Health reform monitor

Health insurance reforms in Singapore and Hong Kong: How the two ageing asian tigers respond to health financing challenges?

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A R T I C L E   I N F O

Article history:
Received 20 September 2017
Received in revised form 21 April 2018
Accepted 23 April 2018

Keywords:
Singapore
Hong Kong
Health financing
Universal coverage
Voluntary health insurance
Health care reform

A B S T R A C T

Singapore and Hong Kong, two high-income “Tiger economies” in Asia, were ranked as the top two most efficient health systems in the world. Despite remarkable similarities in history and socioeconomic development, both economies embraced rather different paths in health care reforms in the past decades, which reflect their respective sociopolitical dynamics. Rapidly ageing populations and the anxiety about future funding of health care have prompted them to embark on major health financing reforms in the recent three years. While Singapore has transitioned to universal health coverage with the implementation of MediShield Life (MSL), Hong Kong is about to introduce the Voluntary Health Insurance Scheme (VHIS) to supplement its health care financing. Based on secondary materials including policy documents, press releases, and anecdotal reports, this essay compares these two recent reforms on their political context, drivers of reforms, and policy contents, and assesses their prospects in terms of coverage, financial protection, and major implementation challenges. The preliminary assessment suggests that while both programs are associated with certain drawbacks, those of the VHIS may be more fatal and warrant close attention. This essay concludes with a central caveat that underscores the pivotal role of the state in managing health care reforms.

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1. Introduction

Once hailed as the Asian Tigers, the industrialized high-income economies of East Asia, namely, Singapore, Hong Kong, Taiwan and South Korea, perform well on a range of population health and financing indicators (Table 1). Singapore and Hong Kong, in particular, were ranked by Bloomberg as the top two most efficient health systems in the world [1]. Spending merely 4.9% and 5.7% of their GDP on health, respectively, Singapore and Hong Kong have achieved outstanding outcomes in population health status. Attributable to a variety of factors, this extraordinary achievement is still made possible by their respective health systems.

These two former British colonies, which had resembled each other in their health system structures due to British legacies, embarked on very distinctive paths of reforms in the 1980s and 1990s, in reflection of their own sociopolitical dynamics. Yet, the common health policy challenges in recent years have prompted both governments to initiate major financing reforms. While Singapore has introduced MediShield Life (MSL), a universal health insurance program, Hong Kong is about to launch the Voluntary Health Insurance Scheme (VHIS) as a supplementary financing instrument. Representing strategic responses to health financing challenges in ageing societies, both reforms are also apparently shaped by the two Tigers’ own welfare politics. The comparability of these two Tiger economies firstly lies in their highly similar level of socioeconomic development and historical background in health systems but divergent reform modalities, meeting both “methods of difference” principle and “methods of agreement” principle in comparative methodology. Moreover, Singapore and Hong Kong have been an important source of policy learning for other health systems in the developing world. Some of their practices – such as medical savings account and corporatization of public hospitals – have been diffused to Mainland China and South Africa [2,3,4]. A comparative study of their recent reform trends will facilitate further policy reflection and possible policy learning in other health systems.

Given the recent and forthcoming nature of Singapore and Hong Kong’s reforms, respectively, the lack of solid empirical data precludes ex post assessment. Mainly drawing from secondary materials including policy documents, press releases, and anecdotal reports, this comparative analysis examines their respective political contexts, drivers of reforms, and policy contents, and assesses their prospects.

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https://doi.org/10.1016/j.healthpol.2018.04.012
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Table 1
Key population health and health financing indicators of selected economies, 2014.

<table>
<thead>
<tr>
<th></th>
<th>Life expectancy at birth</th>
<th>Infant mortality Rate (per 1000 live births)</th>
<th>Total expenditure on health as share of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singapore</td>
<td>82.64</td>
<td>1.8%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>83.74</td>
<td>1.7%</td>
<td>5.7%</td>
</tr>
<tr>
<td>South Korea</td>
<td>81.43</td>
<td>3.0%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Taiwan</td>
<td>79.26</td>
<td>3.9%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Japan</td>
<td>83.31</td>
<td>2.1%</td>
<td>10.2%</td>
</tr>
<tr>
<td>US</td>
<td>78.88</td>
<td>6.0%</td>
<td>17.1%</td>
</tr>
<tr>
<td>UK</td>
<td>80.45</td>
<td>3.8%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Germany</td>
<td>80.66</td>
<td>3.3%</td>
<td>11.3%</td>
</tr>
</tbody>
</table>


2. Background

2.1. Political context

The role of politics in health care often dictates the direction of reforms. While general welfare ideologies enrich as well as limit the policy alternatives that are available to policy-makers, political institutions act as the constraints within which policy-makers can exert influence and make decisions [5,6]. The People’s Action Party (PAP), the ruling party of Singapore, has been historically conservative in the provision of welfare, despite its extensive involvement in public housing [7]. This ideology permeated into the health system. The Singapore Government has repeatedly emphasized personal responsibility when paying for health care. Its underlying belief can be best described as *quid pro quo*: giving back only after individuals contribute [8].

Traditionally labeled as a developmental welfare state, Hong Kong differs from Singapore in many respects. The territory’s overarching philosophy of governance has been positive non-interventionism, adhering to the “small government, big market” principle. In contrast to its residualist stance towards welfare, the Hong Kong Government does intervene to a fairly deep extent in tax-funded health care [7]. With the health system inherited from British rule largely still in place, only minor ad hoc tweaks were undertaken in the past three decades [9].

Despite their remarkable similarities in history and socioeconomic development, Singapore and Hong Kong differ significantly in welfare politics. While the former has an authoritarian state and a popularly elected government that is very efficient in decision-making, the latter is a highly liberal society but a semi-democracy operating under China’s “one country, two systems” framework as a special administrative region. The institutional frameworks have vigorously exerted profound impact on health policy reforms in both economies. While the political system of Singapore is very conducive to structural reforms, the lack of political legitimacy has frustrated several important health care reform attempts of the Hong Kong Government in the past [9,10].

2.2. Key features of Singapore’s health financing system

In 1984, Singapore revolutionized the idea of health financing through Medisave, an individualized medical savings account (MSA) funded by one’s salary and matched by employer’s contribution. The motivation behind the MSA was to shift funding to the individual, with the savings balance paying for one’s own medical expenses. Current contribution rates on average are 8–10.5% for 2016, with older persons paying more [11]. The government initially designed Medisave to financially shelter users from large inpatient bills, not to cover small medical visit costs, but its usage was gradually liberalized to include selected outpatient costs and those of family members.

Realizing that some citizens would still fall through the Medisave barrier, in 1990, the government established a basic catastrophic risk-pooling scheme named MediShield, which covered about 93% of the population, before the reform in 2015 to MSL [12]. MediShield was intended to be a “catastrophic illness insurance scheme” to help Singaporeans cope with prolonged hospitalizations and high medical bills. It operates with age-tiered annual premiums payable from Medisave. If hospitalized, one must first pay a deductible before MediShield benefits begin. During the portion of MediShield coverage, patients also pay co-insurance, further reinforcing the idea of individual responsibility. The lifetime maximum claim capped at $300,000.

For those who cannot pay for bills using the Medisave or MediShield combination, Medifund acts as a last-resort measure ensuring expenditures are paid. Medifund is an endowment fund that uses investment income to pay for claims that must be approved on a case-by-case basis. With the three schemes above, combined with government subsidies, Singapore’s health financing arrangement can be described as a “subsidies + 3M framework” [12].

2.3. Key features of Hong Kong’s health financing system

Contrasting the planned Singaporean financing system, Hong Kong’s system is relatively simple and follows a “dual-track” arrangement that refers to the compartmentalization of both funding and provision for different types of health services. While public facilities dominate secondary and tertiary care, 70 per cent of primary outpatient services are provided by private clinics [13]. This sector is funded largely by out-of-pocket payments (OOP; 65%), employer-provided group health insurance (15%), or individually purchased private insurance (15%). Public hospitals provide approximately 90% of inpatient services. Ninety-three percent of the funding of the public sector comes from the British NHS-style tax-based system, which allows subsidized providers to deliver services at nominal fees to citizens, without means-testing. Patients’ OOP payment accounts for merely 6.6% of incomes for public hospitals [14]. There are no mandatory contributory schemes in Hong Kong’s health system.

All public hospitals, specialist outpatient clinics, and general outpatient clinics are managed by the Hospital Authority (HA), a corporatized statutory organization answerable to the government. Heavily subsidized by the government, public hospitals are subject to rigid financial, administrative and operational control of the HA. Every Hong Kong citizen is entitled to highly subsidized care in public facilities that enjoy very high level of satisfaction and trust [15,16]. This generosity, however, also strains public finance and casts doubt on the long-term sustainability of the system. Frequent
utilization of public hospital services also leads to long waits, non-
attendance, and high occupational stress of medical staff [17,18].

3. Drivers of reforms

Although both Singapore and Hong Kong have generated impressive health outcomes at minimal spending, there is an impetus for reform caused by the anxiety towards future funding of health services. In both economies, rapidly ageing populations and the epidemiological shift to chronic degenerative diseases have strained health resources due to frequent and prolonged utilization of care. A very compelling piece of evidence comes from Hong Kong’s HA, showing that the hospitalization rate of a person aged 65 or above is four times that of someone aged below 65; health care costs also grow exponentially as the age advances [19]. In Singapore, it is estimated that more than 10,000 beds and 30,000 health workers are needed by 2020 to cater for the country’s ageing population [20]. In addition to the stern demographic challenge, there are particular drivers to each economy, as to be discussed below.

3.1. Singapore

The saving nature of Medisave makes it an inadequate safety net for low income earners and the unemployed [21]. Even middle-class individuals often find their savings insufficient to pay medical bills, especially when it comes to catastrophic diseases. MediShield, the next safety net, is also associated with some intrinsic limitations. An estimate suggested that 35% of elderly aged 76–85 were not covered under the scheme [12]. Various restrictions in terms of age and claim limits, as well as exclusion of preexisting conditions further limited its effect in financial protection, leaving the elderly with chronic diseases in a particularly vulnerable position [22].

Inherent to the Singapore system are equity issues. The World Health Organization’s 2000 World Health Report ranked Singapore very low (101–102 out of 181 member states) in terms of fairness in financial contribution. The entire “subsidy + 3M” framework merely accounted for about 40% of total expenditure on health, with the other 60% coming from private pockets. A survey conducted in 2012 showed that 72% of participants agreed to the statement that “we cannot afford to get sick these days due to the high medical costs” [23]. The affordability of health care emerged as one of the top issues of dissatisfaction expressed by the public in the 2011 General Election that saw an unprecedented drop of the long-ruling PAP’s votes, triggering a serious review of the Party’s social policies [24]. The review then prompted the government to announce its vision of universal health coverage for all.

3.2. Hong Kong

Hong Kong faces extreme fiscal pressure to fund its public system. Government health expenditure as the percentage of total government recurrent budget is expected to rise from 17% in 2010 to 25.4% in 2030, beyond what the government can afford [25]. Hong Kong’s heavily subsidized public system is plagued by overutilization and long waiting times, particularly severe in specialist care. The government’s strategic goal of reform is thus to recalibrate the public-private mix and relieve the heavy pressure on the overloaded public system [26]. Realizing its financial unsustainability, the government has pursued multiple rounds of financing reforms since 1993 – all failing in face of public opposition – arguably owing to the government’s lack of political legitimacy and a convincing reform vision. The powerful business sector that has a big say in the governance of Hong Kong were also lukewarm towards health care reforms due to their concerns on the rising labor costs [9]. In the end, the government had to abandon any reform proposal that would require compulsory contribution and proposed a voluntary insurance scheme [27].

4. Reform contents

4.1. MSL

In Singapore, MediShield became MediShield Life, enacted in November 2015. The basis of MSL builds on top of the MediShield framework and so is meant to pay for large inpatient bills and costly outpatient bills (dialysis, chemotherapy, etc.), alleviating patients’ OOP burden. The main differences are in enrollment, funding, and coverage. Enrollment is mandatory for all Singaporean citizens and permanent residents, differing from the original MediShield’s opt-out arrangement. Premiums are still age-based and age-pooled, but increased from the original amounts. Deductibles are static from MediShield, but the coinsurance rate decreased from 10 to 20% to 3–10% under MSL. Maximum claimable limits have also increased, with the per-policy year extending from $70,000 to $310,000, and an unlimited lifetime claim. Lifetime coverage is no longer restricted by age, addressing the coverage shortage for the elderly.

To reduce the burden of premium payment, the government offers various subsidies and rebates. Dependent on age-of-entry, a premium rebate is given which increases as one jumps to the higher age-band. The government also provides subsidies mainly targeting lower- to middle-income households and the elderly. To shift from the voluntary to mandatory scheme, the government also offers a transitional subsidy over the first four years of MSL to ensure a financially smooth entry. MediShield formerly excluded people with certain preexisting conditions, but the new MSL covers them at a cost. Those with “serious preexisting conditions” must pay an additional premium of 30% over ten years.

4.2. VHIS

Expected to be launched in 2018 or 2019, the nature of VHIS is a voluntary and government-regulated private medical insurance program. It aims to encourage the middle- and high-income segments of the society to use private services and leave the overloaded public hospitals to serve the low-income needy. To be operated by private insurers, the VHIS serves mainly to regulate selling of “indemnity hospital insurance” which reimburses policyholders for medical expenses incurred in private facilities. Benefit coverage includes medical conditions requiring hospitalization, prescribed ambulatory procedures, prescribed advanced diagnostic imaging tests subject to 30% coinsurance, and nonsurgical cancer treatments up to a limit.

The VHIS intends to “enhance the quality of insurance in the market” through tighter regulation of what insurers must provide. The government is modifying the regulatory framework of hospital insurance by establishing a set of “Minimum Requirements (MRs)” for which insurers must adhere to if they are to sell the product. Two MRs distinguished the VHIS from ordinary commercial medical insurance: unconditional inclusion of preexisting conditions and guaranteed lifetime renewal without re-underwriting. These features made VHIS manifest certain public medical insurance characteristics, notwithstanding its private nature. To strike a balance between commercial profitability and social protection of the vulnerable population, the government originally proposed a tax-subsidized “high-risk pool” to absorb part of the premiums of those in greater health risks, especially the sick and the elderly. But, this proposal was attacked by some stakeholders as a cross-subsidization of the better-off, thus violating the equity principle of public finance [28]. Worse, the insurance industry was firmly against some MRs that might reduce its commercial interest [29].
In the end, the government had to make major concessions by suspending the establishment of the “high-risk pool” and withdrawing the two central MRs. In the latest version of the policy plan, individuals aged above 80 years old become ineligible to be insured; individuals with preexisting conditions are no longer guaranteed with insurance and may be underwritten to pay significantly higher premiums out-of-pocket only.

Table 2 below compares between the main components of the MSL and VHIS (latest version).

5. Assessment of prospect

An ageing population coupled with escalating costs was the main driver for both reforms. While MSL is still very new, VHIS has yet to be introduced. This section provides a preliminary assessment of their prospect against three key aspects: coverage, financial protection, and major challenge in implementation.

5.1. MSL

Compared to Hong Kong, Singapore had an easier time to transition under the auspice of a strong government. With the role of state reasserted, MSL is accompanied with increased government funding to health care and represents a meaningful development in PAP’s welfare ideologies. Notwithstanding the universal coverage that is achieved, MSL’s increased premiums, same deductibles, and yearly limits may still cause financial hardship for some individuals with chronic diseases. Whether MSL alleviates Singaporeans’ anxiety when it comes to paying large medical bills is yet known.

One commendable effort is the easing of this qualm through subsidy programs like the Pioneer Generation package. MSL has also extended coverage, with the age-limit removed. Preexisting conditions are covered, although these individuals are underwritten to pay higher premiums in the short-term.

A major controversy that arose in the first two years of MSL’s implementation points to the remarkable gap between premiums collected and the actual payout, with the latter being barely one quarter of the former. Looking at the reserves for MediShield and subsequently MSL, one can see that the government amassed nearly a billion dollars more in premiums than it paid out in claims, igniting controversies in the society [30]. The government argues that fiscal prudence is necessary and the surplus serves as a buffer to cover future claims. It cited a pro-elderly effect based on preliminary data, showing that nearly half of the claims paid out in the first 11 months of implementation went to Singaporeans aged above 65, and that the average payout each senior citizen received had increased to S$1639 from S$1425 under the old MediShield [31]. However, considering the percentage of the elderly in the population, the effect of inflation and the increased premiums, the significance of these effects becomes debatable.

5.2. VHIS

VHIS is voluntary and meant for those who are able and willing to afford supplementary insurance for higher-quality private care. In theory, the intrinsic shortcoming of voluntary insurance is adverse selection that may paralyze its finance. Yet, a study undertaken in 2015 found a moderate risk of adverse selection; the survey of close to 1800 Hong Kong adults suggested that one third of the respondents explicitly stated an intention of subscribing to the VHIS, a fairly high figure considering its voluntary nature [27]. However, the recent developments have cast serious doubt on the scheme’s prospect. Despite the government’s commitment of stronger financial protection, its concessions made to the organized interests are very likely to substantially undermine the VHIS’ intended effect and attractiveness to potential subscribers [32]. The removal of key MRs may result in the exclusion of high-risk individuals and low subscription rate.

In addition, although certain prescribed ambulatory services are covered, the exclusion of general and specialist outpatient care may upset the medical needs of many people with chronic conditions but do not presently need hospitalization; this group of the population is exactly those who will remain in the crowded public hospitals and continue their frequent utilization of strained resources. The study cited above suggested that a large number of high-risk individuals would not necessarily flock to the high-risk pool despite the availability of premium subsidies but would most likely stick to the public system [27]. With the suspension of the pool now, the VHIS may ultimately lose appeal to its intended subscribers [33], and therefore, to what extent the VHIS can achieve its stated goals warrants close investigation.

6. Concluding remarks

Both Tiger economies embarked on major health financing reforms, in response to challenges brought about by ageing populations, but Singapore’s MSL reform appeared to be further driven by political consideration whereas Hong Kong’s VHIS was a product of compromise between the government and society. There are also salient differences in terms of their respective pace of reforms. It took the Singapore Government barely two years since the 2011 General Election to complete its milestone health policy review, and another two years for the full-scale implementation of MSL. In Hong Kong, although the proposal of voluntary insurance
finally received public support in 2010, public consultation did not commence until 2014; the actual launch will not be made until mid-2018.

Bloom insightfully elucidated that specific policy interventions are much less important than the way the reform process is managed because any health care reform must ultimately tackle the embedded underlying policy logic if it is to succeed [34]. This essay concludes with a central caveat related to managing health care reforms. One criticism of MSL is that, like its predecessor, it remains a commercially-run operation despite the assertion of being not-for-profit. The long-held principle of fiscal prudence in Singapore may be increasingly questioned by the public. A further enhancement of the state’s role might become necessary if public opinions take another unfavorable turn in the near future. In Hong Kong, the twists and turns of health care reform, once again, reveal the weak policy capacity of the SAR Government. Meaningful reforms repeatedly backfire as the government is sandwiched between business interests and even mild public opposition. Despite its original ambition, the VHS faces a dim future in its modified design. Moving forward, Hong Kong’s health policy reformers must be more astute in the reform process and assert their role as a major player in the health policy arena. This involves a tweak of its non-interventionist ideology. Any ambitious reform may end up in vain if professionally informed policy design is not matched by strong and astute political management, given the myriad intertwined interests in this domain.

Acknowledgements

The authors sincerely thank two anonymous reviewers and the Section Editor for valuable comments.

References


