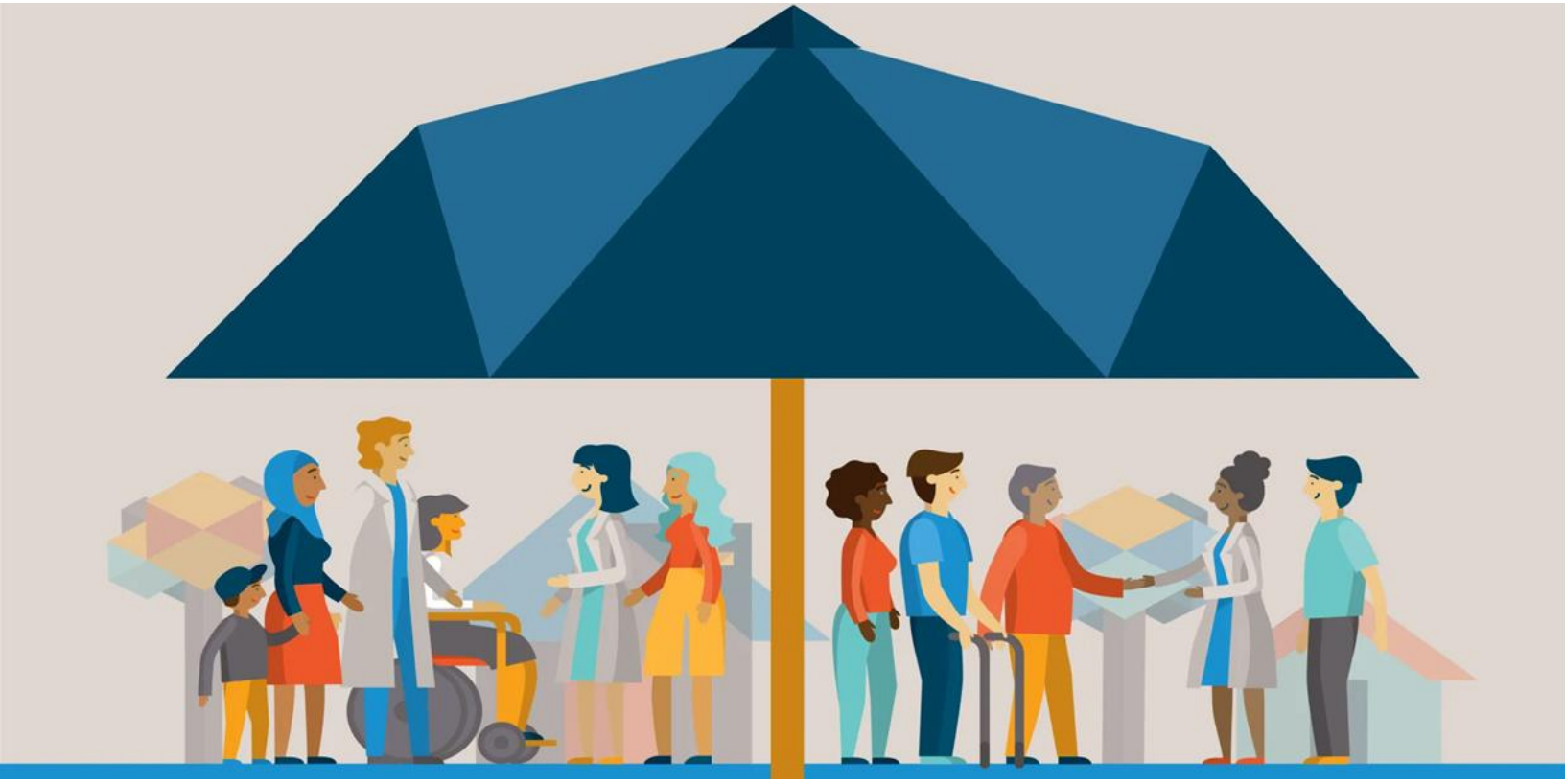
NUS National University of Singapore | Saw Swee Hock School of Public Health



Civil Society Consultation on Universal Health Coverage (UHC) in Singapore

July 2022

Background on the Singaporean Health System

- Singapore's health system operates through a mixed financing system, where care is divided between public and private facilities. Singapore has a universal basic healthcare insurance scheme for Singaporeans and Permanent Residents: *MediShield Life*, which covers large bills arising from hospital care and selected outpatient premiums. Out-of-pocket payments are partially covered through *MediSave*, a mandatory national medical savings scheme funded by personal and employer salary contributions. *MediFund* acts as an additional government safety net for Singaporeans who cannot cover remaining out-of-pocket expenses.

- *Primary care* in Singapore is provided through public polyclinics and private GPs. *Specialist outpatient care* is provided both in the public and private sector. Singapore has both public and private hospitals providing inpatient, outpatient and acute care services.

- Non-citizens and permanent residents in Singapore are generally not covered by government subsidies or insurance plans. Foreign residents may be covered through their employers and can choose to purchase private health insurance.

- As of 2021, Singapore has 849,700 migrant workers (MWs) on Work Permits (out of a total population of 5.68 million). Unlike higher-income expatriates, Work Permit holders work in sectors such as domestic work, construction, and shipping. Employers of all MWs are required to purchase mandatory inpatient, day surgery and personal accident insurance for their workers. As of 2022, Singapore is implementing a new primary healthcare system and financing scheme for its migrant workers. However, this scheme does not cover female migrant domestic workers (MDWs) who provide care work and are required to live-in with their employers.

- Singapore's healthcare spending accounts for 4.08% of the country's GDP, compared to a global average of 9.84%. This means that Singapore spends less on healthcare relative to its GDP than most countries in the world. Out of this health expenditure, 30.15% is out-of-pocket - meaning it is paid by residents directly. The remainder is paid through government subsidies, insurance schemes and other methods.

- Despite its relatively lower spending, Singapore has very good health outcomes and the highest life expectancy in the world at 83.22 years. Singapore's healthcare system has therefore been described as among the best and most efficient globally. Nonetheless, some gaps and challenges remain for ageing populations, vulnerable communities and foreign residents.

Annex IV: Reporting Template

Details of Focus Group Discussion 1

Date:	7 June 2022	Lead organisation:	Leadership Institute for Global Health Transformation, Saw Swee Hock School of Public Health, National University of Singapore (NUS)
Number of focus group participants:	10	Provide description of make-up for the focus group[1]:	Representatives from patient and caregiver organisations; directors of social sector organisations for LGBTQ+ communities, disability groups and mental health; academics and medical social workers.
Facilitator(s): (Name, Organisation)	Capucine Barcellona (NUS) Nikita Mandyam (NUS)	Note Taker(s): (Names, email addresses)	Jacqueline Yap jacquelineyp@yahoo.com Dominic Lim dominiclim@u.nus.edu
Number of breakout rooms:	NA	Composition of breakout rooms:	No breakout rooms - all participants discussed the questions together. This FGD was conducted virtually via Zoom.

[1] Provide information that describes the focus group participants. Be as descriptive as possible without identifying individuals.

Details of Focus Group Discussion 2

Date:	16 June 2022	Lead organisation:	Leadership Institute for Global Health Transformation, Saw Swee Hock School of Public Health, National University of Singapore (NUS)
Number of focus group participants:	11	Provide description of make-up for the focus group[2]:	Youth advocates on public health, political education, LGBTQ+ and disability issues; staff from migrant worker organisations; civil society advocates for sex workers, LGBTQ+ groups and racial & religious unity; leaders of HIV/AIDS and addiction rehabilitation organisations.
Facilitator(s): (Name, Organisation)	Capucine Barcellona (NUS) Nikita Mandyam (NUS)	Note Taker(s): (Names, email addresses)	Jacqueline Yap jacquelineyp@yahoo.com Dominic Lim dominiclim@u.nus.edu
Number of breakout rooms:	NA	Composition of breakout rooms:	No breakout rooms - all participants discussed the questions together. This FGD was conducted in person.

[2] Provide information that describes the focus group participants. Be as descriptive as possible without identifying individuals.

Notes and Findings from Focus Group Discussion 1 and 2

Required Questions[3]	Question	Summary points	Notable quotes
1	Does your government have a coordination government agency/mechanism/ department that engages across sectors for the specific purpose of improving health or advancing UHC? If so, how well is this mechanism or department functioning?	Overseeing agency ● The Ministry of Health (MOH) is in charge of the health of all but does not completely cater to individual group needs. Individual needs ● There is no holistic group that looks at individualised needs, such as intellectual disabilities. ● There is no agency in particular for improving UHC - for example, addiction recovery centres are non-government run. ● In the case of foreign workers, it is not clear because the government has not taken a clear stance on who is responsible for their health. ● There are still gaps in terms of identifying people who are overlooked (e.g. sex workers) and they are not part of the narrative. ● Underserved populations should come into the picture for universal health coverage. Lack of coordination between different agencies ● There are different organisations in charge of different areas, but there are challenges faced when trying to reach out due to the lack of coordination between them. ● Agency for Integrated Care (working on care integration for seniors), MOH Holdings (holding company of local healthcare clusters), HPB (Health Promotion Board) can be quite haphazard in terms of their roles and what they are in charge of. The	*"For UHC, underserved populations should come into the picture of discussion." - director of an organisation that focuses on healthy ageing and the elderly* *"MOH announced that they are looking into it in an implementation approach for UHC, where it is top down, when it should be bottom up." - director of an organisation that focuses on healthy ageing and the elderly* *"When meeting a minister directly or one of their subordinates with much less authority, they say that they are obliged to tell you the government's official line" - youth LGBTQ+ advocate*

[3] Please list the required questions as asked below, including changes made to the language.

		lines are there, but they are not clear and their roles sometimes overlap. This overlap may be due to funding. ● Therefore, those on the ground feel that trying to get things done and figuring out who to go to can be quite challenging. Good experiences ● There are good experiences with the government as well. ● The Ministry of Health is usually top-down. An agency called "consumer engagement and education" - arm of the Agency for Care Effectiveness - is one example of a gradual step towards patient engagement. It is a good step forward but more needs to be done.	
2	If you primarily conduct health advocacy, have you engaged with other government ministries or departments beyond health in your advocacy efforts? How so?	The need for cross-sectoral coordination ● There need to be more ministries involved in health and more inter-ministerial collaboration to make sure that things don't get lost. This should come with more openness. ● The Ministry of Social and Family Development (MSF) should be consulted more on healthcare equity, because currently it is disjointed from the Ministry of Health. ● When addressing policies, it depends on what angle you want to come from (e.g. addressing drugs from a legal, MSF, MOH, or Ministry of Education angle). ● Since there is no coordination between these agencies, it can be difficult to push evidence-based approach that is public health focused. ● There is a lack of resources and because of this, it might eventually result in limiting the issue to an abstinence-only approach.	*"If there are no advocacy groups, you cannot provide adequate healthcare."* - *manager of intellectual disabilities organisation*

		People with intellectual disabilities ● Issues such as intellectual disabilities start from youth into adulthood, and involve several components and transitions across sectors (e.g. life-course health, employment). ● Getting various aspects addressed is hard because there is no one point of contact to bring policies into place. ● Because of the lack of coordination for the intellectual disability group, there is a lack of knowledge of what a person of intellectual disability can do, and what healthcare providers should do. Migrant workers ● Migrant worker organisations mostly interact with the Ministry of Manpower (MOM). But it would be best to be able to go beyond MOM and talk to healthcare policymakers and involve more health stakeholders. ● It should be noted that during COVID, MOM and MOH were consultative on migrant worker health.	
3	a. Which groups of people in your country struggle to gain access to health services? What are the main barriers for them to access health services? b. Considering the needs of the groups identified above, what are the specific health	UHC does not reach vulnerable communities ● Broadly the groups who struggle to gain access are: 1) LGBTQI+, 2) people with disabilities, 3) people with mental health-related issues, 4) the economically disadvantaged without documentation, 5) those at a 'sandwich' income status, not poor enough to qualify for subsidies nor rich enough to afford specific services, 6) non-Singapore citizens. ● Essentially, there is no UHC for anyone who doesn't fall within the normative group (Singaporeans/Permanent Residents (PR)). ● Clinics are usually made for the masses. To be prudent, however, it is still important to	*"The only time I had UHC was in National Service, where I explored all the illnesses I had. Once I left, I couldn't afford the psychiatric medication I needed" - student advocate* *"In general, palliative care is not well covered for anyone. There are no government subsidies and it must come from nonprofit funding." - director at migrant worker organisation*

	services that are under-prioritised?	structure the clinic for people who are underserved and neglected. Mental health issues ● Participants struggled in obtaining care for mental health issues because of a lack of family financial support, despite the family being middle-income, and a lack of subsidy due to non-citizen status. ● There is currently no way to help the people stuck in the middle who do not have adequate finances. ● Mental illnesses receive a lot of stigma – more work needs to be done on awareness and education. Migrant workers ● Migrant workers make up 20% of the population, and the government has only just started a semi-universal healthcare system at the primary care level for them. These so far do not cover domestic migrant workers. ● For domestic migrant workers, care is tied to the employer's responsibility. Domestic workers have hospitalisation insurance capped at $50-60k but the outpatient treatment falls on the employer. Employers are reluctant to pay so this creates barriers for the workers to seek treatment when they are sick. ● Non-Singaporean/PR women don't have access to HIV testing, which is extremely important in the case of foreign sex workers. HIV patients ● In terms of accessing care for the HIV positive patients, hospitals are required to close their case within a year, but patients need a referral letter to be subsidised for	*"A lot of domestic workers with illness get forcibly repatriated because they cannot access healthcare and are not eligible for subsidies" - representative from migrant worker organisation* *"In the case of construction workers, hospitals will not perform procedures unless there is a Letter of Guarantee from the employer, so the timeliness of the medical attention get compromised" - representative from migrant worker organisation* *"Mental Health is not regarded as healthcare yet. For the LGBTQ, HIV-positive, formerly incarcerated, since this is illegal, it is hard to seek help. Especially with regards to trauma-informed care." - representative from drug abuse and rehabilitation centre* *"Elderly people who speak dialect - not mandarin or English - have trouble accessing information. There is nothing for them to read or see on TV that they can understand. How to get that information out to these people? They*

		HIV-management drugs. This process is timely and expensive. FGD participant recommended allowing Singaporeans to have automatic subsidies. ● Preventative healthcare is under-prioritised. For example, PreP (HIV prevention pill) is not under Medisave. It should not necessarily have to be put under Medisave, but there have to be alternative funding options than out-of-pocket. ● After many years into trans HIV advocacy, there is still no trans specific HIV program in Singapore, because tans HIV patients are told there is already access - piggybacking the same programs for gay HIV men. Addiction and rehabilitation ● Drug use and addiction is still viewed as a choice/ moral failing. We need to start viewing it as a mental health condition, especially those experiencing minority stress. The way we approach or think about it needs to change. Men Who Have Sex With Men (MSM) ● There is a consensus that repealing 377A (criminalising sex between consenting male adults) would make a large contribution to UHC in Singapore. For example, same-sex partners are not allowed to be contacted regarding medical purposes as they are not 'family members'. Linguistic access and communication challenges ● Accessibility in UHC also includes awareness of existing services, which requires linguistic accessibility. There are hotlines, but the people who know about these are the people who are exposed to & have access to the advertisements. Even though there are four official languages (English, Malay, Tamil, Mandarin) in Singapore, not all languages are represented in	*technically have access to services but information is not available to them." - advocate for religious, racial and cultural harmony* *"There is not enough consideration for dealing with deaf people. People are still calling deaf people to get information…" - youth representative from disability community* *"A lot [of healthcare access] is tied to family income, but also to your status of employment. [It] assumes everyone has a full-time job, but Covid has revealed that this is not the case. Most people are in more precarious forms of employment without a system of financing." - representative from migrant worker organisation* *"Health is wealth, but when you have neither, it spirals. Investing in healthcare is building capacity for everybody" - patient advocate* *"Based on the experiences of drug users, people living with HIV etc. - I totally agree*

		advertisements. People may not speak any of the official languages, e.g. the older generation speaking Chinese dialects. ● Singapore's healthcare system fails those who are deaf or use sign language. There are not enough translators/interpreters, especially those specialised in medical language. Lack of specialised training for providers to deal with patients with special needs ● There is also an issue of ethics and consent, where providers should be sensitive to ask caregivers to leave at certain moments, and ask the patient if they are comfortable with the caregiver present. Providers are not specially trained to handle vulnerable communities and patients with special needs, making the patient journey and experience sub-par. ● Different groups feel the need to express themselves in different ways. Doctors need to be educated to suit the context/background their patient comes from e.g., elderly, or HIV patients. Clinics need to be equipped to understand cultural and sexual background of patients. Financial hurdles to access ● There is also the high cost of seeking treatment as a potential barrier. ● It goes beyond access to healthcare, as nobody currently wants to see what happens after that - e.g. having a stoma is also a stigma for one to move around in public, when perhaps they do not look disabled. The appliances are not cheap, and patients need proper appliances for a good quality of life but these are not covered by insurance. There needs to be a patient who comes out and highlights these things.	*that access isn't simply the existence of a service. The barrier to access is that the service isn't made by considering the needs of these groups. On the flipside, it is also not feasible sometimes to have a general/primary care service be used only for marginalised groups. I think the community groups need to be empowered to help deliver differentiated health services. Community-led health services are under-prioritised. You cannot do it top-down." - advocate for LGBTQ+ and HIV+ community*

		Role of advocacy and patient groups ● Advocacy groups are needed to advocate for holistic healthcare. ● Patient groups need to start conversations with the authorities and agencies, because otherwise the agencies won't know what the psychosocial issues are and how to solve them.	
4	Do you feel that UHC laws/policies/strategies that exist in your country are being adequately implemented?	UHC policies ● Policies are there but implementation might be an issue. ● Policies are not present in the case of certain disorders. For example, sleep apnea is not covered by insurance or subsidies despite being very common, and it is expensive to manage. ● There are some chronic disease management programs to cover and subsidise treatment. Financial aspect of UHC ● We are doing well in financing. In fairness, the depth and breadth of coverage is increasing. However, financing mechanisms are very tough to navigate especially when involving social care - patients need to go to multiple agencies to navigate and repeat the process. Therefore financing access could be improved. ● UHC should not be paired with personal means and should not be contingent on insurance. There is additional cognitive load on the patient to deal with how to access services. Universality should be the most important goal. Evaluation of UHC ● There are some endpoint indicators to look at the outcomes of UHC management.	*"On the Ministry of health website, you will not find the word equity. There is an implicit impact when talking about inequality. The government doesn't hide anything, but it is not explicit either." - health financing professor* *"[I know of] an instance where a private psychologist for EMDR, which is used to treat trauma, offered their patient conversion therapy. They then asked 'Please don't report me, I could get in trouble for this'." - representative from drug abuse and rehabilitation centre* *"Legislation is different from on the ground. There are laws on paper, but in practice the monitoring and evaluation falls apart." - student advocate for gender and sexuality rights*

		However, these indicators are created without the input of the public. The specific endpoints of management are outcomes based e.g. screening, picking up.	
5	Do you know of any accountability or monitoring mechanisms for UHC in your country? If yes, please explain your answer.	Oversight and accountability for UHC ● UHC in Singapore leaves out vulnerable groups. We need accountability mechanisms, e.g. the UK has strong patient and public involvement that Singapore can learn from. ● There is technically legislation that states you cannot judge based on sexual orientation, but there is no real oversight. Audits of care standards ● There used to be audits of clinical care standards - e.g. using JCI (American system) previously - but this has scaled back. But specific to the monitoring and audit of how UHC is conducted, participants were never aware. ● It may not be helpful to spend resources to audit this as healthcare workers are already sapped. It is more important for civil society to push for expanded areas of care to address gaps.	
6	a. Do you think that health services in your country are of good quality? Can you elaborate and give examples? b. What health services and what communities/population groups experience the gaps in quality?	Overall quality of the system ● By and large, yes, as long as you are a Singapore citizen or PR, you have a safety net and access to well-run public health institutions (PHIs). PHIs have almost a full spectrum of specialist services (although one may argue some hospitals are better than others). For example, every hospital has cancer care, surgery specialties, etc. ● In Singapore doctors will generally treat first and save lives, regardless of whether you have money or not - knowing that the	*"For the trans community, using our preferred name and pronouns is good quality healthcare."* - *transgender community advocate* *"I think we aren't even talking about quality when people who have trouble with drugs or young girls*

		business office will not crucify them for doing so. ● Polyclinics have e-queue systems, electronic health records accessible on an app - these have bested the private medical groups and private GPs, other than the larger ones upstream. ● There is a national-level Health Promotion Board that does preventive health with the government pumping in money to incentivise positive health behaviour. ● Generally, quality is okay compared to rest of the world, but there are areas for improvement. Area of improvement: patient experience ● The system benefits people like [participant], who is cisgender, Chinese, citizen, relatively well-off. There is good quality and affordable healthcare that she can access through the system and benefit from. However, even then, there are problems with timeliness and waiting times. She perceived the patient-doctor relationship to be lacking the longer she lived in Singapore. ● Having proper infrastructure has been identified as the lowest level to fulfil quality of care. But when considering beyond infrastructure, it is the experience of care that becomes important. ● Good quality of care is also defined differently in LMICs and HICs, according to the standards expected. LMICs may focus more on infrastructure and safe drinking water, HICs focus on the experience side. ● There are gaps in this - for example, healthcare should include pregnant underaged girls who are afraid, should help mediate relationships with the law and	*with reproductive health concerns can't even access healthcare providers" - advocate for LGBTQ+ and HIV+ communities* *"There can be a waiting time of 4-6 weeks for a specialist after getting a referral. Is that acceptable?" - public health student advocate* *"Doctors must cover a lot of patients and need to spend a lot of time to provide quality care. [It's difficult] if a consultation goes over 10 mins, as they must clear a certain number of patients within a day otherwise it is additional work for their colleagues." - advocate for religious, racial, and cultural harmony* *"It's good that they have created more ways to book appointments that aren't physical, that are more accessible. There are also improvements on some health topics that are sensitive and mobility issues." - student advocate for gender and sexuality rights* *"Workplace accidents or incidents [can be*

		family, and should pre-empt them in what to expect in their pregnancy. ● Often patients are not presented with all their available options regarding procedures and management of conditions due to a matter of convenience. But this should be a part of quality of healthcare. ● [Talking about kids with intellectual disabilities and ESL] The way and knowledge of the way you express things to patients is important. These children can know and understand concepts, if you can properly identify and talk to them at the level they need. We need to cater to those needs. Area of improvement: catering to the needs of marginalised communities ● Services are not developed in consideration of marginalised groups. ● Quality of healthcare in Singapore is of a certain standard. However, regarding choice, the migrant worker population don't have choice in their healthcare provider. It is often down to employer choice. So they might encounter a doctor who is not aware of the realities of a person coming from a different background, and they have no right to change practitioners. ● Chronic illness is often treated with exclusions, limiting access to healthcare, making it prolonged and costly. ● There are issues in health declarations when applying for jobs, regarding mental health conditions and disabilities. You may be discriminated against in the employment process, or lose your job if it is discovered later. ● There have been cases where schools prompt healthcare providers to misdiagnose. E.g. Participant was a school	*problematic], because there is a disincentive in seeking help and on the employer's side they might have to file a report. [Especially] for people with a more precarious immigration status, as ability to stay in the country is dependent on ability to work." - student advocate for gender and sexuality rights* *"What is baseline healthcare for everyone in society? How can that be implemented?" - student public health advocate*

		sexual assault victim, and was blamed and misdiagnosed with a condition as an excuse to divert the attention. Some solutions for improving quality ● The quality of care that doctors offer is very tied to their wellbeing, so we must do more for public servants in the healthcare sector as well. ● Empowering civil society communities meaningfully in the process and working hand-in-hand with the government would create more inclusive healthcare services.	
7	Where do you think your government should be spending more in terms of achieving UHC?	Education ● Government has a lot of authority and would be able to push health policies and awareness through education. Healthcare workforce ● Attrition in the healthcare sector. There is a need to retain people and a need to factor in the well-being of the staff. ● There is a lack of staff. Many healthcare workers are incentivized to leave the public sector, as there is the privatisation of healthcare. Some of them from the Philippines move on to the US or UK which are better paying. Also, there are no options for these 'migrant workers' and 'nurses' to naturalise - no PR or citizenship path. ● Caregivers also suffer from looking after patients, and investment could help to improve their mental health. Vulnerable communities: ● 1) Infant and child care; 2) eldercare; 3) step-down and community care; 4)	*"I think the perception of cost is more crucial than the actual costs. The state tries to make people responsible [for their health] so there is quite little security to say 'we will help, you can relax'. Therefore people do feel that in Singapore you can't afford to fall sick. It's not just the cost of a polyclinic but access to employment, cost of living etc." - medical social worker* *"There are [now] more pathways for people to access medical and allied professions. But there is a lot of attrition because people take on these [roles] without being compensated appropriately." - student advocate for diversity and inclusion*

		individuals with special needs (both young and old) such as autism, disabilities. ● Migrant workers have some UHC in primary care only, but many gaps in specialist care. Basically, anyone beyond the norm of mainstream Singaporeans and PRs. ● There is a general agreement that the government has been spending on expanding and improving existing health technology and infrastructure, without as much consideration on investments in UHC. Continuity of care ● There should be more investment done for after the completion of primary treatment. What happens to the patient AFTER the primary treatment is given? Because this is currently not considered. ● Seeking medical treatment is generally not supported by the local work culture, in the sense that taking the time to seek treatment can affect your income and employability. Health is a societal issue and is never in silos. Collaboration and change ● The Government is an important player, yes, but the conversation should also revolve around to what extent they should be responsible, and how to cover the rest. ● It depends on their depth and breadth of their involvement and how they work with NGOs. Should NGOs and other special groups get involved? There is a need to identify that these groups are important to achieve UHC. ● NGOs have achieved a lot in mental health even with limited funding over 16 years. However, they have found that there was a need for loss of life for the matter to gain attention.	*"SkillsFuture and WorkForceSG identify 3 sectors as the most crucial: 'tech, carework, green'. But a disproportionate amount of attention is being paid to tech. Care and Green receive less focus, but they intersect a lot. We need to address this, bridge that gap and not have such a disproportionate focus." - representative of drug abuse and rehabilitation organisation* *"Increases in healthcare have mainly been technological advances, upgrades in health. But there has not necessarily been improved equity of coverage." - director of migrant worker organisation*

		● It is also a matter of time - it requires being patient and seeing changes as people come together and put aside their differences.	
8	a. At the national level: are there opportunities for people, civil society organisations, and the private sector in your country to be engaged in planning, budgeting, monitoring and evaluating the health sector? If so, what are those opportunities and are they effective and efficient for the engagement of civil society, in particular, of the most vulnerable and marginalised populations and communities? b. At the community level: Are communities engaged in local level health planning, budgeting and accountability processes? If so, how are they engaged?	Exclusivity of current consultations ● MOH holds public engagement sessions for health - however these are often politically motivated. There is a mentality of 'represent both sides', regardless of whether the information presented is harmful or inaccurate (e.g. LGBTQ and anti-LGBTQ groups both have to be considered, when the latter might be actively harmful). ● Consultation is not a safe space nor is it neutral. In some cases, Muslim and LGBTQ groups were not able to hold a forum and dialogue, because the consultations were regarded as too taboo and sensitive. ● There are differences between public consultations and behind-closed-doors consultations, in terms of whether these are more candid or less open. ● There is also an issue where certain faith groups are considered more authoritative, and others are written off as heterodox. Consulting with specific faith leaders might not provide a representative picture of the whole faith, as there might not be one singular stance on certain issues and less authoritative voices are disregarded. ● The government has specific civil society groups that they 'go-to' for consultation and they can be dismissive to other groups. ● The ministry does not involve the sex worker community because of the stigma associated, even though they could provide a lot of insight into health and drug use issues. By doing this, the government could help many types of people e.g. clients, sex workers.	*"The tudung issue [debate on whether nurses should be allowed to wear tudungs] was a closed-door discussion because it was considered too 'sensitive' by the Government to be discussed openly" - advocate for religious, racial and cultural harmony* *"Often the government has already decided, and they are just going through the 'process' to listen - total crap." - advocate for HIV/AIDS community* *"There should be more engagement with civil societies across the board, apart from those they are more comfortable with." - student advocate for diversity and inclusion* *"I don't understand implementation, after sitting in a lot of groups and in a lot of discussions. Is there an endpoint? Did the change that happened happen because of these talks?" - representative*

		● LGBTQ+ issues are not being addressed in ageing and eldercare, because a support structure is not available for them. It is also a financially/societally risky issue. It is a struggle to narrate this problem, especially within what is taken to be "acceptable" in Singapore. ● The heartlands [typical Singaporean communities in local neighbourhoods, public housing estates] don't have conversations about health. There is not enough education and awareness to hold community discussions yet. ● There should be a platform to ask public servants and teachers to freely voice what they think, because public servants are technically not allowed to voice out anything outside of internal channels. Ensuring vulnerable groups have a voice in the solutions formulated for them ● There is a lack of representation for marginalised groups, so these groups lack opportunities to share their thoughts. ● Some people have become spokesperson of groups without planning and meeting with said groups first. ● We must consider, are NGOs replicating the same top-down approach as the government? Do the marginalised people themselves have a voice in helping to formulate the solution? Involvement of NGOs ● Charity organisations are not allowed to advocate AND provide service. So, organisations for marginalised groups are unable to contribute to advocacy. ● NGOs cannot be disrespected by governments.	*from mental health organisation* *"Are you the best spokesperson for the group you are championing?" - representative of LGBTQ+ community* *"Don't do anything for us without asking. Try to involve all the stakeholders and understand, not assume their needs." - representative of LGBTQ+ community* *"How are we customising the system to fit the people, instead of the other way round?" - representative of LGBTQ+ community*

		● The government has to reach out to NGOs and not make them reach out to other stakeholders, eg. abroad, to get attention/help. Involvement of private sector ● The Government is cautious for the private industry to be involved – they might have their own agenda and might push their own drug and treatment. However, the private industry can mobilise resources and funding quickly. ● In the future there could be a framework for private companies to get involved within a set of rules and regulations. Appropriate frameworks need to be linked up so that industry players can get involved despite the considerations of the risks. ● Industry players are trying to get involved by bringing together patient groups to work together and work for change, but it is not with the blessing of the authorities. Measuring the impact of consultations ● Often, when there are discussion sessions and engagement talks, there are no clear goals and objectives from them. This makes it tough to measure the effect of such conversations on policy-making. There is no metric to measure the impact. ● It would be good to have timelines from discussion sessions to better evaluate the next steps and the impacts from it. This would be good to know whether there has been added value. ● Generally, there is a perception of lack of change despite participating in many discussions.	

9	a. Can you identify some of the major challenges for women and girls in their access to health services? b. What kinds of health services are most challenging for women and girls to access? c. What are the primary challenges to access health care services for individuals who are non-binary?	Low-income female workers ● Female work permit holders are not allowed to be pregnant. They get rid of the babies by themselves. There are systemic discriminatory laws that have knock-on effects which can harm an individual. ● Migrant sex workers are more at risk to get transmitted with STIs. For the unlicensed ones, there are also concerns about safe sex as they are not educated. They should be allowed to consult a doctor and have access to healthcare services. ● A specific challenge some women face in navigating the healthcare system, is that there is a lot of prioritising of those who look sicker, so that may stop some women with less visible issues from receiving access. Examples include non-local women undergoing domestic violence and interpersonal violence. It includes women with multiple caregiving issues also. Gender sensitivity ● Gender or sexual minority care differs based on the goodwill of the doctor you have, as doctors can refuse to treat based on personal beliefs. ● There have been cases of the Ministry Of Education interfering with gender affirming care for transgender underage students, despite the doctor's support. ● The healthcare given to intersex individuals is presumptive and coercive. They are imposed to 'become normal' and patient agency is not considered. ● For the female trans population, once they are allocated to male wards based on their gender markers on identification cards, it is not just a policy issue. The best policies might not be able to reach the ground and translate into real change	*"Doctors are not trained in [LGBTQ] care even when there are decades of scientific research. The quality is inconsistent and doctor-dependent, when [all patients should be] treated in a way that is affirming, respectful and suitable" - student advocate for diversity and inclusion* *"There are disparities in terms of age. For a private abortion, it is at age 21, but at a GP you can get Plan B without facing an age barrier" - student public health advocate* *"[Regarding migrant workers] Are they policing sex or pregnancy? Are they providing workers with condoms, are these at an extra cost? If that's not there, how can we expect them to avoid pregnancy? Aren't we essentially policing sex? What should the states' view of sex be in relation to UHC?" - representative from migrant worker organisation*

		Reproductive health ● In reproductive health, the biggest issue is when the girls are underage. Pregnant teens do not usually have family support. ● Social workers often must work through blocks in healthcare where the girls need a guardian to be with them e.g., they cannot discharge their baby without a guardian. ● When girls are also estranged from their families, it is difficult to find a guardian for them. ● Below a certain age, if you seek help for certain services (eg. pregnant teen), the provider needs to notify the family who might not be supportive. This can lead to more abuse from family and worsening of situations. Patient experience ● The patient experience matters – doctors should not only deal with what the matter is with the patient, but what matters to the patient. The respect for patients and their experience is extremely important in these cases. They need to be accommodating to patient needs. ● Technocratic approaches have to be balanced with human attributes. ● We need the human aspect in UHC.	
10	a. How has the primary health care system been affected by the ongoing COVID-19 pandemic? b. How do you think that PHC can be improved/evolved	Overall performance ● Emergency-wise, Singapore is doing well. For health issues that are not affecting specific niche groups but affect the general masses, they have strong channels to advertise and advocate. There are good channels to educate the public on health. ● Difficulties that arose were capacity-related problems and structural issues that have	*"Government is on top of their game - they have strong channels to advise/ advocate for the public. They also had well known celebrities giving health information." - advocate for religious, racial and cultural harmony*

	to be better prepared for future pandemic and other health emergencies?	persisted over many years. These require long term systematic planning. Opportunity for migrant workers ● Many COVID clusters broke out in migrant worker dorms, due to the densely-populated quarters, prompting the government to take action and bringing the spotlight on the lack of care for vulnerable communities in Singapore. ● COVID has accelerated progress for migrant workers in the primary care space, possibly casting more light on marginalised communities and the need to provide for their health and wellbeing. Opportunity for digital health ● [When a participant had Covid] after teleconsultation, medication reached their house and they didn't have to leave. They didn't want to overload the hospital. ● During Covid there was the teleconsult option. It was a good initiative, works beautifully, and can extend to more services. Delays for non-COVID services ● There were delays in screening services for cancer which made catching disease in early stages harder, limiting patient options and worsening prognosis. E.g. getting polyps removed for colon cancer. ● Because all the primary health care (PHC) efforts were diverted to covid swabbing and testing, people were asked not to go to PHC. This affected not just public screening, but also chronic diseases which were not well-managed during this period. Effect of physical distancing	*"The shortfalls started 20 years ago [regarding] long-term infrastructure and capacity problems. These structural issues persisted partly because of certain world events and trajectories in 2000s" - student advocate for diversity and inclusion* *"[I remember] calls to the ward where the patient was just screaming, confused, dazed [when caregivers could not visit]. Trying not to kill the patient with covid can cause a lot of mental distress." - medical social worker*

		● Caregivers' burden for those with intellectual disabilities was challenging. It has a dual component because caregivers must look after loved ones at home. ● Having to do a lot more home visits during lockdown, intellectually disabled patients' mental health worsened and they developed anxiety issues. ● In general it became a challenge to get mental health support during the covid pandemic. ● It is difficult for someone in palliative care to rely on their domestic worker or their child to take care of them. This caused distress to the patient and the family during Covid, when they were barred from taking care of the patient. Need for community care ● COVID presented an opportunity for community care to make a difference. However, little effort was made to look at other resources in the healthcare system, whether formal or informal - e.g., volunteer community nurses, social workers, etc. ● Community care is important. There is a need to go beyond looking at primary healthcare and look at the full health system, to see how services can complement each other.	
11	Is there another element of UHC and the distribution of health services in your country that was not covered in the discussion today?	Foreign healthcare workers ● Allow foreign healthcare workers to settle down in Singapore to retain talent. ● Allow foreign doctors / dentists / health professionals to practise in Singapore — if it is necessary to 'bubble wrap' them in a parallel healthcare system, do so. They can be culturally more attuned to migrant workers than local trained staff.	*"We need to rethink what drives society, and reorient people to look out for one another" - representative from drug abuse and rehabilitation centre* *"The government can bring our expertise to others as well, uplift our neighbours."*

		● [Regarding foreign labour dependence] The volume of nurses trained does not matter, if they are offered a better package elsewhere. Without human resources, we cannot deliver the service experience well. Other comments ● There should be capacity-building, education, and structural change beyond the health space. ● The government needs to be more attentive to marginalised communities and needs to improve the red tape processes involved. ● The whole social structure and international cooperation are also important. We can learn best practices from other countries, as evidence-based policies are appreciated in Singapore. ● As technocrats, government officials forget they are dealing with human beings. The human attributes are currently missing. It should be more about underserved populations, rather than forcing people into a system. ● The government needs implementation & pilots to demonstrate that a proposed model works, through community groups, financing etc. These resources should involve NGOs to help with data and data analysis.	*- student public health advocate* *"Government has a moral obligation to maintain the health of the population, because it impacts the economic aspects and well-being of the country. Health is not silo-ed, it is a societal issue and responsibility" - representative from an organisation focused on healthy ageing and the elderly*

Photos from Focus Group Discussion 2 (in person)