Healthcare Insurance: A CHRONIC ISSUE

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There has been much public interest and debate on the problem of private insurance, in particular the SMA Position Statement which registered the 61st Council's views on Integrated Shield Plans (IPs) (https://bit.ly/3wPPlwv, https://bit.ly/3sfshnn). Since then, there have been further developments with Senior Minister of State for Health Dr Koh Poh Koon announcing the formalisation of the existing pro-tem committee into the Multilateral Healthcare Insurance Committee (MHIC) appointed by the Minister for Health.

I realised that not many people know the background and evolution of private insurance and many may not quite understand the multiple layers of its complexity. Allow me to summarise in the form of a timeline, which guides my subsequent discussion:

- 1994: First IPs started by NTUC Income, followed by others (co-payments were present from 1994 to 2005)
- 2005: As-charged plans introduced and first-dollar coverage riders were offered in 2006 by insurers themselves
- 2007: SMA Guidelines on Fees was withdrawn in compliance to the Competition Act, leaving doctors/patients without guidance on what fees were reasonable[1]
- 2015: Health Insurance Task Force (HITF) convened and their recommendations published in 2016[2]
- 2018: Ministry of Health (MOH) published fee benchmarks for private sector professional fees

Escalating healthcare costs are a concern for many governments. Learned economists have studied it and there is no simple answer. Personally, I see the need for everyone to be part of the solution. I list five key factors which I will be discussing in this article:

1. Advances in technology leading to better quality of care
2. Healthcare facilities costs
3. Doctors' fees
4. Patients' health-seeking behaviours
5. Insurers

Healthcare technology advances

As research and experimental trials become validated, technological advances grow to be accepted in mainstream clinical practice. Here is an example in the field of breast surgery: 30 years ago, most breast cancer patients had to accept a mastectomy and the resulting change in appearance was unacceptable to some. Now, patients can opt for nipple-sparing mastectomy and immediate reconstruction which allows the patient to regain a physical appearance similar to her former state. This brings better outcomes for some patients, but clearly with increased costs – more complex surgery, longer operating times and longer hospital stays. Clinicians would agree that the advances in medicine are immense, including the use of CT scans/MRIs, use of percutaneous catheters for a myriad of vascular interventions, and medications (especially in oncology).

Healthcare facilities costs

The costs of private healthcare facilities also seem to have been frequently overlooked as a contributing factor of increasing healthcare costs. In 2013, a series of online articles commented on the high markups of a bag of normal saline in the US,[3] and then the subsequent government probe into a national shortage of saline.[4] Now, keep in mind that these are US reports – I do not have any Singapore references, and I have only my own hospital bills to refer to. When I receive the itemised bill as a patient however, how would I know which items are reasonably charged, and which are not? I am heartened that the MHIC will include representatives from private healthcare organisations as part of the solution.

Doctors' fees

Doctors' fees have often been regarded as the main source of increased costs. How true is this? Historically, SMA had published its Guidelines on Fees since 1987, but it had to be removed in 2007 as it was deemed anti-competitive. Then in end 2017, MOH announced that fee benchmarks would be implemented. Since then, the benchmarks served as a guide on what and how doctors should charge. A good analogy is that of speed limits – without a speed limit listed, people tend to drive faster. But if there is a clear limit in place, most people would respect that and drive within the specified limits.

I have personally received mixed feedback stating that although most doctors are now abiding by the fee benchmarks, a few have been implementing multiple codes inappropriately. The professional bodies will work with MOH to better understand the scope of the problem, and assist in (1) education, (2) guidance and (3) peer counselling, failing which recalcitrant doctors will be referred to the Singapore Medical Council (SMC) for disciplinary action.

Patient's behaviours

Patients' health-seeking behaviours also affect costs. When people fall sick, how do they choose their care? Do they just take some painkillers and rest? See a GP, or a traditional Chinese medicine physician? Do they go to a polyclinic, the emergency department, or straight to a specialist? Do they choose a doctor based on an Internet search, or their friends' or insurance agents' recommendations?

Insurers

Finally, how are insurers involved?

Patients factor in financial costs when they need to see a doctor. Some will go

only to their company doctors based on their corporate insurances. When they need to have hospital admissions, day surgeries or major operations, that's when their IPs will come in useful. In my recent Budget speech in Parliament, I highlighted the importance of shared decision-making in healthcare[5] when making medical decisions, and by extension to the patients' purchase of medical insurances!

How much do we actually know about health insurance?

All Singapore citizens and Permanent Residents are covered under Medishield Life,[6] which covers a proportion of bills for B2 and C class admissions. If one chooses to be in A or B1 class in a restructured hospital, or seek treatment in private hospitals, one will need to top up the difference with their Medisave account or cash.

As such, one may buy additional private insurance in the form of IPs.[7]

In my parliamentary speech, I stated that close to 70% of Singapore citizens have an IP. This is based on published 2018 statistics: 2.749 million policy holders[8] on a population base of 3.99 residents (Singapore citizens and Permanent Residents).[9]

Some terms that we need to know about IPs include:[10]

- **Deductibles:** What a patient has to pay first, before any payout.
- **Co-payment:** What the patient has to pay, after the deductible (often expressed as a percentage between 5% and 10%).
- **Riders:** Optional extras to cover deductible and co-payment, or additional benefits.

To recap, 70% of Singapore citizens have IPs and 29% have riders.[11] Since **March 2018**, MOH has required all new rider plans to include 5% co-payment. So what happens to the 29% who had pre-existing policies with riders? MOH has stated that insurers are allowed to impose the 5% co-payment, as part of the contractual terms.[12] As much as I, as a policyholder, don't like it, I see that there is no choice but to have such a mechanism in place to curb the "buffet syndrome" which describes over-consumption, over-servicing and over-charging of healthcare services.

Policyholder's choice

Of note, there is also the phenomenon of policyholders who are eligible to utilise private healthcare services, but instead choose to go to a restructured hospital. Why is this a problem?

If the patient's IP includes private care in a restructured hospital, he/she is still using the resources of the restructured hospital which adds on to the waiting time for scans, operations, etc. I have not left restructured service long enough to forget how "A class" patients expect fast service, only to be told that there is no special queue for private patients. I am aware that some departments have come up with certain slots to try to accommodate these patients, but I also know that we clinicians **prioritise medical need** over class status, as should be the case.

What's even stranger is if the policyholder decides to seek treatment via a polyclinic, to get access to subsidised care in restructured hospitals! This means that the current insurance plan that he/she has paid for would be "wasted". This patient would also be using government subsidies which could have gone to patients who are truly in need. **I vouch for the quality of care**, but we are acutely aware that teaching hospitals come with certain needs and requirements. I know that my patients with breast lumps have declined examination by anyone other than the attending surgeon and requested for the surgery to be done only by a consultant. Can the restructured hospital services accommodate every such request? As a consultant, I have always reassured my own patients that having trainees is part of the system. These are qualified doctors, training to be specialists, and we all have to start somewhere. I also reassured them that I will be there for the whole surgery to personally supervise every step.

So, it is again down to the patient's choice and right. If the patient has been paying for private care and wants to utilise it when he/she needs it, shouldn't he/she have the peace of mind to get the type of care he/she wants?

Another variation that we should know about are **corporate plans**, or employee benefits. These come with different reimbursement rates for doctors, which are frequently pegged very low in return for high volumes of patients. For example, I own company ABC with 50,000 employees. I buy a corporate health plan for them from Insurer XYZ, but my own human resource team is unable to process the paperwork, so I outsource this to a third-party administrator to manage the claims. I urge all SMA Members to think carefully and read the fine print well, whether you are a GP or specialist. What kind of contract are you signing? Are the terms fair?

What about the SMA Position Statement?

As the current President, I felt that there was a need to speak up for doctors and patients. The 61st Council unanimously voted to put out a Position Statement (https://bit.ly/2OLi98g). This forms the basis for any future negotiations, moving forward.

A lot of attention was previously given to how doctors charge, and how insurers can control costs by keeping panels small and reimbursing at lower rates. Some key points to note:

1. Insurers themselves must bear responsibility for contributing to this situation.
2. Insurers should review their management and commission costs.
3. We seek fairness in allowing patients the access to their doctors of choice, without additional man-made barriers or financial disincentives (eg, significant differences in seeing panel versus non-panel doctors).
4. More objective review of insurers, with ranking and a Complaints Committee.

What's the big deal about panels?

Analysis by a team of doctors from the Academy of Medicine, Singapore (AMS) and SMA has shown that panels may have only 20% of registered specialists participating. Of course, this varies from company to company and even by specialty.

For instance, there are around 50 breast surgeons in Singapore, roughly half in private practice. Some panels have 20 doctors, some have five. One

patient told me her panel only has male doctors, but she had preferred a female doctor. As a result, she would have to co-pay more than if she went with a panel doctor.

Patients should have the choice, without feeling like they are being punished for choosing outside the panel. Most of us would rely on a friend's or doctor's recommendation for a good doctor. Now it seems like the first step is to check if they are a panel doctor or not.

Getting a breast cancer diagnosis is very stressful and emotional for most women. In the midst of accepting the diagnosis and worrying about the surgery, upcoming chemotherapy and radiotherapy, they worry about the costs. At the point that they most need health insurance to step in and be fuss-free, they have to check through the fine print of coverage. I have met cases where the policy agents themselves are not familiar with the claims process, and tell patients to just go to their panel doctors to ensure that everything goes smoothly.

The HITF's original intent of panels was to reduce costs by ensuring that doctors' fees are reasonable. Now with MOH fee benchmarks to guide us, perhaps panels can be widened, to allow patients more options.

I am glad that the insurers have taken steps to expand their panels, and in time to come, the SMA will collate more feedback as an ongoing review of insurers.

Proposed ranking and Complaints Committee

Over the years, we have received many anecdotal complaints from doctors about unfair behaviour by insurers. We don't know the full extent of the problem. I want this to be a factual exercise, and to collect objective data. These are some parameters we will look at:

(a) Inclusiveness of panels;

(b) Transparency of selection criteria of doctors for panels;

(c) Ease and timeliness of pre-authorisation process;

(d) Timeliness of payment;

(e) Appropriateness of fee scales with respect to the MOH fee benchmarks; and

(f) Degree of friction and penalties imposed on policyholders when non-panel doctors are used.

The Complaints Committee is for doctors to submit information to, when they find that IP providers have not been fair. This could include patients being denied insurance coverage or doctors not being adequately reimbursed for their services. Members of the public may write in, and the SMA will redirect them to the Financial Industry Disputes Resolution Centre.

What is the next step?

Some newspapers and even some doctors have been calling this a war with insurers. I disagree. What I want is "world peace", or sustainable healthcare. What I see is both sides – insurers and doctors – each saying the other is the cause for war, and arming up to fight to prove that they are peaceful!

To truly get "world peace", negotiations have to happen. We all have to see the many sides that make up this problem: doctors, payers, insurers, policyholders, taxpayers, healthcare facilities and pharmaceuticals!

Healthcare is not like other commercial businesses as patients are typically at a disadvantage, especially if they do not have knowledge of the medical care they need and how much it should be priced at. That is why the professional bodies (AMS, College of Family Physicians Singapore and SMA) and our regulatory body, the SMC, have a strong duty to ensure that doctors are practising good medicine and putting patients' interests first, by providing good medical care and ensuring that charges are within reasonable range.

As announced in the news, the SMA has representatives in the Minister-appointed MHIC. A lot more work lies ahead as the various stakeholders need to hold honest and sometimes painful discussions on (1) existing problems, (2) potential solutions and (3) trade-offs. There may not be a perfect solution, but we will all have to learn together.

Like-minded people from all industries should be aligned in protecting patients' interests. There has to be mutual trust and we will all have to work together to build a sustainable healthcare system, and support a robust subsidised system and fair private practice.

We will all be patients one day – we will need to make sure that we can afford and receive good care when we need it. This will also be for our children, and their children someday. ◆

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