

# **“Towards health care coverage for all Singapore’s elderly”**

**10 June 2013**

*Prepared –on personal title- for Institute of Policy Studies (IPS) for the IPS study day on May 29 2013  
by:*

*Martin Bontje, former Managing Director of the Association of Dutch health care insurers  
(Zorgverzekeraars Nederland), and*

*Jan van den Berg, President Asia of Pramerica Financial (Prudential Financial of USA, mail to:  
jan.vandenberg@pramericafinancial.com)*

## Introduction

Singapore has grown and developed faster than any other country in Asia over the last 40 years. Where previous generations may have been accepting of minimal welfare and social protection given the fledgling country’s meager finances, today’s citizens expect much more governmental interventions, especially in housing, education and healthcare. While the government is prepared to expand social safety nets, it is ambivalent about the extent of involvement. The fiscal impact aside, Singapore is loath to weaken the spirit of ‘self-reliance’ and ‘many helping hands’. Where and how can this balance be struck in healthcare, especially healthcare for the current elderly who may not have sufficient savings or insurance coverage?

History offers many lessons about what to avoid in terms of creating welfare nets. Europe’s welfare states that began as safety nets, have turned into elaborate and costly structures with incentives that undermined productivity and work ethic. The welfare states also are coping with autonomous cost increase around health care and social benefits that have grown into very substantial parts of their cost budgets. It is important to note that these systems have been built up over many decades, and since the eighties many governments have started taking measures to rationalize these welfare benefits.

While the Singapore government is very careful to preserve the strong tradition of hard work and sound government finances and not to make the mistakes the welfare states made, it faces the same challenges as any other government in terms of what citizens expect of their government.

Of all benefits that the welfare state can offer, good health care, accessible to all people regardless of their economic status, is generally viewed as a core characteristic of a highly evolved society. The ability of a society to mobilize quality health care, including supporting citizens in coping with old age and dying with dignity, is one of the highest dimensions of humanity a society can aspire to, especially for people who cannot help themselves.

Singapore health system has enjoyed widespread international acclaim. The quality of the care, as well as the financial management of the system has attracted interest with many governments across the world.

The Singapore government has formulated its philosophy as follows on the website of the Ministry of Healthcare:

“Singapore healthcare begins with building a healthy population through preventive healthcare programs and promoting a healthy lifestyle. Good, affordable basic healthcare is available to Singaporeans through subsidized medical services at public

hospitals and clinics. Our hospitals and healthcare system will never withhold help to a Singaporean because of financial limitations. Yet our philosophy promotes individual responsibility towards healthy living and medical expenses. Medisave, MediShield, ElderShield and Medifund schemes exist to help Singaporeans “co-pay” their medical expenses”.

As a consequence the proportion of private funding (as opposed to public funding) amounts to 67%, one of the highest in the world. Singapore has a relatively efficient health system, in terms of % GDP, the total health care expenditure ranks among the lowest among the countries with highest GDP per capita. A challenging aspect of this efficiency is the relative low health care consumption by the elderly: a study (note 2) conducted by SingHealth on how the elderly pay for their medical bills, also demonstrates the challenges in providing health care for the elderly in Singapore. A large proportion of the bills is paid by family members pooling their Medisave balances. A significant percentage of the total bill is also paid “out of pocket”. A large proportion of Singapore’s elderly does not enjoy medical insurance because insurance was relatively under-emphasized whilst they were younger. Today, due to risk rating and mandatory under-writing before coverage, many are effectively uninsurable. Even for those who had procured MediShield or other coverage, continuing insurance coverage is proving comparatively expensive as premiums are risk based and these premiums increase rapidly with age.

#### The challenge of improving penetration of health insurance for elderly

Singapore’s policy is very explicit for accessibility: public hospitals will never withhold medically necessary care to a Singaporean because of financial limitations. But the reality is that without insurance access to health care is limited. At the same time, health care insurance is not economic for people of age. The risk based premium that people would have to pay for their cover is prohibitively high and most people prefer not to pay this insurance premium but make an attempt to accommodate health care cost as and when they come. The SingHealth study concludes unequivocally that the way to go is to focus on deeper penetration of insurance for the elderly.

But how can that be done, as insurance premiums may always be prohibitively high for this group?

MediShield - an affordable catastrophic illness insurance scheme - was introduced in 1990. It is designed to help Singaporeans meet the medical expenses from major and prolonged illnesses which their Medisave balances may not be sufficient to cover. In her contribution to the IPS study day on May 29, Lai Wei Lin presented that 92% of the population are insured under MediShield or Medisave-approved insurance scheme. However, the coverage for the elderly has not been as widespread. In fact, whilst official figures have not been published, experts estimate that 40% of elderly Singaporeans aged 61 and above are covered by MediShield or Medisave-approved insurance schemes.

The Ministry of Health therefore recognized that there is a need to improve MediShield participation amongst the elderly Singaporeans. However, there were significant challenges. Most Singaporeans pay MediShield premiums out of their Medisave accounts and elderly Singaporeans tend to have lower Medisave balances, since Medisave was only introduced in 1984. Most of these elderly Singaporeans are also economically inactive and would likely have difficulties maintaining payment of premiums post-retirement, especially since as noted earlier, premium quantum typically spikes sharply with advancing age. Hence, the elderly are likely to rely on savings, immediate family members' Medisave or cash in the event of major illness and hospitalization, all of which are vulnerable to large bills since

there is no or limited risk pooling.

In 2001 the government took an action to facilitate the penetration of Medishield for elderly by subsidizing 2 years of premium. This was a strong measure. Despite the strong push, the measure was not highly effective. This could be because some of the elderly were already excluded due to pre-existing illnesses or some may have been concerned about their ability to pay the necessary premiums beyond the initial two years of coverage.

The Government is nonetheless determined to find solutions, as evidenced by a recent speech by DPM Tharman:

“We do need to provide **greater support for older Singaporeans**, particularly in healthcare and for their retirement needs. That's something which we want to do. And we have to go about it in a way that doesn't lead us to the problems we see in Europe and the United States or Japan, **go about it in a way that's sustainable**”.

#### Purpose of this paper

This paper aims to contribute to the intellectual debate around a solution to significantly increase the penetration of Medishield insurance for elderly. In reflecting on this aim, the philosophy of the Singapore government for its health care system was considered a core basis for working on possible solutions.

This paper is based on a health insurance structure that was prevalent in the Netherlands between 1987 and 2006 (“Standard Package Policy”). We believe that “insurance” is the most effective vehicle for delivering solutions for better access to health care for elderly.

#### It is possible to insure retired people for hospital care?

Yes this is possible, but it requires specific structural measures to position health care as a whole life cover, rather than as a term cover. The group of insured needs to be ‘closed’ to be able to run an insurance scheme: anti-selection needs to be impossible. Health care cost is very much age dependent. The table in note 2 shows the Dutch age distribution of hospital cost.

#### The Dutch invention: Standard Package Policy

In a collaborative effort between the insurance industry and the Dutch government a solution was developed to deliver affordable insurance for elderly. The Dutch elderly faced the same problem in the 1980s as the Singaporean elderly do today: health care insurance was simply prohibitively expensive. A key principle for this elderly policy was the maximized premium for elderly at a structurally lower level than their respective risk based premium (that reflects the actual health care consumption). The name of this policy was “Standard Package Policy” and it introduced a basis insurance cover with a related lower premium. The difference in actual cost and premium received was translated into a specific premium addition for younger people. This difference was recalculated every year and confirmed as per the law.

All elderly had the option at age 65 to opt-in. If they decided not to opt in, they could not enter later. In effect, all elderly opted in. Insurance companies supported this strongly. For them the SPP gave them a positive reputation with elderly, and allowed them to service this customer group for a fixed fee without the underwriting risks.

This model could serve as a model to be used by Singapore, as it fits within the core policy principles of MOH. The risks for elderly were pooled in a closed group of eligible people, who were admitted to

SPP at age 65 regardless of their pre existing conditions. The premiums were pooled between all insured and hence the funding was 100% private.

Comparing the demographic data of Singapore and the Netherlands, it is evident that Singapore's distribution is more favorable, which would indicate that it is should be easier to implement the elderly system in Singapore than in the Netherlands, the premium top up for younger people would be comparatively lower than in Singapore. In the Netherlands the premium top up was on average 10 to 15% when the SPP system was started in 1987. In Singapore this top up could therefore be lower.

Age	Netherlands	Singapore
0 – 14	17%	13,8%
15 – 64	67,4%	77,0%
65 and over	15,6%	9,2%.

The Dutch health system has received much recognition for the accessibility. The OECD measures many aspects of the health systems of its members and publishes these results in its annual report "Health at a glance" (note 3). Accessibility to citizens of health care is one aspect that is measured. The Dutch system is very well ranked for accessibility in subsequent rankings. Accessibility is limited by affordability (people not being to afford treatment), waiting time (an organizational characteristic of health care) and geographical distance to health care providers.

### 6.1.1 Unmet need for a medical examination, selected reasons by income quintile, European countries, 2009



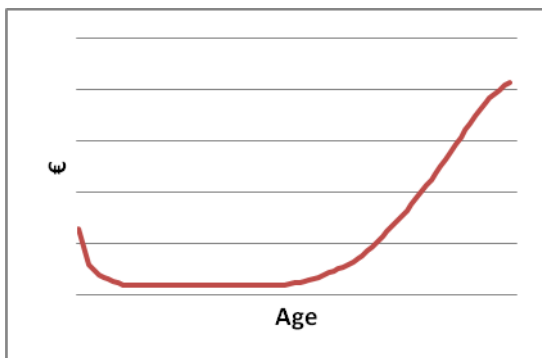
Source: EU-SILC.

StatLink <http://dx.doi.org/10.1787/888932525628>

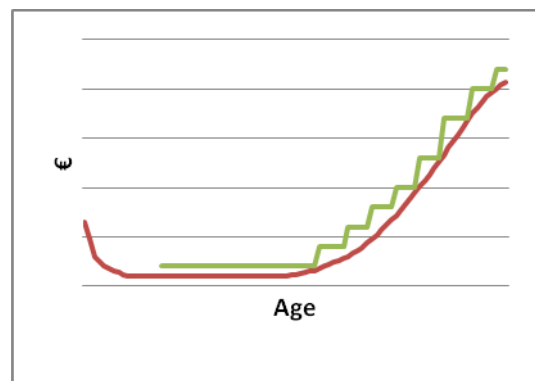
#### Basic workings of system illustrated

The following graphs demonstrate the basic principles behind the premium calculation in the SPP system.

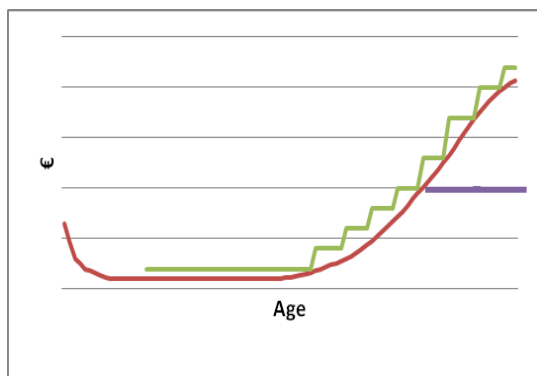
1. Distribution of health care cost per age band.



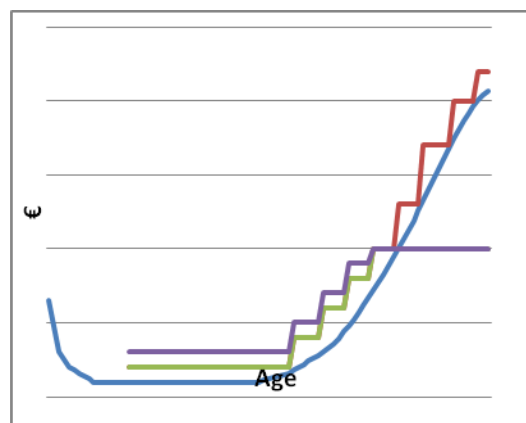
2. Economic Premium per age band:



### 3. Maximizing premium at age 65



### 4. Allocating the premium deficit to younger citizens (purple line).



### The development of the system

Analyzing the premiums of Medishield insurers, it is found that the premium of someone of 70 years is about 11 times higher than someone of 30 years old. These differences of premium reflect the average difference in health care costs between younger and elderly citizens. The premium of people older than 70 is rising very rapidly, similar to the experience in the Netherlands.

Age Next Birthday	MediShield Yearly Premiums
1 to 30	33
31 to 40	54
41 to 50	114
51 to 60	225
61 to 65	332
66 to 70	372
71 to 73	390
74 to 75	462
76 to 78	524
79 to 80	615
81 to 83	1087
84 to 85	1123

As a strawman, we assume that premium to be maximized at age bracket 71-73, which is about 8 times the premium of a young person (31 – 40 years old) and an entry age into the system at age 70. All Medishield insurance companies must rate the same maximum premium for these elderly above 70 years old. People up to 70 pay their respective age dependent premium plus the top-up. The insurance companies will also levy an administration fee for each insured elderly person. The administration fee is subject annually to negotiation between the insurance companies and the government. In the Netherlands this level was approximately 8 % of the premium. The SPP system in the Netherlands was not compulsory at the time, but in practice there was almost 100% participation, as the insurance companies were motivated to bring the elder customers in the SPP system, which eliminated their underwriting risk for the elderly and transformed it into a stable administrative fee. Making the system

compulsory introduces a complexity in the system that needs to be carefully evaluated. Dealing with people who do not pay their premium, but yet need medical care is very complex issue.

All Medishield insurers could be allowed to operate this system. This means that they will have two different kinds of insured people. The Medishield insured until 62 years old (or whenever the retirement age is) and the elderly persons in a SPP policy. The Medishield people pay their regular premium as well an additional premium top up. The elderly insured pay a premium at a maximized level for their SPP (8 times the premium of an 31- 40 years old person).

Each year each insurance company makes the following calculation:

The total premiums paid by the elderly + the total additional premiums paid by the “young” insured + the administration fee per elderly insured -/- the total health care costs of the elderly.

For some of them this will have a positive outcome. Then they have to pay to a central pooling. And some of them will have a negative outcome. They will be compensated by the central pooling. Of course it is necessary to control the correct calculation. For this reason the central pooling system/vehicle needs to have effective authority and control over the insurance company. In the Netherlands this vehicle was called SUO, it was a foundation specifically created for this purpose and charged by law with certain authorities. This body conducted periodic audits in the health care insurance companies and had effective authorities to levy corrected premiums and impose penalties in case insurance companies made omissions. The benefit to the insurance companies was the opportunity to service this customer group and earn an administrative fee, whilst not bearing the insurance risk.

#### Learning from the Dutch SPP experience: The Good and the Bad

In 2006 the Dutch health system was reformed into a national insurance system. The SPP philosophy was however kept, in that elderly kept an affordable premium level and the whole life insurance philosophy was maintained.

Prior to 2006, the Dutch took several decisions that undermined the sustainability of the SPP system. They allowed younger chronically ill people to enter the SPP population. Later they also allowed students to enter the SPP population. They also widened the SPP cover. The lesson learnt was that SPP is a very effective system, but it is imperative that the SPP eligibility and cover remain well controlled. Ideally the cover should be narrower for SPP, than for MediShield. These choices and decisions are sensitive, but very important to keep the system sustainable so it can accommodate expected demographic developments.

#### Conclusion & reflections

Given Singapore's stated policy for health care as well as its desire to expand coverage for elderly, the Dutch system of Standard Package Policy offers useful elements for a solution to insure significant higher proportion, if not all, of Singapore's elderly and thereby develop a meaningful next step-up in health care system evolution, clearly ahead of all other nations in Asia. In principle all Medishield insured people could be offered an SPP at age 65. The Medishield insured would see their insurance change from a term insurance to a whole life insurance, with a 10-15% premium top up, in exchange for which they would receive peace of mind of an affordable cover beyond their retirement. The SPP system can be built on the existing Singaporean system, with its existing 3M pillars. The SPP system is an insurance solution, entirely funded by the policy holders, which is consistent with the principles on which Singapore's current system is built. It would offer a meaningful improvement for a large group of citizens who have served Singapore's development for so many years but who –because of their age- benefited less from Medisave and other benefits that have been created for Singaporeans.

This note serves to support a discussion for a structural solution and help lay the foundation for a decision to start a detailed work to deeper explore possible solutions.

When reflecting on the implementation of the new system, it is important to note the existing situation where about 50% of elderly are already covered by MediShield. It seems that a structural change as discussed above would have to successfully reach a significant proportion of the 50% elderly people who are not already in MediShield. The objective is to improve lives of elderly people who are not already covered and increase their access to health care, as well as to provide a solution for elderly people who are already covered but struggle to continue to afford the premiums and might drop out at later age. Without a significant increase in covered people, the above system would only create higher premiums for younger people and subsidized premiums for elderly people who are already covered. In that case it would only be a generational subsidy.

From a feasibility perspective it may be helpful to think of 4 knobs that can be dialed up or down in implementation:

- Entry age: ideally the entry age should be set at the official retirement age in Singapore. The higher the entry age, the smaller the group is for whom subsidies are needed. The downside is of course that people below this age still need to pay the risk based premium. Implementation of the new system could be such that to enroll in the future people need to enroll in MediShield now and pay risk based premium until they reach the entry age. The implementation could be dialed such that it is commenced at a certain age, say 70, but that this entry age is dialed down over time to the official retirement age.
- Eligibility: if unrestricted above entry age, the group is maximized, but the group could be restricted by for example excluding people above a certain age and then gradually increase this age over time year by year as the eligible group ages. For these very senior a separate solution outside the SPP funding system could be conceived, to deal with this group separately as this generation could not benefit from the Medisave policies.
- Cover: it is possible to restrict the cover for elderly to for example hospital cost and start with a more limited cover than the existing Medishield cover.
- Government subsidy: there are two obvious dimensions in which the government could choose to temporarily subsidize the implementation:
  - (1) to the extent the eligible group would be restricted above a certain threshold age, the government could choose to subsidize the non-eligible group and let this subsidy run off over time, such that every year the threshold age would be increased by one year until in the future every elder is paying the maximized premium without subsidy.
  - (2) to introduce the top ups to younger people below the entry age will be a sensitive message and the government could opt to subsidize the top ups for a certain time to allow the system to settle until people are used to the system and have seen the benefits.

If a system were to be successfully implemented in line with the above, the total health care consumption in Singapore could increase significantly to the extent elderly people would use hospital services more than they do now. This needs to be assessed in terms of the ability of Singapore's hospitals to deal with this additional demand. To the extent that this phenomenon would occur, the implementation could be staged to manage the transition.

Lastly, from an economic perspective there could be an additional non-obvious benefit from a higher Medishield penetration for elderly. As many elderly maintain savings for a disease that may not come, they could spend more once they have the certainty of an affordable health care insurance. The aggregate effect of their additional spending may be meaningful.

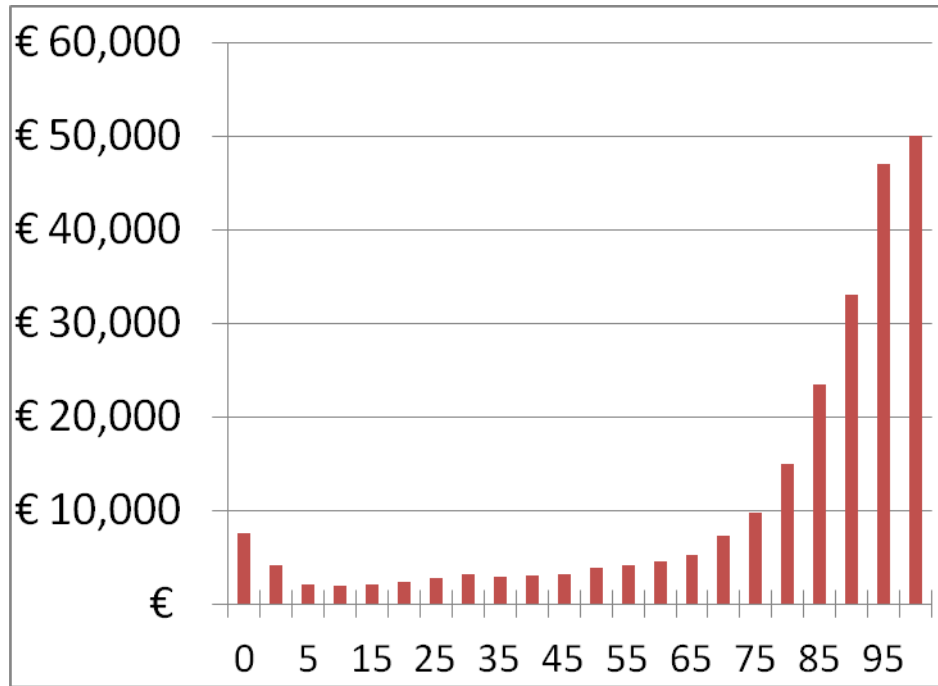
Notes:



1. SingHealth Study

[:http://www.singhealth.com.sg/Research/HealthServicesResearch/publications/conferences/Documents/Conf\\_How%20the%20Elderly%20Singaporeans%20Pay%20for%20their%20Hospitalization.pdf?AspxAutoDetectCookieSupport=1](http://www.singhealth.com.sg/Research/HealthServicesResearch/publications/conferences/Documents/Conf_How%20the%20Elderly%20Singaporeans%20Pay%20for%20their%20Hospitalization.pdf?AspxAutoDetectCookieSupport=1)

2. Table showing hospital care cost distribution across age:



3. OECD (2011), *Health at a Glance 2011: OECD Indicators*, OECD Publishing.  
[http://dx.doi.org/10.1787/health\\_glance-2011-en](http://dx.doi.org/10.1787/health_glance-2011-en)