International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Singapore

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Extending Social Health Protection in Singapore: Accelerating progress towards Universal Health Coverage

1. Introduction

Singapore has achieved excellent health outcomes for its population and one of the highest life expectancies in the world (84.9 years), while spending a modest 4–5 per cent of GDP on health care. Singapore adopts a "mixed payer" social health protection model which is built around four central philosophies: the importance of personal motivation, targeted subsidies, a strong survival motif, and the use of market mechanisms to drive efficiency. This has resulted in a mix of several health protection instruments, including a national health care service financed by taxes and user fees, a public universal health insurance scheme for high medical costs (MediShield Life), a saving scheme structured in individual accounts (MediSave) and two public schemes to cover vulnerable households for the costs of inpatient care (MediFund) and primary care (CHAS). An additional scheme is in place for long-term care for the elderly (ElderShield).

The recent and progressive introduction of a number of rights-based schemes has resulted in an increase in public spending on health and a subsequent decrease in out-of-pocket (OOP) payments, improving affordability of care for Singaporean citizens and permanent residents. Today, the population almost universally benefits from the social health protection programmes in place, and with a rapidly ageing population, Singapore stands out in its recent efforts to provide and finance long-term care in an integrated fashion. However, broad risk pooling across the population and solidarity in financing is limited, and programmes remain scattered for a small population. This creates issues of equity in access to care and difficulties for users to navigate a complex system. Furthermore, narrow entitlement criteria based on migration status, employment status or stringent means testing, limit both benefit adequacy and risk pooling.

2. Context

During British colonial rule, Singapore had a national health service whereby health care provided by public facilities was fully subsidized by the government budget. Post-independence, the Singaporean health system developed further with the introduction of the National Health Plan in

1983. The Plan presented the government's health development strategies, including affordable care and meeting the demands of the population (Haseltine 2013). The national health service, which provided free services at public facilities for all, was deemed unsuitable by the government, who felt it was wasteful, and did not incentivize individuals to focus on their own health, leading to high health care costs and overconsumption.

In response, the government sought to shift some of the burden of health care from the state to the individual (for example, through co-payments), citing the importance of personal motivation and individual responsibility for a productive economy. In addition, Singapore's Government advocated for the power of markets to drive efficiency in the health sector, while seeking to retain government control over key issues, using the market as a policy tool only when deemed appropriate (Lim 2013). Accordingly, the government replaced the national health service model with a system which places responsibility on each individual for their own health and other life contingencies, with the family positioned as the first line of support, followed by government-led interventions as a last resort (Phua 2006; Teo et al. 2003).

Indicative of this shift, in 1984, after the Central Provident Fund Act of 1953 was revised, MediSave was created—a scheme based on individual saving accounts which are contributed to by employers and workers on a mandatory basis, and can be topped up by the government. [1] At the time of the release of the National Health Plan, the use of a savings account model was criticized by some in the medical community who underlined the responsibility of the state to cover medical expenses rather than individuals, and highlighted issues affecting the chronically ill (History SG 2019).

The National health service and MediSave alone were found to be insufficient to cover impoverishing OOP health expenses, which prompted the creation of additional schemes. A public health insurance scheme known as MediShield (now known as Medishield Life), was created under the Central Provident Fund (CPF) in 1990, with a view to cover hospital bills and selected outpatient interventions in both public and private health facilities. Contributions to this scheme are taken out of the MediSave account and subsidized for low-income groups.

In 1993, the government published a White Paper entitled "Affordable Health Care", which aimed to promote the accessibility of basic medical services available to all citizens, regardless of their income (Haseltine 2013; Singapore Ministry of Health 1993). In the same year, the Medical Endowment Fund (MediFund) was introduced under the CPF, and its periodic replenishment was eventually embedded in the Medical and Elderly Care Endowment Schemes Act of 2000. [2] MediFund can be used for similar interventions covered by MediShield Life on a case by case basis, if both MediSave and MediShield Life have been exhausted and the patient is still unable to afford the remainder of the bill (The Commonwealth Fund 2020). MediFund therefore serves as the ultimate resort for indigent citizens.

In 2000, the Community Health Assist Scheme (CHAS), which subsidizes access to primary health care, was created under the Ministry of Health in an attempt to ensure affordability of the entire spectrum of care. Shortly after, in 2002, a long-term care scheme named ElderShield was created under the MOH in response to the demographic reality of an ageing population.

To address coverage gaps among the migrant population, in 2008, the Ministry of Manpower introduced compulsory private medical insurance for migrant workers on temporary residence permits after the MOH withdrew eligibility for migrants to access the subsidies of the national health service. The following year, the MOH introduced means-testing for subsidies for care provided in public facilities for Singaporeans (Haseltine 2013).

To further extend coverage, in 2015, the MediShield Life Scheme Act was passed, which extended coverage to all citizens and permanent residents regardless of employment status. [3] This is now the scheme with the broadest coverage (97 per cent of citizens and permanent residents). Initially, affiliation to MediShield was not compulsory for Singaporeans holding private insurance plans. However, as private insurers primarily targeted the young and healthy, the MediShield pool increasingly consisted of higher-risk individuals,

[1] Central Provident Fund Act of 1953 (revised 2013), available at: Central Provident Fund Act - Singapore Statutes Online (agc.gov.sg)
[2] Medical and Elderly Care Endowment Schemes Act of 2000 [revised 2001], chapter 173a, available at: https://sso.agc.gov.sg/Act/MECESA2000
[3] MediShield Life Scheme Act of 2015, available at: MediShield Life Scheme Act 2015 - Singapore Statutes Online (agc.gov.sg).

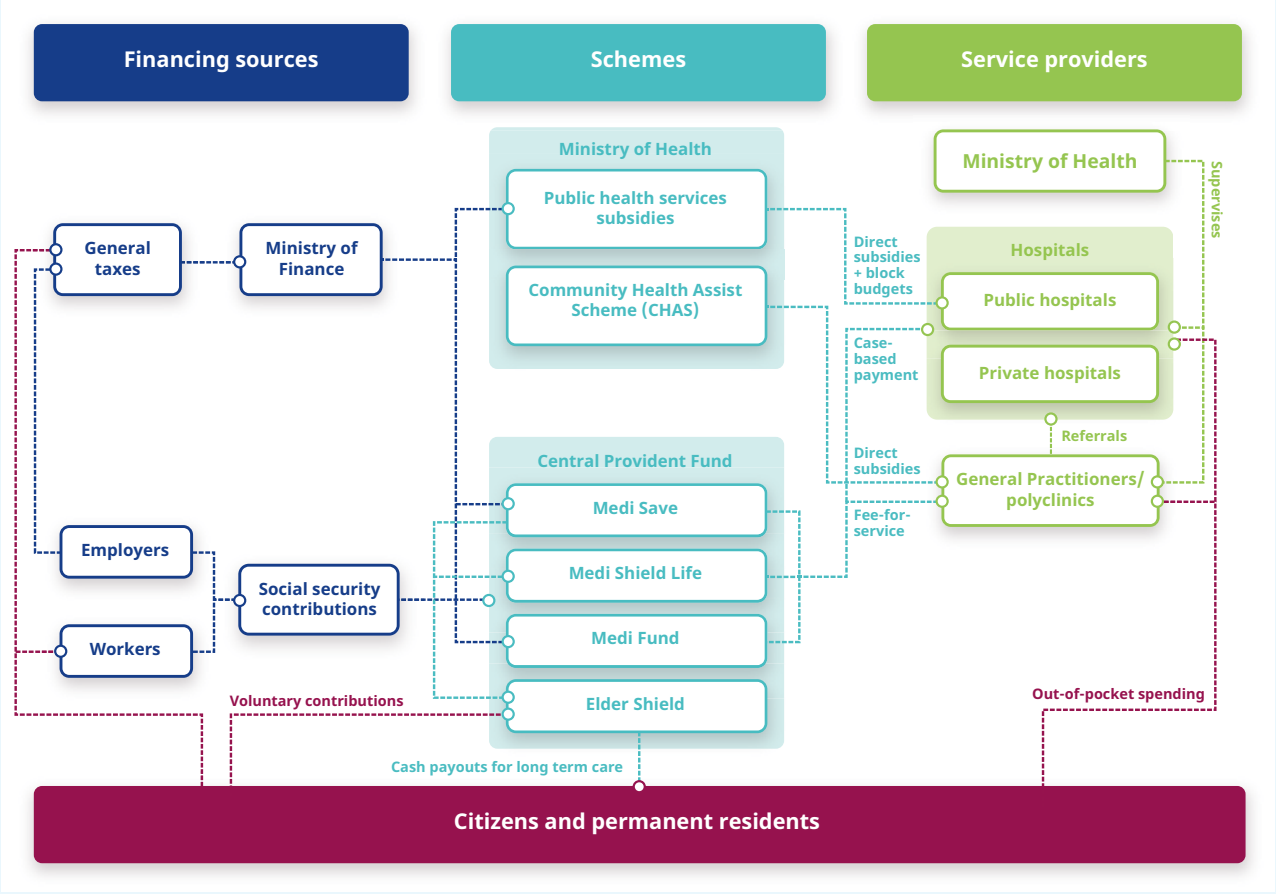
leading to an increase in premiums. To combat this, the government launched the Integrated Shield Plan in 2005, in which private insurers can only offer packages that are supplementary to basic MediShield coverage. Today, the government continues to amend and expand health financing schemes as needs on the ground evolve, while firmly maintaining the Singaporean values and political philosophies that have guided its efforts in the past.

3. Design of the social health protection system

- Financing

The financing flows between the main schemes are schematically presented in figure 1 below.

Figure 1. Overview of main financial flows of the social health protection system in Singapore



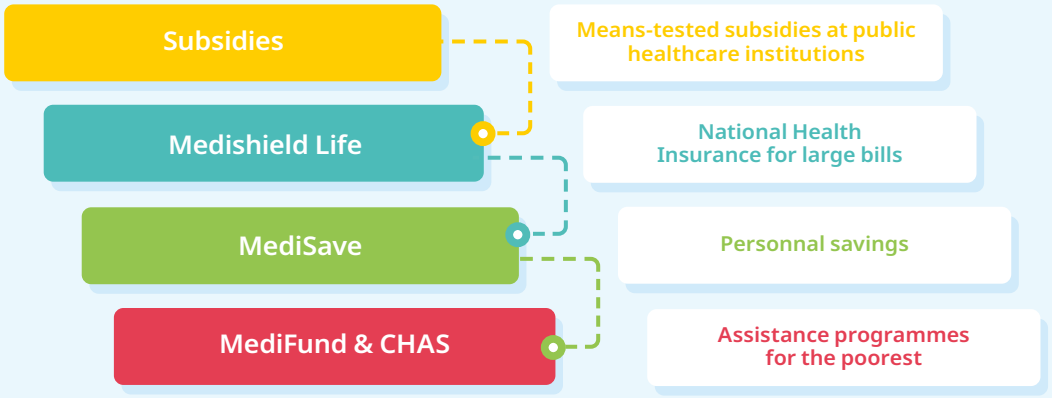
Source: Authors.

MediSave is a receptacle that collects both social contributions from workers and employers, and tax-financed government subsidies. Once placed in MediSave individual accounts, funds can be used to finance MediShield Life contributions (for the household) and ElderShield contributions.

The means-tested subsidies for the public national health service are financed from general taxes, similar to the endowment of the MediFund and the benefits of the CHAS. The public national health service provides a combination of direct subsidies and a block budget to public health care facilities, while CHAS directly subsidizes patients.

MediSave functions as a saving account to be used to cover health care expenses, and it is not a risk pooling mechanism per se. MediShield Life is an insurance-based scheme focused on high-cost health interventions (primarily hospital-based interventions). Both schemes use a case-based provider payment method for public and private hospitals.

▶ **Figure 2. Overview of schemes**



Source: Adapted from Singapore Ministry of Health (2020).

As illustrated by Figure 2, the different schemes are designed to be complementary, and do not overlap. They combine different types of instruments and sources of funding. The system is partially based on collective financing, and partially relies on individual savings. Both MediShield Life and ElderShield establish differential contribution levels depending on personal characteristics such as age or gender. This modus operandi is closer to private insurance premiums than that of social insurance contributions, and therefore may be discriminatory. For example, premiums for women were found to be 23 per cent higher than for men of the same age, allegedly due to higher life expectancies (Gee 2018).

- Governance

The MOH administers the subsidized national health service and the CHAS. As part of the National Health Plan, the CPF manages MediSave, MediShield Life and MediFund under the Central Provident Fund Act (Haseltine 2013). The CPF Board and six Committees supporting its duties and responsibilities, including the MediShield Life and Insurance Schemes Committee, manage the CPF. Based on tripartism, the CPF Board includes members from the government, along with representatives of employers and workers.

On the whole, the government plays an integral role in the management of health care provision and financing, with private players only allowed to enter the market when the government believes it will improve overall efficiencies (Lim 2013). Notably, the management of Eldershield was initially delegated to three private insurance companies appointed by the MOH. However, the scheme recently underwent a review and the government determined that public management by a central agency would be more efficient and better able to respond to the needs of the population through a change in a number of scheme parameters, with a view to improve equity (Singapore Ministry of Health 2021c). To this end, the Long-Term Care

Bill and CareShield Life was established, through which the scheme will be publicly-governed. [4]

The shift in management of the Eldershield scheme is part of a comprehensive package of policies to address ageing over the past decades. Such policies include the introduction of new regulations for residential and non-residential care, the creation of the Agency for Integrated Care, the enactment of a mandatory re-hiring policy for employers of senior workers as well as the subsidization of foreign domestic workers hiring and skill enhancement (Cheah et al. 2012; Mehta and Vasoo 2008; Nurjono et al. 2018; Nurjono and Vrijhoef 2019; Ortiga et al. 2020; Ow Yong and Cameron 2019; Rozario and Rosetti 2012; Tan et al. 2017).

- Legal coverage and eligibility

All Singaporean citizens and permanent residents are covered through one or more of the social health protection mechanisms, with income status and age used to determine eligibility for certain programmes. Joint eligibility criteria and identification mechanisms are in place which ensures coordination between social assistance programmes and subsidized health schemes. For example, eligibility to the CHAS health scheme for vulnerable groups is determined through a centralized system and access is automatic through a Public Assistance Card. Eligibility criteria for each scheme is detailed below in Table 1.

- Benefits

Most services offered at public health care facilities are subsidized, and the government sets fixed, often subsidized prices for drugs listed on the official standard drug list (Singapore Ministry of Health 2021a). In addition, supplementary financial support may be provided to eligible citizens and permanent residents based on results of a means test. The national health service focuses primarily on acute hospital-based care. For other medical care, including primary care provided in the private sector, compulsory savings accounts managed by the Central Provident Fund (namely MediSave) are in place (Tan et al. 2014). MediSave accounts can be used for medical bills for the entire household. More detailed information on specific benefits offered by each scheme is provided below in table 1.

- Provision of benefits and services

The different government-led schemes have a strong focus on secondary and tertiary care. Before CHAS, access to primary care was subsidized in a network limited to 16 public polyclinics, while the country relied on a network of about 800 private clinics for outpatient care. These private structures provided the vast majority (82 per cent) of primary care services in Singapore, and MediSave was the only mechanism that could be used by patients, until the creation of CHAS for low-income households (Lim 1998).

A referral system is in place, gearing access to subsidies and MediShield Life cover for secondary and tertiary care (Singh Bali and Ramesh 2017). In order to support patients to navigate the health care system, particularly the different layers of financial protection (means-tested subsidies, health insurance, and so on), medical social workers are the key point of contact in public health facilities. They provide patients with advice on their expectations of programmes and services provided, as well as any problems regarding hospital billing and technicalities during admission (SingHealth 2021).

As highlighted in figure 1, a purchaser-provider split exists, though there are several schemes purchasing health care services. The means-tested subsidy system and MediShield Life use modern provider payment methods with a view to control costs, though they mostly concern inpatient care and high-cost outpatient care interventions. Purchasing at primary care level remains driven by the use of MediSave. While policies on long-term care have developed over the past decades, financing schemes and subsidies have mostly adopted an approach whereby the patient receives a cash amount that can be used to pay a wide range of providers rather than establishing centralized payment mechanisms for long-term care providers.

- Transparency and accountability

All of the schemes undergo regular adjustments based on consultations with the protected population. Recently, the MediShield Life parameters were revised and a public consultation was conducted with a view to collect public opinions and feedback on the proposed reform parameters (Singapore Ministry of Health 2020). Notably, after an increase in hospital

[4] CareShield Life and Long-Term Care Bill No. 24/2019, available at: https://sso.agc.gov.sg/Bills-Supp/24-2019/Published/20190806?DocDate=20190806

fees in 2002, increased government regulation led hospitals to become more transparent and provide detailed information on prices and patient outcomes, which has enhanced transparency and accountability and contributed to a more efficient health system.

▶ Table 1. Summary of key design features: coverage, benefit and service provision

Scheme	Population coverage	Revenue collection	Benefit package	Benefit level	Benefit provision
Subsidized national health service	Citizens and permanent residents	Taxes	Inpatient and outpatient care	10 to 80 per cent of the costs of medical care is subsidized depending on patient's income.	Public facilities, provider payment mix of block budget and subsidies per intervention.
MediShield Life	Citizens and permanent residents	Employer, worker and government contributions (partial and full subsidies for low and middle-income households as well as the elderly).	Coverage for large hospital bills when the patient is hospitalized longer than eight hours, including day surgery, and some outpatient services.	Co-payment levels range from 3 to 10 per cent depending on the intervention. In addition, the scheme has deductibles. [1]	Public and private facilities [2], case-based payment for hospitals and fee-for-service for polyclinics.
MediSave	Citizens and permanent residents	Employer, worker and government deposits	Inpatient and some outpatient interventions are eligible to be paid by MediSave account. Contributions to MediShield Life and ElderShield can also be paid through MediSave	Savings account – the available funds in the account can be used for health interventions for the contributor and their household up to a ceiling withdrawal amount	
MediFund	Low-income citizens	Tax-financed endowment, revenue from fund interests	Complement the subsidized national health service, MediSave and MediShield	Covers remaining co-payments for citizens unable to afford it on a case-by-case basis	
CHAS	Low-income citizens and permanent residents	Taxes	Outpatient care (GPs, dental care and other primary care interventions)	Benefit level depends on type of health intervention and beneficiary income profile. A co-payment of 15 per cent is required before being able to use MediSave to pay the non-subsidized part of the bills	Public and some private primary health care providers.
ElderShield	Dependent citizens and permanent residents	Contributions from beneficiaries / MediSave account	Long-term care	Periodical cash payments of US$300 or US$400 per month for up to 5 or 6 years depending on the package	Eligibility: an eligible person requires physical assistance of another person for the Activities of Daily Living (ADL).

Source: Adapted from National Health Insurance Service (2019).

[1] The deductible is fixed and to be paid once per year in case of hospitalization. It ranges from 1,500 Singapore Dollars (US$1,078) to 3,000 Singapore Dollars (US$ 2,157) of the claimable amount, depending on age of the beneficiary and type of ward.

[2] The scheme can be used in both public and private facilities, but the benefit is designed to complement the national health service subsidies in public facilities. Affiliates who wish to seek care in private facilities will get the same level of benefit, but will end up paying higher OOP payments as private facilities are not subsidized. The pro-ration for private provider bills is currently 35 per cent, though lowering it to 25 per cent is under consideration.

4. Results

- Coverage

Since its independence, Singapore has provided access to health care services at subsidized costs to all Singaporeans. The national health insurance scheme, MediShield Life, complements the subsidization system with a view to cover remaining user fees in cases of large medical bills. The combination of contributions and tax-financed contribution subsidies ensure broad population coverage of MediShield Life, especially for acute hospital-based care. The scheme initially had many exclusions but progressively became accessible to all citizens and permanent residents. The Central Provident Fund reported the affiliation of 3.908 million persons in 2018, representing 97 per cent of citizens and permanent residents (Singapore Department of Statistics 2021). Significant efforts have been made over time to ensure that the self-employed are included in mandatory coverage.

All the schemes described in table 1 cover citizens and permanent residents, in line with the government's stated priority to provide adequate universal health coverage for all Singaporeans, with transient foreigners and workers left to rely on employers for protection. This excludes coverage of the 1.641 million temporary residents in Singapore, who represented over 28 per cent of the population in 2018 (Singapore Department of Statistics 2021). Temporary residents are mostly migrant workers (1.38 million, representing over a third of the workforce) who are among the most vulnerable workers in Singapore. Under the Employment of Foreign Manpower Act, migrant workers on temporary migration schemes need to be covered for medical care by their employer through a private basic medical care insurance covering high inpatient costs (non-work-related hospitalization or day surgery). There is no risk pooling with the rest of the population, and beyond this basic coverage, employers are liable for uninsured medical expenses, leading to inequities in coverage. The fact that temporary migrant workers remain excluded from the scope of social health protection coverage, combined with the fact that they tend to be concentrated in low or intermediate skilled jobs, reinforces unfavourable perceptions and attitudes towards migrants that encourage discriminatory practices (UN Women and ILO 2019).

- Adequacy of benefits/ financial protection

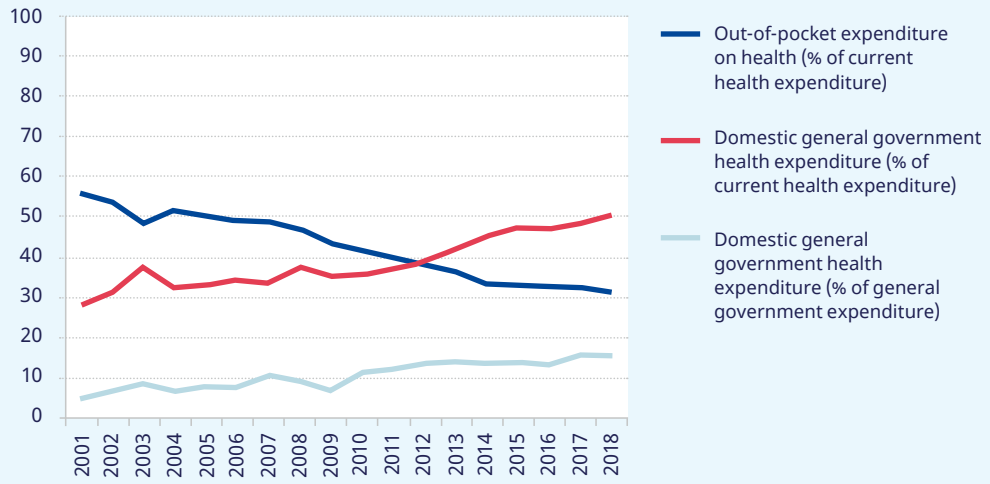
While efforts to improve the affordability of care have yielded some results, OOP payments on health care still represent over a third of current health expenditure, as illustrated by graph 1 below (WHO n.d.). Substantial government subsidies, which in 2017 amounted to 314 million Singapore Dollars (US$222 million), and the existence of multiple schemes covering a wide range of services (from primary health care to long-term care), remain insufficient to effectively provide adequate financial protection, especially for the most vulnerable. For instance, there is evidence that affordability is an issue for people suffering from co-morbidities in old age and lower-income groups, and studies have highlighted that many citizens feel that the current health care financing system provides insufficient "peace of mind" (Asher and Nandy 2008; Tan et al. 2019). However, in terms of tackling increasing OOP payments related to old age health and care needs, the ElderShield long-term care scheme, which provides periodical cash payments in cases of severe disability, provides an interesting experience for the rest of the region.

The implementation of CHAS significantly enhanced financial protection for primary health care in Singapore, highlighting the limitations of focusing exclusively on hospitalization to tackle impoverishing health expenses. As for MediSave, while this was initially presented as a mechanism that would reduce moral hazard, the effectiveness of using a medical savings account as a cost containment tool has been called into question (Hsiao 1995). In addition to the individual saving accounts, contributions to MediShield Life and ElderShield based on the age and gender of contributors are features based on individual risks rather than a solidarity-based system through a single risk pool. These coexist with schemes subsidized on a means-test basis and financed through other approaches, sometimes allocated on a case-by-case basis rather than from a risk pool, which decreases the redistribution and inequality reduction potential of the system as a whole. The ways in which eligibility for means-tested public programmes is determined have been criticized for being narrow and reliant on traditional solidarity mechanisms within the household, which may no longer be as organic as they used to be (Asher and Nandy 2008; Chia et al. 2008; Smith et al. 2015; Yahya 2015).

Another limitation of the system which reduces financial protection for the population is the

fact that Singapore's social protection model is premised on employment and jobs to enable self-reliance. As a result, Singapore does not provide legal entitlements to sickness and maternity benefits to ensure income security during such contingencies. Instead, it relies on an employer's liability, similar to the case of health coverage for temporary migrant workers (Chow 1985). This system remains difficult to enforce and places a financial burden that some employers are not able to sustain, especially in the context of the global pandemic (Addati 2015; ILO 2020; ISSA 2020). This situation reinforces the possible adverse financial effects of sickness and maternity for the Singaporean population. To compound the limitations of providing maternity leave as an employer's liability, maternity care remains subject to co-payments, although efforts were made to include complicated deliveries within the package of MediShield Life in 2019 (Central Provident Fund Board 2018). To ensure that families are more able to cover health and other costs related to childbirth, the CPF put in place a cash payment for new-borns.

▶ Figure 3. Evolution of OOP and public expenditure on health in Singapore, 2001 2018



Source: Adapted from WHO Global Health Expenditure Database.

- Responsiveness to population needs
    - o Availability and accessibility

The mixed system of funding in place has enhanced widespread access to health services for the Singaporean population. However, the high costs of non-subsidized high health care in Singapore act as a significant access barrier to health care services for migrant workers. This inequity in access to health care services has been underscored by the COVID-19 pandemic (Goh et al. 2020; Rajaraman et al. 2020).

In terms of availability of services, the number of hospital beds in Singapore was 2.4 per 1,000 people in 2015, which is below the OECD average. Nonetheless, since 1960, hospital beds doubled in Singapore, with the sharpest increase seen in the private sector, increasing by 370 per cent (Singapore & more in numbers 2019).

The mobile application, ''Health Buddy App'', is a noteworthy feature of the system which enhances accessibility for the population, enabling patients to access health information and services at any time through their personal profile (SingHealth 2021). Using the application, patients can find their nearest GP or clinic, manage appointments, view queue updates, place medicine orders and pay medical bills.

- Quality and acceptability

The MOH and its statutory boards are responsible for regulating the quality of Singapore's health care system. All health facilities such as hospitals, medical centres, community health centres, nursing homes, clinics (including dental clinics),

and clinical laboratories are required to apply for a licence under the Private Hospitals & Medical Clinics (PHMC) Act/Regulations. Moreover, MOH monitors the performance of the health care system against a large number of indicators, several of which rival levels encountered in OECD countries. Notably, waiting times for admission to wards were recorded as under 3 hours in 2019; waiting times for registration and admission at polyclinics were below 20 minutes in 2019; and the number of health personnel (24 doctors per 10,000 people) is more than double the WHO recommended minimum (Singapore Ministry of Health 2021b).

According to a survey undertaken by the MOH[3] with the participation of more than 12,000 patients, the number of patients who rated services provided at public hospitals as good or excellent increased from 79 per cent in 2014 to 86 per cent in 2015. The share of patients who found services to be affordable increased from 69 per cent in 2014 to 72 per cent in 2015. Due to the high bed occupancy in public hospitals, the biggest gap between expectations and satisfaction was the waiting time for a bed at the emergency unit (Khalik 2016).

▶ 5. Way forward

Despite broad population coverage, challenges are emerging related to Singapore's increasingly older population, the rise in non-communicable diseases and conditions which require long-term care, as well as growing concerns among young voters and the elderly about rising health care costs and inequity. In response, the Singapore Government has expressed a desire to create a more holistic, inclusive, and universal health care system by bridging the gaps of the current model (Lim 2017). Recent reforms in this direction are progressively broadening risk pooling and reducing reliance on personal savings to finance health care.

One such reform is the extension of the MediShield Life social health insurance scheme to all citizens and permanent residents regardless of employment status or contributory capacity. In addition, the further revision of parameters to abolish the exclusion of preconditions, and more recently, the transfer of the ElderShield scheme to the public sector, accompanied by a broader scope of coverage, contribute to these efforts. In parallel, the introduction of CHAS, the relaxing of some of the rules of MediShield and MediSave to include more outpatient interventions, and the creation of the agency for integrated care, represent efforts towards a better balance between primary, secondary and tertiary care.

However, as revealed by the COVID-19 crisis, efforts still need to be made to reduce inequality. To this end, coverage of migrant workers is to be expanded further as a result of pressures from civil society, trade unions and the research community. In addition to this, more and better data on multi-dimensional poverty and inequality in Singapore would support monitoring the extension of social health protection and its impact. Indeed, while Singapore has a wealth of publicly available data, it remains challenging to find official evidence and analysis on poverty and inequality (Smith et al. 2015).

▶ 6. Main lessons learned

- The development of legal entitlements and legal reforms were instrumental to the extension of coverage. Recent efforts to extend coverage focused on the development of the legal framework to create mandatory affiliation for citizens and permanent residents to MediShield Life, which reached 97 per cent of its target group. Efforts were also made to embed long-term care entitlements in the law.
- While population coverage is near universal, benefit adequacy, risk pooling and solidarity in financing encounter limitations due to the number and type of programmes adopted as well as the principles and beliefs upon which the programmes are built. Although there is no overlap between the schemes, the Singaporean principle of "many helping hands" has led to a situation in which there are many different programmes to cover a rather small population. In addition, the principle of self-reliance, the use of individual medical saving accounts,

[3] This survey was discontinued and today it is unclear what the tracking mechanisms are.

the limitation of the scope of risk pooling mechanisms for secondary and tertiary care, and the exclusion of temporary residents limit equity in access to care and create adverse incentives for the use of primary care. Narrow eligibility criteria for means-tested services and programmes further limits the equity of the system.

- Although the different social protection mechanisms in Singapore are complementary and do not overlap, the system remains highly fragmented in terms of the number of schemes with respect to the relatively small population of Singapore, which reduces efficiency. As it has been noted, international experience suggests that the presence of multiple health schemes purchasing services "is technically much more complex than a system with a single purchaser and involves higher transaction and administrative costs" (Thomson and Jeurissen 2017, 12).
- The reliance on employer liability for some contingencies and/or population groups has been exposed by the COVID-19 crisis as a weakness of the social protection system. While paid sick leave and maternity leave have a replacement rate of 100 per cent, these are an employer's liability, and there is no risk pooling mechanism in place (Social Security Administration 2016). Similarly, employers of migrant workers on temporary residence permits are responsible for their health expenses. Exclusive reliance on employer's liability schemes tends to create inequities in access to social protection benefits related to employment status, and are generally unsustainable during times of crisis.
- With a rapidly ageing population, Singapore identified long-term care as a contingency in its own right early on. The Singapore experience reveals that innovative financing methods such as the Eldercare scheme should be accompanied by efforts to integrate care and regulate LTC providers. In this context, the role and value of migrant workers ought to be recognized, which may lead to improving both public perceptions and skills over time.

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References

Addati, Laura. 2015. "Extending maternity protection to all women: Trends, challenges and opportunities." *International Social Security Review* 68 (1): 69–93.

Asher, Mukul, and Amarendu Nandy. 2008. "Singapore's Policy Responses to Ageing, Inequality and Poverty: An Assessment." *International Social Security Review* 61 (1): 41–60.

Central Provident Fund Board. 2018. "What Is the Cost of Giving Birth in Singapore?", available at: https://www.areyouready.gov.sg/YourInfoHub/Pages/Views-What-is-the-cost-of-giving-birth-in-Singapore-hospitals-TheHeartlandBoy.aspx.

Cheah, Jason, Wong Kirk-Chuan, and Harold Lim. 2012. "Integrated Care: From Policy to Implementation – The Singapore Story." *International Journal of Integrated Care* 12 (3): e195.

Chia, Ngee Choon, Shawna Lim Shi'en, and Angelique Chan. 2008. *Feminization of Ageing and Long Term Care Financing in Singapore*. National University of Singapore.

Chow, Nelson W.S. 1985. "Social Security Provision in Singapore, Hong Kong, Taiwan and South Korea: A Comparative Analysis." *Journal of International and Comparative Social Welfare* 2 (1–2): 1–10.

Gee, Christopher. 2018. "CareShield Life: What's Fair versus What's Right". *Today online*, 23 July 2018.

Goh, Orlanda Q., Amina M. Islam, John C. W. Lim, and Wan-Cheng Chow. 2020. "Towards Health Market Systems Changes for Migrant Workers Based on the COVID-19 Experience in Singapore." *BMJ Global Health* 5 (9): e003054.

Haseltine, William. A. 2013. *Affordable Excellence: The Singapore Healthcare Story. Washington, DC*: Brookings Institution Press.

History SG. 2019. "Blue Paper on the National Health Plan is Published", available at: https://eresources.nlb.gov.sg/history/events/f1d05600-4263-4981-a0bc-be780f772dd1.

Hsiao, William C. 1995. "Medical Savings Accounts: Lessons from Singapore." *Health Affairs* 14 (2): 260–66.

ILO (International Labour Organization). 2020. *Sickness Benefits during Sick Leave and Quarantine: Country Responses and Policy Considerations in the Context of COVID-19*. Social Protection Spotlight Factsheet.

ISSA (international social security association). 2020. "COVID-19 Crisis: A Renewed Attention to Sickness Benefits", available at: https://ww1.issa.int/analysis/covid-19-crisis-renewed-attention-sickness-benefits.

Khalik, Salma. 2016. "Public Healthcare Services Rated Highly." *The Straits Times*, 14 June 2016.

Lim, J. 2017. "Sustainable Health Care Financing: The Singapore Experience." *Global Policy* 8 (S2): 103–9.

Lim, J. 2013. *Myth or Magic? The Singapore Healthcare System*. Singapore: Select Publishing.

Lim, M.K. 1998. "Health Care Systems in Transition II. Singapore, Part I. An Overview of Health Care Systems in Singapore." *Journal of Public Health Medicine* 20 (1): 16–22.

Mehta, K. K., and S. Vasoo. 2008. "Organization and Delivery of Long-Term Care in Singapore: Present Issues and Future Challenges." *Journal of Aging & Social Policy* 13 (2–3): 185–201.

Nurjono, M., and H. J. M. Vrijhoef. 2019. "Integrated Care Ecosystems in Singapore." *In Designing Integrated Care Ecosystems: A Socio-Technical Perspective*, edited by B. J. Mohr and E. Dessers. Cham, Switzerland: Springer International Publishing.

Nurjono, Milawaty, Joanne Yoong, Philip Yap, Shiou Liang Wee, and Hubertus Maria Johannes Vrijhoef. 2018. "Implementation of Integrated Care in Singapore: A Complex Adaptive System Perspective." *International Journal of Integrated Care* 18 (4): 4.

Ortiga, Yasmin, Kellynn Wee, and Brenda Yeoh. 2020. "Connecting Care Chains and Care Diamonds: The Elderly Care Skills Regime in Singapore." *Global Networks* 21 (11).

Ow Yong, Lai Meng, and Ailsa Cameron. 2019. "Learning from Elsewhere: Integrated Care Development in Singapore." *Health Policy* 123 (4): 393–402.

Phua, Kai Hong. 2006. "Healthcare and Long-Term Care Financing in Singapore." In *Handbook of Asian Aging*. Routledge.

Rajaraman, Natarajan, Teem-Wing Yip, Benjamin Yi Hern Kuan, and Jeremy Fung Yen Lim. 2020. "Exclusion of Migrant Workers from National UHC Systems—Perspectives from HealthServe, a Non-Profit Organisation in Singapore." *Asian Bioethics Review* 12 (3): 363–74.

Rozario, Philip A., and Amanda Leigh Rosetti. 2012. "'Many Helping Hands': A Review and Analysis of Long-Term Care Policies, Programs, and Practices in Singapore." *Journal of Gerontological Social Work* 55 (7): 641–58.

Singapore & more in numbers. 2019. "Hospital Bed Numbers: How Does Singapore Compare with the OECD?", available at: https://numbers.sg/posts/hospital-beds-in-singapore/.

Singapore Department of Statistics. 2021. "Data and News", available at: http://www.singstat.gov.sg/.

Singapore Ministry of Health. 1993. *Affordable Health Care: 1993 White Paper.*

——. 2020. "Public Consultation on MediShield Life Review", available at: https://www.moh.gov.sg/news-highlights/details/public-consultation-on-medishield-life-review.

——. 2021a. "Drug Subsidies & Schemes", available at: https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies/drug-subsidies-schemes.

——. 2021b. "Resources & Statistics", available at: https://www.moh.gov.sg/resources-statistics.

——. 2021c. "What Is ElderShield?", available at: https://www.moh.gov.sg/careshieldlife/about-eldershield.

Singh Bali, A., and M. Ramesh. 2017. *Singapore Handbook of Public Policy: The Healthcare System in Singapore*. Singapore: National University of Singapore.

SingHealth. 2021. "Health Buddy App", available at: http://www.singhealth.com.sg:80/patient-care/patient-visitor-info/health-buddy-app.

Smith, Catherine J., John A. Donaldson, Sanushka Mudaliar, Mumtaz Md Kadir, and Lam Keong Yeoh. 2015. "A Handbook on Inequality, Poverty and Unmet Social Needs in Singapore." *Lien Centre for Social Innovation: Research*. 1–86.

Social Security Administration. 2016. "Social Security Programs Throughout the World: Asia and the Pacific, 2016 - Singapore", available at: https://www.ssa.gov/policy/docs/progdesc/ssptw/2016-2017/asia/singapore.html.

Tan, K.B., W.S. Tan, M. Bilger, and C.W.L. Ho. 2014. "Monitoring and Evaluating Progress towards Universal Health Coverage in Singapore." *PLoS Medicine* 11 (9): e1001695.

Tan, Min-En, Vathsala Sagayadevan, Edimansyah Abdin, Louisa Picco, Janhavi Vaingankar, Siow Ann Chong, and Mythily Subramaniam. 2017. "Employment Status among the Singapore Elderly and Its Correlates." *Psychogeriatrics* 17 (3): 155–63.

Tan, Sok Teng, Rina Yu Chin Quek, Victoria Haldane, Joel Jun Kai Koh, Emeline Kai Lin Han, Suan Ee Ong, Fiona Leh Hoon Chuah, and Helena Legido-Quigley. 2019. "The Social Determinants of Chronic Disease Management: Perspectives of Elderly Patients with Hypertension from Low Socio-Economic Background in Singapore." *International Journal for Equity in Health* 18 (1).

Teo, Peggy, Angelique Chan, and Paulin Straughan. 2003. "Providing Health Care for Older Persons in Singapore." *Health Policy (Amsterdam, Netherlands)* 64 (3): 399–413.

The Commonwealth Fund. 2020. "International Health Care System Profiles: Singapore", available at: https://international.commonwealthfund.org/countries/singapore/.

Thomson, Sarah, and Patrick Jeurissen. 2017. *Single vs Multiple Competing Purchasing Agencies: Analysis of Options for the Health System in Cyprus*. WHO Regional Office for Europe.

UN Women and ILO (International Labour Organization). 2019. *Public Attitudes towards Migrant Workers in Japan, Malaysia, Singapore and Thailand.*

WHO (World Health Organization). n.d. "Global Health Expenditure Database". Available at: https://apps.who.int/nha/database. Accessed 27 February 2020.

Yahya, Faizal Bin. 2015. *Inequality in Singapore*. Singapore: World Scientific Publishing.

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