ECONOMY IN A MISSION HOSPITAL *

A. B. TAYLOR, F.R.C.S. (EDIN.).

McCord Zulu Hospital, Durban

My choice of subject is prompted by my current interest in financial problems at the McCord Zulu Hospital. With a monthly deficit of £900 and the Province's inability to meet our request for aid in 1957, there is reason for this interest. I have recently received two reports bearing on the matter:

Dr. H., formerly on our staff, is now a staff member in a teaching hospital to the north of us in Africa, and in reporting his impressions and observations of it he wrote: 'I doubt whether one staff member in a hundred has any knowledge of the cost of a syringe, a pound of cotton wool, an ampoule of terramycin, or of any other of the things they use daily.' He went on to tell of what to him was shocking waste, and ended with the statement that in a hospital of comparable size they spent as much on drugs and surgical supplies as McCord's spent for everything, including doctors' salaries. (Doubtless he exaggerated somewhat.)

The second report was from a representative of a big drug house. He told of visiting a doctor in the country and spending part of the afternoon with him in his office, talking business from time to time as the nurse examined urines or prepared the next patient. 'No', said the doctor, 'we are not making money though we are all busy, as you can see. I am thinking of selling out and going elsewhere'. At the end of the afternoon, the Firm's representative said: 'You told me, doctor, that you are not making anything out of your practice. Now I'll tell you why. I have been listening to your prescriptions and figuring what you have actually lost on most cases you have seen today. You have no idea of the cost of your prescriptions and so you give in excess and not only what is needed. Secondly, you do not avail yourself of alternative cheaper drugs where you could use them satisfactorily. Finally, you do not charge the cost of the drugs you use.'

Our hospital constitution contains the following clause: 'The purpose of the Hospital is: (1) To give medical and surgical care to sick men, women and children, with special reference to the Bantus but not limited to them; (2) to train nurses and midwives; (3) to train interns and technicians and such other health workers as may seem expedient from time to time; and (4) to provide staff opportunities and hospital privileges for qualified and acceptable local physicians.' Thus it become a duty to see that economy is practised as a means of survival for the hospital itself and for the future of those whom it sends out as nurses and doctors to serve their own people.

The Administrator of Natal once said: 'Dr. Taylor, when you have to ask the Province for the major portion of your support, you may expect it to assume the major part of hospital control.' It seemed a fair statement. In 1951 an increased grant-in-aid brought the Provincial subsidy up to £25,000, which represented approximately 35% of our budget, most of the balance coming in as fees for non-European patients. Only this year we have had to go back, hat in hand, to say that £25,000 from the Province, representing 22% of our present budget, is not enough. We must have more to survive.

To enable you to get the picture clearly in your minds: Our cost per bed per day, which includes the cost of extensive out patient and casualty services, the training school for some 180 pupil nurses and midwives, as well as all staff salaries, etc., works out at about 20s. 6d. per day for 1955-56. Compare this figure with your own cost per bed per day for comparable services to non-Europeans.

With limited funds to provide hospitalization and out-patient services for non-Europeans throughout the country, I accept it as a moral obligation to spend as little as possible, while at the same time giving good treatment so that (1) the Government may have more to spend on African hospitalization elsewhere, and that (2) patients when they have paid the fees required of them at McCord's may still have money left for food for their families. Beyond these two cogent reasons is a third: (3) The teaching of economy to nurse and doctor trainees so that their contribution to the health needs of their people may be the greater when they shall have left McCord's. Unless these trainees go back to their communities imbued with the ideal of good treatment for relatively low fees, their patients will not be able to afford their services.

MEASURES OF ECONOMY

Except in the Transvaal, mission hospitals are expected to depend on the collection of fees to a greater or lesser extent for their support. In Natal this is especially true. Thus the economy of our mission hospitals covers: (1) The careful collection of fees, (2) the economic use of staff and materials, and (3) care in spending. Emphasis on these three aspects of hospital administration is our concern, in part for the benefit of our bank manager, who seemingly doesn't sleep well when McCord's has an overdraft, in part for the benefit of our trainees.

Collection of Fees

At McCord's this is fortunately possible because of the nearness of King Edward VIII Hospital, a fully subsidized Provincial hospital. Most adult patients come to McCord's knowing that they will be expected to pay as out-patients from 2s. 6d. for an injection of penicillin to 8s. 6d. for a full examination plus medicine

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for an ordinary illness, or as ward in-patients 3s. 0d. a day if Africans and 6s. 0d. a day if Indians, including all ordinary medical and nursing care, with medicines. Most of our patients have a near relative employed in Durban to assist in fee payments.

I say 'fortunately' for the charging of fees is our most potent means of preventing overcrowding. Thus it happens that we plan so that every department except the laboratory makes some direct contribution to the finances of the hospital. As yet we have not achieved the efficiency of those nursing homes where Epsom salts and aspirins by the dose are separately charged to the patients. However, at McCord's the almoners, sisters, clerks and medical officers are all, in time, made aware of the actual or assigned cost to the patient of such special items as terramycin injections, X-rays and operations.

The collection of a deposit on admission has greatly simplified collections and cut our losses. Only in emergencies do patients expect admission without an advance payment of £2-3 for Africans and £3-5 for Indians, or alternatively a 'guarantee' from an employer. Unfortunately such guarantees are often worth no more than scraps of paper. Certain departments such as X-ray, out-patients, dispensary, operating theatre, have fees designed to help carry what we call 'overhead'. The fee charged per day is quite unrealistic, but it is all that ordinary patients can pay without depriving themselves and their families of such things as food, which is equally necessary to health. We hope that the moderation of our fees may be carried on into the private practices of our non-European doctors after they leave us.

One cannot leave the subject of collections without noting the need for some system that leaves as little temptation as possible to those who handle cash. Occasionally we 'lock the door too late'. It is advisable to divide the staff into (1) those who record and charge for services, (2) those who collect these charges and issue receipts and (3) those who accept such cash for deposit; and to keep appropriate records at the different levels.

Of the fees we charge, approximates 99·4% are collected: or, put in another way, we write off £400 a year as against the £71,000 odd we collect. Discounts or cancellations marked 'to charity, are not included in that £400. It is perhaps worth noting that fees paid for services rendered amount to £71,633 a year, or 68·1% of our total expenditure. You can compare your own fee collection with this percentage.

Dr. McCord believed, and I agree, that Africans, and in fact all people, set a higher value on that for which they are charged (even though they may attempt to evade payment) than on that which they get for nothing. In charging what we feel patients can reasonably pay, we still at times are criticised by some for charging anything at all as a mission hospital. On the other hand, members of the medical profession doubtless level the same accusation at us as that levelled at Provincial hospitals of 'unfair competition with private practice'. What often happens is that McCord's is a place to go when, like the woman in the Bible 'the woman had wasted all her substance on many doctors'. So much for collections.

Economic use of Staff and Materials

This is a goal relatively unattainable but worthy of pursuit. In the employment of non-European nursing staff, our salary scales are those set by the Province, or slightly below as a mission hospital. We have more senior non-Europeans in proportion to the European staff than the Provincial Hospitals. To illustrate: Of the 9 sisters responsible for the patient's care in the hospital, assisted by non-European staff nurses, 4 are European, 5 are African. Our low ratio of trained to untrained staff is another means of saving. For example, one European sister with a part-time relief supervises the Nurses' Home with its 180 pupil nurses, midwives and resident non-European nursing staff. In passing may I say that to me 'equal pay for equal work' is a shibboleth impossible to define. The differentiation into married and single cost of living, seen in European work, denies it. But I do subscribe in principle to the same pay for medical men doing internship, junior and senior. Conceivably the non-European's expenses may be less, considering housing for his family and the education of his children, but on the other hand he will in general finish his course more in debt and with a larger number of dependents than his European counterpart. If he is to do postgraduate work and keep abreast of the profession he must not be penalized at this time.

The hospital's paid medical staff consists of 3 full-time and 1 part-time European medical officers, 2 full-time and 2 part-time non-European medical officers, and 9 non-European interns, for a daily average of 280 in-patients and 180 daily out-patients. McCord's paid out 50% of its total expenditure for salaries, as compared with 56% at Addington and 59% at Edendale.

One constantly has to set one's face against meeting needs by the mere appointment of more staff. Often what is required is a simplification and redistribution of work. Of prime importance is the development of a team spirit among staff members. This is fostered by giving them more responsibility and so more satisfaction, by giving free medical services to the staff, by making available, where possible, the hospital's facilities for buying, and by the provision of room and board at cost where desired. Recognition of meritorious service helps to build a team spirit, small social functions being held for those going on long leave or severing their connection with the hospital. Any plan for saving in time or materials is bound to fail unless it has the support of the majority of the staff.

The stewardship of materials is presented almost as a religious duty and is repeatedly stressed as a mark of good citizenship in the classroom and in the wards. It includes the use and misuse of food, water, linen, drugs, surgical supplies, etc. 'What do you need for your purpose? What do you use? What do you waste?' An oft-heard remark in the theatre is, 'You act like a specialist, which you are not, in tying that catgut in the middle', 'Don't cut ligatures with curved scissors, they cost 4 times as much to sharpen as straight ones'.

For years I have withstood the objections of matrons and sisters to allowing mothers to have their newborn babies in bed with them (3-foot-wide beds, the extra 6 inches being for the baby). Besides pleasing the mother and baby and ensuring the baby more personal attention, this practice economizes in floor space, cots and baby linen.

Much time is spent drilling doctors on the cost of drugs and the use of cheaper and equally effective substitutes (penicillin and sulphonamides generally are as effective as aureomycin and much cheaper). I must note that doctors who come to us from medical schools and Government hospitals have much to learn in this field. Another case in point is the use of Planocaine for anaesthetics at 9d. as opposed to ethyl chloride or Pentothal plus ether and oxygen costing 3s. 0d.-5s. 0d., not including the much longer time spent waiting for the anaesthetist to get the patient under. Unnecessary lights, leaking taps, the waste of cotton wool and hot water, are daily texts for sermonettes in a mission hospital. Sometimes I ask myself why I worry about these small items and then accept the expenditure of £4 a month per person on milk and meat alone. The answer of course is that unnecessary waste is an offence against a needy society while the expenditure of so much on milk and meat is part of the treatment needed in dealing with an undernourished section of the population.

African patients and staff with their different background have so much to learn as adults of what I had drilled into me as a child! 'Turn off that tap; turn off that light; finish the food on your plate or don't take such a big helping next time.' For instance, whereas in an English hospital it is the cherished privilege of the sister or staff nurse to see to the distribution of the food, at McCord's in spite of all I can do or say, this most important task both from the standpoint of economy and of the patient's appreciation and well being, is left, or handed down, to the most junior nurse as a menial task. In consequence, the food waste on the ward never fails to elevate my blood pressure.

At this point I must comment on the insistence of the Nursing Council on standards and procedures that take no account of values and basic principles as I see them. As we are a training school, our nurses practise in the wards and theatre procedures which are calculated to get an approving nod from the examiners at the end of their courses of training. These procedures have been handed down by word of mouth and text-book from post-Listerian days, quite ignoring both their value to the patient and their cost to the hospital for laundry. Recently, in the opening of an ischio-rectal abscess I counted 12 different pieces of linen being used, all of which would have to go to the laundry. By no stretch of imagination could they make the operation a sterile one. For opening a chest or knee, yes indeed, but not for the rectum or mouth. Those responsible for the training of nurses emphasize memory training and routine to the exclusion of reasoning from basic principles. As one interested in the purchase of linen and paying for its washing, this emphasis on aseptic

technique when it is basically impossible is a thing to which I object. Of course my objection is overruled by the statement, 'Yes, but what will the poor girls do when they face the examiner in their practicals?'

To get back to something more positive: Stewardship in the use of blood is a subject given too little thought. Surgeons too often order it, housemen ask for it for quite hopeless cases. It is as though we men shake our fists in the face of the merciful Angel of Death and shout 'No, you cannot bring him release from his misery and pain. With this bottle of blood I'll withstand you'. Also, there is the unnecessary routine of giving blood to patients with somewhat low haemoglobin for operations in which no severe blood loss is really expected. I deplore the ordering of blood as a routine insurance against some unpredictable disaster. If one reasons that, besides ensuring the doctor's not meeting the coroner, it will also expedite the patient's convalescence, that is another matter. Economy in the matter of blood is effected at McCord's by resisting some of the requests of the housemen for blood, calling for repeat haemoglobin examinations and at the same time getting donors to the blood bank from patients' relatives and from members of the hospital staff. We ask relatives for 2 pints of blood for each one given. Ideally, once a month the Blood Transfusion Service come up to bleed staff, nurses in training, and workers, European and non-European. As a result the blood used by McCord's does not greatly exceed the amount provided for the Transfusion Service. Incidentally this giving of blood deepens the team spirit among staff members and their feeling for the hospital's patients.

Care in Spending

This comes easily when one can neither hand on financial responsibility to those above him or alternatively cannot raise one's fees for services rendered to the public. A Provincial commission visited McCord's in 1951. After a look round and interviews with several key members of the staff such as my secretary, the bookkeeper, and the stores lady, the chairman of the commission, a leading business man and several times Mayor of Durban, asked, 'What do you pay these key people, Dr. Taylor?' His next question was, 'How do you keep them when they could command much better salaries elsewhere in the business world?' As already noted, we are fortunate in that many of our staff feel that their payment is only partly in money, that in part their payment is in the special interest they share in the work of the hospital. Thus it happens that the carpenter supervises the work of the labour pool and does excellent cabinet work, the engineer makes trolleys, tables, etc. in his spare time. For the price of 4 new wheels and 2 sheets of galvanized iron the engineer recently presented the hospital with 2 needed trolleys, thereby saving us some £30-40. Careful enquiry has shown us that the hospital can more cheaply do its own laundry than have it done outside, and can more cheaply make its own coffins for indigents than buy them outside.

And now in conclusion I recall the story of the Vermonter (in American parlance, a Vermonter comes from the same rugged background as the Scotsman, and is said to share with him many of those characteristics which we honour in our humorous prose) —this Vermonter, reflecting on things one day, reckoned that, if he could fool his cow in the matter of taste by the gradual dilution of bran with sawdust, he could in time feed her at no expense to himself from the refuse of a neighbouring saw mill. Later he regretfully told an enquiring friend that just as he had succeeded in getting the old cow off the bran entirely, she up and died of some confounded disease or other! I only hope that, in our zeal for teaching the African economy and for bringing some relief to those individuals who have to find the money that the Province spends, the hospital may not 'peter out' like the Vermonter's cow.

ADDENDA

I find I have failed to cover all the ground outlined in the précis I submitted to the Congress Committee in July 1957; hence these few addenda:

The importance of the hospital beds provided by medical missions in Natal is shown in the following compilation for the year 1956-57:

1. (*a*) The number of Europeans to each registered bed is 88 to 1. (*b*) the number of non-Europeans to each registered bed is 277 to 1.

2. The daily occupied non-European beds number 7,887. Of these, medical missions supply 43·7%.

3. There are 21 Government hospitals in Natal and 44 mission hospitals.

4. (*a*) On its maintenance of 6,090 European and non-European beds (1,854 and 4,236 respectively) the Province spends £3,858,000, or £633 per bed annually.

(*b*) On its maintenance subsidies and capital grants to mission hospitals and assisted hospitals, with their 3,051 beds (160 European and 2,891 non-European) the Province spends £242,000 or £69 per bed annually.

Answering the question, 'Is the era of mission hospitals about to end in South Africa?' my guess would be 'No'. Even if it should ultimately be deemed desirable to do away with them, there is neither personnel nor finance available to make it possible. With the Province of Natal paying only 10% to maintain a mission-hospital bed as compared with what it pays in its own hospitals, one would look rather to an extension of mission hospitalization as a measure of economy.