By Dr Wong Chiang Yin, SMA President

Information, Value and Choice

No one likes to be regulated. Doctors are no exceptions. So it is not surprising that the recent announcement by the Ministry of Health that the PHMC Guidelines have been amended so that patients will be provided with more information before a decision is made to seek a diagnosis or receive treatment is met with some apprehension by the medical community. It is believed that this is a step to reduce the information asymmetry that exists between the patient and doctor so the patient can be empowered to make a more enlightened decision.

There are several points to be made with relation to reducing information asymmetry.

The first point is that SMA is in-principle supportive of reducing information asymmetry. However, we need to be aware of the potential difficulties and inconveniences if and when reducing information asymmetry becomes the be-all and end-all in itself.

The second is while we should try to reduce information asymmetry, some information asymmetry will always remain. This is an essential element of professional services, be it the medical, legal, accounting or other professions. More importantly, it is almost impossible for the buyer (that is, the patient) to value the information. "Indeed, if the patient knew enough to value the information, he would know the information itself (that is, he would be medically-trained). But information, in the form of skilled care, is precisely what is being bought from most physicians, and indeed from most professionals. The elusive character of information as a commodity suggests that it departs considerably from the usual marketability assumptions about commodities"[1].

So while we may provide prices and perform financial counselling, the patient is still unable to accurately know in advance the value of the professional care he is getting. He will perhaps know only later, when he is relieved or cured of his ailments.

The third point to be made is that producing and even obtaining information is not free. In fact, in the field of economics, there is a term called 'information costs'. Information costs can be defined as the costs of acquiring, processing, and using information; it is part of the costs associated with any type of decision.

There is a cost to producing and providing information. More information also implies additional costs are incurred. The direct cost of making signages, posters, tent-cards and so on is the easy part. The cost of itemisation of bills will have to be borne by someone as well. But what is less obvious and probably more important is the opportunity cost of time. Ultimately, the most precious resource is time. Because to make ends meet, doctors have to generate a certain amount of revenue per unit time by seeing a certain number of patients. In other words, there is a limit to the amount of time a doctor (and other health professionals) can spend with a patient. This is no different in concept from allocating a government budget to different demands of defence, health, housing or education. There is only so much money a government has and resources are limited. If a government spends more money on defence and education, there will less money for health. Similarly, if we spend more time telling patients how much consultations, tests, drugs and treatment modalities cost, there is less time to hear the patient's history, attempt health education or perform a physical examination. Research conducted in America in 1984 showed that

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Page 4 ►

◀ Page 3 – Information, Value and Choice

on the average, a patient describing one's symptoms is interrupted by a doctor after 18 seconds[2]. *Only 18 seconds*. I do not think Singapore in 2007 is very much longer than 18 seconds, because there is just so much or so little time we have for each patient.

The question to be asked is: What does the patient want and is the patient given a choice between information and value? Does he or she want to know the prices of every service, drug or investigation in advance? Or does the patient just want the value of a doctor having the time to hear him or her out, take a good history and perform a detailed clinical examination? Does the patient want to know more about medication instructions from a clinic assistant or have an itemised receipt, especially when the receipt has to be submitted to his or her employer for reimbursement who may then infer from the medication given and investigations ordered what condition(s) the patient/worker has?

Perhaps the patient should be informed in advance that on the average, each patient only has X minutes. The X minutes could be spent on receiving financial counselling and price explanations, or they could be spent on clinical interaction, health education and so on, and that if he or she so wishes, the number of minutes could be increased beyond X at a price (there is no free lunch…). This may sound harsh, but it is actually just being honest about the realities of time and resource constraints. Let the patient make a choice based on this knowledge. But at the least, the patient has a choice. Maybe that is a better model for empowering the patient than actively or passively giving a slew of financial information.

Yet another issue we have to deal with in considering information asymmetry is the role of Managed Care. At present, there are some schemes that specifically prohibit the doctor from communicating with the patient or the employer about prices and costs of services rendered and drugs prescribed. There is often great information asymmetry in Managed Care. The doctor very often does not know what the patient or employer is paying the Managed Care company. The patient and employer know what they are paying numerically, but frankly often do not know what they are paying for. Do they know out of every $10 billed to them by the Managed Care, how much actually goes to the clinic or the hospital? Does the GP give the same itemised bill to both the managed care company and the patient or employer?

Just last evening, I had the pleasure of having dinner with a group of doctors in a French restaurant. A man who was having dinner with his family and friends from a nearby table walked over with three bottles of wine. It turned out that one of the private practice surgeons who was at our table had performed an operation on this diner's wife. The man said: "This is for you, doc. Have a nice evening", put down the three bottles and walked away. There were gasps around the table – three bottles of ex-chateau 1982 Chateau Leoville Poyferre[3]! One bottle costs more than $400 now, and the three would have cost at least $1200, probably more – since the bottles were labelled 'ex-chateau' which meant they came directly from the Chateau, not through middle-men, and so were probably in excellent condition.

The surgeon explained rather sheepishly: "I operated on his wife."

One doctor joked with the surgeon: "You probably undercharged him then."

A retired surgeon at our table who spent many years in private practice admonished: "The moral of the story – don't overcharge."

The diner, a prominent local businessman, may not have really known what he paid for when he received the bill for the surgery performed on his wife. But a few years down the road, he certainly now knows that the value of the surgery far surpasses what he had previously paid, as evidenced by the wines.

The surgeon elaborated: "His wife was one of my first patients when I started private practice. I charged well within SMA Guidelines."

Another doctor said in jest: "You mean now you don't?"

At this juncture, a voice interjected softly: "There is no more SMA Guideline on Fees."

We opened two of the three bottles and the wine was sublime. ■

References:

1 ***Arrow, Kenneth J, Uncertainty and the Welfare Economics of Medical Care. The American Economic Review, Dec 1963, Vol LIII, Number 5, 941 - 73.***

2 ***Beckman HB, Frankel RM. The effect of physician behaviour on the collection of data. Ann Intern Med. 1984; 101: 692-6***

3 ***Chateau Leoville Poyferre is a Second Growth from Bordeaux and 1982 is a legendary vintage.***