

SENIOR DOCTORS AND SUBSIDISED PATIENTS

By Dr Jeremy Lim, Editorial Board Member

Should senior doctors in the public sector be expected to see subsidised patients? Or should they be deployed by the public hospitals on an 'ability-to-pay' basis? What is the right balance?

Waiter : "Sir, do you want the \$1 or the \$5 Coke?"
Customer : "What's the difference?"
Waiter : "The \$1 can comes with a straw and is self-service; my boss serves the \$5 one in a glass."



There has been disquiet in the media recently about senior doctors not treating subsidised patients, with Prof Lee Wei Ling stating "it is in the economic interests of senior doctors to focus on paying patients rather than subsidised patients – and it is not always the case that doctors look beyond their economic interests" (Straits Times 16 Dec 2009). In the public sector, this has been a source of tension with unhappiness that certain doctors treat mainly private patients to the alleged detriment of subsidised patients.

There have been two schools of thought articulated: The first is that the role of public sector doctors is to treat subsidised patients, and all public sector doctors should treat their 'fair' share of subsidised patients. A contrarian view is that doctors valued by the market as evidenced by their high loads of private patients should spend their time with these patients and bring in revenue for the hospital (and themselves but that is a story for another day) which can then be used to improve care for subsidised patients.

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Which view is correct? In my view, neither is the appropriate stance to adopt. Let us view senior doctors as a scarce economic resource. As with all scarce resources, they should be allocated optimally for the larger societal good. With this perspective, senior doctors should not be treating their 'fair' share of subsidised patients simply because they are subsidised. It would be a poor use of scarce resources. Instead senior doctors should be treating complex patients in their sub-specialty areas of expertise regardless of their paying status and not spending time on straightforward cases which junior colleagues can adequately manage. That said, I am not condoning today's practices which Prof Lee alluded to.

Senior specialists should be readily available to complex patients and given the reimbursement realities of today, the system must police this appropriately and punish senior doctors who flout this principle severely.

The 'market model' pairing senior doctors with private patients carries two assumptions implicitly in its paradigm: (1) Private patients bring in substantial profit for public hospitals even after the doctors' fees have been discounted and (2) The profits are used to improve care for subsidised patients. To the best of my knowledge, both have never been verified and if not empirically borne out, call into question the fundamental motivation for public hospitals treating private patients.

How should we grapple with this thorny issue of senior doctors and subsidised patients? The pivotal argument must lie in clinical outcomes. Minister Khaw had in a dialogue last year likened private and subsidised patients to business and economy class air passengers and said that while the journey may be different in comfort levels, both classes reach their destination. But do

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both indeed ‘reach their destination’? Do subsidised patients attain the same clinical outcomes as private patients? The United States of America has a ‘Healthy People 2010’ national health objectives framework in which reducing health disparities is an overarching aim and reports data by ethnic and socio-economic groupings. Perhaps there is some salience for us in Singapore as we reflect on the care provided to private and subsidised patients.

Our commitment to subsidised patients should not be ‘care by senior

doctors’; it should be ‘competent care appropriate to needs regardless of grade of doctor’. Senior doctors do not need to treat subsidised patients as a matter of blindly applied policy, but their skills do need to be available for both private and subsidised patients with complex diseases. Hospitals must enforce this even as the Ministry of Health aggressively audits the process. Even that may not be sufficient: we need to go beyond rhetoric and feeble policy statements. Outcomes data comparing private and subsidised patients adjusted

appropriately for known confounders are necessary and the only way to assure that we have not been blinded by profits. Patients should choose based on their financial means whether they prefer the \$1 or \$5 Coke. Our duty is to ensure that both are “the real thing”. **SMA**



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