Reading "the World Health Report 2000, Health Systems: Improving Performance"

This year's WHO Report as titled above raised a few eyebrows. It departs from the usual dry and spiritless reports to deal with something as complex and all-permeating as health system performance. Hard data like infant mortality, tuberculosis incidence rates can be debated but not disagreed upon. Raw and absolute numbers speak for themselves. However, when derived indices such as "disability adjusted life years" (DALYs) and "fairness of financial contribution to health systems in all (WHO) Member States" are thrown around, controversy is bound to arise. Such indices ultimately imply a certain subjective outlook on how health policy should be aligned with the people and indirectly prescribes solutions to perceived problems.

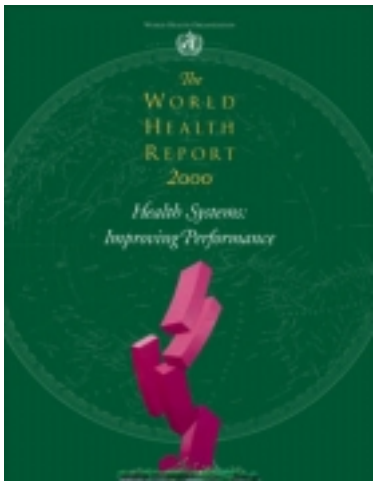
By most accounts and from almost all perspectives, Singapore has done extremely well according to the Report. The Report alone is enough justification for a pay rise for not just Singapore doctors, but other important health professionals, e.g. nurses, physiotherapists, etc. who have kept the system going.

The only "not-so-good" index for Singapore was "fairness of financial contribution to health systems in all (WHO) Member States" in which Singapore appeared in the lower half of the member states' ranking (~101/102 out of 191, same as Lebanon). The Report claims that this index measures "both fairness of financial contribution and financial risk protection" and "therefore reflects inequality in household financial contribution but particularly reflects those households at risk of impoverishment from high levels of health expenditure". The index is "designed to weigh highly households that have spent a very large share of their income beyond subsistence on health". Should we take remedial action immediately to get a better ranking the next time? Maybe. Maybe not.

Not all would agree with Singapore's rather moderate ranking for this index. (see Editor's Note). Certainly, other international agencies such as the IMF and World Bank have been proven to be less than accurate in their fields of expertise in many instances. Some neighbouring countries have deliberately ignored IMF prescriptions and have done pretty well by most accounts. Of course, some haven't either. The IMF is neither infallible nor always wrong. Likewise for WHO. What is needed is neither a press on the panic button nor a knee-jerk denial but some in-depth soul-searching. Sometimes soul-searching achieves more than number-crunching and ranking, no matter what the technocrats and administrators tell you, and whether you are ranked high in some indices or low in the other indices.

Moving forward from the numerical to the experiential, the Report interestingly describes the main failings of many health systems to be:

1) Many health ministries focus on the public sector and often disregard the frequently much larger private sector health care.
2) In many countries, some if not most physicians work simultaneously for the public sector and in private practice. This means the public sector ends up subsidising unofficial private practice.
3) Many governments fail to prevent a "black market" in health, where widespread corruption, bribery, "moonlighting" and other illegal practices flourish. The black markets, which themselves are caused by malfunctioning systems, and low income of health workers, further undermine those systems.
4) Many health ministries fail to enforce regulations that they themselves have created or are supposed to implement in the public interests.



Let us go through the points one by one.

Point 1

I have had the good fortune to observe health systems not just of my own country but many others in the region as well. Certainly, some health ministries disregard the private sector, but there are also those who do not disregard, but plainly have no clue as to how to start "regarding" or to be kept in the loop on how the private sector works, beyond gathering of data and publishing of tables. Yet others conveniently ignore the private sector because the private sector is ultimately both a judge and a witness to the public sector. "What I don't know can't hurt me".

Point 2

The Report decries "unofficial private practice" and draws the conclusion that the private practice will end up subsidising public practice. Does it imply that "official private practice", if properly structured will not suffer this fate? If so, then perhaps the Report should tell us how to do it, so that we will know how to avoid these pitfalls should we decide to implement faculty practice "officially".

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recollection of those events, suffice to say that the events happened long ago. The dating comes from them telling me of the ward that they were in. So if the events happened in TPH or KKH, it was my house officer year. If it was in SGH, it was circa 1973-1975! So, what I saw as labour and mundane then and the tasks I dismissed as such were obviously not so in the eyes of these people. Even the most mundane work had a bigger meaning to those whom we served, as I realised in my ageing years. Perhaps, this is the ultimate meaning of being a doctor that money cannot give. Maybe, this is what motivates us to be good doctors.

ALTRUISM AND MONEY

Dr Loh Keh Chuan's editorial in the Medical Digest of TTSH[3] makes a pertinent observation. He said, "In this materialistic and elitist society of ours, the quantum of financial remuneration of a particular profession serves as the yardstick for the relative import of its contribution to the society at large. Yet we all know the remuneration of doctors in general lags far behind those of the administrators and many other professionals from the public sector. Although money is not everything in life, how can we best ensure an equitable spread of talents in the public institutions to continue with good clinical research and teaching? Are doctors supposed to be a special breed of altruistic individuals answering to a noble calling alone?..."

"Do we help the man in the street to make the best use of his limited health dollar or help him to squander it on some needless thing or service?"

He goes on to say, "Whilst it is inevitable that the medical profession will metamorphose over time, our future may not spell all doom and gloom if we could stand united to improve our lot, and that of our future generations, if all of us can forgo our differences for a common cause. For a start, we should not let turf wars, nasty altercations, unethical practices, etc mar our profession and relegate our role in the society."

Well said. Let me take the reflection further. Society expects the doctor to adopt a social role of being caring and altruistic. In return, it accords trust and respect that money cannot buy. So, where do we go from here? We should begin by asking society the question of what is the icon of success. Is it money and lots of it? Or, is it having lived our lives such that we touch the lives of many that we meet daily in our lifetime and make a difference for them in a positive way? We should spearhead a moral paradigm shift.

On the plane of being health care providers and that include those who sell various health products, we need to ask this fundamental question, "Do we help the man in the street to make the best use of his limited health dollar or help him to squander it on some needless thing or service?"

There is a way of marrying altruism and money. We need to earn enough to pay for the essentials and beyond this subsistence level, reach a comfort level of living for ourselves and family members because doctors too, being human, aspire for themselves and their family members some level of comfort on this earth. Beyond that, the returns of more and more money as reward and motivation to practice medicine really depend on the value system of individual doctors.

Money should remain a hygiene factor. It should not be allowed to permeate into our medical ethos to be the measure of professional success or a measure of a doctor's worth. The practice of medicine is larger than that. ■

References

1. *WHO Report 2000*
2. *Ian McWhinney. The doctor's work. In: Textbook of Family Medicine, 2nd edition, 1998. Oxford: OUP, page 20.*
3. *Editorial. Medical Digest, TTSH, Apr-Jun 2000*

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Point 3

The really poignant point is that which astutely describes the unholy triad of black market, malfunctioning health systems and lowly paid health workers. I have seen for myself how this can function in a nearby country in which state specialists are paid less than farmers, medical schools open and shut for years, grossly understaffed hospitals are the norm and the resulting evening black market clinics flourish in the heart of a capital city.

Point 4

Sometimes, public sector providers think they function on a different plane from private ones and they can commit no sin. In some countries, they can advertise and tout while private ones cannot. Sometimes in the name of informing the public of medical advances, they may even grant self-aggrandising interviews. Others in the past have mission statements that are nothing short of self-laudatory. I am happy to say that the field here is largely a level one, although I know some will disagree with me on this point.

The above four points are given not in bureaucrat-speak but in stark, simple English. To me, these four statements contain many gems of wisdom. It is easy to devise formulas and indices. It is also easy to do rankings. We can agree or disagree with these things. But some epiphanies, though unsupported by numbers and studies, are too compelling to ignore.

These are the reflections distilled from years of observation and understanding. We will do well to heed their advice and avoid these failings. ■

The Hobbit, 30 Jun 2000

Editor's note: On 29 June 2000, The Straits Times reported that the Health Minister, Mr Lim Hng Kiang "disagrees with the WHO report's placing Singapore in the 101st position when it comes to how much a person needs to pay himself for healthcare. He felt that the low ranking resulted from WHO not understanding the Singapore system. He said "WHO considers it fair if you contribute to a social-security system and then can draw on it when you have a health problem. Our Medisave works this way, but WHO classifies it as an out-of-pocket payment"."