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Lessons from Singapore: Opt-Out Health Savings Accounts for Australia

David Gadiel and Jeremy Sammut



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Executive Summary

Compared with traditional public and private health insurance systems in other nations, including Australia, Singapore's distinctive health funding and service provision arrangements are delivering comparable, First World standards of care and health outcomes at much lower cost. This achievement is chiefly attributable to the greater personal responsibility for health expenditures and superior incentives for efficiency that are integral to the Singaporean model.

The so-called '**3M**' health financing system, comprising **Medisave, Medishield and Medifund**, is a component of Singapore's compulsory household and retirement savings system. It could constitute a blueprint for an alternative method of health financing in Australia by linking Health Savings Accounts (HSAs) to the existing compulsory superannuation system.

The central pillar of Singapore's 3M system is **Medisave**, which is a system of compulsory, age-based income contributions to tax-effective HSAs. Funds accumulated in Medisave HSAs can be used for some specialist treatment and chronic care and for the cost of inpatient hospital care; they may also be used to purchase high-deductible hospital insurance through **Medishield**, the state-run health insurance fund, or to purchase additional private hospital cover. **Medifund** represents the safety net of the 3M system. It is a government endowment fund providing means-tested payment of the hospital costs of poor Singaporeans.

The Medisave model encourages saving for unforeseen high-cost health events as opposed to paying for high-frequency, low-severity contingencies or for primary care from a GP or an allied health professional. In Singapore, these minor health costs cannot be met from Medisave money; they must be incurred as out-of-pocket expenses. Similar restrictions apply to most prescription pharmaceuticals, which are paid for directly out-of-pocket (minus a government subsidy for listed medications). Cost sharing also applies to all inpatient hospital treatment, where costs must be met either wholly out-of-pocket or from Medisave accounts or alternatively cost shared on Medishield, by way of a co-insurance and a deductible paid either from Medisave or out-of-pocket.

The existence of a price at the point of consumption in Singapore is designed to instill levels of personal responsibility for health that is unknown in the Australian health system. With their own money at stake, Singapore's citizens are encouraged to make judicious choices about using health services. As a result, Singapore devotes less than half the amount of its GDP to health than Australia, and 60% of health spending is private expenditure. This has contained the cost and increased the affordability of health care, while increasing the overall efficiency of the Singapore health system.

Importantly, this achievement has not detracted from health outcomes and quality of care: Singapore's life expectancy at birth is superior to Australia's, and infant and under 5 mortality rates are substantially below other comparable countries. In a 2000 ranking of the health systems of its 191 member countries, the World Health Organization (WHO) placed Singapore 6 and Australia 32.

Conventional health policy wisdom, drawn mainly from American experience, is that low public health spending and high private health spending is associated with higher health costs and lower health outcomes. Singapore's experience shows that low public spending, low third-party (private insurance) spending, and high out-of-pocket spending is cost effective (see Table 1).

	Singapore	Australia
Health expenditure as % of GDP	3.6	9.5
Public expenditure as % total health expenditure	41.0	70.0
Out-of-pocket expenditure as % total health expenditure	50.5	18.9
Out-of-pocket expenditure as % of private expenditure	85.6	63.0
Acute separations per person	0.08	0.41
Acute hospital bed days per person	0.51	2.36
Life expectancy at birth, M/F	79.9/84.5	79.9/84.3
Infant mortality per 1,000 live births	1.8	3.8
Under 5 mortality per 1,000 live births	2.8	4.9

Table 1: Comparative health spending and outcomes in Singapore and Australia, 2009–12

Source: Tables 2, 3 and 4.

A new vision for funding health in Australia based on the Singapore model could be achieved by applying the principle of choice for those who wish for an alternative to Australia's taxpayer-funded universal health care system.

This model would be applicable to those with accountbased superannuation plans, so-called 'taxed' funds, and would require:

- adapting the superannuation system by modifying the 'sole purpose test' on existing superannuation accounts in combination with an increase in contributions to fund separate but linked HSAs
- permitting individuals to opt out of Medicare in exchange for the right to establish a tax-effective HSA attracting the same 15% concessional tax rate as income in taxed superannuation funds during their accumulation phase
- providing those who cash out their Medicare entitlement with an annual Health Voucher (indexed) for deposit in an HSA, equivalent to total average per person government spending on health—approximately \$4,300 in 2011–12.

HSAs funded from current Health Voucher money and/ or accumulated savings from unspent Health Voucher money received in the past would be drawn on to meet the cost of specified health expenses, including paying for an approved list of GP services and other non-hospital care and health insurance premiums. Upon retirement, HSA funds would be added to the retirement income balance of a superannuation account, as occurs in Singapore.

In exchange for control of one's own health dollars, individuals would agree to save up and take responsibility for their own health care costs in retirement. Health vouchers would cease when pension eligibility age is reached. This means HSAs would yield long-term savings to government by establishing non-government sources of funding for old age health costs.

HSA models operate in conjunction with high-deductible insurance to cover high-cost hospital care and

treatment costs associated with chronic and catastrophic conditions. High-deductible health plans would develop through existing registered health insurers or other institutions managing HSA funds on behalf of account holders. Insurance premiums, co-insurance and deductibles would be met from HSA balances, and health insurers catering for the needs of HSA holders would negotiate service contracts and preferred provider arrangements on behalf of their clients.

If Australia were to emulate a variant of the Singapore model that suited its own needs, the new dynamics that HSAs introduced into the health system would help drive greater supply-side competiveness. Providers would start to recognise the importance of catering for the needs of an emerging clientele attracted to cost-effective HSAs and taking a much keener interest in the cost and content of their services. This would have the potential to help create local contestable markets for health services involving fee discounts, new competitive and innovative care packages, and other forms of non-price competition. The efficiency effects of the HSA sector, depending on the extent of its uptake within local patient catchments, could gradually filter through to the health economy serving Medicare itself-further relieving health cost pressures on government budgets.

An overhaul of the various components of Medicare would be timely. Since its introduction in October 1984, Medicare has remained remarkably intact, entrenching itself as a monopolistic service (for specified medical and hospital services) for everyone—rather than targeting need and conserving resources for the poorest and most vulnerable. In an ageing Australia, Medicare as it stands will be unsustainable without more taxation, or more public debt, or both. One reform option to reduce future health funding pressures on government budgets would be to allow Australians to opt out of Medicare, assume personal financial responsibility for self-funding their own health care, and emulate ways in which Singapore has nurtured a low cost, HSA-based health economy. As technology advances and people live longer, there is no way the healthcare systems of developed nations can survive at a reasonable cost with a minimum level of equity in provision, without putting individual responsibility and public health policy at the centre of the debate.

- Tony Blair¹

The opening ceremony of the 2012 London Olympics paid unusual homage to a national institution: film director Danny Boyle's tribute to the National Health Service (NHS) famously featured 300 illuminated beds emblazoning 'NHS' across the field of the Olympic stadium. Established by the Attlee Labour government after World War II, the NHS has long been viewed by its advocates as a pinnacle of the British welfare state: no matter what else might be said of their country, since 1948 the people of the United Kingdom have accessed 'free and universal' health care paid by tax.

In 2014, however, the celebrated institution thought to have set Britain apart (particularly from the United States) is being subject to mounting critical scrutiny. The core features of the NHS include no or low levels of 'cost sharing' with patients, and low overall levels of private expenditure on health care. The absence of user charges for most services, which shifts the money cost of health away from individuals and directly on to public expenditure, is not sustainable. A recent report on the future of the NHS by the respected independent health think tank, The King's Fund, not only acknowledged the demographic and other financial pressures on the overstretched UK budget, but also risked sacrilege, boldly declaring that 'the whole of current direct expenditure on health and social care, both public and private, cannot be met through public spending.' The scale of the financial challenge facing the NHS led the King's Fund report to consider a number of possible responses, including new or extended NHS charges that might apply to those able to meet them. Examples of proposed cost-sharing measures are a £10 charge for GP, practice nurses, outpatient, or accident and emergency visits, and a daily accommodation charge of between £10 and £50 for hospital inpatient treatment.²

The UK debate about personal responsibility for health care comes as Australia's own 'free' taxpayer-funded health system, Medicare, faces structural, cost and ageing challenges analogous to those confronting the NHS. This in turn has invited national debate about similar initiatives that could require Australians to contribute more to meet the cost of publicly funded health care directly and lessen the increasing burden that health is placing on the federal government budget (Box 1).

Box 1: Co-payments

- Recent argument for greater cost sharing for Medicare services led to a proposal in October 2013 for Australians to incur a \$5 or \$6 statutory co-payment per GP visit³ as a curtain raiser to the government's National Commission of Audit. The 2014-15 federal budget proposes to reduce Medicare Benefits Schedule (MBS) rebates from 1 July 2015 by \$5 for standard GP consultations and out-of-hospital pathology and diagnostic imaging services. Although providers of these services would remain free to set their own charges, they would be encouraged to collect a patient contribution of \$7 per service. Low-gap incentives would replace bulk billing incentives, and would be paid to providers if they collected the \$7 co-payment from general patients and confined the \$7 co-payment to the first 10 services each year for concessional patients and children under 16. This measure was projected to save the government \$3.5 billion over five years.⁴ The saving to the cost of benefits associated with these measures would amount to some 1.6% of all federal health spending over the period of the forward estimates.⁵ States would be permitted to introduce charges for public hospital outpatient services that substituted for GP primary care, even though Medicare has traditionally guaranteed free access to these services. Because demand for primary medical care is likely to be relatively inelastic, especially if states do not follow the federal government's intimation to charge for outpatient care, the likelihood of any distortion to necessary health expenditure would be minimal. This is consistent with findings by Luke Connelly, indicating elasticities for Australian GP services in the range of -0.3 to -0.4.6
- Proposals for a co-payment on GP services have met steadfast opposition from advocates who romanticise
 the capacity of Medicare in its purest form and credit it for Australia's quality health services and health
 outcomes.⁷ The hostility is reminiscent of historical indignation associated with the introduction of a
 \$2.50 co-payment for all out-of-hospital bulk billed GP services for the general (non-concession card)
 population in November 1991—and supposed to have risen to \$4 in November 1992.⁸ This arrangement
 foundered and was withdrawn quickly after igniting a political dynamic that eventually culminated in
 a change of prime ministers.

- Animosity towards the \$7 co-payment proposal is nevertheless consistent with the discredited argument that cost sharing jeopardises the integrity of Medicare and is counterproductive. The medical profession has joined the criticism, *inter alia*, on grounds that barriers to accessing primary care impair health system efficiency.⁹ This disregards the pressure that untrammelled demand for GP services contributes to the alleged shortfall in the effective GP workforce and the difficulties in readily accessing medical services in localities where doctors find private medical practice uncongenial.
- Opposition to a co-payment is paradoxical. Other *ad hoc* examples of cost sharing have long been a feature of Australia's health system. For instance, in the case of Pharmaceutical Benefits Schedule (PBS) pharmaceuticals, at the time of writing (June 2014) indexed co-insurance for the general population, capped at \$36.90, in conjunction with a \$6 co-payment for concessional cardholders, applied to most prescriptions dispensed on the scheme, subject in each case to safety net criteria.¹⁰ These patient contributions are estimated to rise by \$5 to \$42.70 and by 80 cents to \$6.90, respectively, under the 2014–15 Budget,¹¹ with commensurate rises in safety net thresholds.¹² There are travel costs too incurred in obtaining public primary care—including car parking costs at inner Sydney public hospitals of \$20 for three hours, even for patients undergoing debilitating treatment.¹³ State governments never fail minor opportunities to make patients share indirectly in the cost of their treatment, even though they are unable to charge for public treatment itself.

Debate about the introduction of GP co-payments has inspired considerable political heat because Australia's Medicare, like Britain's NHS, has a special national status. Since 1984, Medicare has sought to guarantee all Australians access to health care mostly without user charges. In keeping with the intention of its founders, Medicare has striven to offer access to a 'universal,' single class of a high quality care for well-to-do and poor Australians alike.¹⁴ The stated rationale for Medicare was that 'universalism' would avoid a 'two-class' health system that gave the poor access to services of inferior quality. A uniform health system would hence reflect the national ethos of a 'fair go' for all. In reality, the evolution of a 'mixed,' public-private health system, together with the structural flaws that have marred Medicare's design since inception, has failed this egalitarian promise. In practice, Medicare has delivered an ever-increasing cost to taxpayers, much less its promise of 'free and universal' health care for all.

Medicare: Structure, cost and ageing

Medicare provides on demand access to non-hospital based medical services without user charges if the provider agrees to 'bulk bill' patients and accepts the Medicare Benefits Schedule (MBS) rebate paid by the federal government as payment in full. With around 80% of GP services currently bulk billed, and approximately 75% of all MBS services bulk billed, 'free' medical care is standard, and individuals contributing to the cost of medical care by paying out-of-pocket charges is the exception in Australia. Medicare also entitles Australians to inpatient and outpatient treatment from public hospitals without charge at point of access. The cost of 'free' public hospital care is limited, and the overall cost of the Medicare system contained, by rationing and queuing for public elective surgery. For this reason, Australia's public hospital system, managed by states and territories, is shadowed by a private system as well as by private-paying beds in public hospitals. Private treatment both in public and private hospitals duplicates many types of treatment also delivered from 'free' public hospital beds, and some 47% of the population are willing to hold private health insurance mainly to hedge the risk of public waiting lists.

It is not surprising that Australia's complicated publicprivate health system encourages costly and inefficient allocations of health labour and capital. The federal government contributes to each of the systems. Aside from its activity payments (to start in July 2014) and fixed contributions to state and territory budgets for public hospital operating budgets, the government also contributes to teaching costs and makes discretionary grants to public hospitals for some capital items; and in an attempt to level the playing field, it also indirectly supports private hospitals by subsidising private health insurance premiums via the private health insurance rebate.

Equally not surprising are the constant cost and demand stresses in the public components of Australia's health services, driven in part by Medicare's free entitlements to medical services, and exacerbated on the supply side by rigid industrial practices in the public hospital system and the lack of competition in the market for hospital services.¹⁵ Demand and supply factors have contributed to a rapid increase in government spending on public hospitals and significant growth in unrestricted medical benefits paid through the MBS. The federal government has been the fastest growing source of public health expenditure in the past decade, including rapidly increasing spending on the premium rebate for private health insurance.¹⁶

Currently, more than a quarter of Australian government spending is directed to health care, age pensions, and aged care. Without action to limit spending growth, public spending in these areas is projected to increase significantly over the coming decades, driven mainly by the rising cost of health. Health expenditure is already the largest single area of government spending, totalling \$65 billion in 2013–14 and accounting for 16% of federal expenditure.¹⁷ The Treasury's *Intergenerational Reports* have repeatedly warned about the sustainability of the various components of Medicare, in conjunction with an ageing population and the associated demands that retention of Medicare in its present form will place on government to increase health expenditure.¹⁸

Demographic challenges are also at work. Australia's population is ageing. This increases the dependency ratio as the proportion of the working-age population diminishes. The implication of projections by the Treasury is that the dependency ratio will fall from 2.05 to 1.57 in 2050. Using mostly linear extrapolations (but exponential trending for private health insurance subsidies), the Treasury estimates that the proportion of GDP devoted to public spending on health by the federal government alone will rise from about 4% to more than 7% during the same period, driven by population and population ageing pressures, especially from health spending on those aged over 65 years, as well as by the introduction of new health technologies.¹⁹ Updated projections by the Productivity Commission show federal government health expenditure rising from around 4% of GDP in 2011-12 to 7% in 2059-60. Over the same period, state and territory government health expenditure is projected to rise from 2.5% of GDP to almost 4% of GDP, increasing public health spending as a share of national income to over 11% of GDP by 2060.20

Without an increase in Australia's overall productivity, other things remaining equal, the rising dependency ratio due to the ageing population will contribute to a reduced tax base and hence cause an increasing structural deficit. The implication if government health programs are to be maintained and greater rationing avoided without incurring increases in the public debt, is that taxation will have to rise to support increased public spending. Alternatively, if increases in taxation and rationing are both to be avoided, a realistic plan for reform of government spending on health and a redesign of Medicare that is sustainable will be the single-most important determinant of maintaining quality health services in the future.

Conventional health policy wisdom and the Singaporean experience

Debate in Australia about the future direction of health policy and options for cost sharing is polarised. Some proponents of the status quo argue that growth of health spending is no reason for concern: As Australia's aggregate income grows, inevitably we can expect to spend a greater share on services such as health, education and travel-and proportionately less on staples such as food and clothing. As demand for health services for the country as a whole is income elastic (so the argument goes), it thus meets the classic economic definition of a 'luxury good'-even though it may be a 'necessity' for individuals.²¹ With absolute growth in the economy, we should therefore be quite capable of accommodating Medicare and its expected call on greater public spending over time through higher taxation.²² This argument downplays the significance of spending ever-higher proportions of GDP on health by ignoring the opportunity costs of inefficiency in the health sector, and by overlooking political and economic limits to government revenue and spending on health amid competing policy priorities.23

Nevertheless, opponents of shifting demand for health services away from government subsidies argue that this would simply switch a given demand for funding from Medicare to inequitable private sources, including private insurance. The experience of the United States, where combined public and private spending on health is approaching a fifth of the national income, is interpreted as evidence of the failure and inefficiency of private insurance because of its alleged adverse impact on health costs.²⁴ Others argue that cost sharing is a tax on sickness²⁵ and would jeopardise the integrity of Medicare—it would disproportionately affect the poor and chronically ill by inhibiting them from seeking access to primary care. This would then inhibit prevention or the interception of disease or both, and could ultimately have the perverse effect of increasing the workload of the public hospital system, causing the overall health budget to increase.²⁶

A comparison between Singapore—the one developed nation with a sophisticated cost sharing health system—and other developed nations such as Australia with public and private health insurance systems fails to lend weight to the claim of an inexorable relationship between affluence and health expenditure. On purchasing-power parity criteria at least, Singapore enjoys a real income exceeding Australia, yet the ratio of health to GDP expenditure in Singapore (at 3.6%) is considerably below Australia's (9.5%) (Figure 1). This indicates that consumers in Singapore necessarily devote a lower share of their income to health expenditure than those in Australia-either directly out-of-pocket or indirectly through taxation or private health insurance. The difference in health expenditure patterns between Singapore and Australia and other comparable countries is explained by differences in their respective health funding architectures, including the high levels of 'first-dollar' individual accountability in Singapore that distinguishes its health funding from other high income countries.



Figure 1: Comparative health expenditure as a percentage of GDP, 2011-12

Source: Table 2.

The challenges of sustainability facing health systems around the world contrast with the low spending on health in Singapore, and have made Singapore and its distinctive health funding and service provision arrangements an object of international attention. Compared with other nations, including Australia, Singapore's health system has delivered comparable First World standards of care and health outcomes at a much lower cost—an achievement chiefly attributable to the greater personal responsibility for health expenditures and superior incentives for efficiency that are integral features of the Singaporean model.²⁷

Conventional health policy wisdom, drawn mainly from the American experience, is that low public health spending and high private health spending is associated with higher health costs and lower health outcomes. Singapore's experience (Figure 2) shows that low public spending, low third-party (private insurance) spending, and high out-of-pocket spending is cost effective and has not adversely affected health outcomes (Figure 3).

Figure 2: Comparative sources of health expenditure as percentage of total health expenditure, 2011–12



Source: Table 2.



Figure 3: Comparative life expectancy at birth, 2012

Source: Table 4.

Comparative health expenditure in Singapore, Australia and other countries

Health system architecture and design influence the services they deliver as well as outcomes that ensue. Studies of comparative health system performance using cross-sectional data are an established field of inquiry.²⁸ Tables 2–4 provide cross-sectional data on some key health and other indicators in Singapore, Australia, New Zealand, the United Kingdom, and the United States. This invites inter-country comparisons between selected measures of health expenditure, behaviour and outcome.²⁹

Although each of the countries selected is comparably affluent with similar health goals, the non-Asian countries mostly organise, deliver and finance their health services in ways that differ markedly from Singapore. In Australia, New Zealand and the United Kingdom, for example, the ratio of total health spending to GDP is typically in the range of 9–10%; in the United States it is 17%. This reflects that apart from the United States, annual per person health expenditure of these countries is AU\$5,000–6,000. It is at least double that in the United States. Singapore is a rank outlier: it spends 3.6% of its GDP on health and its expenditure per person on health is less than onethird that of Australia and slightly more than a third for New Zealand and the United Kingdom (Table 2).

Singapore's expenditure patterns also differ markedly from Australia's, New Zealand's, and the United Kingdom's in other respects. Its ratio of public to total health expenditure was 41% (or 1.5% of GDP) compared with 70% in Australia, some 80% in New Zealand and the United Kingdom—and 48% in the United States; its share of private expenditure represented by direct out-of-pocket payments was 85.6%, compared with some 50–60% in Australia, New Zealand, and the United Kingdom—and 20% in the United States.

Private expenditure hence contributes not only twice as much to health in Singapore as in Australia, and three times as much as in New Zealand and the United Kingdom, but almost all of Singapore's private expenditure consists of direct out-of-pocket expenditures. Although private expenditure in Singapore is roughly comparable with that of the United States, some 80% of the latter is covered by third-party payers (private health insurance carriers).

	Singapore	Australia	New Zealand	United Kingdom	United States
Health expenditure % GDP	3.6	9.5	10.3	9.1	17.0
Health expenditure per person, AUD	1,766	6,230	4,751	4,898	12,206
Per person GDP, Purchasing Power Parity (PPP), international dollars	60,799	41,954	29,481	36,569	51,704
Public expenditure % total health expenditure	41.0	70.0	82.7	82.8	47.8
Out-of-pocket expenditure % of private expenditure	85.6	63.0	62.6	53.1	20.9

Table 2: Comparative health expenditure, selected countries, 2011–2012

Sources: For persons resident in Singapore, 2012, Ministry of Health Singapore; AIHW (Australian Institute of Health and Welfare), *Health Expenditure Australia 2011–12* (Canberra: AIHW, 2013); AIHW, *Health & Welfare Expenditure Series 50*, Cat. No. HWE 59 (2011); AIHW, *Health Expenditure*, Table 2.14 (2013); IMF (International Monetary Fund), *World Outlook Database* (October 2013) for PPP GDP 2011; OECD Health Data: Health care resources: OECD health statistics, database, 2012, www.oecd-ilibrary.org/social-issues-migration-health/data/oecd-health-statistics/oecd-health-data-health-care-resources_data-00541-en; Trading Economics, 'Health expenditure—private (% of GDP) in Singapore,' (2009–13); The World Bank, 'Data: Out-of-pocket health expenditure (% of private expenditure on health).'

Why Singapore's health costs are lower than Australia's

Parallels and contrasts

Singapore and Australia share many aspects of their British heritage. Nearly half the population in Singapore speak English at home. It is the only Asian country joined to the Anglosphere.³⁰ The legal and parliamentary systems of Singapore and Australia share common traditions, and there are recognisable parallels between aspects of their health systems. Undergraduate medical training in the two countries is similar, and before Singapore developed its own system of postgraduate medical education through its School of Postgraduate Medical Studies in 1969, Australian colleges had played an important role in developing Singapore's specialist training program.

Figure 4: The 3M system of health finance in Singapore—source, purpose and application of funding



Like Australia, Singapore has public and private hospitals and its hospitals attract significant public money. Public hospitals also play a dominant role in the health systems of both countries. Singapore's Ministry of Health manages a public system of acute and specialist hospitals across six different clusters; its private hospitals operate independently. The finance of Singapore's health services embodies a variety of redistributive features, although they are different in principle and practice from Australia's Medicare. Where possible, public hospital remuneration in each country is activity-based and Singapore even uses Australian casemix grouping criteria.

Nevertheless as far as the culture, modes of finance, and the operation and management of health services are concerned, there are striking differences between Australia's Medicare and Singapore's so-called '3M' system. Australia's Medicare is wholly tax financed and 'universal,' and is quite remote from anything to do with the compulsory savings arrangements that set Singapore apart.

The 3M system

The 3M system—**Medisave, Medishield and Medifund**—is an element in Singapore's method of compulsory household savings that includes health and superannuation, which is administered through its Central Provident Fund (CPF)—a legacy of the British colonial administration. The 3M system is integral to the social objectives of the CPF, and facilitates health goals in harmony with the CPF's mission to help meet population needs for retirement, housing and asset enhancement in a self-reliant manner and without overdependence on taxpayer-funded government support.

Established in the 1980s, the explicit rationale for the 3M system (as set out in the 1983 National Health Care Plan and elaborated in the 1993 'Affordable Health Care' white paper) was to avoid demand and cost spirals that plague other health insurance systems around the world. The aim was to specifically design a system that required people to pay their own way for health so as to control spending on health and keep health care affordable and cost-effective by preventing the overuse that third-party insurance arrangements encourage. Mandating self-reliance was also intended to avoid the rise of an 'entitlement mentality'—the perception of a 'right' to unlimited state-funded care—which is fostered by universal health systems such as Australia's Medicare and Britain's NHS.³¹

The 3M terminology denotes a three-tier hierarchy of household health finance that blends the aims of equity and personal responsibility (Figure 4). Its central pillar is **Medisave**, which is a system of compulsory contributions to tax-effective health savings accounts (HSAs), administered by the CPF. These accounts are generally linked to **Medishield**, a high-deductible health insurance plan. The third tier, **Medifund**, provides a safety net and meets the hospital costs of low-income citizens.

Medisave

Medisave payments, in conjunction with government subsidies to public hospitals and polyclinics, are the core element of Singapore's health finance. Most working people in Singapore contribute (with their employer's assistance) between 7% and 9.5% of their salary (depending on their age) to their individual Medisave accounts. Self-employed people are individually assessed for their contributions. Apart from personal and employer contributions, government contributions can also be made to Medisave accounts through the standing grant it pays into the accounts of all newborns—analogous to Australia's erstwhile Baby Bonus.

Medisave represents the health component of a suite of contributory ledgers that the CPF maintains for every Singapore citizen or permanent resident. They remain portable across jobs and into retirement. Besides Medisave, the other CPF saving accounts are a Special Account for retirement-related financial products and an Ordinary Account for purchasing a home or to pay for education. At the age of 55, the balances of savings in an individual's Special, Ordinary and Medisave accounts are rolled into a Retirement Account, subject to a minimum residual threshold remaining in the Medisave account (SG\$32,000 in 2012). Retirement Account balances are then used to purchase a lifetime annuity from CPF Life.

CPF contributions are tax exempt, as are withdrawals and income accruing. Although prices in Singapore have remained relatively stable, CPF money is not inflation-proof. Investors receive a bond rate pegged to the prime rates of the largest local banks, returning a guaranteed minimum 4% interest and an additional 1% for combined Medisave, Special, and Retirement Account balances up to SG\$60,000. At death, CPF funds, including Medisave balances, can be paid in cash to nominated beneficiaries, free of estate duty.

Limits apply to the total amount that persons may hold in their Medisave accounts (SG\$43,500 in 2012). This removes any incentive for account holders to overspend on health. Amounts exceeding the limit automatically flow to Special Accounts (for persons under 55) or to Retirement Accounts. In 2012, there were some 3 million Medisave accounts with a total balance of SG\$50.2 billion.³²

Medisave allows for a risk-control strategy within families. Shortfalls in a Medisave account may be replenished with payments from cash out-of-pocket or by accessing funds in the Medisave accounts of a spouse, parent, child or grandchild. Older patients make frequent use of their children's accounts. Such transfers are believed to be in the spirit of filial piety and 'Asian values.'

Medishield

'Family risk pooling' contributes to the efficiency of the system; it is not a substitute, however, for general risk pooling available from insurance—or national risk pooling as might occur under a properly funded national scheme such as South Korea's,³³ but this is not really a feature of Medicare in Australia (see below). Funds in Medisave accounts may nevertheless be safeguarded from catastrophic risk by using them to pay a premium to purchase Medishield. This is a basic public hospital insurance policy underwritten by the CPF. The Medishield table is subject to deductibles and co-insurance that can be met directly from Medisave balances or out-of-pocket cash. Use of Medisave funds to purchase first-dollar health insurance is prohibited.

Holders of Medishield usually enhance their basic cover by also purchasing an Integrated Shield Plan, which is offered by five approved private medical insurance scheme (PMIS) carriers. Held in conjunction with Medishield (but administered by a private carrier), a higher plan augments Medishield benefits (analogous to private cover in Australia) by paying for superior public wards or for inpatient and other treatment in private hospitals. Integrated Shield/PMIS plans nevertheless also remain subject to deductibles and co-insurance. Even in the most subsidised wards, the patient must pay at least a fifth of the cost.

Some 75% of Singaporeans hold Medishield cover in conjunction with Integrated Shield/PMIS plans. Certain private insurers write non-PMIS insurance plans, but these remain outside the scope of Medishield, and are generally individual or group medical plans specifically offered to expatriate employees. Since 2008, this form of cover became mandatory for all foreign workers, coinciding with the removal of subsidies for foreign workers in public hospitals and polyclinics.

Medisave money is automatically applied after the age of 40 until the age of 65 to the purchase of an Eldershield disability insurance plan. Just over 1 million Eldershield plans provide cover for monthly cash benefits for up to a maximum of 72 months (depending on the level of cover) in the event of disablement. Eldershield Supplements are available for those seeking higher levels of disability cover.

Medifund

In Singapore, there is entirely separate provision for identifying and targeting need and for assisting the indigent to access public health services. Unlike Australia, Singapore has never aspired to universalism through a one-class health system for everybody. Although Singapore has committed to a 'floor' in health care by way of its Medifund, its objective is equity rather than equality.³⁴

Medifund is constituted as a government endowment scheme. Subject to means-testing and medical social worker authorisation, it provides charity-style relief for the hospital costs of vulnerable people experiencing hardship. It is supplemented by Eldercare and the Community Health Care Assist Scheme (CHAS). The former subsidises voluntary organisations in delivering services to needy seniors; the latter offers means-tested subsidies to Singapore citizens for GP and dental visits.

Paying for health services in Singapore

The key to Singapore's capacity to restrain health costs is the way the 3M system blends public funding for health services with sources of private savings that are quarantined for the purposes and needs of health and retirement, combined with heavy reliance on out-ofpocket payment for most medical services.

There are restrictions in Singapore on which health services may be funded from Medisave accounts, and service-specific limits apply to amounts that can be drawn down. Funds may be expended directly on hospital inpatient care (up to SG\$450 per day or other prescribed limits for various types of surgery) as well as on day surgery, some costly outpatient treatments, and—at the primary care level—on immunisation and specified chronic disease management. With their own savings at stake, households are encouraged to make judicious choices about health services they use.

To control costs, Singapore tends to be a late adopter of new high-cost technologies. In the case of the supply of public hospital services, there is also direct rationing through government control over public hospital spending. Singapore's private hospitals are not bound by the public system's regulatory environment, although they compete with public hospitals as well as with each other.

For out-of-hospital GP, specialist and allied health services, however, supply is mostly free of government intervention. Rationing is left to the price system because most of Singapore's medical care outside hospitals, unlike in Australia, is supplied in a free market, paid for directly out-of-pocket, and accessed primarily in a market-driven GP system, supplemented by competing government-operated polyclinics.

Medisave is designed to encourage a discipline of saving for unforeseen or high-cost health events. It is not intended to provide financial relief from high-frequency, low-severity contingencies amenable to self medication or to primary care management by a GP or by an allied health professional or the like: these services must be incurred as out-of-pocket expenses. Similar restrictions apply in the case of prescription pharmaceuticals. Although the Singapore government subsidises the price of pharmaceuticals on its list, there is no counterpart to the significant entitlements and safety net arrangements available on Australia's PBS.

The principle of patient financial responsibility is extended to the use of all inpatient hospital treatments in Singapore, where cost must either be met wholly from direct cash out-of-pocket, or Medisave money, or alternatively cost shared on Medishield or on a higher table by way of co-insurance and a deductible. There are special circumstances in which in the case of inpatient care or for ambulatory medical care from a polyclinic, first-dollar coverage may apply for the indigent through Medifund or through CHAS.

Demand side factors in Singapore: Avoiding moral hazard

Although most econometric research indicates that health consumers are responsive to price, evidence of the effect of price on various health market aggregates (such as doctors' visits, length of hospital stay, and hospital separations) is not overwhelming.³⁵ Demand is nevertheless likely to be more sensitive to the relatively high levels of across-the-board cost sharing evident in Singapore.

The aggregate evidence in tables 1–3 indicates that Singapore's health pricing at the point of consumption may have encouraged consumers to make considered health choices by weighing, at the margin, perceptions of the worth of incremental care against the value of alternative consumption preferences. This has likely caused consumers in Singapore to become extremely familiar with symptoms amenable to self-care, distinguish conditions that are minor or self-limiting, and discriminate effectively between services that are discretionary and those absolutely necessary (and for which it follows that demand is price inelastic).

By contrast under Medicare's 'universalism' in Australia, consumers are largely shielded from direct exposure to the true cost of most health services. Indiscriminate public first-dollar coverage introduces an element of moral hazard, whereby the existence of insurance (in whichever form) may cause some people to use health services for which they would have been unwilling themselves to pay, had they not possessed an insurance entitlement. Singapore's minister of health once famously remarked how Australia's health insurance system (among others) is 'fraught with over-consumption and over-servicing.' He described it as the 'the buffet syndrome of abuses'³⁶—a remark that has now entered the lexicon in Singapore as a metaphor for the perils of first-dollar coverage on health services and its association with the risk of moral hazard.³⁷

Where demand is price inelastic (as, for example, in the case of insulin for diabetes), moral hazard risks diminish, since demand for care is governed solely by the probability of falling ill. Singapore's policy of targeting full coverage for essential services, such as for immunisation at the primary care level, hence contributes to welfare and efficiency gains.³⁸

Without cost sharing, where demand is at all price elastic, moral hazard will likely cause the costs of insurance for most people to exceed the cost of self-insuring for the risk of a health event. This can augment demand, resulting in an overproduction of health services and a deadweight loss to the economy. It becomes one of the main arguments for scrutinising the Medicare philosophy of guaranteed free public entitlement. Indiscriminate entitlements are likely to be associated with inefficiency, inflated health expenditures, loss of welfare, and an even higher demand for insurance.³⁹

Inflated health expenditures will be occasioned not only by the increased volume of services demanded but also from bidding up provider fees and wage and salary costs. The implicit publicly funded premium hence embodies double components: premium for genuine risk cover protection and premium to pay for the extra resource cost of moral hazard—even though there may be individual welfare gains from decreased risk bearing.

Supply side factors in Singapore: Incentives for efficiency

Risks of health service overproduction are amplified at zero prices where there is excess supply-side capacity. Government in Singapore hence reinforces the effect of pricing on health service demand by rationing public hospital capacity-the source of 80% of Singapore's hospital bed days. Table 3 reveals that Singapore's acute bed endowment of 2.0 per 1,000 persons was considerably below Australia's 3.4 and leaner than other countries. In conjunction with cost sharing, rationing reinforces a low claims experience for insurers: Singapore's hospital separation rate of 0.08 per person per year and its hospital drawing rate of 0.51 bed days compares with Australia's respective separation and drawing rates of 0.41 and 2.36.40 Australia's hospital drawing rates, conditioned by styles of medical practice and supported by firstdollar public and private third party payers, remain among the highest in the world.

Competition policy in Singapore has also helped the 3M system thrive, both as it applies to the operation of public hospitals as well as a consequence of scrutiny by the Competition Commission of Singapore into doctor fee setting practices.

Keeping the costs of health services low and price competitive has made Medisave-funded health care affordable as well as contributing to the overall efficiency of the Singapore health system. In relation to public hospitals, although Singapore's Ministry of Health monitors expenditure on capital items as well as the introduction of new technologies, each public facility operates with more autonomy than tightly and bureaucratically controlled public hospitals in Australia.⁴¹ Although publicly subsidised, Singapore's 10 public hospitals operate as separate corporate entities across six different clusters, with a right to accumulate surpluses and savings, provided they are retained for the benefit of their patient catchments. Their boards are completely independent and not tied into the rigid industrial practices of public institutions to be found in Australia.⁴²

This means Singapore builds and operates hospitals cost effectively; its hospitals can respond flexibly to changes in consumer demand (subject to overarching government policies); and the management and organisational structures of its hospitals enable them to deliver services efficiently (across a geography that is admittedly limited compared with countries such as Australia) at lower cost than in Australia. This accounts for the government's overall low share of total health expenditure remaining below 40%.

There is also price competition for health services in Singapore. Since its foundation as a free port, Singapore has long established a culture of enterprise and price signals.⁴³ The Ministry of Health nurtures hospital price competition by maintaining a website that publishes information on the range of bill sizes that consumers may expect to incur in public hospitals for different treatments and interventions.⁴⁴

Since May 2004, the ministry has encouraged hospitals to advertise their fees and services. Individual public

	Singapore	Australia	New Zealand	United Kingdom	United States
Acute hospital beds per 1,000 population	2.0	3.4	2.6	2.4	2.6
Acute separations per person	0.08	0.41	0.15*	0.27	0.13*
Acute hospital bed days per person	0.51	2.36	0.3#	0.57	0.7#
Doctor visits per person	9.3^	6.7	6.6	5.0	4.1

Table 3: Comparative health usage, selected countries, 2009–12

Sources: For persons resident in Singapore, 2012; Ministry of Health Singapore. Data for Australia: 2010; New Zealand: 2012; United Kingdom: 2011; United States: 2010; OECD Health Data: Health care resources: OECD Health Statistics (database). 2011; England, 2012-13; Health & Social Care Information Centre; AIHW 2013. Australian hospital statistics 2011–12. Health services; 2009; OECD Health Data: Health care resources: OECD Health Statistics database. *Data (2010) for all diagnostic categories, not necessarily strictly 'acute.' Manually adjusted from per 100k persons to per person from stats.oecd.org/ [Health > Health Care Utilisation > Hospital aggregates]. #Data from 2000: www.medscape.com/ viewarticle/452954_4 [Table 4]; ^Data from 2008: www.oecd-ilibrary.org/docserver/download/8110241e.pdf

hospitals maintain their own websites on which they publish their fees for different classes of ward accommodation and other services such as ICU, day theatre fees, and outpatient attendances.⁴⁵ There are significant variations in prices charged. This may be attributable to scale of operation, varying management practices, location or market power accruing from professional reputation, and client perceptions of quality and performance.

Public hospitals are always likely to play a dominant role in Singapore, even though they coexist with a vigorous private hospital industry. In Singapore, it nevertheless remains government policy to encourage a contestable private system that can challenge public sector provision. This is evidenced by the structure of non-hospital care that is paid for, out-of-pocket under Medisave.

With regard to medical services, about 80% of Singapore's primary medical care is by private GPs or private medical chains, independently setting their own fees in a private market. The remainder is from 18 publicly operated and subsidised polyclinics—used mainly for chronic conditions, dental care, and immunisation. Cost sharing on consultations and prescriptions nevertheless still applies. Even though fees may be lower than for private GPs, waiting time for an appointment may be longer.

Specialist care is from specialist outpatient clinics in both public hospitals and private hospitals (without needing a GP referral).⁴⁶ As in the case of other out-of-hospital care, the cost of all non-inpatient specialist care (including an unsubsidised patient component of public specialist treatment) must be met from direct cash out-of-pocket rather than Medisave balances.

Unlike Australia, direct cash payments by patients are the exclusive source of GP income in Singapore. Doctors cannot set fees with reference to a task-specific benefit payment, which under Medicare in Australia, is taken for granted as a benchmark for fee setting. Neither is there scope for Singapore doctors to recommend fees through their professional associations, as occurs through the Australian Medical Association (AMA) and professional societies in Australia. In 2007, the Singapore Medical Association (SMA) withdrew its *Guideline of Fees* (in force since 1987) to avoid the risk of contravening Singapore's *Competition Act*. In 2010, in recognition of the harm that fee recommendations can do to competition, the Competition Commission of Singapore subsequently affirmed the SMA's action.⁴⁷

Because most of it is paid for out-of-pocket, the market for medical care in Singapore is more competitive than Australia's. Pricing not only plays a role in encouraging health consumers to make discriminating choices, it also constitutes an incentive for practitioners to keep their costs down and to maintain affordable charging practices within the means of a clientele paying for services out-of-pocket.

Primary care practices compete for custom on price, waiting time (most GP private clinics are walkins), patient satisfaction, and convenience. Health consumers in Singapore will tend to shop around until they find a practitioner they feel offers good value for money. All GP clinics and many specialist practices also stock medicines and compete as 'one-stop shops' with pharmacies and polyclinics.

The market for primary medical care in New Zealand bears some resemblance to Singapore's. No recommended fee is available in New Zealand and co-insurance applies. In Christchurch, a typical GP visit costs around AU\$30–40 in 2013 and more for out-of-hours, usually AU\$60. A typical Canterbury GP receives roughly half its income from patient contributions.⁴⁸

Like medical care, prescription medicines in Singapore must be paid for directly in cash out-of-pocket—although the government pays a subsidy on a formulary of listed drugs. Some practices compete on consultation price by using their prescription dispensing businesses to cross-subsidise their other work, to the extent that some even believe doctors have become medicine sellers with a licence to prescribe.⁴⁹ The notion of a 'two-sided' market for pharmaceuticals and medical services would be quite alien to Australia, accustomed as it is to a strict division of labour between dispensing and prescribing.⁵⁰

HSAs and health status

A test of Singapore's health funding efficiency relative to Australia would be to assess the veracity of the assertion that cost-sharing discourages access to care and thereby causes deterioration in health status.

The Rand Health Insurance Experiment (RHIE) addressed this question in the United States by conducting a random economic experiment over the period 1974-82 to assess the effect of various health insurance policies on the demand for health services and health status.⁵¹ Households were randomly assigned to different costsharing groups. To control for adverse selection, each was paid a lump sum to ensure the experiment did not make them worse off. The experiment not only found that people of all ages who contributed more to the cost of their health bills purchased less health services, but also that measured on a variety of criteria, there was no statistically significant measurable difference in health status associated with their higher consumption of services. $^{\mbox{\tiny 52}}$ Yet households that were fully insured consumed 40% more care than those who paid directly for their care.

The experience of the Rand experiment, together with the cross-sectional data comparing the extent of Singapore's cost sharing and broad indicators of health status with those of Australia and other countries, suggests that the design of health insurance is of great consequence to the efficient use of health services. Although Singapore's population admittedly is still comparatively young (less than 10% of the population is older than 65 years), the

relative scores for vital health statistics identified in Table 4 indicate that Singapore is generally a healthy society. Its life expectancy at birth is superior to Australia's and that of other comparators, and its infant and under 5 mortality rates are substantially below those of other countries. While Singapore's life expectancy at 65 is lower than Australia's, it is equivalent or superior to those of other countries.

Singapore's low cost health funding and efficient delivery structures, along with the associated high standard of its health outcomes, appear to be serving its clients well. In 2000, in an exercise it has been wary to repeat, the WHO produced a ranking of its 191 member countries on a series of critical scores for public health that included outcomes, responsiveness, fairness of financial contribution, and health expenditure per head. Singapore was placed at 6 and Australia at 32. The United States was close a call at 37 and the United Kingdom scored 18.

Advocates of Singapore's health funding model are legion, despite the limited examples of success with HSA funding models in other countries.⁵³ (See Box 2) Nevertheless, various writers have alluded to Singapore's Medisave or a variant as a possible role model for Australia to consider—or at least to distil from its broad funding architecture a design for principles of cost sharing and supply-side competition that could be applied to Medicare or to an alternative to Medicare.⁵⁴ This could, as a starting point, in turn

	Singapore	Australia	New Zealand	United Kingdom	United States
Life expectancy at birth, M/F	79.9 / 84.5	79.9 / 84.3	79.4 / 83.0	79.1 / 83.1	76.3 / 81.1
Life expectancy at 65, M/F	18.5 / 21.9	19.1 / 22.0	19.0 / 21.2	18.0 / 21.2	17.8 20.4
Infant mortality per 1,000 live births	1.8	3.8	5.5	4.3	6.1
Under 5 mortality per 1,000 live births	2.8	4.9	5.7	4.8	7.1
Pop > 65 years, %	9.9	14.2	13.8	17.0	13.7

Table 4: Comparative health outcomes, selected countries, 2012

Sources: For persons resident in Singapore, 2012; Ministry of Health Singapore; ABS (Australian Bureau of Statistics), *Deaths, Australia, 2012*, Cat. No. 3302.0 (Canberra: ABS, 2011); OECD (Organisation for Economic Co-operation and Development), 'Health Data: Health care resources: OECD health statistics,' database (2009), www.oecd-ilibrary.org/ social-issues-migration-health/data/oecd-health-statistics/oecd-health-data-health-care-resources_data-00541-en; The World Bank, 'Data: Indicators,' http://data.worldbank.org/indicator/SH.DN.MORT; OECD, 'Stat Extracts,' http:// stats.oecd.org/ (Demography and Population > Population Statistics > Population).

invite a review of the wisdom of some of the taxpayerfunded universal entitlements available to all Australians justified by either the principle of targeting public support or liberating consumers by enabling greater choice of health cover.

Despite failing to deliver on its equalitarian promises, Medicare remains a 'sacred cow' of iconic proportions, quarantined from reform mainly due to a matrix of vested interests that underpins the politics of health.* A bolder and broader approach to funding health reform in Australia that drew heavily on Singapore's experience with HSAs and greater cost sharing could unshackle health from the politics of populism and fanciful expectations about the durability of Medicare. If such change were successfully insinuated alongside Medicare without compromising its 'path dependency'⁵⁵ or needlessly alienating its essential constituency, it could become a growing point for compelling more radical systemic change.

Box 2: HSAs in other nations

- The health system in Singapore is unique in the sense that its 3M HSA model has been uniformly adopted as its national system. The United States, South Africa and China have introduced HSAs as partial, optional platforms within a variety of broader health funding arrangements. As in Singapore, these HSAs have been constituted as pre-tax 'savings for health' vehicles, coupled with high-deductible tables. In no other jurisdiction, however, have HSAs developed into the dominant force in funding health, comprehensively integrated with retirement savings, as has occurred in Singapore.
- HSAs were introduced in 2003 in the United States, and remain a popular tax effective option covering some 30 million people, but their destiny may be thrown into obscurity as the *Affordable Health Care Act* ('Obamacare') gradually takes effect. This legislation mandates minimum payout ratios and maximum deductibles to an extent that could ultimately compromise the competiveness of HSA plans and adversely affect their marketability.
- In South Africa, there is no legislation that dictates a design for health insurance. This has led to the evolution
 of an assortment of HSA innovations with varying levels of deductibles as well as bonuses for participation
 in preventive health activities. Of the 20% of South Africans who are affluent enough to purchase private
 health insurance, roughly half purchase HSA cover. However, HSAs remain a 'boutique' offering in a twoclass system where the majority of the population rely on a free, overloaded public system.⁵⁶ HSAs in South
 Africa have become a marker for its dual economy and have little chance of making further headway.
- In 1998, China sought to emulate the success of Singapore by introducing HSAs as a component of the basic health insurance system for urban workers in its 50 largest cities. As the first large urban centre to implement them, the experience of Shanghai seems to indicate that urban China may find it difficult to reproduce Singapore's HSA success.
- The main reasons include Shanghai's older and less prosperous population with a rate of unemployment higher than Singapore's. This has limited the uptake of HSAs because the poor do not earn enough to contribute to HSAs. Furthermore, starved of public subsidies, public hospitals in Shanghai have been obliged to draw down patient savings exhaustively, causing a deteriorating HSA experience. This problem has been aggravated because the Shanghai model excludes family risk pooling so that individual accounts face exposures greater than in Singapore. Finally, the tradition of personal accountability, as practised in Singapore, is alien to China whose citizens have been acculturated to publicly provided social largesse.⁵⁷
- It has not been possible elsewhere to replicate national success with HSAs to the extent in Singapore. Critics argue that Singapore has made them work 'but only as one small part of an extremely complicated system involving extensive government intervention.'⁵⁸ From this, it could be argued that it may be unwise for Australia to borrow a model found simply to work in Singapore's unique social and city-state geographical setting. It is nevertheless evident that there are particular or local systemic reasons that explain any doubts and uncertainty about HSAs in other countries. This is not a general argument against them.

^{*} Medicare's protected status rests largely on its capacity to unite a wide spectrum of stakeholders—even though they may possess apparently contradictory goals: by shielding doctors averse to business risk from exposure to the free market, it underwrites private, fee-for-service income; its over-prescriptive Schedule of Services on which medical benefits are paid is costly to maintain, thwarts technological change, and inhibits labour substitution; its guaranteed hospital and medical entitlements can protect uncertain health consumers even from the most trivial and minor health events; it offers employees in public health systems secure careers, insulating their generous award conditions and outdated work practices from market forces; and it represents a source of great pride to advocates of social justice who regard all forms of cost sharing as taxing ill health or encroachments upon entitlements that should be universal. For government, all that remains is funding responsibility.

Agenda for health and superannuation reform in Australia

Australia could draw upon Singapore's Medisave and Medishield as blueprints for an alternative method of health funding by linking tax effective HSAs, where possible, with the existing superannuation system. At the moment, Australia's occupational superannuation is bound by a set of rigid rules that generally preclude a beneficiary from accessing any benefits until after retirement or transition to retirement. After retirement, opportunities for contributing to superannuation are limited, but since a beneficiary drawing a pension may just as well apply their accumulated savings to health or health insurance as to any other area of their choice, *de facto*, their entitlement can function after retirement much in the same way as a tax-efficient HSA.

It is in the pre-retirement, inflexible and userunfriendly accumulation phase that scope for building up a separate accessible provision for current health service use offers an ideal opportunity to give health consumers with account-based superannuation plans, so-called 'taxed' funds, a greater stake in funding their own health care.⁵⁹

Like Singapore, Australia has a compulsory contributory private superannuation system, as well as a parallel tax-financed government pension system for those with insufficient savings—but at that point, similarities between Australia and Singapore end. Singapore's superannuation is a government monopoly, defined contribution scheme operated by the CPF that covers the entire workforce. In Australia, superannuation is a mixture of generally unfunded government schemes for public servants and lower income earners; privately operated trusts of various types that may compete with each other for custom; and self-managed funds which are trusts that may include up to four beneficiaries.

Funded, account-based schemes in Australia, mostly privately operated, maintain a ledger on each beneficiary, as in Singapore, but they are discrete from Medicare's unfunded, pooled liability for paying the cost of claims for health service use by the general population. The integration and flexibility of arrangements for retirement saving and health in Singapore are different from the rigid dichotomy that exists in Australia between contributory occupational superannuation for retirement and funding for health services. This is notwithstanding that for retirees on private pensions who hold private health insurance, the distinction between the sources of expenditure becomes increasingly blurred, as retirees in Australia are at liberty to apply their savings to fund increasing use of all manner of services, including for their health.

Funded account-based superannuation schemes, which are highly tax effective savings vehicles, could provide a stepping stone to health funding reform analogous to the Singapore model. Their narrow remit, however, would need to be expanded beyond the current 'sole purpose test.' This restricts their role to providing benefits to their members upon their retirement, and specifically precludes a member deriving a direct or indirect benefit beforehand even if, with large account balances, they may be confronted during their working lives with serious financial problems arising from ill health or temporary disablement.

For young members of the workforce whose retirement could be many years distant, access to their savings to meet current health expenses would motivate them to take a greater interest in their superannuation, and become less lethargic and more discriminating about choosing their fund, if its purposes became less restrictive and amenable to their more immediate needs. The Australian superannuation industry, on the other hand, appears preoccupied with maximising the volume of funds under its control and quite unsympathetic to the principle of early withdrawal, even where households are adequately provisioned.⁶⁰

Medicare opt-out HSAs

A new vision for funding health care in Australia based on the Singapore model could involve some modification to the sole purpose test in conjunction with an increase in the contributions to superannuation during a member's working life. This could fund a medical/hospital accumulation reserve, constituted as an HSA, within each member's superannuation account. Members would be able to draw upon these funds during their working lives to meet the cost of specified health expenses in much the same way as under Medisave in Singapore. Upon retirement the medical/hospital accumulation reserve would merge with the pension fund, as occurs in Singapore. The aggregated accumulations would then function exactly the same way as superannuation does now in the pension phase-and, to the extent they were adequately funded, could be applied to selfinsurance or alternatively to purchase private health insurance.

This model would offer an alternative to Medicare. It would require individuals to choose to opt into an HSA and trade their Medicare entitlements in exchange for the right to access their tax-efficient medical/ hospital accumulation reserve. Figure 5 provides a summary of how a possible opting out arrangement might work. The opting out principle has been canvassed by CIS Senior Fellow, Peter Saunders.61 Saunders distinguishes between 'entitlement' opt outs and 'contribution' opt outs. He argues that the former embodies a redistributive factor; the latter would simply return people their own money, leaving the poor no worse off. In exchange for their Medicare entitlement, those opting out would have their Medicare contribution (the levy and a component of their income tax) credited to the funding of an annual Health Voucher equivalent to total average per person government spending on health, indexed—approximately \$4,300 in 2011-12**-for deposit in their HSA (see Figure 5).

Health Voucher money that was unspent would accumulate from year-to-year and the interest accruing might attract the same 15% concessional tax rate as contributions to superannuation for retirement. In the United States, HSA holders are relieved of all income tax, so there may be precedents for treating health balances more generously than retirement balances.

HSAs could be maintained during the accumulation phase of a superannuation account and kept separate from, but linked to, the pension component during a beneficiary's working life.

Part of the trade of Medicare entitlements for HSAs would be that in exchange for control of one's own health dollars, individuals would agree to save up and

take responsibility for their own health care costs in retirement. Health vouchers would cease when pension eligibility age is reached. This means HSAs would yield long-term savings to government by establishing nongovernment sources of funding for old age health costs.

The mechanics of debiting a health bill to an HSA would be similar to lodging a claim with Medicare or a private health fund. Health funds are accustomed to processing large volumes of frequent transactions associated with conventional indemnity claims. They would be well equipped to maintain and remit expenses debited to HSA balances to service providers—either as providers in their own right or as contractors to superannuation funds. Pooled HSA reserves accruing from unspent Health Voucher money would function like earmarked personal bank accounts. They could be managed by approved organisations such as registered health funds or superannuation funds. Their balances would merge with retirement savings once a pension commenced.

The embodiment of the financial incentive from assuming personal responsibility for health services, currently received and paid for by tax at zero prices at the point of consumption, would accrue from the financial benefit of cashing out Medicare entitlements and using cost-effective HSAs, funded by Health Vouchers. As well as the tax concessions, the benefit would include savings from lower premiums for high-deductible insurance that eliminated the inflated costs of first-dollar cover and moral hazard—all of which would eventually accrue to individuals in the form of higher superannuation balances and retirement incomes. A potential indirect effect of HSAs, therefore, could help limit future calls on the public pension.

Since the value of Health Vouchers would remain fixed regardless of any tax contribution to Medicare, they would offer equity between different classes of taxpayers. This would avoid the objection often levelled at HSAs in the United States that they provide disproportionate gains to persons wealthy enough to benefit from the tax concessions and offer nothing to those who pay no tax. The advantages accruing to Australian HSA holders would thus not be limited to those paying tax: the incentives accruing from Health Vouchers would be available to welfare and high-income earners alike, even though, because of the redistributive factor, they might each attach a different value to the potential gain.

HSAs would introduce a new tax-effective regime of private provision and accountability for health not possible under current Medicare arrangements, since individuals claiming against their HSAs would become personally liable for their own health care expenses. Since Medicare entitlements were being cashed out

^{**} In 2011–12, average per person health expenditure in Australia was \$6,230. This includes money spent on health services by individuals from their own pockets and money spent paying for services insured privately or funded through Medicare. The government-funded share of total health spending was 69.7% or \$4,342.31 per person. AIHW (Australian Institute of Health and Welfare), Health Expenditure Australia 2011–12 (Canberra: AIHW, 2013), 31, Table 2.6.



in return for assuming personal responsibility for health, there would be no restriction on the use of HSA funds to pay for approved primary care, and specified prescription pharmaceuticals, as in Singapore. Those joining HSAs will in fact have traded their Medicare benefit entitlement for their Health Voucher.

High-deductible insurance tables, available in conjunction with HSA models, such as Singapore's Medishield, would offer the benefit of risk pooling for an account holder's exposure to outlier high-cost claims involving hospital or day surgery or specified high cost pharmaceuticals, prostheses and appliances, and the cost of managing chronic conditions. By eliminating the overuse problem associated with first-dollar health insurance, HSAs keep health cover affordable by reducing the premiums charged for high-deductible health plans. It is likely that a new market for similar type tables for catastrophic and chronic conditions would develop in Australia, probably offered through existing registered health insurers or other institutions operating HSAs on behalf of their holders.

HSA holders accordingly could choose to apply part of their balances to pay premiums for HSA highdeductible private health insurance if they wished. Their contributions could vary according to the standard of cover and level of entitlement purchased, which could be subject to varying limits and exclusions. All HSA health insurance policies would need to be non-cancellable, and carriers should not have the right to refuse to accept an application for cover. Front-end costs of deductibles, including approved GP services, would be met from HSA balances or, if they were insufficient or could not be met from a close relative's account balance, paid with out-of-pocket cash. HSA carriers would seek to negotiate new service contracts and preferred provider arrangements for their members covered for treatment in both private hospitals and public hospitals.

Upon first entry into the opt-out scheme, a transitional arrangement will be needed to protect a small minority of individuals experiencing exceptional health events from exhausting their HSA balances before they could accumulate. This should take the form of a subsidised government-operated catastrophic health event insurance fund (such as for specified high cost pharmaceuticals) with low cost sharing. The premium would be charged to the Health Voucher for a compulsory initial three- to five-year period. Thereafter, it would be optional, without subsidy, and subject to higher cost sharing.

It may take time for the impact of HSAs to flow through the health care market and remove the existing distortions that affect prices, but all insurers could be expected to analyse data that would quickly enable them to move into the high-deductible market to offer better value for money for HSA holders, principally by negotiating better deals with providers who would be obliged to compete on price and quality to win service contracts.

The AMA has proposed its own version of a contributory HSA for Australia that purports to 'complement' Medicare and private health insurance. The main purpose of the AMA model is 'to meet out-of-pocket health care costs that are not otherwise met by Medicare, the PBS or private health insurance.'62 In such an incarnation, the role of tax-effective HSAs would enhance opportunities for zero price health consumption. The AMA believes that 'a well-designed system of HSAs could strongly complement private health insurance and help it to remain viable into the longer term.' The HSA model proposed by the AMA would effectively subvert the purposes for which HSAs were designed. By contributing to moral hazard, it could serve only to inflate the cost of medical services and ultimately contribute to the destabilisation of private health insurance and Medicare.63

Impact of HSAs on health efficiency

Supply-side competition for out-of-hospital care and prescription medicines in Singapore has contributed to the workability and acceptance of Medisave. In turn, Medisave shapes the competitive environment as much as it reflects it.

If Australia were to emulate the Singapore model with new cost sharing options for funding health as an optional alternative to Medicare, it would help drive greater supply-side competitiveness. Australian HSA holders would further this process by assuming private liability for most of their front-end primary care, apart perhaps from essential, price inelastic services such as immunisation and specified high-cost pharmaceuticals.

Providers would start to recognise the importance of catering to the needs of an emerging clientele attracted into cost-effective HSAs, and who took a much keener interest in the cost and content of their care. If numbers or concentrations of patients within metropolitan geographical areas were to defect to HSAs, doctors in these catchments could be obliged to compete for custom by practising outside the boundaries of the rigid service descriptions of the MBS. This would have the potential to create local contestable markets involving fee discounts, new competitive and innovative service packages, and other forms of non-price competition.

Nurse practitioner labour could become more freely substitutable for medical labour as competition became a driver for legislative change; midwives would gain more responsibility for obstetric work; allied health would compete more aggressively for the first-call of patients; self-care and preventive forms of lifestyle would become greater priorities; and greater allround health workforce flexibility would help mitigate doctor 'shortages.' A non-NHS market for some prescription medicines could germinate. In Singapore, originator brands now account for less than a third of the market in their respective therapeutic classes as against nearly 60% on Australia's PBS.⁶⁴ An HSA market would further the acceptance of generics, as cost-conscious HSA subscribers sought value for money.

The monopoly long enjoyed by community pharmacies licensed to dispense PBS medicines under Section 90 of the *National Health Act* would atrophy. Non-NHS pharmacies would become more viable, and notwithstanding the resilience of the pharmacy lobby, this competition could ultimately become a steppingstone for general retailers to enter the business of retail pharmacy. There may also be a greater call on pharmacist labour, as community pharmacists hone their skills in 'front-of-shop' work in a bid to compete with other primary care providers.

All of such labour market shifts occasioned by a contestable market in HSA primary care could be expected to contribute to greater flexibility and efficiency in the delivery of health services without (as attested by the Singapore experience) necessarily compromising service quality or health outcomes. Cost-sharing and service privatisation would reduce moral hazard and contribute to reducing the generational burden of Medicare. Moreover, as health practitioners started to standardise their service offerings to all classes of their clientele, and because of the interdependence between the labour markets serving competing HSA and Medicare systems, the efficiency effects of HSAs would gradually filter through to the labour and service markets of the health economy serving Medicare itself.

Implications of HSAs for health insurance in Australia

As part of the equity principle associated with community rating for traditional private health insurance, private health insurers at present are required to share the cost of high risk contributors by participating in a national reinsurance pool, the Reinsurance Trust Fund. This shelters funds with a disproportionate share of bad health risks by attempting to spread risk equally and avoid chronic market instability.

Since HSAs are designed to provide incentives for account holders to modify and improve their health and claiming behaviours, and to reduce moral hazard, it would be self-defeating to require HSA deductible tables to be part of a risk equalisation scheme—the cost of which would in any case flow through to account holders. Since HSAs would have nothing to do with community rating, their object being to reward privately and encourage self-accountability, there would be no point in requiring tables specifically designed for HSA use to be obliged to participate in a public system that blunted incentives by spreading bad health risks rather than pricing them into the market.

Neither would there be justification to provide a 30% government subsidy for high-deductible HSA tables as occurs in conventional private tables funded from post-tax dollars, since premiums of the former would in any case be payable from tax-advantaged HSA funds, thereby reducing the tax churn. By the same token, it would need to be impossible for HSA holders to simultaneously contribute to conventional private tables: Once a health consumer had chosen to opt out of Medicare, they would automatically surrender their right to access any form of first-dollar coverage or a government-subsidised private health insurance table. Any public subsidy to HSA tables would obviously contribute to moral hazard.⁶⁵

This raises potential objections to HSAs in Australia. Opponents are likely to claim that Singapore-type HSAs would fracture the national risk pool associated with Medicare. According to this view, a compulsory national system of coverage, such as Medicare, creates a national pooling of risk, which because of its diversity and spread, is the most efficient way of providing insurance and protecting against catastrophic events.⁶⁶ Permitting households to opt out of this risk pool by crediting their Health Voucher to an HSA (including perhaps those persons with a disposition to reduce their claims through behavioural change) would encourage adverse selection and jeopardise the integrity of the risk pool.

On the other hand, although Medicare may give the appearance of a national insurance scheme, it fails to abide by insurance principles. The medical component of Medicare, for instance, is simply an unfunded, open-ended budget liability—it has no connection with insurance in the true sense of the term. It offers a guaranteed first-dollar hospital benefit entitlement; for out-of-hospital services where doctors bulk bill, it embodies very little in the way of effective loss control or supply-side monitoring. This prevents effective pricing of overall risk. It is thus very easy for persons with Medicare coverage to surrender at zero prices to a thirdparty agency arrangement wherein doctors' practice styles may exert influence on the volume of services that is at odds with the principle of consumer choice and sovereignty or consumers' needs. The medical component of Medicare as it stands is effectively no more than a pay-as-you-go rebate program.

There is nevertheless a likelihood of HSA tables eroding the risk composition of traditional private tables currently available through registered health funds. Healthy people who cash out their Medicare entitlements would necessarily be leached from the market for traditional private health insurance as they sought to escape the 'overcharging' that community rating imposes on low risk contributors. Since HSA high-deductible tables would be free to adopt experience rating, they would be open to the accusation of 'cream skimming' and contributing to a redistribution of income towards healthy populations. Under the highly regulated environment in which they operate, private health funds would no doubt regard them as a threat to market stability.

The problem of adverse risk selection could be mitigated by eliminating all forms of first-dollar coverage on traditional private insurance, including the practice of paying 100% of the hospital cost of all private patient stays at public hospitals as well as ceasing to offer medical gap insurance on higher hospital tables. Full gap cover for medical costs can never be guaranteed because health funds have no ultimate control over what doctors may charge. This in turn places continuing demands on gap cover ceilings and could ultimately contribute to the risk of an adverse selection 'death spiral.'⁶⁷

Higher private hospital tables in any case have long become repositories for people who plan or expect to encounter significant private hospital expenses. This is the classic problem of asymmetric information associated with moral hazard where the insured knows more about their risk characteristics than the carrier. At the moment, this exacerbates Australia's comparatively high hospital drawing rate; it thereby inflates the cost of private health insurance and contributes to the overall burden of health expenditure by way of the incremental cost of public subsidies to private health insurance—the fastest component of growth in federal government expenditure on health.

An analogous source of possible objection to HSAs would be that they would destabilise Medicare by fracturing its universalism and lead to a two-class system of health care that arbitrarily created unjust advantages for the recipients of Health Vouchers. These are similar to concerns levelled at private health insurance. To the extent that they have been realised, they may have at least alleviated some of the strain on the public hospital system—and contributed by way of public hospital charges for private patients to an additional stream of state revenue. There are clearly well-established market and political resistances to any draconian attempts to inhibit personal autonomy and health choices in a free society.

Conclusion: A choice-based health reform alternative to Medicare

Singapore's successful experiment with HSAs relies on a complicated and intricate series of mechanisms operating through its CPF, carefully targeted government funding, and a societal consensus. Its health system is unique in the sense that its 3M HSA model has been uniformly adopted as the national system together with its superannuation.

In conjunction with direct rationing through government monitoring of public hospital spending, and rationing through the price system for out-of-hospital care, Singapore's 3M health finance model of cost sharing has helped it become a world leader in efficient and effective health service delivery. It offers a model that attracts increasing attention from other high-income countries.

The personal disciplines and accountabilities that are a corollary of the 3M system go hand-in-hand with the peculiar combination of a tolerance of government intervention and supply side control in conjunction with autonomous, competing public hospitals and market-driven GP and specialist behaviour.

The destiny of HSAs in other countries that have to date implemented them as partial, optional platforms is uncertain for explicit systemic reasons that do not constitute barriers in Australia. An optional HSA model in which participants cashed out their Medicare entitlements hence remains an opportunity for Australia.

There are parallels between the superannuation mechanisms of Australia and Singapore, except that the Australian occupational system of private superannuation is at present limited to the purposes of retirement and cannot be accessed beforehand. Australia's established pattern of contributory savings could be broadened to accommodate Singapore's cost sharing mechanisms in health in conjunction with a right to opt out of Medicare entitlements.

To the extent that Australia has gone some way towards privatising the public pension system by shifting from Pay-As-You-Go taxpayer funding to Save-As-You-Go self-funding for retirement, there are good reasons on the grounds of sustainability and efficiency to emulate this transition for health services by diluting the monopoly of Medicare. Medicare opt-out HSAs have the potential over time to establish substantial non-government sources of health funding and take pressure off government budgets by limiting future exposure to rising health expenditure. The effect of exits from the universal system could relieve pressures on the public hospital system as well as on the cost of medical and pharmaceutical benefits; it would also create a drive towards a more competitive health economy in which there were more effective price signals in both labour and service markets. The private health insurance industry could benefit from new lines of business in HSA account management as well as in writing new HSA high-deductible tables, and there would be savings to the federal government's subsidies for private health insurance. Existing registered benefits tables may nevertheless experience some backwash without measures to arrest anti-selection. This could be a spur to their redesign and to a review of all forms of gap cover. A review of the government's mandate of 100% cover for the hospital costs of private patients treated in public hospitals would also be a priority.

An overhaul of the various components of Medicare would be timely. Since its introduction in October 1984 it has remained remarkably intact, apart from a series of fine tunings at the margin that have extended certainty of entitlement (thus adding to moral hazard) by way of safety nets for high claimants and various incentives to encourage GPs to bulk bill. This has entrenched Medicare as a monopolistic service for everyone—rather than targeting need and conserving resources for the poorest and most vulnerable.

While it is unusual for a country to introduce fundamental change to the way it finances its health care, it is important that the design of Australia's health system bears some relation to the demographic challenges it confronts, as well as representing overall value for money. With the federal government's component of health expenditure alone expected to rise from 4–7% of GDP by the mid-century, Medicare as it stands will be unsustainable without a lift in health productivity or more taxation or more public debt or some combination of these. One obvious alternative to consider is the way in which Singapore has nurtured a low cost, competitive health economy in which HSAs have flourished.

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