Healthcare Costs –
Some more thoughts from the ground

By A/Prof Goh Lee Gan

The many letters in the local press in the months of September and October show concern about healthcare costs. Some suggestions have been offered, and they merit further thought. There are also other thoughts that have so far not been raised in the rounds of vocal responses this year.

MAKING THE GP THE CENTRE OF GRAVITY

Making the general practitioner (GP) the centre of gravity has been proffered as a strategy that will help to reduce healthcare costs. The number of patients seen per day by the GP has dropped from 40 to 33 in the last 8 years from 1993 to 2001. Yet, we are going to train 300 doctors a year. Assuming 50% of each cohort will be GPs, there will be 150 GPs joining the workforce every year. They will have no work to do, unless the hospitals decant some work to them.

What can the hospitals decant? Chronic stable conditions will certainly be one group of conditions. At the moment, the situation is such that it is difficult for patients to see their GPs for such care. Many companies will not pay for this kind of expenditure, but paradoxically, they will be willing to pay for fees chalked up from hospital visits. Government servants receive a flat rate of $10 reimbursement for a GP visit, irrespective of acute or chronic care.

Thus, there is scope for leaders in the GP fraternity to work with the Consumer Association of Singapore (CASE) and the Singapore National Employers Foundation (SNEF) on how we could persuade our employers that it will be cost-effective to involve our GPs to provide the stepped down care that these patients need.

We can certainly build capacity for GPs to be more involved in the care of such patients. It is likely that with an ageing population, the care of chronic diseases is going to be an increasing area of work. So will be home care. The College of Family Physicians, Singapore (CFPS) has taken the right step in having a distance learning CME course on home care.

DRUG COSTS

Drug costs are certainly a big expenditure item. But by how much is the latest drug better than the existing armamentarium of drugs? There are sadly not enough head-on trials to decide on such things. So, there is a proliferation of more and more expensive drugs.

We can reduce drug costs by more prudent prescribing. Thus, we need to ask ourselves if the patient really needs the number of drugs prescribed.

PREVENTION IS STILL BETTER THAN CURE

The old adage "prevention is better than cure" remains true. We need to do more of that. The big killers of diabetes, strokes and heart attacks can often be traced to adverse lifestyles and failure to take sensible measures directed at diet, exercise and weight control. Attention to these will really make a difference to disease burden from the individual, family and national perspectives. Lower disease burden means lower healthcare expenditure. Let us work towards how to continue to keep ourselves healthy.

CONCLUSION

Certainly, healthcare has progressed in its complexity. We need to work out what healthcare strategies will make a difference to health status and what will give the "best bang for the buck". ■