CMAAO 2018 – Singapore Medical Association

Path to Universal Health Coverage

Universal Health Coverage

1. Health is a human right
2. Many facets of universal health coverage
    1. adequate financing
    2. access to essential medicines
    3. governance on health systems
    4. sufficient health workforce
    5. monitoring health statistics
    6. delivering quality service and safety

Universal Health Coverage in Singapore

- Biggest change recently, Medishield Life [introduced Nov 2015]
  - Compulsory, cannot opt-out
  - No exclusion of pre-existing medical conditions
  - Inpatient daily claim limits, selected outpatient procedures
  - Maximum claim limit per policy year, but no lifetime limit or maximum coverage age
  - Deductible and co-insurance component
  - Exclusions for some procedures

Universal Health Coverage in Singapore [con't]

- Another new scheme, Careshield Life [to be launched in 2020]
  - Disability insurance scheme
    - Compulsory for those born in 1980 or later
    - Those born in 1979 or earlier, can choose to join CareShield Life in 2021, if they are not severely disabled
  - Eligible only if unable to perform 3 or more Activities of Daily Living (ADLs)
    - Washing
    - Dressing
    - Feeding
    - Toileting
    - Walking or moving around
    - Transferring
  - Fee for disability assessment, if claim is successful, insurer will reimburse full cost of assessment fee
  - For those eligible, they will receive regular cash payouts

Facet 1 - Financing details

- Medishield Life
  - Patients with serious pre-existing conditions need to pay additional premiums, set at 30% for a limited period of 10 years
  - After the 10-year period, they will pay the same standard premium as the rest in their age group
  - Some treatment items, procedures, conditions, activities and their related complications are not covered by MediShield Life [full list in link inside Reference slide on last page]
- Careshield Life
  - means-tested premium subsidies of up to 30%

Facet 2 - Access to medicines

- *“Subsidies and financial assistance are given for drugs approved under the Standard Drug List (SDL) and Medication Assistance Fund (MAF). Drugs approved under the SDL and MAF must be registered with the Health Sciences Authority (HSA) and assessed to be clinically- and cost-effective.*
- *MAF drugs are generally newer and more expensive, and therefore MAF applies only when these drugs are used for suitable clinical indications so that MAF drugs are appropriately used. In exceptional cases, MAF can also support HSA-registered drugs that are not on the SDL or MAF list, on a case-by-case basis.”*

Access to medicines [con’t]

- The Agency for Care Effectiveness, only formed recently, published first tranche of 11 drug guidances in May 2017
- 1st time the health ministry is making public the rationale behind the committee’s decisions on drug subsidies

Facet 3 - Health systems governance

- Government policies have been shifting regularly to accommodate changes to the healthcare landscape
  - Streamlining hospital groups into geographical zones [reducing from 6 to 3 hospital clusters]
  - Building more polyclinics to handle demand [polyclinic visits grow by 20% over recent 3 years]
  - Expanding existing Community Health Assist Scheme (CHAS) to all patients with chronic ailments, regardless of income [recently announced on 19 Aug 2018, details to be announced]
    - CHAS allows Singapore Citizens to receive subsidies for medical and dental care at participating private General Practitioners (GP) and dental clinics near their home

Facet 3 - Health systems governance [con’t]

- SMA has been actively providing feedback in this area, e.g.
  - patient privacy [specifically regarding electronic health records]
  - medical claims in advertising
  - regulatory compliance [ensuring regulations are fair for patients and doctors]
  - cost of health insurance [member of Health Insurance Task Force]
  - Telemedicine [highlighting concerns about efficacy of patient care]

Facet 4 - Health Workforce

- Major changes to medical training
  - Shift to Residency system
  - Increasing number of local medical students
  - Shift to encourage generalist training [as compared to specialist] to accommodate shifting population profile [aging population, chronic and multiple diseases]
- SMA has been actively in touch with the Ministry, to help push for a sustainable number of doctors to serve the population

Facet 5 - Health statistics

- Data helps in evidence-based decision-making
- Transparency of data remains opaque or difficult to measure
- Room for improvement, e.g.
  - data on whether patients are receiving adequate access to healthcare
  - data on whether patients are experiencing financial hardship due to insufficient subsidies, etc.

Facet 6 - Delivering Quality & Safety

- Some data in selected areas, e.g. readmissions, but often not published regularly
- Data published in 2014 in response to parliament question
  - “readmission rate for patients within 30 days after discharge from public hospitals was 11.7% in 2011 and 12.2% in both 2012 and 2013. In 2013, the readmission rate was 6.2% for KK Women’s and Children’s Hospital and the readmission rates for the other hospitals are similar and ranged from 13.4% at Singapore General Hospital and National University Hospital to 15.1% at Alexandra Hospital.”
- Many hospitals pursue accreditation standards, e.g. Joint Commission International (JCI), but recently a senior minister of state remarked that *“One unintended consequence of JCI is that it encourages healthcare institutions to “chase awards” in the name of quality improvement. ”*

Conclusion: The Path to Universal Health Coverage

- It’s a process and not a destination
- Many moving parts, many stakeholders
- Important for everyone to be on the same path, and to design policies to encourage everyone to move in the same direction

References

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