SMA Practice Management Seminar

By Dr Tan Hooi Hwa

The SMA seminar held on Sunday 9 September 2001 attracted a turnout of 94 doctors. It was chaired by Dr Prem Kumar Nair, General Manager of Raffles Medical Group. The panelists consisted of:

1. A/Prof Goh Lee Gan, Dept of Community, Occupational & Family Medicine, NUS
2. Dr Chin Koy Nam, Director of Integrated Health Plans Pte Ltd (HMI Balestier)
3. Dr Edward Wong Ted Min, General Practitioner in private practice
4. Dr Henry Chia, Director, Human Resources, Changi International Airport Services
5. Dr T Thirumoorthy, Consultant Dermatologist in private practice

A/Prof Goh referred to J K Iglehart's (NEJM, 1994) definition of Managed Care as "a variety of methods of financing and organising the delivery of comprehensive healthcare in which an attempt is used to control costs by controlling the provision of services."

EVOLUTION IN THE USA

In the 1940s, the group or staff model Health Maintenance Organisations (HMOs) were socially motivated to provide affordable care for the immigrants.

However, owing to increasing cost in the 1960s and 70s, pre-payment became an alternative to the fee-for-service system, and in the 80s, insurers were permitted to have contracts with selected providers or Preferred Provider Organisations (PPOs).

In the 90s, broader networks of preferred providers, development of point of service plans for providers not in the network, and multi-tiered plans for different co-payment levels for different options of provider access were introduced. This was in response to patients' complaints about the restricted choice of health providers.

Enrolment in Managed Care plans grew because it cost less than fee-for-service care. Also, Managed Care

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organisations had healthier enrollees. This 'risk selection' increased their cost advantage.

However, patients perceive some Managed Care services as emphasising cost control over quality (Dudley & Luft, NEMJ 2001), the fact being that 70% of HMOs were investor-owned, profit being the most important goal (Circulation 1999, Favaloro).

MANAGED CARE IN SINGAPORE

In Singapore, Managed Care is evolving from a corporate fee-for-service system to an agent system, and HMOs with fee caps.

In the corporate fee-for-service system, the company negotiated with primary providers for fixed consultation fees, which might be very low, as cost control was a priority. Doctors made up for this through inflated drug fees, and were alleged to be profiteering from high volume, low quality care. This eroded the image of the GP.

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In the agent system, the Managed Care Organisation (MCO) collected capitation fees from the employer, and paid its assigned doctors a fee-for-service. It gave the employer some cost control for outpatient care.

In the HMO system, the MCO collected a pre-paid capitation fee from employer or individual, and paid a capitation fee to the provider. Services provided were defined to the enrollees. Since 1999, there have been additional payments for expensive medicines as "one-off", chronic long term medication, and "top-up" for popular doctors to make up 50% of deficits per head below $27 per visit. There is only one true HMO in Singapore, ie. NTUC MHS, which is a not-for-profit HMO.

The HMO provided savings on medical expenditure by narrowing the variation of services for a given condition with similar severity, standardisation of fees for a given procedure, and transparency where treatment and hospitalisation could be scrutinised. The company also saved time from preparing its annual health budget, and collation of expenses. However, some patients and doctors were unhappy with some exclusions, while the MCO was unhappy with some providers for excessive and routine use of more expensive medicines.

Fee cap systems with some cost adjustment might be the most acceptable model eg. $18 for usual consultation and medicine, $26 when more medicine was needed, and $35 for chronic conditions, with 2 weeks of medicine.

The average medical cost per employee for the period 1991 to 1995 was $450 per head per year. A/Prof Goh commented that providers and the medical profession (ie. SMA) need to work on voluntary cost control to dampen the desire for external control, ensure cost control was balanced with quality care, and keep a lookout for unscrupulous for-profit HMOs.

A CASE STUDY

A hypothetical HMO overspent by 25% of the premiums collected for no-frills corporate healthcare and individual plans. It charged $250 per head, and allowed the promoting staff to give a variable discount. Corporate Human Resource (HRs) were told that the premium payable would depend on their usage.

The points of contention by the HMO were that:

1. *Individual plans were claiming a lot for hospital expenditure.*
2. *Doctors were including claims for non-staple medicines, eg. evening primrose oil, where effectiveness was not well proven.*

Doctors complained that they were not given sufficient professional autonomy to prescribe drugs that they wanted, and there was delayed payment of claims.

Patients complained that their doctors reduced the amount and type of prescribed drugs.

Both Dr Chin and Dr Wong agreed that the premium charged was too low. The former felt that the price must be right both for the company and the doctor. But the balance was difficult as there was a lack of data in Singapore on the demography of company employees and health profile viz pattern of illness and nature of visits. Also there must be more transparency regarding what the company and union wanted for the employees.

In the integrated health plan scheme, doctors had autonomy in medicine use, with a drug range and total cost. Approval was needed in excess of a certain amount, or the type of variety. Rogue doctors were interviewed, and removed if the explanation was found unsatisfactory.

Dr Chin also said that the profit element for the HMO had to be there, as administrative cost had to be considered.

Dr Wong felt that the hypothetical scheme was unrealistic to cover both hospitalisation and primary healthcare charges. The premium was unrealistic and GPs were referring to specialists as a 'cost shift', when doctors were paid low and medications were not adequately reimbursed, while the range was limited. Hence, the role of GP as a gatekeeper for onward referrals was not fully utilised.

The dilemma for the doctor was that if he did not join, he would lose out to a corporation with the financial and manpower backing to do the marketing and advertising. However, joining would mean:

1. Consultation costs below SMA guidelines, resulting in a reluctance to spend more time with the patient for less pay.
2. Increased paperwork.
3. Loss of doctor-patient confidentiality due to terms of contracts in the MHC's appointment of the private doctor.
4. Infrequent updating of reimbursement for drugs despite frequent cost adjustment.

Recommendations were put forward to improve the system with more transparency, ie. code of conduct, practice and charges, a system of remuneration commensurate with standard of medical care, and possibly a government subsidy to help MHCs provide a good standard of healthcare thereby relieving the workload on the government polyclinics.

From the company's perspective, Mr Chia noted that the premium or professional fee in MHCs would increase, and there was a need to have a proactive role in the MHC to maintain or possibly lower costs.

HRs would like MHCs to monitor the pattern of visit and trend of illness, be a gatekeeper for referral to specialists, offer counselling and report malingerers, educate employees to be healthy, and help to keep costs down. The company on its part would give incentives for the staff to keep healthy.

In response to a question from the floor, Mr Chia noted that the fee-for-service cost more than the MHC scheme. Also, there was a long term cost risk with ageing workers, and the company preferred to pass the risk to MHOs.

On the issue of MCs, there was a minority who abused MCs, resulting in cost replacement of worker hours. MCs from TCM practitioners are not presently recognised.

TAKE HOME MESSAGES

After a lively Q & A Session, Dr Thirumoorthy summed up the main points brought up at the seminar.

- The old days of fee-for-service is presently challenged by a demand for cost control through integrated care. The question was whether this would affect quality of care.
- Patients, doctors, unions, HRs, and MHCs must jointly discuss and feedback on the systems employed. Presently there is lack of data on all levels, including profiles of patients and data on who abused the system.
- Doctors and patients must be smart enough to check if the MHC lived up to its promises, and patients must be informed early of the exclusion of conditions. Drug lists must be adequate under the MHC, and costs must be transparent.
- Doctors in a group were better able to deliver higher end quality care and therefore more value-added service.

Finally, in recognition of the fact that Managed Care was here to stay, participants proposed an SMA standing Committee on Managed Care to unite doctors and provide professional guidelines. "Our best allies are our patients." ■