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Health Care Financing Policies of Canada, the United Kingdom and Taiwan

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C O N T E N T S

Executive Summary

1. This research introduces and compares the health care financing policies of Canada, England of the United Kingdom and Taiwan. England and Canada institutionalized the current tax-based health care financing system in 1948 and 1966 respectively. In 1995, Taiwan established the current social health insurance system.

2. Although both England and Canada have adopted the tax-based health care financing system, their respective ways of financing health care services are different. In Canada, the insured health care services as stipulated by the *Canada Health Act*, which cover all the medically necessary services, are fully financed by public monies, and private health insurance coverage is prohibited or discouraged. In England, health insurance companies are allowed to provide supplementary medical plans, covering health care services similar to the public sector. In Taiwan, the contributions of the National Health Insurance are used by the Bureau of National Health Insurance to contract a wide range of health care services for the insured.

3. Owing to the increasing financial pressure in funding health care, all the selected places have taken actions to ease the pressure. In Canada, a public inquiry was conducted for bringing out proposals to address the sustainability issue of the Canadian health care system in the early 2000s. In England, the health care system is undergoing reforms according to a 10-year plan, with the objective of ensuring the efficient use of health care resources. In Taiwan, various measures such as increasing premiums have been adopted to meet the challenge of financial imbalance of the National Health Insurance.

4. In England and Taiwan, the Department of Health has the overall responsibility for the formulation of health care policies. In Canada, the federal and provincial governments formulate policies on separate health care areas. While the federal government is responsible for policies affecting Canada as a whole such as distributing transfer payments on health care and preventing public health risks from entering Canada, the provincial governments are responsible for making health policies affecting their respective jurisdictions, in particular the administration and delivery of health care services.

5. In all the selected places, almost all primary health care services are delivered by private medical practitioners. Primary health care services provided by private medical practitioners in Canada and England are fully subsidized by public monies whereas they are partly financed by co-payments in Taiwan. Among the selected places, privately-owned hospitals in Canada and Taiwan and publicly-owned hospitals in England provide a major or substantial portion of hospital services. The occupancy rates of acute care beds in Canada in 2003 and England in 2002 were 87% and 85.3% respectively.

6. The philosophical basis of the guiding principles of health care policies in the selected places all emphasizes collective responsibility to ensure citizens' access to health care services.

7. Apart from out-of-pocket payments and donations from charity organizations, all the selected places use general taxation and health insurance plans to pool health care resources. The general government expenditures on health as a percentage of the total expenditure on health in Canada, the United Kingdom and Taiwan are some 70%, 83% and 64% respectively. Most of the public expenditures on health in all the selected places come similarly from general taxation, depending heavily on income tax, corporate tax and goods and services tax.

8. Being regulated by government policies, private health insurance plays different roles in the selected places. In Canada, the coverage of private health insurance is restricted to health care services not stipulated by the *Canada Health Act* as insured health care services. In England, there is no legal or policy restriction on the types of services covered by health insurance, and the government regulation of health insurance focuses on consumer protection in relation to supplementary medical plans. In both Canada and England, there are no enumerated government policies for encouraging the public to take out private health insurance. Since Taiwan has a universal social health insurance system, private health insurance plays a negligible role there.

9. In Taiwan, the National Health Insurance pools health care resources (premiums) from the insured, employers and the government. For premium calculation purposes, the insured are roughly divided into two types, i.e. income-earners and non-income-earners. For income-earners, the calculation of premiums is largely based on the amount of monthly income, and the premiums in certain categories of the insured are contributed jointly by the insured, employers and the government. For non-income-earners, the premiums are mostly borne by the government.

10. In addition to the common means of pooling health care resources, some of the selected places have their own specific means to pool health care resources, i.e. the National Insurance Scheme in England and health and welfare surcharge and public welfare lottery income in Taiwan.

11. Government budget and health insurance plans are means used, though not to the same extent, by all the selected places for allocating health care resources to the designated authorities responsible for the delivery of public health care services, i.e. the regional health authorities in Canada, primary care trusts in England and the Bureau of National Health Insurance in Taiwan.

12. Canadians are eligible for receiving insured health care services in not-for-profit hospitals free of charge and English people are eligible for receiving public hospital services free of charge if they do not choose doctors in receiving treatment. In Taiwan, patients are required to make a co-payment between 5% and 30% of the cost for each hospital stay, depending on the type of wards they stay in and the duration of hospitalization. A co-payment ceiling is set in order to reduce the financial burden of patients, and co-payment exemptions are applied to specific groups of patients.

13. Fully subsidized by public monies, both Canadians and English people receive primary health care services provided by private medical practitioners free of charge. Under the National Health Insurance in Taiwan, patients are required to make a co-payment for primary health care services they consume. The amount of the co-payment is determined based on the type of health care facilities they visit and services they consume. Co-payment exemptions are applied to specific groups of patients.

14. With regard to medicine expenses, patients of all the selected place have to pay for prescription medicines. In Canada, patients are responsible for the cost of almost all prescription medicines, and some provincial governments establish drug plans to cover or subsidize residents on the cost. In England, owing to the exemptions of specific groups from paying the flat rate for each prescription, around 85% of the prescription items dispensed are free to patients. In Taiwan, a co-payment is charged for prescription medicines worth over NT$100(HK$24), with a co-payment ceiling of NT$200(HK$48).

15. The selected systems yield some achievements and face some challenges, in particular the financial challenge which is common to all of them despite the difference in nature of being tax-based financing and social health insurance systems. All the selected places have taken actions to ensure that their respective health care systems are financially sustainable in the long-term.

16. The Canadian government set up the Commission on the Future of Health Care in Canada in 2001 to address the concern about the sustainability of the health care system. Accepting the Commission's recommendations, the federal and provincial governments agree to preserve the present tax-based system in financing health care services. The present system ensures that Canadians can receive medically necessary health care services on a universal basis while achieving administrative efficiency and economy of scale. Nevertheless, developing a more unified set of insured health care services among the provinces and protecting those people who are not covered by employment-related health insurance plans on health care services not stipulated as insured health care services remain challenges to be met.

17. Starting from 2000, the health care system in England has been undergoing a 10-year reform, covering the demand-side, supply-side, system management and transactional aspects of the health care system. Despite the fact that the reform has yielded some achievements, e.g. faster access to the NHS services, the deficit/overspending problem of the NHS organizations, in particular among primary care trusts, has created a financial challenge for the NHS. Both the National Audit Office and the Audit Commission recommend that the NHS organizations should implement measures to meet the challenge, such as developing a more transparent financial reporting system which could lead to early identification of financial problems and prompt reaction to the problems.

18. In Taiwan, despite the National Health Insurance has yielded some achievements, e.g. universal enrolment, the financial imbalance has created a challenge for the system. The Bureau of National Health Insurance has used the reserve fund to cover the financial discrepancies and adopted measures such as global budgeting and raising premiums to increase revenue and reduce cost of the National Health Insurance. New reform measures of the National Health Insurance system have been included in the *National Health Insurance Act* amendment bill promulgated in May 2006.

Health Care Financing Policies of Canada, the United Kingdom and Taiwan

Chapter 1 – Introduction

1.1 Background

1.1.1 At its meeting on 14 November 2005, the Panel on Health Services requested the Research and Library Services Division (RLSD) to conduct a research on health care financing policies in selected places to facilitate the deliberation of the Panel on the issue in the Hong Kong context.

1.1.2 At its meeting on 12 December 2005, the Panel on Health Services endorsed the proposed outline submitted by RLSD and requested RLSD to split the research into two phases. The first phase covers Australia, New Zealand and Singapore and the second phase covers Canada, the United Kingdom (UK) and Taiwan.

1.2 Scope of research

1.2.1 This research provides a detailed discussion on health care financing in each of the selected places, focusing on the following aspects:

(a) overview of the health care system;

(b) guiding principles of the health care system;

(c) collection mechanism of health care resources and share of contribution among funding sources;

(d) allocation mechanism of health care resources and share of funds received among health care providers;

(e) distribution of health care expenditure among health care programmes and activities (e.g. hospitals and medicines) and share of funding among the relevant parties in each of these programmes and activities; and

(f) policy evaluation, e.g. achievement of and challenges faced by the health care financing system.

1.3 Methodology

1.3.1 This research adopts a desk research method. Information has been collected through various available sources, such as legislation and official reports downloaded from websites of the government agencies concerned and correspondence with relevant authorities. The information obtained is subsequently reviewed, correlated and analysed under each topic of the research scope.

Chapter 2 – Canada

2.1 Background

2.1.1 Amidst the establishment of the Canadian confederation in 1867, the then written Canadian constitution assigned the authority over hospitals (except marine hospitals) to the provincial governments and the authority over quarantine matters and marine hospitals to the federal government.[1] Apart from these specific health care matters, the Canadian constitution did not have provisions assigning power over other health care matters to either the federal or provincial governments.

2.1.2 Judicial interpretations of certain provisions of the Canadian constitution by the courts in subsequent years have clarified the ambit of power between the federal and provincial governments over health care matters. In accordance with such interpretations of the provisions[2], the provincial governments have primary authority on health care in their respective jurisdictions, in the form of providing health care services, training and regulation of health professionals and regulation of health care institutions and health insurance.[3]

2.1.3 In accordance with the interpretations of some other provisions[4], the federal government's involvement in health matters is primarily in the form of legislating criminal law to prohibit or control the manufacture, sale and distribution of products posing a public health risk, allocating federal funds to support the delivery of health care services in the provinces under a national framework, and exercising the power to legislate matters for the peace, order and good government of Canada[5]. Accordingly, judicial interpretations reveal that the provincial governments have primary, but not exclusive jurisdiction over health care.[6]

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1 Sections 91(11) and 92(7) of the *Constitution Acts, 1867 to 1982* and Marchildon (2005), p.8.

2 Sections 92(2), 92(7), 92(9), 92(13), 92(16) and 93 of the *Constitution Acts, 1867 to 1982.*

3 The *Constitution Acts, 1867 to 1982,* Marchildon (2005) p.25, Braën (2002) pp.7-14 and Leeson (2002) pp.3-8.

4 Sections 91(1A), 91(3), 91(7), 91(11), 91(22), 91(23), 91(24), 91(27), 92(10) and 106 of the *Constitution Acts, 1867 to 1982*.

5 The power to legislate matters for the peace, order and good government of Canada is known as the "general power" granted to the Parliament of Canada by section 91 of the *Constitution Acts, 1867 to 1982*. The meaning of this general power is subject to the court's interpretation.

6 The *Constitution Acts, 1867 to 1982,* Marchildon (2005) p.25, Braën (2002) pp.7-14 and Leeson (2002) pp.3-8.

2.1.4 Since the founding of the confederation, the provincial governments have developed a tradition of encouraging not-for-profit organizations such as religious or charity organizations to provide hospital services by providing them with financial subsidies. Up to the 1930s, the provincial governments had gradually become more involved in the provision of public health services and subsidization of out-patient services for targeted populations such as social assistance recipients. Although there were government subsidies, patients had to bear a significant portion of the cost of health care services, not to mention those who received no government subsidy.[7]

2.1.5 As a result of the Great Depression of the 1930s, a substantial number of Canadians were unable to pay for hospital or doctor services. At the same time, revenues of the provincial governments fell so rapidly that it became difficult for the provincial governments to meet the cost of subsidizing health care services. In 1945, the federal government put forward a cost-sharing proposal in health care to the provincial governments but it was ultimately rejected.[8]

2.1.6 The provincial government of Saskatchewan, though under financial constraints, introduced the Universal Hospital Services Plan in 1947. The Plan provided residents of the province universal access to hospital services. Several provinces adopted the Saskatchewan model in the subsequent years. In 1957, the *Hospital Insurance and Diagnostic Services Act* was passed in the Parliament of Canada, setting out conditions (e.g. universality) that the provinces had to satisfy in order to receive federal funding for hospital and diagnostic services under the cost-sharing arrangement. By 1961, all provinces provided residents in their respective jurisdictions universal access to hospital and diagnostic services.[9]

2.1.7 In 1962, the provincial government of Saskatchewan introduced universal access to doctor services for residents of the province. In 1964, the Royal Commission on Health Services recommended the federal government to encourage other provinces to introduce universal access to doctor services through the federal cost-sharing programme. In 1966, the *Medical Care Act* was passed by the Parliament of Canada, providing the legal foundation for the implementation of the Commission's recommendation. By 1972, all provinces had introduced universal access to doctor services.[10]

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7 Marchildon (2005), pp.19-25 and *Canada's Health Care System at a Glance* (2002).

8 Ibid.

9 Marchildon (2005), pp.19-25, Madore, Odette (2003), p.4 and *Canada's Health Care System at a Glance* (2002).

10 Ibid.

2.1.8 In 1984, the *Canada Health Act* was passed by the Parliament of Canada. The Act combined and updated the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*, providing a framework for the universal access to medically necessary hospital, doctor and surgical-dental[11] services by all Canadians. This framework has remained in place since then.

2.1.9 During the 1990s, there were growing concerns about the sustainability and quality of the health care system of Canada. As such, the Commission on the Future of Health Care in Canada was set up in 2001 by the Prime Minister to review the system and to make recommendations to "*ensure the long-term sustainability of a universally accessible, publicly funded health system*".[12]

2.1.10 In November 2002, the Commission released a report entitled *Building on Values: The Future of Health Care in Canada.* In the report, a number of alternative funding sources for health care provision were considered, including[13]:

(a) user fees and charges;

(b) medical savings accounts: individuals being allotted a yearly health care allowance which could be used to "purchase" health care services; and

(c) public-private partnerships.

2.1.11 The federal and provincial governments accepted the recommendation of the Commission that none of the alternative funding sources listed above met the equity and access to service principles underlying the *Canada Health Act*. As such, the existing tax-based health financing system has been maintained.

[11] Surgical-dental services are medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures, e.g. orthognathic surgery.

[12] Commission on the Future of Health Care in Canada (2002), p.1.

[13] Commission on the Future of Health Care in Canada (2002), pp.28-30.

2.2 Overview of health care system

Structure

2.2.1 There is an elaborated inter-governmental system involving different levels of senior government officials for the discussion of policy issues in Canada. Since 1906, the Prime Minister of Canada and Premiers of the provinces have held formal meetings, usually once a year, to discuss inter-governmental affairs, including health. Health policies have also been the focus of discussion in the recent three First Ministers' Meetings[14], which reaffirms the commitment to a publicly-funded health care system framed by the *Canada Health Act*.[15]

2.2.2 Regarding the different roles of the federal and provincial governments in health care policies, the federal government's roles include[16]:

(a) offering federal transfer payments or funding assistance to the provincial governments for the provision of health care services consistent with the principles of the *Canada Health Act*;

(b) being responsible for the programmes and regulation in the area of health protection and promotion, health security and disease prevention;

(c) ensuring that drugs, vaccines and other therapeutic products sold in Canada are safe, of good quality and therapeutically effective;

(d) fostering medical and scientific research through funding and other means; and

(e) ensuring access to health services by specific groups of Canadians, including aboriginal people, military personnel, the Royal Canadian Mounted Police[17] and inmates of federal prisons.

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[14] On health care polices, the Deputy Health Ministers' Meetings discuss health matters of concern to the federal and provincial governments and come up with policy proposals. These policy proposals will be submitted to the Health Ministers' Meetings for further discussion before they are discussed by First Ministers.

[15] Canadian Inter-governmental Conference Secretariat (2004) p.1, *2000 First Ministers' Meeting: Communiqué on Health*, *2003 First Ministers' Accord on Health Care Renewal* and *First Ministers' Meeting on the Future of Health Care 2004: A 10-year Plan to Strengthen Health Care.*

[16] *Overview of the Health Care System* (2004) and *Canada's Health Care System at a Glance* (2002).

[17] Canada's national police forces.

2.2.3 The provincial governments exercise their constitutional power to formulate policies for the administration and delivery of health care services as well as the regulation, inspection, licensing, and monitoring of health-related premises, institutions and personnel within their jurisdictions. In formulating health care policies, the provincial governments must abide by the conditions stipulated in the *Canada Health Act* in order to receive federal transfer payments on health.[18]

2.2.4 The conditions set out in the *Canada Health Act* for provinces to receive federal transfer payments on health include[19]:

(a) provision of insured health care services[20] by each provincial government must adhere to the following five principles:

(i) public administration: publicly financed and administered by a not-for-profit public authority;

(ii) comprehensiveness: comprehensive provision of all medically necessary services;

(iii) universality: universal coverage;

(iv) portability: coverage for insured health care services should be maintained when a person moves or travels within Canada or travels outside Canada; and

(v) accessibility: accessibility of medically necessary services without being impeded by financial or other barriers;

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[18] Marchildon (2005) pp.93-96, *Overview of the Health Care System* (2004), *Canada's Health Care System at a Glance* (2002) and Canadian Institute for Health Information (2005b) p.7.

[19] *Canada Health Act,* Madore and Odette (2003), *Canada Health Act Overview* (2002) and *Canada's Health Care System at a Glance* (2002).

[20] Insured health care services include medically necessary hospital, doctor and surgical-dental services. Medically necessary hospital services, as defined in Section 2 of the *Canada Health Act*, include:

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required;
(b) nursing service;
(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;
(d) drugs, and biological and related preparations when administered in the hospital or clinic;
(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;
(f) medical and surgical equipment and supplies;
(g) use of radiotherapy facilities;
(h) use of physiotherapy facilities; and
(i) services provided by persons who receive remuneration from the hospital or clinic.

Medically required doctor and surgical-dental services are determined by each provincial government and provincial professional bodies of doctors and dentists. The service items as well as their fees and charges are stipulated in the relevant provincial legislation.

(b) financial contribution of patients for insured health services are discouraged by a mandatory dollar-for-dollar penalty to be deducted from federal transfer payments; and

(c) the provincial governments are required to provide the federal government with information about how the conditions set out in the *Canada Health Act* are met as well as how the federal government's financial contribution to health services has been recognized, e.g. by recognizing the federal government's financial contribution to health services in the provincial budget document.

2.2.5 For the delivery of health care services, the provincial governments delegate such power to statutory regional structures, in particular the regional health authorities, to organize or deliver them. Most of the regional health authorities are governed by a board of directors who are appointed by the provincial governments. The number of directors within the board varies from province to province. Meanwhile, subsidization for prescription medicines and doctor remuneration for insured health services are administered centrally by the provincial governments.[21]

2.2.6 The following table presents some basic statistics about the delivery system of health care services in Canada.

Table 1 – Statistics on the delivery system of health care services in Canada in 2003

	Number	**Ratio**
Health workforce		per 10 000 population
Doctors	59 454	18.7
Dentists	18 265	5.8
Pharmacists	27 612	8.7
Nurses	241 342	76
Midwives	440	1
Health infrastructure		
Not-for-profit hospitals	744 (115 000 beds)	39 hospital beds per 10 000 population
For-profit hospitals	Pending information	
Occupancy rate of acute care beds	87%	

Sources: Canada Institute for Health Information (2005a), Canada Institute for Health Information (2005b), Canada Institute for Health Information (2006), Organisation for Economic Co-operation and Development (2005) and World Bank (2005).

[21] Canadian Institute for Health Information (2001) pp.7-8, *Canada's Health Care System at a Glance* (2002), Marchildon (2005) pp.61-68 and Detsky and Naylor (2003), pp.804-805.

Financing

2.2.7 In accordance with Section 3 of the *Canada Health Act*, "*[t]he primary objective of the Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers*".

2.2.8 The Canadian health care financing system is a tax-based financing system in that health care services are predominantly funded by general government expenditure of the federal and provincial governments, especially the latter.[22]

2.2.9 In Canada, the responsibility for financing health care services is clearly defined. Insured health care services, as stipulated in the *Canada Health Act*, are financed by the federal and provincial governments. For health care services not defined as insured health care services in the Act, they are largely financed by out-of-pocket payments and/or private insurance plans. Some provincial governments provide financial support for targeted groups of the population, e.g. elderly and chronically ill persons, to meet the cost of some of these health care services.[23]

2.2.10 The following table presents some basic information about expenditure on health services of Canada in 2003, which may serve as indicators on health expenditure.

Table 2 – Health expenditure indicators of Canada in 2003

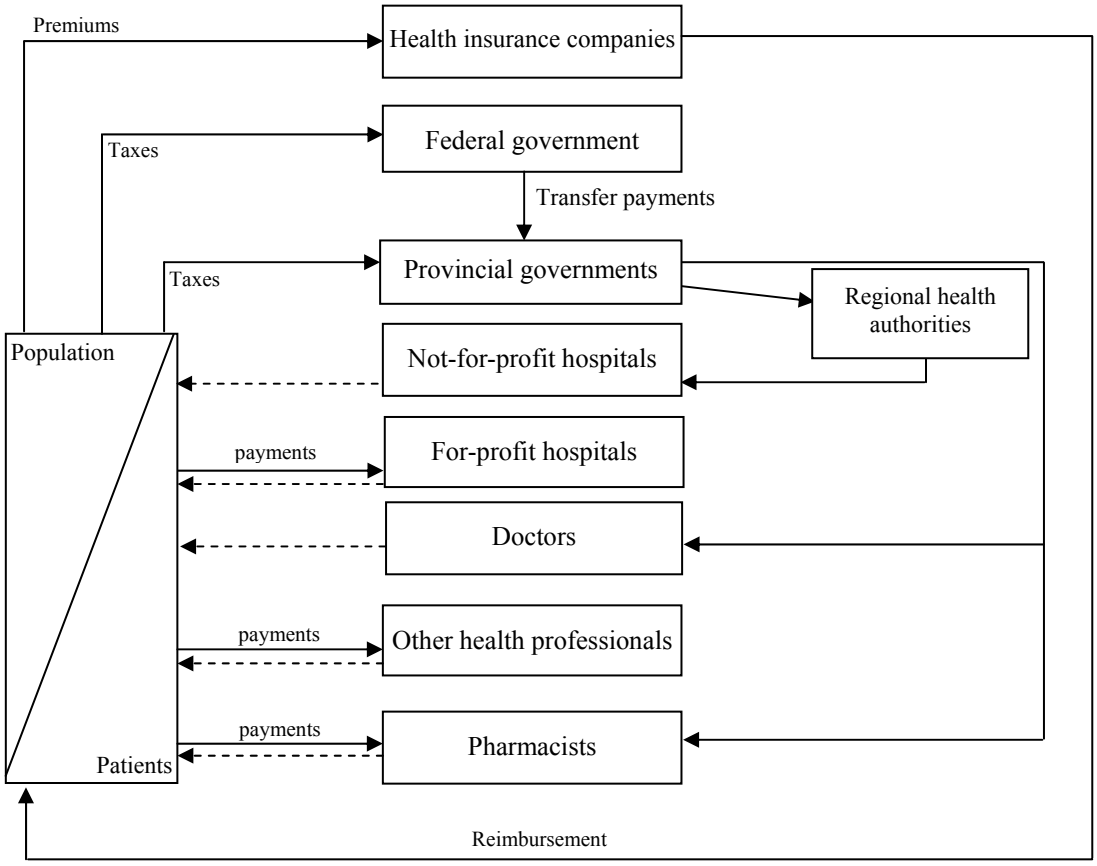
Total expenditure on health as % of GDP	10.1%
Per capita total expenditure on health	CAN$3,884 (HK$27,165)
General government expenditure on health as % of total expenditure on health	70.2%
Non-government expenditure on health as % of total expenditure on health	29.8%
General government expenditure on health as % of total general government expenditure	10%(1)
Health insurance coverage as % of total population	Pending information

Note: (1) 2002 figure.
Sources: Canada Institute for Health Information (2005c), and World Health Organization (2005).

22 Canadian Institute for Health Information (2005c), pp.10-11.
23 *Canada Health Act Annual Report 2004-05*.

2.2.11 Chart 1 summarizes the financing and delivery system of health care services in Canada.[24]

Chart 1 – Health care system of Canada



Source: Machildon (2005).
Legend: ⟶ Financial flows - - - -▸ Service flows

2.3 Collection mechanism of health care resources

2.3.1 Apart from out-of-pocket payments and donations from charity organizations, health care resources are mainly pooled through the following ways:

(a) general taxation; and

(b) health insurance plans.

[24] In this paper, the term "health insurance companies" refers to both profit-making companies which sell health insurance products to consumers as well as not-for-profit organizations such as co-operatives which offer health insurance for their members.

General taxation

2.3.2 The financial support for health care mainly comes from the federal and provincial governments' general revenue which relies heavily on income taxes, consumption taxes and corporate taxes.[25]

Health insurance plans

2.3.3 The private health insurance plans in Canada predominantly cover health care services not stipulated in the *Canada Health Act* as insured health care services because almost all provinces have laws and regulations that either prohibit or discourage the provision of health insurance plans on insured health care services. In essence, all the medically necessary health services are subsidized by the federal and provincial governments, and the private health insurance plans cover the remaining services. In 2003, 53.6% of dental care, 33.8% of prescription drugs and 21.7% of vision care were funded by private health insurance plans.[26]

2.3.4 Most private health insurance plans come in the form of group-based benefit plans that are sponsored by employers, unions or professional organizations.[27] At the end of 2004, 126 insurance companies provided health insurance plans for Canadians.[28]

2.4 Allocation mechanism of health care resources

2.4.1 Health care resources are kept by either the government or the health insurance companies, depending upon the means through which they are collected. Accordingly, these health care resources are allocated through either one of the following mechanisms to health care providers:

(a) government budget; and

(b) health insurance plans.

25 Marchildon (2005) p.41.
26 Flood and Archibald (2001) and Marchildon (2005) pp.47-48.
27 Marchildon (2005) pp.47-48.
28 Canadian Life and Health Insurance Association Inc. (2005a).

Government budget

2.4.2 Through the budgetary process, the federal government allocates public monies in the form of Canada Health Transfer payments to the provincial governments in support of health care services. Canada Health Transfer payments are allocated to all provinces on a per capita basis to ensure equal support for Canadians regardless of their place of residence.[29]

2.4.3 A Canada Health Transfer payment is made up of both a cash transfer payment and a tax transfer payment. The tax transfer payment is an indirect payment involving the federal government reducing its tax rates to allow the provinces to raise their tax rates by an equivalent amount. As a result, revenue that would have flowed to the federal government goes directly to the provincial governments. In the event that a Canada Health Transfer payment is granted, the ratio of the cash transfer payment to the tax transfer payment is announced in the budget. In the financial year 2004-2005, the ratio was 58:42.[30]

2.4.4 Through the provincial budgetary process, the provincial governments allocate public monies (including transfer payments from the federal government) to the regional health authorities. The allocation method applied by individual provincial governments varies across jurisdictions, with the population-based funding method and the historically-based global budget being more commonly adopted. Under the former method, the allocation of resources is based on the size of population in a region and health needs of the population. Under the latter method, the allocation of resources is based on the expenditure pattern of the region in the previous years. The regional health authorities are responsible for providing or purchasing an array of health care services in their respective geographical areas.[31]

2.4.5 With regard to the share of health care financing, the provincial governments contribute more resources for health care services than the federal government. In 2003, 91% of the total public funding on health care came from the provincial governments.[32]

29 *Canada Health Transfer* (2006).
30 *Federal Transfers to Provinces and Territories* (2006).
31 Marchildon (2005) pp.50-51.
32 Canadian Institute for Health Information (2005c), pp.10-11.

Health insurance plans

2.4.6 Private health insurance plans provide explicit benefit packages to cover the costs of those health care services not stipulated in the *Canada Health Act* as insured health care services. The health insurance companies allocate resources to the health care providers by means of reimbursement of claims. The insured can make claims to the health insurance companies for the medical expenses paid. Based on the terms and conditions of the insurance policies, the health insurance companies reimburse money to the insured.[33]

2.5 Distribution of health care resources

Statistical profile

2.5.1 The following table shows the distribution of health care resources by area of expenditure in 2003.

Table 3 – Proportion of health expenditure by area of expenditure of Canada in 2003

Area of expenditure	**2003**
Institutional care	
Hospitals	30.3%
Other institutions(1)	9.3%
Non-institutional care	
Doctor services	13.2%
Services provided by other health professionals(2)	10.7%
Medicines	16.3%
Capital(3)	4.6%
Public health	5.6%
Administration(4)	4%
Other health spending(5)	6%
Total	100%

Notes: (1) For example, residential care types of facilities for the elderly and chronically-ill patients.
(2) For example, dentists, chiropractors and physiotherapists.
(3) For example, expenditures on building health facilities and purchasing health equipment.
(4) For example, expenditures on operating health departments and administration of health insurance plans.
(5) For example, health research and ambulance services.

Source: Canadian Institute for Health Information (2005c).

[33] Canadian Life and Health Insurance Association Inc. (2005b).

2.5.2 The following table presents the share of funding sources for selected types of health care services in 2003.

Table 4 – Share of funding sources for selected types of health care services of Canada in 2003

	Public funding sources(1)	Private funding source			Total
		Private health insurance	Out-of-pocket	Non-consumption(2)	
Institutional care					
Hospitals	91.1%	2.4%	1.7%	4.8%	100%
Other institutions	72.5%	0%	27.5%	0%	100%
Non-institutional care					
Doctor services	98.7%	0.1%	1.2%	0%	100%
Services provided by other health professionals	9.2%	42.9%	47.9%	0%	100%
Medicines	38.1%	28.1%	33.8%	0%	100%

Notes: (1) Including the provincial government expenditure and federal transfer payments.
(2) Non-consumption is non-patient revenue to hospitals, such as donations.
Source: Canadian Institute for Health Information (2005c).

Hospital services

2.5.3 Canadians receive medically necessary hospital services free of charge from not-for-profit hospitals. For those hospital services not stipulated in the *Canada Health Act* as insured health care services, patients have to pay the fees and charges by either out-of-pocket payments or insurance, or a combination of both.[34]

Primary health care services

2.5.4 In addition to in-patient services, Canadians receive medically necessary doctor and dental-surgical services free of charge. For those primary health care services not stipulated in the *Canada Health Act* as insured health care services, patients have to pay the fees and charges by either out-of-pocket payments or insurance, or a combination of both.[35]

[34] Marchildon (2005) p.41, Canadian Institute for Health Information (2005c) and *Canada Health Act Annual Report 2004-05*.
[35] Ibid.

Medicines

2.5.5 Excluding prescription medicines provided to those patients receiving insured hospital services, patients are responsible for the cost of all other medicines. Some provincial governments establish drug plans to cover or subsidize residents on the cost of prescription medicines. The remaining cost of prescription medicines is covered by either out-of-pocket payments or insurance, or a combination of both.[36]

2.6 Policy evaluation

2.6.1 In 2002, the Commission on the Future of Health Care in Canada issued its final report entitled *Building on Values: the Future of Health Care in Canada*. The Commission report pointed out that *"a strong majority of Canadians who use the system are highly satisfied with the quality and standard of care they receive."*[37] As manifested in a Statistics Canada survey published in 2003, most Canadians (87%) aged 15 and older rated the quality of health care they received in the previous 12 months as excellent or good.[38]

2.6.2 Accepting the Commission's recommendations, the federal and provincial governments agree to preserve the present tax-based system in financing health care services, i.e. the division of fully publicly-funded insured health care services as stipulated in the *Canada Health Act* and largely privately-funded health care services not stipulated as insured health care services. As pointed out by some academics, this is considered to be a special feature of the Canadian health care system in that certain health care sectors, i.e. insured hospital and doctor services, are entirely publicly financed, while the other sectors, such as some health care professional services, are predominantly financed by private funding sources, e.g. out-of-pocket payments and/or health insurance plans.[39]

2.6.3 The benefits of such a division of fully publicly financed insured health care services as stipulated in the *Canada Health Act* and largely privately financed health care services not stipulated as insured health care services are considered to be as follows:[40]

(a) Canadians can be ensured to receive medically necessary hospital services and medically required doctor services on a universal basis without financial obstacles of any kind; and

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36 Marchildon (2005) pp.66-67, Canadian Life and Health Insurance Association Inc. (2005b) and *Canada Health Act Annual Report 2004-05*.

37 Commission on the Future of Health Care in Canada (2002), p.xvi.

38 Canadian Institute for Health Information (2005b), p.39.

39 Flood, Stabile and Tuohy (2002), pp.299-300.

40 Marchildon (2005) p.121.

(b) Administrative efficiency and economy of scale can be achieved as the management of specific health care sectors is clearly vested in either the public or private sector.

2.6.4 However, there are some challenges to be met by such a division of health care services[41]:

(a) The provincial governments have the power to define what "medically necessary" hospital services are and each provincial government negotiates with the corresponding provincial medical and dental professional bodies on what constitute "medically required" doctor and surgical-dental services. As such, the scope of insured health care services varies from province to province. The challenge is to develop a more unified set of insured health care services; and

(b) Health care services not stipulated as insured health care services are predominantly financed by private funding sources, i.e. private health insurance plans and/or out-of-pocket payments. Since most of the private health insurance plans are sponsored by employers, unions or professional organizations, the protection of those people who are not covered by employment-related health insurance plans is a challenge to be met.

[41] Commission on the Future of Health Care in Canada (2002), p.xviii and Flood, Stabile and Tuohy (2002) pp.301-305.

Chapter 3 – United Kingdom[42]

3.1 Background

3.1.1 Prior to the 1940s, health care services in England of the UK had been largely delivered by the private sector and on the basis of individuals' ability to pay. For those who could not afford the cost of private health care services, while they might seek free medical treatments from charities or public health services from local governments, the provision of these free health care services was limited at that time.[43]

3.1.2 In 1941, the Inter-departmental Committee on Social Insurance and Allied Services was set up to review the then existing national social insurance schemes (including pension schemes and national health insurance schemes for low-income working people and unemployment insurance) and recommend appropriate changes. In 1942, the Committee released a report recommending the establishment of a universal and comprehensive health care service to address the "*limitation of medical services, both in the range of treatment which is provided as of right and in respect of the classes of persons for whom it is provided…*"[44] Endorsing the Committee's recommendation, the government started to prepare for the establishment of a national health service in the subsequent years.

3.1.3 In accordance with the provisions of the *National Health Service Act 1946*, the National Health Service (NHS) was established in 1948. The NHS was founded on *"the principle of collective responsibility by the state for a comprehensive health service, which is to be available to the entire population free at the point of use."*[45] Whilst different governments in power in the subsequent decades have introduced various NHS reforms, the spirit of this principle has been preserved.

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[42] The UK has devolved responsibility for health care to its constituent countries, i.e. England, Wales, Scotland and Northern Ireland. Instead of going through four similar health care systems, this paper concentrates on the National Health Service in England, which accounts for over 80% (82% in the financial year 2003-2004) of total health expenditure of the UK. When statistical data on England is not available, figures on the UK are used.

[43] *History of the NHS (n.d.)* and *NHS Inheritance (n.d.)*.

[44] Beveridge, William (1942), p.5.

[45] European Observatory on Health Care Systems (1999), p.5.

3.1.4 The NHS delivery system consisted of three components when it was launched in 1948. Primary health care services were provided by general practitioners, dentists, pharmacists and ophthalmic practitioners who were independent contractors of the government. Preventive services were provided by local governments in their respective localities. The provision of hospital services within the regions was the responsibility of regional hospital boards. This NHS delivery system has been restructured during major health care reforms in the subsequent decades.[46]

3.1.5 From the mid-1970s to the early 1980s, substantial growth in the provision of the NHS services and related capital input required a corresponding increase in administrative layers to cope with the mounting management works of the NHS system. Under a series of the NHS reforms carried out in the late 1980s and the mid-1990s based on the concepts of market mechanism, the public health care sector was conceived as a quasi-market, consisting of health services purchasers (e.g. the regional health authorities) and health services providers (e.g. hospitals). Purchasers and providers entered into contracts specifying the terms and conditions of the provision of health care services. This arrangement allowed purchasers more flexibility in choosing providers and created competition among providers to enhance efficiency and cost-effectiveness.[47]

3.1.6 The election of a new Labour government in 1997 has brought in a new wave of NHS reforms. These reforms have been guided by a list of policy papers[48]. Among them, *The New NHS – Modern, Dependable* sets out the government′s vision on the NHS, *The NHS Plan* outlines a 10-year reform plan on the NHS and the other policy papers provide detailed reform plans of *The NHS Plan*:

(a) *The New NHS – Modern, Dependable* (1997);

(b) *The NHS Plan* (2000);

(c) *Delivering the NHS Plan* (2002);

(d) *The NHS Improvement Plan – Putting People at the Heart of Public Services* (2004);

(e) *Creating a Patient-led NHS: Delivering the NHS Improvement Plan* (March 2005); and

(f) *Health Reform in England: Update and Next Steps* (December 2005).

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46 Appendix A of the research report (RP09/PLC) entitled *Health Care Expenditure and Financing in the United Kingdom* also provides a brief description of the NHS reforms up to 1997.

47 *History of the NHS* (n.d.), *Short NHS History* (n.d.) and Legislative Council Secretariat (1998), pp.55-59.

48 Department of Health (2006a), pp.8-9.

3.1.7 The initiatives of the current NHS reforms can be grouped into the following categories[49]:

(a) demand-side reforms such as increasing patients' choice in using health care services;

(b) supply-side reforms such as engaging a wider range of providers to provide health care services;

(c) system management reforms such as setting quality standards and monitoring compliance with the required standards among both the NHS and the non-governmental sectors; and

(d) transactional reforms such as introducing a new payment mechanism that rewards efficient providers.

3.1.8 Since its establishment, the NHS has been funded mostly by general taxation. *The NHS Plan* has examined the following alternative health care financing options, namely:

(a) providing incentives for people to take out private health insurance;

(b) introducing new charges for health care services;

(c) converting the tax-based financing system into a social health insurance system; and

(d) limiting the provision of health care services to the core services.

3.1.9 *The NHS Plan* concludes that the tax-based financing system of the NHS should continue as it meets the tests of efficiency and equity.[50]

[49] Department of Health (2005a), pp.9-12.
[50] *The NHS Plan* (2000), pp.33-40.

3.2 Overview of health care system

Structure

3.2.1 The Department of Health sets the overall policies on all health issues with the aim to improve the health and well-being of the people of England. In respect of the provision of health care services, the Department of Health is responsible for formulating policies, setting national standards and allocating resources for the NHS, through which the public can access various health care services.[51]

3.2.2 The NHS delivery system consists of several types of statutory organizations, in particular strategic health authorities and primary care trusts. The whole of England is split into the territories of 10 strategic health authorities, each serving 2.5 million to 7.4 million people. Each authority is governed by a board which consists of eight to 13 appointed members.[52] Strategic health authorities do not deliver health care services. Their main responsibility is to monitor the public health care services within their respective regions. In fulfilling the monitoring role, strategic health authorities ensure that primary care trusts follow policy directions set by the government and monitor the performance of primary care trusts. In addition, strategic health authorities are responsible for developing strategic directions to improve the public health care services in their respective regions.[53]

3.2.3 At present, there are altogether 152 primary care trusts distributed among the territories of the 10 strategic health authorities, serving populations of between 90 000 and 1.2 million. Each primary care trust is governed by a board which consists of eight to 15 appointed members. Controlling around 80% of the NHS budget, primary care trusts are responsible for planning and managing health care services in their localities, either by commissioning services from other health care providers, e.g. hospital care from an NHS trust, or by providing them directly.[54]

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51 Department of Health (2006a) p.7 and p.12 and *Department of Health* (n.d.).

52 According to *Memorandum by the NHS Appointment Commission*, the NHS Appointment Commission was set up in 2001. Led by a chairperson appointed by the government, the Commission is responsible for the recruitment, selection and appointment of people from the community to serve as chairs and members of the NHS trusts, primary care trusts and strategic health authorities.

53 Department of Health (2006b) pp.9-10, *NHS in England* (n.d.) and *Reorganisation of strategic health authorities* (2006).

54 Department of Health (2006c) pp.11-12, *NHS in England* (n.d.), *Reorganisation of primary care and ambulance trusts* (2006) and Healthcare Commission (2004), p.12 and p.129.

3.2.4 The following table presents some basic statistics about the delivery system of health care services in England.

Table 5 – Statistics on the delivery system of health care services in England in 2002

	Number	**Ratio**
Health workforce		per 10 000 population
Doctors	104 406	21
Dentists	18 400	3.7
Ophthalmic practitioners	8 096	1.6
Pharmacists	33 996	6.9
Nurses, including midwives	367 520	74.2
Health infrastructure		
Public hospitals (NHS hospitals)	665 (183 826 beds)	39.4 hospital beds per 10 000 population
Private hospitals	240 (11 200beds)	
Occupancy rate of acute care beds	85.3%	

Sources: Regional Office for Europe of the World Health Organization (2006), *Health and Personal Social Services Statistics: England* (n.d.), *CareHealth Limited* (2005), NHS Hospital in England (n.d.), *Private Healthcare UK* (2006), Royal Pharmaceutical Society of Great Britain (2004), The NHS Health and Social Care Information Centre (2006a), The NHS Health and Social Care Information Centre (2006b), The NHS Health and Social Care Information Centre (2006c) and *Hospital Activity Statistics* (2005).

Financing

3.2.5 The guiding principles of the English health care system are as follows[55]:

(a) The NHS provides a universal service for all people based on clinical need, not the ability to pay, because health care is a basic human right. Unlike private health care systems, the NHS does not exclude people because of their health status or ability to pay; and

(b) The NHS provides access to a comprehensive range of services through primary and community health care and hospital-based care. The NHS also provides information services and support to individuals in relation to health promotion, disease prevention, self-care, rehabilitation and after-care.

[55] *NHS Core Principles* (n.d.).

3.2.6 The health care financing system of England is a tax-based financing system in that health care is predominantly funded by general government expenditure. Through the budgetary process, public monies for health care purposes are allocated to various types of health care providers, especially the primary care trusts. Meanwhile, the HM Revenue and Customs Department collects contributions from employers, employees and self-employed persons for the mandatory National Insurance Scheme. Since the establishment of the National Insurance Scheme in 1948, the contributions to the scheme have been used for paying unemployment benefits, sickness benefits (compensation for loss of earnings due to sickness) and retirement pensions for individuals who make the contributions and meet other qualifying conditions. In addition, part of the contributions is used to fund the NHS.[56]

3.2.7 While members of the public enjoy free general practitioner consultations and in-patient stays, they may be required to pay partially or fully for prescription medicines, ophthalmic services and dental services. The government has set up a safety net to support those who cannot afford the payments. For example, a means-tested NHS low-income scheme is available to help the low-income families with the costs of medicines and health care services.[57]

3.2.8 The following table presents some basic information about expenditure on health services of the UK in 2002, which may serve as indicators on health expenditure.

Table 6 – Health expenditure indicators of the United Kingdom in 2002

Total expenditure on health as % of GDP	7.7%
Per capita total expenditure on health	£1,165 (HK$16,795)
General government expenditure on health as % of total expenditure on health	83.4%
Non-government expenditure on health as % of total expenditure on health	16.6%
General government expenditure on health as % of total general government expenditure	15.4%
Health insurance coverage as % of total population	11.4%

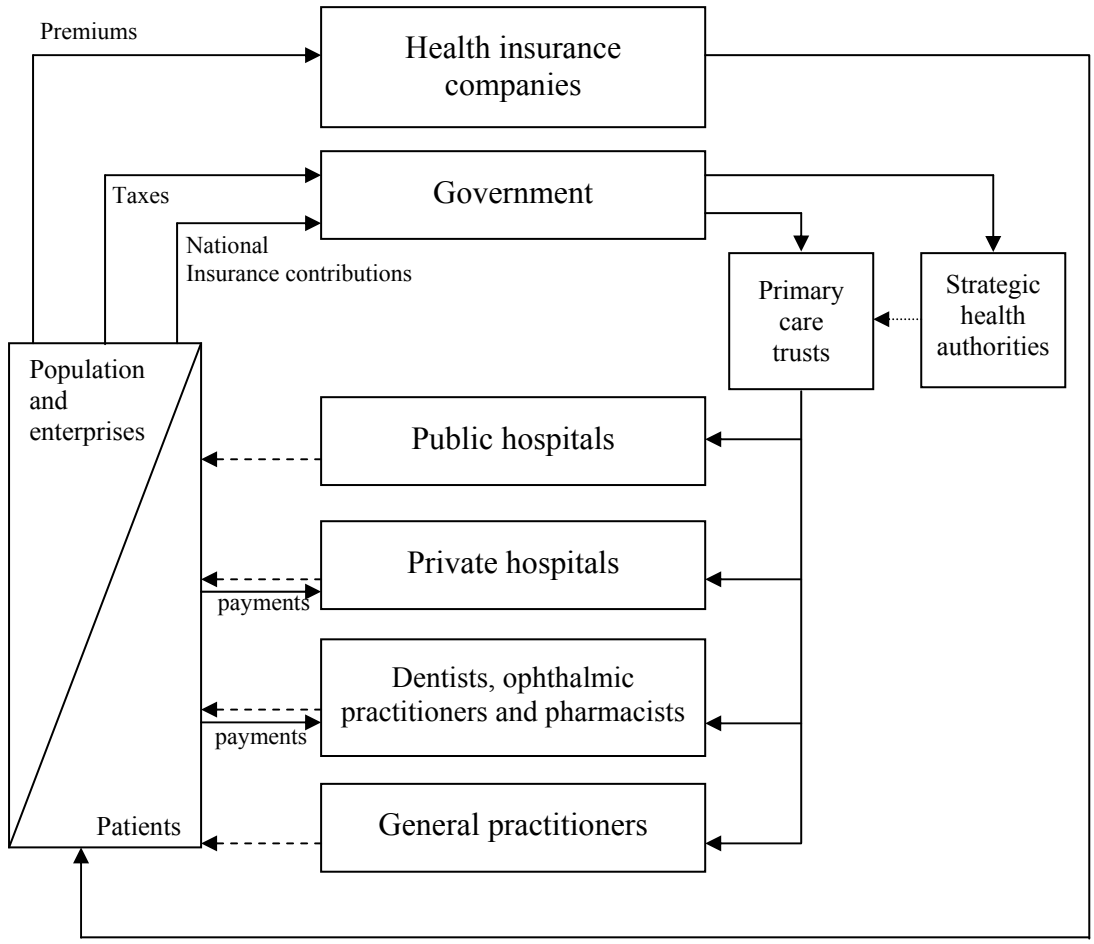
Sources: Regional Office for Europe of the World Health Organization (2006), World Health Organization (2005), Foubister et al (2006) and Organisation for Economic Co-operation and Development (2005).

[56] National Audit Office (2006) p.2 and p.13, Office for National Statistics (2005), p.180 and Dixon and Robinson (2002) p.105.

[57] Department of Health (2005a) and Dixon and Robinson (2002) p.106.

3.2.9 Chart 2 summarizes the financing and delivery system of health care services in England.

Chart 2 – Health care system of England



Sources: Healthcare Commission (2004), National Audit Office and Audit Commission (2006) and *How the NHS Works* (n.d.).

Legend: ⟶ Financial flows ----▶ Service flows ⋯⋯▶ Monitoring

3.3 Collection mechanism of health care resources

3.3.1 Apart from out-of-pocket payments and donations from charity organizations, health care resources are mainly pooled through the following ways:

(a) general taxation;
(b) the National Insurance Scheme; and
(c) health insurance plans.

General taxation

3.3.2 The major source of the government's general revenue comes from income taxes, goods and services taxes (Value Added Tax) and corporate taxes. In the financial year 2004-2005, the respective estimated percentage shares of income taxes, goods and services taxes and corporate taxes in the total revenue were 34%, 19.4% and 9.1%, together accounting for 62.5% of the estimated total revenue.[58]

National Insurance Scheme

3.3.3 The employers, employees and self-employed persons are required to make contributions to the National Insurance Scheme according to the rates set by the government. The employee contribution rate for the financial year 2006-2007 is 11% of weekly earned income between £84(HK$1,214) and £645(HK$9,321) and 1% of all weekly earned income above £645(HK$9,321). The employer contribution rate is 12.8% on all weekly earned income above £84(HK$1,214) of an employee. Employers deduct the employee contributions from employees' monthly earnings and pay the amount to the HM Revenue and Customs Department together with the employer contributions.[59]

3.3.4 The self-employed person contribution rate consists of two components, i.e. a flat weekly rate and a percentage rate of yearly profits. For the financial year 2006-2007, the flat weekly rate is £2.1(HK$30). The percentage rate for yearly profits between £5,035(HK$72,765) and £33,540(HK$484,715) is 8%, and 1% for all yearly profits above £33,540(HK$484,715). The self-employed persons pay the flat rate contributions quarterly and the yearly profits rate contributions annually to the HM Revenue and Customs Department.[60]

3.3.5 Each year, the government allocates a percentage of the total contributions of the National Insurance Scheme to the NHS. The percentages for the financial years 2003-2004 and 2004-2005 were around 19.9% and 21.5% respectively.[61]

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58 Office for National Statistics (2005) p.365 and p.371.

59 *Background to National Insurance Contributions* (n.d.) and *Rates and Allowances – National Insurance Contributions* (n.d.).

60 Ibid.

61 National Audit Office (2006) pp.12-13, Office for National Statistics (2003), p.353 and Office for National Statistics (2005), p.365.

Health insurance plans

3.3.6 The Financial Services Authority, an independent statutory organization, is set up by the government to regulate financial services, including the insurance industry. Regulation under the Financial Services Authority focuses on ensuring that the process of selling insurance plans is transparent and that the information needed for consumers to assess insurance products is presented clearly and consistently across insurers and across products.[62]

3.3.7 In the UK, health insurance companies mainly provide supplementary medical plans which reimburse the insured for surgery and other treatments by private hospitals and private specialists. With supplementary medical plans, patients benefit from the timeliness of health care services offered by private health care facilities as the waiting list for these services in the public sector tends to be long. There are 27 health insurance companies operating in the UK, with the top two market players, i.e. the British United Provident Association and AXA PPP Healthcare, accounting for 40% and 22.5% market share respectively.[63]

3.4 Allocation mechanism of health care resources

3.4.1 Health care resources are kept by the government or health insurance companies, depending upon the means through which they are collected. Accordingly, these health care resources are allocated through the following mechanisms to health care providers:

(a) government budget; and

(b) health insurance plans.

Government budget

3.4.2 Through the budgetary process, public monies are allocated by the government to various policy areas, including health. The resources dedicated to health are allocated to various health care providers, in particular the primary care trusts which control around 80% of the NHS budget. The allocation of health care resources to the primary care trusts is based on a weighted capitation formula. The primary care trusts use the allocated monies for the provision of health care services in their respective districts.[64]

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62 Foubister et al (2006) pp.xi-xix and *Financial Services Authority* (2005).

63 Ibid.

64 Department of Health (2005b), pp.7-9 and p.50.

3.4.3 The weighted capitation formula is an aggregate formula that determines the share of funding to be allocated to each primary care trust. The aim of the formula is "*to secure equal opportunity of access to health care for people at equal risk*".[65]

3.4.4 According to the formula, each primary care trust's share of health care funding is determined by the size of the population and weighted for:[66]

(a) age-related need: recognizing that the level of demand for health care services varies according to the age structure of the population;

(b) additional need: reflecting that the relative need for health care services is over and above the level accounted for by age, e.g. socio-economic profiles of the population; and

(c) cost of providing health care services: taking account of unavoidable geographical variations in the cost of providing health care services, e.g. staff cost.

3.4.5 The primary care trusts assume both a funder's role and a provider's role. For those primary care trusts which own health care facilities, they provide health care services directly. The remaining primary care trusts commission services from other health care providers. With respect to primary health care, these primary care trusts commission services from general practitioners, dentists, pharmacists and ophthalmic practitioners. Concerning secondary and tertiary health services, they commission related hospital services from the NHS trusts which run public hospitals, and psychiatric services from mental health trusts which run mental hospitals.[67]

Health insurance plans

3.4.6 Health insurance plans provide explicit benefit packages to cover the cost of medical and related services. Under a benefit package, the insured makes claim to the health insurance companies for part or all of the medical expenses paid. In the case where the medical institutions have made arrangements with the health insurance companies, the medical institutions make claims directly to the health insurance companies for the medical expenses allowed in the insurance policies.[68]

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65 Department of Health (2005b), p.8.

66 Department of Health (2005b), pp.7-9 and p.50 and *2006-07 and 2007-08 PCT Revenue Allocations: A Short Guide* (2005).

67 Department of Health (2006c) pp.11-12, *NHS in England* (n.d.), *Reorganisation of primary care and ambulance trusts* (2006) and Healthcare Commission (2004), p.12 and p.129.

68 Foubister et al (2006), p.xvii.

3.5 Distribution of health care resources

Statistical profile

3.5.1 The following table shows the distribution of the government's health expenditure by area of expenditure in the financial year 2003-2004.

Table 7 – Distribution of health expenditure of the National Health Service in England by area of expenditure in 2003-2004

Area of expenditure	2003-2004
Hospital and Community Health Services	
In-patient and out-patient medical services provided by hospitals and other related health care facilities owned by the NHS trusts(1)	86.9%
Family Health Services	
General medical services	7.5%
General dental services	2.1%
General ophthalmic services	0.5%
Pharmaceutical services	0.9%
Central Health and Miscellaneous Services(2)	1.6%
Departmental Administration	0.5%
Total	100%

Notes: (1) Around 56% of the expenditure on hospital and community health services is used on acute care services.

(2) While hospital and community health services and family health services receive funding from primary care trusts, services under this category receive funding directly from the Department of Health.

Source: Department of Health (2006a), p.104, p.108 and p.139.

3.5.2 The Office for National Statistics has used health care spending data of the financial year 1999-2000 to compile a sample of the United Kingdom Health Accounts[69]. The following table presents the United Kingdom Health Accounts data in the financial year 1999-2000.

[69] The "System of health accounts" is a health spending statistics reporting system developed by the Organisation for Economic Co-operation and Development in 2000.

Table 8 – Expenditure on health by function and provider versus source of funding in the United Kingdom in 1999-2000

	Public funding source	**Private funding source**	**Total**
Provider			
Hospitals	56%	2%	58%
Retailers of medical goods	10%	8%	18%
Ambulatory facilities(1)	12%	3%	15%
Nursing and residential facilities	2%	1%	3%
General health administration and insurance(2)	1%	2%	3%
Other(3)	1%	2%	3%
Total	82%	18%	100%
Function			
Curative/rehabilitative care	61%	6%	67%
Medical goods dispensed to outpatients(4)	10%	8%	18%
Long-term nursing care	5%	1%	6%
Health administration and health insurance(5)	2%	2%	4%
Prevention and public health services	2%	0%	2%
Ancillary services(6)	1%	0%	1%
Other(3)	1%	2%	3%
Total	82%	18%	100%

Notes: (1) Such as private medical doctor clinics.
(2) Comprising establishments primarily engaging in the regulation of activities of agencies that provide health care, overall administration of health policies and health insurance.
(3) Health care services provide by prisons, armed forces and not-for-profit organizations.
(4) Such as medical goods dispensed by pharmacies, opticians, sanitary shops and other retail traders to out-patients.
(5) Activities of private insurers and central and local authorities relating to the planning, management and regulation of health insurance.
(6) Such as laboratory, diagnosis imaging and patient transport services.

Source: *UK Health Accounts* (2003).

Primary care trust

3.5.3 Based on the weighted capitation formula, each primary care trust is allocated with a budget and has the duty to keep a balanced budget and make efficient use of the allocated resources. To facilitate primary care trusts fulfilling the duties, the government has issued the *Standing Financial Instructions* detailing the financial responsibilities, policies and procedures of primary care trusts. However, a rising number of primary care trusts have failed to keep expenditure within the resources limit. In the financial year 2003-2004, 14% of primary care trusts reported a deficit / overspending problem and the figure increased to 30% in the following year.[70]

3.5.4 The factors contributing to the deficit/overspending problem of primary care trusts include:[71]

(a) cost pressures arising from national initiatives, such as the implementation of a new pay system for health care professionals;

(b) cost pressures arising from meeting performance targets for accessibility to health and service provision; and

(c) poor financial management.

Hospital services

3.5.5 The primary care trusts provide hospital services to people in their respective geographical areas either through their own hospitals or by commissioning services from other hospitals, predominantly the NHS hospitals.[72]

3.5.6 Public hospital services are free of charge for all English people if they choose to be treated as a public patient. On the other hand, private patients have to pay all the fees and charges, e.g. doctor's fee and hospital charges, by either out-of-pocket payments or insurance, or a combination of both. There are private patient units among the some 90 NHS hospitals, with around 10-12 beds in each of these units. As such, the share of private patient beds in public hospitals is only around 0.5%.[73]

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70 Department of Health (2006c), p.60 and National Audit Office and Audit Commission (2006), p.19.

71 National Audit Office and Audit Commission (2006), p.4.

72 *How the NHS Works* (n.d.) and *Delivering Secondary Care* (n.d.).

73 *Private Health Treatment* (2006) and *CareHealth Limited* (2005).

Primary health care services

3.5.7 People enrolling in local general practitioner practices can receive primary health care services which are generally free of charge. According to the *General Medical Services Statement of Financial Entitlements*, primary care trusts make the following types of payments to the general practitioner practices which provide primary health care services for their enrollees[74]:

(a) Global sum payments: Payments that cover costs in delivering essential and additional services[75]. The calculation of this type of payments is based on the number of people enrolled with a general practitioner practice, weighed by need factors, such as demographic and health status of the enrolled population as well as cost factors, such as the location of the practice;

(b) Quality practice payments: Payments that reward quality practice. The calculation of this type of payments is based on the number of points (each point worth a certain amount of money set by the government) that a practice has achieved under the quality and outcomes framework[76];

(c) Directed enhanced services payments: Payments that cover services under the direction of the national government, such as childhood immunizations. The calculation of this type of payments is generally based on the number of people who need the relevant services; and

(d) Specific purposes payments: Payments for specific purposes, such as cost for locums and payments for prolonged study leave.

Medicines

3.5.8 Being subsidized by the government, patients are required to pay a flat rate of £6.65(HK$96) for each prescription. There are exemptions for specific groups, e.g. children under 16 and people over 60, people with chronic illness or disability and low-income families receiving social security benefits. Overall, around 85% of the prescription items dispensed are free to patients.[77]

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74 *Delivering Primary Care* (n.d.) and *General Medical Services Statement of Financial Entitlement 2005 Onwards* (2006).

75 Essential services cover activities, such as looking after patients during an episode of illness, the general management of chronic diseases and the non-specialist care of patients who are terminally ill. Additional services cover contraceptive services, maternity medical services, child health surveillance, cervical screening and some minor surgeries such as skin lesions.

76 The quality and outcomes framework is divided into four principal domains, i.e. the clinical, organizational, patient experience and the additional services domains. Each principal domain consists of a number of indicators, each of which is worth certain points.

77 NHS Health and Social Care Information Centre and Office for National Statistics (2005), *Help with Health Costs* (2005) and *Charges and Optical Voucher Values* (2006).

3.5.9 For people who are not entitled to free prescriptions but require regular in-take of medicine, they can apply for a Prescription Pre-payment Certificate issued by the Prescription Pricing Authority of the NHS. The prices for a 4-month and a 12-month Prescription Pre-payment Certificate are £34.65(HK$501) and £95.3(HK$1,377) respectively. Certificate-holders present the certificate at specific pharmacies to collect prescription items during the specified period.[78]

3.6 Policy evaluation

3.6.1 When the Labour Party returned to power in 1997, they presented their vision of the NHS in *The New NHS – Modern, Dependable*. *The NHS Plan* published in 2000 has further elaborated the government's 10-year health care reform plan. Reform initiatives are classified into the following types: demand-side reforms, such as increasing patients' choice in using health care services; supply-side reforms, such as engaging a wider range of providers to provide health care services; system management reforms, such as setting quality standards and monitoring compliance with the required standards among both the NHS and non-governmental sectors; and transactional reforms, such as introducing a new payment mechanism that rewards efficient providers.

3.6.2 The Department of Health and the Healthcare Commission have jointly evaluated the patients' experiences on the NHS. Surveys on various aspects of the patients' experiences are conducted, namely adult in-patient survey, primary care survey, emergency services survey, out-patient survey and mental health services survey. A national score on each of the above surveys is constructed to generate the patients' satisfaction level on the NHS (the higher the scores, the higher the satisfaction level). The national score of these surveys has maintained at around 75 out of 100, with slight improvement being recorded in the past few years.[79]

3.6.3 The *Chief Executive's Report to the NHS, 2006* states that one of the achievements of the current health care reform is faster access to the NHS services as indicated by the shortened waiting time for in-patient treatments and out-patient services. In addition, the health status of the population is enhanced as indicated by the fallen mortality rates of cancer and coronary heart disease patients and the increasing number of people adopting healthier lifestyles such as giving up smoking.[80]

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78 NHS Health and Social Care Information Centre and Office for National Statistics (2005), *Help with Health Costs* (2005) and *Charges and Optical Voucher Values* (2006).

79 Department of Health (2006e) pp.30-31.

80 Department of Health (2006d).

3.6.4 In spite of the achievements, the NHS is facing a financial challenge, resulting from the deficit/overspending problem of the NHS organizations during the past few years, in particular among primary care trusts. The National Audit Office and the Audit Commission make the following recommendations to the NHS organizations to address the deficit/overspending problem[81]:

(a) The NHS organizations which have achieved a balanced budget should develop a whole organization approach to managing the risk of deficit/overspending. Boards, clinicians, finance staff and the NHS staff should be aware of and prevent the happening of the deficit/overspending problem.

(b) Facing the upcoming national initiatives such as mergers of the NHS organizations, the boards of the NHS organizations have to identify skills needed to respond to these changes, in particular in the area of financial management during organizational restructuring.

(c) The NHS financial regime should provide the right incentives for best practices which enhance quality of service and clinical productivity, e.g. rewarding quality practice under the quality and outcomes framework.

(d) The NHS financial regime should have relevant reporting arrangements to ensure transparency and comparability among the NHS organizations' financial performances. More transparent financial reporting could lead to early identification of any financial problems of the NHS organizations and prompt reaction to the problems.

[81] National Audit Office and the Audit Commission (2006), p.10 and Department of Health (2006d), pp.19-20.

Chapter 4 – Taiwan

4.1 Background

4.1.1 The development of the modern Taiwanese health care system started in the mid-nineteenth century. Between 1865 and 1895, British and Canadian missionary doctors took the lead to develop the Western medical practice in Taiwan. During the Japanese occupation between 1895 and 1945, the Japanese government introduced more varieties of health care services, in particular public health services, in order to attract Japanese to settle in Taiwan. In the aftermath of the Second World War, health care development slowed down in the following two decades. Accompanying with the economic prosperity, the health care system has been expanding since 1972.[82]

4.1.2 In order to minimize individual risk of bearing high health care cost, public health insurance programmes were created from 1950 to the mid-1990s, and most of them were employment-related, e.g. Government Employee's Insurance and Farmer's Insurance. Up to February 1995, there were 10 such programmes covering approximately 59% of the population.[83]

4.1.3 Aiming at the provision of comprehensive health insurance coverage for the whole population, the Taiwanese government launched the compulsory National Health Insurance in March 1995. The National Health Insurance has been in place since then. The National Health Insurance incorporates the health insurance coverage provided by the 10 former public health insurance programmes and further extends coverage to citizens previously not covered by health insurance, most of whom are elderly people, children, students, housewives and disabled persons.[84]

4.1.4 The National Health Insurance is administered by the Bureau of National Health Insurance of the Department of Health. The insured, employers and the government are all required to make mandatory contributions to the National Health Insurance. The Bureau of National Health Insurance contracts health care facilities to provide health care services for the insured and reimburses the health care providers from the National Health Insurance contributions.[85]

4.1.5 Since its establishment, the major challenge faced by the National Health Insurance is the imbalance between revenues and expenditures. The Bureau of National Health Insurance has adopted various measures, such as increasing premiums, to meet the challenge and more such measures are anticipated in the forthcoming reform.[86]

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82 Department of Health (2006a) pp.6-8 and Bureau of National Health Insurance (2006), pp.4-6.
83 Bureau of National Health Insurance (2006), pp.4-8 and Government Information Office (2005).
84 Ibid.
85 Bureau of National Health Insurance (2006), pp.9-12 and Government Information Office (2005).
86 Bureau of National Health Insurance (2006), pp.36-39.

4.2 Overview of health care system

Structure

4.2.1 The Department of Health of the central government has the overall responsibility for the formulation of health care policies and regulation of health care services. The Bureau of National Health Insurance of the Department is responsible for administering the National Health Insurance and contracting health care facilities to provide health care services for the insured.[87]

4.2.2 The Bureau of National Health Insurance implements the National Health Insurance programme through its six local branches, each of which covers a number of cities or counties. In addition, each of the 25 city/county governments has a health bureau which is responsible for the operation of public health centres and the advancement of health within their respective geographical areas under the guidance of the Department of Health.[88]

4.2.3 The following table presents some basic statistics about the delivery system of health care services in Taiwan.

Table 9 – Statistics on the delivery system of health care services in Taiwan in 2004

	Number	**Ratio**
Health workforce		per 10 000 population
Doctors	33 360	14.7
Dentists	9 868	4.3
Pharmaceutical personnel	26 079	11.5
Nursing personnel	101 924	44.9
Health infrastructure		
Public hospitals	90 (43 865 beds)	56 hospital beds per 10 000 population
Private hospitals	500 (83 802 beds)	
Occupancy rate of acute care beds(1)	Pending information	

Note: (1) Occupancy rate of general beds was 68.9% in 2004.
Source: *Health Statistics* (2006).

87 *Current Organization of the Department of Health* (2006) and Department of Health (2006a) p.21.
88 Ibid.

Financing

4.2.4 The guiding principles of the Taiwanese health care system are to ensure that the whole population is insured by social health insurance, i.e. the National Health Insurance, and entitled to the rights of equal access to health care services.[89]

4.2.5 The health care financing system of Taiwan is classified as one of the social health insurance systems. Under a social health insurance system, health care is predominantly funded by contributions paid on a compulsory basis. In accordance with the *National Health Insurance Act*, the insured and employers are required to make contributions to the National Health Insurance and the government is required to pay premiums for some of the insured.[90]

4.2.6 Patients are required to make a co-payment for health care services they consume. For out-patient services, the co-payment for each visit is between NT$50(HK$12) and NT$450(HK$107), depending on the type of institutions they visit and services they use. For in-patient services, the co-payment for each hospital stay is between 5% and 30% of the cost, depending on the type of wards they stay in and the duration of hospitalization.[91]

4.2.7 In order to protect Taiwanese from bearing a significant amount of co-payments and prevent the co-payment system from deterring patients from seeking necessary health care services, co-payment ceilings for hospital care and exemptions from co-payments for certain groups (e.g. low-income families) are prescribed by law.[92]

4.2.8 The following table presents some basic information about expenditure on health services of Taiwan in 2004, which may serve as indicators on health expenditure.

[89] Bureau of National Health Insurance (2006), p.8 and pp.11-12.
[90] Bureau of National Health Insurance (2006), p.13 and Chapter Three of the *National Health Insurance Act*.
[91] Bureau of National Health Insurance (2006), pp.16-17.
[92] Bureau of National Health Insurance (2006), pp.17-18.

Table 10 – Health expenditure indicators of Taiwan in 2004

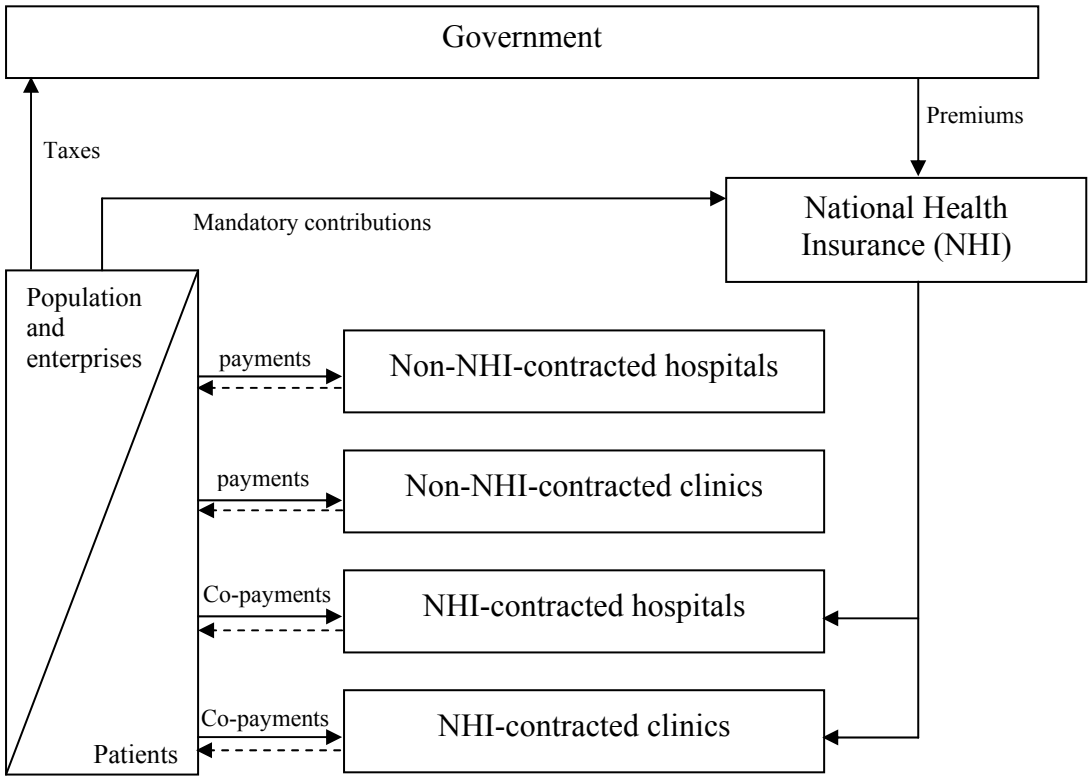
Total expenditure on health as % of GDP	6.3%
Per capita total expenditure on health	NT$25,948 (HK$6,183)
General government expenditure on health as % of total expenditure on health	64.4%
Non-government expenditure on health as % of total expenditure on health	35.6%
General government expenditure on health as % of total general government expenditure	18%
Health insurance coverage as % of total population	99%[1]

Note: (1) One percent of the population is temporarily not covered by the National Health Insurance because of various reasons, such as staying abroad and in transition of jobs.

Sources: Department of Health (2006b), *National Health Accounts Indicators* (2006), *National Health Insurance Key Statistics* (2006) and Wang (2005).

4.2.9 Chart 3 summarizes the financing and delivery system of health care services in Taiwan.

Chart 3 – Health care system of Taiwan



Legend: ⟶ Financial flows ----▸ Service flows

Sources: Bureau of National Health Insurance (2005a), Bureau of National Health Insurance (2006), Government Information Office (2005) and *Department of Health* (2006).

4.3 Collection mechanism of health care resources

4.3.1 Apart from out-of-pocket payments and donations from charity organizations, health care resources are mainly pooled through the following ways:

(a) the National Health Insurance; and

(b) general taxation;

National Health Insurance

4.3.2 The social health insurance system of Taiwan, i.e. the National Health Insurance, has been running since 1995. The collection mechanism of the National Health Insurance can be examined in respect of the following two components:

(a) sources of fund; and

(b) collection of fund.

Sources of fund

4.3.3 The insured, employers and the government all contribute to the National Health Insurance. For premium calculation purposes, the insured are roughly divided into two types, i.e. the income-earners and the non-income-earners. Each type of the insured is subdivided into three categories and each category may be subdivided further into sub-categories. The types and categories as well as their relevant shares of the insured are presented in the following table.

Table 11 – Types and categories of the insured of the National Health Insurance

Income-earners	
Category 1 (53.2% of the insured(1))	
Sub-category 1	Civil servants and full-time and regularly-paid personnel in governmental agencies and public/private schools
Sub-category 2	Employees of publicly- and privately-owned enterprises and institutions
Sub-category 3	Employees employed by particular employers other than sub-categories 1 and 2
Sub-category 4	Employers and self-employed owners of business
Sub-category 5	Independently practicing professionals and technicians
Category 2 (16.7% of the insured)	
Sub-category 1	Members of an occupational union who have no particular employers or who are self-employed
Sub-category 2	Seamen serving on foreign vessels, who are members of the National Seamen's Union and the Master Mariners′ Association
Category 3 (14.5% of the insured)	
Sub-category 1	Members of the Farmers Association and the Irrigation Association, and workers aged over 15 who are engaged in agricultural activities
Sub-category 2	Members of the Fishers Association who are either self-employed or have no particular employers, and workers aged over 15 who are engaged in fishery activities
Non-income-earners	
Category 4 (not available)(2)	Compulsory military servicemen, military school students, dependents of military servicemen, surviving dependents of deceased servicemen and social servicemen
Category 5 (0.9% of the insured)	Members of low-income families as defined by the Social Support Law
Category 6 (14.7% of the insured)	
Sub-category 1	Veterans and survivors of veterans
Sub-category 2	Persons other than the insured or their dependents as prescribed in categories 1 to 5 and sub-category 1 of category 6

Notes: (1) The percentage share of each category of the insured is 2004 figure.
(2) According to the Bureau of National Health Insurance, the calculation of the shares of the insured does not include category 4 because statistics of this category relates to national defense secret.

Sources: *National Health Insurance Act*, Bureau of National Health Insurance (2005b) and Bureau of National Health Insurance (2006).

4.3.4 The premiums paid by the insured, employers and the government to the National Health Insurance are derived from the formulas as listed in the following table.

Table 12 – Formulas for the calculation of premium for the National Health Insurance

Income-earners	
Premium of the insured	insurable monthly income(1) × premium rate(2) × contribution rate(3) × (1 + number of dependents(4))
Premium of the employer	insurable monthly income × premium rate × contribution rate × (1 + average number of dependents(5))
Premium of the government	
Non-income-earners	
Premium of the insured	Mean premium(6) × contribution rate × (1 + number of dependents)
Premium of the government	Mean premium × contribution rate × number of the insured(7)

Notes: (1) Based on the amount of monthly income, the insured in categories 1 and 2 are grouped into 47 grades. Each grade represents an insurable monthly income of the insured who earn a monthly income within a certain range. For example, grade 1 includes the insured who earn a monthly income of NT$15,840(HK$3,767) and below and the insurable monthly income of this group is NT$15,840(HK$3,767). Grade 47 includes the insured who earn a monthly income of NT$126,301(HK$30,030) and above and the insurable monthly income of this group is NT$131,700(HK$31,357). For the insured in category 3, the insurable monthly income is set at NT$19,200(HK$4,571).

(2) Since September 2002, the premium rate has been set at 4.55%.

(3) The contribution rates of the insured, employers and the government vary from category to category. For example, for employees of publicly- or privately-owned enterprises and institutions, the contribution rates of employees, employers and the government are 30%, 60% and 10% respectively. For the unemployed and veterans, the government pays 100% of the premium. For employers, self-employed owners of business and independently practicing professionals and technicians, they pay 100% of the premium.

(4) Dependents of the insured include spouse, parents, children, grandparents and grandchildren. The maximum number of dependents applicable to the formulas is three even if the number of dependents exceeds three.

(5) Since January 2001, the average number of dependents has been set at 0.78.

(6) Since July 1998, the mean premium has been set at NT$1,007(HK$240).

(7) The number of persons whose premiums are paid by the government.

Sources: *National Health Insurance Act* and Bureau of National Health Insurance (2006).

4.3.5 Utilizing the above formulas, the monthly premium of an employee who works in a privately-owned enterprise and has four dependents is NT$1,763(HK$420) if he/she belongs to grade 1, and NT$14,658(HK$3,490) if he/she belongs to grade 47. The respective shares of premiums paid by the grade 1 employee, employer and the government are NT$865(HK$206), NT$770(HK$183) and NT$128(HK$31). For the grade 47 employee, the corresponding shares are NT$7,191(HK$1,712), NT$6,400(HK$1,524) and NT$1,067(HK$254).

4.3.6 Based on the above formulas, the total premiums collected in 2004 accounted for 97% of the total revenue of the National Health Insurance. The shares of premiums receivable among the insured, employers and the government in 2004 were 38.1%, 35.5% and 26.4% respectively.[93]

4.3.7 Apart from premiums, the National Health Insurance has two other funding sources, i.e. the health and welfare surcharge and public welfare lottery income. Since 2002, a health and welfare surcharge has been imposed on tobacco products.[94] In accordance with Article 22 of the *Tobacco and Alcohol Tax Act*, 90% of the surcharge collected should be allocated to the National Health Insurance. In 2004, 1.9% of the total revenue of the National Health Insurance came from this source.[95]

4.3.8 Since 2000, 5% of the surplus of the public welfare lottery income has been allocated to the National Health Insurance. In 2004, 0.4% of the total revenue of the National Health Insurance came from this source.[96]

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93 Bureau of National Health Insurance (2005b), p.4.

94 The rates of surcharge on different tobacco products are as follows:
(a) Cigarettes: NT$500(HK$119) per 1,000 sticks;
(b) Cut tobacco: NT$500(HK$119) per kilogram;
(c) Cigars: NT$500(HK$119) per kilogram; and
(d) Other tobacco products: NT$500(HK$119) per kilogram.

95 Article 64 of the *National Health Insurance Act*, Article 22 of the *Tobacco and Alcohol Tax Act*, *Regulation of the Distribution*, *Utilization of the Health and Welfare Surcharge on Tobacco Products* and Bureau of National Health Insurance (2005b), pp.124-125.

96 Article 65 of the *National Health Insurance Act*, Article 6 of the *Public Welfare Lottery Act*, Bureau of National Health Insurance (2005b), pp.124-125 and《全民健康保險法修正草案總說明》.

Collection of fund

4.3.9 The Bureau of National Health Insurance collects premiums from the insured, employers and the government. For category 1 persons, employers are required by law to deduct employees' shares of premiums from their monthly wages and pay the employers' and employees' shares of premiums to the Bureau each month. For categories 2, 3 and 6, the insured pay their monthly premiums to the Bureau via designated associations, e.g. occupational unions or farmers' association. For category 5, the government pays monthly premiums to the Bureau. For premiums of category 4 and all other categories, the government pays to the Bureau on a biannual basis.[97]

4.3.10 The Ministry of Finance is responsible for collecting the health and welfare surcharge and public welfare lottery income and transferring them to the National Health Insurance.

General taxation

4.3.11 The government's financial support for health care comes from its general revenue which relies on income, business and commodity taxes. In the financial year 2004, 61.2% of the general revenue came from income, business and commodity taxes and the proportion of these three types of taxes were 32.9%, 16.8% and 11.5% respectively.[98]

4.4 Allocation mechanism of health care resources

4.4.1 Health care resources are kept by the government and the National Health Insurance accounts, depending upon the means through which they are collected. Accordingly, these health care resources are allocated through the following mechanisms to health care providers:

(a) National Health Insurance; and

(b) government budget.

[97] Bureau of National Health Insurance (2006), p.12 and Article 29 of the *National Health Insurance Act*.

[98] *Yearbook of Tax Statistics 2004*.

National Health Insurance

4.4.2 The design of the allocation mechanism of health care resources under the National Health Insurance is based on the concept of global budget. According to the World Health Organization, the term "global budget" means an aggregate cash sum, fixed in advance, intended to cover the total cost of a health care service, usually for one year ahead.[99]

4.4.3 The annual global budgeting process of the National Health Insurance involves the following steps:[100]

(a) Setting the expenditure limits;

(b) Allocating funding; and

(c) Contracting health care services

Setting the expenditure limits

4.4.4 In accordance with Article 47 of the *National Health Insurance Act*, the Department of Health must estimate the range of the total amount of health care expenditure of the National Health Insurance for a financial year six months before the start of that financial year. The estimates are then submitted to the Executive Yuan for approval. The approved range of health care expenditure becomes the expenditure limits for that particular financial year.

4.4.5 The Department of Health takes the following factors into consideration when preparing the estimates:[101]

(a) Previous years' health care expenditure pattern: the health care expenditure pattern in the previous years provides a base for setting the expenditure limits; and

(b) Anticipated expenditure growth factors: factors that lead to the growth of health care expenditure include:

[99] Regional Office for the Western Pacific, World Health Organization (2005), pp.34-35, *Regional Office for Europe*, *World Health Organization* (2006) and *Department of Health* (2006).

[100] *Department of Health* (2006).

[101] *National Health Insurance Act*, *Department of Health* (2006), *Bureau of National Health Insurance* (2006)，全民健康保險醫療費用協定委員會 (2005) and 全民健康保險醫療費用協定委員會 (2006).

(i) Changes in the volume and pattern of utilization of health care services, e.g. number and demographic changes of the insured and changes in treatment methodology;

(ii) Changes in benefit packages, e.g. introduction of new benefit items and widening of the payment scope of an existing benefit item;

(iii) Introduction of new measures that improve quality as well as effectiveness of health care services; and

(iv) Others, e.g. anticipated changes in laws and regulations that have financial implication on the National Health Insurance.

Allocating funding

4.4.6 In accordance with Article 49 of the *National Health Insurance Act*, the Department of Health must present the approved range of health care expenditure for a particular financial year to the National Health Insurance Medical Expenditure Negotiation Committee for discussion. The Committee will deliberate and try to reach an agreement on the allocation of funding among health care services and among regions for that particular financial year three months before the start of the financial year and report to the Department of Health for approval. In the case that the Committee cannot reach an agreement on the allocation of funding for that financial year on time, the Department of Health is authorized to decide on its own.[102]

4.4.7 The National Health Insurance Medical Expenditure Negotiation Committee is established in accordance with Article 48 of the *National Health Insurance Act*. Members of the Committee come from three sectors, representing health care providers, premium payers and academics as well as the relevant government departments. Each sector has nine representatives and most of the representatives of the first two sectors are recommended by the relevant organizations, such as doctors' associations and trade unions, and appointed by the Department of Health.[103]

[102] 全民健康保險醫療費用協定委員會 (2005) and 全民健康保險醫療費用協定委員會 (2006).

[103] Ibid.

4.4.8 In exceptional and unanticipated circumstances, e.g. the outbreak of SARS and the global budget being not able to cover the health care cost, the Committee may recommend to the Department of Health that the expenditure limits should be changed. If the Department of Health accepts the recommendation of the Committee, it will seek the Executive Yuan's approval.[104]

Contracting health care services

4.4.9 After the funding has been allocated, the Bureau of National Health Insurance is responsible for contracting health care facilities to deliver a wide range of health care services for the insured, including in-patient, out-patient, dental and pharmaceutical services.[105] As at June 2005, 98% of the hospitals in Taiwan were contracted by the Bureau, and the corresponding percentages for clinics and dental clinics were 86% and 95% respectively.[106]

Government budget

4.4.10 Since the National Health Insurance takes up the major responsibility in allocating health care resources to the health care providers, the government budget for direct health care services is mainly for health care services not covered by the National Health Insurance, e.g. immunization.[107]

4.5 Distribution of health care resources

Statistical profile

4.5.1 The following table shows the distribution of health care resources by area of expenditure in 2004.

[104] 全民健康保險醫療費用協定委員會(2005)，全民健康保險醫療費用協定委員會(2006) and Department of Health (2006b) p.5.

[105] Article 39 of the *National Health Insurance Act* stipulates a list of health care services not covered by the National Health Insurance, such as immunization delivered by the government, cosmetic surgery and non-prescription medicines.

[106] Bureau of National Health Insurance (2006) p.13.

[107] Article 39 of the *National Health Insurance Act* and Department of Health (2006b) p.5.

Table 13 – Distribution of health expenditure by area of expenditure of Taiwan in 2004

Area of expenditure	2004
Public health	4.3%
General administration	2.3%
Capital formation	4.2%
Personal health care	
Hospitals	41%
Clinics(1)	29%
Other speciality institutions(2)	5.3%
Pharmaceutical items(3)	11.1%
Medical equipment and instruments for personal use	2.8%
Total	100%

Notes: (1) Including Western-medicine clinics, Chinese-medicine clinics and dental clinics.
(2) For example, psychiatric institutions and long-term care institutions.
(3) Mainly pharmaceutical items not covered by the National Health Insurance.

Source: Department of Health (2006b), Table 4.

4.5.2 The following table presents the share of funding sources for selected types of health care services in 2004.

Table 14 – Share of funding sources for selected types of health care services of Taiwan in 2004

	Public funding source		Private funding source	Total
	National Health Insurance	Government	Out-of-pocket	
Hospitals	90.2%	0.02%	9.8%	100%
Clinics	54.2%	0%	45.8%	100%
Pharmaceutical items	12%	0%	88%	100%
Medical equipment and instruments for personal use	0%	0%	100%	100%

Source: Department of Health (2006b), Table 4.

Co-payment for health care services

4.5.3 Under the National Health Insurance system, patients are required to make co-payments for health care services they consume. The co-payment schedule for health care services is presented in the following table.

Table 15 – Co-payment schedule for health care services delivered by contracted health care facilities in Taiwan

Out-patient services			
Western-medicine [1]	**Out-patient services**		**Emergency services**
	Without referral	**With referral**	
Academic medical centres	NT$360(HK$86)	NT$210(HK$50)	NT$450(HK$107)
Regional hospitals	NT$240(HK$57)	NT$140(HK$33)	NT$300(HK$71)
District hospitals	NT$80(HK$19)	NT$50(HK$12)	NT$150(HK$36)
Clinics	NT$50(HK$12)	NT$50(HK$12)	NT$150(HK$36)
Chinese-medicine and dental out-patient services			
Chinese-medicine hospitals and clinics and dental clinics			NT$50(HK$12)
For each out-patient service, there is no co-payment for prescription medicines worth NT$100(HK$24) and below. A co-payment of NT$20(HK$4.8) is charged for every extra NT$100(HK$24) worth of prescription medicines, with a co-payment ceiling of NT$200(HK$48).			
In-patient services			
	5% of the cost	10% of the cost	20% of the cost	30% of the cost
Acute wards	——	30 days or less	31-60 days	61 days or more
Chronic wards	30 days or less	31-90 days	91-180 days	181 days or more
A co-payment ceiling is set in order to reduce the financial burden of patients. Since 2005, the ceiling has been set at NT$24,000(HK$5,722) for each hospital stay for the same condition, with an annual cumulative ceiling of NT$41,000(HK$9,776).				

Note: (1) The variation of co-payment levels for Western-medicine services at different types of institutions aims at encouraging patients to use an appropriate level of health care facilities.

Source: Bureau of National Health Insurance (2006).

4.5.4 In addition to the co-payment ceiling, co-payment exemptions are applied to specific groups of patients, e.g. patients of occupational diseases and injuries and patients from mountainous areas and on offshore islands. All these arrangements aim at ensuring that patients will not be deterred from receiving essential health care services.[108]

[108] Article 36 of the *National Health Insurance Act* and Bureau of National Health Insurance (2006) pp.17-18.

4.6 Policy evaluation

4.6.1 After more than a decade of operation, the National Health Insurance has attained the following major achievements[109]:

(a) Universal enrolment: Almost all of the population is enrolled with the National Health Insurance.

(b) Comprehensive coverage: The National Health Insurance provides a comprehensive range of health care services for the insured.

(c) Easy access: Patients have easy access to health care services because most of the health care facilities are contracted by the Bureau of National Health Insurance to deliver services.

(d) Affordable cost: The co-payment for health care services is maintained at an affordable level because the aim of co-payments is to promote the reasonable use of health care resources. Furthermore, measures are in place to assist those who cannot afford the co-payment.

(e) High satisfaction: The satisfaction rate of the general public to the National Health Insurance started with 39% in 1995. The satisfaction rate had increased gradually to 78.5% in mid-2002. With the increase in the premium and co-payment levels, the satisfaction rate dropped to 59.7% at the end of 2002. Since 2003, the satisfaction rate has rebounded and remained at the 70% level, recording a peak of 78.6% in 2004.

4.6.2 The major challenge faced by the National Health Insurance since its establishment is to achieve financial balance. The National Health Insurance operates according to the principle of balanced budget, meaning that revenues must cover health care expenses. However, the National Health Insurance recorded deficits between 1997 and 2004. Another indicator of the financial imbalance is that cost outgrows revenue. For instance, the average growth rate of insurance costs (medical fees plus other financial costs) (5.9%) was higher than the average growth rate of insurance revenues (4.8%) between 1995 and 2004.[110]

[109] Bureau of National Health Insurance (2006) and Wang (2005).

[110] Bureau of National Health Insurance (2005b) p.92, Bureau of National Health Insurance (2006) pp.36-39 and 中央健康保險局 (2006) pp.103-104.

4.6.3 The Bureau of National Health Insurance has used the reserve fund to cover the financial discrepancies. At the same time, the Bureau has adopted the following measures to increase revenues and reduce costs of the National Health Insurance[111]:

(a) Global budgeting was introduced in 1998 to control cost;

(b) Since 2001, payments to health care providers would decrease by a sliding scale if the pre-determined limits on the "reasonable" number of patients treated have been exceeded;

(c) The insurance premium was raised from 4.25% of assessable income to 4.55% in 2002; and

(d) Co-payments for certain types of visits, medicine and in-patient services were also increased in 2002.

4.6.4 Building upon the achievements and taking the challenge into consideration, the government is formulating measures to improve the organizational efficiency, equity in funding and service quality of the National Health Insurance system. With regard to equity in funding of the National Health Insurance, there is a proposal to simplify the premium calculation method. Under the new method, the calculation of premiums for the insured is based on household income and the calculation of premiums of the employers and the government is based on a single rate. The suggested measures have been included in the *National Health Insurance Act* amendment bill promulgated in May 2006.[112]

[111] Bureau of National Health Insurance (2004) p.39, Bureau of National Health Insurance (2006) p.19 and pp.36-39 and Cheng (2003).

[112] 《邁向權責相符的健保制度:規劃概述》,《二代健保政策說明》 and 《全民健康保險法修正草案總說明》.

Chapter 5 – Analysis

5.1 Introduction

5.1.1 This chapter provides a comparative analysis of the health care financing policies of Canada, England of the UK and Taiwan. The aim of the comparative analysis is to identify the distinct features of the selected systems. To facilitate Members' consideration of the issues, the situation of Hong Kong is also covered in this chapter.

5.2 Background on the development of health care financing policies

5.2.1 England and Canada institutionalized the current tax-based health care financing system in 1948 and 1966 respectively. In 1995, Taiwan established the current social health insurance system.

5.2.2 Although both Canada and England have adopted the tax-based financing system, their respective ways of financing health care services are different. Canada differentiates health care services into two distinct categories, i.e. health care services stipulated by the *Canada Health Act* as insured health care services and health care services not stipulated as insured health care services. The former category, which covers all the medically necessary services, is fully publicly-funded, and private health insurance coverage is prohibited or discouraged. The latter category is largely privately-funded by health insurance and/or out-of-pocket payments.

5.2.3 In England, public monies are used to fund a wide range of health care services provided by general practitioners, dentists, pharmacists and ophthalmic practitioners. Since there is no legal or policy restriction on the types of services covered by health insurance, health insurance companies provide supplementary medical plans, covering health care services similar to the public sector. Under these supplementary medical plans, patients benefit from the timeliness of health care services offered by private health care facilities.

5.2.4 In 1995, the Taiwanese government consolidated the then existing employment-related public health insurance schemes into the newly established social health insurance system, i.e. the National Health Insurance. In accordance with the *National Health Insurance Act*, the insured, employers and the government are all required to make contributions to the National Health Insurance. The Bureau of National Health Insurance contracts health care facilities to provide a wide range of health care services for the insured.

5.2.5 Owing to the increasing financial pressure in funding health care, all the selected places have taken actions to ease the pressure. In Canada, a public inquiry was conducted for bringing out proposals to address the sustainability issue of the Canadian health care system in the early 2000s. In England, the health care system is undergoing reforms according to a 10-year plan, with the objective of ensuring the efficient use of health care resources. In Taiwan, various measures such as increasing premiums have been adopted to meet the challenge of financial imbalance of the National Health Insurance.

5.2.6 In Hong Kong, while the Government had been providing only simple public health care services prior to the 1960s, there were significant changes, essentially expansion in services provided, following the publication of two policy papers, i.e. *The Development of Medical Services in Hong Kong* and *The Further Development of Medical and Health Services in Hong Kong*, in 1964 and 1974 respectively. The expansion in the provision of health care services inevitably required higher public expenditure on health care, and thus a tax-based health care financing system was formed in the late 1970s.[113]

5.2.7 Over the years, the health care system has more or less continued to expand in Hong Kong, amidst the establishment of the Hospital Authority[114] in 1990 and the mounting financial pressure faced by the system. Since the financial year 2001-2002, the Hospital Authority has remained in financial deficit.[115]

5.2.8 In order to address the issue of financial sustainability of the health care system in Hong Kong, the Hospital Authority has introduced reform measures since the 1990s, with the intention of re-engineering the health care delivery system and improving the financial sustainability of the health care system. In addition, the Government has initiated several rounds of policy discussions on health care financing, aiming at finding a sustainable health care financing framework for Hong Kong.

5.3 Health care system

Structure

5.3.1 In England and Taiwan, the Department of Health has the overall responsibility for the formulation of health care policies. In Canada, although the Constitution gives the provincial governments the primary jurisdiction over health care, it does not preclude the federal government from involving in health care. As such, there are forums for senior health officials of the federal and provincial governments to discuss health care policies and come up with policy proposals.

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[113] Gauld and Gould (2002), pp.45-47 and Grant and Yuen (1998), pp.168-172.

[114] The Hospital Authority is a statutory organization responsible for delivering and co-ordinating public health care services in Hong Kong.

[115] *Hospital Authority Annual Plan 2006-07*, p.18.

5.3.2 In all the selected places, designated authorities are responsible for the delivery of public health care services. In Canada, the provincial governments delegate the power to statutory regional structures, in particular the regional health authorities, to organize or deliver health care services within their respective regions. In England, several types of statutory organizations, in particular strategic health authorities and primary care trusts, are responsible for providing or ensuring the provision of health care services in their respective geographical areas. In Taiwan, the Bureau of National Health Insurance is responsible for contracting health care facilities to deliver health care services for the insured.

5.3.3 While all the selected places have adopted a dual system in which both public and private facilities are involved in the delivery of health care services, the respective degrees of public and private involvement in the provision of primary health care services and secondary and tertiary health care services are different. In all the selected places, almost all primary health care services are delivered by private medical practitioners. Primary health care services provided by private medical practitioners in Canada and England are fully subsidized by public monies whereas they are partly financed by co-payments in Taiwan. Among the selected places, privately-owned hospitals in Canada and Taiwan and publicly-owned hospitals in England provide a major or substantial portion of hospital services. The occupancy rates of acute care beds in Canada in 2003 and England in 2002 were 87% and 85.3% respectively.[116] In Hong Kong, the occupancy rate of general hospital beds (acute and convalescent beds) in the financial year 2002-2003 was 82.4%.[117]

5.3.4 The Health, Welfare and Food Bureau assumes the overall responsibility for policy formulation and resource allocation in health care in Hong Kong.[118] The Hospital Authority takes the leading role in providing public health care services. The Hospital Authority provides primary, secondary and tertiary health care services through public hospitals, specialist out-patient clinics and general out-patient clinics throughout Hong Kong.[119]

5.3.5 The public and private mix of primary health care services in Hong Kong is different from the selected places. While almost all primary health care services in the selected places are provided by private medical practitioners, the percentage for Hong Kong is 72%. In Hong Kong, public hospitals provide 82% of secondary and tertiary health care services, which is similar to the situation in England.[120]

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[116] The occupancy rate of general beds in Taiwan was 68.9% in 2004.

[117] Hospital Authority (2003), p.122.

[118] The Government of the Hong Kong Special Administrative Region (2006c).

[119] There were 41 public hospitals, 45 specialist out-patient clinics and 74 general out-patient clinics in the Hospital Authority's portfolio at the end of 2004. Information Services Department (2005b).

[120] Health, Welfare and Food Bureau (2005).

Guiding principles

5.3.6 The philosophical basis of the guiding principles of health care policies in the selected places all emphasizes collective responsibility to ensure citizens' access to health care services.

5.3.7 The philosophical basis of the guiding principles of the health care policies adopted in Hong Kong is similar to that of the selected places. According to *Hong Kong 2004*, *"One of the cornerstones of the Government's health care policies is that no one should be denied adequate medical treatment through lack of means."*[121]

5.4 Health care resource collection mechanism

5.4.1 Apart from out-of-pocket payments and donations from charity organizations, all the selected places use general taxation and health insurance plans to pool health care resources. In addition to the above common means of pooling health care resources, some of the selected places have their own specific means to pool health care resources, i.e. the National Insurance Scheme in England and health and welfare surcharge and public welfare lottery income in Taiwan.

General taxation

5.4.2 The general government expenditures on health as a percentage of the total expenditure on health in Canada, the UK and Taiwan are some 70%, 83% and 64% respectively. Most of the public expenditures on health in the selected places come similarly from general taxation, depending heavily on income tax, corporate tax and goods and services tax.

5.4.3 In Hong Kong, health care resources are mostly derived from general taxation which depends heavily on earnings and profits taxes. In the financial year 2005-2006, earnings and profits taxes account for 80% of the internal revenue[122] or 56% of all government revenue. At present, the public health care services that Hong Kong people enjoy is rested on a narrow tax base and a low tax rate. Some academics have commented that the health care system would not be sustainable if the present low-tax, high-subsidy and high-quality policy is to be continued in Hong Kong.[123]

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[121] The Government of the Hong Kong Special Administrative Region (2006c).

[122] Internal revenue is a category of government revenue, comprising the following taxes and duties:
(a) bets and sweeps tax;
(b) earnings and profits tax;
(c) estate duty;
(d) hotel accommodation tax;
(e) stamp duties; and
(f) air passenger departure tax.

[123] Health, Welfare and Food Bureau (2005) and Health and Medical Development Advisory Committee (2005a).

Designated means

National Insurance Scheme

5.4.4 In England, employers, employees and self-employed persons are required to make mandatory contributions to the National Insurance Scheme. Since its establishment, the contributions of the scheme have been used for paying unemployment benefits, sickness benefits and retirement pensions as well as funding the NHS.

Health and welfare surcharge

5.4.5 In Taiwan, a health and welfare surcharge has been imposed on tobacco products since 2002 and 90% of the surcharge collected is allocated to the National Health Insurance for financing public health care services.

Public welfare lottery income

5.4.6 In Taiwan, 5% of the surplus of the public welfare lottery income has been allocated to the National Health Insurance since 2000.

Situation in Hong Kong

5.4.7 At present, Hong Kong has no designated health-related insurance contributions or surcharge to supplement general revenue in funding public health care services. The Government has been considering the feasibility of introducing a medical savings account system. In 2000, the Government proposed in the *Lifelong Investment in Health* paper to study the feasibility of establishing Health Protection Accounts in Hong Kong. Consequently, the Health Care Financing Study Group, a study group consisting of academics, medical and other professionals, staff of the Hospital Authority and government officials, was formed under the Health, Welfare and Food Bureau. In 2004, the study group completed a research entitled *A Study on Health Care Financing and Feasibility of a Medical Savings Scheme in Hong Kong*. The study concludes that it is feasible to introduce a medical savings scheme in Hong Kong.[124]

[124] Health, Welfare and Food Bureau (2004), p.53 and Medical Development Advisory Committee (2005a).

Health insurance plans

5.4.8 Being regulated by government policies, private health insurance plays different roles in the selected places. In Canada, the coverage of private health insurance is restricted to health care services not stipulated by the *Canada Health Act* as insured health care services, e.g. dental care, prescription medicines and vision care. In England, the government regulation of health insurance focuses on consumer protection, and health insurance companies mainly provide supplementary medical plans which reimburse the insured for surgeries and other treatments by private hospitals and private specialists. In both Canada and England, there are no enumerated government policies for encouraging the public to take out private health insurance. Since Taiwan has a universal social health insurance system, private health insurance plays a negligible role there.

5.4.9 In Taiwan, the National Health Insurance pools health care resources (premiums) from the insured, employers and the government. For premium calculation purposes, the insured are roughly divided into two types, i.e. income-earners and non-income-earners. For income-earners, the calculation of premiums is largely based on the amount of monthly income, and the premiums in certain categories of the insured are contributed jointly by the insured, employers and the government. For non-income-earners, the premiums are mostly borne by the government.

5.4.10 In Hong Kong, the Office of the Commissioner of Insurance under the Financial Services and the Treasury Bureau is responsible for the regulation and supervision of the health insurance industry.[125] At present, the Government does not have an enumerated policy for encouraging the public to take out medical insurance policies. Nevertheless, the Government states that it may consider providing a tax deduction for contributions to private medical insurance schemes.[126]

5.5 Health care resource allocation mechanism

5.5.1 Government budget and health insurance plans are means used, though not to the same extent, by all the selected places and Hong Kong for allocating health care resources.

[125] Office of the Commissioner of Insurance Annual Report (2005).

[126] Government of the Hong Kong Special Administrative Region (2006b) and Government of the Hong Kong Special Administrative Region (2006e).

Government budget

5.5.2 The selected places allocate funding to health providers via different channels. In Canada, the federal government transfer payments, on a per capita basis, to the provincial governments in support of the provision of health care services. The provincial governments allocate public monies to the regional health authorities mostly by the population-based funding method or the historically-based global budget. The regional health authorities utilize the allocated budget to provide or purchase an array of health care services in their respective geographical areas.

5.5.3 In England, the government has adopted a weighted capitation formula to allocate health care resources to various primary care trusts. According to the formula, the share of funding of each primary care trust is determined by the size of the population and weighted for age-related need, additional need and cost of providing health care services. Primary care trusts, in turn, allocate health care resources to their own health care facilities or utilize the resources to commission services from other providers such as NHS trust hospitals and general practitioners.

5.5.4 In Taiwan, the design of the allocation mechanism of health care resources under the National Health Insurance is based on the concept of global budget, providing an aggregate cash sum, fixed in advance, to cover the cost of health care services, usually for one year ahead. In addition, the government allocates resources directly to service providers for the provision of health care services not covered by the National Health Insurance, e.g. immunization.

5.5.5 In Taiwan, the annual global budgeting process of the National Health Insurance starts with the Department of Health's estimation of the range of the total amount of health care expenditure for the National Health Insurance in a financial year. The estimation considers previous years' health care expenditure pattern and anticipated expenditure growth factors such as number and demographic changes of the insured. After the Executive Yuan has approved the Department of Health's estimation, the National Health Insurance Medical Expenditure Negotiation Committee, represented by health care providers, premium payers and academics as well as the relevant government departments, negotiates the allocation of the approved budget among health care services and among regions. According to the allocation agreement, the Bureau of National Health Insurance contracts health care facilities to deliver a wide range of health care services for the insured.

5.5.6 In Hong Kong, the Government allocates health care resources to the Hospital Authority to provide all levels of public health services for people of Hong Kong through the Hospital Authority's health care institutions.

Health insurance plans

5.5.7 In Canada, England and Hong Kong, health insurance companies allocate resources to health care providers by means of reimbursement of claims. The insured can make claims to the health insurance companies for the medical expenses paid. Based on the terms and conditions of insurance policies, health insurance companies reimburse money to the insured. In the case where the medical institutions have made arrangements with the health insurance companies, the medical institutions can make claims directly to the health insurance companies for the medical expenses allowed in the insurance policies.

5.6 Health care resource distribution

5.6.1 The following table compares health expenditure indicators of Canada, the UK, Taiwan and Hong Kong.

Table 16 – Health expenditure indicators of selected places

	Canada (2003)	United Kingdom (2002)	Taiwan (2004)	Hong Kong (2003)
Total expenditure on health as % of GDP	10.1%	7.7%	6.3%	5.4%
Per capita total expenditure on health in HK$	27,165	16,795	6,183	9,680
General government expenditure on health as % of total expenditure on health	70.2%	83.4%	64.4%	52.4%
Non-government expenditure on health as % of total expenditure on health	29.8%	16.6%	35.6%	47.6%
General government expenditure on health as % of total general government expenditure	10%	15.4%	18%	12.4 %
Health insurance coverage as % of total population	Pending information	11.4%	99%	26.4%

Sources: Canada, the United Kingdom and Taiwan figures from Tables 2, 6 and 10 of this paper respectively; and Hong Kong figures from Regional Office for the Western Pacific, World Health Organization (2005).

5.6.2 Canadians are eligible for receiving insured health care services in not-for-profit hospitals free of charge, and are seldom treated as private patients at not-for-profit hospitals. In England, people are eligible for receiving public hospital services free of charge if they do not choose doctors in receiving treatment. They may choose to be treated as private patients in public hospitals. In such case, patients resort to either out-of-pocket payments or health insurance plans, or a combination of them to cover the hospital expenses.

5.6.3 Under the National Health Insurance in Taiwan, patients are required to make a co-payment for hospital services they consume. The co-payment for each hospital stay is between 5% and 30% of the cost, depending on the type of wards they stay in and the duration of hospitalization. A co-payment ceiling is set in order to reduce the financial burden of patients, and co-payment exemptions are applied to specific groups of patients.

5.6.4 In Hong Kong, while public patients in public hospitals only need to pay around 3% of the medical cost, private patients in public hospitals are required to pay full cost for their treatments, including in-patient fee (covering general nursing, core pathology investigation, catering and domestic services) and in-patient consultation fee. The in-patient fee for a first-class bed in acute hospitals is HK$3,900 per day and the in-patient consultation fee per specialty is HK$550 to HK$2,250 per visit.[127]

5.6.5 Fully subsidized by public monies, both Canadians and English people receive primary health care services provided by private medical practitioners free of charge. Under the National Health Insurance in Taiwan, patients are required to make a co-payment for primary health care services they consume. The co-payment for each visit is between NT$50(HK$12) and NT$450(HK$107), depending on the type of health care facilities they visit and services they consume. Co-payment exemptions are applied to specific groups of patients.

5.6.6 In Hong Kong, primary health care services provided by private medical practitioners are not subsidized by the Government. Patients who cannot afford primary health care services offered in the private sector can use those services provided by the public sector which are subsidized by public monies.

[127] Hospital Authority (2006).

5.6.7 With regard to medicine expenses, patients of all the selected place have to pay for prescription medicines. In Canada, patients are responsible for the cost of all prescription medicines except prescription medicines provided during hospitalization. Some provincial governments establish drug plans to cover or subsidize residents on the cost of prescription medicines. In England, patients are required to pay a flat rate for each prescription. Owing to the exemptions granted to specific groups, e.g. children and low-income families, around 85% of the prescription items dispensed are free to patients. In Taiwan, the cost of prescription medicines worth NT$100(HK$24) or below is included in the medical fees and charges. A co-payment of NT$20(HK$4.8) is charged for each extra NT$100(HK$24) worth of prescription medicines, with a co-payment ceiling of NT$200(HK$48). In Hong Kong, the cost of prescription medicines is usually included in the medical fees and charges.

5.7 Policy evaluation

5.7.1 The selected systems yield some achievements and face some challenges, in particular the financial challenge which is common to all of them despite the difference in nature of being tax-based financing and social health insurance systems. All the selected places have taken actions to ensure that their respective health care systems are financially sustainable in the long-term.

5.7.2 The Canadian government set up the Commission on the Future of Health Care in Canada in 2001 to address the concern about the sustainability of the health care system. Accepting the Commission's recommendations, the federal and provincial governments agree to preserve the present tax-based system in financing health care services, i.e. the division of fully publicly-funded insured health care services as stipulated in the *Canada Health Act* and largely privately-funded health care services not stipulated as insured health care services.

5.7.3 The objective of such division of health care services is to ensure that Canadians can receive medically necessary health care services on a universal basis while achieving administrative efficiency and economy of scale. Nevertheless, developing a more unified set of insured health care services among the provinces and protecting those people who are not covered by employment-related health insurance plans on health care services not stipulated as insured health care services remain challenges to be met.

5.7.4 Starting from 2000, the health care system in England has been undergoing a 10-year reform, covering the demand-side, supply-side, system management and transactional aspects of the health care system. The achievements of the health care reform include faster access to the NHS services, enhancement of the health status of the overall population and an increasing number of people adopting healthier lifestyles.

5.7.5 In spite of the achievements, the deficit/overspending problem of the NHS organizations during the past few years, in particular among primary care trusts, has created a financial challenge for the NHS. Both the National Audit Office and the Audit Commission recommend that the NHS organizations which have achieved a balanced budget should raise awareness of and develop skills in preventing the happening of the deficit/overspending problem. They also recommend that the NHS financial regime should provide the right incentives for best practices which enhance quality of service and clinical productivity, and develop a more transparent financial reporting system which could lead to early identification of financial problems of the NHS organizations and prompt reaction to the problems.

5.7.6 After more than a decade of operation, the National Health Insurance in Taiwan has achieved universal enrolment, comprehensive coverage, easy access to services, and affordable cost to and high satisfaction of the general public. The major challenge faced by the National Health Insurance is to achieve financial balance. The Bureau of National Health Insurance has used the reserve fund to cover the financial discrepancies and adopted measures such as global budgeting and raising premiums to increase revenue and reduce cost of the National Health Insurance. New measures to improve the organizational efficiency, equity in funding and service quality of the National Health Insurance system have been included in the *National Health Insurance Act* amendment bill promulgated in May 2006.

5.7.7 In Hong Kong, the Hospital Authority has introduced various reform measures since the 1990s in order to ease the financing pressure with regard to the provision of public health care services. These measures are grouped under two broad categories, i.e. re-engineering the health care delivery system and improving the financial sustainability of the health care system.[128]

5.7.8 Reform measures to re-engineer the health care delivery system include:[129]

(a) re-organizing primary medical care to place greater emphasis on prevention, early detection and intervention of illnesses;

(b) shifting the emphasis from in-patient to ambulatory and community care;

(c) tackling both service gaps and duplications, and ensuring adequate service coverage for the territory through service networking and hospital clustering; and

(d) strengthening public/private collaboration, e.g. sharing of clinical information across the public and private sectors.

[128] *Hospital Authority Annual Plan 2006-07*, pp.2-3.
[129] *Hospital Authority Annual Plan 2006-07*, p.3.

5.7.9 Reform measures to improve the financial sustainability of the health care system include:[130]

(a) implementing enhanced productivity programmes to contain costs and increase productivity, e.g. merging services and hospitals and streamlining the Hospital Authority and its administrative structures;

(b) revamping the fees and charges to manage the service demand, e.g. inappropriate use and misuses of health care services; and

(c) supporting the Government to identify the feasible health care financing options, such as conducting willingness-to-pay surveys on the Hospital Authority service users.

5.7.10 Aiming at developing a sustainable health care financing framework for Hong Kong, the Government initiated several rounds of policy discussions on health care financing along with the publication of the following documents:[131]

(a) *Towards Better Health* (1993);

(b) *Improving Hong Kong's Health Care System: Why and for Whom?* (1999);

(c) *Lifelong Investment in Health* (2000); and

(d) *Building a Healthy Tomorrow* (2005).

[130] *Hospital Authority Annual Plan 2006-07*, pp.3-4.

[131] Health, Welfare and Food Bureau (2004) and Health and Medical Development Advisory Committee (2005a).

Chapter 6 – Conclusion

6.1 Introduction

6.1.1 This chapter tabulates the key points of the previous chapters for Members' easy reference.

Table 17 – A comparison of the health care financing policy in selected places

	Canada	England	Taiwan	Hong Kong
Policy-making and delivery of health care services				
Policy-making	• Federal government is responsible for transfer payments on health care, preventing public health risks from entering Canada, fostering medical research and ensuring access to health care services for specific groups of Canadians • Provincial governments are responsible for making policies on the administration and delivery of health care services as well as the regulation of health-related personnel, institutions and premises within their jurisdictions	• Department of Health	• Department of Health	• Health, Welfare and Food Bureau

Table 17 – A comparison of the health care financing policy in selected places (cont'd)

	Canada	England	Taiwan	Hong Kong
Policy-making and delivery of health care services (cont'd)				
Policy-making (cont'd)	• Deputy Health Ministers' Meetings and Health Ministers' Meetings offer forums for senior health officials of the federal and provincial governments to discuss health policies and come up with policy proposals for consideration at First Ministers' Meetings			
Delivery	• Provincial governments delegate the power to statutory regional structures (in particular regional health authorities) to organize or deliver health care services within their regions	• Several types of statutory organizations (in particular strategic health authorities and primary care trusts) are responsible for providing or ensuring the provision of health care services in their respective geographical areas	• Bureau of National Health Insurance is responsible for contracting health care facilities to deliver health care services for the insured	• Hospital Authority is responsible for the delivery of health care services

Table 17 – A comparison of the health care financing policy in selected places (cont'd)

	Canada	England	Taiwan	Hong Kong
Health expenditure indicators				
Total expenditure on health as % of GDP	10.1%	7.7%[1]	6.3%	5.4%
Per capita total expenditure on health in HK$	27,165	16,795[1]	6,183	9,680
General government expenditure on health as % of total expenditure on health	70.2%	83.4%[1]	64.4%	52.4%
Non-government expenditure on health as % of total expenditure on health	29.8%	16.6%[1]	35.6%	47.6%
General government expenditure on health as % of total general government expenditure	10%	15.4%[1]	18%	12.4 %
Health insurance coverage as % of total population	Pending information	11.4%[1]	99%	26.4%
Remark 1: UK figures				

Table 17 – A comparison of the health care financing policy in selected places (cont'd)

	Canada	England	Taiwan	Hong Kong
Health care financing system				
Type	• Tax-based financing system	• Tax-based financing system	• Social health insurance	• Tax-based financing system
Guiding principles	• To protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers	• To provide universal services for all people based on clinical need, not the ability to pay, because health care is a basic human right; and • To provide access to a comprehensive range of services through primary and community health care and hospital-based care	• To ensure that the whole population is insured by social health insurance, i.e. the National Health Insurance (NHI), and entitled to the rights of equal access to health care services	• One of the cornerstones of the Government's health care policies is that no one should be denied adequate medical treatment through lack of means
Funding sources	• General taxation • Health insurance plans • Out-of-pocket payments	• General taxation • National Insurance premiums • Health insurance plans • Out-of-pocket payments	• NHI premiums • Health and welfare surcharge • Public welfare lottery income • Co-payments • General taxation	• General taxation • Health insurance plans • Out-of-pocket payments
Allocation of health resources to health care providers	• Government budget • Health insurance companies • Patients	• Government budget • Health insurance companies • Patients	• NHI • Government budget • Patients • Health insurance companies	• Government budget • Health insurance companies • Patients

Table 17 – A comparison of the health care financing policy in selected places (cont'd)

	Canada	England	Taiwan	Hong Kong
Share of financial responsibility on hospital services	• Patients receive insured health care services in not-for-profit hospitals free of charge • Patients who receive health care services not stipulated as insured health care services in hospitals are responsible for covering the fees and charges by out-of-pocket payments and/or health insurance	• Public hospital services for eligible persons are free of charge unless they choose to be treated as private patients • Private patients in public and private hospitals are responsible for covering the fees and charges by out-of-pocket payments and/or health insurance	• Patients who consume NHI-contracted hospital services are required to make a co-payment between 5% and 30% of the cost • Co-payment ceiling for all patients is set and co-payment exemptions are applied to specific groups of patients • Fees and charges for non-NHI-contracted hospital services are covered by out-of-pocket payments and/or health insurance	• Individuals cover around 3% of the cost for public hospital services by out-of-pocket payments and/or health insurance • Medical safety net to assist patients with financial difficulty in paying public hospital bills • Fees and charges for private hospital services are covered by out-of-pocket payments and/or health insurance
Share of financial responsibility on primary health care services	• Fully subsidized by public monies, patients receive primary health care services provided by private medical practitioners free of charge	• Fully subsidized by public monies, patients receive primary health care services provided by private medical practitioners free of charge	• Patients make a co-payment for NHI-contracted primary health care services they consume • Co-payment exemptions are applied to specific groups of patients	• Patients pay full cost for services in the private sector • Patients who cannot afford private sector services can use subsidized public services

Table 17 – A comparison of the health care financing policy in selected places (cont'd)

	Canada	England	Taiwan	Hong Kong
Share of financial responsibility on medicines	• Patients are responsible for the cost of all prescription medicines except prescription medicines provided during hospitalization • Some provincial governments establish drug plans to cover or subsidize residents on the cost of prescription medicines	• Patients are required to pay a flat rate for each prescription • Owing to the exemptions granted to specific groups such as children and low-income families, around 85% of the prescription items dispensed are free to patients	• Cost of prescription medicines worth NT$100(HK$24) or below is included in the medical fees and charges • Co-payment of NT$20(HK$4.8) is charged for each extra NT$100(HK$24) worth of prescription medicines, with a co-payment ceiling of NT$200(HK$48)	• Patients are usually not required to make any payments for acquiring government-subsidized prescription medicines

Table 17 – A comparison of the health care financing policy in selected places (cont'd)

	Canada	England	Taiwan	Hong Kong
Policy evaluation	Policy: • maintaining the present division of fully publicly-funded insured health care services as stipulated in the *Canada Health Act* and largely privately-funded health care services not stipulated as insured health care services Achievement: • Canadians receive medically necessary health care services on a universal basis • public health care system has achieved administrative efficiency and economy of scale Challenge: • developing a more unified set of insured health care services among provinces • protecting those people who are not covered by employment-related health insurance plans on health care services not stipulated as insured health care services	Policy: • maintaining the tax-based financing system and achieving efficient use of health care resources through a 10-year reform, covering the demand-side, supply-side, system management and transactional aspects of the health care system Achievement: • faster accessibility to the NHS services • enhancement of the health status of the overall population • increasing number of people adopting healthier lifestyles Challenge: • deficit/overspending of the NHS organizations • National Audit Office and the Audit Commission recommend that the NHS financial regime should provide right incentives for best practice to enhance quality of service and clinical productivity; and develop a more transparent financial reporting system to have an early identification of the financial problems of the NHS organizations and prompt reaction to the problems	Policy: • maintaining the social health insurance and achieving financial balance of the National Health Insurance Achievement: • universal enrolment, comprehensive coverage, easy access to services, and affordable cost and high satisfaction of the general public. Challenge: • financial imbalance of the National Health Insurance • Bureau of National Health Insurance has used the reserve fund to cover the financial discrepancies and adopted measures to increase revenue and reduce cost of the National Health Insurance • New measures to improve the organizational efficiency, equity in funding and service quality of the National Health Insurance system have been included in the *National Health Insurance Act* amendment bill	Policy: • developing a sustainable health care financing framework Achievement: • Hospital Authority has introduced reform measures with the intention of enhancing efficiency and cost-effectiveness of the health care delivery system, and improving financial sustainability of the health care system Challenge: • deciding on a sustainable health care financing framework

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