# The Real Cost of NOT Having a Means Test

Well, it is the year of the mutt and it is about time we re-examine why everyone is having a dog's life in healthcare. While not everything can be attributed to this, certainly a significant part of our healthcare problems can be due to the absence of a means test in our public healthcare system.

The most basic tenet of healthcare access and sustainability, as declared by prominent health economist and a former President of the American Economics Society, is that universal access to healthcare cannot be achieved without subsidisation and compulsion[1].

What this means is that we have to subsidise those who cannot pay and compel those who can. We can only compel those who can afford to actually pay for the health services they consume if a means test exists. Otherwise, there will be folks who will naturally become free-loaders and avail themselves to subsidies when they do not need or deserve them.

However, Singapore appears to have beaten the odds and achieved the impossible. We do not have a means test and we give subsidies to all Singaporeans and PRs as long as they choose to go to the polyclinics or get themselves warded in B2 and C class wards. But seriously, who are we trying to kid? We are not in Wonderland, Narnia or Middle-Earth and something's gotta give, chum.

## DIFFICULTIES AND COST OF ADMINISTERING MEANS TEST

Detractors often cite the problems of operational difficulties and cost of administering the means test as arguments against having one. Hobbit acknowledges that having a means test does carry with it these problems and difficulties but they are

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nonetheless surmountable. The real reason why we still do not have a means test is really as Hobbit remarked a few years ago: "A means test is a poisoned chalice".[2] It takes great political and personal courage to do the necessary.

But let us take a step backwards for a moment and examine beyond the superficial difficulties – and we can only conclude that the true, indirect and hidden or direct costs of NOT having a means test are truly quite horrendous.

## TWO FUNDAMENTAL PROBLEMS OF NOT HAVING A MEANS TEST

The two fundamental problems of NOT having a means test are

- inability to control demand leading to 'free-loading' and a 'buffet mentality'; and
- consequent need to try and control demand by class-differentiating: accentuating differences between unsubsidised and subsidised services to discourage 'free-loaders' from using subsidised services.

## PROBLEMS ASSOCIATED WITH INABILITY TO CONTROL DEMAND LEADING TO 'FREE-LOADING' AND A 'BUFFET MENTALITY'

### Abuse of Polyclinic and A&E

Because we have no means test, many patients want to get access to the subsidised specialist outpatient services by going to the polyclinics and A&E to get referrals to the subsidised specialist clinics in hospitals. This creates unnecessary work at the polyclinic and A&E level, as if the folks there do not already have enough to do. It is not uncommon for the polyclinic and A&E doctor to realise that the patient before him is there ONLY because he wants a referral to a subsidised clinic for a chronic disease.

### Inability to control workload or shift workload to private sector which has excess capacity

Because subsidised services are so freely available and cheap, the swarmed hospitals and polyclinics are unable to shift patients to an environment where excess capacity exists – the private sector. They are also unable to control workload as patients in search (but not in need) of subsidies come in waves to them.

### Overload and overworked public doctors leading to talent drain, less time for teaching and research

The previous reason leads to overwork, which results in doctors and other healthcare professionals leaving the public healthcare system, often not in search of better pay but just a comparable figure and a more manageable volume of work. Folks who we have trained at great expense do not stay and we end up in a vicious circle – continually training (and thereby incurring cost) people to address the brain drain.

For those who stay, they also have no time for teaching and research. And because we have no means test and yet have to address the crowds, we pay doctors by work volume – and we wonder how come our doctors do not produce as much research as our Hong Kong counterparts even when we are similarly enmeshed in earth-shattering events like the 2003 SARS outbreak.

With our desire to be a medical hub and a knowledge-based economy, what are the costs of keeping our public doctors running like hamsters on a wheel, with no time for research or teaching?

### Needless subsidising of free-loaders with truly needy not getting adequate care

This is the simplest issue: the cost of needlessly subsidising free-loaders who can actually pay. The opportunity cost is of course that of the resultant denial of adequate services and subsidies to those truly in need due to the crowding-out effects of free-loaders.

### Stifling of private GP services and skills and wrong 'site-ting' of care

The biggest cost to the country as a whole is the wrong 'site-ting' of care. Patients who can easily be treated at the GP or polyclinic, community hospitals and private nursing homes refuse to be treated at these places because hefty subsidies are freely available to all at the public hospitals. It is cheaper to stay in a C class ward than to go to a community hospital or nursing home where the means test already exists.

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Similarly at the primary care level, people would rather remain at the subsidised specialist clinic level than go to the GP or polyclinic because the former is the cheapest option even for those who can afford it (yes, again because there is no means test).

### Supplier-induced demand in areas where there is excess capacity

Because there is no means test, we are unable to shift workload out of the public system; excess capacity exists in the private sector, both for the private GPs and private specialists. More and more GPs now turn to aesthetic medicine. This is good if their patients are mainly foreigners and such work helps to bring in foreign exchange. But we know most are locals, leading to unnecessary spending on healthcare. Private specialists who are not doing too well also are tempted to go down the path of supplier-induced demand.

## PROBLEMS ASSOCIATED WITH THE NEED TO CLASS DIFFERENTIATE BY ACCENTUATING DIFFERENCES BETWEEN UNSUBSIDISED AND SUBSIDISED SERVICES TO DISCOURAGE 'FREE-LOADERS' FROM USING SUBSIDISED SERVICES

### Operational inefficiencies and confusion of having four to five ward classes – Choice is cost

The take-home message some folks would like the masses to get is: "You have a choice. You choose a ward that fits your wallet, ranging from A class to C class but we will not force you. There are always C class services available without a means test for all to choose." The myriad of classes we have is really because we do not have a means test and we cook up as many as five different types of classes hoping that the population will self-allocate themselves into the appropriate class according to their ability to pay.

But the fact of the matter is that ***choice costs***. Hobbit knows of no other public hospital system that offers FOUR or FIVE classes of beds. Most countries' public hospitals only offer two or at most three classes of beds, and for good reasons. The more classes we have, the more inefficient we become. We have to have different furnishings and fittings, different planning parameters, IT systems, even simple things like type of food and cutlery just to differentiate between classes. All these cost money, baby. With a means test, we can straightaway rationalise our inpatient services into two or three classes and gain better operational flexibility and economies of scale.

### Poor Patient Comfort

Because there is no means test, we need to somehow differentiate in creature comforts for different bed classes so that the richer folks will automatically choose the B1 and A class beds. We try to achieve this by deliberately under-providing for B2 and C class beds in terms of material comforts – even though we can easily afford to air-condition B2 and C class beds. Major public hospitals' turnover varies from S$200m to S$600m a year. How much more cost can we incur if we air-condition the B2 and C wards? Even classrooms are air-conditioned in some schools. Although we claim to be first world, we deliberately deny simple amenities like air-conditioning in B2 and C class wards even in the 21st century – when air-conditioning has been declared the greatest invention. We force our patients and staff (they do not have a choice, unlike the patients) to sweat it out. All because we do not have a means test and we promise B2 and C class services to all who want them – it is a half-hearted gesture of generosity that creates more problems than it claims to solve.

### Increase Risk for Hospital-Acquired Infection

Who are we trying to kid when we say that the clinical quality across different bed classes is equal? The inpatient in a B2 or C class ward is more likely to get a hospital-acquired infection than an A class patient. SARS in 2003 conclusively proved that. Hospitals in Chinese cities now only have at most three or four beds to a room. We have eight or ten. Why? Because we have no means test and we need to differentiate between five classes. Our B2 and C class wards are epidemiological 'time-bombs' (yep, sounds familiar?) in case a flu pandemic or some infectious disease epidemic strikes our public hospitals.

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## LET US LIST THE COSTS

What are the hidden, revealed, direct and indirect costs? Let us list out the 12 big chunks of costs associated with NOT having a means test:

- Unnecessary work created for polyclinics and A&E.
- Talent drain due to overwork.
- Less time for research and training.
- Needless subsidising of free-loaders.
- Real needy not getting adequate care due to crowding out by free-loaders.
- Private GPs and polyclinics unable to compete with heavily subsidised specialist outpatient clinics leading to wrong 'site-ting' of outpatient care at more expensive outpatient facilities.
- Community hospitals and private nursing homes unable to compete with heavily subsidised inpatient services leading again to wrong site-ting of inpatient care at more expensive inpatient facilities.
- Lack of work and excess capacity at private healthcare facilities facilitating supplier-induced demand.
- Operational efficiencies associated with running four or five classes of ward classes.
- Deliberately designed facilities to accentuate differences between different bed classes leading to poor patient comfort in our subsidised wards.
- Too many patients sharing one cubicle which increases risk of hospital-acquired infection.
- Too many patients sharing one cubicle which will prove very, very costly in any infectious disease epidemic or pandemic when infection will spread rapidly in such a crowded hospital environment. The costs of treating such infections can be huge, as demonstrated by SARS and VRE.

These above costs are mind-boggling; far more than what we humble and lowly MBBSes (Mouth Big, Brain Small) can fathom. We have quite a few government scholars and administrative officers with Ivy League and Oxbridge degrees and blessed with 'helicopter vision', working in high places making policies, performing systems analyses and running spreadsheets faster than we can write an MC. Can they tell us the real costs of NOT having a means test (caveat: without hiring business and management consultants please, because that would also be another associated cost to NOT having a means test!)? ■

***References:***

1. *Who shall live? – Health, Economics and Social Choice, Victor R Fuchs, World Scientific Publishing*
2. *SMA News, Oct 2002, Hobbit's Nonsensical Guide to Health Economics, Fear #1*