# Health Care Financing Policies of Australia, New Zealand and Singapore

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### Prepared by

### Simon LI

Research and Library Services Division Legislative Council Secretariat

5th Floor, Citibank Tower, 3 Garden Road, Central, Hong Kong

Telephone: (852) 2869 9343 Facsimile: (852) 2509 9268

Website : http://www.legco.gov.hk E-mail : library@legco.gov.hk

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## **Executive Summary**

- 1. This research introduces and compares the health care financing policies of Australia, New Zealand and Singapore. Both Australia and New Zealand institutionalized a tax-based financing health care system in the late 1940s and Singapore retained a similar system amidst its independence in 1965.
- 2. Owing to the increasing pressure on public expenditure in financing health care, all the selected places have introduced health care reforms since the 1970s to ease the pressure. Although both Australia and New Zealand have retained the tax-based financing system, the directions of their reform are different. While the overall direction of the Australian reform is to increase the private sector involvement in the delivery and financing of health care services, the reform in New Zealand aims at promoting the efficient use of health care resources via a devolved health care system.
- 3. Unlike Australia and New Zealand, the Singaporean government abandoned the tax-based financing system and adopted the Medisave system in 1984. Under the medical savings account system, health care is predominantly funded by private financing, including savings in an individual account being restricted to spending on health care.
- 4. In New Zealand and Singapore, the Ministry of Health has the overall responsibility for the formulation of health care policies. In Australia, both the Commonwealth and state and territory governments are involved in formulating health care policies. While the Commonwealth government holds the overarching policy responsibility for all issues pertaining to health, the state and territory governments formulate policies regarding the delivery and regulation of health care services, personnel and facilities within their respective jurisdictions.
- 5. Almost all primary health care services in Australia and New Zealand are delivered by private medical practitioners, whereas the corresponding percentage of private involvement in Singapore is 80%. However, primary health care services provided by private medical practitioners in Australia and New Zealand are partly subsidized by the government whereas it is not subsidized in Singapore. In all selected places, publicly-owned hospitals provide a major or substantial portion of hospital services. The available figures show that the average occupancy rate of acute care beds in the selected places is around 74%.
- 6. The guiding principles of health care policies in the selected places all ensure that their citizens will not be denied health care services. However, they adopt somewhat different philosophical bases. Both Australia and New Zealand emphasize collective responsibility to ensure individuals' accessibility to health care services. On the other hand, Singapore emphasizes individual responsibility for accessing health care services and the government is the last resort for those who are unable to pay.

- 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. Among the selected places, most of the public expenditure on health care in Australia and New Zealand come from general taxation. However, the proportion from individual sources of general taxation varies in these two places. While Australia depends heavily on income tax, New Zealand depends on both income tax and goods and services tax.
- 8. The Australian and Singaporean governments have specific measures in place governing the operation of health insurance companies. In Australia, health insurance companies must ensure access by all members of the community to private health insurance under the community rating principle, and share the risk of high-claiming persons, i.e. older and chronically-ill persons, under the reinsurance principle. In Singapore, only health insurance plans approved by either the Central Provident Fund Board or the government are allowed to use the money saved in individuals' Medisave Accounts to pay for their insurance premiums.
- 9. Both the Australian and Singaporean governments have specific measures to increase the coverage of health insurance of the population. For example, the Australian government uses a rebate on private health insurance for the insured and the Lifetime Health Cover to encourage people to take out health insurance policies earlier in life. The Singaporean government encourages individuals to take out approved health insurance policies by allowing them to pay the premium from savings in the Medisave Accounts. In addition, employers are encouraged by tax incentives to implement employer-sponsored health insurance schemes.
- 10. In addition to the common means of pooling health care resources, i.e. general taxation and health insurance plans, the selected places have their own specific means to pool health care resources, i.e. designated health tax in Australia, accident-related levy in New Zealand and medical savings in Singapore.
- 11. Government budget and health insurance plans are means used, though not to the same extent, by all the selected places to allocate health care resources. In addition, New Zealand and Singapore allocate health care resources through designated organizations, i.e. the Accident Compensation Corporation and Central Provident Fund Board respectively.
- 12. Both Australians and New Zealanders are eligible for receiving public hospital services free of charge if they do not choose doctors in receiving treatment. Singaporeans bear at least 20% of the cost because the maximum government subsidy for the lowest-class public hospital wards is 80% of the cost. Patients may have to resort to out-of-pocket payments, savings in the Medisave Accounts and approved health insurance plans or a combination of them to cover their share of hospital expenses.

- 13. In Australia and Singapore, patients who choose their preferred doctors can still receive some subsidy from the government. For Australians choosing to be treated as private patients in either public or private hospitals, Medicare pays 75% of the Medicare Benefits Schedule fee for services and procedures provided by the treating doctor. In Singapore, the government subsidizes 20% of the cost of B1-class hospital wards, with B1-class patients being able to choose doctors. In New Zealand, public hospitals are allowed to treat private patients only under certain conditions, e.g. when the arrangement leads to an improvement in the clinical quality.
- 14. In both Australia and New Zealand, primary health care services provided by private medical practitioners are subsidized by the government. However, the method of subsidization is different. In Australia, Medicare subsidizes all patients 85% of the schedule fee as stated in the Medicare Benefits Schedule. In New Zealand, the subsidy targets the young, the old, the poor and the chronically-ill groupings. In Singapore, primary health care services provided by private medical practitioners are not subsidized by the government. Patients who cannot afford private sector services can use the subsidized public sector services.
- 15. With regard to medicine expenses, in Australia and New Zealand, patients are required to make a co-payment for acquiring government-subsidized prescription medicines. In Singapore, the cost of prescription medicines is usually included in the medical fees and charges.
- 16. All selected places have engaged in reforming the health care financing system since the 1970s and each selected system yields some achievements and faces some challenges. In Australia, while there is an increase in the take-out rate of private health insurance, the rising government expenditure on rebate, higher-income households receiving a larger rebate and the lack of incentives for insurers to manage cost efficiently for high-cost cases are challenges to be met.
- 17. In New Zealand, the current regional governance model has achieved citizen participation through the elected district health boards and health care resources are allocated based on the needs of the population rather than on the market principle. However, the possibility of political control by special interest groups in the district health boards and the question of equity in the distribution of health care resources among districts are challenges to be met.
- 18. There are diverse views regarding the effectiveness of the Singaporean system. Some academics regard that the medical savings account system has effectively reduced the government's public spending in health care when compared to the tax-based financing system. In addition, the system, through a medical safety net, ensures that the poor and under-privileged groups have access to essential health care services. Some other academics question the effectiveness of the system as the share of health care resources provided by the medical savings account system remains very small when compared to other funding sources such as employer-sponsored health benefits. In addition, the inadequacy of health care resources generated from the system and the high deductibles and co-insurance required may constitute financial barriers for the poor and under-privileged groups to access essential health care services.

# Health Care Financing Policies of Australia, New Zealand and Singapore

#### **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 and Taiwan.

#### 1.2 Scope of research

- 1.2.1 This research provides a detailed discussion on the health care financing policy of each selected place, 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 – Australia<sup>1</sup>

#### 2.1 Background

- 2.1.1 Under the Australian Constitution, health care was regarded as the responsibility of the state governments, and the Commonwealth government was granted powers on quarantine matters only in the early 1900s. As such, the Commonwealth government did not actively participate in the provision of health care services apart from performing some public health and professional functions over the next four decades, such as playing a co-ordination role during the influenza outbreak around 1918.<sup>2</sup>
- 2.1.2 In 1946, the Australian Constitution was amended to enable the Commonwealth government to make laws with respect to its provision of a wide range of pensions and benefits, hence increasing its involvement in the provision of health care services. Since then, the Commonwealth government has gradually increased its participation in the provision of maternity, pharmaceutical, sickness and hospital benefits as well as medical and dental services.<sup>3</sup>
- 2.1.3 For instance, in accordance with the *Hospital Benefits Act 1946*, the Commonwealth government paid the state governments six shillings a day for each patient occupying a bed in a public or private hospital on condition that the state governments would provide free services for patients accommodated in public wards. In the 1950s, the Commonwealth government began to subsidize drug purchases as required under the *Pharmaceutical Benefit Act 1950*, and medical services under the *National Health Act 1953*. This basic framework of the Commonwealth government subsidizing local hospital services and medicine expenses has remained in place since then.<sup>4</sup>

Using the State of Victoria as an example, the last section of this chapter provides facts and figures on the operation of the health care system at the state level.

<sup>&</sup>lt;sup>2</sup> Hilless and Healy (2001), p.12.

Section 51(xxiiiA) of the *Commonwealth of Australia Constitution Act*, Biggs (2003) and Hilless and Healy (2001), p.14.

<sup>&</sup>lt;sup>4</sup> Browning, (2000) and Hilless and Healy (2001), p.14.

- 2.1.4 With regard to health care financing, different Commonwealth governments in power have held different stances on universal health insurance, in particular in the 1970s and the 1980s. In 1975, a universal publicly-funded health insurance called Medibank was introduced by the Labor government. However, the Liberal Coalition government scaled back Medibank to a voluntary scheme in 1981. Then in 1984, the Labor government re-established a universal tax-funded health insurance system, Medicare, which has been largely unchanged till today. In a nutshell, Medicare provides free hospital treatments to Australians and subsidizes Australians on primary health care services and prescription medicines.<sup>5</sup>
- 2.1.5 Since 1984, there have been health care reforms to contain costs and achieve greater efficiency, and to facilitate private sector participation in financing and the provision of health care services. For example, the *Private Health Insurance Incentive Act 1998* introduces a 30% rebate on premiums by the Commonwealth government to the insured to encourage the purchase of private health insurance.<sup>6</sup>

#### 2.2 Overview of health care system

#### Structure

- 2.2.1 The amendment of the Australian Constitution in 1946 has given the Commonwealth government the mandate to play a more active role in the provision of health care services. However, the Australian Constitution does not strictly prescribe the respective role of each level of governments in relation to health care. As such, the government has organized the Australian Health Ministers' Conference which offers a forum for health ministers of various levels of governments to discuss and co-ordinate health policies and programmes.<sup>7</sup>
- 2.2.2 In general, the Department of Health and Ageing of the Commonwealth government holds the overarching policy responsibility for all issues pertaining to health. In particular, it has specific administrative responsibilities for the nation-wide health financing schemes, such as the Medicare Benefits Schedule and the Pharmaceutical Benefits Schedule. The state and territory governments are responsible for formulating policies for the delivery of health care services such as hospital services as well as the regulation, inspection, licensing, and monitoring of health-related premises, institutions and personnel within their jurisdictions.<sup>8</sup>

Australian Health Ministers' Advisory Council (2005).

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<sup>&</sup>lt;sup>5</sup> Hilless and Healy (2001), pp.14-15 and Browning (2000).

<sup>&</sup>lt;sup>6</sup> Hilless and Healy (2001), pp.15-16.

Department of Health and Ageing (2004), p.2, Department of Health and Ageing (2005), p.1 and *Yearbook of Australia 2006*.

- 2.2.3 Private medical practitioners provide almost all the primary health care services. Only a small amount of the primary health care services are provided by public facilities, such as public infant health centres, antenatal clinics, immunization clinics and community health centres. For hospital care, the public sector accounts for 66% of the total hospital beds and the private sector 34%. Owing to the growth of private sector involvement in the delivery of hospital care, the distinction among public, private-not-for-profit and private-for-profit hospitals is blurring.
- 2.2.4 The state and territory governments have introduced measures and arrangements to encourage the involvement of the private sector in public hospitals. The involvement of the private sector in public hospitals can take many forms, including:<sup>10</sup>
  - (a) co-locations: a private hospital being located on the same site as a public hospital with some sharing of facilities;
  - (b) contracting: religious/charitable organizations providing hospital beds and services for public patients under arrangements with the state and territory governments; and
  - (c) Public Private Partnership <sup>11</sup>: under the Build-Own-Operate arrangement, a private sector entity using private funding to build a privately-owned hospital to provide public hospital services.
- 2.2.5 The following table presents some basic statistics about the delivery system of health care services in Australia.

Hilless and Healy (2001) pp.45-46 and pp.56-59 and World Health Organization, Regional Office for the Western Pacific (2005).

Hilless and Healy (2001) pp.56-59, Biggs (2003a), Productivity Commission (1999) pp.5-10 and Senate Community Affairs Committee (2000) pp. 89-92.

Legislative Council Secretariat (2005). Appendix I of the research report (RP03/04-05) entitled *Public Private Partnerships* has a general introduction of the various types of public private partnerships.

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

	Number	Ratio	
Health workforce <sup>1</sup>		per 10 000 population	
Doctors	54 800	27.2	
Dentists	9 400	4.7	
Pharmacists	18 600	9.2	
Nurses	159 600	79.4	
Midwives	14 500	7.2	
Other nursing/auxiliary staff	21 900	10.9	
Other paramedical staff (e.g. medical assistants, laboratory technicians, X-ray technicians)	52 400	26.1	
Other health personnel (health inspectors, assistant sanitarians, etc.)	11 400	5.7	
Health infrastructure <sup>2</sup>			
Public hospitals	748 (52 199 beds)	79 hospital beds per 10 000 population	
Private hospitals	549 (27 112 beds)		
Occupancy rate of acute care beds <sup>3</sup>	73.9%		

Remarks: 1. 2004 figures.

number of bed-days related to acute care in a year

Number of available acute beds x 365

Sources: Regional Office for the Western Pacific, World Health Organization (2005), World Bank (2005) and Organisation for Economic Co-operation and Development (2005b).

#### **Financing**

2.2.6 The guiding principle of the Australian health care system is to facilitate universal access to health care while allowing choice for individuals through substantial private sector involvement in delivery and financing. 12

<sup>2. 2002-03</sup> financial year figures.

<sup>3. 2002</sup> figure. The occupancy rate for acute care beds is derived by the following formula:

Department of Health and Ageing (2004), p.5.

- 2.2.7 The Australian health care financing system is a tax-based financing system in that health care is predominantly funded by general government expenditure. The Commonwealth government, the state and territory governments, consumers and the private sector all participate to some extent in financing the provision of health care services. The Commonwealth government, the state and territory governments, consumers and the private sector all participate to some extent in financing the provision of health care services.
- 2.2.8 Public hospital services, which are free to all Australians, are financed by both the Commonwealth government and the state and territory governments. Through Medicare, the Commonwealth government also subsidizes Australians for receiving services offered by private doctors, optometrists, pharmacists and other allied health practitioners<sup>15</sup>. Patients assume the balance of health care service payments not covered by Medicare or private insurance. A medical safety net, the funding of which again comes from the Commonwealth government, is in place to assist those who cannot afford the health care service payments.<sup>16</sup>
- 2.2.9 The following table presents some basic information about expenditure on health services of Australia in 2003, which may serve as indicators on health expenditure.

Table 2 – Health expenditure indicators of Australia in 2003

Total expenditure on health as % of GDP	9.7%
Per capita total expenditure on health	AUS\$3,931 (HK\$22,407)
General government expenditure on health as % of total expenditure on health	68%
Non-government expenditure on health as % of total expenditure on health	32%
General government expenditure on health as % of total general government expenditure	16.7% <sup>1</sup>
Health insurance coverage as % of total population	42.9%1

Remark: 1. 2001-02 financial year figures.

Sources: Regional Office for the Western Pacific, World Health Organization (2005) and Australian Institute of Health and Welfare (2004) Tables 39, 40 and 41.

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Legislative Council Secretariat (2005). For more information, please refer to the information note entitled *Health Care Financing Systems in Selected Places: Classification and Reform* (IN08/05-06).

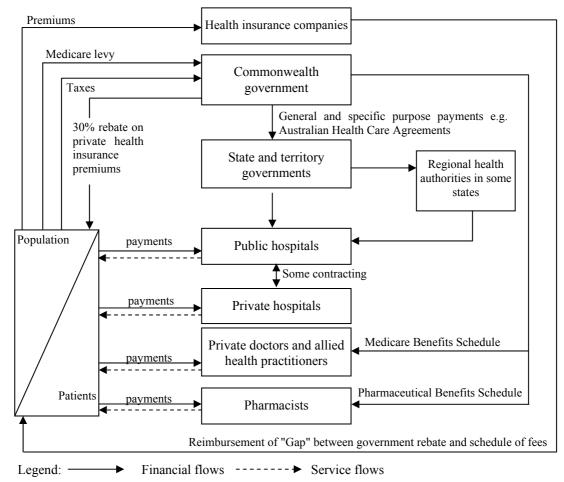
<sup>14</sup> Yearbook of Australia 2006.

Allied health practitioners are professional health care providers who are not physicians, especially medical assistants, technicians, and therapists but not nurses.

<sup>&</sup>lt;sup>6</sup> Yearbook of Australia 2006.

2.2.10 Chart 1 summarizes the financing and delivery system of health care services in Australia.<sup>17</sup>

Chart 1 – Health care system of Australia



Sources: Organisation for Economic Co-operation and Development (2005a) and *Yearbook of Australia 2006*.

#### 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;

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In this paper, the term "health insurance companies" refers to both profit-making companies which sell health insurance products to consumers as well as non-profit organizations such as co-operatives which offer health insurance for their members.

- (b) Medicare levy; and
- (c) health insurance plans.

#### General taxation

2.3.2 The Commonwealth government's financial support for health care comes from its general revenue which relies heavily on income taxes. In the financial year 2004-05, some three-quarters (75.6%) of the general revenue account came from various types of income taxes, with the respective proportion of individual income taxes, corporate tax and other income taxes being 52.3%, 19.5% and 3.8%. <sup>18</sup>

#### Medicare levy

- 2.3.3 When Medicare began in 1984, the mandatory Medicare levy was introduced as a supplement to other taxation revenues to enable the Commonwealth government to meet the additional costs of providing universal health care services under Medicare. Medicare levy is collected by the Australian Taxation Office. The levy rate started at 1% of taxable income above some specified income thresholds and was subsequently raised to 1.25% and 1.4% in 1986 and 1993 respectively. Since 1995, the Medicare levy has been 1.5% of taxable incomes above certain income thresholds.<sup>19</sup>
- 2.3.4 The imposition of income thresholds is to ensure that low-income families and individuals are exempt from paying the Medicare levy. Starting from the 2004-05 financial year, no Medicare levy has been applied to individuals and families earning less than AUS\$15,902(HK\$90,641) and AUS\$26,834(HK\$152,954) per year respectively. An additional amount of AUS\$2,464(HK\$14,045) is added to the threshold for each dependant child or student.<sup>20</sup>
- 2.3.5 An additional 1% Medicare levy surcharge is applied to high-income individuals and families who do not have private health insurance cover. High-income individuals and families refer to individuals earning more than AUS\$50,000(HK\$285,000) per year and families earning more than AUS\$100,000(HK\$570,000) per year respectively.<sup>21</sup>

<sup>&</sup>lt;sup>18</sup> Table G3, 2005-06 Budget.

<sup>&</sup>lt;sup>19</sup> Browning (2000) and Biggs (2004).

Minister for Revenue (2005).

Private health insurance – Medicare levy surcharge (2005).

#### Health insurance plans

- 2.3.6 The Private Health Insurance Administration Council, a financially independent statutory agency, is the prime regulator of the health insurance industry in Australia. Organizations wishing to offer health insurance services in Australia must apply to the Council for registration. The Council also monitors the financial performance of health insurance funds offered by the health insurance companies to ensure that solvency and capital adequacy requirements are met. At present, there are 40 health insurance funds in Australia.<sup>22</sup>
- 2.3.7 The Commonwealth government encourages people to take out private health insurance through rebate, Lifetime Health Cover and Medicare levy surcharge.

#### Rebate on private health insurance

- 2.3.8 In accordance with the *Private Health Insurance Incentives Act 1998*, the Commonwealth government has introduced a non-means-tested 30% tax rebate<sup>23</sup> to those Australians who<sup>24</sup>:
  - (a) have taken out private health insurance policies registered under the *National Health Act 1953*; and
  - (b) are eligible to claim benefits under Medicare.
- 2.3.9 Starting from 1 April 2005, the Commonwealth government has increased the health insurance rebate to Australians aged between 65 and 69 from 30% to 35%, and from 30% to 40% for those aged over 70.<sup>25</sup> Medicare Australia, a statutory agency, administers the scheme on behalf of the Commonwealth government.

The Auditor-General (2005), pp.13-17 and Private Health Insurance Administration Council (2005b).

For every dollar that an individual contributes to his/her private health insurance premium, the federal government will give him/her back 30 cents.

<sup>&</sup>lt;sup>24</sup> Private Health Insurance Administration Council (2005a).

<sup>&</sup>lt;sup>25</sup> Prime Minister of Australia (2004).

#### Community rating

- 2.3.10 The Commonwealth government implements the community rating measure to ensure access by all members of the community to private health insurance. Under the measure, the premiums charged by health insurance funds must not vary with regard to the gender, state of health or family size of the insured. Therefore, a sick old person should pay the same rate as a healthy young person for the same cover offered by the same health insurance fund.<sup>26</sup>
- 2.3.11 Since all health insurance funds are prohibited from selecting customers based on risk and charging higher premiums for persons of higher risk, some health insurance funds may have a membership profile made up of more older and/or chronically-ill persons than other funds.<sup>27</sup>

#### Reinsurance

2.3.12 The reinsurance mechanism is established for health insurance funds to share the costs of hospital treatment for high-claiming persons, i.e. older persons (aged 65 or over) and chronically-ill persons (persons aged 64 or below who have been hospitalized for 35 days or more in a rolling 12-month period). The Private Health Insurance Administration Council administers the Health Benefits Reinsurance Trust Fund. While health insurance funds paying benefits above their state or territory average for hospital services to high-claiming persons receive payments from the Fund, those health insurance funds paying less than the state or territory average in benefits contribute to the Fund to make up for the difference. Payments into and out of the Fund are equalized so that the net result each quarter is always a nil balance.<sup>28</sup>

#### Lifetime Health Cover

2.3.13 Lifetime Health Cover is a Commonwealth government initiative implemented on 1 July 2000. Offering an exemption from the community rating principle, this initiative allows the level of premiums charged on a particular member of a registered health insurance fund to be positively correlated with his/her age when he/she first takes out hospital cover with the fund. This design encourages people to take out hospital insurance earlier in life and to maintain their cover. The objective is to improve the overall health profile of health insurance members, which in turn makes premiums more affordable to all members.<sup>29</sup>

The Auditor-General (2005), p.17 and Private Health Insurance Administration Council (2006), pp.57-58.

<sup>&</sup>lt;sup>26</sup> Private Health Insurance Administration Council (2006), pp.57-58 and Private Health Insurance Administration Council (2005a).

<sup>27</sup> Ibid

<sup>&</sup>lt;sup>29</sup> Lifetime Health Cover (2004).

2.3.14 Under Lifetime Health Cover, people who take out hospital cover earlier in life are charged lower premiums throughout their lives. People who take out hospital cover after 30 years old pay a 2% loading on top of their premiums at aged 30 for every year over. For example, a person who delays joining until the age of 40 pays 20% more than one who joins at the age of 30, other things being equal. The maximum loading a person required to pay is 70%, payable by people who first take out hospital cover at age 65 or older.<sup>30</sup>

#### 2.4 Allocation mechanism of health care resources

- 2.4.1 Health care resources are kept by either the government or the health insurance funds, 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.

#### Government budget

- 2.4.2 Through the budgetary process at the federal level, public money (including health care resources) is allocated by the Commonwealth government to the state and territory governments and Australians through the following funding programmes<sup>31</sup>:
  - (a) Australian Health Care Agreements: Grants are provided to the state and territory governments to assist them with the cost of providing public hospital services;
  - (b) Medicare Benefits Schedule: Under this mechanism, medical benefits are provided to patients in the form of rebates on fees paid to private doctors, optometrists and other allied health practitioners;
  - (c) Pharmaceutical Benefits Schedule: Pharmaceutical benefits are provided to patients, allowing them access to subsidized medicines;

<sup>&</sup>lt;sup>30</sup> Lifetime Health Cover (2004).

<sup>31</sup> Yearbook Australia 2006 and Department of Health and Ageing (2004), p.5.

- (d) Health Program Grants: Grants are provided to government and non-government service providers for a range of health services, e.g. radiation oncology, pathology and primary medical services, to achieve health policy objectives such as improving access to health services for specific population groups;
- (e) Public Health Outcome Funding Agreements: Grants are provided to the state and territory governments to ensure that certain public health activities are undertaken;
- (f) Private health insurance rebate: A 30% private health insurance rebate is provided to the insured of private health insurance; and
- (g) General-purpose funding grants: Grants are provided to the state and territory governments which use part of these grants for the provision of health services.

#### Health insurance plans

2.4.3 Private health insurance plans provide explicit benefit packages to cover the costs of hospital and/or ancillary services that are not covered by Medicare. 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 the insurance policies, the health insurance companies reimburse money to the insured. In the case where medical institutions have made arrangements with the health insurance companies, medical institutions make claims directly to the health insurance companies for the medical expenses allowed in the insurance policies.<sup>32</sup>

#### 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 the financial year 2002-03.

Private Health Insurance Administration Council (2005a).

Table 3 – Distribution of health expenditure by area of expenditure of Australia in 2002-03

Area of expenditure	2002-03
Institutional care	
Hospitals	35.1%
High-level residential care <sup>1</sup>	6.5%
Ambulance and other	1.6%
Non-institutional care	
Medical services	17.2%
Other professional services	4%
Pharmaceuticals	14.3%
Aids and appliances	3.6%
Other non-institutional services <sup>2</sup>	15.7%
Research	2%
Total	100%

Remarks: 1. For example, residential care homes for the elderly.

2. Including community health, public health, dental services and administration.

Source: Australian Institute of Health and Welfare (2004), Table A6.

2.5.2 The following table presents the share of funding sources for selected types of health care services in the financial year 2002-03.

Table 4 – Share of funding sources for selected types of health care services of Australia in 2002-03

	Government fo	unding source	Non-government funding source			
	Commonwealth	State and local	Private health insurance	Individuals	Other <sup>1</sup>	Total
Institutional care						
Public hospitals	47.2%	45.5%	1.5%	1.7%	4.1%	100%
Private hospitals	34.7%	5.2%	45.3%	4.8%	10%	100%
High-level residential care	75.5%	4.6%	0%	19.9%	0%	100%
Non-institutional ca	re					
Medical services <sup>2</sup>	78.4%	0%	4.1%	11.9%	5.6%	100%
Benefit-paid pharmaceuticals	84.5%	0%	0%	15.5%	0%	100%
All other pharmaceuticals	1.5%	0%	1.3%	94.7%	2.5%	100%
Aids and appliances	9%	0%	9.5%	79.5%	2%	100%

Remarks: 1. "Other" includes expenditure on health goods and services by workers' compensation and compulsory third-party motor vehicle insurers as well as other sources of income (for example, interest earned) for service providers.

2. Medical services provided mainly by private medical practitioners.

Source: Australian Institute of Health and Welfare (2004), Table A3.

#### Hospital services

- 2.5.3 The Australian Health Care Agreements are five-year bilateral agreements between the Commonwealth government and each of the state and territory governments on the financing and provision of public hospital services in their respective jurisdictions.
- 2.5.4 In the 2003-08 Australian Health Care Agreements, the calculation of the amount of financial assistance provided to the state and territory governments is based on a set of formulae that takes population, the previous amount of grants received and other factors into consideration.<sup>33</sup>
- 2.5.5 Under the Agreements, the state and territory governments adopt the following principles in the provision of public hospital services<sup>34</sup>:
  - (a) public hospital services must be provided free of charge to public patients, i.e. patients who cannot choose doctors in receiving treatment;
  - (b) public hospital services must be provided on the basis of clinical need and within a clinically appropriate period; and
  - (c) people should have equitable access to public hospital services regardless of their geographical locations.
- 2.5.6 While the Commonwealth funding covers roughly half of the cost of public hospital services, the state and territory governments are committed to fund the remaining cost. Accordingly, Australians are entitled to free public hospital services if they choose to be treated as public patients.
- 2.5.7 Australians can choose to be treated as private patients in both public and private hospitals. A private patient can choose his/her preferred doctor in receiving treatment. Since Medicare pays only 75% of the Medicare Benefits Schedule<sup>35</sup> fee for services and procedures provided by the treating doctor, a private patient has to pay the remaining doctor's fees. In addition, a private patient is also charged for hospital accommodation and items such as theatre fees and medicines. Therefore, a private patient has to employ private health insurance or out-of-pocket payments to cover some or all of the costs that are not covered by Medicare.<sup>36</sup>

<sup>&</sup>lt;sup>33</sup> Australian Health Care Agreements (2004).

Australian Health Care Agreements 1998-2003 Performance Report (2004).

The Medicare Benefits Schedule is a schedule of health service fees determined by the Commonwealth government in consultation with professional bodies. Based on this Schedule, medical benefits are provided to patients in the form of rebates on fees paid to private medical practitioners for both out-of-hospital and in-patient services.

Medicare Benefits Schedule (2005) and Medicare (2006).

#### Primary health care services

- 2.5.8 In addition to in-patient services, the Medicare Benefits Schedule covers the following out-of-hospital services<sup>37</sup>:
  - (a) consultation fees for doctors, including specialists;
  - (b) tests and examinations by doctors needed to treat certain illnesses, including X-rays and pathology tests;
  - (c) eye tests performed by optometrists;
  - (d) most surgical and other therapeutic procedures performed by doctors;
  - (e) some surgical procedures performed by approved dentists;
  - (f) specified items under the Cleft Lip and Palate Scheme; and
  - (g) specified items for allied health services as part of the Enhanced Primary Care programme<sup>38</sup>.
- 2.5.9 For all patients, Medicare benefits usually cover 85% of the Schedule fees for out-of-hospital services. The remaining 15% of the Schedule fees are covered by out-of-pocket payments.<sup>39</sup> For those patients who cannot afford the payment, they may apply to the Medicare Safety Net for assistance.
- 2.5.10 Under the Medicare Safety Net arrangement, when the out-of-pocket payments of an applicant reach a safety net threshold in a calendar year, the applicant can receive further medical benefits. The current safety net threshold for the Commonwealth concession card holders (e.g. pensioners and seniors) and Family Tax Benefit (Part A) families is AUS\$500 (HK\$2,850) and AUS\$1,000 (HK\$5,700) for other Australians. The further medical benefit is equal to 80% of the out-of-pocket payments.<sup>40</sup>

<sup>&</sup>lt;sup>37</sup> *Medicare* (2006).

The Enhanced Primary Care programme aims at providing additional preventive care for older Australians and improving the co-ordination of care for people with chronic conditions and complex care needs.

<sup>&</sup>lt;sup>39</sup> *Medicare* (2006).

<sup>40</sup> How does the Medicare Safety Net work? (2006).

#### Medicines

- 2.5.11 Patients are required to make co-payments for acquiring prescription medicines listed on the Pharmaceutical Benefits Schedule. The maximum out-of-pocket payment for a pharmaceutical benefit item is AUS\$29.5(HK\$168) for general patients and AUS\$4.7(HK\$27) for concessional patients.<sup>41</sup>
- 2.5.12 The Pharmaceutical Benefits Safety Net is established to protect Australians from bearing significant cost on medicines. When the accumulated pharmaceutical expenses of a general patient (and/or his/her family) reach the safety net threshold of AUS\$960(HK\$5,472), he/she is required to pay only AUS\$4.7(HK\$27) per pharmaceutical benefit prescription for the rest of the calendar year. The concessional safety net threshold is AUS\$253(HK\$1,442). Once the accumulated pharmaceutical expenses of a concessional patient (and/or his/her family) reach this amount, he/she will receive pharmaceutical benefit items free of charge for the rest of the calendar year. <sup>42</sup>

#### 2.6 Policy evaluation

- 2.6.1 In 2000, the Senate Community Affairs Committee issued a report entitled *Healing Our Hospitals: Report on Public Hospital Funding.* The Committee report pointed out that publicly-funded health services were supported very strongly by the Australian community. As shown in the 2000 annual survey conducted by the Health Insurance Commission (renamed Medicare Australia in 2005), 83% of the community was satisfied with Medicare.<sup>43</sup> The satisfaction level of the community has maintained at around 90% in the subsequent years.<sup>44</sup>
- 2.6.2 Since its introduction in 1984, major political parties have been committed to the continuation of Medicare. As such, there have been no fundamental changes to the system. In order to make the Medicare system financially sustainable, the Commonwealth government has encouraged the development of private financing and delivery arrangements operating in parallel to the public system that offers universal access to Australians.

Senate Community Affairs Committee (2000), p.9.

Schedule of Pharmaceutical Benefits for Approved Pharmacists and Medical Practitioners (2005) About the PBS (2004) and Biggs (2003b).

<sup>42</sup> Ibid

Health Insurance Commission 2004-05 Annual Report (2006).

- 2.6.3 With respect to private health insurance, the Organisation for Economic Co-operation and Development study entitled *Private Health Insurance in Australia: A Case Study* suggests that the insured benefits from the Australian system as they can choose between private and public hospitals. In addition, they benefit from the timeliness of hospital care offered in private hospitals, in particular elective surgery, as the waiting list for such services in the public sector is long.<sup>45</sup>
- 2.6.4 Although the study recognizes the benefits from the promotion of private health insurance, there are some challenges to be met<sup>46</sup>:
  - (a) While the introduction of the private health insurance rebate boosts the take-up rate of private health insurance, government expenditure on rebate has increased correspondingly;
  - (b) While the regulation of the health insurance industry through community rating helps ensure equal access of the public to private insurance, higher-income households receive a larger rebate because they tend to purchase more expensive health insurance plans;
  - (c) While the regulation of the health insurance industry through reinsurance helps ensure equal opportunity of the health insurance companies to operate in the market, this measure reduces health insurance companies' incentives to manage high-cost cases in the most cost-efficient manner because the cost of treatment for those cases are shared by the industry; and
  - (d) While patients have the choice to be treated as public or private patients in public hospitals, higher payments for professionals when treating private patients may affect the allocation of doctors' time between public and private patients.

#### 2.7 State of Victoria

#### Introduction

2.7.1 This section provides information on the health care resources as well as health care delivery system and its reforms in the State of Victoria.

<sup>&</sup>lt;sup>45</sup> Colombo and Tapay (2003), pp.37-39.

<sup>&</sup>lt;sup>46</sup> Colombo and Tapay (2003), pp.37-39 and Denniss (2005).

#### Distribution of health care resources

- 2.7.2 In the financial year 2005-06, the State of Victoria spends AUS\$7,651.1 million (HK\$43,611 million) on health care. This amount of spending represents 25.2% of the total state government expenditure and 66.9% of the total expenditure by the Department of Human Services, the responsible department for health, aged care, housing, children and community services.<sup>47</sup>
- 2.7.3 The following table presents figures on the State of Victoria's distribution of health expenditure among different health sectors in the financial year 2005-06.

Table 5 – Distribution of health care resources among health sectors in the State of Victoria

	Amount in million	Percentage
Acute health services <sup>1</sup>	AUS\$5,650.5 (HK\$32,208)	73.8%
Mental health	AUS\$732.5 (HK\$4,175)	9.6%
Ambulance services	AUS\$363.5 (HK\$2,072)	4.8%
Small rural services <sup>2</sup>	AUS\$318.6 (HK\$1,816)	4.2%
Primary and dental health	AUS\$280 (HK\$1,596)	3.7%
Public health	AUS\$195.1 (HK\$1,112)	2.5%
Drug services <sup>3</sup>	AUS\$110.9 (HK\$632)	1.4%
Total	AUS\$7,651.1 (HK\$43,611)	100%

Remarks: 1. Acute hospital in-patient, ambulatory, emergency, community-based and specialist

- 2. Health and aged care services delivered in small rural towns.
- 3. Services to reduce and prevent the death, disease and social harm caused by the use and misuse of licit and illicit drugs.

Sources: 2005-06 Victorian Budget Paper: Service Delivery (2005) and 2005-06 Human Services Strategic Framework (2005).

<sup>&</sup>lt;sup>47</sup> 2005-06 Victorian Budget Paper: Statement of Finances (2005) p.43, 2005-06 Human Services Strategic Framework (2005) and 2005-06 Victorian Budget Paper: Service Delivery p.67.

2.7.4 The Department of Human Services of the state government is responsible for the distribution of health care resources. It has established guidelines for the allocation of resources to health care providers and also a reporting system to make sure that health care providers utilize the resources in an appropriate way. For example, in the *Victoria — Public Hospital & Mental Health Services Policy & Funding Guidelines 2005-06*, the policy objectives to be achieved in public hospitals and mental health services and the financial commitments in the financial year 2005-06 are stated. The document also describes how the health care providers are funded and the reporting requirements.<sup>48</sup>

#### Health care delivery system

- 2.7.5 With respect to health, the Department of Human Services is responsible for "funding and/or delivering high quality and efficient health care services through the public hospital system, community health services and ambulance services". 49
- 2.7.6 Two divisions under the Department of Human Services are responsible for health and aged care services within the State of Victoria. The Metropolitan Health and Aged Care Services Division and the Rural and Regional Health and Aged Care Services Division are responsible for the full range of health and aged care services in the three metropolitan regions and five rural regions within the state respectively. The metropolitan regions altogether have 73% of the total population of the State of Victoria and the rest of the population live in the rural regions.<sup>50</sup>
- 2.7.7 The Metropolitan Health and Aged Care Services Division performs the function of co-ordinating 15 Metropolitan Health Services, each of which consists of one or more health institutions providing a combination of geographically- and specialty-based services. For example, Bayside Health, one of the Metropolitan Health Services, is the main provider of health services to people in the inner south-east suburbs of Melbourne through two hospitals and one medical centre. The Alfred, a hospital under Bayside Health provides statewide specialty services such as heart and lung transplantation. In addition, the Metropolitan Health and Aged Care Services Division is also responsible for the registration and regulation of private hospitals.<sup>51</sup>

<sup>&</sup>lt;sup>48</sup> Victoria — Public Hospital & Mental Health Services Policy & Funding Guidelines 2005-06.

<sup>49</sup> Departmental Plan 2005-06: Department of Human Services (2005), p.4.

Department of Human Services Annual Report 2004-05 (2005), pp.36-37 and pp.40-42, and Metropolitan Health & Aged Care Services (2005).

Metropolitan Health Strategy (2003), p.3 and pp.65-68 and Metropolitan Health & Aged Care Services (2005).

- 2.7.8 Three of the 15 Metropolitan Health Services, i.e. Calvary Health Care Bethlehem, Mercy Health and Aged Care and St. Vincent's Health, are governed by not-for-profit religious organizations. Each of the others is governed by a board with its directors appointed by the Minister for Health of the state government.<sup>52</sup>
- 2.7.9 The provision of ambulatory services either collocates with hospitals or is originated from community-based facilities, including community health services, community rehabilitation centres, private medical practitioners and allied health practitioners who provide primary care services and mental health community-based services.<sup>53</sup>
- 2.7.10 The state government has adopted the Primary Care Partnership Strategy, initiated in 2000, to ensure that primary care providers work effectively together to improve health and well-being in their local communities. In addition, the strategy aims to enhance the positive experience and outcomes for people who use primary health care services and to reduce avoidable uses of hospital, medical and residential care services.<sup>54</sup>
- 2.7.11 The Metropolitan Health Strategy, introduced by the state government in 2003, has provided four strategic directions to meet the demand for health care services across metropolitan Melbourne in the coming decade. The four strategic directions are<sup>55</sup>:
  - (a) increasing capacity of the health care system by increasing the number of hospital beds and emergency department services;
  - (b) making better use of existing facilities by redistribution and reconfiguration;
  - (c) promoting service substitution and diversion to reduce the reliance on hospital services, e.g. developing community-based ambulatory care; and
  - (d) developing new service models, e.g. developing health precincts in metropolitan communities to bring together a range of health services such as aged care and disability, community mental health and rehabilitation, dental, diagnostic and general practitioner services.

<sup>&</sup>lt;sup>52</sup> Public Hospital Governance (2006).

<sup>&</sup>lt;sup>53</sup> *Metropolitan Health Strategy* (2003), p.3.

<sup>&</sup>lt;sup>54</sup> Primary Care Partnerships (2006).

<sup>55</sup> Metropolitan Health Strategy (2003), p.iv and Department of Human Services (2005) p.6.

#### **Chapter 3 – New Zealand**

#### 3.1 Background

- 3.1.1 Immediately near the close of the World Depression in the 1930s, the Labour government of New Zealand introduced the *Social Security Act 1938*, instituting a comprehensive health care system that mandated the provision of free care for all New Zealanders. By 1947, New Zealand had set up a predominantly tax-funded health care system that made most available services free to users at the point of delivery with a mixed public and private provision. This centrally-funded and centrally-managed health care system was in operation in the next few decades. <sup>56</sup>
- 3.1.2 Starting from the mid-1970s, New Zealand has witnessed a series of health reforms almost every time following a change in government. Subsequent to the publication of a report entitled *A Health Service for New Zealand* in 1974, the Special Advisory Committee on Health Services Organizations was set up to advise the government on ways to integrate the array of health services. The Committee's recommendations led to the enactment of the *Area Health Boards Act 1983*, which provided the basis for establishing local health boards. Health boards were initially elected and later composed of both elected members and members appointed by the Minister for Health, to plan and manage the delivery of health services for their respective areas.<sup>57</sup>
- 3.1.3 The introduction of 14 Area Health Boards in the 1980s marked the beginning of a devolved health care system, which was maintained as the centre-piece of reform amidst the reforms of the health care financing system in the subsequent decades, particularly in the 1990s.
- 3.1.4 The health care reform in 1993 featured a greater reliance on the market mechanism. The central feature of the restructuring was the establishment of "buyers" and "sellers" through the separation of the roles of health services purchasers and providers. This arrangement allowed purchasers more flexibility in choosing health care providers and created competition among health care providers.

French, Old and Healy (2001), pp.23-24 and World Health Organization (2004) pp.16-19.

<sup>57</sup> Ibid.

- 3.1.5 In the 1993 health care reform, the Department of Health was transformed into the Ministry of Health, the focus of which was on policy development. Four Regional Health Authorities were set up to purchase primary, secondary and tertiary health and disability support services with a capped budget. The services previously provided by the 14 Area Health Boards introduced in the 1980s were placed under 23 Crown Health Enterprises which contracted with the Regional Health Authorities and the Accident Compensation Corporation to provide health services. The Crown Health Enterprises were structured as for-profit companies and, under the *Health and Disability Services Act 1993* (section 11), were required to "be as successful and efficient as comparable businesses that are not owned by the Crown". 58
- 3.1.6 While the 1996 health care reform retained the purchaser/provider split, the market-oriented elements were removed. Under the reform, the Regional Health Authorities were replaced by a single national purchasing organization, the Health Funding Authority. The Crown Health Enterprises were also reconfigured into not-for-profit government-owned organizations, i.e. Hospitals and Health Services.<sup>59</sup>
- 3.1.7 Under the latest health care reform in 2000, the purchaser/provider split principle was abandoned and a system of elected local health boards returned. Twenty-one district health boards are set up under the *New Zealand Public Health and Disability Act 2000*. Each district health board consists of a maximum of 11 board members. Seven members are elected every three years at the local government election and up to four members can be appointed by the Minister for Health.<sup>60</sup>
- 3.1.8 The district health boards are funded by the central government on a population basis. In spite of their status not being a government agency, they are responsible for either purchasing or directly providing public health care services for a geographically-defined population. The population within a health board ranges from 31 000 to 489 000. This system of citizen participation in the provision of health care services has remained in place since then.<sup>61</sup>

61 Ibid.

Ministry of Health (2003a) p.4, World Health Organization (2004) pp.19-21 and French, Old and Healy (2001), pp.26-29.

Ministry of Health (2003a) p.4, French, Old and Healy (2001), pp.29-30 and World Health Organization (2004) pp.21-22.

Frequently asked questions about District Health Boards (2004), French, Old and Healy (2001), pp.30-34 and World Health Organization (2004) p.22.

#### 3.2 Overview of health care system

#### Structure

- 3.2.1 The Ministry of Health of the central government is responsible for policy formulation, funding, monitoring, regulation and evaluation of the health care system. In particular, it is responsible for allocating funding to the district health boards and other statutory corporations in the health sector and monitoring their performance. 62
- 3.2.2 The district health boards take a leading role in the delivery of health care services within their geographical areas. They either deliver services themselves or fund other providers to do so. As statutory corporations reporting to the Minister for Health, they are responsible for setting their strategic direction, appointing the chief executives, and improving, promoting and protecting the health of the population within their districts. With regard to the provision of care to the injured involved in accidents, the Accident Compensation Corporation, a statutory organization set up in 1974, purchases services from health care providers for injured people across all districts. Accident Compensation Corporation injured people across all districts.
- 3.2.3 The following table presents some basic statistics about the delivery system of health care services in New Zealand.

Table 6 – Statistics on the delivery system of health care services in New Zealand

	Number	Ratio	
Health workforce <sup>1</sup>		per 10 000 population	
Doctors	8 790	21.9	
Dentists	1 582	4	
Pharmacists	Data no	Data not available	
Nurses	34 660	85.3	
Midwives	3 780	9.3	
Health infrastructure <sup>2</sup>			
Public hospitals	85 (12 484 beds)	62 hospital beds per 10 000 population	
Private hospitals	360 (11 341 beds)		
Occupancy rate of acute care beds	Data not available		

Remarks: 1. doctors and dentists are 2003 figures, and nurses and midwives are 2004 figures.

2. 2002 figure.

Sources: Regional Office for the Western Pacific, World Health Organization (2005) and World Bank (2005).

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Ministry of Health (2005) pp.7-8.

<sup>&</sup>lt;sup>63</sup> Frequently asked questions about District Health Boards (2004), The New Zealand Public Health and Disability Act 2000 (2005).

<sup>&</sup>lt;sup>64</sup> *History of ACC* (2006).

#### **Financing**

- 3.2.4 The guiding principles of the New Zealand health care system are as follows<sup>65</sup>:
  - (a) All New Zealanders must have access to an acceptable level of health and disability support services when they need them, regardless of ability to pay; and
  - (b) It is a core responsibility of the government to finance and provide (or ensure the provision of) a comprehensive public health system.
- 3.2.5 The health care financing system of New Zealand 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 the district health boards. Meanwhile, the Accident Compensation Corporation collects levies from employers, earners and motor vehicle owners for purchasing accident-related health care services. 66
- 3.2.6 While members of the public may be required to pay partially or fully for health care services or medicines received, the government has set up a safety net to support those who cannot afford the payments. For example, a low-income family can apply for a Community Services Card which allows the family access to subsidized doctor visits and pharmaceuticals.
- 3.2.7 The establishment of the district health boards aims to promote community participation in planning and providing health care services in their respective districts. In particular, the district health board system promotes the integration of health services, especially primary and secondary care services.
- 3.2.8 The following table presents some basic information about expenditure on health services of New Zealand in the financial year 2002-03, which may serve as indicators on health expenditure.

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<sup>65</sup> Ministry of Health (2004a), p.2.

The accident-related levy is collected in accordance with the *Injury Prevention, Rehabilitation, and Compensation Act* 2001.

Table 7 – Health expenditure indicators of New Zealand in 2002-03

Total expenditure on health as % of GDP	8.7%
Per Capital total expenditure on health	NZ\$2,807
	(HK\$14,453)
General government expenditure on health as % of total expenditure on health	78.3%
Non-government expenditure on health as % of total expenditure on health	21.7%
General government expenditure on health as % of total general government expenditure	14.2%
External resources for health as % of total government expenditure on health	4.6%
Health insurance coverage as % of total population	33%

Sources: Regional Office for the Western Pacific, World Health Organization (2005) and Ministry of Health (2005b), Tables 7.1 and 8.1-8.4. and Appendices 3 and 4B.

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

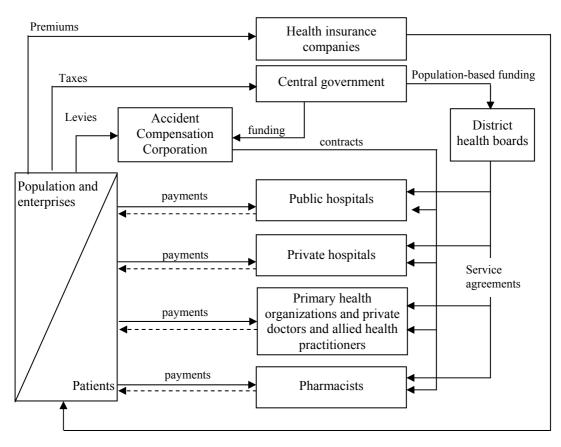


Chart 2 – Health care system of New Zealand

Legend: → Financial flows ----- Services flows

Sources: Ministry of Health (2005a) and Organisation for Economic Co-operation and Development Secretariat (2005a).

#### 3.3 Collection mechanism of health care resources

- Apart from out-of-pocket payments and donations from charity 3.3.1 organizations, health care resources are mainly pooled through the following ways:
  - (a) general taxation;
  - (b) accident-related levies; and
  - (c) health insurance plans.

#### General taxation

The major source of the government's general revenue (including health 3.3.2 care resources) comes from individual income taxes, goods and services taxes and corporate taxes. In the financial year 2005-06, the respective estimated percentage share of individual income taxes, goods and services taxes and corporate taxes in the total revenue are 43%, 19% and 17%, together accounting for 79% of the estimated total revenue.<sup>67</sup>

#### Accident-related levy

- 3.3.3 The Accident Compensation Corporation is responsible for operating an insurance-based scheme to rehabilitate and compensate people who suffer from personal injuries. The accident insurance scheme provides comprehensive no-fault insurance for accident-related injuries and disabilities.<sup>68</sup>
- The accident-related levies are collected from the following sources<sup>69</sup>: 3.3.4
  - (a) Employers pay a levy based on their total payroll and the relative safety/risk involved in the type of work performed. An employer's work record also influences the levy level;
  - (b) Earners pay a levy based on their total earnings which is collected by deducting from their salaries;

About ACC (2006).

Budget 2005: Key Facts for Taxpayers (2005).

How ACC is funded (2006) and French, Old and Healy (2001), pp.55-56.

- (c) Motor vehicle owners' and drivers' levies are included in the annual vehicle registration fee and an excise duty component on petrol sales; and
- (d) The government makes an annual payment to cover people who are not earning any income.

#### Health insurance plans

- 3.3.5 The New Zealand government considers that its approach to the privately-financed health sector can be described as *laissez faire*. Private insurance and direct payments for treatment in the private sector are not subsidized and the regulation of health insurance companies is minimal.<sup>70</sup>
- 3.3.6 In New Zealand, health insurance companies insure people against "gap" and "supplementary" costs, rather than providing a comprehensive health cover. People can insure against some or all of the gaps between the government subsidy and the charges levied by providers on a range of health services. Health insurance companies also provide supplementary insurance to reimburse the insured for surgery and other treatments by private hospitals and private specialists. While there are many health insurance companies operating in the private health insurance market of New Zealand, Southern Cross Healthcare is by far the biggest with an estimated 60% market share. 71

#### 3.4 Allocation mechanism of health care resources

- 3.4.1 Health care resources are kept by the government, accident insurance scheme accounts or 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) government budget;
  - (b) Accident Compensation Corporation; and
  - (c) health insurance plans.

French, Old and Healy (2001), p.55 and McPherson (n.d.).

Ministry of Health (2004a), p.38.

#### Government budget

- 3.4.2 Through the budgetary process, public money is allocated by the central government to various policy areas, including health. The resources dedicated to health are allocated to the district health boards according to the population-based The district health boards use the allocated money for the funding formula. provision of health care services in their respective districts.<sup>72</sup>
- The population-based funding formula is an aggregate formula that determines the share of funding to be allocated to each district health board. aim of the formula is to fairly distribute available funding among district health boards according to the relative needs of their populations and the cost of providing health and disability support services to meet those needs.
- According to the formula, each district health board's share of health and 3 4 4 disability funding is determined by:<sup>73</sup>
  - (a) its share of the projected population, weighted according to the national average cost of the health and disability support services used by various demographic groups;
  - (b) an additional policy-based weighting for unmet need that recognizes the challenges the district health boards face in reducing disparities between population groups; and
  - (c) a rural adjustment and an adjustment for overseas visitors, each of which redistributes a set amount of funding among the district health boards to recognize unavoidable differences in the cost of providing certain health and disability support services.
- 3.4.5 The district health boards assume both a funder's role and a provider's role. With respect to primary health care, each district health board provides funding for the primary health organizations<sup>74</sup> within its geographical area which supply a range of primary health care services for their enrollees. At the same time, the district health boards are the main providers of secondary and tertiary health services through their public hospitals.

Ministry of Health (2005c), p.55.

Ministry of Health (2004b), p.vii.

## **Accident Compensation Corporation**

- 3.4.6 Levies collected by the Accident Compensation Corporation for the accident insurance scheme are deposited in the following accounts to cover compensation on various injuries:<sup>75</sup>
  - (a) Employers' account covering work-related injuries;
  - (b) Self-employed work account covering all personal work-related injuries to the self-employed;
  - (c) Earners' account covering non-work injuries (including those occurred at home, and during sport and recreation) to earners and the self-employed;
  - (d) Medical misadventure account covering injuries from error by health professionals or from unexpected outcomes of medical or surgical procedures properly carried out;
  - (e) Non-earners' account covering all personal injuries to people not in the paid workforce, including students, beneficiaries, older people and children;
  - (f) Motor vehicle account covering all personal injuries involving motor vehicles on public roads; and
  - (g) Residual claims account covering the continuing cost of work-related injuries occurred before 1 July 1999 and non-work injuries suffered by earners prior to 1 July 1992.

## Health insurance plans

3.4.7 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.

Accident Compensation Corporation (2005), p.12.

#### 3.5 Distribution of health care resources

# Statistical profile

3.5.1 The following table shows the distribution of the health care resources by area of expenditure in the financial year 2002-03.

Table 8 – Distribution of health expenditure by area of expenditure of New Zealand in 2002-03

Area of expenditure	2002-03
Institutional care	
Public institutions <sup>1</sup>	35%
Private institutions <sup>2</sup>	14%
Non-institutional care	
Community care <sup>3</sup>	44.9%
- General practitioners	7.7%
- Medicaments	11.4%
Public health	2.3%
Teaching and research	2.3%
Ministry of Health	1.5%
Total	100%

Remarks: 1. This category corresponds to publicly-owned hospitals. It also includes some in-patient community treatment centres.

- 2. This category includes all private hospitals and community homes providing disability services.
- 3. Personal health care services provided under the category of community care correspond to ambulatory and domiciliary services provided other than those provided through public and private institutions. They include the services of general medical practitioners, medical specialists, nurses, midwives, dentists and various other health care practitioners.

Source: Ministry of Health (2005b), Appendix 5A.

3.5.2 The following table presents the share of funding sources for selected types of health care services in the financial year 2002-03.

<b>Table 9 – Share of funding sources</b>	for selected	types of	health car	re services o	f
New Zealand in 2002-03					

	Public fur	nding source	Priv				
	Central government	Accident Compensation Corporation	Private health insurance	Out-of- pocket	Not-for-profit organizations	Total	
Institutional care							
Public institutions	92.1%	7.8%	0.02%	0.1%	0.004%	100%	
Private institutions	31.9%	9.1%	41.8%	17%	0.2%	100%	
Public age-related disability support institutions	100%	0%	0%	0%	0%	100%	
Private age-related disability support institutions	96.7%	0%	0%	0%	3.3%	100%	
Community care							
General practitioners <sup>1</sup>	49.6%	7.2%	6.9%	36.1%	0.2%	100%	
Medicaments <sup>2</sup>	66.1%	1%	2.4%	30.5%	0.001%	100%	

- Remarks: 1. General practitioners are doctors or nurses, providing personal health services in general primary care settings. Among such settings are solo and group practices, union-based or indigenous people-based health centres, accident and medical centres, student health centres, family planning centres and health services provided in prisons, barracks and factories.
  - 2. "Medicaments" include medicines, dressings, syringes and other therapeutic devices, along with associated dispensing costs. They cover prescription medicaments as well as those available over the counter from doctors, pharmacists or other outlets.

Source: Ministry of Health (2005b), Appendix 5A.

#### District health board

- Based on the population-based funding formula, each district health board is 3.5.3 allocated an annual budget and each of them "must operate in a financially responsible manner and, for this purpose, must endeavour to cover all its annual costs (including the cost of capital)."<sup>76</sup> In the case where it appears likely that deficits may arise, the district health board must immediately advise the Minister for Health of why such a situation happens. The Ministry of Health will discuss with the district health board ways to rectify the issue.<sup>77</sup>
- In addition to the formula-based funding arrangement, each district health board is required to prepare the following business plans with regard to its distribution of health care resources:<sup>78</sup>

Section 41 of the New Zealand Public Health and Disability Act 2000.

Ministry of Health (2003b), p.10.

Sections 38, 39 and 40 of the New Zealand Public Health and Disability Act 2000.

- (a) District Strategic Plan which has a 5 10 year focus and is developed in consultation with the community and endorsed by the Minister for Health;
- (b) District Annual Plan which consists of the annual Crown Funding Agreement and the Statement of Intent (budget), and is agreed by the Minister for Health; and
- (c) monthly and quarterly reports against the District Annual Plan which are submitted to the Ministry of Health.

# **Hospital services**

- 3.5.5 The district health boards provide hospital services to people in their respective geographical areas either through their own hospitals or purchased services from other hospitals. Proposals for establishing new hospitals, purchasing new services and rolling over of existing purchased services must be included in a district health board's District Annual Plan for approval by the Minister for Health and Minister for Finance.<sup>79</sup>
- 3.5.6 Public hospital services are free of charge for all New Zealanders. The government regards that public hospitals should primarily be used for the provision of publicly-funded services. The public hospitals are allowed to treat private patients only when they prove that the privately-funded services lead to an improvement in the clinical quality or the efficiency of services for public patients; there are spare capacities beyond that required for providing services to public patients; and patients are informed of the publicly-funded option.<sup>80</sup>

### Primary health care services

3.5.7 General practitioners can make claims for a General Medical Services subsidy<sup>81</sup> from the Ministry of Health whenever they deliver services to a patient entitled to the subsidy. Patients who are eligible for the subsidy are those aged 17 or below as well as the disadvantaged adults, i.e. low-income and chronically-ill persons.<sup>82</sup> The subsidy rates are presented in the following table.

<sup>&</sup>lt;sup>79</sup> Ministry of Health (2003b), p.34.

Ministry of Health (2003b), p.34 and Waitemata District Health Board (2003).

The subsidy has been in effect since the late 1930s.

<sup>&</sup>lt;sup>82</sup> Government Funding of General Practice Services (2005).

<b>Table 10</b> –	Government	subsidy	per	standard	general	practice	visit	in	New
	Zealand								

Age group	Community Services Card <sup>1</sup> and High Use Health Card <sup>2</sup> holders	No Community Services Card or High Use Health Card
Under 6 years	NZ\$35(HK\$178.5)	NZ\$35(HK\$178.5)
6 to 17 years	NZ\$20(HK\$102)	NZ\$15(HK\$76.5)
18 years or over	NZ\$15(HK\$76.5)	Nil

- Remark: 1. Community Services Cards are issued to families whose income is below an income threshold of their respective family sizes. For example, the income threshold for a single person who shares accommodation with others is NZ\$20,275(HK\$103,402.5) per year.
  - 2. High Use Health Cards are issued to people who have visited the doctor 12 times or more in the last 12 months for an on-going condition.

Sources: Government Funding of General Practice Services (2005) and Ministry of Social Development (n.d.).

- 3.5.8 A subsidized patient pays the difference between the general practitioner's charge and the government subsidy. Adults who are 18 years or over and without a Community Services Card or High Use Health Card pay the full fee to general practitioners. The General Medical Services subsidy applies to those general practitioners not joining any primary health organization only. There are two categories of primary health organizations. "Access" primary health organizations are primary health organizations in the deprived areas as defined by the New Zealand Deprivation Index, and all others are categorized as "Interim" primary health organizations.
- 3.5.9 For general practitioners who join the primary health organizations, they are being reimbursed by capitation. Annual capitation payments are distributed by the district health boards to the primary health organizations in each district based on the number and characteristics (such as age and gender) of New Zealanders enrolled with them. The annual capitation rates are calculated by multiplying the number of times a person is expected, on average, to visit a general practitioner in a year by the amounts shown in the following table. As at October 2004, more than 92% of New Zealanders were enrolled with primary health organizations.<sup>83</sup>

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Ministry of Health (2005c), p.25.

Table 11 -	- Amount of	government	subsidy	for	the	calculation	of	annual
	capitation in	New Zealand	l					

Age group	Access Primary Health Organization	Interim Primary Health Organization
Under 6 years	NZ\$37.4(HK\$190.7)	NZ\$37.4(HK\$190.7)
6 to 24 years		NZ\$26.75(HK\$136.4)
25 to 64 with a CSC <sup>1</sup> or HUHC <sup>2</sup>	N7¢24 75/HV¢124 4)	NZ\$15(HK\$76.5)
25 to 64 without a CSC or HUHC	NZ\$26.75(HK\$136.4)	Nil
65 years or over		NZ\$26.75(HK\$136.4)

Remark: 1. CSC = Community Services Card

2. HUHC = High Use Health Card

Sources: Government Funding of General Practice Services (2005) and Ministry of Social Development (n.d.).

3.5.10 Enrollees of a primary health organization who are aged 25 to 64 and without a Community Services Card or High Use Health Card pay the full fee of NZ\$30(HK\$153) to NZ\$45(HK\$229.5) set by the treating general practitioners. Enrollees of other age groups pay a somewhat lower fee, e.g. NZ\$5(HK\$25.5) to NZ\$10(HK\$51) for patients aged under six.

#### Medicines

3.5.11 Prior to April 2004, all New Zealanders aged six or above were required to pay a co-payment on government-subsidized prescription medicines up to NZ\$15(HK\$76.5) per pharmaceutical prescription. Starting from April 2004, the maximum co-payment has gradually been reduced to NZ\$3(HK\$15.3).<sup>85</sup>

Waitemata District Health Board (2003) and Government Funding of General Practice Services (2005)

Pharmaceutical co-payments (2006).

## 3.6 Policy evaluation

- 3.6.1 The New Zealand health care system has undergone several rounds of significant structural changes over the last two decades. In the 1980s, the regionalized Area Health Boards were introduced. In the 1990s, a quasi-market model with health care services being considered as quasi-commodities was put in place, with distinguished health purchaser and provider roles. With the establishment of the district health boards, the regional governance model of the 1980s has resumed. Some academics point out that these rounds of restructuring have made the health sector "weary and wary of change". 86
- 3.6.2 The performance of the district health boards are monitored by the Ministry of Health. One of the performance indicators of the district health boards is the rate of patient satisfaction. The district health boards are required to conduct a quarterly patient satisfaction survey according to the guidelines set by the Ministry of Health and submit the result of the survey to the Ministry. According to the Ministry, the overall patient satisfaction rate for all district health boards went up from 86% in the fourth quarter of 2001 to 88% in the fourth quarter of 2005.
- 3.6.3 After the establishment of the district health boards, two district health board elections were held in 2001 and 2004, with the candidates per contested seat ratio being 7.4 and 3.5 respectively. Despite the drop in the ratio from 2001 to 2004, 3.5 candidates per contested seat still indicated a fairly high participation rate. With regard to the voter turnout rate, 50% of the voters cast their vote in the 2001 election, and the 2004 election was 42%. Overall, the concept of citizen participation appears to be well received by the general public, as reflected by these figures.
- 3.6.4 The current district health board system runs on a non-market principle, under which health care resources are utilized to provide social services to fulfil the needs of the population. According to some academics, such a system faces the following dilemmas:<sup>89</sup>
  - (a) While the district health board system emphasizes citizen participation in decision making by having elected members, there is the danger that they may be controlled by special interest groups, despite the presence of appointed members; and
  - (b) The population-based funding is based on the number of people living in each region, their ethnicity and age structure, and other population characteristics that affect the need for health and disability services. As these factors are changing, ensuring equal access to health care services among the district health boards is a challenge.

French, Old and Healy (2001), p.108 and p.111.

Ministry of Health (2005d), various issues.

<sup>88</sup> Gauld (2005).

French, Old and Healy (2001), pp.111-113.

# **Chapter 4 – Singapore**

# 4.1 Background

- 4.1.1 Singapore retained a British-style, tax-based, largely publicly-provided health care system amidst its independence in 1965. At that time, health care services were mainly provided free or at a nominal charge to the general public by the public sector and financed through general taxes.<sup>90</sup>
- 4.1.2 In view of the imminent problem of the escalating health care budget, the former Prime Minister Lee Kuan Yew suggested in 1975 "to set aside part of each person's monthly Central Provident Fund contribution for co-payment of that person's medical bills." In 1981, the Minister for Health announced that "a cradle-to-grave health system, like that of the British National Health Service and those of other welfare states, is not for Singapore."
- 4.1.3 The major health care financing reform started in 1984. Instead of modifying the tax-based financing system, Singapore developed a medical savings account system. According to the *National Health Plan* announced in 1983, Medisave Accounts under the Central Provident Fund were established in 1984. The Medisave system has been in place since then. Both employees and employers are required to make mandatory contributions to the Medisave Accounts. The accumulated savings in an individual's Medisave Account may be used for paying his/her own and/or immediate family members' hospital bills. 93
- 4.1.4 Since the establishment of the medical savings account system, the government has developed the following measures to supplement the system. 94
  - (a) MediShield: It is a low-cost catastrophic medical insurance scheme set up in 1990 and run by the Central Provident Fund Board to help Singaporeans pay for hospitalization bills at the lower-class wards in public hospitals. Participants of the Central Provident Fund are automatically registered under MediShield once they have started making contributions to the Fund. Nevertheless, they are allowed to opt out of the scheme;

<sup>92</sup> Sunday Times, 11 May 1981, quoted from Legislative Council Secretariat (1999), p.7.

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<sup>&</sup>lt;sup>90</sup> Lim (2004), p.85 and Hanvoravongchai (2002), p.10.

<sup>&</sup>lt;sup>91</sup> Lee (2000), p.100.

<sup>93</sup> Aw and Low (1997), p.55 and Phua (1991), pp.3-4.

Medisave, Medishield and Other Subsidy Schemes (2006).

- (b) MediFund: It is an endowment fund set up by the government in 1993 to help poor Singaporeans pay for their medical care. As a safety net, the MediFund Committee<sup>95</sup> of an approved hospital or medical institution considers each application according to the applicant's financial circumstances and the size of the bill;
- (c) MediShield Plus: It is a high-cost catastrophic medical insurance scheme set up in 1994 to allow Singaporeans to upgrade the MediShield benefits, such as paying hospitalization bills at upper-class wards in public hospitals and private hospitals; and
- (d) ElderShield: It is 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.
- 4.1.5 In the 2005 reform, MediShield and MediShield Plus have undergone the following changes to strengthen the role of the private sector in the provision of health insurance: <sup>96</sup>
  - (a) The MediShield Plus schemes have been transferred en bloc from the Central Provident Fund Board to a tendered health insurance companies and renamed IncomeShield; and
  - (b) The Central Provident Fund Board and health insurance companies have become the joint insurers for an integrated MediShield plan. The insured of an integrated MediShield plan is eligible for the MediShield benefits plus additional benefits, such as upgrading to higher-class hospital wards. While the Central Provident Fund Board is responsible for the provision of MediShield benefits, health insurance companies offer a variety of packages of additional benefits for different levels of premiums.

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The MediFund Committee comprises largely government appointed members who are actively involved in community social work.

Ministry of Health (2005a).

## 4.2 Overview of health care system

### Structure

- 4.2.1 The Ministry of Health has the overall responsibility for the formulation of health care policies and regulation of health care services. The National Healthcare Group and the Singapore Health Services, two public corporations set up in 2000, aim at facilitating a seamless provision of public primary, secondary and tertiary health care services in their respective geographical areas through a network of public hospitals and clinics. These two public corporations co-ordinates the distribution of operating subventions provided by the Ministry of Health to public hospitals. In addition, they implement programmes to make health care services better, faster, safer and more affordable to the public. An example of such programmes is the Medication Safety Collaborative started in 2004 by the National Healthcare Group, which aims at reducing the incidence of adverse drugs events by 60% across its network of institutions by the end of 2006. The services is a service of the public of such programmes is the Medication Safety Collaborative started in 2004 by the National Healthcare Group, which aims at reducing the incidence of adverse drugs events by 60% across its network of institutions by the end of 2006.
- 4.2.2 The following table presents some basic statistics about the delivery system of health care services in Singapore.

Table 12 – Statistics on the delivery system of health care services in Singapore

	Number	Ratio		
Health workforce <sup>1</sup>		per 10 000 population		
Doctors	6 492	15.31		
Dentists	1 227	2.89		
Pharmacists	1 288	3.04		
Nurses (and assistant nurses)	19 330	55.4		
Midwives	365	0.86		
Health infrastructure <sup>2</sup>				
Public hospitals	13 (8 813 beds)	34 hospital beds per		
Private hospitals	16 (3 027 beds)	10 000 population		
Occupancy rate of acute care beds <sup>3</sup>	73.1%			

Remarks: 1. 2004 figures.

2. 2002-03 figures.

3. 2002 figure.

Sources: Khoo (2004), Regional Office for the Western Pacific, World Health Organization (2005) and World Bank (2005).

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Hospitals, Clinics and Other Healthcare Establishments (2004), Healthcare Delivery System in Singapore (2003) and Minister for Health (2000).

National Healthcare Group (2006) and SingHealth (2006).

## **Financing**

- 4.2.3 The guiding principle of the Singapore health care financing system is based on individual responsibility, coupled with government subsidies to keep basic health care affordable. Working Singaporeans are encouraged to take responsibility for their own health by saving for medical expenses through the Medisave and approved health insurance schemes. However, no Singaporeans will be denied access to the health care system if they are unable to pay. 99
- 4.2.4 The health care financing system of Singapore is a medical savings account system. Under this system, health care is predominantly funded by private financing, including savings in individual accounts that are restricted to specific health care spending, such as hospitalization expenses. 100
- 4.2.5 Singaporeans are usually required to pay the full cost for general practitioner services at their own expenses. For public hospital services, patients bear at least 20% of the cost because the maximum government subsidy for a lowest-class hospital ward is 80% of the cost and under 80% for wards of other classes. Accordingly, patients may have to resort to out-of-pocket payments, savings in the Medisave Account and health insurance or a combination of them to cover their hospital expenses. <sup>101</sup>
- 4.2.6 Despite the emphasis on individual accountability in health care policies, the government has set up a safety net, i.e. MediFund, to support those who cannot afford the health care service payments. MediFund is an endowment fund and only its earnings can be used to help the patients in financial difficulties. Meanwhile, the government considers MediFund as the last resort which should only be offered to the needy. Therefore, it is the responsibility of the MediFund Committee to make sure that an applicant has indeed exhausted all available resources before it considers granting the subsidy. In the financial year 2002-03, 178 209 MediFund applications were considered and 177 949 of them were approved. 102
- 4.2.7 The following table presents some basic information about expenditure on health services of Singapore in the financial year 2002-03, which may serve as indicators on health expenditure.

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<sup>99</sup> Healthcare Philosophy in Singapore (2003).

Hanvoravongchai (2002), p.6.

<sup>&</sup>lt;sup>101</sup> Available Services (2004) and Delivery System and Philosophy (2004).

<sup>102</sup> *Introduction to Medifund* (2004).

Table 13 – Health expenditure indicators of Singapore in 2002-03

Total expenditure on health as % of GDP	3.7%
Per capita total expenditure on health	S\$1,703
	(HK\$8,137)
General government expenditure on health as % of total expenditure on health	27%
Non-government expenditure on health as % of total expenditure on health	73%
General government expenditure on health as % of total general government expenditure	5.9%1
Health insurance coverage as % of total population	75%

Remark: 1. Financial year 2003-04 figure.

Sources: Regional Office for the Western Pacific, World Health Organization (2005) and World Bank (2005).

4.2.8 Chart 3 summarizes the financing and delivery system of health care services in Singapore.

Government Taxes MediFund Medisave Mandatory contributions Health Premiums insurance Subsidy companies Grant disbursement Population payments and Private clinics National Healthcare enterprises Group payments Singapore Health Private hospitals Services payments Public hospitals payments **Public clinics Patients** → Financial flows ----- Service flows

Chart 3 – Health care system of Singapore

Sources: Hanvoravongchai (2002), Hospitals, Clinics and Other Healthcare Establishments (2004), Available Services (2004), Delivery System and Philosophy (2004) and Medisave, MediShield and Other Subsidy Schemes (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) medical savings accounts;
  - (b) health insurance plans; and
  - (c) general government expenditures.

## Medical savings accounts

- 4.3.2 The medical savings account system of Singapore, i.e. Medisave, has been running since 1984. The operation of the Medisave system 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 Employees, employers and the government all contribute to the Medisave Accounts, which are sub-accounts under the Central Provident Fund accounts of individual members. Both employees and employers make monthly contributions to the Central Provident Fund. The total contributions collected are split and credited into three sub-accounts of the employees, namely Ordinary Account, Special Account and Medisave Account. The following table lists the contribution rate of the Central Provident Fund and the allocation rate among the sub-accounts.

Table 14 – Contribution rate and allocation rate of the Central Provident Fund of Singapore in 2006

Age of	Contribution	Contribution	Total	C	credited into	
employee (years)	by employer	by employee (% of wage)	contribution (% of wage)	Ordinary Account %	Special Account	Medisave Account
35 or				22	5	6
below	13	20	33	22	3	U
36 - 45	13	20	33	20	6	7
46 - 50	1			18	7	
51 - 55	9	18	27	12	/	8
56 - 60	6	12.5	18.5	10.5		
61 - 65		7.5	11	2.5	0	
66 or above	3.5	5	8.5	0	U	8.5

Source: CPF (Central Provident Fund) Contribution and Allocation Rates for 2006 (2006).

4.3.4 For the year 2006, the salary ceiling for the Central Provident Fund contribution is S\$4,500 (HK\$21,375) per month for an individual. Singaporeans earning more than the ceiling are not required to contribute to the Fund out of the additional income they earn over that amount. Based on this salary ceiling and the rates listed in the above table, the following table lists the maximum amount of contribution that an individual can make to the Central Provident Fund and the corresponding distribution among the sub-accounts. <sup>103</sup>

<sup>&</sup>lt;sup>103</sup> CPF (Central Provident Fund) Contribution and Allocation Rates for 2006 (2006).

Table 15 – Maximum monthly contribution to the Central Provident Fund of Singapore and distribution among the sub-accounts in 2006

Age of	Maximum	Maximum	Total	(	Credited into		
employee (years)	contribution by employer	contribution by employee	maximum contribution	Ordinary Account	Special Account	Medisave Account	
35 or				S\$990	S\$225	S\$270	
below				(HK\$4,702)	(HK\$1,069)	(HK\$1,283)	
36 - 45	S\$585	S\$900	S\$1,485	S\$900	S\$270	S\$315	
	(HK\$2,779)	(HK\$4,275)	(HK\$7,054)	(HK\$4,275)	(HK\$1,283)	(HK\$1,496)	
46 - 50				S\$810			
				(HK\$3,848)	S\$315		
51 - 55	S\$405	S\$810	S\$1,215	S\$540	(HK\$1,496)	S\$360	
	(HK\$1,924)	(HK\$3,847)	(HK\$5,771)	(HK\$2,565)		(HK\$1,710)	
56 - 60	S\$270	S\$562.5	S\$832.5	S\$472.5			
	(HK\$1,282)	(HK\$2,672)	(HK\$3,954)	(HK\$2,244)			
61 - 65		S\$337.5	S\$495	S\$112.5	S\$0		
	S\$157.5	(HK\$1,603)	(HK\$2,351)	(HK\$534)	(HK\$0)	S\$382.5	
66 or	(HK\$748)	S\$225	S\$382.5	S\$0		(HK\$1,817)	
above		(HK\$1,069)	(HK\$1,817)	(HK\$0)			

Source: Annex B of the Employers' Handbook (2006).

4.3.5 On top of the mandatory contributions jointly made by employees and employers, employees may choose to make voluntary contributions to their Central Provident Fund accounts which are in turn credited into the sub-accounts. However, the combined mandatory and voluntary contributions cannot exceed the annual contribution limit, which is \$\$25,245(HK\$120,030) for 2006. As such, the maximum amount of voluntary contributions can be made is the difference between the annual contribution limit and the annual mandatory contribution. For example, for a 35-year-old employee who has made the maximum mandatory contribution in 2006, his/her maximum voluntary contribution will be:

$$S$25,245(HK$120,030) - S$1,485(HK$7,054) \times 12 = S$7,425(HK$35,382)$$

4.3.6 Apart from employees, employers, as a means to reward employees, may also choose to contribute more to their employees' Medisave Accounts through the Additional Medisave Contribution Scheme. Under this voluntary scheme, employers decide how often the additional contributions to be made and to whom. The limit of additional contribution to be made is \$\$1,500(HK\$7,130) per employee each year.

Employers' Handbook (2006), p.13.

Additional Medisave Contribution Scheme (2006).

4.3.7 For all self-employed persons who earn a yearly net trade income<sup>106</sup> of more than S\$6,000 (HK\$28,500), they are also required to contribute to Medisave. The amount of Medisave contribution is capped based on an annual income ceiling of S\$60,000 (HK\$285,000). <sup>107</sup> The maximum contribution by the self-employed persons of different age brackets to Medisave is listed in the following table.

Table 16 – Annual maximum contribution by self-employed Singaporeans to Medisave in 2006

Age of self-employed person (years)	Contribution rate	Maximum amount
34 or below	6%	S\$3,240 (HK\$15,384)
35 – 44	7%	S\$3,780 (HK\$17,954)
45 or above	8%	S\$4,320 (HK\$20,519)

Source: *Medisave for the Self-employed Handbook* (2006).

- 4.3.8 In accordance with Section 14(1) of the *Central Provident Fund Act*, the government may offer cash grant to the Central Provident Fund Board for "the benefit of any person who qualifies for such grant under any approved scheme, and the Board shall credit the cash grant into such account of that person as the Minister may direct." This kind of cash grants is known as "Top-Ups" and the government usually announces the offer of Top-Ups in the budget speech.
- 4.3.9 Accumulated savings in a Medisave Account are subjected to a Medisave Contribution Ceiling, which is the maximum amount of savings permitted to be retained in the account before retirement. Savings beyond the ceiling will overflow to the Ordinary Account. The Medisave Contribution Ceiling for 2006 is \$\$32,500(HK\$154,241).
- 4.3.10 When a member of the Central Provident Fund reaches 55 years old, he/she is allowed to withdraw savings from his/her three sub-accounts under the Fund. With respect to the savings in the Medisave Account, he/she can only withdraw the amount of savings that exceeds \$\$27,500 (HK\$130,513) which is the minimum amount to be retained to cover the medical expenses during his/her retirement. When the actual Medisave Account balance is lower than the Medisave Required Amount i.e. (\$\$8,300 or HK\$39,010) and there are savings in the other two sub-accounts, the member is required to transfer savings from these two sub-accounts to meet the Medisave Required Amount before he/she can withdraw savings from the sub-accounts. The member is not required to meet the Medisave Required Amount if he/she has no extra savings in the other two sub-accounts.

<sup>&</sup>quot;Net trade income" is the gross trade income minus all allowable business expenses, capital allowances and trade losses as determined by the Inland Revenue Authority of Singapore. It excludes income from share dividends, employment and interest from savings.

<sup>&</sup>lt;sup>107</sup> Medisave for the Self-employed Handbook (2006).

<sup>&</sup>lt;sup>108</sup> Central Provident Fund Board news release on 9 June 2005.

<sup>&</sup>lt;sup>109</sup> CPF (Central Provident Fund) Minimum Sum Scheme Handbook (2005).

# Collection of fund

- 4.3.11 The Central Provident Fund Board is the statutory agency to collect the Central Provident Fund contributions and credit the relevant proportion of the funds collected into the corresponding Medisave Accounts. Employers are required by law to pay the employers' and employees' shares of the Central Provident Fund contributions and they can recover the employees' share of contribution from their wages. The self-employed persons make their contributions directly to the Board. 110
- 4.3.12 The Central Provident Fund Board occasionally receives top-up money from the government and credits them into the Medisave Accounts in accordance with the government's instructions.
- 4.3.13 The table below lists the accounts and balances of the Central Provident Fund as at 30 September 2005.

Table 17 – Accounts and balances of the Central Provident Fund of Singapore as at 30 September 2005

Account	Balance (in million)		
Ordinary Account	S\$58,883.4 (HK\$279,399)		
Special Account	S\$19,551.2 (HK\$92,770)		
Medisave Account	S\$34,037.6 (HK\$161,507)		
Retirement Account and others	S\$6,001.2 (HK\$28,475)		
Total	S\$118,473.4 (HK\$562,151)		

Source: CPF (Central Provident Fund) Quarterly Statistics - July to September 2005 (2006).

## Health insurance plans

- 4.3.14 Health insurance plans approved by either the Central Provident Fund Board or the government serve the function of pooling health care resources. These approved health insurance plans include:
  - (a) Medisave-approved health insurance schemes; and
  - (b) employer-sponsored schemes.

Employers' Handbook (2006), p.15 and Medisave for the Self-employed Handbook (2006).

## Medisave-approved health insurance schemes

- 4.3.15 Medisave-approved health insurance schemes are schemes that are allowed to use the money saved in individuals' Medisave Accounts to pay for their insurance premiums, subject to an annual limit of S\$800 (HK\$3,760) per person per policy year. The premium in excess of the limit has to be paid out of a policyholder's own pocket. MediShield, Integrated MediShield (which includes IncomeShield) and ElderShield are the major Medisave-approved health insurance schemes.
- 4.3.16 MediShield is a low-cost catastrophic medical insurance scheme run by the Central Provident Fund Board. If participants of the Central Provident Fund choose to join MediShield only, premiums will be collected by the Central Provident Fund Board. With an integrated MediShield scheme comprising the MediShield benefits and additional benefits, the Central Provident Fund Board is supposed to be responsible for administering the MediShield benefits and the health insurance companies concerned is responsible for administering the additional benefits. For administrative convenience, health insurance companies offering the integrated MediShield schemes take up the full responsibility of administering the schemes. In 2005, there were five health insurance companies in Singapore providing 15 integrated MediShield insurance products. 112
- 4.3.17 For ElderShield, policyholders pay premiums to the two approved health insurance companies from which they have bought ElderShield insurance. Between July and September 2005, the amount of contributions to the Medisave-approved health schemes was \$\$294.7 million (HK\$1,402 million).

#### *Employer-sponsored schemes*

4.3.18 The Singaporean government encourages employers providing employees with medical benefits by tax incentives. Employers who implement the Portable Medical Benefits Scheme or the Transferable Medical Insurance Scheme may enjoy a tax deduction of 2% of the total payroll in a financial year. For example, from 1 April 2004 to 31 March 2005, a company spent S\$40,000 (HK\$188,000) on the Portable Medical Benefits Scheme and the company's total payroll within the same period was S\$1,000,000 (HK\$4,700,000). In this case, 2% of the total payroll or half of the expenses, i.e. S\$20,000 (HK\$94,000), on the Portable Medical Benefits Scheme are tax-deductible in the 2005-06 financial year.

<sup>111</sup> Central Provident Fund Board (2006).

Medisave, MediShield and Other Subsidy Schemes (2006) and CPF Quarterly Statistics -- July to September 2005.

<sup>&</sup>lt;sup>113</sup> Ibid.

Ministry of Manpower (2005).

- 4.3.19 The running of the Portable Medical Benefits Scheme is similar to that of the Additional Medisave Contribution Scheme described in paragraph 4.3.6. In both cases, employers make an additional contribution to employees' Medisave Accounts. However, the Portable Medical Benefits Scheme is an institutionalized scheme, consisting of a contribution rate negotiated between employers and unions or employees, with the former making monthly contributions to employees' Medisave Accounts. Contribution to this scheme is limited to S\$1,500 (HK\$7,130) per employee per year. 115
- 4.3.20 The Transferable Medical Insurance Scheme is an employer-sponsored group insurance plan. At present, 19 health insurance companies provide transferable medical insurance products. An employee who is covered under one of these insurance plans receives an extension of in-patient coverage up to a maximum period of 12 months when he/she leaves the job for whatever reasons. Within the 12-month period, when the employee joins a new employer who also has a transferable medical insurance plan, the employee is deemed to be continuously insured. <sup>116</sup>

## General government expenditure

- 4.3.21 MediFund is set up by the government as the last resort to help the needy, who are unable to pay their hospital bills using their Medisave and MediShield accounts. As at 31 March 2004, the capital sum of the endowment fund stood at \$\$900 million (HK\$4,230 million), with a balance of some \$\$17.7 million (HK\$832 million) available for use, after deducting expenses and grant disbursements. 117
- 4.3.22 In the financial year 2005-06, the government spends S\$320 million (HK\$1,483 million) to top up the Medisave Accounts in the form of cash grants. The amount of top-ups for each Medisave Account is between S\$50 (HK\$232) and S\$350 (HK\$1,622), with the elderly receiving a higher top-up. 118

### 4.4 Allocation mechanism of health care resources

4.4.1 Health care resources are kept by the government, the medical savings accounts or 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:

Ministry of Manpower (2005).

<sup>116</sup> Ibid

More MediFund handed out in 2003 to help pay for hospital bills (2004).

<sup>&</sup>lt;sup>118</sup> Budget 2005 (2005).

- (a) approved health insurance companies;
- (b) Central Provident Fund Board; and
- (c) government budget.

### Health insurance plans

- 4.4.2 Approved health insurance plans provide explicit benefit packages, including: 119
  - (a) limits of benefits for in-patient treatment, day surgery and out-patient treatment;
  - (b) limits of benefits for each policy year and lifetime limits; and
  - (c) amount of deductibles and percentage of co-insurance.
- 4.4.3 Health insurance companies allocate resources to health care providers in a combination of the following two ways: 120
  - (a) Capitation fee: Doctors in the primary health care sector are paid a capitation fee on a regular basis, e.g. every month, for looking after a given number of insured persons. The amount of capitation fee is calculated based on the age and gender of the insured assigned to a doctor. Doctors keep the capitation fee even if the insured assigned to them do not visit their clinics. This arrangement provides an incentive for doctors to treat their patients effectively and to keep them healthy; and
  - (b) 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 the appropriate amount of money to the insured. In the case where medical institutions have made arrangements with the health insurance companies, medical institutions make claims directly to the health insurance companies for the medical expenses allowed in the insurance policies.

Central Provident Fund Board (2006) and Medisave, MediShield and Other Subsidy Schemes (2006)

<sup>&</sup>lt;sup>120</sup> NTUC Income Insurance Cooperative Ltd (2006) and Central Provident Fund Board (2006).

## Central Provident Fund Board

- 4.4.4 Health care resources can also be transferred directly from patients to health care providers. Payments from patients to health care providers can be made in the following ways: 121
  - (a) Medisave Account: Patients at their admission to hospitals are required to sign an authorization form. With the patients' authorization, the health care providers can request the Central Provident Fund Board to pay medical expenses from the patients' Medisave Accounts; and
  - (b) Out-of-pocket payment: Patients make out-of-pocket payments to health care providers for health care services not covered by their health insurance plans and Medisave.

# Government budget

- 4.4.5 Through the budgetary process, public money is allocated to health care providers in the public sector and Singaporeans for expenses on health care services through the following transfers:<sup>122</sup>
  - (a) Operating subventions are provided via the Ministry of Health to the National Healthcare Group and Singapore Health Services, the public deliverers of health care services in Singapore. The operating subvention is used to subsidize patients' bills, with the subsidy for hospital ward classes A, B1, B2+, B2 and C being 0%, 20%, 50%, 65% and 80% respectively;
  - (b) Financial assistance is available, via the Ministry of Health, for voluntary welfare organizations to provide health care services for the elderly. It is used for funding the capital and operating costs of community hospitals, chronic sick hospitals, nursing homes and hospices, day rehabilitation services, home medical and home nursing services; and
  - (c) Through the Financial Transfers Programme, public money is used to top up Medisave Accounts of Singaporeans via the Central Provident Fund Board. In addition, public money is used to finance MediFund which provides a medical safety net for needy Singaporeans.

A Guide to Medisave (2006) and Central Provident Fund Board (2006).

<sup>&</sup>lt;sup>122</sup> Budget 2005 (2005).

#### 4.5 Distribution of health care resources

### Statistical profile

4.5.1 The distribution of financial responsibility on health care among different sources is presented in the following table.

Table 18 – Share of financial responsibility on health care among source of fund in Singapore

Source of fund	Percentage		
Government subsidies	25%		
Medisave Accounts	8%		
MediShield and MediFund	2%		
Employer-sponsored benefits	35%		
Out-of-pocket payment	25%		
Private insurance	5%		
Total	100%		

Source: Lim (2004), p.86.

### Hospital services

- 4.5.2 In order to prevent individuals exhausting the savings in the Medisave Accounts before retirement, the government sets limits on the use of Medisave, e.g. the claim limit for hospital charges is limited to \$\$400(HK\$1,880) per day.
- 4.5.3 For hospital care, 80% of the services are provided by the public sector and the remaining 20% by the private sector. Under the hospital ward subsidy policy, the amount of subsidy that the government provides to patients staying at public hospitals rises as the class of wards declines. According to this subsidy policy, Singaporeans bear at least 20% of the cost because the maximum government subsidy for the lowest-class hospital wards is 80% of the cost. For private hospitals, patients have to resort to private health insurance and their own resources (including their Medisave Accounts) to fix the medical bills. 123

Delivery System and Philosophy (2004), Available Services (2004), Lim (2004), p.87, Ministry of Health (2005b) and Medisave, MediShield and Other Subsidy Schemes (2006).

Class	Subsidy	Class specifications				
A	0%	One-two bedded, air-conditioned, attached bathroom, TV, telephone, choice of doctor				
B1	20%	Four-bedded, air-conditioned, attached bathroom, TV, telephone, choice of doctor				
B2+	50%	Five-bedded, air-conditioned, attached bathroom				

Six-bedded, no air-conditioning

Open ward with more than six beds

Table 19 – Singapore's hospital ward subsidy policy

Sources: Lim (2004) p.87 and Ministry of Health (2005b).

## Primary health care services

65%

80%

B2

4.5.4 Primary health care is provided at out-patient polyclinics and private medical practitioners' clinics. Private medical practitioners provide 80% of primary health care services while public polyclinics provide the remaining 20%. Patients pay the full cost or part of the cost of primary health care services if they have insurance plans covering such services. 124

## **Medicines**

4.5.5 The cost of medicines is usually included in the medical fees and charges. Therefore, it is being handled simultaneously when a patient pays for the hospital or doctor's bill.

### 4.6 Policy evaluation

4.6.1 The subject of medical savings accounts has been one of the frequently discussed topics with regard to health care financing around the world in the past decade. Since Singapore is the only place<sup>126</sup> in the world that fully adopts the medical savings account system, its system has been used as the prime case to evaluate the achievements of and challenges faced by such a system.

Delivery System and Philosophy (2004), Available Services (2004) and NTUC Income Insurance Cooperative Ltd (2006).

Ministry of Health (2005a) and Available Services (2004).

The United States, the Mainland and South Africa have incorporated medical savings accounts as a component of their health care financing systems, and Canada and Hong Kong have discussions on whether medical savings accounts should form part of their health care financing systems.

- 4.6.2 With regard to the effectiveness of the medical savings account system, some academics point out that although Singapore has adopted the medical savings account system since 1984, the combined shares provided by Medisave, MediShield and MediFund in health care financing remain relatively small when compared to employer-sponsored benefits, government subsidies and individuals' out-of-pocket payments. Some other academics opine that the benchmark for measuring the effectiveness of the system is whether Singapore's spending on health care is lower under the medical savings account system than if it had retained the tax-based financing system. Statistics show that the health care expenditure as a percentage of GDP fell from 4.5% in 1965 to 3.7% in 2002. 127
- 4.6.3 With regard to the equity in accessing health care services, there are views that as the Medisave Account is an individual account, low-income families and other under-privileged groups, such as the unemployed, may not be able to accumulate sufficient savings to finance their health care expenses. In addition, high deductibles and high co-insurance may on the one hand prevent consumers from abusing the system, and on the other hand constitute financial barriers for the poor to access required health care. Academics who disagree with these views state that the government has a clear policy statement that no Singaporeans will be denied access to the health care system if they are unable to pay. The purpose of MediFund is to serve as the medical safety net to ensure that the poor and under-privileged groups have access to essential health care services. 128
- 4.6.4 With regard to the risk of misusing savings in Medisave Accounts, an academic points out that the existence of assets that are restricted to use for health spending may give Medisave Account owners false sense of security and encourage them to spend more than they can afford out of current income. Likewise, health care providers may also induce inessential demand for health care services, recognizing the existence of available Medisave balances. Nevertheless, another academic states that although Medisave Accounts are the personal accounts of individual members, the government determines to which procedures the accounts can be applied, and where and how much they can be spent. 130

<sup>&</sup>lt;sup>127</sup> Hanvoravongchai (2002), pp.16-18 and pp. 21-26, Lim (2004), p.91, and Pauly (2001), p.728.

Hanvoravongchai (2002), pp.18-20 and pp.26-27, Barr (2001), p.722, Hsiao (2001), p.735, Lim (2004), p.91, and Pauly (2001), p.728.

<sup>&</sup>lt;sup>129</sup> Hanvoravongchai (2002), pp. 19-20.

<sup>&</sup>lt;sup>130</sup> Hanvoravongchai (2002), pp.19-20 and Barr (2001), pp.716-718.

## Chapter 5 – Analysis

#### 5.1 Introduction

5.1.1 This chapter provides a comparative analysis of the health care financing policies of Australia, New Zealand and Singapore. 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 Both Australia and New Zealand institutionalized a tax-based financing health care system in the late 1940s and Singapore retained a similar system amidst its independence in 1965. Owing to the increasing pressure on public expenditure in financing health care, all the selected places have introduced health care reforms since the 1970s to ease the pressure.
- 5.2.2 While retaining the tax-based financing system, both Australia and New Zealand have introduced various measures to increase the share of financial responsibility of sources other than the government and to ensure the efficient use of the available health care resources. The overall direction of health care reforms in Australia is to increase the private sector involvement in the delivery and financing of health care services. While aiming at the efficient use of health care resources via a devolved health care system throughout, New Zealand's health care system has gone from a regional governance model in the 1980s to a quasi-market model in the 1990s and back to a regional governance model in the 2000s.
- 5.2.3 The Singaporean government abandoned the tax-based financing system and started the Medisave system in 1984. In this medical savings account system, health care is predominantly funded by private financing, including savings in an individual account restricted to spending on health care. In addition, measures to ensure the efficient use of the available health care resources have also been introduced by the Singaporean government, e.g. setting up public corporations to manage public hospitals.

- 5.2.4 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. <sup>131</sup>
- 5.2.5 Over the years, the health care system has more or less continued to expand, amidst the establishment of the Hospital Authority in 1990 and the mounting financial pressure faced by the system. Since the 2001-02 financial year, the Hospital Authority has remained in financial deficit. 133
- 5.2.6 In order to ease the financing pressure with regard to the provision of public health care services, the Hospital Authority has introduced various reform measures since the 1990s. 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.<sup>134</sup>
- 5.2.7 Reform measures to re-engineer the health care delivery system include: 135
  - (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.

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

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

Hospital Authority Annual Plan 2006-07, p.18.

Hospital Authority Annual Plan 2006-07, pp.2-3.

Hospital Authority Annual Plan 2006-07, p.3.

- 5.2.8 Reform measures to improve the financial sustainability of the health care system include: 136
  - (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 option, e.g. conducting willingness-to-pay surveys on the Hospital Authority service users.
- 5.2.9 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:<sup>137</sup>
  - (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).

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Hospital Authority Annual Plan 2006-07, pp.3-4.

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

## 5.3 Health care system

### Structure

- 5.3.1 In New Zealand and Singapore, the Ministry of Health has the overall responsibility for the formulation of health care policies. In Australia, although the Constitution has given the Commonwealth government the mandate to take a leadership role in health care policy-making, the Constitution does not strictly prescribe the respective role of each level of governments in relation to health care. As such, the Australian Health Ministers' Conference offers a forum for health ministers of various levels of governments to discuss health care policies and come up with agreements on various related issues.
- 5.3.2 In Australia, the state and territory governments are responsible for the delivery of public health care services within their jurisdictions. In New Zealand, the elected district heath boards play the leading role in providing or ensuring the provision of health care services in their respective geographical areas. In Singapore, the National Healthcare Group and the Singapore Health Services, two public corporations, co-ordinate a network of public health care service organizations to deliver services within their respective geographical areas.
- 5.3.3 While all the selected places adopt 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 as well as secondary and tertiary health care services are different. Almost all primary health care services in Australia and New Zealand are delivered by private medical practitioners, whereas the corresponding percentage of private involvement in Singapore is 80%. However, primary health care services provided by private medical practitioners in Australia and New Zealand are partly subsidized by the government whereas it is not subsidized in Singapore. In all selected places, publicly-owned hospitals provide a major or substantial portion of hospital services. The occupancy rate of acute care beds in Australia and Singapore in 2002 was 73.9% and 73.1% respectively. In Hong Kong, the occupancy rate of general hospital beds (acute and convalescent beds) in the financial year 2002-03 was 82.4%.

Data for New Zealand is not available.

<sup>&</sup>lt;sup>139</sup> Hospital Authority (2003), p.122.

- 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. 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. 141
- 5.3.5 The public and private mix of primary as well as secondary and tertiary health care services in Hong Kong is similar to that in Singapore. Private medical practitioners provide 72% of primary health care services and public hospitals provide 82% of secondary and tertiary health care services in Hong Kong. 142

## Guiding principles

- 5.3.6 The guiding principles of health care policies in the selected places all ensure that citizen will not be denied health care services. However, they adopt somewhat different philosophical bases. Both Australia and New Zealand emphasize collective responsibility to ensure citizens' accessibility to health care services. On the other hand, Singapore emphasizes individual responsibility for accessing health care services and the government is the last resort for those who are unable to pay.
- 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." 143

#### 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, the selected places have their own specific means to pool health care resources, i.e. designated health tax in Australia, accident-related levy in New Zealand and medical savings in Singapore.

<sup>&</sup>lt;sup>140</sup> The Government of the Hong Kong Special Administrative Region (2006c).

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).

Health, Welfare and Food Bureau (2005).

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

## General taxation

- 5.4.2 The general government expenditures on health as a percentage of the total expenditure on health in Australia and New Zealand are 68% and 78.3% respectively. Although most of the public expenditures on health in these two places come similarly from general taxation, their proportion from individual sources of general taxation varies. While Australia depends heavily on income tax, New Zealand depends on both income 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 2005-06, earnings and profits taxes take up 80% of the internal revenue or 56% of all government revenue. At present, the public medical 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. 145

### Designated means

## Medicare levy

5.4.4 In Australia, a designated levy called Medicare levy is collected from all taxpayers to supplement general revenue in financing the Medicare system. The rate of Medicare levy is 1.5% on taxable income and an additional 1% Medicare levy surcharge is applied to high-income individuals and families that do not have private health insurance cover.

Internal revenue is a category of government revenue, comprising the following taxes and duties:

<sup>(</sup>a) bets and sweeps tax;

<sup>(</sup>b) earnings and profits tax;

<sup>(</sup>c) estate duty;

<sup>(</sup>d) hotel accommodation tax;

<sup>(</sup>e) stamp duties; and

<sup>(</sup>f) air passenger departure tax.

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

## Accident-related levy

5.4.5 In New Zealand, a designated levy is collected from employers, earners, motor vehicle owners and drivers as premiums to the accident insurance scheme. The government pays the premiums for those people who are not earning any income so that they are also covered under the scheme. The accident insurance scheme offers comprehensive no-fault insurance for accident-related injuries and disabilities, and this approach in financing is similar to that of the social health insurance system 146.

# Medical savings account

5.4.6 In Singapore, a designated medical savings account is set up for each member under the Central Provident Fund. Employees and employers make mandatory contributions to the Medisave Accounts, while the government also occasionally contributes top-up money to the employees' Medisave Accounts. The savings in the Medisave Accounts are restricted for medical-related usage, including paying hospital bills and premiums of approved health insurance plans.

## Situation in Hong Kong

5.4.7 At present, Hong Kong has no designated health-related tax or levy 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.

### Health insurance plans

5.4.8 The Australian and Singaporean governments have specific measures in place governing the operation of health insurance companies and increasing the coverage of health care insurance of the population.

A social health insurance system is predominantly funded by contributions from employees, the self-employed, employers and the government on a compulsory basis.

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

- 5.4.9 In Australia, a financially independent statutory agency, i.e. the Private Health Insurance Administration Council, is the prime regulator of the health insurance industry. Health insurance funds operated by health insurance companies under the community rating principle must ensure access by all members of the community to private health insurance and the reinsurance principle to share the risk of high-claiming persons, i.e. older and chronically-ill persons. The Australian government uses a rebate on private health insurance for the insured and the Lifetime Health Cover and the Medicare levy surcharge to encourage people to take out health insurance policies.
- 5.4.10 In Singapore, the Ministry of Health is the regulator of the health insurance industry. The government encourages individuals to take out approved health insurance policies by allowing them to pay the premium from savings in the Medisave Account. In addition, employers are encouraged by tax incentives to implement employer-sponsored health insurance schemes.
- 5.4.11 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. 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. 149

#### 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 to allocate health care resources. In addition, New Zealand and Singapore allocate health care resources through designated organizations, i.e. the Accident Compensation Corporation and Central Provident Fund Board respectively.

### Government budget

5.5.2 The selected places use different ways to allocate the health budget to health providers. In Australia, the Commonwealth government, through the budgetary process, allocates resources to various health care programmes, e.g. hospital services, out-of-hospital services and pharmaceutical benefits.

Office of the Commissioner of Insurance Annual Report (2005).

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

- 5.5.3 In New Zealand, the central government adopts a population-based funding formula to allocate health care resources to various district health boards. District health boards, in turn, allocate health care resources to public hospitals owned by them or utilize the resources to purchase services from other providers such as primary health organizations.
- 5.5.4 In Singapore, the government allocates health care resources to public hospitals and clinics via the National Healthcare Group and the Singapore Health Services and establishes a clear policy on subsidizing various ward classes in public hospitals. In addition to top up Medisave Accounts, public money is also used to set up the medical safety net, i.e. MediFund.
- 5.5.5 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.

# Designated scheme

### Accident Compensation Corporation

5.5.6 In New Zealand, the levies collected by the Accident Compensation Corporation for the accident insurance scheme are deposited in seven accounts which cover compensation on different types of injuries, such as work-related injuries and medical misadventures.

### Medical savings account

5.5.7 In Singapore, the Central Provident Fund Board determines both the type of medical services that can be paid out of the Medisave Account by individuals and the corresponding limits as well.

## Health insurance plans

5.5.8 In all the selected places 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 medical institutions have made arrangements with the health insurance companies, 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 Australia, New Zealand, Singapore and Hong Kong.

Table 20 - Health expenditure indicators of selected places

	Australia (2003)	New Zealand (2002-03)	Singapore (2002-03)	Hong Kong (2003)
Total expenditure on health as % of GDP	9.7%	8.7%	3.7%	5.4%
Per Capita total expenditure on health in HK\$	22,407	14,453	8,137	9,680
General government expenditure on health as % of total expenditure on health	68%	78.3%	27%	52.4%
Non-government expenditure on health as % of total expenditure on health	32%	21.7%	73%	47.6%
General government expenditure on health as % of total general government expenditure	16.7%	14.2%	5.9%	12.4 %
Health insurance coverage as % of total population	42.9 %	33%	75%	26.4%

Sources: Australia, New Zealand and Singapore figures from Tables 2, 7 and 13 of this paper respectively; and Hong Kong figures from Regional Office for the Western Pacific, World Health Organization (2005).

- 5.6.2 Both Australians and New Zealanders are eligible for receiving public hospital services free of charge if they do not choose doctors in receiving treatment. Singaporeans bear at least 20% of the cost because the maximum government subsidy for the lowest-class public hospital wards (where patients cannot choose their preferred doctors) is 80% of the cost. Patients may have to resort to out-of-pocket payments, savings in the Medisave Accounts and approved health insurance plans or a combination of them to cover their share of hospital expenses.
- 5.6.3 In Australia and Singapore, patients who choose their preferred doctors can still receive some subsidy from the government. For Australians choosing to be treated as private patients in either public or private hospitals, Medicare pays 75% of the Medicare Benefits Schedule fee for services and procedures provided by the treating doctor. The private patients are responsible for the remaining 25% doctor's fee as well as other fees and charges such as hospital accommodation fee. In Singapore, the government subsidizes 20% of the cost of B1 class hospital wards, with B1-class patients being able to choose doctors. In New Zealand, public hospitals are allowed to treat private patients under certain conditions, e.g. when the arrangement leads to an improvement in the clinical quality.

- 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. Private patients in private hospitals receive no subsidy from the Government, unlike the case of Australia.
- 5.6.5 In both Australia and New Zealand, primary health care services provided by private medical practitioners are subsidized by the government. However, the method of subsidization is different. In Australia, Medicare subsidizes all patients 85% of the schedule fee as stated in the Medicare Benefits Schedule and patients use out-of-pocket payments to cover the remaining 15%. The Medicare Safety Net is in place to provide assistance to those patients with difficulty in handling the payments. In New Zealand, the subsidy targets the young, the old, the poor and the chronically-ill groupings, while the other patients have to pay full cost in using primary health care services.
- 5.6.6 In both Singapore and 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 money.
- 5.6.7 With regard to medicine expenses, in Australia and New Zealand, patients are required to make a co-payment for acquiring government-subsidized prescription medicines. In Singapore and Hong Kong, the cost of prescription medicines is usually included in the medical fees and charges.

### 5.7 Policy evaluation

- 5.7.1 All selected places have engaged in reforming their tax-based financing system since the 1970s and each of them has followed a specific direction of reform. Under the specific reform direction, each selected system yields some achievements and faces some challenges.
- 5.7.2 Being a tax-based financing system, the reform direction of the Australian system is to increase private sector involvement in the delivery and financing of health care services. While there is an increase in the take-out rate of private health insurance, the rising government expenditure on rebate, higher-income households receiving a larger rebate and the lack of incentive for insurers to manage cost efficiently for high-cost cases are challenges to be met.

Hospital Authority (2006).

- 5.7.3 Being a tax-based financing system, the reform direction of New Zealand's system is to achieve efficient use of health care resources through a devolved health care system. Adhering to this reform direction, the form of a devolved health care system has shifted from a regional governance model in the 1980s to a quasi-market model in the 1990s and back to a regional governance model in the 2000s.
- 5.7.4 The current regional governance model adopted in New Zealand has achieved citizen participation through the elected district health boards and allocated health care resources based on the needs of the population rather than on the market principle. However, the possibility of political control by special interest groups in the district health boards and the question of equity in the distribution of health resources among districts are challenges to be met.
- 5.7.5 The Singaporean government has abandoned the tax-based financing system and instituted a medical savings account system. Being the only place in the world that fully adopts the medical savings account system, the Singaporean system has been considered by academics as the prime case for studying such a system. Nonetheless, there are diverse views regarding the effectiveness of the system.
- 5.7.6 Some academics regard the Singaporean system as one which has effectively reduced the government's public spending in health care when compared to the tax-based financing system. In addition, the system, through a medical safety net, ensures the poor and under-privileged groups not being denied access to essential health care services. Some other academics question the effectiveness of the system as the share of health care resources provided by the medical savings account system remains relatively small when compared to other funding sources such as employer-sponsored health benefits. They consider that the inadequacy of health care resources generated from the system and the high deductibles and co-insurance required may constitute financial barriers for the poor and under-privileged groups to access essential health care services.
- 5.7.7 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.

# **Chapter 6 – Conclusion**

#### Introduction 6.1

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

Table 21 – A comparison of the health care financing policy in selected places

	Australia	New Zealand	Singapore	Hong Kong		
Policy-making ar	Policy-making and delivery of health care services					
Policy-making	Commonwealth government holds the overarching responsibility for making and administering nation-wide health financing policies     State and territory governments are responsible for formulating policies governing the delivery of health care services and regulation of health-related personnel and premises within their jurisdictions     Australian Health Ministers' Conference offers a platform for health ministers of various levels of governments to discuss health policies and programmes	Ministry of Health	Ministry of Health	Health, Welfare and Food Bureau		

Table 21 - A comparison of the health care financing policy in selected places (cont'd)

	Australia	New Zealand	Singapore	Hong Kong	
Policy-making and delivery of health care services					
Delivery	<ul> <li>Commonwealth government administers health care financing schemes</li> <li>State and territory governments/regional health authorities are responsible for the delivery of health care services within their jurisdictions/regions</li> </ul>	District health boards are responsible for the delivery or ensuring the provision of health care services within their geographical areas     Accident Compensation Corporation purchases health care services for personal injuries caused by accidents across all districts	National Healthcare Group and Singapore Health Services facilitate the provision of health care services in their respective geographical areas through a network of hospitals and clinics	Hospital Authority is responsible for the delivery of health care services in Hong Kong	
Health expenditur	re indicators				
Total expenditure on health as % of GDP	9.7%	8.7%	3.7%	5.4%	
Per capita total expenditure on health in HK\$	22,407	14,453	8,137	9,680	
General government expenditure on health as % of total expenditure on health	68%	78.3%	27%	52.4%	

Table 21 – A comparison of the health care financing policy in selected places (cont'd)

	Australia	New Zealand	Singapore	Hong Kong
Health expenditure indic	ators			
Non-government expenditure on health as % of total expenditure on health	32%	21.7%	73%	47.6%
General government expenditure on health as % of total general government expenditure	16.7%	14.2%	5.9%	12.4 %
Health insurance coverage as % of total population	42.9 %	33%	75%	26.4%
Health care financing sys	stem			
Type	Tax-based financing system	• Tax-based financing system	Medical savings account system	Tax-based financing system
Guiding principles	Facilitating universal access to health care while allowing choice for individuals through substantial private sector involvement in delivery and financing	<ul> <li>All New Zealanders must have access to an acceptable level of health and disability support services when they need them, regardless of ability to pay; and</li> <li>It is a core responsibility of the government to finance and provide (or ensure the provision of) a comprehensive public health system</li> </ul>	• Based on individual responsibility, coupled with government subsidies, to keep basic health care affordable. Working Singaporeans are encouraged to take responsibility for their own health care by saving for medical expenses through the Medisave and approved health insurance schemes. However, no Singaporean will be denied access to the health care system if they are unable to pay	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

Table 21 - A comparison of the health care financing policy in selected places (cont'd)

	Australia	New Zealand	Singapore	Hong Kong			
Health care financing sy	Health care financing system (cont'd)						
Funding sources	<ul> <li>General taxation</li> <li>Medicare levy</li> <li>Health insurance plans</li> <li>Out-of-pocket payments</li> </ul>	<ul> <li>General taxation</li> <li>Accident-related levies</li> <li>Health insurance plans</li> <li>Out-of-pocket payments</li> </ul>	<ul> <li>Employer-sponsored benefits, including employer-sponsored health insurance schemes</li> <li>Out-of-pocket payments</li> <li>General taxation</li> <li>Medisave contributions, including health care insurance plans paid by savings in Medisave Accounts</li> </ul>	<ul> <li>General taxation</li> <li>Health insurance plans</li> <li>Out-of-pocket payments</li> </ul>			
Allocation of health resources to health care providers	<ul><li> Government budget</li><li> Health insurance companies</li><li> Patients</li></ul>	<ul> <li>Government budget</li> <li>Accident Compensation Corporation</li> <li>Health insurance companies</li> <li>Patients</li> </ul>	<ul><li>Health insurance companies</li><li>Government budget</li><li>Central Provident Fund Board</li><li>Patients</li></ul>	<ul><li> Government budget</li><li> Health insurance companies</li><li> Patients</li></ul>			

Table 21 - A comparison of the health care financing policy in selected places (cont'd)

	Australia	New Zealand	Singapore	Hong Kong		
Health care financing sy	lealth care financing system (cont'd)					
Share of financial responsibility on hospital services	Public patients in public hospitals are free of charge     Private patients in either public or private hospitals receive 75% government subsidy on medical services and cover all other costs by out-of-pocket payments and/or health insurance	<ul> <li>Public hospital services for eligible persons are free of charge</li> <li>Fees and charges for private hospital services are covered by out-of-pocket payments and/or health insurance</li> </ul>	<ul> <li>Individuals cover at least 20% of the cost for public hospital services by a combination of out-of-pocket payments, savings in the Medisave Accounts and approved health insurance</li> <li>Medical safety net to assist patients with financial difficulty in paying public hospital bills</li> <li>Fees and charges for private hospital services are covered by out-of-pocket payments and/or health insurance</li> </ul>	<ul> <li>Individuals cover around 3% of the cost for public hospital services by out-of-pocket payments and/or health insurance</li> <li>Medical safety net to assist patients with financial difficulty in paying public hospital bills</li> <li>Fees and charges for private hospital services are covered by out-of-pocket payments and/or health insurance</li> </ul>		
Share of financial responsibility on primary health care services	<ul> <li>Patients receive government subsidy to cover 85% of the cost on private out-of-hospital services and the remaining 15% is covered by out-of-pocket payments but not by health insurance</li> <li>Medical safety net to provide assistance to those patients with difficulty in handling payments</li> </ul>	<ul> <li>The young and the old as well as the poor and chronically-ill persons enjoy subsidized services</li> <li>Healthy adults pay full cost for services</li> </ul>	<ul> <li>Patients pay full cost for services in the private sector</li> <li>Patients who cannot afford private sector services can use subsidized public services</li> </ul>	<ul> <li>Patients pay full cost for services in the private sector</li> <li>Patients who cannot afford private sector services can use subsidized public services</li> </ul>		

Table 21 - A comparison of the health care financing policy in selected places (cont'd)

	Australia	New Zealand	Singapore	Hong Kong		
Health care financing sy	Health care financing system (cont'd)					
Share of financial responsibility on medicines	<ul> <li>Patients are required to make a co-payment for acquiring government-subsidized prescription medicines</li> <li>Pharmaceutical safety net to assist patients in making the co-payment</li> </ul>	<ul> <li>Patients are required to make a co-payment for acquiring government-subsidized prescription medicines</li> <li>Pharmaceutical safety net to assist patients in making the co-payment</li> </ul>	Patients are usually not required to make any payments for acquiring government-subsidized prescription medicines	Patients are usually not required to make any payments for acquiring government-subsidized prescription medicines		
Policy evaluation	Policy:  • increasing private sector involvement in the delivery and financing of health care services  Achievement:  • increase in the take-out rate of health insurance  Challenge:  • corresponding increase in government expenditure on rebate  • higher-income households receiving a larger rebate  • lack of incentive for insurers to manage high-cost cases cost-efficiently	Policy:  • achieving efficient use of health care resources through a devolved health care system  Achievement:  • citizen participation through the elected district health boards and allocated health care resources based on needs of the population rather than market principles  Challenge:  • the frequent restructuring of the devolved health care system in the past two decades has made the health sector "weary and wary of change"	Policy:  • developing a medical savings account system  Achievement:  • some academics consider that the system has effectively reduced the government's public spending in health care when compared to the tax-based financing system.  • they opine that the system has ensured the poor and under-privileged groups access to essential health care services through a medical safety net	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  • Hospital Authority has introduced reform measures with the aim of improving financial sustainability of the health care system		

Table 21 - A comparison of the health care financing policy in selected places (cont'd)

	Australia	New Zealand	Singapore	Hong Kong		
Health care financing s	Health care financing system (cont'd)					
Policy evaluation (cont'd)		Challenge:  • possibility of political control by special interest groups in the district health board system and the question of equity in the distribution of health resources among districts	health care resources provided	health care financing framework		

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