Public Hospitals Should Be Cost Effective

Of course. But can they?

By Terence Lim, SMA News Editorial Board Member

Should public institutions be expected to have a balanced bottom line when the outcome of their "work" is often intangible. How does one decide on the cost of one life saved or improved? What is monetary value of a healthy population?

When I was a house officer, I wrote an article for this magazine which contained the line: *"Anyway, medical treatment should never really differentiate very much between classes of wards."*

Looking back at these words now, I feel a pang for the time I wrote it, and a sadness tinged with regret. It was on a busy call, and in between patients and procedures, that I wrote an entire story. Usually this takes me much longer, but I was driven by frustration, adrenaline and an ideal. My ideal was that sentence. That was almost two years back.

Sometime in the middle of last year, I overheard a conversation between the nurses while doing early morning bloods in an intensive care unit. Someone from the hospital's lab had called to borrow the machine used to obtain stat blood gases. The nurse manager was very unwilling to loan the machine as she feared the charge for its use would not be channelled into her ward accounts, and that might affect the balance sheet.

I guess she was only doing her job. She claimed to be under pressure from above. After all, the hospital was in the red, and everything had to be properly accounted for.

I felt an initial rush of anger on hearing the exchange. But in the end I stood there, doing my procedures and saying nothing. If I had heard the same conversation a year, maybe even six months back, I might have felt compelled to say, "Can you just lend them the machine first and settle the money later." But that was when life in medicine seemed uncomplicated. That was before I realised there were so many monetary issues involved in day-to-day healthcare provision.

But on that day, I just wondered how long it would take before I would be uttering the same words as the nurse manager. And it saddened me. I wondered whether when she was a young nurse, did she think that one day, after climbing the rungs, she would be saying these things. I pondered the power of an establishment to shape a person, and I felt sorry for her.

Non-medical people I meet socially often quip, "So you are a doctor, it must be so fulfilling helping people." And the truth is, it is. And I tell them so.

But then these people tend to spoil the moment by saying, "It's so noble compared to my job, I just juggle figures around and try to make money for the company."

I wish practising medicine were as simple as juggling figures to make money. At least there is a certain straightforward appeal in that pursuit. Corporations provide goods and services, and in exchange make money for shareholders and owners. More work means more money. More efficiency means more money. There is nothing altruistic about it, and that is reassuring, for altruism complicates.

Our public healthcare system lacks such straightforward appeal. And it should. After all government hospitals are expected to provide a public service and serve a social or societal function. There is an essential altruistic component to it, for why else would we be treating the elderly handicapped and disabled children. But in Singapore these hospitals are also expected to be cost efficient corporate entities. Are the two aims contradictory?

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Does anyone quibble about the cost effectiveness of our armed forces or police? Does one even bother to measure it? Yet we pour large sums of money to these essential services hoping that their 'work' will remain largely intangible i.e. no war, no domestic violence. Can it not be the same for public healthcare?

As in everything, the devil is in the details. We know that public hospitals are now classified as non-profit organisations, and so on principle they are not expected to be revenue generating. This is an important principle for it establishes that public hospitals are first and foremost for the public 'good'.

But of course, it gets muddy after. Although hospitals are not supposed to be revenue generating, inter-institution and inter-departmental comparisons are still based on bottom lines and revenue. This is probably because using figures and dollars is the easiest way of making across the board comparisons.

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But it is also simplistic and misses the point. The whole point of "intangibles" in the public healthcare service. The fact of public hospitals being for public good.

Take for instance geriatric services versus aesthetic surgery services. No points for guessing which is the revenue earner and which is the cost centre. No points for guessing which doctors drive the big cars. Yet I do not doubt even plastic surgeons think the former is more important for public good.

The problem is that departments who do most public good (basically any department with the word general in front) do not generate much revenue. What pays is the procedural stuff, the lifestyle services such as Lasik surgery, Botox injections, and the like.

If public hospitals are to serve public good above all, then departments that serve this function have to be given their due recognition, even if they do not make money for the hospital.

It is also not right to compare the cost effectiveness of departments as diverse as psychiatry and cardiology. In the same vein, the reward structure between and within hospitals should take into account more than mere revenue generation. Public hospitals must not forget their primary function.

When talking about the cost effectiveness of hospitals, the issue of basic healthcare has to be analysed. The government has stated that it will ensure affordable basic healthcare for everyone. The big question is: What is "basic"?

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Of course there is no such thing as basic healthcare. It does not exist because it is always changing. The term itself is so vague that it is practically useless.

A decade ago, CT scans were considered fairly high-end investigations. Nowadays, it is so routine that it is probably pre-basic.

For practical purposes though, there is one way of defining basic healthcare – and doctors use it all the time. It means doing enough so your ass is covered in case of litigation. That is why the relative of a lawyer in a C ward is likely to get investigated much more aggressively than some ex-Samsui woman with no kin overflowing to a B2+ ward.

So hospitals are in trouble because on one hand they are to make basic healthcare affordable, yet no one knows what basic healthcare really means. And everyone applies it differently to different patients and circumstances. All this while everyone is looking at their bottom lines.

Sometimes attempts are made to cut costs by ordering less fancy investigations and treatment for subsidised patients. After all, only what is basic is promised to them, even by the government. But wait a minute, subsidised patients can still sue the doctor and hospital for missing more esoteric conditions that these less fancy investigations may not immediately reveal.

That is why it is so stressful to be a polyclinic doctor. How can anyone meet those time and cost constraints without missing important problems every so often. And yet polyclinic doctors are still exposed to the same risk of litigation. Cheap and good is an unreal expectation in any field, yet doctors who are limited by institutional setups are not protected by these same institutions when things go wrong i.e. MOH will not pick up the tab if you get sued. Is this reasonable?

It's really tough, this healthcare business. Or perhaps it is only tough because we are treating healthcare as a business.

Fortunately, most of us can leave these details to the bureaucrats and administrators. But should we? After all it affects us all, it affects our work, it affects our patients. And sooner or later, if we don't do anything about it, we will end up like that manager, arguing about a machine loan, putting cost before patient, being pitied by her junior. ■