INFORMATION NOTE

Health Care Financing Systems in Selected Places: Classification and Reform

1. Introduction

1.1 This information note provides information on the health care financing system adopted in 28 selected places, focusing on two particular aspects. The first aspect is regarding the classification of health care financing systems in the selected places. The second aspect is related to major health care financing reforms undertaken by some of the selected places. The aim of this information note is to facilitate Members in the discussion of health care financing in the Hong Kong context.

2. Characterization of the selected places

2.1 The selected places, including Hong Kong, share all or most of the following characteristics:

(a) The selected places are high-income economies (except Mainland China) under the World Bank's classification, i.e. places where the Gross National Income per capita has reached US$10,066 (HK$78,052) or more.

(b) The selected places have a similar pattern of health risks. According to *The World Health Report 2002*, non-communicable conditions, such as cardiovascular diseases, cancers and neuro-psychiatric disorders, are the major health risks in the developed economies.

(c) The selected places, unlike most of the developing economies, do not rely on out-of-pocket payments to finance health care. Instead, they all depend on prepayment, i.e. paying for the cost of health care services in advance of their use.

3. Classification of health care financing systems in selected places

3.1 Prepayment can be pooled by means of tax, contribution or premium. All the selected places adopt a combination of prepayment methods to fund health care services. Table 1 presents data about the percentage share between public and private financing in the total expenditure on health care in the 28 selected places. The table reveals the following facts:

(a) Twenty-four out of the 28 selected places have at least half of their total expenditure on health care coming from public financing. Among these primarily publicly-financed systems, 11 are mostly financed by general government expenditure while eight are predominantly financed by social health insurance.

(b) The remaining four selected places have at least half of their total expenditure on health care derived from private financing.

Table 1 — Percentage share of public and private financing in total expenditure on health care in selected places in 2003

	Public financing (%)			Private financing (%)			
	General government expenditure	Social health insurance	Total	Private insurance	Out-of-pocket payments	Other private funds	Total
Luxembourg	11.74	79.13	89.86	0.93	7.01	2.2	10.14
Sweden	--	--	85.25	--	--	--	14.75
Iceland	53.02	30.51	83.53	0	16.47	0	16.47
Norway	68.28	15.2	83.48	0	15.75	0.77	16.52
United Kingdom	--	--	83.36	--	--	--	16.64
Denmark	82.96	0	82.96	1.28	15.76	0	17.04
Japan	15.9	65.58	81.48	0.32	17.27	0.93	18.52
New Zealand	78.67	0	78.67	5.67	15.36	0.3	21.33
Germany	9.84	68.37	78.21	8.76	10.43	2.6	21.79
Ireland	77.34	0.63	77.97	6.39	13.36	2.28	22.03
Finland	60.06	16.49	76.55	2.4	19.04	2.01	23.45
France	2.51	73.76	76.27	12.69	10.01	1.03	23.73
Italy	75.01	0.12	75.13	0.95	20.71	3.21	24.87
Belgium	--	--	71.2	--	--	--	28.8
Spain	65.87	5.29	71.16	4.29	23.66	0.89	28.84
Canada	68.45	1.46	69.91	12.73	14.92	2.44	30.09

Table 1 — Percentage share of public and private financing in total expenditure on health care in selected places in 2003 (cont'd)

	Public financing (%)			Private financing (%)			
	General government expenditure	Social health insurance	Total	Private insurance	Out-of-pocket payments	Other private funds	Total
Portugal	--	--	69.74	--	--	--	30.26
Australia	67.78	0	67.78	7.71	20.97	3.54	32.22
Austria	23.16	44.47	67.63	7.62	19.17	5.58	32.37
Taiwan	8.7	57.3	66	0	30	4	34
Netherlands	4.39	57.99	62.38	18.87	9.5	9.25	37.62
Switzerland	18.04	40.49	58.53	8.97	31.53	0.97	41.47
Hong Kong	53.8	0	53.8	1.6	37.6	7	46.2
Greece	--	--	51.3	--	--	--	48.7
South Korea	9.02	40.39	49.41	2.08	41.89	6.62	50.59
United States	31.45	12.98	44.43	36.64	14.07	4.86	55.57
Mainland China	--	--	33.7	--	--	--	66.3
Singapore	--	--	30.9	--	--	--	69.1

Sources: *OECD Health Data 2005*, World Health Organization (2005a), The World Bank (2005b), and Health, Welfare and Food Bureau (2004).

Notes: Figures for Hong Kong are 1999 figures.
Figures for Australia and Taiwan are 2001 figures.
Figures for Belgium, Japan, Mainland China, Norway and the United Kingdom are 2002 figures.

3.2 Based on the percentage shares of funding sources in the total expenditure on health care, the health care financing systems of the selected places can be roughly classified as the following four types, namely tax-based financing, social health insurance, private health insurance and medical savings accounts.

3.3 Table 2 classifies the selected places according to their respective type of health care financing systems:

Table 2 — Classification of health care financing systems of selected places

Tax-based financing	
Definition	Total expenditure on health care is predominantly funded by general government expenditure
Sources of fund	Taxes on income, purchases, property, capital gains, and a variety of other items and activities
Places	Australia, Canada, Denmark, Finland, Greece, Hong Kong, Iceland, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden and the United Kingdom
Social health insurance	
Definition	Total expenditure on health care is predominantly funded by contributions being paid on a compulsory basis
Sources of fund	Employees, the self-employed, employers and the government
Places	Austria, Belgium, France, Germany, Japan, South Korea[1], Luxembourg, the Netherlands, Switzerland and Taiwan
Private health insurance	
Definition	Total expenditure on health care is predominantly funded by premiums being paid directly to insurance companies
Sources of fund	Employers, associations, individuals and families
Places	The United States and Mainland China[2]

Table 2 — Classification of health care financing systems of selected places (cont'd)

Medical savings accounts	
Definition	Total expenditure on health care is predominantly funded by private financing, including savings in individual accounts that are restricted to specified health care spendings, such as hospitalization expenses
Sources of fund	Employers, employees, the self-employed and the government
Place	Singapore

Sources: Cheung and Gu (2004), Grosse-Tebbe, Susanne and Josep Figurras (eds.) (2004), Hanvoravongchai, Piya (2002), Health, Welfare and Food Bureau (2004), Kontozamanis, Vassilis (n.d.), *Ministry of Health, Singapore* (2005), *Ministry of Health and Welfare, the Republic of Korea* (2005), Mossialos, Elias et al. (eds.) (2002), Murray, J.L. Christopher and David B. Evans (eds.) (2003), OECD (2004), Saltman, Richard B. Reinhard Busse and Josep Figueras (eds.) (2004), Savedoff, William (2004), State Council of the People's Republic of China (2004), The World Bank (2005b), World Health Organization (2000) and *中央健康保險局* (2005).

Notes: 1. South Korea: Although the percentage share of private financing in South Korea is slightly over half of its total expenditure on health care, South Korea is classified as belonging to the social health insurance system because there is a national health insurance system in place.
2. Mainland China: Although there is a Basic Medical Insurance System for employees in urban areas, the health care financing system is classified as belonging to the private insurance system because it has a high percentage share of private financing in the total expenditure on health care.

4. Reform of health care financing systems in selected places

4.1 This section provides information on the reform of the health care financing system in some of the selected places. Based on comparative researches conducted by international organizations such as the World Health Organization and the Organisation for Economic Co-operation and Development and the academia, the overall trend of reform on health care financing in developed economies is illustrated in this section. Recently implemented reforms and reform proposals in some of the selected places in each of the four types of health care financing systems are also discussed below.

4.2 The health care financing reform in developed economies is basically geared towards two directions, i.e. achieving cost containment and promoting cost efficiency. There are five groups of measures adopted to achieve these two goals:[1]

(a) Controlling wages, prices and health-care production resources through the following measures:

- wage control of health care personnel;
- price controls over health care services and pharmaceuticals; and
- restriction on the growth of health care production resources such as health care personnel and supply of hospitals.

(b) Budgetary caps through the following measures:

- the government setting the budget on health care through the budgetary process;
- the central government capping the provincial or local government budget on health care through inter-governmental transfers or limits on tax increase; and
- capped budgets for various health sectors such as public hospitals, pharmaceuticals and primary care.

[1] Materials in this part come primarily from Docteur, Elizabeth and Howard Oxley. (2004) Health-System Reform: Lessons from Experience, in: OECD. *Towards High-Performing Health Systems: Policy Studies.* Paris, OECD and cross reference with these publications: Mossialos, Elias et al. (eds.) (2002), World Health Organization (2000), Saltman, Richard B. Reinhard Busse and Josep Figueras (eds.) (2004), Carrin, Guy and Piya Hanvoravongchai (2002), Murray, J.L. Christopher and David B. Evans (eds.) (2003), Evans, Robert G. (2002), Flood, C.M., Mark Stabile and C.H. Tuohy (2002), Hanvoravongchai, Piya (2002), Health Evidence Network, (2004), Ramesh, M. (2003), and Savedoff, William (2004).

(c) Shifting the costs to the private sector through increasing patient cost-sharing arrangements:

- co-payment: a fixed amount per service or prescription medicine;
- co-insurance: a fixed percentage of the total charge or payment; and
- deductibles: a level of patient spending to be met in a given time period before insurance payments will be made.

(d) Restructuring the public and private mix of the health care financing system to increase health care resources, for example, incorporating other health care financing methods into the existing system or changing the ratio among the existing health care financing methods.

(e) Introducing measures that aim to improve the cost-efficiency of the hospital sector:

- Creating or strengthening the distinction between the roles of purchasers/funders and providers of health care. While the purchasers/funders are responsible to the budgetary authorities for cost control and to patients for the quality and accessibility of care, the providers are responsible for the delivery of contracted services. The clear distinction between the roles of purchasers/funders and providers allows purchasers/funders more flexibility in choosing health care providers and bargaining terms with them.
- Improving managerial independence and cost accountability of hospitals. With greater managerial freedom, hospitals can involve the private sector in the service delivery process, e.g. contracting out non-medical services and increasing the flexibility of labour employment and deployment.
- Increasing competition among hospitals by encouraging/requiring them to compete for health care customers on the basis of price.
- Enhancing competition among insurers by encouraging them to minimize administrative costs and improve services to the insured.

4.5 Table 4 below is a summary of reforms that have been either proposed or implemented in selected places in recent years:

Table 4 — Reform of health care financing in selected places

Type of system	Reform strategies and measures
Tax-based financing	Australia • The existing health care financing system has gradually been developed since the early 1980s. In 1984, the Medicare programme, a compulsory national health insurance system funded by general government expenditure, was introduced. • In 1984, the Medicare levy was introduced as a supplement to other tax revenues to meet the cost of the universal national health care system. • *The Private Health Insurance Incentive Act 1998* was introduced to encourage the purchase of private health insurance. The Act contains measures such as a 30% rebate on premiums by the Australian government to the insured. Canada • The existing health care financing system was established in 1984 under the *Canada Health Act*. The Act affirms the government's commitment to a health care system which has the following characteristics: - universal coverage; - accessibility of medically necessary services without being impeded by financial or other barriers; - comprehensive provision of all medically necessary services; - coverage for insured services should be maintained when a person moves or travels within Canada or travels outside Canada; and - publicly financed and administered by a non-profit public authority.

Table 4 — Reform of health care financing in selected places (cont'd)

Type of system	Reform strategies and measures
Tax-based financing (cont'd)	Canada (cont'd) • In November 2002, the Commission on the Future of Health Care in Canada released an inquiry report entitled *Building on Values: The Future of Health Care in Canada.* • In the report, the following proposed alternative funding sources were considered: - user fees and out-of-pocket co-payments; - medical savings accounts: individuals being allotted a yearly health care allowance which could be used to "purchase" health care services; - tax-based co-payments, tax credits and deductibles; and - public-private partnerships. • 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 system has been maintained. New Zealand • The existing health care system was established under the *New Zealand Public Health and Disability Act 2000*. Under the Act, District Health Boards are set up to be responsible for providing or funding the provision of government-funded health care services for the population in the districts. • In 2004, a paper entitled the *Future Funding of Health and Disability Services in New Zealand* was made publicly available by the Ministry of Health. • In the *Future Funding of Health and Disability Services in New Zealand*, the following options were considered: - strongly earmarked health tax to raise all of the revenues required to finance the public health system; - weakly earmarked health tax to supplement existing financing by raising additional funds for health at the margin; - earmarked excise tax in that all of the revenues from one or more of the health-related excises (on tobacco, alcohol and gambling) were dedicated to health spending; - user charges for publicly-funded services; and - other private financing, i.e. private insurance and direct payments, for treatment in the private sector. • The report regarded the earmarked excise tax option as worth considering. However, this option has not been translated into policy practice.

Table 4 — Reform of health care financing in selected places (cont'd)

Type of system	Reform strategies and measures
Tax-based financing (cont'd)	Hong Kong • The existing health care system started to take shape in 1990 when the Hospital Authority was established. The Hospital Authority is vested with the power to manage public hospitals which were previously managed by a government department and charity organizations. • In the past few decades, there were frequently policy discussions on health care financing, especially during the time periods when the following documents were released: - *Towards Better Health* (1993); - *Improving Hong Kong's Health Care System: Why and for Whom?* (1999); and - *Lifelong Investment in Health* (2000). • In 2004, the Health Care Financing Study Group, a study group consisting of academics, medical and other professionals, staff of the Hospital Authority and government officials formed under the Health, Welfare and Food Bureau, completed a research entitled *A Study on Health Care Financing and Feasibility of a Medical Savings Scheme in Hong Kong*. The conclusions of the study are: - There is no single best combination of funding sources which can meet the needs of every economy, and each economy has to take into account its own particularities, e.g. the level of subsidy to health care services and the rate of taxation, in coming up with the appropriate solution. - It is feasible to introduce a medical savings scheme in Hong Kong. However, it is important to examine carefully the role of a medical savings scheme, and how it will complement other measures, in Hong Kong's health care financing arrangement. - No matter which option is adopted, the Government should uphold the long-established principle that no one will be denied appropriate medical care due to lack of means.

Table 4 — Reform of health care financing in selected places (cont'd)

Type of system	Reform strategies and measures
Tax-based financing (cont'd)	United Kingdom • In 2000, the British government published a policy paper entitled *The NHS Plan,* which introduced changes to the practice of the existing National Health Service (NHS) system. • *The NHS Plan* examined four alternative health care financing options: - providing incentives for people to buy private health insurance; - introducing new charges for health care services; - converting the tax-based financing system into a social health insurance system; and - limiting the provision of health care services to the core services. • *The NHS Plan* concluded that the tax-based financing system of NHS would continue as it met the tests of efficiency and equity. Nevertheless, the practice of NHS should be changed in a way to improve the efficient use of health care resources. • Since the publication of *The NHS Plan*, the British government have implemented various reform initiatives based on the following directions : - 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 NHS and non-governmental sectors; and - transactional reforms such as introducing a new payment mechanism that rewards efficient providers.

Table 4 — Reform of health care financing in selected places (cont'd)

Type of system	Reform strategies and measures
Social health insurance	Taiwan • The existing National Health Insurance programme was introduced in 1995. The Bureau of National Health Insurance (BNHI) was set up to operate the compulsory health insurance programme for all citizens of Taiwan. • Since the establishment of BNHI, the following measures were adopted to deal with the imbalance between revenues and expenditures of the programme: - Global budgeting was first introduced in 1998 to control cost. - Since 2001, BNHI's payments to providers would decrease by a sliding scale if pre-determined limits on the "reasonable" number of patients treated have been exceeded. - The insurance premium was raised from 4.25% of assessable income to 4.55% in 2002. - Co-payments for certain types of visits, drugs and inpatient care were also increased in 2002. France • Since 2000, the government has introduced a series of initiatives to reform the French health care system. One of the changes is the implementation of the *Universal Health Coverage Act*. Under the Act, the health insurance system is extended to cover not only employees but also non-employees who are legal residents in France. • In 2004, the government proposed a series of reforms to raise revenues and reduce expenditure: - charging all patients who visited a doctor; - obliging pensioners who can afford it to pay substantially more; - raising health care levies on firms; - reducing reimbursement of expensive pharmaceuticals; and - establishing computerized, personal medical records accessible by any French health care professional to prevent patients from "shopping around."

Table 4 — Reform of health care financing in selected places (cont'd)

Type of system	Reform strategies and measures
Private health insurance	United States • Introduced in 1965, Medicare and Medicaid are the major government programmes to finance health services: - Medicare protects the elderly aged 65 years or above, the disabled and people with permanent kidney failure. - Medicaid targets the low-income and needy people. • Most of the private health insurance schemes are employment-based, which provide coverage to employees, retired employees and their dependants. • There are three challenges confronting the health care system: - Escalating health care spending will make the Medicare and Medicaid programmes unsustainable for future generations. - Increasing number of non-elderly Americans, especially people in poor health and near-elderly people, are not covered by health insurance because they cannot afford insurance or do not opt to purchase. - Increasing number of the insured are not covered by all essential health services. • In 2003, the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* was introduced to address some of the above challenges: - Providing a voluntary programme for prescription drug coverage under the Medicare Program. - Establishing Health Savings Accounts, which are tax-advantaged savings accounts that can be used to pay for medical expenses incurred by individuals, their spouse or their dependents. Contributions by an eligible individual are tax deductible and contributions to the Health Savings Accounts by the employer are not included in the individual's taxable income. In addition, the interest generated from the savings is also tax deductible. Health Savings Accounts are portable: when an individual changes jobs, the account goes with the individual.

Table 4 — Reform of health care financing in selected places (cont'd)

Type of system	Reform strategies and measures
Private health insurance (cont'd)	Mainland China • Before 1994, the health care system in the urban areas consisted of two parts: - Government-funded health care which covered state employees in government, military, and other state institutions such as schools at all levels funded directly by the state budget. - Labour insurance health care which applied to employees in state-owned enterprises and most of the collectively-owned enterprises that were financed by the enterprises' welfare fund. • In 1994, a pilot project on health care financing was implemented in the cities of Zhenjian and Jiujiang. In view of the result of the pilot project, the government promulgated the *Decision on Establishing a Basic Medical Insurance System for Urban Employees* in 1998. Subsequently, basic medical insurance systems have been gradually developed in various cities. • In 2004, the State Council promulgated the white paper entitled *China's Social Security and Its Policy*. The white paper reiterated the direction of development of the health care financing system in urban areas: - The government expects to expand the basic medical insurance system to include more employees in urban areas. - The funding of the basic medical insurance system comes from premiums paid by employers and employees. - The premiums of an employee as well as 30% of the employer's premiums for the employee are credited to the employee's individual medical account. The remaining 70% of the employer's premiums are pooled into a fund. - While the money in the individual medical accounts is mainly used for paying outpatient treatment fees, the pooled fund is primarily employed for paying hospitalization expenses.

Table 4 — Reform of health care financing in selected places (cont'd)

Type of system	Reform strategies and measures
Medical savings account	Singapore • The existing system started to take shape in 1984 when Medisave Accounts were established under the Central Provident Fund. • Employees and employers jointly make contribution to the Medisave Accounts. The medical savings account system is complemented by: - MediShield Schemes, a catastrophic medical insurance scheme set up in 1990; - Medifund, a safety net set up in 1993 to help poor Singaporeans pay for their medical care; and - ElderShield, a disability insurance scheme set up in 2002 to provide financial protection for the elderly who are unable to perform basic activities of daily living such as eating, dressing and toileting. Medisave account holders are automatically enrolled in the programme when they reach age 40 unless they opt out.

Sources: Australian Bureau of Statistics (2005), Australian Government Department of Health and Ageing (1999b), Centers for Medicare & Medicaid Services (2004), Cheng, Tsung-Mei (2003), Cheung and Gu (2004), Commission on the Future of Health Care in Canada (2002), Department of Health (2005), Grosse-Tebbe, Susanne and Josep Figurras (eds.) (2004), Hanvoravongchai, Piya (2002), Health Council of Canada (2005), Health, Welfare and Food Bureau (2004), Hurley, Jeremiah et al. (2002), *Ministry of Health, Singapore* (2005), Ministry of Health, New Zealand (2004), *The NHS Plan* (2000), Sandier, Simone et al. (2004), State Council of the People's Republic of China (2004), and *中央健康保險局* (2005).

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