Health and Racial Discrimination

Submission by the Community Action Network (Singapore) to the UN Committee on the Elimination of Racial Discrimination on Singapore's Compliance with the International Convention on the Elimination of All Forms of Racial Discrimination, focussing on health and racial discrimination.

Introduction

Existing literature and public data show that health outcomes of individuals in Singapore are socially determined by and correlate with factors such as a person's income and education level. Lower-income households with residents of lower education levels are more likely to have poorer health outcomes. Similarly, there are statistics that indicate a correlation between ethnicity and health outcomes, where ethnic minorities are more likely to suffer from certain chronic illnesses.

Various studies have also outlined structural barriers than ethnic minorities are more likely to be subject to, in order to access healthcare. This report is a non-exhaustive summary of existing policies, public data, and case studies on direct and indirect racial discrimination in the healthcare system in Singapore.

We highlight how low-wage individuals and families, who are disproportionately racial minorities and foreign nationals in Singapore are discriminated against in accessing quality and timely healthcare. We also show how healthcare policies implemented by the State, as well as the working conditions of these groups, may adversely affect their health. In particular, we look to the following articles in the Convention on the Elimination of All Forms of Racial Discrimination for guidance in this report:

Article 1

(3) Nothing in this Convention may be interpreted as affecting in any way the legal provisions of States Parties concerning nationality, citizenship or naturalization, **provided that such provisions do not discriminate against any particular nationality.**

Article 5

In compliance with the fundamental obligations laid down in article 2 of this Convention, **States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law**, notably in the enjoyment of the following rights:
(e)(iv) **The right to public health, medical care, social security, and social services**

1. The HOPE scheme indirectly discriminates against Malay women to have fewer children, affecting their reproductive health

Introduced in 2004, the Home Ownership Plus Education (HOPE) scheme is a voluntary government programme wherein low-income families receive housing grants and financial aid contingent on limiting family size to two children. In the event that families have more than two children, they will no longer be eligible for the scheme. Beneficiaries of the scheme also receive cash incentives to fund ligation or vasectomy procedures.[1]

Benefits of the scheme include generous housing grants, annual educational bursaries for each child, employment incentives for full-time working mothers among many others.[2] HOPE is discriminatory towards low-income households as such reproductive policies do not apply to more well-to-do families. While the scheme is technically voluntary, low-income families already facing significant financial hardship are less likely to feel that they have a real choice. Several note that the HOPE scheme is one of many policy instruments among others to socially engineer highly-educated women to have more children and, in contrast, to encourage lower-educated women to have fewer children. The assumption behind this agenda is eugenicist—that if more highly-educated women had enough children, the quality of Singapore's workforce would improve because these women supposedly produce more intelligent children.[3] As academic Teo You Yenn notes, although the eugenics rationale for pro-natalist policies has diminished, we still see its legacy continue to linger in programmes such as the HOPE scheme. In 2015, the government stated that about 2700 families[4] remained on the HOPE scheme.

The HOPE scheme is indirectly racially discriminatory as it disproportionately affects Malay families more than others. To be eligible for the scheme, one's gross monthly household income should not be more than S$1,700 (US$1,262).[5] In the absence of a poverty line in Singapore, a proxy for low-income households is housing type. Low-income households are usually housed in public rental flats, which are reserved for households that do not earn a gross monthly household income of more than S$1500 (US$1,114).[6] According to the latest national census in 2020, the number of Malay households in one- and two-room public rental

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1 https://www.aljazeera.com/opinions/2013/3/30/singapores-hunger-for-some-babies

2 For example, a $60,000 housing grant, a once-off $1000 grant to offset utilities charges, up to $10,000 worth of employment incentives for full-time working mothers, annual bursaries up to $3000 for each child attending preschool to university to pay for their educational expenses, among many others.

3 These remarks, which launched the eugenics approach to population, were made by then-Prime Minister Lee Kuan Yew in his now infamous 1983 National Day Speech. There are several accounts of key moments in the history of Singapore's population policy (Heng and Devan 1995; Lazar 2001; Saw 1990; Teo 2013a, 2013b; Wong and Yeoh 2003).

4 This number is derived from figures indicated in this article. "Ms Low said in Parliament that 306 families have withdrawn from the programme." If 9 in 10 families remain on HOPE, then 1 in 10 withdrew. This means 306 families represent 10% of the total number of families that initially signed on to HOPE.

5 In relative terms, the median gross monthly income from work of full-time employed residents in Singapore in 2020 was S$4,534. See Ministry of Manpower Research and Statistics Department, 'Summary Table: Income', https://stats.mom.gov.sg/Pages/Income-Summary-Table.aspx.

6 In relative terms, the median monthly household income from work in 2020 in Singapore was S$9,189 (US$6,827). See Department of Statistics Singapore, 'Key Indicators On Household Income From Work Among Resident Employed Households',

flats grew from about 9,100 in 2010 to about 18,600.[7] This means that Malay households make up about 37.2% of all 50,000[8] public rental flat units in Singapore. More significantly, Malay families make up about 44% of all 42,500 rental flat units that comprise at least 3 household members (assuming a nuclear family with at least 2 parents and a child). Meanwhile, Malays only comprise 13.5% of the national population.

The HOPE scheme is also indirectly discriminatory towards Malays when one considers that Malay women have historically had higher fertility rates than Singaporean women of other ethnic groups.[9] Despite the decline in the fertility rate of Malays, as of 2020, Malays continue to have the highest birth rate among all ethnic groups.[10] It is worth noting that the proportion of Malays in Singapore declined from 15% in 1970 to 13.5% in 2020.[11]

In conclusion, the HOPE scheme discriminates against Malay women as it affects them much more than other ethnic groups. This is due to the overrepresentation of Malays in poverty statistics and Malay women having the highest fertility rate among all ethnic groups. The HOPE scheme is a violation under Article 1(1) which refers to the "purpose or effect of nullifying or impairing the recognition, enjoyment or exercise" of human rights, as the HOPE scheme indirectly has the effect of presenting a trade-off that would affect Malay women more than women of any other ethnic group—of deciding to either have more than 2 children or greater economic security. In making financial aid contingent on a curtailing of one's reproductive autonomy—through ligation or a vasectomy[12]—the scheme most directly discriminates against lower-income households, but indirectly discriminates against lower-income Malay households, more specifically.

Recommendation:

Ensure financial aid is adequate and untied from conditions that restrict the reproductive rights and autonomy of persons living in poverty.

2. Ethnic minorities are statistically more likely to be chronically ill and suffer higher mortality rates than members of the ethnic majority

According to a longitudinal study in 2001, Indian males are found to have 3 times the risk of coronary heart disease (CHD) compared to Chinese males. The more recent 2021 National Health Survey (NHS) revealed that Malays had the highest prevalence of self-reported hypertension (16.7%), followed by Chinese (15.8%) and Indians (12.6%). The same survey indicated that Indians had the highest prevalence of self-reported diabetes mellitus (11.5%), followed by Malays (8.8%) and Chinese (6.2%).

Moreover, other studies indicated that Malays and Indians had higher rates of myocardial infarction event and case fatality as well as coronary mortality than the Chinese.[13][14]

7 https://www.todayonline.com/singapore/worry-malays-living-rental-houses-will-become-entrenched-lead-falling-home-ownership

8 https://www.mnd.gov.sg/newsroom/parliament-matters/q-as/view/written-answer-by-ministry-of-national-development-on-households-living-in-hdb-rental-flats

9 https://www.amp.org.sg/wp-content/uploads/2017/06/12-Section-9_Demographic-Study.pdf

10

11 https://www.singstat.gov.sg/-/media/files/publications/cop2020/sr1/cop2020sr1.pdf

12 https://www.aljazeera.com/opinions/2013/3/30/singapores-hunger-for-some-babies

According to a report by the National Registry of Diseases Office, the rate of decrement in crude mortality rate of 100,000 population from acute myocardial infarction was higher for Indians than for Chinese from 2007 to 2010.[15] Similarly, stroke rates from 2009 to 2018 continue to be the highest among Malays.[16] In that same decade, the highest proportion of stroke deaths was observed among Malays aged 80 years and above (36.1%).[17]

The higher incidence of chronic illnesses among ethnic minority groups, especially Malays, unsurprisingly aligns with life expectancy rates according to ethnicity. Although life expectancy for all 3 major ethnic groups has increased since national independence in 1965, there are significant differences both in the magnitude of life expectancy and the rate of increases in life expectancy according to ethnicity. The greatest overall gains in life expectancy have been by the Indians, whose life expectancy at birth has increased by 18.8 years in females and 15.7 years in males, followed by the Chinese, where it has increased by 13.8 years in females and 14.2 years in males. The Malays, however, have seen an increase of only 13.6 years in females and 11.2 years in males.[18] Moreover, from 2008 to 2012, infant mortality, neonatal mortality, and perinatal mortality rates were the highest among Malays compared to the Chinese and Indian ethnic groups.[19]

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13 Trends in acute myocardial infarction in Singapore 2007 – 2010. Singapore Myocardial Infarction Registry Report. Singapore: National Registry of Diseases Office, Ministry of Health, http://www.nrdo.gov.sg/uploadedFiles/NRDO/Publications/AMI_16.pdf,

14 Mak KH, Chia KS, Kark JD, Chua T, Tan C, Foong BH: Ethnic differences in acute myocardial infarction in Singapore. Eur Heart J. 2003, 24: 151-160.

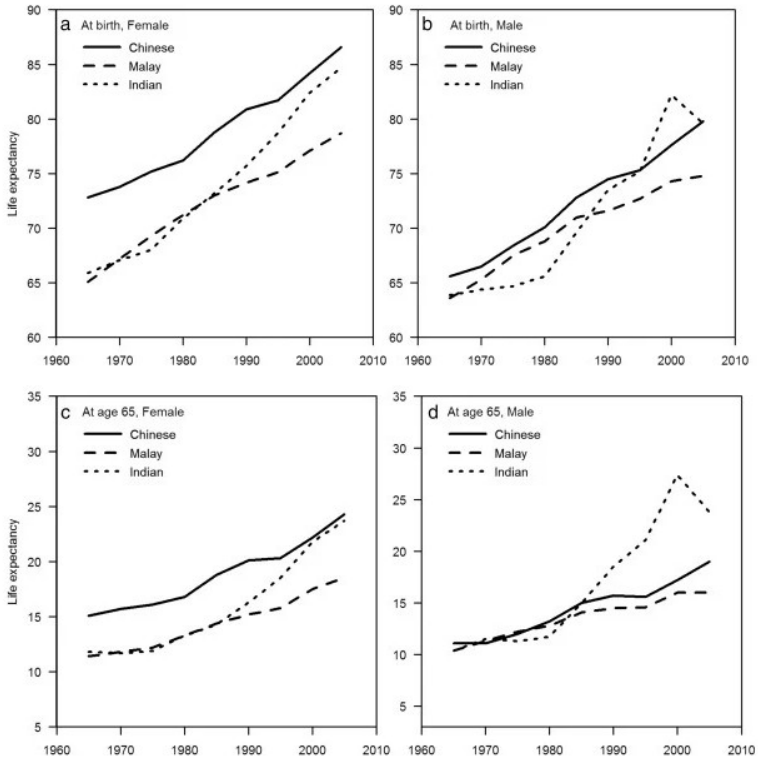
15 Trends in acute myocardial infarction in Singapore 2007 – 2010. Singapore Myocardial Infarction Registry Report. Singapore: National Registry of Diseases Office, Ministry of Health, http://www.nrdo.gov.sg/uploadedFiles/NRDO/Publications/AMI_16.pdf,

16 https://www.nrdo.gov.sg/docs/librariesprovider3/default-document-library/ssr-web-report-2018.pdf?sfvrsn=58eb7c4c_0

17 https://www.nrdo.gov.sg/docs/librariesprovider3/default-document-library/ssr-web-report-2018.pdf?sfvrsn=58eb7c4c_0

18 https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1012

19 Singapore Demographic Bulletin 2008 to 2012. Republic of Singapore: Registration of Births and Deaths, Immigration and Checkpoints Authority, http://www.ica.gov.sg/page.aspx?pageid=369,



[20]

Life expectancy at birth (a & b) and at age 65 (c & d) by ethnicity and gender, Singapore, from 1965 to 2009[21]

Relatedly, the 2021 NHS indicated that Malays are less likely than Indians and Chinese to seek health screening for several chronic illnesses. For example, a higher proportion of Indian (41.0%) and Chinese women (40.1%) had undergone mammography compared to their Malay counterparts (28.9%). Chinese (49.9%) and Indian women (46.1%) were more likely to have undergone Pap smear tests compared to Malay women (34.8%). According to a recent qualitative study of health inequality in a public rental flat neighbourhood, many low-income residents interviewed (of whom half were Malay), found health screenings necessary but too costly[22]. Apart from screenings for specific illnesses,[23] comprehensive health screenings are not subsidised by the public healthcare system, making it unaffordable for many who are low-income.

The incidence of higher rates of chronic illnesses among ethnic minorities and higher mortality rates among Malays, along with the lower likelihood of Malays to go for certain chronic health screenings, indicate a potential violation of Article 5 (e)(iv). As the data suggests, many of these statistics are also historical trends, indicating systemic inequalities in healthcare in Singapore that occur along ethnic lines, suggesting that there is indeed racial discrimination in the right to public health.

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20 https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1012

21 https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1012

22 Kumarr, S., &; Chok, S. (2021). 'Stretched at Work, Stretched at Home, Thinking Twice Before Seeing Doctor': Healthcare Capacities of Lengkok Bahru Residents. Singapore: Beyond Social Services.

23 For Singapore citizens, screenings for cardiovascular diseases, cervical cancer, and colorectal cancer and several others are subsidised at a low fee. However, further eligibility criteria apply.

Recommendation:

- *Commission an independent, comprehensive study to investigate the structural causes of ethnic- and class-based differences in chronic health outcomes. The study's team should include diverse members, including researchers that represent a range of ethnic groups and have a clear understanding of and commitment to rights-based approaches.*

- *Ensure public resources are directed to dealing with the structural drivers of health inequalities linked to racial and class differences.*

3. Implicit racial bias in healthcare settings which manifests in patient-provider interactions, exacerbating health disparities in ethnic minorities.

While there have been many qualitative and quantitative studies about racism in the healthcare sector in many countries, there has been no such study conducted in Singapore.[24] Nonetheless, in January this year *Minority Voices (MV)*, a civil society organisation based in Singapore called for submissions[25] from ethnic minorities who have experienced medical racism in Singapore. Within a month, MV published 10 self-reported anecdotes about racial bias in healthcare settings affecting ethnic minorities' access to public health.

Racial bias among health care providers manifests in both implicit and explicit ways, resulting in ethnic minority patients receiving inadequate care. For example, an anonymous submission to MV by an ethnic minority patient of presumably South Asian descent recounted being judged based on her ethnic attire, which led to her not receiving required treatment for her health issue.[26] The patient once went to a Polyclinic to see a General Practitioner (GP) for lower back pain. She was wearing a *salwar kameez* (South Asian ethnic wear). The GP asked what was wrong and asked a few questions about the probable causes. When he found out there was no direct cause, he remarked that she looked depressed because of her "whole look, (her) face, (her) outfit". The patient started tearing up, to which the GP responded, "I have 50 patients in my office each day and none of them cry like you do. I must be right. Depression can sometimes cause aches and pains in the body". The patient was subsequently referred to counselling services instead of a follow-up appointment and she did not receive any care or medication for her back problems.

More explicitly, at least two submissions to MV indicate healthcare professionals' refusal of medical treatment to ethnic minorities for various reasons. In February this year MV shared a submission by a nurse at one of the largest private hospitals in Singapore, that a specialist instructed another nurse to not accept patients of Indian nationality.[27] The hospital has since reached out to MV requesting to get in contact with the complainant. There have been no publicly available updates on the case ever since. In another instance of explicit racial bias, an ethnic minority child was refused treatment for a jellyfish sting on account of various GPs (of Chinese ethnicity) claiming not being able to identify and diagnose skin problems "on

24 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0255936
25 https://www.instagram.com/p/CKtHPZplCHv/
26 https://www.instagram.com/p/CML9cxMFn_l/
27 https://www.instagram.com/p/CLqpyPHFKkX/

darker skin". Eventually, the child's sister managed to find an Indian GP in Little India, a neighbourhood further from where she and her brother were. The GP listened to the patient and her sister's account of what happened and diagnosed the child's issue as a jellyfish sting and administered the proper treatment.

In another anonymous submission,[28] a patient of Pakistani nationality with an injured knee recounted his conversation with an orthopaedic specialist in which he was racially profiled. The specialist asked if he was "local", if he was "working", and when the patient said he was a teacher, the specialist remarked, "Oh, so you're the educated kind". The specialist asked further questions about whether he went to university, and which college. After finding out that the patient had a university degree, the specialist's demeanour changed—from a colloquial form of speech or the Queen's English, before inspecting his knee. In the medical report, the surgeon indicates the patient's race as Malay, which the patient corrected, insisting that he is Pakistani. The specialist however changed his race from Malay to Indian. The patient was essentially racially profiled and the quality of treatment he received from the doctor might have depended on the particular racial profile he already had in mind.

As a result, implicit to explicit forms of racial bias that manifest in misdiagnosis, refusal of equal treatment, and racial profiling indicate how racial bias directly harms ethnic minorities' health, violating Article 5(e)(iv).

Recommendations:

- *Review existing policies to ensure that there is proportionate and adequate representation of ethnic minority doctors*

- *Provide racial sensitivity training to all healthcare professionals. Ensure that professional associations of doctors, nurses, social workers and other allied professionals have feedback mechanisms that are accessible and publicised to those seeking healthcare and advice.*

4. The lack of Malay and Tamil language interpreter services in healthcare settings discriminates against ethnic minority elders

Despite being two of the four official languages in Singapore, there is a lack of readily available Malay and Tamil language interpreters in healthcare settings. This discriminates against minority elderly patients who are less likely to be fluent in English or Chinese. A submission to MV by Shariffah Nureza[29] recounted how their elderly Malay parents struggled to navigate the healthcare system due to their inability to fluently converse in English. As a result of this, her parents find the healthcare system inaccessible without the help of their children who are more proficient in English. Chinese-speaking elderly are less likely to face such barriers accessing the healthcare system as there is no shortage of healthcare workers who can converse in Chinese. Shariffah Nureza recounts seeing many elderly Chineser patients in clinics and hospitals who demand to speak in Mandarin and are attended to immediately almost all the time. Despite Malay being 1 of the 4 official languages, such services are not made available to ethnic minority patients.

28 https://www.instagram.com/p/CLWKflvFPfH/
29 https://www.instagram.com/p/CL_OHNGFUTs/

Recommendation:

- *Review existing hiring policies to ensure that hospitals and clinics have adequately qualified interpreters for all national languages, and for this service to be made known to patients.*

5. Disparities in healthcare access according to citizenship status, disproportionately affecting low-income foreign spouses from the Global South[30]

As citizens, Singaporeans gain access to government-subsidised healthcare while non-Singaporeans do not. The common assumption is that non-Singaporeans are generally affluent and therefore able to afford the exorbitant non-subsidised healthcare expenses. However, non-Singaporeans in Singapore are a heterogeneous demographic—some are affluent and many are not. About 1 million are low-wage workers on temporary permits without a minimum wage who come from the Global South. There are also resident non-Singaporeans who are in low-wage jobs on other work passes, who also tend to migrate from the Global South (namely Malaysia, the Philippines, Indonesia) and live in public rental housing with gross monthly household incomes that amount to less than S$1500. These non-Singaporean residents are only able to stay in rental housing because they are married to a Singaporean. However, there are instances when the marriage ends in a separation or divorce, leaving the non-Singaporean resident housing insecure. A significant number of non-Singaporean residents living in rental housing are single mothers of Singaporean children. Without the right to subsidised healthcare, the caregiving capacities of low-income foreign single and wedded parents of Singaporeans are significantly constrained by the exorbitant healthcare costs.[31]

The treatment of the class of low-income foreign spouses in Singapore violates Article 5 (e) (iv). Despite low-income foreign spouses living in Singapore and performing the same social reproductive labour of giving care to Singaporean children as more affluent foreign spouses or Singaporean spouses, they face significantly more barriers to enjoying the same right to public health and medical care. This is fundamentally racially discriminatory as it is not merely an issue concerning distinguishing between citizens and non-citizens as laid out in Article 1 (2) and (3). Low-income foreign spouses tend to be on a work pass known as the “long-term visit pass”(LTVP) which does not immediately allow one to work, and they tend to have Global South nationalities (e.g. Indonesia, Philippines, Vietnam, India, China). In contrast, higher-income foreigners are more likely to be on the S-Pass or Employment Pass which both have minimum qualifying salaries of S$2500 and S$4500 respectively—and they tend to come from both the Global South and North (some of whom are white Americans or Europeans). Many high-income foreigners in Singapore are also CEOs or business owners from Europe, the US, China, and India for whom the public healthcare system is irrelevant.

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30 For more information on low-wage migrant labour’s access to healthcare read HOME and TWC2’s joint submission

31 Kumarr, S., &; Chok, S. (2021). 'Stretched at Work, Stretched at Home, Thinking Twice Before Seeing Doctor': Healthcare Capacities of Lengkok Bahru Residents. Singapore: Beyond Social Services.

For foreign workers on S-Pass and Employment Pass however, many rely on health insurance packages offered by their employers, to offset some (if not all) healthcare costs. For low-income foreign spouses who are LTVP holders, employment is not an immediate possibility as they would need to first apply for a 'letter of consent' (LOC) to work in Singapore or get a regular work pass. Such jobs may not provide health insurance as well. One possibility is for LTVP holders to apply for LTVP+ which grants one some healthcare subsidies as long as they have been married for at least 3 years and have a Singaporean child (among other criteria). Nonetheless, given the additional barriers to healthcare low-income foreign spouses have to face compared to higher-income and capital-owning foreigners and Singaporeans, despite doing the same social reproductive labour to care for Singaporean children, their treatment in Singapore violates Article 5(e)(iv).

Recommendation:

- *Grant foreign spouses and their children living in Singapore the same amount of government subsidies as Singaporeans for healthcare expenditure.*

6. With rising temperatures due to the climate crisis, low-wage migrant workers are more prone to heat-related illnesses

Outdoor manual labour in the construction, marine and process sectors is carried out by around 300,000 low-wage migrant workers in Singapore, many of whom are recruited from South Asian countries. According to Associate Professor Jason Lee from the National University of Singapore's Yong Loo Lin School of Medicine, rising temperatures will affect construction workers more so than the average population, causing heat-related illnesses.[32] Due to the onset of the COVID-19 pandemic, migrant workers have also reported working much longer hours, under blazing temperatures, as projects are rushed to be finished following a halt last year during Singapore's "circuit-breaker".

The vulnerability of low-wage migrant workers to heat-related illnesses is linked to their lack of collective bargaining power to challenge unsafe work measures such as working outdoors in extreme heat. As low-wage migrant workers are easily deportable, and are unable to unionise, they are legally disempowered from collective bargaining. This renders low-wage migrant workers particularly vulnerable to reject unsafe working conditions which cause them to suffer from heat-related illnesses as a result of global rising temperatures.

Recommendations:

- *Allow workers of all nationalities equal access to unionise and union rights, including the right to collectively bargain*

- *Unions should include heat-stress related demands on their agenda of workplace issues (e.g. workplace safety, wages, benefits etc). Some heat-stress related demands may include workers demanding to invest their labour in less environmentally destructive construction projects such as building hospitals as opposed to an oil refinery.*

32https://www.straitstimes.com/singapore/environment/spore-at-risk-of-heatwaves-and-more-dengue-outbreaks-as-climate-change-worsens

- *Legalise independent workers' unions. Currently workers are only allowed to unionise under the state-linked National Trade Union Congress (NTUC). NTUC is a tripartite union that believes in the common interests of businesses, the state, and labour. However, it is puzzling that while it is legal for associations to be explicitly interested in business and state affairs, a union that is explicitly dedicated to the interests of labour is illegal. As a result, explicitly labour unions should be made legal again, for workers to independently unionise, so that workers can democratically decide for themselves the direction of the labour movement without state or business interference.*