Enhancing Universal Health Coverage through Public-Private Partnerships in Primary Care - The Case of Community Health Assist Scheme in Singapore

Executive Summary

Singapore’s healthcare financing system functions on the twin philosophies of individual responsibility and affordable healthcare for all. The 3Ms (MediSave, MediShield and MediFund) have been the means in which the Singapore government ensures majority of the Singaporeans have access to good healthcare. However, the healthcare financing system has been deemed increasingly inadequate. High levels of out-of-pocket payment are required for primary care in Singapore as Singapore’s healthcare financing system is skewed towards supporting the acute sector. This has led to low-income Singaporeans to delay seeking timely and much needed treatment. Given the importance of primary care, it is important to make that the consumption of primary care is at a socially optimum level. The Community Health Assist Scheme (CHAS) is a public-private partnership collaboration to provide middle to low-income Singaporeans with government subsidies to seek treatment in private primary care clinics. This is to encourage them to manage their conditions early and alleviate the problem of long wait times in the public polyclinics.

An Overview of the Singapore Healthcare Financing System

A nation whose policy making milieu is strongly against the disbursement of generous welfare benefits, healthcare in Singapore is not free, rather the nation’s healthcare financing system functions on the twin philosophies of individual responsibility and affordable healthcare for all. The national healthcare expenditure has long stood at 3-4 per cent of Singapore’s Gross Domestic Product (GDP). Yet, the little island state has managed to put together a system that is worthy of international accolades for its performance. In a 2000 World Health Organization (WHO) study of world’s health systems, Singapore was ranked sixth out of 191 countries on health systems performance. More recently in 2010, the IMD’s World Competitiveness Yearbook ranked Singapore’s health infrastructure third out of 55 countries.

The Singapore healthcare system is a mixed service delivery model with a co-payment policy. About 80 per cent of acute care services are provided by the public sector, the government also subsides up to 80 per cent of the bill in public acute hospital wards. In the primary care sector, private General Practitioners (GPs) provide about 80 per cent of the primary care services; with the rest being offered by public polyclinics. Polyclinics are one-stop healthcare centres offering subsidised primary care to all Singaporeans, an average consultation fee per visit is about $10.50. Singaporeans age 65 years and above, all schooling children and children up to 18 years of age receive at 75% concession on their consultation and treatment fees. All other Singapore citizens regardless of their income level are given a 50% concession.

Chief to understanding the healthcare financing system in Singapore is to examine the Central Provident Fund (CPF). Employers and employees contribute a percentage of an individual’s wages to the person’s individual CPF account; and this can be withdrawn for an individual’s
retirement when the person turns 55, and when the CPF Minimum Sum (MS) requirements are met. The monthly CPF contribution is then allocated in varying proportions into three accounts – Ordinary Account, Special Account and Medisave. Every employee contributes 7% - 9.5% (depending on age group) of his/ her monthly salary to a personal Medisave account. Medisave forms the cornerstone of the healthcare financing system and is used to meet their personal or their dependants' healthcare expenses, especially during retirement. Medisave can be used to pay for the hospitalisation and certain outpatient expenses.

Along with the Medisave, there is MediShield which covers hospitalisation bills for treatment of catastrophic illnesses or prolonged hospitalisations at Class B2/C wards in restructured hospitals as well as certain approved outpatient treatments. For additional coverage that will allow for treatment in private hospitals or in Class A/B1 wards in restructured hospitals, individuals can purchase a Medisave-approved Integrated Shield Plan (IP). This is an enhancement plan offered by a private insurer and the premiums for an IP can be paid using Medisave. Finally there is the Medical Endowment Fund (Medifund) which is an endowment set up by the Singapore government to help needy Singaporeans to pay for their medical expenses despite having the subsidised rates at restructured hospitals and the existence of Medisave and MediShield. Together, they form the 3Ms of the Singapore healthcare financing system and have been a major means by which the Singapore government ensures majority of the population have access to good medical care.

Table 1 below provides a breakdown of Singapore’s total health expenditure. The breakdown shows that Singapore has a particularly low share of government expenditure on health, with the bulk of it being private expenditure. Singaporeans rely extensively on out-of-pocket payments to finance their healthcare, with at least 50 per cent of total healthcare expenditure being borne by out-of-pocket payments. However in 2010, data indicated that the out-of-pocket payments as a share on total health expenditure for OECD nations averaged 20.1 per cent; while the public expenditure’s share on total health expenditure for OECD nations averaged 72.2 per cent. In contrast, the public expenditure’s share on total health expenditure in Singapore stood at 36.3 per cent in 2010. The share of public expenditure on total health expenditure has indicated an upward trend over the years, and this poses critical public policy questions on the sustainability of the current financing model. Although the share of out-of-pocket payments on total health expenditure has shown a downward trend over the years, out-of-pocket payments still form the bulk of total health expenditure. This also raises public policy questions on efficiency, equity and adequacy of Singapore’s healthcare system.

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1 Dependants refer to spouse, children, parents and grandparents. Grandparents must be Singaporeans or Singapore Permanent Residents.
2 The term 3Ms refer collectively to Medisave, MediShield and Medifund.
Table 1: Singapore’s Healthcare Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Expenditure, total (% of GDP)</td>
<td>3.3</td>
<td>3.2</td>
<td>3.6</td>
<td>4.1</td>
<td>4.0</td>
</tr>
<tr>
<td>Health Expenditure, public (% of GDP)</td>
<td>1.0</td>
<td>1.0</td>
<td>1.1</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Health Expenditure, private (% of GDP)</td>
<td>2.3</td>
<td>2.2</td>
<td>2.5</td>
<td>2.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Health Expenditure, public (% of total health expenditure)</td>
<td>30.1</td>
<td>29.8</td>
<td>31.9</td>
<td>36.1</td>
<td>36.3</td>
</tr>
<tr>
<td>Out-of-pocket health expenditure (% of total health expenditure)</td>
<td>60.2</td>
<td>60.1</td>
<td>58.4</td>
<td>54.6</td>
<td>54.0</td>
</tr>
</tbody>
</table>


Challenges to Singapore’s Healthcare Financing System

The 3Ms have been the means in which the Singapore government ensures majority of the Singaporeans have access to good healthcare. However, the healthcare financing system has been deemed increasingly inadequate. Firstly, with the increased life expectancy of the average Singaporean, the sufficiency of the amount saved in individual Medisave accounts has been a source of concern. In 1980, the life expectancy of a Singaporean at age 65 years was 12.6 years for male and 15.4 years for female. By 2010, the projected life expectancy at age 65 years had increased to 18.1 years and 21.5 years for males and females respectively. The additional years lived often mean that they are faced with an extended period of medical expenses, and most likely without a steady income stream that will contribute regularly into their Medisave accounts.

Singapore therefore has to cope with the impact of an ageing population. In 2011, 9.3 per cent of its population was age 65 years and above. By 2030, it is estimated they will form 18.7 per cent of the population. This growth in the elderly population is expected to escalate when the first batch of baby boomers starts turning 65 years old in year 2012, and this marks the beginning of a rapid phase of the Singapore society’s demographic transition into an elderly population. The healthcare system is set to be put to test as older persons are expected to consume more healthcare. With a rising proportion of the Singapore population to be above 65 years of age, this will have huge implications on the organization and delivery of healthcare and ultimately financing.

Secondly, an ageing population will require a focus on chronic diseases. This means that the delivery of healthcare will shift from episodic delivery to correct an illness at a point in time to the long-term management of chronic conditions as well as comorbidities. The long-term costs of outpatient treatment and management of chronic diseases will be extremely debilitating to
an individual as these are not covered by MediShield. Although Medisave allows for the coverage of outpatient treatment, these cover a selected range of conditions and are subjected to withdrawal limits. This means that it may require out-of-pocket payments if the condition is not covered or exceeds the withdrawal limit. It is also essential to point out that Medisave is a form of private expenditure, and the amount that one has is dependent on his/her earning capacity to generate savings in their Medisave account.

Thirdly, with medical advances expected to push up medical costs, the total national healthcare expenditure is simultaneously set to increase. The Ministry of Health (MOH) has attempted to rein in costs by making public the costs of treatment and procedures for certain conditions among public hospitals to encourage competition and transparency. This has successfully brought down the costs of certain procedures like LASIK, however it is unclear that cost savings is a result of price wars and/or efficiency improvements in the surgical process. The Pharmaceutical Society of Singapore also publishes a price list of drugs for common conditions; such price lists can remove information asymmetries and encourage physicians and pharmacists to prescribe generic drugs when available and cheaper.

**Shortcomings in Singapore’s Healthcare Financing Policies**

The government is well-aware of these challenges and has made efforts to address them. In the 2012 Budget, the Singapore government pledged to double their healthcare expenditure from $4 billion to $8 billion over the next five years. The increased budget will be aimed at ramping up healthcare capacity, increasing healthcare affordability and paying healthcare professionals more competitively. At this critical juncture of the boom of “silver-heads” that is set to take place, this has been deemed a necessary healthcare expansion. However, this does not deal with the fundamental problems underlying Singapore’s healthcare financing system. There remains a limit to which the government can continually increase their health expenditure.

1. **Adequacy**

To guide Singaporeans into being individually responsible for their healthcare expenditure, Medisave and MediShield have undergone repeated reformulation with incremental changes made to the schemes to ensure financial adequacy for the healthcare of Singaporeans. These include instituting the Medisave Minimum Sum (MMS) requirement, which is the amount an individual needs to maintain in his/her Medisave account before they can withdraw the excess at the CPF drawdown age. This amount has been raised progressively over the years to adjust for inflation and to the needs of rising longevity. Most recent measures from the 2012 Singapore Budget to help Singaporeans included a one-off Medisave top-up to all MediShield-insured Singaporeans. However, many Singaporeans struggle to meet the MMS requirement. In 2011, approximately 55 per cent of active¹ Singaporean citizens and Permanent Residents (PR) managed to meet the MMS requirement (CPF Trends Feb 2012). The ability to meet the MMS requirement is ultimately dependent on one’s earning ability, and for a low-wage worker to

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¹ This is defined by CPF as persons who have at least one CPF contribution paid for them in any of the four months preceding their birth month.
attain the MMS might be an uphill endeavor. The issue of healthcare financing in Singapore is therefore triangulated with the issue of inclusive economic growth for all Singaporeans.

2. Equity
The Singapore government touts having universal health coverage, however this remains disputable as the co-payment element of the healthcare financing system has posed barriers for the low-income into seeking healthcare. The out-of-pocket expenditure as a share of private expenditure is substantial in Singapore, and the figure was 84.8 per cent in 2010. The co-payment policy was intended to prevent moral hazard and curtail wastage. But it has become an inhibition to the poor seeking medical treatment or rehabilitation, leading to over-rationing of medical resources to patients who are truly in need of them. This has been deemed detrimental to the health status of the poor as they delay medical treatment and spiral into more critical conditions; or medical rehabilitation that is pivotal to a full recovery is not sought and patients relapse.

3. Allocative Efficiency
The current financing model is heavily biased towards public hospitalization, misaligning the incentives towards institutionalization in public hospitals. This neglect the healthcare needs at the other points of the healthcare spectrum. For one, the primary care sector which forms the cornerstone of every good healthcare system is however left mostly into the hands of private operators and requires out-of-pocket payments. Although polyclinics are public facilities that offer primary care, these clinics are few in number relative to private clinics and serve a huge population. Long wait-times much to the discomfort and inconvenience of patients are not uncommon at polyclinics. Moreover, a system of means-testing does not exist in these polyclinics and blanket subsidies are offered to Singaporean citizens regardless of their income levels. This has inadvertently benefited some high-income patients who do not mind the long-wait times and opt to have their treatment or check-ups in polyclinics where it is subsidised. A 2010 study of the primary care sector showed that 15 per cent of the patients living in private apartments or houses sought subsidised treatment in polyclinics (see Table 2). This is a three percentage point increase from 2005, thus suggesting that increasing number of high-income Singaporeans are unfairly benefitting from subsidised primary healthcare. The system of financing for primary care in Singapore is therefore regressive and inequitable.

Table 2: Primary Care Patient Visits by Housing Type

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th>Polyclinics</th>
<th>Private GP Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDB 1-3 room</td>
<td>2005</td>
<td>27%</td>
<td>73%</td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>28%</td>
<td>72%</td>
</tr>
<tr>
<td>HDB 4-5 room/ multi-generation/ executive/ HUDC</td>
<td>2005</td>
<td>24%</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>22%</td>
<td>78%</td>
</tr>
<tr>
<td>Private apartment/ house</td>
<td>2005</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>15%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, 2010
At the other end of the healthcare continuum, the long-term care sector has been overlooked and the responsibility devolved to private and non-profit operators. With the changing disease profile due to an ageing population, in recent years the government has committed to building more nursing homes to deal with the shortage from increased demand. However, the government has yet to restructure the financing model for the use of long-term care services. At present, neither Medisave nor MediShield covers long-term care. Low-income elderly are entitled to appeal to Medifund for subsidies, and the other alternative scheme for older Singaporeans is ElderShield – an insurance scheme that offers basic financial protection to those who need long-term care. Under this scheme, members receive a monthly pay-out of $400 for a maximum period of 72 months. However, this is proving inadequate as the need for long-term care is more often than not costly, and may span more than a period of six years. The ElderShield is currently under government review, and it is expected that there will be an enhancement in the pay-outs. For needy and disabled elderly Singaporeans who are unable to join ElderShield because of their age or pre-existing disabilities, the Interim Disability Assistance Programme for the Elderly (IDAPE) exists to help provide some form of subsidy. However, the disbursements are highly inadequate and up to a maximum of 72 months only. Under the IDAPE, for applicants whose household per capita income is $1501 - $2200 receives $150 monthly, and for applicants whose household per capita income is $1500 and below receives $250 monthly.

The Primary Care Sector in Singapore
The major failure of Singapore’s healthcare financing system is in its oversight of the primary care sector. Financial resources can be better directed at supporting treatment in the primary care sector. Numerous studies have generated strong evidence that primary care is associated with a more equitable distribution of health in populations. The lack of access to primary care has also been linked to increased hospitalization, delays in seeking needed and timely preventive care, greater emergency department admissions and to higher mortality and healthcare cost, and are less likely to seek medical treatment in the face of symptoms (Starfield et al, 2005). Clearly, evidence for a healthcare system with a strong primary care base is abundant and consistent.

Apart from the 18 public polyclinics, private GPs are geographically well-situated to service the Singapore population. Private GPs operate in all residential estates across Singapore, and it is not uncommon to see multiple clinics compete within a residential estates. The private primary care sector is therefore infrastructurally ready to play a bigger role in proving primary care. In examining the market share of the public and private sector in primary care, Table 3 below reveals that for “sick” visits, 20 per cent of the visits are serviced by polyclinics and 80 per cent by private GP clinics. The situation is roughly similar for “well” visits, with 10 per cent being served by polyclinics and 90 per cent by private GP clinics. However in the case of treating chronic conditions, polyclinics are responsible for 45 per cent of the visits and private GP clinics handle 55 per cent of the conditions. This suggests that there can be a greater role for private GP clinics in helping management of chronic conditions.
Table 3: Market Share of Visit Types in Primary Care Sector

<table>
<thead>
<tr>
<th></th>
<th>Polyclinics</th>
<th>Private GP Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Attendances</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>19%</td>
<td>81%</td>
</tr>
<tr>
<td><strong>Sick Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Well Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Chronic Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>45%</td>
<td>55%</td>
</tr>
</tbody>
</table>

Source: Ministry of Health, 2010

1. “Sick” visits are made by patients with medical complaints.
2. “Well” visits are made by patients who come for immunization, pre-employment medical check, preventive care for females, developmental assessment for children, family planning visits etc.
3. Chronic conditions refer to conditions that require long-term follow-up and in general, regular medication and management of risk factors such as hypertension, asthma and chronic obstructive lung disease, diabetes and cancers.

**A Policy Innovation: Public-Private Partnership of Primary Care**

The government has sought to enhance the use of primary care through the introduction of the Community Health Assist Scheme (CHAS)\(^4\). CHAS is offered to “middle to lower income Singaporeans, aged 40 and above or disabled, to receive subsides for medical care for chronic conditions and/or common illnesses as well as dental services at participating private General Practitioners (GPs) and dental clinics near their homes” (CHAS, 2012). The scheme was intended to ease the long waiting times at polyclinics by diverting some of the patient traffic to private providers as well as to help Singaporeans better manage their chronic conditions by enabling convenient access to healthcare. In addition, CHAS works with the Chronic Disease Management Program (CDMP)\(^5\). This enables patients to use Medisave for outpatient treatment of the list of chronic conditions covered under the CHAS.

Singaporeans with per capita household monthly income of $1500 and below; or economically inactive households with the annual value of their property $13,000 and below are eligible to apply for the scheme. Successful applicants will receive either a blue or orange Health Assist card depending on the per capita household monthly income (See Exhibit 1). The Health Assist card is valid for two years. There are two tiers of subsidies offered under the CHAS, and are differentiated according to card colour held by the applicant (See Exhibit 2 for the complete list of subsidy coverage). The Blue Health Assist card is issued to individuals with per capita household monthly income of $900 and below; or households with no income will be assessed

\(^4\) CHAS was formerly known as the Primary Care Partnership Scheme (PCPS). PCPS was first introduced in January 2009. The scheme was re-launched as CHAS in 2012.

\(^5\) A total of ten diseases are covered under the CDMP, these include: diabetes mellitus, hypertension, hyperlipidemia (lipid disorders), stroke, asthma and chronic obstructive pulmonary disease (COPD), schizophrenia, major depression, bipolar disorders and dementia.
by the annual value of their property which should be $13,000 and below. Blue Health Assist Card holders get up to $18.50 in subsidy for treatment of common illness; and annual subsidy of up to $320 or $480\(^6\) (depending on the severity of one’s condition) for chronic conditions. The Orange Health Assist card is issued to individuals with per capita household monthly income of $900 above but less than or equal to $1500. Orange Health Assist card holders are not entitled to subsidy for treatment of common illnesses, however they receive an annual subsidy of up to $200 or $300\(^7\) (depending on the severity of one’s condition) for chronic conditions.

The introduction of CHAS thus signalled a significant and innovative rethink by the Singapore government towards the greater engagement of private GPs in the provision of primary care. The government has long held the view that the free market forces will compel GPs to be competitive and ensure cost efficiencies, thereby keeping the cost of healthcare low. A large private primary care sector will also guard against the overconsumption of healthcare as patients are required to pay from out-of-pocket. However, it is clear that the consumption of primary care is not at the socially optimum level and therefore a subsidy is required to encourage its consumption. The merits of CHAS are therefore as follow:

1. CHAS taps on the existing network of private providers in place to provide primary care. Given that long-wait times in polyclinics have been an endemic problem, the building of more polyclinics will be a viable but costly solution to the problem. CHAS removes the need to incur developmental expenditure while mitigating the problem of long-wait times in polyclinic in a shorter time frame.

2. CHAS is a way of bringing primary healthcare to Singaporeans rather than having them go seek it. It is a way of reducing traveling times and providing convenience for those who are already unwell. In particular for low-income Singaporeans, CHAS increases access their access to primary care services by reducing the sum of out-of-pocket payment required from them.

3. Numerous studies have demonstrated the impact of primary care on the early management of health problems. GPs are capable of providing superior care as unlike specialists, they are trained to look at the condition in the context of the patient’s other health problems or concerns not just a particular morbidity. Hence GPs are well-equipped to handle most chronic conditions which are often lifestyle related diseases such as diabetes, hypertension and hyperlipidemia. For chronic conditions such as dementia, schizophrenia and depression, the ability of GPs to build long-term relationships with their patients close also ensures that there is continuity of care and better management of their conditions. By linking the CHAS with the CDMP, it ensures that middle to low-income patients can reap the benefits from a regular source of care and not delay seeking needed and timely care for their chronic conditions due to costs. Other possible benefits also include fewer diagnostic tests and fewer hospitalizations and visits to emergency departments as a regular source of care from GPs enables doctors to recognize their patient’s problems early.

\(^6\) Subsidy is capped at $80 per visit for Blue Health Assist Card Holders.

\(^7\) Subsidy is capped at $50 per visit for Orange Health Assist Card Holders.
4. The CHAS employs a two-tiered system of subsidies so that it can offer targeted subsidies to those who truly need financial aid. While providing for the low-income, CHAS also takes into consideration of the middle class who are increasingly struggling with the rising cost of standard of living. Also known as the “sandwich class”, they often fail to qualify for government aid as their income level exceeds the income ceiling. This group needs some support however they are not destitute. The two-tiered system of subsidy adopted by CHAS is therefore allocatively efficient as it ensures that aid is given at appropriate levels to one’s needs.

5. The CHAS limits the claimable amount for its Health Assist card holders. This prevents moral hazard as users are compelled to use it when needed lest they exceed the limit before each calendar year. The scheme also exercises discretion by allowing patients with more severe conditions higher claimable limits.

**Lessons for Asia**

The issue of adequacy, equity and allocative efficiency are complex issues that governments across the world contend with. As Adam Smith rightly pointed out, the fundamental economic problem is the issue of “unlimited wants and limited means”. The unbridled increase in health expenditure is clearly not a solution as seen in the case of the United States of America – the nation has failed to improve health outcomes despite their high levels of healthcare expenditure (17.6 per cent of GDP in 2010, OECD data). Evidently, it is not about how much a nation spends on healthcare but how the spending is done efficiently and equitably on healthcare resources.

Many Asian nations face the challenge of affordable health delivery, and out-of-pocket expenditures remain one of the main means of financing health care. Catastrophic payments for healthcare in Asia are also one of the causes of poverty. The phenomenon of rapid economic growth in some developing Asian nations has also led rise to a situation of the “double burden of disease” whereby nations have to deal with infectious diseases and the emergence of chronic disease at the same time. Developing Asian nations therefore grapple with the dual challenge that may threaten to overwhelm their resource-poor health system. Developed Asian nations on the other hand are faced with the challenge of an ageing population; their situation can be akin to that of Singapore’s as healthcare expenditure rises from rising longevity and utilisation of more expensive medical technology.

Public-Private Partnerships such as the CHAS enable access to primary care for the middle to low-income might be a model for consideration to other Asian nations. Good primary care reduces the adverse effects of income equality on health, and results in fewer differences in self-rated health between the rich and poor. Programs such as CHAS are vital policy instruments to develop equitable health systems that benefit the population. It is also in governments’ interest to do so as a strong primary care system reduces the total costs of health services as there can be better preventive care. For developed and developing nations alike, the goals of containing costs and improving health outcomes are desirable but often an uphill task. But primary care offers an effective and efficient approach to achieving those goals. By
changing the way private GPs are reimbursed, governments can work in partnership with the private sector to provide vital primary care for the population.
Exhibit 1: Health Assist Card

Source: Community Health Assist Scheme (CHAS)
## Exhibit 2: CHAS Subsidy Tiers

<table>
<thead>
<tr>
<th>CHAS Subsidy Tiers</th>
<th>Subsidy Received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Common Conditions</td>
</tr>
<tr>
<td>CHAS Subsidy Blue Tier</td>
<td>For those with per capita household monthly income of $900 and below OR Households with no income will be assessed by the annual value of their residence, which should be $13,000 and below</td>
</tr>
<tr>
<td>CHAS Subsidy Orange Tier</td>
<td>For those with per capita household monthly income above $900 and but less than or equal to $1500</td>
</tr>
</tbody>
</table>

Source: Community Health Assist Scheme (CHAS)
References


