Health Policy in Mainland China, Hong Kong, and Taiwan

Lok Sang Ho
Economics Department
Lingnan University

March 6, 2011 CUHK
<table>
<thead>
<tr>
<th></th>
<th>Forced</th>
<th>Voluntary, Non-Market</th>
<th>Voluntary Market</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Direct</td>
<td>Indirect</td>
<td>Supplementary Financing</td>
</tr>
</tbody>
</table>

**Disadvantages**

<table>
<thead>
<tr>
<th></th>
<th>Forced</th>
<th>Voluntary, Non-Market</th>
<th>Voluntary Market</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand-side Moral hazard</td>
<td>Not exactly a healthcare financing tool, as money stays with the patient; but may be complemented by insurance</td>
<td>Could hide away costs and lead to demand-side moral hazard</td>
<td>Could delay care and lead to more costly and even less effective care down the road</td>
</tr>
<tr>
<td>Supply-side Moral hazard</td>
<td>Savings may be excessive or inadequate</td>
<td>Medical staff on salary may complain of not earning according to workload</td>
<td>Could lead to excessive burden if charges are set too high. Problem can be mitigated by capping user-paid expenses per year</td>
</tr>
<tr>
<td>Advantage</td>
<td>Description</td>
<td>Chronic costs</td>
<td>Patients</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Loss of autonomy over how to spend one's earnings</td>
<td>Potential loss of autonomy</td>
<td>Chronically ill and known cost-drivers may be denied protection</td>
<td>High financial risks for patients</td>
</tr>
<tr>
<td>Funding allocation by “Money Follows Patient” may lead to supply-side</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>moral hazard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advantages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal Coverage can be guaranteed: known cost-drivers can be covered</td>
<td>Government has comfort in knowing that the public purse may not be</td>
<td>Consumers have choice of plans and of insurers</td>
<td>Motivates preventive care</td>
</tr>
<tr>
<td></td>
<td>overburdened</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May better inform citizens of the cost of healthcare than tax-financing</td>
<td>May complement supplementary financing through user charges</td>
<td>Can help contain supply-side moral hazard if charges are set at</td>
<td>Doctors earn more if they work more</td>
</tr>
<tr>
<td></td>
<td>May invigorate private healthcare market</td>
<td>non-remunerative levels</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Funding by “Money follows patient” could motivate innovations; claim is</td>
<td></td>
<td>Consumers have autonomy over services purchased</td>
</tr>
</tbody>
</table>
What do we want?

• Universal coverage: everyone must be protected (by government or otherwise);
• Quality of care has to be acceptable, so the protection is meaningful;
• System has to be sustainable.
• System should be efficient.

• All this means we need a Multi-Pillar System with government provision as last resort available to everybody.
Role of Fees in Publicly Provided Care:

• Fees at the right level will encourage the right behavior: prevention on the part of patients, and care on the part of caregivers;

• Low fees paid lead to waste and too little prevention;

• Low fees received lead to underprovision of care;

• High fees paid discourage seeking of care;

• High fees received lead to overprovision of services

• Fees bring resources to the system to uplift quality of care.
Fees in HK, Taiwan, and Mainland

• Too low in HK, fees generally at 3% of cost; leading to waste and inadequate resources;

• Outpatient fees too low in Taiwan; more reasonable in Taiwan, which charges fees = to 10% of cost; fees received by caregivers contained and capped by global budget, which leads to occasional under-provision of care;

• Very high fees charged on some items on the mainland lead to supply side moral hazard and excessive risks for patients.
Role of ABCs: Limits Financial Risks and Ensures Affordability

• Taiwan caps annual in-patient expenses:
  – there is a cap on cumulative copayments paid: at NT$29,000 for a single hospital stay for a particular condition and NT$48,000 cumulative for the entire calendar year. For outpatient visits, the typical co-payment is NT$50, but visits to better equipped medical centers and hospitals can require copayment of NT$210 with referrals or NT$360 without referrals. (ABC= Annual Budget Cap)
• The NHI premium rate was 4.25% from the time the system was launched until September 2002, when it was adjusted to 4.55%. The premium rate was then adjusted to 5.17% in April 2010. The government will subsidize 100% of the increase in the premiums for the poor.

• Copayments were introduced in 1999 and increased in 2002 and again in 2005.
Satisfaction Rating at Historical High despite higher premiums and copayments

Figure 17 - NHI Public Satisfaction Ratings
Role of Tax-Funded Care

• Safety net in HK and in Taiwan (Taiwan’s NHI is funded by an earmarked tax; HK’s HA is funded by the general revenue);
• Provides a benchmark against which private caregivers must compete;
• Covers infrastructure and public health initiatives as well as medical research, all of which are in the nature of public goods;
• Mainland’s inadequate funding leads to profit-seeking behavior on the part of caregivers, which undermines the public interest.
Role of Tax Funded care

• To provide basic care that meets minimum quality requirements;
• Community has to define the limit of basic care. (i.e., what is covered and what is not)
Role of Market Caregivers

• To provide alternatives to the basic care offered under the public system (greater choice);
• To provide supplementary care not covered under the basic plan;
• To allow innovations initiated by private caregivers......
• For “frontier care”, i.e., care that is at the forefront of research and development, the cost of regulating prices is probably too high as it could stifle innovation. Here the discipline of the market, jettisoned by the scrutinizing eyes of the discriminating consumer, may help strike an optimal balance between consumer and supplier interests.
Role of Private Health Insurers

• To give people a chance to get supplementary and alternative care at their own cost;
• Mutually beneficial; so they are valuable.
• Private health insurers thrive in HK, and less so in Taiwan, and are on the rise on the mainland.
Role of Medical Savings Accounts

• Beginning from an experiment from 1994 a number of mainland cities have set up medisave arrangements, requiring monthly contributions from both employers and employees to a personalized medisave account.

• In Beijing, employees and employers pay 2% and 9% of their average monthly salaries in the previous year. Of the 9 per cent contribution from employers, the fraction put into employees’ personal accounts varies with age.
Role of Medisave

• Ensures that patients can pay fees charged by the public caregivers.
• Medisave plans in Singapore, Malaysia, and on the mainland are mandatory, but they need not be. It is possible to provide tax incentives or even outright subsidies to induce people to put money into their medisave accounts.
Conclusions(i)

• All pillars serve a good purpose. The tax funded pillar has to be strong and reliable. It provides the backbone of healthcare in society, against which private caregivers must compete.

• Accountability achieved through clear lines of responsibility is better than “internal market competition” whose “money follows the patient” model may lead to supply side moral hazard.
Conclusions(ii)

• ABC plus appropriate fees is important to ensure affordability and well behaved consumers and suppliers of services. Taiwan’s successful experience is worth emulating.

• To promote the cause of greater choice, I have championed the setting up of a “Lifetime Healthcare Supplement”, which offers each citizen support for alternative and supplementary care under a cost sharing formula, with lifetime contribution from public coffers capped at some level.