By Dr Wong Chiang Yin, SMA President

Trust and Stewardship

In my former job working in a public hospital, I had the good fortune to meet many hospital administrators from China as well as to visit quite a few large hospitals in China. These hospitals are located in mid-sized and large cities, and are crowded. They are usually more than a thousand-bed large and each such hospital sees literally thousands of patients in their outpatient clinics a day. The crowds throng the clinics without appointments and the patients carry with them their case-sheets. In such a system, the medical record office does not keep outpatient case-sheets and it is impossible to predict workload for the day since practically each patient is a walk-in case.

Many hospital administrators from China have told me that the going is tough for them because government subsidies account for about only 5% to 15% of a hospital's revenues. In other words, even though it is a public hospital in name, the lion's share of revenues comes directly from patient pockets and health insurance. This is in contrast to Singapore's public hospitals where if one considers that two-thirds of patients are either from B2 or C class and in subsidised SOCs[1], a good "guesstimate" is that government subsidies account for 45% to 50% of revenues. In other words, Singapore's public hospital administrators need to recover 50% of their operating costs from the patient while their Chinese counterpart has to recover around 90%!

So on one end, we have the public hospitals in UK NHS, Malaysia or Hong Kong, which are subsidised almost totally by the government, and at the other end, we have the Chinese model which leaves the hospital administrators to recover almost all costs from the patient. Singapore is somewhere in the middle of the spectrum.

But wait. The statistics actually show that Singapore has roughly the same GHE (Government Health Expenditure)/ THE (Total Health Expenditure) ratio as China: about one-third. In other words, for every dollar that the government spends on healthcare, the private sector spends two. If that is the case, why is it that our hospitals are more subsidised than the ones from China?

The answer lies in the GP system which we inherited from the British and enjoy. The GP system handles the simple conditions which constitute the bulk of the disease load and leaves the hospitals to handle the complex disease conditions. As we all know, the GP system is largely privately-funded, which therefore spares government funds for the purpose of subsidising hospital patients.

Unfortunately, the GP healthcare delivery system hardly exists in Chinese cities and the hospitals have to see all and sundry. This is compounded by the fact that rural health is heavily subsidised (as it should be). The end result is that many people crowd the city hospitals and the hospital subsidies are spread too thinly among too many patients, many of whom could have been treated by a GP.

In contrast, our GP healthcare delivery system has enabled public health funding to be concentrated in hospital patients, and allowing public funds to pay up to about half the costs incurred in hospitals.

Our system of subsidies is designed to subsidise more expensive healthcare services to a greater degree than the cheaper services. The logic therein is sound but there is a danger of employing this tenet overzealously. Polyclinics account for only 20% of the primary care market segment. The target subsidy rate for polyclinics is about 50%. As such, a "guesstimate" is that government subsidies only account for 10% (50% of 20% = 10%) of primary healthcare expenditure. This is a simplistic estimate because we ignore the government funding of Health Promotion Board, MINDEF medical services and so on, as well as private expenditure in the form of the sick who self-medicate or seek alternative or complementary medicine services. Whatever the case, the GHE/ THE ratio for primary care is way below that for hospital services and public healthcare funding for primary care is only a small fraction of that for hospital services.

Page 11 ▶

Dr Wong Chiang Yin is the President of the 49th SMA Council. He is a hospital administrator and also a Public Health Physician. When not working, his hobbies include photography, wine, finding good food, calligraphy, travelling and more (non-paying) work.

◀ Page 10 – Trust and Stewardship

What is the optimum public funding level for primary care? What proportion of total expenditure on primary care should be borne by the government? And what proportion of the healthcare budget should be devoted to primary care? These are difficult questions and highly dependent on local context. But nonetheless, we see over-crowded subsidised SOCs and large numbers of GPs turning to aesthetic medicine or experiencing declining patient load and income as disturbing trends. These situations point to a distinct possibility that primary care is under-funded. There is much anecdotal evidence that many patients flock to the subsidised SOCs because subsidies there are greatest and hence services there are cheapest when the converse is obviously true – services at SOCs cost a lot more than at the primary care level.

Although we have a GP system, we may also end up with what the Chinese hospitals are experiencing now – everyone flocks to the hospital SOCs (and maybe the polyclinics too) with subsidies inefficiently spread between too many patients, while the GP healthcare delivery system actually does less and less meaningful work (compare this with Chinese cities where there is practically no GP system at all). This is a scenario that we ought to try our best to avoid.

How can we better fund primary care? By building more polyclinics or giving funds to GPs? The issue of funding for GP services has always been an emotional one. The prevailing mood in the past can be said to be one of angst and cynicism.

As such, it was heartening to note from Prof Chee Yam Cheng's article published in last month's issue of the SMA News "Primary Care Partnership Scheme" that the government is going to launch PCPS Chronic some 9 years after the launch of PCPS Acute, in October 2000. The latter put into flesh the concept of public funding for GP services.

PCPS Chronic may well embody the belief and investment in primary care of MOH, to try and restore the GP to his rightful role – to treat most of the chronic (and acute) diseases of the population and leave the hospitals to serve those with complex disease states. The devil is always in the details, for example, how complicated and laborious PCPS Chronic will be to implement at GP clinics and so on. But the underlying idea is that PCPS Chronic is a step in the right direction. PCPS can be seen to be the intent on the part of MOH to increase government participation in primary care and especially the GP sector. More importantly, PCPS formalises the relationship between government, GPs and the (poorer) patient.

Two aspects of the PCPS Chronic are worthy of highlight. The decision to give PCPS Chronic the same level of subsidy as the polyclinics is transparent and equitable. One may argue that polyclinics pay lower rent than GP clinics and hence deserve more subsidies. But we should remember that PCPS Chronic is the attempt of MOH to pay for efficient services that lead to good clinical outcomes. PCPS is not an attempt to subsidise GP's rental costs (having said that, I am sure GPs would welcome higher subsidy rates...). The other point is the move to allow GPs to refer PCPS Chronic patients to subsidised SOCs. This is an unequivocally bold move as access to subsidy is now tied to a patient's economic status and not as previously linked to a location.

These two aspects encapsulate the point that there is recognition that GPs can be trusted to be stewards of public funds, as they are empowered to manage subsidies responsibly. And public hospitals can then do the job they are supposed to do – treat patients with complex medical conditions.

But PCPS is more than a funding mechanism. PCPS symbolises a relationship. And like all relationships, I think it boils down to an issue of mutual trust. MOH needs to trust the GPs to do the right thing; MOH has to believe GPs can and will use government funding prudently to serve their poorer patients well. Some simple checks and balances are necessary, but we need not implement a fail-safe system that can prevent all forms of exploitation and wastage. Sometimes, implementing a 100% loophole-free system entails onerous effort at great cost (and wastage) too.

On the other hand, the GPs have to believe that MOH takes the (current and future potential) contribution of GPs to the overall health of Singaporeans seriously; GPs cannot take government funding as "easy money" that can be used to fatten their wallets while little is done to improve the management of chronic diseases of their poorer patients.

As the name suggests, PCPS is a "partnership". Partnerships are founded on trust. MOH has taken the first step. I am confident that GPs will rise to the occasion and demonstrate that they are trustworthy stewards of public funds. For everyone's sake: the government, the doctors and most importantly the patient – we need to make PCPS work. Because similar to what I have learnt from Chinese colleagues, life without an effective GP healthcare delivery system can be very unpleasant for many. ■

Reference

1 Target Subsidy rate for B2 is 65%, C is 80% and subsidised SOC is 50%