Oman Medical Journal (2011) Vol. 26, No. 5: 301-302
DOI 10. 5001/omj.2011.76

Editorial

How Much the Quality of Healthcare Costs? A Challenging Question!

Ismail Al Rashdi

Received: 15 Mar 2011/ Accepted: 26 Jun 2011

To meet the economic challenges faced in the healthcare industry and to continue to provide low cost and high quality services; healthcare organizations and private hospitals in particular are striving to control operational costs. Thus, considering cost is essential in order to accomplish this. Costing should promote cost effectiveness of medical practice, maximize the resources available to the healthcare provider by managing the services offered to patients, and explore opportunities for further improvements.[1]

Traditionally, the cost of quality was considered from the production oriented point of view where the quality costing process takes into account only the cost of deviation from the specifications intended. In services such as healthcare; quality costing is more challenging due to the complexity of the processes and the fact that such processes contain a wide range of costs, a lot of which are intangible and hidden, particularly in not for profit organizations.

Although the clinical practice in healthcare organizations of the public sector is evidence based with consideration to cost effectiveness. However, the exercise of quality costing has not been taken seriously. Quality costing is given less attention in public healthcare for several reasons such as the complexity of some of the costing methods and the limited resources to run such an exercise. This is because health managers continue to separate finance when quality programs are introduced or because public healthcare providers perceive themselves sufficiently sheltered from competition.[2-4]

The three key challenges in producing rigorous cost information about healthcare activities are the heterogeneity in the nature of the cost objectives between and within health organizations, and problems of information quality and variations in costing practices such as allocation of indirect costs.[3] These challenges are related to the complexity of the processes and the fact that such processes contain a wide range of costs, a lot of which are intangible and hidden.

Defining quality is one of the challenges facing today's healthcare. Healthcare quality is described as having "uniquely intangible, variable and inseparable characteristics."[5,6] Thus measuring patient satisfaction (when cost of dissatisfaction to be measured) is more important but also very complex.

Ismail Al Rashdi
Department of Child Health, Royal Hospital, P.O Box 1331, PC 111, Sultanate of Oman.
E-mail: alrashdi.7@gmail.com

In fact, non-technical aspects of quality (such as altitude of staff and their behavior), which may be more difficult to measure and cost are more influential in patients' rating of quality than the technical aspects.[7] In addition, since the patient perception of the quality of service covers all levels or parts of the healthcare organization; the overall satisfaction is based or influenced by all the encountered experiences.[8] When intangible costs of quality are taken into account, the agreed expectations of patients which are excessively identified in order to provide reasonable quality of care are difficult to determine and measure.

There has been significant progress in standardizing the collection of expenditure data. However, there has not been much progress in establishing standard measures of program activities as activity based costs for health services. Information on the number of patients seen and the quality of services provided in a patient-oriented approach is often not available.

The cost of quality is measured by the cost paid by the hospital or part of it, but it does not take into account the cost to the society, families, and other agencies such as court, foster care, and police. Even if the healthcare provider is not charged or penalized, there are costs for cooperation with investigators. Such costs may be more difficult to estimate due to the variability of cases and complexity of such processes. Very often, the cost of training and experience or stress to staff is not considered, which may be very difficult to estimate. On the other hand, saving on future costs as a result might help the society to improve the economy and reduce crime rate for example, which may not be deducted.[9]

Apart from the financial costs, another aspect to consider is human cost, namely; the failure in healthcare quality, which may be underestimated if the cost of quality is the main concern for profit making organizations.

The issue of poor quality related litigation is still very narrow and it focuses only on physical injuries, deaths and other technical quality related aspects, but it ignores functional quality related issues such as insufficient counselling and poor communications, which may be very costly. There are no terms and conditions for functional quality breach which justifies litigation. The issue of poor quality-related litigation focuses on the transfer of poor health service costs back to the provider.

Unfortunately, the quality costs only focus on the cost to the organization. While the cost to the patients who may have encountered failure in hospital services is not usually taken into account. Examples include; travelling costs (revisiting the hospital), time consumption (waiting areas), travelling costs for a

second opinion and expenses for repeating investigations abroad due to poor counselling, etc.

Improving quality aims to virtually reduce the cost of services. However, in health services in particular, it can be argued that efficiency of service can increase the throughput of patients by increasing the associated costs. This conflict can be attributed to the interests of managers. The question worth noting is: is it wise and possible to consider all costs? It may not be a healthy practice to insist on identifying controversial costs which may be challenged by mangers who doubt that they are quality related. Such practice may undermine the role of quality costing in planning for the implementation of total quality management.

Pondering on quality issues using the economic concept (of quality costing) may be opposed within health organizations for several reasons according to Ovretveit,[10] such as:

- Clinicians are more concerned about clinical outcome without considering resources in their daily practice.
- Some clinicians are not interested in costs and consider it a waste of time, and view non-clinical issues not to be useful to them or their patients.
- Some healthcare professionals think that quality programs add advance bureaucracy and diverges the focus from clinical care.
- Some healthcare professionals may not be aware of the benefits of quality improvement programs in providing better quality services and reducing costs.
- Most healthcare professionals are only trained in clinical specialty, thus lacking experience in running costs and quality improvement programs.
- Some healthcare professionals fear that spending cuts would lead to job cuts, thus becoming less supportive of costing procedures. Managers may become reluctant to introduce quality costing if it induces such fear among the staff.

Although quality costing focuses mainly on the cost to the organization, it is worth noting how much failures in healthcare services can cost the nation. Economic costs of a nation can be significant, when considering daily minor errors such as hospital revisits, and long waiting lists.

Although quality costing is not a fundamental practice in public healthcare organizations, it may present solutions to reduce waste and improve performance. Management of public healthcare or other non-profit organizations may not adopt this concept, but this attitude may change when facing increased costs of healthcare services coupled with limited resources. There are advantages to implementing quality costing, but not without its challenges, most of all being that the concept is not well established yet as it is in private sectors and other industries.

Acknowledgements

The author reported no conflict of interest and no funding was received on this work.

References

1. Ramsey RH IV. Activity-based costing for hospitals. Hosp Health Serv Adm 1994;39(3):385-396.
2. Lin B, Clousing J. Total quality management in health care: a survey of current practices. Total Qual Manage 1995;6(1):69-77 .
3. Northcott D, Llewellyn S. Challenges in costing health care services, recent evidence from UK. Int J Public Sector Management 2002;15(3):188-203 .
4. Taner T, Antony J. Comparing public and private hospital care service quality in Turkey. Leadersh Health Serv 2006;19(2):1-10 .
5. Zeithaml VA, Parasuraman A, Berry LL. (1990) *Delivering Quality Service: Balancing Customer Perceptions and Expectations*, New York: The Free Press
6. Rashid WE, Jusoff HK. Service quality in health care setting. Int J Health Care Qual Assur 2009;22(5):471-482.
7. Soliman AA. Assessing the quality of health care: a consumerist approach. Health Mark Q 1992;10(1-2):121-141. PubMed
8. Sureshchandar GS, Rajendran C, Anantharaman RN. The relationship between service quality and customer satisfaction – a factor-speciðc approach. J Serv Mark 2002;16(4):363-379 .
9. Alemi F, Sullivan T. An example of activity based costing of treatment programs. Am J Drug Alcohol Abuse 2007;33(1):89-99.
10. Ovretveit J. The economics of quality - a practical approach. Int J Health Care Qual Assur 2000;13(5):200-207 .