Report

IPS Workshop on "Healthcare Financing for the Elderly in Singapore"

29 May 2013

Introduction

Singapore's healthcare system has enjoyed widespread international acclaim since 2000 when the World Health Organization proclaimed Singapore's system the sixth best in the world, whilst in the World Health Statistics 2010 Singapore ranked second lowest for infant mortality and ninth highest for life expectancy at birth (81 years). Notwithstanding these robust health metrics, Singapore spent only 4.0% of its Gross Domestic Product (GDP) on healthcare services in 2010, less than half of the United Kingdom (9.6%) and less than a quarter of the United States (17.6%).

Singapore's public healthcare system is widely considered to be well-designed and financially sustainable. The combination of subsidies in the public healthcare sector and the "3Ms" system of financing (Medisave, MediShield and Medifund) ensures that all Singaporeans have affordable access to good healthcare while still providing patient choice. State ownership of public hospitals, as well as its dominant role in the supply of tertiary healthcare helps to contain cost pressures.

Singapore's healthcare system will face a number of significant challenges in the years to come, but especially so in the next 10 to 15 years with the rapid ageing of the population due to increased longevity, decades of below-replacement fertility and the ageing of the baby boomers. Many of the current and future elderly aged 65 and older have insufficient Medisave balances to provide for their healthcare needs; CPF data showed that at the end of 2011, 40% of active CPF members, or 708,000 members, did not have the $36,000 Medisave Minimum Sum at age 55. The growth in the proportion of the elderly in the population will increase the demand for expanded financing of healthcare.

This workshop brought together policy-makers, practitioners and academics to discuss sustainable solutions to increase healthcare financing coverage for the elderly, and specifically examined the Dutch *Standaard Pakket Polis* (Standard Package Policy, or SPP) model. In their presentation, Martin Bontje, former Managing Director of the Association of Dutch Healthcare Insurers and Chairman of the Association of General Practitioners Netherlands (VHN) and Jan van den Berg, President Asia of Pramerica Financial[1], shared some of the features of the Dutch SPP that they felt Singapore could consider as the country reviews its system of healthcare financing.

To kick off the presentations session, Dr Jeremy Lim, Principal Consultant from Insights Health Associates spoke on the healthcare challenges confronting Singapore's elderly population, whilst Lai Wei Lin, Director (Healthcare Finance)

1. Guest speaker, Martin Bontje, is based in the Netherlands while Jan van den Berg is based in Singapore.

from the Ministry of Health rounded up the session with a presentation on Singapore's healthcare financing system. Participants came from government agencies, healthcare practitioners and consultants, life insurance companies, the social service sector and academic institutions.

Presentation by Dr Jeremy Lim: "Healthcare Financing for the Elderly"

Dr Jeremy Lim's presentation focused on three main topics: (1) the challenges presented as a result of Singapore's ageing population; (2) the need to match healthcare resources to cater to rising clinical needs of a larger elderly population and (3) setting up a conceptual "flow" model of elderly healthcare financing.

Dr Lim cited projections from the National Population and Talent Division (NPTD)[2] showing a more than tripling in the number of elderly citizen population from 2005 to 2030 (from 270,000 in 2005 to 900,000 in 2030, or from 9% to 24% of the citizen population). He noted that most of Singapore's hospitals are in practice already geriatric hospitals given that utilisation of the hospitals is the highest amongst the elderly. He cited a study by the NUS Saw Swee Hock School of Public Health projecting that Singapore could have as many as one million diabetics by 2050[3], which may have implications for long-term care and its financing.

Healthcare infrastructure in Singapore is below the OECD average and at the lower end of the range of selected OECD countries[4], which included Japan, Germany, the UK and Finland. Singapore's projected ratio of 2.27 acute beds per 1,000 population in 2020 is still markedly below the OECD average in 2011 of 3.40. With regard to manpower, staffing would likely continue to be a significant challenge as Singapore is not the only choice destination for global healthcare talent. Dr Lim noted there was an opportunity to leapfrog the OECD countries in healthcare infrastructure in terms of efficiency and sustainability, as Singapore was not weighed down by legacy infrastructure (for example, older, less efficient hospitals and under-funded pension schemes for retired health workers).

Dr Lim pointed out significant intergenerational transfers in healthcare financing — both in terms of both money and time — that impact especially the sandwich class. The accumulated savings of the elderly for healthcare purposes have become inadequate due to healthcare cost inflation; the elderly are consuming healthcare in 2013 prices with earnings from the 1980s and 1990s. At the same time, we now have a more educated public with higher expectations for their healthcare.

He agreed with the government's stance on co-payments, which are seen as necessary to reduce moral hazard and over-consumption, and that subsidies would need to be targeted notwithstanding a commitment to increase healthcare expenditure. He reiterated Deputy Prime Minister Tharman Shanmugaratnam's

2. NPTD Occasional Paper. Projection of Foreign Manpower Demand for Healthcare Sector, Construction Workers and Foreign Domestic Workers (Nov 2012).
3. S. Khalik, "1m diabetics by 2050 as Singaporeans get older, fatter", *The Straits Times*, 2 October 2012. Straits Times, 2 Oct 2012, at http://www.straitstimes.com/breaking-news/singapore/story/1m-diabetics-2050-singaporeans-get-older-fatter-20121002.
4. OECD 2011 data from OECD Stats Extracts at http://stats.oecd.org/.

comments that a greater priority be placed on preventive and primary care in a shift in the balance of Singapore's spending on healthcare[5].

Presentation by Jan van den Berg and Martin Bontje: "Towards Healthcare Insurance Coverage for all Singapore's Elderly"

Van den Berg started his presentation by sharing a personal anecdote of having met a 76-year old taxi-driver who described himself as both lucky and unlucky. The taxi-driver had retired at age 61 after a career in a multinational company but had been diagnosed with cancer a couple of years later. Although he had been lucky to be cured from cancer, the treatment had exhausted his savings, and thus he had been forced to return to work as a taxi-driver so as not to be a burden to his children.

Van den Berg acknowledged that the Singapore healthcare system had won widespread international acclaim for its quality, cost and public financial management. However, he also noted there was significant stress on public health providers whilst private providers had unusually high service levels partly based on excess capacity (private health providers are generally not operating at full capacity in Singapore). He also pointed to Singapore's proportion of private (individual and family) funding of healthcare costs, which at 67% was the highest in the world. Private insurance funding is low, representing only 4.7% of the total for hospitalisation payments amongst those above 65 years of age[6], which could indicate that some elderly may struggle to pay for their treatments, or settle for less treatment than is optimal. Low insurance coverage for the elderly, resulting from prohibitively high premiums and ineffective funding vehicles for the elderly (as a result of onerous premium payments and inadequate coverage) was a major financing concern. Whilst the Medishield coverage for the total Singapore population stands high (higher than 90%), the cover for those older than 65 is relatively low.

He noted the dominant mode of insurance in Singapore is term life insurance, whereas an adoption of whole life insurance concepts could potentially even out age-based premium differentials. He believes that aspects of the Dutch SPP could be adapted to the Singapore healthcare financing system as it complies with key principles embedded in the Singapore system (universal access, private funding and individual responsibility) and is not dependent on public funding.

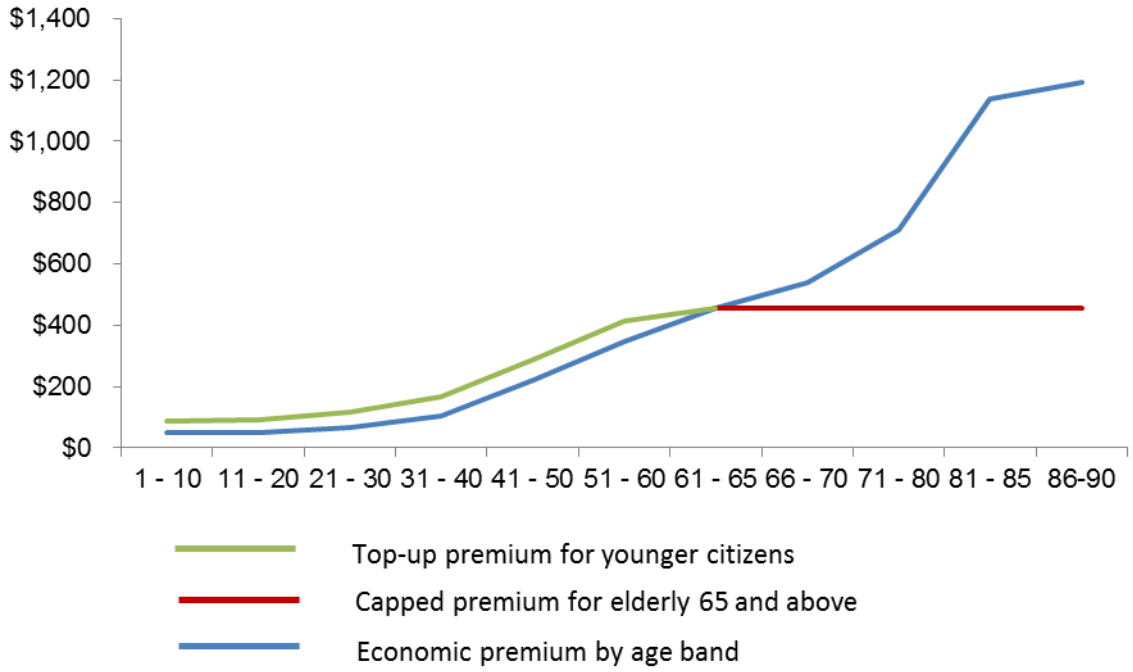
Bontje provided a summary of the SPP in the Dutch health insurance system from 1987 to 2006. He began by noting that the Dutch health insurance system comprised three components: a mandatory social insurance for long-term care and chronic mental care (known as AWBZ); a mandatory insurance with coverage for hospitalisation, primary care, drugs and maternity for those with incomes below a certain level (known as *Ziekenfonds*); and private health insurance with broader coverage for those with incomes above the level. The SPP arose from a tweaking of the private insurance component in 1987. That year, all of the private insurers in the country came together to create the SPP specifically for retirees who would have

5. Singapolitics. "Ask DPM Tharman", 12 April 2013. http://www.singapolitics.sg/features/ask-dpm-tharman-full-transcript.
6. T. Abeysinghe, H. Agarwal and J. Lim, "Singapore's Healthcare System: Some Challenges", a presentation at the Singapore Economic Policy Conference 2009.

been excluded from group health insurance schemes organised by employers upon their retirement, and who would have had to insure individually at risk-based premiums which were prohibitively expensive.

The SPP was an affordable fixed premium insurance scheme with a broad coverage (more than those provided by private insurers at the time). Set at a level that was higher than that for the individual privately insured person aged 64 years, but lower than for the individually insured person aged 65 years, the premium was not linked to health status or age. Risk variances between private health insurance companies due to the different risks presented by individual policy-holders were compensated through risk equalisation and a common risk pool. Where the claims were higher than the premiums received, the losses were pooled and "recovered" from younger insured cohorts via a top-up premium (set initially at about 10–15% of the risk-based premium). Insurers received an administration fee for servicing the SPP, amounting to about 8% of premium payments (and incorporated into the economic premium).

Figure 1. Illustration of SPP premium determination by age band



At the inception of the scheme, all privately insured elderly aged 65 and older could choose the SPP. Subsequently, everyone who turned 65 years old had a one-time option to join the scheme (which broadened the pool of insured and minimised adverse selection). In effect, almost all eligible persons continued participation in the SPP because of the low premium and broad coverage.

According to Bontje, the Dutch government supported the SPP through legislation covering (inter alia) premiums, coverage, eligibility, pooling rules and administration fees, via the establishment of a regulatory body, the *Stichting Uitvoering Omslagregeling* (SUO). SUO was a strong body that managed the central risk pooling and monitored the insurance companies to ensure eligibility rules were followed, audited claims related to the SPP, and ensured the insurers kept proper

financial records and accounts. SUO had the authority to impose strict penalties on non-conforming insurers. SUO also monitored the insurance companies to keep control of hospital bills. As costs of the SPP are pooled, there is no incentive for the insurance companies to control hospital bills.

Some issues with the SPP were highlighted by Van den Berg, namely, the coverage was too broad (which led to higher than anticipated claims) and that the expansion of eligibility to other groups apart from the elderly led to rising premium top-ups, which rose to 20% of the total premium, from 10–15% at the SPP's inception.

Van den Berg pointed out that there were four conceptual levers that could be adjusted when considering the implementation of a SPP-like system in Singapore: (1) Entry Age; (2) Eligibility; (3) Coverage and (4) Government Subsidies. He also indicated the need for the pooling of risks to insure senior citizens effectively, with compulsory coverage the best way to minimise adverse selection. In his opinion, Singapore had the ability to structure sustainable coverage for senior citizens by restricting eligibility to the SPP strictly to seniors — and not to broaden eligibility with other risk groups — and that initial coverage could be restricted to not more than what was covered by MediShield, with care tailored for old age needs and structured in favour of palliative geriatric care instead of expensive cure interventions, especially for the oldest seniors. Whole life coverage would offer security to the young, although top-up premiums would need to be tightly controlled to ensure sustainability of the system.

Specifically, Van den Berg suggested an entry age of 70 initially, which could be lowered to 65 once the system was stabilised and the top-ups contained. Eligibility could begin with an age band of 70 to 85 years, with the oldest seniors aged above 85 sequestered and provided for with government subsidies on a closed book basis (funded by a one-off contribution). The eligibility band could be extended by one additional year as each year passes, to maintain coverage of those included in the system to begin with, and participation would be compulsory for all. In terms of the government's role, he suggested that the state could subsidise top-up premiums for selected groups until the system was stable.

He concluded with a list of conditions that needed to be in place before an SPP-like scheme could be implemented in Singapore. These included:

1. Estimates of healthcare consumption for the group of elderly who are currently un- or under-insured;
2. Precise calculations of actual hospitalisation costs for the elderly in the past year and reliable estimates of these costs going forward;
3. Reliable estimates of the population participating in the scheme, especially in the elderly category;
4. Clear definition of the coverage provided and precise definition of hospital costs that would be covered;
5. Central pooling system of actual claims paid to hospitals and the collection of premiums;
6. A group of private insurance companies that would be needed to administer the scheme;

7. A regulatory body that supervises the implementation of the scheme and controls the central pooling system; and
8. Capacity testing of public and/or private healthcare providers for certain types of treatments.

Presentation by Lai Wei Lin, "IPS Workshop: Healthcare Financing for the Elderly"

Lai's presentation covered the general objectives of healthcare financing in Singapore — affordability, accessibility, quality and sustainability — and provided the historical development of its hybrid healthcare financing system (i.e., funding provided by a combination of government subsidies, insurance, and out-of-pocket (OOP) expenditure paid through savings). She shared about the "3Ms" system: Medisave (individual health savings scheme for all workers built from employment income to help with retirement healthcare expenses); MediShield (state-run, low-cost health insurance scheme that risk-pools protection for catastrophic expenses); and Medifund (a safety net for those in need to ensure no Singaporean is denied access to healthcare by the inability to pay).

Whilst Singapore's health indicators had improved markedly over the years, challenges to the system are expected to arise from an ageing population, a growing burden of chronic diseases from longer life expectancy and medical cost inflation (from price factors as well as quality improvements).

The government has introduced several recent initiatives to improve healthcare affordability and accessibility for Singaporeans. Initiatives to improve affordability include expanded eligibility for the Community Health Assist Scheme (CHAS); greater subsidies for Intermediate and Long Term Care (ILTC) services; and support for elderly at home, amongst others. Initiatives to further increase accessibility includes more acute and community hospital beds and more Community Health Centres and Family Medicine Centres. The government also plans to increase access to aged care services through the roll-out of additional nursing homes, senior care centres and senior activity centres by 2020, and to improve the quality of such services with enhanced standards and integration across care settings and between the social and health care support infrastructure. Health manpower capacity would be increased by 50% (or 20,000 more persons) between now and 2020 with local training capability to be boosted and supplemented with foreign-trained professionals (both Singaporeans and foreigners).

The government has been seeking feedback from the public about their concerns regarding healthcare. Respondents noted that some key concerns were with rising healthcare costs, uncertainty over the possibility of incurring large bills and the cumulative costs of chronic conditions. Some respondents also wanted greater understanding of the options available for long-term care for their parents and for themselves in the future.

Lai shared four thematic areas for consideration by workshop participants:

1. Engendering greater shared responsibility to tackle rising healthcare costs through joint action, such as clinical guidelines, and encouraging responsible utilisation and consumption of healthcare.

2. Enhancing risk-pooling to improve assurance for all Singaporeans, while guarding against over-consumption. To also address how to best fund lifelong insurance coverage, such as by considering pre-funding so that premiums do not rise sharply in old age.

3. Broadening Medisave in line with its role while ensuring sufficient savings for old-age needs.

4. Ensuring sustainability with peace of mind: As Singapore's population ages, National Health Expenditure is likely to rise in absolute terms and as a percentage of GDP. How can these increases be financed in a sustainable manner?

Discussion on Health and Eldercare Coverage and the Economic Implications

There was consensus amongst workshop participants over the need for healthcare expenditure and health and eldercare coverage to be increased given the demographic trends. In general, there was an appreciation that Singapore's "3Ms" system worked reasonably well, although some participants felt that there was too much reliance on Medisave. One participant noted that the large savings base provided a good starting point, but another was of the view that health savings accounts can only go so far to provide a level of coverage commensurate with expectations of well-being in a developed country, and that better risk-pooling and health insurance was necessary.

Some participants shared historical background and underlying philosophies of Singapore's healthcare financing system, noting that there was a greater need for a compulsory and more comprehensive system. According to one participant, in Singapore the dominant practice was to cover by way of exclusion, and by excluding a large number of conditions, Singapore's health financing metrics look very good, but this may lead to socially inadequate and undesirable outcomes.

The subjects of pre-existing conditions and exclusions from MediShield were brought up to highlight the point that notwithstanding MediShield's strengths, it cannot be considered a national, comprehensive health insurance scheme.

Dr Lim raised the issue of solidarity, that Singaporeans have been sold on the idea of individual responsibility for such a long time, and questioned how prepared we are to now share their hard-earned savings into a common pool? A participant argued that an over-emphasis on individual responsibility made us look very selfish, and there has to be a balance between a tax-based system to help those that cannot pay, a strong base of medical savings framed in a family-first context and an insurance system that efficiently pools catastrophic risks. Workshop participants generally agreed that more discussion over social redistribution was needed, and it was noted that these issues were likely to feature in the on-going Our Singapore Conversation process.

A couple of participants highlighted the need for inflation-indexation of the government's share of National Health Expenditure. Dr Lim added that Singapore lacked a transparent system to decide on what is and is not covered by health subsidies. In establishing such a system (which had already been set up in jurisdictions such as the United Kingdom, Canada, Sweden, South Korea, Taiwan and Australia), it would be important to pay attention to rising expectations of healthcare quality from the people and look at the value generated by any incremental healthcare spending.

There was an extensive discussion on sequestration of the group of elderly Singaporeans who did not accumulate sufficient savings over their working lifetimes, in order to isolate the specific issues pertinent to this group instead of complicating the debate over the structural, long-term issues of healthcare financing. Some participants were in favour of using national reserves to cater to this group, although they were also aware of the issues of potential over-consumption and under-supply if this were to happen. One person suggested that instead of an age threshold to identify the needy, it might be better to define this targeted group on the basis of a lack of Medisave balances.

Others pointed out that the government was already "writing cheques" to address the issues of healthcare financing faced by this group, and the process of moving towards solidarity had already started and would continue. The Government had provided increased subsidies both directly at point of healthcare consumption and via ad-hoc and regular Medisave top-ups to help less well-off Singaporeans. .

<u>Discussion on Administrative, Process and Infrastructural Changes to Provide for the Elderly's Healthcare Needs</u>

Van den Berg noted that there were many complex issues being considered, and that it was not possible to solve everything at once; one participant used the analogy of such radical reforms as "trying to convert a B747 to an A380 in mid-flight with a thunderstorm raging". Van den Berg's opinion was that a "Big Bang" approach to reform would be dangerous, but solutions driven by the right principles should be approached first.

There was consensus amongst participants that more data and analysis were required not just about the extra costs of financing the growing healthcare needs of an ageing population, but also the number of elderly who may need assistance as well as their caregivers. A participant pointed out that the government had largely outsourced eldercare to the voluntary sector and therefore had very little information about whether the donation dollars were really effective.

Bontje pointed out that in the Netherlands, long-term care was expensive, but was funded partly by health insurance and partly by eldercare insurance. One participant noted that if the government needed to step in and provide a level of re-insurance, then the system needed to be universal with no opt-outs. He noted that Medifund was established to cover vulnerable groups (those who cannot pay) and already performs a function of payer of last.

Dr Lim noted that Singapore, like many other jurisdictions, has a healthcare business model based on consumption, with a fee for treatment, instead of payments for keeping people healthy. Co-payments can dampen moral hazard, but incentives are still skewed such as not allowing Medisave to be utilised for a number of chronic diseases or for preventive or palliative care, leading to an accumulation of conditions until they precipitate into medical emergencies and hospital admissions where Medisave or MediShield can be tapped. A participant suggested that instead of a fee-for-treatment model, there was a need to introduce managed care models, possibly within the context of a universal social insurance scheme with co-payments.

Participants debated how to deal with "frequent fliers" (defined as those who use acute care facilities three or more times in a year). One participant suggested that these people be offered community-based alternatives instead of treatment at the first instance in an acute care hospital.

The workshop learnt that private insurers are not doing enough to control hospital costs. One insurance industry participant pointed out that it was possible for intense private sector competition to drive over-consumption — if the private insurers are competing on the basis of which is the most generous in paying claims. This generosity to private insurance claimants could then in turn fuel healthcare cost inflation for all. Other insurance industry participants made the point that insurers are being squeezed between policy-holders and the government and between profitability and the need to be affordable. They suggested the government set out very clear guidelines to manage competition amongst the insurers.

Bontje mentioned that in the Dutch system, the SUO collects a large amount of data and exerts pressure on the insurers to manage healthcare costs. Van den Berg pointed out that an effective pooling system would require the full co-operation of the insurers as well as a regulatory body like the SUO, which could be structured similar to the CPF (and linked to the culture and values of the local population).

Participants agreed that ElderShield was not a complete solution. For example, ElderShield claims are only permitted when three out of six Activities of Daily Living (ADLs) are compromised, but a practitioner observed that it is sometimes difficult to identify whether some people fall into this category especially when they say they are fine. Furthermore, ElderShield covers only physical disabilities, and those with mental health issues such as dementia would not be eligible for payouts.

Workshop participants concluded that the objective of these changes would be to give more certainty to Singaporeans, both young and old, about their healthcare expenditure. There was a need to look holistically at the health and eldercare systems, and to calibrate the mix of funding from savings, taxation and from risk-pooling.

Main Takeaways from the Workshop

Two important principles emerged from the workshop: it was recognised by participants that Singapore's healthcare financing system needed to (1) incorporate more universal insurance coverage both of people and of conditions, and (2) shift

towards whole life insurance model (rather than term insurance which currently dominates). Adopting these principles would mean minimising exclusions by reducing or eliminating age-based risk premiums, and including those with pre-existing medical conditions in the risk pool. Coverage should be extended by default to more groups, including home-makers and lower-income groups (in 2012, 8% of the population was not covered by MediShield[7]), with the system incorporating strong disincentives to opt out of this national health insurance scheme.

The infrastructure and administration of Singapore's MediShield scheme appears to be a foundation upon which such a system could be built, with elements such as the establishment of a risk equalisation fund and a strong regulatory body (similar to SUO) to be added if the Dutch SPP system were to be emulated.

Strong consideration would also be needed to ensure that such a scheme similar to the Dutch SPP system remains sustainable in the longer term, especially with a rapidly ageing population that will incur increasing healthcare expenditure. The scheme was also dependent on the younger population's agreement to co-fund expenses for elderly members, even as these costs rise with a shrinking pool of younger members.

Workshop participants concluded that there was a need to consider carefully how to cater for those who cannot pay for this insurance, especially the elderly, the disabled and low-income households. One consideration would be to sequester a target group (for example, the elderly poor defined as those aged 75 or above with no or insufficient Medisave balances) by taking responsibility for their premiums, with funding coming either from current and future taxation or from national reserves. Such a group would be closed with an age-bar, which would facilitate an accurate estimation of the actuarial liabilities from absorbing their premiums.

Another factor that may need to be considered in assessing whether elements of the Dutch SPP can be adapted effectively is the specific structure of the private insurance market and the life insurers in Singapore. Unlike Singapore, the Dutch private life insurance market is dominated by not-for-profit co-operatives, many of which have a social agenda. In Singapore, a small but competitive life insurance market is dominated by multinational insurers with a profit motive, making it potentially more difficult to co-ordinate industry-wide initiatives that may not have clear commercial returns. The government may therefore have to take a leadership role in establishing the main parameters of any reform of healthcare insurance.

Additional research and analysis would be required to calculate:

1. Reliable estimates of healthcare consumption for the elderly who are currently un- or under-insured;
2. Hospitalisation cost projections for the elderly going forward; and
3. Top-up premiums required for the younger cohorts

7. W.L. Lai, Ministry of Health, Presentation at the IPS Workshop on Healthcare Financing for the Elderly 29 May 2013.