Public-Private Partnership

Speech by Ms Yong Ying-I,
Permanent Secretary for Health, at Gleneagles Hospital's
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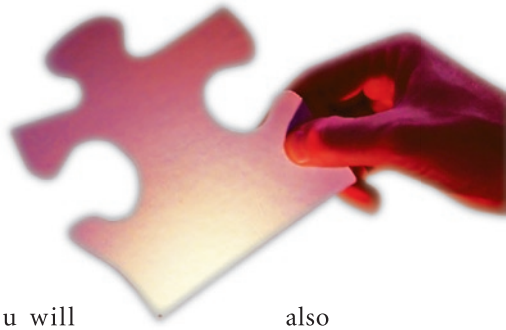

Many Government announcements have been made recently. Just to mention a few – Minister for Health Khaw Boon Wan has talked about the major programme to better manage chronic disease conditions. Minister Mentor Lee has signalled publicly his support for the SingaporeMedicine international business initiative. More than one announcement has been made about the expansion in the number of foreign medical degrees we recognise to practise here. You have also heard of teleradiology. Yesterday's *The Straits Times* headline was the announcement of the Government's decision to invest in translational and clinical research as part of our biomedical thrust. All in all, many changes. You have probably heard more on the grapevine.

PIECING THE JIGSAW TOGETHER: COMMUNICATION AND CO-CREATION

I am sure that you are curious about the big picture behind what the Ministry of Health (MOH) is doing. How do the pieces fit together in the jigsaw? Indeed, do they fit together at all? With many activities going on, with many changes happening, it is critical for MOH to communicate clearly and actively to you the thinking behind the press announcements. Beyond being aware of what we are doing, I think it is important that we consult you because we do not know all the answers. Your suggestions and feedback can also help us in the Government to make better decisions. You will also make better business decisions if you have as much information as possible. This is why I was pleased to receive Chi Chiu's invitation to speak here this morning, and it is in the spirit of sharing ideas that I ask you to hear my remarks. In an era of rapid change and faced with competitive challenges from Thailand and Malaysia, there is benefit in our thinking together and collaborating together. We are in the same sector and on the same side; "the enemy is out there".

So let me speak on three themes today that I think will be of interest to you.

a. First, the shift we are making from episodic management to long-term care management.
b. Second, the shift in the public sector from just efficient service volume to evidence-based practices, developing academic medicine and clinical research.
c. And third, the development of Singapore as an international medical hub, that is, our SingaporeMedicine thrust.
d. Related to that, I would like to say a few words about manpower development which is of

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great interest to everyone and a topic that always causes great angst.

In each area, I only have time to describe briefly our thinking, without going into much detail. More in-depth discussions can be arranged with people who are really interested or need to know. I will also not go into other burning issues in the public sector.

FROM EPISODIC TO LONG-TERM CARE MANAGEMENT

The first theme is about the shift from episodic management to long-term care management. We are tackling this through our big push to better manage chronic diseases. On the surface of it, the chronic disease programme is straightforward. Today, our management of chronic diseases is episodic and largely reactive. Yet diseases like diabetes, hypertension and high cholesterol are at the root of so many medical problems. If we can help patients manage their chronic diseases, it can help them live healthier lives and reduce downstream healthcare problems and costs.

Beneath the surface however, I think that the chronic disease management represents a major shift in our approach. **Emphasising long-term care management is a shift from treatment of established illness to prevention of illness or at least treating pre-illness.** It is a big shift for the professional community, and it is an equally big shift in patient behaviour that we are trying to achieve. Let me highlight three features where our approach involves big change.

a. First, the mindset of tracking and analysing clinical outcomes. Did the patient actually improve over time with the treatment? How is he doing compared to the outcome performance of the cohort treated by the same clinician? What is the agreed treatment protocol, and did the physician treat the patient according to that protocol? This last matters because Medisave can only be used by the patient if the clinical treatment guidelines are followed. When I visited InterMountain Healthcare and Kaiser Permanente on the US West Coast earlier in the year, I was very impressed by their strength in health sciences research. MOH needs to build this capability.
b. The second supporting feature is national electronic medical records. My Minister is keen to see "one patient, one medical record" regardless of which private or public institution he has been treated at. IT seems to have been a challenge for us so far. Well, long-term care is only possible if records of each visit and test are kept and they are shared. The Electronic Medical Record Exchange (EMRX) implementation within the public sector has reached the stage where the initial teething problems have been worked out, and more and more doctors are comfortable using it. More doctors can now see the benefits of having access to the patient's previous discharge summaries, allergy and medical alerts. The chronic disease programme will draw the private sector in to what will eventually be a national EMRX. Certainly, if GPs are to closely partner specialists in hospital institutions to manage the patient over time, they need to access the patients' medical records. Government will fund the software development and help roll out the system to the private sector, especially GPs.
c. The third feature of long-term care management is that it will build a different relationship between primary care and specialist or acute care professionals because they will be working together to manage patients in a more integrated way. This partnership will have huge benefits to the public sector in terms of workload pressure because our specialist outpatient clinics are swamped today by people rushing to see specialists without consulting their GPs. Some of these visitations are not necessary from the clinical point of view. Considering that 60% of each cohort of medical students becomes GPs, for patients to swamp the public sector specialists and under-use the private GPs is not a good outcome nationally. We will work to persuade Singaporeans to trust their family physicians to provide the holistic first-line care for their chronic diseases, and we will need to help our GPs build their capabilities and the wherewithal to take on this role. GPs and specialists will need to figure out how to pass the patient appropriately back and forth.

KNOWLEDGE-BASED PRACTICE, ACADEMIC MEDICINE AND CLINICAL RESEARCH

The second theme is greater emphasis on knowledge-based practice, academic medicine and clinical research. Developing health sciences research and tracking clinical outcomes will not only be for the management of chronic diseases. It would apply to all medicine, particularly those in acute settings. This is a logical evolution for Singapore given what we have already achieved in terms of an excellent

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standard of service. Our population has rising expectations and patients will compare offerings. Our doctors who have visited specialist centres in Shanghai and Bombay say that some of them are very good. They are also cheaper. To differentiate ourselves from the competition and to continue to serve Singaporeans better, we want to deliver better medicine.

The Government has resisted spending money on clinical research for a long time because it could be a bottomless pit of spending with little return. Individual clinicians kept up with developments in their field through attending international seminars. But we did not invest in creating new knowledge. The National Medical Research Council has given grants but the total scale of funding has historically been small. What the Prime Minister announced on Friday was that Government has decided that it is timely for clinical research to be a strategic thrust of MOH in our next phase of development. This recognises the existence of a world-class capability in basic biomedical research at the Biopolis. With top-flight capabilities in basic research and with excellent standards of patient care, it seems a pity not to invest in translational and clinical research which is the gap between the two. Government has therefore given MOH more funds to more systematically build focused research capabilities in translational and clinical research and to train interested clinicians to be clinician scientists and clinical investigators. With this, we hope to generate real value in terms of better treatments for patients. I should point out that the government wants to see results for the money put in. I envisage that there will be quite a bit of restructuring of our grant allocation so as to substantially strengthen the weight of international benchmarking, and have a more robust peer review and justification of achievements. As with basic science, we will put in place infrastructure, supporting regulations and enabling systems to support research.

We do not want clinical research activities to be limited to the public sector. I want to use this opportunity to say that we welcome competitive grant bids from the private sector medical community. Indeed, funding priority will go to strategic areas of focus which should involve collaborative research drawing in clinician investigators and clinician scientists from different institutions in the public and private sectors. As international clinical research leaders have pointed out to us, Singapore's cohort base is already small. It is a lose-lose strategy for institutions here to compete by hoarding patients or data. On the contrary, we will need to expand our reach for large clinical trials to patients from the region, in order to do more meaningful and robust research.

I think that a question many of you in the audience have by now at the back of your minds is, "Gosh, what happened to the theory that the public sector will provide basic healthcare and it will leave the rest to the private sector? What happened to managing costs and delivering affordable healthcare?" We can plan for the future but I am anchored in the reality of the present. The government's priority remains affordable healthcare to our citizens. But we have had some hard-hitting discussions within the public sector where we have come to accept that simply cutting costs and leveling down capabilities is not the way forward. We will always have to manage our operations as cost-effectively and as efficiently as possible, but we also have to invest in building new capabilities. Otherwise, we will go into decline.

SINGAPOREMEDICINE

The third area that I want to mention is SingaporeMedicine. As most of you would know, the Economic Review Committee studied the idea of developing Singapore as a regional medical hub. While Government accepted the recommendation, the thinking within Government then was that the private sector should take the lead. What has changed in recent months is that the Government has decided that the public sector should also participate more actively in this effort to develop ourselves as an international medical hub attracting patients from around the world. We still see the private sector as being the dominant player, treating the majority of patients. But we do see the public sector hospital serving some of these through private wings, distinct from the mainstream hospital blocks treating subsidised local patients.

Is our entry into business a ricebowl issue for you? Many of you may ask why the government is competing with the private sector for business? The straight answer is that we are not competing with you for the same pie, so there is no ricebowl at stake. Rather, our focus in SingaporeMedicine is to grow the pie, and grow it fast. Last year, Singapore attracted 374,000 foreign patients. Maybe our statistics are wrong, but this figure is lower than the number of patients treated in Bumrungrad in Thailand alone. Our declared target is one million international patients by 2012. This is three times the current number of foreign patients. If all of you in the private sector treat the majority as we expect, that is going to be a lot more business for you.

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The challenges I think you should be discussing are not whether the Singapore General Hospital will compete with you for patients, but rather where you are going to get the land and new buildings to house your new clinics and in-patients. We also need significant new capabilities in hospitality management and customer concierge services. And of course, we need a lot more manpower. Our past approach, especially in the last decade, of crimping the supply of doctors and other personnel like nurses, pharmacists, therapists and so on means that we are now severely constrained in our manpower. As patient volumes grow in the private sector, your obvious response is to *(ahem)* poach from us. We obviously cannot afford an increased rate of outflow because our current tight manpower situation is already a hot political issue. If the rate of doctors departing from the public sector increases, queues will lengthen further. So it makes sense for us to plan together with you so as to reduce unpleasant surprises, and for us to ramp up the supply of doctors nationally. Simple Mathematics tells me that we must expand the local pipeline and we must recruit from overseas.

We have expanded the number of places in the National University of Singapore School of Medicine slightly, and we have ramped up the training pipeline of nurses and allied health professionals. For nurses, we are reviewing career pathways to allow them to develop themselves further with undergraduate, postgraduate and APN training. As for overseas sources of doctors, we changed our regulatory stance to recognise more of the better schools overseas. In terms of actual recruitment of doctors, our first priority will be to target Singaporeans and Malaysian doctors trained and working overseas. Then we can supplement gaps with other nationalities. In this regard, I hope that Gleneagles and its doctors will consider how your institutional structure can accommodate more doctors from overseas as your patient load increases.

PUBLIC-PRIVATE PARTNERSHIP

I have spoken on three themes. Let me draw the speech together by raising the issue of how the relationship between us might change going forward. In my visits to our private medical institutions, a Chairman of an institution commented that MOH had been the "Ministry of Public Healthcare Services" rather than the national Ministry of Health. In other words, while MOH focused on regulating national clinical standards and public sector service delivery, we had not actively facilitated development of the private sector.

I think times have changed. We should facilitate the development of the whole eco-system, including the private sector. First, we should facilitate your business development. For example, MOH can be helpful to private institutions like Parkway in facilitating discussions with government agencies on things like land-use and recruitment of foreign manpower. For investments in countries like the Gulf states where a presence by the Government is seen as a plus, there are opportunities for business partnerships. Second, we should look at the whole landscape, and consider how the delivery of care by the public sector, the private sector, and the charity and NGO sectors can be best integrated. The Chairman of one of your private hospital groups asked me why the actual delivery of patient care services must be entirely provided by the public sector. Good question. Conceptually, going forward, our subsidies, even for acute care, could be portable, but the criteria would be that you can offer the services as cheaply and better than the public sector can. Realistically, this is unlikely to be very attractive to you. However, in chronic disease management, we see a considerably bigger role for private sector primary care. We have also extended portable subsidies to step-down care and nursing homes which we do not own.

Putting the question another way, many doctors in the public sector and private sector have asked me why the line between public and private must be drawn so clearly. That is another good question. I think that it may be good for Singapore if the dividing line was more fuzzy. Professionally, you are a closely inter-connected professional community. In the context of academic medicine and clinical research which I have spoken about, it would be good to find ways for more of you to come back flexibly to teach, to collaborate in research and also to treat patients. From the SingaporeMedicine perspective, I see the dividing line becoming more fuzzy because our institutions may collaborate in business ventures here or overseas.

CONCLUSION: MOVING FORWARD

Let me close by saying that I have tried to share today not so much the content details of the public sector initiatives and Government policies, but some of the thinking that is shaping the strategies. I hope this has been helpful to you, as you plan how to move Gleneagles and Parkway forward. MOH looks forward to work more closely with you in the future. ■