Health Care Financing: A Voluntary Approach

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Mandatory Insurance System

The health care financing system proposed by the Harvard's consultants is a mandatory and centralised insurance system. The system requires all income earners to contribute and therefore restricts the choices of users. The system is unfair, since the contribution is fixed at a percentage of income, regardless of the efforts people make to improve their health conditions. It also gives an impression that the Government is going to shirk its responsibility in financing medical and health services. It is foreseeable that the system would not gain the support of the Hospital Authority (HA), private insurance companies, and income earners.

Voluntary Insurance System

An alternative is a voluntary and decentralised approach, which allows users to enjoy wider choices. The users of medical services can decide on buying medical insurance or not; they can choose the services provided by the public or the private sector; and they can choose standard or enhanced services.

A voluntary subsidised insurance system incorporates the features of Joey Hay's ChoiceCare and Lok-Sang Ho's Swedish approach.

Under this system, the roles of the Government include:

(1) Provision of public-good services and infrastructure facilities: e.g. information collection and dissemination; policy study, formulation and implementation; medical education and training; research and development; health promotion; prevention and monitoring of diseases; planning and building of new hospitals and clinics.

(2) Subsidisation of medical and health services because of their externalities.

(3) Implementation of a health care financing system which can promote high quality services and improve efficiency (through competition and user choice). The financing system should also be financially sustainable and cost-effective. The features of this voluntary subsidised insurance system are:

   (i) The recurrent expenditure of HA is capped (e.g. at $26 billion in 1998/99). HA has to maintain its existing service level and has to compete with the private sector for new resources. HA and the Department of Health are encouraged to contract out services to reduce costs.

   (ii) HA's direct funding from the Government will be reduced steadily (e.g. by $1 billion each year). The reduction is to be compensated by a

corresponding increase in user fees. The money saved by the Government is used for subsidizing the purchase of private family medical insurance.

(iii) Public hospitals and clinics are allowed to raise user fees steadily from the existing 3% of costs to 30% of costs in 7 years. An annual health spending limit based on the ability to pay (e.g. 6% of family income) will be set.

(iv) Any future increase in public expenditure on medical and health (due to GDP and population growth) will be used for subsidizing the purchase of family medical insurance.

(v) Tax incentives will be provided to employers and employees for the purchase of family medical insurance, e.g. through tax allowances for children and parents: additional allowances for the purchase of family medical insurance; insurance premium is tax deductible. At present, similar tax allowances have been given to mortgage payment and education/training.

(vi) The Government is responsible for monitoring the services of HA and private medical insurance plans.

The following illustrates the financial arrangement of the proposed system (all figures are in billion and in real terms):

Financial year	1998/99	2000/01	2001/02	....	2006/07
Income of HA	26.0	26.0	26.0	....	26.0
-From Govt	25.2 (97%)	24.2 (93%)	23.2 (89%)	....	18.2 (70%)
-From user fee	0.8 (3%)	1.8 (7%)	2.8 (11%)	....	7.8 (30%)
Insurance Subsidy	0	2.7	4.7	....	14.9
-From user fee	0	1.8	2.8	....	7.8
-From GDP growth (3.5%)	0	0.9	1.9	....	7.1

By 2006/07, Government's direct funding to HA is estimated to be $18.2 billion (55% of total expenditure), and Government's subsidy given to private medical insurance plans is estimated to be $14.9 billion (45% of total expenditure). If all households take the subsidy, each family will receive a subsidy of $6,000-7,000 per year.

The advantages of the proposed system include:

(1) Maintaining the stability of HA (as the current income of HA is not affected)

(2) Increasing the cost-effectiveness of HA (as part of its income depends on user fees: if they are set too high, patients will go "private")

(3) Reducing abuses of the public medical services (as user fees are increased)

(4) Increasing the utilization rate of private hospitals (as the fees of public hospitals are raised)

(5) Protecting the uninsured (as users can always choose the existing system by paying affordable fees)

(6) Encouraging voluntary medical insurance (as insurance premium is subsidised)

(7) Promoting healthy lifestyle (so as to enjoy lower insurance premium)

(8) Encouraging competition among private insurance companies (to receive the subsidy)

(9) Encouraging competition among private and public medical service providers (to earn more income through medical insurance plans)

(10) Improving the quality and increasing the range of services (through competition and the provision of different medical insurance plans)

(11) Expanding the choices of users (as they can select different insurance companies, different plans and different service providers)

Questions about the System

(1) Is 30% of cost recovery too high?

Ans. It is not high as compared with Ho's Swedish model, in which a 100% of direct cost recovery is proposed. At present, users have to pay 20-50% of the costs of public housing and tertiary education. A 30% of cost recovery for medical service should be affordable and people can choose to purchase medical insurance with government subsidy to reduce the burden.

Examples:

	Recurrent costs in 1996/97	30% cost recovery
Cost per discharge (overall)	$15,000	$4,500
Cost per bed-day	$2,000	$600
Specialist emergency	$480	$144
General outpatient	$200	$60

Annual spending limits are also imposed to avoid creating enormous burden to the chronic sick. e.g. 6% of median family income (HK$210,000) in 1996 = $12,600. The Government will pay all expenses above the limits. Family without any income will be exempted.

(2) Is the system financially sustainable?

Ans. The percentage of cost recovery and the amount of insurance subsidy are parameters that can be adjusted. Competition introduced by the new system will improve resource allocation. As a result, medical costs will be lowered and the resources saved can be used for providing additional services.

(3) Would insurance companies deny the old and sick; and only accept the healthier people?

Ans. The Government's subsidy is on a family basis. In order to receive the subsidy, insurance companies would design insurance plans that cover children, parents and other unemployed family members. The subsidy can also be targeted at insurance plans that cover the old and sick; or a higher subsidy is given to these plans. Even if the chronic sick are not able to buy insurance, they can rely on the existing public health care system.

(4) Would the insurance subsidy attract those who have already purchased medical insurance to join the system?

Ans. Yes, it would. But the problem would be less serious as compared with ChoiceCare. Under the subsidised insurance system, the Government would only subsidise a portion of the insurance premium; while under ChoiceCare, basically a 100% subsidy is given.