SINGAPORE MEDICAL ASSOCIATION

NEWSLETTER

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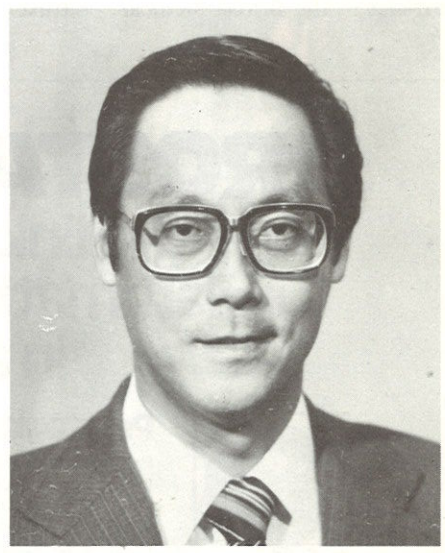
MEDISAVE

Goh Chok Tong reveals details in an exclusive to SMA Newsletter

The Second Minister for Health and Minister for Defence, Mr. Goh Chok Tong, said that hospitalised patients must expect to pay more realistic fees than the present nominal rate. He added that the fee increase will be done gradually so that no one will be "priced out of medical care". He went on to indicate that 'C' Class patients in government hospitals will continue to be subsidised but this will be reduced from the present 90% to 50% over the next eight years.



Mr. Goh, who is responsible for the National Health Plan, disclosed details of the Medisave scheme to the SMA Newsletter.

The following is the full text of his reply to questions posed by the Newsletter.

Newsletter:

There have been a number of reports in the press about the proposed Medisave scheme. Could you give us the gist of the scheme?

Mr. Goh:

Medisave is a saving scheme to pay for hospitalisation. Every working Singaporean is required to contribute 3% of his wages into his Medisave Account. His employer will match with another 3%. The total 6% monthly contribution is subject to a maximum of $180.

The saving in the Medisave Account can then be withdrawn to pay hospital bills incurred by the account holder or his immediate family members (viz spouse, parents and children).

The philosophy behind the saving scheme approach to health care is that people must be rewarded for staying well. They must be given the incentive to stay well. The monthly payments into Medisave, unlike insurance premia which go into a common pool and are gone even if medical services are not subsequently used, belong to the contributor. If he and his family members stay well throughout their lives and do not have to visit the hospital even once, the huge balance accumulated belongs to him. But in the unfortunate event that hospitalisation is needed, he will have sufficient funds in his Medisave Account to pay for it.

There is another reason for Medisave. As individuals, and as a nation, we must save for a rainy day. If we do not, 20 years from now when we need hospitalisation most because there will be more old people then, there may be no funds in the Treasury to pay for this expensive social service. Look at Britain. Her National Health Service is near bankruptcy. Never assume Singapore will always travel at top-speed indefinitely. Sooner or later, our train must slow down. If it does, and we have not stocked up surplus fuel, how do we tide over the difficult stretch?

Patients must therefore, expect to pay more realistic fees than the present nominal rates. Fee increases will be done gradually so that no one will be priced out of medical care. 'C' Class patients will continue to be subsidised, by as much as 50%, even in 1990.

Newsletter:

We understand that the Medisave scheme is basically designed to cover hospitalisation expenses of those patients who currently opt for 'C' class wards. Does this mean that the current rate of subsidy by the government for these beds will continue unchanged?

Mr. Goh:

At present Class 'C' patients are subsidised up to 90% of our running. All capital expenditure, land, building and equipment costs are not recovered. They are paid out of general taxation. The subsidy is therefore, more than 90% of actual cost.

We will continue to subsidise Class 'C' patients because our study shows that there are still many people who cannot afford to pay the full cost of hospitalisation. We will, however, try to reduce the level of subsidy to 50% of the running over the longer period. The rate of reduction will take into account the population's ability to pay. The aim is to reach the 50% subsidy level only in 1990. By 1990, most people should be able to pay up to 50% of the hospital running cost because they would have accumulated some savings in their Medisave Accounts.

Why do we want to reduce subsidy? The answer is simple. By not cutting subsidy, we are assuming that the country can always raise enough taxes to pay for subsidized medical care, housing, education and other social services. This assumption is false. If we have 2 or 3 years of recession, when we need money most, we will find that that is also the most difficult time to squeeze the taxpayer. The umbrella will not be there when it is raining. When the sun is out, let us pay for our services and save enough at the same time to buy an umbrella when it rains.

Newsletter:

Can Medisave be used to pay for private hospital bills?

(see back page)

INSIDE

Medical Audit: the British and Australian Experience

Controversy over the quality of medical care is as old as the profession itself. Like any commodity, the service a doctor renders his patients is subject to market conditions and affluence which, in turn, gives rise to higher expectations.

The recent medical climate seems to point to the advantages of audit – a term usually used in accountancy – as a form of quality control measure. There is, however, a conflict of opinion on the subject.

Here, two eminent names in British and Australian medical circles give their views on medical audit, and their countries' experience of it.

THE Chairman of the Council of the British Medical Association, **Dr A H Grabham**, feels that medical audit is an ill-defined subject which has different meanings to different people.

The term 'audit' as has been suggested in a series of articles in the British Medical Journal by Charles Shaw, is 'a numerical review by an outside investigator directed at, among other things, the prevention of fraud.'

This connotation of outside interference, Dr Grabham feels, has given rise to anxiety, suspicion and mistrust among doctors, and this in turn, has led to the development of other alternative names.

In Britain, it seems, the best definition of the term comes from a Working Party chaired by Sir Anthony Ament of representatives drawn from the major Royal Colleges and the British Medical Association.

They defined 'medical audit' as 'the sharing by a group of peers of information gained from personal experience and/or medical records, in order to assess the care provided for their patients, to improve their own learning and to contribute to medical knowledge'. Peers were defined as doctors who practise in the same speciality in broadly similar conditions of practice.

In Britain, the need for assessment of the quality of care by a system of inspection was advocated as far back as 1944, when the then Minister of Health made proposals for a National Health Service.

Since then, the profession has continued to monitor its own performance and standards in a series of informal ways.

There have, however, in recent years been a number of voices who came out in favour of formal audit. Amongst them are the joint working party of representatives of the Department of Health, the Royal Colleges and the BMA; the Ament Committee; the Conference of Senior Hospital Doctors in 1978; the representative body of the BMA in 1979; and in 1980, the General Medical Services Committee of the BMA and the Royal College of General Practitioners agreed to work together to study the possible introduction of audit into general practice.

Problems

In the BMA, the task of producing 'practical recommendations' was passed to the Board of Science, but they encountered the same problems as others before them: that it is extremely difficult to produce precise plans for the introduction of audit, which are practical and at the same time of positive value to the profession.

What the Board of Science found, however, was that there were already other exercises taking place to protect the public from poor doctors and, at the same time, encourage the practice of good medicine.

Dr Grabham outlined these as:

1) the procedure of appointing doctors within the National Health Service, which is presided over by a panel of assessors;
2) programmes of continuing education and study leave for all hospital doctors;
3) the fact that both general practitioners and hospital doctors tend to work in teams helps to maintain standards and makes for an easy exchange of opinions;
4) the 'merit award' system by which cash awards are made to hospital doctors who make outstanding contributions to medicine and to the National Health Service;
5) regular visits to all hospitals by representatives of the Royal Colleges who determine whether standards in each unit are suitable for the training of junior doctors.

Dr Grabham also points out that there are other outside groups who make occasional assessments of hospital cases.

Among these are the courts of law which intervene in cases such as malpractice suits against doctors; the coroner's court in the case of hospital deaths; community health services which are empowered to make comments and suggestions to the Local Health Authority; the Health Service Commissioner (or the Ombudsman) who represents the public's interest; health officials of the Hospital Advisory Service who examine the way the wards are being run. The Health Service Commissioner (the Ombudsman) is an eminent lawyer appointed by the Government. If a patient or relative is unhappy about the administration aspects of a case, he or she may complain to the administration aspects of a case, he or she may complain to the Ombudsman who will investigate and make a report together with recommendations.

In view of all this surveillance on the medical profession, Dr Grabham is of the opinion that formal medical audit would be of limited value in Britain.

He is more in favour of ensuring that every doctor be given the opportunity to take study leave, to undergo revision courses and to keep up-to-date in his own speciality and in medicine in general.

He admits, however, that there are a few areas in which audit is being applied successfully in Britain, such as a confidential enquiry into maternal deaths; the National Laboratory Quality Control Scheme; the Royal College of Radiologists which has introduced a series of investigations to assess the value of common radiological proce-

continues on page 10

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1 Acta Paediatrica Scand. 1979; 68: 351-5, 441-2, 813-17.
2 Codex Alimentarius Commission Joint FAO/WHO food standards programme. Recommended international standards for foods for infants and children. CAC/RS 72/74 – 1976. Rome: Secretariat of the joint FAO/WHO food standards programme, 1976.
3 American Academy of Pediatrics. Committee on Nutrition. Commentary on breast-feeding and infant formulas, including proposed standards for formulas. Pediatrics 1976; 57: 278-85.

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Kupat Holim: Israel's guardian angel of health

Dr Chng Puay Sian graduated in 1972 from the University of Singapore. Since then, she has worked for a period in New Zealand. In 1974, she first visited a kibbutz in Israel. In the months she spent in the Ma'agan Michael Kibbutz, Dr Chng had a first hand experience of the social system there. In 1981, she returned for 2 months to Israel to do a health course. From these visits, she is able to give us the following account of the Israeli health system.

Health System:

IN Israel, health care services are provided by four voluntary health insurance agencies known as Sick Funds. The largest of these is called Kupat Holim (K.H.).

Its role is more than the usual health insurance scheme. It is based on 'mutual aid', with its guiding principle "from everyone according to his means, to everyone according to his needs." Kupat Holim provides a prepaid comprehensive health care service, including hospitalisation to 76% of Israel's population (approximately equivalent to 3 million). The other three smaller sick funds take care of the 21% of the population, while the balance of 3% provides for their own health needs.

Brief History:

The fund was started in 1911 by a group of early agricultural settlers. The members contributed a monthly portion of their wages to it for the medical needs of the member and his family, irrespective of the size of his family or the level of his income.

Membership:

After the formation of Histadrut (the General Federation of Labour) in 1928, Kupat Holim was incorporated into it and members of the Histadrut are automatically members of Kupat Holim. In fact there is now no direct membership in Kupat Holim as one has to be a member of the Histadrut first, with the exception of immigrants, people on welfare, pensioners, soldiers and young workers (14 to 18 years). On the average, a member's contribution is proportionate to his income, up to a ceiling of 4.5% of his wages. From all the fees collected, the Histadrut will then allocate 63% to Kupat Holim.

Ministry of Health:

This ministry plays a secondary role in the delivery of health care, for the simple reason that the state of Israel was established much later than Kupat Holim. The health ministry defines the country's health priorities, plans the health service, fixes the minimum standard of health and administer to the hospitals that were previously owned by the British prior to their withdrawal from Palestine.

Services:

Kupat Holim runs an extensive network of health services across the country. It has:—

1225 outpatient clinics
253 maternal and child health clinics
304 pharmacies, 39 X-ray institutes
59 rehabilitation centres
16 recreation centres and convalescent homes
15 hospitals — these include general, specialised and mental hospitals

It owns a total number of 5262 beds, which is about 30% of the hospital beds in Israel. Research Institutes are incorporated in most hospitlas. To facilitate the delivery of health care, the country is divided into six regions: each serviced by a network of clinics which may be urban or rural and drained by regional hospitals.

Kupat Holim also trains its own medical and paramedical staff. All the staff are salaried and belong to the Histadrut. It employs about 30,000 people of which 5,300 are doctors and 9,700 nurses. About 50% of all doctors in Israel are employed by Kupat Holim, 40% work in government and municipal hospitals and the remaining 10% in private practice. The standard of medical practice in Israel as exemplified by Kupat Holim is exceptionally high and there is now a centre for computerised medicine.

Medical Care:

Medical services, including investigations and hospitalisation, are provided free of charge to every member. Furthermore, there is only one class of accommodation in all the Kupat Holim's hospitals. As a prepaid comprehensive health insurance scheme, Kupat Holim makes possible the care of the patient as a whole with all the technology that medicine can offer. For example, in an urban health care centre, the set-up is similar to our polyclinic, but with more facilities available.

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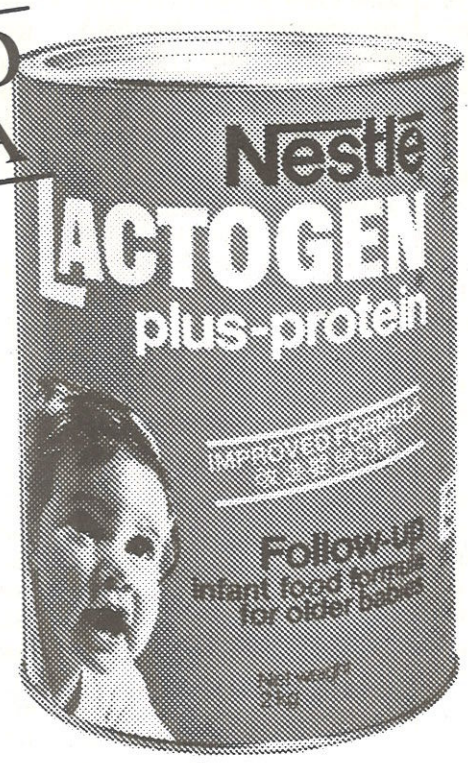

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"Present day practice in infant feeding"
Dept. of Health and Social Security, U.K. 1974

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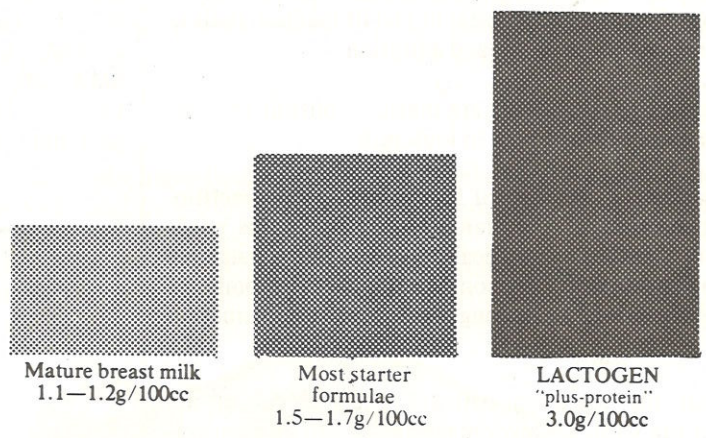

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EDITORIAL

Quality Assurance

IT is fashionable to talk of quality in Singapore and this may be an opportune time to consider the topic.

Quality assurance in medicine is a concept of ensuring adequate and appropriate patient care at all times. In this issue of the Newsletter we report on the British and Australian experience. The American experience was outlined by Dr Paul Sanazaro during a keynote address at a recent local congress and a television panel discussed some aspects of the problem

Why is there a need for quality assurance? Have we not been doing well to keep the status quo?

It is pertinent to look at past practice. The situation prior to 1970 was one comparable to the British system that Dr Grabham refers to on page 2. The service was almost entirely public with very minimal institutional private practice; technology in imedicine was in its infancy. The 'fee-for-service' practice was limited to outpatient services; the fee was modern and the expectations were limited.

The pattern of practice in Singapore has changed. Open heart surgery is a daily event in the private sector. Coronary artery by-pass surgery has the potential of growing into an industry. Medical centres proliferate and more than 40 per cent of doctors with a post-graduate qualification are in private practice. The segment of the population that is paying a fee-for-service is increasing. Hence the need for quality assurance.

Solution

How do we ensure quality? The practical solution in Singapore is for the profession to accept some form of peer review as a necessary evil before the situation warrants a bureacratic response. Private and public hospitals should set up performance review committees to assess utilisation of facilities, standards and outcome of care. A system which clearly delineates privileges of individual doctors, renewable periodically, is an important first step. The management of hospitals has a responsibility to ensure that only competent persons are allowed to work in their institutions. The Austin Hospital model of medical audit in Australia is commended for study and adoption.

The vast majority of patients are managed outside the hospitals. This is a more difficult area to look into.

In New Zealand, a sampling of letters written by practitioners are being scrutinized. The standard of our records needs more attention. Continuing medical education, in a palatable form, should be encouraged. The computer holds the promise of improving records as well as making the spread of information easier.

What about the aggrieved patient? The concept of the Ombudsman in the United Kingdom may be worth an examination and adoption. Very often a failure to communicate, complicated by personality problems, creates a situation that an Ombudsman can solve.

The time has come for the SMA with other related bodies like the Academy of Medicine, College of General Practitioners and the Association of Private Medical Pratitioners, to jointly set up a Resource Centre for Quality Assurance and continuing medical education. The expertise from overseas can be tapped, the funding can be raised and a local modus operandi evolved.

The major ingredient for success is one of attitude. An editorial in the Lancet commented, "Without a willing spirit of enquiry, audit is worthless".

DR J A TAMBYAH

News from Council

NEWSLETTER

The Singapore Medical Association (SMA) has acquired the services of Miss Jane Chew as part-time editorial assistant for the SMA Newsletter. Miss Chew is currently the editor of "Lion City", a weekly tourist newspaper. The SMA is also in the process of recruiting an assistant executive secretary, who will subsequently be responsible for the Newsletter and the Singapore Medical Journal.

DONATIONS

Further to the appeal sent out to all SMA members on 1 September 1982, the Association has received $15,136 (as on 31/10/1982) in donations. Several members have also pledged their organs for donation.

FEE GUIDELINES

At the closing date for submission of the survey questionnaire on "Guidelines on Fees for Doctors in Private Practice in Singapore", (which was extended to September 15 1982), the SMA received 485 replies, which is about 30% of the total SMA membership. Although a 30% return is reasonably good for a mail questionnaire, the SMA sent another appeal on October 15 to those who have not responded to do so, as both the SMA and APMPS wish to know the members' views before any recommendations are put up.

The Ad-hoc Committee met Professor A Peter Ruderman for an informal discussion on Friday, September 24 1982 at the SMA Conference Room. Professor Ruderman is a visiting professor at the Department of Social Medicine and Public Health of the National University of Singapore. Professor Ruderman provided the ad-hoc committee with some new perspectives on the subject of doctors' fees.

The SMA together with APMPS recently made a joint press release to advise the public to discuss fees with their doctors when they seek consultation or treatment. When patients fail to do so, doctors are advised to inform their patients in order to avoid any subsequent allegations of overcharging.

CHECK-UP RATES

The SMA is once again attempting to negotiate with the Life Insurance Association of Singapore for increased standard rates for medical examinations on proposers for life insurance policies. A Joint SMA/-APMPS Ad-hoc Committee was formed with Dr Low Lip Ping as Chairman and Drs Hia Kwee Yang and Goh Lee Gan as members. SMA has also written to APMPS to nominate three representatives to this ad-hoc committee.

CMA COUNCIL MEETING

The Commonwealth Medical Association (CMA) held its 10th Council Meeting and Scientific Conference in Trinidad from November 1 to 6, 1982. SMA's representative to the CMA was Dr Jerry Lim Kian Tho.

CMAAO IN TOKYO

Dr Teo Chew Seng, SMA's representative to the Confederation of Medical Associations in Asia and the Oceania (CMAAO) attended the 17th CMAAO (Midterm) Council Meeting held in Tokyo on November 4 and 5, 1982. Following a decision made at the AGM, SMA has officially applied to rejoin CMAAO and is awaiting formal acceptance of our application.

WORKSHOP SESSION

The RIHED Workshop Session was held from November 16 to 19 1982 at Mahidol University, Bangkok. As Dr Low Lip Ping was unable to attend, the SMA was represented by Dr Gwee Hak Meng, associate editor of the Singapore Medical Journal.

CONGRATULATIONS

THE Singapore Medical Association would like to congratulate the following who have passed the Master of Medicine (Paediatrics) Examination held in September:

Dr. Chao Sing Ming (Miss)
Dr Lau Tien Khoon
Dr Loke Hing Leng (Miss)
Dr Wong Keng Yean

Letters to the Editor

Dear Sir,

THE move by the government, through NPB, to upgrade the standard of industrial medical practice is good in principle. The way this is to be implemented, however, from what can be gleaned from the press, raises some questions which I hope the authorities will consider.

First, the problem appears to be one of lack of updated information being freely available. Certainly, doctors are given lectures on occupational health during their undergraduate training, and therefore they are expected to have a grounding on what is required of them.

The problem is that, once graduated, they are not kept informed of new changes and requirements. Of course, it can be argued that it is the business of the practitioner to find out for himself. But not everybody is able to do so, for some reason or another. Thus I would see it an important step in the achievement of better industrial medical practice to make some form of a newsheet available to doctors.

The Epidemiological News Bulletin is an example in point. Through it, doctors are kept informed of the latest in infectious diseases. Can't the same be done with industrial practice? NPB could produce such an information newsheet.

Cartel

Second, certification, unless properly implemented, may create a form of cartel. It may not necessarily mean better industrial practice. Based on supply and demand, if the the number of certificates is not enough, the factories may be held to ransom. The necessary work to be done may be limited to a few hands, and standards may suffer from overload. Thus, if it is deemed necessary to legislate, the law should not come into effect until the number of certificates inssued is enough to prevent the formation of cartels and unnecessary overload through undersupply.

Further, every doctor should have a reasonable, if not an equal, chance of signing up for the certification course without an unnecessary waiting time.

Third, the required period of six month appears to be unduly long. To know what steps must be taken to ensure that the health of industrial workers is not jeopardised in the 20 odd industrial diseases surely does not need six months, especially when the doctor has had some training on the clinical presentation and investigation of these diseases during his undergraduate training. If he has not, then there must be something fundamentally wrong with the undergraduate curriculum!

What is needed are lectures – maybe 10 – together with factory visits and demonstrations to the various industries. The visits can be done on a rotating basis. To train 20 doctors at a time that the NPB is now thinking of is poor utilisation of the teaching resources.

Fourth, certification must be backed by a strong CME (continuing medical education) programme if the industrial doctors are to be kept continually up to date.

Dr Goh Lee Gan

Dear Sir,

I WRITE to congratulate Earl Lu on his fine article regarding fees in the October issue of the Newsletter. I think he has put the subject in proper perspective.

The article would have been complete if he had ended by encouraging all patients to have family doctors.

The family doctors will not only are for them during their illnesses, counselling them in their needs, but even act as arbitrators in the dispute of fees.

Dr Philbert S. S. Chin

"Of course I do housecalls. Your place or mine?"

THE Editor welcomes your comments and opinions on relevant issues, as well as suggestions on improving the Newsletter.

Letters must be typewritten, signed and addressed to:

The Editor
SMA Newsletter
Singapore Medical Association
4A College Road
Singapore 0316

The Editor reserves the right to edit and publish all letters.

Portrait of a Surgeon

THE hand with the Chinese paint brush executes deft strokes with smooth, self-assured precision born of years of experience. And no wonder: Earl Lu Ming Teh is the surgeon behind the brush and the proliferation of roses, in a burst of pastels and ink, that have become a feature of the annual art exhibition in aid of St Andrew's Mission Hospital.

Earl Lu the surgeon is well knew to many. Earl Lu the painter is no less conspicuous.

This articulate doctor is brimming with talent. But it is also his incredibly awe-inspiring self confidence that gives a Midas-like quality to all his pursuits.

"I was always top in school, and I knew that whatever I did I would do well," he said with the compelling resonance that makes for star quality in the theatre. "So, with a rather bloated ego, I thought I would make something of painting."

"My art teacher, Chen Wen Hsi, has always told me to give up medicine and concentrate on painting. He says if I were to do it full-time, I would be a very good painter."

It is a safe bet, too, that, given the chance to start all over again, he would have excelled similarly in music or, perhaps, architecture which, he said, he would have taken up if his father had not enrolled him in medical school.

Being a realist, he is quick to point out that his painting has not reached the standards that he, as a collector, requires of others.

The painting brush is as familiar as the scalpel to Earl Lu, the surgeon who paints roses.

The archetypal cultured scholar, Dr Lu captures the western subject of the rose in the Chinese brush technique, using poster colours as well as Chinese ink.

"When I first started painting, I used to do fishes and animals. But I knew that if I continued at that, I would at best become an inferior Chen Wen Hsi. So I decided on something different, and chose the rose, my favourite flower."

Like his art, Earl Lu is a happy harmony of both worlds. The product of a privileged education in Australia and UK, he was nevertheless reminded of his roots. His parents were collectors of works by the classical Chinese masters, and young Earl Lu grew up in an artistic environment.

Vitality

This has instilled in him an eye for beauty – for that 'universal rhythm, that life's breath and vitality' – that enables him to size up a piece of art in five minutes.

Today, Dr Lu prides himself on being a discriminating collector of Chinese art and Asian antiques.

This side of the man is also juxtaposed with his profession with its attendant criticism of being built upon materialism.

If anything, he can hardly be described as such. A gold medal was recently awarded to him for his service in the armed forces in which he holds the rank of lieutenant-colonel. He has also been the prime mover of the annual exhibition in aid of St Andrew's for 18 years.

This year's exhibition, held in October, has been of special significance to him. He sold 12 of his 14 paintings, two of which fetched a price of $1,000 each. The exhibition netted $30,000.

Dr Lu admits that he has never felt the need to be competitive because he has never lacked for anything. But this has not made him impervious to the inherent privilege of his training.

"I think that doctors, in many ways, are more privileged than others. We have an ability to make people well, and if they are not well off we have the right not to charge anything. I think that is a tremendous privilege and something for which we should be grateful."

It is this simple, magnanimous philosophy that contributes to the 57-year-old surgeon's enjoyment of life. When he retires, he would like to go back to art school and start all over again, but not necessarily Chinese art, because art is universal.

"One must never learn how to do this or that," he admonishes. "It's like surgery. Don't learn how to do an operation; learn how to solve a problem with basic surgical principles. All good surgeons do that. Only the chaps who don't know learn the technique. It's the same with physicians."

Then, with the wisdom of one who has seen and learnt

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continued from page 8

much, he said: "People like being young, but I don't look at the end as something terrible. I feel that I have lived a rich life, more than the average person deserves.

"It is important to love the younger generation instead of being jealous of them. It is important to love talent when you see it – no matter who has the talent – to support it, praise it and make sure it goes in the right direction.

"To me, it is sad to have grown old and not learnt anything – not to realise that you can't last forever."

It is indeed a philosophy you would expect from this stature of a man with a name to match. – **J. Chew**

DR . David Kwo, an authority on Chinese art, is well acquainted with Dr Earl Lu and the latter's style of painting.

Dr. Kwo, who lives in the US, is currently here as resident artist of the Singapore Art Society, and lectures at the Extramural Studies Department of the National University of Singapore.

Of Dr Lu's style, he says:

"Earl prefers to go his own way rather than follow someone else's footsteps. Why did he choose to have the rose as his logo? It's because no one else has ever picked this subject.

"Earl seems to enjoy my philosophy and technique in Chinese painting thoroughly, yet he never once copied my compositions, because this man has his own ideas as to what and how he wants to paint. He has his own aesthetic standards. This is of paramount importance if one wants to be a true artist, rather than be known as a slavish imitator.

"He is one of the best surgeons in the country. Despite his busy schedule, he has found time to ripen his style, and I am glad to note that he has recently added urns to his rose compositions, subtle in colour and texture, and done in interesting archaic shapes.

"Colour preference, as a rule, does reflect one's temperament and disposition. Earl's favourite colour seems to be blue, reflecting a peace-loving sentiment.

"In painting, however, blue is not an easy colour to work with. This man has an excellent taste when it comes to colours. He can blend all the other pigments into the blue and compose a harmonious symphony. They say there are two different kinds of music – alive or dead. Earl's art belongs to the former.

"Although Earl started as an amateur painter, he has certainly developed over the years, creating a unique style of his own.

"He certainly deserves professional recognition. It is about time we had a one-man show from him."

Calendar of events

THE International Association of Gerontology (Asia/Oceania Region) will hold its second regional congress from January 22 to 25, 1983 at the Sydney Science Centre, Australia.

THE Second International Urinary Stone Conference will be held from February 6 to 10, 1983 in Singapore. For more information, write to:

The Secretariat
Second International
Urinary Stone Conference
c/o Royal Perth Hospital
Box X2213, GPO Perth
6001
Western Australia

THE Second Asian Pacific Congress of Nephrology will be held in Melbourne, Australia, from February 13 to 19, 1983.

For information, write to:

Dr Gavin J. Becker
Secretary-General
Second Asian Pacific
Congress of Nephrology
Box 1920R, GPO
Melbourne, Victoria
Australia 3001

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Medical Audit

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dures; and the Association of Anaesthetists which encourages regular reviews of anaesthetic procedures following post-operative deaths.

Dr Grabham concludes that carefully selected topics are suitable for study by audit if it is done in collaboration with the medical profession.

He believes that the future of medical audit lies with the voluntary participation of doctors rather than with government imposition.

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IN a paper presented at the 13th Singapore Medical Convention in April, **Dr L L Wilson**, President of the Australian Medical Association, outlined the three A's of modern medical practice facing Australian doctors: assessment, accountability and audit.

Assessment

Hospital accreditation is a voluntary quality assurance programme in which hospitals invite assessment by an outside, non-governmental organisation, the Australian Council on Hospital Standards.

This assessment takes the form of a survey of the hospital, with emphasis on quality assurance, and the physical and clinical well being of the patient.

The survey is conducted by a team a medical practitioner, a nurse and an administrator.

The surveyors' task is to assess the hospital's performance according to the 'accreditation guide' standards developed by the council in consultation with national medical, hospital and health care organisations.

The report is studied by the council and a decision on whether to accredit the hospital is made.

Failure to achieve accreditation has proved to be an effective spur to corrective action.

Both public and private hospitals are included in this programme of accreditation which is operating in all, except for two, Australian states.

Acceptance of this programme, in fact, is higher in Australia than in either the USA or Canada, the model for the Australian system.

The medical profession is undergoing a change, which is not brought about by its government but rather by its own association through the mechanism of hospital accrcdition.

Accountability

Dr Wilson feels it is not possible to guarantee standards of care in hospitals unless the clinical responsibility of doctors is matched to their training and experience.

This process of delineation specifies procedures of a general practitioner or a specialist in a hospital. Only two states in Australia have identified this need to delineate clinical privileges, but accreditation will soon change this.

According to Dr Wilson, legislation will soon make it mandatory for public hospitals.

The committee which decides on clinical privileges is known as a credentials committee and is composed entirely of medical practitioners.

Increasing technology in medicine makes a formal system of accountability necessary. This not only enables a hospital to cope with the occasional irresponsible doctor, but also with the doctor who is psychologically or physically unfit.

Audit

Audit is the essence of peer review, contends Dr Wilson.

Peer or clinical review is the term used in Australia to describe the process of assessment by which peers continually assess one another's professional competence.

The development of peer review in Australia has been brought about by a concern for excellence; increasing costs; threats to professional autonomy; and the changing organisational and scientific basis for medical practice.

Before 1970, there was little discussion of peer review, and the traditional methods were orientated towards medical education, but which did not provide for corrective action where deficiencies were detected.

Dr Wilson points out that there is an increasing feeling, especially in the USA, that continuing medical education has little to do with the maintenance of medical care standards.

He considers health care an industry which, in the last few years, has received positive action in formal peer review than during the mid 1970s when there was a great deal of controversy and debate.

A 1974 survey of 92 Australian hospitals showed that, although many hospitals carried out some review, none of them had a comprehensive quality assurance programme.

In 1980, the Australian Council on Hospital Standards found that only 22 percent of 56 hospitals had even basic clinical review activities.

Since these surveys, however, commitments to quality assurance have been made by many hospitals, the learned colleges and most professional organisations.

Dr Wilson gave the example of the Royal Australian College of Obstetricians and Gynaecologists which, together with the AMA/-ACHS Peer Review Resource Centre, embarked upon a national audit for hysterectomy for benign conditions, this year.

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Another example is the Standards Committee of the Royal Australasian College of Surgeons' survey with the Peer Review Resource Centre of 2000 cases on the justification for an appendicectomy.

This survey covered public and private hospitals in two states.

In the field of internal medicine, the most comprehensive quality assurance programme is the one at Austin Hospital in Victoria.

This model – the Austin model – has been followed in over 20 Australian and New Zealand hospitals, and has the participation of the visiting, full-time and resident medical officers of the department of medicine.

It is essentially a random selection of discharge summaries which are used for group discussion and analyses. Records of proceedings are kept and problems are dealt with.

This programme is closely indentified with continuing education, and is dependent on the enthusiasm and personality of the physician running it, and is only feasible in a large teaching hospital.

Criteria auditing:

Australian surgeons are in favour of criteria auditing – a system of quality assurance in a hospital based on the criteria developed by the medical staff of that hospital.

Dr Wilson asserts that, by a careful choice of criteria, it is possible to justify a procedure, and to determine whether the process of care or the outcome was satisfactory. It minimised the involvement of medical staff by using medical record administrators to do the initial screening of records.

The steps are:

1. choice of subject
2. criteria setting
3. medical record search
4. examinations of variations for justification
5. identification of problems
6. action to overcome problems
7. re-study

The Australian experience of this system has revealed the following:

1. The subject chosen must be a problem. The interest of medical staff will not be maintained by auditing for its own sake.
2. Criteria chosen should be applicable to the local conditions of the hospital.
3. Criteria should be chosen by a committee of staff whose work is to be evaluated, and it must be agreed upon by the group.
4. There should be an even distribution of cases so that the performance of all the medical staff is reflected in the audit.

Opinion

This system is being used in private and public hospitals throughout Australia.

In Dr Wilson's opinion it is essential that the results of the exercise are reported to an advisory body within the hospital. A restudy of the subject will ensure that the problems have been corrected.

A major objective in the introduction of audit into Australian hospitals has been to avoid the development of a government or professional bureaucracy, such as the American Professional Standards Review (P.S.R.O.).

A key event has been the establishment in 1979 of the AMA/ACHS Peer Review Resource Centre, which werves to promote formal quality assurance techniques.

This includes keeping a list of all quality assurance activities in all hospitals, answering enquiries and putting interested parties in touch; and providing materials such as audit criteria for guidelines.

The centre also compiles brochures on pertinent subjects and produces videos for hire.

In 1981 it started publishing a quarterly journal, Australian Clinical Review, the first of its kind in Australia.

Dr Wilson concludes that although the quality of care in Australian hospitals is high by international standards, it has to be proved.

It is his view that there will soon be two compulsory requirements for accreditation by any hospital. These are the delineation of clinical privileges of doctors and a formal programme of quality assurance and utilisation review.

So far, emphasis has been on medical care in institutions because this is more likely to succeed.

The next major challenge Dr Wilson feels is to find an acceptable technique for measuring quality of medical care outside the hospital setting.

(Kupat Holim:

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The multidisciplinary staff is made up of a team of medical officers; family physicians, an O & G specialist and a paediatrician. In terms of delivery of personalised health services the Israelis have patterned their clinic on an integrated system which would provide primary health care backed up by a team of specialists and paramedical personnel. By careful screening (done by qualified trained staff nurses), health education (done by doctors) and good team work, the work load of the doctors is reduced to a reasonable volume (about 30 patients per day), thus enabling personalised doctor-patient relationship. There is also continuity of care with a follow-up of patients by social workers, nurses or rehabilitation counsellors where necessary.

Financing and Problems:

As the membership of the Histadrut increases, it has become painfully clear that not everyone in the organisation shares the same idealism of the early pioneering spirit. Abuses of the system began to occur. These included:

i) Excessive patronage by members. Israelis average 14 visits to the doctor per capita per year. This is the highest number of visits per person in the world.

ii) Excessive consumption of drugs by members. K.H. manufactures a large proportion of the common drugs used in the clinics and hospitals, and it has an approved drug list of about 2000 times, selected solely in accordance to their therapeutic value (some of which are imported and expensive). It admits that there is an excessive consumption of drugs by its members. For example, in terms of numbers of prescriptions per capita per year, in Israel it is 24.0, in Germany 6.5 and in U. K. 5.0. To combat this problem, Kupat Holim has begun to levy a token charge per prescription and to educate the patients on the use and abuse of medications.

Kupat Holim has, since the mid 1950's, been incurring budget deficits that have to be met by Government subsidies and loans.

PROMOTIONS AT THE TOP IN MINISTRY

Professor Seah Cheng Siang, Senior Professor of Medicine and Head, Department of Medicine (III), Singapore General Hospital tops the list of senior doctors promoted in the Ministry of Health. The Singapore Medical Association congratulates all those selected.

The following is the list of promotions which take effect from 1 December 1982.

Prof Seah Cheng Siang
Medical Specialist Grade C

Prof Lee Yong Kiat
Medical Specialist Grade D1

Dr (Mrs) Sivakami Devi
Medical Administrator Grade D1

Dr Tan Seng Huat
Medical Specialist Grade D1

Dr Chew Chin Hin
Medical Specialist Grade D1

Dr Chia KimBoon
Medical Specialist Grade D1

Dr Chow Khuen Wai
Medical Specialist Grade D1

Dr Tan Bock Yam, Frederick
Medical Specialist Grade D

Dr Moses Yu
Medical Administrator Grade D

Dr Ng Kwok Choy
Medical Administrator Grade D

Dr Teo Seng Hock
Medical Administrator Grade D

Dr N Kunaratnam
Medical Specialist Grade D

Dr Tan Kheng Ann Lenny
Medical Specialist Grade D

Calendar of events; continued from pg. 9

THE 9th Haridas Memorial Lecture will be delivered by Associate Professor John Tay Sin Hock of the Department of Paediatrics, National University of Singapore. The lecture entitled 'Consanguineous Marriages in Singapore' will take place on Friday, 10 December, 1982 at the Pathology Lecture Theatre, Singapore General Hospital, Outram Road at 8.00 pm.

THE National University of Malaysia and the British Council will jointly organise an advanced paediatric course in child neurology.

Held from February 24 to March 6, 1983 the venue will be the Faculty of Medicine of the Universiti Kebangsaan Malaysia at Jalan Raja Muda, Kuala Lumpur.

The course content will cover the diagnosis, management and prevention of cerebral palsy, neuro-muscular disorders, infections, epilepsy, neuro-degenerative disorders, mental retardation and minor neurological dysfunction.

A SPORTS Science Conference will be held at the Singapore Hilton International Hotel from May 25 to 27, 1983.

Fore more information, write to:

Dr Giam Choo Keong
Organising Secretary
1983 Sports Science Conference
Singapore Spots Council
National Stadium,
Kallang
Singapore 1439

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Mr. Goh:

Yes, but because the 6% contribution rate was calculated based on the cost of hospitalisation in a Government Class 'C' ward, we can only allow withdrawal up to the Class 'C' entitlement. This is to avoid a situation whereby the account-holder may use up all his Medisave funds at the first episode of illness. He will then have no funds to take care of his hospitalisation needs after retirement.

Newsletter:

Will expenses incurred in outpatient services, like consultations, medication, laboratory tests, X-rays and other procedures be covered by Medisave?

Mr. Goh:

Medisave is meant for hospitalisation expenses. It does not cover outpatient care. At present it only costs a patient $10 to be treated at the Government Hospital Specialist Clinic. This is within the means of most Singaporeans. There is no need for him to dip into his Medisave Account for such outpatient treatment fees.

If we want to include outpatient care, we have to rework our sum. We may need more than 6% of the wages to be put aside.

Newsletter:

How do you envisage the chronic sick and disabled will manage on the limited coverage offered by Medisave?

Mr. Goh:

Medisave is designed to finance acute hospitalisation. It is not intended to cover chronic sickness such as kidney dialysis programmes, mental illnesses etc. If it should be extended to cover such programmes, then the contribution rate would have to be higher than 6%.

The chronic sick and the disabled will be taken care of through other Government programmes. For instance, the mentally ill pay only nominal fees at Government hospitals. They will remain heavily subsidised.

Government will continue to provide the safety net for the truly indigent who require health care. The chronic sick and disabled who have no funds, friends or relatives will have to be taken care of by the community as a whole. Government is part of this community.

Newsletter:

How will Medisave be administered? What is the expected cost of operating the scheme?

Mr. Goh:

Medisave will be jointly administered by the Ministry of Health and CPF Board. We are presently working out the detailed mechanics of administration. It will be tied in with the Ministry's overall computerisation programme. We do not expect any significant increase in administrative cost as a result of Medisave.

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