Episode 2

Should your hospital die?

MONSTER under the BED

Podcast: Monster Under the Bed

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Transcript: Episode 2

Intro

Allar: Don't be scared. This is the podcast that always leaves the light on.

Music

Allar (over the music): This is Monster Under the Bed. The podcast that takes some of the fears and myths in our society and busts them wide open. I'm Allar Tankler.

End of intro

Janel: What do you remember, Viv?

Vivienne: I remember it was around Christmastime. We had gotten all ready because my mom wanted to take a picture in front of the Christmas tree like every year and she had gotten all ready. She had gotten her hair done and her dress and stockings on, and so us being very small we wanted to play hide and seek again, and so we were running around and Maxine had to go hide but she slid on the hardwood floors and she bumped her head into the table. So there was a lot of blood and it was very scary. Mom also got very scared and very angry. And so we had to rush Maxine to the hospital. I just remember having to wait in the waiting room and I looked up to see where Maxine was and she was laying down on the bed with a lot of anesthesia, and my mom was next to her.

Janel: How about you Maxine, do you remember any of that?

Maxine: I don't remember anything actually.

Janel: But you still have a scar, right, on your forehead.

Maxine: Yes I do. A tiny little scar.

Janel: And what if I told you that if you bust your head open today, we wouldn't go to the hospital? How do you feel about that?

Maxine: If I opened my head again today and if you told me I couldn't go to a hospital, I don't know what I could do because …

Janel: Because you would be a little bit scared, right?

Maxine: Yes.

Janel: So the hospital makes you feel safe, right? And secure knowing that the hospital is right next door.

Maxine: Yes.

Allar: So the hospital makes your daughter Maxine feel safe, **Janel**. What about you?

Janel: Allar, I've always found **hospitals** to be very **strange** places. On the one hand, **they are terrifying.** The white beds. The blood. The people rushing around. Not to mention **The Death**.

Yet on the other hand, I find them very reassuring.

Allar: So that is kind of like Maxine says she feels. How old is she?

Janel: She's 12. Like her, a lot of people are afraid of having fewer hospitals around. Yet hospitals are an expensive way of treating sick people. And that's an issue in an era of shrinking government budgets and rising health care costs.

Allar: So that's what this episode of 'Monster under the bed' will explore. The fear that closing hospitals will hurt the quality of our health care.

Janel: Or as I prefer to phrase it: ***Does your hospital need to die?***

Music

Allar: Monster Under the Bed is a podcast from the European Investment Bank, the EU bank. What we'll do here is explore different fears and beliefs people have which are costing us as a society. In each episode of the podcast, we fight one imaginary monster under the bed and win the battle for a more rational way of doing things in the spheres of education, healthcare, food and many others.

Janel: Hi, I'm Janel. I work with Allar at the European Investment Bank. So that you don't **miss** an episode, subscribe to **Monster Under the Bed** on iTunes, Acast, Stitcher, player.fm or wherever you get your podcasts.

Music fades out

Allar: Ok, Janel, let's start with the basic facts. How much does Europe spend on health care?

Janel: In the EU, it's 9.6% of GDP, according to a recent report by the European Commission.

Allar: Wow, that's huge. I think I remember that the EU's GDP is more than 15 trillion euros. So take almost 10% of that and we're talking about 1.5 trillion euros in health care spending a year – and that's just in the EU.

Janel: Exactly, it's massive. But there's a lot of waste. The OECD says that, globally, around 20% of health spending makes no or minimal contribution to good health outcomes.

Think of what we could do with all that money.

Allar: Build more hospitals?

Janel: Or maybe build better ones. Ones that are made for the 21st century. Because hospitals are a major source of waste. Things like discharging patients late, or overtreatment, or long hospital stays for simple procedures such as cataract surgery or tonsillectomies -- all these things end up costing a lot of money.

Allar: Also, it can turn into kind of an arms race. I remember in Estonia a lot of rural hospitals were all investing in very expensive equipment, until it was centrally decided that maybe you don't need several hospitals in a small area all with a state of the art MRI scanner. And then a number of smaller hospitals were shut down. A lot of people got really freaked out.

And I have to admit**,** as a taxpayer, saving money on healthcare sounds like a great idea, but the minute you start talking about closing hospitals I get a chill.

Janel: When I first starting researching this episode, so did I. But then I learned a few things that made me feel calmer. For example, some European countries, like **Germany**, have really **high number of beds per 1 000 people**, and some countries, like **Spain, have a really low number**. But the health care

system in **Germany isn't better than in Spain**. The **World Health Organisation** ranks **Spain's** health care system one of the **best** in the world.

But **health care in the 21st century** is about getting people in and out of hospitals more quickly – sort of following the Spanish example instead of the German one. It's about **day surgeries** as opposed to **overnight stays**. And patient-centered care that gets rid of routine, expensive tests and scans that may not be necessary.

Allar: So is it really about **closing** hospitals, or just **refurbishing** them?

Janel: Mainly it's about taking a **scalpel to some of the enormous waste** without making the quality of the healthcare worse. I talked to **Tünde Szabó** in the EIB's life sciences division about how health care has changed in the last **20 years** and how we can remake our infrastructure so it is more efficient.

Tünde: What I have seen in the last 10 to 15 years in the European health care sector overall is a large number of improvements but also some steps back or worsenings, deteriorations. Of course I think we all recognize that there has been huge progress in health care technology. We have new devices, we have less invasive surgery, shorter recovery times for the patients. We have much better, much more effective drug therapy. We have personalized medicine. Much more health care information, much better health care information. Better access to information by the citizenry, by the patients. We have more educated and better educated patients who are able to actively take part in the their own care. They become managers of their own health, which is all positive.

But unfortunately we have also seen some growing problems. The first of them is more strained health care budgets. Growing health care costs – of course improving health care and better health care technology costs more money. People have more expectations. We have the aging problem – the aging population which creates a higher disease burden for the European health care system. And European policymakers have to cope with all these challenges, so this a growing problem, a growing challenge.

Janel: I also talked to **Dana Burduja**, who works with Tünde in the life sciences division. She says that hospitals are having a **hard time adapting**.

Dana: I think if I had to summarise I would say that the technology advanced, the information technology advanced and the hospitals are trying to put the patient in the center in their approach. That's not easy in the old infrastructure or in using the old approach and mentality of working in a hospital from the medical staff point of view. So I think we're at the point where we see a difference between the way the technology evolved and the patients' level of information and the response from the hospital on how they can organize themselves to face these challenges and changes. This is a natural evolution due to the general health status of the population and advances in technology and so on. Hospitals do have their place in the 21st century, but they need to be calibrated to keep up with the 21st century. And to the extent possible anticipate what will happen to health care and the health systems in this century.

Janel: I asked Tünde how we could make health care more efficient. She said a lot of work needed to be done to make sure that patients with **chronic health issues, like diabetes**, got **treatment outside** of a hospital setting.

Tünde: This is also about treating the patient in the right place, not treating the patient in an acute care setting if the patient can be treated in chronic care institution or the patient can receive home care.

Another typical waste is of course when for instance the hospital doesn't economize properly on the inputs, on the resources, like unused medicines, overpriced inputs, like using brand medicines when generic medicines could be used. Using not the appropriate inputs but using more costly inputs when less costly inputs could be used, like using physicians instead of nurses, or in-patient care instead of out-patient care.

And then of course resources can be unnecessarily taken away from patient care. This is something the report you mention is dealing with, like a lot of administrative waste, too much money spent on administration, too much money spent on printing unnecessary papers. In some certain countries, also in some European countries there are a lot of resources wasted on fraud or corruption, so that the money was originally meant to spent on patients ends up being spent on something else.

Janel: Can you tell me a little bit about the role of the hospital and also the role of the patient. Are there better ways to provide care for people who aren't really so sick – who need basic operations like knee surgery, like cataract surgery? People who maybe are being treated for chronic illnesses like diabetes? Is there a better way to treat these people than to send them to the hospital?

Tünde: Acute care establishments are meant for acute care. An acute care is to be received by patients who have an acute illness episode. The definition of episode is that it has a beginning and it has an end. And the end is either restored health or largely improved health in a predictable number of days. This is what acute bed establishments are meant for. And those are the most expensive establishments and those should be appropriately used. For chronic patients there are the chronic care establishments, and there is a growing role for home care or community care. So the overall health policymaker's aim should be to keep people out of the hospital and to put the locus of care much more outside the acute care hospital because this is the most expensive form of care that can be provided to patients.

For instance, if we take into consideration a terminally ill patient. Given the treatment in an acute care establishment is roughly twice as expensive as in a hospice and probably around 10 times more expensive than palliative home care.

Allar: I had no idea that the cost of treating patients in hospitals was so much higher than other forms of care.

Janel: This is where some of the waste comes from. Another source of potential savings is **day surgery**. A recent **report** in **France** estimated that increasing the **rate of day surgeries by 4%** could save **€200 million** a year.

Allar: But I imagine that not all countries use day surgery as much as they could.

Janel: You're right. The **OECD says** that an increasing number of **minor surgeries** can be performed on the **same day** so we don't have to keep somebody in the hospital overnight. Look at cataract surgeries, in some parts of the developed world, most of the people who get cataract surgeries are in

and out in a day. But in other countries, only 25% of them are, so the other 75% end up staying in the hospital for care that they don't need anymore.

Tünde: There are huge differences for the time-being. The pioneers in day surgeries were the Nordic countries and Great Britain, and there are other countries that are also on the way to implement one day surgery like Spain, France and Germany but are much slower in implementing. And there are countries like the Czech Republic, the Slovak Republic or Hungary where we don't even have data on the share of day surgeries within the total number of surgeries performed, so they still have a long way ahead.

Janel: There's another issue, and that's how countries reimburse hospitals for procedures. In some countries, **hospitals are reimbursed at higher rates** when patients are kept **overnight**, which discourages them from putting day surgeries in place.

Dana: There within the acute care hospitals ways to deliver the services that are not so expensive for the hospital. You have the day stay and the one-day procedures that are becoming more and more the norm, and I think the knee surgery and cataract surgeries are the classical examples.

The problem when you try to implement these changes is not so much the technology – it's quite well advanced. It's on two fronts: one that you need to have the staff trained and able to perform these procedures within the context for the specific legal protocol that sets up the day surgery intervention, and secondly you need to ensure that the hospital is not getting a loss by performing this day surgery. So depending on how the hospital is getting reimbursed for the procedures, they may have an incentive to keep the patient in an expensive type of care or less expensive type of care.

Tünde: As Dana mentioned, it's pretty much about incentive systems. I you as a health administrator reimburse a day surgery at four times lower than the same surgery with hospitalization, as was the case of Germany just six or seven years ago, then of course you will have a 4 percent rate of day surgeries for a tonsillectomy as it was in Germany was four or five years ago. That is compared to 70, 80, 90% in the Nordic countries or in Great Britain where the same surgical procedure was reimbursed at the same rate whether a day surgery or hospitalization. So these are the best practices that other countries

should also follow. The right incentives should be put in place in order to achieve the results because the technology is there, and I believe that the knowledge is also there. All these countries can perfectly perform these procedures on an ambulatory (day) surgery basis.

Allar: So if we move more simple procedures to day surgery instead of outpatient surgery, that means we need fewer hospital beds?

Janel: **Well that's exactly what it means**. In some countries, there are **too many** hospital beds. The capacity is **outdated** – it was meant for a time when some surgeries were **way** more **invasive** and required a **longer healing** time.

Allar: But are we letting people heal sufficiently? It sounds like we are just operating and then throwing them out on the street.

Janel: I think it's about the **kind of follow-up care** we provide. My Dad lives in the U.S. and last year he had knee **replacement** surgery. Literally a bionic knee; we call him the **bionic man**. He was in and out in a **day**, but then he had a nurse who came afterwards and a physiotherapist who came for weeks on end.

Allar: And how did he recover?

Janel: Well, this summer he and the kids were hiking in Colorado. He's not going to run a marathon anytime soon, **but then he's 76**.

Allar: If we start cutting the number of hospitals beds, won't there be a public backlash?

Janel: Well, it certainly isn't **popular politically**.

Tünde: I think there is just fear for the sake of it because it give a bad image to the government that it's closing hospitals but this is a completely necessary process because everybody is doing it.

We are in an era where, as we said, health technology is improving, average hospitalizations are decreasing. Instead of 10 days or 11 days, the average length of stay is 8.5 days for all types of hospital stays. No sorry, 7 and a half. It's always going down. So obviously, we don't need that much infrastructure.

Tünde: If we look at the hospital beds per 1 000 population in Europe, Germany is heading this comparison or distribution with 8.1 hospital beds per 1 000 population. Sweden is on the lowest rank, having the least number of beds per 1 000 population, at 2.3 beds per 1 000 population, so we see that there is a fourfold difference between the lowest and the highest number of beds per 1 000 population in Europe, but there is not a fourfold difference in the outcome. The outcome in the two countries is comparable.

But then we also have after Germany, the second highest ranking country is Austria, followed by Bulgaria, Hungary , Czech Republic, Romania, Lithuania, etc. etc. The countries I just mentioned, starting from Bulgaria, Hungary, Czech Republic, Romania, Slovakia – my own country of origin – all these countries are countries with the heaviest infrastructure with the most hospital beds per 1 000 population, but they are producing the worst health care outcome for the time being. They are improving, we have to recognize, but they are relatively still the worst. The size of infrastructure is not necessarily a good predictor of health outcomes of a given country

For instance, Spain, a country where I am also a citizen and where I have lived for more than 15 years, 20 years, sorry, is my favorite good example. Spain is one of the countries with the lowest bed infrastructure and is one of the top countries in terms of health outcome in the European Union.

Dana: I think a lot of the reluctance in reducing the number of beds in certain countries is linked with the fact that there is nothing else to be put in place.

Austria, the country Tünde mentioned with a very high ratio of beds per 1 000 population, they are currently implementing a program in which they will put in place primary healthcare centres dealing with every type of care during extended opening hours, eventually referring people to the hospital but under very strict and patient-centered regulations that will improve the outcome for the patients in the end.

Allar: So how do we convince the public that hospitals need to close in some countries?

Janel: ***It's a difficult subject, that's for sure***. Part of the answer is in showing them what other **European countries are doing** to make health care better.

Tünde: I think that we, together with the European Commission, the Bank is in a privileged position. We can see in real time what is happening out there in Europe. And we can be kind of an eye-opener for these countries. Whether they are Hungary or Romania or Slovakia, the typical Visegrad countries, which typically look at the Austrian and German examples, which are good in some senses but not in the sense of health care administration because these are the countries with the highest beds per 1 000 population.

We are there to open their eyes that this is **not** the example to follow. You should not copy a country's healthcare system but you should listen more to the advice, the recommendation of the European Commission.

We hope that non-efficient hospitals will kind of die away or fade away, but it's something that never happens. This never, ever happens. Non-efficient hospitals are eating away scarce resources that could be spent on other much more necessary services.

Allar: So it sounds like the REAL monster under the bed isn't **closing** hospitals…

Janel: It's **wasting** scarce money for health care.

Allar: Thank you, Janel, for shining a light underneath the hospital beds to show that there is, indeed, no monster there. To all our listeners, if you want to keep up with Monster Under the Bed, subscribe to this podcast. We have episodes on education, climate, cyber security, pretty much anything that will keep you awake at night. Subscribe on Acast, iTunes, Spotify, PlayerFM.

We'll see you back here soon for the next episode of Monster Under the Bed.

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