A Real Market in Medical Care? Singapore Shows the Way

By George P. Shultz And Vidar Jorgensen

Does a real health-care market exist anywhere in the world? It certainly doesn't in the U.S., where health-care providers don't tell patients in advance about pricing, outcomes or alternatives. Consumers don't know what they're buying or how much it costs. And the costs are largely paid by insurance companies, which don't spend their own money. With a health-care market this dysfunctional, little wonder the U.S. spends 18% of gross domestic product on health.

If the U.S. wants lower costs, better outcomes, faster innovation and universal access, it should look to the country that has the closest thing to a functioning health-care market: Singapore.

The city-state spends only 5% of GDP on medical care but has considerably better health outcomes than the U.S. Life expectancy in Singapore is 85.2 years, compared with 78.7 in the U.S. Singapore's infant and maternal mortality rates are less than half the corresponding U.S. rates and rank among the lowest in the world.

What does Singapore do that's so effective? A few things:

• *Price transparency.* All health-care providers in Singapore must post their prices and outcomes so buyers can judge the cost and quality.

• *Health savings accounts.* Singaporeans are required to fund HSAs through a system called MediSave and to purchase catastrophic health insurance. As a result, patients spend their own money on health care and get to pocket any savings.

• *A limited but effective safety net.* The MediFund program serves those who, after exhausting their health savings and government subsidies, still need help paying their bills.

The combination of transparency and financial incentives has led to price and quality competition so intense that health-care costs are 75% lower in Singapore than in the U.S. Scripps College economist Sean Flynn estimates a heart-valve replacement costs $12,500 in Singapore ($160,000 in the U.S.) and a knee replacement $13,000 ($40,000).

Singapore's system of health-care finance shouldn't seem foreign to Americans, nor should we doubt that it could work here. The U.S. has already seen that the combination of competition and price transparency can be successful: Witness the falling prices for Lasik and cosmetic surgery, which aren't covered by insurance.

America also has HSAs—Congress authorized them in 2003—and one alternative model for U.S. health care would have employers and government provide everyone with a fully funded HSA. Consumers' financial incentives would be aligned with keeping costs down, since this money would now be theirs—to spend on health care or to save for other purposes, such as retirement or giving to relatives.

U.S. transparency is improving, too. The Trump administration has put forward an executive order which would require insurers and providers to make price information available to beneficiaries, enrollees and participants in health-care plans. While this will take some time to implement, companies like MyMedicalShopper and Healthcare Bluebook have already "cracked the code," finding secretly negotiated prices in the American market. People spending their own money can turn to them for the information they need to find value.

Key elements of the Singapore model can be implemented by U.S. employers right now without any additional legislation. Thanks to the Employee Retirement Income Security Act of 1974, employers have a fiduciary responsibility to know and justify the costs of health spending—just as they must for retirement funds. Erisa exempts health-insurance plans from various state-specific laws, allowing employers to adopt HSAs and self-insure. About 60% of U.S. covered workers are in self-funded plans subject to Erisa.

Some American companies have embraced elements of it, such as price transparency and HSAs.

Rising prices and lackluster outcomes are already leading U.S. employers to drop large insurance networks. Instead, they're contracting directly with providers via risk arrangements that hold providers accountable for fixed costs and guaranteed quality outcomes. Large employers can manage the financial risks of self-insurance, and smaller employers can purchase stop-loss insurance to cover large unanticipated expenses. Many employers who go to full self-insurance save 20% their first year and up to 40% by the fifth year with better outcomes and higher employee satisfaction.

Some employers with direct-contracting plans and their own on-site or shared near-site clinics, like Rosen Hotels and Resorts in Orlando, Fla., share some of the savings with their employees. As a result, Rosen has much higher employee satisfaction and retention rates than the best-known competing hotels.

Employers and employees can get better care and outcomes at a lower cost through direct contracting with centers of excellence—health systems and hospitals that offer exceptionally good or innovative care related to a particular expertise. Walmart, Lowe's, and many other employers are using financial incentives to encourage their employees to undertake elective surgeries at centers of excellence like the Mayo and Cleveland clinics. Employers like these have found that when employees can get second opinions at these centers, a large share of the most expensive procedures aren't medically necessary—including 50% of spine operations and 30% of hip and knee replacements. In these cases, less-expensive treatments yield superior results.

It has been well established by the RAND Health Insurance Experiment, the Dartmouth Atlas of Health Care and similar research that consumer involvement in price and treatment decisions results in savings and improved outcomes. New investments in digital health solutions are making market competition—facilitated by price and outcome transparency—increasingly achievable in America.

Let's follow the path of Singapore, Rosen Hotels and Resorts, and Walmart by using markets and competition to make health care affordable for all while improving quality and innovation.

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