Could SMA Have Not Withdrawn the Guideline on Fees?

By Dr Wong Chiang Yin

The following piece is a suitably edited and updated reprint of a President's Forum column written by Dr Wong, then President of SMA. The earlier article was published in the April 2007 edition of SMA News *(http://goo.gl/6e9KGK).*

"A sick person often has neither the time nor inclination to shop around to determine what a reasonable price should be."

– "Time now for a guideline", an editorial published in the* Straits Times *(ST) on 20 January 1982

Though the *SMA Guideline on Fees for Doctors in Private Practice in Singapore* (GOF) is now another flicker in the pyres of history, this concern raised by an ST editorial[1] more than 30 years ago remains relevant today. Indeed, it succinctly encapsulates the crux of the issue.

To understand the issues around the withdrawal, we need to understand or answer the following:

- History and rationale for GOF
- Market asymmetry and limitations of the (market) price system
- Effect of GOF
- Events leading up to withdrawal and should SMA have appealed for an exemption
- Could we and should we have not withdrawn GOF?

History and rationale for GOF

Firstly, it is important to know the history of GOF: how did it come about?

The first edition of GOF was originally issued in 1987 when SMA and the Ministry of Health (MOH) discussed and agreed that there was a need to draw up a schedule of fees for medical practitioners, following complaints of overcharging. The main objective then was to enable greater transparency of medical fees and to safeguard patients' interest. GOF was neither an instrument to protect doctors' (GPs and specialists) incomes nor an effort by SMA to facilitate physicians engaging in cartel-like behaviour.

It is important to note that there is often an emergency or urgent nature to medical services that does not permit the luxury of time in decision making for consumers and patients.

Information asymmetry and limitations of the (market) price system

Information asymmetry and trust

Nobel Prize economics laureate Kenneth Arrow was one of the founding fathers of healthcare economics in the 20th century. He summed up the main problem with choice in healthcare in his seminal work, "Uncertainty and the Welfare Economics of Medical Care" – consumer choice as we know in market economics seldom apply because of information asymmetry (the term he used was "information inequality").[2] And this is no secret because "both parties are aware of this informational inequality, and their relation is coloured by this knowledge". Under competitive market conditions, a consumer is able to insure away his risk and uncertainty, but in healthcare he cannot do so. In the absence of this, he has to look for substitutes.

One substitute comes in the form of a guarantee that "at least the physician is using his knowledge to the best advantage. This leads to the setting up of a relationship of trust and confidence, one which the physician has a social obligation to live up to. … To put it another way, the social obligation for best practice is part of the commodity that the physician sells, even though it is a part that is not subject to thorough inspection by the buyer." Arrow adds: "One consequence of such trust relations is that the physician cannot act, or at least appear to act, as if he is maximizing his income at every moment of time. As a signal to the buyer of his intentions to act as thoroughly in the buyer's behalf as possible, the physician avoids the obvious stigmata of profit-maximising. … The very word, 'profit' is a signal that denies the trust relations."

The Nobel laureate's thinking is in obvious contradiction to the claim that "physicians qua businessmen will try to maximise their profits over the long run by leveraging on their market power".[3]

Even the then Minister for Health, Mr Khaw Boon

Wan commented on many occasions that there was information asymmetry in the healthcare sector, and one of his priorities highlighted in the 2007 Budget Speech was to reduce information asymmetry by publishing outcomes and performance indicators, so as to increase market transparency and help patients make better choices.

Limitation of the (market) price system

It is noteworthy that at the end of his landmark paper, Arrow stated matter-of-factly: "The logic and limitations of ideal competitive behaviour under uncertainty force us to recognise the incomplete description of reality supplied by the impersonal price system." In other words, prices that appear to be set freely by market forces (without guidelines) in healthcare may not be what they seem.

Effect of GOF

Keeping private healthcare affordable

It is a well-known fact that healthcare inflation is often, if not always, higher than the consumer price index. However, if you look at how much GOF price ranges rose in its 19-year history from 1987 to 2006, one will realise that GOF recommendations were modest and responsible. For example, surgical and anaesthetist fee recommendations for common operations such as transurethral resection of the prostate and total knee replacement increased by only 29% and 18% respectively. An abdomen ultrasound only went up by 19%. This is very modest for a 19-year period when the prices of many things would have doubled, if not tripled.

SMA can look back proudly and be confident that GOF did its part to keep private healthcare in Singapore affordable.

Events leading up to withdrawal

To appeal or not

Should SMA have applied for, either on its own initiative or with the assistance of MOH, an exemption under the Third Schedule of the Competition Act? It would be necessary here to recap the sequence of events leading to the withdrawal of GOF.

SMA had sought MOH's guidance on this matter at an early stage. MOH's advice to us in November 2006 was essentially that we should follow the advice of our lawyers.

We had consulted independently five of our honorary legal advisors, all of whom are widely recognised to be eminent experts in their field. One of our legal advisors had advised that: "recommendations and guidelines on fees for medical services *would not qualify for exemption or be exempted from the prohibition by virtue of the Third Schedule*". Another advised similarly: "*The Act provides for some exclusions and exemptions to the prohibition but the Fees Guidelines are unlikely to satisfy the requirements*".

We did ask one of our legal advisors to draft a letter of appeal to the then Minister for Trade and Industry, whose purview the Competition Commission of Singapore (CCS) comes under. However, the legal advisor told us that the law does not provide for such a direct appeal.

Letter to CCS

We then wrote to the then CCS Chief Executive Officer (CEO) on 28 February 2007, informing him that we might have no choice but to withdraw GOF soon after our Annual General Meeting (AGM) on 1 April 2007.[4] That four-page letter, which was copied to MOH, set out the history of GOF, the economic argument for keeping GOF – from the standpoint of decreasing information asymmetry, as well as the consequences of GOF withdrawal. It also put on record our attempts to obtain input from CCS, including the suggestion of having a meeting.

In particular, we pointed out the following major consequences of withdrawing GOF:

- Consultation fees for GPs and private specialists would be floated.
- Medical report fees would also be floated.
- There would be no guidance for doctors on how to charge for court appearance fees for civil cases.
- SMA Complaints Committee would no longer handle complaints about overcharging.
- SMA would also withdraw its guidelines on drug price mark-ups.

Our concerns then could be summed up by what we had stated in the same letter: "*The withdrawal of the GOF and the resulting increase in information asymmetry will mean that patients' interests might not be better served, especially amidst rising concerns of increasing and unaffordable healthcare costs.*"

The CCS CEO's reply to us, dated 9 March 2007, stated the relevant parts of Section 34 in the Competition Act and Paragraph 3.5 of the CCS Guidelines on the Section 34 Prohibition, and ended only with: "The CCS notes that SMA has received legal advice that the GOF may contravene section 34(2)(a) of the Competition Act."[5]

Based on this reply from CCS, and with the earlier advice from MOH, the 47th SMA Council decided to recommend to the Association's general membership during its AGM that GOF be withdrawn. This recommendation was unanimously accepted at the AGM.

Both letters as well as our media briefing slides are available for download from our SMA website at http://www.sma.org.sg/ourvoice/index.aspx?ID=71. SMA would like to urge all interested parties to read the documents and decide for themselves, that given the circumstances, if SMA could have avoided withdrawing GOF.

In any case, CCS's media briefing held on 5 April 2007 vindicated our course of action as CCS Chairman supported our decision to withdraw. That would by inference mean that any application or appeal for an exemption would have been unlikely to be supported by CCS. Thankfully, this was a case of foresight being as good as hindsight.

Could we and should we have not withdrawn GOF?

The most important issue here was the legal one. The 47th SMA Council leadership in 2007 firmly took the premise that first and foremost, SMA must be a law-abiding organisation. No SMA leadership would want to go down in history as the one that led SMA into breaking the law! But withdrawal did come with a fair amount of angst, because we were putting away some 20 years of work.

We were also prudent, if not exhaustive, in our attempts to know what the legal position of GOF was. Four out of five legal advisors were unequivocal in their advice: GOF in all likelihood contravened Section 34 of the Competition Act. Only one of them was more accommodating in his interpretation. As with most professional matters, it was hard to have unanimity among five professional minds. Four out of five in complete agreement were more than enough to go on. I would like to put on record SMA's deep appreciation to these five honorary legal advisors who provided invaluable advice to us pro bono.

It was opined that one important consideration for not withdrawing the fee guidelines should be that SMA's GOF was only a set of guidelines and GPs were not obliged to follow them.

However, SMA would like to reiterate what the then CCS Chairman was quoted as saying in ST (on 6 April 2007), that any form of fee guide, even if not mandatory, "can become a signal to market players and result in prices clustered around a narrow range".[6] CCS also said that "with the guidelines acting as an 'unofficial sanction' to peg fees at a certain level, doctors who are able to price their services more cheaply will have less incentive to do so".[6] Hence, it was no longer a question of whether GOF was only a guide or an obligatory fee structure to follow. It was about encouraging a pro-competition environment and creating a system in which prices are set individually and the forces of supply and demand are allowed to work.

The future

I once received this email from an insightful public sector oncologist:

"If one takes away the speed limit on a highway, what will happen? We know that some cars are already driving really slowly, some cars are really going beyond the speed limit, especially when traffic cops are not looking, so they are already not following the speed limit sometimes. If the highway speed limit is removed, over the years, will more cars drive faster or slower?"

Unfortunately, he did not provide any answer to his question. After all that is said and done, GOF is indeed no more. But we still have to grapple with the issue of pricing. There are really five ways to price anything:

- **Do not charge a fee** – this is similar to how SMA runs its Complaints Committee. Complainants do not pay SMA anything to lodge a complaint. This has also been the time-honoured approach to the very poor patient – doctors have, since time immemorial, personally waived part or all of their professional fees for such patients.
- **Charge a nominal fee** – this is more symbolic than anything else. One example is the fees charged by government primary and secondary schools. The fees are so low that they have little bearing on the true costs of education. A parallel example of this in healthcare is our C class services in public hospitals.
- **Charge at cost recovery** – this is commonly practised by related parties. For example, when a public agency sells its services to another public agency or a charitable organisation, it usually does so at cost recovery.
- **Charge at cost plus** – this is commonly practised, and really was the spirit in which GOF was originally drawn up: to keep that commodity of "trust and confidence" between physicians and patients that Arrow described, which would otherwise be lacking due to information asymmetry. In the 80s, MOH and SMA arrived at the consensus that doctors should NOT set their professional fees to maximise profit, but to make a decent living after costs are covered. Hence, SMA's GOF was born.
- **Charge at what the market can bear** – this is probably the brave new world we are now entering without GOF.

The economic argument that GOF limits consumer choice has also been raised repeatedly. Here, it is perhaps pertinent to quote another eminent health economist,

past President of the American Economic Association, and author of the classic health economics text, *Who Shall Live? Health, Economics and Social Choice* – Prof Victor R Fuchs. His take on the limits of applying economic theory to healthcare is that "the discussion of choices reveals some of the limits of economics in dealing with the most fundamental questions of health and medical care. The questions are ultimately ones of value, what value do you put on saving a life? On reducing pain? On relieving anxiety? … According to one well-known definition, 'economics is the science of the means, not of ends': it can explain how market prices are determined, but not how basic values are formed; it can tell us the consequences of various alternatives, but it cannot make the choice for us. These limitations will be with us always, for economics can never replace morals or values."[7]

In retrospect, SMA could not unilaterally choose to keep or withdraw GOF. The guidelines began with a set of values more than two decades ago. GOF is now gone because society's values, which find expression in our laws, have also changed in the last 20 years.

Endnote

In 2009, a group comprising members of the SMA Council and one well-wisher subsequently contributed a sum of $5,000 from their pockets, to request CCS to formally decide whether SMA's GOF would infringe the Competition Act. The group also managed to secure pro bono legal advice from a leading law firm in Singapore. This was in response to CCS's comments that SMA should have done so in 2007 before withdrawing GOF. In the end, as expected, the CCS's formal decision was that GOF would have contravened the Competition Act. The Statement of Decision, released on 19 August 2010, can be found at the CCS website.[8] The following are excerpts from the press release:

- CCS has therefore, on 18 August 2010, formally advised SMA that the GOF would contravene the Section 34 prohibition of the Competition Act. However, as no GOF has been issued since April 2007, no further action or direction by CCS is required in respect of this Statement of Decision.
- CCS understands that the GOF is an attempt to address information asymmetry in the medical sector. However, CCS notes that there are other more effective measures in place today.
- In particular, the government provides Hospital Care services for 80% of the population. These restructured hospitals make their pricing decisions without referring to the GOF. The charges in the restructured hospitals are available to provide a benchmark for comparison by patients who choose to go to private hospitals.
- The Ministry of Health ("MOH") requires patient medical bills to be itemised and financial counselling be provided, and publicises hospital bill sizes on MOH's website for public information. MOH also requires all private medical clinics to display their common charges. CCS would like to encourage SMA to work with MOH and hospitals to further improve the delivery of pricing information in the healthcare sector so as to allow patients to make more informed choices.
- In general, price recommendations by trade or professional associations are harmful to competition because they create focal points for prices to converge, restrict independent pricing decisions and signal to market players what their competitors are likely to charge. This is a common position adopted by many competition agencies in the world, even for the medical sector.
- The Statement of Decision issued to SMA is available on our website http://www.ccs.gov.sg.

The formal decision issued by CCS on 18 August 2010 also vindicates the legal basis for the SMA Council's decision to withdraw the GOF in 2007. ■

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