

# Medical Savings Accounts in Singapore: A Critical Inquiry

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**Abstract** With the United States currently experimenting with medical savings accounts (MSAs), it is appropriate to revisit the Singapore experience, where the practice has been in place for a decade and half. Singapore runs a modern, effective health system at a fraction of the cost of most systems operating in the developed West. Although MSAs contribute to the framework of a cultural rhetoric of personal responsibility for health care, this article argues that the heart of the Singapore system of health funding, with its financial discipline, is government control of inputs and outputs and strict rationing of health services according to wealth.

Since the end of the Second World War, when Western governments began accepting increased levels of responsibility for the health of their citizens, the cost of health care to national economies has increased steadily and became a major concern for most governments after the 1970s. Regardless of different models of health funding used, and despite the fact that governments are not generally bearing all of the costs themselves, health care expenditures have escalated to levels that have made it difficult to reconcile conflicting fiscal, social, and political imperatives. In 1997 the United States considered itself fortunate to have held its expenditure on health services at 13.6 percent of its gross domestic product (GDP) (Bishop 1998). In the European Union, the expenditure on health services has been rising 50 percent faster than the rise in GDP since the 1970s, leading to the current situation wherein EU countries

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spend between 5.4 percent (Greece) and 8.8 percent (France) of their GDPs on health care (Hitiris 1997). Australians spend 8.6 percent of GDP on health services (Harper 1998). Yet one developed country seems to have defied this general rule.

Singapore runs a modern, effective health system that absorbs 3 to 4 percent of GDP (Ministry of Health 1999c) and 8 percent of government expenditure (Ministry of Health 1998). The government and many theorists attribute the health system's success primarily to its program of medical savings accounts (MSAs), but this essay argues that MSAs have been a minor element in the Singapore system and that the explanations for Singapore's success—insofar as it is a success—lie elsewhere. Regardless of the tendency of Singapore's MSAs to encourage personal responsibility in health matters, there is no evidence that they have been effective in restraining health costs. Singapore's record of successfully keeping its health costs low is attributable primarily to heavy-handed government cost control of both inputs and outputs, rationing based on wealth, and to social and demographic features peculiar to Singapore. Unfortunately the negative features of government control and rationing are intrinsic features of what is otherwise a laudable achievement: the building of a modern, low-cost health system that works satisfactorily for most people most of the time.

### **The "Singapore System"**

According to the Singapore Ministry of Health (1999a), the financing philosophy of Singapore's health care delivery system is based on: "individual responsibility, coupled with Government subsidies to keep basic health care affordable. Patients pay part of the cost of medical services that they use, and pay more when they demand a higher level of services. This principle of co-payment applies even to the most heavily subsidized wards or services." The "Singapore system" is a continually evolving effort to reconcile the Singapore government's aversion to welfare with the reality that, for both economic and political reasons, it must ensure the provision of health services to the whole population, including low-income earners and the poor. In fact, the Singapore system developed explicitly in reaction to the perceived failures of "social and health welfare" in Europe and the United States—a perception premised more on ideological preconceptions than on empirical data.<sup>1</sup> In November 1981,

1. The cause of former prime minister Lee's evolution from a Fabian socialist to an economic liberal is a study in itself. It certainly involved observations and studies of the effects of welfare systems in developed countries, but his observations were already colored by ideological

on the eve of the moves to introduce medical savings accounts, then-Prime Minister Lee Kuan Yew (1981: 8) told a meeting of government MPs: “Subsidies on consumption are wrong and ruinous . . . for however wealthy a nation, it cannot carry health, unemployment and pension benefits without massive taxation and overloading the system, reducing the incentives to work and to save and care for one’s family—when all can look to the state for welfare. . . . Social and health welfare are like opium or heroin. People get addicted, and withdrawal of welfare benefits is very painful.”

It is of some importance to realize that the compulsory savings scheme (Medisave) was not a “progressive” attempt to ameliorate the effects of a laissez-faire health system, but a bold attempt to introduce market forces into government-funded health care. Under the previous system, hospital care was free and government clinics were subsidized directly by the government. Furthermore there was no immediate funding problem with the old system: in fact health costs fell dramatically as a proportion of GDP between 1960 and the introduction of Medisave in 1984, though there had been signs that costs were starting to creep up again with the embourgeoisement of Singapore (Toh and Low 1991: 26). This reading suggests that the government’s introduction of Medisave and hospital fees, along with the use of the rhetoric of self-help and personal responsibility, was an attempt to both meet and restrict rising middle-class expectations by replacing government regulation with the archetypal middle-class mechanisms of financial constraint and self-regulation. If it worked, then self-regulation would be more sustainable in the long term as Singapore moved into first-world status.

The Singapore scheme as it stands today has two core institutional components: a medical savings account called Medisave and a top-up “catastrophe insurance” scheme called MediShield. A third component, Medifund, operates as a national endowment fund to assist the very poor. These components form an integrated system that is unofficially called the “3Ms.” Medisave and MediShield operate within a broader government-regulated compulsory savings scheme called the Central Provident Fund. Unlike the American current experiment in MSAs, which is voluntary, employer sponsored, and managed by insurance companies, the Singapore system is universal, compulsory, and managed by the government.

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preconceptions that disposed him to draw harsh lessons about welfare leading to people “malingering and laying about.” See, for instance, Barr 2000.

## Medisave

The feature of the Singapore health system that has attracted the most international attention is the compulsory savings plan, Medisave.<sup>2</sup> Since its inception in 1984, Medisave has operated on the principle that every person in the paid workforce contributes into a personal, but government managed, savings account, which builds up a nest egg to cover the patient's share of hospitalization costs. This savings plan is necessary because every ward of every hospital in Singapore charges fees representing at least 19 percent of total costs, with the government meeting the balance from general revenue. Private hospitals charge the patient 100 percent of costs.

The rates of contribution to Medisave range from 6 percent of monthly income for those aged thirty-five and younger, to 8 percent for those at age forty-five and older and are shared equally between employees and employers. The self-employed have to pay the whole amount. A cap on monthly contributions protects high-income earners from having to contribute unreasonable amounts to the scheme, and those people who reach a set minimum balance in their Medisave accounts have their contributions diverted to other government-regulated savings mechanisms within the structure of the Central Provident Fund. This threshold is currently S\$17,000 (Ministry of Health 2000a), which is 47 percent of the average annual income for a wage or salary earner (Ministry of Manpower 2000: A31).

Contributions are tax free, earn interest, and form part of one's estate after death. To protect one's Medisave account from being run down unnecessarily, the member does not have complete freedom to pay all hospital costs from Medisave. A strict schedule of payments operates, and Medisave will not pay beyond those limits. If a person chooses a hospital or a ward that charges more than the standard rates, then the cost must be met privately or from MediShield. MediShield also set limits on what it pays, and the remainder must be paid out-of-pocket by patients. It is the responsibility of the patient and the family to choose affordable options. Financial counseling is available upon booking and admission. Patients who have insufficient funds in Medisave to cover their costs may commit their future Medisave contributions toward the bill, except for bills related to assisted conception procedures, outpatient renal dialysis,

2. The description of Medisave, MediShield, and Medifund is based upon information provided by the Central Provident Fund and Singapore Ministry of Health. See Central Provident Fund 1999a and 1999b and Ministry of Health 1999a.

radiotherapy, chemotherapy, and AZT treatment. Without a sufficient Medisave balance, people requiring these treatments must meet their bills another way or go without treatment.

In addition to hospitalization costs, Medisave will pay for a small number of outpatient services, such as surgery, radiotherapy, IVF, and hepatitis B vaccination. Otherwise Medisave is not involved with either outpatient or nonhospital medical services. (Private medical practitioners operate without any special financial ties to the state or the 3Ms, and government clinics and hospital outpatient services rely upon direct government subsidies.)

### **MediShield/MediShield Plus**

MediShield is a basic, low-cost, catastrophic illness insurance scheme to help Medisave members meet hospital expenses resulting from a major or prolonged illness. While Medisave is compulsory for all workers, MediShield is a voluntary “opt-out” scheme introduced in 1990. Premiums can be paid from the Medisave account.

MediShield pays benefits when a hospital bill exceeds a high deductible amount and will pay 80 percent of the amount above the deductible. The remainder can be paid from Medisave except in particular, prescribed circumstances. There is, however, no deductible (and therefore no MediShield copayment) for a handful of long-term, expensive procedures: outpatient kidney dialysis, chemotherapy, and radiotherapy. MediShield has a daily claim limit designed to allow a patient to stay in one of the bottom two classes of wards (open wards with an 81 percent government subsidy or wards with up to ten beds per room and a 65 percent government subsidy).

MediShield Plus is a more expensive version of MediShield targeted at high-income earners. It has very high deductibles, and provides sufficient coverage to enable a patient to be treated at a private hospital or in one of the top two classes of ward in the public hospitals (private wards and wards with fewer than five beds per room).

### **Medifund**

Even with the security of Medisave, some people are unable to meet any costs. Rather than waiving the fees for such people, the government has established an endowment fund to offer charity-style relief. The capital from this fund is left untouched, and interest is distributed to public-

sector hospitals that consider applications for assistance and allocate the funds. Medifund was established in 1993 with an initial capitalization of S\$200 million. The capitalization has been increased by S\$100 million a year and now stands at S\$700 million (Ministry of Health 2000a).

### **Voluntary Welfare Organizations**

Another element of the Singapore system is government aid to charity organizations that care for the poor who require long-term institutionalized care. This reliance upon voluntary welfare organizations (VWOs) is not usually considered to be part of the health system at all, but without it many poor people would be destitute and completely deprived of care. After this account of Singapore's health care system, it is easy to overlook the fact that the whole edifice is underpinned by direct government expenditure. Except in the private hospitals, the 3Ms supplement government expenditures, rather than replace them.

### **Preliminary Reservations about the Singapore "Success"**

The levels of government expenditure on the health sector are nevertheless low by Western standards—though even on this point two serious qualifications need to be introduced. First, the Singapore government does not follow OECD standards in measuring health expenditure. This makes international comparisons extremely difficult, and adds to the risks of using the Singapore as a model for other countries. Furthermore the government is highly secretive about the detailed operation of its system and has not made either the data source or method of its calculations available to anyone outside those in the Civil Service and the government who need to know—not to the public; not to academic researchers. So although we can safely say that expenditures are low by Western standards, they are probably higher than the government's published figures suggest.

Second, the contrast between Singapore's levels of health expenditures appears less stark when it is compared to other developed Asian countries rather than to the United States, Europe, and Australia. The Hong Kong and Taiwan governments each spend around 5 percent of GDP on health: a figure that is higher than Singapore's 3–4 percent, but not drastically so. In itself this does not diminish the Singapore achievement, but should mitigate against any tendency to idolize it. It also suggests that an

investigation into the features of commonality between these societies—whether in terms of styles of health care, systems of health funding, or perhaps more nebulous elements related to mores or diet—could be a useful adjunct to the current study.

### **Personal Responsibility**

As it was originally envisioned in the early 1980s, the key component of the Singapore system was to be the fostering of personal responsibility for one's own health and that of one's family. Although this essay argues that the importance of this feature has diminished in the 1990s, it still remains the central element of the rhetoric. The promotion of "personal responsibility" extends to media campaigns promoting health and fitness, and employer-sponsored rewards for workers who take no sick leave (Goh 1982). The institutional linchpin of this attitude is Medisave, which ensures that everyone who can possibly afford to pay anything is paying something for his or her own health care.

In the process of ushering in this new regime the government introduced a paradigm shift in the way Singaporeans thought about health care—a shift that brought the government's rhetoric and actions on health into alignment with its approach to other aspects of social and economic life.<sup>3</sup> The very vocabulary of this health care dialogue ensures that no one slips into a state-dependent mode of thinking. Hence, when the government put in place a mechanism to assist the very poor, it refrained from making this expenditure part of the ordinary health budget, but instead established an endowment fund that operates like a charity. It should also be noted that no one in Singapore speaks of "government expenditure" on health. The term used in Singapore is "government subsidies."

### **Moral Hazard**

As a simple matter of principle, most people will regard the encouragement of personal responsibility as a positive step in any aspect of life, but the operation of the principle in this case can be stated more explicitly. Medisave and MediShield are designed to avoid the "moral hazard"

3. See Barr (2000) for an account of parallel developments in other aspects of welfare policy. Also see chapter 3 of Rahim (1998: 29–48) for a deeper consideration of the assumptions at work in the government's approach.

associated with government supplied health cover, and even with most private health insurance. The moral hazard was defined thus by Toh Mun Heng and Linda Low (1991: 9):

A moral hazard problem is encountered when payment of medical expenses is borne by a third party, either an insurance company or the government, affecting the individual's own behaviour. It may lead the individual to overconsume medical services and his doctor to over-treat. It has nothing to do with morality but represents a misallocation of resources by a particular method of finance. Since the third party, be it the government or the insurance company pays the full cost, the individual bears no financial burden or faces a zero price for medical care. Consequently, consumption is greater following the law of demand.

It may have been thought that a degree of increased use of health services, particularly by the poor, was part of the purpose of a benevolent healthcare-funding scheme, but to the Singapore government it is a trap to be avoided. Nevertheless, it was found that although the introduction of Medisave reduced the moral hazard considerably, it did not reduce or even contain health expenditure. In fact, immediately following the introduction of Medisave in 1984, the rate of increase of health expenditure per capita jumped from 11 percent to 13 percent per annum (Hsiao 1995). The share of GDP absorbed by health expenditure also increased in the immediate post-Medisave period, due largely to a sudden increase in expenditure on physician fees and the purchase of new technology as hospitals competed with each other for business and reputation in the new fee-paying environment (Toh and Low 1991).

### **Government Control**

Eventually the government realized that merely avoiding moral hazard and encouraging personal responsibility was insufficient to restrain increases in health costs. In 1993 direct government control of costs replaced personal responsibility as a central plank in the government's health policy, though not in its promotional material. The Ministerial Committee on Health Policies (1993: 3) put it thus in its 1993 White Paper: "Market forces alone will not suffice to hold down medical costs to the minimum. The health care system is an example of market failure [to produce the result desired by the government]. The government has to intervene directly to structure and regulate the health system." The

Ministry of Health still uses the same words to justify its funding philosophy today, and over the years since the 1993 White Paper it has introduced a substantial number of initiatives to enforce control and rein in costs. Working toward the stated end of “prevent[ing] over-supply of medical services and dampen[ing] demand” (Ministry of Health 1999c), the Ministry of Health has:

- controlled the introduction of technology and specialist disciplines in government hospitals (Ministry of Health 1999c);
- introduced price caps on all medical services delivered in government hospitals (Low 1998);
- introduced a predetermined rate of subsidy for government hospitals (leaving the responsibility on the hospitals to break even) (Ministry of Health 1999c);
- restricted the number of government hospital beds (Massaro and Wong 1995), and periodically released new land for the development of private hospitals (Ministry of Health 1999c);<sup>4</sup> and
- tightened control on the supply of doctors in the country (Massaro and Wong 1995), ensuring at the same time that specialists number no more than 40 percent of the medical profession (Ministry of Health 1999c).

A further comment is warranted on these measures. The last measure is seen to be critical, since the Ministry of Health is convinced that “to a significant extent health services are supply driven” and that “countries with more doctors tend to spend more on health care” (ibid.). Apart from controlling the number of medical graduates produced by local universities, the government reduced from 176 to 28 the number of overseas medical schools whose degrees are recognized. Most of the surviving institutions were American (Massaro and Wong 1995).

On the question of price caps it should be noted that costs are kept genuinely low in government hospitals. Toa Payoh Hospital is a government hospital offering general surgery; orthopedic surgery; radiology services, ear, nose, and throat services; and eye services. The daily ward fee for an open ward is S\$19 (U.S.\$11 as of August 2000), while the intensive care ward fee is S\$50 (U.S.\$30). With an 81 percent subsidy, this means that the real full cost is S\$100 (U.S.\$57) and S\$265 (U.S.\$150)

4. It should be noted that the government’s absolute discretion in land use, combined with the scarcity of land, is one of the government’s most potent mechanisms for exercising social and economic control.

respectively. Even for those staying in single-bed rooms (with an 8 percent subsidy) the real full costs are only S\$244 (U.S.\$139) and S\$380 (U.S.\$216), respectively. The real cost of surgery is capped at S\$1,210 (U.S.\$690) per operation for the most heavily subsidized patients. For patients in single-bed rooms, the real cost of a single operation is capped at S\$6,086 (U.S.\$3,470). These figures include anesthetic, surgeon's fees, and so forth. The rates for Toa Payoh Hospital are comparable to those of other public hospitals (Ministry of Health 2000a). These caps, however, do not bind private hospitals. Gleneagles Hospital, for instance, charges S\$3,000 (U.S.\$1,710) a day for its most luxurious suite (Gleneagles Hospital 2000).

It also important to note that even though Medisave accounts are the personal accounts of the individual members, the government determines to which procedures they can be applied and where and the rate at which they can be spent. The government's high level of control is not usually mediated even by private or employer-sponsored health insurance schemes because, although such schemes exist and are growing in Singapore, they have failed to become dominant players in the health industry<sup>5</sup> (Tan and Chew 1997; Low 1998; Ramesh 1992).

Direct government controls are thus a central feature of Singapore's health funding regime, but even in tiny, not-very-democratic Singapore, this technique has its limits. The government found the ceiling of its political will when, throughout the 1980s, it gradually reduced the proportion of C Class beds—those used by the poorest sections of the community. In the end pressure from government backbenchers forced the Ministry of Health to replenish the supply of C Class beds (Toh and Low 1991).

5. The employer-sponsored schemes have been of limited value, partly because they are restricted to large employers, most of which are linked to the government, and also because they have been associated with much broader government-endorsed "company welfare" schemes. When these schemes were introduced they were greeted with a healthy dose of skepticism from both employers and employees. In the field of health coverage, this skepticism has been augmented by the perception that they give little extra benefit over and above that provided by the 3Ms.

The lack of penetration by private health insurance is more problematic. According to Low (1998), it results from a combination of Asian disdain for insurance per se, and government discouragement of insurance because of its aversion to moral hazard and adverse selection. It also seems reasonable to assume that there is a widespread perception that paying more for health insurance over and above the 3Ms is an excessive expense, and this has led to a willful trust that the 3Ms will be adequate. Certainly the Ministry of Health is continually trying to overcome exaggerated perceptions of the comprehensiveness of the 3Ms.

## Rationing

Implicit in government control of inputs is the principle of rationing of health services based on wealth. The 1993 White Paper on Health stated this without voicing the criterion of wealth:

We cannot avoid rationing medical care, implicitly or explicitly. Funding for health care will always be finite. There will always be competing demands for resources, whether the resources come from the State or the individual citizens. Using the latest in medical technology is expensive. Trade-offs among different areas of medical treatments, equipment, training and research are unavoidable. (Ministerial Committee on Health Policies 1993: 17)

Although the government is committed to ensuring the provision of “basic health care” for the population, it is unembarrassed about excluding particular procedures from that definition. For instance Medisave cannot be used to cover maternity ward and associated costs beyond the third child, nor long-term hospital care (Tan and Chew 1997), and MediShield does not cover a wide range of conditions including congenital abnormalities, cosmetic surgery, maternity charges, abortion, infertility and contraceptive procedures, sex change operations, mental illness and personality disorders, AIDS, drug addiction or alcoholism, treatment of injuries arising from direct participation in civil commotion or strikes, and self-inflicted injuries. MediShield is also protected from a considerable amount of liability because, even though the government runs it, it operates on insurance underwriting principles, and so it excludes some illnesses if the patient was already receiving treatment before joining MediShield. These illnesses are blood disorder, cancer, stroke, chronic liver cirrhosis, chronic obstructive lung disease, chronic renal disease, including failure, coronary artery disease, degenerative disease, ischemic heart disease, rheumatic heart disease, and systematic lupus erythematosus (Ministry of Health 1999c; Central Provident Fund 1999b). For the very poor, and for lower- and middle-income earners with insufficient Medisave funds, obtaining treatment for these conditions has been problematical in Singapore: Medifund helps some people, but there can be no assumptions that one will be treated.

The significance of this list of exclusions can be appreciated by comparing the list of Medisave exclusions (both complete and conditional) with the list of National Health Priority Areas (NHPA) in Australia. The NHPA is an initiative of Australia’s nine commonwealth, state, and ter-

ritory governments, and it focuses on “diseases and other conditions that contribute most significantly to Australia’s burden of illness and for which there is potential for the burden to be significantly reduced” (Australian Institute of Health and Welfare 1999: 93). The NHPA list accounted for 40 percent of total hospital patient days in Australia in 1998–1999 and two of the three most prevalent conditions treated also appear on the list of MediShield exclusions: cardiovascular disease and control of cancer. Care involving dialysis, treatment of HIV, mental health, and diabetes also appears on the NHPA list of prevalence and on the MediShield list of exclusions (Australian Institute of Health and Welfare 1999: 94, 95).<sup>6</sup> The only items on the NHPA list that do not appear on the MediShield list of exclusions are asthma and personal injury. It should also be realized that except for assisted conception procedures, all of the procedures for which a patient is precluded from committing *future* Medisave funds also appear on the NHPA list: outpatient renal dialysis, radiotherapy, chemotherapy, and AZT treatment. Clearly rationing has been an important element in the control of Singapore’s health costs.

## Lessons

Learning the “lessons” of the 3Ms is no easy task. The first difficulty is in establishing whether the 3Ms has really “worked,” which is not made easier by the Singapore government’s reticence to provide figures on which to base detailed analysis, nor by the fact that hospital restructuring was introduced in conjunction with Medisave. Regardless of these qualifications, William Hsaio (1995) leaves no room to doubt that Medisave failed to curtail costs. This is a sensitive point for advocates of MSAs. Thomas Massaro and Yu-Ning Wong were so defensive on this point in 1995 that they argued that Medisave was not intended to contain costs but “to ensure that when Singaporeans enter the medical marketplace, they are able to pay the costs of their own care without relying on the charity of others or subsidies from the state” (278). Although it is true that this was the stated focus of the reforms, it was disingenuous to argue that the government was not trying to contain costs.

Despite this heavy qualification, we cannot ignore the fact that Singapore spends a lot less on health care than most, if not all, developed countries and yet still ends up with a system that provides a modern, effi-

6. The Comprehensive Chronic Care Programs that began late in 2000 are designed to fill some of these gaps. See reference to the CCCP later in the article.

cient, and technically universal service. This success still begs an explanation. The heart of the success is unquestionably the strict regime of controls and rationing, but some incidental features of Singapore society also have helped. The most important such factor is that Singapore has yet to face the costs of an aging population, which is one of the major factors straining health systems in other developed countries.<sup>7</sup> In 1991, 6.2 percent of Singapore's population was sixty-five or older, as opposed to proportions between 10.9 percent and 15.4 percent for the United States, Canada, United Kingdom, Australia, New Zealand, and West Germany (Ministerial Committee on Health Policies 1993: Appendix B). In 1988, the Ministry of Health estimated that by 2030, 52 percent of the population will be sixty years of age or older, though later figures suggest that this trend may have slowed a little (Toh and Low 1991; Low 1998). This became a serious concern for the government when it was realized that in 1996 the aged of Singapore (sixty-five and older) were admitted to hospital at 2.8 times the frequency of younger people and stayed in hospital an average of 1.66 times as long. The aged were also higher consumers of the two most heavily subsidized classes of ward (Prescott 1998:43). Thus an increase in their proportion will inevitably increase demand for health services. The Ministry of Health is, therefore, resigned to further increases in both national and government health expenditures and is continually reviewing the health system to deal with actual and anticipated problems. It expects the rate of Medisave contributions to approach 10 percent of individual monthly incomes in due course (Ministry of Health 1999b), and it has recently foreshadowed the creation of a U.S.\$600 million fund to subsidize nursing homes to be run by voluntary welfare organizations (i.e., charities) for the elderly poor (*International Market Insight Reports* 2000). This latest development—with its systemic extension of the charity principle—suggests that parsimony and paternalism, rather than personal responsibility, provide the real conceptual framework of Singapore's health funding system.

A further factor contributing to the low expenditure on health is the anomaly of traditional medicine. All the ethnic groups of Singapore contain significant minorities that rely on a mixture of Western and tradi-

7. In 1996, industrialized countries' per capita health care expenditure on the aged was up to five times that of the expenditure on those under age sixty-five (Japan) and rarely less than twice the figure. The Netherlands, the United States, Australia, Switzerland, Finland, the United Kingdom, and New Zealand all spent approximately four times the amount on the aged that they did on the younger portion of the population (Prescott 1998: 13).

tional medicines, or turn to Western medicine as only a last resort (Somjee 1995).<sup>8</sup> The Ministry of Health estimates that about 12 percent of daily outpatient users also visit traditional Chinese medicine practitioners (Ministry of Health 1995). The significance of this figure is that traditional medicines operate outside the government's health funding regime, and excluded from its national health expenditure figures, thus artificially depressing the expenditure figures.

### **Systemic Faults**

Even with the advantages provided by Singapore's peculiar demographics and society, and despite the fact that the government has insulated itself from many costs, the 3Ms have still failed substantial sections of the population. Most obviously the chronically sick are extremely vulnerable, as the Minister for Health freely admits: poor people (and many not so poor) requiring long-term institutionalized care must currently rely upon charity organizations, which in turn receive some support from the government (Prescott 1998: 2). In recognition of this weakness the government recently announced two new programs designed to mitigate the effects of rationing for some of the chronically ill. The Comprehensive Chronic Care Programs and the Primary Care Partnership Scheme will eventually deliver directly subsidized long-term health care to those suffering from three specific chronic conditions: diabetes, high blood pressure, and high cholesterol (Ministry of Health 2000b). The poor—including the working poor and most of the aged—are also seriously disadvantaged, even if they are not chronically sick.

Particularly vulnerable are old women, who even in Singapore are more likely to have been homemakers for most of their lives, whether as wives, widows, or divorcees (Low 1998). Medisave helps such women only if their husbands left money in their own account or voluntarily funded a Medisave account for them. An alternative solution is to call upon their adult children to help. Currently more than 65 percent of private funding for acute care for those sixty-five and older derives from the Medisave accounts of adult children (Prescott 1998: 44). But if one's children are low-income earners themselves this may not be an option and in any case would be merely shifting the burden of poverty within the pool

8. I witnessed the faith placed in traditional Chinese medicines during a bout of illness during a visit to Singapore in 1996. My friends plied me with little pills that seemed to appear out of small, deep cupboards that I had not noticed before.

of the poor. This highlights a serious problem with the family-based self-help concept: It can, and does, result in calling on one disadvantaged group to subsidize another. Malays are especially vulnerable to this trap because, due to systemic discrimination, they have been, and continue to be, an economically disadvantaged group in Singapore (Lee 1998; Rahim 1998) and therefore are more likely to face the crippling combination of poorly paid jobs, poor aged parents, small Medisave accounts, and no MediShield coverage.

Interestingly the middle class also is more vulnerable than one might expect. For instance, MediShield covers the children of middle-income earners only if they are included on their parents' plans and the parents pay an extra premium (Central Provident Fund 1999b). The vulnerability of this group shows how easy it is to fall through the cracks of the rather ad hoc Singapore system, which is why the government is continually conducting reviews and amending the system to change its character and increase its scope.

## Postscript

Mark V. Pauly and John C. Goodman, in their defense of the 3Ms (1995: 278), accused William Hsiao of using "an out-of-context quote from a government White Paper" to give the impression that Singapore is ready "to replace the current system with government regulation and controls." They went on to reiterate their confidence that "Singapore is firmly committed to individual choice and free markets." Alas, this is true only for those with a capacity to write a check for medical services. For this exclusive group Singapore offers world-class private hospitals and open access to top specialists. But for the poor and even for the lower middle class, the government has increased its controls over the health market since 1993.

For most of the population, the cost of moving outside the parameters set by the 3Ms (for instance, by having a fourth baby) is prohibitive. Far from allowing an open market, the government even regulates the number of doctors and specialists with the stated purpose of dampening demand for health care. The levels of government control and rationing of health services to the poor are so stringent that it would require great political will and bureaucratic efficiency to introduce them into a larger polity, especially if that polity was a democracy. This control and rationing, and the concomitant manipulation of demand by controlling supply, tarnish Singapore's considerable achievement of building a mod-

ern health system that works satisfactorily for most people most of the time. MSAs provide the core of the institutional framework of the Singapore system, but the practical and spiritual heart of the system lies in control and parsimony.

Perhaps the real lesson of the Singapore experience lies in this negative truth: There is no “magic bullet” on health care funding. The more effective a system is in containing costs, or even in just shifting responsibility away from government, the more inequities are likely to appear in the system. The solution to this dilemma is surely found in one of the unspoken assumptions behind the Singapore system: the presumption that the vast majority of the population is working (or has spent a lifetime working and saving) and is paid enough to participate in Medisave and MediShield. As of 1995, Singapore had a workforce participation rate of 64.3 percent and an unemployment rate of only 2.7 percent<sup>9</sup> (Ministry of Information and the Arts 1996: 240). It is a basic truth that under any system of health care funding, the unemployed cannot afford to contribute very much to the cost of their own care. Neither can the working poor. American legislators seem to have recognized this truth intuitively. The current American experiment with MSAs (complete with a MediShield-style top-up with a high deductible) is being sold to employers as an inexpensive means of providing health benefits to their employees. Since providing such benefits is not likely to appeal to the owners of sweatshops or those paying casual workers a pittance, it is reasonable to assume that the scheme is targeted exclusively at the section of the population with relatively stable jobs that pay a decent wage or salary. And there lies the rub, for this is the very portion of the population most at risk in developed countries from the hegemonic forces of globalization and “dry” liberal economics.

Chris Ham, writing in *The Lancet*, made a salient point about the Singapore system:

The most important lesson is that a stakeholder welfare system must grow out of a stakeholder economy rather than vice versa. If citizens feel valued through their employment and incomes then it may be possible to persuade or compel them to take greater responsibility for their welfare. If, on the other hand, they feel excluded from the economy and society, then there is no economic or moral basis for expecting them to take a stake in the system. (1996: 953)

9. There also is a large number of relatively low-paid foreign “guest workers” who are not considered in employment figures or in this article.

Ham's insight, which is valid enough for Singapore, also contains the seeds of a basic truth that applies in other countries. With or without MSAs, the cost and equity problems associated with health care are at least manageable if most of the population has disposable income. A working population does not solve the problems of health care in itself, but without that precondition other "solutions" must either become more exclusive or must impose an extraordinary financial burden on the working population.

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