SWK 6061
LECTURE 9: AFFORDABLE AND SUSTAINABLE HEALTH CARE

Prof. Wong Hung

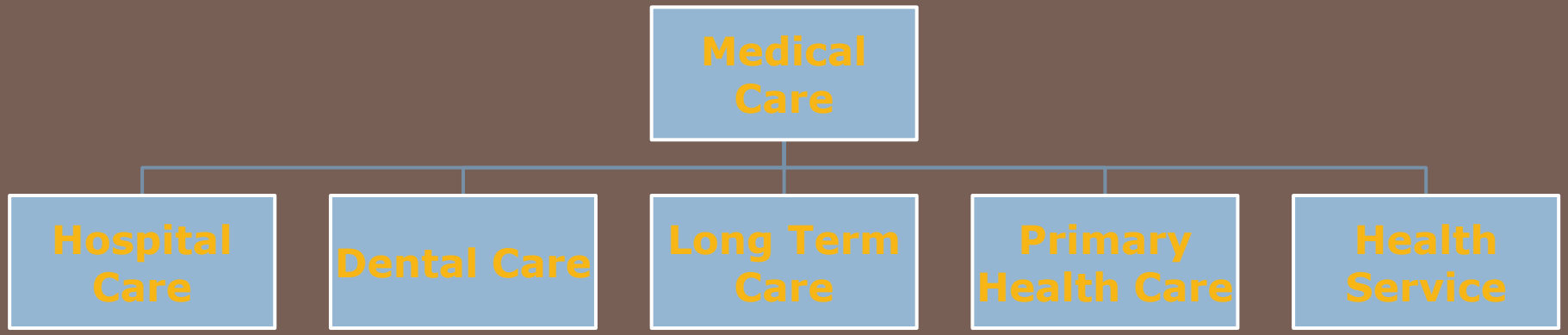

Medical Care
Hospital Care
Dental Care
Long Term Care
Primary Health Care
Health Service

Table 1: Health care expenditure as a percentage of GDP in western European countries and the United States, 1970-2004

	1970	1980	1990	2000	2004
Austria	5.2	7.5	7.0	9.4	9.6
Belgium	3.9	6.3	7.2	8.6	**10.1
Denmark	-	8.9	8.3	8.3	*8.9
Finland	5.6	6.3	7.8	6.7	7.5
France	5.3	7.0	8.4	9.2	*10.5
Germany	6.2	8.7	8.5	10.3	10.6
Greece	6.1	6.6	7.4	9.9	*10.0
Iceland	4.7	6.2	7.9	9.2	*10.2
Ireland	5.1	8.3	6.1	6.3	7.1
Italy	-	-	7.7	8.1	8.7
Luxembourg	3.1	5.2	5.4	5.8	*8.0
Netherlands	-	7.2	7.7	7.9	*9.2
Norway	4.4	7.0	7.7	8.5	*9.7
Portugal	2.6	5.6	6.2	9.4	*10.1
Spain	3.5	5.3	6.5	7.2	*8.1
Sweden	6.8	9.0	8.3	8.4	*9.1
Switzerland	5.5	7.4	8.3	10.4	*11.6
United Kingdom	4.5	5.6	6.0	7.3	***8.1
United States	7.0	8.8	11.9	13.3	15.3

Source: OECD Health Data 2006
* estimate
** data for 2003
*** differences in methodology

Some Counter Thoughts

- Growth in expenditure
- recent re-interpretation of international evidence on the relationship between health spending and GDP per capita suggests that the elasticity measure is close to unity, indicating proportionate increases in health spending (Gerdtham and Jonsson, 1999).

Aged population and medical expense

- A challenging study by Zweifel *et al* (1999) indicates that large health care expenditures are concentrated in the last two years of a person's life and as such health care expenditure depends primarily on remaining lifetime and not calendar age, at least for those over 65 years of age.
- If correct, this finding raises rather different policy questions to those associated with the conventional assumption about the age-health expenditure profile.

Table 2: Changes in health care expenditure as a percentage of GDP in Western Europe and the United States, 1970-2004

	% growth 1970-1980	% growth 1980-1990	% growth 1990-2000	% growth 2000-2004	% growth earliest to latest available year
Austria	44.2	-6.7	34.3	2.1	84.6
Belgium	61.5	14.3	19.4	17.4	159.0
Denmark	-	-6.7	0.0	7.2	0.0
Finland	12.5	23.8	-14.1	11.9	33.9
France	32.1	20.0	9.5	14.1	98.1
Germany	40.3	-2.3	21.2	2.9	71.0
Greece	8.2	12.1	33.8	1.0	63.9
Iceland	31.9	27.4	16.5	10.9	117.0
Ireland	62.7	-26.5	3.3	12.7	39.2
Italy	-	-	5.2	7.4	13.0
Luxembourg	67.7	3.8	7.4	37.9	158.1
Netherlands	-	6.9	2.6	16.5	27.8
Norway	59.1	10.0	10.4	14.1	120.5
Portugal	115.4	10.7	51.6	7.4	288.5
Spain	51.4	22.6	10.8	12.5	131.4
Sweden	32.4	-7.8	1.2	8.3	33.8
Switzerland	34.5	12.2	25.3	11.5	110.9
United Kingdom	24.4	7.1	21.7	11.0	80.0
United States	25.7	35.2	11.8	15.0	118.6

Source: OECD Health Data 2006

Rate of growth:	highest	second highest	third highest	lowest

Plateau Effect

- there has been a long term growth in the share of GDP devoted to health care in OECD countries
- This share seems to have remained constant or actually fallen in many countries for much of the 1990s.

Public Spending Sustainable?

- Can public spending meet the demands placed upon it?
- limited capacity to fund public spending and the scope for generating additional private finance.
- **the burden placed upon the economy by health spending (i.e. its opportunity cost) is independent of the particular public-private mix**.

Private Finance?

- Admittedly, there may be incentive effects associated with, for example, higher marginal tax rates necessary to fund higher public spending, but these are rarely investigated rigorously.
- **In fact, the case for pursuing private finance is primarily political rather than economic.**

health service financing,

- international comparative analysis carried out in recent years has made policy makers increasingly aware of the prevailing models of tax-funded (local and national), social insurance and voluntary, private insurance based systems - and the mix between them - found in different countries.

Most industrialized countries have established hybrid systems in which the public sector, which has the greater share of responsibility, works alongside the private sector, both in the funding of health care …

	Health system's main source of financing		
	Taxes	Social Security Funds	Private Insurance
Australia (1992)	✓		
Canada (1990)	✓		
Denmark (1993)	✓		
France (1990)		✓	
Germany (1989)		✓	
Italy (1988)	✓		
Japan (1991)		✓	
Netherlands (1983)		✓	
Norway	✓		
Sweden	✓		
Switzerland (1991)			✓
United Kingdom (1994)	✓		
United States (1990)			✓

Source: Blanchette, Claude, "Public and Private Sector Involvement in Health Care Systems: An International Comparison," Bulletin 438E, Library of Parliament, 1997

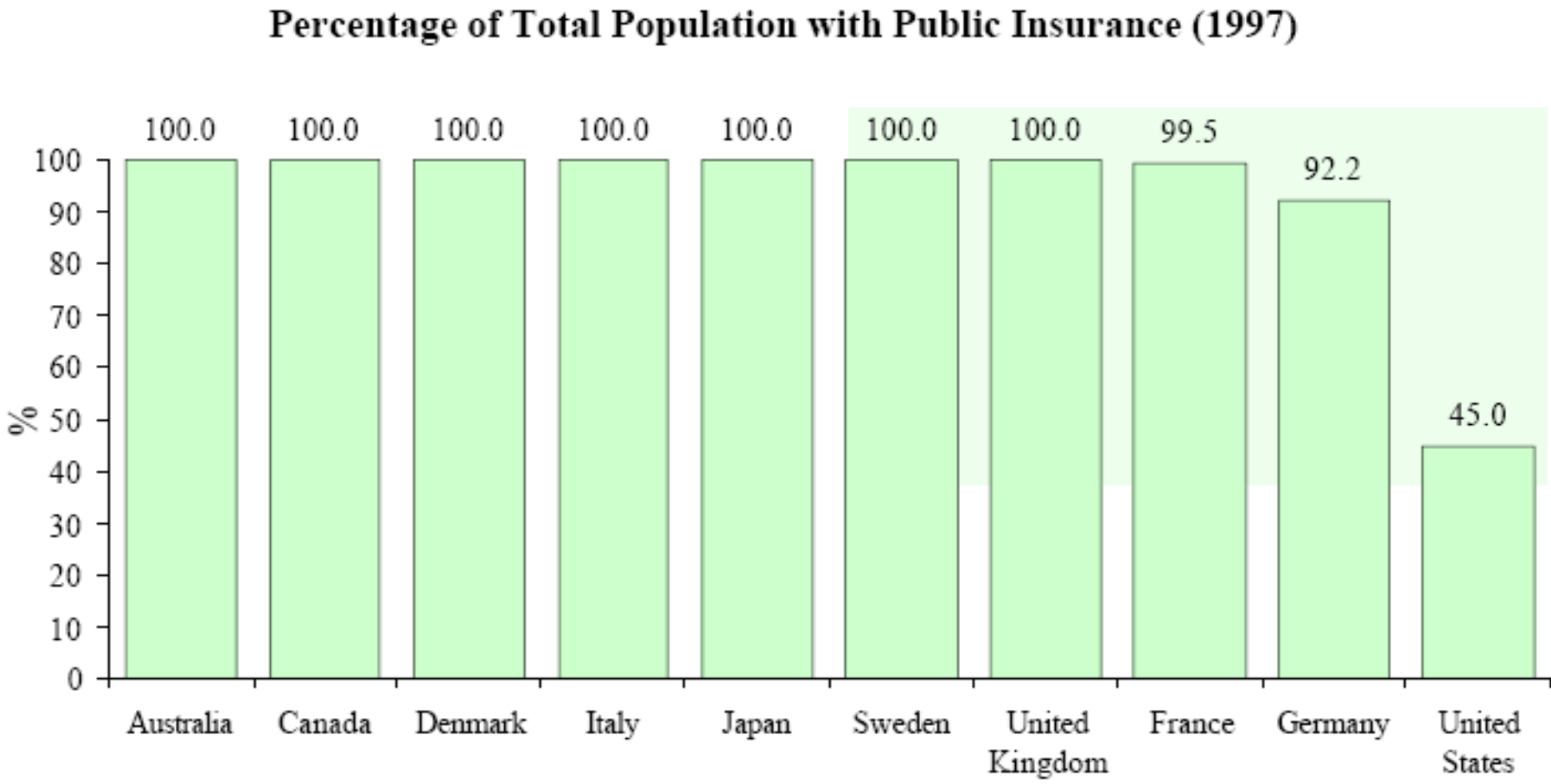
… and in the delivery of hospital care

	Main Delivery Entity of Hospital Health Care (as percentage of hospital beds)		
	Public	Non-Profit	Private
Australia (1992)	75	---	25
Canada (1990)	98	---	2
Denmark (1993)	Most	---	---
France (1990)	65	16	19
Germany (1989)	51	35	14
Italy (1988)	80	20	0
Japan (1991)*	19	---	81
Netherlands (1983)	15	85	0
Norway	Most	---	---
Sweden	Most	---	---
Switzerland (1991)*	46	32	22
United Kingdom (1994)*	5	90	5
United States (1990)**	27	59	14

* As percentage of hospitals ** As percentage of acute-care hospital beds

Source: Blanchette, Claude, "Public and Private Sector Involvement in Health Care Systems: An International Comparison," Bulletin 438E, Library of Parliament, 1997

With the exception of Germany and the United States, most of the industrialized countries have <u>universal</u> publicly funded health care systems



Source: 2000 OECD Health Data

United States: private insurance & patient choice

- **Health spending as part of GDP:** 15.3%
- **System type:** Employer-employee based (54%) and government funding (46%). Government covers all older adults and the disabled (Medicare), the poor (Medicaid), veterans, government employees and Native Americans.
- **Coverage:** 82% of people under 65; 100% of people 65 or over.

United States

- **Average annual per-person spending: Total:** $6,402.
- **Breakdown:** $2,884 by government; $2,676 for private insurance, with 52% paid by employers, 48% paid by employees; $842 by consumer out-of-pocket*

USA

- **Financing:** Larger companies self-insured. Employers and employees share costs. Income taxes fund Medicare, Medicaid and other public programs. Co-payments and deductibles highly variable in the private system.
- **Notable features:** Leading-edge technology, drugs and facilities. Most patients can choose doctors, hospitals.

USA: Biggest challenges

- Health access for working poor.
- Discrepancies in care between rich and poor
- Rising costs
- Overuse of tests and procedures
- Low international rankings on basic health measures, including infant mortality and preventable deaths.

USA: System

- **Prescription drug coverage:** Of those with insurance, 84% are covered. Most plans require co-payments. No government controls on prices or availability.
- **Doctors:** Payments regulated in government programs; insurers set fees; no price controls for uninsured.
- **Hospitals:** Payments regulated in government programs; insurers set fees; no price controls for uninsured.

Germany: Employment-based insurance & comprehensive coverage

- **Health spending as part of GDP:** 10.7%
- **System type:** Universal coverage. Mostly employer-employee based (88%).
- **Coverage:** 99.8 % -- all citizens and legal residents

Germany: Spending

- **Average annual per-person spending: Total:** $3,673
- **Breakdown:** $2,518 on mandatory employment-based coverage, nonprofit insurance; $259 on for-profit insurance; $349 by government;
- $547 consumer out-of-pocket*.

Germany: Financing

- **Financing:** Workers split premiums with employers, with each paying about 8% of workers' gross income to nonprofit "sickness funds."
- Those earning over $75,000 may purchase insurance from for-profit insurers.

Germany: Notable features

- Comprehensive coverage including basic dental and long-term care.
- Short waits - usually less than a month - for elective surgery.
- New programs provide extra attention to diabetes and other chronic illnesses.

Germany: Biggest challenges

- Large and growing aged population, high costs, high rate of specialist visits.

Germany: System

- **Prescription drug coverage:** Full coverage with small copayments. Federal panel controls prices and an expert committee decides which new treatments should be covered.
- **Doctors:** Regional groups of office-based doctors negotiate with insurers over annual budgets. Hospital-based doctors, including most specialists, are salaried.
- **Hospitals:** Insurers negotiate with hospitals over annual budgets.

Performance Criteria

- The body of international evidence is now sufficiently well-founded to make some broad observations about the performance of these systems

Performance key criteria

- **macro efficiency (aggregate cost control)**
- **micro efficiency**
- **Equity**
- **Transparency,**
- **accountability,**
- **user choice and**
- **responsiveness**

Trade Off

- **tax-based systems** generally exert the **strongest aggregate cost control**
- **voluntary private insurance** usually embodies **greater user choice**
- **there are trade-offs between these objectives although the precise size of these trade-offs is difficult to establish.**

National Priority

- ***The precise choice of a funding system in any particular country will depend not only on its perceived performance but the relative importance, or weights, that are applied to the criteria of efficiency, equity, choice etc***.
- These are matters of social and political values and will vary between countries.

Role of incentives and link to performance.

- Evidence on the effects of various attempts to increase competition in health care is more ambiguous.
- The numerous health reforms of the 1990s that were ostensibly aimed at improving performance through competition seem to have had limited impact (EHMA, 2000).

Partial implementation

- To some extent this was the result of only partial implementation of competition-based reforms in the light of countervailing political pressures (e.g. UK, Netherlands).
- Elsewhere reform proposals were introduced without the institutional infrastructure necessary to cope with them (e.g. Eastern Europe).

Allocation to primary care

- **A primary care-based agent acting on a patient's behalf can improve the coordination, or integration, of care particularly at the interfaces between primary, secondary and social care**.
- In addition, **incentive structures based on devolved budgets seem to act as a powerful lever for change, particularly when clinical and financial decision-making are combined** (Robinson and Steiner, 1998).

The payment of user fees is a common practice in most OECD countries, but this practice is less widespread in Canada

Public Health Care User Fees
1993 ($CDN)

	Physician/ specialist	Drugs	Hospital	X-Ray/ laboratory
Australia	$5-$8	$11	---	---
Canada	---	D/C*	---	---
Denmark	---	0%-50%	---	---
France	25%	30%-100%	20%<30days+$6/day	35%
Germany	---	$1.25	$3<14days	---
Italy	$0/$7-$8	$3+50% or $0	---	30%
Japan	10%-30%	10%-30%	10%-30%	10%-30%
Netherlands	---	fixed-price	---	---
Norway	$11/$16	25% (max $43)	---	$11
Sweden	$6-$9/$0	D $15 and $1/drugs	$8	---
Switzerland	10%	$7	$7	10%
United Kingdom	---	$4-$5/drug or $65/annual	---	---
United States	20%>$100D	100%	$676<60days	20%>$100D

D: Deductible, C: Co-insurance *Depending on provinces
Source: Blanchette, Claude, "Public and Private Sector Involvement in Health Care Systems: An International Comparison," Bulletin 438E, Library of Parliament, 1997

PATIENT FINANCIAL RESPONSIBILITY (Cox 2004)

- Moral hazard and price sensitivity
- Economic theory suggests that individuals shielded from the full cost of health care through insurance will use health services beyond the point at which the marginal benefits of use outweigh the marginal costs (Pauly 1968).
- This behaviour, known as moral hazard, may be apparent in public or private health insurance systems, and lowers societal welfare because scarce resources might be better spent on other goods and services.

Cost sharing to control moral hazard

- Economists and others usually assume if some form of cost sharing is introduced to mitigate the effect of moral hazard, rational consumers will forego the health services of least benefit to them ('unnecessary' use);
- reductions in use attributable to cost sharing will contain health care expenditure.

Dilemma for policy makers

- To balance the need for health insurance, which provides valuable financial protection from the costs of ill health, and the need to control patients' use of health care through user charges.
- From an economic perspective, health insurance covering catastrophic risks that do not occur very often but involve large financial outlays is efficient
- Health insurance covering high-frequency but low-cost care, which may be more predictable, is generally considered to be less efficient (assuming no major market failures) (Barr 2004).

Insurance + pre-payment

- Most health systems provide both 'insurance' covering catastrophic risks and 'pre-payment' covering smaller risks and predictable expenses (for example, for those who are already ill)
- Both elements play a central role in ensuring financial protection, particularly for poorer people and people in ill health.

United States

- Most research in this area confirms economic theory, providing strong evidence that patient cost sharing leads to significant reductions in the use of health care in North America
- Those with insurance coverage are more likely to use health services, while the generosity of insurance coverage influences the volume of consumption

Europe Union

- European studies of the impact of cost sharing show mixed results in terms of reductions in the use of health care, which does not seem, on the whole, to have a significant impact on the use of primary care, outpatient specialist services or acute care
- This may be due to the relatively low levels of user charges applied in most countries

EU: voluntary health insurance

- Studies assessing the impact of additional voluntary health insurance coverage on utilization also show mixed results, with some finding that voluntary coverage does not have much impact on use but others finding that it does
- People with low incomes are most sensitive to price
- Demand for prescription drugs falls when cost sharing is introduced

No sustained cost control

- no evidence to suggest that cost sharing leads to sustained cost control over time.
- Few studies have been of sufficient duration to allow assessment of long-term expenditure control.
- Some find lower expenditure in the short term (generally the first one or two years) with little effect beyond this period.

Substitution

- reductions in expenditure on the services subject to user charges may cause expenditure to rise in other parts of the health system, particularly if patients substitute more expensive forms of free care for non-free care
- for example, use of accident and emergency departments rather than primary care providers or prescription drugs
- leading at best to minimal net savings and at worst to higher overall spending on health care.

Type of Co-payments

- Co-payments (for example, a fixed fee per prescription or visit to a doctor) are a poor instrument in this respect because the price to the patient does not vary based on the actual value of the care being provided.
- Co-payments that vary according to type of care or co-insurance rates create stronger incentives, but having a separate rule of reimbursement for each type of care might not be cost-effective or transparent.

Equity

- A simpler solution may be to introduce an appropriate level of deductible below which there is a high co-insurance rate (for example, 100% in Switzerland). A lower co-insurance rate could be applied between the deductible, with an out of pocket ceiling above which all expenses would be fully reimbursed by the health system.
- In order to address concerns about equity, the level of co-insurance, deductible and out of pocket ceiling could be linked to income.

Advantages

- The advantage of this system is that it requires patients to pay for small and regular health care expenses
- At the same time protecting them against catastrophic expenditure.
- Insurers would benefit from lower administrative costs as minor expenses would not involve billing

Methods of paying providers: Prospective Payment

- play a key role in determining efficiency and quality in health systems.
- Recognising that retrospective forms of reimbursement fail to control costs, many European countries are moving towards prospective payment.
- Prospective payment systems present purchasers with considerable challenges due to information problems that make it difficult for purchasers to assess provider cost and quality

Competitive Tools – CB & DRGs

- Competitive tools can be used to overcome information asymmetry - for example, competitive bidding for hospital contracts or case-based payment linked to diagnosis (DRGs).

Cost Saving but quality??

- Both tools provide powerful incentives for providers to control costs, although concerns about quality and access to health care remain unresolved.
- European health systems increasingly use DRGs to pay for health care, for a range of reasons, usually in combination with other financial and non-financial mechanisms.
- Their experience requires careful monitoring and evaluation to ensure that cost savings can be achieved without lowering quality and access.

US experience: managed care

- Incentives created by organisational structures such as vertical integration or gatekeeping, and payer and purchaser influence over provider behaviour (for example, through selective contracting, utilisation review and clinical guidelines) can contribute to cost savings
- benefit patients through the delivery of **co-ordinated and integrated** services.
- However, mechanisms need to be in place to ensure quality and access, and restricting patient choice may be difficult in some contexts.

EU: competition among insurers

- to create incentives to strengthen purchasing and enhance equity (by encouraging convergence in contribution rates, as in Germany).
- However, their impact on efficiency has been limited due to the difficulty of designing risk adjustment mechanisms that are effective in removing incentives to select risks
- the absence of tools permitting purchasers to exert control over providers and the high costs to patients of changing from one insurer to another.

Institutional arrangement

- Any consideration of options for reform should bear in mind institutional contexts.
- Institutional arrangements vary considerably, even among western European health systems, and are likely to have substantial influence on policy goals and outcomes due to political differences as well as differences in payer, purchaser, provider and patient motives and behaviour.

Market mechanisms: Cost saving in short term

- Market mechanisms may be effective in lowering health care costs, but there is some evidence to suggest that cost savings may not be sustained in the long-term.

Careful regulation and management

- the strong incentives they create present opportunities for 'gaming‘
- policy makers require tools and resources for careful regulation, management, monitoring and evaluation.
- The development and use of regulatory and management tools may incur heavy transaction costs, but these costs may be worthwhile if they bring visible benefits to patients.

香港醫護改革--為何要改？為誰而改？哈佛報告書 (1999)

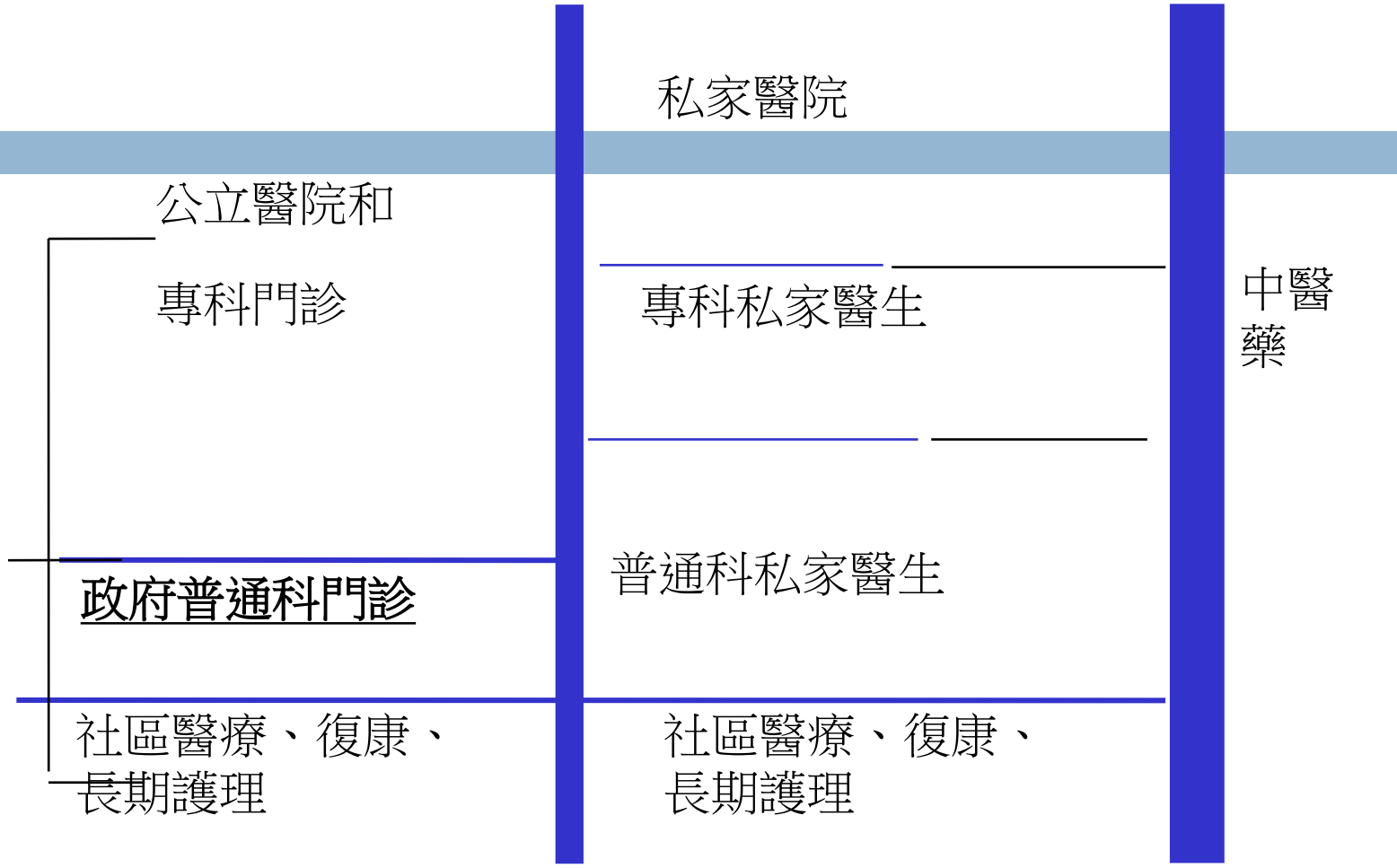
- **現有的醫療融資制度能否維持也很有疑問**
- 政府的醫療支出在本地生產總值(GDP)中的份額由1989年的1.7%上升到 1996年的2.5%。若要保持現有的服務質素、讓病人繼續享有目前的方便，今後的開支增幅必須維持近年的速度。
- 原因很簡單：人口老化、醫療分工日益精細、市民對服務質素的要求提高，加上新穎的醫療技術相當昂貴，這些都增加政府的醫療支出。

醫療開支佔GDP比例

- 預測即使本地生產總值今後每年平均仍然有5%的實質增長，到了2016年，政府醫療開支亦將會由目前本地生產總值的2.5%上升到3.4%甚至4.0%。**換言之，今後18年內，醫療開支在政府每年總預算中所佔的份額將會高達20%到23%，大大高於目前14%的水平。**

資源並非放在最有效益的服務

- 目前的醫療撥款並未做到最貼切需要，使政府財政也就受到更大的壓力。例如不論以服務性質區分（例如推廣衛生教育、預防疾病與住院服務兩者的比重)，還是人口組別區分（例如確有需要的市民與有能力自付者的比重），政府都沒有把資源用在最有效益的醫療衛生服務。



疾病預防，公共衛生，醫療衛生教育

分裂隔離、偏重專科的醫療服務制度

- 目前分裂隔離、偏重專科的醫療制度，已難迎合時代的需要。香港正面對精神病、酗酒、性病、暴力和吸毒等工業發展後形成的社會性健康問題。而市民日益長壽，平均壽命79歲，容易受到糖尿病、心臟病、中風和癌病的困擾。
- 日本、英國和美國早已發現，分裂隔離和偏重專科的醫療服務，難以應付社會性的健康問題和慢性病，更無法治理多種疾病纏身的老年人。

基層及預防醫療的重要性

- 英國在五十年前就認識到，要滿足工業發展後社會的醫療需要，須建立家庭醫生制度。其他先進國家陸續跟進。香港顯得遠遠落後。
- 先進國家也認識到，疾病預防、社區醫療、門診、住院、復康等相關服務必須連成一體，醫療服務才能達到高效益。英、美在這方面已帶了頭。香港卻停留在幾十年前醫療制度分裂隔離的局面。

香港的醫療制度以醫院為中心

- 在制訂醫療服務的發展緩急和分配資源時，都先考慮醫院的需要，而忽視了基層護理和社區醫療。
- 醫管局幾乎就是專門為提供專科服務而設的。隨著人口日漸老化，香港必須發展基層護理和社區醫療，才能控制和應付慢性病上升的趨勢。
- 此外，傳統的中醫藥雖然令不少慢性病人得益，卻未被納入正規的醫療服務。

醫管局身兼買家和賣家角色

- 醫管局身兼醫療服務的買家和賣家，角色矛盾。醫管局總部一方面透過對屬下醫院發放所需的經費，代表公眾與各醫院洽商服務的種類和範圍(為公眾擔當買家)，
- 另一方面又負責管理各醫院，確保醫院可以維持，並為轄下員工提供工作保障。

角色矛盾

- 換言之，醫管局總部作為服務提供者(也就是以公眾為對象的賣家)，須照顧屬下醫院員工的利益，但同時又為公眾採購醫療服務。
- 醫管局一手包辦買和賣，在相當程度上決定了病人的需要和利益，但又不直接對病人或公眾負責。因此，所提供的服務不一定從病人的利益出發。

改革目標

- 維持及增進平等；
- 改善質素，提高效益；
- 控制政府的醫療支出，使政府的資源分配更切合社會需要，從而提高醫療財政的穩定性，並可以適應社會的變遷；
- 滿足未來市民的需要；及
- 避免醫療總開支不合理上漲。

五種方案

- 世界上沒有一種醫療制度是十全十美的。更重要的是，每個社會有本身的歷史、文化、社會價值觀、政治環境、醫療衛生的需要、既有的制度和管理能力。
- 故此，任何社會都不能照搬他人的制度。本報告建議以強制性的個人儲蓄支付護老開支的方案D，有新加坡和日本的先例；
- 分開醫管局買和賣的角色，從而提高效益和服務質素的建議，取自英國、瑞典和新西蘭經驗。
- 方案E的「競爭性一體化醫療護理」則參照英國、美國、德國和澳洲做法。

A. 維持現狀

- 維持現狀是最簡單的一種做法。但是，現有的制度縱然有許多優點，也有嚴重的缺點。從分析所得的證據顯示，變革是必需的。
- 勉強維持現狀既不可能控制住政府的醫療開支，也不可能使政府的資助更切合社會的需要。
- **延誤必需的變革只會令目前的缺點惡化**，將來要付出更大的代價，才能改善目前制度上的分裂隔離、服務質素和效益的缺點、滿足未來市民的需要，或控制醫療總開支不合理地上漲。

B. 政府醫療預算設置上限

- 表面上看，政府醫療預算只要設置上限，即可控制政府的醫療支出。這事實上只是錯覺。醫療預算設置上限只會降低服務質素，使病人較難使用服務。英國的先例應引以為鑑。
- 英國為醫療預算設置上限後，非緊急的外科手術大排長龍，有些服務實施配給。加上投資不足，醫療設備和科技無法及時更新。香港的政府醫療預算若設置上限，經濟條件和健康較好的市民將會因為公共醫療服務質素下降，轉移光顧私家醫生和私家醫院，並自行購買醫療保險，把老弱多病、貧困的市民留給公立醫院去照顧。

B. 政府醫療預算設置上限

- 結果,有損目前平等對待市民，一視同仁的做法。同時，美國的經驗顯示，一旦中上層人士不使用公共醫療，就不願意在這方面投入足夠的公帑，令公共服務更加惡化。
- 此外，預算設限也難以改善服務質素和效益、滿足未來市民的需要、打破醫療服務的分裂隔離的局面。

C. 用者自付

- 提高公立醫院及診所的收費。方法可以是全面提高所有項目或只是提高部分服務的收費。這其實是把醫療成本上升的負擔由政府轉移給病人。
- 政府醫療總開支若要維持在本地生產總值2.5%的水平，到了2016年，病人自付的部分須由現在政府醫療總開支的3%增至35%。但提高收費後，政府必須減免對低收入者的收費。因此要自給付費的市民負擔也就更重。
- 換言之，到時釐訂收費時，自費的病人須負擔約50-70%的醫療成本。

用者自付沒有風險分擔

- 用者自付無法享有市民分擔風險(risk pooling)所帶來的效益和平等。純粹靠用者自付，病者必然加重負擔；
- 反之，讓市民 分擔風險，也就能彼此分擔住院的費用。此外，純粹靠增加收費也難以達到改善服務的質素和效益、滿足未來市民需要、控制醫療開支上漲、打破分裂隔離的局面。

D. 聯合保健與護老儲蓄（HSP＋MEDISAGE）

- D方案包括兩部分：
  - 護老儲蓄戶口(MEDISAGE，簡稱「護老儲蓄」)：供退休或不幸殘障時購買長期護理保險用；(國內術語: 個人專戶)
  - 聯合保健 (Health Security Plan，簡稱HSP)：全民的強制性保險，用來支付住院及某種慢性疾病專科門診的收費。(國內術語: 社會統籌)

護老儲蓄

- 全港市民均須開設個人「護老儲蓄戶口」。全港的供款集中進行投資。個人戶口內的存款只能在退休或不幸殘障時用來購買長期護理保險。
- 根據外國經驗，一般人在有工作時連年存入薪金的1%，應足以在65歲退休時購買一份長期護理(long term care)保單。萬一不幸未到退休年齡即告去世，名下護老儲蓄的存款自動撥入遺產內。

聯合保健 (HSP)

- 用來支付住院和某種慢性病的專科門診費用，例如癌病、糖尿病、中風等。但病人須分擔部分費用。初期保費約佔薪金的1.5%-2.0%，由僱主和僱員分擔。
- 病人可自由選擇私家或公立醫療服務。由政府成立半公營(quasi-government)的聯合保健基金公司(Health Security Fund, Inc.)承保全港市民的醫療風險，並代為選購最合適的醫療服務。

「錢跟病人走」

- 基金公司由董事會負責監管，成員包括政府、勞方、資方和病人的代表。不論病人去看私家醫生還是公立醫院，基金一律按標準支付率代付費用，所謂「錢跟病人走」(Money follows the patient)的概念
- 不論病人選用公營或私營服務 ，基金均會代付費用；病人自此無須光顧不能滿足個人需要的醫療服務。公立醫院也不再像目前那樣，自動獲得政府撥款。這也就分開了醫管局買和賣的角色。

聯合保健基金成為買方

- 聯合保健基金直接對病人和公眾負責。支付率則由基金和服務提供者的代表透過洽商釐訂。
- 方案D全部落實後，目前醫管局住院服務的經常預算大部分會轉用來補助無力付費的市民、以及提供更多基層門診和社區醫療服務予貧困和低收入人士。
- 聯合保健(HSP)不包括的醫療服務，將透過現有的融資方式提供。

方案D能有效地五大改革目標：

- **維持及增進平等：**
  - 聯合保健分擔全港的風險，為每個市民提供同等的醫療保險，確保每個人在有需要時都可以獲得醫療服務。
  - 平常身體健康時繳付保金，有病時即可獲得診治
  - 無力負擔的市民由政府全部或部分資助。有能力負擔者在收入裡扣除同一個百分率作為保險費
  - 由於「錢跟病人走」，也就能使病人選用服務時有充分的自主權。

改善質素，提高效益

- 由於「錢跟病人走」，公立和私營醫療服務都沒有一方在財務上享有優勢，因此，雙方在市場上可以公平競爭。
- 醫療服務也不像目前那樣分裂隔離。聯合保健基金對病人和公眾有一定的問責性，對醫學界相對於病人的優越地位也提供了制衡。醫療服務一買一賣分開後，病人的權益可望獲得較多的保障。

提高醫療的財政穩定性

- **控制政府的醫療支出：**
  - 方案D內含多種控制機制，例如透過洽商釐訂支付率、由病人分擔費用，有助於控制住政府的預算。
  - 分開了醫療服務的「買家」和「賣家」身份，加上「錢跟病人走」的新概念，私營服務得以和公營服務公平競爭，從而提高問責性和效率。

使政府的資源分配更切合社會需要

- 方案D調撥更多政府資源為貧困和低收入市民服務，加強疾病預防，增加復康和門診服務。
- 政府為無力付款的市民代付全部的聯合保健保險費，津貼老年人和收入偏低者的保費，以及為貧困和低收入市民代付 病人所須分擔的費用。

集中資源

- 政府津貼無力付款市民的保費。目前的公共醫療由政府大量津貼，但有錢人與貧窮人享有同等的待遇。採用方案D後可望對症下藥，集中幫助無力付款的市民。

滿足未來市民的需要

- 方案D設立護老儲蓄戶口，使體弱的老年人得以聘專人上門照料生活，由長期護理保險金支付，在家安享晚年。
- 護老儲蓄令市民得以及早為晚年的需要作安排，有助於舒緩人口老化的壓力，避免政府負擔過重。
- 政府因而得以集中資源，加強對社會中沒有經濟能力的市民的服務。

避免醫療總開支不合理地上漲

- 分開醫療服務的買和賣，從而提高效益、加強問責；
- 透過洽商釐訂支付率以控制成本
- 錢跟病人走，使公營和私營服務得以公平競爭，提高效益；
- 醫療保健中設置病人分擔部分費用，以緩和需求，避免濫用資源。

E. 競爭性一體化醫療護理

- 方案E的「競爭性一體化醫療護理」(Competitive Integrated Health Care)屬於一體化的醫療服務，
- 範圍包括預防、基層醫療、門診、住院、復康護理。融資方式和特色與方案D的聯合保健與護老儲蓄(HSP＋MEDISAGE)大致相同。仍然由聯合保健基金公司負責管理；「錢跟病人走」的新概念；由基金和服務提供者透過洽商釐訂支付率；政府對醫管局的撥款改用來為貧困人士代付保費和津貼低收入人士的保費；僱主和僱員則自行供款。

地區性醫療一體化系統

- 醫管局重組為12-18個地區性醫療一體化系統(Health Integrated Systems，簡稱HISs)；
- 由醫院與普通科和專科私家醫生（或聯營執業的私家醫生）設定合同，共同提供預防、基層醫療、門診、住院 、復康護理等服務。
- 私家醫院和聯營的醫生亦可自組一體化系統，以提供這些服務。不論以醫院還是普通科醫生為單位，

地區性醫療一體化系統

- 「競爭性一體化醫療護理」均由服務提供者自行監察質素，不像美國現有的「管治醫療」(managed care)，用非醫療專業人員管理醫護人員的診治。
- 方案E 是由服務提供者權衡成本和質素，切合病人的需要。再加上一定的法規，外界提供了一定的制衡。

各種醫療結合

- 把預防、基層醫療、門診、住院、復康護理各種醫療結合起來，打破了服務提供者分裂隔離的局面，
- 改善了醫療質素和提高對慢性疾病護理的質素和效益，滿足未來市民在這方面的需要。

你我齊參與 健康伴我行 (2001)

- 只接納設立頤康保障戶口(MEDISAGE)作為長者未來長期護理保障
- 否決HSP 聯合保健的建議, 只改以鼓勵市民購買私人醫療保險。