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Editorial

Health management and patient care

Sathiadas MG

Productivity in general means an average output per period by the costs incurred or the resources, such as personnel, consumed in that period. When health is considered, this measure may not correctly reflect on productivity. The traditional approach to measuring health care productivity typically defines output as spending on health goods and services—e.g., drugs, hospital services, physicians' services. It can be argued that most of the productivity growth in health care has come in the form of improved quality rather than lower cost. There has been a large push toward redefining the health sector's output as disease treatments, rather than as medical goods and services. This approach was advocated by the National Academics committee on national statistics in 2002.

Hospital productivity is measured as the ratio of outputs to inputs. Outputs capture quantity and quality of care for hospital patients; inputs include staff, equipment, and capital resources applied to patient care. Output measures are based on number of patients treated, average cost for patients treated, the quality of treatment, quality-adjusted life years (QALYs) associated with treatment, waiting time for treatment, 30-day post discharge survival rates, the ratio for elective patients to non-elective patients, age and gender profiles of patients treated. Utilising a variety of different inputs including labour, capital such as land and buildings, intermediate inputs comprise drugs, dressings, disposable supplies and equipment are Considered. Teaching hospitals might incur higher costs and appear less productive than non-teaching hospitals because they tend to treat more complex or more severe patients. Moreover, teaching might introduce delays to the treatment process, as consultants tend to spend more time when assessing a patient in order to train medical students

Many innovations have reduced the cost and thereby the productivity is increased by several factors. Moving from inpatient care to outpatient care was a key step forward (1). Converting human double checking of medications to electronic checking and minimizing human documentation is one innovation.

Contrast to this the healthcare productivity has remained low due to complex new equipment which are used with limitations, increased capabilities of healthcare workforce with subspecialities, and reduced provision with a lack of a system integration plan. The health leadership insist on the productivity more when compared to the values of healthcare.

There is broad agreement that health care value needs to be improved. Preventable harm continues to cause significant morbidity and mortality. While medical practice is continuously improving, it has not kept up with patients' rising expectations. In the mid-20th century, when medicine could do a great deal less than it can now, much more attention was given to kindness, caring, good communication, honesty, reliability and trust are the interpersonal parts of a doctor patient relationship. The rise of scientific medicine has led to a preoccupation in our minds to erode the personal values. The systems that are in place for better productivity have hindered the professional touch and care towards patients (2).

The whole care of a patient is affected not because of the actions of individuals and despite the impressive care and professionalism of so many of the staff who care for patients, but because of the lack of values reflected in uncaring systems and processes that leave patients so powerless, frustrated and frightened (3).

Time spent with a patient, a handheld, a small kindness, a caring act, honesty – any of these seemingly inconsequential actions have a critical impact well beyond their stand-alone worth. These critical but unmeasurable behaviours cannot be bought or commanded, they arrive with a set of values and thrive or wither as a function of organizational culture (4).

An organization must thrive to serve patients than delivering targets. Doctors believe that targets have compromised patient care and undermining clinical decision making. The concept of setting targets has exerted a profoundly corrosive effect on the healthcare of our country introducing a form of corruption much worse than the monetary kind. The unintended consequences are deep intellectual, moral and spiritual decline that renders all official statements doubtful. We as a profession fail to voice and challenge the leadership to make things right for the patient and rediscover the lost values (5).

Our lives begin to end the day we become silent about things that matter'

Martin Luther King

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