



**MINISTRY OF HEALTH**  
SINGAPORE

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**“Quality Healthcare for the Low-Income Group”**

**Opening Address By**

**Mr Khaw Boon Wan, Minister for Health**

**at the 2nd International Conference of the Asia Pacific Society for  
Healthcare Quality 2008**

**on Wednesday, 17 January 2008, 0830 Hrs**

**Grand Copthorne Waterfront Hotel, Singapore**

Professor Seto Wing Hong, Founding President of the Asia Pacific Society for  
Healthcare Quality

Mdm Halimah Yacob, Chairperson GPC(Health)

Distinguished Guests

Ladies and Gentlemen

1. Quality is a difficult subject, because it is not easy to have consensus on what constitutes quality, let alone on how to measure it. For example, a car is to carry us from one point to another safely, smoothly, speedily, with minimal damage to the environment. Such criteria of car quality can be measured objectively. But often car buyers go beyond these engineering specifications and go for look, style, “hip-” or “cool-ness” and other X-factors. That is why the automobile industry is thriving with thousands of brands, models and new releases. An entire ecosystem of car critics and motoring magazines has evolved to help buyers choose. Presumably, buyers will choose the model which they think offer the best perceived quality within the budget that they set for themselves.



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2. If product quality is difficult to assess, then service quality is even more challenging. Which primary school is the best for our children? I suppose the following factors are important: location, education qualifications of teachers, range of extra-curricular activities, schooling hours, sports facilities, past academic results of their graduates. But what weightage do we assign to each of these factors, even if we are able to assess each factor objectively? The years of public debate on school rankings, both here in Singapore as well as elsewhere, are symptomatic of these difficulties.

### **Our Job Is Particularly Tough**

3. Among the service sectors, health quality is particularly daunting. For a sick patient, his key concerns are presumably two: (a) a prompt and accurate diagnosis, and (b) an effective way for him to return to good health. But even then, the best doctors and hospitals in the world cannot save every life, and unfulfilled expectations often lead to disappointment, frustration and anger. I read somewhere that some hospitals in certain Chinese cities had to issue helmets to their doctors as part of their uniform as there had been cases of assaults by angry relatives when their loved ones died!

4. Most patients are not in a life-threatening situation. Their quality concerns often stray beyond the clinical aspects to include the quality of hospital food, the physical environment, the furnishings, the friendliness of hospital staff, the quality of hospital linen, waiting times. This adds further complexity to the subject of health quality.

5. In other sectors, consumers express their preferences for quality, perceived or real, through their choices. Most will decide based on what they feel is “best value for money”. Here lies the particular challenge in the case of health quality where a third party often picks up the bill. When a Government and an insurer pick up the bulk of the bill, leaving patients and their doctors to make resource allocation decisions without incurring any personal cost, “best value” inevitably leads to unrealistic expectations. Why settle for generic medicine even if that is



clinically good enough? If Government is picking up the bill, why not demand brand-name medicine, never mind that it is more costly? If the insurer is picking up the bill, why settle for a subsidised Class C ward? Why not select a Class A ward, with better privacy, air-conditioning and fancier food choices?

6. Thorny as these issues are, we all have to grapple with them as they are at the crux of most healthcare problems today. There will be many more new and costly drugs, medical devices and treatment regimes, emerging year after year. Often these new innovations come with a higher price tag, but with marginal and sometimes even questionable value. But patients, bombarded with heavy, emotion-tugging advertising by the industry, end up demanding for them and pressuring the doctors to prescribe them. The end result, sadly, is rapidly escalating healthcare costs, without corresponding proven or sustained enhancement in healthcare status.

7. My current bed-side reading is a new book, suitably titled “Overtreated” by Shannon Brownlee, a frequent commentator in the Time and New York Times Magazine. It is full of anecdotes of over-treatment in the US healthcare sector, shaped by a culture which seemingly forgets that we all die some day. As a result of medical advances, and I quote, “practitioners and the health care system’s recipients have come to perceive medicine as possessing even the power to deny death”. Or as breast cancer specialist Susan Love once put it, “We like to think death is optional.” As a result, we want doctors to do everything and try everything, and we think that failing to do so is tantamount to killing the patient. Little wonder that the US spent 16% of GDP on healthcare, with a significant part of that spending on the last few months of patients’ lives.

8. The Americans may be able to afford their kind of health spending but most Asian countries cannot. Certainly, Singapore spending 16% of its GDP on healthcare, must mean that we will have much less to spend on education, law and order, economic infrastructure, arts and sports.



## **But We Need To Tackle It**

9. It is therefore in our interest to better understand health quality and to forge a greater consensus among our people on what health quality should focus on. If budget is unlimited, we can try to improve on all aspects of health quality, from surgical expertise, through nursing competence, waiting time, to non-clinical frills like quality of food and hospital linen. But since budget is not unlimited, we must return to basics and ask, what offers best value for money? And let us focus spending on basic clinical care, particularly when we as Government are making resource allocation decisions on behalf of taxpayers. Our duty is to focus on delivering care that is “safe, effective, patient-centred, timely, efficient and equitable” as recommended by the US Institute of Medicine in its 2001 report on health quality.

10. The challenge is to translate this operating principle into day-to-day practice and sustain its adoption over time and across all institutions. We need to speed up the adoption of discoveries that have been proven to be effective, into treatments, procedures and care processes. Currently, this adoption process takes years and is too long. Moreover, changing habits is often an uphill task. For example, we know that hand hygiene works in reducing hospital infections, and yet compliance is inconsistent.

11. Many different approaches have been tried to accelerate improvement, including medical audit, evidence-based guidelines, accreditation, disease management, public reporting of performance indicators and financial incentives. Results have remained patchy, but we should nevertheless persevere.

## **LOCAL QUALITY INITIATIVES**

12. My Ministry will continue to push our hospitals along this track. We now have a Health Quality Improvement Fund to pilot clinical quality improvement projects that would advance the safety and quality of patient care.



13. Some projects have done very well. For example, a medication reconciliation project by Alexandra Hospital reduced potential medication errors by half and prevented potential adverse events by 5%. This project was featured in the recent global edition of "Medication Management and Reconciliation"<sup>1</sup>. We are currently working with hospital pharmacies to extend this practice across all hospitals.

14. Our initiative to publish hospital bill sizes is now in its 5<sup>th</sup> year. It is well-received and effective in getting public hospitals to focus on this important concern of our patients. We must now extend this to the private hospitals and the doctors practising there. Current efforts by them are on a voluntary basis and hence incomplete with large data gaps. MOH will push this effort more aggressively through healthcare legislation, later this year. We will require all private hospitals and the doctors accredited there to submit bill size data and the patients' disease codes. This will benefit our patients, and the hospitals too. It is worth doing.

15. My job at the Ministry of Health is to continuously push and raise the quality of healthcare to benefit all patients, rich or poor. My particular concern is for the lower half of the population, for unlike the higher-income group, they have no viable alternative. They look to the Government for their basic medical services. This is the context behind the current public discussion on means-testing in public hospitals.

### **MEANS-TESTING**

16. I have by now met more than 1,000 Singaporeans from all walks of life. We have had very lively and candid discussions. I thank them for their participation and their ideas. They help me shape the proposed scheme so that it can achieve its objective of helping the poor by keeping healthcare affordable, and yet be fair to the middle-income group.

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<sup>1</sup> Special publication by HCPRO, an international medical publication.



17. While a range of views have been expressed, there is a clear consensus among the vast majority of the participants:

a. First, everyone agrees that all patients, rich or poor, should be free to choose Class C or B2, if they wish;

b. Second, all support the principle that high-income patients in subsidised wards should co-pay more than lower-income patients, but remain subsidised. There is good support for a reduced subsidy of 50% in Class B2 and 65% in Class C. In other words, high-income patients, from the top 20% earner bracket, will remain heavily subsidised if they choose Class B2 or C;

c. Third, there is support for a more generous approach in defining the “low-income” group who will continue to enjoy the full subsidy. Instead of the traditional definition of the bottom 20% as the low-income group, we can extend full subsidy to the lower middle-income group as well. This way, the current subsidy of 80% in Class C and 65% in Class B2 will remain available to the bottom half of workers;

d. Fourth, there is strong support for a gradual sliding scale of subsidy, with subsidy reduction in 1%-points from 80% to 65% for the upper middle-income in C wards, and from 65% to 50% in B2 wards;

e. Fifth, all agree with my proposed approach that we keep the scheme simple for easy implementation. If the patient is working, we will use his average monthly income, as declared to CPF Board or IRAS, as the sole criterion. If he is no longer working, we will rely on his housing type. As a special concession to retirees and those not working, we will allow them to enjoy the current full subsidy, except for those living in the top 20% of properties; and

f. Finally, I agree with the consensus that implementation must be flexible to allow for those with special deserving circumstances. For example those with a large number of dependents or who are suffering from frequent and prolonged hospitalisation will be fully reviewed by hospital Medical Social Workers.

18. We are continuing the public consultation on the basis of this consensus package. Meanwhile, we will also begin technical discussions with the CPF Board and IRAS to work out a simple, automated assessment process that will not cause undue hardship at the margins.

**CONCLUSION**

19. We are introducing means-testing now, not to tackle a current problem but to avoid a future problem. We want to keep the standard of Class C and B2 wards high, so that they can meet the higher expectation of the low-income Singaporeans come year 2020. As we raise the standard of Class B2 and C, and narrow the gap with, say, Class B1 which costs 2 to 4 times more, we need a mechanism to minimise subsidised wards from being inundated with patients who can actually afford unsubsidised rates. Hence the case for means-testing today.

20. Just as you and I embark on healthcare quality initiatives because we want the best for our patients, we are taking an important step with means-testing because this way we can continue to deliver good and affordable care on a sustainable basis to all Singaporeans.

21. Thank you.

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