"Let's Face It: We Are Mortals"

Speech by Mr Khaw Boon Wan, Minister for Health at the Opening Ceremony of the Southeast Asia Health Insurance Conference 1 August 2007, Wednesday, 9am, Raffles City Convention Centre

Last week, *The Straits Times* carried a thoughtful article by Prof Muriel Gillick of Harvard Medical School, titled "Major surgery for a 97-year-old?" (*The Straits Times*, 27 July 2007). She wrote about Dr Michael DeBakey, a famous cardiac surgeon, undergoing a cardiac surgery using a technique which the doctor invented many years ago. What made the surgery news worthy was that Dr DeBakey was now 97-year-old and the surgery was against his express wishes. He had stated while in good health that he would not want to undergo major surgery.

WE ARE MORTALS

However, Mrs DeBakey demanded that the surgery be done and it was duly carried out. The operation involved putting him on cardiac bypass and opening the aorta. The damaged part of the aorta was then replaced with a synthetic graft. The risks were high. Moreover, surviving the surgery does not mean returning to one's usual state of health. It typically means an extended hospitalisation marked by multiple complications and considerable suffering. Dr DeBakey spent three months in hospital, much of the time unable to speak or eat. He was hooked to a respirator and to another machine to clear wastes from his body, and was fed through a stomach tube. The cost of the hospital stay exceeded US$1 million.

The number of potentially life-prolonging technologies offered by modern medicine is proliferating. Some of these therapies have brought benefits to patients. But where the treatment is invasive and costly, has a miniscule chance of success and is proposed for people at the very end of life, Prof Gillick asked if we should not limit such treatment and concentrate instead on improving these older people's quality of life. By this, she meant "assuring compassionate nursing home care, coordinated management of chronic diseases and competent palliative care as death approaches, rather than using ever more technology to try to eke out a little more life".

In short, Prof Gillick reminded us to accept human mortality. We are all mortals, so let's accept it. I noted that she has also authored a book, titled *The Denial of Ageing: Perpetual Youth, Eternal Life, and Other Dangerous Fantasies.*

POSTPONING DEATH

Prof Gillick's article has highlighted one reason why healthcare has now become such an intractable problem. When medical science was less developed, ageing, sickness and death were readily accepted as facts of life. But with progress in medical science, people often forget that we are mortals after all and there are limits to medical science, with eternal life as mere fantasy.

The US healthcare system now consumes 16% of the country's GDP. A big part of that expenditure goes to sophisticated high-tech hospitals trying to postpone death by a few days or weeks, often with little or no quality of life to the patients. The problem is that there is no natural

Page 10 ▶

◀ Page 9 – "Let's Face It: We Are Mortals"

limit to such pursuit, and so some US economists have already projected their healthcare spending to go beyond 20% of their GDP.

In the upcoming US Presidential Elections, all candidates are calling for healthcare reforms as the status quo is not sustainable. They know that healthcare is not immune to the law of economics, and unlimited demand has to be rationed. But nobody dares to talk about getting the economics of healthcare right. Instead, the tendency is to continue to feed the fantasies, and somehow hope that the future will take care of itself.

PROTECTING SELF-INTERESTS

Part of the problem is that many interest groups and lobbies will be hurt by any serious reform. Under their current operating models, hospitals and specialists are rewarded for high-tech interventions. Costs are high but Medicare pays the bills for the elderly, and Medicaid, for the poor. For the employees, their insurance, paid for by their employers, will pick up the tab.

As patients do not have to pay, most have little interest to find out what goes into hospital bills or whether the services rendered are necessary. Some weeks ago, there was a media article on one American patient who took the trouble to understand his bill and was shocked to find it exceeding US$1 million for a treatment which was not particularly complex. When he called up his insurer to question the details, he was shocked a second time to find the insurer not particularly worked up by the seemingly ridiculous over-servicing and over-pricing.

In other economic sectors, we do not find such unusual consumer behaviour. We ask and shop around before we decide which mobile phone to buy. We yell if we are overcharged for food, or services. Yet somehow, healthcare consumers behave differently. Why?

"SOMEONE ELSE IS PAYING MY BILL"

Third-payer payment systems are at the root of this market failure. When a buyer does not have to pay the bill, he has no incentive to seek out the most efficient and cost-effective seller. Instead, he goes to the seller who can most meet his demand. When a seller is paid by a third party and not directly by the buyer, he is less inclined to try to save money for the buyer. For example, he would not bother to offer a lower cost but similarly effective treatment for the patient. After all, somebody else is paying.

Whether the third-party payer is an insurer or a government, the distorted outcome and the damage to the system are the same. Singapore is not sheltered from such human behaviour.

Recently, our hospital reported a case of a patient whose doctor prescribed two years' supply of a health supplement. The patient demanded such a prescription, knowing that the bill will be fully paid by his employer. The doctor, pressured by the patient and others waiting to be treated, went along. A conscientious pharmacist called the doctor to double-check the prescription, which was then amended. The patient left the pharmacy angry! While good service means satisfying the customer, it takes courage to say no to a customer who is out to abuse the system for his self-interest. I commend the hospital pharmacist. We must say no to such irresponsible behaviour.

NOT MINDLESSLY COPYING OTHERS

That is why we decided that Singapore's healthcare financing system cannot simply follow the US insurance model, or the UK taxation model, or any other model.

Instead, we carefully incorporate the best elements from each model, and evolve one that would best serve the interests of Singapore.

Firstly, we incorporate the UK taxation model as a first tier of healthcare financing. Our public hospitals and polyclinics provide heavily-subsidised treatment. The subsidies also extend to intermediate and long-term care, in community hospitals, hospices, nursing homes and day rehabilitation centres, where we require means-testing so that subsidies go to those who need them most.

Secondly, we also incorporate the US insurance system of risk-pooling. We help organise financial protection for patients requiring major medical treatment through MediShield and those with severe disability requiring long term nursing care through ElderShield. While these insurance products are private-sector driven, the government plays a key role to protect the national risk pool to the largest possible extent, thus keeping premiums at the most competitive level.

Thirdly, we strongly emphasise the need for personal responsibility and actively implement this through policy. We require our subsidised patients to co-pay a meaningful proportion of their medical bills. Co-payment helps to re-establish the primary relationship between buyer and seller, so critical in ensuring the proper

Page 11 ▶

◄ Page 10 – "Let's Face It: We Are Mortals"

functioning of any market. But knowing that co-payment can sometimes be a burden, we instituted Medisave, a compulsory health saving account, for all economically-active Singaporeans.

Finally, we provide a means-tested social safety net in the form of Medifund, through which the government provides financial help to the needy. This way, no patient is left in dire straits after medical treatment.

In simple terms: pay cash for small bills, use Medisave for medium-sized bills, insurance and Medifund for large bills. This is how we manage our healthcare expenditure and we think it is the most sensible way to go.

MANAGING MORAL HAZARD

As this is a conference on health insurance, let me share our thoughts on this important subject.

Firstly, unlike others, we discourage comprehensive first-dollar coverage insurance for Singaporeans. For MediShield, we insist on a deductible and a co-payment. Our MediShield coverage only kicks in for large hospital bills. Setting a reasonable deductible reduces premiums considerably, and keeps the product affordable for the vast majority of the population. Co-payment reduces the moral hazard that risk-pooling creates. Without deductibles and co-payment, there will be a tendency for patients to unnecessarily and indiscriminately consume, or what we call the "buffet syndrome". It is human nature to want a lot but pay as little as possible – that is why we over-eat at buffets. This buffet syndrome ultimately hurts the patients as insurers need to balance their accounts. When payouts grow rapidly because of over-consumption, insurers will have to raise premiums to keep pace with the payouts, or face financial insolvency.

Secondly, we safeguard market competition so that insurers have full play in competing to provide innovative products that meet the diverse needs of the people. The needs of four million people in Singapore vary over a wide range, as does their ability and willingness to spend. But while we encourage an active insurance market, we consciously ensure that the national risk pool is not fragmented through adverse selection.

For MediShield, the Government operates a basic product, and requires all participating insurers to operate compatible rider products on top of this basic layer. The insurers compete aggressively for customers on their riders to provide additional coverage. There are today more than 20 MediShield riders, allowing Singaporeans a wide choice.

MediShield and MediShield riders now cover more than three-quarters of Singaporeans. Our next priority is to get other Singaporeans not yet insured to purchase coverage early, before they develop pre-existing illnesses. A large proportion of those uninsured are children. A common reason for staying uninsured is inertia. We will get people to overcome their inertia and get insured in a hassle free way. We should be able to get those newborns from this December onwards automatically covered by MediShield. In parallel, we are working with the Education Ministry to extend coverage to students.

For ElderShield, we require the insurers to provide the same basic ElderShield product, on top of which they market their ElderShield Supplements for additional coverage. I am pleased to report that Great Eastern Life will shortly be marketing two approved ElderShield Supplements, allowing policyholders who pay more to top up their basic ElderShield with higher payouts. One Supplement will provide monthly payouts of up to $3,000 for 10 years, in the event of severe disability. I am sure that NTUC Income and Aviva will finalise their Supplements soon.

VALUE-ADDED INNOVATIONS

Our healthcare financing policies have helped us to achieve good results so far, but imminent ageing of the population will present new challenges. We must continue to anticipate problems, adapt, and stay ahead.

Besides demographics, we also have to adapt to societal changes. Better educated consumers have higher expectations of their healthcare providers and their insurers. This is a plus. Better informed and better engaged consumers will make better informed choices and be more pro-active in maintaining their health and managing their chronic diseases. Our job as the Ministry is to collect and publish timely and relevant information on health products, services and pricing.

In Singapore, some hospitals publish data on clinical outcomes on their websites. The Ministry of Health also publishes data on hospital bill sizes.

Singaporeans welcome this transparency and want more. We urge insurers to take this cue and do the same – publish to demonstrate your competitiveness. With greater competition,

Page 12 ►

◀ *Page 11 – "Let's Face It: We Are Mortals"*

consumers will seek better services. For example, there have been recent comments by ST readers on how patient admissions to hospitals could be facilitated if their insurers could make prior arrangements with the hospitals to waive hospital cash deposits. I support the call by the policyholders. Singapore has only a few hospitals and it should not be too difficult to make such prior administrative arrangements. NTUC Income has done so with public hospitals. I encourage the other insurers to follow suit.

Another example of service improvement is in the rate of claims assessment. Insurers used to take between seven and 28 days to process a claim. After we published the data, they reviewed their processes and were able to cut it down to only one to two days to process a claim. This has benefited the policyholders.

But more can be done, especially in two areas. Firstly, give your policyholders the incentive to stay healthy and prevent existing illnesses from worsening. This is a good way for insurers to add value to their policyholders and to society at large. This is a trend overseas where there are insurance plans that provide no-claims bonus, premium discounts for non-smokers and discounted or complimentary health screenings.

Secondly, give doctors and hospitals the incentive to focus on the health outcomes of your policyholders. Try piloting pay-for-performance measures that reward doctors based on the health of the patients they care for, and not the number of procedures performed on patients. For example, when a diabetic patient visits a doctor, the doctor bills the buyer for checking the patient's feet and eyes. But the doctor is today not paid for ensuring that the patient controls his diet and exercises regularly, which may really be the most important thing to do.

I am sure our insurers too can come up with such innovations and more.

CONCLUSION

This conference brings together insurance practitioners and actuarial professionals from many countries. It is a good platform for ideas and experiences, and to learn from one another. I wish all an enriching and stimulating conference.

Thank you. ■