Health Care Costs Revisited

By A/Prof Phua Kai Hong

Much concern has been expressed on the price increases in hospital services recently. From the position of a health economist, let me provide some macro and international perspectives to the problem of "rising health care costs" affecting Singapore today.

Most developed countries spend between 5-10% of their GNP on health care, with the US even spending up to 15%, while developing countries spend only 1-3%. WHO recommends that countries should aim to spend about 5%. But what should be the optimum level of spending?

Is Singapore spending too little at 3% of GNP, a level that has been maintained over the past decades? Given the excellent health indicators in Singapore, is the health system considered to be efficient and cost-effective? The WHO has recently ranked the Singapore health system as No.6 in the world in terms of performance. In other words, we seem to be getting relatively excellent value for money for what we spend in relation to the health status of our population, after adjusting for factors such as income and education levels.

But it did not rank Singapore favourably in terms of equity in financing, based on its criteria of estimating the extent of financial burden in health costs that are borne by individual households, relative to total public expenditure. However, it seems that WHO has classified Singapore's Medisave as private rather than public spending. Nevertheless, this still begs the question of what is an equitable distribution for sharing the costs of health care. Singapore appears to have one of the lowest shares of government subsidy in the world at about $^1/_3$ of total expenditure. Is this proportion desirable for allocative efficiency? What should be the relative allocations to achieve optimum efficiency between public, private and household levels?

Rising health care costs are inevitable the world over, and Singapore is no exception. From an economic analysis, all the demand and supply factors that are responsible for pushing up health care costs are present. On the demand side, there are the demographic variables of population growth and age structure, changing epidemiological patterns of diseases with a shift towards chronic degenerative conditions requiring intensive and longer-term care, social behaviour and lifestyles which can affect health status and preference for certain types of health care. Supply factors have also influenced the levels of health care consumption and provision. These include the rapid advances of complex capital-intensive technology requiring highly specialized labour, as well as prevailing systems of payment and incentives to health care providers.

There is growing evidence that much of the demand in medical care could be generated by the suppliers themselves – the so-called "supply-induced demand". Since consumers cannot exercise their sovereignty in purchasing the appropriate amount and level of medical care in most cases, they are invariably dependent on the expert judgment of the providers. Unless health care providers are bound by an ethical code of conduct and subjected to the audit of an effective watchdog body or system of checks and balances, it is almost inevitable that they could induce increasing and even unnecessary spending. This implies the need for careful matching of supply and genuine demand for services.

Is "supply-induced demand" present in Singapore? To a certain extent it is here, as shown by the rapid rise in utilization for specialist and high-tech care following the major expansion and redevelopment of the public hospitals in Singapore. Costs have multiplied in the hospital sector but these have been absorbed through various means of financing – government subventions, Medisave, employers' reimbursement, and increasingly more out-of-pocket cash payments.

Prices and capital expenditure are moderated since these have to be officially approved. Over the recession, prices have been suppressed and even reduced for lower-priced wards, while wages have been maintained or increased to retain essential staff like nurses. However, it is difficult to pass on more of these cost increases directly to patients and their families, especially those affected by the economic recession.

While there is Medisave, its current use is limited to $300 per day of hospital stay and a restricted schedule of fees for operations. This has not been adjusted to keep up with inflation and accumulation of Medisave funds since it was launched in 1984. Medifund is also available to take care of the indigent and criteria for eligibility was liberalized during the recession. The dramatic shift in demand from private to public hospitals and from higher to lower-class wards should be an indication of the public burden that is borne during bad times. Further adjustments of Medisave limits should be made to align costs and prices with the new case-mix funding based on diagnostic-related groups (DRG).

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Many governments all over the world have intensified cost-containment measures in addition to finding alternative sources of financing for health care. Periods of economic recession, increasing pressures to provide social benefits including health care, as well as shrinking tax bases because of a smaller proportion of the working population supporting a growing proportion of dependents, especially the elderly, have made the need for cost-containment measures more urgent. Increasingly, the limited tax dollars will have to be targeted more at deserving areas such as essential public health services and subsidies for the poor.

Thus, there are attempts to shift the burden of care back to the community, the family and individuals themselves instead of relying on funding from the state or public sector, while scarce resources are shifted to areas where private means and sources cannot provide for adequately. These moves at privatisation and cost-sharing in the health services, not unexpectedly, have not been too popular.

Various cost-containment measures aimed primarily at the supply side have also been put into effect in other developed countries. Some well-known examples include implementing global budgets and clinical budgeting, prospective payment to set reimbursement limits and hospital length-of-stay norms for diagnosis-related groups (DRG), pre-paid or capitation systems with incentives for both providers and consumers to prevent over-utilisation, like disease management in managed care systems and the Health Maintenance Organisation (HMO). Patients are channelled through a referral system that practises gate-keeping for the most appropriate levels of care, and according to acceptable clinical guidelines and protocols for specific disease management.

Measures that operate on the demand side, apply mainly to cost-sharing and broad strategies for disease prevention and health promotion. There are also considerable efforts made to educate the public on health matters, to encourage inculcation of healthy lifestyles and to seek the proper use of health services in order to minimise health expenditure. Practical application of such measures and health services research into the efficiency and cost-effectiveness of alternative systems and methods are sorely needed in the search for solutions to rising health care expenditure in Singapore.

There are calls to develop the health sector further in Singapore's economic restructuring. While there is great potential to add more to the value chain for private medical and related services industries, caution must be exercised to protect the public health services from negative side-effects, such as inflationary cost pressures and perceptions of inequity. Maintaining a balance between the economic benefits of developing the health care industry against the social costs for the local population will continue to be a challenge for Singapore. Achieving an acceptable trade-off will have to be reached by consensus through more informed discussion and public education. ■

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