Efficiency in Healthcare Delivery

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Lower middle income countries (LMIC) are often cited as struggling to deliver healthcare in resource-constrained settings. For over a decade, there have been calls to invest in health systems in LMIC to ensure stable platforms are in place to maximize evidence-based health interventions through their delivery at scale (1). Developed regions too have challenges of rising healthcare costs, as highlighted by the Organisation for Economic Cooperation and Development (2). It behoves health practitioners in developing settings to be aware of the different faces of efficiency—technical versus allocative (3)—even as they continue to serve patients the best way they know how.

In this issue, Bello and others (4) showcase the use of autogenous molar transplantation to address the dual challenge of cost-effectiveness and functional adaptability Guthua and others share their experience with multidisciplinary teams in securing good outcomes for patients with maxillofacial osteosarcomas (5). Both experiences are seemingly different from Ndegwa et al. (6), who though reporting on safe laparoscopic Heller myotomy in a rural setting, also cite "issues encountered… unreliable electricity, lack of operative support personnel to assist in trouble shooting problems that occur intraoperatively, supply chain issues, and patients who have limited resources to fund the procedure and to allow appropriate follow-up."

How can surgeons bridge the divide between access to healthcare by patients and quality of care? A possible solution lies in surgeons taking the lead in emphasizing technical efficiency, because this is readily amenable to their control. In layman's terms, technical efficiency refers to the ability to maximize outputs, holding all inputs—labour, equipment, funds—as constant.

If we drill down technical efficiency to a surrogate such as operating room efficiency, there is no consensus on how the latter should be measured. Some studies focus on access to care (3) while others examine the number of operations performed (4) or overtime costs (5). Unfortunately, the measures are typically from intermediate components derived from the fundamental purpose of the healthcare system: to maximize the produced health with the given resources. Nakata and others (7) share findings from their evaluation of surgeons practising in a universal health coverage system with reimbursement schedules for procedures done. They demonstrate that practitioners with lower volumes have higher technical efficiency. They extrapolate that this may be due to high-volume centres serving as referral facilities for more complex cases that reduce surgeons' efficiency.

Would this serve as motivation for surgeons in the district to know that they have the ability to do better? Yet, even as we consider improving patient outcomes, we must not forego the basics of practice. Muturi and others remind us of an oft-forgotten preoperative evaluation: pregnancy status (8).

Our rallying call as surgeons in our different setups within the African continent therefore ought to be "Do the best you can to the most you can with what you have – but do not overlook the basics". Further work to look for more efficient ways of achieving this call within the region would serve us well.

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