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SMA NEWS

Managed Healthcare Singapore 2006: Report and Reflections

Left–Right: Dr Chong Yeh Woei, Dr Lee Yik Voon, Dr Tan See Leng and Ms Yong Ying-I.

The spotlight of this year's 37th National Medical Convention was on "Managed Healthcare". Held on 19 August 2006 at SAFRA Mt Faber, it attracted almost 160 participants.

The one-afternoon Convention was divided into two sessions. The first session kicked off with a keynote address from the Permanent Secretary for Health, Ms Yong Ying-I. The other presenters dealt with different aspects of managed care in Singapore: its history, perspectives on economic considerations from two medical practitioners and one managed care organisation (MCO), and the mechanics of processing the managed care payment.

The second session was devoted to presentations on professional and ethical issues, a report on dialogues with MCOs, a preliminary presentation of the SMA Managed Care in Singapore 2006 survey results, and finally an analysis of the future of managed care in Singapore.

POINTS TO NOTE FROM THE FIRST SESSION

Keynote address – Ms Yong Ying-I, Permanent Secretary for Health

- In Singapore, managed healthcare has never taken off in a big way and the fundamental reason is probably the success of our 3M framework, the Government's ability to exercise policy and management control to achieve cost-containment and cost effectiveness in delivery. Nevertheless, it is to our interest to learn and adapt the good points of managed healthcare system (MHS) to our needs.
- The chronic disease management scheme will bring Singapore closer to our version of managed healthcare later this year when we launch the use of Medisave to help pay the treatment for diabetes, hypertension, lipid disorders, and post-stroke management.
- For the chronic disease management scheme to work well, five features need to be present:
  1. Every patient suffering from a chronic disease has a primary care physician;
  2. Patients are engaged as active partners in treatment through patient education and publicity materials to support self-care efforts, compliance, and incentives to stay in control of their diseases;
  3. Doctors follow treatment protocols which disease experts in Singapore have come together to design;
  4. Professional community helps GPs strengthen their capabilities to manage chronic diseases, tool kits, and educational materials for doctors to better explain chronic disease management to their patients; and
  5. Our public sector SOCs make a big push to strengthen their partnership with primary care physicians, including those in the private sector and what further measures at the SOCs need to be taken to remove barriers to right-siting.

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- If done well, the chronic disease management will benefit patients; primary care doctors will now have an opportunity to treat a larger number of patients with more complex ailments; and doctors in SOCs are freed to focus more efforts on cases that require specialist care.

History of managed care – A/Prof Goh Lee Gan

- Managed care is a form of healthcare financing inspired by America. Like in the United States, the basic concept of capitation in healthcare maintenance organisations (HMO) has undergone changes in Singapore.
- The common feeling about managed healthcare is dissatisfaction because it is a system where the healthcare provider is restricted in the payment he can receive and the end-user is restricted in the services he will receive. Only one-third of Singapore doctors surveyed in 2003 (169 responses) would want it to continue.
- Lessons learnt from Singapore and the United States are many:
  1. Enough must be given to the healthcare provider for him (which is often not the case presently and hence the dissatisfaction) to provide a service without undue risk-taking;
  2. The MCO and end-user both need to be aligned on what is to be received from the healthcare provider;
  3. Need for guidelines, policy statements, exclusions that are transparent and clear;
  4. Appetite of the end-user for services needs to be moderated by co-payments and
  5. The premium that the MCO needs to collect per capita to cover primary care, specialist outpatient care, and hospital is about $450 (circa 1991-1995) or more in the present to remain viable.
- Cost control without being quality driven is the backlash of managed care.
- The future of managed care lies in pay-for-performance (P4P). The United States and the United Kingdom are leading the way in this new breath of fresh air in managed care. This is of particular relevance in the present era of patient safety awareness.
- The real healthcare savings for the patient, family and nation are yet to come – from the efforts of risk reduction, alignment of care to evidence-based care/best practice and right-siting of care.

Economic considerations in managed care: perspective from a group practice – Dr Arthur Tan Chin Lock

- There is a need to correct underpayment of the primary care provider in the managed care schemes.
- As an example: His reimbursement for seeing a typical cough and cold patient can be as little as a $5 co-payment paid directly by the patient, $5 for medications dispensed, and a discounted consultation fee, to be paid 90 days later by his MCO.
- The medical profession should close rank to support SMA, and work collectively with SMA to push the many regulators such as MOH, SMC, MAS and so on, to re-examine the terms and conditions of the MHC scheme, so as to allow for a more equitable, more ethical and more flexible delivery of medical services by their doctors to their patients.

Economic considerations in managed care: A perspective from a single clinic practice – Dr Wong Tien Hua

- The main problem, and also a constant source of many complaints from fellow GPs, is the low fees paid for GP consultations.
- Complex claims procedures and increased administrative workload are also part and parcel of any managed healthcare scheme. Margins for drugs and procedures are low. Late payments expose the solo GP to cashflow problems.
- To stay on top of things, the GP must be very familiar with each and every scheme he engages. He must know the rules and exclusions. The GP should keep a long-term view by developing a strong doctor-patient relationship. Schemes come and go, but the satisfied patients are more likely to remain with their preferred family doctors in the long run.

Economic considerations in managed care: A perspective from a MCO – Ms Janice Yeo

- Ideally, managed care schemes can work towards saving costs by embarking on health

Left-Right: Dr Wong Tien Hua, A/Prof Goh Lee Gan and Dr Jeremy Lim.

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maintenance programmes and reducing sick absenteeism. This is probably difficult to achieve in the short run.

Processing managed care payment: A perspective from a group practice – Dr Wong Weng Hong

- The total time taken to process managed care payment is four to nine weeks, with an additional four weeks if a review of the claims is needed.
- Causes of delays come from: errors in plan or system setup; errors in claim submission; delays in batching at month end; delay by payer; delay by GIRO issues, separation of payments and review of exceptional claims.

POINTS TO NOTE FROM THE SECOND SESSION

Professional & ethical issues in managed care – Dr Chin Jing Jih

- The three questions that a doctor should ask when evaluating managed care contracts are:
  1. Do the terms of the plan prevent me from meeting my obligations to my patients?
  2. Is the nature of financial and other mechanisms consistent with providing competent and compassionate care? (Amount allowed to charge allows adequate time with each patient? Are patients denied clinically effective healthcare services? Capitation amount able to provide quality care under the arrangement? Any "gag" clause?)
  3. Does appellate process have room to meet duty as patient advocate?
- Guidance on these issues are found in the following sources:
  1. AMA Council of Ethical & Judicial Affairs Policy 8.13;
  2. Ethics in Practice: Managed Care and the Changing Healthcare Environment – Medicine as a Profession Managed Care Working Group, American College of Physicians (Annals of Internal Medicine 2004; 141:131-138); and
  3. SMA Ethical Code and Ethical Guidelines: 4.1.7.3 – Relationship with system of care, and 4.6.1 – Financial and commercial conflicts of interest.

Report on dialogue with MCOs – Dr Tan See Leng

- A dialogue was conducted by the GP Task Force Committee with five MCOs (Ezy-Health, MIB/MHC, Parkway Shenton, Vista HealthCare Plan, Raffles Medical Group). The operational characteristics of these organisations are shown in Figure 1.
- Four questions were asked in the dialogue and answers to these are given below:
  1. How many GPs are paid within 30 days? No firm commitment from MCOs on whether claims can be paid within 30 days.
  2. Will there be a provision for a tiered system of reimbursements for GPs (that is, one system of payment for acute illness, and one for chronic illness)? No commitment to a tiered system for reimbursements between acute and chronic illnesses but some of the HMOs are open to the idea, provided all the rest will follow.
  3. Is there a need for some security deposit to be placed with an independent trustee for payment to GP providers? Most MCOs feel that there is a need to monitor the financial credentials of MCOs; those with insurance licenses have permits from the Monetary Authority of Singapore (MAS) and may be exempted.
  4. Does GP provider bear the risk of the schemes if the company folds? All third party administrators will pass at least some of the risks back to the GPs especially in the fee-for-service schemes. One MCO has a working float (lump sum of money put in by the company) and so manages the risk accordingly.

Dr Arthur Tan Chin Lock

Dr Wong Tien Hua

Ms Janice Yeo

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Figure 1.

Operational Characteristics of MCOs Participating in the Dialogue

HMO	Accounts Receivable	Admin Fee	Chronic Diseases	Tracking of Clinical O/C	Contractual Terms
Ezyhealth	60 days	No comments	Capitation	No	Risk-sharing
MHC/MIB	60 days	10-15%	FFS	Yes	HMO underwrites
Parkway Shenton	45 days	10-15%	FFS	Yes	HMO underwrites
Vista Health Plan	60 days	10%	FFS	No	Risk sharing
RMG	60 days	Varies	FFS	No	Float

- An independent authority to balance the needs of all interested parties and provide a platform for quality controls, audit, checks and balances as well as arbitration was felt to be necessary by the GP Task Force Committee.

Preliminary report on SMA Managed Care in Singapore Survey 2006 – Dr Chong Yeh Woei

- Compared to the 2003 survey, there are more participants and results are still coming in. In 2003, there were 169 respondents. At the time of presentation for the 2006 survey, there were about 300 respondents.
- The interim survey results showed that the percentage of doctors who want managed care to continue in Singapore has increased from 31% to 45%.
- The proportion of doctors with very dissatisfied/dissatisfied feeling (score of 1 and 2) towards the managed care schemes in 2006 have dropped compared to 2003 figures. (See Figures 2 and 3.)
- The proportion of doctors with experience of payment period after invoicing MCOs of more than 180 days in the 2006 survey compared to the 2003 survey has gone up. (See Figures 4 and 5.)

Future of managed care – Dr Goh Jin Hian

- Rising healthcare costs will come from newer, more expensive pharmaceuticals; medical technology – CT angiogram, 3 tesla MRA, PET scans; ageing population; medical litigation; and increasing specialisation of doctors.
- National efforts in managing healthcare costs will come from:
  1. CPF – Medisave; Payment for chronic illnesses;
  2. Medishield – Second or third line payer in most instances;

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3. Employer as payer and
4. Other measures – self insurance, insurance/managed care, portable medical benefits, private insurance.

- How insurance companies may manage healthcare costs?
  1. Compete for market share – this may result in low premiums initially;
  2. Manage using sub-limits and other financial risk management methods;
  3. Pass the risk on to doctors;
  4. Work with select group of doctors and
  5. As an industry, push for "portability" of insurance; retain and grow market base.
- Some predictions for the future:
  1. Managed care and insurance market will grow;
  2. Managed care is currently regulated by MAS, but MOH may enter the picture;
  3. Life insurance companies have advantage of size and being able to cross-subsidise products; and
  4. Doctors will be divided and conquered.

PERSONAL REFLECTIONS

Dr Goh Jin Hian's prophecy is that doctors will be divided and conquered. Indeed this will be *true* if doctors continue to undercut one another and open the way for managed care organisations to divide and rule.

However, this scenario need not be inevitable. One roadmap to a better future from my perspective is given below:

1. The Government polyclinics are already embarking on a two-tier consultation fee scheme, $8 and $16. Herein lies the solution of getting out of the sweat shop consultation fees. The family physician can certainly work towards the SMA recommended consultation fee for the higher end care for a start.

Figure 2.

2003 Survey – Distribution of Respondents by Doctors' Dissatisfaction/Satisfaction with Managed Health Schemes (1 = very dissatisfied, 5 = could not be better)

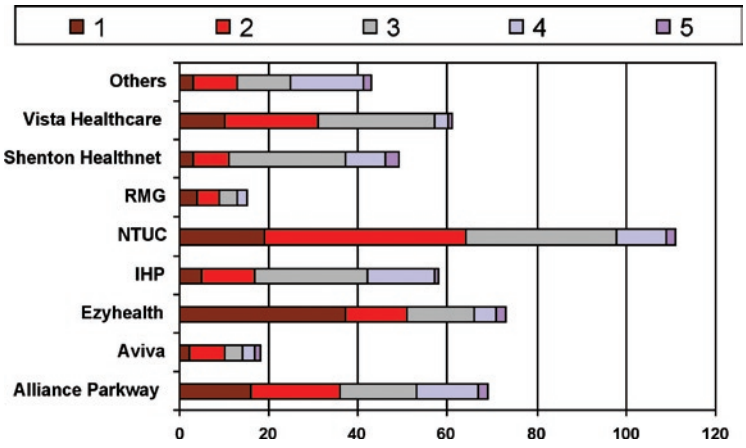

Figure 3.

2006 Survey – Distribution of Respondents by Doctors' Dissatisfaction/Satisfaction with Managed Health Schemes (1 = very dissatisfied, 5 = could not be better)

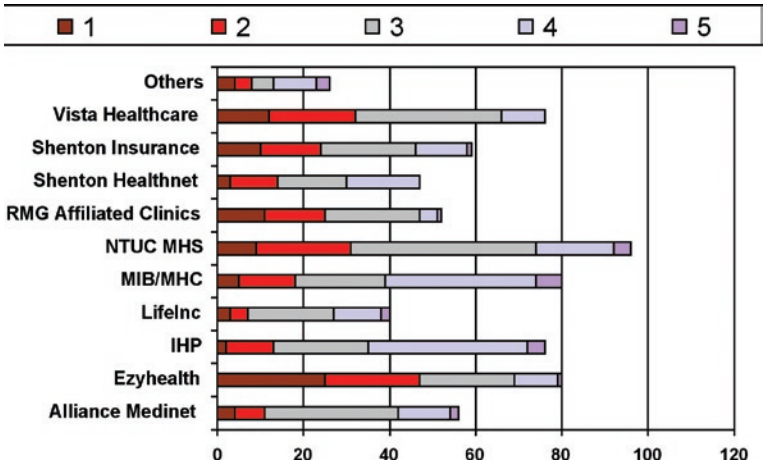

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Figure 4.

2003 Survey – Distribution of Respondents by Doctors' Feedback on Payment Period after Invoicing MCOs

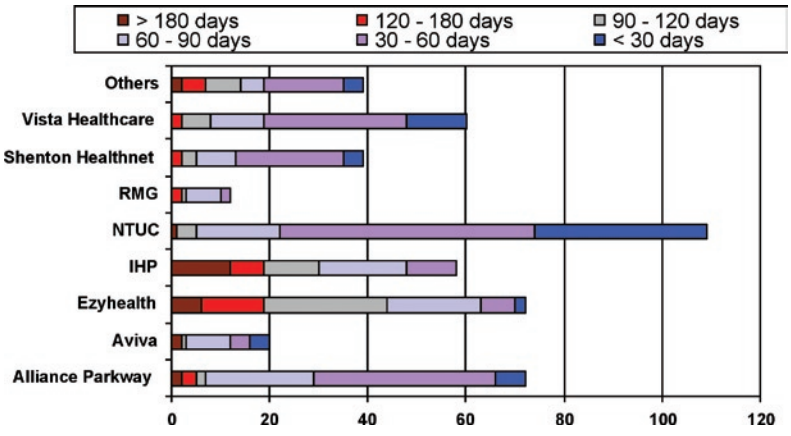

Figure 5.

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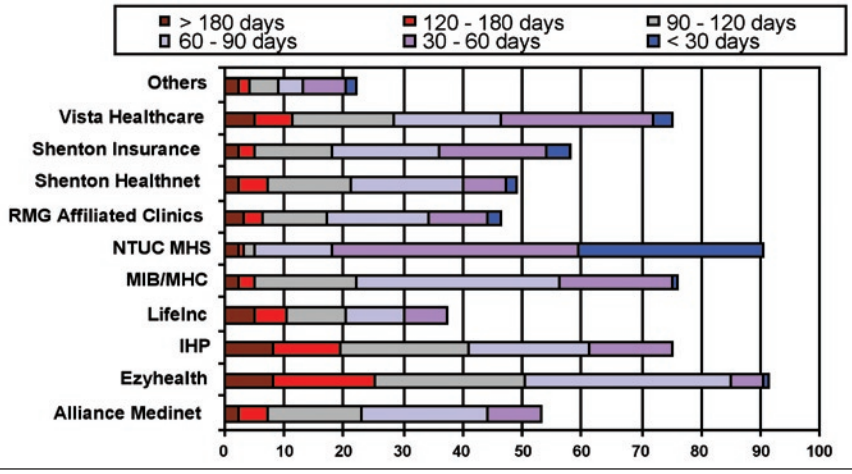

2. There is a need for the rank and file family physician to convince the patient that the recommended SMA consultation fees are necessary for him to deliver the quality of care that is needed. We will need to work individually with our patients to prove our worth.
3. The SMA leadership will need to work with the MCOs and patient interest groups like CASE to blueprint the pay-for-performance (P4P) paradigm as opposed to cost containment without regard for patient safety or quality.
4. We need to shift away from drug pricing to provide a major portion of the practice's revenue. SMA has issued guidelines on this. Certainly, it should be no higher than the pharmacy retail prices in the market.
5. We need to participate actively in the spirit of the chronic disease management programme that MOH is initiating. This will be the prototype of P4P into the future.
6. We need to be convinced of the usefulness of the family practice register (FPR) and promote its implementation as a visible benchmark for the public that doctors on the register are committed to providing good care. It can be a powerful hallmark. Everyone should be on the register.
7. The real healthcare savings for the patient, family and nation are yet to come – from the efforts of risk reduction, alignment of care to evidence-based care/best practice and right-siting of care. There is a lot to say about new cheese for the family physician.

FINALLY: THE WISDOM OF HIPPOCRATES

The wisdom of Hippocrates seems to be pertinent even in grappling with the issues of managed care. Let me conclude with a quote from this ageless sage:

"Life is short, and Art long; the crisis fleeting; experience perilous, and decision difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate."

- *Hippocrates. In: Aphorisms (translated by Francis Adams)* ■

A/Prof Goh currently teaches Family Medicine and Public Health at the Department of Community, Occupational and Family Medicine at the Yong Loo Lin School of Medicine, National University of Singapore. He is also a Past President of SMA (1999-2001).