Over-Servicing by Medical Doctors

What Does That Mean?

Text by Dr Jimmy Teo, Editorial Board Member

This article is adapted from Dr Jimmy Teo's original article which first appeared in TODAY.

There have been articles by authors from insurance companies arguing that over-servicing by doctors causes insurance losses and rising premiums. While there is increased utilisation of diagnostic and therapeutic procedures, it must be kept in mind that by the ethical code of conduct and professional repute, doctors do exercise restraint. However, third-party funders may have misunderstood what professional medical practice is and what patients seek.

Let's take the example of a "simple" hypertension for the purpose of this article's discussion. Professional consensus on cut-offs of blood pressure determine the diagnosis of hypertension. Blood pressure rises with age and life insurance companies know that people who have lower blood pressures throughout their lives survive the longest. Patients who are diagnosed and treated for their hypertension live longer than those who do nothing. That is the evidence from the many clinical trials on treating hypertension. Yet we still have patients and families who ask, "Doctor, he was taking medications, why did he suffer a stroke (or heart attack, or kidney failure, or die)?" This is because it is not possible to identify all the risk factors and completely control them. The choice of technology, method and cost will determine the fidelity of medical assessment and management.

Diagnosis

The diagnosis is usually made based on office blood pressure measurements higher than 140/90 mmHg on two or more visits. Most of the epidemiologic studies and clinical trials are based on office measurements. However, office measurements may underdiagnose hypertension and therefore, its residual risk. Some patients have masked hypertension, or non-dipping or rising blood pressures during sleep. These patients actually have hypertension which can only be diagnosed by undergoing a 24-hour ambulatory blood pressure monitoring.

The greatest impact to health from a public perspective is to make medical care for common conditions accessible, simple and affordable. The office measurement is the main method for diagnosis in primary care clinics. The patient-public will have a good chance of identifying hypertension and monitoring while on treatment, and the cost-benefit is very good. However, is the doctor who misses a case of hypertension because he did not use 24-hour monitoring guilty of under-servicing? Or is the third-party funder that declines coverage of 24-hour monitoring guilty of causing bodily harm?

Assessment

The usual minimum standards of care include physical assessments and laboratory tests to determine the cause of hypertension and the degree of hypertension-mediated organ injury.

Current methods cannot identify all causes, and most patients are diagnosed with primary hypertension. For affordability, further testing is limited for third-party-funded services. Unless one exhibits obvious signs of severe hypertension, it is hard to diagnose a secondary cause without more tests. At least 5% of unselected hypertensive patients in primary care clinics may have hyperaldosteronism, but only 20% of these patients would have a low blood potassium. The relevant screening test is rarely done in primary care clinics and is more commonly ordered by specialists.

The public must be counselled that the moment they elect to use a third-party funder, some decisions are made on their behalf, and these decisions are likely based on a combination of actuarial, cost-benefit and cost-effectiveness analyses. When a commercial insurance company is paymaster, a further third-party is involved – the shareholder who is interested in the lowest benefits payouts and highest profits. A government funder will have to raise taxes to pay for benefits. Ultimately, if medical care is to benefit individuals, why is a third party asked to pay? Therefore, the theoretical construct of patient-centred care should be completely privatised doctor-patient relationships sustained on professional codes of conduct.

Treatment

Hypertension is "easily" treated at younger ages by an aggressive modification of lifestyle. It is easy to advise this but I can literally count with the digits of my hands the number of patients who are successful with these measures alone. Most patients require several medications to control their hypertension. Some might argue that doctors drive costs up as a result of over-servicing. Then again, the patient who is on multiple hypertensive medications and refuses to exercise or engage in a healthier lifestyle may eventually wind up with complications of hypertension, such as stroke, heart failure, or chronic kidney disease. And these costs escalate exponentially. Perhaps some doctors may over-service. Perhaps some patients, through their personal choices, over-consume.

Primary versus specialist care

If the specialist does the same thing as the primary care doctor, why should they exist? The specialist aims for definitive diagnoses and specific treatment through a battery of tests. The specialist also manages cases of hypertension that are more difficult to diagnose, hard to control, or involve organ complications. Patients are evaluated to identify residual risks, and the public develops the impression that specialist doctors are "better". In the example of hyperaldosteronism, is the specialist over-servicing? From a third-party payer perspective, the cost-benefit calculation may not be favourable. However, like most things in life, the perception of value lies with the recipient.

Unprofessional not to offer all options

Insurance companies cannot influence professional medical care because they can only stipulate what a covered benefit is or isn't. A patient is provided the same professional service whether they are on a lower tier insurance plan, government subsidies, or an "as charged" medical insurance plan. The recommendations are the same, but priority of access is determined by the covered benefits. Actual access is a patient choice, as they have to assent to the test, treatment, co-pays, deductibles or non-reimbursable items.

Competing medical insurance plans set out to attract participants by offering seemingly unlimited benefits including "as charged" plans. In the absence of negotiations with doctors on standard formulary, stipulated benefits and pre-approvals, beneficiaries will be indignant if you curtail coverage. Most doctors already work with constraints like patient health literacy, financial concerns and social support, among others. Working within formulary and standard tests are routine in most hospitals. Ultimately, the most important pre-approval comes from the patient. In professional medical practice, all reasonable options have to be discussed, including expensive ones.

Insurance companies and government funders that bemoan "over-servicing" misunderstand professional medical practice. The reality is that you pay for what you get, but the law of net marginal benefit applies. Most benefits for the majority of patients are already obtained through primary care management. Specialty care can reduce residual risk and define other diagnoses. The higher costs are often due to treating complications of hypertension. The patient-public sees the benefits of specialist care but cannot see economic value, and yet wish for the same level of service resulting in the politicisation of medicine not only here in Singapore but all over the world.

To contain public expenditure on medical costs would be to limit access to specialty treatment of late complications and focus the majority proportion of public and private health expenditure on primary care. Late complications are inevitable for lifestyle-related non-communicable diseases that come with ageing. To guide the patient-public on cost-effective care by not over-consuming, the Government and insurance companies should work with the professional specialty societies to establish standard access at different tiers of service for patients at different age groups for the most common conditions, particularly chronic diseases. This will define costs and help with complex decision-making for patients with advanced complications beyond the average age of life expectancy. ◆

For the original article, please visit https://bit.ly/32DMp8F.

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