# Paying for Health

## – The Fundamentals Are… Fundamental

By Dr Jeremy Lim, Editorial Board Member

Many have called for a transformation of Singapore's healthcare system, and it is perhaps timely to revisit the sobering fundamentals of healthcare financing. What are these fundamentals? There are four I would consider most critical, and they can and should guide future policy making and moderate expectations of any new initiatives.

While it is trendy to exhort the government to "provide more and more", the truth is that most governments rely almost exclusively on taxation to fund public services. And taxes are inevitably paid by the man in the street, either directly to the government or indirectly through higher prices. More public services equal higher taxes. Former Singapore Health Minister Khaw Boon Wan put it succinctly, saying, "There is no free healthcare; someone has to pay the bill." It really is as simple as that. The more important discourse therefore, is not whether the government should do more, but rather how much society, i.e., all of us individually and corporately through the state, should spend on healthcare and what we are prepared to trade off to live within our set budget.

The paradigm of "finite resources, infinite demand" strikes at the very core of the tension that beguiles modern Medicine. As much as we teach medical students about the doctor-patient relationship and doing one's best for one's patients, as a larger collective, there will never be enough. As long as we pursue longevity and renounce death and disability, demand for healthcare will always outstrip the resources available. Hence rationing healthcare, despite the ugly connotations, is a practical reality. The *New York Times* columnist David Leonhardt states baldly: "The choice isn't between rationing and not rationing. It's between rationing well and rationing badly."

Singapore rations explicitly, with the Ministry of Health once declaring that public hospitals will provide "good, up-to-date medical practice, which is cost-effective and of proven value. But it will not provide the latest and best of everything." Is this the correct stance? Yes, it is necessary. No country is rich enough to provide everything of anything to everybody. Have we as a country engaged in deep dialogue as to what this means in practice? No. Our Standard Drug List was not even public knowledge until very recently! We have never had those difficult societal discussions on the price of life and what we as a humane society will pay for out of the public purse. Is this tenable moving forward? I think not.

The necessity of rationing and a keen pragmatic awareness that there is "no free lunch" should form the bedrock of policy thinking around healthcare financing and be augmented by clever mechanisms, to combat moral hazards as well as ensure social protection. The moral hazard is simply overconsumption because another party is paying. Minister Khaw has termed this the "buffet syndrome", drawing an analogy with how people overeat at buffets. Herein lie the dangers of first dollar insurance coverage common in America (at least partially responsible for runaway costs), and the ideological basis of England's National Health Service at its founding in 1948 (which despite, the nobility of its intent, has faced budget challenges almost from its first days and the most severe may be imminent). Singapore has prudently adopted co-payments as an integral part of financing through Medisave and out-of-pocket payments, and the lessons of history make clear that co-payments or at least measures to minimise overuse of healthcare services and control costs are necessary.

That said, unexpected illness can be financially disastrous, and some form of social protection through risk pooling and insurance is vital. Healthcare can be horrendously expensive, and as Harvard professor David Himmelstein famously remarked, "Unless you're Warren Buffett, your family is just one serious illness away from bankruptcy." Subsidies and MediShield as a national health insurance programme underpin this risk pooling by mitigating the out-of-pocket expenses, but both are heavily inpatient-biased and designed for a time when "catastrophic" meant lengthy hospitalisations and hospital-based treatments. Today, medical advances have transformed the delivery of healthcare. Ever shorter lengths of stay and ever pricier outpatient therapies such as chemotherapy comprising just one pill to be swallowed are commonplace. Our subsidy framework and MediShield need to be revamped but whatever we do, we should not forget the core of risk pooling and social protection. Nobody should lose his home to save his life.

Moving forward, Singapore faces formidable challenges in healthcare. The twin spectres of rapid ageing and a chronic disease epidemic loom large on a background of severe underinvestment in healthcare infrastructure and a global contest for healthcare talent. Innovative "game-changing" solutions need to be found but the economic fundamentals still matter. The late Randy Pausch of "The Last Lecture" fame frames it appropriately: "Fundamentals, fundamentals, fundamentals. You've got to get the fundamentals down because otherwise the fancy stuff isn't going to work." Similarly, in redesigning Singapore healthcare and its financing, we must not forget the fundamentals. SMA

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