

Re-conceptualising value for sustainability in a rapidly ageing society

Dr Calvin Ho

Assistant Professor; Yong Loo Lin School of Medicine, National University of Singapore

Co-Head, World Health Organization Collaborating Centre in Bioethics

medhwlc@nus.edu.sg

Overview

- Concept of 'Value' for Sustainability must ultimately be about:
 - Patient Empowerment and Patient-Centred Care
 - Fairness among all stakeholders involved under the “Many Helping Hands” Approach
- Fairness as an Ethical Imperative
 - Secures legitimacy and cooperation
 - Encourages trustworthiness and builds trust
 - Ensures effectiveness and sustainability
- Be mindful of:
 - Global Policy Trends (with focus on Universal Health Coverage)
 - Challenges within Singapore and beyond
 - Core values (fairness, sustainability and empowerment)
- Sustainability will depend on **effective collaborative partnership** among key stakeholders, within which insurers must adopt a more proactive role in promotion health and financial wellbeing.

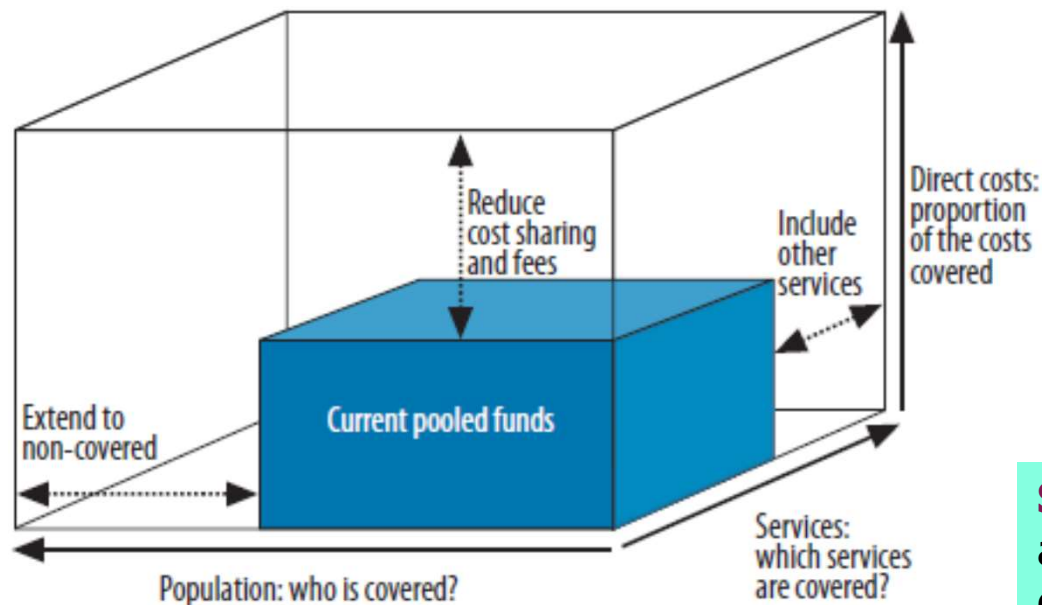
Universal Health Coverage

An initiative based on the 1948 constitution of the World Health Organization.

It aspires to ensure that health services are available to all people in need without undue financial hardship in paying for them.

Healthcare specific conditions that must be in place in order to achieve UHC include:

- **Acceptably functional** health system;
- **Affordability** of health services;
- **Access to essential medicines and technologies** for diagnosis and treatment; and
- **Sufficient, well-trained and motivated health workers** to meet healthcare needs based on the best available evidence.



Financial Protection:

Protect populations against impoverishment due to illnesses since most of health care is paid for out-of-pocket

Service Coverage: Define a set of essential health care services based on the priority health needs for each country

Population Coverage: Expand coverage to allow equal access for all persons

Trade-offs: Given resource constraints, each country has to prioritise between increasing share of population covered, enhancing the level of financial protection, or to expand the range of health services

Source: World Health Organization, *World Health Report* (2010)

An Approach – Fair & Progressive Realisation of UHC

- Categorise services (including medicines) into priority classes. Considerations include:
 - Cost-effectiveness
 - Priority to the worse-off
 - Financial risk protection
- First expand coverage for high-priority services to everyone
 - Eliminate OOP payments
 - Increase mandatory progressive prepayment with pooling of funds
- Ensure that disadvantaged groups are not left behind

Health system building blocks

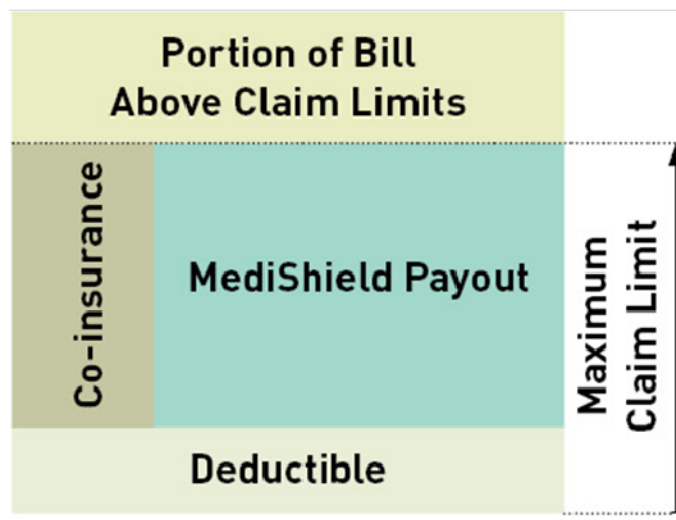
Action domains of UHC

Outcomes and impact

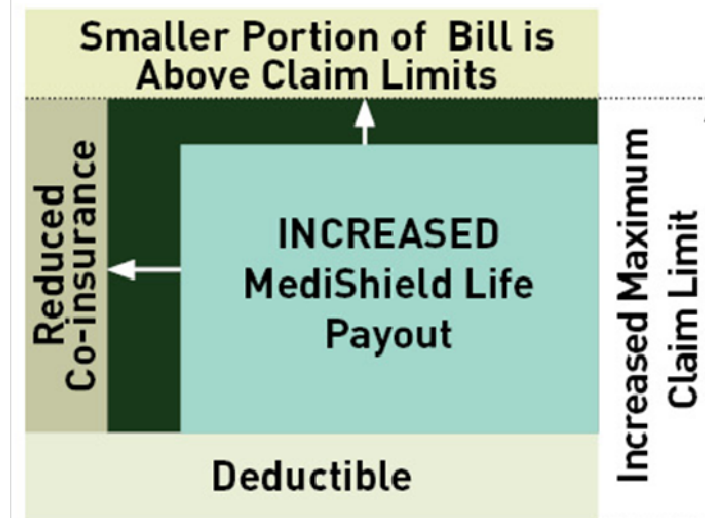


MediShield Life (from 2016)

MediShield Payout



MediShield Life Payout



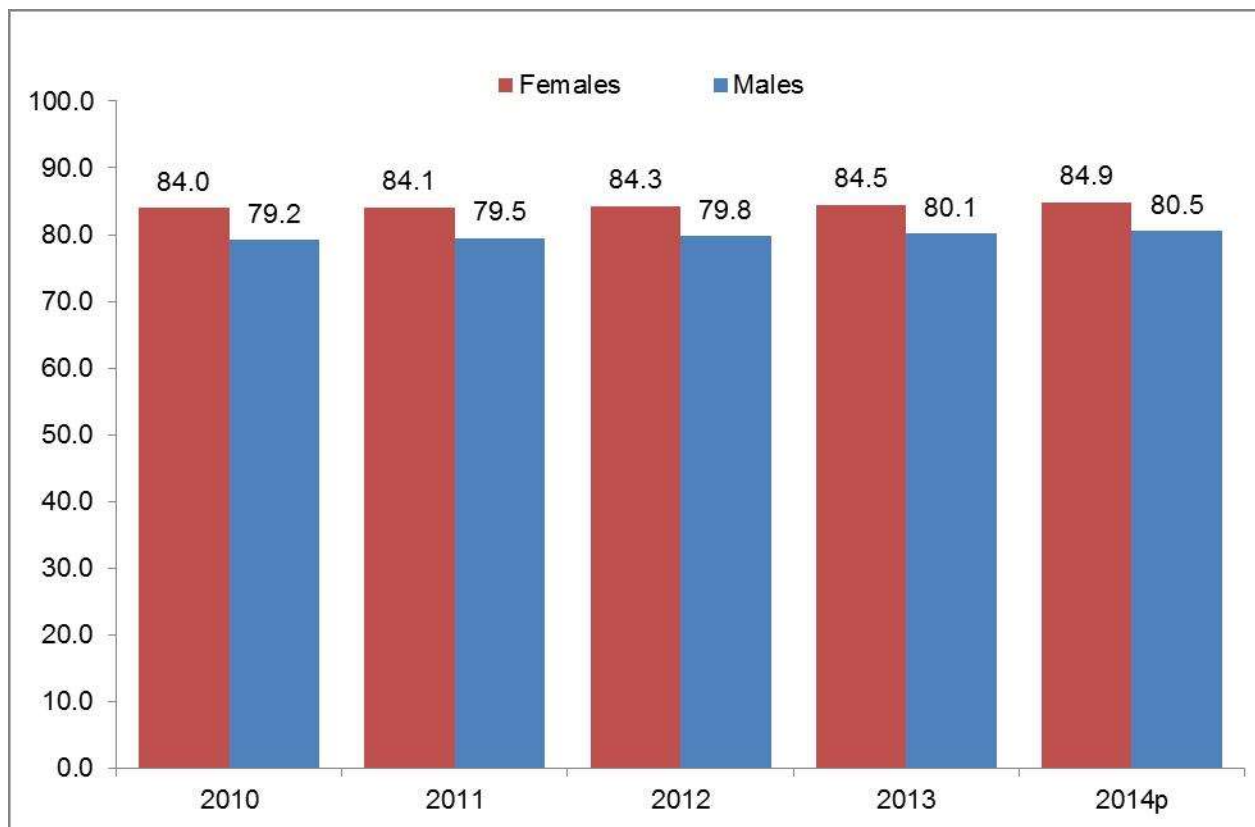
Under MediShield Life, the payout is increased by the amount represented by the area in **dark green**.

MediShield Life – Key Changes

- Mandatory for all citizens and PRs, and will cover those with pre-existing conditions
- Removal of lifetime claim limits
- Increasing daily claim limits for normal wards and ICU wards by up to 55%
- Substantially increasing claim limits for outpatient chemotherapy and radiotherapy
- No change to deductibles but co-payment reduced to between 3 to 10%

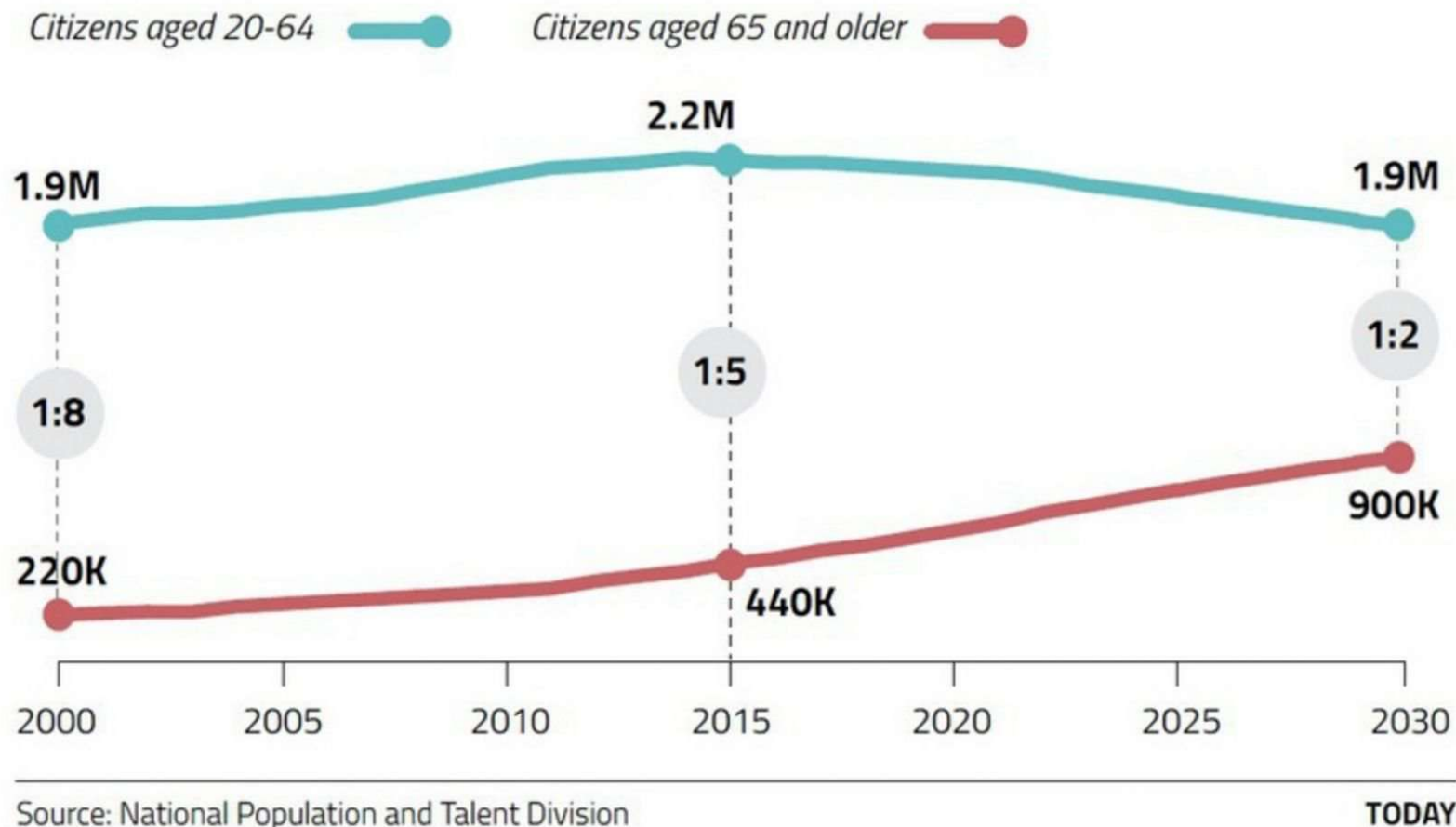
How Sustainable?

Life Expectancy at Birth



Source: Ministry of Social and Family Development

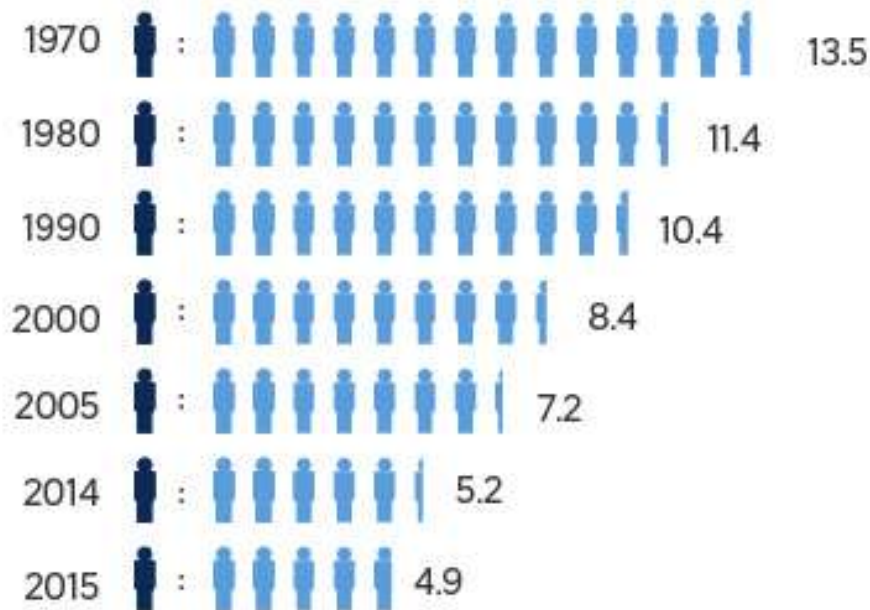
Number of working-age citizens has peaked



Population in Brief 2015: Citizen old-age support ratio, 1970 to 2015

Fewer working-age adults to each citizen aged 65 and above since 1970.

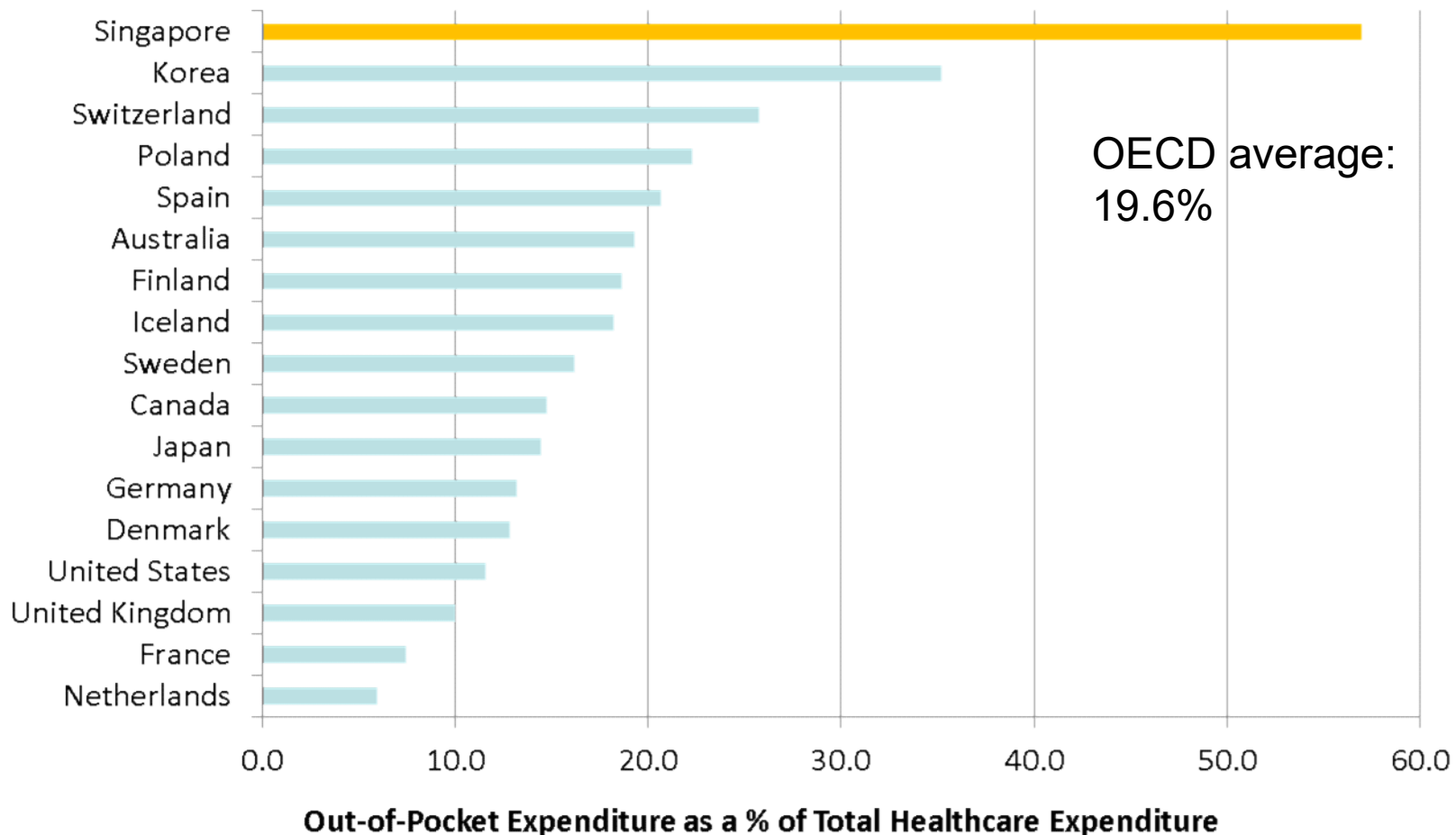
 = Citizen aged 65 years & above  = Citizens in working-age band of 20-64 years



SOURCE: Department of Statistics

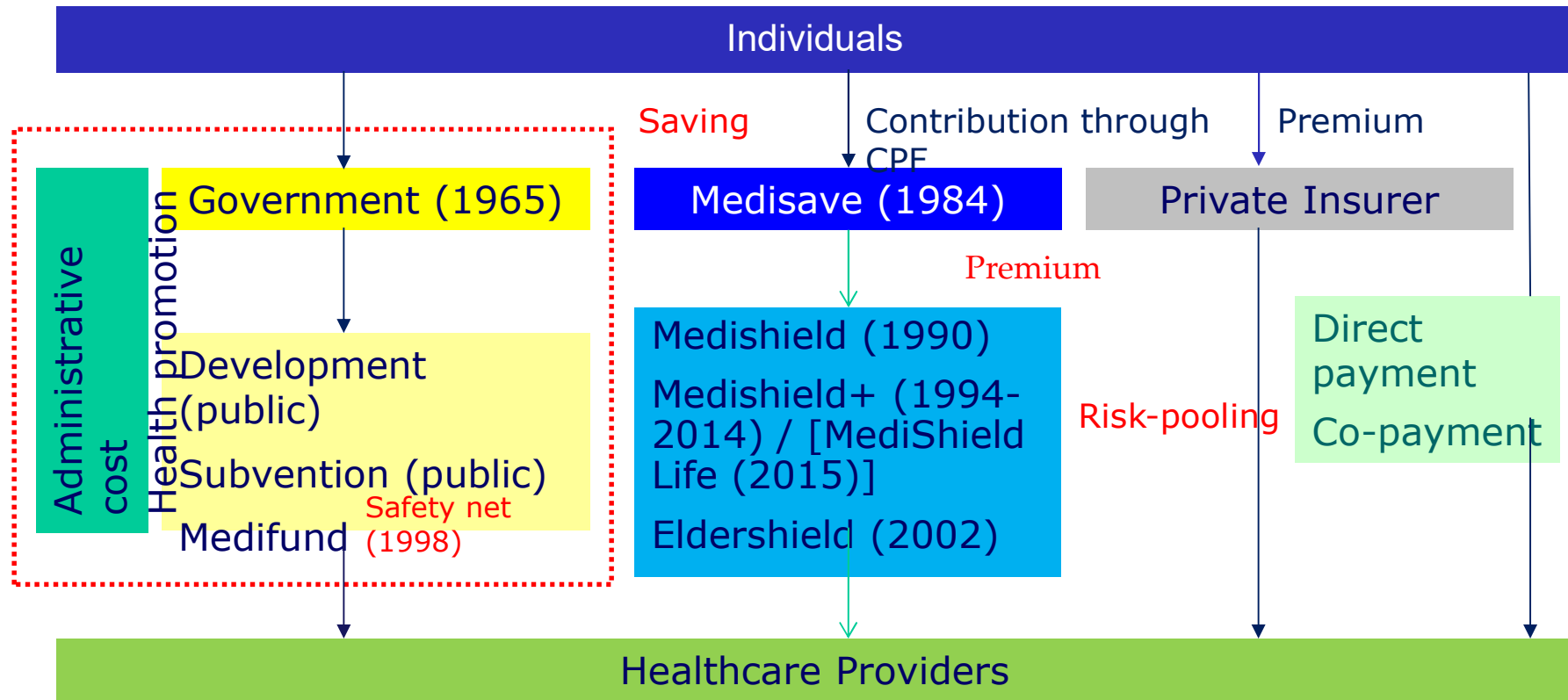
ST GRAPHICS

High OOP Share in Singapore

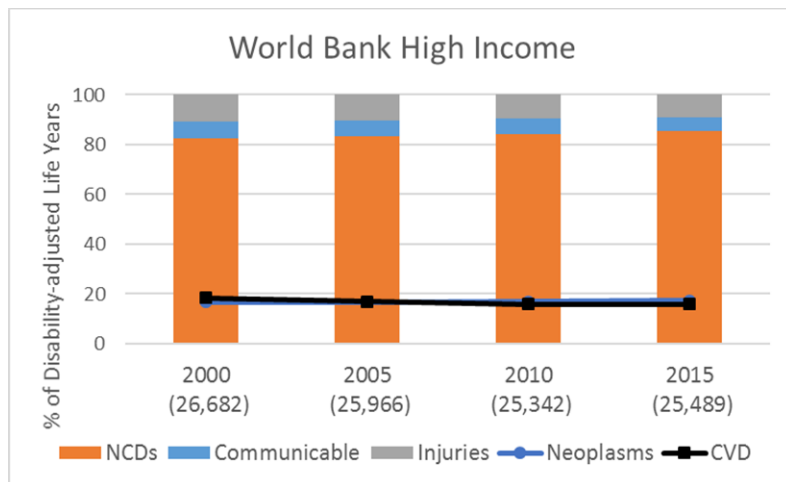
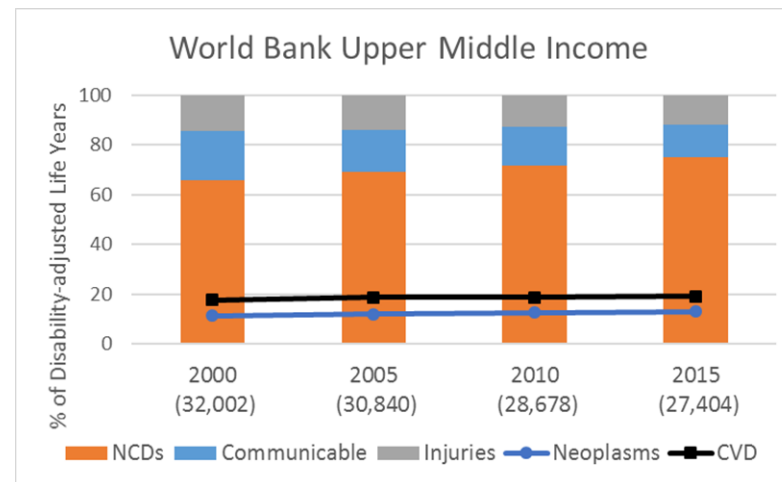
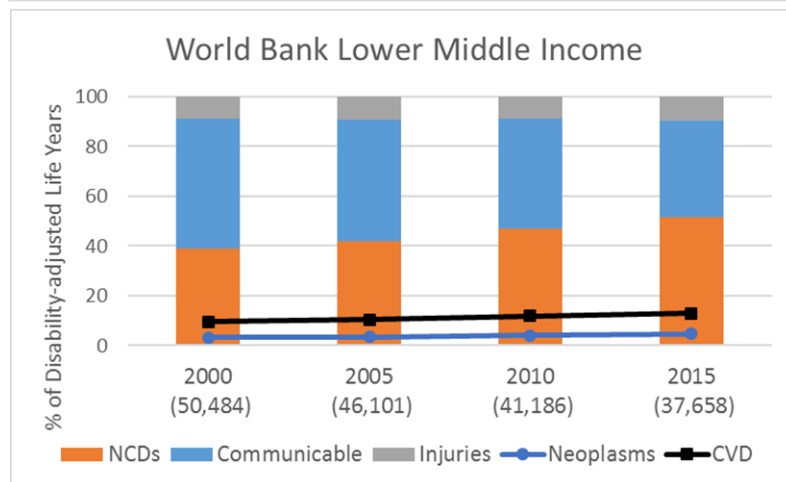
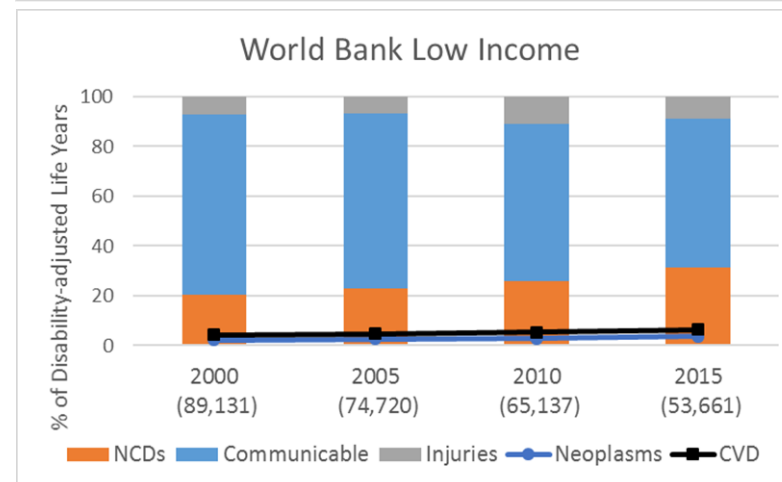


Source: For all countries except Singapore; OECD Health Data 2013
<http://stats.oecd.org/Index.aspx?DataSetCode=SHA>

Financing Framework



CANCER AS CAUSE OF DALYS* BY COUNTRY INCOME GROUP

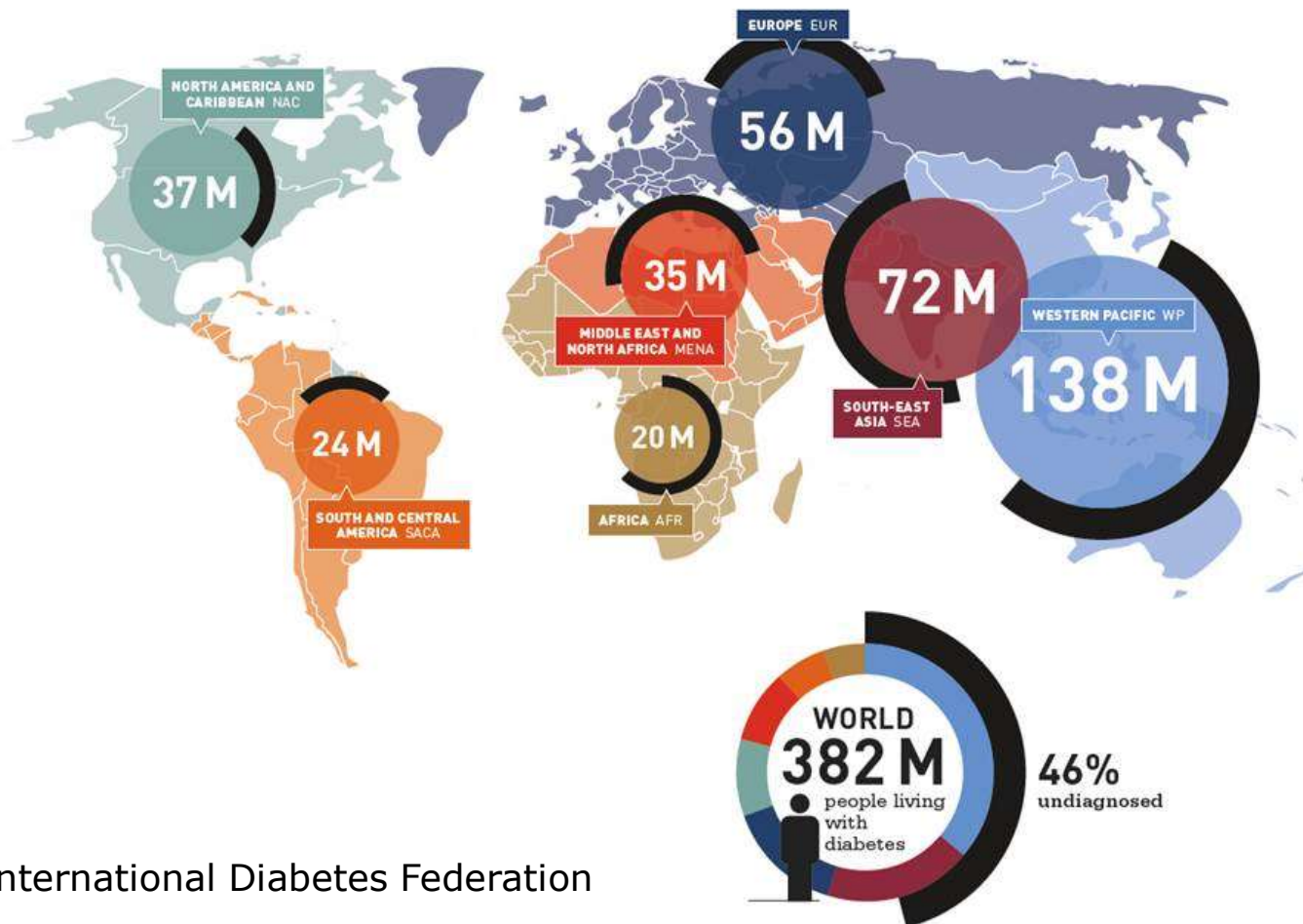


* Sum of Years of Life Lost (YLL) and Years of Life Lived with Disability (YLD)

Data from Global Burden of Disease Study 2015 (See also Lancet 2016;388)

Prevalence of Diabetes

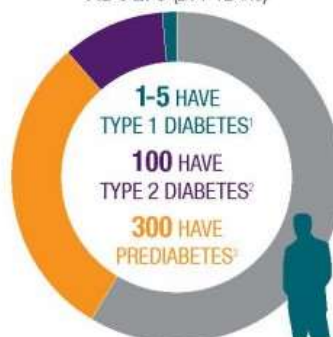
Number of people with diabetes by IDF Region, 2013



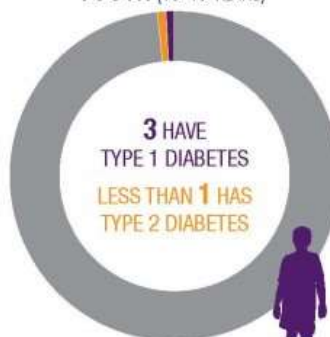
Source: International Diabetes Federation

OVER 29 MILLION AMERICANS HAVE DIABETES

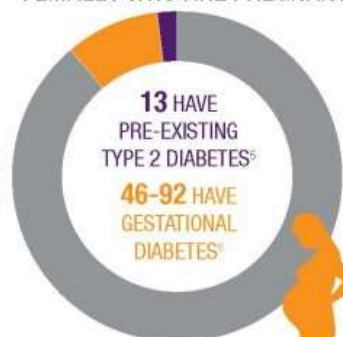
FOR EVERY 1,000 AMERICAN
ADULTS (20+ YEARS)



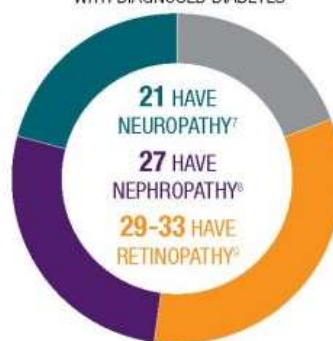
FOR EVERY 1,000 AMERICAN
YOUTH (10-19 YEARS)⁴



FOR EVERY 1,000 AMERICAN
FEMALES WHO ARE PREGNANT



FOR EVERY 100 AMERICANS
WITH DIAGNOSED DIABETES



COST BURDEN

IN 2012, DIABETES COST
THE US HEALTHCARE SYSTEM

\$245 BILLION¹⁰

BY 2021, IT IS ESTIMATED
TO COST AS MUCH AS

\$512 BILLION¹¹

TOTAL ANNUAL HEALTHCARE COSTS (PER CAPITA)

\$11,700

vs.

\$4,400¹¹

ADULT WITH DIAGNOSED DIABETES

ADULT WITHOUT DIABETES

\$9,061

vs.

\$1,468¹²

YOUTH WITH DIAGNOSED DIABETES

YOUTH WITHOUT DIABETES



**TYPE 2 DIABETES ACCOUNTS FOR
90-95% OF ALL DIABETES CASES.**

Source:

- 1 Menke et al. *Epidemiology*. 2013;24(5):773-774.
- 2 Selvin et al. *Annals of Internal Medicine*. 2014;160(8):517-625.
- 3 National Diabetes Statistics Report. Centers for Disease Control and Prevention. 2014.
- 4 Dabelea et al. *The Journal of the American Medical Association*. 2014;311(17):1778-1786.
- 5 Lawrence et al. *Diabetes Care*. 2008;31(5):899-904.
- 6 DeSisto et al. *Preventing Chronic Disease*. 2014;11:E104.
- 7 Cheng et al. *American Journal of Epidemiology*. 2006;164(9):873-880.

- 8 Koopman et al. *Annals of Family Medicine*. 2006;4(5):427-432.
- 9 Zhang et al. *The Journal of the American Medical Association*. 2010;304(6):649-656; Wong et al. *American Journal of Ophthalmology*. 2006;141(3):446-455.
- 10 American Diabetes Association. *Diabetes Care*. 2013;36(4):1033-1046.
- 11 Voigt et al. *Health Affairs (Project Hope)*. 2012;31(1):20-26.
- 12 Shrestha et al. *Diabetes Care*. 2011;34(5):1097-1101.

For more information, e-mail factsandfigures@endocrine.org

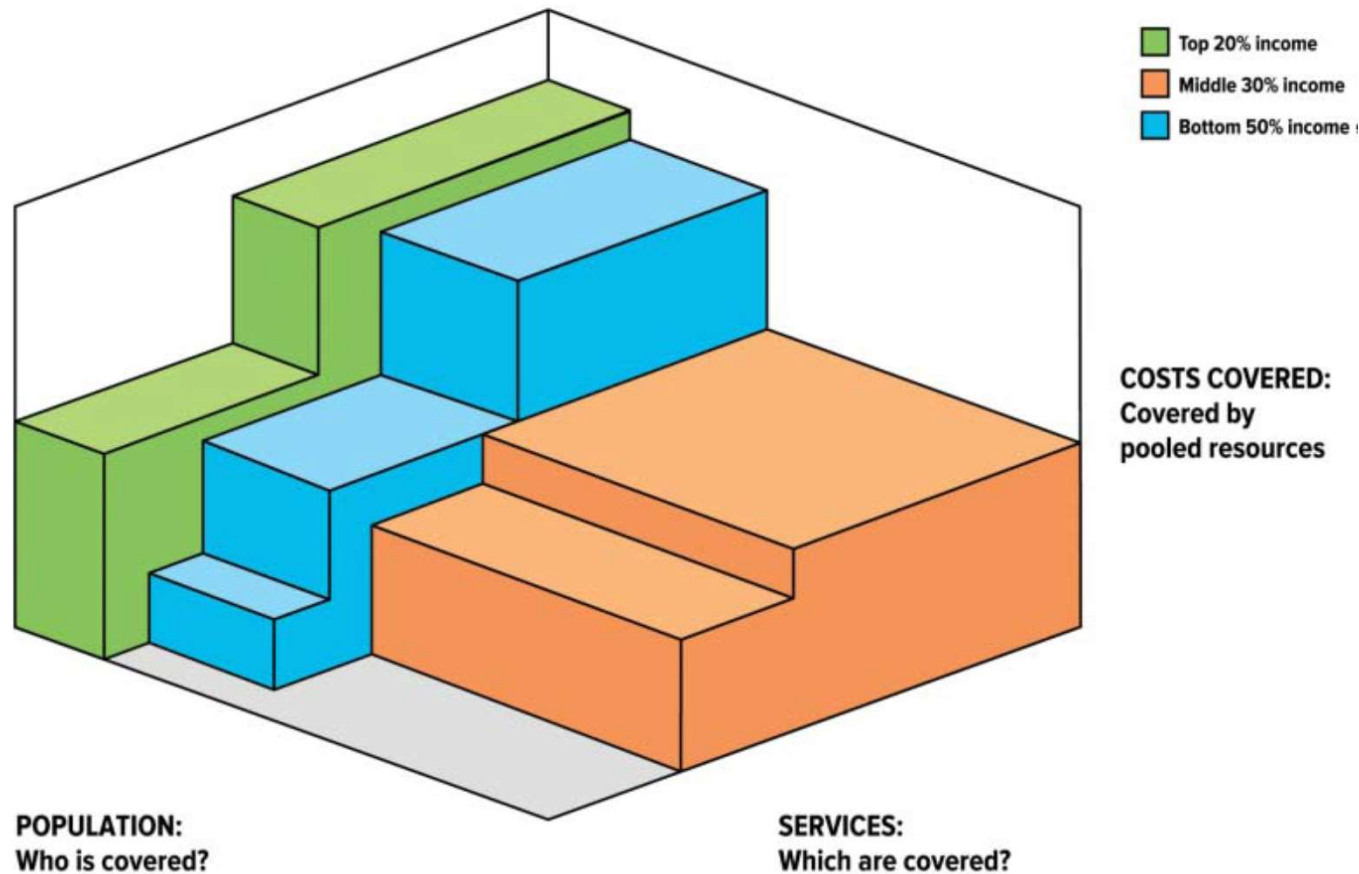
© 2015 The Endocrine Society. All rights reserved.

“Many Helping Hands” Approach



Healthcare Philosophy

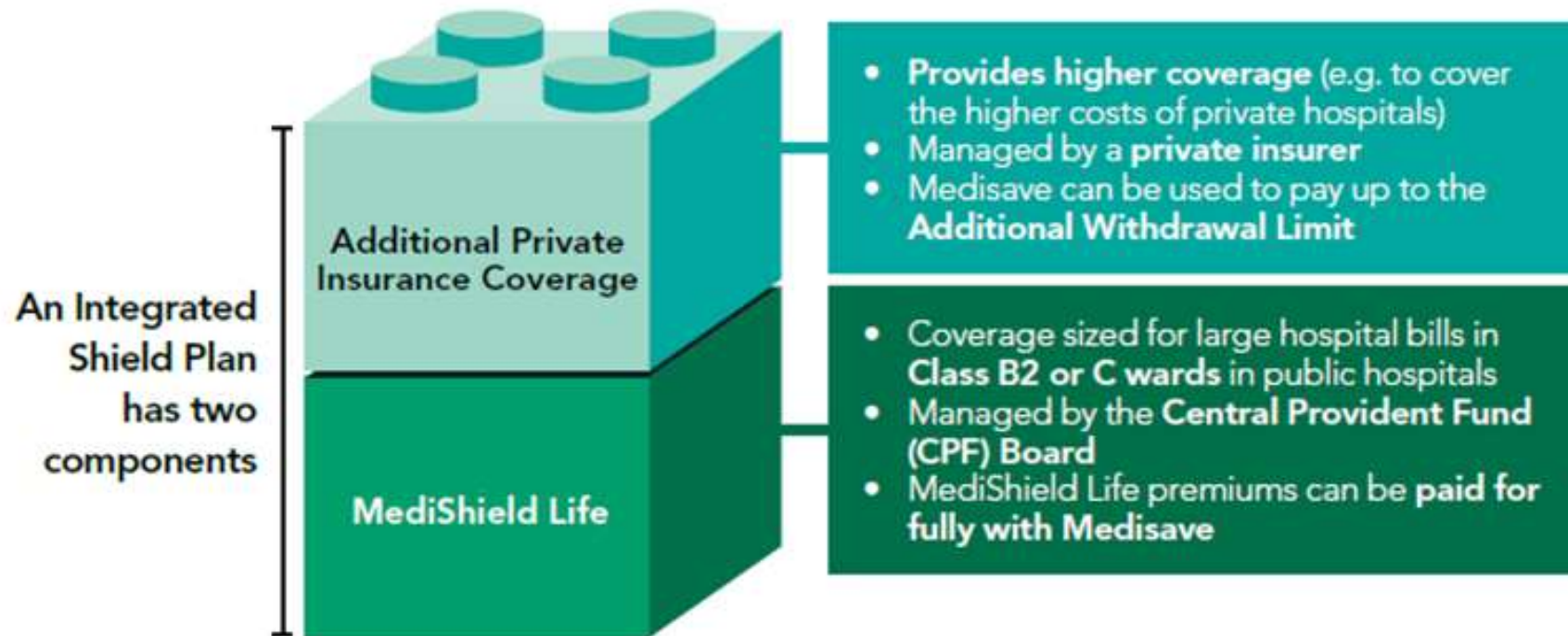
- **Shared and collective** responsibility for healthcare expenditures (“Many Helping Hands” Approach)
 - State continues to provide highly subsidised healthcare accessible to all
 - Medisave empowers individuals to save up for their healthcare expenditures
 - MediShield Life highlights the importance of collectively pooling resources to fund catastrophic expenditures
- Public providers focus on social mission, not financial bottom-line
- Private providers spurs competition in service provision and cost reductions



Source: Authors

Source: Marc J. Roberts, William C. Hsiao & Michael R. Reich (2015) Disaggregating the Universal Coverage Cube: Putting Equity in the Picture, *Health Systems & Reform*, 1:1, 22-27

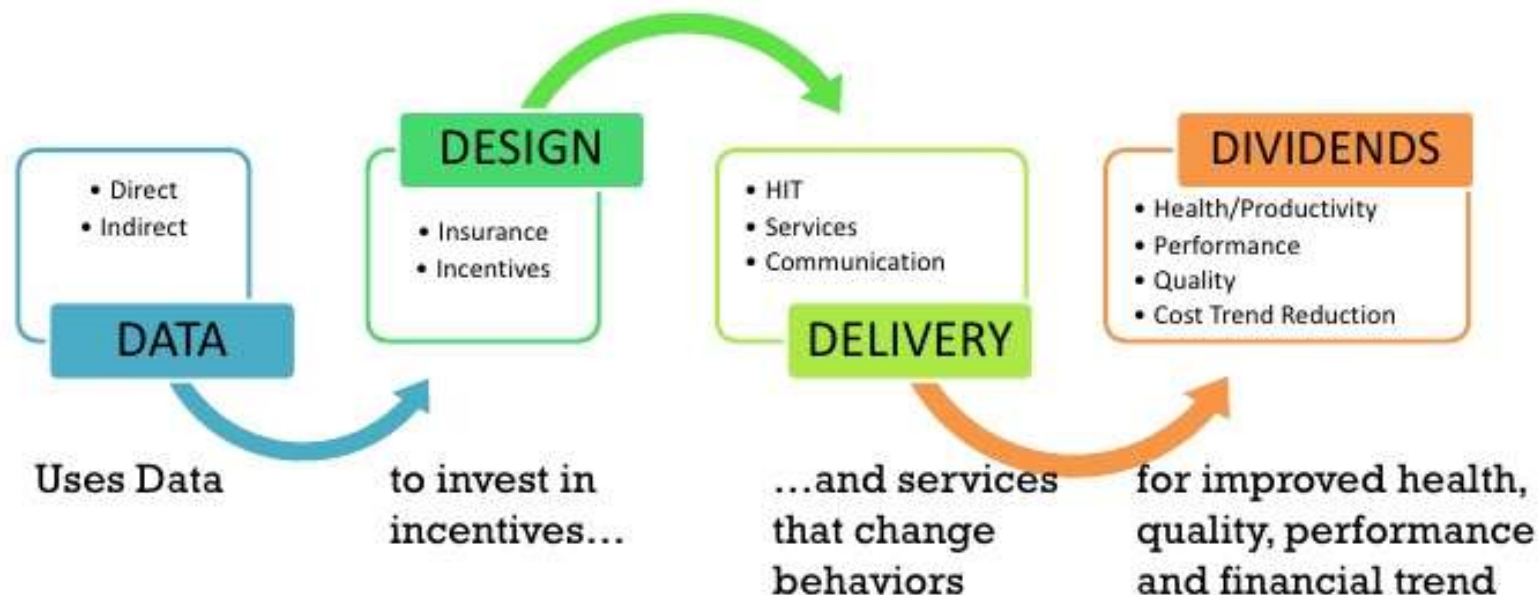
Integrated Shield Plan



Source: Ministry of Health, Singapore

Fundamentals of Value-Based Design

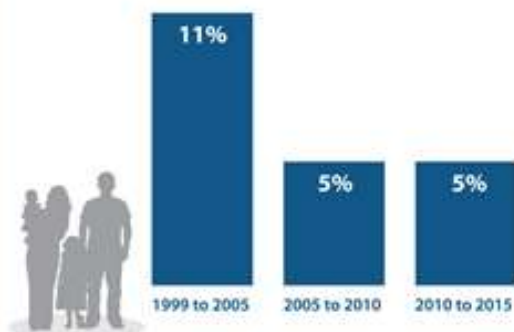
Value-based design is an **ENGAGEMENT TOOL**
for the **CONSUMER AND PLAN SPONSOR AND PROVIDER**



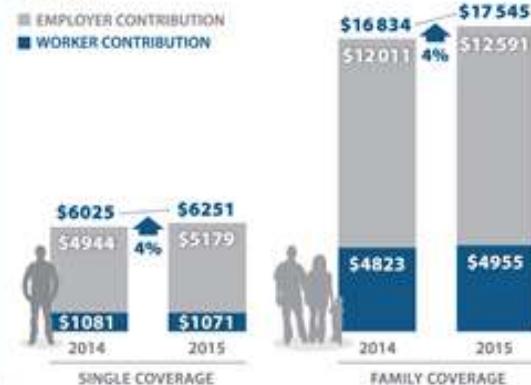
VBD is focused on OUTCOMES

RECENT TRENDS IN EMPLOYER-SPONSORED HEALTH INSURANCE PREMIUMS

Average Annual Premium Increases for Family Coverage, 1999–2015



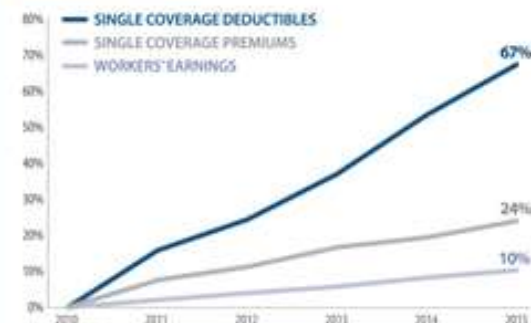
Average Premiums Increased by 4% Between 2014 and 2015



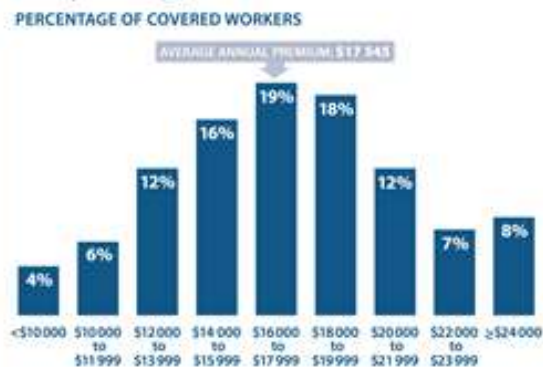
Increases in Premiums Between 1999 and 2015 Have Outpaced Inflation and Workers' Earnings
CUMULATIVE INCREASE



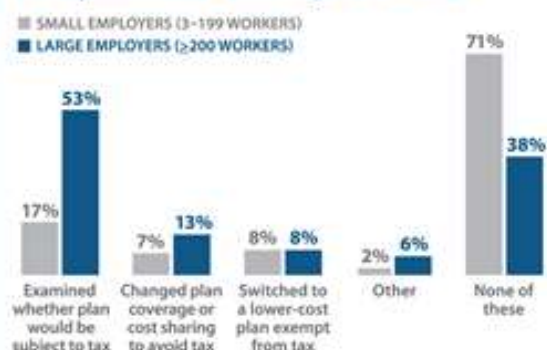
Over the Past 5 Years, Deductibles Have Risen Much Faster Than Premiums and Wages
CUMULATIVE INCREASE



Distribution of Annual Premiums for Workers With Family Coverage, 2015



Many Employers Took Action in 2015 to Address Anticipated Excise Tax on High-Cost Plans



NUS
National University
of Singapore

Authors: Michelle Long, MPH; Matthew Rae, MPH, MPA; Gary Claxton; Anne Jankiewicz, and David Rousseau, MPH; for the Kaiser Family Foundation

Source: Kaiser Family Foundation analysis. Original data and detailed source information are available at http://kff.org/JAMA_01-05-2016. Please cite as JAMA. 2016;315(1):18. doi:10.1001/jama.2015.17349.

VBID in Practice

- Research on employer-sponsored value-based insurance design (VBID) conducted in the United States shows significant cost-savings.
- Stabilises direct and indirect medical costs through chronic disease prevention and disease management.
- Mechanism includes:
 - Lowering or eliminating co-payments
 - Adjusting the tiered structure tied to these payments
 - Changing out-of-pocket payments through co-insurance percentages.

In One Study

- Employees with diabetes in a large firm divided into four groups:
 - With disease management (DM) plan and VBID.
 - With DM but without VBID.
 - Without DM but with VBID.
 - Without DM or VBID.
- VBID reduced co-insurance rate for all antidiabetic medications to 10% from a range of 10% to 35%
- Over a period of three years, it was found that medication adherence was higher for employees in both VBID and DM.
- Employees in this group also received a higher rate of medical services that are recommended in treatment guidelines.

Maximising the Best Outcome for All

- On the whole, the combination of VBID and DM generated a return on investment of US\$1.33 for every dollar that the firm spent.
- Similar research on diabetes-related VBID suggests that when DM is aligned with financial incentive, their effects on medication adherence and utilisation are mutually reinforcing, resulting in significant cost savings.

Source: Gibson TB, Mahoney J, Ranghell K, Cherney BJ, McElwee N. Value-based insurance plus disease management increased medication use and produced savings. *Health Affairs*. 2011; 30(1): 100-108.

Supporting Patient-Centred Care

- Efforts to promote patient-centered care consider patient-centeredness of patients (and their families), clinicians, and health systems to improve the quality of personal, professional and organisational relationships.
- Helping patients to be more active in consultations represents a shift from physician-dominated dialogues to those that engage patients as active participants.
- Focus on being **informative** and **integrated**.
- Goals of care are thereby defined through partnership, solidarity, empathy, and collaboration.
- Systems-wise, this is a move away from productivity-driven assembly-line medicine.

Avoid Consumerism

- Being only about what a patient wants, rather than need?
 - May be more detrimental to the well-being of the patient in the long run.
 - Inconsistent with the requirements of distributive justice.
- Over-emphasis on “consumer’s choice” may add to cost.
 - Some patients are not used to decision-making.
 - Other patients may be open to serious negotiation on relative benefits and risks of plausible treatment options.

Inter-locking values

- Requires a **broader focus** on general wellbeing and therapeutic relationship, rather than only focus on making transactional decisions.
- Establish inter-locking values, where each agrees with and appreciates some part of the other's values and interests. Also makes **shared decisions possible**.
- Even in **one-off encounter** with a patient, attempt should be made at a shared decision, where the patient's personal preferences is balanced with what is medically and financially beneficial.
- Continuing care important as a means of **continuing to share and negotiate values**. It could help to address some structural challenges.

Relational Trust Emphasised

Singapore Medical Council (Ethical Code and Ethical Guidelines):

- Patients and the public must be able to trust doctors implicitly with their lives and well being. To justify this trust, doctors have to maintain a good standard of care, conduct and behaviour.
- Adherence to this Code will enable society to have **trust and confidence** in the profession. ... In general, a doctor is expected to: ... Maintain a professional relationship with patients and their relatives and not abuse this relationship through inappropriate personal relationships or for personal gain.
- A doctor shall not let financial considerations imposed by his own practice, investments or financial arrangements influence the **objectivity of his clinical judgement** in the treatment of his patients.

Supreme Court in **Lim Mey Lee Susan v SMC [2013] SGHC 122**

- There are ethical obligations which professionals must observe regardless of their respective professions.
- Emphasis is on **trust and confidence** in a professional relationship.
- Even in the absence of express statutory provisions or regulations, there are ethical obligations over and above contractual and market forces (e.g. charging patients a fair and reasonable fee for services rendered).

Financial Barriers

- Doctors should be supported in addressing issues of cost, and to involve other allied health workers, if there are financial barriers to care.
 - Substantive requirement in the principle of respecting the autonomy of patients
- Important to have clear policies so that doctors will be able to provide patients with a clear idea of the treatment options available to him or her.
 - Substantive requirement in the principle of justice

Call for Greater Responsibility

- Study on views of US Physicians about Controlling Healthcare Costs (Tilburt *et al*, 2013, JAMA):

Only 36% reported that practicing physicians have “major responsibility”.

- Ezekiel Emanuel and Andrew Steinmetz argue that physicians must recognise healthcare costs are a problem, and be willing to accept that cost containment is a primary responsibility of the profession:

“Physicians must commit themselves to act like the **captain of the health care ship** and take responsibility for leading the United States to a better health care system that provides higher-quality care at lower costs.”

- They argue that healthcare delivery must be transformed in 6 ways:
 - More cost (or value) consciousness in medical decisions
 - Increased emphasis on keeping patients healthy rather than treating acute exacerbations of chronic illnesses
 - A move towards team-based care delivery and away from individual practitioners
 - More organized and coordinated systems
 - More process standardisation with customization for selected patients
 - Greater price and quality transparency

Some Concluding Thoughts

- Ethical and legal responsibility to enable patients to manage healthcare costs in a manner that is fair, within a shared or interlocking values framework.
- Within the context of a health financing system that emphasises shared individual responsibility, there is arguably a stronger ethical responsibility on the part of physicians and insurers to empower their patients.
 - Recognise healthcare costs as a problem
 - Adopting a proactive role in promoting health and wellbeing
- Keeping true to the UHC Ideal – Equity as empowerment
- Fairness as a basis for sustained cooperation
 - Enabling and Empowerment Conditions
 - Realistic goal-setting through accountable processes
- Challenges of a rapidly ageing society is also an opportunity for meaningful and substantive collaboration.

Thank
you !

