Macau medical financing system inspired by Singapore model

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1. Introduction

The population of Macau was 549,200 in 2008. Among which, 7.2% were aged 65 years and above (Health Bureau, 2009). Macau's population is becoming aging and mostly aging population has more chronic diseases than others in comparison therefore consumed more health resources. In the past two decades, the government expenditure on health was growing rapidly by 8.03% on average annually. Could the health care policy at present be sustainable in future while the medical cost is increasing every year?

2. Health care system and health care financing in Macau

Health care service providers in Macau are classified as either governmental or non-governmental. The governmental providers include the Conde S. Januário Hospital, Health Care Centers. The non-governmental providers include Kiang Wu Hospital, University Hospital, the Worker's Clinic and Tung Sin Tong Clinic, and other private clinics and laboratories. The health care system in Macau is financed mainly by government. Macau Government provides subsidiaries to the residents. According to the Decress-24/86/M, the Macau residents who are 1) known or suspected to have contracted a communicable disease, toxic dependency, the patient with carcinoma or psychosis; 2) pregnant, in the process of giving birth, 10 years old or below, students or 65 years old or above; 3) destitute people; 4) prisoner; 5) public official and their family members can have almost all kinds of medicine treatment free of charge by using public health care service. The charges of private health care services are not extremely expensive. In additional, some non-profit organizations would abate part of charge of those who have financial difficulties.

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Government expenditure on health had increased from MOP 434 millions in 1990 to MOP 2,117 millions in 2008. It was approximately by five times multiplied during 18 years. However the population was only increased by 61.8% and the inflation was increase by 71.92% from 1990 to 2008. Government expenditure on health as percentage of total government expenditure was on average 10.05% from 1990 to 2008.

To project on future, government forecasts that the population will increase to approximately 750,000 in 2020 and 12% are aged 65 or above (Macau Statistics and Census Service, 2008). Moreover, the quality and demand of health is getting higher therefore the health authorities are studying the feasibility of establishing a second public hospital in Taipa to relieving the stress of medical resources. Furthermore, the threat from outbreak of communicable diseases such as dengue fever and influenza or even sudden disasters may substantially increase the government expenditure on health. At present, government still can fund vast majority to resident on health expenditure. However, it may not be feasible in future thereby establish an integrity health care system and policy for long term is very important.

3. Comparisons of four main healthcare systems around the world

Different countries have different approaches to social health protection, but all have one thing in common: a risk pool. A risk pool allows a large group of people to share the risk that they might become ill and need expensive care. The risk of having to pay for health care will be borne by all the members of a pool and not by each contributor individually. Four types of health insurance are widely used to pool risks, foster prepayment, raise revenues, and purchase services (Du, Liu & Yang, 2008).

3.1 State-funded systems

Financed by: Taxation.

Coverage: Universal population.

Strengths: Comprehensive coverage of the population; large scope for raising resources; a simple mode of governance and a potential for administrative efficiency and cost control.

Weaknesses: Unstable funding; disproportionate benefits for the rich; potential inefficiency in health care delivery; sensitivity to political pressure.

Example: Canada; England.

3.2 Social health insurance

Financed by: Employer, individual and taxation.

Coverage: Insurant.

Strengths: More resources for the health care system; less dependence on budget negotiations than state-funded systems; high redistributive dimension; strong support by the population.

Weaknesses: Possible exclusion of the poor; negative economic impact of payroll contributions; complex and expensive to manage; escalating costs; poor coverage for chronic diseases and preventive care.

Example: Germany; Japan.

3.3 Medical Savings Accounts (MSAs)

Financed by: Employer and individual.

Coverage: Insurant.

Strengths: To encourage people to save during their working years to pay for their future health expenses; to enlist people in controlling health care costs and let them have incentive to assess the cost-effectiveness of treatments before deciding to use money; it could use on family members.

Weaknesses: Generally not enough to cover costs associated with severe or chronic conditions; it could not assist the poor who have little or no capacity to accumulate enough savings to pay for their health care needs.

Example: Singapore.

3.4 Private health insurance

Financed by: Individual.

Coverage: Insurant.

Strengths: Afforded financial protection; enhanced access to health services; increased service capacity and promoted innovation; to helped finance health care services not covered publicly, in the case of supplementary.

Weaknesses: Benefit only those citizens or businesses with the ability to pay; total health expenditure of the country is out of control.

Example: In the United States, private health insurance provides the main coverage for the non-poor who are under 65 years of age. Besides, Medicare is a social insurance programme administered by the government to provide health insurance coverage to people who are aged 65 and over or who meet other special criteria. Medicaid is a programme for people and families with low incomes and people with certain disabilities; Africa also funding a significant percentage of their health care costs through private insurance.

Governments want to make sure all their people have access to health services and provided with social health protection. None of these approaches are found to be inherently good or bad. Rather the challenge of the policy maker is to create viable pathways for the development of health insurance in a country.

It is peculiar to Singapore among all the developed countries. Singapore achieves fruitful results on health through low cost because of her medical insurance system - 3M systems (Lao & Yu, 1999). The financing philosophy of Singapore's healthcare delivery system was different from others based on individual responsibility and community support. The 3M system of Singapore was made up of Medisave, Medishield and Medifund. Patients were expected to co-pay part of their medical expenses and to pay more when they demanded a higher level of

service. At the same time, government subsidies help to keep basic healthcare affordable.

4. Discussion

There is no health insurance that can be replicated 100% in another country. But there are quite a number of similarities, which have to be dealt with. One is the problem of covering or including the poor and the unemployed. Another issue is the difficulty to cover and include the self-employed. The medical insurance system of Singapore achieves remarkable success based on individual responsibility and community support resulted in low cost of expenditure but satisfactory outcomes on health. Singapore has a lower infant mortality and a longer life expectancy than many countries; waiting times for surgery are minimal; also Singapore spends less than 4% of GDP on health care (World Health Organization Regional Office for the Western Pacific, 2008b). Could it be an example to inspire other countries considered to try out this scheme? Could it achieve the same result? The characteristics of Singapore are the deposit rate; education level and income level of nationals are higher. The population is comparatively younger. These factors help to control needs of medical treatments; easier to build up MSAs and nationals could bear high ratio of self-payment for MSAs.

To date, there is no country entirely adopting MSAs except Singapore. America tries to transfer voluntary health insurance into voluntary MSAs with high down payment. China experiments MSAs on two cities at first stage and then expands the location progressively. Personally, I deem that Macau government could also consider MSAs stage by stage and to ameliorate the programme that suited for locals. There are some issues must be considered in advance. For instance:

4.1 The coverage of the programme

Government should consider whether the MSAs is implemented as compulsory, generally (like Singapore) or voluntary (like U.S.A.)?

4.2 The sources of the fund

The MSAs is financed by salary (like Singapore) or by taxation? What is the percentage of salary for being deposited in the MSAs? How to distribute the fund into MSAs if it is financed by taxation?

4.3 The utilization of MSAs

What items can be applied to use MSAs- only for hospitalization or the outpatient services?

4.4 The management of MSAs

Who will be the administrator of the programme? Will it be managed by government (like Singapore), a statutory organisation or a private company?

4.5 The standard to achieve government subsidies

Government should set up a safety net to help the needed for obviating the possibility of those couldn't obtain medical services because of poor. How does government provide subsidies to people who are at low income that unable to pay for their medical expenses? What are the qualifications for those could obtain the subsidies?

Anyhow, government should take into account the major premises and details of the programme in its entirety.

5. Conclusion

Many developed countries agree by mere coincidence that government, employers and individuals must share responsibility to cope with future savings. The main role of government is just to establish systems; to encourage or force people to save up to deal properly with their later years of life and health care expenditure; also to provide a safety net for people on low incomes. Health insurance is the only one-way people could get coverage for medical expends. A system of affordable insurance or a government-funded programme allows people to access essential health services without risking impoverishment or severe financial hardship. Under the pressure of aging population, perhaps it is time to develop the healthcare reform gradually in order to mitigate the government expenditure on health in the future. A national health insurance system can start under every condition. What is needed the most is awareness, a political willingness and an opportunity!

(轉24頁)

The Oxford Dictionary of English Etymology. (1966). The University Press, Oxford.

Volicer L. (1997). Goals of care in advanced dementia: comfort, dignity, and psychological well-being. *American Journal of Alzheimer's Disease 12,* 196-197.

Walker, L. & Avant, K. (1995). Strategies for Theory Construction in Nursing. Appleton & Lange, Norwalk, CT.

Walsh, K & Kowanko, I. (2002). Nurses' and patients' perception of dignity. *International Journal of Nursing Practice, 8,* 143-151.

Webster's New Collegiate Dictionary. (1973). Springfield, MA.

Woolhead, G., Calnan, M., Dieppe, P. & Tadd, W. (2004). Dignity in older age: what do older people in the United Kingdom think? *Age and Ageing, 33,* 165-170.

長期照護尊嚴促進之概念分析

韋淑玲 吳淑貞

本文以縱合文獻回顧的方式，以關鍵詞「尊嚴」或「人性尊嚴」結合「老年人」、「護理」或「長期照護」廣泛查證此概念定義。並以Walker和Avant' s(1995)所提方法進行尊嚴促進於長期照護之概念分析。經分析結果顯示「尊嚴促進於長期照護之概念」定義性特徵為：(1)尊重(2)維護(3)有感受性的傾聽(4)個別性的照護。前置因素包含角色補足、文化敏感度、創造新選擇及支持自主。結果指標為自我尊重的能力、自尊感及成功的調適。希望藉此概念分析提供護理人員尊嚴照護教育的參考，進而在實務中運用此概念架構以增進長期照護機構老年人的身心健康。

(接34頁)

References

Du, G., Liu, G. E. & Yang, Y. C. (2008). Comparative study of the main healthcare systems in the world and their inspirations to China. *China Journal of Pharmaceutical Economics, 6,* 41-47.

Health Bureau (2009). *Annual Digest of Statistics 2008.* Macau: Government of Macau Special Administrative Region Health Bureau.

Lao Ki Ka & Yu Sin Yui (1999). *Health care Expenditure and Financing in Singapore.* Hong Kong: Research and Library Services Division of Legislative Council Secretariat.

Statistics and Census Service (2008). *Macau Resident Population Projections 2007-2031.* Macau: Government of Macau Special Administrative Region Statistics and Census Service.

World Health Organization Regional Office for the Western Pacific (2008b). Singapore. *Country Health Information Profiles,* 401-417.

新加坡模式對澳門的醫療融資制度的啟發

黃敏靜

澳門醫療保健費用的支出在日漸增加，受到老齡化問題的困擾，如何控制醫療費用的快速增長成一個緊迫的問題。在過去二十年中，澳門政府衛生支出平均每年迅速增長8.0%。本文將世界上四種主要的醫療保險制度作比較。研究了它們的優缺點將對發展和改革澳門的醫療保健制度有所啟發。