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Health reform monitor

Health insurance reforms in Singapore and Hong Kong: How the two ageing asian tigers respond to health financing challenges?

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ABSTRACT

Singapore and Hong Kong, two high-income "Tiger economies" in Asia, were ranked as the top two most efficient health systems in the world. Despite remarkable similarities in history and socioeconomic development, both economies embraced rather different paths in health care reforms in the past decades, which reflect their respective sociopolitical dynamics. Rapidly ageing populations and the anxiety about future funding of health care have prompted them to embark on major health financing reforms in the recent three years. While Singapore has transitioned to universal health coverage with the implementation of MediShield Life (MSL), Hong Kong is about to introduce the Voluntary Health Insurance Scheme (VHIS) to supplement its health care financing. Based on secondary materials including policy documents, press releases, and anecdotal reports, this essay compares these two recent reforms on their political context, drivers of reforms, and policy contents, and assesses their prospects in terms of coverage, financial protection, and major implementation challenges. The preliminary assessment suggests that while both programs are associated with certain drawbacks, those of the VHIS may be more fatal and warrant close attention. This essay concludes with a central caveat that underscores the pivotal role of the state in managing health care reforms.

1. Introduction

Once hailed as the Asian Tigers, the industrialized high-income economies of East Asia, namely, Singapore, Hong Kong, Taiwan and South Korea, perform well on a range of population health and financing indicators (Table 1). Singapore and Hong Kong, in particular, were ranked by Bloomberg as the top two most efficient health systems in the world [1]. Spending merely 4.9% and 5.7%of their GDP on health, respectively, Singapore and Hong Kong have achieved outstanding outcomes in population health status. Attributable to a variety of factors, this extraordinary achievement is still made possible by their respective health systems.

These two former British colonies, which had resembled each other in their health system structures due to British legacies, embarked on very distinctive paths of reforms in the 1980s and 1990s, in reflection of their own sociopolitical dynamics. Yet, the common health policy challenges in recent years have prompted both governments to initiate major financing reforms. While Singapore has introduced MediShield Life (MSL), a universal health insurance program, Hong Kong is about to launch the Voluntary Health Insurance Scheme (VHIS) as a supplementary financing instrument. Representing strategic responses to health financing challenges in ageing societies, both reforms are also apparently shaped by the two Tigers' own welfare politics. The comparability of these two Tiger economies firstly lies in their highly similar level of socioeconomic development and historical background in health systems but divergent reform modalities, meeting both "methods of difference" principle and "methods of agreement" principle in comparative methodology. Moreover, Singapore and Hong Kong have been an important source of policy learning for other health systems in the developing world. Some of their practices – such as medical savings account and corporatization of public hospitals – have been diffused to Mainland China and South Africa [2,3,4]. A comparative study of their recent reform trends will facilitate further policy reflection and possible policy learning in other health systems.

Given the recent and forthcoming nature of Singapore and Hong Kong's reforms, respectively, the lack of solid empirical data precludes ex post assessment. Mainly drawing from secondary materials including policy documents, press releases, and anecdotal reports, this comparative analysis examines their respective political contexts, drivers of reforms, and policy contents, and assesses their prospects.

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Table 1
Key population health and health financing indicators of selected economies, 2014.

	Life expectancy at birth (total)-2013	Infant mortality Rate (per 1000 live births)-2013	Total expenditure on health as share of GDP-2014
Singapore	82.64	1.8%	4.9%
Hong Kong	83.74	1.7%	5.7%
South Korea	81.43	3.0%	7.4%
Taiwan	79.26	3.9%	6.2%
Japan	83.31	2.1%	10.2%
US	78.88	6.0%	17.1%
UK	80.45	3.8%	9.1%
Germany	80.66	3.3%	11.3%

Source: health expenditure data from Global Health Expenditure Database, the World Health Organization. Infant mortality rate data from OECE. Stat. Life expectancy data from United Nations Department of Economics and Social Affairs, *World Population Prospects*, 2015 Revision.

2. Background

2.1. Political context

The role of politics in health care often dictates the direction of reforms. While general welfare ideologies enrich as well as limit the policy alternatives that are available to policy-makers, political institutions act as the constraints within which policy-makers can exert influence and make decisions [5,6]. The People's Action Party (PAP), the ruling party of Singapore, has been historically conservative in the provision of welfare, despite its extensive involvement in public housing [7]. This ideology permeated into the health system. The Singapore Government has repeatedly emphasized personal responsibility when paying for health care. Its underlying belief can be best described as *quid pro quo:* giving back only after individuals contribute [8].

Traditionally labeled as a developmental welfare state, Hong Kong differs from Singapore in many respects. The territory's overarching philosophy of governance has been positive non-interventionism, adhering to the "small government, big market" principle. In contrast to its residualist stance towards welfare, the Hong Kong Government does intervene to a fairly deep extent in tax-funded health care [7]. With the health system inherited from British rule largely still in place, only minor ad hoc tweaks were undertaken in the past three decades [9].

Despite their remarkable similarities in history and socioeconomic development, Singapore and Hong Kong differ significantly in welfare politics. While the former has an authoritarian state and a popularly elected government that is very efficient in decision-making, the latter is a highly liberal society but a semi-democracy operating under China's "one country, two systems" framework as a special administrative region. The institutional frameworks have vigorously exerted profound impact on health policy reforms in both economies. While the political system of Singapore is very conducive to structural reforms, the lack of political legitimacy has frustrated several important health care reform attempts of the Hong Kong Government in the past [9,10].

2.2. Key features of Singapore's health financing system

In 1984, Singapore revolutionized the idea of health financing through Medisave, an individualized medical savings account (MSA) funded by one's salary and matched by employer's contribution. The motivation behind the MSA was to shift funding to the individual, with the savings balance paying for one's own medical expenses. Current contribution rates on average are 8–10.5% for 2016, with older persons paying more [11]. The government initially designed Medisave to financially shelter users from large inpatient bills, not to cover small medical visit costs, but its usage was gradually liberalized to include selected outpatient costs and those of family members.

Realizing that some citizens would still fall through the Medisave barrier, in 1990, the government established a basic catastrophic risk-pooling scheme named MediShield, which covered about 93% of the population, before the reform in 2015 to MSL [12]. MediShield was intended to be a "catastrophic illness insurance scheme" to help Singaporeans cope with prolonged hospitalizations and high medical bills. It operates with age-tiered annual premiums payable from Medisave. If hospitalized, one must first pay a deductible before MediShield benefits begin. During the portion of MediShield coverage, patients also pay coinsurance, further reinforcing the idea of individual responsibility. The lifetime maximum claim capped at S$300,000.

For those who cannot pay for bills using the Medisave or MediShield combination, Medifund acts as a last-resort measure ensuring expenditures are paid. Medifund is an endowment fund that uses investment income to pay for claims that must be approved on a case-by-case basis. With the three schemes above, combined with government subsidies, Singapore's health financing arrangement can be described as a "subsidies + 3M framework" [12].

2.3. Key features of Hong Kong's health financing system

Contrasting the planned Singaporean financing system, Hong Kong's system is relatively simple and follows a "dual-track" arrangement that refers to the compartmentalization of both funding and provision for different types of health services. While public facilities dominate secondary and tertiary care, 70 per cent of primary outpatient services are provided by private clinics [13]. This sector is funded largely by out-of-pocket payments (OOP; 65%), employer-provided group health insurance (15%), or individually purchased private insurance (15%). Public hospitals provide approximately 90% of inpatient services. Ninety-three percent of the funding of the public sector comes from the British NHS-style tax-based system, which allows subsidized providers to deliver services at nominal fees to citizens, without means-testing. Patients' OOP payment accounts for merely 6.6% of incomes for public hospitals [14]. There are no mandatory contributory schemes in Hong Kong's health system.

All public hospitals, specialist outpatient clinics, and general outpatient clinics are managed by the Hospital Authority (HA), a corporatized statutory organization answerable to the government. Heavily subsidized by the government, public hospitals are subject to rigid financial, administrative and operational control of the HA. Every Hong Kong citizen is entitled to highly subsidized care in public facilities that enjoy very high level of satisfaction and trust [15,16]. This generosity, however, also strains public finance and casts doubt on the long-term sustainability of the system. Frequent

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