
Healthcare Financing: How should costs shift from private pockets to the public purse?

Wanted: The cure for demographic, cost and distributional challenges

In early 2013, Singapore's Finance and Health Ministers announced that the government was reviewing the healthcare financing framework with a view to having the State shoulder a larger share of healthcare costs.¹ When implemented, part of the costs (and risks) that are currently borne by individuals and families would shift to the State and be borne by taxpayers instead.

Singapore, like other advanced economies, face multiple challenges, such as an ageing population, rising income inequality, and healthcare inflation (between 2006 and 2012, the healthcare CPI has increased by 19.8 percentage points; see **Exhibit 1**).² Increasingly, the Government also faces challenges to its firm ideological position against generous state welfare. The fundamental principles underlying Singapore's welfare system are personal and family responsibility, with the State providing a residual safety net. Where healthcare financing is concerned, this philosophy has led to growing criticisms by citizens, public commentators and scholars who argue that notwithstanding the excellent health outcomes that Singapore achieves in spite of low public spending, the healthcare financing system imposes potentially high risks and costs on both the individual and the family. It is also inequitable since wealthier individuals and their families are better equipped for the contingencies of life.

Yet, it is unclear if there is sufficient support and hence demand for a different distribution of risks between state and citizens, for example, one that is based on the principles of universalism (instead of means-tested as is common in Singapore), and of equality of access to a high quality of care – cornerstones of the welfare regimes of the social democratic Nordic countries. Sustaining such a regime would require broad-based commitment to much higher level of taxes than many in Singapore are prepared to accept.

What this means is that policymakers reviewing the healthcare financing framework have to grapple with three key challenges: demography, costs and distribution effects. This main objective of this case is to analyse how policymakers should review the healthcare financing system so that it is appropriate for an ageing population, fiscally sustainable and economically fair from the standpoint of a broad range of actors – citizens with unequal distributions of wealth and health, medical care professionals, and insurers. The case approaches this task by, first, presenting a brief history of

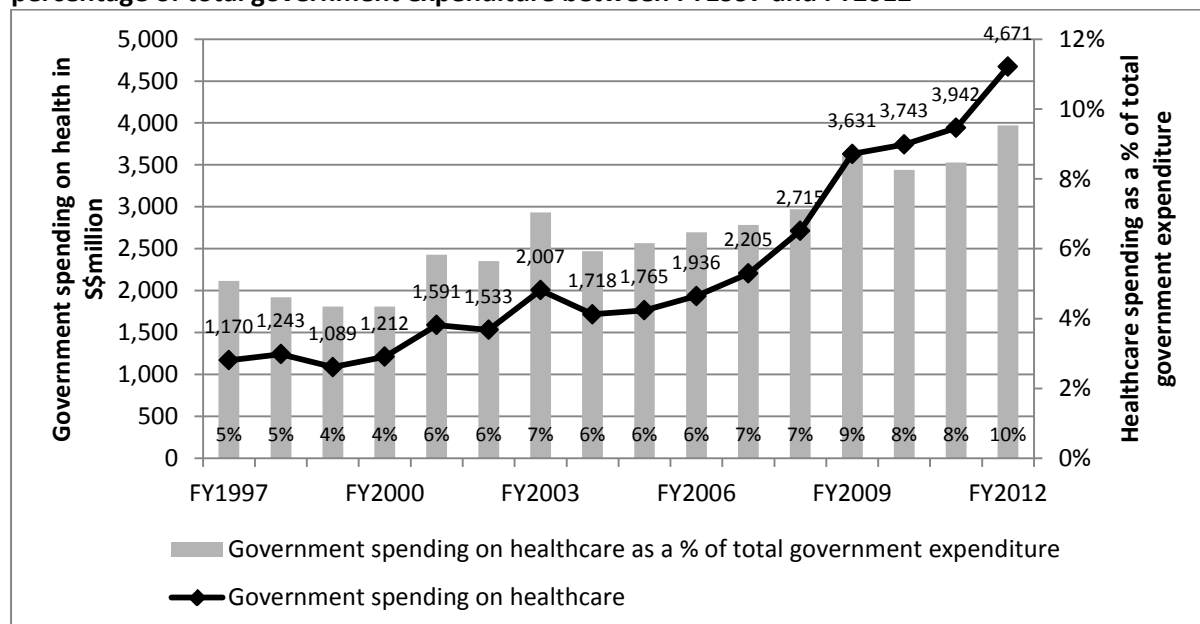
¹ Ministry of Finance, "Budget Speech 2013," updated 25 February 2013, <http://www.singaporebudget.gov.sg/budget_2013/speech_toc/download/FY2013_Budget_Statement.pdf> (accessed 30 April 2013); Ministry of Health, "Better Health for All (Part 2 of 2)," updated 13 March 2013, <http://www.moh.gov.sg/content/moh_web/home/pressRoom/speeches_d/2013/MOH2013COSMinSpeechBetterHealthforAllPart2of2.html> (accessed 30 April 2013).

² Ministry of Health, "Consumer Price Index," http://www.moh.gov.sg/content/dam/moh_web/Statisti (accessed on 22 March 2014). During the same period, consumer price index, which has healthcare CPI as one of its components, increased by 21.8 percentage points.

This case was written by Alisha Gill under the guidance Donald Low, Lee Kuan Yew School of Public Policy (LKY School), National University of Singapore and has been funded by the LKY School. The case does not reflect the views of the sponsoring organization nor is it intended to suggest correct or incorrect handling of the situation depicted. The case is not intended to serve as a primary source of data and is meant solely for class discussion.

Singapore’s healthcare and social welfare financing framework, the broad-based support it has enjoyed, and the subsidies + 3M system. This is followed by a discussion about the emerging weaknesses of the extant financing framework, and the new challenges that health policymakers face as a result of the growing contentiousness of politics in Singapore. The case concludes with interventions that the healthcare policymaker can make.

Exhibit 1: Government spending on healthcare in S\$million and healthcare spending as a percentage of total government expenditure between FY1997 and FY2012



Source: Ministry of Finance, “Government Total Expenditure by Sector (S\$million),” http://data.gov.sg/Agency_Data/MOF/220201000000013562P.xls (accessed 22 March 2014).

Singapore’s Philosophy towards Social Welfare and Healthcare Financing

Singapore’s philosophy to social welfare financing has been shaped largely by the beliefs of the leaders of the People’s Action Party (PAP), which has formed the government since Singapore achieved self-government in 1959. The first Prime Minister, Lee Kuan Yew, often stressed that the western-styled welfare state was not viable for Singapore because it bred dependency on the government and led to wastage and over-consumption. This belief has endured; subsequent generations of PAP leaders have adopted an approach where the individual, and not the state, are expected to bear the main responsibility for meeting his/her needs in healthcare, retirement, unemployment and other episodes of income volatility. The family is expected to buttress self-reliance by providing care to its members, and by providing opportunities for income and risk pooling at the *household* level. As a result of these normative principles, Singapore, in comparison to other advanced economies, provides relatively little by way of social protection and redistribution. There is no state pension, no automatic unemployment benefits, and little by way of intergenerational transfers (except in education, and in the various endowment funds that the Government has established over the years).

Although healthcare is subsidised, the government relies extensively on patient co-payments and other market mechanisms to ration demand and minimise the moral hazard of providing free or heavily subsidised healthcare. This reflects the government’s thinking that though subsidies for

healthcare are unavoidable, they “could be extremely wasteful and ruinous for the budget”.³ Instead of providing healthcare for free, in 1980, Lee Kuan Yew tasked his then-Health Minister, Goh Chok Tong, to establish “good health services, with waste and costs kept in check by requiring co-payments from the user”.⁴ To be sure, Singaporeans were already familiar with the concept of co-payments for healthcare well before 1980; co-payments were introduced in 1960, when the then newly-installed PAP government imposed a user charge of 50 cents for each attendance at government outpatient clinics.⁵ Prior to 1960, the healthcare financing framework in British-ruled Singapore was modelled after Britain’s National Health Service, that is, health services in government hospitals and outpatient clinic were provided for free.

These incremental steps of cost shifting to the individual and the family culminated in the 1993 White Paper on Affordable Healthcare⁶, in which the Health Ministry formally identified personal and family responsibility as the cornerstones of Singapore’s healthcare financing framework. Since then, patient co-payment has become a central feature of Singapore’s healthcare system. This approach is widely seen to be the main reason for containing national and public spending on healthcare. Singapore’s national healthcare expenditure is about only 4 per cent of gross domestic product (GDP), with the state financing about a third (or slightly above 1 per cent of GDP) of costs – both very low by the standards of rich countries (see **Exhibits 2 and 3**). Healthcare costs in Singapore are also contained through the government’s supply side controls through limits on the number of medical graduates, fee controls, and the ownership of public hospitals. The principles articulated in the White Paper continue to guide policymaking in Singapore.

Exhibit 2: National healthcare expenditure as a percentage of GDP of Singapore and selected OECD countries

Country	2006	2007	2008	2009	2010	2011
Singapore ⁷	3.4	3.4	3.8	4.2	3.9	3.8
Australia	8.5	8.6	8.8	9.0	8.9	NA
Canada	10.0	10.0	10.3	11.4	11.4	11.2
France	11.0	10.9	11.0	11.7	11.7	11.6
Germany	10.6	10.5	10.7	11.8	11.5	11.3
Japan	8.2	8.2	8.6	9.5	9.6	NA
Korea	6.1	6.4	6.6	7.1	7.3	7.4
Netherlands	10.7	10.8	11.0	11.9	12.1	11.9
United Kingdom	8.4	8.5	9.0	9.9	9.6	9.4
United States	15.9	16.2	16.6	17.7	27.7	17.7
OECD Average	8.6	8.6	8.9	9.6	9.4	9.3

Exhibit 3: Public expenditure on health as a percentage of national health expenditure of Singapore and selected OECD countries

Country	2006	2007	2008	2009	2010	2011
Singapore ⁸	25.1	25.2	27.9	32.4	31.1	31.0
Australia	66.6	67.5	67.9	68.5	67.8	NA

³ See Lee, *From Third World to First* (Singapore: Times Media Pte Ltd, 2000), 123.

⁴ Ibid.

⁵ Ibid.

⁶ See Ministry of Health, “Affordable Health Care: A White Paper,” updated 11 December 2011, <http://www.moh.gov.sg/content/dam/moh_web/Publications/Reports/1993/Affordable_Health_Care.pdf> (cited 30 April 2013), 41.

⁷ This includes expenditure from endowment funds.

⁸ This includes expenditure from endowment funds.

Canada	69.8	70.2	70.5	70.9	70.8	70.4
France	77.2	77.3	76.8	77.0	76.9	76.8
Germany	76.4	76.4	76.4	76.8	76.7	76.5
Japan	79.4	80.4	81.4	81.5	82.1	NA
Korea	54.8	55.1	54.8	56.7	56.5	55.3
Netherlands	84.4	84.5	85.0	85.9	86.1	85.6
United Kingdom	81.3	80.2	81.1	82.6	83.5	82.8
United States	45.0	45.2	46.0	47.2	47.6	47.8
OECD Average	71.4	71.3	72.0	72.6	72.3	72.2

Sources for Exhibits 2 and 3: OECD, "OECD Health Statistics 2013 – Frequently Requested Data," <http://stats.oecd.org/Index.aspx?DataSetCode=SHA> (accessed 22 March 2014); Ministry of Health, "Healthcare financing sources," http://www.moh.gov.sg/content/moh_web/home/pressRoom/Parliamentary_QA/2013/healthcare-financing-sources0.html (accessed 22 March 2014); Department of Statistics of Singapore, "Time Series on Annual GDP at Current Market Prices," http://www.singstat.gov.sg/statistics/browse_by_theme/economy/time_series/gdp2.xls (accessed 22 March 2014).

As a result of these cost and risk-shifting policies, the Singapore government's share of total healthcare expenditure fell from 50 per cent in 1965⁹ to 31 per cent in 2012. Even though these policies entailed a concomitant increase in the private cost of care, the government has, for most of the previous four decades, enjoyed broad-based societal support, or at the very least acquiescence, for its healthcare financing policies. Academic Lim Meng Kin has argued that Singaporeans demonstrate "ready acceptance for a social contract based on "individual responsibility" and "co-payment"" because of three unique features of Singapore's politico-social context.

First, Singapore has prospered in spite of great odds largely due to a strong government. As a result, the government has enjoyed enduring trust from the people as it delivered on its promises. Second, Singapore has no tradition of state largesse or generous welfare benefits. The colonial health system, though free, was primarily targeted at the colonisers instead of the colonised. Local residents relied mostly on traditional healers for healthcare. As a matter of fact, even though diseases and poverty were rampant in British Singapore, the first hospital, Tan Tock Seng hospital, was built using funds raised by Chinese community leaders (that is, by self-help) and not the state. Third, Singaporeans are pragmatic and understand that irrespective of whether the healthcare financing burden falls on taxes, Medisave, employer benefits or insurance, it is ultimately Singaporeans who pay.¹⁰

Though there is no strong empirical support for the reasons posited by Lim, the 2002 *World Values Survey* (WVS) confirms that a majority of Singapore's respondents (55 per cent) thought that Singapore should be a society where taxes are low and individuals take responsibility of themselves. Only about 25 per cent felt that the state should provide extensive social welfare and collect high taxes. Significantly, this finding lends credibility to assertions made by political leaders, such as the Prime Minister Lee Hsien Loong, that Singaporeans would "not be willing to pay taxes that Scandinavians pay".¹¹

⁹ Lim, 83.

¹⁰ Lim, 89.

¹¹ Prime Minister's Office Singapore, "Speech by Prime Minister Lee Hsien Loong at Economic Society Of Singapore Annual Dinner," updated 18 June 2012, http://www.pmo.gov.sg/content/pmosite/mediacentre/speechesninterviews/primeminister/2012/June/speech_by_prime_ministerleehsienloongateconomicsocietyofsingapor.html (cited 30 April 2013), para 33.

The Subsidies + 3M System

Singapore's healthcare financing framework comprises government subsidies for health services obtained at public healthcare institutions and select private general practitioners' clinics, a mandatory savings account (Medisave), a catastrophic medical insurance scheme (MediShield), and a means-tested financial assistance scheme (Medifund).¹² Together, they form what is commonly referred to as the "subsidies + 3M" framework.

1. Subsidies

The government provides means-tested subsidies to citizens and Permanent Residents for inpatient services, day surgery, and specialist outpatient treatments received in government-owned restructured hospitals. These subsidies cover between 20 and 80 per cent of the cost of treatment. Means-tested subsidies are also given for intermediate and long-term care (ILTC), while universal subsidies are provided to those who obtain general practitioner (GP) care at government-owned polyclinics. Private GPs provide the bulk of GP care (about 80 per cent of GPs in Singapore are in the private sector), but elderly citizens who pass a means test can apply for a Community Health Assist Scheme (CHAS) that allows them to receive subsidised care at private GP clinics.¹³

2. Medisave

The primary aim of Medisave is to help individuals and their families save for their hospitalisation expenses, including those that will be incurred during retirement. Employed individuals are required to make monthly contributions, which increases with age, to their Medisave accounts. To prevent over-consumption of health care and the premature depletion of Medisave, the Health Ministry sets detailed rules concerning the permitted uses of Medisave. Apart from individual responsibility, Medisave also incorporates the principle of family responsibility. Patients can use the Medisave of immediate family members for healthcare financing. This enables income and risk-pooling at the household level.

3. MediShield

The primary aim of MediShield is to harness the power of risk pooling for medical catastrophes or healthcare episodes for which it would neither be efficient nor equitable to require individuals to save. It is thus explicitly designed to address medical episodes that are infrequent in nature, but impose high financial impacts (i.e. low frequency, high impact events). Although it is a national insurance scheme, MediShield is quite unlike health insurance schemes in other developed countries for at least three reasons.

First, it is neither mandatory nor universal. Though, at present, everyone is automatically enrolled in MediShield by default, they can choose to opt out. The elderly above 90 are excluded and those with severe pre-existing conditions cannot re-join MediShield once they have opted out. Second, MediShield is not an open-ended insurance that covers all medical treatments. Instead, it covers only catastrophic illnesses. Third, MediShield is designed based on market, instead of equity, principles. High-risk individuals, such as those with severe pre-existing conditions and the very old,

¹² Another component of the healthcare financing framework is ElderShield, which was introduced in 2002. ElderShield provides basic financial protection to the elderly who need long-term care due to severe disabilities. At present, all CPF members who reach the age of 40 will be automatically enrolled in ElderShield. As the insurance is voluntary, members can opt out. They can, however, rejoin the scheme as long as they are below 65 and subject to a medical assessment. See Ministry of Health, "ElderShield," updated 19 April 2013, <http://www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/ElderShield.html> (cited 30 April 2013).

¹³ Agency for Integrated Care, "About CHAS," updated n.d. <http://www.chas.sg/page_patients.aspx?id=320#eligible> (cited 30 April 2013).

are excluded in order to keep premiums low. The premiums also increase with age to minimise cross-subsidisation across age groups; in 2013, those aged 1 to 20 years old paid \$50 in annual premiums while those between 86 and 90 paid \$1,190.¹⁴ The MediShield claim limits – of \$70,000 for each year and \$300,000 per policyholder¹⁵ – and the absence of ‘stop-loss’ measures effectively transfers all the risk of catastrophic medical bills to patients and their families.

4. Medifund

While Medisave and Medishield were designed very much with efficiency considerations in mind, Medifund was designed to ensure a certain degree of social equity. If a patient who has received subsidised care cannot afford his bill even after using Medisave, MediShield and seeking help from his family, he can apply for financial assistance from Medifund, which serves as a safety net of last resort. Medifund is administered by the various public healthcare institutions.

Since 2002, the subsidies + 3M system has accounted for between 31 and 39 per cent of the total health spending (see **Exhibit 4**).¹⁶ Out-of-pocket payments by patients and other third-party insurers account for the remaining 60 per cent of the national health expenditure.

Exhibit 4: National health spending by source for 2002 to 2011 in S\$million

Year	National Health Expenditure	Government Health Expenditure		Medisave	MediShield	Other third-party insurers and out-of-pocket payments
		Medifund	Subsidies			
2002	5,916	26	1,532	361	77	3,920
2003	6,479	34	2,036	328	77	4,004
2004	6,911	32	1,746	367	84	4,682
2005	7,437	39	1,804	398	88	5,108
2006	8,000	40	1,970	445	113	5,432
2007	9,055	50	2,233	517	137	6,118
2008	10,100	59	2,755	558	161	6,567
2009	11,538	64	3,670	601	215	6,988
2010	12,365	79	3,767	678	249	7,592
2011	13,141	91	3,988	722	282	8,058

Source: Ministry of Health, “Healthcare financing sources,” <http://www.moh.gov.sg/content/moh_web/home/pressRoom/Parliamentary_QA/2013/healthcare-financing-sources0.html> (accessed on 22 March 2014).

Weaknesses of the Healthcare Financing System

Scholars and commentators have evaluated Singapore’s healthcare financing system according to three criteria: efficiency, equity and adequacy.

¹⁴ Ministry of Health, “MediShield Premiums,” updated 1 March 2013, <http://www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/MediShield/Premiums.html> (cited 30 April 2013).

¹⁵ See Central Provident Fund Board, “General Information on MediShield Scheme”, updated 26 March 2013, <http://mycpf.cpf.gov.sg/CPF/my-cpf/Healthcare/General_Info_MSH-Scheme.htm> (cited 30 April 2013).

¹⁶ Ministry of Health, “Healthcare financing sources”, updated 13 May 2013 <http://www.moh.gov.sg/content/moh_web/home/pressRoom/Parliamentary_QA/2013/healthcare-financing-sources0.html> (cited 30 May 2013). Refer to **Appendix A** for a detailed breakdown of the healthcare financing sources.

First, Asher and Nandy argue that the financing system is inefficient because it has limited risk-pooling features such as mandatory health insurance or broad government subsidies, which are widely regarded as efficient as they address adverse selection and other market failures.¹⁷ As previously discussed, MediShield is *not* an extensive risk-pooling arrangement when measured against the universal health insurance of other developed economies. This is because MediShield operates very much like private insurance and is run on commercial, rather than social, principles. As noted, to prevent cross-subsidisation, premiums are not pooled across age groups. MediShield also excludes both high-risk individuals (the elderly above 90 and those with severe pre-existing conditions),¹⁸ and a wide range of health risks from coverage. While private insurers have filled in the gap by providing insurance plans that cover some of the health risks currently excluded from MediShield, these insurers stop short of providing affordable coverage for high-risk individuals. These individuals are thus forced to accumulate large savings to finance healthcare episodes that may or may not materialise, leading to an inefficient and inequitable curtailment of their consumption and well being.

Second, Abeysinghe, Himani and Lim argue that the reliance on personal and family responsibility and co-payments means that the system is highly income dependent.¹⁹ This is not problematic if the healthcare financing system is progressive, that is, the government subsidies provided to lower and middle income Singaporeans are large enough to ensure that they spend a smaller fraction of their income on healthcare than richer individuals. There is admittedly little hard evidence that sheds light on the progressivity (or lack thereof) of the financing system. Abeysinghe, Himani and Lim speculate that if HDB 1-3 rooms, 4 rooms, 5 rooms & executive, private flats and landed property owners sought treatment at Class C, B2, B2+, B1, A wards respectively, the financing system would be regressive.²⁰

A related concern is the extent to which the current healthcare financing system provides “peace of mind”. A 2012 survey by Mindshare revealed that 72 per cent of respondents agreed with the statement “we cannot afford to get sick these days due to the high medical costs”.²¹ The staggering agreement raises question about whether healthcare remains affordable and accessible for the *majority* of Singaporeans. If healthcare is affordable on average, further questions ought to be raised about the reasons for the gap between the actual and perceived cost of healthcare.

A discussion about the equity of the financing system will not be complete without considering Medifund, the means-tested financial assistance scheme. Medifund’s stringent and opaque eligibility criteria have led some to challenge its efficacy in providing assurance to Singaporeans facing large medical bills. For example, Member of Parliament Lam Pin Min recounted the story of Marjorie Soh who was diagnosed with bone cancer in 2003 and raked up an estimated \$400,000 in medical bills. Her bills were financed through the sale of her family’s flat, her family’s savings, bank loans and the good will of friends. Lam asked his fellow parliamentarians if Singaporeans should be “subject to financial distress in seeking medical treatment”; if they should “have to borrow from banks and friends to pay their bills”; and if they should have to “sell their assets before they can qualify for

¹⁷ See Asher, and Nandy, “Healthcare Financing in Singapore: A case for systemic reforms,” International Social Security Review 59.1 (2006): 87.

¹⁸ Those with pre-existing medical conditions form less than 1% of the total resident population.

¹⁹ Abeysinghe, Himani and Lim, 14.

²⁰ Abeysinghe, Himani and Lim, 15. The hospital expenditure as a share of income would be as follows: Class C (47%), B2 (34%), B2+ (28%), B1 (40%), and A (40%) (Abeysinghe et al, 2010). The authors used data of 30,192 hospitalisation episodes of 18,935 elderly patients who sought treatment at a tertiary public hospital in 2007. They linked dwelling types to the class of ward used by the patient to overcome the constraint of the absence of data that links income to patient expenditure.

²¹ Joyce Hooi, “Singapore’s emigration conundrum,” Business Times Singapore, 6 October 2012, n.p.

medical assistance under the stringent eligibility criteria”.²² Cases like Marjorie’s, while not representative, demonstrate that some Singaporeans, especially those who do not (or cannot) accumulate sizable savings, might face significant financial distress when their family members experience a catastrophic health condition.

Third, there are signs that the financing system may be inadequate. Many Singaporeans do not meet the Medisave Minimum Sum, or the minimum amount of savings that they must accumulate in their Medisave when they turn 55 (see **Exhibit 4**). In addition, MediShield is not universal; as at the end of 2011, it covered 92 per cent of the population and excluded 35 per cent of elderly above 75.²³ Moreover, though MediShield is ostensibly for protecting patients from catastrophic health expenses, Abeyasinghe, Himani and Lim find that MediShield covered only 40 per cent of the most expensive 10 per cent of medical episodes faced by elderly seeking treatment in a particular public hospital in 2007.²⁴ Separately, academics Asher and Nandy have criticised the exclusion of high-risk individuals from Medishield and its exclusion of many health risks from coverage.²⁵ Medishield also excludes those who cannot afford the premiums. Between 2006 and 2011, about 1 per cent of MediShield policyholders saw their policies lapse each year due to non-payment of premium caused by insufficient Medisave balances.²⁶ Low-income elderly Singaporeans, who have to pay high premiums, may be especially vulnerable to such lapses of their and their family member’s MediShield policies.

Exhibit 5: Percentage of CPF members (excluding the self-employed) meeting MMS at 55



Source: Ministry of Finance, “Growing Incomes and Strengthening Social Security,” <http://app.mof.gov.sg/data/cmsresource/SPOR/2012/SPOR%202012%20Chapter%202.pdf> (accessed 22 March 2014).

Changes in Singapore’s Operating Context and its Impact on the Welfare Regime

²² Parliament of Singapore, “Debate on President’s Address,” 17 October 2011 (Dr Lam Pin Min), <<http://160.96.186.106/search/topic.jsp?currentTopicID=00076369-WA¤tPubID=00075801-WA&topicKey=00075801-WA.00076369-WA%207%2Bpresident-address%2B>> (cited 30 April 2012), column 67-68.

²³ See Ministry of Health, “MediShield Coverage of Population,” updated 17 February 2012, <http://www.moh.gov.sg/content/moh_web/home/pressRoom/Parliamentary_QA/2012/medishield_coverageofpopulation.html> (cited on 30 April 2013). MediShield coverage for those below age 21 stood at 94%. Of the working age population (those 21 to 65 years old), coverage was 95%.

²⁴ Abeyasinghe, Himani, and Lim, 10.

²⁵ Asher, and Nandy, 89.

²⁶ Ministry of Health, “Medishield Lapsed Policies,” updated 11 September 2012, <http://www.moh.gov.sg/content/moh_web/home/pressRoom/Parliamentary_QA/2012/medishield_lapsedpolicies.html> (cited 30 April 2012), para 1.

Overlaying the weaknesses of the financing system are the changes to Singapore's socio-political context. Population ageing is producing a new set of policy and political challenges. As the population ages, the national healthcare spending (both public and private) will increase since older persons consume more healthcare than the young. The risks associated with ageing, whether retirement adequacy or healthcare financing, are mostly concentrated on the individual and the family. This financing arrangement accentuates the rising income inequality in Singapore because richer households are better placed to absorb the risks faced by an ageing member than a middle or low-income household. The rich may also be able to afford significantly better care for their elderly members. These divergent circumstances between the rich and the rest have the potential to offend Singaporeans' sense of fairness, triggering a re-examination of a welfare regime founded on personal and family responsibility.

Apart from sharpening the differences in the quantity and quality of healthcare that rich and poor (or middle income) households can afford, income inequality can also reduce intergenerational social mobility. Economists studying Western economies have found a negative correlation between income inequality and intergenerational mobility – that is the higher the income inequality in a society, the greater is the correlation between the incomes of fathers and their sons.²⁷ While there is no evidence as yet to suggest that social mobility has declined in Singapore over time, Prime Minister Lee Hsien Loong remarked in 2011 that “[w]e are seeing our society stratifying, which means that children of successful people are doing better while the children of less successful people are doing less well ... (MPs) see these in our daily lives, we watch out for it because we are shepherds and responsible for Singaporeans”.²⁸ If the Prime Minister's diagnosis is correct, declining social mobility will inevitably reduce the ability of “less successful” households to share and pool risks, and to improve the life chances of the next generation. This could well be another factor that could offend the sense of fairness among Singaporeans and lead to calls for greater social protection and more vigorous fiscal redistribution.

Singaporeans are also concerned about the high cost of living. The Institute of Policy Studies' (IPS) Post-Election Survey 2011 revealed that 85 per cent of respondents felt that cost of living was important or very important in their voting decisions; this marked a 9 percentage points increase from the 2006 Post-Election Survey.²⁹ As medical cost continues to increase, it is likely to weigh on the minds of Singaporeans. The larger increase in healthcare costs relative to median and lower wage growth would also lead to gaps in the ability of low and lower middle-income families to afford good healthcare over their lifetimes.³⁰ This is because their modest wage gains limit their ability to accumulate sufficient savings to finance their own and their families' healthcare expenditures. This problem is likely to worsen as the population ages. The confluence of rising healthcare costs, stagnating wages, rising income inequality and population aging is likely to increase the demand for redistribution, which might, in turn, lead to incremental shifts away from personal and family responsibility.

Perhaps politics is the most vexatious of all the structural changes to Singapore's operating context. The 2011 General Elections has resulted in a significant transformation of Singapore's politics. There

²⁷ Corak, “Inequality from Generation to Generation: The United States in Comparison,” in Robert Rycroft, ed. *The Economics of Inequality, Poverty, and Discrimination in the 21st Century* (Santa Barbara, California: ABC-CLIO, 2013).

²⁸ Prime Minister's Office, “Speech by Prime Minister Lee Hsien Loong at the Debate on the President's Address, 20 October 2011 At Parliament”, updated 24 October 2011, <http://www.pmo.gov.sg/content/pmosite/mediacentre/speeches/interviews/primeminister/2011/October/Speech_by_Prime_Minister_Lee_Hsien_Loong_at_the_Debate_on_The_President_Address.html> (cited on 30 April 2013), para 6.

²⁹ Institute of Policy Studies, Singapore, “POPS (4) IPS Post-Election Survey 2011,” updated September 2012, <http://www.spp.nus.edu.sg/ips/docs/events/pops/POPS%204_May%2011_slides.pdf> (cited 30 April 2012).

³⁰ Between 2009 and 2012, medical inflation increased by 9% (Singstat, 2012).

is now greater political competition and lower popular support for the PAP as evidenced by the six-percentage points decrease in popular votes for the PAP. The electorate, which used to trust the PAP government by default, today demands greater voice, accountability and political representation. Admittedly, it is difficult to get a sense of what concerns the large majority of Singaporean where politics and policies are concerned. Are Singaporeans dissatisfied with the social compact and the healthcare financing system that prioritises personal responsibility over social protection? Or are they unhappy only with the inadequacies of the policies that impinge on their daily-lived experience, such as public transport, housing, and immigration policies? Perhaps, their disaffection is with the PAP government's heavy-handed, non-consultative, government-knows-best *style* of governing rather than its substantive policies? As the criticisms are often fragmented and diffused, it is difficult to distil what citizens want, and their positions on the level of social protection that the state should provide in healthcare, especially for the sick, old, poor and those who currently excluded from MediShield.

Finding a Cure

To recapitulate, the main deficiencies of the healthcare financing system are its poor coverage in terms of the types of people and the types of health risks that it covers. Healthcare may be unaffordable, especially if patients face catastrophic medical bills. The system also falls short in giving Singaporeans "peace of mind". The policy options available to the healthcare policy maker ranges from the incremental to the radical.

If policymakers choose an incremental approach, they might pursue the following to foster greater "peace of mind":

1. *To address limited coverage*, MediShield can include high-risk individuals at actuarially fair premiums. MediShield could also insure against a greater variety of health risks at higher premiums. Alternatively, policymakers can continue to exclude high-risk individuals from insurance coverage and instead increase efforts at assuring high risk individuals that financial assistance will be made available to them through Medifund should they face bills that they cannot afford.
2. *To address concerns over affordability*, the Government could increase tax-financed subsidies for healthcare and therefore its share of national healthcare expenditure. It could also increase the variety of health risks covered by MediShield and raise the claim limits. The mean-testing criteria for Medifund can also be relaxed to make it easier to qualify for financial assistance.

If policymakers choose a more radical approach, they could consider the following:

1. *To address limited coverage*, they could make MediShield universal and compulsory so that everyone, regardless of age, health and economic status, is covered. To ensure that premiums are affordable, policymakers can rely on more extensive risk-pooling so that there is cross-subsidisation between the rich and poor (as a result of premium subsidies given to the poor); young and old; and healthy and sick. Extensive risk-pooling will improve the equity of the healthcare financing system. MediShield could also insure against a greater variety of health risks.

2. *To address concerns over affordability*, policymakers could impose stop-loss limits that cap the financial risks patients face. These limits would ensure that patients know upfront the financial risks that they will be exposed to should they face a particular health risk.

Discussion Questions

1. What are the challenges facing Singapore's healthcare financing system? How do these challenges constrain the policy interventions that the healthcare policy maker can propose to the elected government?
2. What principles should guide the review of the healthcare financing system? Based on the principles, what is the best mix of interventions that healthcare policy makers can make?
3. Given the diffused and fragmented nature of public debate on policies and healthcare policies in particular, how should the principles and policy changes be explained and communicated to Singaporeans?