliably measurable category. In this regard, the quantification of this type of risk is not expressed quantitatively, but as it is reduced as a rule only to the descriptive comparison with the similar organizations or with the organizations from other public sector branches.

2.3. Market Risk

A special form of risk that affects the success of the implementation of programs within the health care organization is ***market risk***, which has a number of specific features, of which the most important are the following:

- the object of satisfaction of service activities is the already established health care needs, which means that there is a "customer", i.e. demand, which significantly reduces the level of market risk in relation to other types of needs;
- the health care needs have extremely low levels of substitutability, which influences the high importance/priority of their satisfaction, which increases the level of market risk on the basis of obligation and/or the quality of its execution;
- the demand for health care is determined by extremely individual requirements, which is why the market risk increases in terms of possibilities for the customization of the offer according to the customer's needs (treatment process needs), for example, timeliness, individual approach, satisfying the specific needs, etc.

Regardless of the specificity of market risk in health care field, the general diversification of the program risk in accordance with the requirements of the end-users (patients) is applicable in this case as well. Defining the health care offer as the portfolio of sub-program units – treatments, methods and treatment approaches based on the respect for special requirements (individualized offers), provides risk reduction of the stand-alone programs for the amount of the effects of diversification, which is graphically presented in *Figure 1*.

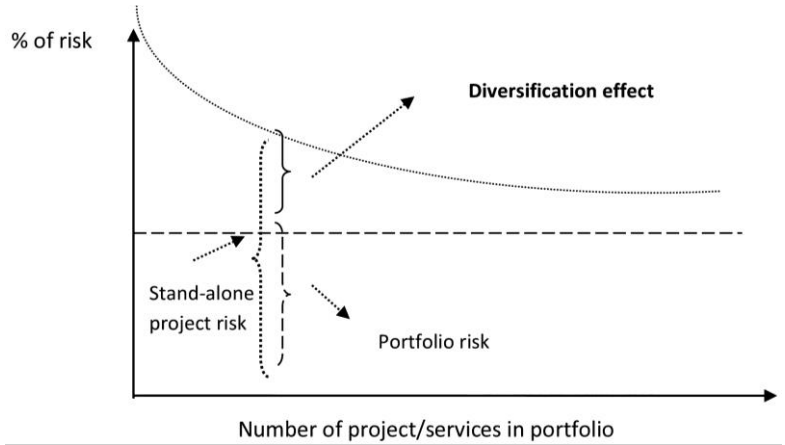

Figure 1 The effect of diversification on reduction of the stand-alone project risk (portfolio of business program/individualization of offer) (Gapenski LC, 2004, p. 300).

The vertical axis on the graph represents the height of the business risk of the stand-alone program, while the dashed horizontal line shows the level of the risk reduction based on the effect of diversification. The general rule is – the higher the risk of the stand-alone program, the possibilities for its reduction, based on the effect of diversification, are greater; also, the higher the number of programs (services) in the portfolio, the lower the business risk (the decreasing function is shown with the dotted line). The effect of diversification in the case of medical activity depends on the type of the health care service and types of end-users to which the service is intended (according to the representation of special requirements, the diversity of users, the scope and/or duration of the disease, etc.), as well as the organization's capacities and opportunities to meet the customized demands. In this sense, the level of diversification or, in economic terms – the level of sophistication of the offer, is conditioned by the different grounds and/or characteristics of distinction, which is why when it comes to diversification of the health care services, one can talk about the types of treatment, treatment intensity, user groups, level of health care, quality level etc.

3. STRATEGIC, OPERATIONAL AND FINANCIAL RISKS OF THE HEALTH CARE ORGANIZATIONS' BUSINESS

As already mentioned, the concept of risk is linked to the probability of occurrence of the unforeseen circumstances and events that may adversely affect the operations and realization of the objectives of an organization. According to the possibilities of the influence, that is, the control of the risks and timely search for the alternative solutions that help avoid or mitigate the negative impacts of the potential dangers, all risks are divided into strategic and operational. Strategic risks are those risks which are associated with the functioning of a health care organization. Management of a health care organization has a weak or negligible impact on certain strategic risks, such as: the risks of changes in the health policy (especially in its development part), changes in legislation, inflation, budgetary stability and liquidity, tax policy, changes in funding sources, demographic changes, change in habits and lifestyles, the emergence of epidemics or new diseases, the emergence of new health needs or changes of the existing ones, etc. Health care organizations must start from these limits and appropriately formulate their strategy, implement and continuously improve it, which is the direct responsibility of its management. In this process, risk management really becomes visible.

However, the needs of the business risk management in health care organizations are linked to the operational activities in terms of monitoring and control of the business operations. In this context, risks are identified and evaluated within the business and financial activities. The intensity of the business risks in the area of health care is determined by the type of health care programs and coverage of users to which the program activities' effects are related, as well as the time and/or speed of their influence. It is known that the risk of programs that meet the existential health needs is higher in relation to the programs that have additional significance in terms of the preservation of life or improvement of health condition in its biological sense. Also, the risk of programs whose effects have an impact on a larger number of users is higher in relation to the programs of personalized benefits. At the same time, in both cases, the risk is decreasing in relation to the waiting time for the effects arising from health care, given that time and the length of waiting for the outcome of the treatment process directly diminishes the importance, that is, the value of the achieved effects. This is because the significantly delayed effect of the health benefits decreases its value in relation to the real needs, because of the urgency of their meeting, and also increases the uncertainty in relation to the manner of its manifestation, as well as to the real needs of the treatment, given that the health needs are changeable over time as well.

The management's response to the business risks characteristic for the health care is based on a commitment for a greater professionalization and improvement of the efficiency of health care processes and procedures in the

process of recovery of patients. By reducing the risks of avoiding the subsequent complications, as well as by improving the treatment process or accelerating recovery, the additional savings and business rationalization are achieved. These are the instruments of the so-called **active management policy**, which include policies related to:

- the adoption of better business solutions (by shortening the waiting lists/timely treatment, individual approach to the patient, more professional services, etc.);
- the improvement of control systems in order to reduce errors and omissions, and reduce the risk of subsequent complications (defining strict procedures and processes, introduction of professional supervision, favouring teamwork, etc.);
- the organizational improvement (a more efficient synchronization and coordination of work, a more intense use of equipment, an increase in the number of visits or treatments per a work shift, a multipurpose utilization of the capacities, etc.);
- a more rational use of the resources (achieving of additional efficiency, savings, economizing, etc.).

The above mentioned forms of business improvements, which the health care organization, that is, its management, can directly influence, are carried out through increasing the efficiency of health care in the narrow sense, whose positive effects are graphically represented in *Figure 2.*

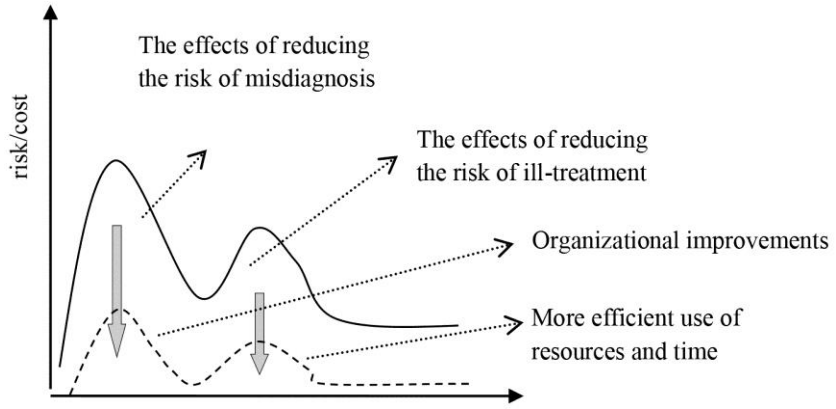

Figure 2 Models of contribution of the health care efficiency in the narrow sense to the improvement of business results (Bohmer R.J., 2009, p. 8).

The vertical axis in the graph shows the movement of the risks and costs that, respecting the logic of the health care activities and the direct interdependence between these categories, change in the same direction. The effects on the basis of professionalization, expertise and quality of work that are marked with the full line in the graph have higher amplitudes

that show business improvements, considering that their contribution to the positive or negative direction is dominant. As a result of the previously stated, those business improvements based on the organizational, cost and other operational or technical rationalizations, have a lower effect on the business results, and are shown in the graph with smaller amplitudes (dashed lines).

The financial risk is the risk of the source and stability of financing, which in the case of health care organizations is characterized by a high level of predictability (due to the relatively stable, reliable and predictable source of funding), but also a low level of financial flexibility (due to the assigned orientation and nominal certainty of the inflow provided by law or contract financing). These characteristics of the entities whose business is financed from the public funds significantly reduce the financial risk of these entities in relation to the economy entities, but on the other hand, make financial system rigid and less flexible. In addition, besides a relatively low level of financial risk from the aspect of volume and/or dynamics of the inflow of funds, business operations of health care organizations are characterized by a high level of predictability of the prices of the services, given the controlled and/or limited prices (because those are the basic needs), as well as by the expressed non-market nature and lack of competitiveness of the entities belonging to this sector.

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УПРАВЉАЊЕ РИЗИКОМ ПОСЛОВАЊА ЗДРАВСТВЕНИХ ОРГАНИЗАЦИЈА ЧИЈЕ СЕ ПОСЛОВАЊЕ ФИНАНСИРА ИЗ БУЏЕТСКИХ СРЕДСТАВА

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Резиме

Праћење и контрола фактора ризика у циљу неутралисања или избегавања околности које могу негативно утицати на пословање здравствених организација захтева проактивно оријентисан менаџмент који би осмишљено и одговорно реаговао на изазове и претње савременог пословног окружења. Све већи продор конкурентности и тржишних принципа пословања у делатности здравства уз обавезност заштите непрофитних циљева пословања од менаџмента здравствених ентитета захтева да посебну пажњу усмере ка унапређењу вештина управљања, посебно управљања ризиком и остваривању пословних побољшања по том основу. Управљање ризиком заснива се на праћењу и идентификовању потенцијалних ризика ради благовременог предузимања корективних активности и прилагођавања ради ефикасне реализације пословних циљева. Специфично, фактори ризика са којим се суочавају здравствене организације могу се класификовати као фактори ризика који могу довести до накнадних здравствених компликација и тешкоћа у опоравку пацијената, као и фактори ризика који се односе на очување ефикасности и рационалности пословања здравствене организације као пословног субјекта. У првом случају, ради се о очувању здравствене ефикасности у ужем смислу, која се односи на већу професионалност рада, елиминисање пропуста и грешака у поступцима и појаве накнадних компликација, усавршавање процедура и третмана лечења, као и на модернизацију технологије, док се у другом случају мисли на организациона и техничка унапређења, посебно у делу очувања наменске и рационалне потрошње јавних средстава, заштиту ликвидности, ефикасно коришћење ресурса, благовремено измиривање

обавеза и сл. Значај, односно примарност прве у односу на другу групу фактора ризика, последица је специфичности тумачења захтева успеха здравствених организација с обзиром на то да је успешност њиховог пословања не само у интересу предузећа као самосталног пословног ентитета већ и друштва у целини. У том смислу, основни правци и/или сегменти пословних унапређења су, пре свих, усмереност на реализацију захтева корисника (пацијената), а потом и унапређење организационих и техничких решења као предуслова ефикасног извршења циљних задатака. Дакле, резултат пословних унапређења по основу управљања факторима ризика треба да обезбеди увећање укупних здравствених и економских погодности, од којих позитивне ефекте остварује не само здравствена организација, као пословни ентитет, већ и укупна друштвена заједница и сваки грађанин појединачно. Ту се, пре свега, мисли на користи који произлазе по основу несметаног и континуираног здравственог деловања, обезбеђења безбеднијих, доступних и свеобухватнијих здравствених услуга, рационалнијег коришћења опредељених средстава, очувања расположивих капацитета, као и увећања општег друштвеног благостања и осећаја сигурности, безбедности и правичности. На крају треба нагласити да се, у условима сталног раста здравствене тражње у односу на могућности њеног потпуног задовољења, од менаџмента здравствених организација све више очекује да у делу својих овлашћења, односно могућности путем одговорног управљања ризиком, допринесе реализацији бољих пословних резултата и постизању додатних уштеда и рационализација.