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<th><strong>Title</strong></th>
<th>Case study in good governance: health care in Singapore</th>
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Case Study in Good Governance:
Health Care in Singapore

M Ramesh

Paper presented at the 2010 international conference on "Good Governance and National Development" organized by the UN Project Office on Governance (UNPOG) and the Ministry of Public Administration and Safety (MOPAS), June 17 (Thursday), 2010.
Introduce Market and Government Failures in Health care
Describe Singapore’s key healthcare achievements
Chronicle health care reforms in Singapore
Examine how the reforms address
  Market failures
  Government failures
Conclusion
  The Goal of healthcare reforms should be to steer clear of both government and market failures
  Healthcare reforms require constant tweaking of market and government arrangements
Market and Government Failures in Healthcare

Market failures prominent in health care sector:
- Externalities,
- Imperfect information,
- Non-competitive markets.

Government failures prominent in health care sector:
- Principal-Agent problem,
- Rising Costs
- Stagnant and/or deteriorating quality,

Challenge for governments is to simultaneously overcome both types of failures.

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Ramesh #3
### State of healthcare in Singapore

- Infant mortality rate (IMR) of 2.1 per 1000 births in Singapore is less than half the OECD average.
- Life expectancy of 80.6 years is higher than the OECD average.
- Singapore spends little on healthcare:
  - Per capita health spending is PPP$ 1,536, compared to average of PPP$ 2,920 in OECD.
  - Total health expenditures formed 3.3% of GDP, compared to 8.9% in OECD.
- Healthcare CPI lower than general CPI in recent years!
The healthcare system in Singapore

Singapore’s achievements may be partially explained by its youthful population (albeit ageing rapidly)

The Health care system explains much of the achievements

Key features of the healthcare system

Provision:

- 80.7% of all hospital beds are in the public sector
- 55% of all physicians in the public sector

Financing

- Government expenditure on health care forms only 33% of THE
- Almost all of private expenditures is from non-insurance sources
# Healthcare Reforms in Singapore

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Description</th>
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<tr>
<td>Mid-1980s</td>
<td>Privatization of public hospitals and adoption of new public management techniques in the hope of improving servicing quality and lowering costs.</td>
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<tr>
<td>Early 1990s</td>
<td>Reassertion of state's role</td>
</tr>
<tr>
<td></td>
<td>Current arrangement</td>
</tr>
<tr>
<td></td>
<td>Market-based tools used to address government failure</td>
</tr>
<tr>
<td></td>
<td>State-based tools used to address market failures</td>
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Began in the mid-1980s

In the face of worries that traditional public institutions and processes were too inflexible and lacked sufficient incentives for improvements.
# Healthcare Policy Components and their target failures: Provision

<table>
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<tr>
<th>MARKET FAILURE</th>
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<tr>
<td>• State ownership of hospitals and polyclinics</td>
<td>• Competition among public providers</td>
</tr>
<tr>
<td>• Large hospital clusters</td>
<td>• Public hospitals registered as private firms, but entirely owned by the government.</td>
</tr>
<tr>
<td>• Quality accreditation for hospitals</td>
<td>• Autonomy for managers of public hospitals</td>
</tr>
<tr>
<td>• Transparency in healthcare price, bill, and outcomes</td>
<td>• Private hospitals compete with public hospitals</td>
</tr>
<tr>
<td>• Integrated information technology platform</td>
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Healthcare Policy Components and their target failures: **Payment System**

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<tr>
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<tbody>
<tr>
<td>• Block and Case mix funding for public hospitals</td>
<td>• Public hospitals allowed to retain surplus revenues</td>
</tr>
<tr>
<td>• Fixed salary for physicians in public hospitals</td>
<td>• Bonus for physicians in public hospitals</td>
</tr>
<tr>
<td>• Government oversight of billing practices and bill sizes</td>
<td>• Clinical standards</td>
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</table>
Healthcare Policy Components and their target failures: **Financing**

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<thead>
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<tr>
<td>• Subsidy for public hospitals and polyclinics</td>
<td>• User charges at all public hospitals and clinics</td>
</tr>
<tr>
<td>• Medisave</td>
<td></td>
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<tr>
<td>• Medishield</td>
<td></td>
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<tr>
<td>• Medifund</td>
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Conclusion

Comprehensive and incessant reform efforts
Singapore’s turn to market-centred mechanisms to address failings of the government-centred system in the mid-1980s had wide-ranging impacts

Promoted cost consciousness and improved service quality
But also worsened affordability and raised total expenditures with increasing share accounted by OOP payment.

The trends necessitated corrective actions to address market failures.
Constant tweaking of the system In the following years, encompassing provision, provider payment and financing of health care.
Conclusion

Provision

The key to containing market failures is the government’s continued ownership of hospitals. Complemented by measures to promote international accreditation for hospitals and transparency in pricing and performance information with the purpose of improving quality while containing costs. To offset the associated government failures, public hospitals required to compete for patients and revenues. Managers given operational autonomy, but under government watch.
Provider Payment
To check the flipside of competition for revenues:
Public hospitals are paid on a block grant or Casemix basis, not FSS.
Physicians are employed on fixed salary and not the volume of services they provide.
To contain the moral hazards entailed in fixed income, the government allows hospitals to retain surplus revenues within permitted range and pays physicians a modest bonus based on performance.
Conclusion

Financing

failures addressed through

Subsidy to public hospitals.
– Necessary to offset the adverse effects of user charges in place to address government failures.

Medisave. Individual Medical Savings account
Medishield. Catastrophic insurance.
Medifund. Means-tested public assistance

The 3Ms play a relatively small role.

Warrant reconsideration of their use

Government failure addressed through user charges at public hospitals.

Has equity effects

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