By Dr Jeremy Lim, Editorial Board Member

The Long Road Ahead for Right-Siting

The Ministry of Health (MOH) and public healthcare providers have embraced 'right-siting', the provision of appropriate medical care wherever cost is the lowest possible, with almost religious zeal. However, the path ahead is far from clear. Minister Khaw's wry comment at the Joint China-Singapore Healthcare Forum: "*The theory behind right-siting is simple but making it happen is not easy*"[1], belies the formidable challenges ahead and it must be 'all hands on deck' if we are to even have a chance to make right-siting a reality.

RIGHT-SITING – BIGGER THAN WE THINK

Simply put, the implementation of right-siting successfully will engender fundamental changes in the way society regards not only delivery of healthcare, but also the way we pay for healthcare, the way we structure employment benefits and the yardsticks we measure providers against. For example, many employers, including at least one of the public health clusters, divide outpatient benefits into non-specialist and specialist care. With such a distinction, it is natural for employees to split their healthcare needs between specialists and non-specialists so as to secure the maximum dollar coverage even if all their healthcare needs can be appropriately catered to at primary care level. We presently measure our public sector doctors based on number of patients seen and waiting times, but if our doctors are to encourage right-siting, more time will need to be spent explaining the principles and processes to patients, and success will result in a more complex specialist outpatient casemix, or fewer patients AND longer waiting times!

In keeping with the optimism of a new year, I shall not enumerate a litany of barriers to right-siting, but instead adopt a stakeholder perspective focusing on two of the key stakeholders: the government and the healthcare institutions. The rationale for concentrating on only two of the many stakeholders is that ***right-siting requires a systems approach*** – hence the critical actions are at the policy level; individual physicians and patients will simply behave in accordance with the appropriate incentives and controls. Hrebiniak, a Wharton professor of management, writes of the absolute necessity to 'obtain individual and organisational goal congruence', and decries the strategy that fails to take into account appropriate incentives and controls[2]. In short, right-siting needs a strong steering body and everyone, from the patient to his employer to his doctor to the government, must benefit in very direct and obvious ways for the whole-hearted support from all stakeholders necessary for success.

Dr Lim is Director, Policy and Research for Singapore Health Services and heads the health services research programme for the cluster. This commentary is contributed in his personal capacity.

Page 19 ►

◀ Page 18 – The Long Road Ahead for Right-Siting

WHAT CAN THE GOVERNMENT DO TO PROMOTE RIGHT-SITING?

The government plays a pivotal role in the success of right-siting. There are four key areas the government should actively pursue in addition to ongoing efforts in job re-design and expanding the role of nurses: firstly, incentivising healthcare providers to implement right-siting initiatives; secondly, developing a national information technology (IT) platform conducive to right-siting and shared care; thirdly, promoting to the public through transparency of outcomes and fees that right-siting will maintain the quality of care while driving down the individual's cost; and finally adroit utilisation of policy levers to disincentivise general practitioners (GPs) from other activities that distract from their role in managing the increased primary care demands arising from right-siting at tertiary level.

INCENTIVISING HEALTHCARE PROVIDERS

It is ironic but many in the public healthcare corporate offices are concerned that 'overly successful' right-siting will decrease the number of consultations, or even worse, change the casemix of patients to a more difficult and expensive group by 'right-siting away' all the simple cases, and give MOH reason to make hefty cuts into the subsequent year's block budget. It is a pity as we shall discuss later that the healthcare institution is really the most appropriate level to drive right-siting. At primary health level, GPs find it difficult as economic creatures to spend the necessary amount of time counselling diabetics and other patients with chronic diseases while trying to maintain some semblance of parity with polyclinic fees. Polyclinic doctors, already facing 58 patients a day, have scant interest in increasing their workload further and are thus not overly concerned about the appropriateness of patients seen at specialist clinics.

INFORMATION TECHNOLOGY

MOH has already been infusing massive amounts of funds to support electronic medical records but perhaps the most important effort it can spearhead is a nationalised IT platform that all healthcare providers are mandated to adopt. 'Inter-operability' seems to be the preferred buzzword and the current approach is that of a decentralised minimalist one. But any regular business traveller who has to carry different chargers for different mobile phones, PDAs and laptops will attest to the challenges in realising this.

PUBLIC EDUCATION AND ENGAGEMENT

How can we convince the public that the family physician is 'better' than the specialist for management of the majority of undifferentiated symptoms? Or that the family physician should be the port of call for all non-urgent conditions and the conductor of the health orchestra that will be assembled to take care of the patient? It may not be that difficult as in contradistinction to the United States, the majority of Singaporeans rank cost rather than quality as the most important factor in choosing a primary care provider[3]. Hence, a 'dollar and cents' argument could be persuasive: the outcomes are more or less the same but your family physician will charge you substantially less and is much more convenient.

POLICY DISINCENTIVES

It is all well and good to proclaim the virtues of right-siting, but if the lynchpin of right-siting, the general practitioner, finds it more financially viable to spend five minutes seeing a patient with an upper respiratory tract infection, perform a three minute domestic health screening or invest in the latest laser and a signboard advertising his services as an 'aesthetic physician', then there would be not enough community-based practitioners to right-site too.

A balance of policy levers is probably required for maximal effectiveness. Adopting the 'push and pull' lingo of public transport policy planning, 'push' measures to encourage GPs to play a larger role in managing right-sited patients such as the recent Medisave liberalisation, and perhaps even mobile government subsidies for private chronic disease care and making available public sector allied health professionals to private GPs at subsidised pricing will be needed. At the same time, 'pull' measures to draw GPs from 'over-involvement' in other medical conditions merit due consideration. These would include reducing the volume of self-limiting illnesses presenting to GPs through the use of 'self-determined sick days', doing away with superfluous medical demands such as mandated medical examinations for foreign workers and domestics and discouraging GPs from engaging in 'beauty treatments' through additional licensing requirements.

The guidance from MOH should be straightforward and unequivocal:

1. Right-siting benefits society.
2. Patients must pay less for primary care as opposed to specialist care (including medicines and lab tests) and community-based health services must be priced less than hospital-based services. There must be a natural pricing gradient going down from specialist care to step-down institution care to community care.

Page 20 ▶

◀ Page 19 – The Long Road Ahead for Right-Siting

3. Government will lead the way and lead by example. The civil service will do away with medical benefits policies that segment care into specialist and non-specialist care and permit its employees to call in sick without need for medical certification for up to three to five days per year depending on seniority.

HEALTHCARE INSTITUTIONS – POLICIES THAT DRIVE PHYSICIAN AND PATIENT BEHAVIOUR

As long as our doctors are monitored, measured and rewarded by the number of patients they see (especially private patients), the procedures they carry out and the dollar value they bring to the **institution** (as opposed to the country), right-siting will never succeed.

A renal physician has no reason to refer out patients with early renal disease whether private or subsidised. The private patients he sees represent **his** value to the institution and the subsidised ones provide the buffer he needs to devote more time to the more complex cases. His orthopaedic colleague in the adjacent clinic will likewise not discharge the pleasant old lady with osteoarthritis and consider also the off-chance she may need a knee replacement in future and keep her on his patient list.

What can healthcare institutions do to incentivise doctors? Opportunities abound to reconfigure the entire system of physician incentives. Should doctors who discharge more than *x* patients from their clinic have more 'free' sessions to conduct research or more time to spend with the remaining patients? Should clinic slots be booked based on not just 'new versus repeat' but also 'simple, complex and very complex' and whether there are medical students or trainees? Should doctors manage their own schedules and determine how much time patients need to have their medical problems resolved?

It would be a disaster for the right-siting movement if discharged patients were simply replaced with new and more difficult patients in an ever-faster treadmill of care delivery though without strict referral criteria, this would be likely to occur[4]. Likewise, it would be hypocrisy to exhort right-siting and holistic care while at the same time, penalise the doctor who sees fewer but more complex patients and maintains the best possible outcomes for them. There are no magic formulae to compute the number of patients any individual doctor should see, but the Porterian concept of 'value for patients over the full cycle of care' should clearly come into the forefront when devising new performance measures and rewards systems[5].

With regards to shaping patients' expectations, it is unrealistic for any individual physician to go against the tide. In a block budget setting, pricing is in theory a cluster rather than a MOH prerogative. Hence, the clusters need to take the lead in setting the record straight and pricing appropriately to influence patient behaviour. Identical medicines in primary care settings, that is, polyclinics must be priced less than in the hospitals and pricing for consultations must be tiered with the highest at national centres and the lowest at polyclinics. After all, who would be surprised that a can of Coke costs less in a food court than in a swanky restaurant and that the two-star Michelin kitchen cost more to operate than the neighbourhood *'chi char'* hawker stall?

Institution level policies directly affecting patients will also need fundamental review. For example, it is presently difficult to re-enter the subsidised tertiary healthcare system once one has been 'discharged'. Patients therefore perhaps naturally choose to return to their specialists before the end of the 'open date' period and remain in the system "just in case" the disease progresses and specialist care is needed. Can we build a system that encourages porosity such that patients can stay with GPs or polyclinics and return to their specialists when necessary regardless of elapsed time?

Lastly, the allocation of funds by the MOH and cluster HQs should reflect the priorities given to primary healthcare. A larger proportion of cluster funds going to primary care and earmarked for tertiary-to-primary right-siting initiatives will send a strong signal that right-siting is more than lip service. When the latest imaging device is passed over for HSDP funding in preference for a community-based nurse educator programme to complement GP management of chronic disease and when family physicians' salaries are comparable to specialists, the healthcare community will know that the era of right-siting has well and truly arrived.

A cautionary note must be sounded. The advent of block budgeting for the public sector allows clusters and individual institutes the financial leeway to develop their own human resource schemes but the changes in patient numbers and casemix arising from successful right-siting needs to be recognised and rewarded by MOH. And that might be the biggest leap of faith for institute financial officers to take.

Institute for Healthcare Improvement President Donald Berwick had noted on multiple occasions how systems deliver perfectly what they are designed to deliver. Our present healthcare system was not designed for right-siting: the perversity of financial incentives encourages specialists to hoard

Page 26 ▶

◀ Page 20 – The Long Road Ahead for Right-Siting

straightforward patients and militates against GPs' involvement in chronic disease care. We should not be surprised at the difficulties right-siting faces in the current milieu. Only by profound system change spearheaded by MOH and the two clusters and engaging non-health sector stakeholders can we realise the fullest potential of right-siting and enjoy its benefits of appropriate and affordable healthcare as individuals and as a society. ■

References

1. *Khaw BW. Speech made at China-Singapore Joint Healthcare Forum. Xiamen, China. 8 September 2006*
2. *Hrebiniak. Making Strategy Work: Leading Effective Execution and Change. Wharton School Publishing 2005*
3. *The US EBRI survey found quality outweighed cost for all groups of patients including those without health insurance. The SingHealth survey on public perception of healthcare found instead that distance (35.2%) and cost (27.2%) far outweighed expertise of doctor (11.3%) in deciding on healthcare provider.*
4. *A dermatology unit in the UK actively managed down waiting times of 57 weeks and was rewarded with a further increase in referrals. The team concluded that there was a need to 'limit demand by using agreed referral exclusion criteria in order to balance supply and demand'. Appleby and Lawrence. From blacklist to beacon, a case study in reducing dermatology outpatient waiting times.* Clinical and Experimental Dermatology 2001 Vol. 26 No. 6 Page 548-55.
5. *Harvard professor Michael Porter delivered a lecture in Singapore on 28 November 2006 where he articulated the principles of value-based competition in healthcare and the application to Singapore. In the lecture, he emphasised that high quality care should be less expensive and that we should focus on value for patients rather than lowering of costs.*