

The equity of universal health coverage: Reflections from Singapore

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The challenges confronting health systems in Asia include known and emerging infectious diseases and an increasing prevalence of non-communicable diseases. For a number of countries, such as Singapore, a rapidly aging population is expected to exacerbate the latter. In 2005, member states of the World Health Organization (WHO) from East Asia and elsewhere made a commitment to develop their health financing systems in ways that will ensure that all people have access to health services and do not suffer financial hardship in paying for them (WHA, 2005). By this initiative, how successfully health systems meet the challenges ahead will depend on the extent that equity in access and equity in financing are achieved.

Equity is difficult to define simply, but it is regarded as a cornerstone not only of policy decisions, but also of ethically legitimate social institutions (Rawls, 1999). Broadly speaking, equity is concerned with maximising the benefits, capabilities and general well-being of the worst-off members of a society. In the context of universal health care (UHC), equity in access could be understood as necessitating the prioritisation of those with the greatest health needs in order to secure for them equality of opportunity or capability to the furthest extent possible. At the same time, health systems must ensure that households are not made to contribute more than they are able to pay so that equity in financing can also be secured.

Equity in health care

For many health systems in East Asia, there is as yet inadequate information on whether coverage meets the health care needs of their populations and on how they ensure that patients receive appropriate services at costs that both households and systems can afford. When the coverage does not meet important population needs, equity in financing is compromised and households are put at risk of impoverishment (Yip and Hsiao, 2009; Parry, 2012). Inadequate investment in primary health care could raise inequities in both the access and finance components, since payment for hospitalisation could have been avoided with affordable access to outpatient care (Wagner et al., 2008). For this reason, the 2008 World Health Report focused on improving the place of primary health care in health systems. It calls for all WHO member states to:

- Aim for UHC reforms to improve health equity, end exclusion and promote social justice
- Reorganise services around primary care through service delivery reforms

- Integrate public health initiatives into primary care delivery and
- Aim for intersectoral collaboration
- Adopt a participatory style that promotes policy dialogue with multiple stakeholders in leadership reforms (WHO, 2008)

All countries provide some degree of health coverage and financial protection, and perhaps none can claim to have attained UHC in a substantively comprehensive way. Hence UHC continues to be a policy challenge for all countries and different paths are embarked upon. When evaluated in terms of its key dimensions of range of services, direct costs and population, it is questionable if equity in UHC is always and only about the need for member states to 'extend coverage to more people, offer more services, and/or pay a greater part of the cost' (WHO, 2010: p. 13). Take for instance the private health care sector in health systems. Equity in access and finance may require a multiplicity of arrangements and orderings, depending on the values, social institutions, politics and traditions (or 'path dependency') of the health systems concerned, rather than a radical transformation towards a single ideal-typified system (Gauld et al., 2012). It may also require a clearer evaluation of the contributory roles and responsibilities of the different stakeholders involved.

Singapore's experience

Singapore's health system gives emphasis to self-reliance, individual responsibility for one's own health and collective responsibility in maintaining health care affordability. These values are manifest in a number of distinct system features and could point to a particular conception of equity in access and finance. Similar to Hong Kong, Singapore has a predominantly private primary health care sector. About 80 per cent of Singapore's primary health care needs are met mainly by private general practitioners (GPs). These GPs dispense their own medicines, which are (along with cost of consultation) usually fully paid for by patients, unless subsidised by employment insurance. In contrast, public health care centres (or polyclinics) provide about 20 per cent of the primary care services to all citizens at a subsidised rate, with certain groups of Singaporeans (such as those under the age of 18 years or above the age of 65 years) receiving greater subsidy. In giving effect to self-reliance and individual responsibility as desirable ends, most Singaporeans are expected to pay for their own primary health care needs. This financing arrangement is also intended to discourage the over-consumption of health care services.

Responsibility for one's own health needs is also the philosophy that underpins Medisave, a mandatory savings account scheme.



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Equity is part of legitimate social institutions and should be a cornerstone of policy decisions

Depending on his or her age, a working Singaporean contributes seven to 9.5 per cent of his or her monthly salary into this personal account. Savings can be used to meet the health care expenses of the account holder, including hospitalisation, certain vaccinations, health screening and other outpatient services, and home-based hospice services. In addition, Medisave may also be drawn on to pay the premium for MediShield, a low-cost basic medical insurance scheme designed to meet the cost of hospitalisation for treatment of catastrophic illnesses or prolonged hospitalisation in moderate- to lower-grade wards of 'public' restructured hospitals.¹ Claimable limits and co-payment features of MediShield, such as co-insurance and deductibles, are similarly directed at ensuring a level of self-reliance and individual responsibility.² More recently, a severe disability insurance known as ElderShield has been introduced to enable risk sharing as a means of providing a level of financial protection to those who need long-term care, especially in later years. Under certain medical diagnoses, the insured may receive a monthly payout of S\$400 over a maximum period of 72 months. Again, coverage under this scheme is at best supplementary as it is unlikely to be adequate in the light of rising costs and the very real prospect of long-term care extending beyond six years.

Beyond the individual, families are expected to be the first line of support. Consequently, funds in the Medisave account may also be drawn upon to meet the health care expenses of dependents of

the account holder. Some have argued that these policies, along with a statutory requirement for adult children to care for their aged parents, are reflective of Confucian precepts that are deeply embedded in Singapore's predominantly Chinese population (Lim, 2012). While the actual influence of particular ideologies on public policy is difficult to establish with certainty, it seems clear that the state has emphasised the involvement of the private and voluntary sectors in its 'Many Helping Hands' approach, through which community organisations are promoted as the next level of support after the individual and the family (Lim, J., 2013; Rozario and Rosetti, 2012). In addition, the participation of private insurers has been evident: insurance coverage in addition to MediShield may be purchased from a private insurer as a Medisave-approved Integrated Shield Plan. Premiums for this enhanced coverage may be paid using Medisave funds. Similarly, ElderShield Supplements may be purchased from private insurers to enhance the disability benefits coverage provided under the ElderShield scheme.

The Community Health Assist Scheme (CHAS or the Primary Care Partnership Scheme, as it was known until 15 January 2012) also represents an innovative policy of public-private partnership (Ng, 2012). Started in 2000 by the Ministry of Health, a key objective of CHAS is to improve accessibility of primary care to needy, elderly, disabled and low-income Singaporeans. Under this scheme, private GPs and dentists provide common outpatient medical and dental treatment to enrollees at subsidised prices. Since its inception,

CHAS has undergone a number of changes and in the past five years the coverage of the scheme has been progressively broadened. In 2009, it was extended to cover more chronic conditions. In 2012, the qualifying age was lowered from 65 to 40 years and the income criteria raised from \$800 to \$1,500 per capita monthly household income, significantly broadening the pool of potential enrollees. Two subsidy tiers (the Blue Health Assist scheme for individuals with per capita household monthly income of less than \$900 and Orange Health Assist scheme for individuals with per capita household monthly income of more than \$900 but less than or equal to \$1,500) have been added to increase accessibility of primary care services for more needy Singaporeans. From January 2014, even more changes will be introduced to expand coverage further: the qualifying age limit of 40 years will be removed, five new chronic conditions will be added to the list of subsidised conditions and greater subsidies will be provided for specified screening tests, including those conducted by a GP. Aside from these, charges at Specialist Outpatient Clinics in public hospitals will be lowered for lower- and middle-income groups. In addition, a number of changes are being considered in developing MediShield into MediShield Life. These include enhancing MediShield benefits by raising claim limits, reducing the co-insurance borne by patients for large bills and providing lifetime coverage. MediShield coverage will be extended to all Singaporeans, including those currently uninsured. For those who are unable to pay premiums for coverage under MediShield Life, additional government support will be provided.

Measuring effectiveness

In general, eligible individuals with income levels below \$900 per month (bottom 30th percentile of the population by income) can receive treatment at the same prices as at government-run polyclinics. Conceivably, enrollees under the scheme would be more likely to seek outpatient care at GP clinics rather than at tertiary care institutions, given the greater accessibility of the former in terms of number of clinics and wider geographical distribution. A difficulty in ascertaining whether CHAS has been effective in enhancing coverage for its target population is the scheme's reliance on self-identification and enrolment by qualifying individuals. In addition, it will be difficult to assess the actual impact of CHAS, as available data is unlikely to provide information on incidence of catastrophic expenditures prior to enrolment or otherwise in a control group. Furthermore, nothing definite can be said about those who are eligible, but not enrolled in the scheme. It is also currently unclear if CHAS has been effective in encouraging the greater utilisation of GP clinics for outpatient care. While CHAS is undoubtedly an important policy innovation that is likely to be impactful, its contribution to the UHC agenda should be considered against these limitations.

In moving away from a full capitation-funding model like the United Kingdom³ (where co-payment is not required), the role of Singapore's Government in providing health care access and financial protection is rather more circumscribed. The state assumes a more prominent role in meeting the acute health care needs of citizens, as public hospitals account for about 80 per cent of tertiary care. A majority of the public hospitals' beds, about 81 per cent (in moderate and lower-category wards), are heavily subsidised. It has been reported that, in 2012, the average length

of stay in public acute care hospitals was about 5.8 days while the average occupancy rate was around 85 per cent.⁴ Apart from acute hospitals, community hospitals have more recently been introduced for the convalescent sick and aged. For the impoverished, Medifund has been set up as a public endowment fund to serve as a safety net for Singaporeans who cannot afford to pay for subsidised bill charges. In 2012, the capital sum was reported as \$3 billion. In November 2007, a capital sum of \$500 million was set apart as Medifund Silver to provide aid specifically to needy, elderly Singaporean patients.⁵

In anticipation of growing health care needs and challenges, the government has committed to doubling its health care expenditure over the next five years from \$4 billion to \$8 billion (Ho, 2012). If this means that the government will now pay a greater part of health care costs for greater health care coverage to more people for more services, does this also mean that greater equity in access and finance is achieved? Not necessarily. Where the prevailing philosophy is still a mix of self-reliance, individual responsibility for one's own health and collective responsibility in maintaining health care affordability, equity in access and finance is also a question of contributory roles and responsibilities of the different stakeholders, as well as the arrangements and orderings that they put in place.

Acknowledgement

This article first appeared as a Brookings East Asia Commentary (Number 74, December 2013). Reproduced by kind permission of the Centre for East Asia Policy Studies, Brookings Institution.

Endnotes

- 1 For information on restructured acute hospitals and specialty centres, see: www.moh.gov.sg/content/moh_web/home/our_healthcare_system/Healthcare_Services/Hospitals.html [Accessed 12 April 2014]. It has been observed that a quasi-free market for health care has been developed in Singapore to control cost and maintain high service quality (Haseltine, 2013).
- 2 For information on MediShield, see: www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/Medishield/How_MediShield_Works.html [Accessed 12 April 2014].
- 3 i.e. where public health care is largely free at the point of delivery and paid for out of general taxation.
- 4 For more information, see: www.moh.gov.sg/content/moh_web/home/our_healthcare_system/Healthcare_Services/Hospitals.html [Accessed 12 April 2014].
- 5 For more information on Medifund and Medifund Silver, see: www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/Medifund.html [Accessed 12 April 2014].

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