

## **HMOs AND MANAGED CARE IN MALAYSIA: WHAT CAN WE ANTICIPATE FROM THE EXPERIENCE OF SINGAPORE AND THE UNITED STATES?**

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### **ABSTRACT**

*Managed Care Organisations (MCOs) are now part of the Malaysian medical landscape. Its proponents believe that it will shift the emphasis of medicine back to preventive and primary care, increase efficiency as well as control costs. Its detractors believe that, among other things, it will result in deterioration of quality of care. This paper discusses the experience of Singapore and the United States with managed care. It is noted that managed care has not taken off in Singapore. However, managed care is the dominant mode of organisation of healthcare services in the United States. Factors likely to affect the growth of managed care in Malaysia are discussed. Whatever its future here, useful innovations from managed care such as clinical practice guidelines, use of formularies and generic drugs etc. can possibly be adopted for Malaysia. Nevertheless, there is a need for proper regulation of Malaysian MCOs.*

### **INTRODUCTION**

“Managed Care” can be defined as healthcare services supplied by or through organisations that also take active steps to influence the care-seeking behaviour of patients (“healthcare consumers”) and the care-providing behaviour of doctors and other health professionals (“healthcare providers”)(Robinson and Steiner, 1998)

Two major goals of managed care are:

- To encourage appropriate utilisation of health services by consumers, e.g., to reduce the number of unnecessary visits to the doctor, to influence patients with minor ailments to see a General Practitioner rather than a specialist
- To encourage appropriate supply of health services by providers, e.g., to reduce supplier-induced demand (Folland et al., 1993)

Proponents of managed care believe that it would shift the emphasis of medicine back to preventive and primary care, increase rationality and efficiency in the healthcare system, promote the provision of medically necessary care instead of overtreatment and overprescription of drugs, and help to control healthcare cost inflation.

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## **MANAGED CARE ORGANISATIONS (MCOS) IN THE UNITED STATES**

Managed care began with prepaid group practices which first appeared in the United States in the late 1920s (Raymond, 1994). These prepaid group practices allowed healthcare consumers to contract for the supply of a fixed range of services with a group of providers. The providers were paid a fixed fee per enrollee in advance. This form of payment is known as "capitation".

The introduction of the Medicare and Medicaid programmes in 1965 contributed to the problem of accelerating healthcare costs (Feldstein, 1979). The result was a revival of interest in prepaid group practice as a possible solution to rising healthcare costs. This culminated in the passage of the Health Maintenance Organisation Act (HMO Act) in 1973. This Act was designed to encourage the growth of Health Maintenance Organisations (an early type of MCO) so as to increase competition in the health services sector of the American economy (Davis et al., 1990)

The HMO was followed by other kinds of MCOs such as the PPO (Preferred Provider Organisation), IPA (Independent Practice Association), POS (Point of Service plan) and so on. MCOs are constantly evolving. Hence, variants and new types of managed care organisations continue to make their appearance in America.

MCO growth was slow during the 1970s. However, in recent years, MCOs have proliferated and have become a dominant part of the medical landscape in the United States. In 1997, 92% of all American doctors held at least one contract with an MCO (Washington Post, April 5, 1999)

According to the National Center for Policy Analysis (an American think tank), the Investor's Business Daily reported in June 1998 that out of a total U.S. population of about 286 million, approximately 41 million were not covered by any kind of health insurance. The rest were covered by public programmes such as Medicare or Medicaid, plans for government employees, or by private health insurance. It should be noted that more than 80% of all Americans with employer-sponsored health insurance were enrolled with MCOs (National Center for Policy Analysis, 1998). Lately, those who are covered by Medicare (the elderly) or Medicaid (the medically indigent) are being moved into specially-designed Medicare and Medicaid MCOs.

## **MANAGED CARE IN SINGAPORE AND MALAYSIA**

The first Singaporean MCO was established in 1992 with tacit support from the Government. Individual enrollees were allowed to use funds from their Medisave account to pay for the cost of enrolment with the MCO. Furthermore, individual enrollees as well as group enrollees were allowed to use Medisave to pay the hospitalisation co-payment fee should they be treated as an in-patient (NTUC INCOME Insurance Co-operative Limited, Managed Healthcare System)

Currently, there are about 10 MCOs in Singapore. The biggest MCO has an enrolment of 22,000 (Phua, 1999). If one assumes that each MCO has 20,000 enrollees, this would amount to a total MCO enrolment of 200,000. Hence, out of a

total population of about 3.5 million, not more than 5.7% of the population is covered by an MCO. Therefore, one can conclude that although MCOs have been in existence in Singapore for almost a decade, it has not become the dominant form of healthcare organisation there.

In the case of Malaysia, the first MCO became operational in 1995. There are 32 registered MCOs today. In 1997, Malaysian MCOs had a total enrolment of approximately 300,000 or only about 1.5% of an estimated population of 20 million. These MCOs covered only about 10% of the private labour force (Pilus, 1999)(Bakar, 1999).

### **THEORETICAL BENEFITS OF MANAGED CARE**

As mentioned earlier, proponents of managed care believe that managed care would shift the emphasis of medicine to preventive and primary care, increase efficiency in the healthcare system, promote the provision of medically necessary care and help to control costs (Robinson and Steiner, 1998).

### **PREVENTIVE CARE**

In contrast to the customary fee-for-service system of provider reimbursement, prepayment reduces the incentive to overtreat or overprescribe drugs in order to increase revenue (Glaser, 1970). Instead, in theory, systems of prepayment such as capitation are likely to influence providers to educate the healthcare consumer to stay healthy and prevent disease so as to make less use of healthcare services. Steps taken to prevent disease or to detect disease in the early stages would include things like healthy lifestyles, proper nutrition, avoidance of tobacco and excessive alcohol consumption, antenatal care, immunisation, Pap smears and mammograms.

### **EFFICIENCY**

Under managed care, efficiency in the supply of healthcare services is increased (Folland et al. 1993) because the GP handles minor ailments and also acts as a "gatekeeper" to more expensive specialist and tertiary care. Direct access to specialists is restricted in the sense that the patient needs to obtain a referral letter from the GP first.

The GP also acts as the co-ordinator of care. This prevents the fragmentation of care and lowers the risk of adverse drug interactions because of polypharmacy (especially when the patient is being treated for different medical conditions by different specialists).

MCOs typically encourage providers to prescribe generic drugs and drugs from a preferred list known as a "formulary". The use of generic drugs in place of branded drugs would help to lower the cost of healthcare. MCOs can also use their bargaining power to negotiate discounts on drug prices from pharmaceutical companies.

Increasingly, MCOs encourage providers to follow clinical practice guidelines and protocols and to practise evidence-based medicine so as to reduce variations in treatment and to avoid unproven procedures. Managed care can also help to reduce hospitalisation rates and cut down on lengthy hospital stays through mechanisms such as ambulatory care, day surgery, utilisation review, etc.

### **MEDICALLY NECESSARY CARE**

On the demand side, MCOs attempt to discourage unnecessary visits to the doctor through co-payments payable by the healthcare consumer. Co-payments can be waived for preventive care but increased for elective care. In POS plans, patients are allowed to go out of plan (e.g. by seeking treatment from a provider who has not contracted with the MCO) but they have to pay much higher co-payments than if they had sought treatment from an in-plan provider (Raymond, 1994).

On the supply side, capitation reduces the incentives for overtreatment and overprescription of drugs. Hospitals which are reimbursed for inpatient care on the basis of DRGs (Diagnosis Related Groups) would not be likely to keep a patient hospitalised longer than necessary.

Critics of managed care are worried that in contrast to the fee-for-service method of provider reimbursement, capitation and DRGs would lead instead to undertreatment of patients. This problem can be reduced through programmes of quality assurance, allowing enrollees to change providers, third party review of medical decisions and competition between MCOs for large groups of enrollees (Davis et al. 1990).

### **COST CONTROL**

Mechanisms of cost control found in managed care include cost-sharing with healthcare consumers and risk-sharing with healthcare providers. Cost-sharing includes things like co-payments, deductibles and co-insurance. In the case of drugs, a three-tier system can be designed such that there is minimal co-payment for generic drugs, a moderate co-payment for branded, formulary drugs, and a high co-payment for branded, non-formulary drugs (Mavrogordato and Featherstone, 1999).

Part of the financial risks will be borne by providers when they are prepaid for contracted services (regardless of the level of healthcare services provided eventually to their enrollees). Similarly, reimbursement for in-patient care based on DRGs would transfer some of the financial risk to the hospitals.

In the case of PPOs (Preferred Provider Organisations) which continue to use the fee-for-service system to reimburse providers, negotiated fee schedules are used to lower the cost of healthcare.

In managed care, alternatives to in-hospital care are used whenever possible. These include treatment outside the hospital, ambulatory care, day surgery and active monitoring of hospital stays. In fact, researchers have concluded that managed care has reduced costs mainly through lower rates of hospital admissions and shorter

lengths of stay in the hospital (Luft, 1981)(Manning et al. 1984)(Robinson and Steiner, 1998).

### **EXPERIENCE WITH MANAGED CARE IN SINGAPORE**

The author's actual experience gained from managing Singapore's first MCO indicates that employers are very interested in managed care. However, the response from their employees tend to be less positive. Providers typically react to the introduction of managed care with apprehension or even strong resistance.

Employers are interested in managed care because a contract with an MCO enables them to calculate the costs of healthcare benefits for their employees in advance. However, employees are unsure about managed care because they are not in favour of co-payments and generic drugs. They also dislike what they perceive as restriction of access to doctors. The latter is a misperception in the sense that most employees actually visit only one provider (their GP) for routine care and MCOs may even allow them to choose two primary care providers, i.e., a GP clinic near the home and another GP clinic near their workplace (NTUC INCOME Insurance Co-operative Limited, Managed Healthcare System).

Primary care providers are used to the fee-for-service method of reimbursement and fail to appreciate that under capitation, they are paid a fixed monthly fee per enrollee on their list even if the enrollees never seek treatment from them at all during the month. Furthermore, they may even be paid an additional "chronic disease capitation" fee for patients who are affected by chronic disease.

### **EXPERIENCE WITH MANAGED CARE IN AMERICA**

Managed care is most highly developed in the United States. It has been shown to be effective in controlling costs. As compared to unmanaged care, it has led to fewer hospital admissions and shorter hospital stays (Manning et al., 1984). It has also resulted in much lower usage of expensive medical procedures, procedures of unproven efficacy, and procedures for which less expensive alternatives exist (Miller and Luft, 1994)(Robinson and Steiner, 1998).

The big debate in the United States is over the question of whether managed care results in deterioration in the quality of care. Recently, Robinson and Steiner carried out a comprehensive review of the literature on this important question for the British Government (Robinson and Steiner, 1998). They concluded that: Structural quality of care (access to treatment, continuity of care, professional training levels) is no different in managed care as compared to care provided under the fee-for-service system.

However, MCO enrollees had significantly less access to treatment than fee-for-service patients. Findings on process quality of care (the extent to which treatment patterns satisfy pre-established standards) are inconsistent. From 23 studies and 146 observations (variables), 20% indicate better treatment under fee-for-service, 36% indicate better treatment under managed care and 44% revealed no significant differences. MCO enrollees tended to be less satisfied than fee-for-service enrollees

for various reasons. Nevertheless, health outcomes were virtually the same in both systems of care.

Robinson and Steiner also concluded that although "Managed care is associated with rather more frequent visits to physicians .... an important exception is for mental health visits, where MCO patients receive less – and less specialized – treatment" (Robinson and Steiner, 1998).

A recent study comparing investor-owned and nonprofit MCOs concluded that the quality of care in the former is lower than that in the latter. Investor-owned MCOs scored lower on all of the 14 quality-of-care indicators used in the study (Himmelstein et al. 1999). Further research is needed on this topic because most previous research on quality of care in MCOs has focused on nonprofit organisations.

## **CONCLUSION: IMPLICATIONS FOR MALAYSIA**

Managed care has not taken off in Singapore. However, it is now the dominant mode of organisation of healthcare services in the United States. Managed care is quite new to Malaysia as it was introduced into this country only during the middle 1990s (Pilus, 1999). The future growth of managed care in Malaysia is likely to depend on a number of factors. These include:

Whether GP care continues to remain affordable to most Malaysians  
Whether the Malaysian Government continues to provide heavily subsidised outpatient and inpatient services to the public  
Whether more and more major employers decide to sign contracts with MCOs to provide care for their employees  
Whether barriers to penetration of the Malaysian market for healthcare services by foreign MCOs continue to remain significant

It is likely that GP care will continue to remain affordable to most Malaysians because the market for GP services is quite competitive.

This is especially true in the case of the larger Malaysian cities and towns where GPs tend to cluster.

The Malaysian Government may reactivate its policy of corporatisation and privatisation of public healthcare facilities and services (Chan, 1996). It may also reduce the level of subsidy for outpatient and inpatient care as well as for pharmaceuticals. These would lead to higher charges for patients and probably encourage the growth of private health insurance and managed care.

As to the question of whether more and more large employers would sign contracts with MCOs, this may depend on the response of the Malaysian Trades Union Congress and workers to managed care. The Singaporean experience indicates that employees are unlikely to greet the concept of cost-sharing through co-payment with any enthusiasm. It will also take time for employees to accept the idea that generic drugs can be safely and effectively prescribed in place of more expensive branded drugs.

If foreign managed care organisations are allowed to operate freely in Malaysia, e.g., including the right to buy existing (or to set up new) hospitals and healthcare facilities, this would strengthen the presence of managed care in the country.

Provider resistance is unlikely to be a major factor in affecting the growth of managed care (unlike globalisation, market forces and the rise of what Paul Starr has called “corporate medicine”) (Starr, 1982). This is because some providers may actually gain by participating in managed care although their professional autonomy will be reduced to some extent. Managed care will strengthen the position of GPs vis-à-vis specialists because of its emphasis on primary care and its emphasis on GPs as gatekeepers to more expensive care. Furthermore, providers who move into management positions in MCOs will also gain in terms of power and influence.

Whatever the future of managed care in Malaysia, certain innovations arising from the managed care movement in America can possibly be considered for adoption in Malaysia (Robinson and Steiner, 1998:19-26)(Mavrogordato and Featherstone, 1999) (Geraty, 1999). This is especially true in the case of the public sector: although this sector is not profit-oriented, it can attempt to increase its cost-effectiveness and efficiency using managed care innovations. These innovations can be grouped into two categories – “less controversial” and “more controversial”.

The less controversial innovations include:

- . self-care by patients
- . co-payments to discourage unnecessary utilisation
- . no or minimal co-payment charges for preventive care
- . queuing and other forms of rationing for elective care
- . case management (for complicated cases)
- . clinical practice guidelines and evidence-based medicine
- . control of access to new technologies and expensive procedures
- . formulary and generic drugs
- . teleconsultations (to reduce unnecessary referrals)

More controversial innovations include:

- . financial risk-sharing by providers
- . utilisation review (pre-admission review, concurrent review, and retrospective review)
- . medical practice profiling
- . mandatory second opinions
- . management of pharmacy benefits, imaging management etc.
- . greater use of “physician extenders” such as medical assistants for routine care, nurse midwives for normal deliveries and so on

Lastly, it must be pointed out that there should be proper regulation of MCOs in Malaysia by the Government. For example, there can be mandated standards which MCOs have to meet in order to be allowed to operate, e.g., in terms of facilities, staffing, range of services provided etc. There can also be open enrolment periods, a proper appeals process and independent review of disputed decisions. All these actions would help to protect the welfare of MCO enrollees (Davis et al., 1990).

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