

Health For All By Year 2000 - A Singaporean's Perspective

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PREAMBLE

It is with a deep sense of gratitude and humility that I stand before you today. By inviting me to give this oration, you have certainly done the Department that I represent great honour—and I thank you.

It was not my privilege to have known the late Dr Baratham Ramaswamy Sreenivasan, Founder-President of the College and the first local Vice-Chancellor of the University of Singapore (1962-1964). The respect that he commanded was clearly evident as I went through some of the early writings and published speeches in the local medical literature. It is an apt reminder to those of us younger in the profession and in life, that what matters and lives after we are long gone is not our cleverness, nor even our skills, but our integrity and standing as respected members of society.

The College is certainly very fortunate to have had such noble and far-sighted leaders, including those who followed in Dr Sreenivasan's footsteps. Having worked closely with the Council since 1986, starting with the joint memorandum, I am impressed by the social consciousness and selfless dedication of your members. In seeking to promote continuing medical education, thereby upgrading the practice of primary medical care, you are making a significant contribution to effective health care delivery in Singapore.

INTRODUCTION

As one whose main interest is in epidemiology and community medicine, it would not be in order for me to comment on the clinical aspects of family practice as in many previous orations. Instead, I would be better advised to keep to my turf and hopefully, avoid exposing my ignorance. Health and health care are crucial issues at the interface between family and community medicine. They should therefore be of some relevance to you as well.

The context for our discussion is the much-publicised WHO-sponsored endeavour called 'Health for All by the Year 2000' (HFA). As a man of great vision, Dr Sreenivasan would have been excited by this social movement which was launched in 1978. Ten years have passed and we have twelve to go before 2000. Are we any nearer the goals? I venture to present to you a Singaporean's perspective. In doing so, let me emphasise that it is a personal viewpoint, as I have no mandate to represent the Ministry of Health, nor the University.

WHAT IS 'HEALTH FOR ALL'?

The slogan is very simply worded, almost naive, but the thrust of concern is revolutionary. I can think of no other worldwide movement in recent history that has had so much impact. After all, what is human existence all about, except to acquire the means to live in health, harmony and happiness?

I am reminded of the World Health Assembly, which I attended in 1984. A politician, quite inadvertently, referred to HFA as "health for all in 2000 years..." The slip is almost prophetic, because some people genuinely believe that it is almost impossible to achieve HFA by the year 2000.

'Health for All' is a rallying call to the international community to enable *"the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life"* It is a battle cry to give renewed impetus to the whole process of social and economic development, of which health is a vital component. It is not a single, finite target. Rather, it is a developmental process leading to progressive improvement in the health of our people.

Implicit in the strategy of HFA is the realisation that health is only a part of socio-economic wellbeing. Good health is an important ingredient for higher productivity and development. A buoyant economy will support a high standard of health care; in turn a healthy population will contribute substantially to economic growth. Thus, it is in the interest of all countries to invest in people—their health and education. In Singapore, this is vital.

It is important that we get the concepts right. 'HFA' does not mean that:

- a) the best health care will be made available for all people to take care of all diseases;
- b) nobody will be sick or disabled by the year 2000

It does mean the following:

- a) Essential health care will be made available to all individuals and families in an acceptable and affordable way.
- b) There will be more equitable and needbased allocation of finite health resources.

We are all well aware of the three universal concerns in the delivery of health care ViZ:

- 1) increasing and seemingly limitless cost of health care;
- 2) over-dominance of hospital care and the use of high-technology support;
- 3) finiteness of available resources.

The fundamental principles governing the 'HFA' movement include the following:

- 1) Health is a basic human right.
- 2) Health resources should be more equitably distributed, between and within countries.
- 3) People must be involved in the planning and implementation of their health care system.
- 4) There must be political commitment on the part of the government to the movement.
- 5) Countries must take the initiative to solve their own problems, although they may need international assistance.
- 6) Health development is an intersectorial activity that requires the co-operation of many disciplines and experts.

THE PRIMARY HEALTH CARE APPROACH

A well organised health care system would invariably encompass the following:

- 1) coverage of the total population,
- 2) provision of comprehensive, essential care,
- 3) integration of preventive and curative services,
- 4) co-ordination of primary, secondary and tertiary services,
- 5) mechanisms for quality control of services,
- 6) adequate funding and equitable distribution of resources for all relevant services.

Right from the very beginning, the leaders of the movement recognized that Primary Health Care would be the cornerstone of 'HFA'. It was and still is the only rational, cost-effective strategy to achieve basic health for the majority of our people.

Primary Health Care (PHC) is not primitive health care. Neither is it opposed to high technology or excellence. It is the first level of contact in the National Health Service and incorporates promotional, preventive, curative and rehabilitative functions. As such, excellence in PHC will go a very long way in maintaining and promoting the health of our people.

The PHC movement, as exemplified by the Alma-Ata Declaration, came about because in many developing countries, people in rural and poor areas were deprived of essential health care. In such situations, there was an urgent need to reorientate political and administrative thinking, so as to achieve a more equitable distribution of health resources. We had to agree on the essentials and ensure that they were made available to the people who were in need of such care. Relevant technology had to be developed and wisely applied.

WHERE DOES SINGAPORE STAND?

There is no denying that we have gone beyond the minimal targets of 'HFA'. This is seen when we compare some of the health indicators against the global targets suggested by WHO:

Indicator	Global Target	Singapore
a) GNP (per capita)	US\$500	US\$7500 (1987)
b) Infant mortality rate (per 1000)	50	9.4 (1986)
c) Expectation of Life at Birth	60 yrs	M :70.3 (1985) F: 75.7
d) Dr: Pop. ratio	-	1:889 (1987)
e) Beds per 1000 pop.	-	3.9 (1987)

Health services at all levels are readily available. Aided by our smallness and good infrastructure, no person in Singapore is more than a few kilometres away from a primary health care clinic, estimated to be about 750 in the whole island. He is also less than an hour's drive away from a general hospital. Economically and socially, these services are accessible to all whether they be in the private or public sectors.

Although we have achieved a commendable level of health together with an enviable health service, let us not be deluded into thinking that PHC is no more relevant. We have the new challenges of the increasing expectations of a health-conscious people, increasingly sophisticated and costly technology and the growing health needs of an aging population. Even wealthy nations like the USA have realised the importance of maintaining a highly effective PHC system to cater to the bulk of health needs in society.

High-technology hospital-based health care is vital to handle the end stages of the disease spectrum. But these expensive facilities should not be used to tackle common health problems, which can be more effectively managed at PHC centres, public or private. How then should we go about organising a truly effective PHC system? From the medical perspective, I suggest that we need four vital ingredients, and they are:

- 1) a clinically-competent profession,
- 2) a caring profession,
- 3) a cost-conscious profession, and
- 4) a more organised profession

A CLINICALLY-COMPETENT PROFESSION

Undoubtedly, patients who are sick deserve the best possible care and cure available. We need well-trained doctors in PHC and in specialist care. Certainly, PHC doctors can be more effective, to do much more than they are doing now.

The Medical School's main objective is to produce primary care doctors and those who can undergo further training in specialisation. This overriding concern is not just for one department, but for the whole faculty. Clinical training, if it is to be more relevant to the objectives, will have to include more exposure in the primary care setting. The range of medical topics taught and the strategies for management should also reflect the epidemiology of community-based practice.

A CARING PROFESSION

We cannot emphasise this enough, that we need health personnel who care. Technological advancement has given us machines which can do much of the technical aspects of our work. In fact, they are sometimes better: they are less prone to human error, they don't get bored and tired and they don't shout back. But they are at best still machines. A human being in pain and suffering needs another human being for comfort and sympathy. Much of doctoring is still an art.

In PHC, the human element is crucial. Patients and their families must feel comfortable in relating to their primary care doctor — the first person to be called in case of need. They must have the confidence that he will provide good and sound advice, which may include referral to a

specialist. The primary care doctor is not a glorified postman — he is a true health manager who has the interest of the patient and his family at heart.

A COST-CONSCIOUS PROFESSION

When a person is sick, either he or his relatives will want the best possible attention for him. Cost considerations do not feature very prominently because conscience dictates that we must do all we can to save a life. Spending the inevitable is one thing, but whether we get value for our money is another. To pay more for what can be done less expensively is wastage that we can ill afford. It is even worse when money is used to give the appearance of effect.

The Medisave scheme has enabled our people to have the means to pay for hospitalisation costs. That is only one side of the equation. To provide the means without proper checks and controls is to fuel runaway expenditures, thereby escalating costs from the national perspective. This would in turn backfire and cause even greater hardship for the people in the long run.

The non-applicability of the free market model in health care is best exemplified by medical licensure. Medically trained personnel must be subject to licensing control to maintain standards, including ethical standards, of practice. Precious lives are at stake and it is imperative that we do not just allow a free play of market forces in this regard.

It is not my task in this lecture to discuss the weighty issues of health care financing. My main thesis is that health care can be made more cost-conscious and cost-effective by proper planning, coordination and control at the national level.

A MORE ORGANIZED PROFESSION

To avoid undue wastage and duplication, there must be greater co-operation among health care providers. They can be usefully organised on a regional basis incorporating both public and private sectors under a single co-ordinating body (e.g. Community Health Council), very much like our Town Councils. This dichotomy between the public and private sectors is increasingly being blurred. Similarly, the relationship between primary care doctors and specialists should be one of mutual respect and support, not bigoted rivalry.

Every person should have a primary care doctor who serves as the gateway and guide to the whole health care system. The patient as consumer does not have adequate knowledge to exercise his sovereignty in the first place. This is especially, so when symptoms are vague or where patients have multiple pathologies requiring the attention of different specialists.

A family practitioner is one who "assumes primary responsibility for both the acute medical care and the continuing health maintenance of the family" (LB Carmichael, 1973). Treating an illness is not just an episodic event. There must be continuing responsibility in maintaining health. The public would be well advised to develop a good long-standing rapport with a chosen family doctor, and not doctor-hop. And the doctor on his part must provide professional, competent service at reasonable rates.

The advantages of a regionalised health care system include the following:

1. more effective coverage of all people;
2. sharing of expensive support facilities (e.g. laboratories, x-ray machines according to economies of scale);
3. arrangement of night cover for registered patients round the clock (or a rotational basis);

4. having a critical mass for a viable CME programme in mutual learning and teaching;
5. establishment of a network of supporting institutions e.g. hospitals, hoary' nursing, pharmacies, etc. in providing total care.

It is in the direct interest of everyone that primary care doctors and specialists play a complementary role. A specialist who is overloaded with patients having everyday illnesses will have difficulty tackling the truly complicated conditions. His skills as a specialist need honing. He needs the time and energy which complex problems demand.

This pyramidal structure of health service is not an attempt to deny free access to health care. Instead, it is a rational approach to ensure that relevant care is given to patients according to the type and level of need. In this way, we get what we need and thus avoid having to spend more than is necessary. Furthermore, we will be assured of proper specialist care as and when the situation demands.

CONCLUSION

We all want better health care. It should be cost-effective and affordable. There should be good doctor-patient rapport for continuing care and health maintenance. Such objectives cannot but bring health professionals together to work for the common good. To let each sector — government, university and private—proceed freely in an open market will result in duplication and wastage. If health care is to be properly developed and equitably distributed, there must be reasonable and effective control and co-ordination. Only then can we hope to achieve HFA by 2000 at a level that will satisfy the rising expectations of a population reaching out for excellence.