Can Healthcare be Cheap and Good?
The Promise of Primary Healthcare

By Dr Jeremy Lim

The eternal dilemma of healthcare is that of infinite demand versus limited supply. All over the world, governments and countries grapple with the issue of how to provide affordable, quality healthcare to the entire population, and not one has succeeded in totality. The United States prides herself for her cutting edge medicine, but over 40 million Americans are without insurance and hence regular healthcare. The United Kingdom preaches a sermon of healthcare for all regardless of social class or income, but long waiting times force her to send patients overseas for treatment, and anecdotal accounts abound of mishaps due to excessive lengths of time before surgery or treatment.

What about Singapore? We have a highly regarded healthcare system, ranked sixth in the world by the World Health Organization[1], and the vast majority of Singaporeans enjoy ready access to healthcare. However, with increasing sophistication of technology and a more discerning (the cynic would use the term "demanding") public, coupled with a rapidly ageing population, it is clear that infinite demand will exceed limited supply, if it has not already. The Acting Minister for Health, Mr Khaw Boon Wan, describes it colloquially as "money no enough"[2]. Medical practitioners, however, view it simply as the government asking for healthcare to be "cheap and good". Is this a contradiction in terms? Can any commodity, least of all healthcare, be both cheap and good?

There are certain fundamental tenets of healthcare that are universally accepted. Firstly, prevention is better than cure: modifying risk factors such as smoking and obesity is cheaper than managing strokes and heart attacks. Secondly, care gets progressively more expensive as we move from primary to tertiary care. Thirdly, care should be commensurate with expertise: it is a waste of time and money for a respiratory physician to manage uncomplicated asthma. With these concepts in mind, let us examine the state of healthcare here.

While the Ministry of Health acknowledges "health education and disease prevention will always be a cornerstone of our health policy"[3], the total budget for the Health Promotion Board of $81 million[4] pales in comparison to the $4.7 billion the nation as a whole spends on health. Furthermore, hospitals, which deal mainly in acute care, accounted for 48% of health operating receipts, or $2.26 billion.

Comparing public sector utilisation of primary versus tertiary services, we find that the 2.9 million visits to the polyclinics is only slightly more than the 2.7 million visits to specialist outpatient centres. Granted that private general practitioners do not figure into this equation, it is still somewhat disturbing that the pyramid of healthcare may not have a broad base and narrow apex, and that there is suggestion of inappropriate usage of tertiary services[5].

The answer to our cost predicament seems clear then:

1. Emphasise prevention INSTEAD of cure.
2. Focus on primary healthcare and family physicians INSTEAD of hospital specialists.
3. Ensure expertise is appropriate to the clinical problem at hand and that specialists are not managing cases that can be managed just as competently by their GPs.
   (The word INSTEAD is in capital letters to emphasise the author's view that funding should be diverted from curative services and tertiary care to primary healthcare, including lifestyle modification and disease prevention.)

This major paradigm shift, however, will not come easily, and the major players have to march to the same drum beat to realise the vision of "the world's most cost-effective healthcare system"[6].

GENERAL PRACTITIONERS (GPS)

Family medicine has come out of the shadows and gained much credibility amongst other doctors. But more must be done to overcome the image of the "cough and cold" GP and to convince hospital colleagues and the public alike that GPs can play a far more active role in patient care.

It is regrettable that any doctor can practise as a family physician, as young and inexperienced or simply disinterested practitioners can cause unwarranted malign of the whole discipline. Family practice cannot be the default mode of medicine, and must grow into its own specialty, with accreditation and standards accordingly. In countries such as the United States and Australia, family medicine is recognised as a distinct discipline and without board certification or other accreditation, doctors cannot practise as family physicians. Singapore should also work towards the gradual certification of all new GPs as family practitioners and require the appropriate post-graduate qualifications for independent family practice. Young doctors without the necessary experience or qualifications should perhaps limit themselves to working in a group practice under the supervision of an accredited colleague.

In addition to raising standards, family physicians have to demonstrate the vibrancy of their own specialty and their professionalism. Conducting of trials, publishing papers and a closer working relationship with their hospital counterparts would be a good start in the right direction. Ultimately, all

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GPs should be the "ideal GP" as envisioned by the Minister (sans the appendicectomies)[7], and patients should regard them as the first (and for the majority of health concerns, ONLY) contact point for acute healthcare and preventive medicine advice.

HOSPITAL SPECIALISTS

The present system of remuneration provides no incentive for hospital specialists to co-manage private patients with their GP colleagues. As long as specialists are appraised, in part, on the number of private patients they see, they will in general be loathe to return them to the care of the referring GP. In such circumstances, consideration should be made to appraise specialists only on new cases rather than repeat consultations. In the ideal world, GPs and specialists would work hand-in-hand to manage difficult cases, and all reasonably simple cases returned to and managed at the primary healthcare level. In other words, care at the appropriate level of expertise.

THE PUBLIC

Despite the high educational qualifications of our population, I submit that the majority remain blissfully ignorant of health-related issues. While physicians as a profession must accept some responsibility for this sorry state of affairs, the general public also is not free from blame. The "medical activism" that exists in the rest of the developed world, cannot take root here if the public remain apathetic towards their health. It continually amazes me that some of my friends, all professionals, do not even know the name and dosage of the medications they consume. The apron strings that purportedly protect the public should be cut: over-the-counter category of drugs should be greatly expanded and people should be allowed to self-medicate for the most common and routine illnesses such as upper respiratory tract infections and gastroenteritis. Human biology should also not be the exclusive domain of "wanna-be" doctors, but instead, routine knowledge for all school-going children. Of course, the scheme of medical certification will need to be re-examined also. As long as workers and students need medical certification to be excused from work and school respectively, GPs will always have a significant burden of "cough and cold" patients distracting them from managing chronic illnesses. It is not impossible to contemplate a situation where employers allow five to seven days of self-determined sick leave.

POLICY MAKERS

The powers that be play a critical role in the journey towards "cheap and good" healthcare. Primary healthcare friendly policies must be encouraged (perhaps even formalisation of the gatekeeper role of the GP?) and greater empowerment of the population with regards to their own health engendered. Financial considerations will always be paramount, and instead of subsidising tertiary care and limiting Medisave funds to be used mainly in tertiary institutes, why not allow citizens to invest in their own health at the primary level?

The effects of moral persuasion and leading by example are also crucial. Ministers and senior civil servants should proudly proclaim that their primary physicians are GPs, and not specialists in the Singapore General Hospital or National University Hospital. This would give primary healthcare that much needed boost of confidence and support. Years ago, we were reassured that our local universities were first-class, but all our top government scholars flocked overseas. The public read the signals and will take the cue from their leaders.

Controlling healthcare costs is more than cutting down on over-consumption. It is more than asking "Do I need an X-ray?" or "Do I need a CT scan?" It is more fundamentally asking "Do I need to see a doctor, or can I handle this myself?" and "Must I really see a specialist?" The answers to these questions depend on all of us, and will decide ultimately whether medicine in Singapore can be appropriate and hence affordable. ■

Reference:

1. *World Health Report 2000 Health Systems: Improving Performance. World Health Organization.*
2. *Speech made at 2nd NHG Scientific Congress Dinner. 4 Oct 2003.*
3. *Permanent Secretary Mr Moses Lee in a speech to the Chapter of Public Health and Occupational Physicians. 16 Nov 2002.*
4. *Singapore Budget 2003. Ministry of Finance website. http://www.mof.gov.sg/budget/budget_2003/*
5. *Singapore Department of Statistics Economic Surveys Series: Health dated 4 June 2003.*
6. *Part of the mission statement of the Ministry of Health, Singapore.*
7. *Attributes of an "ideal GP" as described by Mr Khaw Boon Wan in the Straits Times, page 5, 26 August 2003.*