

Hidden trade-offs in healthcare affordability

How financing rules shape resource allocation among “sandwiched” households in Singapore

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TAKE-HOME MESSAGE: Formally financeable ≠ affordably absorbable

Authorisation to draw on a payment source is not evidence of a household’s sustainable capacity to pay.

01 Why this matters

PROBLEM	Coverage, subsidy entitlement and expenditure indicators do not reveal whether a household can absorb healthcare costs while meeting competing care obligations. ⁶
GAP	The assessed unit is the <i>co-resident</i> household; obligations to relatives at another address are not counted in it. ¹
OBJECTIVE	To develop a household-level framework linking Singapore’s healthcare financing rules to resource-allocation and access decisions among sandwiched households — working adults who may simultaneously support older parents, children and their own healthcare needs. ²⁶

PROPOSED CONCEPTUAL CONTRIBUTION

Care-adjusted capacity to pay

Can the household absorb the residual cost without sacrificing essential consumption, other care obligations, or future healthcare resources?

Capacity to pay net of subsistence and competing claims — not the presence of income, or of a permitted payment source.⁶

02 Methods

1 Scope

Recurring subsidised specialist outpatient chronic care, Singapore Citizens. A financing decision point is any statutory rule that sets eligibility, a payable amount, or a permitted payment source. In scope: SOC means-tested subsidy¹, MediSave (CDMP)², MediShield Life³. Not combined: CHAS primary care; long-term care schedules.

2 Policy mapping

PCHI & household definition¹ → subsidy bands¹ → co-payment, deductible, co-insurance³ → MediSave rules and limits² → family payment assumptions. Each parameter retrieved from its official MOH or CPF page and dated at retrieval; current to 26 July 2026.

3 Conceptual synthesis

Rules → household allocation → access decisions → perceived affordability, informed by the catastrophic-expenditure and ability-to-pay literature.⁶

4 Claim protocol

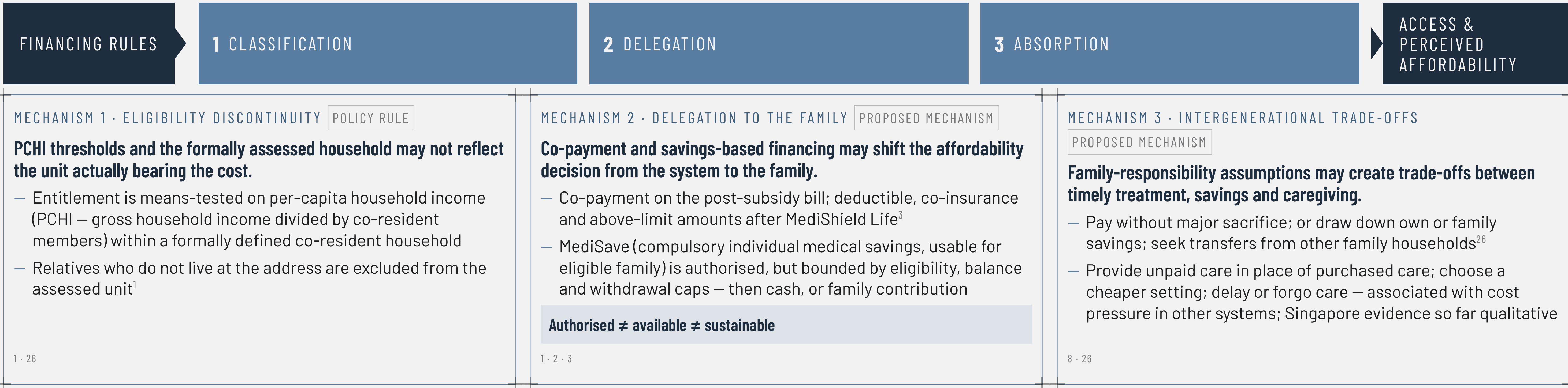
Every claim tested against five checks: current official source · evidence support · non-causal wording · selected reference · scope fit. Nine claims retained, one moved off the poster, none rated weak.

Conceptual analysis; no prevalence estimation or causal inference. The framework is specified at the points where rules meet household resources, which is what makes it testable.

03 Proposed framework · three mechanisms

How financing rules can translate into household-level affordability barriers

Affordability is not only a system-level financing outcome — it is a household-level allocation process, produced at three successive decision points.

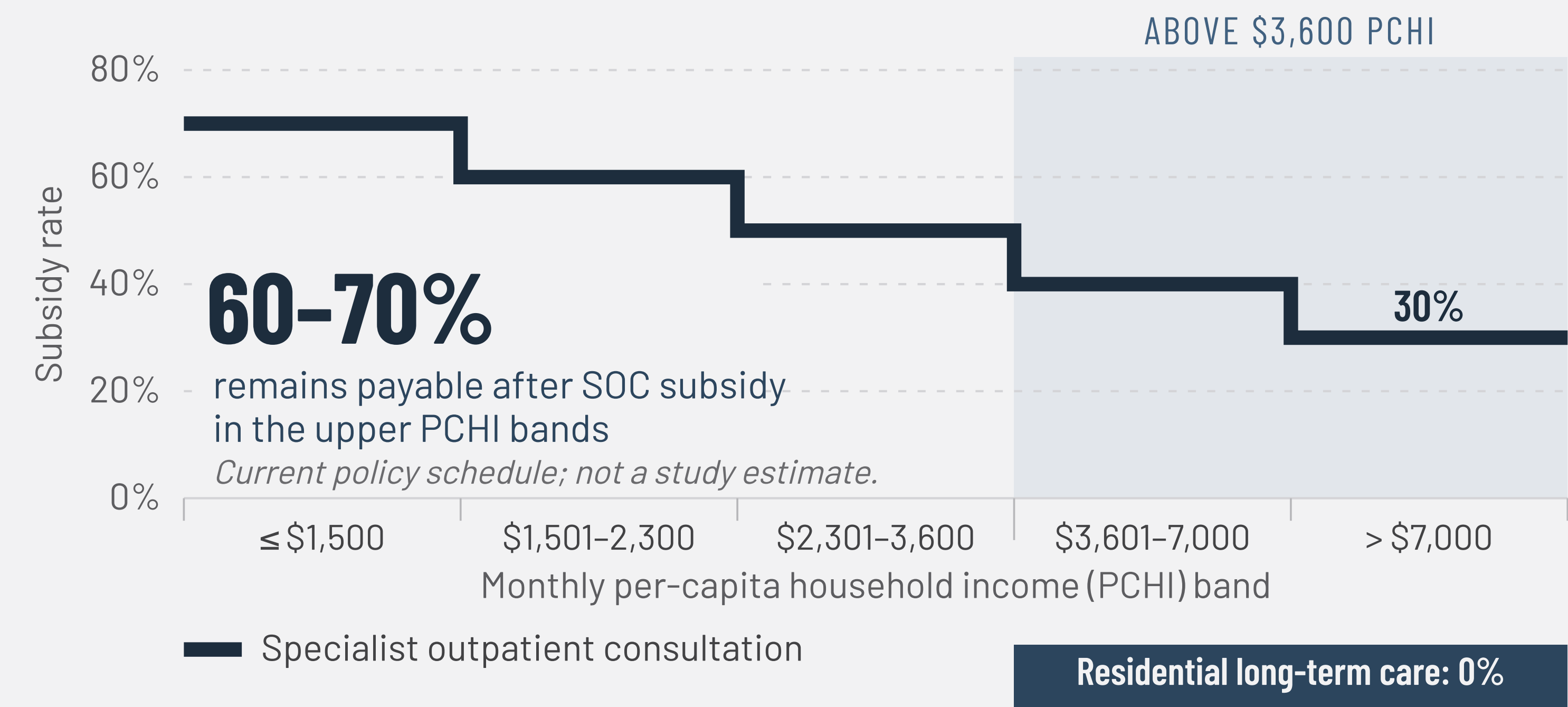


Proposed mechanisms; not prevalence or causal estimates.

FIGURE 1 · MECHANISM 1 IN POLICY: SUBSIDY ELIGIBILITY CHANGES BY PCHI BAND

As PCHI rises, subsidies fall — and residential long-term care subsidies reach 0% above \$3,600.

Current statutory subsidy schedules for Singapore Citizens.

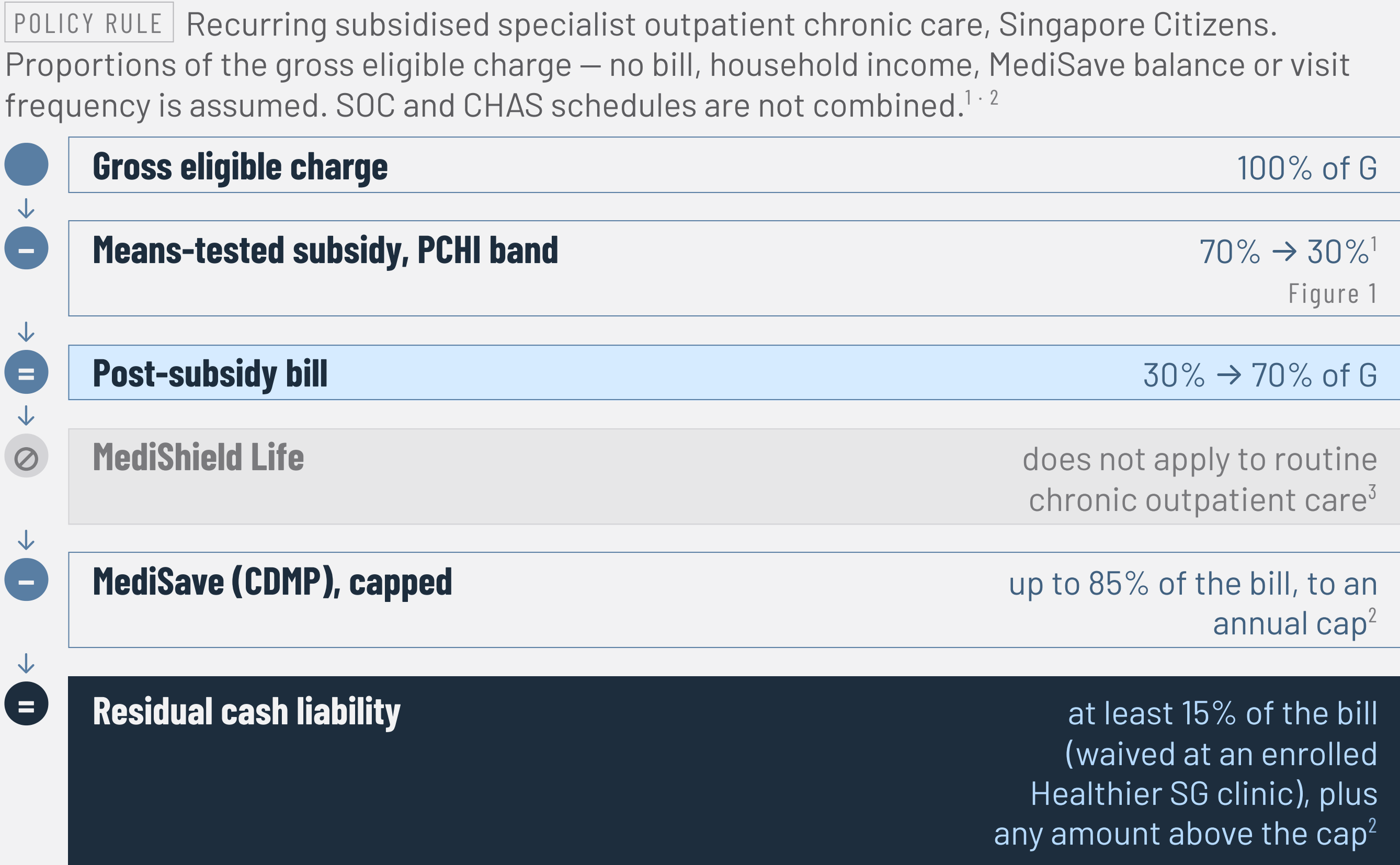


Statutory subsidy percentages for Singapore Citizens by monthly PCHI band (MOH specialist outpatient schedule, current to 26 July 2026). Bands are categorical and unequal in width; the top band is unbounded.¹ Residential long-term care follows a separate schedule reaching 0% above \$3,600 PCHI. Policy parameters, not study results.¹

05 What affordability policy should ask

01 FROM CLASSIFICATION	02 FROM DELEGATION	03 FROM ABSORPTION
Who is assessed?	What counts as capacity to pay?	How much relief is enough?
Does the assessed household match the unit bearing the cost?	Is an authorised payment source sustainable?	Does subsidy reduce burden — or relocate it?
→ Measure: obligations outside the assessed unit.	→ Measure: MediSave drawdown relative to residual liability and competing claims.	→ Measure: residual liability / care-adjusted capacity to pay.

04 Worked policy pathway



In the top PCHI band the post-subsidy bill is 70% of the charge — the upper end of Figure 1.

READ-OUT
Financing rules determine how a bill may be paid. They do not establish whether the household can sustainably absorb the remaining cost alongside other essential and care obligations.
Chronic Disease Management Programme annual caps and the Healthier SG co-payment waiver are set out behind the QR code. Parameters current to 26 July 2026. ²

06 Strengths & limitations

STRENGTHS	LIMITATIONS
- Every policy parameter is traced to a current official MOH or CPF source and dated.^{1 · 2 · 3} - The framework is specified at the decision points where rules meet household resources, so it is directly testable.	- Conceptual: mechanisms are proposed, not estimated; no prevalence, effect size or causal claim. - Care-adjusted capacity to pay is not yet operationalised or validated.

07 · CONCLUSION [proposition]

Affordability should be evaluated not only at the point of coverage, but at the point where households absorb the residual cost.

A household decision lens supports a more patient-centred and equity-sensitive approach to affordability in Singapore and other rapidly ageing Asia-Pacific health systems. Next: empirical identification and validation of care-adjusted capacity to pay.

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Full reference list · 26 sources



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