Hobbit's Nonsensical Guide
to Health Economics

Health economics is a major minefield for the uninitiated. The truth is often obscured, hidden or just not understood. Not to worry, the Hobbit will now give you his nonsensical guide to this Secret Art. For the avoidance of doubt, the Hobbit wishes to tell you that the only professional qualification he has is a MBBS obtained some years ago from the local university, where the curriculum time allocated to health economics is about the same as that for nuclear physics.

The dark realm of health economics can be summarised into:

a) Two myths
b) Three fears
c) Four facts
d) Five rules
e) One conclusion

TWO MYTHS

Myth #1

The greatest component of healthcare cost is manpower. This is completely rubbish.

The greatest component of healthcare cost is patient expectation. And the greatest driver of patient expectation is NOT increasing manpower costs or new technology BUT some people saying that "our public healthcare system is the best" and all that stuff once every couple of years, and "we will continue to give you the best and at the same time be affordable". Get real, baby, quality costs and this country is paying for it. Lower expectations and I will show you lower manpower costs and health costs as well.

Myth #2

We have a wonderfully efficient healthcare system because we spend so little of our GDP *(only 3%)* and we get a world class healthcare system and wonderful health indices for infant and maternal mortality rates and life expectancies, compared to industrialised countries which spend between 6% to 14% of GDP and get the same results.

The real reason why we have great indices is that our environment is clean and our nutrition good, not because we have good hospitals and clinics. And we spend so little because we are a young population *(ageing but not aged like Europe)*. Moreover, our health spending *(also known as National Health Expenditure or NHE)* is only 3% of GDP because we have had great economic growth in the past 20 years, such that absolute increases in NHE still translates to only 3% of GDP. Now that economic growth is slowing to <5% per annum, NHE will surely bust 3% soon. Our great economic growth in the past and young population have given the illusion that our healthcare infrastructure is wonderfully efficient. We should stop kidding ourselves.

The worst is yet to come because we are too hospital-based *(read: expensive)* in our delivery of services.

THREE FEARS

Fear #1

A means test is a poisoned chalice. Whoever moots it and implements it will be put on the rack, crucified and burnt at the stake *(in this order)*.

Fear #2

Supplier-induced demand is Singapore's second greatest fear in healthcare. That assumes doctors have the free time to induce demand. Try telling this to public sector doctors who don't have time for lunch to meet their nutritional demands, let alone induce demand – the only time they induce demand is when they are constipated. On the flip side, some wise guy has also noted with some basis that because we have limited a certain profession to even-numbered lorongs of Geylang and not to odd-numbered ones as well, we have prevented supplier-induced demand in the services rendered by this particular ancient profession.

Fear #3

There is a lot of money in treating foreign patients. But there is the third biggest fear: demonstration effect, which is the effect of increasing demand from the local populace *(i.e. the heartlanders who need healthcare subsidies)* for more expensive care as a result of seeing such services being offered to rich, foreign patients at full fee-paying prices. A means test may counter the demonstration effect, but then, that would lead to Fear #1.

FOUR FACTS

Fact #1

Subvention is a noun. The verb "subvent" does not exist. However, along the way, someone invented the word "subvent" and mangled the English language in health economics. The closest verb we have to "subvent" is "subvert".

Fact #2

GPs are practically unsubsidised *(except for some cases)* and VWOs' step-down care is usually subsidised at 50%. Acute hospital care is subsidised between 65% to 80%. Asking people to step-down to less subsidies is like trying to have anti-gravity boots. The acceleration towards subsidy is certainly greater than 9.8 m/s^2.

Fact #3

Outpatient subvention is an episode-based fixed rate. The less you do during each episode and the more episodes you have, the more subsidy there is, and the more money public institutions

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make. Take home message: Do less but do more frequently. Somehow doctors in public institutions have not awoken to this fact yet. We not stupid? Maybe not.

Fact #4

There is no such thing as health economics – only socio-politico health economics. Sometimes the social, and especially the political aspects, far outweigh economic considerations *(see Myth #1)*.

FIVE RULES

Rule #1

Polyclinics are NOT meant for the poor. They are meant for anyone who can wait *(see Fear #1)*.

Rule #2

The best way to detract people from the problems of health economics is to indoctrinate the masses with the idea that doctors are the root of the problem in health economics. Fix them and you fix everything.

Rule #3

To explain away Fear #1, we tell people that a means test may create a permanent social under-class, which is bad. But then again, it's OK to create a permanent upper-class establishment with elite schools and scholars. But an under-class is a definite no-no. *(Food for thought: can there be an upper-class without a lower-class? Can there be an under-class without an "above-class"? More importantly, how come "under-class" is an accepted word but there is no such word as "above-class"?)*

Rule #4

More on classes: we have five classes of beds in public hospitals to cater to different segments of population and affordability. We product-differentiate to "give choice". We also product-differentiate to avoid the means test *(see Fear #1 again)*.

Rule #5

Healthcare subsidy is a bottomless pit. There is a limit to housing and education subsidies per capita *(one family – one 4-room flat; one child – one place in school)*. One patient can receive from $1 to $1 million worth of subsidy.

FINALLY

Conclusion #1

Health economics is often not rational. Don't spend too much of your time on it. Better do something more useful like study the gross anatomy of the limbic system *(which incidentally came out as an anatomy test question during my year: a fine testimony to the quality of the highly subsidised yet expensive medical education my classmates and I had)*. ■