Development and Change
Published on behalf of the Institute of Social Studies, The Hague

Grievance Politics and Technocracy in a Developmental State: Healthcare Policy Reforms in Singapore

Ijlal Naqvi, Federico M. Rossi and Rayner Kay Jin Tan

ABSTRACT

This article uses a process-tracing approach to understand changes in Singapore's health sector from the start of self-rule in 1959 to the end of the COVID-19 pandemic in 2022. Singapore is a developmental state recognized for its effective management of healthcare costs and its lack of political freedom. In both respects, the 'Singapore model' is of interest to other cities and nations. The standard narrative is one of technocratic proficiency in a context in which civic freedoms are heavily constrained, but this article identifies the surprisingly important role of social voices at key moments. It finds episodes in which effective changes to social policies are not the product of a state embedded in an organized society, but rather are influenced by the independent organizational capacity of certain social groups providing inputs to state elites on social grievances and policy needs. Effective policy changes require a responsive state elite that — even if it is technocratically dominated, as is the case in Singapore — can listen to social claims and provide answers that are not repressive. The article conceptualizes these dynamics as 'grievance politics' and shows their role in explaining health reforms. It contributes to understanding global health systems and policy making in developmental states by a fruitful cross-fertilization with social movement studies.

INTRODUCTION

Autocratic states with developmental aspirations run the risk of getting poor-quality policy feedback due to the limited number of public channels between society and state. Under such circumstances, how do autocratic developmental states obtain policy feedback as they produce or

The fieldwork and archive research on which this article is based has benefited from a Short-term Research Collaboration Programme of the School of Social Sciences, Singapore Management University, which supported Federico M. Rossi's participation in fieldwork in Singapore. The open access publication of this article is funded by the Universidad Nacional de Educación a Distancia (UNED). The authors are very grateful for the excellent and constructive comments and suggestions from the reviewers and the editors of *Development and Change*.

Development and Change 55(2): 244–275. DOI: 10.1111/dech.12821

evolve their health policies? This article argues that there is an important role for relatively independent social groups as important interlocutors for policy feedback. It shows how this works in Singapore in what the article defines as a specific moment of 'grievance politics', during which claims for social accountability emerge with the potential to shift technocratic politics without resorting to mobilization or other riskier political actions, and thus to express dissidence within the windows of 'tolerated' freedom. Singapore is a particularly informative case because it serves as a model of governance for both autocratic states (Ortmann and Thompson, 2016) and democratic states (Haseltine, 2013), yet it does not fit easily into either category.

Informed by social movement studies and complementing the literature on developmental states, the article identifies episodes of grievance politics in which changes to health policies are not exclusively the product of a technocratic state, embedded in an organized society, but rather are prompted by the independent organizational capacity of certain social groups providing inputs to state elites on social grievances and policy needs. Thus, even though civic freedoms and the media are heavily constrained in Singapore, elections give some scope for public competition and contestation, and expressions of dissidence and critique do emerge to influence transformations on health policies when elites listen and respond without repression. This article introduces to global health discussions a political sociology perspective that reinserts social conflicts into policy making on health issues in a developmental state and sheds light on the emergence and contribution of civic feedback outside of a liberal democratic context. The article begins with a political sociology perspective on health policy making, building bridges between the global health, developmental states and social movements literatures. In the next section it outlines the argument and methodology. Subsequent sections develop a process-tracing analysis of health reforms in Singapore from 1959 to 2022, highlighting the role of technocracy, party politics, and crucial social groups for this policy area. The article ends with some concluding remarks.

CONNECTING GLOBAL PUBLIC HEALTH, DEVELOPMENTAL STATES AND SOCIAL MOVEMENTS LITERATURES

The field of global public health derives from public and international health efforts that are historically rooted in colonial and tropical medicine (Koplan et al., 2009), with dominant discourses attempting to offer technical solutions to the issues of global health inequity. One example is the social determinants of health framework, which argues that global health should focus its agenda on social and political conditions that lead to health inequities, as well as policies to deal with them (Bell et al., 2010). Outside of the literature on global health governance, calls have been made to decolonialize global health through structural reforms that promote participation by

experts and communities in low- to middle-income countries, privileging indigenous expertise over experts from the Global North (Khan et al., 2021).

Although these discussions help us to understand how technical solutions potentially shape national health policies, the global public health literature has had little to say about the political contexts and actors that favour specific health reforms. A separate global health literature that is rooted in sociology and political science addresses some of the social and political factors that shape national health reforms. Scholars such as Harris (2017) have shown how professional movements, comprising doctors and lawyers, can be empowered through collective mobilization and voice to influence health policies beyond their traditional roles as technocratic experts. Others have also explained large-scale health reform through the confluence of three streams (see, for example, Agartan, 2015; Kingdon, 1984), where problems, policies and politics converge. In the confluence of these streams, exceptional political will among political leaders created a window of opportunity for change in health reform. McGuire's (2010) study of health policies in East Asia and Latin America, analysing the relationship between wealth and democracy and the differential success of public health, is an exemplar of inserting political sociology into the global health literature. A review of explanations for health policy reform by Haeder (2012) highlights multiple theoretical approaches, including path dependence, pivotal politics and gridlock, and presidential power, as well as multiple streams.

The literature on developmental states helps us conceptualize and explain the changes experienced by certain states that do not follow the liberal Western path and how this has influenced the direction taken by their healthcare systems. The developmental state literature, mainly focused on Asia, suggests that such states are characterized by strong authoritarian executives who incentivize a meritocratic and autonomous bureaucracy to prioritize economic growth through industrial policy (Haggard, 1990; Johnson, 1982). However, not all would-be developmental states have enjoyed the successes of Japan, Singapore, South Korea, Taiwan and Thailand, as shown in cross-national studies (Evans, 1995; Kohli and Woodward, 2004). Given the importance this literature attributes to feedback loops between bureaucrats and key stakeholders, we might ask, '*how* do these states get the necessary information from society to improve their health systems without providing civic freedoms?'. The common argument in the developmental state literature is that a combination of formal governmental structures and informal links to the wider society have been crucial in enabling this to happen (Evans, 1995; Maxfield and Schneider, 1997). Japan's Ministry of International Trade and Industry famously combined rationalized bureaucratic systems with a dense network of linkages between industrial and bureaucratic elites that helped the coherent formulation and implementation of industrial policies (Johnson, 1982). Evans' (1995) 'embedded autonomy' became the explanation par excellence of these dynamics, but its focus — like that of the developmental state literature in general — was on

industrial transformation rather than public health or some other diffuse public investment.

Until recently, the embedded autonomy argument was only applied to state–business relationships in industrial and technological processes, which included a subordinated labour sector and a highly repressed Left. Studies of investments in human capital in developmental states have received less attention, despite their importance as antecedents to the developmental project (Hanushek and Woessmann, 2008; Ranis et al., 2000). The question that is still not answered by this literature is how social policies were developed, bearing in mind that developmental states invested in human capital with the improvement of public education and, in some cases such as Singapore, health (McGuire, 2010; Ranis et al., 2000). So, in this article, we ask, '*how* do technocratic elites receive effective and timely social feedback in the absence of secure civic liberties and a free media?'

The trajectory of developmental states changed direction significantly after the 1990s, and the literature moved to reflect these shifts (Haggard, 2018). Importantly, many of the authoritarian developmental states liberalized from a position of strength, leaving the regime's party structures and networks largely intact while allowing for fundamental democratic freedoms to be established in a more competitive political environment (Slater and Wong, 2022). Singapore remains a notable exception to this trend, and continues to disavow liberalism (Chua, 2017), while retaining a long-established rational and administrative emphasis on statecraft, such as technocracy (see Chan, 1975; K.P. Tan, 2017). By technocracy, we refer to a governance model wherein highly educated elites who control political and economic institutions are committed to producing authoritative decisions through an instrumental rationality (Centeno, 1993; Fischer, 1990). Inherent in technocracy is a rejection of ideological constraints (Putman, 1977; on Singaporean pragmatism see Chua, 1985; Ong, 2015). According to Fischer (1990: 18):

> Technocracy, in this respect, refers to the adaptation of expertise to the tasks of governance. It gives rise to a theory of governmental decision making designed to promote technical solutions to political problems. … Technocracy, in short, pertains to the use of experts and their technical disciplinary knowledge in the pursuit of political power and the 'good society' in the spheres of both the state and the economy.

A prominent example of Singapore's technocracy in action is the Committee for the Future Economy, whose 2017 report the Prime Minister accepted, declaring the government's intent to implement the proposed strategies with a 'hard-headed pragmatic approach' (Ministry of Trade and Industry, 2017). In contrast to Singapore, many newly democratic states shifted their focus from economic growth to social distribution and the expansion of human capabilities and freedoms as both the means and ends of development (Sen, 1999). Tracking these shifts among developmental states, Evans and Heller (2015) refined the developmental state model for the 21st century in terms

of a reorientation towards social rather than industrial policy, reflecting the greater returns to human capital in contemporary economies. Embedded autonomy is given a new meaning in this 21st century context, as the necessary feedback loops for successful social policy cannot be achieved through elite networks of civil servants and industry leaders alone, but must involve the affected groups, entailing an openness to voices from below. Singapore takes on a particular significance for the 21st century developmental state because the feedback model described by Evans and Heller (2015) presupposes civil liberties which are not present in Singapore. How Singapore can nonetheless deliver high quality and efficient public services such as healthcare represents an informative test of the 21st century developmental state theoretical framework, but it also has practical significance for those authoritarian states with developmental aspirations that look to Singapore as a model (Ortmann and Thompson, 2016).

To address this gap, we turn to the growing literature on grievances. This scholarship informs us about a dimension that has been neglected in studies of both health policy and developmental states, and explains how developmental states deal with social dissatisfaction and criticism. The study of grievances was originally associated with strain and breakdown theories (Blumer, 1951). Among these theories, relative deprivation theory explains how the psychological dissonance between what is materially desired and what is actually received can lead to collective action (Gurr, 1970). These classical perspectives have been criticized by the resource mobilization theories of social movements as overly materialistic and lacking a rational understanding of actors (McAdam, 1999; Tarrow, 1998). Other recent social movements scholarship, however, has reclaimed the relevance of grievances in explaining the emergence of protest. Snow et al. (1986) recovered the study of grievances as the expression socio-political dissatisfaction as central to understanding disruption. Almeida (2019) reconnected both traditions through the analysis of perceived threats as mobilizers and Snow and Soule (2010) made a crucial distinction between 'mobilizing grievances', which are collectively shared and promote collective action, and 'individual grievances', which create moral hazards but do not trigger mobilization. For these authors, protest requires the generation of deeply felt, shared grievances. This view has been further developed by the culturalist turn in social movements studies. Reintegrating grievances into the core of social movements analysis, Jasper (1997) argues that moral shocks, as abrupt changes in daily life, are generators of grievances that lead to spontaneous organizations of collective action. Summarizing most of these debates, Simmons (2014) argues that grievances are materially and ideationally constituted. The grievance literature originally conceived these processes in democratic contexts and as promoters of disruption. As we will argue below, this original conception can be extended beyond the Western liberal setting, filling a gap in the three literatures reviewed.

Grievance Politics: A Definition

This article analyses conflictual dimensions of health policy making in a context of weak civic liberties by examining the attribution of responsibility — and the search for solutions — that actors experiencing a grievance bring to bear in a developmental state. It proposes bridging literatures to explain what drives technocratic elites to produce policy changes when society is not allowed to organize. Complementing the recent wave of studies in developmental states, as mentioned above, we define a different combination of embeddedness and autonomy in developmental states that we call grievance politics. Grievance politics in developmental states means a public expression of dissatisfaction by a policy's critics, but one that does not lead to mobilization due to the high risk of repression. Instead, grievances are generally expressed through the few windows of freedom that an autocratic developmental state tolerates, such as electoral agendas of minor parties, experts' or social actors' critical comments on policies, and other dissident expressions that limit themselves to the issue at hand and do not push towards broader regime liberalization. This ability of actors to put grievances on the political table as a low-intensity conflict is still disruptive enough in this autocratic context, as it challenges certain policies when this would not normally be tolerated. However, this grievance politics could potentially build a coordinated opposition if left unaddressed. It is because of this risk that technocratic elites respond during key moments with reforms of social policies to avoid escalating the issues raised into wider systemic claims. This combination of global health, developmental state and social movements literatures into a political sociology of health reforms allows us to reintroduce the ideational and material constitution of political conflicts to healthcare policy making.

HEALTHCARE REFORMS IN A DEVELOPMENTAL STATE: THE SINGAPOREAN CASE

The process of healthcare reforms in Singapore shows the central role of a technocratic state fulfilling the role of the 'competent authority', although policy directions are corrected in response to the airing of grievance politics in the domestic sphere. State funding of the media and the public sphere notwithstanding, Singaporeans' concerns over the availability and affordability of healthcare can prompt corrections in the rollout of policy. The dominance of the People's Action Party (PAP) is so comprehensive, and its controls over electoral procedures so extensive (N. Tan, 2013), that while the expression of these grievances around elections might carry some opposition leaders into parliament, in general grievances are registered more subtly through fluctuations in the share of votes. Feedback through grievance politics is distinct from the state being embedded in an active civil society;

Table 1. Summary of Periods, Policy Episodes, Grievance Politics and Reform Responses

Periods and Episodes	Technocracy	Domestic Politics	Social Groups
1959–83 Preventative health	Focus on preventative public health	Consolidation, legitimacy through primary healthcare delivery	Charitable healthcare institutions incorporated into public system
1983–2000 Corporatization of healthcare institutions	Corporatization, 3Ms financing, White Paper on Affordable Healthcare	Perceptions of profit-making and revenue maximization	Concerns from medical profession over commercialism
2000–11 Healthcare restructuring to promote competition	Healthcare restructuring and clustering,	Polyclinic waiting times, lack of hospital beds and affordability.	Innovations at the healthcare institutional level
2011–19 Managing rising healthcare costs	Financing for chronic conditions through CHAS and Pioneer Generation Package. Masterplan 2020	Perceptions of unaffordable healthcare alongside rising costs of living	Participation without power; GP engagement sessions, CHAS town hall
2020–22 Pandemic	Lessons of SARS, vaccine rollout	Domestic surveillance	Focus on migrant workers

Source: Authors' compilation.

medical professionals tend to maintain independent practices and views, and rarely act collectively. Grievance politics is thus a limited and perhaps delayed feedback loop which operates in the absence of deep and broad democratic governance structures. By analysing these periods of healthcare reform, we illustrate that while technocratic expertise and competency played the leading role in the development of policies, subsequent iterations and refinements have been influenced through increasingly autonomous demands from the electorate and opposition parties. However, no period of democratic opening has resulted. The expressed logics of state action remain technocratic, emphasizing efficiency and competition, and ceding no political space to the legitimation of autonomous demands or allowing collective action which would further those demands. Nevertheless, the state has responded to the substance of claims arising from social actors with far-reaching policy reforms that look to substantially address those grievances, even when this means walking back from a commitment to market-based competition and expanding the role of public healthcare institutions.

Table 1 summarizes the periodization of our case trajectory, along with the contending dynamics that inform the historical evolution of healthcare policy in Singapore from the start of self-rule in 1959 to the end of the COVID-19 pandemic in 2022. Following a brief description of our data and methodology in the next section, subsequent sections will elaborate on each of these periods in more detail.

Data and Methods

We used a process-tracing method to locate the paths taken by Singapore's public health system and the specific moments at which relevant transformations occurred. This allowed us to identify phases in this historical reconstruction as shown in Table 1. In addition, it allowed us to empirically locate the actors and events that were crucial and to pinpoint when grievance politics was at play. To do this, we collected all published government documents relating to healthcare and reform from 1959 to 2022. Based on the assortment of published documents, further research was carried out to identify parliamentary debates, as well as official statements and press releases made by the Singapore government or the Ministry of Health (MOH) that reflected policy makers' positions on key structural or distributive reforms in the healthcare system. We conducted an online database search and review of the academic literature on healthcare financing and reforms in Singapore to guide our selection of cases. We then supplemented our secondary research by generating primary data through direct observation and in-depth interviews with a sample of purposively selected key stakeholders. From March to December 2016 we made a total of 14 field visits to primary healthcare settings such as planning offices, government-run polyclinics, family medicine centres and privately owned general practitioner clinics. During this period, we also conducted in-depth interviews with a total of 14 key stakeholders in the Singapore healthcare governance structure, including general practitioners, physicians in government-run healthcare settings, clinic managers, polyclinic directors, staff at voluntary welfare organizations, policy makers and academics. We explored themes broadly relating to healthcare governance, policy development, policy implementation and policy feedback through these interviews.

SELF-GOVERNANCE AND SHIFTING POLITICAL ETHOS (1959–83)

In 1959 Singapore achieved self-governance from British rule.[1] The years that followed saw the first move towards a coherent, consolidated system, dictated and planned by the ruling PAP, who won the first general election in the same year. After attaining self-rule, the government first expanded free outpatient healthcare services, modelled on the UK's National Health Service (NHS). With increasing healthcare costs, and recognizing that patients needed to bear some of the costs of healthcare services, in the late 1960s the government began taking steps away from a free system; previously free services had to be paid for through what it termed 'token' fees and charges

1. Singapore gained full internal self-governance (excepting external affairs and internal security) in 1959. Singapore left colonial rule entirely when it joined the Malaysian federation in 1963, and then became fully independent in 1965 when it separated from Malaysia.

(Singhealth Group, 2021). Over the next three decades, the government started the process of consolidating its public healthcare institutions and processes (Tong and Narayanan, 2015), and stepped away from the ideology of welfarism that underpinned the existing system inherited from the UK's NHS.

The early years of self-governance were fraught with political and economic uncertainty for the PAP-led government and the then Prime Minister, Lee Kuan Yew. In his memoirs, Lee Kuan Yew (2000) noted that he had three immediate concerns for the country: to build a strong defence programme, to grow a strong economy and to gain recognition for Singapore's independence on the international stage. Healthcare was not a major priority for the Singapore government at this time, but it had taken measures to improve primary care and to tackle malnutrition, infectious diseases and other fundamental issues of health and sanitation that could have impeded the growth of Singapore's economy, initiating a path of investment on human capital typical of developmental states (H.L. Lee, 2013).

One of Singapore's earliest health concerns was tuberculosis or TB (for a detailed social history see Loh and Hsu, 2020), but the colonial government's 1947 medical plan prioritized other areas and did not address the disease. This spurred a group of concerned public figures and doctors, both European and Asian, to form the Singapore Anti-Tuberculosis Association (SATA). While SATA was non-governmental and was formed in explicit response to government inaction on an issue of public concern, its Patron and President were the Governor General of Malaya and the Governor of Singapore respectively, demonstrating the organization's strong official linkages. SATA not only shaped the debate on TB but provided crucial resources such as the land for a regional diagnostic and outpatient clinic built in Changi in 1962 (donated by council member G. Uttaram). SATA's work in the 1950s focused on early detection, rehabilitation, vaccination and community outreach (termed 'propaganda'). Funding was a constant struggle. SATA's services (for example, chest X-rays) were provided on a fee-paying basis at a time when the equivalent services through the public Tan Tock Seng Hospital were provided for free. Over time, SATA's work in coordination with state authorities successfully minimized the danger posed by TB, even as increased industrial employment gave more Singaporeans access to preventative healthcare via insurance benefits. SATA served chronic and cured patients, though the need for rehabilitation services declined over the years and SATA eventually transitioned to be more of a medical provider than an advocacy body. Loh and Hsu (2020) praise SATA for its contribution to TB control in Singapore, describing it as an achievement of the community as well as the state.

By the 1970s, having enacted mandatory nationwide vaccination programmes against smallpox, diphtheria and poliomyelitis, and provided malnourished children with nutritional supplements, Singapore had achieved a good level of sanitation and had rid itself of most communicable diseases

except for remnants of TB, typhoid and dengue fever (Thomas et al., 2016). With a wide network of primary care facilities and having set the foundation for growth in its healthcare sector, the government began to invest in and offer specialized medical care by appointing a Committee on Medical Specialization to examine the extent to which specialization should be implemented in Singapore (Lim, 2013). Singapore's GDP had grown from US$ 0.70 billion in 1960 to US$ 9.29 billion in 1979,[2] and with growing economic prosperity, the government began investing in the health of its population, and its status as a hub for healthcare excellence in the region.

In the years after 1959, following the attainment of self-governance, there was a fundamental shift in the healthcare ethos of Singapore as the country moved away from its colonial roots. Britain's NHS was founded on 5 July 1948, on three core principles: that it meets the needs of everyone, that it be free at the point of delivery, and that it be based on clinical need and not the ability to pay. However, the political leadership of Singapore, and specifically the then PM Lee Kuan Yew, considered this problematic. While Lee shared his amazement over the free medical care that the NHS offered in his time as a law undergraduate at Cambridge University (K.Y. Lee, 2002), he held a pessimistic view of human nature and behaviour, and firmly believed that Singaporeans would abuse the system of free healthcare and welfarism from the state (K.Y. Lee, 2000).

An acceptable compromise that began to take shape as a political ethos underpinning Singapore's healthcare financing was the idea of self-reliance: in the context of healthcare, this means the sharing of costs between an individual and the state. In what was seen as a bold step away from the NHS-type system, Lee first introduced a system of user charges for healthcare in 1960, whereby individuals had to pay a flat fee of 0.50 Malaya and British Borneo dollar[3] for visiting any government outpatient clinics, which doubled to 1 Malaya and British Borneo dollar on public holidays (Lim, 1998). From that point on, co-payment of healthcare costs became a persistent and defining feature of Singapore's healthcare ethos.

On the political front, by the end of the 1970s, substantial 'Malayization' had taken place whereby national workers had largely replaced colonial expatriates, and the government had actively sought to shift the identity of Singaporean Chinese away from vernacular dialects, clan associations and Chinese-language tertiary education (E.K.B Tan, 2003), which further strengthened the ideological centricity of the PAP government (Thomas et al., 2016). The emerging Singaporean developmental state, with its monopoly on parliamentary seats, strong bureaucracy, and suppression of the influence of clans and associations, unapologetically and unilaterally

2. See: https://data.worldbank.org/country/singapore
3. In 1960 the US$–Malaya and British Borneo dollar exchange rate was 3.06–1; https://fred.stlouisfed.org/series/FXRATESGA618NUPN. Launched in 1967, the SGD maintained the same exchange rate to the US$ until 1971.

developed and implemented policies that were admittedly intrusive or unpopular, but which elites claimed were necessary for the survival and progress of the nation (Siraj, 1987). The direction taken by the PAP favoured an efficient organization of the health system as part of an articulated plan for developing Singapore into a wealthy nation, which included explicitly devaluing civil and political freedoms to express dissent.

In 1968 the President of Singapore, Yusof Ishak, made a speech at the First Session of the Second Parliament, highlighting how Singapore's health bill had risen over the years, and stressing that steps must be taken to keep costs manageable. This led to increases in inpatient ward charges across the board in 1969, with the most significant change being that fees for the lowest-class wards were also introduced when previously such care had been free. For outpatient services, patients who were previously treated for free at specialist outpatient clinics in hospital were charged an attendance fee of SGD 1.50, introduced in 1969, except for clinics dealing with issues of major public health significance, such as TB, psychiatric treatment, venereal diseases and diabetes (Singapore Government, 1969). Throughout the 1970s, under the leadership of Chua Sian Chin and then Toh Chin Chye, costs for healthcare services climbed steadily: by 1978 fees had doubled to about SGD 3 for a visit to an outpatient clinic on a weekday and to SGD 4 on a weekend or public holiday. In 1978, accident and emergency fees were increased 150 per cent from SGD 4 to SGD 10 (Fong, 1978), leading to heated debate in Parliament regarding the cost of healthcare.

Also in 1978, the Minister for Health announced that a new intermediate ward class between the existing B and C categories would be introduced to provide patients with more privacy (Singapore Government, 1978). In subsequent years, the introduction of what came to be known as ward class B2 led to a reduction in the number of class C wards across all major hospitals. For example, Singapore General Hospital had 1,069, 1,225, 1,149 and 216 class C wards in 1970, 1975, 1980 and 1985, respectively, as the hospital was renovated and converted a substantial number of C wards to class B1 wards (Singapore Government, 1986). While the government attempted to reduce the proportion of class C beds throughout the 1980s, pressure from government backbenchers led to an eventual replenishment of the supply of such beds by the MOH (Barr, 2001).

THE CORPORATIZATION OF HEALTHCARE AND SHIFTING PRIORITIES FOR THE DEVELOPMENTAL STATE (1983–2000)

As Singapore began focusing its efforts on reforming the healthcare system from the 1980s, several developed nations across the world were engaging in neoliberal policy reforms. In the United States and the United Kingdom, such a move was characterized by processes of deregulation, privatization and developing free trade agreements, in a bid to create a

more laissez-faire economy. Singapore was arguably influenced by this neoliberal economic movement, with the Special Report of the Economic Committee (published in 1986) charting Singapore's course for deregulating and privatizing various industries, including the healthcare industry (Ministry of Trade and Industry, 1986). However, international diffusion alone could not explain such broad reforms in the economic and healthcare system in Singapore, given that concerted efforts were made to weigh such politico-economic ideologies against a backdrop of development and modernization. Moreover, the neoliberalization of health provoked the first moment of grievance politics, leading to a reformulation by the PAP of the originally planned health reforms in the two decades to come.

Technocracy

Singapore's 1983 National Health Plan — the first such national plan — was initiated in response to rising expenditure on healthcare, which had risen from SGD 59 million in 1971 to SGD 257 million in 1981 (B. Tan, 1983). The National Health Plan had three explicit developmental state goals: first, to secure a healthy, fit and productive population through active disease prevention and promotion of healthy lifestyles; second, to improve the health system's cost-efficiency; and third, to meet a rapidly ageing population's growing demand for healthcare (Phua, 2003). The 1983 National Health Plan explicitly emphasized an individual's responsibility for their health (Ministry of Health Singapore, 1983). Singapore departed from 'an NHS-like system' in its nascent years of self-governance, when healthcare was financed by taxes, with relatively low levels of co-payment, and hospitals were run by the MOH, as healthcare expenditure was getting out of hand for the government (Lim, 2006). In place of this NHS-derived system, individual Singaporeans were to take greater personal responsibility for their health and the costs of their healthcare.

Essential to this shift to an individualized system was the introduction and implementation of the 3M Framework (Medisave, Medishield and Medifund), a self-funded financing system for healthcare which remains a central feature of Singapore's health financing today. This was an important complementary feature of corporatization and reform, with the ultimate aim of ensuring that citizens had enough savings to pay for increased healthcare costs, while employing the concept of risk pooling within a national insurance scheme. The first 'M', Medisave, implemented in 1984, is an individual savings account funded through contributions from one's monthly income. Contributions to Medisave are thus not pooled and used for subsidies across the population. Any balance or leftover Medisave contributions become a part of an individual's estate upon death, to be passed on (by bequest) to immediate family members, or to charitable organizations in Singapore. Medisave was set up with the intent of allowing an individual to

offset costs resulting from hospitalization, day surgery or limited outpatient services. The second 'M', Medishield, implemented in 1990, is a risk-pooling insurance plan that covers hospitalization bills and very limited outpatient services (for example, kidney dialysis) for patients suffering from catastrophic illnesses. The third 'M', Medifund, was implemented in 1993 'to help needy Singaporeans' with unaffordable medical expenses, as determined through means-testing (Public Service Division, 2015).

The question of who pays for healthcare was intensely debated when Medisave was proposed as part of the National Health Plan in 1983 (Singapore Government, 1983). Dr Toh Chin Chye, a PAP backbencher who had previously been Health Minister from 1975–81, objected to the characterization of healthcare as a commodity which citizens might consume as a matter of choice. He stressed that healthcare was a social responsibility of the government and pointed to the continuing budget surpluses as well as specific tax revenues as sufficient means of meeting that responsibility. Goh Chok Tong, then second Minister for Health (and later to become Singapore's Prime Minister), accepted Dr Toh's point that healthcare was a social responsibility of government, while countering, 'But it does not mean that you discharge your social responsibility by dispensing free medicine or heavily subsidized medicine' (ibid.: n.p.). His rationale for the plan was based on 'financial considerations' in light of 'ominous signs' due to a 'quickly aging population' and he was opposed to seeing current fiscal strength as a guarantee of future adequacy. Goh Chok Tong accepted that some aspects of health were out of one's personal control, but he did not see that as reason for a patient not to pay for care, with exceptions provided for the truly indigent. Goh Chok Tong's articulation of the government's position prevailed, and this logic of patients directly bearing costs of care through mandatory savings became an established feature of Singapore's healthcare. The sole opposition member (J.B. Jayaretnam) voted against, and Dr Toh was absent from the vote, but the PAP's strong majority meant that there was never any other outcome for Medisave. Nonetheless, the debate articulated important grievances which continued to be salient considerations for health policy over the next 40 years.

The state had thus contemplated and rolled out several measures to equip its citizens and healthcare institutions for an era of corporatized hospitals, where the cost of healthcare would be shared across the tripartite model of the state, hospitals and the population. Hsiao (1995) highlights four basic principles that underlie the guiding ethos in this concerted endeavour of neoliberal reform of the healthcare system: first, 'patients' were replaced by 'consumers' who should have free choice; second, self-accountability and self-reliance should be stressed; third, free market competition should be deployed wherever possible; and fourth, only as a last resort should the government pay for treatment and provide affordable minimal standards of healthcare to those who cannot afford to pay.

With these guiding principles in place, the government announced in May 1984 that plans were underway to reform the governance of public hospitals in Singapore, which characterized the shift into a privatized model of healthcare governance. The 'Special Report of the Economic Committee' in 1986 highlighted the healthcare sector as a prime field for privatization of services (Ministry of Trade and Industry, 1986). The Kent Ridge Hospital was a newly established hospital, set up in 1985, and was made a testing ground for this reform process. The Kent Ridge Hospital was subsequently incorporated and renamed the University Hospital (Pte) Limited, a subsidiary of Temasek Holdings, which serves as Singapore's state investment firm. In the same year, the Health Corporation of Singapore (HCS) was established to pave the way for privatization of several more hospitals in the years to come; this included the privatization of the national University Hospital (Pte) Limited in 1987, the National Skin Centre in 1988, Singapore General Hospital in 1989, Kadang Kerbau Hospital and Toa Payoh Hospital in 1990 and Tan Tock Seng Hospital in 1991.

Party Politics

How and why did the state, over which the PAP had a political monopoly, decide on the privatization of healthcare institutions as part of a broader national health plan? The PAP had retained a monopoly in parliamentary seats up until 1981, when a by-election was triggered in the single member constituency of Anson, and J.B. Jeyaretnam of the Workers' Party became the first politician from an opposition party to win a parliamentary seat since independence in 1965. In 1984, the PAP suffered its first loss of parliamentary seats to opposition parties at a general election, with J.B. Jeyaretnam of the Workers' Party retaining his seat in Anson, and Chiam See Tong of the Singapore Democratic Party winning a seat in the single member constituency of Potong Pasir. Despite oppositional political presence across this timeframe, little was said over healthcare in Singapore. Hot button issues that were raised in the run-up to the 1984 general elections included the age of withdrawal for an individual's Central Provident Fund contributions (Singapore's mandatory retirement fund), as well as the issue of elitism and national policies that favoured or benefited those of higher socioeconomic status or educational attainment (B.H. Lee, 1985). The 1980s was a turning point in the political history of Singapore, as a growing oppositional presence in parliament and in the Singapore political scene provided greater space and capacity for the articulation of grievances by constituents.

While decision making in healthcare policy before the 1990s was driven by a strong developmental state, the growing influence and political capacity of opposition parties gave constituents an opportunity to air their grievances about the effectiveness of health policies through what we term grievance

politics. This served as an important feedback loop for the single party dominated developmental state. In the early 1990s, perceptions that public hospitals were focusing too much on profit making and efficiency, at the expense of cutting costs for patients, created widespread unhappiness in the population. This also 'provided fodder for opposition parties' (Ramesh, 2008: 68) and led to debates in public, media and parliamentary sessions (Okma and Lim, 2010).

At this juncture, the PAP government appointed a ministerial committee on health policy, which led to the publication of the 1993 'White Paper on Affordable Healthcare' (Ministry of Health Singapore, 1993). The paper noted that 'market forces alone will not suffice to hold down medical costs to the minimum' (ibid.: 3) and emphasized the role of 'subvented hospitals' (as opposed to 'privatized' hospitals) and how the MOH could step in to regulate the industry in the event of market failures (ibid.: 2–3). This was seen as a form of retreat or backpedalling on the push for privatization, in response to negative public opinion (Okma and Lim, 2010). Throughout this period of growing negative public sentiment, the term 'corporatization' gained preference over 'privatization', as it denoted benefits from a free market economic system, while allowing the government to unilaterally intervene in the event of market failures. In other words, the neoliberal ethos was preserved, mimicking a market-driven healthcare, while the system remained state-controlled in terms of developmental aims such as improvements in human capital.

Social Groups

During corporatization of the healthcare industry, concerns over revenue maximization and profit-making also arose within the medical profession. These concerns grew more salient at the turn of the century as the state began to cluster institutions and emphasize the need for competition in the healthcare system. A common theme that appeared across several speeches made by prominent doctors was the threat of the corporation to the relationship between doctors and patients (Chee, 1999). Commercialism was seen as being in diametric opposition to the tenets of medical professionalism, and Chee's language offered no room for a marriage between medical professionalism and the corporatization of the healthcare sector. No collective action resulted, but a clear political critique to neoliberal health reforms was posed when a window for freedom of dissent became available, showing grievance politics in practice as it expanded among medical professionals.

After the initial articulation of such resistance, the tone employed by professionals was a combination of optimism and uncertainty. The decision to create two healthcare clusters was seen as being favourable for the healthcare industry in the context of managing chronic illnesses and diseases, as

it facilitated the vertical integration of primary, secondary and tertiary care facilities that was necessary for the efficient transition of patients' care in line with the progression of such illnesses (Cheah et al., 2002; C.C. Tan, 2002). Nevertheless, while it was clear that medical professionals had not advocated for changes to the broad reforms, they had sought to mitigate the effects that such a consumer-centric industry might bring. For example, in his address at the 3rd Tan Tock Seng Hospital Oration, Balachandran (2000) underlined the role of ethics, professionalism and medical morals in the face of new technologies and economic development. C.C. Tan (2002) espoused the need for patient advocacy as a means of upholding professionalism in the context of increasing medical costs and technological advances. E.H. Lee (2002: 563) addressed the conflict between consumerism and professionalism by urging medical professionals to 'reflect and to re-examine ourselves and our organizations in terms of our values, missions and goals'. Medical professionals were active in voicing concerns over corporatization, although policy reforms continued to favour a market logic of efficiencies resulting from competition.

The Health Feedback Group convened by the Singapore government in 1997 demonstrated one potential pathway for the PAP to achieve policy reform through public participation, albeit on terms entirely controlled by the state. Rodan and Jayasuriya (2007) report that several of the group's recommendations were made into policy, and quote the group's chairman as highlighting how the group's main contribution was to prioritize actions that were already on the government's agenda. In contrast to the health group, Rodan and Jayasuriya (ibid.) point to the political reform group as producing no such policy impact, as its suggestions (for example, an independent electoral commission) did not fit the ministerial agenda or priorities. Some frustrated participants gave up trying to make a difference, while others turned to explicit political opposition by running for election. The health group, populated by doctors, was able to effectively work within the existing system, but the critiques of the state offered in the political reform group found no purchase. The critiques of systemic changes in health described above did not lead to direct policy change, but they occurred in settings where medical ethics and a sense of professional mission could serve as an ideological fulcrum for shaping views.

RESTRUCTURING HEALTH SYSTEMS AND EXPANDING PRIMARY CARE (2000–11)

The Health Corporation of Singapore was eventually dissolved in 2000, and its subsidiary entities comprising corporatized hospitals and national health centres were split between two geographically defined health clusters, namely, the National Healthcare Group and SingHealth, also known as the Western and Eastern clusters, respectively. Both clusters or groups existed

as separate corporate entities that were owned by a new holding company called the Ministry of Health Holdings Private Limited and sought to link government-run primary care clinics, also known as polyclinics, with the tertiary-level hospitals within each region in a vertically integrated network. The justification for the two competing clusters was provided by the MOH in a press release in 1999, which stated that such clustering was needed 'to encourage greater collaboration and co-operation among all service providers', and to 'minimize duplication of services and wastage of resources, as well as ensure optimal development of clinical capabilities', and claimed that it would help to 'unlock hidden synergies inherent in our healthcare delivery system' by 'leveraging on information technology and sharing professional expertise' (Ministry of Health Singapore, 1999). In sum, in response to medical professionals' criticisms, there was a limitation to the solely market-driven logic originally formulated, with a shift to a coordinated health system.

Technocracy

From 2008 to 2011, healthcare institutions in Singapore underwent further clustering to become a six-cluster regional health system. In response to a parliamentary question in 2010 on what benefit there was to ordinary Singaporeans from the original Eastern and Western clusters, the Minister for Health responded that the clustering experience 'has generally been positive' (Ministry of Health Singapore, 2010: n.p.), thus justifying the further clustering of hospitals. The ministry reiterated the benefits of clustering for Singapore's health system by highlighting how regional clusters have helped public health institutions 'build partnerships and seek synergies beyond the public healthcare sector'. However, the ministry also emphasized the need to better integrate non-governmental and charity organizations into each cluster, and highlighted how these regional clusters would 'focus on providing integrated patient-centric care in partnership with other healthcare institutions within their respective geographical areas' (ibid.).

The idea that technocratic decision making was a key driver for reform was echoed across various key stakeholders who were interviewed throughout the course of this research. One policy maker at a healthcare cluster said that 'it's always the ministry' who makes decisions regarding clustering.[4] However, the role played by grievance politics in pushing for a reformulation of the path taken on health reforms should not be overlooked: these changes also responded to what had been expressed in the dissenting voices of medical doctors and the Workers' Party.

4. Interview, policy maker at a healthcare cluster, Singapore, 6 March 2016.

Party Politics

No clear process of grievance politics was articulated by constituents or through opposition parties in the 2001 and 2006 general elections over the processes of clustering and re-clustering, which might be interpreted as some degree of satisfaction with these reforms in hybridizing the neoliberal path initiated in the 1980s. Rather, the urgent need to expand on the available primary care services became apparent as cracks and strains started to appear in the primary healthcare system. The first patient satisfaction survey (PSS) was conducted in 2004 across hospitals, specialization centres and polyclinics (National Healthcare Group, 2019). Patient waiting times surfaced as an issue following the 2009 PSS and has remained a focus of the yearly publication (Singapore Government, 2010). However, the issue of hospital bed and service waiting times had already been raised by members of parliament prior to the commissioning of the inaugural PSS. Hospital waiting times were also brought up by the opposition Workers' Party in the 2011 and 2015 elections. In its 2011 party manifesto, the Workers' Party raised several issues around hospital bed shortages that had existed since 2006, highlighting the lack of planning between health services and the deliberate foreign population surge (The Workers' Party, 2011). Hospital waiting times was a hot button issue in the 2015 elections and featured prominently at rallies held by the Workers' Party (The Workers' Party, 2015).

The government subsequently introduced several measures to tackle the issue of waiting times by expanding secondary and tertiary facilities. The MOH released a statement in 2015 that highlighted the progress that it had made in expanding these networks and its plans to increase the number of community hospitals and polyclinics, as well as increasing nursing home capacity by 2020 (Ministry of Health Singapore, 2015a).

Further to the expansion of care facilities, the MOH launched a primary care masterplan to expand the role of the private sector in this national healthcare endeavour and to outline the role of community hospitals (or secondary hospitals), the agency for integrated care, polyclinics and general practitioners (GPs) in addressing the ageing population as part of the masterplan for health. An update to the Healthcare 2020 plan was published in 2014 announcing the building of an additional 12 polyclinics (above the existing 18) by 2030. The update also introduced the concept of the Community Health Centers (CHC) and Family Medicine Clinics (FMC). These were 'new models of primary care': the CHCs supported privately run GP clinics with ancillary healthcare services that would otherwise not be typically available at GP clinics, and the FMCs provided organizational collaboration between proprietors of privately owned GP practices or medical groups and specific healthcare clusters (Ministry of Health Singapore, 2013a).

Social Groups

While broad healthcare policy reform had been implemented by technocrats, they were shaped in part by grievance politics, coming both from party politics, such as the claims of the Workers' Party, and from medical doctors' dissidence against the reforms promoted by the PAP. In this sense, several key informants articulated how actors from society were able to work with professionals to effect change at a smaller, institutional level as another expression of grievance politics. For example, one polyclinic director described how the polyclinic engages the community in its delivery of care, thanks to a 'fairly enthusiastic community' and active grassroots. These include a non-clinical Voluntary Welfare Organization and a care centre that runs an elderly activity corner. It had been two years since the director started working with them, and she explained that this approach allowed the social and the medical to be somewhat integrated.[5] A polyclinic doctor said:

> We work with one of the community centres nearby who are sponsored by a larger organization. There is also a statutory-level, but non-state-owned organization that provides community nurses to conduct house visits to several populations that comprise needy patients with poorly managed chronic diseases. They form a multidisciplinary team comprising nurses, medical social workers, and doctors to discuss these cases. These patients are located within three blocks of rental flats located within the vicinity of the polyclinic.[6]

Key informants from government-run primary care institutions in our interviews highlighted that while they were held to rigid standards of reporting through key performance indicators (for example, waiting times at clinics, cost-based indicators) that restricted or narrowed the ways in which they could exercise their duties, they often made efforts outside of their official duties and performance indicators in order to optimize care for specific patients. These efforts took the form of innovations at the local level that manoeuvred and worked around the dogmatic systems that were put in place by broader bureaucratic and organizational structures, and not through wider reforms made to the clustering of these institutions. Even though the state's administrative apparatus is the undoubted prime mover of health policy changes in this period, Barr (2008) identifies complaints channelled through civil society as limiting the most inhumane consequences of the search for technocratic efficiency.

HEALTHCARE FINANCING REFORMS AND THE SILVER TSUNAMI (2011–19)

The period following the 2011 general election in Singapore saw consequential changes in the structuring and financing of healthcare which sought to

5. Interview, polyclinic director, Singapore, 7 December 2016.
6. Interview, polyclinic physician, Singapore, 14 December 2012.

address issues of affordability and access, particularly regarding chronic conditions, which had been highlighted through grievance politics at the time of the election. The likely impact of Singapore's demographic trends of low and declining birth rates combined with increased life expectancy started to loom closer: by 2030 the ratio of the population aged 65 and older to the number of working-age adults will increase to 7:1 (Sim, 2021).

Technocracy

Important changes to make healthcare more affordable were implemented through modifications to the 3M framework. In line with the increasing focus on primary care and chronic disease management over the past decade, several schemes were introduced that would allow Singaporeans to utilize their Medisave contributions for an increasing array of services in outpatient and community settings (Ministry of Health Singapore, 2016). These schemes included the Chronic Disease Management Program introduced in October 2006, which allowed citizens to use their Medisave accounts for treatment of a growing list of chronic diseases (ibid.); Medisave400 introduced in January 2012 as a complementary scheme that allows individuals to utilize up to SGD 400 annually for vaccinations and preventive health screening services in outpatient settings (ibid.); and Flexi-Medisave introduced in April 2015 to allow citizens (and their spouses) aged 65 and above to use up to SGD 200 per year for outpatient medical services (Ministry of Health Singapore, 2015b).

Important changes to the other 'M's also took place during this time. Medishield Life replaced Medishield in November 2015 to provide patients with: better protection and higher payouts, so that patients pay less Medisave or cash for large hospital bills; protection for all Singapore citizens and permanent residents, including the very old and those with pre-existing conditions; and protection for life. Furthermore, Medifund Silver was introduced in November 2007 with a capital sum of SGD 500 million. This fund specifically assists needy elderly patients and means testing is done through medical social workers in restructured hospitals. Any Singaporean aged 65 years and older could apply for Medifund Silver (Ministry of Health Singapore, 2008). In March 2013, Medifund Junior was launched to help needy Singaporeans below the age of 18. MOH allocates SGD 8 million annually for this purpose (Ministry of Health Singapore, 2013b).

Party Politics

Despite the 3M framework, policy makers overlooked several flaws that exacerbated the plight of ageing Singaporeans in the context of affording healthcare. Firstly, older Singaporeans were placed at a disadvantage at

the point of the framework's implementation as they had fewer available working years left for contributions to their own Medisave accounts. Secondly, this was compounded by a generally lower educational attainment of older cohorts. The affordability of healthcare was indeed a key issue raised by opposition parties in the 2011 general election, in contrast to briefer treatment from the PAP.

The Workers' Party demonstrated an emphatic commitment to providing solutions for affordable healthcare in its 2011 manifesto: 'We can die but cannot afford to be sick. This common refrain from the people is certainly no laughing matter. Healthcare is an essential service and no one should be deprived of health care for any reason' (The Workers' Party, 2011: 18). Amidst the growing sentiment that the PAP was disconnected from the needs of the population, then Prime Minister Lee Hsien Loong stepped up to deliver a rare apology on behalf of his party during a lunchtime rally on 3 May 2011. In the election, the PAP's popular vote share dipped to 60.14 per cent, the lowest since Singapore's independence, and the opposition won a record number of seats. The PAP implemented swift measures to address these grievances before the next general election cycle. While critics credited the opposition with prompting the PAP to undertake these policy changes, former Prime Minister Goh Chok Tong suggested that this was akin to crediting the rooster for the next day's rising sun, and that the PAP needed no political checks and balances beyond itself (Rodan, 2018).

In response to this new dynamic of grievance politics, the Community Health Assist Scheme (CHAS) was introduced in 2012, which replaced the 2000 Primary Care Partnership Scheme (PCPS). The PCPS originally served to provide financial assistance to Singaporeans aged 65 and above with a per capita monthly household income of less than SGD 800, to subsidize their care for acute illnesses at privately run, primary care facilities. This was subsequently expanded in 2002 and 2009 to cover a range of dental conditions and chronic illnesses, respectively. The introduction of CHAS saw an expansion of the coverage of the PCPS which led to at least half of all Singaporean households being eligible for the scheme (Luo et al., 2018).

The Pioneer Generation Fund Act was introduced by the Singapore parliament in October 2014, which led to the establishment of the Pioneer Generation Fund. A total of SGD 8 billion was set aside for this fund, which provides government-issued health benefits to 'pioneers' (those aged 65 and above as of 2014) through additional subsidies in outpatient medical care and hospital clinics. Pioneers also enjoy subsidized outpatient care at private GP and dental clinics through CHAS. Furthermore, pioneers born in 1934 or earlier enjoy fully subsidized premiums.

The Pioneer Generation Package of 2014 and CHAS of 2012 were two of the many schemes introduced after the 2011 election that served to address the cost of healthcare amongst Singaporeans. The success of these schemes was evident as polyclinics saw a greater number of elderly patients that were not previously registered at these polyclinics, and greater participation

of CHAS-subsidized patients and private sector medical services in CHAS. Several primary care providers we interviewed corroborated this view. Regarding the Pioneer Generation Package scheme, one polyclinic director mentioned that, 'following the subsidy', they had seen 'about 1,800 elderly patients as novel cases — never seen before in the polyclinic setting'.[7] Another polyclinic physician spoke about what had brought about the demographic shifts: 'the introduction of the Pioneer Generation Package has led to the increase in older patients. A lot of older patients have shifted from the general practitioner setting to the polyclinic setting due to the subsidies provided'.[8] Responsiveness on healthcare issues contributed to the PAP's popular vote share increasing from 60.14 per cent in 2011 to 69.86 per cent in 2015, as many Singaporeans validated the incumbent party's leadership.

Social Groups

The state put in place several fora to engage different social groups in the healthcare policy reform process; these included several GP groups as well as town hall sessions where policy makers met with professionals and constituents to gather feedback and suggestions on newly implemented policies, or impending healthcare policy reforms. While providing these professionals and constituents with a platform to have their voices heard, these fora were not designed to empower civil society or professional bodies in the policy-making process. This position was corroborated by several key stakeholders interviewed in this study, as following exchange with a medical researcher illustrates:

> Q: What voice do doctors have in terms of changing policy? There are these CHAS Townhall events, GP engagement sessions… But often there is no tangible next step. Not a deliberative process.
> A: Well, there isn't really any [voice given to doctors]. GPs can write to the CFP [College of Family Physicians] who may then write to MOH. Most of these forums are organized by the CFP anyway. In some way, the GPs can vote by not choosing to become a partner in the CHAS scheme. Initially, we saw only 20–30 per cent of clinics take part. But AIC [Agency for Integrated Care] has recently been dangling more carrots for GPs.[9]

C.W. Lee et al. (2015) draw a parallel to other such forms of participation without actual power, positing that while opportunities for public participation through social media, town halls and other public fora may be increasing, these forms of participation are not truly democratic, and may in fact reinforce elite power in decision-making processes. This resonates with the sentiment shared by key informants in our interviews, who were able to

7. Interview, polyclinic director, Singapore, 7 December 2016.
8. Interview, polyclinic physician, Singapore, 14 December 2016.
9. Interview, medical researcher, Singapore, 22 December 2016.

identify opportunities where the state had consulted or involved stakeholders as a precursor to several broad reforms, but who were uncertain if their participation ultimately translated to changes in such policies.

MARGINALIZED MIGRANT WORKERS IN THE PANDEMIC (2020–22)

The COVID-19 pandemic subjected these healthcare reforms to a major systemic test of efficiency and social equity. The wealth and high degree of coordination of healthcare in a rich, urban and small developmental state had placed Singapore in a favourable position. However, even if initially praised for effective and efficient containment of COVID-19 in early 2020, the migrant worker dormitory clusters sparked a different narrative of Singapore, with the media framing it as the 'price' or 'dark side' of Singapore's success (Stack, 2020). Despite these difficulties, Singapore's response to COVID-19 has been seen as largely effective, boasting low death rates (Geddie and Aravindan, 2020), quick policy implementations, and efficient, clear communication between the government and citizens (Thong et al., 2021). More broadly, this seems to be a general pattern of the East Asian countries.

Technocracy

Singapore's preparedness was attributed to lessons learned from the 2004 Severe Acute Respiratory Syndrome (SARS) crisis. The outbreaks in migrant worker dormitories were therefore depicted by the government as a product of unforeseen circumstances, rather than an oversight consistent with the pre-existing neglect of migrant workers' health and safety (Ong, 2020). The government's daily COVID-19 reporting separated cases between the 'local community' and those in 'migrant worker dormitories', reinforcing the narrative that Singapore was effectively facing two pandemics. This separation was not just in the number of cases, but in the policies and logics of the government's COVID-19 response. By mid-April 2020, all dormitories were placed under isolation. On 25 April 2020, migrant workers' dormitories constituted 94 per cent of the COVID-19 cases in Singapore (TWC2, 2020a).

The government's response to these clusters was to test, isolate and sometimes relocate workers, employing a 'novel strategy' to prevent deaths rather than transmission of the virus (Begum, 2020). Social groups argued that while the government emphasized social distancing to stop the spread of the virus within the local community, the strategy for dormitories resembled one of 'containment'; in other words, preventing COVID-19 from spreading to the rest of the country with less focus placed on minimizing infection amongst the workers themselves (TWC2, 2020c).

Party Politics

Prior to the COVID-19 pandemic, the opposition parties discussed foreign workers primarily with regards to job security for Singaporeans and over-dependence on low-cost foreign labour, and not the well-being and safety of the workers themselves (Toh, 2013). Then-chief of the Workers' Party, Low Thia Khiang, argued that 'a reduction in foreign-worker quotas should be calibrated by industry, depending on which ones needed them more' (ibid.). This 'Singapore First' stance was mostly maintained by the Workers' Party in the 2020 general elections and shared by other opposition parties including the newest, Progress Singapore Party, which advocated for job priority for Singaporeans and reducing dependence (Progress Singapore Party, 2020: 4). But, in addition to criticizing the over-reliance on low-cost migrant labour, the Workers' Party they included improving the living conditions in foreign worker dormitories in their 2020 manifesto (The Workers' Party, 2020).

Social Groups

Having established that the health and safety of migrant workers have long been neglected by both the governing and opposition parties in Singapore, this issue is primarily raised by social organizations. Social organizations have highlighted a consistent neglect of migrant workers' health and safety, foreshadowing heightened vulnerability in the event of a public health crisis. As early as 2012, members of civil society highlighted the overcrowding in dormitories (TWC2, 2012).

In the early stages of the COVID-19 pandemic, social organizations began drawing attention to the exacerbated vulnerability of migrant workers due to the packed and overcrowded living spaces. On 2 March 2020, a volunteer doctor at HealthServe, Jeremy Lim, stated that workers do not have the option to socially distance given the densely populated nature of their accommodation (Zhang, 2020). On 23 March 2020, TWC2 submitted a letter to the Straits Times Forum entitled 'Employers' Practices Leave Foreign Workers Vulnerable to Infection' (TWC2, 2020b), emphasizing the possibility of a COVID cluster forming in these dormitories.

As COVID-19 cases in migrant workers' dormitories decreased and the rest of the country began to re-open, social organizations drew attention to the government's bifurcated approach. By 25 June 2020, the general population was allowed out in groups of five, while migrant workers were under strict lockdown measures even though the Ministry of Manpower declared that more than 80 per cent of migrant workers had either recovered from or tested negative for the virus as of 29 July 2020 (Ng, 2020). At this time, cases in the community, and those imported from outside Singapore, far outnumbered cases in the dormitories.

This differentiation is consistent with the segmented approach to migrant workers' health and well-being since the inception of the healthcare system. Without access to healthcare financing schemes covering Singaporeans, such as the M3 Framework, migrant workers are dependent on their employers for insurance (Rajaraman et al., 2020). Additionally, social organizations highlighted mental health concerns for migrant workers during long periods of enforced isolation. Although the Ministry of Manpower 'was aware of the recent spate of suicides and attempted suicides involving migrant workers living at the dormitories' in August 2020, it had not noted a spike relative to past years (Phua, 2020). Nonetheless, a study by Yale–NUS College in 2021 confirmed that the mental health concerns raised were legitimate (Goh, 2021).

The public health response to the COVID-19 pandemic revealed blind spots as well as the important contribution of increasingly autonomous social groups. The efficient and well-resourced health system was primarily oriented to meeting the needs of the Singaporean community, but it neglected the migrant worker population in its initial response. Singapore removed all restrictions on group sizes for socializing and workplaces in April 2022, and scrapped all travel restrictions and most other requirements regarding mask-wearing for the general population in February 2023. However, it was only in March 2023 that all restrictions on migrant workers staying in dormitories were lifted (Kok, 2023). Social organizations were among the first voices to call attention to the plight of migrant workers during the COVID pandemic, and the shortcomings of the public health system's response to the needs of migrant workers was a distinct weakness in its overall performance.[10]

CONCLUSION

We studied Singapore's health system using a process-tracing method of analysis, tracking its historical path, stages and specific turning points to explain how the health system has changed in Singapore from its inherited British colonial model to the current neoliberal one. We showed the role played by dissidence in prompting some reformulations of health policies by a technocratic policy apparatus. In this sense, we find episodes where effective changes to social policies are not the product of a state embedded in an organized society, but rather are prompted by the independent organizational capacity of some social groups providing inputs to state elites on social grievances and policy needs. We defined this as *grievance*

10. While the time period covered in this paper ends with the pandemic, the 2022 'White Paper on Healthier SG' also has no mention of migrant workers (Ministry of Health Singapore, 2022).

politics, a particular combination of embeddedness and autonomy in autocratic developmental states. As we have conceptualized and empirically demonstrated, grievance politics in Singapore did not escalate into broader systemic conflicts because the state was able to respond with policy changes that at least partially addressed societal grievances.

So, what does grievance politics achieve? Is it integral to technocracy or does it get in its way? Does grievance politics adequately substitute for an organized society in the 21st century developmental state, or does it just offer a limited resistance against untrammelled high modernism? Grievance politics will do some, or all, of these things at different points in time, but the key to its contribution is its location outside of the technocratic state elites, and the opening it affords to voices which may be independent but not necessarily oppositional to the regime.

The findings of this article add to the global health literature by offering a political perspective to healthcare reforms that insert technocratic decisions into a context of conflicts, actors and disputes for the direction and ethos of the healthcare system. In addition, it contributes to developmental states studies by positing a different type of state–society relationship not previously identified in this literature. We have also shown how grievance research in social movements studies can be adapted to apply to contexts where collective action is not allowed. Finally, by combining these three literatures we showed a process not acknowledged by any of the three individually. We identified a feedback loop in the reformulation of policies in a state that is usually perceived as technocratically efficient rather than socially accountable. In this sense, we could theoretically and empirically explain how autocratic states get social feedback for improving social policies. These findings are crucial for the study of how policy making on social issues is produced in regimes where democratic participation is constrained.

REFERENCES

Agartan, T.I. (2015) 'Explaining Large-scale Policy Change in the Turkish Health Care System: Ideas, Institutions and Political Actors', *Journal of Health Politics, Policy and Law* 40(5): 971–99.

Almeida, P. (2019) 'The Role of Threat in Collective Action', in D.A. Snow, S.A. Soule, H. Kriesi and H.J. McCammon (eds) *The Wiley Blackwell Companion to Social Movements*, pp. 43–62. Oxford: Wiley.

Balachandran, N. (2000) '3rd Tan Tock Seng Hospital Oration: The Changing Fabric of Medicine — An Ethical and Social Revolution', *Annals, Academy of Medicine, Singapore* 29: 268–72.

Barr, M. (2001) 'Medical Savings Accounts in Singapore: A Critical Inquiry', *Journal of Health Politics, Policy and Law* 26(4): 709–26.

Barr, M. (2008) 'Singapore: The Limits of a Technocratic Approach to Health Care', *Journal of Contemporary Asia* 38(3): 395–416.

Begum, S. (2020) 'Dorm Coronavirus Cases: "Novel" Strategy in Isolating those Most at Risk', *The Straits Times* 24 July. www.straitstimes.com/singapore/dorm-cases-novel-strategy-in-isolating-those-most-at-risk

Bell, R., S. Taylor and M. Marmot (2010) 'Global Health Governance: Commission on Social Determinants of Health and the Imperative for Change', *Journal of Law Medical Ethics* 38(3): 470–85.

Blumer, H. (1951) 'Collective Behavior', in A.M. Lee (ed.) *Principles of Sociology*, pp. 208–10. New York: Barnes and Noble.

Centeno, M.A. (1993) 'The New Leviathan: The Dynamics and Limits of Technocracy', *Theory and Society* 22(3): 307–35.

Chan, H.C. (1975) *Politics in an Administrative State: Where Has the Politics Gone?* Singapore: Department of Political Science, University of Singapore.

Cheah, J.T.S., S.C. Emmanuel and B.H. Heng (2002) 'Chronic Disease Management: Challenges for Clinicians and the Way Forward', *Annals, Academy of Medicine, Singapore* 31(4): 413–14.

Chee, Y.C. (1999) 'Early 21st Century Professional Practice: Change and Challenge', *Annals, Academy of Medicine, Singapore* 28(6): 890–94.

Chua, B.H. (1985) 'Pragmatism of the People's Action Party Government in Singapore: A Critical Assessment', *Southeast Asian Journal of Social Science* 13(2): 29–46.

Chua, B.H. (2017) *Liberalism Disavowed: Communitarianism and State Capitalism in Singapore*. Ithaca, NY: Cornell University Press.

Evans, P. (1995) *Embedded Autonomy: States and Industrial Policy*. Princeton, NJ: Princeton University Press.

Evans, P. and P. Heller (2015) 'Human Development, State Transformation, and the Politics of the Developmental State', in S. Leibfried, E. Huber, M. Lange and J.D. Levy (eds) *The Oxford Handbook of Transformations of the State*, pp. 691–713. Oxford: Oxford University Press.

Fischer, F. (1990) *Technocracy and the Politics of Expertise*. Newbury Park, CA: Sage.

Fong, L. (1978) 'Sharp Hike in A and E Fees', *The Straits Times* 24 March. https://eresources.nlb.gov.sg/newspapers/digitised/article/straitstimes19780324-1.2.2

Geddie, J. and A. Aravindan (2020) 'Why Is Singapore's COVID-19 Death Rate the World's Lowest', *Reuters* 17 September. www.reuters.com/article/health-coronavirus-singapore-explainer-idINKBN2680TF

Goh, T. (2021) 'Migrant Workers under Lockdown in S'pore Had Higher Symptoms of Depression and Stress: Yale–NUS Study', *The Straits Times* 30 August. www.straitstimes.com/singapore/health/migrant-workers-under-lockdown-here-had-higher-symptoms-of-depression-and-stress

Gurr, T.R. (1970) *Why Men Rebel*. Princeton, NJ: Princeton University Press.

Haeder, S.F. (2012) 'Beyond Path Dependence: Explaining Healthcare Reform and its Consequences', *Policy Studies Journal* 40(s1): 65–86.

Haggard, S. (1990) *Pathways from the Periphery: The Politics of Growth in the Newly Industrializing Countries*. Ithaca, NY: Cornell University Press.

Haggard, S. (2018) *Developmental States*. Cambridge: Cambridge University Press.

Hanushek, E. and L. Woessmann (2008) 'The Role of Cognitive Skills in Economic Development', *Journal of Economic Literature* 46(3): 607–68.

Harris, J. (2017) *Achieving Access: Professional Movements and the Politics of Health Universalism*. Ithaca, NY: Cornell University Press.

Haseltine, W.A. (2013) *Affordable Excellence: The Singapore Healthcare Story*. Washington, DC: Brookings Institution Press.

Hsiao, W.C. (1995) 'Medical Savings Accounts: Lessons from Singapore', *Health Affairs* 14(2): 260–66.

Jasper, J.M. (1997) *The Art of Moral Protest: Culture, Biography, and Creativity in Social Movements*. Chicago, IL: The University of Chicago Press.

Johnson, C.A. (1982) *MITI and the Japanese Miracle: The Growth of Industrial Policy, 1925–1975*. Stanford, CA: Stanford University Press.
Khan, M., S. Abimbola, T. Aloudat, E. Capobianco, S. Hawkes and A. Rahman-Shepherd (2021) 'Decolonising Global Health in 2021: A Roadmap to Move from Rhetoric to Reform', *BMJ Global Health* 6(3): e005604.
Kingdon, J.W. (1984) *Agendas, Alternatives and Public Policies*. Boston, MA: Little, Brown and Company.
Kohli, M. and A. Woodward (2004) *Inclusions and Exclusions in European Societies*. London: Routledge.
Kok, Y. (2023) 'Govt to Announce Plan for Existing Dorms to Meet Improved Standards Later in 2023: Tan See Leng', *The Straits Times* 20 March. www.straitstimes.com/singapore/politics/govt-to-announce-plan-for-existing-dorms-to-meet-improved-standards-later-in-2023-tan-see-leng
Koplan, J.P. et al. (2009) 'Towards a Common Definition of Global Health', *The Lancet* 373(9679): 1993–95.
Lee, B.H. (1985) 'Singapore in 1984: A Time for Reflection and a Time for Change', in J.J. Lim (ed.) *Southeast Asian Affairs*, pp. 297–305. Singapore: ISEAS Publishing.
Lee, C.W., M. McQuarrie and E.T. Walker (2015) 'Realizing the Promise of Public Participation in an Age of Inequality', in C.W. Lee, M. McQuarrie and E.T. Walker (eds) *Democratizing Inequalities: Dilemmas of the New Public Participation*, pp. 247–50. New York: New York University Press.
Lee, E.H. (2002) 'Addresses at the 50th Anniversary Celebration of the Department of Orthopaedic Surgery, National University of Singapore on 5 April 2002', *Annals, Academy of Medicine, Singapore* 31: 561–67.
Lee, H.L. (2013) 'Speech by Prime Minister Lee Hsien Loong at World Health Summit Regional Meeting — Asia'. Press release. www.pmo.gov.sg/Newsroom/speech-prime-minister-lee-hsien-loong-world-health-summit-regional-meeting-asia
Lee, K.Y. (2000) *From Third World to First. The Singapore Story: 1965–2000. Memoirs of Lee Kuan Yew*. Singapore: Singapore Press Holdings.
Lee, K.Y. (2002) 'Commemoration Eve Dinner/Commemoration Day — Tuesday 22 October 2002/Wednesday 23 October 2002'. News release. London: Imperial College. www.imperial.ac.uk/news/6313/commemoration-eve-dinnercommemoration-day-tuesday-22/.
Lim, J. (2013) *Myth or Magic: The Singapore Healthcare System*. Singapore: Select Publishing.
Lim, M.K. (1998) 'Health Care Systems in Transition. II. Singapore, Part I. An Overview of Health Care Systems in Singapore', *Journal of Public Health Medicine* 20(1): 16–22.
Lim, S.W. (2006) 'Corporatization of Hospitals "The Singapore Experience"'. Paper presented at the Hospital Authority Convention, Hong Kong.
Loh, K.S. and L.Y. Hsu (2020) *Tuberculosis — The Singapore Experience, 1867–2018: Disease, Society and the State*. New York: Routledge.
Luo, M., Z. Poh, G. Koh, T.Y. Tham, W. Lau and S.A. Toh (2018) 'Diabetes Management in a Primary Care Network (PCN) of Private General Practitioners in Singapore: An Observational Study', *Medicine* 97(43): 1–7. https://journals.lww.com/md-journal/Fulltext/2018/10260/Diabetes_management_in_a_Primary_Care_Network.42.aspx.
Maxfield, S. and B.R. Schneider (1997) *Business and the State in Developing Countries*. Ithaca, NY: Cornell University Press.
McAdam, D. (1999) *Political Process and the Development of Black Insurgency, 1930–1970* (2nd edn). Chicago, IL: The University of Chicago Press.
McGuire, J.W. (2010) *Wealth, Health, and Democracy in East Asia and Latin America*. Cambridge: Cambridge University Press.
Ministry of Health Singapore (1983) 'National Health Plan'. Singapore: Ministry of Health Singapore.
Ministry of Health Singapore (1993) 'White Paper on Affordable Health Care'. Singapore: Ministry of Health Singapore.

Ministry of Health Singapore (1999) 'Reorganisation and Restructuring of Public Healthcare Services'. Singapore: Ministry of Health Singapore.
Ministry of Health Singapore (2008) 'Medifund Silver'. Press release. Singapore: Ministry of Health Singapore.
Ministry of Health Singapore (2010) 'Updates on Clusters'. Singapore: Ministry of Health Singapore. www.moh.gov.sg/news-highlights/details/updates-on-clusters
Ministry of Health Singapore (2013a) 'State of Health: Report of the Director of Medical Services 2003–2012'. Singapore: Ministry of Health Singapore. https://www.moh.gov.sg/docs/librariesprovider5/resources-statistics/reports/report-of-the-director-of-medical-services.pdf
Ministry of Health Singapore (2013b) 'MOH Pumps Additional $10 Million over Five Years to Help Needy Children with Healthcare'. Singapore: Ministry of Health Singapore. https://web.archive.org/web/20140927194410/https://www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2013/moh_pumps_additional10millionoverfiveyearstohelpneedychildrenwit.html.
Ministry of Health Singapore (2015a) 'Speech by Senior Minister of State for Health Dr Amy Khor at the MOH Committee of Supply Debate, 12 Mar 2015'. Singapore: Ministry of Health Singapore. www.moh.gov.sg/news-highlights/details/speech-by-senior-minister-of-state-for-health-dr-amy-khor-at-the-moh-committee-of-supply-debate-12-mar-2015
Ministry of Health Singapore (2015b) Introduction of Outpatient Flexi-medisave for the Elderly on 1 April 2015. Singapore: Ministry of Health Singapore. www.moh.gov.sg/content/moh_web/home/pressRoom/pressRoomItemRelease/2015/outpatient-flexi-medisave-for-the-elderly.html
Ministry of Health Singapore (2016) 'Speech by Senior Minister of State for Health Dr Amy Khor at the MOH Committee of Supply Debate' 13 April 2016. www.moh.gov.sg/news-highlights/details/speech-by-senior-minister-of-state-for-health-dr-amy-khor-at-the-moh-committee-of-supply-debate-2016
Ministry of Health Singapore (2022) 'White Paper on Healthier SG'. Singapore: Ministry of Health Singapore. www.healthiersg.gov.sg/resources/white-paper/
Ministry of Trade and Industry (1986) *The Singapore Economy, New Directions*. Singapore: Ministry of Trade and Industry.
Ministry of Trade and Industry (2017) 'Report of the Committee on the Future Economy'. Singapore: Ministry of Trade and Industry. www.mti.gov.sg/Resources/publications/Report-of-the-Committee-on-the-Future-Economy
National Healthcare Group (2019) *Building a Home for Patient Safety: NHG's Blueprint*. Singapore: National Healthcare Group. https://corp.nhg.com.sg/QnS/Documents/Books/Ebook_Building%20a%20Home%20for%20Patient%20Safety.pdf
Ng, K.G. (2020) 'Over 80% of Dorm Residents Coronavirus-free, 95 More Dormitories Cleared of Covid-19: MOM', *The Straits Times* 30 July. www.straitstimes.com/singapore/over-80-of-dorm-residents-coronavirus-free-95-more-dormitories-cleared-of-covid-19-mom
Okma, K.G.H. and M.K. Lim (2010) *Six Countries, Six Reform Models: The Healthcare Reform Experience of Israel, The Netherlands, New Zealand, Singapore, Switzerland, and Taiwan. Healthcare Reforms 'Under the Radar Screen'*. Singapore: World Scientific.
Ong, E. (2015) 'Complementary Institutions in Authoritarian Regimes: The Everyday Politics of Constituency Service in Singapore', *Journal of East Asian Studies* 15(3): 361–90.
Ong, T. (2020) 'Lawrence Wong on Spike in Dorm Cases: "Unfortunately, We Do not Have the Luxury of the Benefit of Hindsight"', *Mothership SG* 9 April. https://mothership.sg/2020/04/lawrence-wong-do-things-differently-foreign-workers/
Ortmann, S. and M.R. Thompson (2016) 'China and the "Singapore Model"', *Journal of Democracy* 27(1): 39–48.
Phua, K.H. (2003) 'Attacking Hospital Performance on Two Fronts: Network Corporatization and Financing Reforms in Singapore', in A.S. Preker and A. Harding (eds) *Innovations in*

Health Service Delivery: The Corporatization of Public Hospitals, pp. 451–84. Washington, DC: World Bank.

Phua, R. (2020) 'COVID-19: No Spike in Number of Migrant Worker Suicides, says MOM', CNA 6 August. https://web.archive.org/web/20200807191417/https://www.channelnewsasia.com/news/singapore/migrant-workers-mental-health-suicides-covid-19-mom-12989854.

Progress Singapore Party (2020) 'A GE2020 Manifesto by Progress Singapore Party: For Country, for People'. Singapore: Progress Singapore Party. https://psp.org.sg/ge2020-manifesto-by-progress-singapore-party-for-country-for-people/

Public Service Division (2015) 'Keeping our Nation Healthy'. Singapore: Public Service Division, Singapore Government. www.psd.gov.sg/heartofpublicservice/our-institutions/keeping-the-nation-healthy/

Putnam, R.D. (1977) 'Elite Transformation in Advanced Industrial Societies: An Empirical Assessment of the Theory of Technocracy', *Comparative Political Studies* 10(3): 383–412.

Rajaraman, N., T.W. Yip, B.Y.H. Kuan and J.F.Y. Lim (2020) 'Exclusion of Migrant Workers from National UHC Systems: Perspectives from Healthserve, a Non-profit Organisation in Singapore', *Asian Bioethics Review* 12(3): 363–74.

Ramesh, M. (2008) 'Autonomy and Control in Public Hospital Reforms in Singapore', *The American Review of Public Administration* 38(1): 62–79.

Ranis, G., F. Stewart and A. Ramirez (2000) 'Economic Growth and Human Development', *World Development* 28(2): 197–219.

Rodan, G. (2018) *Participation without Democracy: Containing Conflict in Southeast Asia*. Ithaca, NY: Cornell University Press.

Rodan G. and K. Jayasuriya (2007) 'The Technocratic Politics of Administrative Participation: Case Studies of Singapore and Vietnam', *Democratization* 14(5): 795–815.

Sen, A. (1999) *Development as Freedom*. New York: Knopf.

Sim, R. (2021) 'A "Silver Tsunami" Looms. What Can Singapore Do about it?', *The Straits Times* 27 June. www.straitstimes.com/singapore/a-silver-tsunami-looms-what-can-singapore-do-about-it

Simmons, E. (2014) 'Grievances Do Matter in Mobilization', *Theory and Society* 43(5): 513–46.

Singapore Government (1969) 'Revision of Charges'. Singapore: Singapore Government. www.nas.gov.sg/archivesonline/data/pdfdoc/PressR19690103a.pdf

Singapore Government (1978) 'Addendum to Presidential Address at the Opening of the Second Session of the Fourth Parliament on Tuesday, 26th December 1978'. Press release. Singapore: Ministry of Health, Singapore Government. www.nas.gov.sg/archivesonline/data/pdfdoc/bhs19781226fs.pdf (accessed 8 March 2024).

Singapore Government (1983) 'Medisave Scheme'. Singapore: Singapore Government. https://sprs.parl.gov.sg/search/#/report?sittingdate=31-08-1983

Singapore Government (1986) '"C" Class Beds in Government Hospitals'. Singapore: Singapore Government.

Singapore Government (2010) 'Waiting Time for Beds in Public Hospitals'. Singapore: Singapore Government.

Singhealth Group (2021) 'Our Transformation Journey'. Singapore: Singhealth Group. www.sgh.com.sg/about-us/corporate-profile/Pages/OUR-TRANSFORMATION-JOURNEY.aspx

Siraj, Z. (1987) 'Government's Hard-nosed Approach Defended', *The Straits Times* 20 April. http://eresources.nlb.gov.sg/newspapers/Digitised/Article/straitstimes19870420-1.2.26.13

Slater, D. and J. Wong (2022) *From Development to Democracy: The Transformations of Modern Asia*. Princeton, NJ: Princeton University Press.

Snow, D.A. and S. Soule (2010) *A Primer on Social Movements*. New York: W.W. Norton.

Snow, D.A., E.B. Rochford, Jr., S.K. Worden and R.D. Benford (1986) 'Frame Alignment Processes, Micromobilization, and Movement Participation', *American Sociological Review* 51(4): 464–81.

Stack, M.K. (2020) 'A Sudden Coronavirus Surge Brought Out Singapore's Dark Side', *The New York Times* 20 May. www.nytimes.com/2020/05/20/magazine/singapore-coronavirus.html
Tan, B. (1983) 'Govt's New 20-Year Health Plan', *The Straits Times* 3 February. https://eresources.nlb.gov.sg/newspapers/digitised/article/straitstimes19830203-1.2.2.
Tan, C.C. (2002) 'National Disease Management Plans for Key Chronic Non-communicable Diseases in Singapore', *Annals, Academy of Medicine, Singapore* 31(4): 415–18.
Tan, E.K.B. (2003) 'Re-engaging Chineseness: Political, Economic and Cultural Imperatives of Nation-building in Singapore', *The China Quarterly* 175(175): 751–74.
Tan, K.P. (2017) *Governing Global-city Singapore: Legacies and Futures after Lee Kuan Yew*. New York: Routledge.
Tan, N. (2013) 'Manipulating Electoral Laws in Singapore', *Electoral Studies* 32(4): 632–43.
Tarrow, S. (1998) *Power in Movement: Social Movements and Contentious Politics* (2nd edn). Cambridge: Cambridge University Press.
Thomas, J.S., S.E. Ong, K.S. Chia and H.P. Lee (2016) *A Brief History of Public Health in Singapore*. Singapore: World Scientific.
Thong, G., S.P. Ooi, E. Araral and A.M. Wu (2021) 'How Singapore Is Handling the Pandemic'. Policy Forum. 23 June www.policyforum.net/how-singapore-is-handling-the-pandemic/
Toh, E. (2013) 'WP: Immigration Policy Has Led to Many Problems', *The Straits Times* 24 January. www.straitstimes.com/politics/wp-immigration-policy-has-led-to-many-problems
Tong, Y.T. and S. Narayanan (2015) *Caring for Our People: 50 Years of Healthcare in Singapore*. Singapore: Ministry of Health Holdings Pte Limited.
TWC2 (2012) 'Only 150,000 Dorm Beds for over 700,000 Workers'. TWC2 (Transient Workers Count Too) 19 December. https://twc2.org.sg/2012/12/19/only-150000-dorm-beds-for-over-700000-workers/
TWC2 (2020a) 'Dorm Residents now Make up 94% of New Covid-19 Cases'. TWC2 (Transient Workers Count Too) 25 April. https://twc2.org.sg/2020/04/25/dorm-residents-now-make-up-94-of-new-covid-19-cases/
TWC2 (2020b) 'Forum: Employers' Practices Leave Foreign Workers Vulnerable to Infection'. TWC2 (Transient Workers Count Too) 23 March. www.straitstimes.com/forum/forum-employers-practices-leave-foreign-workers-vulnerable-to-infection
TWC2 (2020c) 'Migrant Bodies Sacrificed on the Altar of Self-Praise'. TWC2 (Transient Workers Count Too) 3 August. https://twc2.org.sg/2020/08/03/migrant-bodies-sacrificed-on-the-altar-of-self-praise/
The Workers' Party (2011) *Towards a First World Parliament*. Singapore: The Workers' Party.
The Workers' Party (2015) 'Sylvia Lim's Rally Speech, Bedok Stadium, 9 September'. www.wp.sg/sylvia-lims-rally-speech-bedok-stadium-9-sep/
The Workers' Party (2020) 'Make Your Vote Count: The Workers' Party Manifesto 2020'. Singapore: The Workers' Party. https://d3bnzwrhehvhbjiwmja.s3-ap-southeast-1.amazonaws.com/The+Workers+Party+Manifesto+2020.pdf
Zhang, J. (2020) 'S'porean Doc Who Sees Migrant Workers: If We Don't Look after the Weakest Link, We All Pay the Price'. Mothership SG 2 March. https://mothership.sg/2020/03/singapore-migrant-workers-doctor-covid-19/

Ijlal Naqvi (ijlalnaqvi@smu.edu.sg) is Associate Professor of Sociology at the School of Social Sciences, Singapore Management University, Singapore. He is the author of *Access to Power: Electricity and the Infrastructural State in Pakistan* (Oxford University Press, 2022).

Federico M. Rossi (corresponding author; federicorossi@poli.uned.es) is Ramón y Cajal Research Professor at the Department of Sociology II, Universidad Nacional de Educación a Distancia, Madrid, Spain and is on sab-

batical as Senior Research Professor at CONICET-UNSAM, Buenos Aires, Argentina. He is the author of *The Poor's Struggle for Political Incorporation* (Cambridge University Press, 2017) and editor of *The Oxford Handbook of Latin American Social Movements* (Oxford University Press, 2023), among others.

Rayner Kay Jin Tan (rayner.tan@nus.edu.sg) is Assistant Professor of Public Health at the Saw Swee Hock School of Public Health, National University of Singapore, Singapore. He conducts research on the social determinants of health, health equity, and community engagement in areas such as HIV, sexual health and substance use.