Health Policy in the Asian NIEs

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Abstract

This paper compares the health policies of Hong Kong, South Korea, Singapore and Taiwan with the purpose of drawing policy lessons. The study finds two distinct policy clusters: Hong Kong and Singapore on the one hand, and Korea and Taiwan on the other. With respect to provision of health care, the former rely largely on public hospitals for delivering inpatient care while the latter rely on private hospitals. In matters of financing, they are similar in that out-of-pocket is a major source of financing in all four countries. However, they are also different because Korea and Taiwan have universal health insurance while the city states do not. The study concludes that public provision of hospital care, as in Hong Kong and Singapore, yields more favourable outcomes than many mainstream economists would have us believe. Conversely, private provision in combination with social insurance, as found in Korea and Taiwan, severely undermines efforts to contain health care costs.

Keywords

Health policy; Financing; Public versus private provision; Newly industrializing economies

The proliferation of research on public policy in East Asia continues to be biased towards economic policies despite the increasing realization of the importance of social policies in national development. Health policy is one such area of neglect, even though some of the countries in the region enjoy health outcomes that are among the best in the world. This paper is an effort to close the gap by systematically comparing the health policies of Hong Kong, South Korea, Singapore and Taiwan, collectively referred to as the Newly Industrializing Economies (NIEs) or just “dragons”.

The objective of this paper is to compare the health policies of the NIEs and draw lessons from them. This is expected to shed light not only on their health policies but also on the policy measures that work and are worthy of emulation elsewhere. The four NIEs are eminently comparable for a variety of reasons. They occupy similar ranking on the Human Development

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Index—Hong Kong and Taiwan at 23, Singapore at 25 and Korea at 27—and are believed to share a common Confucian heritage. While the two city states have considerably higher levels of income than the other two, they have all enjoyed exceptional economic growth over the last four decades. They were all ruled by foreign powers until the mid-twentieth century: two by Britain and two by Japan, and the policies put in place during colonial rule continue to shape their policy choices. They also share a similar non-democratic political history. Their broad development strategy has generally focused on economic growth at the expense of other objectives—“Oikonomic” or “productivist” welfare states in the words of Jones (1990) and Holliday (2000) respectively—and all except Hong Kong have been described as having experienced state-led development.

This paper will show that the NIEs employ different combinations of state and market mechanisms for providing and financing health care. At a more abstract level, however, we find two distinct clusters: Hong Kong and Singapore on the one hand and Korea and Taiwan on the other. With respect to provision of health care, the former rely largely on public hospitals for delivering inpatient care while the latter rely on private hospitals. In matters of financing, they are similar in that out-of-pocket is a major source of financing in all four countries, but they are also different because Korea and Taiwan have universal health insurance while the city states do not. The study will show that public provision of hospital care, as in Hong Kong and Singapore, yields more favourable outcomes than mainstream economists would have us believe. Conversely, private provision in combination with social insurance, as found in Korea and Taiwan, undermines efforts to contain costs.

Policy History

Hong Kong

After more than a century of neglect, the colonial government in Hong Kong quickly became the dominant player in the colony’s health system in the mid-1960s. Its involvement concentrated largely on hospital care and the legacy continues to this day. The evolution of the government’s health policy is reflected in seven major government documents released over the last four decades: 1964, 1974, 1986, 1990, 1993, 1999 and 2000.

The 1964 White Paper defined the government’s health policy objective as “providing, directly or indirectly, low cost or free medical and personal health services to that large section of the community which is unable to seek medical attention from other sources”. The 1974 White Paper proposed further expansion in the government’s role, especially in hospital-based curative services. The two measures—low-cost or free health care and emphasis on hospital care—continue to form the foundations of the health care system in Hong Kong (Liu and Yue 1998).

The increasing incidence of debilitating diseases such as cancer, heart disease and stroke, and the considerably higher treatment costs they involve, alarmed the government and led it to search for improving its hospitals’ efficiency. The 1986 report recommended the establishment of an independently
administered hospital system with each hospital management responsible for its operations within the fiscal and regulatory framework laid out by the government. The establishment of the Hospital Administration (HA) in 1991 marked the onset of efforts to “corporatize” health care delivery in Hong Kong. To allay fears that the move was a step towards privatizing health care, the Working Party on Primary Health Care in its 1990 report reiterated the principle that “no one should be prevented, through lack of means, from obtaining adequate medical treatment”. The principle was subsequently incorporated into the Hospital Authority Ordinance.

The consultation document, *Towards Better Health*, published in 1993, mooted the idea of increasing private financing of health care, but no significant measure was taken to put it into effect. The government revived the issue with the commissioning of a study team led by Harvard University’s William Hsiao. The report, *Improving Hong Kong’s Health Care System: Why and For Whom?*, popularly known as the Harvard Report, was published in 1999 (Harvard Team 1999). The report commended the existing system for its efficiency as well as equity. However, it predicted a 50 per cent rise in public medical expenses by 2010 and projected that public health expenditures would increase by up to 4 per cent of GDP by the year 2016, taking up to nearly a quarter of the total government budget. The centrepiece of the report was the proposal to target subsidies and to establish compulsory medical savings accounts, together with a limited but compulsory health insurance.

In late 2000, however, the government published a consultative document called *Lifelong Investment in Health* in which it rejected the financing mechanisms proposed by the Harvard Report. Instead, it proposed a Health Protection Account, which was to be a personal savings account to which everyone would contribute 1–2 per cent of their income. The balance in one’s account would be available only after the age of 65 years and that only to pay for hospital care, and only at rates applicable at public hospitals. It promised to finalize the details by the end of 2003.

Much of the hospital care in Hong Kong, as we shall see later in this paper, is provided in public hospitals. Beds in public hospitals are divided into three categories: general, semi-private, and private wards. However, the private and semi-private contain less than 2 per cent of all beds and are used mainly by civil servants, who pay a reduced rate. Inpatient fees for general wards amount to HK$68 per day, revised according to the rise in average operating costs of all HA hospitals.

Total health expenditure in Hong Kong increased at an average annual rate of 16 per cent during the 1990s, while GDP grew by only 13 per cent each year. Much of the growth in health care expenditure was in the public sector, where it more than tripled between 1989 and 1996. Government health expenditures consist mainly of spending on public hospitals, which provide heavily subsidized services without means testing. The cost recovery rate from user charges in public hospitals is low, ranging from around 2 per cent in general acute care wards to 21 per cent in general outpatient clinics (Liu and Yue 1998). The bulk of total health expenditure, however, is on outpatient care which is largely provided by the private sector and funded out-of-pocket.
Singapore

Its former British rulers left Singapore with a reasonably well developed health care system in which public and private provision and financing co-existed, and the arrangement largely continues to this day. However, without conscious policy decision, by the 1960s, public hospitals had begun to play the dominant role in providing acute care. The cost effects of this became evident in the early 1980s following the decline in incidence of infectious diseases and a rise in modern diseases which were expensive to treat.

The National Health Plan announced in 1983 was the government’s first major effort to come to grips with the shift and contain costs. The plan initiated a range of privatization measures designed to reduce the share of expenditures borne by the government. The establishment of Medisave in 1984 was intended to gradually increase private payment for health care. The scheme requires compulsory saving of 6–8 per cent of one’s monthly income, depending on age. The amount accumulated in one’s account may be used for payment for the hospital care of the account-holder and his/her immediate family, except siblings. Since savings in Medisave constitute one’s own money, it is expected that people will spend them cautiously. Nevertheless, there are a large number of exclusions, ceilings, and co-payment requirements to curb (mis)use of the fund.

In the same year that Medisave was established, the government announced a plan to grant greater autonomy to government hospitals in managing their operations. Operational autonomy was intended to lead to greater competition, which in turn was expected to lead to lower costs and higher standards.

In 1990, the government established a publicly managed but voluntary health insurance scheme called Medishield. It covers hospitalization expenses for surgery and outpatient treatment for specified “serious” illnesses. Its establishment, despite the government’s opposition to social insurance, was in response to the realization that most Medisave accounts did not have sufficient funds to pay for the treatment of serious illnesses. Premiums are kept low—the annual premium is S$12–136 for the basic scheme—by imposing a large number of exclusions and cost-sharing requirements. Even those with Medishield insurance need to bear up to three-quarters of the cost of major surgery from out of pocket (Tan 1997: 300–2). A voluntary disability insurance scheme called Eldershield was launched in June 2002. This scheme charges low premiums and in return offers low benefits (S$300 per month, up to a maximum of 60 months) for severe disability encountered after the age of 65 years.

The realization that there was a segment of the population that could not afford even highly subsidized health care led the government to establish a public assistance scheme called the Medifund in 1993. It is an endowment trust fund built on a S$1 billion contribution from the government. To prevent dissipation of the fund, income from it is only used to pay the bills of those unable to afford hospital care. Under the scheme, patients in the lowest-class wards at public hospitals, and outpatients needing expensive services, may apply for complete or partial waiver of their bills. To receive assistance, applicants need to pass a means test administered by the hospital.
The government provides only a quarter of outpatient care in Singapore, with the rest provided by the private sector. The opposite is true for inpatient care, which is heavily dominated by the public sector as it accounts for four-fifths of all hospital beds on the island. Public hospitals offer a choice of different classes of ward accommodation, ranging from a one-bedded (class A) room to a dormitory with 10 or more beds (class C), at different prices. The different wards provide equivalent clinical services but different levels of comfort and physician choice. Patients in class A wards pay the full cost whereas patients in other classes pay from 80 per cent (class B1) to 20 per cent (class C); the rest is subsidized by the government. Thus, the choice of ward class involves not only a choice of level of comfort but also the level of subsidy because the two are linked. In recent years, however, only about 20 per cent of hospital beds have been in class C wards.

Singapore is one of the smallest spenders on health in the world and, more remarkably, the share of GDP devoted to health has actually declined over the last 40 years. In the early 1960s, national health expenditures formed around 4.5 per cent of GDP, but then began to decline and, since 1985, have hovered around 3 per cent. The government’s share of total health expenditures exceeded 50 per cent in the late 1960s, but then declined to hit 25 per cent by the mid-1990s. However, its share began to rise again in the late 1990s, reaching 42 per cent by 1999.

Government expenditures on health include subsidies to public hospitals and outpatient clinics, capital expenditures by the Ministry of Health, and the cost of providing medical care to state employees. As mentioned earlier, different ward classes at public hospitals are subsidized to different degrees. Those unable to pay even for the lowest-class and most highly subsidized service in public hospitals may request a partial or total waiver, which comes through the Medifund.

Almost three-fifths of total health expenditure in Singapore is privately funded. Private health expenditures take the form of indirect payment through Medisave or Medishield or directly from out-of-pocket. However, Medisave and Medishield form a rather insignificant share of the total spending: the former accounted for only 8 per cent of total health expenditure in 1999 while the latter accounted for 1.2 per cent (Singapore, Ministry of Health 2000: 17). But their small role is hardly surprising given the limitations on their use.

Korea

The turning point for Korean health policy was 1977 when a public health insurance scheme compulsory for firms with 500 or more employees was launched, followed by a compulsory scheme for school employees in 1979. The membership threshold for firms was reduced to 300 employees in 1979, to 100 in 1981, 16 in 1983, and 5 in 1988. The final expansion took place when the rural self-employed were covered in 1988 and the urban self-employed in 1989. The schemes not only insure the members, but also their dependants, who are defined rather liberally. Only those with less than one month of continuous employment and the unemployed continue to be
excluded from insurance. The excluded, who form about 3.5 per cent of the population, are covered by a Medicaid scheme, which is means-tested and funded out of the regular government budget.

In the face of escalating health care costs and financial problems faced by the insurance schemes, plus the realization that the premium burden was not being equitably shared among members, the government introduced deep reforms in the late 1990s (Kwon 2003). These included integration of the different health insurance schemes, reform of the pricing scheme for medical equipment and pharmaceuticals, and separation of prescription and dispensing of drugs. There is now a new health insurance organization—the National Health Insurance Corporation (NHIC)—responsible for the entire insured population.

Health insurance in Korea pays for the full range of inpatient and outpatient services, medication, preventive care, ambulance and nursing. Traditional medical therapy was covered in 1987 and medicines prescribed by pharmacists in 1989. However, insurance does not cover such things as plastic surgery, many types of dental care, many expensive new procedures, narcotics abuse and self-inflicted wounds.

Health insurance premiums used to vary considerably across health schemes, but are now fixed at 3.9 per cent of income for all members. The premium is split evenly between employers and employees, except that the government contributes 20 per cent of the premium for private school teachers (the employer pays 30 per cent), 46 per cent for the rural self-employed, and 34 per cent for the urban self-employed.

Korea’s national health expenditure increased at an annual average of 7.5 per cent over the period 1990–8, compared to an inflation rate of 6.0 per cent and GDP growth rate of 5.8 per cent (Korea Times, 10 May 1999). Public expenditure’s share of total health expenditure increased from 36 per cent in 1987 to 45 per cent in 1997; the rest being funded from out-of-pocket payments. About three-fifths of the public expenditure is derived from social insurance and the remainder from the government’s general revenues. Much of the government’s direct health expenditure is directed at the Medicaid scheme and subsidizing the insurance premium for the poorer self-employed members. But the fact that more than half of all health expenditure is from out-of-pocket is extraordinary for a country with compulsory health insurance—and is due to the high co-payments required at the point of service. Out-of-pocket payments are required even for covered services: 20 per cent for inpatient services and 30–55 per cent for outpatient care, and 30–40 per cent for dispensing and drug cost at pharmacies, in addition to a flat fee of about US$4 for each unit of service.

The insurance schemes’ expenditures began to exceed revenues in the mid-1990s and they began to experience varying levels of financial difficulties. Their expenditures increased by 20.5 per cent each year on average between 1994 and 1998, while revenues increased by only 12.2 per cent. In 1999, the various schemes suffered a combined deficit of 718 billion Won, despite the legal requirement for the schemes to be self-sufficient. It is in this context that recent reforms were introduced, though it is still unclear if they will be sufficient to ensure the scheme’s financial viability.
Taiwan

Similarly to Korea, Taiwan has a privately provided but publicly financed health care system. The health care providers are lightly regulated, though the adoption of National Health Insurance (NHI) in 1995 was accompanied by tightened regulations.

Public health insurance began with the establishment of Labour Insurance (LI) in 1950, followed by Government Employees’ Insurance (GEI) in 1958. In the beginning the health care benefits were modest, but this changed when inpatient benefits were made available in 1958 and outpatient benefits in 1970 (Lin 1997: 71). However, nearly half of the population remained outside their net in the early 1990s despite decades of efforts to expand coverage.

The expansion of insurance coverage and benefits paralleled massive increases in health care costs, which put an enormous strain on those not covered by insurance. Between 1975 and 1993, the average monthly private expenditure on health increased by over twelve times, compared to eightfold increase in average monthly earnings (Lin 1997: 112). Yet, at the same time as the people were feeling the increasing burden of health care, the government was faced with a ballooning deficit incurred by GEI and LI. It was in this context that NHI was hurriedly established in the early 1990s and came into operation in 1995.

NHI pays for most inpatient and outpatient services, dental services, prescription drugs and Chinese medicine, psychiatric services, laboratory and X-ray services, pre- and postnatal care, and physical examination for adults over 40 years of age.

National health expenditures in Taiwan grew by 34.0 per cent over the period 1991–8, which was much faster than the 8.2 per cent growth in GDP. The government’s budget, compulsory insurance (NHI), and out-of-pocket spending are the main sources of health care financing. But these three have grown at different paces over the years, leading to a realignment of their respective shares. The compulsory insurance’s share of total health expenditure increased from 36 per cent in 1991 to 57 per cent in 1998. Over the same period, the direct government expenditure share declined from 16 to 8 per cent, while the private payments share declined from 49 to 35 per cent. Taking both insurance and direct government expenditures into account, the public sector’s share of total health expenditures increased from 51 per cent in 1991 to 65 per cent in 1998; leaving out-of-pocket payments to form around one-third of the total: the smallest proportion among the NIEs.

While the NHI’s contribution rate is set at 5.2 per cent of income (it was 4.25 per cent until 2000), the formula by which it is shared among the employer, employee and the government varies by occupational group and employment status. The government’s share of contribution varies across occupational groups, ranging from nil for the high-income professionals and self-employed (except farmers and fishermen) to 100 per cent for low-income families and retired veterans. For most private sector employees, the government contributes 10 per cent of the total and the employer 60 per cent, while the employee pays 30 per cent.
Receipts from insurance premiums and government subsidy formed 72 and 28 per cent respectively of the NHI’s total revenues in 1998 (<www.nhi.gov.tw/achievement.htm>). Despite the large subsidies, the scheme has been running deficits in recent years, amounting to NT$20 billion in 1999 (Taipei Times, 12 May 2000). The government has increased user co-payment to reduce the scheme’s deficit and may have to further increase the premium.

Meanwhile, in addition to paying premiums, the insured are required to make co-payments at the point of service. For outpatient visits, the co-payment ranges from NT$50 at local clinics and district hospitals to NT$100 at regional hospitals, and NT$150 at medical centres. For inpatient care, the co-payment ranges from nil to 30 per cent depending on the length of hospitalization. Since 1999, there is also co-payment for drugs, which ranges from nil to NT$100, depending on the cost of the drugs. Co-payments recovered 5 to 13 per cent of the outpatient costs, depending on the type of institution, and about 6 per cent of inpatient costs in 1998 (<http://www.nhi.gov.tw>).

**Comparative Provision**

The ratio of doctors to population has improved tremendously during recent decades and is now similar across the NIEs, as shown in table 1.

The ratio of hospital beds to population also increased and they now have a similar ratio, except for Taiwan where it is somewhat higher. While the ratio for both physicians and hospital beds in the NIEs is considerably lower than the OECD average, there is no evidence of overall shortage. It may well be that the small geographic size and high population density makes it possible for them to utilize their health resources intensively. Even Korea and Taiwan are geographically compact places where much of the rural population lives relatively close to urban centres.

The distribution of hospital beds and physicians says a great deal about a health system in that it indicates the freedom providers enjoy for making

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<th>Physicians and hospital beds, per 1,000 persons</th>
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<td><strong>Physicians</strong></td>
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<td>1970</td>
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<td>Hong Kong</td>
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<td>Taiwan</td>
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<td>High-income OECD</td>
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*Source: World Bank (2002); DGBAS (1999).*
profits. With respect to physicians, table 2 above shows little difference between Hong Kong, Singapore, and Taiwan, since a majority work in the private sector. The exception is Korea where all but a tiny minority work in the private sector.

The dimension along which the NIEs differ the most, however, is the sectoral distribution of hospital beds. At one extreme is Hong Kong and Singapore, where more than 80 per cent of all beds are in the public sector, while at the other extreme is Korea with only 23 per cent of beds in the public sector and Taiwan with 33 per cent. More remarkably, the public sector’s share has declined by a large margin in Korea and Taiwan as a result of government efforts to reduce its involvement in the provision of health care. The dominance of private providers in Korea and Taiwan has thus allowed them to shape the volume and price of health care.

### Comparative Financing

Health care financing arrangements in the region display two distinct patterns: Korea and Taiwan rely on universal health insurance supplemented by substantial co-payment, while Hong Kong and Singapore rely on direct government subsidy to public hospitals combined with out-of-pocket payment for outpatient care (see table 3).

The insurance schemes in Korea and Taiwan are compulsory and provide comprehensive coverage, but involve sizeable co-payments. They are supposed to be self-financing, but in reality the government contributes significant sums towards premium subsidy and deficit. They also have government-funded schemes for those not covered by the insurance schemes. The public schemes in Hong Kong and Singapore, on the other hand, centre on public hospitals and public health clinics subsidized by the government. As mentioned earlier, public hospitals account for over four-fifths of hospital beds but an insignificant proportion of outpatient care in the two city states. Singapore also has a compulsory savings scheme (Medisave) and a voluntary

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<td>Public sector’s share of total physicians and hospital beds (%)</td>
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<tr>
<th>Physicians</th>
<th>Hospital beds</th>
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<tr>
<td>1980</td>
<td>Late 1990s</td>
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<tr>
<td>Hong Kong</td>
<td>NA</td>
</tr>
<tr>
<td>Singapore</td>
<td>45</td>
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<tr>
<td>Korea</td>
<td>NA</td>
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<td>Taiwan</td>
<td>31 (1993)</td>
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health insurance scheme (Medishield); but these play a relatively minor role in the overall financing of health care.

Regardless of financing arrangements, however, out-of-pocket payments account for nearly half, or perhaps more, of total health expenditure in all the NIEs, except Taiwan. Their prominence in the two city states is understandable, because of the absence of health insurance and the dominance of private providers in outpatient care. The cases of Korea and, to a lesser extent, Taiwan are unusual in that they have large out-of-pocket payments despite having comprehensive insurance coverage.

Health care expenditures in the NIEs, as indeed elsewhere, have risen faster than the consumer price index. Table 4 depicts the massive increase in per capita health expenditure in the NIEs: in current US$, it grew by 282 per cent in Korea, 270 per cent in Singapore, 110 per cent in Hong Kong, and 67 per cent in Taiwan during the 1990s. Korea and Singapore, however, started from a low base and are therefore still modest spenders per capita. Hong Kong is the largest spender per capita, followed by Korea, then Singapore and Taiwan. But even Hong Kong spends less than half of the average for the OECD countries. The ranking is consistent with the expectation that health care expenditures depend on income levels: Hong Kong is the richest in the region and Korea the poorest. However, Singapore’s placement conceals the fact that its per capita income is similar to (and by some measures exceeds) Hong Kong’s, yet it spends 43 per cent less on health care.

A different picture emerges when we look at total health expenditures as a percentage of GDP. By this measure, Korea is the largest spender followed by Taiwan, Hong Kong and, distantly, Singapore. But even Korea spends a much smaller portion of its GDP on health than the OECD average of 11 per cent. Hong Kong and Singapore are remarkable because they rank among the richest countries in the world, yet spend less than the minimum of 5 per cent of GDP recommended by the World Health Organization.
The public and private distribution of total health spending again reveals interesting patterns. Unlike many developed and developing countries around the world which experienced a decline in the public sector’s share of health spending during the 1980s and 1990s, the four NIEs experienced varying degrees of increase. Table 4 shows that public spending’s share of total health spending is highest in Taiwan, followed by Hong Kong, Korea, then Singapore. The low placement of Korea despite universal health insurance is the result of—as mentioned before—high co-payments. While Taiwan too has steep co-payments, this is somewhat offset by the large subsidies towards insurance premiums that the government provides. The high share of public expenditures in Hong Kong is the result of the nearly free services provided at public hospitals. Singapore is similar to Hong Kong in this latter respect, except that its public hospitals levy significant user charges. In both city states, outpatient care and pharmaceuticals are funded largely from private sources.

### Comparative Outcomes

While the exact relationship between health policy and health outcomes is unknown (Gupta et al. 1999), there is a presumption of a strong relationship, which is why nearly all governments devote so much resources to it. But even if we accept that health policy affects health status, there is no agreement on how to measure the latter (Smith 2002). This is not the place for resolving the issue. I adopt infant mortality rates and life expectancy as indicators, knowing that these are crude and may not present the full picture.

Infant mortality rates in the four NIEs have declined by a large margin—and in the case of the two city states are now superior to the average for...
OECD countries. Only Korea lags significantly behind the OECD, which is unremarkable, given its considerably lower level of income (see table 5).

A similar picture emerges from the data on life expectancy. Life expectancy in all four NIEs in the 1960s was lower than in high-income OECD countries, but by the mid-1990s they had all closed the gap and Hong Kong actually had a longer lifespan. Women in the NIEs on average live six years longer than their male counterparts, which is the same differential as in the OECD countries.

When we consider health care expenditures and health status together, we find that Singapore seems to have achieved the best health care outcomes at the lowest cost, followed by Hong Kong and Taiwan, with Korea coming last. The two city states would thus seem excellent case studies for drawing potential health policy lessons. Their health systems are not only efficient in terms of lower costs but also relatively equitable.

In Hong Kong, the lowest income quintile spends 1.8 per cent of household income on health whereas the highest quintile spends 2.4 per cent (Harvard Team 1999). Moreover, there are only small differences in the rates of both inpatient and outpatient visits by different income quintile. The government’s health expenditures too are largely equitable: in 1996, the poorest quintile attracted 25 per cent of the Hospital Authority’s inpatient expenditures, compared to 16 per cent for the richest quintile (Harvard Team 1999). While there is no formal study of the equity implications of health policy in Singapore, one may surmise that government subsidies are egalitarian from the fact that a large proportion of them are directed at public hospitals and that the subsidies are the highest for the classes of ward most likely to be used by low-income households. Against this, however, Medisave and Medishield are likely to have replicated or even worsened the overall income inequality in Singapore.

The Korean and, to a lesser extent, Taiwanese health care systems suffer from inequities despite their systems of comprehensive health insurance. This

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<th>Infant mortality rate per 1,000 persons</th>
<th>Life expectancy at birth (years)</th>
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<td>1970</td>
<td>Late 1990s</td>
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<tr>
<td>Hong Kong</td>
<td>19.4</td>
<td>2.9</td>
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<tr>
<td>Singapore</td>
<td>19.7</td>
<td>2.9</td>
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<tr>
<td>Korea</td>
<td>46.0</td>
<td>8.2</td>
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<tr>
<td>High-income OECD</td>
<td>22</td>
<td>5.8</td>
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is largely due to the heavy co-payment requirements, which restrict the poor, yet are too low to dissuade the affluent from using the service (Peaboy et al. 1995: 37; Yang 1991: 126; Tsay 1998: 94). Medicaid in Korea only partially addresses this problem, since the completely free component of the scheme is available to only 1.6 per cent of the population—compared to the 9.8 per cent of the population which lives under the poverty line (Yang 1997: 74). The situation is somewhat better in Taiwan, since the government subsidizes the entire premium for low-income families and 70 per cent of the premium for farmers, who tend to have significantly lower incomes than the rest of the population (Chiang 1997: 229). The Korean government, by comparison, subsidizes a much smaller portion of the poorer households’ health insurance premium.

**Conclusion**

The paper finds significant similarities as well as differences in the NIEs’ health policies. There is extensive direct government involvement in the provision of health care in Hong Kong and Singapore, compared with much less in Korea and Taiwan. This should be surprising given the city states’ free market image, set against their Northeast Asian counterparts’ image of being interventionist states. In the area of financing, however; Hong Kong, Korea and Singapore depend largely on private sources and only in Taiwan is the state the dominant source of finance. The dominance of private funding in Korea is surprising, given that it has a comprehensive system of health insurance which is intended to relieve the burden on individual families, but this has been mitigated by its steep co-payment and user charges.

The NIEs spend a relatively small percentage of GDP on health care, compared to other developed and developing countries. Only Korea’s total expenditure on health is more than what might have been predicted by its income level (Griffin 1992: 60), while Singapore’s is extraordinarily less. The difference between the two extreme cases cannot be explained by sources of finance, because private payments are the largest source of financing in both Korea and Singapore. This surely undermines the case of those who argue that private payments reduce overall health expenditure by curtailing demand.

The two countries that have the best outcomes at modest costs are Singapore and Hong Kong. What the two share in common is the provision of inpatient health care largely by the public sector. Centralized public provision of acute care, which is the most expensive component in health care expenditures, is more efficient (Hammer and Berman 1997) because it allows economy of scale, avoids duplication and, most significantly, avoids incentives for over-servicing. Global budgetary allocations characteristic of the system also have the effect of rationing supply and thereby expenditures. Moreover, the concentration of public subsidies on inpatient care, which is expensive, in Hong Kong and Singapore, has fostered a system that is both efficient and equitable. There is little evidence to suggest that Medisave in Singapore deserves the large amount of attention devoted to it (Barr 2001; Ham 2001; Lin 2002; Pauly 2001; Hsiao 2001) given that it accounts for only a small percentage of total expenditure.
Korea and Taiwan are illustrations of the danger of combining fee-for-service private provision with insurance financing. They also are examples of how demand management techniques such as co-payment and user charges may not work in this sector, since their own health care expenditures have skyrocketed despite large co-payment requirements.

International organizations and mainstream economists calling for a greater role for private providers and financing in health would do well to keep in mind the lessons offered by the Asian NIEs.

References


