Population ageing requires adaptive responses, not just technical ones

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The Singapore government’s Budget for 2012 has been widely lauded for its commitment to increase social protection and invest in the country’s capacity to cope with an ageing population. In a Budget remarkable for its emphasis on social spending, the measures in healthcare were arguably the boldest and most important. The government has projected a doubling of healthcare spending, from the current $4 billion to about $8 billion a year, over the next five years. This will support a 30% increase in the number of beds in acute hospitals and a doubling of the capacity of long-term care services. Equally welcome were the announcements to expand the coverage of MediShield to those aged between 85 and 90, the extension of subsidies for long-term care to a larger segment of the elderly population requiring such services, and top-ups to citizens’ Medisave accounts.

But although the increased spending is timely and necessary, there are other longer-term structural and societal issues which leaders and policymakers in healthcare have to consider. Increasing spending in healthcare does not automatically produce better outcomes in the health and well-being of the population. Much would also depend on the organisation of our healthcare system, how incentives are designed, and whether we foster the norms and values to support successful ageing.
Harvard University’s Ronald Heifetz made a distinction between *technical* challenges and *adaptive* ones. The former can be quite clearly defined and addressed with known solutions or ones developed by technical experts. They often can be addressed using current structures and systems, and typically do not involve a large change in the organisation’s culture. Adaptive challenges, on the other hand, require significant and sometimes painful shifts in people’s habits, roles, status, identities and ways of thinking. They require people to change their behaviours and mindsets from well-worn neural pathways. People also have to learn new skills, take on new roles, adopt new beliefs, and honour new values. Adaptive challenges invariably involve conflicts as they often challenge people’s expectations and comfort levels. These conflicts wisely managed and channelled by leaders to support positive change.

The ageing of our population, and its implications for our health, social and fiscal systems, constitute an adaptive challenge. It requires leaders and policymakers in public healthcare to pursue a holistic approach that encompasses at least three perspectives beyond increasing public spending in healthcare.

*Taking a systems approach to the organisation and delivery of care*

The first perspective is that beyond making improvements to the existing system, leaders in healthcare also have to contend with how the healthcare delivery system itself should be adapted for a different context. Incremental changes ought to be guided by a shared vision of how the healthcare system would be transformed in the long-term. This is necessary in light of significant changes in the demographics and disease patterns of our population. For instance, the incidence of chronic illnesses will increase as Singapore ages. Already, around 80% of those above 65 suffer from one or more chronic illnesses. Along with this epidemiological transition, healthcare utilisation patterns would shift from acute care to the primary, long-term and social care sectors.
Historically, the Singapore government has invested in developing a strong acute care sector, but has left primary care and long-term care mostly to private and non-profit providers. The shifts in our disease patterns, largely as a consequence of ageing, will necessitate significant changes in the way care is organised and delivered. This is a process which the government has already embarked on, but sustained commitment from leaders in healthcare is essential for this structural transformation process to succeed. The reorganisation of Singapore’s health services clusters – from two large clusters to six geographically-based regional health systems – reflects a shift to a more population and patient-centred approach in healthcare delivery. The measures announced by the Health Minister in this year’s Budget to engage private and non-profit providers also hint at longer-range efforts to harness the resources that reside outside of the public sector.

Within each regional health system, the emphasis is very much on providing more patient-centric care through multi-disciplinary teams involving specialists, general practitioners, nurses, care coordinators, social workers, and allied health professionals. There are also now efforts to integrate care across different parts of the healthcare system. For instance, the government already plans to roll out an integrated electronic health records system to all public healthcare institutions, six community hospitals, two nursing homes, selected GPs, and care coordinators from the Agency for Integrated Care. This would enable the delivery of better-coordinated care. Over time, these efforts will serve to transform our healthcare system from one organised as separate hierarchies – usually with doctors at the apex – to one organised as a fluid network in which the organisation or the professional taking the lead may change depending on the context and the circumstances of the patient. Our healthcare system would also become one that is better organised around the needs of the patient and the population, rather than the needs of professionals or healthcare organisations.

These changes to the organisation of the healthcare system reflect the government’s recognition that an older population with a higher incidence of people with co-morbidities will require a more connected healthcare system. In this context, it is
critical for leaders in healthcare to take a systems approach to healthcare. A systems approach encourages policymakers to think about how the marginal dollar in healthcare should be allocated. It also reminds us that the magnitude of the inputs into healthcare matters less than how the resources are allocated and which specific interventions are implemented. For instance, a systems approach would lead the policymaker to think in terms of how healthcare expenditures should be allocated over the lifetime of citizens. Taking a “systems” view also says that sometimes what is optimal for the system as a whole may not be optimal for individual institutions or constituent parts of the system.

The changes to the way healthcare in Singapore is organised and delivered represent an adaptive, rather than technical, challenge for leaders in this sector. They involve changes in organisational cultures, the expectations of healthcare professionals, and ways of working with one another and across government. They require leaders and policymakers in public healthcare to take a systems view of policy reforms, and to “work on the system” besides making improvements to the existing system.

*Getting incentives in healthcare right*

Second, the allocation of risks between state and individuals in healthcare also has to adapt to the ageing of our population. Besides increasing healthcare spending, the government is also considering how its subvention and subsidy systems should change, and how these changes would alter incentives in healthcare.

Singapore’s healthcare financing system is widely regarded to be a well-designed and financially sustainable one. The 3Ms (Medisave, MediShield and Medifund) and state subvention ensure that the large majority of Singaporeans have affordable access to good healthcare while maintaining patient choice. For instance, seven out of ten patients in our restructured hospitals do not have to pay anything out-of-pocket. The state’s ownership of public hospitals also limits cost pressures, while the emphasis on individual responsibility and co-payment curbs the tendencies for over-consumption. In addition, the provision of a low-cost, near-universal catastrophic
insurance scheme (MediShield) provides citizens a certain degree of protection against the risks of catastrophic medical episodes.

But Singapore’s healthcare financing system will come under increasing stress. First, increasing longevity and a larger proportion of older persons will raise national expenditure in healthcare. The state will come under increasing pressure to expand its financing of healthcare. Second, medical advances will push healthcare costs up as more conditions become treatable and as more effective drugs and treatments become available. Again, there will be greater citizen expectation for the state to provide these new drugs and treatments on a subsidised basis. Third, citizens will expect seamless, integrated care. Adapting to these long-term, structural challenges will require Singapore’s healthcare system to develop efficient financing schemes that provide citizens greater assurance without health spending spiralling to unsustainable levels.

Singapore’s healthcare financing philosophy of shared responsibility – reflected in the combination of tax-financed subvention to public healthcare institutions, individual savings, social and private insurance, and patient co-payment – has served the country well. Because the severity of market failures in healthcare varies significantly across the healthcare system, it makes economic sense to calibrate the extent of government intervention in different parts of the healthcare continuum. For instance, in primary care where informational asymmetries are less pronounced, it is easier for consumers to exercise informed choice. Consumers also have relatively more discretion over how much care they consume. In this sector, it is not inefficient for citizens to bear a larger part of the costs and responsibilities. In acute care on the other hand, bill sizes are much larger, patients have less control over their consumption of such care, and they are far more reliant on the advice of their physicians (i.e. informational asymmetries are more severe). Correspondingly, there should be more state intervention and subvention in this sector. This calibrated, “surgical” approach to healthcare financing is one of the strengths of Singapore’s healthcare system, and helps to contain spending in healthcare.
Nonetheless, the state-market balance in healthcare should not be a static one but one which responds dynamically to changes in our socio-economic context. The larger increase in healthcare costs relative to median wage growth in recent years may have led to gaps in the ability of low and middle-income families to afford good healthcare over their lifetimes. The relatively high share of private spending in healthcare is another area of concern. The confluence of these factors may result in inadequate access for a growing minority that has insufficient financial provision for long-term care but who face higher risks of needing it. At the same time, an ageing population and the rising incidence of chronic conditions which are best managed at the primary and long-term care sectors would require a different state approach to those sectors. In this regard, it is worth noting that in this year’s Budget, the Health Ministry announced the extension of long-term care subsidies to two-thirds of Singaporean households with elderly members, or about 80% of elderly in Singapore. Further, all patients in community hospitals will now be eligible for government subsidies. The Health Ministry will also change the means-test criteria in the ILTC sector from per capita family income to per capita household income, which will help to increase the affordability of step-down care services.

The distribution of risks in long-term care and the rising costs of such care also suggest that the state should make more aggressive use of risk-pooling and social insurance. This means, for instance, expanding and possibly restructuring ElderShield. The introduction of universal health insurance (UHI) models in advanced Asian countries like South Korea and Taiwan has seen out-of-pocket shares in healthcare spending fall significantly. While co-payment also features in these systems, out-of-pocket amounts are capped for insured services, and the exposure to the risks of catastrophic spending is significantly reduced. On the other hand, UHI systems are more expensive, and require ever increasing premiums as the population ages unless benefits are curtailed or rationed.

Clearly, there are few easy answers as to how Singapore’s healthcare financing system should be adapted and calibrated for an ageing population. While there is certainly a need for more risk-pooling to finance higher health and long-term care
costs – something which the government has acknowledged, the benefits of such risk-pooling have to be balanced with longer-term considerations of affordability and how changed incentives might alter healthcare consumption patterns. At the same time, changes to incentives in healthcare are also shaped to a large extent by societal values and the extent to which the government can forge a social consensus on more risk- and cost-sharing

**Shaping norms and values for an ageing population**

Finally, an ageing population will require leaders and policymakers in healthcare to foster the “right” norms and values. Much of the emphasis so far has been on what the government has to do to deal with ageing. But the state cannot mandate or incentivise a change in norms and values. In this realm, its technocratic options are more limited.

That we need a culture and a set of norms that would support successful ageing was recently made more salient by the reactions of some Singaporeans to the proposed development of eldercare facilities in their estates. There is some evidence to suggest that these are not isolated responses but constitute a wider pattern. Government policies and rhetoric in the past – especially those emphasising individual responsibility, and those promising continual house price appreciation – may have contributed to this “not-in-my-backyard” streak among some segments of the population. Another norm in Singapore healthcare that needs to change is the perception that the better doctor is the one who orders more tests and prescribes more treatments or drugs.

But perhaps the most contentious subject for leaders in healthcare to engage the public on is death. Not only do people generally avoid thinking about bad outcomes, but they may also hold unrealistic expectations of what medicine can do for people with terminal illnesses. Addressing end-of-life issues would require leaders – not just in government, but also in society – to engage in difficult conversations with citizens on how they wish to be cared for and where they want to be cared for, and
on different end-of-life care options. For patients with incurable conditions, these options should not include assisted suicide, but should include greater utilisation of hospice and advance care planning services where healthcare providers focus on providing enough pain relief, coordinating treatment across different specialists, allowing people to be cared for at home where possible, and ensuring that patients close to the end of their lives receive high quality care and have the option to die close to their loved ones rather than at the ICU.

Fostering new norms for an ageing society is arguably the hardest adaptive challenge facing Singapore. This challenge cannot be addressed simply by government spending more or doing more. Similarly, changes to the healthcare financing regime are only viable if they command the support of broad swathes of society. More so that before, leaders in healthcare will have to engage in an ongoing dialogue with Singaporeans on the trade-offs that an ageing population brings; on the difficult shifts that the government is trying to make in our health care systems; on the changing roles of the state, the community and individuals; and on the limits of medicine. Not only will such a dialogue help to shape citizens’ expectations of what the state should do as our population ages, but it will also foster a stronger sense of citizenship and ownership of the challenges of an ageing society.

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