MINISTRY OF HEALTH
SINGAPORE

MOH COS 2021 FACTSHEET

# TARGETING HEALTHCARE SUBSIDIES TO THOSE WHO NEED IT MORE

The Ministry of Health (MOH) will introduce a set of changes to the means-tested subsidy frameworks for inpatient care at acute hospitals (AH) and community hospitals (CH), as well as Specialist Outpatient Clinic (SOC) care, to ensure that our subsidies are better targeted towards those who need it more. These changes will be implemented in mid-2022.

2. Healthcare expenditure is expected to rise over time with our ageing population, rising incidence of chronic diseases, and improvements in the accessibility and quality of care, even as the government continues to work on managing costs. In FY20, government expenditure on patient subsidies is projected to be $6.5 billion compared to $4 billion five years ago. The government will continue to set aside an increasing healthcare budget over time to support the needs of our population. At the same time, we must ensure that our resources are distributed in a manner that better targets those who need greater support. Our subsidy frameworks must also support patients to access care at the most appropriate healthcare settings. These changes to the subsidy framework finetune our system to achieve these objectives.

3. With the changes, all patients will continue to be able to choose subsidised care at public healthcare institutions. Taken together, the changes do not result in a reduction in government expenditure on patient subsidies. The government will continue to spend more on healthcare subsidies in the coming years as our healthcare needs grow. Together with the 3Ms (MediSave, MediShield Life and MediFund), subsidies will continue to be a key pillar in ensuring that healthcare is affordable for all Singaporeans.

## Changes in the Acute Inpatient Subsidy Framework

4. Today, the basis of means-testing in the acute inpatient setting is a patient's individual monthly income. In all other healthcare settings, MOH uses per capita household income (PCHI) which better reflects the means of the patient, as it takes into account the overall financial resources of the household against the number of household members who are supported by that income. For example, an income-earner supporting a family of four will get more subsidies than an income-earner with the same income but with just one dependent when PCHI is used. **MOH will change the basis of means-testing in the acute inpatient setting from individual monthly income to PCHI**[1]. This alignment will ensure that subsidies are better directed towards those who need it more. As PCHI is already the basis of means-testing in all other

[1] Monthly PCHI is computed as the total gross household monthly income divided by the total number of family members living together in the household. Gross monthly household income includes basic employment income, trade/self-employed income, overtime pay, allowances, cash awards, commissions, and bonuses.

healthcare settings, it will also encourage care to be sought at the most appropriate setting, and avoid disadvantaging the patient with a different subsidy status as he moves across different care settings.

5. **MOH will also adopt a single common subsidy framework for B2 and C wards**. Today, B2 wards are subsidised at 50% to 65% of the hospitalisation bill, and C wards at 65% to 80%. With the adoption of PCHI, we now have a better basis for means-testing in the acute inpatient setting and no longer need to rely on our legacy system of using ward choice as a proxy of means, to differentiate the levels of subsidies. Furthermore, as physical differences between B2 and C wards have narrowed due to changes in ward configurations driven by improvements in patient safety and infection control standards, the ward choice has also become an inadequate proxy of means.

6. The revised common subsidy framework that will apply to both subsidised B2 and C wards will continue to range from 50% to 80%. There is **no change to the maximum and minimum subsidy levels**, as the purpose of the revision is to better target subsidies. Patients can continue to choose between B2 and C wards. While the subsidy level that any given patient will be eligible for will be the same whether he chooses B2 or C ward, the C ward charges will continue to be lower than B2 ward charges. The acute inpatient subsidy framework will also be applied to day surgeries where subsidies are 65% today.

7. The majority of patients subject to the inpatient subsidy framework will not see a change in their Out-Of-Pocket (OOP) payments[2]. About 30% of patient bills, mainly from households with lower PCHI, will see a median decrease in OOP by about $150. This includes day surgery bills, where 70% will see higher subsidies. 15% of patient bills, mainly from households with higher PCHI, will see a median increase by about $200.

### *Changes in the Community Hospital Subsidy Framework*

8. CHs play an increasingly important role in our healthcare landscape. Key services they provide include sub-acute care[3] for patients who have been medically assessed to no longer require the more intensive care provided in AHs, as well as rehabilitation care for patients who require an extended period of rehabilitation to regain functional abilities. Average daily bill sizes are smaller at CHs and subsidy levels are therefore also lower.

9. **To facilitate right siting of patients, MOH will therefore enhance subsidies in CHs[4]**. The maximum subsidy level at the CH will be raised and aligned with that of acute inpatient at 80% of the hospitalisation bill. The minimum subsidy level at the CH will also be raised to 30%. Overall, almost all patients will see an increase in subsidies. The revised community hospital subsidy framework will apply to sub-acute and rehabilitative care at CHs.

[2] OOP in the AH setting was computed after factoring in coverage by MediShield Life and MediSave.
[3] Sub-acute care at community hospitals is for complicated medical conditions that require additional medical and nursing care, but at a lower intensity compared to acute hospitals.
[4] Applicable to sub-acute and rehabilitation care at community hospitals.

10. With the community hospital subsidy changes, 95% of sub-acute and rehabilitation patients are expected to benefit from higher subsidies. After accounting for MediShield Life claims, close to 60% of CH patient episodes will see a fall in co-payment[5], with the median decrease in co-payment at about $120.

***Changes in the Specialist Outpatient Clinic Subsidy Framework***

11. In 2014, MOH enhanced SOC subsidies for lower-income families, who now can enjoy subsidies of 60% or 70% of their SOC bills. For all other patients, subsidies are at 50%. This means that both median and higher-income households enjoy the same level of subsidies even though they have different means.

12. MOH will **introduce two new subsidy tiers in the SOC setting for patients whose PCHI is above $3,300.** For those with PCHI above $3,300 and not more than $6,500, subsidies will be set at 40%. For those with PCHI more than $6,500, it will be set at 30%. For a family of 4, these PCHI levels correspond to household incomes of $13,200 and $26,000 a month respectively. These changes will allow resources to be distributed to those who are of greater need. Nonetheless, higher-income households will continue to be eligible for SOC subsidies and be able to tap on MediSave up to the applicable withdrawal limits to help pay for their healthcare bills. MediShield Life also remains available for selected costly outpatient treatments. With the introduction of the Community Health Assist Scheme (CHAS) Green tier in 2019, higher PCHI patients with chronic conditions also have access to subsidised chronic care at CHAS General Practitioner (GP) clinics as an alternative. Complex chronic patients who are not suitable for management at primary care will also be able to avail of the higher MediSave limits that have been introduced for such patients.

13. With better targeted subsidies at SOCs, MOH will also make it easier for patients to access subsidised SOC consultations. Today, patients who opt for private wards in public hospitals (i.e. A or B1 wards) are not eligible for subsidies in SOCs should they require follow-up SOC visits after their discharge. Some of these patients who require a long tail of post-discharge SOC follow-ups have concerns over affordability. In view of the above, MOH will **allow private patients in the inpatient setting to opt for subsidised follow-up care at the SOCs** based on the means testing framework.

14. As a result of the SOC subsidy changes, about 30% of all subsidised SOC patients, mainly from higher PCHI households, will see an increase in their bills, of which 7 in 10 will see an increase of less than $100 in total co-payment[6] in a year. For some of these patients, the changes will not translate into higher OOP if they are able to tap on MediSave or MediShield Life. For Pioneer Generation (PG) and Merdeka Generation (MG) seniors, any increase in co-payment will be partially offset by larger PG or MG subsidies.

15. About 20% of inpatient admissions today are to private wards. These patients will now benefit from the option of subsidised follow-up care at SOCs.

[5] The co-payment in the CH setting was computed after factoring in coverage by MediShield Life.
[6] Co-payment in SOCs does not factor in coverage by MediShield Life and MediSave.

16. The full details of the subsidy frameworks in the various settings are provided in **Annex A**. To allow time for details to be finalised as well as for the necessary changes to IT systems to be completed, the subsidy changes will be implemented in mid-2022. MOH will announce the effective start date(s) of the new subsidy frameworks nearer the implementation dates.

17. Please refer to **Annex B** for an illustration of the impact of the subsidy changes on typical households.

***Enhancing Flexi-MediSave to Better Support Elderly Patients***

18. From 1 June 2021, the Flexi-MediSave limit will be raised from $200 per year to $300 per year to better support elderly patients. This enhanced limit will reduce out-of-pocket payments and better support elderly patients in the outpatient setting.

19. The Flexi-MediSave scheme allows patients aged 60 and above to withdraw from their own, or their spouse's MediSave Accounts to pay for outpatient expenses at polyclinics, public SOCs and CHAS GP clinics. The scheme may also be used in conjunction with other outpatient MediSave schemes, such as MediSave500 and MediSave700.

20. MOH will continue to review our MediSave schemes to ensure that they remain relevant and adequate for all Singaporeans. Recent changes include introducing cash withdrawals under the new MediSave Care scheme from October 2020 for those who are severely disabled to support their long-term care needs. The annual limit on MediSave withdrawals for patients with complex chronic conditions under the Chronic Disease Management Programme was also raised to $700 with the introduction of MediSave 700 since January 2021.

***Ensuring healthcare remains affordable***

21. Over the last few years, we have enhanced our existing healthcare financing and subsidy schemes, and introduced new ones, to ensure access to affordable healthcare. These include introducing Flexi-MediSave, CareShield Life, MediSave Care, and ElderFund; and enhancing MediShield Life and CHAS. In October 2019, we also implemented a revision in income criteria for all schemes and services that were means-tested using the PCHI criteria, which saw more than 365,000 Singapore Residents benefitting from higher subsidies.

22. These latest comprehensive subsidy changes will allow us to ensure our subsidies are progressive, so that those with more need, especially lower to middle income households, will receive the support they need, while also encouraging patients to seek care at settings appropriate to their medical needs. It will also make for more streamlined healthcare system.

23. MOH is committed to ensuring that healthcare remains affordable for all Singaporeans. Patients who require financial assistance after government subsidies, insurance and MediSave will continue to be able to apply for MediFund assistance and other financial assistance schemes through medical social workers.

**Annex A**

## Details of the Subsidy Frameworks in Acute Hospitals, Community Hospitals, and Specialist Outpatient Clinics

Table A1 shows the revised subsidy framework for Inpatient B2 and C wards, as well as Day Surgery, for Singapore Citizens (SCs).

**Table A1**: Day Surgery, and Inpatient B2 and C subsidy framework for SCs

| Monthly PCHI[7] | Subsidy |
| --- | --- |
| No PCHI | AV[8] ≤ $13k: 80%<br>AV > $13k: 50% |
| $0 < PCHI ≤ $1,800 | 80% |
| $1,800 < PCHI ≤ $2,000 | 75% |
| $2,000 < PCHI ≤ $2,200 | 70% |
| $2,200 < PCHI ≤ $2,500 | 65% |
| $2,500 < PCHI ≤ $2,800 | 60% |
| $2,800 < PCHI ≤ $3,100 | 55% |
| PCHI > $3,100 | 50% |

Table A2 shows the revised Community Hospital (CH) subsidy framework for SCs.

**Table A2**: CH subsidy framework for SCs

| Monthly PCHI | Subsidy |
| --- | --- |
| No PCHI | AV ≤ $13k: 80%<br>AV > $13k: 30% |
| $0 < PCHI ≤ $1,200 | 80% |
| $1,200 < PCHI ≤ $2,000 | 70% |
| $2,000 < PCHI ≤ $2,200 | 60% |
| $2,200 < PCHI ≤ $2,800 | 50% |
| $2,800 < PCHI ≤ $3,300 | 40% |
| PCHI > $3,300 | 30% |

[7] Monthly PCHI is computed as the total gross household monthly income divided by total number of family members living together in the household. Gross monthly household income includes basic employment income, trade/self-employed income, overtime pay, allowances, cash awards, commissions, and bonuses.

[8] Annual value (AV) is the estimated gross annual rent of a property if it were to be rented out, excluding furnishings and maintenance fees. It is determined by the Chief Valuer's Office based on estimated market rentals of similar or comparable properties, and not on the actual rental income received. All references to AV refer to AV of the patient's residence.

Table A3 shows the new Specialist Outpatient Clinic (SOC) subsidy framework for SCs.

**Table A3**: SOC subsidy framework for SCs

| Monthly PCHI | Subsidy |
|---|---|
| **No PCHI** | AV ≤ $13k: 70%<br>$13k < AV ≤ $21k: 50%<br>AV > $21k: 30% |
| **$0 < PCHI ≤ $1,200** | 70% |
| **$1,200 < PCHI ≤ $2,000** | 60% |
| **$2,000 < PCHI ≤ $3,300** | 50% |
| **$3,300 < PCHI ≤ $6,500** | 40% |
| **PCHI > $6,500** | 30% |

**Annex B**

## Illustration of the Impact of Subsidy Changes on Typical Households

The impact of the subsidy changes on different households living in public housing is illustrated below. For SOCs, the OOP impact shown could be smaller with the use of MediSave or with MediShield Life coverage. The different household types are:

(i) Elderly couple with low income
(ii) Three-generation, median-income household
(iii) Two-generation, high-income household

**(i) Elderly couple with low income**

Total monthly household income: $1,200
Per capita household income: $600
Expected change in annual OOP: ↓$82
Total amount of subsidies received by household:

- Before the subsidy changes: ~$8,800 (Subsidy per household member: ~$4,400)
- After the subsidy changes: ~$8,900 (Subsidy per household member: ~$4,450)

| Household Members | Income | Healthcare Utilisation | Current Subsidy Level | Subsidy Level After Changes | Change in Annual OOP[9] |
|---|---|---|---|---|---|
| 73 year-old male | $0 | 1 C ward inpatient stay | 80% | 80% | - |
| | | 1 follow on CH stay | 75% | 80% | ↓$82 |
| | | 8 SOC visits | 70% | 70% | - |

[9] OOP in the inpatient and CH settings factor in coverage by MediShield Life and MediSave, while OOP in the SOC setting does not. This is because the availability of applicable MediShield Life and MediSave limits at SOCs depends on the condition that the patient is being managed for.

| 63 year-old female | $1,200 | 8 SOC visits | 70% | 70% | - |
|---|---|---|---|---|---|

The inpatient and SOC changes will not affect this elderly couple. They continue to receive maximum subsidies after the changes. The enhancement in community hospital subsidy framework will reduce their OOP and contribute to the timely transfer of the male elderly member to the community hospital when he is medically assessed to be ready to do so.

**(ii): Three-generation household earning median income**

Total monthly household income: $12,000
Per capita household income: $2,000
Expected change in Annual OOP: ↓$267
Total amount of subsidies received by household:

- Before the subsidy changes: ~$9,300 (Subsidy per household member: $1,550)
- After the subsidy changes: ~$10,200 (Subsidy per household member: $1,700)

| Household Members | Income | Healthcare Utilisation | Current Subsidy Level | Subsidy Level After Changes | Change in Annual OOP[10] |
|---|---|---|---|---|---|
| 67 year-old male | $0 | 1 C ward inpatient stay | 80% | 75% | ↑$234 |
| | | 1 follow on CH stay | 50% | 70% | ↓$15 |
| | | 8 SOC visits | 60% | 60% | - |
| 65 year-old female | $1,500 | Nil | - | - | - |

[10] OOP in the inpatient and CH settings factor in coverage by MediShield Life and MediSave, while OOP in the SOC setting does not. This is because the availability of applicable MediShield Life and MediSave limits at SOCs depends on the condition that the patient is being managed for.

| | | | | | |
|---|---|---|---|---|---|
| 40 year-old male | $8,500 | 1 B2 ward inpatient stay | 50% | 75% | ↓$486 |
| | | 4 SOC visits | 60% | 60% | - |
| 38 year-old female | $2,000 | Nil | - | - | - |
| 12 year-old male | $0 | Nil | - | - | - |
| 9 year-old female | $0 | Nil | - | - | - |

In this household, the primary breadwinner earns a relatively high individual income, which means that he would have been accorded lower subsidies for his acute hospital admission. However, the primary breadwinner has many dependents, as is common in sandwiched families. When PCHI is adopted in the acute inpatient setting, he will thus receive more subsidies. The retired elderly male in the family receives lower subsides as it is now recognised that he has access to support from the rest of his household. Overall, OOP is reduced for this median-income household.

**(iii): Two-generation household earning high income**

Total monthly household income: $28,000
Per capita household income: $7,000
Expected change in Annual OOP: ↑$152
Total amount of subsidies received by household:

- Before the subsidy changes: ~$2,700 (Subsidy per household member: $675)
- After the subsidy changes: ~$2,500 (Subsidy per household member: $625)

| Household Members | Income | Healthcare Utilisation | Current Subsidy Level | Subsidy Level After Changes | Change in Annual OOP[11] |
|---|---|---|---|---|---|
| 49 year-old male | $16,000 | Nil | - | - | - |
| 48 year-old female | $12,000 | 1 B2 ward inpatient stay | 50% | 50% | - |
| | | 1 follow on CH episode | 20% | 30% | ↓$11 |
| | | 4 SOC visits | 50% | 30% | ↑$163 |
| 18 year-old male | $0 | Nil | - | - | - |
| 15 year-old female | $0 | Nil | - | - | - |

Improved targeting of subsidies will result in a reduction of subsidies for this high PCHI household. This is slightly mitigated by an increase in CH subsidies. The OOP increase in the SOC setting could be smaller if MediSave usage or MediShield Life are applicable. Overall, the increase in annual healthcare OOP is small relative to the household's income. Even after the changes, this household would still be eligible to receive $2,500 in healthcare subsidies.

[11] OOP in the inpatient and CH settings factor in coverage by MediShield Life and MediSave, while OOP in the SOC setting does not. This is because the availability of applicable MediShield Life and MediSave limits at SOCs depends on the condition that the patient is being managed for.