Healthcare Financing Revisited

By A/Prof Goh Lee Gan, Deputy Editor

Healthcare is made up of the following components of care: acute care, care of chronic medical conditions, surgery and hospitalisation care, and care of catastrophic conditions. Each of these components can be managed on its own financially. The following are thoughts that could hopefully trigger new ways of looking at managing and financing healthcare.

ACUTE CARE

The cost of acute care and the number of times per year an average person requires acute care is fairly well known. A sum of $25 times 6 visits or $150 should cover the needs of most people quite well. Instead of having a company contract, an alternative plan that Human Resource (HR) Managers can consider is to give each employee the $150 and let him or her look for the doctors they trust and feel that they can get value for their money. In this way, doctors will be motivated to provide good care at a reasonable cost and have a good doctor-patient relationship based on the patient's choice. Employees who are well can keep the money as a bonus.

CHRONIC CARE

This is an area that the whole world is now paying attention to finally. It is an area where care is badly provided. A new industry called disease management is about to be spawned to deal with it. It is an area where if well done, will result in substantial personal and national savings from hospitalisations, disability care and untimely deaths. The top three conditions requiring good chronic care are diabetes mellitus, hypertension and hyperlipidemia.

Chronic disease is a graph of continuous decline to disability and finally death. Money has to be spent for the consequences of the disability e.g. poor diabetes control leads to foot infection that is hard to control and this leads to hospitalisation and often amputation; other complications of poorly controlled diabetes are heart attacks and eye problems. All these lead to more and more hospitalisation as one organ after another packs up.

There is a need for everybody to consciously work to reduce the slope of decline so that complications can be postponed if not averted. The game then is to work on incentives to reduce the slope of decline:

a. For the doctor – to provide the necessary control through drug and non-drug measures (namely weight control, compliance monitoring, and complication detection and intervention early on – the 3 Cs of chronic disease care; and
b. For the patient – to be persuaded to be the compliant patient – follow the advice on medications, exercise, weight control, diet restraint, and that is all for diabetes. The same formula applies for hypertension and high cholesterol control.

The insurance model can be used, complete with rebates and rewards for efforts to reduce the slope of decline. Rebates are given if the insured shows evidence of compliance as evidenced by good intermediate outcomes (BP control, blood sugar control) and good process outcomes (doing exercises, weight control programme). Doctors will also be given rewards for showing they are contributing to the efforts to lessen the slope of decline. We can work out a reward system using targets for intermediate outcomes (blood sugar control, blood pressure) and process outcomes. All these will direct new efforts to control chronic diseases a bit better than now.

SURGICAL AND HOSPITALISATION

There are already insurance packages. The challenge is to ensure the patient does not consume such services unnecessarily and yet give due attention to conditions that need to be attended to. One alignment of incentives will be the use of co-payment for hospital services. Also, the flexibility of topping up for a higher level of services can be considered. What is important is that at the usual service level, the care is not short-changed. Outcome, quality and cost need to be considered together, and not just cost alone.

CATASTROPHIC CARE

There are again insurance models like Medishield and Income Shield. The challenge is how insurance premiums keep pace with technology. Oncological care and intensive care may need scrutiny to balance outcome, quality and cost.

INSURANCE TO POOL RISKS

As healthcare becomes more costly, risk pooling through insurance appears to be the way ahead. Instead of providing subsidies to poor patients, the government may also consider paying their premiums for catastrophic care, surgical and hospital care, and even insurance for care of chronic medical conditions. We can then do away with the C-class beds for the destitute and poor. Rich or poor, everybody will be covered by some insurance or other. This may well be the way ahead.

NOT JUST COST CONTROL ALONE

Whatever modes of pre-payment are introduced, there is a need for the management of not only cost control, but also to pay enough to the providers to allow them to provide the quality of care necessary. Managed care must not deteriorate into managed cost alone, which is the prevailing evil. It must jointly manage costs and quality. Also, there is a need to align the patient's incentives to be in line with cost control and quality. The co-payment idea seems to be the way to go. ■