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A Means to A Healthy Nation

Keynote Address by Mdm Halimah Yacob, Member of Parliament for Jurong GRC and Chairman of Government Parliamentary Committee for Health at the 38th SMA National Medical Convention, 19 May 2007, Suntec Convention Centre

Healthcare in Singapore has come a very long way. Over a period of only 42 years since our independence, we have made tremendous progress in keeping our population healthy and in providing for their healthcare needs. By any count, Singaporeans enjoy a high standard of healthcare. No doubt we have our fair share of complaints about waiting times and other unhappiness, but using the usual WHO indicators to measure outcomes such as infant mortality rate or lifespan, we are doing well. In fact, much better than even some developed countries like the US according to one foreign report, which I read although we spend much less than the 16% of the GDP that the US spends on healthcare, and the US also has a whopping 45 million not covered under any health insurance.

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MEANS TESTING

But a rapidly ageing population, expectations of a better-educated population and advancements in medical technology have been pushing medical costs up. Today, two-thirds of our healthcare cost is borne by the private sector and one-third by the government, which according to the WHO, is low compared to many countries, although we appreciate the fact that it is not healthcare expenditure alone that is important but also the level of productivity. Nevertheless, the issue of how much should the individual bear and how much should be borne by the state is not an easy question.

Recently, the possibility of means testing for our hospitals has been raised. The subject of means testing has touched a raw nerve, particularly among middle income Singaporeans who feel that they will be the most affected if means testing is introduced in our public hospitals. If we take a very cool and rational look at this issue, one cannot disagree with the principles of means testing. The logic is that like other goods and services, healthcare too should operate on market principles. The better off should pay more for consuming healthcare services so that more can be provided to the less well off. But healthcare is not something that can be looked at in a very cool, rational way. Very much like the education system, everyone has an opinion about our healthcare system. This is to be expected because although only a small percentage of the population gets hospitalised at any point in time and most of the bills are affordable, everyone worries that they will fall ill one day and worry that they cannot afford to pay their medical bills when they are hospitalised. And everyone has heard stories about how someone falls sick and finds it difficult to pay for his medical bills, and sometimes the stories get distorted as it gets passed from mouth to mouth. Also, unlike other goods and services, healthcare is not something optional, that you can choose to consume or not to consume. When you are sick, you have to seek medical treatment. And as the population is ageing very rapidly, people find themselves sandwiched between having to take care of their family as well as providing for the needs of elderly and ailing parents.

PUTTING BASICS IN PLACE

But quite apart from the emotive issues, there are genuine reasons why we must not be hasty in introducing means testing. In my view, means testing should only be introduced if the basic essentials are in place.

First, we should complete the restructuring of our Medishield and Eldershield schemes. Medishield reforms were introduced in 2005 and have helped considerably to reduce patients' concern over the big hospital bills. But whilst the bigger bills are now better taken care of, because of the higher deductibles and co-payment, people need to have adequate savings in their Medisave to pay for the medium-sized and smaller bills without which they have to rely more on out of pocket expenses. Some insurance companies have introduced riders, to cover part of the deductible and co-payment amount but patients are not allowed to use Medisave to purchase the riders. The Eldershield reforms have just started, with the MOH asking for feedback and calling for tenders for the supplementary Eldershield scheme. One of the problems that means testing is meant to deal with is long-staying patients, particularly among the elderly but families leave them there in the first place because of the cost and they do not have anyone to take care of them at home. Also, home-based patient care services, such as physiotherapy, are limited and not always affordable for all Singaporeans.

Second, we should make sure that as many Singaporeans as possible are covered under Medishield. Currently, quite a significant number of Singaporeans, largely women and children, are not covered under Medishield. This is something that is worrying and we should do more to make sure that they are covered under Medishield. If means testing is introduced, this group of patients will suffer, as more will have to be paid out of pocket.

Third, we should first make sure that right-siting works. Right-siting and incentives for doctors to right-site, such as giving them access to Medisave for the four chronic diseases, has just started and has not taken deep roots yet. If right-siting is very successful, we will see less people going to the hospitals seeking treatment as the family physicians would be the first line of treatment and this would help to reduce the need to get into the hospitals for treatment, and is also less costly.

Fourth, there is the issue of how to determine who can and cannot afford subsidised healthcare or what level of subsidy should be given. Income and assets could

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be used as indicators but are they the best indicators in determining affordability particularly now that incomes are getting more stretched and medical inflation is higher than the general inflation rate? For 2007, for instance, the MOH's KPI is to ensure that healthcare costs do not increase beyond the rate of medical inflation! This by itself speaks volumes as it shows that healthcare cost will definitely go up year by year. The poor and low income earners have less to worry, but those who are in the middle income range, will be affected particularly now that many are in the sandwiched generation – they have to take care of their own children but at the same time also have to provide for the needs of elderly and often sick parents, as we know from statistics that people consume the most medical services in the last few years of their lives. While we recognise that children do have responsibilities over their parents and we should not condone abandonment of the old and sick in our society, nevertheless the reality is that there are many financial pressures that the middle income today face which makes their situation not so cut and dried.

Finally, I think that we can also be a lot more flexible in dispensing Medifund. According to MOH, almost all who applied succeeded in getting help from Medifund but the point is that there are cases where they do not qualify because of the income criteria and do face great difficulty in paying for their hospital bills because some medical treatments such as cancer is extremely expensive. I know of a young couple with a child suffering from leukemia who does not have access to Medifund because they exceed the income ceiling, but they are already in debt. This is one example of a middle-income family who is struggling to cope with healthcare costs.

BALANCING QUALITY AND COST

I think the point I want to make here is that we agree that we cannot have a system where we expect quality of healthcare to keep going up but the costs remain the same. We also understand the pitfalls of a free healthcare system, as there is really no free lunch as somebody has to pick up the bill and in countries where it is supposed to be free, this is picked up by the taxpayers. So, a system of co-payment and subsidies is the correct approach.

The only issue that we have to grapple with is the challenge of how to balance the two – what proportion of the total cost in a subsidised healthcare system should be borne by the individual and what portion by the state. The current balance is two-thirds and one-third on a general basis. If means testing is introduced, even if this balance is maintained, at the individual level, there will be those who will end up paying much more, and the real issue is whether Singaporeans are prepared for that.

Of course, this is something that not only Singapore is grappling with. It is a global problem. China too is trying to manage this problem of rising healthcare costs and increasing demand. The *Asian Wall Street Journal* reported in a recent article that the Chinese government had asked the WHO for help in revamping their healthcare system. The Chinese system used to be one where free service is provided to all citizens. This system was subsequently dismantled and now the Chinese people have to pay 64% of their bills and the government picks up the rest. As a result of this, not everyone has access to health services in China. China realises that this is not sustainable and they need to invest more in healthcare but they are not sure how. They are now toying with the idea of whether the government hospitals should directly provide more of these subsidised services or instead they should allow the private sector to provide them and the government purchases them on behalf of the people.

The UK government has however adopted a different approach. In a recent article, the *Financial Times* noted that as governments elsewhere struggle to contain healthcare costs over the last decades, the UK government almost uniquely has deliberately doubled spending on the National Health Service in real terms. The aim was to put right decades of under investment, taking the UK health expenditure up to the European average. At the same time, it has introduced quasi markets into the provision of state health – turning hospitals into more free standing businesses, competing more and paid more for performance than for process. The challenge for us is how to provide a good quality healthcare system, which is at the same time affordable.

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ARE WE READY FOR SINGAPOREMEDICINE?

Let me touch briefly on another development, which is the SingaporeMedicine and Public Private Partnership. Last year, Singapore attracted 370,000 foreign patients and the goal is to attract one million patients by 2012. And the public sector hospitals will also be roped in to achieve this target. Looking at it objectively, we cannot dispute the reasons – among others to develop Singapore as a medical hub which will contribute to our GDP and create more jobs for Singaporeans.

With more private patients, we will have more scope to develop sub-specialties and train our doctors; cross-subsidise the less well off, as well as ensure better returns on new medical technologies as the public sector in Singapore is generally known to be more advanced than the private sector in terms of investment in medical technology.

All these are good arguments, but the question is: are we ready, considering that the public sector hospitals currently treat 80% of all patients in Singapore? Can we afford to have even more private patients in the public hospitals; are there enough beds? Do we have enough manpower to deal with an additional 600,000 foreign patients over the next five years, in addition to dealing with accelerated needs of a rapidly ageing population?

I am afraid that the general sense is that we are not yet prepared for this huge influx and the bigger fear is that it will then affect the quality of healthcare service to the subsidised patients. Some of these issues are really interrelated. If public hospitals reward doctors based on the number of fee-paying patients that they see, then doctors would be pushed to treat more fee-paying patients. There are fears that the quality of healthcare to the subsidised patients will be affected.

These are challenging issues, which I am sure have also been occupying the SMA as you represent doctors and have patients' interest at heart. We also know that there are no magic bullets and that many of the recent changes introduced by the MOH have been beneficial to patients. What I am doing is just to share some of the perspectives from the patient and public's point of view, in my capacity as the chairperson of the Government Parliamentary Committee for Health.

BREAKING NEW BARRIERS IN PAIN MANAGEMENT

Let me take this opportunity to congratulate the SMA for organising this annual convention and to commend you for selecting "Breaking New Barriers in Pain Management" as this year's theme.

Many people live with pain thinking that it is their fate and something that they have to accept. But there are better pain management strategies now, which might not only help to alleviate their suffering but also improve their quality of life. Indeed, in today's context, doctors and other healthcare professionals should be concerned not only with how to treat illnesses and prolong life but also how to improve their patient's and the general population's quality of life.

In a cross-sectional survey of the Singapore population initiated by the Pain Association of Singapore and completed in 2006, it was found that the incidence of chronic pain was 8.7% in the general population. The incidence climbs steeply in the older population, reaching 16.7% in those 60 years and above, which is equivalent to one in six persons. Among females, this incidence is higher; 9.9% among the general female population and 19.6% among women 60 years and above. Of note is that more than 80% of them have moderate or severe pain, a very significant figure in view of our rapidly ageing population. Most of those suffering from chronic pain usually also suffer from a lower quality of life and a limitation at times with their daily living activities.

Certainly, the annual cost of pain is high. Medical expenses account for much of it, but lost income and reduced productivity also contribute to the overall economic burden. In 1985, pain in general was associated with four billion lost workdays. In elderly nursing home patients, non-malignant pain has been shown to impair activities of daily living, cause mood changes, including anxiety and depression, and cause decreased involvement in activities, which impact the quality of life.

I am glad that SMA has invited many eminent experts in pain control internationally, from Europe, Australia, China, Japan and Malaysia, to share with us the impact of pain in their own countries and how they are coping with pain control in their countries.

On this note, I wish you a fruitful discussion. ■

Thank you.