Role of the Government in Healthcare Provision and Financing in Singapore

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Government White Paper 1993

- **Background**
  - Rising Health Care Costs
  - Expenditure 3.1% of GDP
  - Ageing Population
  - Government plays a significant role in provision of healthcare
  - High standard of healthcare
  - Concern about financing future burden
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Government White Paper 1993

- Singapore Governments’ Strategy
  - Nurture a Healthy Nation
    - Health monitoring and counselling programmes
  - Promote Personal Responsibility for Health and Healthcare Financing
    - Press campaigns
    - Use of CPF/Medisave for insurance
    - Deductibles and Co-payments for insured
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Government White Paper 1993

– Provide Good and Affordable Medical Services
  • Government Hospitals and special centres subsidised
  • Funding since 1999 on casemix (DRG) to manage costs
  • Control/certification of doctors and other medical practitioners
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Government White Paper 1993

- Intervene when Market Forces Fail to keep Costs down:
  • Subsidies to public sector
  • Constraint on use of Medisave
  • Private treatment also on DRG basis (planned for 2004)
- Rely on Market Forces to Improve Services
  • Private treatment based on ability to pay
  • Private compete with (subsidised) public sector
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• Public Hospital System Dominant (over 80% of hospital beds)

• Reforms in Public Sector
  - Hospital boards corporatised (not for profit basis)
  - Hospital facilities aggregated (integrated services)

• Moves to
  - Step-down and rehabilitation facilities
  - Case management and „clinical pathway“ initiatives
  - Disease Management
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• Funding Mechanism
  - Ministry of Health subsidies
  - Co-payment as a driver for patient driven cost management
  - Funding via Medisave, Medishield, Medifund

• Private Hospital System
  - Dominated by one or two large care groups
  - More expensive than public sector (subsidised)
Central Provident Fund Scheme and other Government Initiatives

- Central Provident Fund
  - Statutory, tax-free fund
  - Compulsory savings
  - Three accounts
    • Ordinary
    • Medisave
    • Special
  - Contributions: 20% Employee, 16% Employer
  - Medisave: 6%-8% of Total CPF contribution
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Central Provident Fund Scheme and other Government Initiatives

- **Medisave**
  - Compulsory
  - Covers 2.9 million individuals (US$ 12.5 billion)
  - Health saving scheme, self-funded.

- **Medishield**
  - Voluntary Major Medical Insurance Scheme
  - Introduced in 1990
  - Protects Medisave being depleted due to prolonged or major illnesses
  - Administered by CPF
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Central Provident Fund Scheme and other Government Initiatives

- Premiums paid using Medisave funds.
- Features to induce care with healthcare spending (deductibles, co-insurance, annual/lifetime limits).
- 1.9 million lives covered (60 % of population).
- 78 % in lowest plan (A), 22 % under two higher plans.
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- **Impact of CPF Schemes**
  - Private Health Insurers can offer insurance (subject to approval)
  - Three approved plans offer higher coverage levels
  - Singaporeans now opt for more expensive treatments (cover costs themselves)
  - 3% of GDP spent on healthcare (S$ 1,347 per capita)
Encouragement Private Health Insurance

• CPF-approved Private Insurance Plans
  Minimum:
  - Minimum deductible 5 times daily claim limit or co-payment at least 15 %
  - Uniform premiums by age/sex. No substand loadings
  - Guaranteed renewability
  - Maximum premium withdrawal from Medisave
  - Certain hospital benefits excluded.
  Private insurers have some basic underwriting.

• Government Objective
  - Encouraging individual rather than group contracts (employee mobility)
  - Flexibility of individual in selecting benefits
  - Problems: Underinsurance, higher cost of individual plans
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Provision and Financing of Healthcare for the Elderly

- Singapore has a rapidly ageing population.
  1997: 7 % over age 65
  2030: 18.4 % over age 65
- Health promotion for elderly (Free annual health screening)
- Primarily care responsibility of family
- Acute care by hospitals
- Financing via Medisave, Medishield or from own/insurance resources.
- Government help for low income groups (mean test).
- New elder care insurance scheme – Eldershield
  - Government scheme: managed and underwritten by private sector.
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Supervision of Health Insurance Industry

– Health insurance under umbrella of life and non-life
– Likely to change
– Industry-wide sales guidelines and standards subject to review by MAS („best advice“)
– Actuaries likely to take on greater responsibilities (design, pricing, reserving)
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Opportunities for Private Health Insurers

- Medisave – not insurance pool
- Insurance Products
  - Must include individual retention
  - Avoid overutilisation of health facilities
  - Only 3 % of total healthcare expenses
  - Medishield has shortcomings
- Demographic Change
  - Rapidly ageing population
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Population Pyramid - 2000

- Male
- Female
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Population Pyramid - 2025

[Diagram showing the population pyramid for 2025 with bars for each age group and gender, indicating the number of males and females in each age group.]
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Population Pyramid - 2050

- Male
- Female
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**Table**

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<th>Inpatient Expenses</th>
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<tr>
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<td>Cost per capital</td>
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<td>Cost per 20-64 year old</td>
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Costs of Medical Services and Health Care

- Per capita spending S$ 1,347 (US$ 750) in 1999.
- Project future costs
  
  • Based on projected population development
  
  • Inflation and medical inflation ignored
  
  • Uses German age-dependent health costs

(Andres Webersinke)
Opportunities

- The German Model
  Actuarial approach as for life insurance
  • Premiums based on entry age (“level” approach)
  • Premiums adjusted for medical inflation

- The South African Model
  • Medical Savings Account (MSA)
  • Annual deductible for non-discretionary care
  • Accounted balances retained
  • Motivation of all parties to minimize expenses
  • Major medical events insured
  • Combine pre-funding, risk pooling and aim to reduce over-utilisation.
Thank You for your Attention

Edward Reiche