CB(2) 2494/98-99(01)

Health Security Plan

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July 1999
Revised Version

Summary of the Article

This article considers the recently proposed Health Security Plan (HSP) in the Harvard Report by comparing it with the Health Insurance system in Japan. The author provides a few points that may be of interest for policy formation based on the comparison above and experience from foreign countries.

LegCo: document {presentation on 21/7/99} submission deadline 6/7/99.

Prelude

It is my honor having the chance today to share with you some of my opinions on the health care reform in the Legislative Council. Being nominated by our department chair, Professor Sung, to participate in this panel, I think that I should be sharing with you some of my findings based on my preliminary research, driven by my interest and curiosity.

Introduction

Economic reform on health care is becoming one of the most exciting policy topics lately worldwide over the past decade. Hong Kong is no exception, facing a similar problem, like many other developed countries. I will focus on one of the recent proposals in the Harvard Report, namely, the Health Security Plan (HSP). I choose to discuss this particular proposal because it seems that this proposal has a good chance to be implemented by the Hong Kong SAR government, therefore, its efficacy and financial future would be important to us all in Hong Kong.

In the Harvard Report, Professor Hsiao and his team recommend the mandatory health insurance program to be implemented in the Hong Kong, called the Health Security Plan (HSP). Under this plan, a Health Security Fund Inc. will be established. Contribution to the Fund will be gathered through a tax on wages, around 2.5%, shared by both employees and employers. The plan covers a benefit package that includes inpatient hospital services and specialist outpatient services, including some chronic disease. Insured persons can then receive medical services from either public or private hospitals at their own choice. For those who are genuinely poor and sick will be subsidized by the government for their medical needs. This system is similar to a National Health Insurance plan that provides universal coverage, but not really identical.

Before I continue, I would like to draw your attention to a short discussion on the Japanese Health Care system that recently arouses interest of many American academics.

The Japanese Health Care System

Campbell and Ikegami (1998)[1] points out nine features on the Japanese Health Care System:

1) Virtually the entire population is included in the mandatory health insurance.
2) Most enrollments are automatic with little choice of coverage for either consumers or insurers.
3) The benefit package in all programs covers all regular health care.
4) Payment for health insurance is largely determined by ability to pay, through contribution as a share of income.
5) Differences in burdens across social groups are reduced by such mechanisms as support from general revenue and cross-subsidization among insurance plans.
6) Nearly all prices are strictly controlled by a fee schedule.
7) The fee schedule is periodically renegotiated between insurers and providers.
8) Spending that is not directly related to health care, such as medical research and administrative expenses for insurers and providers, is kept low.
9) Total health care spending is tracked and controlled.

These characteristics of a health care system are not uncommon in countries that adopt the NHI. The first three of them seem to be what the HSP would like to achieve. The Japanese system has a reputation of achieving a remarkably cost effective result comparing to the United States pluralistic free market system. Health care spending as a percentage of GDP is around 7% in Japan; whereas health care spending in the United States is more than double that figure, around 14% of her GDP.[2] If we compare the broad health indicator like the mortality rate between the two countries, we find that the probability of dying under age 5 and between 15 and 59 across genders is lower in Japan than that in America in 1998. Infant mortality rate in Japan is also lower.[3] Anecdotal evidences suggest that people in Japan are in general healthier too.[4] The stark difference, especially its cost effectiveness, triggers academics in the US to consider the Japanese healthcare system and to learn from it. Our aim here is to find out what kind of inspiration we may have by looking into the Japanese System.

Let me provide a snapshot of the Japanese system base on Campbell and Ikegami (1998). Figure 1 describes the Japanese health care financing system. Health insurance is broadly separated into three categories: the Society-Managed Health Insurance (SMHI), Government-Managed Health Insurance (GMHI), and Citizen Health Insurance (CHI). The first category SMHI is financed by premium shared by employees and employers. The second category GMHI is financed by premium shared by employees and employers,

[1] Campbell, John Creighton and Naoki Ikegami, The Art of Balance in Health Policy, Cambridge University Press, 1998.
[2] This comparison is currency adjusted using Purchasing Power Parity.
[3] WHO report (1999)
[4] See discussion in Campbell and Ikegami (1998).

accompany with government subsidies. The third category CHI is financed by non-employees, including those who are self-employed and retired. Government contributes the CHI through taxation revenue. Management-labor committees in big companies manage the private SMHI, whereas the Ministry of Health and Welfare manages the GMHI. Finally, the municipal government manages the public CHI. Managers in both the SMHI and CHI are not entrepreneurs. They are the Chief clerks in maintaining the inflow of premium and outflow of insurance claims. There is virtually no competition in the insurance industry over benefit packages and prices, but over some other dimensions.

Under the Japanese system, there is a restriction over the choices of insurers; namely, the whole population has been covered by the three categories since 1960's.[5] Some Japanese buy supplementary insurance for additional protection from foreign private carriers. Patients are free to choose among public or private providers.

The crux of the Japanese System in its effectiveness in cost control lies on the fee schedules and global budgeting. The Medical Care Division, which under the Health Insurance Bureau (HIB) of the Ministry of Health and Welfare, prepares the fee schedule, governing nearly all goods and services in health care provision. The Planning Division sets the premium, indirectly determining the amount of government subsidy. HIB has to negotiate with providers (Japan Medical Association) about expenditures and the Ministry of Finance about the subsidy portion of the revenues. Since the GMHI is directly under government control via the Health Insurance Bureau, GMHI spending and the negotiation of HIB over the fee schedule importantly influence the premium to be set by SMHI and CHI, varying across numerous insurance pools. There is global budgeting mechanism that holds the health care cost down. It is the total amount of expenditure that comes first, then the prices of all health care items will be determined afterwards through negotiation. The use of a single relatively simple insurance plan, managed by the government, as the regulator for a pluralistic system appears to be unique to Japan. This is what is known as the Macro-health care policy in containing cost.

Regarding the Micro-health care policy, the fee schedule plays an important role. Price ceilings, manipulations of relative prices, regulative directives, and a system of claims reviews are important tools in controlling health care cost. The fee schedule is universally applied to all physicians, regardless of their qualification, experience, and location of work at national level. The schedule itself is not set to reflect the cost of each procedure. Its function is to have each broad type of facility's expenditures balanced by its revenue. Since the fee schedule affects importantly the revenue of physicians, it is designed so that no single group of physicians will be winners or losers in the long run. However, it is set to maintain a favorable position of private practitioners, the major contributor to the Japan Medical Association. Relative income of providers is balanced, maintaining a stable share of the pie, adjusted according to the demand and supply situation. These strategies maintain the Status quo, so as to contain conflicts among

[5] SMHI insures employees of large firms at company level, covering 26% of the population. GMHI insures employees of small firms, covering 30% of the population. The rest will be covered by CHI, roughly 34% of the population. Mutual Assistance Associations cover government or quasi-public employees, making up the remaining 10% of the population.

numerous contenders due to fees revision. Since prices are negotiated among HIB and providers, they are usually considered legitimate.[6] Fee schedule is also used for manipulating provider behavior through setting of relative prices; in particular, it is used to affect volume of various treatments transacted.[7]

What have I learnt from it?

Let me highlight several points that strike me as relevant and interesting in the discussion of HSP.

1) Although there are a pluralistic health insurance sector in Japan, in essence there is only one: "one" is "many" and "many" is "one". This, I think, could be, and is, the spirit of the Health Security Plan. Although the HSF Inc is a single entity, it contracts private insurers to provide the services under the influence by the government. This is therefore essentially the Society Managed Health Insurance. There can be still competition between the contracted private insurers, assuming there are enough number of suppliers, but only not over the dimension of the defined benefit package and the basic premium. Competition may be over the quality of services and provision of additional benefit package.

2) The role of Health Insurance Bureau that negotiates with the Japan Medical Association is taken up by the Health Security Fund. In the Harvard Report, it suggests price negotiation between insurers and providers based on cost of treatment. However, we can learn from the Japanese that prices may not necessary reflect costs. The fee schedule is an important tool for mirco-policy tools for cost containment. I think we should spend more time investigating what we can adopt based on the Japanese experience.

3) The second important tool for containing cost in Japan is the global-budgeting. It is this global-budgeting that comes first before the negotiation in Japan. The feature of global budgeting has already been inherited from the Basic Law in Hong Kong, given that there is an explicit constraint on the growth rate of our government expenditure. It is worth investigating into the top-down negotiation arrangement in Japan.

The last two are not really related to the Japanese system but I think that they are worth mentioning:

4) Although the theory of competition is very attractive, it should not be over-emphasized in the area of health care. For example, ungoverned competition among insurers might fail to achieve the Hong Kong government's objective. We can learn from the current experience in the United States pluralistic competitive health care

[6] There is, however, complication in pricing of pharmaceutical products. There is no bargaining between representatives of drugs manufacturers and HIB, prices are sometimes set unfavorable to producer's profit; for example, an unusually large price cut on some drug, causing big resistance from the industry.
[7] For a detail discussion, see Chapter 6 in Campbell and Ikegami (1998).

market. Although there are government regulations, competition is still creating one of the most complex and expensive systems in the world.

5) I think that the government should provide a clear signal that it is providing universal coverage but not free care to everyone. Smart use of deductibles and copayment will save us from the problems like the ones in Taiwan with her NHI.[8] Deductible and copayment can be set in accordance with the different illness categories. Time do not allow me to continue this discussion but, I think, we should not under-emphasize the appropriate of these instruments as one of the gateway to the health care system.

It is very hard to please everyone in the discussion of health care financing. The Japanese fee schedule obviously does not please the physicians in general, since it is telling or directing what they should do. High copayment effectively stops patient from abusing the system, but the price system certainly lowers the universal accessibility to the system. Quality is always a concern. We want a uniform improvement in quality in both the private and public sectors. Supply side cost sharing however may lower the perceived quality of treatment. In fact, it would ultimately be determined by different specialist groups, for example, physicians, patients groups, politicians, and government officials on what is the best system to be implemented in Hong Kong. Although the general public is not in favor of the implementation of such a scheme, according to a recent survey by the CPU, I think the discussion about a suitable financing system for health care services in Hong Kong is an on going process. Whereas, the timing for its implementation requires political intelligent. We may not be ready now, but we will be ready for changes for the betterment of Hong Kong in the future. Once we are ready, we should have already the issue sorted out nicely and plans can be implemented in a politically sound moment. This requires patient and vision that I wish to see in the leadership in the Hong Kong government. Thank you, this is all I want to share with you today.

[8] According to the seminar on Sustainable Health Care Services, 1999, Hong K[illegible] f the major problems in the Taiwanese Health care system is the over-insurance of mino[illegible]

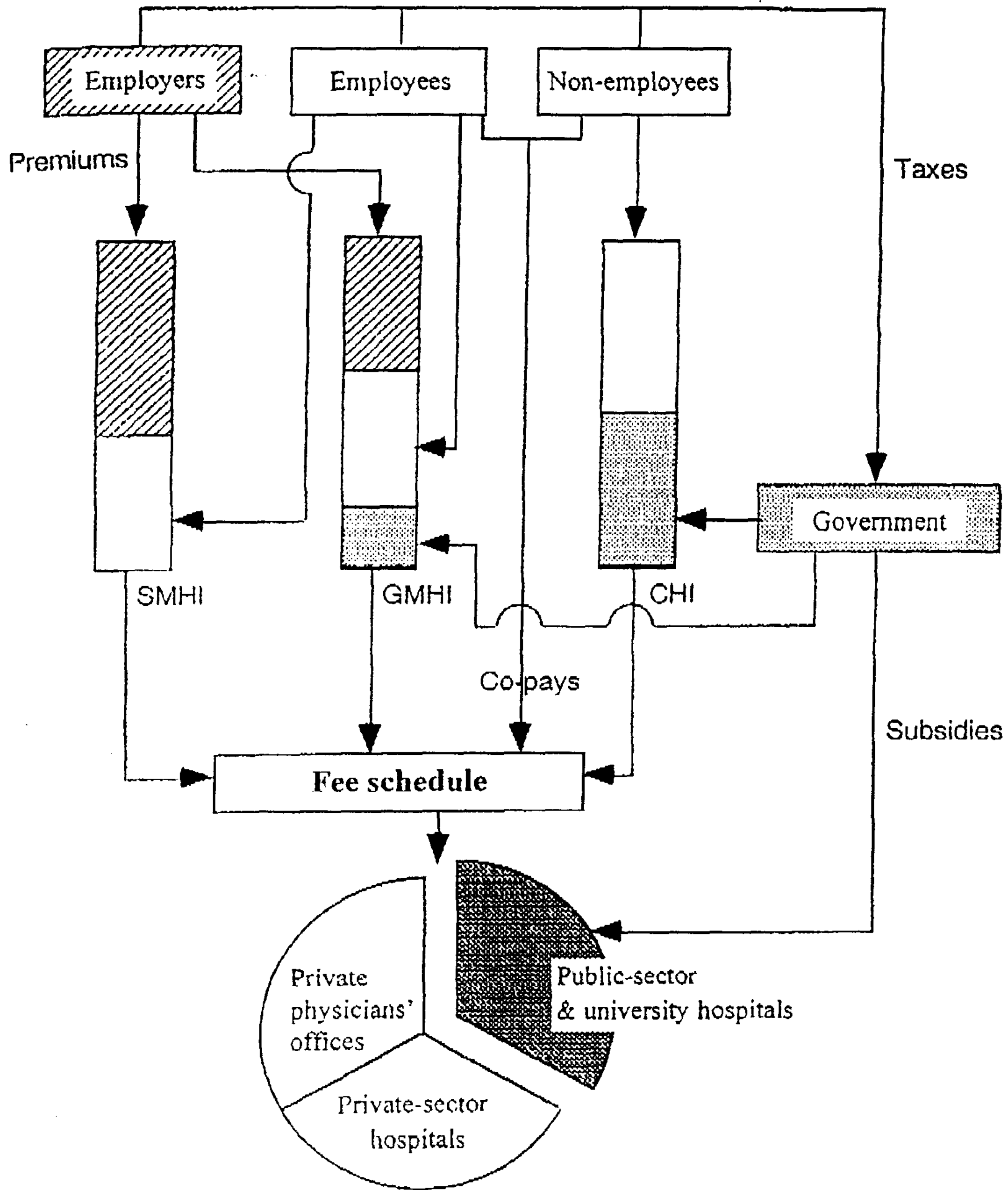

Figure 1 Flow of Money in Japanese Health Care.