

Commentary

Values and Health Policy: The Case of Singapore

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Health care systems do not develop in isolation. They are products of the societies in which they are embedded and of the values held to be important in those societies. There could be no better illustration of this truth than the comparison between Sweden and the United States. The commitment in Sweden to equity and to the belief in that country in the benefits of action by the state has resulted in the development of a universal, tax-funded health service in which the emphasis is on ensuring access to health care for all. In contrast, the commitment in the United States to individual freedom and the aversion to government intervention has led to the development of a market-based health care system in which choice is highly valued and inequities in access tolerated.

The case of Singapore described by Michael Barr is a further illustration of the influence of social embeddedness and values in health care. A former British colony that gained independence in 1965, Singapore has attracted attention mainly because of the success of its economy. Rapid economic growth since independence has created a city-state of 3 million people in which per capita incomes are among the highest in the world. Singapore is a paradigm case of the tiger economies and has come through the economic downturn in Southeast Asia relatively unscathed. In recent times, the country's health care system has also attracted interest because of its ability to deliver good health outcomes at what appears to be a remarkably low cost (only 3 percent of GDP, according to government figures). Singapore's economic success is of course a major fac-

tor contributing to the health outcomes achieved, but its adoption of a middle way between a *laissez-faire* system and a government-owned national health service has acted as a magnet for policy analysts searching for new thinking on health care reform. Its attractions will only increase following the ranking of Singapore as sixth in the World Health Organization's assessment of health systems performance (WHO 2000).

As Barr shows, Singapore has developed a health care system involving a mix of public and private funding and provision. Equally important, the system combines a commitment to personal responsibility and government regulation. In primary care, most services are delivered by private practitioners operating on a fee-for-service basis and paid for directly by patients. These services are supplemented by government polyclinics offering subsidized (but not free) care to patients who prefer polyclinics to the private sector. Similarly, public hospitals coexist with private hospitals, and patients can choose different standards and costs of care. The government subsidizes public hospitals, but patients there also have to bear part of the cost even in the lowest standard of accommodation. The role of the state is not to provide services from the cradle to the grave along the lines aspired to by western European governments, but to offer a minimum level of support and to encourage individuals to supplement this.

The feature of health care that has attracted most interest in Singapore is the use of medical savings accounts (MSAs). These accounts are mandated by government and require those who are employed to pay a proportion of their income into a personal savings scheme. Contributions are matched by employers and are drawn on to meet the costs of hospital care. Unlike in Western European social insurance schemes, there is no risk pooling and savings accounts have been established on the basis that each generation should meet its own needs rather than build up reserves or commitments for future generations. This principle of intragenerational accountability rather than intergenerational solidarity reflects the values on which the Singapore system is based and the emphasis placed on personal responsibility (Ham 1996).

In seeking to analyze Singapore's system, it is important to understand the context in which the country gained independence and then went about developing its economy and services. Of particular importance was the concern to avoid the perceived failings of health care systems like those of the United Kingdom, where the commitment to provide free health services to all was seen as a clear warning of what could happen in the absence of price signals. It was for this reason that from the outset

copayments were felt to have a fundamental part to play. Furthermore, when the government decided to develop a medical savings system in the 1980s, the emphasis on personal responsibility continued by ensuring that these accounts were the property of the individuals concerned. The structure of MSAs contained incentives, through the ability to use surpluses for other purposes or pass on credits on death, to encourage the prudent use of resources. Also important was the requirement that patients should pay more for services of higher quality, thereby encouraging cost consciousness.

Singapore was able to put these arrangements in place because the institutional obstacles found in more mature societies did not exist. The absence of these obstacles, in particular the attachment of powerful interest groups to established structures of funding and provision, enabled the post-independence government to make a decisive break with the past. This included replacing a system that had significant tax financing with a more mixed regime in which there is now around 80 percent private and 20 percent public funding. The competitive individualism of Singaporean society after independence carried no expectation that society would look after the vulnerable, enabling government to reduce its role as individuals became more self-reliant.¹ Within this system, the tradition of families helping their own members in times of need was also important. In the case of health care, this includes the use of funds from MSAs to assist family members to pay for treatment. Add to that a political regime based on social authoritarianism, and the distinctive ingredients that make up health care in Singapore become apparent.

Yet if MSAs had by the mid-1980s become a cornerstone of the health funding system, it was not long before their limitations as a means of protecting against illness became clear. Medisave therefore had to be supplemented by a scheme to insure against catastrophic illness and by a fund to provide a safety net of last resort for people unable to meet medical expenses. The evidence reviewed by Barr suggests that despite the existence of these funding mechanisms, people on low incomes and

1. At the end of a visit to Singapore I applied the standard test of checking out the veracity of what the medical and policy experts had told me by asking the opinion of the taxi driver who took me to the airport. After ascertaining that I had obtained an accurate account of how health care is paid for in Singapore, I then responded to the taxi driver's question about the funding of the U.K. national health service. When I explained the principles of tax funding, services being available free at the point of use, and everyone having access to health care, the question put to me was didn't British people think it unfair that the costs of care for those on low incomes should be subsidized by those on middle and high incomes? Almost as much as anything else I learned on the visit, this brought home to me differences in values between the two societies and their impact on the health care system.

the retired still find the costs of health care problematic and may not be able to access needed services. As in other countries, free choice is a reality only for those able to write a check; access to health care reflects the distribution of incomes in society as a whole. In this respect, in relation to equity of access, MSAs may offer an advance over private insurance markets but they do not score as highly as systems that are funded through taxation or social insurance. This is borne out by the World Health Organization's assessment that based on the criteria of fair financing, Singapore ranked only 101 out of 191 countries studied (WHO 2000). The absence of risk pooling and the emphasis on personal responsibility supplemented by family support almost inevitably creates problems for those with limited means and patients with high health care costs.

The existence of market failures and concerns about rising health care costs led to a white paper published in 1993 that acknowledged the need for government regulation. The lesson here, echoing experience in other countries, was that demand side controls, in particular creating incentives for patients to use services prudently, were insufficient in themselves to secure the delivery of policy objectives. Part of the reason for this was the ability of patients with supplementary private insurance provided as an employment benefit to ameliorate the effects of these incentives by reducing the amount of expenses paid out of pocket. More fundamentally, the existence of information asymmetries in health care, and the power of supplier-induced demand, together with competition among providers, led to the expansion of services and to the overprovision and duplication of specialist facilities.

In response, the government felt compelled to strengthen regulation in a number of areas, including the supply of doctors, the degree of medical specialization, the number of hospital beds, the provision of facilities like intensive care units, and the availability of tertiary services. Government controls extend to the prices hospitals charge and the level of copayments by patients. These measures have been implemented in parallel with a program to restructure public hospitals. Beginning in the 1980s, public hospitals and specialist institutes have been incorporated as private companies wholly owned by the government, and these hospitals enjoy greater management freedoms than previously. The resulting hybrid arrangement is a further illustration of Singapore's search for a middle way, and the Health Corporation of Singapore is now the largest health care provider in the country (Phua 2001).

As Barr shows, another important means of cost control is explicit rationing of care. Not only does this mean that MSAs can be used only

to cover hospital costs, thereby excluding primary care and outpatient services, but also that some treatments are not included in the benefits package. Exclusions encompass services that are regarded as nonessential or cosmetic, experimental drugs and treatments whose effectiveness is not yet proven, and heroic efforts to keep people alive irrespective of their quality of life and prospects of recovery. Also outside the package are in vitro fertilization, gender reassignment operations, and heart, lung, liver, and bone marrow transplants. These treatments are available in the private sector for those who can afford to pay. On a visit to Singapore in 1995 I questioned the exclusion of in vitro fertilization and was informed that in Singapore a commonly held view was that if prospective parents could not afford to pay for this treatment then they probably did not have the means to raise a family. This was a nice illustration of the values underpinning the system.

Looking to the future, the challenge facing Singapore is how to maintain the progress made as the population ages, causing demands on the health care system to increase. In fact, it was in anticipation of these demands and concerns at the inability of tax-funded systems to pay for the care needed by elderly people that the government decided to set up Medisave. The resources held in savings accounts are used both to pay for the costs of care during employment and to build reserves that can be drawn on in retirement, and it is recognized that contribution rates will have to increase to ensure adequate provision in old age. Another challenge facing Singapore is how to respond to an economic downturn, should one occur. Medical savings accounts are dependent on high levels of participation in the labor market, and this has not been a problem in a country in which the economy has grown at around 8 percent a year. Should a recession occur, other sources of financing may be needed to supplement existing schemes. Another unknown is whether families will continue to be supportive of their members in times of need. Any weakening of traditional family ties would undermine a key building block on which the Singaporean system is based.

To highlight these challenges is to acknowledge yet again the absence of simple solutions to complex policy problems. Despite this, the experience of Singapore, especially its use of medical savings accounts, continues to attract international interest. In the Southeast Asian context, proposals for the reform of health care funding in Hong Kong released at the end of 2000 include plans for a limited form of savings account (Health and Welfare Bureau 2000), contrary to the advice of the Harvard team hired to review options for the authorities in Hong Kong, while ana-

lysts in the United States have also been attracted to this form of financing. The paradox in the United States is that a form of compulsory self-help developed under a system of social authoritarianism should find favor in a land of freedom and enterprise that has an aversion to government interference. To be sure, the advocates of MSAs in the United States are pursuing rather different objectives than their Singaporean counterparts, but the feeling nevertheless remains that health care reform has become an Alice-through-the-looking-glass world.

The broader lesson from Singapore is that health care reform continues to swing back and forth between a belief in market forces and the use of government regulation. In reality, health policy is replete with examples of market failures and government failures as policy makers experiment with different instruments. The variety of health care systems developed around the world indicates that the choice is neither pure markets nor government control but the balance to be struck between the two. And to return to our starting point, where the balance is struck will be shaped by social values and the political choices that follow from them. In view of enduring dissatisfaction with existing methods of funding and delivery, the settlement reached at any one point is invariably fragile as the dynamics of health care systems throw up new ideas for change and improvement. Despite this, radical change tends to be the exception rather than the rule, especially in mature societies where the inertia of entrenched interests makes incremental reform the limit of what is usually possible.

In this context, it is no more realistic to expect Sweden to abandon its commitment to social democracy and privatize its health care system (even though this is happening at the margins) than it is to expect the United States to give up on markets and opt for socialized medicine (even though the government pays for almost half the costs of medical care). Recognizing the importance of context, and the border controls that restrict the portability of policy ideas, Singapore is best seen as an example of the need for government intervention in health care, even in a society in which private enterprise and personal responsibility are valued highly. As a middle way between a *laissez-faire* system and a government-owned national health service, Singapore will no doubt continue to be studied by those seeking innovative ways of tackling the wicked problems of health policy. The fact that it fails to offer a panacea will come as no surprise to those with even a cursory knowledge of health systems. To be sure, Singapore has much to be proud of, but its experience needs to be examined “warts and all.” And even in Singapore, the path of

change will most likely entail gradual adjustments to a system that is now embedded in its social context rather than fundamental upheaval.

References

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