LAW AND POLICY IN HEALTHCARE DECISION-MAKING: A COMPARATIVE ANALYSIS OF SINGAPORE AND JAPAN

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Abstract

This study provides a comparative legal and policy analysis of healthcare decision-making frameworks in Singapore and Japan, focusing on informed consent, mental capacity, and advance directives. Singapore's common law-based system emphasizes individual autonomy through mechanisms such as the Lasting Power of Attorney (LPA), providing clear legal safeguards and structured planning for incapacity, though clinical practice may still reflect relational decision-making. By contrast, Japan's civil law-influenced and community-oriented framework relies more heavily on familial involvement and physician discretion, reflecting culturally embedded relational values. The comparison highlights trade-offs between legal certainty and cultural appropriateness and identifies opportunities for mutual policy learning. Japan could strengthen patient autonomy by adopting elements of Singapore's LPA framework, while Singapore could benefit from Japan's community-based care practices. Overall, the study emphasizes the importance

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The healthcare decision-making frameworks of Singapore and Japan are characterized by distinct legal traditions and policy approaches, reflecting their unique sociocultural values, demographic structures, and governance models. Singapore's approach is characterized by an effort to strike a balance between legal safeguards for patient autonomy and the imperative of cost efficiency, facilitated by the compulsory MediShield Life insurance scheme. Japan, in contrast, is characterized by a communal decision-making framework, a universal healthcare insurance system that prioritizes equitable access, and physician-driven discretion. This analysis explores the legal foundations and policy mechanisms of these systems, highlighting their comparative strengths and limitations, and stimulating further inquiry into the practical applications and ethical implications of each approach.

Despite their differing approaches, Singapore and Japan face similar demographic shifts and pressing social challenges that require robust and adaptable healthcare systems (see Table 1). Both countries are experiencing rapid population ageing and declining fertility rates, resulting in heightened

demand for long-term care, palliative services, and chronic disease management amid shifting demographic structures. These shared challenges present a compelling rationale for comparative analysis, as each country can potentially benefit from the other's legal and policy innovations in healthcare, irrespective of differences in population size.

Notwithstanding these shared challenges, fundamental differences in the design of their healthcare systems remain pronounced. Singapore adopts a hybrid healthcare model that combines substantial state subsidies with individual financial responsibility, implemented through schemes such as MediSave and MediShield Life, which are discussed in greater detail below. The system places a strong emphasis on cost containment and allocative efficiency, relying on demand-side controls and market-based incentives to regulate healthcare utilization. A clear illustration is the cost-effectiveness requirement for MediShield Life's oncology drug coverage, under which only cancer treatments that demonstrate sufficient clinical benefit relative to their cost, typically assessed through formal health technology assessment, are eligible for reimbursement. Singapore's legal system, grounded in the English common law tradition, further shapes its regulatory architecture and institutional approaches in the healthcare sector.

Conversely, Japan's universal healthcare system is structured around a fee-for-service model supported by a national health insurance scheme, with policy priorities centered on equitable access and comprehensive coverage. This framework is rooted in a legal and social policy tradition influenced by older German law and social insurance principles, providing a jurisprudential and institutional foundation that contrasts markedly with that of Singapore.

This paper aims to clarify the differences and similarities between the healthcare systems of Singapore and Japan, fostering a deeper understanding of how each nation addresses the complexities of modern healthcare. By highlighting the strengths and limitations of their respective frameworks, this analysis seeks to facilitate a constructive dialogue that could lead to mutual learning and policy improvement. Even with existing differences, a comparative study illuminates potential avenues for mutual learning, especially in addressing the similarities of demographic change.

This article analyzes healthcare policy and decision-making in Singapore and Japan from a legal and policy perspective. It presents a macro-level analysis of the systemic factors that influence healthcare decision-making. To provide a foundation for this study, a comprehensive review of literature in both English and Japanese was conducted, focusing on legal and policy research. The materials analyzed span several domains, including capacity

law and ethics,[1] medical law and ethics,[2] and healthcare policy.[3] In addition, policy documents and online resources from Singapore's Ministry of Health (MOH) and Japan's Ministry of Health, Labour, and Welfare (MHLW) were examined from a medical law and policy perspective. The research was further enriched by insights from expert commentary and academic literature on health law and policy in Singapore.

The following section presents an overview of the healthcare decision-making frameworks in Singapore and Japan, encompassing healthcare policy, legal structures, and their practical implementation. This is followed by a comparative analysis of the two systems, focusing on four key areas: (i) healthcare policy and cost management; (ii) legal foundations and consent frameworks; (iii) mental capacity and substitute decision-making; and (i) advance directives and end-of-life care. The subsequent discussion draws upon this comparative analysis, and the paper concludes by outlining three principal legislative and policy implications.

1. Healthcare decision-making framework in general

A healthcare decision-making framework constitutes a structured approach to guiding medical decisions, rooted in legal principles, such as informed consent regulations, ethical considerations like respect for persons, and the protection of individual rights. It provides a systematic methodology for resolving complex situations where competing interests, such as patient autonomy, clinical judgment, and societal welfare, intersect. At its core, the framework upholds the principle of autonomy, ensuring that individuals retain the right to make informed healthcare choices to the greatest extent possible.[4] These principles are balanced by beneficence and non-maleficence, which obligate healthcare providers to prioritize patient well-

1 Inaba, K. (2003). Healthcare decision-making: Patients, families, and representatives in the terminal stage [in Japanese]. *Medicine, Life, Ethics, and Society*, *2*(2). https://www.med.osaka-u.ac.jp/pub/eth/OJ_files/OJ2-2/inaba.htm; Donnelly, M. (2010). *Healthcare decision-making and the law: Autonomy, capacity, and limits of the liberalism*. Cambridge University Press. https://doi.org/10.1017/CBO9780511760679; Donnelly, M. (2017). Developing a legal framework for advance healthcare planning: Comparing England, Wales and Ireland. *European Journal of Health Law*, *24*(1), 67–84. https://doi.org/10.1163/15718093-12341412; Scholten, M. (2025). Mental capacity and supported decision-making. In Helmchen, H., Sartorius, N., Gather, J. (eds.), *Ethics in Psychiatry: European Contributions* (pp. 27–51). Springer Netherlands. https://doi.org/10.1007/978-94-024-2274-0_3

2 Herring, J. (2022). *Medical law and the ethics* (9th ed.). Oxford University Press; Yonemura, S. (2016). *Lectures on medical law* [in Japanese]. Nippon Hyoron Sha Co., Ltd; Menon, S., Entwistle, V. A., Campbell, A. V., et al. (2020). Some Unresolved Ethical Challenges in Healthcare Decision-Making: Navigating Family Involvement. *Asian Bioethics Review*, 12, 27–36. https://doi.org/10.1007/s41649-020-00111-9

3 Shimazaki, K. (2013). *The path to universal health coverage: Experiences and lessons from Japan for policy actions*. Japan International Cooperation Agency; Shimazaki, K. (2020). *Japan's healthcare: Systems and policies. Revised and expanded edition*. [in Japanese]. University of Tokyo Press; Ramesh, M., & Bali, A. S. (2017). *The healthcare system in Singapore*. Global-is-Asian, Lee Kuan Yew School of Public Policy Singapore.

4 Beauchamp, T., & Childress, J. (2019). Principles of biomedical ethics: Marking its fortieth anniversary. *The American Journal of Bioethics*, *19*(11), 9–12. doi: https://doi.org/10.1080/15265161.2019.1665402

being and minimize harm .[5] Additionally, the principle of justice ensures that healthcare decisions remain equitable, preventing discrimination or unjust disparities, particularly in the allocation of medical resources and access to care.[6]

From a jurisprudential perspective, a healthcare decision-making framework necessitates procedural mechanisms that uphold fairness, inclusiveness, and legal certainty.[7] A key component of this process is capacity assessment, recognizing that an individual's decision-making ability fluctuates based on the complexity of the medical decision and their personal circumstances. For individuals with diminished capacity, supported decision-making mechanisms facilitate their involvement to the greatest extent possible, often incorporating the assistance of legally appointed representatives or family members.

This approach also aligns with the concept of relational autonomy, which emphasizes the interconnectedness of individuals and the central role of social relationships, particularly those involving family members and close friends, in healthcare decision-making. When substitute decision-making becomes necessary, it must adhere to established legal standards, giving precedence either to the patient's previously expressed wishes or, where unavailable, to their best interests. The latter is typically determined by considering the patient's values, beliefs, and overall well-being.[8] These processes are guided by the principles of proportionality, transparency, and accountability, ensuring that interventions are legally justified, decision-making procedures are appropriately documented, and fundamental human rights are safeguarded.

The theoretical foundation of a healthcare decision-making framework draws upon established legal and ethical doctrines. The principles model, emphasizing autonomy, beneficence, non-maleficence, and justice, serves as a normative guide while allowing flexibility to accommodate diverse cultural and legal contexts. The framework typically employs a two-stage process: first, evaluating medically appropriate options through clinical expertise; and second, subjecting these options to an ethics-legal analysis that incorporates patient values, statutory requirements, and broader societal considerations.[9] By integrating legal rigor with procedural safeguards, a healthcare decision-making framework ensures that decisions are not only medically sound but also legally defensible and culturally sensitive. This

5 *Ibid.*

6 *Ibid.*

7 Donnelly (2010); Scholten (2025), *supra* note 1.

8 Inaba (2003), *supra* note 1.

9 Tang, S. L. (2023). When providers and families cannot agree: A new look at due process for end-of-life care disputes. *Houston Law Review*, *61*(1). https://ssrn.com/abstract=4454895

approach facilitates adaptability across jurisdictions while reinforcing the primacy of patient dignity and the rule of law in medical decision-making.

Healthcare decision-making instruments constitute both legal and non-legal frameworks, which vary by nation based on healthcare policies and legislative foundations. Non-legal frameworks include government-issued guidelines and those developed by medical academia or industry professionals.[10] While lacking formal legal authority in judicial proceedings, these guidelines often inform the standard of care applied in clinical settings. Healthcare decision-making frameworks differ across nations depending on healthcare policies, even though clinical ethics provide a shared foundation. In other words, each nation exercises discretion in designing healthcare decision-making frameworks that best align with its population's unique needs.

It is therefore imperative that legal systems consider regional traditions and values.[11] The effective development of healthcare decision-making policies requires cross-national collaboration and information exchange. Striking a balance between legal and ethical considerations is a shared objective, ethical principles are diverse laws and guidelines vary across nations, allowing for both shared challenges and context-specific solutions. Moreover, as social environments evolve and medical technologies advance, the design of laws, guidelines, and ethical frameworks must adapt accordingly to maintain their relevance and effectiveness.

2. Singapore's healthcare decision-making framework

Singapore's healthcare system balances individual liberties and macroeconomic healthcare management through calibrated demand- and supply-side interventions, supported by a legal framework built on informed consent, mental capacity, and advance directives. Singapore employs demand-side and supply-side regulatory mechanisms to modulate healthcare expenditures and maintain quality.[12]

Demand-side controls incorporate fiscal measures, such as MediSave limits and differential subsidies based on ward class, alongside mechanisms to influence patient behavior, such as public hospital price transparency mandates. Supply-side regulation centers on hospital management, with public hospitals, constituting 80 percent of the market, mandated to adhere to MOH service caps, approved drug formularies, and standardized

10 Sakurai, Y. (2024). The role of law and bioethics in human life and death: Japanese medical law in end-of-life care. *Australian Journal of Asian Law*, *25*(1), 89–105. https://ssrn.com/abstract=4964356

11 Sakurai, Y. (2025). The political process involved in formulating healthcare policy in Japan: With a particular focus on advisory councils, interest groups and medical officers. *The Rest: Journal of Politics and Development*, *15*(1), 82–96. http://hdl.handle.net/10131/0002001605

12 Sy, J. A., Tan, M. M. J., & Radha Krishna, L. K. (2015). A review of decision-making models in end-of-life care in Singapore. *Clinical Case Reports and Reviews*, *1*(8), 169-172. https://doi.org/10.15761/CCRR.1000157

clinical pathways.[13] While these measures promote efficiency, they also raise concerns about potential access limitations for lower-income patients. Singapore's emphasis on co-payment structures exemplifies a hybrid approach that integrates free-market efficiency with state-moderated healthcare accessibility.

Singapore has attained universal health coverage through a hybrid financing system commonly referred to as the "3Ms" (see Table 2): MediShield Life, a mandatory national health insurance scheme; MediSave, a compulsory medical savings program; and MediFund, a government-funded safety net for low-income citizens. MediShield Life, which is compulsory for all citizens and permanent residents, offers lifelong insurance coverage for major hospitalization costs and selected high-cost outpatient treatments. To ensure affordability, the government provides premium subsidies, thereby distributing the financial burden equitably across different age cohorts. MediSave functions as a mandatory savings mechanism, with both employee and employer contributions deducted from salaries to cover individual out-of-pocket healthcare expenditures.

MediFund complements these schemes by offering discretionary government assistance to citizens who are unable to meet their healthcare costs, even after exhausting MediSave balances and MediShield Life benefits. The MOH oversees the regulation of both public and private healthcare sectors. While it leverages market-based mechanisms and inter-institutional competition to improve service quality and system efficiency, the MOH also exercises direct regulatory authority to control healthcare costs and maintain equitable access.[14]

Care delivery in Singapore involves a mix of public and private sectors, with strong government oversight. Primary care is provided through public polyclinics and private general practitioners (GPs), while specialist care is available in both sectors. The government regulates the number of doctors and ensures quality through licensing and audits of healthcare facilities. Electronic health records are progressively deployed to integrate patient information across different healthcare providers, enhancing care coordination. Cost containment is a key focus, with the government using various strategies such as demand-and-supply-side controls, price transparency, and encouraging the use of cost-effective treatments.

Healthcare innovation is strategically managed through initiatives such as the LEAP Sandbox, which facilitates pilot testing of novel care models under controlled conditions, mirroring international regulatory sandboxes.

13 Ministry of Health (MOH) of Singapore. (2025a). *Improving our health in the next bound*. https://www.moh.gov.sg/ (accessed 2025, 27 March).

14 *Ibid*; Ministry of Health (MOH) of Singapore. (2025b). *Schemes and subsidies*. https://www.moh.gov.sg/managing-expenses/schemes-and-subsidies/medifund (accessed 2025, 27 March).

Quality assurance is upheld via a rigorous provider licensing system, established by the Healthcare Services Act 2020, which delineates four license categories. The evolving digital governance landscape necessitates ongoing legal adaptations to address emerging issues in data protection, patient confidentiality, and algorithmic decision-making in healthcare.

Informed consent, a cornerstone of patient rights, requires that medical authorization be granted either by a competent individual or, where capacity is lacking, by a legally authorized representative. It is predicated on three essential components: the patient's capacity, adequate and comprehensible disclosure of relevant treatment information, and voluntary, uncoerced assent. In Singapore, the Mental Capacity Act (MCA) 2008 and the Vulnerable Adults Act 2018 provide statutory safeguards for individuals who lack decision-making capacity. Singapore's MCA was influenced by, but is not identical to, the Mental Capacity Act 2005 (England and Wales), which similarly adopts a functional test of capacity and a best-interests framework but affords broader statutory recognition to advance decisions. The MCA establishes five core principles, including the presumption of capacity and the obligation to act in the individual's best interests.

Capacity under the MCA is decision-specific and time-specific, and a person lacks capacity only if he or she is unable to understand, retain, use or weigh relevant information, or to communicate a decision, in relation to the matter at hand. Early judicial interpretation of the MCA in *Re LPY* affirmed that an individual is not to be treated as lacking capacity merely because he or she makes an unwise decision, reinforcing the functional and autonomy-preserving nature of the statutory test (*Re LPY* [2014] 3 SLR 104 (HC)). In Re BKR, the High Court emphasized that best-interests determinations must take into account the individual's past and present wishes, values, and beliefs, and that the court retains a supervisory role to ensure that substitute decision-making does not become purely convenience-driven (Re BKR [2015] 4 SLR 81 (HC)).

To operationalize these principles, the MCA provides legal instruments such as the Lasting Power of Attorney (LPA) and the appointment of Deputies by the court, enabling substitute decision-making on behalf of those deemed incapable. A further dimension of incapacity planning comprises instruments relating to advance decision-making, including the Advance Medical Directive (AMD), a statutory instrument grounded in specific legislation, common law expressions of prior wishes, and advance care planning (ACP), which, although supported by policy frameworks, remains non-binding. These instruments differ in their legal status and activation criteria, thereby shaping their practical relevance and enforceability across various clinical contexts.

In 2017, the Singapore Court of Appeal in *Hii Chii Kok v Oii Peng Jin London Lucien* shifted Singapore's disclosure standard from a physician-centric to a patient-centric paradigm (*Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] 2 SLR 492 (CA)). This shift aligns with international jurisprudence, notably the United Kingdom (UK) decision in *Montgomery v Lanarkshire Health Board*, which established the duty of doctors to disclose material risks to patients (*Montgomery v Lanarkshire Health Board* [2015] AC 1430 (UKSC)). This legal shift enhanced patient autonomy and mandated increased physician diligence in risk communication. The "reasonable patient" standard, interpreted through legal precedent, medical ethics guidelines, and professional judgment, presents challenges in addressing the heterogeneous patient population. *Hii Chii Kok* located the standard of care for medical advice primarily within judicial assessment of materiality from the patient's perspective, thereby reducing traditional deference to professional medical opinion in determining disclosure obligations.

Consequently, further scholarly inquiry is needed to examine how physicians navigate this standard across diverse cultural and socioeconomic strata and whether current training adequately prepares them for these challenges. Furthermore, the standard of care for medical advice, previously governed by the *Hii Chii Kok* case law, was substantively recalibrated under section 37 of the Civil Law Act 1909, which came into effect in 2022. Rather than merely codifying *Hii Chii Kok*, section 37 reinstates the Bolam and Bolitho tests as the governing framework for assessing the standard of care in medical advice (*Bolam* [1957] 1 WLR 582 and *Bolitho* [1998] AC 232). Under the Bolam test, a medical practitioner is not negligent if the advice or treatment accords with a practice accepted as proper by a responsible body of medical professionals, while the Bolitho refinement requires that such professional opinion must also withstand logical analysis and be internally consistent. While section 37 preserves the obligation to disclose material information, it re-anchors legal liability within a clinician-centred evaluative structure by according greater weight to professional judgment, subject to rational scrutiny, thereby marking a partial retreat from the patient-centric orientation articulated in *Hii Chii Kok*.[15]

Singapore's legal framework for advance directives is primarily governed by the Advance Medical Directive Act (AMDA) 1996. The scope of the AMD is deliberately narrow: it applies only where a patient is terminally ill, suffering from an irreversible condition with no reasonable prospect of recovery, and where extraordinary life-sustaining treatment merely prolongs the dying process. The AMDA allows individuals to

15 Amirthalingam, K. (2021, 1 October). Medical duty to advise: Legislating the standard of care. *NUS Law Working Paper*, No. 2021/020. https://ssrn.com/abstract=3949456

formally refuse extraordinary life-sustaining treatment in cases of terminal illness, thereby reinforcing personal responsibility and self-determination.

The Ministry of Health (MOH) actively promotes advance care planning (ACP) through national campaigns and digital initiatives. Nevertheless, participation rates remain relatively low. The strong cultural emphasis on familial decision-making poses a significant challenge to implementing a system that prioritizes individual autonomy, necessitating ongoing policy calibration to balance personal choice with family involvement. Importantly, the AMD does not govern routine or day-to-day healthcare decisions, nor does it authorize substitute decision-makers to consent to or refuse treatment; such decisions continue to be regulated by the MCA framework and the exercise of professional clinical judgment.

The MCA's scope excludes participation in clinical trials absent LPA authorization and restricts restraint measures to immediate safety concerns. Instead, this is covered by the Medicines (Clinical Trials) Regulations 2016 and sections 7-8 of the Human Biomedical Research Act 2015.[16] The operationalization of advance directives necessitates a meticulous process encompassing registry verification, multidisciplinary team evaluation, and palliative care transition protocols, with legal immunity granted to compliant practitioners. The evolving discourse on advance directives highlights the tension between legal formalism and the practical realities of end-of-life decision-making.

Scholars have critically examined Singapore's approach to advance directives, highlighting tensions between autonomy and cultural expectations. Tracey Chan points out that Singapore's adoption of English common law principles, including the AMDA, contrasts with its Asian familial ethos, where family members play a dominant role in medical decision-making.[17] Hang Wu Tang further emphasizes the dual pressures of caregiving responsibilities and cultural values that shape healthcare choices, suggesting that clearer professional guidelines could help mediate conflicts between patient autonomy and family expectations.[18]

Sumytra Menon and her colleagues advocate for an autonomy-supportive approach in clinical practice, ensuring that ACP and AMDA processes align with both legal mandates and cultural sensitivities.[19] Menon also argues that while legal and professional ethics codes generally uphold patient autonomy in healthcare decision-making, cultural norms in

16 Chan, T. E., Peart, N. S., & Chin, J. (2014). Evolving legal responses to dependence on families in New Zealand and Singapore healthcare. *Journal of Medical Ethics*, *40*(12), 861–865. doi: https://doi.org/10.1136/medethics-2012-101225

17 *Ibid*.

18 Tang, H. W. (2022). Singapore's adult guardianship law and the role of the family in medical decision-making. *International Journal of Law, Policy and the Family*, *36*, 1–12. doi: https://doi.org/10.1093/lawfam/ebac002

19 Menon et al. (2020), *supra* note 2.

communities prioritize family involvement, sometimes even overriding a competent patient's choices.[20]

To navigate these tensions, she suggests that a relational approach to autonomy, which allows for supportive interventions by healthcare professionals and family members, may help balance respect for patient autonomy with cultural and ethical considerations. These insights underscore the need for a tailored legal and policy framework that acknowledges Singapore's unique sociocultural landscape.

The effectiveness of registry verification and multidisciplinary team evaluations necessitates assessment through empirical studies, examining parameters such as timeliness, accuracy, and impact on patient outcomes. Cultural barriers to AMD usage might be an obstacle, but the root-causes are currently ambiguous. Educational campaigns and culturally tailored information materials could help mitigate these barriers.

Advance directives uphold patient autonomy by ensuring that healthcare preferences are respected even in circumstances of diminished or lost decision-making capacity. Their effective implementation, however, requires alignment between legal provisions and clinical practice, necessitating ongoing policy refinement. Singapore's healthcare system seeks to balance patient autonomy with financial sustainability, maintaining cost containment without compromising the quality of care. This model integrates individual rights, which are expressed through informed consent legislation, mental capacity protections, and advance medical directives, with macro-level healthcare management achieved through carefully calibrated demand- and supply-side controls.

3. Japan's healthcare decision-making framework

Japan's healthcare policy is grounded in a universal health insurance system, instituted in 1961, which delivers comprehensive coverage through programs such as the National Health Insurance (NHI) and the Medical Care System for the Elderly Aged 75 and over. This structure ensures universal health insurance coverage, equitable access to healthcare services for all citizens, unrestricted access to medical institutions, patient autonomy in selecting medical providers, and in-kind payment for medical services. The national healthcare policy is predicated on the provision of high-quality care at a reasonable cost, primarily via a fee-for-service model.[21]

To manage healthcare expenditures, Japan employs reimbursement caps set by the Central Social Insurance Medical Council (*Chuikyo*), aiming to balance provider remuneration with national budgetary constraints. *Chuikyo*

20 Menon, S. (2017). Advance decision-making, in Singapore. in J. Chin, N. Berlinger, M. C. Dunn, & M. K. Gusmano (eds.), *A Singapore bioethics casebook* (Vols. 1–2). National University of Singapore. http://www.bioethicscasebook.sg

21 Shimazaki (2023; 2020), *supra* note 3.

is tasked with conducting public deliberations on fee schedule revisions and broader healthcare policy. The system also emphasizes preventive care and health promotion, aligning with the nation's focus on longevity. However, the long-term viability of the fee-for-service model warrants close scrutiny, especially in the context of rising healthcare costs and an ageing population. Ongoing research is essential to assess the effectiveness of reimbursement caps in controlling costs without undermining quality, while also examining alternative financing models, such as integrated care systems and technological innovations to improve efficiency.

Healthcare delivery in Japan follows a mixed model of public and private providers, with private institutions, including clinics and smaller hospitals, constituting roughly 80 percent of total capacity (Shimazaki 2020). Policy formulation involves a broad range of stakeholders (Sakurai 2025), including advisory bodies such as *Chuikyo*, advocacy groups like the Japan Medical Association,[22] and medical officers in the Ministry of Health, Labour and Welfare (MHLW). *Chuikyo* plays a mediatory role in reconciling stakeholder interests.[23]

Japan's healthcare system faces significant challenges, including healthcare spending that reached 8.18 percent of GDP in 2021.[24] The sustainability of the national health insurance and long-term care insurance systems is at risk, exacerbated by demographic shifts involving population ageing and declining fertility rates. Additionally, the increasing prevalence of lifestyle-related diseases and the growing need for long-term care services call for strong policy interventions.

The legal foundation of Japan's healthcare decision-making framework lies in Article 1(4), paragraph 2 of the Medical Care Act of 1948, which mandates healthcare professionals to provide sufficient explanations to ensure patient understanding. This provision underpins the principle that medical decisions should be informed by adequate explanation and dialogue among patients, caregivers, and relevant parties, particularly when patient preferences are unclear.

Nevertheless, the Act lacks specific implementation provisions, and detailed operational guidelines or codes of practice have yet to be established. This has created ambiguity among stakeholders, despite the presence of general advisory materials. Concerning mental capacity, the adult guardianship system, which is governed by the Civil Code and the Act on the Voluntary Guardianship Contract of 1999, primarily depends on court-appointed guardians. These guardians, however, are not legally

22 Japan Medical Association (JMA). (2025). *Introduction*. https://www.med.or.jp/english/

23 Morita, A. (2016). *Politics of the conference 3: The reality of the chuikyo* [in Japanese]. Jigakusha Publishing.

24 Ministry of Health, Labour, and Welfare (MHLW) of Japan. (2023). *Overview of national medical expenses for fiscal year 2021* [in Japanese]. https://www.mhlw.go.jp/toukei/saikin/hw/k-iryohi/21/dl/data.pdf

authorized to make medical decisions on behalf of the principal; they may assist in understanding medical matters but cannot act as substitute decision-makers. Voluntary guardianship contracts may include healthcare clauses by mutual agreement, though they remain underutilized.

Although not codified in formal guidelines, this approach has been discussed as a conceptual understanding of the relationship between medicine and supported decision-making by a study group organized by the MHLW. When a patient's preferences can be reasonably inferred by family members, such preferences should be respected. In cases where this is not possible, decisions should be guided by the patient's best interests through collaborative discussions among family members and healthcare professionals. Ultimately, informed decision-making should be facilitated by healthcare providers through comprehensive explanations and transparent communication with both patients and their families.[25]

In practice, informed consent in Japan often reflects complex dynamics. Physicians retain considerable discretion, and families play a central role, particularly in cases of severe or terminal illness. This can sometimes result in familial preferences taking precedence over patient autonomy. Ethics committees and professional medical societies provide guidance in challenging cases. Standardized documentation tools and electronic systems can facilitate the recording of patient preferences, and it is essential that healthcare providers receive training to respect and uphold these decisions.

Although Japan lacks a definitive judicial precedent shifting the standard of informed consent from physician- to patient-centric, unlike the *Hii Chii Kok* case in Singapore, the MHLW has issued several supported decision-making guidelines. However, a comprehensive, unified framework remains absent. The 2018 Guidelines for the Process of Medical and Care Decision-Making in the End-of-Life (2018 Guidelines) aim to foster shared decision-making among professionals, patients, and families, emphasizing autonomy and documentation of preferences.[26]

Some scholars contend that the 2018 Guidelines do not constitute soft law due to their lack of sufficient detail and clarity.[27] Cheung and Dunn classify Japan as a "non-regulated" jurisdiction with respect to advance directives.[28] Although these guidelines were developed for professionals

25 Ministry of Health, Labour, and Welfare (MHLW) of Japan. (2022). *Relationship between medicine and supported decision-making* [in Japanese]. https://www.mhlw.go.jp/content/12601000/000932592.pdf

26 Ministry of Health, Labour, and Welfare (MHLW) of Japan. (2018a). *Policy on medical and care at the end of life* [in Japanese]. https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000161103.html (accessed 2025, 27 March); Ministry of Health, Labour, and Welfare (MHLW) of Japan. (2018b). *Survey report on awareness regarding medical care in end of life* [in Japanese]. https://www.mhlw.go.jp/toukei/list/dl/saisyui-ryo_a_h29.pdf

27 Uchida, H. (2021). *Medical law and the rights of patients and medical workers* [in Japanese]. Misuzu Shobo. pp. 22-23.

28 Cheung, D., & Dunn, M. (eds.). (2023). *Advance directives across Asia: A comparative socio-legal analysis*. Cambridge: Cambridge University Press. https://doi.org/10.1017/9781009152631

and care workers, they are not intended for public application and do not explicitly address advance directives or ACP. Consequently, Japan's legal framework concerning end-of-life care remains ambiguous, lacking both hard and soft law protections.

Conflicts between patient wishes and family preferences are generally resolved through informal negotiations, with physicians acting as mediators. These processes can be time-consuming. Although the 2018 Guidelines provide general guidance, they do not specify clear procedural rules for resolving disagreements. This highlights the need for more robust protocols and enhanced professional training. More importantly, the development of standardized decision-making principles applicable to all parties, patients, families, and healthcare professionals, represents a pressing policy priority. At present, hospitals rely on a variety of guidelines, including the 2018 Guidelines and other institutional rules.

A notable example of institutional guidelines is provided by the National Center for Child Health and Development (NCCHD), which articulates distinct frameworks for adults and minors, emphasizing patient-centered and shared decision-making. For adults, autonomy is prioritized through informed discussions involving patients, families, and interdisciplinary teams. Treatment decisions are based on medical assessments and are updated regularly in response to patient needs or expressed preferences. When patient intent is unknown, the institution follows structured procedures that prioritize the patient's best interests while considering inferred family perspectives.[29]

For minors, decisions are guided by the child's best interests, with attention to age and developmental maturity.[30] The NCCHD promotes child participation through tailored communication and infers intent from non-verbal cues when necessary. These measures ensure that decisions align with the child's welfare while incorporating guardians into the process. Although the NCCHD provides a public institutional model, many hospitals lack similarly explicit policies.

Unlike Singapore's legally binding Advance Medical Directive (AMD) framework, end-of-life decisions in Japan typically rely on physician judgment or family input. Despite initiatives such as the "Life Conference", a colloquial term for ACP in Japan, promoting end-of-life discussions, the absence of legal enforceability remains a significant challenge. Strategies to encourage broader engagement may include public education campaigns,

29 National Center for Child Health and Development (NCCHD). (n.d.a). *Principles for decision-making for adults* [in Japanese]. https://www.ncchd.go.jp/hospital/about/information/ishikettei.html (accessed 2025, 27 March).

30 National Center for Child Health and Development (NCCHD). (n.d.b). *Principles for decision-making for minors* [in Japanese]. https://www.ncchd.go.jp/hospital/about/information/ishikettei_kodomo.html (accessed 2025, 27 March).

financial or administrative incentives, and integration of ACP into routine medical practice.

Japan continues to lack a codified, legally binding framework for advance directives. Cultural norms emphasizing family responsibility, coupled with stigma surrounding declarations of incompetency, inhibit widespread utilization of the guardianship system. Further academic investigation, particularly through qualitative research, is required to understand these dynamics and to develop interventions that enhance societal acceptance and practical use of these legal mechanisms.

4. Comparison of law and policy on healthcare decision-making between Singapore and Japan

Singapore and Japan's healthcare decision-making frameworks exhibit divergent legal and policy paradigms, stemming from their distinct sociocultural values, demographic profiles, and healthcare governance models. Singapore's system prioritizes a strategic equilibrium between legal protections for patient autonomy and cost-effectiveness. In contrast, Japan's approach is predicated on communal decision-making principles, a universal insurance system, and a less prescriptive regulatory framework for ACP. This comparative analysis elucidates the disparities in their legal structures, consent protocols, mental capacity safeguards, and advance directive mechanisms.

4.1. Healthcare policy and cost management

Singapore and Japan employ fundamentally different healthcare financing models, which in turn shape their respective policy approaches to medical decision-making. Singapore's system, anchored by mechanisms such as MediSave, MediShield Life, and MediFund, strategically balances individual financial responsibility with governmental oversight. Demand-side controls, including co-payment schemes and tiered subsidies, are designed to ensure fiscal sustainability while preserving a measure of patient autonomy. The broader framework integrates public ownership, market competition, and price transparency to pursue diverse yet mutually reinforcing objectives (Ramesh and Bali, 2017).

In contrast, Japan's universal healthcare model, founded on mandatory national health insurance, diverges markedly from Singapore's cost-sharing paradigm. The fee-for-service approach and uniform reimbursement structure under the National Health Insurance (NHI) scheme emphasize universal accessibility, albeit at the expense of rising healthcare expenditures. Policy interventions in Japan primarily target cost containment through periodic fee schedule revisions rather than through direct patient cost-sharing mechanisms.

Moreover, while Singapore actively utilizes regulatory sandboxes, such as the LEAP Sandbox, to pilot healthcare innovations within controlled environments, Japan's regulatory regime remains comparatively conservative. Although Japan's framework ensures comprehensive medical coverage, it exhibits a relative deficiency in adaptive governance mechanisms when compared with Singapore's more agile and experimental policy orientation.

4.1.1. Legal foundations and consent frameworks

While both Singapore and Japan recognize informed consent as a fundamental patient right, their respective implementations and emphases diverge considerably. Singapore's landmark *Hii Chii Kok v Ooi Peng Jin (2017)* decision established a patient-centric standard, requiring the disclosure of material risks that a reasonable patient would consider significant. This judicial precedent has since been codified in section 37 of the Civil Law Act 1909. In contrast, Japan continues to operate under a predominantly professional-discretion model, in which medical professionals retain substantial authority over the scope and timing of disclosure. Although Article 4(1), paragraph 2 of the Medical Care Act formally mandates informed consent, its practical application remains inconsistent, largely contingent upon physician judgment and familial involvement.

In Japan, family participation in healthcare decision-making is institutionalized, often superseding individual patient autonomy, particularly in end-of-life contexts. Medical practitioners frequently employ implicit consent practices, consulting family members in lieu of patients when making critical medical decisions. The 2018 Guidelines issued by the MHLW aim to promote collaborative decision-making in end-of-life care while reaffirming respect for patient preferences. In addition, various medical societies have issued professional guidelines on informed consent, which collectively shape prevailing medical norms and clinical practices. Hospital ethics committees play a pivotal role in mediating conflicts and offering recommendations in complex or disputed cases, particularly where patient wishes are ambiguous or contested.

4.1.2. Mental capacity and substitute decision-making

The legal frameworks protecting individuals who lack decision-making capacity differ markedly between Singapore and Japan. Singapore's MCA 2008 establishes a structured regime grounded in five fundamental principles that emphasize the presumption of capacity and the primacy of best-interests decision-making where capacity is lacking. The LPA mechanism enables individuals to pre-designate substitute decision-makers, while court-appointed Deputies provide an additional safeguard for vulnerable persons who lack suitable or willing family members.

However, in cases involving extraordinary life-sustaining treatment, the legal decision-making process in Singapore follows a distinct and sequential

hierarchy. The threshold inquiry is whether the patient has executed a valid Advance Medical Directive (AMD) under the Advance Medical Directive Act. Where an AMD exists and is applicable to the clinical circumstances, the patient's prior autonomous refusal of extraordinary life-sustaining treatment takes legal precedence and must be respected. In the absence of an AMD, decisions concerning such treatment are made on the basis of the patient's best interests, consistent with the principles underlying the Mental Capacity Act (MCA). Although LPAs and court-appointed Deputies are expressly excluded from authority over decisions relating to extraordinary life-sustaining treatment, physicians assume primary decision-making responsibility, guided by professional judgment, consultation with family members, and consideration of the patient's previously expressed values and preferences. The overarching objective in such circumstances is to determine and act in the patient's best interests, rather than to substitute familial or representative consent for the patient's own will.

In contrast, Japan's adult guardianship system, governed by the Civil Code, strictly confines the authority of court-appointed adult guardians to property management and legal representation upon the onset of legal incapacity, explicitly excluding any competence over healthcare or treatment decisions. There are neither statutory provisions nor detailed administrative guidelines that regulate medical decision-making for incapacitated adults, nor a clear legal framework that formally legitimizes or structures family involvement in such decisions. Consequently, Japan's approach to healthcare decision-making relies heavily on the discretionary judgment of medical professionals, informed by professional ethics, customary clinical practice, and prevailing social norms that emphasize familial trust, harmony, and consensus-building. In practice, the invocation of legal guardianship is often perceived as a public acknowledgment of familial failure or inadequacy, prompting families to eschew formal legal mechanisms in favor of informal arrangements. This cultural resistance, combined with a deeply embedded ethos of familial responsibility for care, encourages informal, family-centered decision-making processes. As a result, critical healthcare decisions are frequently made within the family unit in the absence of clear legal authorization or procedural safeguards, even in circumstances where legal intervention or oversight might better protect the individual's rights and welfare.

This divergence underscores Singapore's structured, legally codified approach to incapacity planning, in contrast to Japan's culturally mediated and largely informal family-based practices. Nevertheless, despite these institutional and cultural distinctions, both systems exhibit a practical reliance on familial trust in the implementation of decision-making for persons lacking capacity. This shared reliance gives rise to a further systemic

challenge, namely how medical professionals are to manage decision-making for older adults who live alone and lack family members or close social ties, a demographic group that is increasing in prevalence in both jurisdictions. The growing number of such individuals exposes potential gaps in existing legal and institutional frameworks, particularly with respect to safeguarding autonomy, ensuring continuity of care, and allocating legitimate decision-making authority in the absence of familial support.

4.1.3. Advance directives and end-of-life care

The implementation of ACP and advance directives reveals substantial divergence between Singapore and Japan. Singapore's legal framework explicitly recognizes two distinct instruments: the Advance Medical Directive (AMD) and ACP documentation. The AMD, codified under the Advance Medical Directive Act, establishes a statutory mechanism enabling individuals to refuse life-sustaining treatment in terminal conditions. Complementing this, the ACP framework facilitates structured discussions among healthcare professionals and family members, promoting the documentation and observance of patient preferences.

In practice, however, Singapore's AMD remains infrequently utilized. As Menon observes, only around one percent of the population has executed an AMD. Moreover, its applicability is narrowly defined – it pertains solely to terminally ill patients and specifically to circumstances in which life-sustaining treatment serves only to prolong the dying process. Although ACP has gained increasing prominence through policy initiatives, it lacks a legally binding character: there is no statutory duty to initiate, participate in, or complete ACP discussions. Notably, the MCA does not expressly reference ACP, underscoring its status as a policy-based rather than legislatively mandated instrument. By contrast, English courts have emphasized in cases such as *Aintree University Hospitals NHS Foundation Trust v James* that best-interests assessments in life-sustaining treatment cases must be evaluated from the patient's perspective, including their values and wishes, even where treatment withdrawal is contemplated (*Aintree University Hospitals NHS Foundation Trust v James* [2014] AC 591).

In contrast, Japan does not possess a codified or legally enforceable regime governing advance directives. While various medical societies have issued guidelines promoting ACP, their legal authority remains indeterminate. The 2018 Guidelines published by the MHLW advocate for patient autonomy and the recording of treatment preferences yet function only as non-binding recommendations. The MHLW's "Life Conference" initiative further encourages ACP discussions; however, participation is voluntary, and implementation differs significantly across healthcare institutions. Hospital ethics committees may intervene in complex end-

of-life cases, offering advisory opinions but lacking enforcement powers. Consequently, in the absence of statutory support, Japanese healthcare providers frequently defer to familial preferences over documented patient wishes, generating potential ethical tensions in end-of-life care.[31]

4.2. Discussion on cross-national comparative analysis

Singapore's meticulously structured, legislation-centered approach to healthcare decision-making reinforces patient autonomy through legally binding directives and proactive incapacity planning. The foundation of familial trust is evident in Singapore's LPA model, where most donors appoint relatives as donees: 88.1 per cent selecting immediate family members and 8.1 per cent extended family.[32]

In contrast, Japan's reliance on culturally embedded, family-based decision-making norms and physician-centric discretion produces a more flexible, though less legally formalized, system. This comparative analysis demonstrates that while Singapore's codified framework provides robust legal safeguards, it requires continual adaptation to address evolving ethical dilemmas and healthcare needs. Conversely, Japan's emphasis on familial authority, though conducive to flexibility and consensus, may expose patients to inconsistencies in the protection of individual rights.

Accordingly, the analysis suggests that Japan could strengthen its statutory frameworks to enhance patient autonomy, whereas Singapore could improve policy adaptability to better accommodate diverse patient needs and cultural sensitivities. Potential avenues for policy transfer include adapting Singapore's LPA model to provide more structured legal protection in Japan and integrating Japan's community-based integrated care initiatives into Singapore's healthcare system. Japan's community-based care model, which fosters social inclusion and supports vulnerable populations, may offer valuable insights for Singapore's evolving healthcare landscape.

Further research should explore the nuanced influence of traditional values, such as filial piety and social harmony in Confucian culture, on familial healthcare decision-making in both societies. Such inquiry should examine how these values shape communication patterns, the prioritization of family wishes over patient preferences, and attitudes toward advance directives, including low utilization rates and barriers to implementation. Parallel research should assess the impact of Singapore's pragmatic policy orientation, particularly the effectiveness of cost-containment mechanisms (such as co-payment schemes and tiered subsidies) on the quality and accessibility of long-term care. This includes analyzing how the emphasis

31 Sakurai. (2024), *supra* note 10.

32 Office of Public Guardian (OPG) of Singapore. (2022). *Statistical Tables – Ageing*. (The tables were available at the OPG HP in 2022, but now not accessible.).

on individual responsibility interacts with principles of equity and social justice, especially in relation to marginalized or low-income communities.

Comparative studies on the regulation of digital health technologies, cross-border data privacy, and the ethical implications of artificial intelligence in healthcare are also crucial, given the potential for both benefit and harm in these rapidly evolving domains. Such analyses should evaluate how Singapore and Japan differ in data governance and patient privacy approaches amid increasing reliance on digital health solutions. This theme is important; however, the scope of this study does not allow for further consideration of the issues involved. Similarly, assessing the effectiveness of palliative and long-term care strategies in both nations is imperative in the context of ageing populations and rising chronic disease prevalence. Future research should identify best practices for culturally sensitive care delivery and equitable resource allocation, including how each country finances long-term care-through mechanisms such as MediSave and ElderShield in Singapore and the Long-Term Care Insurance (LTCI) system in Japan and how caregivers are supported within these frameworks.

Identifying adaptable policy elements, such as Singapore's LPA framework and Japan's community-based integrated care model, would substantially advance global discourse on healthcare governance. Such comparative insights illuminate how differing legal and cultural contexts can inform more responsive, rights-based healthcare policy design. Furthermore, a comprehensive examination of the Japanese healthcare system is warranted, focusing on the implications of demographic shifts, including declining fertility rates, population ageing, and workforce contraction. This analysis should also consider the potential effects of intergenerational wealth transfer and the commercialization of healthcare services on cost containment, equitable access, and the sustainability of the national health insurance system. Attention should likewise be given to workforce challenges in both nations, including strategies for the recruitment, retention, and training of healthcare professionals.

Finally, it is notable that healthcare systems in both Singapore and Japan remain predominantly shaped by professional and bureaucratic discourse among healthcare providers, legal experts, and administrators, with limited avenues for public participation. In Japan, debates over health insurance and elderly care policies often become politically sensitive, prompting policymakers to adopt short-term, electorally driven strategies. As a result, structural reform remains constrained, and decision-making continues to be largely delegated to healthcare professionals.

To address these challenges, cross-national comparative analysis provides a particularly valuable foundation for evidence-based and pragmatic policy

development. For countries such as Singapore and Japan, which confront similar demographic trajectories marked by rapid population ageing, declining family size, and increasing social isolation among older adults, the systematic exchange of policy lessons and institutional insights is especially important. Both bilateral comparisons, such as those undertaken in this study, and broader multilateral analyses, particularly within the OECD framework, should therefore be actively promoted. Comparative research enables policymakers and practitioners in each jurisdiction to identify transferable best practices, anticipate structural risks, and refine legal and institutional responses to shared challenges. Moreover, the findings of such research should be disseminated to the public in accessible and comprehensible forms in order to foster informed civic engagement with healthcare policy and decision-making. Such transparency and public dialogue are critical not only for enhancing social awareness but also for sustaining long-term public trust and legitimacy in healthcare governance amid profound demographic change.

Conclusion

This article has presented a comparative legal and policy analysis of healthcare decision-making in Singapore and Japan, with particular attention to informed consent, mental capacity, and advance directives. The comparative analysis thus reveals not a simple dichotomy between individual and relational autonomy, but rather differing configurations of legal formality, cultural practice, and institutional reliance. Singapore's framework prioritizes legal clarity and rights-based safeguards, yet may accommodate relational autonomy in practice, whereas Japan's approach explicitly embeds relational decision-making while operating with weaker formal legal protections. These contrasting models highlight inherent trade-offs between legal precision, cultural embeddedness, and flexibility in healthcare governance.

Effective healthcare decision-making frameworks must therefore balance legal certainty, ethical sensitivity, and socio-cultural responsiveness to advance patient-centered care, protect individual rights, and ensure equitable access. Policy lessons emerging from this analysis suggest that Japan may benefit from selectively adopting Singapore's legal instruments to enhance procedural transparency and autonomy protection, particularly in relation to advance decision-making and capacity assessment. Conversely, Singapore may draw insights from Japan's community- and family-oriented practices to better align formal legal norms with lived clinical realities, especially in an ageing society characterized by evolving family structures. Such a balanced approach can support autonomy in its relational context and inform adaptive healthcare policies suited to rapidly ageing societies.

The absence of empirical data on actual decision-making practices in both jurisdictions constitutes a limitation of this study and underscores the need for further research. Future empirical and interdisciplinary inquiry, engaging patients, families, and healthcare professionals, would be particularly valuable in examining whether and how relational autonomy is operationalized within formally individualistic legal systems such as Singapore's, and how informal systems such as Japan's manage risk and accountability in practice. ●

Table 1: Demographic Change Estimates in Singapore and Japan

Items	Singapore (2024)	Singapore (2040)	Japan (2024)	Japan (2040)
Percentage of population aged 65 and above (Percent)	19.9	29.0	z29.3	34.8
National population aged 65 and above (Million)	0.75	2.03	36.2	39.3
Total fertility rate (TFR)	0.97	n/a	1.15	n/a
Total population (Million)	6.0	6.2	123.8	112.8

Remark: The average total fertility rate (TFR) in Japan is 1.15, while in Tokyo it is 0.96, which is almost the same as in Singapore.[33]

Table 2: 3Ms for Healthcare System in Singapore

Item	MediSave	MediShield Life	MediFund
Eligibility	Singaporean citizens and permanent residents employed in Singapore (also applies to others with Central Provident Fund (CPF) contribution obligations)	Nationals receiving government subsidies	MediSave members (those facing financial hardship, etc.)
Beneficiary	Self and family (spouse, children, parents, grandparents, and siblings, if they are Singaporean citizens or permanent residents)	Self	Self

33 Cabinet Office of Japan. (2025). *Annual Report on the Ageing Society (Summary) FY2024*. https://www8.cao.go.jp/kourei/english/annualreport/2024/pdf/2024.pdf; Statistics Bureau of Japan. (2023). *Current population estimates as of October 1, 2023*. https://www.stat.go.jp/english/data/jinsui/2023np/index.html (accessed 2025, 27 March); Singapore Department of Statistics. (2024a). *Births and fertility rates, annual*. https://data.gov.sg/datasets/d_e39eeaeadb571c0d0725ef1eec48d166/view (accessed 2025, 27 March); Singapore Department of Statistics. (2024b). *Population and population structure - Latest data*. https://www.singstat.gov.sg/find-data/search-by-theme/population/population-and-population-structure/visualising-data (accessed 2025, 27 March).

Benefits	MediSave can be used for medical expenses for hospitalization, chronic diseases, high-cost tests and treatments (such as dialysis, radiotherapy, and chemotherapy), specific outpatient expenses, and MediShield Life premiums.	Medical expenses for hospitalization, outpatient care, long-term care, chronic diseases, high-cost tests and treatments (dialysis, radiotherapy, chemotherapy, etc.)	Medical expense coverage, fully covered by the national treasury.
Co-payment	Full self-payment (within the balance of the savings account)	Claim amounts are capped based on expenses, length of stay, and type of surgery. Deductibles, ranging from $1,500 to $3,000, apply and vary depending on ward type and age. Co-payment rates, ranging from 3 percent to 10 percent, apply depending on the claim amount.	No co-payment
Premium	A fixed percentage of salary is accumulated into an individual account by employers and employees.	Annual premiums vary by age. For example: $145 for ages 1-20, $525 for ages 41-50, and $2,025 for ages 86-90.	None
Government	None (excluding CPF management costs, etc.)	Government subsidy	Fully covered by the national treasury

Source: Nagano Ken Shinkumi Bank[34]

34 Nagano Ken Shinkumi Bank, Singapore Representative Office. (2021). *Singapore Report,* No. 27 [in Japanese]. https://www.naganokenshin.jp/ck/2/files/info_20211020.pdf (English-translated by the author)

References

[1] Amirthalingam, K. (2021, 1 October). Medical duty to advise: Legislating the standard of care. *NUS Law Working Paper*, No. 2021/020. https://ssrn.com/abstract=3949456

[2] Beauchamp, T., & Childress, J. (2019). Principles of biomedical ethics: Marking Its Fortieth Anniversary. *The American Journal of Bioethics*, *19*(11), 9–12. https://doi.org/10.1080/15265161.2019.1665402

[3] Chan, T. E., Peart, N. S., & Chin, J. (2014). Evolving legal responses to dependence on families in New Zealand and Singapore healthcare. *Journal of Medical Ethics*, *40*(12), 861–865. https://doi.org/10.1136/medethics-2012-101225

[4] Cheung, D., & Dunn, M. (eds.). (2023). *Advance directives across Asia: A comparative socio-legal analysis*. Cambridge: Cambridge University Press. https://doi.org/10.1017/9781009152631

[5] Donnelly, M. (2010). *Healthcare decision-making and the law: Autonomy, capacity, and limits of the liberalism*. Cambridge University Press. https://doi.org/10.1017/CBO9780511760679

[6] Donnelly, M. (2017). Developing a legal framework for advance healthcare planning: Comparing England, Wales and Ireland. *European Journal of Health Law*, *24*(1), 67–84. https://doi.org/10.1163/15718093-12341412

[7] Herring, J. (2022). *Medical Law and the Ethics* (9th ed.). Oxford University Press

[8] Inaba, K. (2003). Healthcare decision-making: Patients, families, and representatives in the terminal stage [in Japanese]. *Medicine, Life, Ethics, and Society*, *2*(2). https://www.med.osaka-u.ac.jp/pub/eth/OJ_files/OJ2-2/inaba.htm

[9] Menon, S. (2017). Advance decision-making in Singapore. in J. Chin, N. Berlinger, M. C. Dunn, & M. K. Gusmano (eds.), *A Singapore Bioethics Casebook* (Vols. 1–2). National University of Singapore. http://www.bioethicscasebook.sg

[10] Menon, S., Entwistle, V. A., Campbell, A. V., et al. (2020). Some unresolved ethical challenges in healthcare decision-making: Navigating family involvement. *Asian Bioethics Review*, *12*, 27-36. https://doi.org/10.1007/s41649-020-00111-9

[11] Morita, A. (2016). *Politics of the Conference 3: The reality of the Chuikyo* [in Japanese]. Jigakusha Publishing

[12] Ramesh, M., & Bali, A. S. (2017). *The healthcare system in Singapore*. Global-is-Asian, Lee Kuan Yew School of Public Policy Singapore

[13] Sakurai, Y. (2024). The role of law and bioethics in human life and death: Japanese Medical Law in end-of-life care. *Australian Journal of Asian Law*, *25*(1), 89–105. https://ssrn.com/abstract=4964356

[14] Sakurai, Y. (2025). The political process involved in formulating healthcare policy in Japan: With a particular focus on advisory councils, interest groups and medical officers. *The Rest: Journal of Politics and Development*, *15*(1), 82–96. http://hdl.handle.net/10131/0002001605

[15] Scholten, M. (2025). Mental capacity and supported decision-making. In Helmchen, H., Sartorius, N., Gather, J. (eds.), *Ethics in psychiatry: European contributions* (pp. 27–51). Springer Netherlands. https://doi.org/10.1007/978-94-024-2274-0_3

[16] Shimazaki, K. (2013, June). *The path to universal health coverage: Experiences and lessons from Japan for policy actions*. Japan International Cooperation Agency

[17] Shimazaki, K. (2020). *Japan's healthcare: Systems and policies* (Revised and expanded edition). [in Japanese]. University of Tokyo Press

[18] Sy, J. A., Tan, M. M. J., & Radha Krishna, L. K. (2015). A review of decision-making models in end-of-life care in Singapore. *Clinical Case Reports and Reviews*, *1*(8), 169-172. https://doi.org/10.15761/CCRR.1000157

[19] Tang, H. W. (2022). Singapore's Adult Guardianship Law and the role of the family in medical decision-making. *International Journal of Law, Policy and the Family*, *36*, 1-12. https://doi.org/10.1093/lawfam/ebac002

[20] Tang, S. L. (2023). When providers and families cannot agree: A new look at due process for end-of-life care disputes. *Houston Law Review*, *61*(1). https://ssrn.com/abstract=4454895

[21] Uchida, H. (2021). *Medical law and the rights of patients and medical workers* [in Japanese]. Misuzu Shobo

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Author Contribution

The author contributed to the study conception and design. The author read and approved the final manuscript.

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