

Managed Care in Singapore

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Editorial note:

The following article is an edited version of an earlier posting in the online SMA Discussion Forum, in response to a lively discussion on Managed Care in Singapore.

ORIGINS

In the early nineties, concerns about rising healthcare costs led to the setting up of managed care schemes, of which the NTUC MHS was one of the first few. Over the years, we have seen a proliferation of schemes because of certain driving factors:

1. Some hospital groups realised the potential of such schemes to be a channel to higher-yield procedures.
2. The general practitioner (GP) groups were trying to increase market share and hold on to big corporate customers.
3. The insurance companies wanted to provide better service as they were mainly doing the highly profitable inpatient schemes. This resulted in intense competition among insurance companies for these lucrative contracts. In order to hold on to their customers, they started to provide both outpatient and inpatient schemes. As the inpatient schemes were lucrative, the outpatient schemes were cross-subsidised to compete.
4. Commercial outfits that were not involved in healthcare came into the picture to try to capitalise on the situation, thinking that there was money to be made off ownership of patient pools and cash flow.

MECHANICS OF MANAGED CARE

The cost of running a managed healthcare scheme is quite hefty, and it depends on whether it is done manually, semi-automated with a fax interface, or via an IT system connected directly to the GP via the internet.

Manual systems involve lots of paperwork generated from the GP and data entry at the back end of the scheme managers. The bulk of the work arises mainly from verification of patient data, such as similar names and whether the patient is still covered by the scheme at the time of the consult. This is hardly surprising in high turnover labour situations.

The back end depends heavily on data entry and the estimated cost of doing all these is approximately S\$4 to S\$5 per visit. This cost includes salaries of clerks, marketing staff and data entry personnel. Another problem with manual schemes is that they are not scaleable. As the number of enrollees grows, costs keep rising because of the correspondingly higher volumes of paperwork.

Automated systems are obviously better because of the ability to scale up. However, initial investments can start from half a million dollars upwards for an internet browser based IT system. There are currently three players with such a system: MHC Health Care, Ezyhealth and IHP. One way out

for the existing players who are not willing to pay for the infrastructure is to enter into an arrangement with any of the three infrastructure providers to ride on their systems, with their own branding, e.g. AXA scheme is administered by MHC Healthcare.

FINER POINTS OF THE MECHANICS

Most of the schemes are fee-for-service with caps on consultations and procedures. Some schemes depend on complex formulas where they collect premiums from insurance companies and pay the drug costs from the pool first. They then pay the consultations from the remainder pool on a pro rata per visit basis.

NTUC uses an innovative scheme where a capitation is paid to the doctor for each patient, regardless of whether the patient shows up at the practice, and leaves it the doctor to allocate resources. The capitation paid for a large number of patients can be quite substantial.

Drug costs are decided by either a fixed drug list or an exclusion list, e.g. vitamins. The prices paid by the MCO (Managed Care Organisation) for the drugs used depend on the agreement with the healthcare provider. These arrangements vary from pegging it to DIMS pricing, or prices that the providers claim for, or prices that the MCOs dictate.

PROBLEMS

There are an average of 150 to 300 GPs involved in most of the schemes. The client companies will find the coverage adequate while the schemes will start to have problems for both MCOs and their providers the GPs if the network gets larger. The usual disputes are the tensions between employers and GPs over medical leave, drug costs, complaints by patients and referrals to specialists.

With the complex schemes, there may be some difficulties with excessive claims for medications that skew the pooled premiums, thus resulting in low consultation rates. That is, the "first bite of the cherry" has been distorted by excessive medication claims.

The NTUC scheme is also "problematic" when the pool of GPs is too large, resulting in small pools of patients registered with each GP. Again, it has been estimated that the scheme will work well if there are ideally about 100 patients for each GP.

Therefore restricting access to these schemes becomes a problem, especially for newer GPs.

The other problems include low consultation rates set by these managed care players in order to build market share. These objectives are compounded by the GPs who are willing to accept such low rates. In the long term, these low rates might lead to under-servicing and a host of other problems.

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Despite setting such low rates for consultations, the reality is that these managed healthcare players may be marking up the fees they charge the corporate clients. The general view is that there is **no transparency** on how the managed healthcare players conduct their business.

WHAT CAN THE SMA DO?

The reality is that the SMA cannot be involved in running such a scheme as some members have suggested in the online SMA forum discussions. The financial risk is huge especially with regards to infrastructure, and riding on the infrastructure of one of the three players would raise

conflict of interests issues. We certainly cannot administer a scheme involving all of our GP members.

What we can do is to conduct surveys and analyse the returns, and then rank the various managed health schemes right down to consultation fees, drug reimbursements, payment terms, transparency, transaction interfaces, restriction of professional practice and the financial viability of the managed healthcare providers. These rankings could be published and updated regularly. We are also analysing the results of the managed healthcare survey circulated earlier this year, the first report of which is published in this issue of the SMA News. ■