*By Dr Toh Han Chong, Editor and Dr Jeremy Lim, Editorial Board Member*

# Interview with Professor Narayan Pant

*"In a lot of ways, Singapore's healthcare is an ongoing lesson to the rest of the world. They are watching to see what happens. Now one of the things we should not forget is that this is a system that is incredibly lucky. What I mean by that is while healthcare costs were growing 8% to 10% every year, the economy was also growing at 8% to 10% every year. It is a constant, right? But now watch the last two, three years. Look at what is happening. It is now already at 4% whereas it was constant at 3% for about 10 to 12 years. 3% to 3.3%. Suddenly we see a leap up because GDP has slowed down – Singapore is now an advanced economy which cannot grow at 8% to 10% each year. So now we cannot count on luck anymore. We got to find a financing system that can take the burden, distribute to consumers so that basic care is still kept managed."*

*Professor Narayan Pant is no stranger to many senior leaders in healthcare. As the Associate Dean of Executive Education at INSEAD, he has been intimately involved in preparing many Singapore doctors for senior leadership positions in hospitals. He also teaches Strategy and has consulted for a variety of healthcare organisations in Singapore, including the Ministry of Health (MOH) and the National Healthcare Group (NHG).*

*Prof Narayan has also helped large Integrated Delivery Networks decide on the scope of services they should offer and ways in which they can offer holistic health maintenance solutions for their users. In addition, he has worked with individual pharmaceutical companies on issues from sales force effectiveness to designing processes for the efficient ramping up of production of new products.*

*In this issue, Prof Narayan speaks to Dr Toh Han Chong and Dr Jeremy Lim in a wide-ranging interview covering issues like the mobile subsidies, SingaporeMedicine and how hospitals should use management consultants.*

**JL:** How did you get interested in healthcare?

**PROF NARAYAN:** It was completely by chance, really. I did my PhD in another highly regulated industry, the banking industry in the United States. And it was going through turmoil at that point and I was looking to see if something from one regulated industry could be applied to another. I had also just moved to Canada and Alberta was an oil rich state. And using revenue from oil, they invested in a lot of hospitals. In the first

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couple of years that I was there, they tore down the old university of Alberta hospital and built brand new, absolutely state-of-the-art hospitals. Within a year, a new government came into power and they said they were going to cut healthcare costs by 30% over three years, in the state. The University of Alberta Hospital was faced with challenges on how to cut back. They faced the need to mothball 50% of their beds. I had some colleagues who were working in healthcare and a couple who were the head of departments for affected organisations. I got involved with them talking about how you think through what you should shut down, how you think through value created by healthcare systems and that was the beginning of my interest in healthcare systems.

When I came to Singapore, one of the things I started was the Johnson & Johnson hospital manager programme here in Singapore. What I started thinking about at that time was 'How do we create a programme which brings the essentials of business management to the medical sector but does so in a way which is relevant in a few short days?' Even if you talk about hospitals, public health, hospital operations and so on, they need to be viable in order to survive. But the viability of an institution differs from country to country, depending on the objectives the country sets for healthcare provision.

This subsequently led to work with other parts of the healthcare value chain specifically with pharmaceutical companies. I worked with the Organisation of Pharmaceutical Producers of India, which was trying to attract more activities in the pharma value chain to India. This then led me to think about the supply chain of pharmaceutical companies, asking why some drugs are so expensive, what happens in the overall regulation and patenting of drugs? Conventional wisdom says that patenting encourages pharmaceutical companies to invest and develop novel drugs. Over the last few years, however, the number of true blockbusters entering the market is small and the number of filings to extend the protected life of existing products is large. This led me into the whole space of when is it viable for a drug to be generic and when should it not be generic and why should governments protect it and so on and so forth. So the short answer to your question is I spent a lot of time expanding into new areas within healthcare.

**JL:** What do you see as the common threads in terms of the global challenges for health in Singapore, in the United States or anywhere else in the world?

**PROF NARAYAN:** All healthcare systems trade-off three dimensions – cost, quality and access. The particular trade-off each system comes to is unique because the history and legacy of each system is unique. The common feature of all systems, then, is that all of them are dissatisfied because nobody is ever happy trading off something as important as cost, quality or access. So the similarity is that we are all unhappy. The United States is unhappy over the number of people who are not being served by the system; the United Kingdom is unhappy because of waiting times for procedures; Canadians are unhappy because the state decides what healthcare they can get and so many go across the border to pay for and get what they want.

Interestingly, many commentators now believe that the solution could be a common one too. There is a growing feeling that we have spent too much time focusing on technical solutions to the problems of healthcare and too little time thinking about value to the end-user. We have focused our time and attention in trying to look for ways to finance the current technical solutions instead of thinking of new business models altogether.

In other words, beyond a basic minimum package of care, we need to see healthcare as a consumption item like any other, over which informed consumers make choices over alternative value-creating solutions. Every society will have to make a determination about what that socially acceptable minimum is which they guarantee to their citizens, and this may well be different. However, all of them will have to allow their citizens private consumption of healthcare – and multiple providers will compete for this private consumption.

**JL:** In Singapore, there were previously attempts to define what is the basic medical package. It started with cardiology and there were plansto roll out to other specialties but there were great difficulties determining what constitutes the basic medical package and that would fall within the healthcare budget. What are your thoughts on what constitutes the basic medical package?

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**PROF NARAYAN:** You know, there are much wiser and more knowledgeable people than me who are grappling with this subject, even as we speak. A few comments: first, we need to recognise that the 'package' as it were will be determined differently in different social and economic contexts. This is natural. Second, we also need to be comfortable with the fact that the solution of the basic minimum package, will be a political solution, not a technical one. In other words, there is no technical answer for this question. There is only the answer of 'what will our society and policy accept as a basic minimum package?'

A few things need to go hand in hand when we grapple with this subject. Whatever the contents of the minimum package, the system as a whole will only work to its optimal level when competitive forces are allowed to operate at all parts of the system. Imagine some services that constitute part of this package – should we contract with alternative providers for them? Should we designate some providers to provide these services? Clearly, one option will force greater efficiency than another.We could push this argument even further. Why should we force participants to receive their basic package at a particular location? Could we not say – all citizens are entitled to so many dollars for a given service; you decide where is the best location for you to obtain that service. What this does is that it brings market forces in, brings discipline in, brings different providers in – all of which could improve the level of efficiency in the system.

Currently, what we do is we provide the subsidy to the location, not the person, which is ok from a practical perspective, it is quite convenient. From an economic efficiency perspective, perhaps it is not the best thing to do. Thinking about how to get away from that requires us to start thinking about how we decide who deserves what subsidy. I think here in Singapore, you call it 'means testing'.

**JL:** But 'means testing' was a political hot potato in the last General Election.

**PROF NARAYAN:** That is not the sort of thing I am worried about in the case of Singapore because Singapore is not scared of tough discussions, right? Discussions about CPF, National Service, race relations, HDB entitlements – these are tough discussions. So I do not see Singapore as a society that backs away from tough discussions and tough decisions. Look at the GST discussion – it needed to be done, lots of people were consulted, then it was done.

**JL:** In a nutshell, what is your analysis of Singapore healthcare system?

**PROF NARAYAN:** The bottom line is this is a great, unbelievable, public health system. If you think about public health, things like disease rates, mortality rates and so on, Singapore does extremely well. And to have gotten to where it has in one generation! It is a fact that every other healthcare system in the world comes to study your system, to look at what you did in one generation. The challenge now is what else can the system achieve? I think it is these further aspirations that make you think about possible changes in the way the system is structured. And it is natural that there will be great resistance to think about this, because it does what it was designed to do, extremely well.

I believe there is a contradiction in a system which is supply controlled and one that is cutting edge, simply as a matter of logic.

A supply-controlled system keeps all parts of the system fully occupied and imposes no pressure on these parts of the system to experiment and innovate. The Singaporean public healthcare system is probably operating at or near full-capacity. This means two things: one, people do not have the time to think about innovating; two, they have very little incentive to do so, other than professional pride, because they are fully occupied.

**JL:** Can you elaborate on this point?

**PROF NARAYAN:** Do you do as much research and cutting edge work as you feel you should be doing?

**JL:** I think we are grossly under-delivering in the medical research mission.

**PROF NARAYAN:** And one reason for that could simply be the volume of work which you do, accompanied by the incentives that get provided internally. For instance, if I need to buy your time to do research, what is my ability to do so?

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**THC:** I think we are creating structures to do that. Certainly there are career structures in Singapore such that the service career structure is the more attractive package financially compared to a research career structure. We do not have the tradition and legacy as in the United States where they will say I do not mind a 15 to 20% pay cut but I am going to do this stuff and research. I am going to be a key opinion leader in the United States and I am willing to accept that pay cut. I think in Singapore we are nervous because there are a lot of people who are not willing to take the cut and do research.

**PROF NARAYAN:** You have got to be well aware of the model in the US. If you look at the top medical centres in the US such as the Massachusetts General Hospital, I can be a physician, a professor and a researcher all at the same time. And different people buy my time for different activities. The medical school buys my time for various teaching courses and various NIH grants fund some of my time to do research and the hospitals pay me to conduct a certain number of procedures over the year. And then what happens is that some people who are the best at certain activities will only do the activities they are good at. I have friends in that system who only do research because they are not great physicians. That is fine.

The response that I often hear in Singapore, and I think it is the correct response, is that we are a very, very small country. We do not have the scale to allow this incredible amount of specialisation in these various areas. I agree, but I think this has consequences. Specifically, if we do not allow more slack in the system – and this comes from allowing greater amounts of time for non-clinical activities – it will be hard to aspire to global recognition. Incidentally, I do not think there is such a thing as regional recognition, it is either global recognition or no recognition.

**THC:** I think that is correct because we cannot compete with other kinds of service providers because they are cheaper elsewhere.

**PROF NARAYAN:** I mean I do not go to the Mayo Clinic because they are cheap.

**THC:** Right but you might go to Bumrungrad because they are cheap.

**PROF NARAYAN:** Yes, you might but you do not want to be in there for a serious complex disease. That is my point. Let's take a very trivial example. Let's take the example of Singapore retail – Orchard Road. If you think the people are going to come to Orchard Road rather than go to Bangkok, forget it, it is not going to happen. The price structure simply will not support that. What you are hoping is that people will say: "Rather than go to Tokyo, I will come to Singapore" or "Rather than go to London, I will come to Singapore". If we cannot pull that off then we are in deep trouble because Kuala Lumpur and Bangkok will always undercut us. We do not have the cost structure to compete with them. If we are playing in the Bumrungrad league, we have lost already.

**THC:** But do you think there is any space in terms of service commitment or service delivery that we can still catch up in terms of imitating Bumrungrad, I mean can we catch up in the service game?

**PROF NARAYAN:** Well, I think we had better ask what we want to be. I think it is easy to say we want to compete for the spa business. For instance, a lot of what Bumrungrad does is providing some elective procedures all packaged together with the spa experience. They do that very well in Bumrungrad. I do not think it is sustainable for us. I do not think Parkway can compete nor sustain itself in this space because they have got valets to park your car. So let's talk about how you can compete in different parts of the healthcare space.

At the level of primary care, I think, it is relationships that drive the value proposition. It is true I want to have a relationship with my GP, the one I have been going to. So the competitive edge in the primary care relationship is the localisation of things. I do not think that is going to globalise very quickly.

Maybe the value added systems, the compliance systems in the United States, the accreditation or something can play a part in improving competitive posture but it is ultimately relationships that matter. At tertiary levels, all the evidence suggests research positioning drives the value proposition and flow of patients. I am sorry but everything else is going to be just a commodity business as has happened in the United States a long time ago. Most routine procedures such as angioplasties moved out of the tertiary hospital and into the secondary

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hospital in the United States about five years ago. 50% of the revenue of the tertiary hospital disappeared over a period of two years.

**JL:** What do you think of the model of private healthcare here in Singapore?

**PROF NARAYAN:** I think the current model needs to decide how it plans to compete. The difficulty that the most serious contender in the private space – Parkway – has is that they have no real control over the physicians who work at their hospitals. Hence it is difficult for the hospitals to create any coherent positioning other than the fact that we have great physicians, come to us. But some of the most interesting and advanced procedures and technology exist in the public sector, and that undercuts the appeal. There is also no incentive for private sector physicians to engage in research other than personal interest, and that is quite variable.

Government subsidies are an important consideration here. The truth is, the private sector may be cheaper for standard procedures in terms of cost structure, but thanks to subsidies, the private sector cannot be attractive on the price dimension, thanks to subsidies. Also, thanks to the nature of funding, you could end up having more advanced and sophisticated technology in the public sector, which again undercuts the private sector's appeal.

**JL:** Where does that leave training? Because under the Singapore healthcare system, training is exclusively in the public sector unlike in the United States where even if the patients with simple conditions flow into private secondary hospitals, trainees can follow the patients.

**PROF NARAYAN:** It is still possible to do that. What is training after all? Training is the allocation of a certain amount of resources. It is the purchase of people's time. So now under this system, I can buy people's time anywhere. So that is what training is. So you can effectively ask someone from the private sector to come and do training for positions because you are just buying time. And of course that time may not be completely competitive but there will always be people in the private sector who will be willing to do that. I know of a cardiologist who has just gone from the public sector to the private sector who basically says: "I am going to continue teaching because this is something that I love and I am going to give back time." It is going to happen.

**JL:** Over time, do you see the Singapore healthcare system with the lines between public and private being increasingly *blurred*, so that one day we may not even have public or private specialists, we just have specialists who spend some of their time in the public sector and some of their time in the private sector?

**PROF NARAYAN:** From a pure efficiency perspective, the ownership of the resources should not be important in the provision of service. Subsidies should be linked with segments of the population who are deserving, the extent of subsidies linked with the nature of the condition, and the location of the service left to the market.

For a variety of reasons, we are very far from that system today. However, in several simple steps – private sector physicians practising in the public sector and vice versa, the ownership of resources is becoming less important. I can see how the authorities might feel that by limiting subsidies to the public sector, they may have greater control over the provision of services. The reasons for this feeling might include asymmetry of information between the patient and the physician and so on. However, time will only reduce this asymmetry.

In other words, over time, I think we will get to a pure efficiency driven structure.

**JL:** Where does public sophistication and medical information asymmetry step into this equation to make the market work as best as it can?

**PROF NARAYAN:** I do believe that to improve market efficiency, you need to be more customer-centric and public awareness is absolutely crucial.

Markets will always function, people will make choices, which then drive the equations in the market. The reason why healthcare is seen as a different kind of business is because of information asymmetry. But healthcare has changed dramatically over the years. Look at the difference between 1993 and 2006. Given the amount of information people have access to today, what we were living with in 1993 was just outrageous. You know what we were using to access the Net? It was called Mosaic. It was just about to come into being. I remember in 1993 and 1994, getting onto Mosaic saying: "Where can I go with this thing?" I can go to the Louvre website and look at the painting and it took about five to 10 minutes for the painting

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to be downloaded enough to be seen. I mean look at the difference. Everybody is hooked on the computer to everybody else. I can get an answer to medical conditions in a second.

**JL:** Let's move on to the issue of healthcare leadership. You mentioned that you have previously done work for the NHG. Are there any insights you can share on how we can prepare doctors who have for 10 to 15 years never managed anyone other than the individual patient in front of them? How do we prepare them for leadership positions as department heads, chairmen of medical boards and so on?

**PROF NARAYAN:** I firstly think too much is made of this job distinction between physicians and managers in healthcare systems. You know if you are a world class orthopaedic surgeon, why should you be a world class accountant as well? It is not necessary. So I think the way for us to get past this system is to get the following clear. Whether you are a physician or a manager, the most important word relevant to you is the word 'leader'. You need to be a leader, which means you need to lead people. Eventually whether you are a physician or a manager, you need to lead different categories and groups of people. This is going to include business managers, going to include physicians.

It is going to include a variety of people in different parts of healthcare. What you are going to require is just basic understanding of areas outside your expertise. You do not need to be experts in these areas. You do not need to be expert managers. Unless of course you want to stop being a doctor, and say: "I am going to make management my career." But once you do that, you know you are not going to be a physician, you are not going to be a surgeon. You are going to give that up and say that is all you are going to do.

But the point I am making is that you do not need to be either a doctor or a manager to manage doctors or managers – you need to be a leader. So the key attribute, I think, which we have to start bringing, is this notion of leadership in managing people. And if we bring those attributes, I think the rest becomes easier.

**JL:** I think hospital systems have gotten themselves into situations where we must have a Chairman of a medical board who must be a senior physician; we must have a Director of Nursing who must be a senior nursing leader. Because it is only the CEO position where you could arguably say that the best person gets the job, regardless of whether his background is in healthcare or not in healthcare.

**PROF NARAYAN:** I think once again it is the leadership. You need to have different groups of people to form the leadership. Traditionally, we made the assumption that if you are going to be in the position of hospital head, you have got to be a physician. I think you can start with this assumption because after all, if you think of things like the jury system or if you think of things like the legal system, qualified legal people have made decisions on technical subjects without experts on these technical subjects. They rely on experts to make those choices for you. So if you are a physician Chief Executive, you do not need to be an expert accountant. You rely on the accountants to make those decisions for you. Similarly, if you are going to be a Chief Executive who is an accountant or a lawyer, you are not going to make medical decisions. You are going to rely on medical people to make those decisions. So to me the key attribute is: Are you going to be a leader of people? And if you are a leader of people then the structure or constraints that you place on what you can do, they are not important. My experience with leadership has been that the best leaders of the world are those who managed to put together a strong team. They manage them, they motivate them, they challenge them and they push them to go all the way. I think that is the same thing that should be put in healthcare systems.

I belong to an institution which is like the institution you belong to; I believe hospitals and universities are the last two dinosaurs of the organisational age. Academics and healthcare are still the last two supplier oriented organisations of the 21st century. Kicking and screaming, we are going to give in and become client-centred. We are not going to like it because it involves the usual mess of change but I think this change is going to happen. That is where new ideas on how to configure to create value can arise.This is where those ideas are going to come from.

**JL:** In the meantime, how should hospitals get physicians and clinician leaders to work together better?

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**PROF NARAYAN:** Set them on projects, joint projects where they both have joint responsibilities and need to collaborate. Not just across medicine and medical and administration but even across different medical specialties. That would be useful too. You guys do not talk very much to one another across specialties. It is the same thing in business school. If I am in Finance, I do not talk to those behavioural researchers. They do different things. I think joint projects are often used by organisations to bring different sides together. They work quite well.

**JL:** In the last issue of the *SMA News*, there was a scathing criticism of the use of management consultants in healthcare. Can you share your thoughts on how healthcare as a sector, given the resistance of doctors to other external experts, how can we best use these external management consultants?

**PROF NARAYAN:** I will be curious to find a company or an organisation that actually welcomes outside experts. I do not think they exist.

**THC:** But surely organisations like Toyota, Ford, they will probably embrace consultants better than healthcare?

**PROF NARAYAN:** No. There are CEOs who say on the record: "I will never allow consultants to cross the border of my organisation."

A consultant's job is not to tell you how to do your job. Their job is to answer your questions, help you refine your thoughts, and otherwise bring perspectives to your thinking that your own perspectives would not permit you. Their job is not to tell you how to do your business. To play that kind of role, every industry could use those questions. But I do not think consultants do well when you go to them and say: "What should we do?" Because they do not know your business. If you ask them that question, they will tell you what to do because that is what you are paying them for, right? Unfortunately, that is not what they are designed to do. They are designed to do specific tasks. They are designed to probe questions, answer or test your assumptions. They are designed to be people who potentially benchmarked between you and other people who say this. They are potentially people who benchmark across industries. You should not ask them: "Can you please tell me what strategy I should have?" because if you do that, why are you developing the organisation and not them?

**THC:** But I think a lot of times that is what consultants do, right? Suggest strategic positioning.

**PROF NARAYAN:** Well, I think it is legitimate to ask a consultant a question which says: "Tell me what all these organisations in other parts of the world do" or "I have an aspiration to compete based on a particular strategic positioning. Tell me what I need to do to be successful in that position; but ultimately it is the organisation that makes the determination as to whether it will take the advice. I think it is a mistake to ascribe immutable authority to the consultant – they are giving you their best opinions based on the data that in part you have given them. Ultimately, you need to make the determination as to whether their prescribed course is right for you.

**THC:** This is part of corporate intelligence, right?

**PROF NARAYAN:** This is part of that. It is benchmarking, which is part of that. There is drawing lessons from different industries, which is a part of that. But you know,consultants are a tough sell in any organisation. But they do create value when they are used in the right way.

What is a consultant's business model? A consultant's business model is not to do one transaction because that is too expensive. They have to learn your business, they have to figure out what you do; it is incredibly expensive to do all that. Their business model is to get themselves invited back. The only way they can do that is to demonstrate value in the first instance. So the point is it is their job to continue to try and demonstrate value to you because if they do not do that, they are out of jobs. So they will do that. And for good consultants, repeat business is a great percentage of their business. In a certain sense, the market is saying that they do add value.

**THC**: Thank you, Prof Narayan, for your time.

**PROF NARAYAN:** Not at all. ■