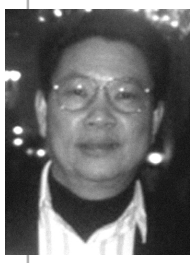
The Impact of President George W. Bush on

Medical Practice in Singapore

By Dr Lim Shun Ping



Dr Lim graduated from Monash University, Australia after which he returned to Singapore for 6 years to fulfill the terms of his Colombo Plan scholarship. Thereafter, he spent 20 years working in the States, where one of his appointments is Clinical Associate Professor of Medicine at Ohio State University in Columbus. Currently, he is back in Singapore as a cardiologist in private practice.

On January 20, 2001, George W. Bush was sworn in as the 43rd President of the United States of America. Soon after taking office, in mid-February 2001, President Bush rocked the global medical community, the proponents of a woman's right to choice, and thousands of women (and supportive men) around the world by reinstalling the "Mexico City Policy", prohibiting the use of US funds for organisations such as the International Planned Parenthood Federation which provide or counsel patients on abortion. The London-based IPPF lost more than US$5 million in funding for 2001.

The impact of this decision on women in Singapore will be minimal, according to O & G colleagues to whom I chatted over lunch in the Doctor's dining room at Gleneagles Hospital. However, it prompted me to start thinking about the influence of American healthcare practices and policies on medical practice in Singapore and more specifically about the potential impact of President Bush's healthcare policies on the way we physicians will practise medicine in the years to come.

What influences medical practice in Singapore? We are all aware of the origins of Singapore medicine in the British colonial era. Since the end of the Second World War, the dominance of the US in the geopolitical arena and the pre-eminence of its tertiary educational system and premier medical institutions have profoundly influenced the course of Singapore medicine. Which physician in active medical practice in Singapore is not aware of the need for continuing medical education? Are we not struggling to come to terms with CASEMIX (the Australian version of US Medicare DRGs), managed care, evidence-based medicine, clinical practice guidelines, malpractice litigation and a small host of other American imports?

Healthcare issues are not a priority with the Bush administration. In his recently concluded first hundred days in office, he pursued his election campaign priorities: the US$1.6 trillion tax-cut plan, education reform and the national missile defence system. His 100-day record on healthcare was reported in a press release put out by the Department of Health and Human Services which cited a number of healthcare initiatives as being underway, including strengthening Medicare. It was given a solid B grade by Robert Reischauer, PhD, former director of the Congressional Budget Office and now head of the Urban Institute. Whether he wants to or not, however, George W. Bush will have to devote more time to healthcare issues than he intends. The Bush Administration ordered a review of all the rules which President Clinton issued during the last month of his Presidency and these included the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Far above any other accomplishment in the healthcare arena, the way in which President Bush and his advisers manage HIPAA and the mandated "Provisions for Administrative Simplification" during his term in office could profoundly affect the way medicine is practised in America and around the world, including Singapore.

What is HIPAA? This is a complex body of legislation with rules and regulations which are still being crafted and fine-tuned. Several parts of HIPAA are of great potential significance for Singapore medicine. It is not without flaws, and further legislative and regulatory tinkering will be needed to improve its robustness. It will take years before its seminal provisions become part of the everyday practice and business of American medicine. Its important potential ultimate effect, however, is monumental in scope, and that is the establishment of a US national healthcare electronic information infrastructure. For the average physician, this will completely change the way in which he interacts with his patient during the patient encounter. History-taking and physical examination will be computer-based, and therefore necessarily highly structured and standardised, with a uniform and comprehensive data set required to be gathered for each body system or anatomical region examined, and few, if any, short cuts! Data entry via keyboard, touch screen or voice recognition technologies will be essential to facilitate ease of use. The clinical record will be accessible, together with demographic, laboratory, drug allergy, treatment, billing and insurance information in whole or in part, to doctors, patients, insurers, government entities and other authorised users anywhere in the world via personal computers or other internet access devices with appropriate built-in security features, and legal protections for patient privacy and healthcare information confidentiality.

If America succeeds in this vision, then the knock-on effects to the rest of the world will be equally revolutionary. Singapore is committed to a national IT vision, and the potential advantages of a national standardised electronic healthcare information system to the government, regulators and administrators will be difficult to resist. Having every citizen's complete and standardised medical record in cyberspace can improve medical practice, medical communication and reduce medical errors, but much more enticing to the national decision-makers is the ease with which this structured and comprehensive record will be amendable to audit, quality assurance activities and computer analysis for regulatory, research and planning purposes. For the foot soldiers at the lowest level of this information pyramid, however, it has the potential to turn out to be an impossible nightmare. Doctors, nurses, laboratory technicians, social workers, dieticians, pharmacists, hospital administrative staff and other ancillary healthcare workers will have to gather and enter their respective pre-determined

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data sets, and should these prove to be excessively onerous, data quality will inevitably suffer. Garbage in, garbage out. Beyond the cost to the healthcare worker in the increased time he will need to spend in gathering and entering data, is the cost in time and effort required to learn how to use the software and hardware systems (yet to be developed) and in dealing with the inevitable bugs and glitches which are part and parcel of new IT systems. Protecting the integrity and security of the system, even one of relatively small scale from a global perspective, as Singapore's will be, will require a small army of IT specialists and anti-hacking strategies and tactics that need to keep pace with the ever more active and ingenious hackers around the world. What may happen if we decide our electronic health information systems should be regionally or even globally compatible? Will the Indonesians, by virtue of the overwhelming size of their population base decide that we should adopt their data sets, or will the Malaysians have the final word in the choice of compatible hardware? Will we adopt the EU's software standards or those of the North Americans?

Computerisation of patient medical record information and a comprehensive and standardised national electronic health information system appears inevitable, and may be upon us in Singapore in its full force and glory before the end of the first decade of this new millennium. Individual health practitioners are well advised to prepare themselves to enter this new era, and decision-makers should begin the process of deciding what are appropriate data sets to capture without overburdening the data gatherers and degrading the quality of the resultant information. George Bush has an aversion to minutiae; let us hope he helps us by crafting "administrative simplifications" that really work. ■