Health Care Delivery and Financing: In Search of an Ideal Model - Reflections on the Harvard Report

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Abstract:

There are three models of health care delivery and financing: the market model, the professional model, and the bureaucracy-dominated model. The Hospital Authority in Hong Kong is essentially a professional model, but it is supplemented by the bureaucracy-dominated model (the Department of Health) and private suppliers. The Harvard consultants see such a system as fragmented and inefficient, but their proposals place too much emphasis on the market and have ignored the peculiar nature of the health care market. Although some of the principles that they espouse, such as protection against excessive burden and prevention of moral hazard, are good and important, failing to address the incentive problems has rendered their proposals impractical, costly, and even inequitable.

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I. Introduction

There are essentially three models of health care delivery and financing. The first is the market-driven and administratively decentralised "survival of the fittest" model("Model I" or "the market model"). The second is the professionally and bureaucratically run "social welfare maximization" model("Model II" or "the professional model"). The third is the bureaucracy-based self-interest maximization model("Model III" or the "Niskanen model").

Under the first category are included both the more traditional fee-for-service model and the managed care model, with the former often complemented with third party insurance. Under the second category are various designs which vary in quality and effectiveness but which are all aimed at maximizing social welfare as perceived by welfare-minded professionals and bureaucrats. Under the third category is the bureaucracy-dominated, self-interest maximization model(Niskanen, 1971) under which the welfare of medical service suppliers and that of patients are subordinated to the self-interest of regulator-bureaucrats. In the literature on health care reform and in practice, the first two models are always seen to be competing with each other in terms of social welfare maximization. The market driven model is not by design social welfare maximizing, but there is widespread belief among many economists that the invisible hand of the market will be more effective in enhancing social welfare than any system that sets out to maximize social welfare in the first place.

The third model, as it is not meant to compete with the other two models in terms of social welfare maximization, will not be pursued in this paper beyond the mention that in the search for the best practical health care system some mechanism will be needed to tame the selfish behavior of bureaucrats.

II. The Harvard consultants’ proposals

The Hong Kong SAR Government in November 1997 engaged a research team from the Harvard School of Public Health to examine Hong Kong's health care system and to recommend reforms. The team was led by Professors William Hsiao and Winnie Yip.

The prevailing health care system in Hong Kong consists of some element of each of the three models. There is, in the first place, the professionally run Hospital Authority system which provides in-patient care as well as specialist out-patient services. Then there is the bureaucrat-run Department of Health general out-patient clinics and health centres. Finally there is the private sector health service providers, who provide about seventy per cent of out-patient care but only eight per cent of the in-patient service market in terms of in-patient days.

According to the Harvard consultants, this system suffers from a serious problem of compartmentalization. In particular, the team referred to the "lack of coordination and cohesion between primary and inpatient care, acute and community medicine, and

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1 According to the Department of Health Annual Report, the Department’s services cover five general areas, namely personal health services, non-regionalized services, special health services, hygiene services, and dental services. They cover out-patient services, health education and various preventive programmes, family planning, advice on pest control, forensic pathology service, etc.
the private and public sectors," which is seen to engender waste and loss of effectiveness. The Hospital Authority Head Office (HAHO) is seen to be at the same time a supplier of health care services (thus by nature a guardian of hospitals' interests) and a buyer on behalf of the public for health services (i.e., at the same time a guardian of patients' interests). In such a mixed capacity, the HAHO cannot be expected to serve the best interest of society. The solution, according to the Harvard consultants, is to give patients command over the funds with which to buy services from the hospital of their own choice, which may be a public or a private hospital.

The Harvard consultants believe that the prevailing system has not harnessed the forces of the market and competition sufficiently. They believe that there should be a reorientation towards the market, so that all health care service providers will be subjected to the test of the market. The underlying assumption is that a provider that fails to draw patients because of poor quality of services will not get the financial resources. Following this logic they propose that the resources of hospitals should be based on the number of hospital admissions. Those hospitals that fail to draw patients will therefore have to wind up. Patients are to be given the choice of gaining admission into private hospitals if they want to, and private hospitals will be able to draw resources from the government based on admissions just like the public hospitals. This is the so-called "money follows the patient" principle and is clearly in line with the spirit of Model I.

A key proposal of the Harvard consultants is to set up a Health Security Plan, under which Hong Kong's working class will have to contribute up 1.5 to 2 per cent of their salaries into the Plan (subject to a ceiling), and they will be entitled to subsidized in-patient health care subject to the payment of a deductible per hospital admission. This is designed clearly to relieve the government of the increasing burden of financing health care. The poor, however, will have exemption to both the contribution and the deductible charges. Thus, the Harvard team subscribes to the principle of "the able pays more" for health care.

Another key proposal of the Harvard team is the Medisage Plan. The Medisage Plan is a compulsory savings plan, under which the working class contributes about 1 per cent of their incomes up to the time of retirement. Upon retirement they are required to buy an insurance policy for chronic care. By their calculation, the accumulated savings should be adequate for financing one out of seven elderly who will be expected to need long term care.

III. The Guiding Principles behind the Harvard Consultants' Proposals

Implicit in the Harvard consultants' recommendations are ten guiding principles. There is an element of truth in each of these principles, but some of them may be subject to misinterpretation and thus can be misleading. We will discuss each of them in turn.

1. The "Competition Improves Efficiency" Principle

Economists generally share the belief that competition would improve efficiency. However, this is predicated on consumers having sufficient information about the quality of the products or services that are offered in the market place. Only then
will they know whether they get a "good deal" from a doctor. Colton (1993) pointed out consumers' ability to avail themselves of the necessary information is a precondition to the emergence of "workable competition." It is well known that the market for health care services is characterized by "asymmetric information," i.e., doctors know many things that patients do not, particularly whether they are providing a good service. Lacking the professional knowledge, patients often rely on doctors to tell them what is the best treatment for them. Indeed this aspects of health care markets is the first topic students are introduced in standard health economics texts (see Chapter One in Phelps (1992)).

2. The "Able Pays More" Principle

The Harvard consultants believes that the poor should be offered assistance. Few would disagree with this general dictum. However, we should be concerned with how the poor are to be assisted. In general, economists favor direct transfer rather than price subsidies, for the simple reason that efficiency requires people facing the same set of prices. This does not mean that they ignore distributional matters. Granted that distributional matters need to be addressed to (through direct transfers as far as practicable), there are good reasons why the "principle of universality" is superior to the "able pays more principle." On the surface, universal access to subsidized health care is unfair. However, once it is recognized that any subsidy associated with universal access to health care inevitably has to come from the well to do, universal access does not seem unfair at all. The fact is that when a "rich" patient gets subsidized care, the implicit transfer that he gets is sourced either from himself or from other "rich" tax-paying individuals. There is no distributionally perverse transfer from the poor to the rich. There is only a transfer from the more healthy taxpaying individuals to the less healthy taxpaying individuals. It is not apparent that this is undesirable in any way. Indeed, because universality is administratively simpler than limiting access to subsidized care to the poor, it is an eminently sensible principle in the conduct of public policy.

Another important consideration that we must bear in mind is that while few would disagree with the general idea that those with a greater ability to pay should pay more, the "able" is not indefinitely able. There will come a point when even the "able" finds it hard to come up with the resources to support a very costly treatment. Thus there is a need for protection against excessive burden even for the rich.

3. The "Saving for the Rainy Day" Principle

This is the principle implicit in the Medisave program of Singapore. In general, adopting the saving for the rainy day principle in its pure form suffers from two drawbacks. The forced savings may be inadequate or may be too big. If the accumulated savings are inadequate there is no security in the event of a serious health problem. If the accumulated savings are too big the enrollee may use the accumulated savings on health services even when they have a low value. The Harvard consultants' proposal of Medisave is not a pure Medisave program. It combines mandatory saving with mandatory purchase of an insurance policy. Individuals are required to put aside one per cent of their wages throughout the

\[ \text{It is in recognition of this problem that Singapore introduced the Medishield scheme, a form of} \]
working life and to "purchase long-term care insurance upon retirement or disability." (p.12, Executive Summary) They claim that international experience suggests that the contribution rate of one per cent is sufficient. However, they have ignored the fact that once people have been forced into purchasing such a policy, the likelihood of their claiming the benefits will be much greater. Family members who otherwise will take care of the elderly may decide that it makes good sense to send him to an institution. This will cause costs to escalate rapidly, rendering the one per cent contribution rate inadequate.

4. The "Protection against Excessive Burden" Principle

The Health Security Plan (HSP) provides that patients need pay no more than a specified amount per hospital admission, and that they enjoy specialist outpatient care for certain chronic diseases. Excessive burden protection is an important principle and is discussed in detail in my book (Ho, 1997). However, whereas Ho (1997) recommends setting a yearly spending limit for eligible health services the Harvard team recommends setting a per hospital admission spending limit. There are two problems with the Harvard team's approach. First is that it unnecessarily causes disputes, and may unnecessarily cause patients to refuse to be discharged for fear of having to be readmitted and thus be subjected to the deductible charges. Second is that a patient cannot tell how much he may have to spend in a year. Someone who is admitted to the hospital several times may be subject to a rather heavy financial burden.

5. The "Moral Hazard Needs to be Checked" Principle

The Harvard team proposes that when a patient is admitted into a hospital, he will have to pay a rather hefty charge on the first day, and then much lower charges on the second day and beyond up to a specified threshold. The idea is to check against demand side moral hazard. Demand side moral hazard is a well known problem in the health economics literature, but the Harvard team's approach in dealing with moral hazard seems to be misplaced. First of all, we should be reminded that hospital admissions are generally subject to a gatekeeping mechanism. Without the recommendation of a professional doctor a patient cannot gain admission on demand. Second, hospitalization is very costly in terms of the opportunity cost of time, and being hospitalized is not an enjoyable experience, so that demand-side moral hazard is rather minimal.

Demand side moral hazard is most serious with Accident and Emergency and is somewhat less of a problem for outpatient care, and least for inpatient care. The right approach to dealing with demand-side moral hazard is to charge patients for the use of A&E services, and for other services as well, on a direct-cost-recovery basis. The yearly spending limit provided under excessive burden protection will ensure that the costs will not be overly burdensome.

Apart from demand-side moral hazard is the problem of supply-side moral hazard. Unfortunately, the Harvard team seems to have ignored the problem completely. The "money follows the patient" framework will not help control the

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catastrophic insurance, in 1990.
supply-side moral hazard problem. Because “money follows the patient” means that hospitals get more funding by admitting more patients, they may admit patients for financial reasons. This will certainly be inefficient and counterproductive.

6. The “Patient Needs Independent Advocacy” Principle

Because of the information asymmetry problem, patients are not in the position to protect themselves. Patients need independent, professionally trained people to help them air their grievances and seek redress. The Harvard team’s recommendation in this regard has gained widespread support among the public.

7. The “More Choice is Better Than Less” Principle

The Harvard team argues that patients should have the choice to buy health care services from any supplier in either the public sector or the private sector. According to the consultants, the Health Security Fund will pay a standard payment rate regardless of the identity of the supplier. The consultants also recommended the offer of better quality services at higher prices by the public sector for those who are willing to pay the premium in prices. This is in the same spirit as the ChoiceCare plan proposed by Joel Hay(1992), although the latter, allowing Hong Kong citizens to opt out of the government health care system altogether, is even more revolutionary.

In principle, more choice is better than less choice, other things being equal. The bottom line, however, must be that there should be universal access to basic care at an acceptable quality, and that health services should be supplied efficiently.

Choice should not be achieved at the expense of these more fundamental goals. Although I agree that the prices of health care services of a similar quality should be the same I believe that “money follows the patient” is neither a necessary nor a sufficient condition for increasing choice. As I argued above, there is the worry that supply side moral hazard may hurt economic efficiency. There is also the worry that instability of funding may make long term planning difficult for hospitals, thus hurting long term efficiency.

8. The “Public Expenditure on Health Care Needs to be Capped” Principle

An important message from the Harvard consultants’ report is that the long term financial sustainability of the health care system as prevails in Hong Kong presently is questionable. According to their calculations, health care expenditures may account for 20 to 23 per cent of the total government budget in the next eighteen years, up from the current 14 per cent. The implication is that public expenditures on health care has to be capped.

It is not my intention to call into question the calculations of the consultants. However, even if the calculations are correct, the conclusion that public expenditures should be capped is not.

First, because of a shift in preference, a shift in demographics, or a shift in technology, increasing public expenditures on health care may be exactly what we need. Cutting back is justified if and only if the saved resources have a better alternative use in light of citizens’ choice, demographics, and technology.
Second, if capping public expenditures on health care means shifting the burden to the general public, such as proposed by the Harvard team, then the justification for capping public expenditures, even if valid, is defeated. If the same resources is expended, no efficiency will be gained. What is worse, the way the Harvard team proposes for Hong Kong is likely to lead to a gross escalation of total health care expenditures, because of a failure to control supply-side moral hazard and because of an inducement for more demand-side moral hazard, by virtue of the fact that the poor will continue to enjoy free or very low-cost health care, while the "insured" will try to take out as much benefit as possible.

9. The "Universal Coverage for Basic Care" Principle

There is no controversy over the general principle of "health for all" as highlighted in the World Health Organization documents. In Hong Kong there is a provision in the Hospital Authority Ordinance that no one should be prevented, through lack of means, from obtaining adequate medical treatment (Section 4(d)).

Universal coverage for all means coverage for the rich and the poor, the presently healthy and the presently chronically ill, the young, and the old. This makes sense not only because people have a natural tendency to care for their fellow human beings, but also because everyone of us is susceptible to illness and misfortunes. Ho(1997) defined a just society as "one such that its institutional arrangements...are acceptable to free and rational persons who have no predetermined interests." Following the Rawlsian mental experiment, assuming that there is an imaginary "veil of ignorance" and no one knows in which shoes one is going to stand. We generally would appreciate that there is a real need to protect everyone of us from the burden of misfortune. Without universal coverage, leaving health care to the market, someone will not be able to afford health care, and someone will never be able to buy health insurance from a financially independent private insurer.

10. The "Seamless Care" Principle

The "compartmentalized" nature of Hong Kong's health care system is not something newly discovered by the Harvard consultants. Indeed, the Hospital Authority is aware of the problem and has specifically made "seamless care" as a goal. For example in the 1995-96 Annual Report, "Creating Seamless Health Care" was the first among several corporate strategies highlighted. The Hospital Authority is keenly aware of the need to break the barriers which currently exist between different health care providers. If the Hospital Authority had the choice, it would have preferred to take over all the clinics currently under the jurisdiction of the Department of Health. The fact remains, however, that general clinics are still under the direct management of the Department of Health and are subject to a different set of rules governing what drugs can be purchased and prescribed from those governing the Hospital Authority system.

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1 Plan of Action for Implementing the Global Strategy for Health for All by the Year 2000 was approved in the World Health Assembly in 1982.
IV. Elements of an Ideal Practical System

It is important to point out that any health care system is subject to some drawback, and it is therefore unrealistic to try to find the perfect system. We can, however, find the best practical system. The best practical system must be:

- administrative feasible and not too costly
- able to provide protection against unexpected excessive burden for all
- able to provide protection for chronic patients
- one that incorporates sufficient incentives on both the supply side and the demand side to ensure efficiency so that the overall burden to society will be minimized
- able to provide the greatest degree of choice and freedom for patients
- able to provide sufficient autonomy to medical professionals for them to do a good job
- able to provide protection for patients against unprofessional practice
- able to provide room for private health care professionals to operate and thus serve as a benchmark against which public sector doctors can compare

This is not a list of impossible things. Actually, with today’s computer technology we can easily build a system that records the “eligible health care expenditures of a household” and ensure that no household spend beyond the “excessive burden” threshold. Any eligible expenditures within the year beyond the threshold can be taken up by the government through general tax revenue. This takes care of the first three desirable features.

A key proposition developed in my work on health economics (Ho, 1997, 1999) is that efficiency of health care delivery requires charging patients an appropriate fee and compensating caregivers at an appropriate rate. Charging patients appropriately not only will help avoid abusive utilization of the health care system, but will promote preventive activities and encourage people to adopt a healthy lifestyle. This means that we need to compile a list of “basic health services” to be covered and the charge rates. But this is not excessively cumbersome. Indeed a number of private insurance plans provide a list of eligible services and their reimbursement rates. Another requirement for efficient delivery of health care services is that health care givers should not receive a highly remunerative fee. Otherwise they will have a strong incentive to oversupply their services. I would propose that fees be set at cost recovery levels, so that health care givers will have no incentive to over-supply or to under-supply their services. To encourage them to participate in such restrictive pricing, the government should give them a lumpsum subsidy per year that varies with the range of services provided and the capacity of the facility. Private healthcare givers can supply services beyond the covered list and charge market rates.

Seamless health care can be achieved by covering both primary, secondary, and tertiary care, and even accident and emergency care, whether supplied by public sector providers or private sector providers, under the same plan.

Using the terminology introduced in the beginning of this paper, the “professional” or “social welfare maximizing model” should be the dominating element within a society’s health care system. The professional model works best
when it is not subject to the sway of market forces or the influence of the financial motive. The "market model" should be given a role to play too, in those areas of the health care market which are not considered basic. Consumers should be given the freedom to buy the services that they want at prices which they agree to pay. Finally, public participation would be necessary to prevent bureaucrats from making decisions that go counter to the public interest. Indeed, bureaucrats can serve a coordinating role and act as a bridge among the public, the professionals, and the market.

V. Conclusions

Nobel Laureate Amartya Sen is right when he argued that an assessment of inequality in general should go beyond figures on income and wealth. As he explains, "Quality of life depends on various physical and social conditions, such as the epidemiological environment in which a person lives. The availability of health care and the nature of medical insurance...are among the important influences on life and death..." (1995, p.35) He argued that it was no coincidence that a dramatic rise in life expectancy occurred in the same decade as the National Health Service of Britain emerged, i.e., 1941-51. (op.cit., p.12).

Consistent with the same logic, the Director General of World Health Organization in 1981 explained that "health for all" is a holistic concept (Roeper, 1993, p.335). Not only does it require universal access to primary care with adequate referral services to more specialized care, but it also implies a commitment on the part of the government to promote the advancement of all citizens on a broad front of development. This, however, cannot be done through a one-way delivery of services from the government to the citizens. This has to be predicated on the emergence of a greater awareness and a sense of responsibility on the part of the citizens to take care of their own well being. We argue that making citizens pay for the direct cost of health care is an important element in this strategy. We also argue that this need not compromise accessibility, provided that we have in place a system of protection against excessive burden, such as proposed in this paper and currently in practice in Sweden. Justice, equity, and efficiency can go together, while the market, the professional, as well as the bureaucrat can all have a role to play to further these ends. Certainly bureaucrats need not be content with acting out the role as portrayed by Niskanen in his early book.
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