Medicine and the Marketplace*

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I would like to share some views on the practice of Medicine, from the perspective of a clinician, administrator and politician. This speech is not a policy statement. It has not been cleared by the Ministry of Health (MOH) or the Cabinet.

When I was CEO of SGH, I faced much angst from many of you who were extremely uncomfortable with the transformation of Medicine from a noble profession into a business. Many of you felt that the corporatisation of SGH meant that SGH had entered the marketplace, and it was not necessarily a good thing.

This debate is not going to end tonight. Nevertheless, I thought it useful to shoot down some of the many myths or fallacies that surround this debate.

MYTH #1 — PRICE IS DIRECTLY RELATED TO COST

The price of a service is what the provider charges the consumer. If the provider is a monopoly, or has asymmetry of knowledge, or is unscrupulous, then the price may far exceed the cost of providing such services. This is both politically and economically undesirable. The MOH's recent release of data, which allowed the public to compare charges between healthcare institutions, was a masterstroke in the right direction.

On the other hand, a government may mandate a fixed price, which may be much lower than the cost of providing such a service. If you stop to think about it, revenue caps or diagnosis related groups are actually attempts to fix prices.

On the other hand, costs reflect the resources consumed to produce a specific service.

My point is that price and costs are two related but separate issues.

What we should be more concerned about is the cost of medical care, and not just price.

Whenever a price of a product or service is artificially suppressed, what do you think happens? First, demand will go up. Often this is "unjustified" demand. Secondly, the producers have less incentive to produce a service or goods at a loss. This mismatch between supply and demand results in shortages, and ultimately, some form of rationing is necessary. Let me ask you, are long waiting times, short consultation times, poor doctor patient communications merely symptoms of this underlying problem?

What is even more pernicious is that although we may have lowered unit price, as a system, we have increased costs, because more resources are needed to meet this excess demand.

MYTH #2 — SUBSIDIES REDUCE COSTS OF MEDICAL CARE

If you followed my earlier argument, you would agree that the same problem actually exists with subsidies. At some level, all that subsidies achieve is a lower price, increased demand, and ultimately greater consumption of resources.

I am not arguing against subsidies. They fulfill essential political objectives, in particular to ensure access to health care by the less well-off. However, don't be fooled into thinking they achieve economic efficiencies per se.

* Delivered at the Eleventh SGH Lecture and Formal Dinner held on 25 April 2004. At the time of the Lecture, Dr Balakrishnan was Minister of State for National Development and Trade and Industry.

MYTH #3 — UNDERPAYING STAFF REDUCES COST OF MEDICAL CARE

Many of us in this room belong to the generation that underpaid junior staff. If we cast our minds back to those bad old days, what did these underpaid housemen do? I would argue that because they were, in a sense cheap, they ended up doing a lot of clerical and unnecessary routine work like tracing results. However, if you consider how we were using highly qualified and motivated human talent, you would agree that this actually represents a waste of resources.

The same problem existed for nurses. For a long while, we dithered over whether nurses were professionals or handmaidens. In reality, nurses can, and should, be deployed to do professional jobs. While we dithered, we wasted human talent, lost many nurses or potential nurses because we paid them very little to do unprofessional tasks.

The point I want to make is that if you pay people what they are worth, and make them do work which stretches their potential, then, and only then, are you really utilising resources wisely.

MYTH #4 — COMPETITION EQUALS COMPETITIVENESS

Competition is a necessary but not sufficient condition for competitiveness. The presence of competition does not automatically lead to competitive behaviour. What do we mean by competitive behaviour? We want hospitals and institutions to provide better services and lower rates as a matter of reflex. The presence of competition helps act as a prod, however, we must remember that it is a means to an end.

Merely setting up two duplicates to compete in a contrived way may not necessarily lead to competitive behaviour. In a sense, our equivocation about National Centres reflects our ambivalence on this issue. My view is that we should have at least one centre in each discipline within Singapore, which is capable of competing internationally. We must give them enough critical mass of talent and economies of scale for it to compete internationally. At a local level, we will ensure contestability, but there is no need to ensure equality just for the sake of competition.

MYTH #5 — EVERYONE CAN BE AN EXCELLENT CLINICIAN, RESEARCHER AND TEACHER

This may have been true in the good old days, but it is certainly not true today. The sooner we come to terms with this the better. I have watched this myth erode the morale of staff and competitiveness of many teaching hospitals, both locally and internationally.

We must accept that teaching, research and clinical service are three distinct tracks that must be measured, remunerated and supported separately. Only then can we get top clinicians, teachers and researchers. Otherwise, we will end up with jacks of all trades, or worse.

As SGH contemplates playing host to the Duke Medical School in Singapore, I hope you will not make this mistake. Research staff should have primary appointments in the University, and not expect SGH to pay for their activities. Similarly, clinicians should stop chasing academic titles and concentrate on providing top level services, for which they can expect good wages. Teachers will have to be specially selected from a subset of researchers and clinicians who truly have the spirit to teach.

MYTH #6 — HE WHO PAYS THE PIPER CALLS THE TUNE

This is a major part of the problem in health care financing. Patients need care. Medical staff provide care. However, the real question is "Who pays, and who decides how much is consumed"?

If you strip away the political arguments, ultimately, the patient always pays. The patient pays directly in fees, or indirectly through taxes or insurance premiums.

The problem is that the person who decides how much to consume is not the person paying for it.

Let me illustrate with a story. I have a good friend who is a self-made multi-millionaire. He always travels first class, even on holidays. However, he bought economy class tickets for his children. One day, his children confronted him, and told him, "Daddy, this is supposed to be a family holiday. Why do you leave us behind in economy class? You can afford it. We should be traveling together with you in First Class". My friend is a genius, not just in business but also in human nature.

He told his children that he would give them $10,000 in cash, the value of the first class tickets. His children would then have the choice of either purchasing First Class tickets to join him or purchase Economy Class tickets and keep the balance. What do think they chose?

In a sense, we have the same situation in health care. Our patients need to understand that they are spending their own money, not someone else's money.

However, this is not enough, because doctors are often guilty as well. Let me illustrate. All of us surgeons use implants. We used to order these implants by consignment, use them, and then the hospital just passes the cost plus to the patient. Very often, we were not even aware of the cost of these implants. We liked the luxury of providing care without letting money cloud our clinical judgement. I believe this attitude is wrong. Our patients pay, and therefore, they should make that judgement, after we give them the appropriate information. How many of us actually do this? It is far easier to rail against the hospital administrator for not letting us exercise clinical judgement for the patient's welfare.

CONCLUSION

In the final analysis, I believe that duty of doctors, medical administrators and politicians is to maximise the use of limited resources to achieve the greatest health for all our patients. We need to think through these issues critically, dispassionately and honestly. Our patients deserve the best medical care that we as a society are able to provide, but there will be trade-offs. Our patients must be given honest counsel to empower them to make these choices. After all, the fundamental lesson in politics is that the voter decides.

Thank you.