Synopsis of Healthcare Financing Studies

Healthcare System and Financing: Overseas Experience

Introduction

In the deliberations of possible financing options to enhance the sustainability of Hong Kong's public healthcare system, reference has been made to the healthcare financing arrangements in different developed economies and their response to contemporary healthcare system challenges. This document provides a summary of the experience of 12 selected economies – Australia, Austria, Belgium, Canada, Finland, Japan, Korea, Netherlands, Singapore, Switzerland, The United Kingdom (UK), and the United States of America (US). In view of state/provincial differences in the US and Canada, the summary also specifically covers the healthcare financing arrangement in the state of Massachusetts and the province of Alberta respectively.

2. Summary of the healthcare financing arrangement of the individual economies includes major funding source, coverage, fees and charges, and major challenges. They are prepared based on information available from official website and other publications as well as comments from government officials of the respective economies. The order of the individual summaries is as follows:

AUSTRALIA

Major Funding Source

General taxation and Medicare levy

Australia has a predominantly publicly funded healthcare system (Medicare) financed through general taxation and supplemented by the compulsory Medicare levy (established in 1984) on personal income tax. The highest personal income tax rate in 2006 was 48.5%, which is inclusive of the health tax levy (Medicare levy) of 1.5% of taxable income above certain income thresholds. Higher income earners who do not have an appropriate level of hospital insurance with a registered health fund incur a Medicare Levy Surcharge of 1% of taxable income. The Medicare Levy Surcharge is in addition to the Medicare Levy. The aim of the Medicare Levy Surcharge is to encourage high-income earners to take out private hospital cover. The general taxation system includes a 10% sales tax.

Coverage of Publicly Funded Healthcare Services (Medicare)

2. Medicare offers universal access to publicly-funded healthcare for all Australian residents and visitors from countries with which Australia has Reciprocal Healthcare Agreements, e.g. New Zealand and United Kingdom, regardless of their ability to pay. However, Medicare does not cover all medical services. Medical services subsidies are limited to those items listed on the Medicare Benefits Schedule, e.g. consultation fees, surgical and therapeutic procedures by general practitioners and specialists. For drugs, Medicare only provides subsidies to drugs included in the Pharmaceutical Benefits Schedule (PBS).

Exclusions

3. Medicare does not cover dental treatment, ambulance services, home nursing, physiotherapy, occupational therapy, speech therapy, chiropractic and podiatry services, treatment by psychologists, visual and hearing aids and prosthetic, medical services that are not clinically necessary, or cosmetic surgery, as well as drugs that are not listed in the PBS. Private health insurance may cover these under 'ancillary' tables to some extent with both service and benefit limitations.

Fees and Charges

4. Publicly-funded healthcare services in Australia are not necessarily provided by public institutions or public providers. Australians are free to choose treatment in public or private hospitals, and if in public hospitals, as public or private patients which entitles them to differing degrees of subsidy from public funds. All out-patient services are provided by private providers but may be subsidised by public funds.

5. The government publishes a schedule of medical fees – called the Medicare Benefits Schedule (MBS) – for all items covered by Medicare but doctors are allowed to charge above the MBS fee.

6. For medical services provided out of hospital, Medicare can reimburse doctors fees at either 85% or 100% of the MBS fee, depending on whether treatment is provided by a general practitioner or a specialist. Doctors can choose to charge more than the MBS fee, and any 'gap' between the MBS fee and the fee charged by the doctor will have to be paid out-of-pocket by the patient. For in-hospital services, under Medicare, Australian residents and 'eligible persons' from countries with reciprocal healthcare agreements who choose to be admitted as a public patient are entitled to free treatment in a public hospital, including free accommodation, doctor(s) services, diagnostic tests and medications. A public patient is treated by a doctor(s) appointed to the hospital.

7. A private patient can either be self-funded (that is, pays all the cost except those costs covered by Medicare), or have private health insurance. Private health insurance covers accommodation, theatre and prostheses costs. When an individual receives medical treatment in hospital as a private patient, Medicare pays 75% of the MBS fee for the service of the treating doctor(s). For those individuals who have private health insurance, the health fund pays at least the remaining 25% of the MBS fee. If a doctor charges above the MBS fee, health funds are able to cover the 'gap' if there is an agreement between the fund and the doctor, or the fund has a 'gap' cover scheme and the doctor chooses to use this scheme.

8. The government provides a subsidy for every prescription for a PBS listed medicine, and around 80% of all prescriptions dispensed in Australia are subsidised under the PBS. As at 1 January 2007, individuals pay up to A$30.70 (HK$202) for most PBS medicines or A$4.90 (HK$32) if they have a concession card. The government pays the remaining cost. The patient co-payment for subsidised

drugs is adjusted every year in line with inflation. The government's expenditure on the PBS is currently around A$6.0 billion (HK$39.4 billion) annually. The government contributed to paying around 170 million prescriptions for subsidised medicines supplied up to the year ending June 2005. The scheme accounts for around 15% of the total Australian Government's health budget and continues to grow at a fast rate.

Safety net measures

9. Safety nets are provided for the poor and high frequency users of the medical system. For out-patient medical charges, if the 15% Medicare co-payment fee reaches a threshold of A$358.90 (HK$2,355) in a given year, Medicare reimbursement will increase to 100% of the MBS fee for any further out-patient medical services in that calendar year (but the MBS fee may still not be equal to the actual fee charged by the doctor).

10. As for subsidised drugs, when the drug co-payment reaches A$1,059.00 (HK$6,967) in a calendar year, the patient and his/her family members are entitled to pay the concessionary rate of A$4.90 for each drug item for the rest of the calendar year. For concession cardholders, the corresponding threshold is A$274.40 (HK$1,805), and once the threshold is reached, subsidised drugs are provided free for the rest of the calendar year.

Coverage of Private Health Insurance

Incentives for private health insurance

11. Private health insurance is voluntary but strongly encouraged by the government. The government has introduced various incentive schemes to encourage the taking up of private health insurance. For example, since 1997, tax penalties in the form of higher Medicare levy are imposed on high-income earners who do not have private health insurance coverage (1% extra), and rebates (currently at least 30% of the premium) on private health insurance have been offered since 1998 to all who take out private health insurance. To ensure equity of coverage, premiums of private health insurance are basically community rated under the *National Health Act 1953* rather than calculated based on the health risk of individuals. In other words, all consumers pay the same premium for the same plan offered by the same health fund, regardless of age or health risk. However, the premiums may differ considerably between different plans offered by the same

fund and between different insurance funds. All the insured, regardless of age and health conditions, are guaranteed access to and automatic membership renewal of private health insurance with no right of refusal on the part of the insurance funds.

12. To protect insurers against adverse selection through increasing the pool of young and healthy insurees, the 'Lifetime Health Cover' (LHC) regulation was introduced to allow insurance funds to rate premiums on the basis of age of entry. LHC was introduced in July 2000 and involves a penalty for people aged over 30 who do not hold private health insurance hospital cover. When a policy holder first purchases hospital cover, for every year their age is over the LHC age of 30, a 2% loading (cumulative) is added to the cost of the private health insurance premium up to a maximum of 70%.

13. Health funds are required to charge different premiums based on the age of each particular member depending on when they first took out private health insurance. As of April 2007, the Government proposes amendments to the LHC scheme. Individuals who have paid a LHC loading on their private health insurance for 10 continuous years would be entitled to have the loading removed (with the first beneficiaries in 2010). People who benefit from removal of the loading, then leave health insurance and rejoin in the future, would pay the same LHC loading as people who have never held private hospital insurance.

Types of private health insurance coverage

14. There are two main types of private health insurance coverage: private hospital insurance and private ancillary insurance. Private hospital insurance covers hospital in-patient charges for private patients, including palliative, rehabilitative and psychiatric care. Funds are obliged to pay 25% co-payments for hospital medical services that are imposed on private patients by Medicare, though it is allowed to impose cost-sharing arrangements for other hospital charges such as accommodation, food, drugs, and 'gaps' between the MBS fee and the fee charged by the hospital doctor.

15. On the other hand, private ancillary insurance is not allowed to cover any of the out-patient medical services and prescription drugs that are subsidised by Medicare, including the 15% co-payments for MBS doctor fees and any 'gap' between the MBS fee and the fee charged by the doctor. It can only cover non-medical services not reimbursed by Medicare such as dental care,

physiotherapy, optometric services, ambulance, home nursing care, acupuncture, other ancillaries, and unsubsidised drugs that are not listed in the PBS.

16. The premiums of private health insurance may be lower for individuals who opt for higher deductibles or co-payments, or who settle for restricted benefits for or exclusions of some conditions (such as maternity, hip replacements, etc.) in the insurance coverage. Some insurance funds also offer lower-premium polices that cover only private services received in public hospitals and exclude private hospital services. Although health insurance funds cannot reject high-risk patients, including those with pre-existing illness or charge these patients a higher premium, they are allowed to impose a waiting period before the insured can claim benefits. The waiting periods for coverage under private hospital insurance are regulated. The maximum waiting periods are 12 months for pre-existing illness and obstetric cases, and 2 months for all other cases. The waiting period for private ancillary insurance is not regulated.

Major Challenges and Problems

I. *Rise in cost of healthcare services*

17. The per capita health expenditure in Australia has increased on average by 3.4% each year between 1985-86 and 2004-05. Thus improving cost-effectiveness of the healthcare system is an ongoing concern. Current financial challenges include cost pressures upon governments given limited budgets and rising health expenditures, the need to ration supply in the face of growing demand, and controversies over the right balance between public and private funding.

18. There does not appear to be any demand among Australians for radical changes on sources of healthcare funding, amount of spending or the basic structure of the healthcare system. Instead, public dissatisfactions are with regard to long hospital waiting lists for public patients and the huge disparities in health status between Indigenous and other Australians.

II. *Effectiveness of promoting private health insurance to reduce demand on the public system*

19. The government has introduced various measures since 1997 to encourage the general public to take out private health insurance with a view to

reduce demand on the public health system and thereby diminish cost pressures on public hospitals. Provisional data has revealed an increase in overall utilisation, however, this has occurred in both the public and private sectors. Private health insurance funds increase premiums annually, citing rising costs. The average annual percentage premium increase has increased less than the cost of all health services over the last few years. There is a huge cost to the government in offering rebates to encourage people to take out private health insurance and Medicare subsidy for private in-hospital medical treatments. Further research is therefore required to determine if private health insurance can improve the overall cost-effectiveness of the healthcare system.

CANADA

Major Funding Source

General taxation

Canada has a publicly funded healthcare system (Medicare) that is jointly funded by the federal and provincial governments through general taxation. Publicly funded healthcare is financed with general revenue raised through federal, provincial and territorial taxation, such as personal and corporate taxes, sales taxes, payroll levies and other revenue. Provinces use their own-source revenues to finance most of their healthcare expenditures. Federal transfers, the most important of which is the Canada Health Transfer, support provincial healthcare expenditures. Three provinces, British Columbia, Alberta, and Ontario, charge health premiums, but non-payment of a premium does not limit access to medically necessary services.

2. The highest personal income tax rate in 2006 was 46.4%. The general taxation system includes sales taxes collected by the federal and provincial governments. The federal government has a 7% Goods and Services Tax (GST) and provincial governments have their own provincial sales taxes that range from 7% to 10% (2005 figures). Three provinces have integrated their sales tax with the federal tax for a combined Harmonized Sales Tax (HST) rate of 15% (Nova Scotia, New Brunswick, and Newfoundland and Labrador); one province does not have a sales tax (Alberta).

Social health insurance

3. There is a small element of social health insurance in some provinces which cover medical expenses arising from occupational illness/injury, and certain drug expenses.

Coverage of Medicare

4. The basic guiding principle of healthcare policy is universal and equitable access to healthcare services provided on the basis of need, rather than the ability to pay. Medicare pays for essential or medically necessary services, e.g. examination and treatment by family doctors, most types of surgery, most

treatments by specialists, hospital care, many laboratory tests and most vaccinations.

Exclusions

5. Medicare does not cover ambulance services, prescription drugs, dental care, and glasses and contact lenses.

Fees and Charges

6. There are no user charges for core healthcare services covered by Medicare. Hospitals, most of which are private non-profit corporations, are publicly funded by block budgets with some incentives for complexity and volume of services. Doctors, on the other hand, are paid by Medicare on a fee-for-service basis. In most provinces, doctor fees are set by the provincial medical associations through an internal bargaining process among different specialties, which is constrained by a global budget cap of the public expenditure. Although the services are free, patients have a choice of doctors and hospitals.

7. Healthcare services that are not covered by Medicare, such as prescription drugs, have to be paid out of the patient's pocket or through private health insurance if the patient has such coverage. As a safety-net measure, all provinces provide drug subsidy programs to elderly people and social assistance recipients that cover prescription drugs ("Pharmacare").

Major Challenges and Problems

Fee-for-service arrangement contributing to rise in cost

8. As in the case of other countries like the United States and Switzerland, the fee-for-service arrangement in Canada has contributed to healthcare expenditure inflation. Debate over the sustainability of Medicare has been ongoing for several years due to escalating costs.

Government Response

9. Federal government as well as several provinces have commissioned separate studies on healthcare reforms, and two issues regarding healthcare financing have been highlighted:

(a) whether the financing of healthcare should be modified to change incentives or to allow more private money into the system. Some argued that the Medicare monopoly should be relaxed to allow private insurance for core medical and hospital services. Others advocated the introduction of user fees, deductibles, or medical savings accounts within Medicare, and

(b) whether the emphasis should be on higher levels of funding or tighter management of existing resources. It was recognized that simply increasing the level of funding would never satisfy providers and consumers without a substantial change in management. But opinions differed on the questions of who should make those changes and whether a parallel private sector should be allowed to grow up alongside a tightly managed public system.

10. However, there have been little consensus or action on these issues. Furthermore, proposals to eliminate the fee-for-service payment mechanism have surfaced repeatedly since 1972 but to no avail because any reforms to the organisation of and payment system for healthcare professional in Canada require a negotiated agreement and cannot simply be imposed.

11. Through three First Ministers' Meetings in 2000, 2003 and 2004, there has been a joint agreement among federal, provincial and territorial governments to implement healthcare reforms to ensure sustainability, improve access to quality healthcare services and increase accountability. All governments remain committed to a single-payer publicly funded healthcare system. The reforms, supported by increased federal transfers, focus on the supply side to increase efficiency in the healthcare system.

12. The most recent agreement, the 2004 *Ten Year Plan to Strengthen Healthcare*[1], supported by an additional C$41 (HK$311) billion in federal transfers to provinces and territories:

(a) continues progress to cover home care and catastrophic drug;

(b) continues progress in key reform areas – primary healthcare, health technology assessment and health human resources; and

(c) adds a waiting time reduction strategy.

Notes:

1. Further information on the 2004 Ten Year Plan to Strengthen Health Care is available on the Health Canada website at http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html.

Alberta, CANADA

Major Funding Source

General taxation

As with other provinces in Canada, Alberta has a publicly funded healthcare system that is established in accordance with the federal Canada Health Act and funded through general taxation and healthcare premiums. Most of the provincial healthcare expenditures are financed by the provincial government, supplemented by federal transfers. Alberta is the only province without a sales tax, while other provinces have their own provincial sales taxes that range from 7% to 10% (2005 figures). However, as with British Columbia and Ontario, Alberta charges healthcare premiums under the Alberta Health Care Insurance Plan (AHCIP), though non-payment of a premium does not limit access to medically necessary services. Health funding amounted to C$10.3 billion (HK$78.2 billion) in 2006-07, with 9% coming from health premiums, 18% from federal transfers, 68% from Alberta's general revenues, and 5% from lottery and other revenues. The AHCIP is accountable to the Minister of Health and Wellness and administered under the department of Health and Wellness.

2. AHCIP provides one basic and one supplemental coverage to Albertans. Health premiums for the basic health coverage are flat-rate, at C$88 (HK$668) per month for family coverage (two or more people) and C$44 (HK$334) for single coverage. The majority of residents are required to pay the premiums. Those who are exempt include persons aged 65 and over and their dependents. Individuals with family income below a certain threshold are entitled to premium subsidy in part (if annual income under C$20,970 (HK$159,213) for a single-person family) or in full (if annual income below C$17,450 (HK$132,477) for a single-person family). Among the 3.2 million residents in Alberta who were entitled to basic health coverage in 2004/05, 23% paid reduced premiums or were fully exempt. Residents may choose to opt out of the system, and they and their dependents are responsible for paying all of their healthcare expenses. Only 300 people opted out in 2004/05.

Supplemental health plans

3. There are many options for supplemental coverage and enrolment is

voluntary. One option is the non-group supplemental health plan subsidized by the Government and administered by Alberta Blue Cross. What distinguishes Alberta Blue Cross non-group plans from Alberta Blue Cross group plans (e.g. employment benefit packages) or from other insurers' plans is that premiums are exempted in certain circumstances for certain populations, such as for people 65 years of age and over and their dependents, and for needed medications for terminally-ill patients receiving their treatments at home. However, many Albertans' supplemental coverage is through employment benefit plans with Alberta Blue Cross or other insurers.

Coverage

Basic health plan

4. The tax-funded and premium-covered basic health plan provides coverage for medically necessary services, following the principles of the Canada Health Act. Medically necessary services include hospital and physician services and specific kinds of services provided by oral surgeons and other dental professionals. The AHCIP also provides limited coverage for services provided by some allied health professionals, such as chiropractors, optometrists (for residents under 19 and over 64 years) and podiatrists.

Supplemental health plans

5. The Alberta Health Care Insurance Act prohibits insurers from providing policies which cover services that are covered under the AHCIP. In other words, supplemental health plans can only cover services not covered under the AHCIP basic health plan, which can include prescription drugs, ambulance services, home care, private or semi-private room accommodation in a public hospital, etc.

Fees and Charges

6. There are no user charges for services under the basic health coverage though patients have a choice of doctors and hospitals. As for services under the supplemental health plans, the insured patients are subject to deductibles and co-payments according to the different terms and conditions of individual insurance plans.

7. Alberta Health and Wellness allocates operational funding to regional health authorities, which run hospitals, based on a population funding formula. Each population's healthcare funding requirements are measured by taking into account the total population of each region, age, gender and socio-economic composition of the population, and services regional health authorities provide to residents of other regions. Most doctors are reimbursed on a fee-for-service basis, although some physicians are paid on a contract basis or through alternative arrangements.

Existing Problems

8. The federal Canada Health Act, which is based on a set of five principles: comprehensiveness, universality, accessibility, portability and public administration, has rendered many Canadians, including Albertans, to believe that it is the government's duty to provide all services and benefits needed to support their health. Although over one-third of the Alberta budget has already gone towards healthcare, the government faces continuing pressure to spend even more. It is estimated that if expenditures continue at the same rate of growth, the cost of healthcare in Alberta will quadruple from C$10 billion (HK$75.9 billion) to C$48 billion (HK$364.3 billion) by 2025[1].

Health Financing Reform

9. In February 2006, the government issued a new Health Policy Framework (a public consultation document) to delineate 10 policy directions for giving patients more options to healthcare services and for improving the sustainability of the public healthcare system, though no concrete proposals were given. Three policy directions that have an implication on healthcare financing are:

(a) Establishing parameters for publicly funded health services – to determine what should and should not be covered through the publicly funded system as the government cannot afford to continue to fund every health service or drug that can be prescribed.
(b) Creating long-term sustainability and flexible funding solutions – to look at alternative ways (in particular, purchasing private insurance) to pay for prescription drugs and continuing care.

(c) Paying for choice and access while protecting the public system – to provide an option for Albertans to purchase private care for certain services they are waiting for now, such as hip, knee or cataract surgery.

10. Feedback on the Health Policy Framework shows that although Albertans generally agreed that there should be incentives for greater choice and innovation in the public health system, they had some concerns about the concept of allowing physicians to practice in both the public and private health system. They also felt that allowing more private pay services could lead to two-tiered healthcare. In view of the responses from the consultation exercise, a revised Health Policy Framework was released in August 2006, in which the policy directions of allowing more private pay services as mentioned in Paragraphs 9(b) and (c) above were removed. With regard to the policy direction of defining publicly funded health services, the document referred to a newly established Alberta Advisory Committee on Health Technologies that would provide recommendations as to whether public funding should be used for new health services and technologies.

Notes:

1. Source: Getting on with Better Health Care – Health Policy Framework (August 2006), Alberta Health and Wellness.
   http://www.health.gov.ab.ca/healthrenewal/GettingBetterHealthcare.pdf

FINLAND

Major Funding Source

General taxation

In Finland, healthcare is universal and predominantly publicly financed through general taxation. Most healthcare services are provided and funded by the municipal government, with subsidy from the central government according to a weighted capitation formula which is designed to adjust the subsidy for differences in the need for services. The highest personal income tax rate in 2006 was 48.8% excluding social security contributions. The general taxation system includes a 22% sales tax.

Social and Private health insurance

2. In addition to the public healthcare system there is a private healthcare market. A social health insurance scheme, the National Health Insurance, is in place to finance private healthcare and occupational healthcare. In 2005, 60.1% of the total healthcare expenditure in Finland was financed through general taxation while 16.4% was funded by the social health insurance. National health insurance is financed by contributions from employers, employees and pensioners. It is administered by the Social Insurance Institution under the ambit of the Parliament. The central government guarantees the solvency of the National Health Insurance.

3. Private health insurance, on the other hand, is insignificant in Finland (constituted about 2% of total healthcare expenditure in 2005) and mainly includes healthcare cost paid out of life and accident insurance policies. It has grown only recently owing to the slight increase in rehabilitation payments paid by private insurance companies.

Coverage of Public Funding

4. Healthcare services covered by municipalities or the National Health Insurance are not explicitly listed. Most of the primary curative, preventive and public health services are provided in multi-disciplinary primary health centres operated by the municipalities. Rehabilitative and dental care are also provided. Municipalities may also buy services from the private sector. Secondary and

tertiary care are predominantly provided by public hospitals managed by hospital districts, which are federations of municipalities. Municipalities negotiate the provision and prices of services with their hospital district annually and make the payment directly to the hospital's account.

5. In the public sector, patients do not have much choice, either of primary care doctor or of hospital. To improve continuity of care, a 'population responsibility' system has been adopted by some municipalities, whereby health centre doctors and nurses form a team to be responsible for the care of a geographically defined area of population.

6. The National Health Insurance, which finances private healthcare and occupational healthcare, provides partial reimbursement for medication prescribed in out-patient care, transport costs, occupational healthcare, rehabilitation services and private medical services. It also compensates for loss of income due to sickness, maternity or parental care for a sick child.

Fees and Charges

7. Most public services incur user fees although some are provided free of charge, such as preventive care, treatment of some communicable diseases, medical aids and prostheses. The fees are subject to a maximum out-of-pocket payment per service. In-patient care for patients under 18 can be charged for only 7 bed-days per calendar year. However, charges for long-term (more than 3 months) in-patient care are determined according to the income of the patient, but not exceeding 80% of the patient's net income and the person must have at least EUR80 (HK$877) per month for personal expenses.

8. Doctors and dentists in the private sector are paid on a fee-for-service basis. Patients pay the fees first and then claim reimbursement from National Health Insurance. The reimbursement levels are 60% of established fees for consultations, and 75% for treatment and tests subject to a deductible of EUR13 (HK$142). Out-patient drugs are only dispensed at private pharmacies. Patients receive 42% reimbursement from National Health Insurance for pharmaceutical charges. For a pharmaceutical to be licensed as a reimbursable drug, its wholesale price – as determined by the Pharmaceuticals Pricing Board of the Ministry of Social Affairs and Health – must be reasonable. The "reasonable" whole-sale price refers to the maximum price at which a drug may be sold to pharmacies.

Safety net measures

9. Low-income and other vulnerable groups are not exempted from user charges. Nevertheless, there are some safety net measures that are universal regardless of income: an annual ceiling for total out-of-pocket payments made by a patient for services received at municipal hospitals and healthcare centres, and a separate ceiling for co-payments on pharmaceuticals. Patients with chronic conditions are subject to a reduced deductible (EUR4 or HK$44) for pharmaceutical costs and are reimbursed at a higher level (75% or 100%). Subsistence through the social welfare system can also be sought by those unable to pay the medical bills.

Major Challenges and Problems

10. In many respects, the Finnish health system performs well in international comparisons. The technical quality of health services is good, there are policies that favour prevention, the level of professional skills among the health personnel is high, and many indicators show results that are above the OECD average.

11. Technological change and rising expectations will be putting the health system under increasing strain in future. Also, Finland will be facing the problem of an ageing population sooner than many other countries and this poses a great challenge for the Finnish health system.

12. A rapidly increasing pharmaceutical expenditure, long waiting time for patients to access public healthcare services, and shortage of health personnel are also challenges to the health system. There is still room for improvement with regard to access to appointment with health centre physicians and elective surgery, although the targets for maximum waiting times for treatment and the guidelines on treatment that came into force in spring 2005 seem to have reduced the queues.

13. There is a need for pursuing more structural reforms of the health system in order to ensure financial sustainability and good value for money.

14. Recently, attention has been given for inequitable access to some services. International comparisons suggest that access to general practitioners in Finland is comparatively inequitable across income groups. The employed population seems to have better access to general practitioners due to their entitlement to free occupational healthcare whereas the non-employed population,

typically the worse off, has to pay for services provided by health centres and the private sector.

THE UNITED KINGDOM (UK)

Major Funding Source

General taxation

The UK government provides comprehensive health services to its people through the National Health Service (NHS). The NHS is financed mainly through general taxation together with an element of national insurance contributions by both employers and employees. The latter finances all sorts of social benefits such as old age pension and unemployment benefits apart from public healthcare. The highest personal income tax rate in 2006 was 40% excluding social security contributions. The general taxation system includes a 17.5% sales tax (Value Added Tax or VAT).

Coverage of the NHS

2. The NHS provides universal coverage, access and provisions for care at all levels. Most of these services (general practitioner, specialist and in-patient services) are provided free at the point of delivery and according to people's clinical need. All persons normally resident in the UK are eligible for NHS services. Unlike those countries in which the range of healthcare benefits covered under private or social health insurance plans is defined explicitly, the NHS does not specify an explicit list of services to be provided[a]. However, there are drug lists that restrict the range of medicines that are available through NHS prescriptions. Some drugs are not allowed to be prescribed under the NHS by general practitioners and some drugs may only be prescribed to specified types of patients or for specified conditions. The National Institute of Health & Clinical Excellence (NICE) makes recommendations on the use of new and existing medicines, treatments and procedures within the NHS.

Fees and Charges

3. Although most NHS services are free at the point of use, nominal charges are imposed on some services, such as prescription drugs, ophthalmic services and dental services. However, certain patients are exempt from paying

[a] Whilst there is not 'a list', providers and health authorities are very clear on the range of services which are provided.

the charges; these include children and adolescents, social welfare recipients, pregnant women and new mothers, and people with medical conditions that are listed by the NHS (e.g. Hypoparathyroidism, myasthenia gravis, etc). Charges are also levied on insurance companies following NHS treatment for patients injured in road accidents if the patients have received injury compensations (Road Traffic Act).

4. About 12% of the population (8% are group insurance purchased by employers) have supplementary private medical insurance to cover out-of-pocket user charges or to pay for private rooms in hospitals, or to top up provision of elective surgical procedures – where traditionally patients elect to see a named doctor of their choice. Private health insurance does not usually cover primary healthcare. There is no regulation on premium and no specific insurance policies to cover co-payments in the NHS.

Major Challenges and Problems

Insufficient funding for public healthcare services

5. On the finance side, there has been a recognition that healthcare in UK has been under-funded in comparison with most other Western European countries for at least the last two decades. This is a characteristic of the past not the present, however, the NHS Plan now describes the largest building programme in the history of the NHS – 100 new hospitals, 3000 new or upgraded General Practitioner premises.

Government Response

6. Presently, the scale of the private healthcare sectors involvement is modest. The government has seen the private sector as a resource for cutting down on the NHS waiting lists. For example, purchasers (Primary Care Trusts) have been encouraged to contract with the private sector for specific services, mainly elective surgery. A programme of Independent Treatment Centres (ITC's) has been installed – these private providers contract to provide free NHS care. This in turn drives the NHS improvement agenda. A few NHS patients have been offered treatment in France and Germany for surgery. There is also a strong commitment to the Private Finance Initiative (PFI, a major hospital building programme) and to Local Improvement Finance Trusts (LIFT) – the PFI equivalent to Primary Care.

7. The government is also committed to rectifying the situation of under-funding. There will be a 7.4% (real terms) per year increase in public spending on the NHS between 2002-03 and 2007-08. In 2002/03, the NHS expenditure was about £55.7 billion (HK$880 billion), that is, £1000 (HK$15,808) per person. By 2007-08 the NHS budget is set to rise by over 44% in real terms to over £90 billion (HK$1,423 billion), roughly £1400 (HK$22,132) per person.

8. However, there are worries that the rhetoric of consumer choice will render NHS being further driven by demand and that expectations may be raised. Also, the present spending spurge is temporary, facing the prospect of a massive deficit, the government may be forced to choose between cutting expenditures and raising taxes after the commitment ends in 2007-08. After that, the NHS will have to change significantly to cope with budgetary constriction and at the same time satisfy the expectations raised by the period of euphoric expansion. In this regard, two government initiatives aimed at 'market management' have been introduced as part of the health reform programme: 'Payment by Results' and the 'Patient Choice' programme. Under 'Payment by Results', instead of receiving block grants as previously, healthcare providers will be paid for the activity that they undertake, adjusted for case-mix. It is considered that it will reward efficiency, support patient choice and encourage providers to reduce waiting time. The 'Patient Choice' programme offers NHS patients a choice of at least four hospital providers for the top 14 specialties at the point of referral. Apart from giving patients more choices, the arrangement also encourages providers to be more responsive, increases competition and improves standards.

AUSTRIA

Major Funding Source

Social health insurance

Austria's healthcare system is based on a social health insurance model, which is compulsory for the working population. Those in part-time employment may opt into the social health insurance system on a voluntary basis while people who are eligible for unemployment benefits are automatically insured. The insurance is provided by various sickness funds, coverage of which is extended to the dependents of the insured. Citizens cannot choose their sickness funds but are assigned one according to their occupation or region of residence.

2. Contributions are paid directly to the sickness funds which are organised in the Federation of Austrian Social Security Institutions. The rates differ among sickness funds but are always shared equally between employers and employees. Contribution rates for different occupational groups vary between 6.4% to 9.1% with ceilings for maximum income and contributions.

Coverage

3. The statutory health coverage is comprehensive; other than preventive, curative and long-term nursing healthcare, it also provides cash benefits for inability to work due to sickness or maternity. Social assistance claimants are not covered by statutory health insurance per se but receive health benefits and services directly from the state authorities.

4. Patients are free to choose their healthcare providers although general practitioners generally coordinate care and referrals and serve, more or less, as gatekeepers to in-patient care except in emergency cases.

Fees and Charges

5. Sickness funds contract with doctors, who work mostly in solo practice, on the basis of negotiations with medical associations at the states (Länder) level. Contracted doctors are reimbursed by per capita flat rates for basic services and fee-for-service remuneration for services beyond these. In addition, patients are

required to pay a fixed sum for the first consultation in a given quarter of the year. For visits to non-contract doctors, patients are only reimbursed by their sickness funds at 80% of the contracted rate. For drugs and therapeutic products, only those included in the social insurance funds' approved lists are covered. Patients need to pay a flat-rate charge of EUR4.45 (HK$49) for each pack of drugs and a 10% to 20% co-payment for therapeutic products.

6. Hospital care is provided mainly by 'fund hospitals', which are primarily public and non-profit acute care hospitals financed mainly through public resources (sickness funds around 60%, government subsidy around 40%). Sickness funds may also selectively contract with private hospitals. Fund hospitals derive additional income from supplementary insurance, their owners, co-payments (e.g. 20% co-payment for in-patient care for the self-employed and 10% for dependents of insurees) and deductibles (e.g. patients need to pay a flat-rate charge of around EUR10 to EUR15 (HK$110 to HK$165) per day for the first 28 days in hospital).

7. Other out-of-pocket payments include co-payments for dental care and allied healthcare. As a safety net measure, out-of-pocket payments are subject to exemptions that take into account minimum income levels.

8. Around one-third of Austrians subscribe to supplementary private health insurance policies, mainly to cover co-payments and the cost of better accommodation and service in hospitals, allow for visits to non-contract doctors and to reduce waiting times for tests and therapeutic services.

Major Challenges and Problems

Funding insufficient to meet high utilisation and population ageing

9. A major challenge facing the Austrian healthcare system is the growing deficits of social health insurance funds in the face of ageing population and high utilisation of in-patient care. Acute care bed capacities and utilisation in Austria are high compared to other European countries.

Government Response

10. One principal reform measure is budget-setting for hospital care which aims to help social insurance funds to match their expenditure more effectively to

the amount of revenues collected. Securing the revenue basis of the statutory health insurance system through, for example, the raise in prescription charges and pensioners' contribution rate is also an important strategy adopted.

BELGIUM

Major Funding Source

Social health insurance

Belgium's healthcare system is based on a compulsory social health insurance model, coverage of which is universal for all residents. This compulsory health insurance is part of the social security system financed by the working population. Its contributions and those of other types of social security are pooled together and distributed to different public agencies responsible for the respective social security function. The agency responsible for health insurance is the National Institute for Sickness and Disability Insurance, a non-governmental public body accountable to the Minister of Social Affairs, which disburses the allocated fund to the various sickness funds called "mutualities".

2. Mutualities are managed by non-profit organisations mainly of religious or political affiliations. Membership of a mutuality is compulsory but citizens are free to choose which mutuality they prefer. Competition for membership between mutualities is intense as the level of government subsidy for administrative costs is based on the number of members. These mutualities compete for new members on a non-price basis offering a wide range of supplementary services (home care, savings accounts, holidays for children, etc.) as both the contribution rates and services covered are identical.

3. Contribution rates for social health insurance are 3.80% and 3.55% of income for employers and employees respectively, and 3.20% for the self-employed, with no fixed upper limit.

Coverage

4. The compulsory health insurance system covers curative healthcare while preventive healthcare and health promotion activities are financed by the federal government through general taxation. Services which are covered are described in the nationally established fee schedule which is extremely detailed, listing more than 8,000 services. Due to the lower overall contributions made by the self-employed, they are only covered for major health risks while the general

population are covered for both major and minor risks. Coverage is extended to the dependents of the insured.

Exclusions

5. Any services not listed in the fee schedule are not reimbursable. Some types of healthcare, such as plastic surgery, spectacles and orthodontistry are reimbursable only under certain conditions.

Fees and Charges

6. Doctors work mostly in solo practice and are remunerated on a fee-for-service basis. Most hospitals are either not-for-profit institutions or public hospitals, and specialists working in hospitals are also paid on a fee-for-service basis. Patients are free to choose their healthcare providers, including specialists as there is no referral system in Belgium. The fee schedule is negotiated every year between the insurance funds and the medical professions.

7. For ambulatory care, patients pay the fees first and then are reimbursed by the mutuality at 70% of scheduled fee for a general practitioner and 60% for a specialist. For hospital care, the mutualities reimburse the hospitals for healthcare utilised by their members although patients are also required to make co-payments, which are statutory. User charges for in-patient care include separate flat rate charges per day for hospitalisation, pharmaceuticals and diagnostic tests or radiology. Pharmaceuticals are paid for by the mutualities at varying levels (0% to 100%) depending on the therapeutic value of the medicine. Patients are required to pay the remaining percentage to the pharmacy. However, for the self-employed, pharmaceutical costs are entirely borne by the patients.

Safety net measures

8. For vulnerable groups who do not pay contributions, such as widows, orphans, disabled and retired persons, the beneficiaries of the minimum wage and certain other vulnerable groups, the federal government either meets their healthcare cost to a mutuality, or pays directly for their medical care costs.

9. To ensure that the accessibility of healthcare will not be affected by the statutory co-payments/hospital costs, a social exemption and a fiscal exemption have been established. Social exemption applies to vulnerable groups which

entitles them to be exempted from making co-payments for the rest of the year after reaching a special reduced rate of EUR450 per annum (HK$4,926). Fiscal exemption applies to all households, which permits them to deduct their co-payments from their income tax if the co-payments exceed a certain amount in a year. The threshold for fiscal exemption depends on the household's taxable gross income.

Voluntary health insurance

10. In addition to the compulsory social health insurance, mutualities may also offer voluntary health insurance to their members, particularly the self-employed, to cover services not covered by the compulsory insurance or for certain in-patient service extras over and above the basic, for example, for a single room or for pharmaceuticals. However, these mutualities are legally barred from covering statutory co-payments and hospital costs, which are usually covered by private health insurance run by for-profit insurance companies.

Major Challenges and Problems

Lack of effective control over utilisation and cost

11. Access to healthcare in Belgium is easy and equitable. However, the fee-for-service remuneration system, low co-payment and lack of primary care provider as a gate-keeper for specialist/hospital care have undermined incentives to control the system and making it vulnerable to abuse, inefficiency, over-supply and over-consumption of services, wasted expenditure and cost escalation. Cost containment has therefore been a general priority in the Belgian healthcare reforms.

Government Response

12. The government has restricted the annual growth of health expenditure to 1.5% in real terms since 1995. To minimise doctor-shopping and direct access to specialist care, a new plan has been implemented to encourage the development of patients' loyalty towards one particular general practitioner since 1 May 2002. Patients have the option to register with a general practitioner who will maintain a general medical record of the patient. Patients who choose to register will be granted a reduction of 30% of their contribution to the doctor's fee for a period of two years. At the end of 2005, 4.4 million (44%) of Belgium's residents had registered with a general practitioner. The Minister of Health's target is 80%,

which may be ambitious in view of the different response to the scheme according to the region. For instance, the take-up rate is 60% in the Flanders Region, and below 25% in Belgium's two other regions: Wallonia and Brussels. More recently, as a measure to further minimise direct access to specialist care, patients who first consult their general practitioner will pay the specialist to whom they are subsequently referred a reduced fee.

JAPAN

Major Funding Source

Social health insurance

Japan's healthcare system is based on a social health insurance model that is composed of two main insurance systems: workers' health insurance for employees (Kumiai and Seikan) and community health insurance for the self-employed and unemployed (Kokuho). Kumiai is a corporate-managed programme for employees of large corporations and their dependents while Seikan is a government-managed programme covering employees of small and medium-size firms and their dependents. Kokuho covers the self-employed, unemployed, workers at companies with less than five employees, and retirees. Altogether, there are about 4,400 insurers in the country.

2. Contribution rates for Kumiai vary from 3% to 9.5% of salary, with the average being 8.5%, which is also the standard rate for Seikan. The contributions are normally shared evenly by employers and employees but under Kumiai, employers tend to shoulder a slightly higher share of the contributions (around 56% instead of 50%). Kokuho contributions, on the other hand, are calculated on the basis of household income and asset. Taking into account employer contributions, the household premium rates for Kumiai, Seikan and Kokuho in 2001 were 4.6%, 6.7% and 10.2% respectively.

3. To tackle ageing population, the Central Government in 1983 established the elderly insurance, a common fund for providing medical care to elderly people aged 70 and above that is financed by pooling contributions from all the social health insurance schemes and by government subsidy. Both central and local governments subsidise the elderly insurance by contributing at least 30% of the total medical expenditure of the elderly insurance and the proportion is expected to increase to 50% in the coming years.

Coverage

4. All the insurance programmes offer patients a free choice of service providers and are similar in terms of the range of medical services covered. However, there are significant differences among the different health insurance

programmes in eligibility, co-payments, cash benefits, and the level of government subsidy provided to cover administrative costs and to recover deficits.

5. Mandatory coverage includes ambulatory and hospital care, extended care, most dental care and prescription drugs. Kumiai and Seikan provide cash benefits for extended sickness and injury and for maternity leave and childbirth expenses, while cash benefits from Kokuho cover only childbirth expenses.

Exclusions

6. Health services not covered by the social health insurance include abortion, cosmetic surgery, traditional medicine, certain hospital amenities and some high-tech procedures.

Fees and Charges

7. Healthcare services are mostly privately provided. Service providers are paid directly by the social insurance funds. Payments for out-patient care are predominantly on a fee-for-service basis while in-patient care is paid through a mixture of flat-rate per visit/episode basis and fee for service. Fees for different medical services are set out in the Fee Schedule announced by the government and revised every two years.

8. Patients have to pay co-payments of between 20% and 30%, with a cap of ￥63,600 (HK$4,270) per month per household. The co-payment cap for low-income families is lower, at ￥35,400 (HK$2,377) per month. For elderly, the co-payment is 10% and the cap for in-patient services for low-income elderly is ￥24,600 (HK$1,652) and that of out-patient services is ￥8,000 (HK$537).

Major Challenges and Problems

I. <u>Insufficient funding due to low growth in revenue and ageing population</u>

9. Japan's healthcare system has to deal with a serious financing problem. Part of the problem stems from a low growth of revenues and a strong pressure on spending due to a rapid ageing of population.

II. Lack of control over utilisation and cost

10. In Japan, the volume of services arising from the fee-for-service payment to service providers is naturally high. Insurers have little control over the volume of medical services provided. There are no restrictions on the frequency of out-patient consultations or in-patient length of stay. As a result, the number of out-patient visits per capita per year is more than twice the OECD average and the average length of stay is about four times more than the OECD average, with many acute care beds having taken on the long-term care function for the elderly.

11. Hospitals have also been providing significant amount of out-patient service not only because it is an attractive revenue source arising from the generous payments by insurers but also because it represents an important source (60%) of admission to beds. As a result, many private clinics have developed a small in-patient capacity and evolved into small hospitals. The situation of everybody trying to do everything has contributed to wastage and inefficiency. Also, there has been a rapid increase in drug spending, largely due to volume expansion stimulated by the fact that doctors' incomes depended heavily on dispensing drugs until recently.

Government Response

12. The government has attempted to address the problems but the measures have tended to be incremental instead of implementing a systemic reform. This is largely because the decision making process has relied heavily on consensus between the service providers, insurers and the government. Attempts to control healthcare expenditure have mainly involved three mechanisms: (a) the government has adjusted the Fee Schedule to constrain the overall rate of price increases and to encourage the most cost-effective services; (b) increased co-payments to dampen demand, though this effect seems limited because of a capping at a relatively low level compared to a relatively high average monthly disposable income per household (￥561,000 or HK$37,658); and (c) supply-side control, through regulation of the number of medical students and hospital bed numbers. The government has also tried to cut down on over-prescription by making drugs less attractive as a source of income for doctors and hospitals by promoting the separation of prescription and dispensing of drugs.

13. In view of the fact that rapid population ageing has challenged the sustainability of the elderly insurance established in 1983, a co-payment of 10% was

introduced in 2002. The government has also raised the youngest age eligible for the elderly insurance gradually from 70 to 75 in 5 years effective from 2002. Further reforms will be implemented starting from 2008, when a new elderly insurance system will be established for elderly people aged 75 and above. A co-payment of 20% will be imposed on elderly people aged 70-74 while those of age 75 and above will continue to make a co-payment of 10%. Apart from co-payments, the new system is expected to be financed through government subsidy (50%), contributions from all social health insurance schemes (40%), and premiums collected from the elderly themselves (10%).

Lessons

14. The combination of the predominantly fee-for-service payment, unhealthy competition in the market for patients leading to over-supply of service, and an ineffective third payer control of service provision have resulted in the expansion of service volumes beyond what might be necessary on clinical grounds.

KOREA

Major Funding Source

Social Health Insurance

Korea's healthcare system is based on a social health insurance model that is compulsory for the whole population. The system is called the National Health Insurance (NHI) and is administered by a statutory organization, the National Health Insurance Corporation (NHIC). The compulsory insurance was first introduced in 1977 for large companies employing more than 500 workers and was administered by autonomous employment-based insurers with different contribution rates. The benefits were gradually extended to smaller companies and the self-employed over the years, and eventually, to the whole population in 1989. However, it was not until 2000 that all insurers were integrated into a single insurer, the NHIC. The insurance category is classified into two groups: employment-based insurance and self-employed insurance. All employees, employers, public servant, teachers and their dependents are covered by employment-based insurance. All residents in rural areas and the self-employed in cities are covered by self-employed insurance.

2. NHI is financed through monthly contributions from the insured and their employers, and government subsidies. For employees, the contributions are determined in proportion to their income. For the self-employed, contributions are calculated by considering their income, assets, the standard of living and other factors. Employees' contributions are deducted from their salary and the contribution rate, which is shared equally between the employer and the employee, is 4.77% of their monthly salary. In the meanwhile, the national government subsidizes 50% of benefits for the self-employed insured. Employees who are working in underserved area such as islands or remote rural areas or are working abroad but have a dependent living in Korea are eligible for a 50% reduction in monthly contributions. Those who are working abroad with no dependents living in Korea are exempted from paying contributions.

3. In parallel to NHI is the Medical Aid Programme (MAP), which provides needy families with free health insurance cover for the same benefits included in NHI. MAP is financed by the government through general taxation and is part of Korea's welfare system. Although the NHI and MAP are separate

systems, there are no differences in their benefit coverage. At the end of 2006, 96.3% of the total population were covered by NHI, while the remaining 3.7% by MAP.

Coverage

4. Coverage includes in-patient and out-patient care, dental services, oriental medicines, prescription drugs, childbirth, rehabilitation and health promotion. These include diagnosis, tests, drugs, medical materials, treatments, surgery, nursing, transfer services (from secondary to primary healthcare facilities), and health check-ups. Insured patients have a free choice of providers and can choose between western and oriental medicine. All insured employees as well as the self-employed are entitled to free health check-ups once every two years, in particular, non-office work employees get check-ups once a year. All dependents who are aged 40 or above get check-ups once every two years.

5. More than 90% of the medical facilities are run by the private sector. All pharmacies are owned and operated by individual pharmacists, and since 2000, the roles of prescribing and dispensing drugs are separated between doctors and pharmacists. Every authorized healthcare institution is obliged to provide medical services covered by NHI to the insured and their dependents. The healthcare benefit costs are generally paid by the NHIC to providers on a fee-for-service basis. Payment of medical care claims is made according to a fee schedule, which is negotiated annually directly between providers and the NHIC.

6. Other than benefits in kind, cash reimbursements are made to insured patients who receive medical care in an emergency situation at a healthcare institution that has been excluded from the healthcare providers under the NHI system. In addition, cash benefits are provided in the case of the death of an insured patient to cover funeral expenses, the allowance of which is set at 250,000 won (HK$2,108). Cash benefits at 80% of the appliance expenses are also payable to people with disability for the purchase of mobility aids and prostheses such as walking sticks, wheelchairs, glasses, hearing aids, etc.

Exclusions

7. NHI coverage excludes medical services and drugs pertaining to: (1) treatment of diseases not causing serious problems in daily life – e.g., simple fatigue, dermatology problems (e.g. freckles, acne, etc.) and urogenital illnesses, (e.g.

impotence); (2) medical care for appearance improvement – e.g., plastic surgery, strabismus correction and operation to correct eyesight; (3) unnecessary preventive medical care – e.g., voluntary health examination and treatment for motion sickness prevention; and (4) medical services that are incompatible with the principle of social insurance benefits – e.g., additional room charges for amenities, assisted reproductive technology, dental prosthesis, treatment for narcotic addition, new medical technologies, and medical services that are not deemed to be cost effective.

Fees and Charges

8. Patients have to pay the full cost for services not insured by NHI. For insured services, patients also have to make substantial co-payments. Co-payment for in-patient care is 20% of total charges. Co-payments for out-patient care vary depending on the type of medical institutions and the amount of total charges. For example, for out-patient services provided at a clinic, patients pay 3,000 won (HK$25.3) when the total charges do not exceed 15,000 won (HK$126). If the total charges exceed 15,000 won, the co-payment is set at 30%. For out-patient services provided at a hospital, the co-payment is 40% or 50% depending on the types of hospital. Co-payments for drugs with prescription are 20% for people aged 65 or above and 30% for those aged below 65.

Safety net measures

9. The NHI benefits coverage includes a compensation for excessive co-payments, which is payable when insured patients make co-payments exceeding 1,200,000 won (HK$10,117) within 30 days; the insured will receive a compensatory reimbursement of 50% of the exceeded amount.

10. To further protect the insured against financial burden due to catastrophic or high-cost illnesses, a co-payment ceiling has been instituted. If co-payments exceed the ceiling threshold (currently set at 3,000,000 won or HK$25,292) within a period of six consecutive months, the insured is exempted from any further co-payments. The ceiling is applicable for in-patient, out-patient and pharmaceutical services.

Major Challenges and Problems

I. Financial instability of NHI

11. Although there were deficits in the compulsory health insurance system as a whole prior to two major health reforms in 2000—(i) integration of health insurers into a single insurer, and (ii) separation of prescribing and dispensing of drugs—the NHI experienced an unprecedented financial crisis after the reforms. Part of the reason was that there were prolonged doctors' strikes after the separation of drug prescribing and dispensing, and to placate them, medical fees were raised. A complex mix of effects, including fee increases, higher volumes of out-patient consultations and higher reimbursement of insured drugs contributed to the financial crisis. At the end of 2001, deficits had reached a fifth of total NHI expenditures for the year.

II. Growing demands for greater protection

12. Patients are shouldering high out-of-pocket expenses in Korea, which amounted to 37.7% of total health spending in 2005, mainly due to the substantial co-payments and the many exclusions of NHI. They not only share the cost of insured services, but also make direct payments in full for uninsured services. Fees for the uninsured services are mostly unregulated, market-based and vary significantly with facilities. This raised concerns on financing equity. As such, there have been persistent demands for a stronger insurance protection.

III. Inappropriate use of hospitals for long-term care

13. There are no distinctions between chronic and acute care beds in hospitals. The continued use of hospital beds for long-term care purposes creates an undue burden on the already strained NHI system in terms of longer stays and higher cost of treatment in hospitals, compared to care in appropriate long-term care settings, such as residential care homes and home care. The demand for long-term care is expected to increase in view of the rapidly ageing population and the weakening of informal family network in Korea, but appropriate and affordable long-term care services are not yet adequately available.

Government Response

14. The government has taken several measures to tackle the financial crisis of NHI. These include an increase in government subsidies and patients' co-payments and more thorough detection mechanisms for providers frauds, and the contribution rates are highly possible to increase annually. As a result, NHI's financial status improved dramatically and the previous huge deficits were eliminated by the end of 2004. However, the revenue side actions are not sufficient to guarantee the long-term stability of NHI while a sustainable expenditure control is needed. In this connection, a new mechanism of payment for providers, such as global budgeting system or case payment system has been considered. With the rapid growth of ageing population and the advancement of new medical technology, financial instability remains a major concern for NHI.

15. In an effort to secure adequate healthcare protection, benefit coverage has been expanded and user charges reduced. For example, high-cost services such as CT and MRI have come under the NHI umbrella. Also, measures have been taken to further improve the affordability of care, including applying a co-payment rate of 10% to out-patient cancer treatments, co-payment exemption for natural childbirth, reducing out-patient co-payment rates for severe psychiatric patients, benefit day extension for osteoporosis drugs, etc.

16. To cope with the growing demand for long-term care, the government has set up a special task force to map out a comprehensive measure to expand the availability of long-term care services for the elderly, tentatively aiming at introducing a long-term care insurance programme in July 2008.

THE NETHERLANDS

Major Funding Source

Compulsory Health Insurance

The Dutch's healthcare system is mainly financed through compulsory health insurance contributions. There are two separate compulsory health insurance systems, one for covering curative medical care (under the Health Insurance Act) and the other for covering mainly long-term nursing and care (under the Exceptional Medical Expenses Act). The Health Insurance Act is a private health insurance scheme newly established under a major healthcare reform introduced on 1 January 2006. The Exceptional Medical Expenses Act, on the other hand, is a social health insurance that has been in existence since 1968. Both schemes are overseen by the Health Insurance Board under the ambit of the Ministry of Health, Welfare and Sport. Participation in the schemes is mandatory for all residents of the Netherlands, regardless of age. Prior to the reform, curative medical care was covered by two types of health insurances: compulsory social insurance for people with an income lower than a certain level and voluntary private insurance for higher income people.

The Health Insurance Act

2. The Health Insurance Act is operated by private health insurance companies and funded through premium revenues (45%), an income-related contribution (50%), and government contribution (5%). The insurance companies are obliged to accept anybody who applies for the basic insurance, and the premiums, though set by individual insurers, are community-rated (i.e. all the insured pay the same premium for the same plan offered by the same insurer, regardless of age, gender or health risk).

3. While the premiums are paid directly to the insurers, the income-related contributions are collected by the Inland Revenue Service from the insured and deposited in a Health Insurance Fund together with the government's contribution towards financing the insurance of children. The Health Insurance Board manages the Health Insurance Fund, which is used to pay insurers the children's premiums and to compensate insurers for any financial disadvantage they incur in insuring high-risk individuals. The Health Insurance Act has also

provided for the disbursement of public funds if an insurer is unable to meet its financial commitments.

Premiums

4. The Health Insurance scheme offers a basic, standard coverage of health services but the premiums could vary according to the type of policy (benefits in kind, i.e. insured to receive care from contracted providers or through reimbursements or a combination of both), the level of deductibles (from zero to EUR 500 (HK$5,167)), and the service provided by the insurers. A plan with no deductibles must always be made available, though people are free to choose any plans and they may change plans or insurers every year. The average annual community-rated premium charged by the insurers in 2006 was EUR 1,050 (HK$10,850). Children up to age 18 are insured for free as their premiums are paid by the government.

5. A no-claim reimbursement of premium is awarded to insured adults who have claimed less than EUR 255 (HK$2,635) in care in a year. Visits to general practitioners and maternity care are excluded in the calculation of claims quota for the no-claim reimbursements. A penalty equal to 130% of the premium is imposed on people who did not take out the basic insurance. The fine is payable over the number of months that somebody was not insured, with a maximum of 5 years. However, starting from 1 January 2008 the no-claim reimbursement will no longer exist and will be replaced by a compulsory excess of EUR 150 (HK$1,550) a year, which will be collected by the health insurer. People with unavoidable long-term health expenses, for example due to chronic illness or disability, will be compensated financially. Also, the method of dealing with defaulters is going to be more diverse, including the issuance of reminders and serving of writs during the first six months of defaulting, and engaging the service of a national debt collection agency to collect outstanding amounts if the insured is still defaulting after these six months.

6. For people whose premium is excessive compared with their income, they are entitled to a government subsidy called Health Care Allowance. The allowance is means-tested and is administered by the Inland Revenue Service. Income of both the insured and his/her partner are taken into account when determining the eligibility for the allowance. The maximum allowance payable is determined by the average premium charged by insurers (EUR 1,050 in 2006), instead of the actual premium paid by the insured.

7. The insured may take out supplementary insurance in addition to the basic insurance. The supplementary insurance is unrelated to the Health Insurance scheme and thus is not subjected to the statutory requirements, such as obligatory acceptance of applications and community-rated premiums as in the basic insurance. Once insured, insurers are not allowed to unilaterally cancel an insured person's supplementary insurance if he/she decides to take out basic insurance with a different insurer.

Income-related contributions

8. The income-related contribution is set at 6.5% of income. It is levied up to the first EUR 30,000 (HK$309,974) of annual income, which means that the maximum contribution is EUR 1,950 (HK$20,148) per year. Self-employed persons and pensioners pay 4.4%. The contributions are included in the income tax paid to the Inland Revenue Service. However, employers are required to reimburse their employees in full for these contributions.

Coverage

9. The Health Insurance scheme covers essential medical care, institutional care, maternity care, paramedical care, pharmaceuticals, medical devices, dental care (for children and young people up to age 22) and transport. Medical care includes care provided by general practitioners (GPs), specialists, clinical psychologists, midwives, and the associated laboratory tests and nursing. With effect from 1 January 2007, mental health care, which was previously covered by the Exceptional Medical Expenses Act, is brought under the Health Insurance scheme. Other than sickness and maternity, the Health Insurance Act also covers the insurance of medical care required for industrial accidents and occupational diseases.

10. The vast majority of hospitals and other care institutions are privately owned. 42% of the GPs are in group practice, 35% in duo practice and 23% in solo practice. More than 90% of the hospitals are private, non-profit facilities. Prior to the reform, insurers have to enter into a contract with every provider. Under the new Health Insurance Act, insurers can choose which hospitals and doctors to contract with and set requirements in terms of the provision of care, giving them a stronger position vis-à-vis the care providers. Insured persons are free to choose their care providers but GP referrals are necessary for access to specialist care and

hospital care. People who have opted for benefits-in-kind plans can choose to receive care from non-contracted care providers but they may not get full reimbursement in this situation.

11. The Health Insurance Act provides worldwide cover. No matter where they are in the world, insured persons are insured in exactly the same way as they are in the Netherlands.

Fees and charges

12. There are no stipulated fees and charges for services covered under the Health Insurance Act. However, out-of-pocket payments are expected from insured persons if they have opted for plans with deductibles or if they have opted for in-kind plans but have chosen to receive care from non-contracted healthcare providers. In some cases the insured must pay costs of certain medicines and medical devices.

The Exceptional Medical Expenses Act

13. The Exceptional Medical Expenses Act is a national insurance scheme, the fund of which is managed by the Health Insurance Board but disbursed through health insurers that are either private health insurance companies or sickness funds.

14. Every resident with a taxable income, either from employment or other income sources (including some social security benefits), are required to contribute to the scheme. Contributions are income-related and are paid to the Inland Revenue Service. Every year the government sets the contribution rate as a percentage of taxable income in the lowest two income tax bands. The contribution rate in 2005 was 13.45%. Employers are not required to share the contribution made by their employees. Children below age 15 and people with no taxable income are also exempt.

Coverage

15. Services covered by the Exceptional Medical Expenses Act include home care, admission to residential care homes or nursing homes for people with physical or mental disabilities, hospital and rehabilitation care (after the institutional stay under the Health Insurance Act exceeds 365 days), and vaccinations under the national vaccination programme.

16. An endorsement has to be issued by an independent organization called CIZ before an insured person can qualify for care under the scheme. CIZ will determine whether care is necessary and the type of care required. The insured person can choose to receive his/her entitlement in kind or in the form of a personal care budget, or a combination of both. The personal care budget is a sum of money awarded to the insured person to enable him/her to purchase care independently. However, it is available only for certain care such as nursing, and not for treatment and institutional care, which are available only in kind. The insured can also receive care either at home or in an institution but the basic principle is that people should continue to live at home for as long as possible.

17. An insured person is generally required to use care providers contracted by the body responsible for implementing the Act's provisions (usually a regional health office). An implementing body may also contract care providers in other countries, thus allowing the insured to receive care abroad. Nevertheless, an insured person is allowed under the Act to approach non-contracted care providers in the Netherlands or other countries although prior consent of the implementing body is sometimes required.

Fees and Charges

18. For most types of care covered by the scheme, cost sharing is required of insured persons above the age of 18. The size of the relevant fees and charges depends partly on an insured person's taxable income and domestic circumstances (whether he/she lives at home or in an institution). Other determining factors include whether the person is older than 65 and whether he/she is married. If the person has opted for a personal care budget instead of benefits in kind, the cost-sharing portion is deducted directly from the budget.

Healthcare Reforms

19. For decades, the Netherlands had a fragmented system of health insurance. The introduction of the Health Insurance Act on 1 January 2006 is the beginning of a major restructuring of the healthcare system to bring together different types of health insurances into one broadly-based standard insurance package for the entire population. The government has been researching on the Exceptional Medical Expenses Act, and significant amendments to the Act are expected in the near future. The government further intends to introduce the

Social Support Act, which will transfer to local authorities responsibility for elements of care currently covered by the Exceptional Medical Expenses Act.

20. The Dutch healthcare system is undergoing a series of reforms that see a waning government role. The general development is that members of the public, care providers and insurers will get greater responsibilities and must be more cost conscious. The reform measures are designed in an attempt to keep healthcare accessible and affordable in the face of population ageing and advancing medical technology.

SWITZERLAND

Major Funding Source

Compulsory health insurance

Switzerland's healthcare system is mainly financed through compulsory health insurance premiums. Prior to 1994, individuals were responsible for purchasing voluntary health insurance more akin to a private health insurance model offered by insurance companies that were registered with the Federal Office for Social Insurance. However, rising healthcare costs combined with a lack of solidarity between insurance companies meant reform had become necessary. The Revised Health Insurance Law of 1994, which came into effect in 1996, has mandated health insurance, expanded the benefits package to include in particular nursing care, changed the premiums from risk-rated to community-rated (i.e. the same for everyone living in the same region who takes out insurance with the same company), and eliminated cream skimming by stipulating a legal obligation for insurance companies to accept anyone purchasing compulsory health insurance from them. The revised Law also terms the obligatory health insurance as a social health insurance.

2. Compulsory health insurance can only be purchased from registered insurance companies, which may be regional, federal, religious or occupational based or private-for-profit. These insurance companies are not allowed to make profits from their compulsory health insurance activities. However, they are at a liberty to offer their members a variety of other insurance products, like supplementary health insurance, life and accident insurance products that are profitable. The access to a huge pool of customer-base has provided an incentive for private-for-profit insurance companies to participate in the compulsory health insurance system. To safeguard the interests of the insured, insurance companies have to set aside a security reserve fund, amount of which is determined as a certain percentage of premiums that varies according to the size of the company. The smaller the company, the higher is the percentage of premiums that has to be set aside as reserves.

3. All people residing in Switzerland for more than 3 months have to purchase compulsory health insurance. Every family member is insured individually, regardless of age. Patients can choose their insurers and are allowed

to change their insurers twice a year. Insurance companies can only compete on the levels of premium and deductibles required of the insured as the package of services covered is defined in law and is uniform. The premiums are subject to annual auditing by the Federal Office of Public Health before they are introduced and the Office can force the insurance companies to reduce the premiums if they are deemed to be too high. To ensure that companies with high-risk enrollees are not at a disadvantage, Foundation 18, an organisation formed by insurance companies, is responsible for making risk-adjustment and transfers between companies based on the age and sex of the insured people.

Coverage

4. Other than curative and preventive care, services covered by the compulsory health insurance include care provided in nursing homes and limited dental treatment (for very severe dental treatment, in connection with a disease). There is no time limit in the duration of service utilisation, which means that the insured are entitled to unlimited hospital or nursing home stay if needed. Patients are free to choose their healthcare providers although most have a regular doctor. Some insurance companies also offer managed care schemes whereby insured patients have to choose a doctor within the service network or are subject to gate-keeping by having to consult a general practitioner first before being referred for hospital or specialist care except in an emergency.

Exclusions

5. Services not covered include routine dental care, complementary medicine, pharmaceuticals not listed in the approved lists, and non-essential interventions. Transportation and emergency rescue services, spectacles and medical aids are partially covered.

Fees and Charges

6. Premiums have to be approved by the government and they varied among different insurance companies and different regions ('cantons'). In 2003, the average monthly premium (with minimal deductible) ranged from CHF 184 (HK$1,213) to CHF 398 (HK$2,623) among the different regions. Most of the insurance policies require a deductible from the insured other than those below the age of 18. The level of deductible is set annually and varies among companies. In 2005, the minimum deductible a year was CHF 300 (HK$1,970) and maximum was

CHF 2,500 (HK$16,411). Individuals may choose the level of deductible that he or she wishes to pay. The incentive for choosing a higher deductible is that the premium will be lower. Alternatively, individuals who wish to pay a lower premium may opt for a managed care scheme. In addition to the deductible, there is a 10% co-payment for all services covered by compulsory health insurance which has to be paid by patients out-of-pocket. The co-payment may be itemised or on a per-visit basis and subject to different upper limits for adults and children. The upper limits per year are CHF 700 (HK$4,594) for adults and around CHF 350 (HK$2,297) for children.

7. Payments to healthcare providers are negotiated between service providers/associations of service providers and associations of health insurance funds at cantonal level. Most categories of healthcare professionals in the ambulatory sector (doctors, dentists, chiropractors, midwifes, physiotherapist, nurses) are paid by fee-for-service. As for doctors, a national tariff structure was introduced in 2004. In-patient services (one night or more) are paid by the insurance companies on a flat-rate (per day or per episode (DRG) basis). This type of payment is acceptable to hospitals because the cantonal government subsidizes the capital costs and at least 50% of the running cost of public and publicly subsidized (private) hospitals. For treatments in private hospitals (not subsidized) which correspond to cantonal planning, health insurance pays its tariff. Remaining costs have to be covered by complementary insurance or out-of-pocket payments.

Voluntary private health insurance

8. Services that are not covered by compulsory health insurance can be covered by supplementary private health insurance, which are usually risk-rated and allow for free choice of hospital doctor and cover for superior in-patient accommodation. However, the number of people with supplementary private health insurance is declining due to the rising level of premiums charged and the expansion of compulsory health insurance benefits package.

Safety net measures

9. To reduce the social impact of per capita premiums, the government subsidises compulsory health insurance premiums on a means-tested basis through allocations from general taxation. Premium subsidies vary according to the income and wealth of the insured person. The cantons are autonomous in defining

the principles on which the premium subsidies are based. For example, in some cantons, the premiums paid by individuals or families cannot exceed a certain percentage of their total income (e.g. 10%). For people on very low-income, the entire premium is paid by social assistance of the municipality. If several children in one family are insured for compulsory health insurance by the same company, the total amount of out-of-pocket payments must not exceed twice the maximum amount for one child for both deductible and co-payment.

Major Challenges and Problems

Lack of control over utilisation and cost

10. Switzerland has a very high healthcare expenditure although a number of cost-containment measures have been implemented, such as reducing the number of subsidised hospitals and beds, global budgeting for hospital subsidies and regulating the retail price of reimbursable drugs and health services by setting maximum limits. It is also noted that premiums of the compulsory health insurance have increased almost every year. The high expenditure may be partly due to a fee-for-service system, which encourages prescriptions of expensive drugs and treatment. Other factors include high levels of supply (high hospital density, concentration of high-technology equipment and high doctor to population ratio) and utilisation. Moreover, tertiary care has developed in a largely uncoordinated fashion rather than in a few centres of excellence, resulting in excess capacity. There are also perverse incentives for providers and insurers to favour the more expensive in-patient care (of more than one night) since hospitals and nursing homes are subsidised by the government while out-patient and short in-patient stay (less than one night) are not.

THE UNITED STATES (US)

Major Funding Source

Private health insurance

Healthcare services in the US are mainly financed by health insurance (public or private). The private sector in the US plays an important role in both the provision and financing of healthcare services. Most hospitals are owned by private non-profit organizations or for-profit organizations. Most physicians are in private solo-practice and are paid separately by insurance for their services both in their offices and at hospitals. The majority of the population is covered by voluntary private health insurance provided by employers, with the cost being shared by the employer and employee. Self-employed individuals must purchase private health insurance by themselves, consequently paying the total costs. This is the most expensive means to enjoy health insurance.

2. Insurance companies reimburse or pay healthcare providers for the volume of services consumed, but usually under a contract that the provider (hospital, physician or clinic) has signed with the insurance company. Reimbursement or payment using the fee-for-service basis yields incentives for providers to provide additional or more expensive treatment that may be unnecessary, which drives up the healthcare expenditure or cost. Fee-for-service has been replaced by "managed care insurance". Preferred provider organization (PPO) plans have become the most popular form of managed care insurance among privately insured people, selected by 55% of the workers enrolled in employment-based health plans in 2004. PPOs provide networks of independent providers who have agreed to accept lower fees negotiated with the plan in exchange for access to a greater number of patients. PPO members generally have access to a wide range of providers without gatekeepers and prior approvals, including the option to use out-of-network providers. Members who use out-of-network providers will be reimbursed, albeit at a reduced rate which may include higher deductibles, co-payments, lower reimbursement percentages, or a combination of the above.

3. Nevertheless, in the US there are two Government sponsored national health insurance programmes. Medicare is the programme created for the elderly (those aged 65 and older) and some disabled persons. Medicaid is a Federal State

partnership insurance programme for delivering and financing healthcare to the poor and includes poor elderly people, poor disabled people and poor families with non-adult children.

Medicare

4. Prior to 1965, elderly persons who became ill and had to use hospital services found that they had to deplete their savings or even sell their homes to pay for hospital services. So the US Congress, with the support of President Lyndon Johnson passed the Medicare National Health Insurance into law in 1965. Medicare is a social health insurance programme providing health insurance to the elderly and the disabled. It is funded by payroll taxes of 2.9% of monthly salary, shared evenly by employers and employees. The tax is part of the larger Social Security tax, which also includes Social Security Pensions and Social Disability Insurance.

5. Medicare is non-means-tested but the beneficiaries need to share cost in one form or another. For instance, there is a monthly premium for the Medicare Part B, which must be paid by each beneficiary in order for him or her to have coverage for out-patient services. Besides the premium, beneficiary also needs to pay 20% of the approved amount (according to a fee schedule) for covered services after he/she has paid an annual deductible of US$100 (HK$780). The purpose of cost-sharing is to help the beneficiary understand that healthcare services are expensive and need to be used wisely.

Coverage

6. Medicare Part A automatically covers in-patient hospital services, skilled nursing facilities, home healthcare services and hospice care. Part B is voluntary, in that one must pay the monthly premium in order to enjoy the benefits. Part B covers doctors' fees and out-patient hospital services, including emergency room visits, ambulatory surgery, diagnostic tests, laboratory services, durable medical equipment, and may include some home health services.

7. Since 2006, Medicare Part D, payment for out-patient prescription medicines, has been added to the Medicare programme. Prior to this, there was no Medicare coverage for out-patient prescription drugs. Prescription medicine is always covered when the Medicare patient is an in-patient in the hospital. In order to have Part D coverage, Medicare beneficiaries must choose a prescription plan

from one of the 60 private insurance out-patient prescription drug benefits plans. Each beneficiary will pay a monthly premium determined by the private insurance plan. The average monthly premium is approximately US$35 (HK$273).

8. Some Medicare beneficiaries have supplemental private health insurance to assist in payment for the cost-sharing features of the programme. The annual premiums of these supplemental private health insurance plans range from approximately US$1,000 (HK$7,800) to US$3,500 (HK$27,300). Some enjoy this insurance at low cost as a retirement benefit from their employer, which includes retired government employees.

Medicaid

9. Medicaid is a health insurance programme jointly funded by the Federal and State governments for low-income and needy people. It is funded mainly through general taxation both at the Federal and State levels.

Coverage

10. Medicaid provides a minimum set of services including both in-patient and out-patient hospital services, general practitioner and specialist out-patient services, both long and short term nursing home services, home healthcare services and medical transportation services. States have the discretion of providing coverage to additional services, which include prescription drugs, spectacles, dentures, hospice care and personal care to their Medicaid beneficiaries.

11. Since the beneficiaries are predominantly poor, the government limits cost-sharing by beneficiaries to a nominal flat-rate charge. The nominal user charges may range from US$0.5 (HK$4) to US$3.00 (HK$23), depending on the amount of the state's payment for the items or services. However, user charges cannot be imposed for emergency room visits, family planning services and hospice care. Also, children, pregnant women, and elderly and disabled beneficiaries who are on welfare are exempt from user charges.

Major Challenges and Problems

I. *Insufficient cover for the population*

12. The US citizens/workers rely heavily on private insurance as their primary means of access to affordable healthcare services. If they do not have the benefit of low cost health insurance at work, their access to healthcare depends on the ability to pay. Many who do not have financial resources to pay from their own pockets tend to use the hospital emergency room for obtaining healthcare when they are very sick. This is either because they cannot afford the insurance premiums or because private insurers refuse to insure them due to their pre-existing health conditions that would be expensive to treat. In 2004, 45.8 million (15.7%) were without health insurance coverage in the US.

II. *Lack of control over cost*

13. There are also problems with cost control, with spending largely driven by the demand of the patients, people wanting "the latest and the best" treatment after having paid the insurance premium, hospitals competing on the basis of having the most modern equipments and facilities, an absence of global budgets and the fragmented commissioning of healthcare services. Moreover, the National Medicare Health Insurance programme is now facing potential financial problem because funding from payroll taxes is inadequate as the working population is not growing as fast as the elderly population. The actuaries who track the costs of the programme provide an annual report to the Trustees of the Medicare Trust Funds and to the US Congress. Congress has the power to increase the payroll taxes, if necessary, to assure the adequacy of the Medicare Trust Funds. Congress also has the power to increase the cost-sharing features of the programme.

14. Among the current debates concerning health insurance in the US, one will find discussions about what the Congress should do to assure the adequate funding of the Medicare and Medicaid programmes for the future; the current structure of the Medicare Part D, out-patient prescription programme, and whether Medicare beneficiaries have the lowest prices for their medicines through the current structure for obtaining their medicines; and what should the US Government do to provide health insurance coverage for all persons.

Massachusetts, The UNITED STATES

Introduction

Similar to other states in the US, healthcare services in Massachusetts are mainly financed by health insurance (public or private). The majority of the working population is covered by voluntary private health insurance provided by employers or purchased by individuals themselves. Elderly people and the disabled, on the other hand, are covered by the federal social health insurance programme called Medicare, while low income people are eligible for the Medicaid programme which is jointly funded by the federal and the state governments using general taxation. The Medicaid programme is known as "MassHealth" in Massachusetts.

2. In 2006, around 6% of the 6.4 million residents in Massachusetts were uninsured and this was a significant improvement over 2004, where 7.4% of the residents were uninsured. One reason for the improvement was due to the rise in the proportion of insured non-elderly residents who obtained health insurance coverage through their employer, increasing to 83% in 2006 from 79% in 2004. Unemployed persons and low-income individuals were more likely to be uninsured, although the majority of the uninsured were in employment. The state government provides an additional safety net, known as the Uncompensated Care Pool, for low-income uninsured patients to ensure their access to healthcare services.

Major Funding Source

Private health insurance

3. The majority of working population is covered by private health insurance, most of which provided by employers. However, the arrangement is on a voluntary basis. In 2005, only 70%[1] of employers in Massachusetts subsidized health insurance for their employees. Even though most of the employer-based health insurance plans require deductibles and co-payments from employees, there are still double-digit annual increases in health insurance premiums, which have made it increasingly difficult for employers, particularly small employers, to offer health insurance benefits to their employees. The state government has established an Insurance Partnership Programme to assist small employers (less

than 50 employees) and their low-income employees in purchasing employer-based health insurance, by providing subsidies to both employers and their low-income employees. Nevertheless, there are still employers who do not offer health insurance to their low-income employees, thereby "dumping" them into the Uncompensated Care Pool.

Social Health Insurance – Medicare

4. Medicare provides health insurance coverage to the elderly and the disabled. It is funded by the working population through payroll taxes of 2.9% of monthly salary, shared evenly by employers and employees. It is non-means-tested and automatically covers in-patient hospital services, skilled nursing facilities, and hospice care.

Tax-funded MassHealth and Uncompensated Care Pool

5. MassHealth and the Uncompensated Care Pool are both healthcare safety net programmes for low-income and needy people. MassHealth, being a federal Medicaid programme, is jointly funded by the federal and state governments through general taxation. Low-income kids, families, pregnant women and the disabled, and the long-term unemployed and uninsured are all eligible for MassHealth. It has an enrolment of around 1 million and offers a comprehensive range of healthcare services, including prescription drugs, by paying for all or part of a member's health insurance or paying healthcare providers for services provided to members on a capitation basis.

6. On the other hand, the Uncompensated Care Pool (also known as Free Care) has been established at Massachusetts' own initiative since 1985. The Pool amounted to US$711 million[2] (HK$5.5 billion) in 2004/05, is primarily funded from three sources: an assessment on acute hospitals' private sector charges; a surcharge on payments made to hospitals and ambulatory surgical centers by Health Management Organizations, insurers, and individuals; and an annual appropriation from the Commonwealth's General Fund. The Pool reimburses acute hospitals and community health centers for the costs of medically necessary services provided to low-income uninsured and underinsured patients. In addition, it makes payments to hospitals for emergency services for uninsured individuals from whom the hospitals are unable to collect payment. The Pool is always the payer of last resort on any claim.

7. People with family incomes at or below 200% of the federal poverty level (FPL) qualify for "full free care", while people with family incomes from 200% to 400% FPL qualify for "partial free care" and they are responsible for a deductible based on family income. The Pool also provides assistance to people regardless of income whose medical expenses exceed 30% of family income and who have insufficient assets to cover the expenses.

Existing Problems

8. The liability of the Uncompensated Care Pool has exceeded its available funds since 1990, despite a number of major reforms. The Pool's growing liability could be due to a number of reasons. Other than the fact that uninsured patients are guaranteed access to healthcare and so enabling employers to dump their low-income employees into the safety net, there are also perverse financial incentives for service providers to turn to the Pool for reimbursement even though their patients may be eligible for MassHealth. This is because the different ways of calculating reimbursements under the two programmes result in some hospitals receiving higher reimbursements from the Pool than from MassHealth.

9. The current system has encouraged uninsurance and escalated costs of uncompensated care. In an attempt to redress the problems, Massachusetts has recently legislated a series of reform measures to shift the public healthcare funding from supporting uncompensated care to subsidizing the purchase of private health insurance for low-income individuals and to make health insurance coverage mandatory. In other words, the reform aims at directing more public money to individuals and less to institutions, and subsidizing the purchase of private health insurance for low-income individuals to reduce the number of uninsured.

Healthcare Financing Reform

10. On April 12, 2006, a landmark healthcare legislation was signed by the Massachusetts Governor that every Massachusetts resident age 18 and over would be required to have health insurance coverage (either individually or as a named beneficiary) starting from July 1, 2007. Tax penalties will be imposed on individuals who do not have coverage of private health insurance, Medicare or MassHealth. The fines received will be deposited into a Commonwealth Care Trust Fund, which will be providing premium subsidy to low-income individuals. Some of the hospital funding from the Uncompensated Care Pool will also be

redirected to the Trust Fund, with the Pool being eliminated effective October 1, 2007.

11. To facilitate compliance of the mandatory requirement, a series of reform measures will be put in place to make private health insurance more affordable, which include:

(a) *Subsidized health insurance programme* for currently uninsured individuals at 300% FPL who are ineligible for MassHealth or Medicare. The programme will be managed by a newly created independent public authority called the Connector, using the Commonwealth Care Trust Fund. The Connector will certify and contract affordable private health insurance products for non-working individuals and uninsured employees and collect premiums from eligible individuals. Premiums to be paid by the eligible individuals will be set on a sliding scale based on household income and the difference will be covered by the Trust Fund. The full premium is yet to be determined but it is expected to be around US$300 (HK$2,340) per month with no deductibles. For individuals who earn less than 100% FPL (US$10,212 or HK$79,654 per year), the Connector will procure basic benefit plans with premiums waived but with co-payments similar to MassHealth. To qualify for assistance, an individual must not have accepted any financial incentive from the employer to decline the employer's subsidized coverage.

(b) *Insurance market reforms* to merge non-group and small-group insurance companies, thereby pooling risk and creating more affordable choices for individuals and small employers.

(c) *Insurance Partnership Programme's* eligibility will be expanded for employees from 200% to 300% FPL to encourage employer-based health insurance for low-income employees.

(d) *Imposing* a *moratorium* on the creation of new health insurance mandated benefits through 2008.

(e) *Lower cost and specially designed products for young adults* age 19-26 will be offered.

(f) Allowing employees to *use pre-tax dollars to pay health insurance premiums* is made mandatory.

(g) *Improving transparency in quality and cost.* The Act creates a Health Care Quality and Cost Control Council which collects cost, price and quality data from healthcare providers, pharmacies, payers and insurers. This information will be made publicly available in the web.

12. In addition, though employers are still not mandated to provide healthcare coverage, their responsibility for healthcare will be enhanced under the following requirements:

(a) A "Fair Share Contribution" will have to be paid by employers who do not provide health insurance for their employees. The contribution, estimated to be around US$295 (HK$2,301) per full time employee per year, will be calculated to reflect a portion of the cost paid by the state for free care used by uninsured employees. This requirement applies to employers with 11 or more employees.

(b) Free Rider Surcharge will be imposed on employers who do not provide health insurance and whose employees use free care. Imposition of the surcharge will be triggered when an employee receives free care more than three times, or a company has five or more instances of employees receiving free care in a year. The surcharge will range from 10% to 100% of the state's costs of services provided to the employees, with the first US$50,000 (HK$390,000) per employer exempted. Revenue gained from the surcharge will be deposited in the Commonwealth Care Trust Fund.

(c) Employers who offer subsidized insurance will be required to make an equal contribution to all employees regardless of their income. This will prevent employers from dumping low-income employees into safety net programmes.

Major Challenges

13. The recent healthcare reform aims at achieving nearly universal health insurance coverage by reducing rate of uninsurance from the current 6% to 1% by 2009. The reform would expand insurance protection and would retain substantial financing for uninsured people and other costs of uncompensated care provided by hospitals or health centers. All these engender higher health spending. Thus, its sustainability and affordability are yet to be determined.

Notes:

1. Figure is from Massachusetts Employer Health Insurance Survey commissioned by Massachusetts Division of Health Care Finance and Policy, December 2005 (accessed 21 Dec 2006): http://www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/er_2005_core_results.pdf.

2. Figure is extracted from the Uncompensated Care Pool PFY05 Annual Report, Massachusetts Division of Health Care Finance and Policy (accessed 21 Dec 2006): http://www.mass.gov/Eeohhs2/docs/dhcfp/p/ucp/pfy05_annual.pdf.

SINGAPORE

Major Funding Source

Medical Savings Account

Singapore is the first economy in the world to implement medical savings accounts on a nationwide basis (known as Medisave and established in 1984). It is the only country which integrates medical savings account program within the national health financing structure. Medisave accounts are embedded in a broader framework that backs up the medical savings accounts with a cross-sectional catastrophic risk pooling scheme called Medishield (introduced in 1990) and a means tested safety net for the poor called Medifund (introduced in 1993). This three-tier package (Medisave, Medishield and Medifund) is backed up by government financing of supply-side subsidies to public providers aimed at lowering the net prices charged to patients. Government subsidy for a patient's hospital charges varies according to the type of wards that the patient has opted for. The subsidy rates are 80% for "C" class wards*, 65% for "B2" class wards, and 20% for "B1" class wards. There is no subsidy for the private "A" class wards. The unsubsidized portion of the hospital charges may be paid out-of-pocket or through Medisave, Medishield or Medifund depending on whether the patients meet the coverage criteria of the respective schemes. The unsubsidized charges could also be paid through private health insurance if the patients have such coverage.

Medisave

2. Contributions to Medisave are an integral part of Singapore's compulsory Central Provident Fund (CPF), which is funded by a mandatory contribution equivalent to 10% – 34.5% of an individual's wage bill, split between employers and employees[1]. Between 6.5% to 9% are allocated to the member's

* The amenities of the different classes of wards are as follows:

- Class A wards – air-conditioned single or double room with attached bathroom and toilet, toiletries, television, telephone, fully automated electric bed, choice of meals
- Class B1 wards – air-conditioned 4-bedded room with attached bathroom and toilet, television, telephone, semi-automated electric bed, choice of meals
- Class B2 wards – naturally ventilated 6-bedded room with individual ceiling fans, semi-automated electric bed
- Class C wards – naturally ventilated 8-bedded room

Medisave account. These contributions are income tax-deductible, interest bearing and can accumulate up to S$33,500 (HK$173,092), ceiling of which is adjusted annually. Interest for these contributions are at an annual rate of 4%.

Coverage

3. Withdrawals from the Medisave accounts can be used to pay medical bills incurred by the account holder and immediate family members. Medisave can be claimed only if the patient stays in the hospital for at least 8 hours, unless the patient is admitted for day surgery. As Medisave is meant for covering class B2 or C ward charges, patients who opt for higher class wards or private hospitals have to pay the amount in excess of the class B2 or C rates out-of-pocket or through private health insurance. Medisave does not cover ambulatory care services, except for the treatment of four chronic diseases - diabetes, high blood pressure, lipid disorders and stroke - under the Chronic Disease Management Programme, and for certain approved out-patient treatments such as kidney dialysis and chemotherapy.

4. All withdrawals are subject to fixed limits. For example, the withdrawal limit for in-patient care is S$400 (HK$2,067) per day for daily hospital charges, which includes a maximum of S$50 (HK$258) for doctor's daily attendance fees. The withdrawal limits for surgical operations vary depending on the complexity of the operation and are listed in the 'Table of Surgical Operation', ranging from S$150 (HK$775) to S$5,000 (HK$25,833). For other approved services, the withdrawal limits are S$150 per day and S$3,500 (HK$18,082) per year for psychiatric treatment, S$50 per day and S$3,000 (HK$15,496) per year for stay in convalescent hospitals. The withdrawal limit for out-patient treatments under the Chronic Disease Management Programme is S$300 (HK$1,549) per year. Patients need to pay the first S$30 (HK$155) for each bill as well as 15% of the balance of the bill. Medisave can be used to pay for the remaining amount.

Medishield

5. Medishield is a catastrophic health insurance scheme set up by the government for all Medisave account holders and their dependents up to 85 years old. All Singaporeans who start working and have their Medisave accounts set up will be automatically covered under Medishield. Dependents or family members of an insured may also participate in the scheme and pay the premiums themselves or using the insured's Medisave account, but all of them must be individually insured. New applicants must participate in the scheme before age 75 but existing

members can renew their membership up to age 85. All applicants are subject to health declaration. Those who suffer from a serious or chronic illness may not be covered by the scheme or may be insured with an exclusion for the illness. The premium level increases with increasing age bands, ranging from S$30 (HK$155) per annum for those below 30 years old to S$705 (HK$3,640) per annum for those between the age of 84 and 85 years old.

Coverage

6. Medishield helps pay for hospital bills in excess of S$1,000 (HK$5,163) if the illness being treated is covered under the scheme, and for certain approved out-patient treatment such as kidney dialysis and chemotherapy. As Medishield is meant for covering up to class B2 bills, the Medishield claims of patients who opt for higher class wards or private hospitals have to pay the amount in excess of the class B2 rates through out-of-pocket or private health insurance. The premiums of the private health insurance plans can be paid for using Medisave if the design of these plans complies with guidelines set by the Ministry of Health. Claims for Medishield are subject to a high annual deductible (S$1,000 for class C wards and S$1,500 (HK$7,745) for class B2 wards), a 10% to 20% co-payment (the larger the bill the lower is the percentage) and claims limit of S$50,000 (HK$258,153) per policy year and S$200,000 (HK$1,032,636) per lifetime. As a last resort, patients who are unable to pay for their hospital bills despite government subsidies, Medisave and Medishield, can apply for assistance from Medifund.

Medifund

7. Medifund is an endowment fund set up by the government as a help of last resort (that is, as a safety net) for patients who, despite heavy government subsidies, Medisave and Medishield, are unable to pay for their medical expenses. Medifund was established in 1993 as an endowment fund with an initial capital of S$200 million (HK$1,033 million). Capital is injected into the fund as and when there are overall government budget surpluses. The capital sum currently stands at S$1.48 billion (HK$7.6 billion). To ensure sustainability, only interest income from the capital sum is used.

Coverage

8. Medifund is means-tested. Furthermore, only patients who receive subsidized medical services in public hospitals or Medifund-accredited Voluntary

Welfare Organisations (VWO) step-down care facilities may apply for help from Medifund. Each individual hospital or VWO has a Medifund Committee, which is given discretion to make the final decision on a Medifund application.

Major Challenges and Problems

Lack of control over cost

9. In theory, medical savings accounts could reduce utilisation through cost-sharing and therefore should result in overall reductions in health expenditure. However, Singapore's healthcare expenditure actually rose after the introduction of Medisave in 1984. Part of the initial increase was attributable to the upgrading of public hospital services but the annual rate of increase over the last decade was 3.8%, 1.7% higher than the overall inflation rate. It is not known if the rate of increase would have been faster had the stringent demand-side measures not been in place. It is clear, however, that the public share of healthcare costs has been moderated to a greater degree than the private share, while the total healthcare expenditure has risen exponentially.

10. The increase in healthcare expenditure was largely due to the fact that hospitals compete on "quality", as reflected in the level of high technology care offered and the reputations of senior doctors, which has resulted in inflated costs. In addition, when consumers need to decide which healthcare service to purchase, they tend to choose "the best money can buy". Thus, even if medical savings accounts reduce the utilisation incidences, they do not seem to reduce costs associated with the intensity of services.

Government Response

11. To tackle these problems, Singapore introduced regulations on the supply side. For example, there are limits to what savings can be spent on and there is significant supply side regulation over hospitalisation expenses caps; patients must pay the difference between the regulated expenses caps and the actual fee charged by the hospital out-of-pocket. The contribution of medical savings accounts to the financial sustainability of the system is yet to be determined.

Notes:

1. The contribution rates to CPF accounts are as follows:

Employee Age (years)	Contribution by employer (% of wage)	Contribution by employee (% of wage)	Total contribution (% of wage)	Credited into		
				Ordinary account (%)	Special account (%)	Medisave account (%)
35 & below	14.5	20	34.5	23	5	6.5
Above 35 - 45	14.5	20	34.5	21	6	7.5
Above 45 - 50	14.5	20	34.5	19	7	8.5
Above 50 - 55	10.5	18	28.5	13	7	8.5
Above 55 - 60	7.5	12.5	20	11.5	0	8.5
Above 60 - 65	5	7.5	12.5	3.5	0	9
Above 65	5	5	10	1	0	9

Food and Health Bureau
Hong Kong Special Administrative Region Government
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