By Dr Jeremy Lim, Editorial Board Member

PUBLIC SECTOR HOSPITALS GOING INTERNATIONAL:

Will Subsidised Patients Suffer?

"Our public hospitals already serve some private patients. This segment can be expanded by attracting high-end fee-paying patients from the world."

Minister Mentor Lee
On the occasion of SGH 185th Anniversary Formal Dinner
16 April 2006

Minister Mentor's address to the Singapore General Hospital and more largely the public sector community exhorts the public institutions to embrace an international perspective, citing such an approach as necessary to the continued existence of a high-quality, affordable public healthcare system. He forcefully put forward the point that only by engaging in private medicine can the public system grow sub-specialty services and retain its top specialists.

There is certainly cogence in such an argument as a population base of 3.87 million Singaporeans is undoubtedly not conducive to sub-specialty practice. A public sector which only emphasises on subsidised patients will likely be poorly resourced in terms of facilities, and would not be able to even come close to the private sector in terms of salaries. And without revenue from private patients providing for capital investment in equipment and supplementing public sector incomes, we can expect a haemorrhage of top doctors seeking and expecting modern facilities to practise their skills and appropriate remuneration for these skills.

The most important issue to the 'man in the street', however, is not how successful Singapore's public sector healthcare institutions can be in the pursuit of international patients or how many sub-specialists renowned in their fields Singapore possesses. It would be wonderful to have a Singapore Airlines equivalent in healthcare, and Singapore physicians enjoying global recognition for clinical excellence, but the public sector's *raison d'être* is as what Minister Mentor Lee repeatedly stressed in his address: 'high quality affordable healthcare'.

The 'man in the street's' first concern is the cost of healthcare. Singaporeans enjoy such a high quality of public healthcare that marginal differentiation in terms of clinical quality between public and private healthcare is a given. Can the primacy of the 'high quality affordable healthcare' mission be maintained and even improved by regional initiatives? How can Singapore be a premiere medical centre to private-paying patients from all over the world and still provide good, subsidised and affordable healthcare to our heartlanders?

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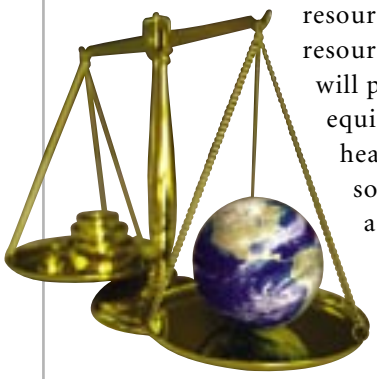
WILL HEARTLANDERS BE DISADVANTAGED?

The proponent for private medicine will cite the fact that private medicine by definition enjoys no subsidies and hence does not compete for limited healthcare budget resources. In fact, new resources brought in will provide for better equipment, better trained healthcare workers and so on. This will have a positive impact on healthcare for heartlanders. He will also put forward the argument that for Singapore to be a premiere medical centre that is attractive to foreigners, all aspects of the healthcare system must be impeccable. Therefore, doctors and nurses will be sent to top centres for training, robust systems of patient care and clinical governance will also be put in place and these systems improvements will benefit everyone. The resultant better, safer and more efficient care as a healthcare system will benefit all patients, rich and poor, local and foreign.



The optimist may even cheekily make the case that profits from foreign patients can be channelled to cross-subsidise needy Singaporeans and hence heartlanders will actually pay less out-of-pocket.

Sceptics will argue the converse and say that while private foreign patients do not burden the public purse, the scarcity of doctors and especially top specialists will force a decrease in time spent by top specialists on public patients. Financial incentives will also inevitably result in a drain of top specialists from public to private medicine and that as with the United States, cutting-edge medicine will lead to all-round increase in healthcare costs.

The naysayer will also bemoan the 'demonstration effect' and the potential increasing of the gap between the 'haves' and the 'have-nots'. These issues will plague the two-tiered system that will naturally arise from ventures into private medicine.

So will heartlanders be disadvantaged? The answer can be a whispered 'yes' or a firm 'no' depending on how the situation is managed but it is this author's contention that Singapore will be able to manage well enough for the answer to be an unequivocal 'no'. There are three ingredients essential for success in this endeavour: structure, clinical emphasis and robust measurement.

Structure

In public hospitals that decide to engage aggressively in private medicine, it will be necessary to clearly delineate private services from subsidised healthcare in all aspects including delivery, financing and manpower allocation of costs. This will be vital to avoid accusations from the socialist-minded that public patients are being deprived and even more vehement outcry from the private sector that there are hidden subsidies given to private patients seen by public hospitals and hence no level playing field.

This said, separation of private from public patients, at least in front-facing operations, may be required to mitigate the 'demonstration effect' and allow the private enterprise in public hospitals to cater to private patients' needs for service quality, convenience and privacy. However, clinical quality cannot be compromised and must be comparable between public and private healthcare.

Clinical Emphasis

Subsidised public healthcare should focus on 'preventive health' and private medicine should emphasise 'experiential care' *a la* the Ritz Carlton or the Four Seasons hotels. Aggressive preventive health measures including screening and close follow-ups to minimise complications of chronic disease offer the potential to shift Singaporeans westerly on the disease spectrum, for example, detecting diabetes when asymptomatic and relatively well rather than when afflicted with kidney failure or diagnosing cancer in Stage I or II instead of Stage IV, where treatment is far more expensive and less effective.

If done well, this can contain costs substantially, not by compromising on clinical care but by reducing the need for expensive remedies. The cost savings garnered from the improved health of the majority can then be channelled into the needs of the minority who despite all efforts still succumb to late-stage disease and require expensive treatments. Hence, the overall public healthcare budget need not grow to match the private purse and can still fulfil the needs of the nation.

Private medicine can emphasise costly novel therapies since patients are paying out of their own pockets, but at the same time private medicine can also offer, commensurate with fee, levels of service quality and convenience

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that cannot and should not be paralleled in the public healthcare system. Public medicine, on the other hand, should focus on proven, cost-effective interventions and maintain a reasonable standard of service quality and convenience. However, clinical standards must not be eroded and this is where measurement is absolutely essential.

Measurement

Healthcare systems are generally appraised on quality, cost and access and it is necessary to establish and maintain robust systems to track all these parameters to assure the public that public healthcare is not and will not be compromised by the venture into private medicine. Hence, clinical indices of mortality and morbidity in public healthcare before and after the foray into private medicine must remain unchanged or must be improved, as must access norms such as waiting time to be seen before specialist consultation for suspected cancer.

Ms Yong Ying-I, Permanent Secretary of the Ministry of Health has suggested in the March issue of the *SMA News* that foreign patients should be treated by additional healthcare resources, and that 'the total number of clinicians treating Singaporeans, particularly at the senior level, (should not be) is not reduced'. This is a very sound approach, and public tracking and reporting of not only clinical but also process indicators, which are easily understood by the layman, would be helpful in reducing the potential unhappiness and misgivings.

The Ministry of Health is already openly reporting bill sizes and taking tentative steps in disclosing clinical outcomes. Continued and even expanded tracking and intervention where necessary will be needed for public confidence that citizens are not being short-changed.

COMMUNICATE, COMMUNICATE, COMMUNICATE

The best efforts in effecting the above measures will be for nought if a well-conceived communications strategy is not executed effectively. The strategy must be multi-layered and nuanced enough to assure Singaporeans they are not being disadvantaged, assure healthcare workers the 'nobility' of public healthcare has not been cast aside and assure foreign patients they are welcome in Singapore.

The approach to the casinos and the public debate and consultation before and after the decision are instructive: highlight the benefits and acknowledge the fears of the people. Then implement measures to assuage genuine concerns and drive home the key point forcefully that these difficult policy issues are really about what is best for Singapore.

The take-home message in the private medicine initiative is simple: Public healthcare can and must embrace private medicine for foreigners and rich citizens alike because Singapore and Singaporeans are the ultimate beneficiaries. ■