By Dr Wong Chiang Yin, SMA President

Who Shall Use B1 Beds (and the Private SOCs)?

There is a classic health economics text written by leading American economist Victor R Fuchs titled *Who Shall Live? Health, Economics and Social Choice.* The book deals with the importance of choices in a world with limited resources. Implicit in the title "Who Shall Live" is the provocative and sobering question of "Who shall die?", because in a world where we decide who shall live, there will be those who we have to unfortunately, deliberately let nature take its course.

Means-testing is also decision-making under resource constraints. The questions are similar: who shall pay more and who shall pay less. For the record, the SMA supports mean-testing in-principle because it prevents the moral hazard of the rich unnecessarily using up limited subsidies. In the long term, means-testing gives us some assurance that access to healthcare remains universal without compromising healthcare quality.

On 3 March 2008, the Minister for Health announced details of the impending means-testing. Those who earn $3,200 a month and below will continue to receive the same subsidies as before and only those who earn $5,201 or more will receive the least possible subsidies for B2 and C. Those who earn between $3,201 and $5,200 will receive less subsidies on a graduated scale.

I have to admit that these criteria are a little more generous than I expected. Going by recent data on household and personal income, I think about 60% to two-thirds of Singaporeans earn less than $3,200 a month and hence will not be adversely affected by means-testing. Those earning more than $5,200 a month probably make up the top 15% to 20% of earners in Singapore.

I did a little survey on my part. I questioned three colleagues aged between 40 to 60 years old whom I think earn between $5,000 and $6,000 a month. One can guess with some accuracy how much a person earns in a public hospital because salary scales are no secret.

I asked: "Would you choose B1 or pay the highest rates for B2 (50% subsidy) if you need a hospitalisation that would last between four to six days (note: the average length of stay of public hospitals is 5.3 days[1])?"

All three of them replied: "B2."

"Why not B1?"

One of them said: "I can probably afford a five-day hospital stay with Medisave and Medishield but what about the SOC (Specialist Outpatient Clinic) follow-up? I get 50% subsidy in the subsidised SOCs if I choose B2 while I pay the full-price in the private SOCs when I choose B1. It's the SOC follow-ups that I can't afford, especially if I may well be followed up for life."

Another said: "Even if I pay the highest possible price for B2, I pay only half price and I receive 50% subsidy. With B1, I receive only 20% subsidy. If a bill costs $8,000 at B1, I pay only $5,000 at B2. That is still a difference of $3,000, no small potatoes."

To be fair, my miserably small sample of three is not representative of the general population because these three are well-informed people who work in public hospitals.

The recent and ongoing enhancements to Medisave, Medishield and enhanced Medishield insurance products will make B1 more affordable. But we still need to ask if B1 is affordable to the upper-middle class of Singaporeans, especially

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when we take into account that these patients will usually end up as private patients in the private Specialist Outpatient Clinics.

MOH bill size data for hip replacement surgery and stroke are illustrative[2]:

Table 1: Hip Replacement Surgery

	50th Percentile
SGH B2	$4,096
SGH B1	$13,744
Difference	+$9,648
Difference (%)	+235%

Table 2: Stroke

	50th Percentile
TTSH B2	$870
TTSH B1	$1,964
Difference	+$1,094
Difference (%)	+125%
NUH B2	$1,105
NUH B1	$2,303
Difference	+$1,198
Difference (%)	+108%

The differences in bill sizes are quite large for B2 and B1 bills because the difference between B1 and B2 subsidy rates is large: a gap of 45% (B2 subsidy rate: 65%; B1 subsidy rate: 20%). The differences will diminish by about a third (gap shrinks from 45% to 30%) for those earning more than $5,200, but this may not be enough to shift consumption patterns for these people (the upper-middle class).

The answer is obviously NOT to make B2 even more expensive for these folks (that is, decrease the subsidy rate of 50% further), but to increase the attractiveness of B1 services, and to address the issue of these patients paying full SOC rates.

This is because the top 15% to 20% (that is, roughly those earning more than $5,200) has to pay 75% more for C class and 42.8% more for B2 class when compared to the current subsidy rates. For example, if a C class bill is $1,000 for the poor, the top 15% to 20% earners will have to pay $1,750, an additional amount of $750. Or, if the B2 class bill is $1,750 for the lower 60%, the top 15% to 20% has to pay $2,500, a difference of $750. Had the same person chosen B1, he would pay $4,000, that is, $1,500 more than the B2 rate, even with diminished subsidy rates, assuming that the unsubsidised cost structure for B1 is the same as B2 and C (for discussion purposes, we have made a somewhat unrealistic assumption in this hypothetical case that the unsubsidised cost structure is the same for all bed classes: $5,000).

To sum up using the above example, assuming the same illness and length of stay, a 'rich' person in the top 15th to 20th percentile bracket is faced with the following options: C class – $1,750; B2 class – $2,500, B1 class – $4,000 and A class – $5,000. The figures for the poorer two-thirds of Singapore would be $1,000, $1,750, $4,000 and $5,000 respectively. Hospital charging is a complicated affair and this is a somewhat gross simplification, but the numbers should not be too far off.

If we are convinced that B1 is affordable to the top 15% to 20% of earners, then it would be indeed right to make them pay more for B2 and C class beds. Certainly those who earn five-figure salaries will have no problems affording B1 or even A rates. It is those who earn just more than the cut-off ($5,200), say those earning between $5,200 and $8,000 who we have to worry about. For example, can they afford years and years of paying private SOC rates for the treatment of chronic diseases (even if we assume they use Medisave and withdraw up to $300 a year for some diseases)? Of course, these folks could go for a downgrade years later when they are retired and less well-off. But not many would want to experience the anxiety and uncertainty of getting a downgrade later from the medical social worker when one can exercise one's choice now to use subsidised SOCs. There are few if any local insurance products that can help to pay for specialist outpatient services and a single encounter at a private SOC could easily set you back by hundreds of dollars when investigations and medications are also consumed.

It is good that we have settled the question of who shall pay more for B2 and C class beds. The next question we need to answer is who shall use B1 beds and the full-paying, private SOCs. After all, the two questions could well be talking about the same group of people. ■

References:

1. **Minister for Health Khaw Boon Wan. Speech delivered at Parliament on 3 March 2008.**

2. **MOH Hospital Bill Size. http://www.moh.gov.sg/mohcorp/billsize.aspx?id=302 Accessed 6 February 2008.**

Editor's note: The English translation of the last President's Forum in January is now available for viewing online at http://news.sma.org.sg/sma_newsmainpges/4001main.html