MINISTRY OF HEALTH
SINGAPORE

SPEECH BY MR KHAW BOON WAN, MINISTER FOR HEALTH (SINGAPORE), AT THE EAST ASIA HEALTHCARE POLICY DIALOGUE, 21 JULY 2.00PM, BANYAN ROOM, SHANGRI-LA HOTEL, SINGAPORE

Managing Healthcare Contradictions

Colleagues and Friends

1 Once every two years, the ASEAN Health Ministers take turns to host a meeting among themselves. At each session, we also co-chair the ASEAN+3 Health Ministers Meeting with our East Asian counterparts, as well as co-chair with China the ASEAN-China Health Ministers Meeting.

2 This year, it is my turn to do so. The meetings will take place over the next two days.

3 At past meetings, we were consumed by the need to manage some on-going health crisis. For example, there was the melamine crisis during our last meeting in Manila. This year, there is no such regional crisis requiring our

urgent attention. H1N1 is there but fortunately very mild. We will be spending some time discussing how to wrap up H1N1 during this meeting. In a more relaxed mode, we can brainstorm longer term strategic issues, and share ideas and insights. As health ministers, we share many common challenges and there are solutions practised elsewhere that we can learn from.

4 My Ministry takes the opportunity to convene this East Asia Healthcare Policy Dialogue. It allows us to tap on some external healthcare experts and should enrich the Health Ministers' discussions over the next two days. I would like to thank Lord Ara Darzi, Prof Alan Lopez and Dr Michael Merson for coming here to share your wisdom.

5 The Policy Dialogue centres around "Achieving better quality, improved access and lower costs" in healthcare. At first glance, these seem like contradictions: better, cheaper and still available to all. Too good to be true. But in the ICT sector, these are not contradictions. IT, broadband and mobile telephony have indeed been getting more powerful, ubiquitous and cheaper at the same time.

6 Healthcare, on the other hand, has not done as well. Medical science has reduced mortality and extended lifespan, but cost has gone up

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tremendously. As a result, even in some rich countries, good healthcare is not universally available.

7 Thankfully, there are exceptions. When I started my career in healthcare, cataract surgery required several days of hospitalisation. Now it is a routine day surgery, with great savings in cost and time to the patient. As another example, with proper vaccination, all Singaporeans born after 1987 are protected from Hepatitis B, reducing their risk of getting liver cancer and its associated costs and trauma. Hepatitis B among Asians, especially Chinese, is a problem. Hepatitis B vaccination used to be expensive but now the price is more competitive, with all Singaporeans vaccinated at birth. However, new problems appear, such as Hepatitis C, which is now a main cause of liver cancer.

8 Dr Henke will share with us later a few more examples of such innovations that give hope that one day good quality healthcare can consistently be cheaper and more widely available.

9 Meanwhile, “better but more expensive” healthcare solutions are more common.

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10 And often, the industry ends up touting just “more expensive” solutions even though there is skimpy evidence of them being better.

11 This is partly due to the politicisation of healthcare, making rational solutions more elusive. So, health ministers end up holding the can, trying to juggle these contradictions.

12 But we should be optimistic. As the problem of rising healthcare cost gets more serious, voters will support responsible politicians who are prepared to push for rational solutions. For example, healthcare used to take up 13% of US’ GDP. The figure is now 17%, and it may increase to 25% in the future. This means that a quarter of income is spent on “sickness” care. Is this the right way to spend our income?

13 In Singapore, we have tried to do just that. We do not dangle the myth of “free healthcare”, instead we argue for “individual responsibility” and “some co-payment”. We offer a range of services at different subsidy levels, so that consumers make their choices, from Class A to Class C. But we ensure that the most heavily subsidised Class C provides a good standard of clinical care, so that nobody is denied good care. But if you want frills, or demand non-essential services, please pay for them.

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14 To ensure that everyone can afford “some co-payment”, we require everyone to save in their health saving accounts, which we call Medisave, every month. These are individual, not pooled, accounts. This way, if you do not overspend, your Medisave Accounts grow. There is incentive to do the right thing.

15 But as good healthcare services do not come cheap, we have properly designed national insurance schemes in place, with high deductibles and co-insurance, to minimise moral hazard. We stay away from comprehensive insurance schemes based on first-dollar coverage which are popular in the west but have been shown to lead to over-servicing and over-consumption.

16 Our system is not perfect but it has delivered results. For example, Singapore is world number 2 in infant mortality rate, and world number 9 in life expectancy. Prof Alan Lopez co-authored a recent article in the Lancet which tracked adult mortality across 187 countries over 40 years. It is a fascinating article and I am glad that Singapore has fared quite well in this study.

17 We have achieved good outcomes while keeping healthcare expenditure at less than 4% of GDP. This way, we minimise the tax burden

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on individuals and companies and Singaporeans get to spend more of their income on other things in life.

18 A big reason for how we have achieved this is that we have let the market dynamics of demand and supply function as much as possible. If we camouflage pricing signals it must spur over-consumption. So we publish bill sizes for the common procedures to reduce the information asymmetry between patient and provider. This allows the more sophisticated consumers to do some shopping around for elective procedures. In practice, from what I observe, patients do not seem to shop around, except in the field of obstetrics. Women are better shoppers. The product (pregnancy and delivery) is also more homogeneous. Hence there is good information symmetry. In antenatal care, patients talk to one another while waiting in the clinics, leading to the possibility of a competitive market. Hence in obstetrics, the price package has remained the same since 15 years ago. Another example is Lasik, where competition has worked very well. Five years ago, Singaporeans travel elsewhere for cheaper Lasik procedures. I collected data from all the clinics here and published them. Lasik prices dropped by more than $1,000 per eye within a few months and Singaporeans no longer travel overseas for Lasik.

19 But we still have much work to do. Today, we can deliver good, affordable episodic care of acute conditions. We have not yet been able to

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consistently integrate care for those with multiple or complex chronic conditions. We will need to transform many aspects of care delivery, and put in place new infrastructure like a national electronic health records system. We are learning from the UK and Australia in this aspect. This is my priority for Singapore healthcare over the next 10 years: integrating care for patients and helping them transit seamlessly among different providers. This will especially benefit the elderly patients as they tend to have multiple chronic illnesses.

20 Today's Dialogue is an opportunity to learn how others are trying to attain "better, cheaper, widely available care". We cannot blindly transplant solutions from one system to another, but their success stories will trigger ideas on how to adopt and make improvements.

21 Finding workable solutions to the region's health challenges will require strong capabilities in health policy, deep understanding of the trade-offs involved and an open mind to learn.

22 To help build such capabilities in the region, I am pleased that the National University of Singapore is launching the NUS Initiative to Improve Health in Asia (NIHA). This is a $17mil programme for research, education

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and capacity building in health policy across Asia, supported by the very generous donation from the GSK-EDB Trust Fund.

23 It will provide funding for research on health policy through regular grant calls. It will sponsor mid-career healthcare executives across Asia to a three-week leadership programme in Singapore. And it will also organise a regular high-level forum to discuss health challenges, identify possible solutions, and foster partnerships between Asian health policy makers. The first forum will be in November and I hope to see many of you or your representatives taking part in it.

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24 I hope the NUS Initiative will enable the region to take further strides in managing the healthcare contradictions. I wish all of you a productive Policy Dialogue.

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