Singapore's health system: a model for Australia?

Impressive, responsive and innovative, but not without its problems

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A book by William Haseltine, a United States medical researcher and founder of the biopharmaceutical company Human Genome Sciences, describes the Singapore health care system — how it works, its financing, its history and its future directions.[1] Might it hold any lessons for Australian health care?

The statistics on Singapore's health care system are impressive. An enviable life expectancy, low infant and child mortality rates, and low rates of mortality from chronic conditions such as cancer and heart disease were achieved with health care expenditures of around US$2787 per capita in 2011 and health expenditure at 4.6% of gross domestic product (GDP), with the government financing about 1.2% of GDP. The sources of financing were employers (35%), government subsidies (25%), out-of-pocket payments (25%), private health insurance (5%), Medisave, a compulsory medical savings scheme (8%) and Medishield, a social insurance scheme for catastrophic medical conditions (2%).

The three original pillars of Singapore financing (Medisave in 1984, Medishield in 1990 and a government-subsidised Medifund to protect low-income citizens in 1993) were innovative and far-seeing. A subsequent fourth pillar (Eldershield in 2002 to pay the high costs of severe disability through insurance, followed by Medishield Silver in 2007) and changes to Medisave in 2006 to fund chronic disease management showed a government unafraid to update the original concepts when gaps appeared.

These pillars judiciously mix taxation, personal cost-sharing, personal savings and social insurance. Taxes and patient charges pay for primary health care and public health services, Medisave creates compulsory savings to pay for acute care, Medishield and ElderShield offer social and private insurance against the catastrophic costs of long-term care, and Medifund and Medifund Silver protect the indigent with targeted government subsidies.

The title of Haseltine's book suggests that Singapore offers lessons to other nations. That position might be tenable if those nations also had a stable political system with one party in power for a long time, a relatively young population prepared to accept personal responsibility in health care financing, and citizens ready to surrender 40% of their income into a national savings plan (the Central Provident Fund) that funds access to home ownership, higher education, medical care and old-age security.

Unfortunately, there are no compelling insights into why it works. Haseltine applauds the competition between, and quasi-market pricing of, hospitals and medical services as major reasons for Singapore's impressive health outcomes for a relatively low percentage of GDP. However, he understates the importance of a prescient and interventionist national government listening to the electorate, aiming subsidies at low-income residents and allowing greater risk-pooling of insurance for catastrophic illnesses to embody the ethos of collective responsibility. Furthermore, Singapore can provide uniform care and financing without answering complaints about geographical resource misallocation and the resulting political interference at a subnational level.

> "we have to find political leaders who eschew populist rhetoric … and who can tell us how they intend to achieve affordable excellence"

What Singapore does better than most nations is watch for signs of gaps in the access to or affordability of health care, building on the existing financing framework and directing subsidies to the neediest first. The August 2013 Medishield Life reform, offering compulsory universal coverage for pre-existing conditions and subsidies for low-income families, exemplifies this.

However, the system still has problems. In a 2012 survey, 72% of Singaporeans indicated that they "cannot afford to get sick these days due to high medical costs". In a nation where public hospitals offer 80% of acute bed care, allowing competition between hospitals has seen doctors leave the subsidised wards for the poorer citizens to move to unsubsidised, profit-creating "A class" wards. With population ageing, once age-specific rates for the use of services involving expensive medical technologies rise, Singapore will be paying a forecast 6%–8% of GDP for health care.

Even with recent reforms, copayments remain a silent threat to the four pillars model of financing. If you mandate a medical savings scheme with copayments acting as price signals, you accept the risk that rising copayments will restrict access to both necessary and unnecessary care. With copayments and a steady movement of doctors away from the hospital care of the 85% of Singaporeans who live in public housing, Singapore has created a two-class health care system based on a range of amenities tied to charges in public hospitals. Wealth buys more amenities.

What does Haseltine's book tell Australian politicians? If we were looking for a health financing system that made sense for its sustainability in both 1990 and 2013, Singapore stands out. To get to a similar position, Australia cannot delay reforms to doctor payment, quality-driven hospital reimbursement and price transparency. Affordable health insurance to deal with chronic illness, ageing and disability beyond age 65 years will be a massive challenge until we consider how Singapore's four pillars model could inform a revamped health and social insurance system in Australia.

And then we have to find political leaders who eschew populist rhetoric and random tinkering, and who can tell us how they intend to achieve affordable excellence in care — a problem that Singapore has never experienced.

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1 Haseltine WA. Affordable excellence: the Singapore healthcare story. Washington, DC: Brookings Institution Press, 2013. ❑