Compulsory Medical Insurance: Can it Fix the Roof?

By Dr Jeremy Lim, Editorial Board Member

"It is our protection,
our roof against a heavy
but infrequent thunderstorm...
our roof is now leaking,
with some holes."
- Mr Khaw Boon Wan, Minister for Health, 17 August 2004

THE PROBLEM...

"If a patient is unlucky, requires an intensive treatment in a Class C ward and ends up with a bill of S$20,000, he would be disappointed to find out that his Medishield policy today only pays about 40% of his bill. He will still have to pay about 60% of the bill. Very few Medisave accounts have a balance of S$12,000 to settle such a bill."

Minister Khaw puts it aptly: Catastrophic illness will be financially crippling under the existing Medishield scheme. Is there an alternative? The avenues are essentially three-fold: Medisave, out-of-pocket payment and Medishield, or other insurance coverage.

Medisave accounts can contain a maximum of S$30,000 which should be adequate for the majority of catastrophic illnesses, but 17% of Central Provident Fund (CPF) members have Medisave accounts with less than S$1,000. Clearly, this will not be enough. Dipping into savings is also unrealistic. How many of us will be able to afford a bill of S$12,000 at short notice? This thus leaves only one tenable option: insurance.

HOW DOES INSURANCE WORK?

Insurance pools the risk of catastrophic illness by spreading costs. The theory is simple: both healthy and not-so-healthy people subscribe and monies not utilised by the healthy are used to pay for the treatment of the ill. The assumption is that the majority of people are healthy and will not need to tap the insurance fund. Hence, there will be sufficient funds for the ill. Two concepts are essential to understand fully the implications of insurance: adverse selection and moral hazard.

Adverse selection, or what Minister Khaw terms "cherry-picking", occurs when insurers choose only the "good risk" individuals and exclude the "high risk" ones. The resultant scenario is where the insurer of last choice, usually the government, is left with a population prone to disease and hence higher premiums. Alternatively, "high risk" individuals are left without insurance. In both instances, the private insurers laugh all the way to the bank while the government is left to carry the baby because of its obligation to provide healthcare to all its citizens.

The "buffet syndrome" or **moral hazard** as it is more typically termed, results when individuals over-consume healthcare resources because they are covered by insurance and a third party is paying the bill. This is easily resolved by imposing co-payments or deductibles so that healthcare usage is considered more seriously by the patient. However, the quantum of deductibles must be handled sensitively so that they do not deter the poor from seeking healthcare even when it is appropriate.

FIXING THE ROOF: CAN MEDISHIELD LIVE UP TO EXPECTATIONS?

The Minister has expressed his intention to fix the leaking roof and return Medishield to its "original purpose of only looking after the large hospital bills and do so adequately." The writing is already on the wall that both premiums and deductibles will be raised. Insurers may also be compelled to

Page 11 ►

About the author:
Dr Jeremy Lim, MBBS (1997), MRCS (2002), MPH (2003) is a recent Fulbright / Shaw Foundation scholar who obtained a Masters in Public Health at the Johns Hopkins University. Dr Lim can be contacted at his email: jeremyfylim@yahoo.com.sg

◄ *Page 10 – Compulsory Medical Insurance*

accept all participants in their insurance schemes and hence minimise "cherry-picking". Can it work?

Raising Premiums and Deductibles

This is a foregone conclusion. S$12 a year for those under 30 years of age is a ridiculously low amount to pay. Even factoring in age, the maximum yearly premium is only S$390 for those aged 79 to 80 years. Premiums have to go up. But how about slightly higher premiums for the young and maintenance of these premiums even into old age? Or even paying only during economically active times and enjoying coverage thereafter? This pre-funding would spread the burden over time and is especially important given that disposable income will typically plummet upon retirement. Assuming a person signs up for Medishield at age 16 and stays in the scheme until 80, the total amount of premiums based on current rates is S$5292. Spread over 20 economically productive years, this would only work out to S$265 annually. Even given a rise in premiums by 20%, this would amount to S$318 yearly for 20 years.

Compulsory Insurance

"To minimise administrative costs, a compulsory national scheme is best. It ensures full coverage with the lowest premiums. It ensures maximum equity and efficiency."

The theoretical benefits of a compulsory scheme are clear: minimal administrative overheads and access to all. The reality is not so straightforward. Let me explain.

If Medishield is compulsory, either the insured or the insurers will be unhappy in the ensuing scenarios. In the first scenario, the insurer demonstrates healthy returns and public outcry is strident with charges of excessively high premiums and profiteering. The healthy will then insist on opting out. If the scheme haemorrhages, no insurer will stay in the market for long without raising premiums or increasing deductibles, both of which will be politically very unpopular since the public have no choice but to pay the increased sums.

There will thus be a recurring problem of finding a very fine balance between financial viability of Medishield and treading the political minefield of premium adjustment. Still, healthcare will always be emotive and compulsory insurance may be the most equitable and financially sustainable of all schemes. The public will need to be educated that compulsory insurance is a necessary evil for the good of society. Structuring Medishield under the umbrella of a not-for-profit may make it more politically acceptable to defuse charges of profiteering.

WHAT ELSE CAN BE CONSIDERED?

Preventive Health

We should perhaps look proximally into preventing catastrophic illnesses or at least mitigating their impact. Countries such as Germany and Australia offer wide, publicly funded health coverage, and this includes access to preventive health. Should we do likewise? Since Medishield is structured to provide only medical coverage, it would appear prudent then to encourage the public to attend health screening regularly. There is very strong evidence that preventive health measures such as screening not only minimise the impact of disease by early detection and early intervention, but are also cost-effective. For example, a Dukes' A colonic tumour is treated by resection alone but progression to a Dukes' B will necessitate adjuvant therapy in addition, increasing costs and reducing life expectancy and quality of life. Incentives for appropriate healthy behaviour, such as regular exercise, sensible eating and not smoking, should also be considered. The existing stratification of risk based on simply age, smoking and pre-existing illnesses may not be sensitive enough to encourage healthy living. Perhaps, there should be cash returns for achieving blood cholesterol targets, or lowering premiums for passing the IPPT (Individual Physical Proficiency Test)?

Removal of the Age Limit

Medishield has a maximum covered age of 80 years. This would be counter-intuitive if the intention is to ensure that healthcare needs are met. The last two years of life are where the majority of healthcare is consumed, and with life expectancy rising every year, it would be difficult to assure the public that Medishield will be adequate. Most private insurance schemes only permit coverage if purchased while still young and reasonably healthy, and it would require a Herculean effort to persuade the public to buy into Medishield rather than private insurance if Medishield coverage expires at the most crucial times.

Compulsory health insurance is necessary to ensure population healthcare coverage and Medishield is the best vehicle to spearhead this. Nonetheless, there are formidable obstacles ahead. Backseat passengers are potentially hazardous and there are certain potholes in the road ahead that we should be wary of. But at least the way forward is clear and with able drivers, there is every reassurance that Singapore will reach its destination of "the world's most cost-effective healthcare system". ■

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