The Road Ahead – Medicine in Singapore in 2004

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What would the road ahead for Medicine in Singapore be like in 2004? A lot would depend on where we want it to go, to recap the conversation between Alice and the Cheshire Cat in Lewis Carroll's Alice in Wonderland.

The road ahead has several directions that we can consider: a medical hub for service, training or research, or combinations of these; better use of available resources; a more effective service in reducing disease burden; a more equitable healthcare financing system; and the road towards unity for healthcare that the World Health Organization (WHO) and the World Organisation of Family Doctors (Wonca) talk about.

A MEDICAL HUB

A medical hub can be geared for service, training or research, or combinations of these. Hitherto, Singapore has focused on a medical hub for service.

As a service centre, the Acting Health Minister has given the Singapore profession his formula. His call to make zero defect Toyotas is a reasonable one. The majority are not looking for a Formula One solution. This concept could go into our roadmap for the year ahead. Being a service centre need not mean the deprivation of local users so long as local needs are met.

A paradigm shift will be to work towards a medical hub that is focused on training. This will require a review of throughput, resources and firepower. A training service, to be effective, needs strategic planning into costs and returns too.

What about Singapore as a research centre? Certainly, that is a thought in the minds of many. With the emergence of the biological sciences and genomics, the venture into being a research centre is attractive.

To be a medical hub of choice, we need to pay more attention to infrastructure and logistics, forward and backward integration of services, a one-stop convenience, uniform service quality, service providers, pricing and leadership. Seeing how other medical hubs around us are doing will be illuminating too.

BETTER USE OF AVAILABLE RESOURCES

There is no doubt that much can be done in the year ahead. The GPs are under-utilised. The Specialist Outpatient Clinics are still over-utilised. The polyclinics are still overloaded. Stakeholders need to get together to see how they can work out a shared vision for serving the Singapore population better. Some reform on financing and pricing will be necessary to even out the service load.

Who would take the lead?

A MORE EFFECTIVE SERVICE IN REDUCING DISEASE BURDEN

Dr Tan Poh Kiang, in "General Practice in an Age of Anxiety" (see page 14), has alluded to the importance of preventive medicine. Singapore has embarked on the healthy lifestyle campaign for more than a decade now. We are on the right track.

The way ahead lies in working on the populations at risk. One such population is those with the metabolic syndrome. The Third Report of the National Cholesterol Education Program's Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III [ATP III]) (NCEP III, 2001) has defined individuals with metabolic syndrome as having three or more of the criteria listed in Table 1.

Table 1. Diagnostic Criteria for the Metabolic Syndrome.

Three out of five of:

- Abdominal obesity (waist circumference > 102 cm [40 in] in men, > 88 cm [35 in] in women)
- Hypertriglyceridemia (>/= 150 mg/dL)
- Low HDL-C (< 40 mg/dL in men, < 50 mg/dL in women)
- High blood pressure (>/= 130/85 mm Hg)
- High fasting glucose (IGT [blood sugar >/= 110 mg/dL and < 126 mg/dL] without diabetes)

Source: NCEP III, 2001

The West of Scotland Coronary Prevention Study (WOSCOPS) in Glasgow has important results to tell the world. The impact of metabolic syndrome is clear with the results of the WOSCOPS by Sattar et al (Sattar et al, 2003). They found that in a study of 6,447 men who at entry had moderate hypercholesterolemia, 26% of the men had metabolic syndrome as measured by the criteria in Table 1. They had 1.7 times the risk of a coronary heart disease (CHD) event and 3.5 times the risk of developing diabetes during 4.9 years of follow-up. This level of risk was similar to an increase in age of ten years, or to the risk in smokers.

Page 5 ►

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◄ *Page 4 – The Road Ahead – Medicine in Singapore in 2004*

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The risk increased as the number of metabolic abnormalities rose. Men with four or five features of metabolic syndrome had 3.7 times the risk of CHD and 24.5 times the risk of diabetes compared to those with no abnormalities. Interestingly, the cholesterol-lowering drug seemed equally beneficial for men with and without metabolic syndrome. It reduced the risk of CHD by 27% in those with metabolic syndrome and 31% in those without it.

So, for clinicians in the different sectors and levels, picking out and treating the patients with metabolic syndrome to bring them closer to normality will be one important task in the year ahead. A reduction of five to ten per cent of body weight in the overweight will result in substantial drops in blood pressure, cholesterol levels and if diabetic, blood sugar levels.

I will not be surprised that if we all work at it, we will begin to see reductions in morbidity and mortality figures that we have not seen before. Preventive care in such people may well bring the best dividends to them and the nation.

A MORE EQUITABLE HEALTHCARE FINANCING SYSTEM

This will apply to not only patients but doctors too. The healthcare financing system today in Singapore is far from equitable to many of the stakeholders and users.

For a start, we need to have a paradigm shift in thinking. Cost control without quality is meaningless. This is the bugbear of most of the managed care systems in Singapore and around the world. That is why doctors hate managed care.

For a change, managed care companies need to pay doctors a premium that enables them to provide reasonable quality care with the money given to them. Patients need to be educated to be aligned on the same vision of appropriate use of services and refrain from the buffet syndrome. Some controlling mechanism may be needed. In the U.S., it has been found that co-payment is a good instrument to align patient behaviour.

The variation in healthcare costs for the treatment of a given condition is due to variations of treatment, or pricing of items of service or product, or both. Clinical practice guidelines that are agreed by providers will reduce variation of treatment. Some uniform pricing will also be needed to reduce variation of pricing of items of service or product.

Ultimately, it is the doctors' alignment that will mean success or failure of a managed care system. Doctors must be seen to be wanting to cooperate to keep costs down. Then, they will earn the discretion to spend more on the patients who need the extra medication or service. Checking for errant behaviour need not be necessary if doctors earn the managed care organisations' trust.

The big question is what are doctors going to do if managed care and healthcare insurance take on a greater part as financing instruments in Singapore? Will we as a corporate professional body be able to work out a equitable system for all? I believe it can be done – use a capitation formula, work out the sums, align everyone to a common vision of reducing disease burdens and improving health status. This may well be the thinking for the year ahead should managed care become the flavour of the day.

TOWARDS UNITY FOR HEALTH (TUFH)

The road ahead brings me to the TUFH initiative of the WHO and the Wonca. Their belief is that working towards unity for health is the solution to increasing healthcare costs. Some of the gains are through the use of resources which have the biggest yield. For example, the yield from a preventive programme may save more costs than building a hospital. But this will require the shared vision of the stakeholders and the support of the policy maker who is enlightened enough to see this.

Essentially, healthcare delivery needs to have the following:

- coordinated individual and community health activities for a given target population, and
- sustainable partnerships among key stakeholders: policy-makers, health managers, health professions, academic institutions and communities.

Unity in health actions is a practical approach that requires shared values on the part of stakeholders, active research and development for its implementation, as well as political and legislative support. Would anybody wish to take a lead in starting a dialogue amongst the stakeholders in 2004 towards a shared vision? ■

References

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