Grading guidelines 2026

HMAN4101 Introduction to Health Care Systems and Health Management

The exam is presented below, followed by the grade guidelines

Exam (2026)

Exam HMAN4101 Introduction to Health Care Systems and Health Management
Time: October 8 (2026) at 9:00 AM (5 hours)

Both parts shall be answered. Part A will count 40% and part B will count 60% when the final exam grade is calculated. In *Part A Short answers,* only six of the seven questions should be answered. If more than six are answered, only the first six will be assessed. An answer should not exceed half a page (250-270 words). In *Part B Essay* you should answer only alternative 1 or alternative 2. There is no word limit to the answer.
No examination support material is allowed.

Part A Short answers
(only answer six of the seven questions)

1. Why do people insure?
2. What are the main differences between a retrospective risk-sharing model and a prospective risk-adjustment model as these are implemented in market-based insurance systems?
3. Define the concepts: creaming, skimping and dumping.
4. What's the difference between tax equalization and need equalization in an intergovernmental grant system?
5. Private health insurance can be supplementary, complementary or substitutive. Define these three concepts.
6. In a prospective payment system (i.e. where prices are set in advance), what is the main difference between 'fee-for-service' and capitation payments?
7. Which variables are usually used for risk-adjustment in a capitation-based payment

system?

Part B Essay

(only answer alternative 1 or 2 below, do not answer both)

Alternative 1

Change initiatives can sometimes fail. Discuss why changes might fail in healthcare. (If you want, you may provide a real or made up description of a failed change process, as part of the discussion.)

or:

Alternative 2

You are a new manager in a healthcare organization (for example a hospital or a nursing home). The organization has challenges with lack of motivation among healthcare personnel. First, describe the situation in some more detail. For example, add a few sentences to describe the specific reasons for why the healthcare staff is having trouble with motivation. Then, discuss what you might do as a manager to improve the situation.

Grading guidelines (2026)

Part A Short answers

(only answer six of the seven questions)

1. Why do people insure?

   There are basically two reasons: a) Insurance allows people to shift money from times when they do not need it very much to times when they need it much more. b) Insurance allows pooling of resources: It is most valuable when it provides a mechanism for a large group of people to each pay a small amount of money so that there is a large sum available for the few who really need it.

2. What are the main differences between a retrospective risk-sharing model and a prospective risk-adjustment model as these are implemented in market-based

insurance systems?

Risk sharing (retrospective) imply that sickness funds are reimbursed by the solidarity fund for all or some of their actual costs. This can happen in several ways:
- Proportional: The solidarity fund reimburses a fixed share of "acceptable" costs
- Outlier: The solidarity fund reimburses costs above an annual threshold
- High risk: The solidarity fund reimburses costs for i.e the 5% most costly insured

Prospective risk adjustment implies that the sickness funds are compensated by predefined prices (prospective financing system).

3. Define the concepts: creaming, skimping and dumping.

- Creaming: Attracting patients that demand little resources while providing high contributions
- Skimping: Reducing quality for patients that demand high resources while providing low contribution
- Dumping: Avoiding patients that demand high resources while provide low contribution

4. What's the difference between tax equalization and need equalization in an intergovernmental grant system?

- Tax (revenue) equalization corrects for differences in fiscal capacity: how much revenue a jurisdiction can raise at a standard tax effort. Jurisdictions with a tax base below the average are partly or fully compensated, usually funded by the central government or by transfers from rich to poor jurisdictions. It is based on per-capita tax income or tax base relative to the national average.
- Need (expenditure) equalization corrects for differences in expenditure needs: how much it costs to deliver a standard level of service, given factors the jurisdiction cannot control. These include demographic structure (elderly, children), morbidity and social factors, settlement pattern and distances, and scale disadvantages. It is based on a cost-key built from objective criteria, not actual spending, to avoid rewarding high spending.

5. Private health insurance can be supplementary, complementary or substitutive. Define these three concepts.

- Supplementary: Covers similar services as the SHI/tax based systems, but maybe at a better quality (lower waiting times).
- Complementary: Covers services that is not part of the public system
- Substitutive: A full alternative to the public insurance system

6. In a prospective payment system (i.e. where prices are set in advance), what is the main difference between 'fee-for-service' and capitation payments?

In both systems the price is fixed in advance. The main difference is what the price is attached to, and so who bears the financial risk of how much care is used.

Fee-for-service: the provider is paid a fixed price for each service or activity delivered

(a consultation, test, procedure). Revenue rises with volume, so the payer bears the volume risk. The incentive is to provide more services, which risks over-treatment and supplier-induced demand.

Capitation: the provider is paid a fixed amount per enrolled person per period (e.g., per patient per year), whatever services that person uses. Revenue is independent of volume, so the provider bears the risk of utilisation. The incentive is to contain costs, which risks under-provision, cream-skimming of healthy patients, and referring patients on to other levels of care.

In short, FFS prospectively prices the activity, while capitation prospectively prices responsibility for a population.

7. Which variables are usually used for risk-adjustment in a capitation-based payment system?

   Risk adjustment uses variables that predict expected healthcare costs and lie largely outside the provider's control. They usually fall into two groups:

   - Demographics (the basic, near-universal adjusters): age and sex, sometimes combined with region or urban/rural residence.
   - Socioeconomic and contextual factors: income or deprivation indices, education, employment or welfare status, living alone, ethnicity or immigrant background, and geographic cost or access factors such as remoteness and population density.

Part B Short answers

(only answer six of the seven questions)

Alternative 1

Change initiatives can sometimes fail. Discuss why changes might fail in healthcare. (If you want, you may provide a real or made up description of a failed change process, as part of the discussion.)

Comment:

Kotter's book chapters from the syllabus are the most relevant to describe and discuss. Kotter discusses eight steps of change: 1. Establishing a sense of urgency, 2. Creating a guiding coalition, 3. Developing a vision and strategy, 4. Communicating the change vision, 5. Empowering broad-based action (includes getting rid of obstacles), 6. Generating short-term

wins, 7. Consolidation gains and producing more change, 8. Anchoring new approaches in the culture). It is also possible to draw on other parts of the syllabus, such as book chapter 20 (Quality improvement in healthcare) in Walshe & Smith's book "Healthcare Management". It is also possible to mention and discuss other concepts from the syllabus. If the student chooses to do so, they should ideally explain or make it clear within their answer why it is relevant to include those parts of the syllabus. It can also be a strength to provide some background context about healthcare, such as the value that many healthcare professionals place on autonomy (if this is relevant to the discussion).

or:

Alternative 2

You are a new manager in a healthcare organization (for example a hospital or a nursing home). The organization has challenges with lack of motivation among healthcare personnel. First, describe the situation in some more detail. For example, add a few sentences to describe the specific reasons for why the healthcare staff is having trouble with motivation. Then, discuss what you might do as a manager to improve the situation.

Comment:

The example (i.e. the short description of the situation) provided by the student does not have to be very elaborate, but it should allow the student to discuss some relevant topics from the course about motivation. The students are also expected to discuss what they would do to improve the situation (for example how they would attempt to motivate the staff). There are not necessarily right or wrong answers in regard to the proposed solutions, but the student should be able to discuss some possible approaches/solutions and make it clear why they think that these solutions might be helpful for their example.

Some relevant motivational theories or models to possibly discuss include: Self-determination theory (the basic psychological needs of competence, autonomy and relatedness), Maslow's need hierarchy, Herzberg's two factor theory, and McClelland's aquired needs theory (achievement, power and affiliation). For the latter, students might point out the similarities between McClelland's theory and the three needs from self-determination theory. It is also

possible to mention intrinsic and extrinsic motivation, and to discuss reward mechanisms, as described in the syllabus. It is possible to mention and discuss other concepts from the syllabus, but it should be clear why this is relevant to the topic of motivation. It could also be a strength to provide some background context about healthcare, such as the value that many healthcare professionals place on autonomy.