Your Health Your Life

Healthcare Reform Consultation Document

Food and Health Bureau
Hong Kong Special Administrative Region Government

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March 2008

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CONTENT

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MESSAGE FROM DR YORK CHOW, SECRETARY FOR FOOD AND HEALTH

Dear Citizens,

Hong Kong's healthcare system is at an important crossroads. Over the years we have built a healthcare system that provides high quality services. We have achieved outstanding results and the healthcare professions have maintained high professional and ethical standards. At the same time, the system is facing major challenges due to the ageing population and the need to keep pace with rapid developments of medical technology.

This challenge is not one that can simply be met by acquiring more resources for healthcare services. It also calls for a critical look at how to channel the available resources into the system to achieve the best results for all and to enable the healthcare system to continue to meet the healthcare needs of the community. We have to examine how the financing of services can drive the further interaction and collaboration between different service providers while retaining our existing strengths. We have to look at how different areas and levels of healthcare services can be organized in the future. We have to address shortcomings of the present system and introduce changes to the market structure to bring about more and better choices to meet the demand of different market segments.

Hong Kong is a caring and compassionate society. We will continue to uphold the treasured principle of our healthcare policy that no one should be denied adequate healthcare through lack of means. To this end, we have looked at how the current safety net can be strengthened to provide better assistance to the unfortunate members of our society who have their means outstripped through having to shoulder costly medical treatment.

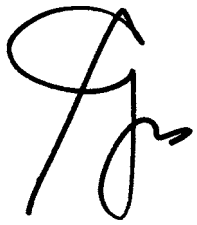
The Government has examined the existing service structure and the need for change. We propose enhancement to the primary care system, and improvements to the healthcare safety net. We propose to reform the healthcare market structure to promote greater public-private partnership. We propose to develop a territory-wide electronic health record system as the infrastructure for these reforms. To take forward these initiatives, we need to reform the current financing arrangements to provide supplementary financing. We have examined the whole range of financing options, and have set out their pros and cons in this consultation document for consulting the public.

To achieve our vision of a sustainable healthcare system, we must take forward this series of inter-connected reform proposals as a whole package. The proposals should thus be considered in their entirety.

In the process of developing our future healthcare system, the Government's commitment to public healthcare will only be increased and not reduced. The Government will continue to provide the main financing source for healthcare services. The Chief Executive has pledged to increase government expenditure on healthcare from 15% to 17% of recurrent government expenditure by 2011-12. The Financial Secretary has also committed in the Budget announced in February that, after the implementation of supplementary financing arrangements after consultation, no matter what the final arrangements are, he will draw $50 billion from the fiscal reserves to assist the implementation of healthcare reform so as to help meet this major challenge to future public finances.

Where healthcare is concerned, every member of the society is a stakeholder. Our future rests with our choice. Our healthcare system is important for each and every one of us, and is an important asset that we leave for our future generations for the protection of their health. I hope we can all seize the opportunity to build a consensus to reform the healthcare system to make it sustainable.

Finally, I would like to express my sincere gratitude to members of the Health and Medical Development Advisory Committee and to members of the Committee's Working Group on Health Care Financing for their thorough analysis of the problems involved and their constructive and valuable recommendations. Their contributions have been instrumental in the formulation of this consultation document.



Dr York Y N CHOW
Secretary for Food and Health
March 2008

EXECUTIVE SUMMARY

Preamble

We want a healthcare system that makes our community healthier and continues to improve the quality of care. To do so, we need to reform our system to make it sustainable and more responsive to the increasing needs of the community. Everyone in the community is a stakeholder. Further to "Building a Healthy Tomorrow"[1] for public discussion on the future service delivery model of our healthcare system, we are now initiating a two-stage public consultation to engage **YOU** the stakeholder in taking forward the reform.

2. At this first stage consultation, we would like to consult you on –

(a) the key principles and concepts of our service reform proposals; and

(b) the pros and cons of possible supplementary financing options.

3. On the basis of the views received during the first stage consultation, we will formulate detailed proposals for the reform including those of supplementary financing arrangements. We will then consult you further at the second stage consultation.

Our Vision for the Healthcare System

4. **Our vision is to achieve a healthcare system that improves the state of health and quality of life of our people, and provides healthcare protection for every member of the community.**

5. **We want to reform the healthcare system so that it can develop on a sustainable basis and keep up with medical technology advances to –**

(a) provide you with access to lifelong, comprehensive and holistic primary care, with emphasis on health-improving preventive care;

(b) provide you with more choice of quality, efficient and cost-effective healthcare in both the public and private sectors;

[1] Discussion paper issued by the Health and Medical Development Advisory Committee (HMDAC) in July 2005 on the future service delivery model of our healthcare system.

(c) provide you with healthcare protection and peace of mind in case you are struck by illnesses that need costly treatment; and

(d) continue the partnership between the Government and you in sharing the financial commitment for your better health.

6. **In reforming the healthcare system, we shall –**

(a) uphold our long-established healthcare policy that no one should be denied adequate healthcare through lack of means;

(b) ensure that necessary healthcare services remain accessible and affordable to the community;

(c) maintain the public healthcare system as a safety net for the low-income and under-privileged groups and those in need; and

(d) upkeep the professional standards and conduct of the healthcare professions.

7. **To reform the healthcare system, the Government is committed to increasing recurrent government expenditure for medical and health services from 15% to 17% of overall recurrent government expenditure by 2011-12.**

We Need to Change – To Change for You

8. Everyone wants to stay healthy. Everyone wants a healthcare system that improves our health, offers quality healthcare services, both preventive and curative, and protects us against illnesses requiring costly treatment (e.g. complex or chronic conditions). However, unless we reform our current system promptly, it will not be able to continue to provide you with the necessary healthcare in the future. If nothing is done, the community as a whole including you will suffer. Let us explain why.

Public Hospital Services at Risk

9. The proportion of elderly people in our community will double from 1 in 8 in 2007 to 1 in 4 by 2033. There are also signs of increasing occurrence of certain lifestyle-related diseases. Both factors will cause the healthcare needs of our community to increase significantly. The waiting queues for public hospital services, especially non-urgent and/or elective surgeries and specialist out-patient

services will thus become longer because of these factors, if we do not reform our system to address them. If we do nothing, there is a real risk that the level and quality of services in public hospitals will decline, for instance –

(a) occupancy in public in-patient wards for major specialties could reach congestion (over 90% occupancy) within the next three years, and saturation (100% occupancy) by 2012 for Medicine specialty, and by 2015 for Oncology specialty;

(b) the waiting time of new cases for specialist out-patient services in all specialties could be tripled by 2012, e.g. the notional waiting time for new cases for surgery would increase from 31 weeks in 2006 to 96 weeks by 2012, and the follow-up interval for old cases would also increase significantly;

(c) the waiting time for various special services could increase significantly, e.g. there would be around 22% or 2,000 patients who might not receive sufficient renal replacement therapy in public hospitals by 2015 due to waiting time; and

(d) the waiting time for non-urgent surgery could lengthen significantly, e.g. waiting time would increase from three years in 2006 to six years in 2015 for cataract surgery, and from 2-3 years in 2006 to 4-5 years in 2015 for benign prostatic hyperplasia surgery.

10. As mentioned in paragraph 7 above, we will increase the funding for public healthcare, and these situations will be alleviated to some extent. The public healthcare system has over the years sustained efficiency gain of around 1% per year on average. Looking forward, we will continue to take measures to enhance the efficiency and cost-effectiveness of the public sector as well as the healthcare system as a whole. We will also take forward various reform to healthcare services and market structure, with a view to enhancing the quality of healthcare services (details are set out in paragraph 19-22 below). However, even with increased government funding, and even with sustained efficiency gain and service enhancement of the public healthcare system, we can only defer but not resolve the problem of declining level and quality of services.

Rising Tax Bills or Less Funding for Other Public Services

11. Ageing population and rising medical costs brought about by advances in medical technology will cause health expenditure to increase rapidly and at a much faster pace than our economy –

		In year 2004	In year 2033	Increased by	Annualised growth rate
Population		6,783,500	8,384,100	24%	0.7%
Economic growth (GDP)	total ($billion in 2005 dollar)	1,287	3,413	165%	3.4%
	per capita ($ in 2005 dollar)	189,700	407,100	115%	2.7%
Total health expenditure	as % of GDP	5.3%	9.2%	74%	2.0%
	total ($billion in 2005 dollar)	67.8	315.2	365%	5.4%
	per capita ($ in 2005 dollar)	10,000	37,600	276%	4.7%
Public health expenditure	as % of GDP	2.9%	5.5%	90%	2.2%
	total ($billion in 2005 dollar)	37.8	186.6	394%	5.7%
	per capita ($ in 2005 dollar)	5,600	22,300	298%	4.9%
Share of public health expenditure in total health expenditure		55.7%	59.2%	-	-

12. If we do not reform the healthcare system and its financing arrangements, and need to meet the increasing public health expenditure by the public purse to avoid the level and quality of public services from declining, you will be affected by either of the following situations –

(a) **Rising tax bills**: to meet the increasing public health expenditure by government funding, total public expenditure would have to be expanded to 22% of GDP by 2033. To fund such a required increase in public expenditure could mean substantial increase in Salaries Tax and/or Profits Tax. This would depart from the principle of small government and low-tax regime, and erode Hong Kong's economic competitiveness; or

(b) **Reduced funding for other public services**: if total public expenditure is to be kept below 20% of GDP, public health expenditure would increase from 14.7% of total public expenditure in 2004 to 27.3% in 2033, at the expense of funding for other public services (e.g. the share of funding for education, social welfare or security, which account for

some 23.8%, 17.6% and 11.8% of recurrent government expenditure in 2008-09, may have to be reduced).

Limited Alternative Choice to Public Hospital Services

13. At present, even if you want to avoid the long waiting queues, you may not have much choice other than unsubsidised and more costly private hospital and specialist services. There is significant public-private imbalance in our healthcare system where the public sector dominates in-patient care while the private sector provides the majority of out-patient care. This has resulted in limited choice for you as well as inadequate competition and collaboration among healthcare providers in both the public and private sectors.

Present Safety Net Not Wide Enough

14. The present public healthcare safety net does not sufficiently cater for patients struck by illnesses requiring costly treatment. This is especially the case for a patient who comes from a middle-income family which does not meet the means-testing criteria under the current fee waiver and financial assistance mechanisms.

Insufficient Emphasis on Holistic Primary Care

15. Better primary care will mean better health for you and everybody in the community and less chance that you will need to go for hospital care. Eventually, this will mean reduced demand for hospital care. However, there is at present insufficient emphasis by both patients and healthcare providers on holistic primary care and wellness promotion.

Limited Continuity and Integration of Care

16. At present, not enough attention is being given to the development of long-term doctor-patient relationships and effective interface between different healthcare providers at different levels of care, which are essential for providing better quality of care.

Healthcare Reform Proposals

17. To achieve our vision of a healthcare system that makes our community healthier and to address the above challenges to the system, we plan to undertake the following reform –

(a) **Enhance primary care** to put greater emphasis on preventive care, reduce the need for hospital care, improve the health of our community, and contain the overall healthcare needs and expenditure of our community in the long run. (See Chapter 2)

(b) **Promote public-private partnership in healthcare** to provide more choice of quality, efficient and cost-effective services and promote further healthy competition and collaboration between the public and private sectors in providing healthcare services. (See Chapter 3)

(c) **Develop electronic health record sharing** to allow individuals' health records to follow them wherever they go for healthcare to improve the quality of healthcare for the public and provide the necessary infrastructure to support the healthcare reform. (See Chapter 4)

(d) **Strengthen public healthcare safety net** to retain and improve the current public healthcare safety net for the low-income families and underprivileged groups, while strengthening the safety net for patients struck by illnesses requiring costly healthcare. (See Chapter 5)

(e) **Reform healthcare financing arrangements** to provide supplementary financing, apart from increased government funding, to ensure the sustainable development of the healthcare system and support the reform of the healthcare market. (See Chapter 6 to Chapter 13)

18. These reform proposals form an integral package and complement each other. To meet the challenges to the healthcare system, not only do we need to introduce reforms to the existing healthcare service and market structure, but we also need to reform the financing arrangements in support of the service reforms. The reforms would also require continued improvement in the light of outcomes and experience in the years ahead.

Enhance Primary Care

19. Effective primary care will help improve the health of individuals in our community and reduce the need of the community for hospital care. Primary care is not just about the curing of episodic illnesses, but should provide continuous, comprehensive and holistic (whole-person) healthcare. It also puts emphasis on preventive care that promotes the well-being and improves the quality of life of individuals. To enhance primary care in Hong Kong, we propose the following –

(a) **Develop basic models for primary care services**: as the basic standard for different age/gender groups with emphasis on preventive care, for reference by both healthcare professionals and individuals.

(b) **Establish a family doctor register**: to register private doctors who serve as family doctors and provide comprehensive primary care to patients, for reference by individuals who wish to receive such care.

(c) **Subsidize individuals for preventive care**: to subsidize individuals of different target age/gender groups to undertake preventive care through private family doctors. The basic models developed above could serve as a reference for these family doctors.

(d) **Improve public primary care**: to purchase primary care services from the private sector and incorporate preventive care in the public clinics for low-income families and under-privileged groups.

(e) **Strengthen public health functions**: strengthen public health education, healthy lifestyle promotion, disease prevention, as well as development of and standard-setting for primary care services.

Promote Public-Private Partnership in Healthcare

20. Public-private partnership (PPP) is collaboration between the public and private sectors to provide healthcare infrastructure or services. PPP offers greater choice of services for individuals in the community, promotes healthy competition and collaboration among healthcare providers, makes better use of resources in both the public and private sectors, benchmarks the efficiency and cost-effectiveness of healthcare services, and facilitates cross-fertilization of expertise and experience between medical professionals. To promote PPP, we will explore the following initiatives through pilot projects progressively –

(a) **Purchase primary care from the private sector and subsidize individuals to undertake preventive care in the private sector**, as mentioned in paragraphs 19(c) & 19(d) above.

(b) **Purchase hospital services from the private sector**, especially those in low-priority areas of the public healthcare system such as non-urgent and/or elective procedures.

(c) Pursue PPP in hospital development which could take the form of

co-location of public and private hospital facilities at the same site to enable co-ordinated planning and shared use of facilities.

(d) **Set up multi-partite medical centres of excellence** to draw together top expertise of the relevant specialties locally and overseas, and participation of experts both in the public and private sectors.

(e) **Engage private sector doctors to practice in public hospitals**, particularly in tertiary and specialized services, on a part-time basis, to facilitate cross-fertilization of expertise and experience.

Develop Electronic Health Record Sharing

21. The development of a territory-wide electronic health record (eHR) infrastructure is essential to enhancing continuity of care as well as better integration of different healthcare services for the benefits of individual patients. It also provides the infrastructure to support the healthcare reform especially in the areas of primary care and public-private partnership. The Hospital Authority has already established an eHR system that we can leverage on. To take forward the initiative, the Government will take the lead. We have set up a Steering Committee on Electronic Health Record Sharing comprising members from the healthcare professions in both the public and private sectors. The Steering Committee's work will include the following –

(a) **Consider funding the capital cost for development** of the eHR sharing infrastructure.

(b) **Make available public sector know-how** for further development and deployment of eHR systems in the private sector.

(c) **Consider other financial assistance** to facilitate the development and deployment of eHR system in the private sector.

(d) **Consider ways to promote the benefits** of health record sharing to patients and providers.

Strengthen Public Healthcare Safety Net

22. The public healthcare system will continue to serve as an essential safety net for the population, especially for those who lack the means to pay for their own healthcare. The current fee waiver mechanism and other financial

assistance schemes will continue to be available as a safety net for CSSA recipients, low-income families and under-privileged groups as at present. If we can reform the financing arrangements to relieve the strain on resources for the public healthcare system, there should be room for strengthening the public healthcare safety net. Specifically, we propose to consider the following –

(a) **Reduce waiting time of public hospital services** through strengthening existing service provision or purchasing services from the private sector.

(b) **Improve the coverage of standard public services** especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment.

(c) **Explore the idea of a "personal limit on medical expenses"** beyond which financial assistance would be provided to protect individual patients against financial ruin due to illnesses requiring costly treatment.

(d) **Inject funding into the Samaritan Fund** as extra funding to finance those in need of but lack the means to obtain certain medical treatment outside the standard public services.

Reform Healthcare Financing Arrangements

23. As mentioned in paragraph 9 above, even though we will increase government funding, continue to enhance efficiency and reform healthcare services and the market structure, we still cannot guarantee the sustainability of our healthcare system in face of the challenges posed by the ageing population and rising medical costs. The experience of other advanced economies also shows that their total and public health expenditure may grow to as large as 8%-15% and 6%-8% of GDP respectively. It is not certain to what extent this experience is directly applicable to Hong Kong against our better record of containing public health expenditure and enhancing efficiency of the healthcare system. However, our projection based on this experience shows that, without reform, our total and public health expenditure may grow from 5.3% and 2.9% of GDP respectively in 2004, to as large as 9.2% and 5.5% of GDP respectively by 2033.

24. It is clear that we need to reform the healthcare financing arrangements, in addition to healthcare services and market structure reforms. With increased government funding continuing to provide a major financing source,

what we need is a supplementary financing source for healthcare to supplement government funding to cope with increasing healthcare needs, and to sustain the reform as set out in paragraphs 19-22 above, with a view to improving healthcare services.

Supplementary Financing Options for Hong Kong

25. Apart from examining the option of maintaining the existing financing model, i.e. to continue to meet increasing health expenditure by government revenue including increasing tax, we have studied various options to provide supplementary financing for healthcare in Hong Kong, having regard to experiences of overseas economies. During this first stage consultation, we do not recommend any particular option and would like to seek your views on the pros and cons of the following six options for providing supplementary financing for healthcare –

(a) **Social health insurance**: to require the workforce to contribute a certain percentage of their income to fund healthcare for the whole population.

(b) **Out-of-pocket payments (user fees)**: to increase user fees for public healthcare services.

(c) **Medical savings accounts**: to require a specified group of the population to save to a personal account for accruing savings (with the option to invest) to meet their own future healthcare expenses, including insurance premium if they take out private health insurance.

(d) **Voluntary private health insurance**: to encourage more individuals to take out private health insurance in the market voluntarily.

(e) **Mandatory private health insurance**: to require a specified group of the population to subscribe to a regulated private health insurance scheme for their own healthcare protection.

(f) **Personal healthcare reserve**: to require a specified group of the population to deposit part of their income into a personal account, both for subscribing to a mandatory regulated medical insurance before and after retirement, and for accruing savings (with the option to invest) to meet their own healthcare expenses including insurance premium after retirement.

26. Each option has its own pros and cons and the choice between the options is very much a choice of the community reflecting its societal values on the following –

(a) **Financial stability and sustainability**: we all hope that our healthcare system can sustain quality healthcare services for the community and our future generations. Is the supplementary financing option able to ensure stable financing for the sustainable development of the healthcare system?

(b) **Accessibility of healthcare**: if you are contributing to supplementary financing, do you want your contribution to go to funding healthcare for everyone in the community including yourself through queuing and triage as necessary, or do you want your contribution to provide you with better access to healthcare?

(c) **Pooling and sharing of risk**: do you want your financial risk arising from illnesses to be pooled or shared out with others, so that when you become ill you would be subsidized by the healthy, the corollary being that when you are healthy you will have to subsidize the unhealthy ones?

(d) **Wealth re-distribution**: current public healthcare services funded by tax-payers are already a form of wealth re-distribution. How far do you think supplementary financing should further require those with higher income to pay more for healthcare subsidizing those with lower income? Or do you think supplementary financing for healthcare should not be generated through a form of tax or similar systems?

(e) **Choice of services**: is the supplementary financing option able to bring about more choice of personalized healthcare services tailored to your own preferences (e.g. choice of doctors/providers, amenities of care, or options for treatment)?

(f) **Market competition and efficiency**: is the supplementary financing able to bring about a market system that drives competition among healthcare providers and enhance price transparency, quality, efficiency and cost-effectiveness of healthcare services?

(g) **Utilization and cost control**: the excessive use and increasing cost will lead to ever more costly healthcare for the community as a whole. We

need a mechanism that can inherently encourage judicious use of healthcare resources and contain the cost of healthcare. Does the supplementary financing arrangement have such an effect?

(h) **Overhead cost**: options that offer certain benefits such as more choice or greater competition (e.g. insurance or savings) entail administration or other transaction costs. How expensive is the supplementary financing option's overhead costs?

27. It is important to note that there is no perfect option that can offer us the best in all aspects – every option will involve trade-offs between the above considerations. Overseas experience also suggests that the healthcare system and financing arrangements of each economy has its own specific history and circumstances requiring its own solution. No one single model can be readily transplanted.

28. An assessment and comparison based on the considerations in paragraph 26 above of the existing financing model and the various supplementary financing options in a number of aspects (accessibility of healthcare, choice of services, market competition/efficiency, financing sustainability, utilization/cost control, overhead cost, risk-pooling/sharing, and wealth re-distribution) is summarized in **Table 1** (page *xvi)*. An analysis of the different contributors under different financing options and the impact of the options on different groups of the community are in **Table 2** (page *xviii*). A summary of the pros and cons of all the financing options is in **Table 3** (page *xxi*).

Financial Incentives for Supplementary Financing

29. As the Financial Secretary has announced in the 2008-09 Budget Speech, after the supplementary financing arrangements have been finalised for implementation after consultation, the Government will draw $50 billion from the fiscal reserve for taking forward the healthcare reform. This demonstrates the Government's commitment to share the responsibility for healthcare financing together with the community, and to increase the resources available to individual members of our community for healthcare. It can be used, for instance, to provide each participant in a contributory supplementary financing scheme with individual start-up capital.

30. In this regard, we will further examine how financial incentives can be provided to participants in a supplementary financing scheme, after receiving views during the first stage consultation, when developing detailed proposals for the

supplementary financing arrangements. The financial incentives may take different forms, depending on the supplementary financing option to be adopted. These may include, for instance, tax deduction, start-up capital, or other forms of direct subsidization.

31. The public healthcare system will also continue to provide an available and accessible safety net for the community as a whole. This safety net will still offer protection to those who are taking a greater share of responsibility for their own healthcare when they are in need.

We Need Your Support

32. Please give us your support and constructive views to turn our vision into reality. Please send your views on this consultation document to us **on or before 13 June 2008** through the contact below. Please indicate if you do not want your views to be published or if you wish to remain anonymous. Unless otherwise specified, all responses will be treated as public information and may be publicized in the future.

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Table 1 Comparison of different supplementary financing options and existing financing model

	Financing sustainability	Accessibility of healthcare	Risk-pooling/ sharing	Wealth re-distribution
Government funding (existing model)	Subject to fluctuations of fiscal position; unsustainable in the long-term	Accessibility based on needs (through triage and queuing)	Effective risk-sharing (healthy subsidize unhealthy)	High-income pay more and subsidize low-income
Social health insurance	Quite stable but unsustainable with shrinking workforce; require higher contribution rate as utilization increases to be sustainable	Accessibility depending on design (whether population coverage is universal or not)	Effective risk-sharing (healthy subsidize unhealthy)	High-income pay more and subsidize low-income
Out-of-pocket payments	Unsustainable	Accessibility based on affordability to pay user fees (heavy users pay more)	No risk-pooling (unhealthy pay more)	High income and low-income pay the same
Medical savings accounts	Secure a sizeable and sustainable potential source of financing, but injection of financing unstable and unpredictable	Accessibility based on availability of savings (heavy users will use more from the savings)	No risk-pooling	Not applicable
Voluntary private health insurance	Subscription unpredictable and financing unstable; unlikely to be a sizeable and sustainable supplementary financing source	Accessibility based on affordability to pay insurance premium (better access for those insured)	Some degree of risk-pooling (unhealthy or higher-risk pay more)	Not applicable
Mandatory private health insurance	Quite stable; require higher premium as utilization increases to be sustainable	Accessibility depending on design (whether population mandated to take out insurance is universal or not)	Effective risk-sharing (healthy subsidize unhealthy)	High-income and low-income, regardless of risk profile, pay the same
Personal healthcare reserve	Sustainable source of financing through savings; stable injection of savings into the healthcare system through insurance	Accessibility depending on design (better access for those insured and for those with savings)	Effective risk-sharing (healthy subsidize unhealthy)	High-income and low-income, regardless of risk profile, pay the same

Table 1 Comparison of different supplementary financing options and existing financing model (cont'd)

	Choice of services	Market competition/ efficiency	Utilization/cost control	Overhead cost
Government funding (existing model)	Little choice	Not enhancing competition or efficiency drive	Effective through supply and budget control	Low
Social health insurance	Some choice	Some competition through procurement of services from different providers	May not be effective due to increased demands from contributors	Moderate
Out-of-pocket payments	Some choice	Not enhancing competition or efficiency	Very effective but can result in healthcare less available to those more in need	Low
Medical savings accounts	Some choice	Some enhancement of competition and efficiency	Control effective to some extent when cost is borne by patients	Moderate, but can be reduced by using MPF framework; disbursement admin. cost still required
Voluntary private health insurance	More choice	Some enhancement of competition and efficiency	Little control	High
Mandatory private health insurance	More choice	Enhance competition and efficiency if insured pool is large; support market reform	Little control, but insurers with bigger pool in better position to control moral hazards and bargain fees	Moderate
Personal healthcare reserve	More choice	Enhance competition and efficiency if insured pool is large; support market reform	Little control, but insurers with bigger pool in better position to control moral hazards and bargain fees	Moderate, but can be reduced by using MPF framework; admin. cost for claims processing still required

Table 2 Summary of contributors of supplementary financing options and existing financing model and their impacts on different groups

	Contributors	Impacts on Different Groups
Government funding (existing model)	• Taxpayers (higher income pay more)	• Everyone in the community access subsidized healthcare equitably by queuing and triage • Those who can afford to pay but cannot afford to wait can resort to unsubsidized private healthcare • Low-income and under-privileged continue to be taken care of by public system funded by taxpayers • Unsustainable financing will cause everyone especially the high-risk groups (chronic patients, the elderly, etc.) who need to rely on the public system to suffer in the long-run
Social health insurance	• Working population (higher income pay more) • Employers (if they are required to contribute) • Taxpayers (for public healthcare system)	• Everyone in the community provided with subsidies for healthcare equitably through social insurance • Some extra choice of private services for those who can afford higher co-payment • Low-income and under-privileged subsidized by contributions from high-income • Overall utilization increase will require the contributors to pay more
Out-of-pocket payments	• Patients who need to use healthcare (heavier users pay more) • Taxpayers (for public healthcare system)	• Healthier individuals in the community will not need to pay more • Those who can afford to pay can resort to unsubsidized private healthcare • The high-risk groups (chronic patients, the elderly, etc.) in heavy need of healthcare will pay substantially more • Low-income and under-privileged continue to be taken care of by public system funded by taxpayers • Unsustainable financing will cause everyone especially the high-risk groups who need to rely on the public system to suffer in the long-run
Medical savings accounts	• A specified group of the population subject to medical savings accounts (depending on design, higher income will save more for their own accounts) • Employers (if they are required to contribute) • Taxpayers (for public healthcare system)	• Those who save will have financing to meet their future healthcare needs especially after retirement • Those with illnesses requiring costly treatment will unlikely have enough savings to meet their healthcare needs and will fall back on safety net • Those relatively healthier will have less healthcare needs and will accrue a sizeable savings to be left to their estates • Low-income and under-privileged continue to be taken care of by public system funded by taxpayers • Medical savings unlikely to reduce demand for public healthcare services significantly and will not be funding public system, and thus unlikely to benefit those who need to rely on public system especially the high-risk groups, and the low-income and underprivileged groups

Table 2 Summary of contributors of supplementary financing options and existing financing model and their impacts on different groups (cont'd)

	Contributors	Impacts on Different Groups
Voluntary private health insurance	• Those who buy insurance voluntarily (higher-risk pay higher premium) • Employers (those who provide medical insurance for their employees) • Taxpayers (for public healthcare system)	• The insured will enjoy protection for their health risks and access to private healthcare services • The high-risk groups (chronic patients, the elderly, etc.) unlikely to be able to get insured or have to pay expensive premium • Low-income and under-privileged continue to be taken care of by public system funded by taxpayers • The insured will have better access to more choice of healthcare services while the choice of services will not be enhanced for the uninsured • The shift of some of the insured to the private sector may reduce pressure on public system and benefit those who need to rely on it especially the high-risk groups, and the low-income and under-privileged groups, but extent of the shift likely to be limited • Utilization increase by participants will cause higher premium • Unsustainable financing will cause the uninsured especially the high-risk groups who need to rely on the public system to suffer in the long-run
Mandatory private health insurance	• A specified group of the population subject to mandatory insurance (depending on design, everyone pays the same insurance premium) • Others who buy the insurance voluntarily (depending on design) • Employers (those who provide medical insurance for their employees) • Taxpayers (for public healthcare system)	• The insured will enjoy protection for their health risks which are shared out with other insured, and access to private healthcare services • The high-risk groups (chronic patients, the elderly, etc.) will be able to enjoy healthcare protection through community-rated premium, and regulated terms including no exclusion of pre-existing medical conditions and continuity of insurance • Low-income and under-privileged continue to be taken care of by public system funded by taxpayers • The insured will have better access to more choice of healthcare services while the choice of services will not be enhanced for the uninsured • The shift of the insured to the private sector or requiring the insurance to pay for public services will reduce pressure on public system and benefit those who need to rely on it including the high-risk groups, and the low-income and under-privileged groups. Extent of the shift likely to be much larger than in the case of voluntary insurance • Utilization increase by participants will cause higher premium

Table 2 Summary of contributors of supplementary financing options and existing financing model and their impacts on different groups (cont'd)

	Contributors	Impacts on Different Groups
Personal healthcare reserve	• A specified group of the population subject to personal healthcare reserve (depending on design, higher income will save more for their own accounts, but everyone pays the same insurance premium) • Employers (if they are required to contribute or those who provide medical insurance for their employees) • Taxpayers (for public healthcare system)	• Those who participate will have financing to meet their future healthcare needs especially after retirement, and will also enjoy protection for their health risks which are shared out with other insured, and access to private healthcare services through insurance • The high-risk groups (chronic patients, the elderly, etc.) will be able to enjoy healthcare protection through community-rated premium of the insurance, and regulated terms including no exclusion of pre-existing medical conditions and continuity of insurance • Low-income and under-privileged continue to be taken care of by public system funded by taxpayers • The insured will have better access to more choice of healthcare services while the choice of services will not be enhanced for the uninsured • The shift of the participants to the private sector or requiring the insurance to pay for public services will reduce pressure on public system, and benefit those who need to rely on it including the high-risk groups and the low-income and under-privileged groups • Utilization increase by participants will cause higher premium • The building up of a source of financing to meet the future healthcare needs of the participants will reduce future burden on the public system and benefit those who need to continue to rely on it including the high-risk groups and the low-income and under-privileged groups

Table 3 Summary of pros and cons of supplementary financing options and existing financing model

	Advantages	Disadvantages
Government funding (existing model)	• Equitable healthcare • Simple administration and lower administration cost • High-income to subsidize low-income	• Rising tax bills and expanding government budget • Increasing burden on future generations of a shrinking workforce • Encourage over-reliance on highly-subsidized public healthcare • Further aggravate public-private imbalance and insufficient competition between the two sectors • Lack incentives for judicious use of highly-subsidized public healthcare • Not conducive to enhancing public sector efficiency and cost-effectiveness • Inadequate choice in healthcare services • Unsustainable financing
Social health insurance	• Equitable healthcare • More stable financing • High-income to subsidize low-income • Some choice of services: can cover both public and private services depending on design	• A new hypothecated tax • Increasing burden on future generations of a shrinking workforce • Encourage over-reliance on highly-subsidized healthcare • Lack incentives for judicious use of highly-subsidized healthcare • Difficult to control healthcare utilization • May encourage tendency to overuse healthcare • Increasing contribution rate due to ageing population and shrinking working population • Incur administration cost • Prescribed choice of healthcare services
Out-of-pocket payments	• Effective means to encourage judicious use of healthcare • Instil sense of self-responsibility for health	• No risk-pooling and disproportionate burden on low-income and under-privileged groups • Cannot provide a significant source of supplementary financing • Increase cost for administering safety net mechanisms
Medical savings accounts	• Saving for own use • Saving for individuals to meet future medical needs • Reduce burden on future generations • Instil sense of self-responsibility for health • Promote judicious use of healthcare services	• No risk-pooling • Not a guaranteed source of supplementary financing • Does not in itself support market reform especially redressing public-private imbalance • Use of savings before retirement defeats purpose of saving for future medical expenses • Incur administration cost • Lock up huge pool of funding

Table 3 Summary of pros and cons of supplementary financing options and existing financing model (cont'd)

	Advantages	Disadvantages
Voluntary private health insurance	• Individuals' choice to pool risk • More choice of services	• Expensive for the high-risk groups • Costly premium due to anti-selection (tendency that those who take out insurance are those who are more likely to claim insurance) • Coverage may exclude pre-existing medical conditions • No guarantee of continuity especially at old age • Little protection for consumers if unregulated • Little control on healthcare utilization and costs • May encourage tendency to overuse healthcare • Increasing premium over time due to individuals' age and health conditions • Not helping individuals to save to meet future healthcare needs • Incur administration and other insurance costs • Not relieving the pressure on the public healthcare system • Unpredictable and inadequate supplementary financing
Mandatory private health insurance	• Guaranteed risk-pool and avoid risk-selection/anti-selection • Guaranteed acceptance and continuity • Enable more affordable community-rated premium • Enhance consumer protection through regulated insurance • More choice of services • Relieve the pressure on the public healthcare system • Stable financing	• Incur administration and other insurance costs • Regulatory costs • Not helping individuals to save to meet future healthcare needs • May encourage tendency to overuse healthcare • Increasing premium over time due to increasing age profile of insured population
Personal healthcare reserve	• Benefits of medical savings accounts and mandatory private health insurance as above • Complementary savings and insurance: provide both risk-pooling and savings for the future • Relieve the pressure on the public healthcare system • Sustainable and stable financing	• Incur administration and other costs for both insurance and savings • Regulatory costs • May encourage tendency to overuse healthcare • Increasing premium over time due to increasing age profile of insured population

PREAMBLE OUR VISION

Our vision is to achieve a healthcare system that improves the state of health and quality of life of our people, and provides healthcare protection for every member of the community.

Turning Vision into Reality - Healthcare Reform

2. To turn our vision into reality, we need to reform our healthcare system to ensure its sustainable development and respond to the increasing healthcare needs of the community. Specifically, we want to reform the healthcare system to –

(a) **Provide Better Care for the Community**: by providing individuals with access to lifelong, comprehensive and holistic care with particular emphasis on health-improving primary care, especially preventive care;

(b) **Provide More Choices of Quality Services**: by reforming the healthcare market structure to provide our community with more choice of quality, efficient and cost-effective services in both the public and private sectors;

(c) **Provide Healthcare Protection and Peace of Mind**: by enabling our community to afford lifelong healthcare protection while continuing to provide a safety net for those in need; and

(d) **Promote Partnership for Health**: by encouraging shared responsibility for health, with individuals taking greater responsibility for personal health, and the Government providing a sustainable healthcare system for all.

Healthcare Reform Proposals

3. We aim to achieve our vision by embarking on the following reforms set out in this consultation document –

(a) **Enhance primary care** to put greater emphasis on preventive care, reduce the need for hospital care, improve the health of our community, and contain the overall healthcare needs and expenditure of our community in the long run. (See Chapter 2)

(b) **Promote public-private partnership in healthcare** to provide more choice of quality, efficient and cost-effective services and enhance healthy

Chapter 3)

(c) **Develop electronic health record sharing** to allow individuals' health records to follow them wherever they go for healthcare to improve the quality of healthcare for the public and provide the necessary infrastructure to support the healthcare reform. (See Chapter 4)

(d) **Strengthen public healthcare safety net** to retain and improve the current public healthcare safety net for the low-income families and underprivileged groups, while strengthening the safety net for patients struck by illnesses requiring costly healthcare. (See Chapter 5)

(e) **Reform healthcare financing arrangements** to provide supplementary financing, apart from increased government funding, to ensure the sustainable development of the healthcare system and support the reform of the healthcare market. A range of possible supplementary financing options have been examined and their pros and cons evaluated having regard to overseas experience. (See Chapter 6 to Chapter 13)

What Are Not to be Changed?

4. We shall maintain our long-established healthcare policy that no one should be denied adequate healthcare through lack of means. While introducing changes to our healthcare system, we must also take care to preserve its current strengths and advantages that are fundamental to our common values and pivotal to the success of the reform –

(a) **Healthcare services remain accessible and affordable**: by maintaining government funding as the primary financing source for healthcare and maintaining the public healthcare system as a safety net for the low-income families and under-privileged groups, and other members of the community in need.

(b) **Maintain professional standards and conduct**: by maintaining a regulatory framework that ensures the high professional standards and conduct of the healthcare professions, and by strengthening the role of the Government in ensuring the proper functioning of the healthcare system as well as the quality and cost-effectiveness of services.

Chapter 1 THE NEED FOR CHANGE

1.1 Over the years, Hong Kong has developed a high-quality and highly efficient healthcare system supported by healthcare professionals known for their dedication as well as high standards of professionalism and ethical conduct. The system has delivered high quality services for the public and has achieved impressive health standards – Hong Kong's health indicators such as life expectancy and infant mortality rank among the best in the world. Notwithstanding its outstanding performance so far, the present system is suffering from increasing strain and facing certain fundamental challenges. If we do nothing, the system will deteriorate significantly in the foreseeable future and become incapable of providing quality healthcare to our community and maintaining its impressive record.

Challenges to Existing System

1.2 The present healthcare system is facing a number of major challenges –

(a) **Increasing healthcare needs** due to demographic changes especially the rapidly ageing population and increasing occurrence of certain lifestyle-related diseases –

(i) **Rapidly ageing population**: the proportion of elders (aged 65 or above) in our population will double from one in eight in 2007 to one in four by 2033 (see **Figure 1.1** on page 7). The elderly dependency ratio (the number of persons aged 65 or above per 1,000 persons aged 15-64) will increase from 170 in 2007 to 428 in 2033. The elderly population has much greater healthcare needs, e.g. a person aged 65 or above uses on average six times more in-patient care (in terms of bed-days) than a person aged below 65 (see **Figure 1.2** on page 7).

(ii) **Increasing disease occurrence**: the occurrence of certain lifestyle-related diseases has been on the rise, e.g. the proportion of the population with hypertension has increased from 18.0% in 1995 to 27.2% in 2003 (see **Table 1.1** on page 8).

(b) **Rising medical costs** due to advances in medical technology and public expectations for healthcare to keep up with such advances (a trend known as "medical inflation") –

(i) **Advancement of medical technology**: advances in medical technology can lead to a rise in medical costs in a number of ways. New, better and often more expensive diagnostic methods may allow diseases to be detected earlier or more effectively treated. New, better and often more expensive treatments and drugs may appear for diseases either hitherto incurable or untreatable or have been treated with drugs less expensive but less effective or with more side-effects. New and better treatment may result in longer lives of patients with chronic illnesses or other conditions who may in turn require longer treatment. New medical technology may also require more substantial investment in both equipment and manpower. For instance, development in medical technology has led to specialisation and sub-division of the healthcare professions, including doctors and allied health professionals.

(ii) **Higher public and consumer expectation**: along with advancement of technology and improved access to medical information, there is growing expectation among the public for healthcare to keep up with the latest technology development, and a growing tendency for healthcare consumers to obtain second opinion and demand alternative options of healthcare services, which often lead to higher cost of healthcare. Demand for better quality of healthcare poses greater demand for healthcare manpower.

(iii) **Medical inflation**: international experience[2] as well as local trend indicate that adoption of new medical technology alone, to keep pace with international developments and keep up the quality of care, has caused public medical costs per capita to rise on an average of one percentage point per year faster than the growth of the economy (as measured by per capita Gross Domestic Product or GDP) (see **Figure 1.3** and **Figure 1.4** on page 8 and page 9 respectively). Even without the effect of demographic changes, the cost of healthcare is likely to continue to rise due to medical inflation.

(c) **Health expenditure growing much faster than the economy** as a result of both increasing healthcare needs and rising medical costs –

(i) **International trend**: this trend is evident both locally and in many other advanced economies (see **Figure 1.5** on page 9). In most

[2] Source: OECD (2006) "Projecting OECD health and long-term care expenditures: What are the main drivers?" Economics Department Working Papers No. 477.

advanced economies, irrespective of the rate of economic growth, the real growth rate of total health expenditure exceeds the real growth rate of the economy (in GDP) by more than 50%.

(ii) **Projected health expenditure**: our projection indicates that, if the current healthcare system remains unchanged, the total health expenditure required to meet the healthcare needs for the whole population is expected to increase at an average annual rate that is 59% faster than that of economic growth (in terms of real GDP growth) between 2004 and 2033. This takes into account both demographic changes (including both population growth and ageing population) and rising medical costs. At this rate (see also **Table 1.2** on page 10) –

- total health expenditure will increase by 3.6 times between 2004 and 2033, when GDP will only grow by 1.7 times during the same period. As a result, total health expenditure as a share of GDP would increase from 5.3% in 2004 to 9.2% in 2033 (see **Figure 1.6** on page 10);

- in real dollar terms (in 2005 price), total health expenditure will increase from $67.8 billion to $315.2 billion between 2004 and 2033, when GDP will increase only from $1,287 billion to $3,413 billion during the same period; and

- in per capita terms, health expenditure will nearly quadruple in real terms (in 2005 price) from $10,000 to $37,600 between 2004 and 2033, when per capita GDP will slightly more than double from $189,700 to $407,100 during the same period.

(iii) **Increasing share of public health expenditure**: if the current market structure and utilization pattern of both public and private healthcare services remain unchanged, the rapidly increasing healthcare needs of the community will pose intensifying pressure on the public healthcare system, especially because the elderly population rely more on public healthcare. Public health expenditure required for public services to meet the healthcare needs of the population would as a result increase at an even faster rate than the total health expenditure, and the share of public health expenditure in total public expenditure would also continue to rise. Our projection indicates that public health expenditure is expected to increase at an average annual rate that is 66% faster than that of economic growth (in GDP) between 2004 and

2033 (see **Figure 1.7** on page 11). At this rate (see also **Table 1.2** on page 10) –

- public health expenditure will increase by 3.9 times between 2004 and 2033, when GDP will only grow by 1.7 times during the same period. As a result, public health expenditure as a share of GDP will increase from 2.9% in 2004 to 5.5% in 2033;

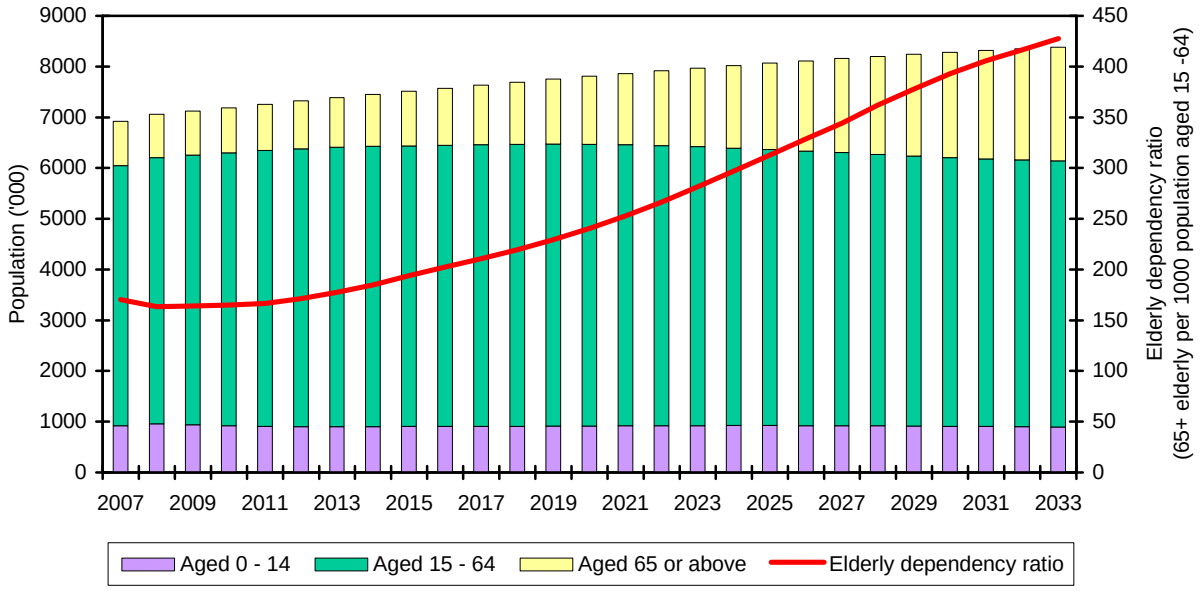
- assuming that total public expenditure will be kept below 20% of GDP, the share of public health expenditure as a share of total public expenditure will increase from 14.7% in 2004 to 27.3% in 2033;

- in real dollar terms, public health expenditure will increase from $37.8 billion to $186.6 billion between 2004 and 2033, when GDP will increase only from $1,287 billion to $3,413 billion during the same period; and

- in per capita terms, public health expenditure per capita will be quadrupled in real terms from $5,600 to $22,300 between 2004 and 2033, when GDP per capita will slightly more than double from $189,700 to $407,100 during the same period.

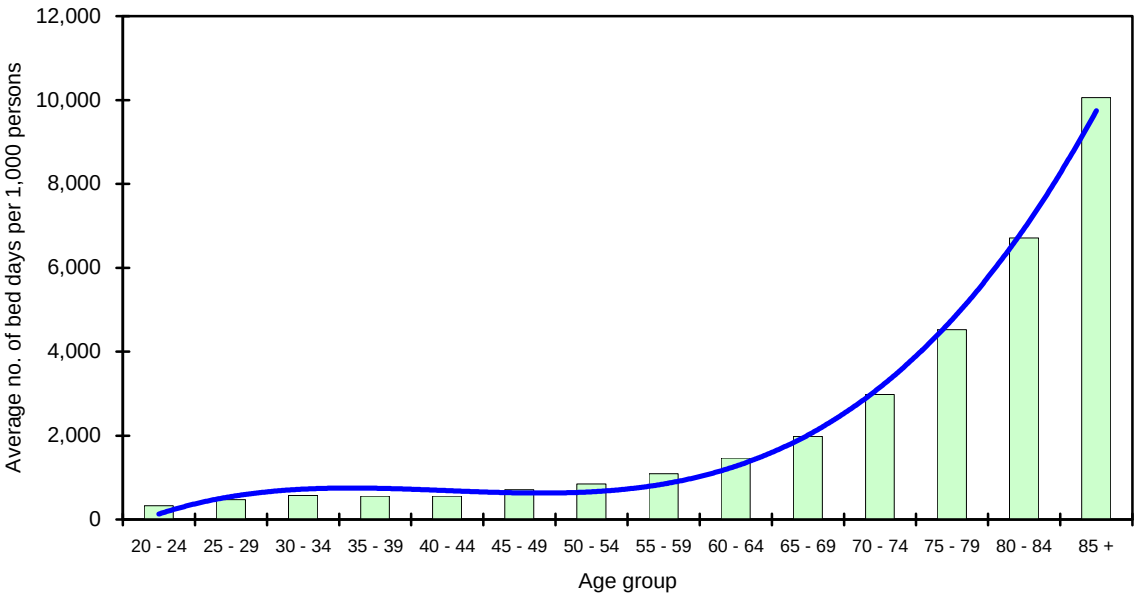
(d) **Increasing burden on future generations:** if we maintain the present financing arrangements of the healthcare system without reform, the burden on our future generations will get heavier. Having an ageing population means that the proportion of the working population will continue to decrease (see **Figure 1.8** on page 11), and so would be the tax base unless reform to the tax regime is carried out to broaden it. The increasing health expenditure funded predominantly by government revenue will thus pose an increasing burden on future generations of the working population.

Figure 1.1 ***Hong Kong has a rapidly ageing population***
Projection of total population, elderly population and elderly dependency ratio, 2007-2033



Source: Hong Kong Population Projections 2004-2033, Census and Statistics Department.

Figure 1.2 ***The elderly population has greater healthcare needs***
Average number of public hospital bed days utilized by age (2006)



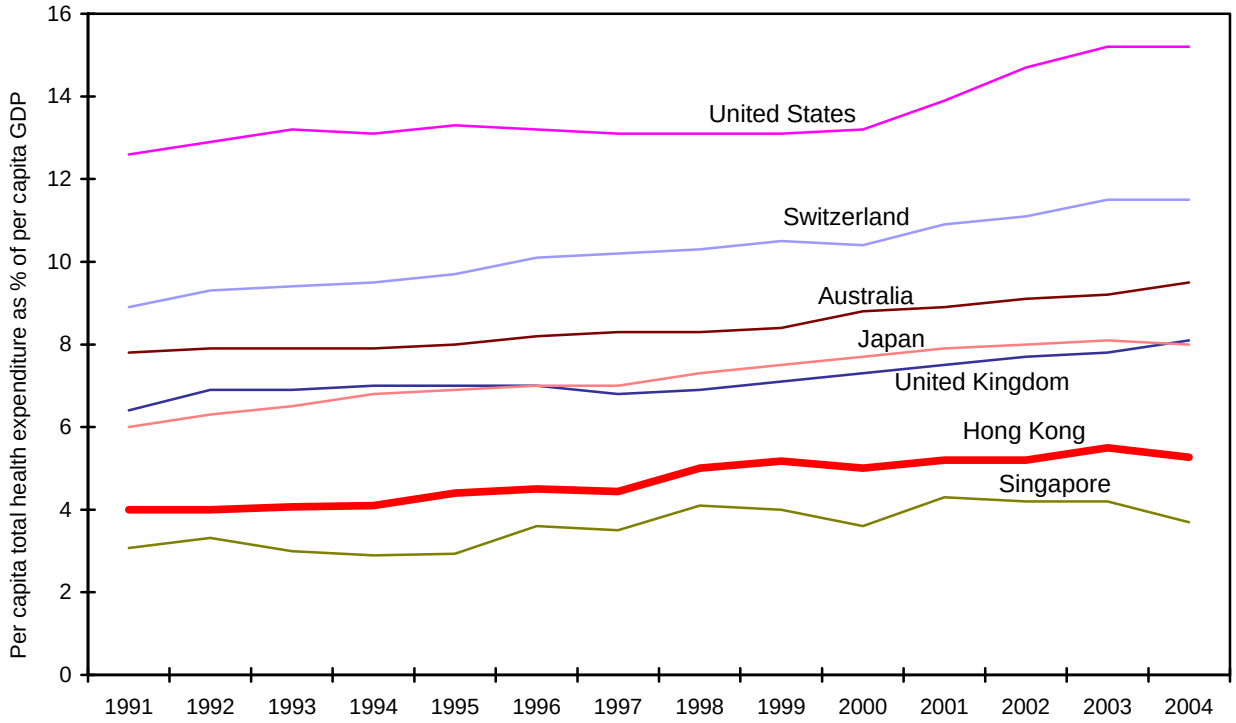
Source: Data from Hospital Authority.

Table 1.1 ***Occurrence of certain lifestyle-related diseases is increasing***
Comparison of occurrence of selected diseases over time

Diseases	Age group	1995	2003
Prevalence of hypertension [1, 2]	Below 65	13.7%	20.5%
	65 or above	53.2%	68.8%
	Total	18.0%	27.2%
New cases of colorectal cancer in males (per 100,000 population)[3]	Below 65	20.5	23.2
	65 or above	323.4	315.3
	Total	47.0	56.1

Source:
1. E.D. Janus. The Hong Kong Cardiovascular Risk Factor Prevalence Study 1995-1996. The figure refers to age group 25 – 74. Hypertension is defined as blood pressure of 140/90 or above.
2. Population Health Survey 2003/2004, Department of Health and University of Hong Kong. The figure refers to age group 15+. Hypertension is defined as blood pressure of 140/90 or above.
3. The Hong Kong Cancer Registry, Hospital Authority.

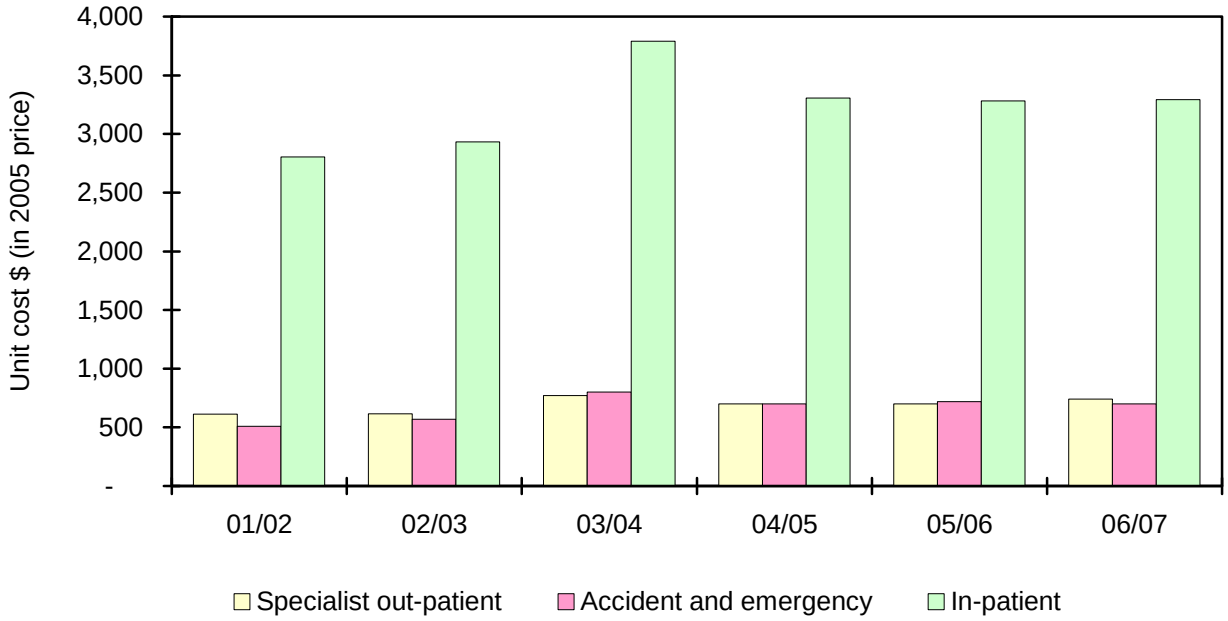
Figure 1.3 ***Medical inflation is driving increase in health expenditure everywhere***
Per capita total health expenditure as percentage of per capita GDP in Hong Kong and selected economies (1991-2004)



Source:
1. OECD Health Data 2007 (Oct 2007).
2. World Health Organization - National Health Accounts Series.
3. Singapore Ministry of Health, Healthcare Economics, Policies and Issues in Singapore by Toh Mun Heng and Linda Low.
4. Hong Kong's Domestic Health Accounts: 1990-2004.

Figure 1.4 ***Medical inflation - cost of healthcare is getting more expensive in Hong Kong***

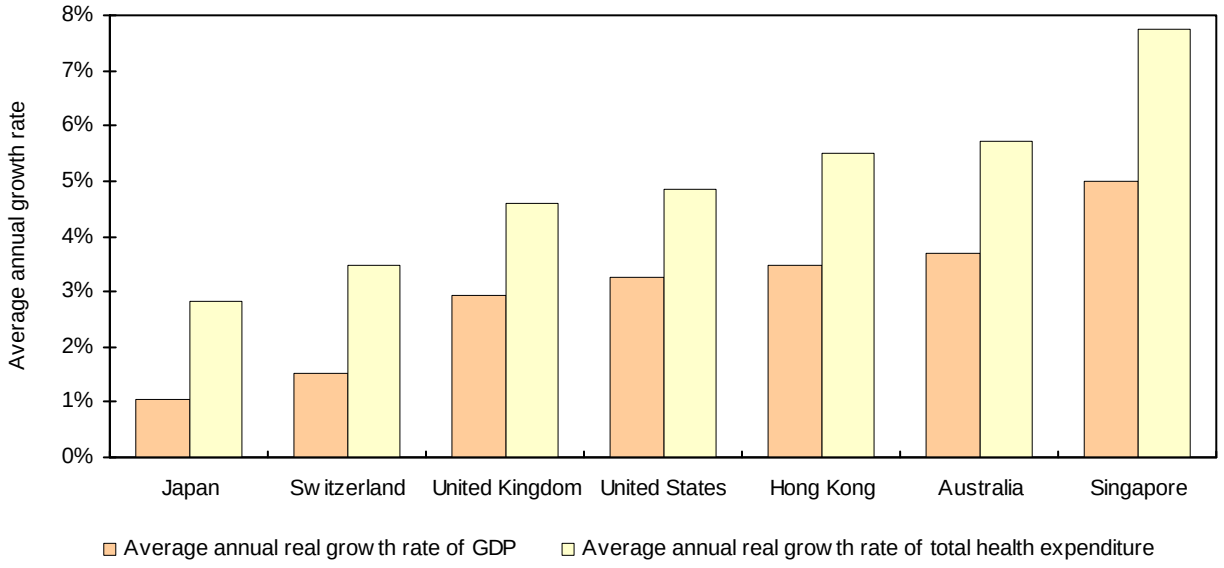
Unit cost per in-patient bed-day, specialist out-patient attendance, and accident and emergency attendance of public hospitals over the years



Note: In-patient services for infirmary, mentally handicapped and psychiatric services were excluded.
Source: Data from Hospital Authority.

Figure 1.5 ***Everywhere health expenditure is growing faster than the economy, Hong Kong is no exception***

Average annual real growth rate of total health expenditure and real growth rate of GDP in Hong Kong and selected economies (1995-2004)



Source:
1. OECD Health Data 2007 (Oct 2007).
2. World Health Organization - National Health Accounts Series.
3. Singapore Ministry of Health, Healthcare Economics, Policies and Issues in Singapore by Toh Mun Heng and Linda Low.
4. Hong Kong's Domestic Health Accounts: 1990-2004.

Table 1.2 ***Without reform, Hong Kong's health expenditure will increase at a much faster rate than the economy***

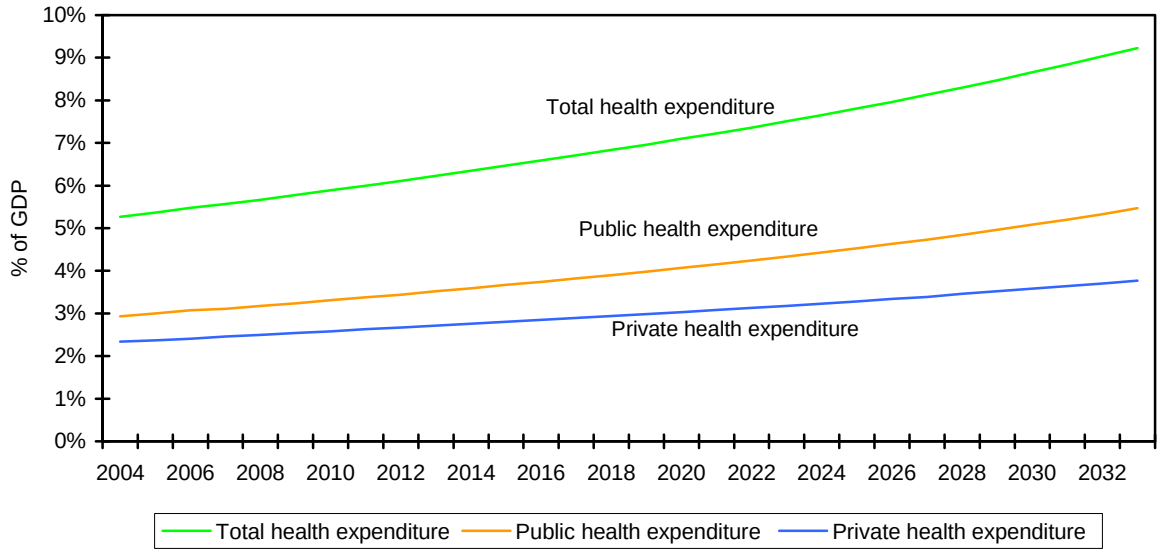
Comparison of projected economic growth and health expenditure growth

		In year 2004	In year 2033	Increased by	Annualised growth rate
Population		6,783,500	8,384,100	24%	0.7%
Economic growth (GDP)	total ($billion in 2005 dollar)	1,287	3,413	165%	3.4%
	per capita ($ in 2005 dollar)	189,700	407,100	115%	2.7%
Total health expenditure	as % of GDP	5.3%	9.2%	74%	2.0%
	total ($billion in 2005 dollar)	67.8	315.2	365%	5.4%
	per capita ($ in 2005 dollar)	10,000	37,600	276%	4.7%
Public health expenditure	as % of GDP	2.9%	5.5%	90%	2.2%
	total ($billion in 2005 dollar)	37.8	186.6	394%	5.7%
	per capita ($ in 2005 dollar)	5,600	22,300	298%	4.9%
Share of public health expenditure in total health expenditure		55.7%	59.2%	-	-

Source: Hong Kong's Domestic Health Accounts: Financial projection of Hong Kong's total expenditure on health from 2004 to 2033. Hong Kong Population Projections 2004-2033, Census and Statistics Department. Working assumptions on GDP growth by the Government Economist.

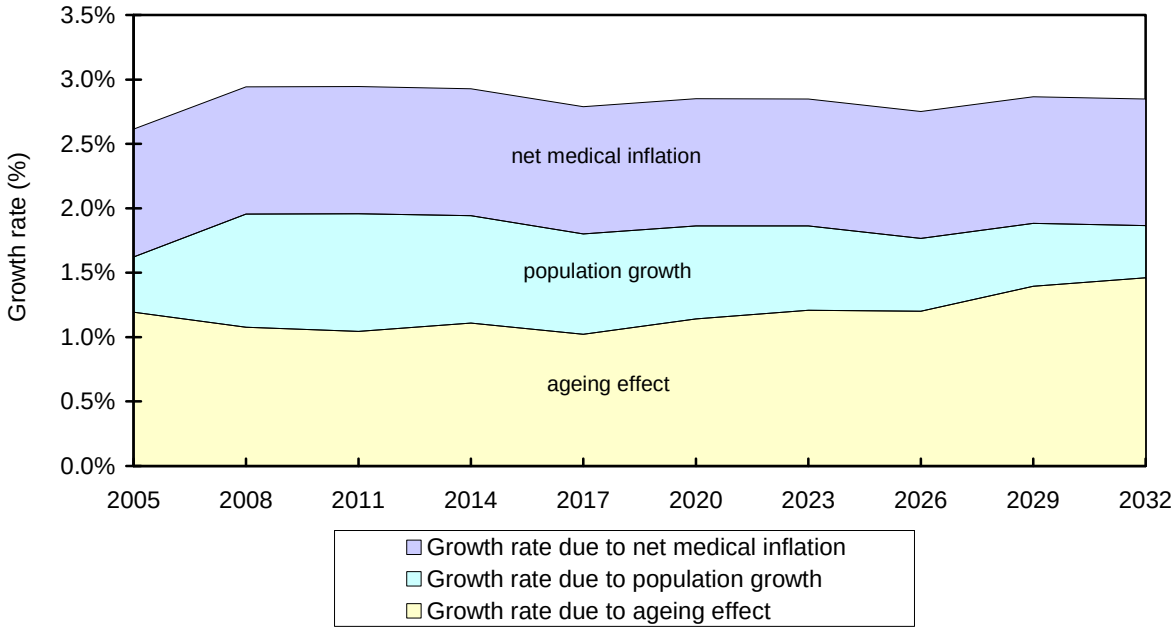
Figure 1.6 ***Without reform, Hong Kong's health expenditure will take an increasing share of our GDP***

Projected growth of health expenditure (total, public, private) in percentage of GDP



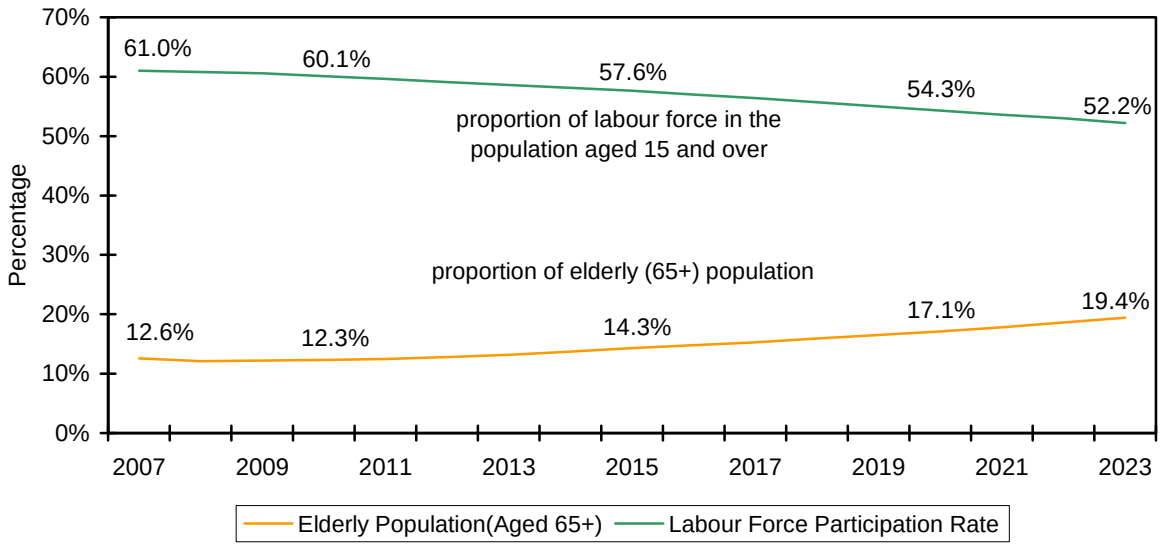
Source: Hong Kong's Domestic Health Accounts: Financial projection of Hong Kong's total expenditure on health from 2004 to 2033.

Figure 1.7 ***Without reform, demographic changes and medical inflation will drive Hong Kong's health expenditure to increase rapidly***
Projected growth rate of public health expenditure (on top of per capita real GDP growth) due to net medical inflation, population growth and ageing effect



Source: Hong Kong's Domestic Health Accounts: Financial projection of Hong Kong's total expenditure on health from 2004 to 2033.

Figure 1.8 ***Without reform, the burden of financing future healthcare for a growing elderly population will fall on a shrinking workforce***
The percentage of elderly population and labour force participation rate in Hong Kong, 2007-2023



Source: Hong Kong Population Projections 2004-2033, Census and Statistics Department; and 2003-based Projection for Labour Force Participation Rate 2004-2023, Census and Statistics Department.

Weaknesses of Existing System

1.3 In *"Building a Healthy Tomorrow"*[3], we have also identified the following structural weaknesses in the current healthcare system –

(a) **Insufficient emphasis on holistic primary care**: effective primary care can often improve the health of individuals in the community, and reduce their need for more expensive medical services especially specialist and hospital services. However, holistic primary care, especially preventive care and wellness promotion, is not sufficiently emphasized at present. Most patients seek and private doctors provide mainly curative care on an episodic basis. Few private practitioners offer comprehensive primary care including preventive care based on the family-doctor model. The concept of preventive care and wellness promotion such as assessment of health risks, screening and surveillance of health problems, health education and healthy lifestyle promotion is left to individuals and private doctors to pursue and is not extensively practised in the community. The current culture has impeded the development of an effective primary care system that can help to improve the overall health of the population, contain its curative healthcare needs, reduce reliance on hospital care, and improve the efficiency of the healthcare system as a whole.

(b) **Over-reliance on the public hospital system**: the public hospital system provides a comprehensive range of quality services (in-patient and specialist out-patient services) at very low fees (about 95% subsidies). At present, the public rely heavily on the public hospital system, which provides over 90% (90.8% in 2006) of all in-patient services (in terms of bed-days)[4]. The high subsidization rate and quality healthcare services offered by public hospitals continue to channel patients into the system, resulting in overstretched public hospitals as well as ever longer waiting lists and waiting time for services despite the fact that actual public health expenditure has grown by more than 2.8 times in real terms between 1989-90 and 2004-05.

(c) **Significant public-private imbalance**: the share of public hospital services is expected to continue to increase if the current system remains unchanged, even while private ambulatory care providers account for the majority of health expenditure on out-patient services. The significant

[3] Discussion paper issued by the Health and Medical Development Advisory Committee (HMDAC) in July 2005 on the future service delivery model of our healthcare system.

[4] Source: Data from Hospital Authority and private hospitals.

imbalance between public and private healthcare services means there is very limited competition between the two sectors. There is in effect very limited choice of services too: on the one hand, the 95% subsidized public services, offering little or no choice[5], is available to all; on the other hand, the unsubsidized but more readily available private services are accessible only to those who could afford the personalized choice over doctors, carers, treatments and amenities. Some patients who prefer and are in a better position to afford private sector services may be deterred from choosing such services due to the potential financial risk, sometimes unknown at the outset, unless they have substantial financial means or are adequately insured. This structure of the system offers little scope and incentive for the two sectors to collaborate, and is not conducive to better utilization of resources and further improving the quality and efficiency of services in both sectors.

(d) **Limited continuity and integration of care**: healthcare is a continuous process. The continuity of a long-term relationship between patients and their primary care doctors is essential to ensuring and improving the quality of care offered to patients. Interface and integration of healthcare at different levels of care, i.e. between primary care and hospital care, as well as communication of the primary care doctor with care-providing specialists and hospitals in both the public and private sectors, are crucial in ensuring timely, appropriate and efficient care for their patients. However, little emphasis is currently placed on the continuity of relationship between the primary care doctor and the patient, and also on the interface and integration of different levels of healthcare. This is mainly because of the current culture of over-emphasizing quick cure for illness and the tendency of patients to switch between doctors. There is much room for improving the interface, collaboration and integration between different parts of the healthcare system, which are essential for providing better quality of care.

Resultant Shortcomings of the Existing System

1.4 There are already signs that the above challenges and weaknesses are adversely affecting the current health system and resulting in the following complaints –

[5] Public hospitals essentially offer only one standard level of service accessible by all members of the public through the same waiting list, where timing of treatment is subject to queuing and triage, and depends on availability of services, with little choice over level of amenities and other ancillary services, and effectively no choice on the service-providing healthcare professional.

(a) **Long waiting time for public services**: the long waiting time for public medical services have long been a source of complaints, given the lack of accessible and affordable alternatives especially in the current private market for specialist and in-patient care. For instance, the notional waiting time in 2006 for the specialties of Surgery, Medicine, Psychiatry and Paediatrics was 31, 20, 14 and 10 weeks respectively.

(b) **Limited alternative choice to public services**: under the current system, the only alternative for those who do not want to wait on the long queues for public hospital services is to turn to unsubsidized private hospital services, which may entail relatively expensive charges and significant financial risks. Some patients may get some financial relief from employer-provided medical benefits or individual medical insurance, but often without adequate coverage – the former are not portable between employments and may be subject to the financial situation and discretion of the employer, while the latter could be unaffordable especially for the high-risk groups (e.g. the chronically-ill and the elderly).

(c) **Present safety net cannot cater for middle-income families**: the fee waiver mechanism and other financial assistance schemes under the current public hospital system serve primarily as safety net for the low-income families and under-privileged groups. The current safety net does not provide sufficient coverage for the middle-income families with patients having complex illnesses (e.g. catastrophic or chronic illnesses) that entail lengthy or costly treatment (e.g. chronic drugs or surgical consumables not covered by standard services). The sudden drain on a family's finances due to healthcare can lead to severe deterioration of the financial condition of these families within a short time, and the problem would be aggravated if the costly treatment has to continue for a long time.

The Consequences of Status Quo

1.5 Without undertaking fundamental reform of the healthcare system and improving the health of the population, the public healthcare system will not be sustainable. An immediate and readily felt consequence is the decline in the service level and quality of public hospitals. It is estimated that the continued growth in service demand could result in the following consequences for public healthcare if prompt action is not taken to improve the present system –

(a) **Waiting list and time for specialist out-patient services will continue to lengthen**: the notional waiting time for new cases of specialist out-patient

services is expected to triple by 2012. For example, the new case notional waiting time for Surgery at present at 31 weeks is expected to increase to 96 by 2012. The interval between follow-ups for old cases is also expected to increase significantly. For example, the follow-up interval would increase from 12 weeks in 2006 to 16 weeks by 2015 for Oncology specialty, 16 weeks in 2006 to 20 weeks by 2015 for Medicine specialty, and 26 weeks in 2006 to 37 by 2015 for Surgery specialty. The utilization by the elderly will increase from 1.9 million consultations at present to 2.4 million consultations in 2015.

(b) **In-patient wards will become more over-crowded and ward conditions will deteriorate**: the occupancy rate of public in-patient wards for a number of major specialties, including Medicine, Oncology, Orthopaedics and Infirmary, is expected to reach congestion (over 90% occupancy rate) within the next three years. The occupancy rate of public in-patient wards is expected to reach saturation (100% occupancy rate) by 2012 for Medicine specialty, and by 2015 for Oncology specialty. The utilization by the elderly will increase from 3.6 million bed-days at present to 4.4 million bed-days in 2015. For acute medicine, it is expected that the demand will outgrow supply such that no hospital bed would be available for 6,000 patients in 2015.

(c) **Waiting list and time for special services will continue to lengthen**: the waiting list and time for a number of special services are projected to increase significantly. For example, there would be around 22% or 2,000 patients by 2015 who might not receive sufficient renal replacement therapy (for instance haemodialysis) in public hospitals. The waiting time for non-urgent surgery would also lengthen significantly, e.g. the notional waiting time for cataract surgery is expected to increase from 33 months in 2006 to 75 months in 2015, the notional waiting time for benign prostatic hyperplasia surgery (a surgery for a common problem with the prostate) is expected to increase from 24-36 months in 2006 to 48-60 months in 2015.

(d) **Cannot sustain investment in healthcare facilities and equipment**: limited resources would constrain the ability of the public healthcare providers to upgrade or replace obsolete or expiring equipment and facilities within the usual equipment lifecycle of 10 years. This is expected to result in disruptive services and prolonged waiting time due to equipment breakdown, and compromise reliability, safety and diagnostic accuracy.

(e) **Cannot keep up with proven new medical technology (new drugs and procedures)**: prolonged under-investment would result in certain new technology for treatments and drugs becoming inaccessible or unavailable, leading to declining level and quality of public healthcare services in general. The Government will continue to allocate resources for public healthcare to alleviate these situations. However, the increase in resources for the public healthcare system will only defer but not resolve the problems, and sooner rather than later the increased resources will be outstripped by demand, unless we further increase the resources at the expense of other public services.

1.6 If we do not reform the current healthcare system and its financing arrangements, and we need to meet the increasing public health expenditure by the public purse to avoid the level and quality public healthcare services from deteriorating, either of the following situations will happen –

(a) **Rising tax bills**: if the extra funding required to meet public health expenditure is to be funded fully by government revenue, it is estimated that total public expenditure would have to be expanded to 22% of GDP by 2033. To fund such a required increase in public expenditure could mean substantial increase in Salaries Tax and/or Profits Tax. This would depart from the principle of small government and low-tax regime, and erode Hong Kong's economic competitiveness; or

(b) **Reduced funding for other public services**: if total public expenditure is to be kept below 20% of GDP, public health expenditure will increase from 14.7% of total public expenditure in 2004 to 27.3% in 2033, at the expense of funding for other public services (e.g. the share of funding for education, social welfare or security, which account for some 23.8%, 17.6% and 11.8% of recurrent government expenditure in 2008-09, may have to be reduced).

1.7 Without undertaking fundamental reform to address the rising healthcare needs and structural challenges to the healthcare system, and to improve the health of the community and reduce our reliance on hospital care, even if the Government could further increase its funding for healthcare within the limits of its budget, the increase would still be outstripped by healthcare needs sooner rather than later.

The Time for Reform is Now

1.8 **It is clear that maintaining the status quo is not a sustainable option.** To ensure the long-term sustainability of the healthcare system to provide quality

healthcare services to meet the increasing needs of the community in future, we must embark on fundamental reforms to both the service delivery and financing arrangements of the healthcare system in a comprehensive manner. If we do not take any action, we shall be depriving the public and our future generations of the chance to enjoy better and more sustainable healthcare services. We also have to bear in mind that it takes time to implement the reform measures, to build the right infrastructure to support the reform, and for the reform measures to take effect. **We must therefore act now.**

Chapter 2 ENHANCE PRIMARY CARE

Importance of Primary Care

2.1 Primary healthcare is an integral part both of an economy's health system and of the overall social and economic development of the community. While no uniform and universally applicable definition of primary healthcare exists, primary healthcare is usually taken to mean the first point of contact individuals and the family have with a continuing healthcare process and constitutes the first level of care in the context of the healthcare system. It is the base upon which the rest of the healthcare system is organized. Primary medical care (or primary care in short) refers to the medical part of primary health care which is the first contact of patients with their consulting doctors.

2.2 Studies[6] including those in advanced OECD economies have shown that stronger primary health care results in better health of the population at lower cost and greater user satisfaction. Evidence also suggests that enhanced primary care can reduce the demand for expensive, specialist-led hospital care, thereby reducing healthcare cost and increasing efficiency of the healthcare system. By providing continuous and comprehensive care as well as serving as a gateway to other parts of the healthcare system, primary care have other benefits such as less hospitalization, less utilization of specialist and emergency services, and less chance of being subjected to inappropriate health interventions. In contrast, frequent direct access to specialists without first using primary care doctors often reduces the appropriateness of care and increases healthcare costs.

Primary Care in Hong Kong

2.3 Currently, primary medical care is predominantly provided by the private sector, by solo practitioners or group practices, mainly on out-patient curative care with some preventive elements. The public sector on the other hand is responsible for general health promotion and education, diseases prevention and control, as well as preventive healthcare services for certain targeted groups (pregnant women, infants and children, students, with partial coverage for women and the elderly) through services offered by the Department of Health (DH). The Hospital Authority (HA) also provides primary curative care through general out-patient clinics (GOPCs) mainly to the low-income, chronically-ill and poor elders.

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[6] See Atun R (2004), *What are the advantages and disadvantages of restructuring a healthcare system to be more focused on primary care services?*, Regional Office for Europe, World Health Organization, for a summary of related findings.

2.4 Primary care is not just about the curing of episodic illnesses, but should provide lifelong (continuous), comprehensive and holistic (whole-person) healthcare to individuals in their home environment. It puts emphasis on preventive care, the promotion and protection of well-being, as well as the improvement in the quality of life through holistic care. This contrasts with the common practice in Hong Kong where most patients seek and private doctors provide mainly curative care on an episodic basis. At present, the offer of comprehensive primary care including preventive care based on the family doctor model is not common.

2.5 Most people in Hong Kong do not have the habit of seeking preventive care and are not provided with very good access to primary preventive care either. The Population Health Survey conducted by DH in 2003-04 shows that only 23% of persons aged 15 and above have regular physical check-ups. Even for those who do go for check-ups, the emphasis is very often on "detection of diseases" rather than comprehensive and holistic assessment or tailored investigations and health advices. While seeking curative care, it is not very common for the public to seek also preventive services as part of the consultation such as screening for risk factors, detection of early symptoms and signs of disease, and corrections of health risks. Health education and promotion is often perceived as the sole responsibility of the government.

2.6 Apart from the lack of emphasis on preventive care, our current primary care also needs strengthening in its role as the gateway for healthcare. As the first contact point, primary care doctors should be responsible for the screening and assessment of medical conditions to see if they could be dealt with in the primary care setting or if further intervention is necessary. If another level of care is deemed necessary, the primary care doctors should serve as the gateway for advising and directing patients for necessary and appropriate healthcare including specialist and in-patient care. Primary care practitioners should also assume the role of managers of care and long-term providers of holistic care to patients, including necessary preventive care, health risk assessment, as well as follow-up care after medical conditions of patients have stabilized and after discharge from hospitals. As most people in Hong Kong do not have a family doctor, they have little access to such a level of care.

Enhance Primary Care

2.7 We have set out in *Building a Healthy Tomorrow* our vision for our future healthcare system featuring a robust primary care system at its foundation –

(a) A population which is knowledgeable about health and health risk factors, where the general public can and will adopt a healthy lifestyle, and take responsibility for their own health; and a healthcare profession that views health promotion and preventive medicine as priorities, and exercises its practice professionally and ethically.

(b) A primary medical care system that can provide a good family and community medicine service affordable to all whilst incorporating strong elements of health promotion and preventive care, with standards set for the care of different age groups and health status.

2.8 To strive towards our vision, we have recommended in *Building a Healthy Tomorrow* the following ways to improve the healthcare system –

(a) Promoting the family doctor concept which emphasizes continuity of care, holistic care and preventive care.

(b) Putting greater emphasis on prevention of diseases and illnesses through public education and through family doctors.

(c) Encouraging and facilitating medical professionals to collaborate with other professionals to provide co-ordinated services.

2.9 Our proposals to implement the above recommendations are as follows –

(a) **Develop basic models for primary care services**: to develop service models with emphasis on preventive care as the basic standard for comprehensive primary care services for different age/gender groups, for reference by both doctors and patients in both the public and private sectors.

(b) **Establish a family doctor register**: to register private doctors who serve as family doctors and provide comprehensive primary care to patients.

(c) **Subsidize patients for preventive care**: to subsidize individuals of different target age/gender groups to undertake preventive care with reference to the basic models through family doctors in the private sector, requiring a certain level of co-payment in line with the principle of health as a shared-responsibility and to prevent abuse.

(d) **Improve public primary care**: to enhance public primary care services for the low-income families and under-privileged groups through exploring various models of public primary care, including purchase of general out-patient services from the private sector, and to provide more comprehensive public primary care by incorporating elements of preventive care alongside curative services provided by general out-patient clinics (GOPCs). Primary care and community-based healthcare should be appropriately interfaced and integrated with other social services for the under-privileged and the elderly.

(e) **Strengthen public health functions**: to continue to strengthen public health education, healthy lifestyle promotion and disease prevention provided by the Department of Health (DH). DH should also strengthen its role in the development and standard-setting of primary care services to ensure the quality and standards of such services.

2.10 These recommendations are elaborated in the following paragraphs.

Develop Basic Models for Primary Care Services

2.11 To promote primary care especially preventive care, we propose to develop in conjunction with the medical profession basic models of primary care services for different age/gender groups. The basic models, with emphasis on preventive care, should aim at providing the public as well as the healthcare professions a reference on what a comprehensive range of primary care services should cover. Through developing and promoting the basic models among the public and healthcare providers, coupled with other reforms to the service delivery model for primary care, we hope to bring about a paradigm shift that would put a much greater emphasis on preventive care.

2.12 The basic models should cover essential elements of primary care including assessment of health risks, surveillance and screening of health problems, health education and healthy lifestyle promotion, primary prevention and curative services. More specifically, we believe that the basic models should be developed on the basis of the following guiding principles –

(a) **Life-course approach**: the models should cover every stage during the lifespan from first born to old age, and devise appropriate primary care services including preventive care for each stage of life.

(b) **Holistic health**: the models should take into account not only physical health, but also psychosocial, emotional, behavioural, developmental and functional health.

(c) **Essential**: the models should include services essential not only for prolonging life but also for functional independence, with the aim of attaining optimal health outcomes and ensuring a healthy life with quality.

(d) **Evidence-based**: services included in the models should be based on empirical evidence (local and/or international data) on their efficacy, efficiency and cost-effectiveness.

(e) **Need- and risk-based**: services in the models should be provided based on professional assessment of need having regard to risks, and intervention including screening tests must be preceded by assessment.

2.13 The basic models of primary care services should be supported by specific clinical protocols developed for use by healthcare professionals involved in delivering primary care. These clinical protocols would cover services included in the models, referral of patients for appropriate healthcare in other parts of the healthcare system or with other healthcare professionals, as well as follow-up of patients post-discharge or after specialist or other referred healthcare. Involvement of the healthcare professionals in the development of these protocols is essential. We therefore intend to engage the medical profession and other healthcare professions in developing the basic models and the clinical protocols for primary care services.

Establish a Family Doctor Register

2.14 Family doctors can come from diverse backgrounds. A family doctor can be a general practitioner, a family medicine specialist, or any other specialist. To help the public identify those who are practicing as family doctors from those who would like to pursue a practice in other specialty areas, and to provide patients with adequate information that will facilitate them to choose the provider, we propose to establish a **family doctor register** with the following features –

(a) **Information for patients**: the register should contain relevant information about the family doctors such as their qualifications, training they have undergone, their experience, as well as any other information that may be relevant to the services they offer, e.g. addresses, opening hours, availability of service outside normal hours, contact arrangements in case

of emergency, availability of and form of backup arrangements in case of absence. Such a register would not only facilitate individuals in choosing their primary care providers who can serve them as family doctors, but also provide the public with a concrete idea of a family doctor practice.

(b) **Training and qualification requirements**: initially all registered medical practitioners who are practicing in Hong Kong and providing family doctor service or willing to provide family doctor service may register as family doctors. For the future, we believe it is imperative that registered family doctors should undergo continued professional training and medical education, especially in the field of family medicine. We therefore recommend that appropriate training requirements and qualification milestones for registered family doctors to remain on the register be set in order to promote the continuous enhancement of quality of primary care.

(c) **Accessibility and back-up arrangements**: family doctors should be encouraged to provide patients with out-of-hours access especially in cases of urgency. To ensure uninterrupted access to family doctor service by patients, private doctors should be encouraged to provide mutual support in service provision, and doctors who register as solo practitioners should be required to make back-up arrangements in the event that they take absence from practice.

(d) **Sharing health records**: to enhance continuity and integration of care, especially between family doctors, specialists and hospitals in the referral of patients, family doctors should share their patients records with relevant parties subject to their patients' consent, and should make use of the future electronic health records (eHR) sharing infrastructure to be developed (see Chapter 4).

2.15 We propose that the establishment of a family doctor register be further developed through a working group with the involvement of the medical professions in the public and private sectors as well as other stakeholders.

Subsidize Patients for Preventive Care

2.16 To encourage the provision and uptake of comprehensive and quality primary care, the Government is prepared to consider providing subsidies for individuals to receive preventive care in the form of primary care voucher. The

provision of subsidization through primary care voucher should be considered on the basis of the following principles –

(a) **Protocol-based**: the preventive care services to be subsidized must be based on clinical protocols for different age and gender groups and should be provided on the basis of need and risk assessment. The clinical protocols to be developed under the basic models for primary care will be the reference.

(b) **Age/gender/disease group-based**: as individuals of different age, gender or disease groups may require different types and levels of preventive care, the subsidy levels should be set differently for individual groups, e.g. the level for the elderly should generally be higher.

(c) **Through family doctors**: the provision of comprehensive primary care requires a long-term continuous relationship between a patient and his family doctor. The subsidized preventive care should therefore be obtained through family doctors on the family doctor register.

(d) **Co-payment required**: the subsidy is not intended to subsidize the full cost of preventive care, and a certain level of co-payment should be required to encourage appropriate and judicious use of preventive care services and to reflect that health is a shared-responsibility.

(e) **Secondary prevention**: the subsidy should also cover secondary prevention which includes post-discharge care since this is also an important part of preventive care, especially in maintaining the health of patients with chronic diseases as well as minimizing their risk of suffering from other complications and their need for re-admission to hospitals.

(f) **Not for curative care**: the subsidy is not intended to cover curative services for episodic illnesses. An appropriate monitoring mechanism will need to be put in place (e.g. through the introduction of an electronic health record (eHR) system, see Chapter 4) to ensure that the subsidy is directed towards preventive services.

(g) **Initial health assessment and screening**: in principle the subsidy should cover initial health assessment and screening. Further investigation or treatment of health problems should generally be paid for through the patient's own means.

2.17 We will further develop the concept of a primary care voucher scheme and the implementation details in the light of the experience of different pilots to test the feasibility of such a scheme.

Improve Public Primary Care Services

2.18 Over the past few years, the services of GOPCs have been gradually enhanced with initiatives such as introducing elements of family medicine with the setting up of family medicine specialist clinics alongside certain GOPCs. We reaffirm the current policy that the **general out-patient services of HA should continue to be made available to the low-income families and under-privileged groups to provide a safety net of primary care services** for these groups. To provide more comprehensive and holistic primary care services to these target groups, who may not be able to afford the co-payment required in the use of the proposed government subsidy to purchase preventive care services in the private sector, we see a need to enhance primary care provided by the public sector.

2.19 To this end, we propose the following –

(a) **Explore future public primary care models**: we will explore with HA and DH the future service delivery model for public primary care services for the target groups, having regard to the basic models of primary care services. In particular, we recognize that public-private partnership including purchase of primary care services from the private sector would offer opportunities for providing comprehensive primary care services to the target groups in an even more accessible setting, thereby improving the quality and enhancing the efficiency of publicly-funded primary care services. The further development of electronic health record sharing should facilitate better integration and collaboration of the public and private sectors in providing primary care services. We propose that such opportunities be explored as far as possible.

(b) **Incorporate preventive care in public primary care**: we propose that public primary care services provided by HA and DH should be enhanced and better integrated. In particular, preventive care services should be incorporated alongside existing curative care services in GOPCs, having regard to the basic models of primary care services. The aim is to make available the range of preventive care in the basic models to the target groups of GOPCs who may not be able to afford preventive care with family doctors in the private sector. To avoid double benefits, those receiving preventive care services at GOPCs would not be eligible for the

subsidy for preventive care services with private family doctors and vice versa.

(c) **Examine interface of primary care with social services for the under-privileged and the elderly**: primary care and community-based healthcare provided by the public sector form an important component in the whole spectrum of social services offered to the under-privileged and elderly population. We propose that the Government should take the lead in facilitating the establishment of necessary liaison networks between the relevant institutions and professionals at the district level, for the purpose of ensuring that primary care services and community-based healthcare services are appropriately interfaced and integrated with other social services provided to the under-privileged and the elderly population.

Strengthen Public Health Functions

2.20 To complement other proposals for enhancing primary care, we see a need to strengthen existing public health functions –

(a) **Enhance public health education**: public health education is an essential complement to enhancing primary care for the population. The Central Health Education Unit of the Department of Health has played a key role in formulating the direction of, and providing resources for, public health education. Such public health education functions should continue to be led and co-ordinated by the Government, with the engagement and co-operation of the private healthcare sector especially the family doctors.

(b) **Public health promotion through community involvement**: through the Department of Health, the Government should continue to strengthen the promotion of healthy lifestyles and the prevention of diseases. There should be greater involvement of healthcare professionals in the private sector, especially family doctors who would have a much more direct and continuous relationship with individual patients, as well as other non-government organizations in the community which would also have their established networks within the local community.

(c) **Strengthen DH's role in primary care**: to facilitate the development of the primary care services in the private sector, as well as to ensure the quality and standards of such services, the Department of Health should focus on devising appropriate standards and protocols for various primary care services, and to promote and monitor the application of such standards

and protocols in the private sector. With the reform recommended for primary care, DH as the public health authority should increasingly focus on developing and setting standards for primary care services.

Chapter 3 PROMOTE PUBLIC-PRIVATE PARTNERSHIP IN HEALTHCARE

Benefits of Public-Private Partnership

3.1 Public-private partnership (PPP), which brings together the resources and expertise from both the public and private sectors, is becoming increasingly popular in many advanced economies. We believe that it is also worth pursuing in Hong Kong as it will not only help redress the mentioned imbalance between public and private healthcare services, but will, more importantly, result in an overall improvement in the quality of care for patients, make better use of the resources available in the community, and facilitate training and sharing of experience and expertise, thus helping to ensure sustainability of the healthcare system. The benefits of PPP are explained in the following paragraphs.

Achieve Savings and Enhance Cost-Effectiveness

3.2 We note from examples overseas that the purchase of services at a lower cost from the private sector under negotiated bulk contracts can often achieve savings and enhance cost-effectiveness. The service contract must, however, set the standards and ensure quality of service. Public hospitals can then focus more on its priority services such as acute cases and the treatment of complex illnesses (e.g. catastrophic or chronic illnesses) requiring costly treatment. This would relieve the service demands on public hospitals, while leaving the private sector more room to develop. In the case of sharing facilities between co-located public and private hospitals, both would achieve cost savings and the patients would enjoy a reduction in fees.

Enable the Optimal Use of Human Resources

3.3 Healthcare human resources are costly and medical and healthcare professionals take time to train. PPP models would enable the community to make fuller use of human resources in the private sector to deliver service for public sector patients. This is particularly beneficial for patients when public sector human resources are stretched to the limit and cannot meet the demand in time. Similarly, engaging private sector doctors to practice in public hospitals on a part-time basis also helps to relieve resources demand and encourage continuing enhancement of service quality in both sectors.

Facilitating Cross-Fertilization of Expertise and Experience and Promoting Healthy Competition and Collaboration

3.4 The involvement of the private sector in the setting up of medical centres of excellence and the engagement of private sector doctors in public hospitals would create opportunities for collaboration and cross-fertilization of experience between public and private sector medical professionals. This will facilitate skill transfer and cross-sector training. For the private sector, the increase in the number of patients and case volume would also be conducive to upgrading the skills and expertise of private healthcare professionals. At the same time, a more balanced spread of caseload of certain types of hospital services between public and private hospitals would create competition between the two sectors for service quality and standards. All these would be beneficial to patients of both the public and private sectors.

Possible PPP Models for Hong Kong

3.5 For primary care, we have proposed in Chapter 2 to purchase primary care services from the private sector, and to partially subsidize patients to undertake preventive care in the private sector. This is a form of PPP that makes use of the private sector's capacity to meet part of the service demand on the public sector. For secondary and tertiary care services, we believe that PPP should also be explored even though public hospitals will continue to expand and their services should be further improved.

3.6 PPP in secondary and tertiary care can take a variety of forms, with variations in financing, construction of facilities, and service delivery, etc. Some of the models commonly found overseas are developed to suit the specific needs of the relevant economies at the time. For Hong Kong's healthcare system, we believe the following PPP models would suit our developments in secondary and tertiary medical services –

(a) **Purchase of hospital service from the private sector**: services which are in the lower priority areas of the public healthcare system such as elective procedures can be purchased from the private sector where –

  (i) the cost of such purchase is lower than providing the service direct by public hospitals;

  (ii) there is a long waiting list and only limited capacity in public hospitals to provide the service; and

(iii) while purchasing services from the private sector, however, public hospitals would retain sufficient caseload for training purposes.

(b) **Hospital development**: consideration should be given to pursuing PPP in hospital development in the future, which could take the form of co-location of public and private hospital facilities at the same site. Co-location would enable co-ordinated planning and avoid duplication of equipment and facilities. It also enables mutual purchase of services and sharing of supporting services, e.g. diagnostic services and facilities.

(c) **Setting up of multi-partite medical centres of excellence**: a medical centre of excellence should draw together top expertise of the relevant specialty from both the public and private sectors, including the academia, as well as from both within and outside the territory.

(d) **Engaging private sector doctors in public hospitals**: one option worth exploring is the engagement of private sector doctors to practice in public hospitals, particularly in tertiary and specialized services, on a part-time basis.

Way Forward on PPP

3.7 The Hospital Authority will conduct a pilot scheme of subsidizing public patients to undergo cataract surgeries in the private sector in order to reduce the waiting time for such surgeries in public hospitals. We are also exploring the feasibility of introducing PPP in the development of a hospital project in North Lantau and the setting up of multi-partite paediatric and neuroscience medical centres of excellence.

3.8 We propose to quicken the pace of PPP only after the completion of the cataract service pilot scheme for purchase of private sector service, and after prudent assessment of the feasibility of introducing PPP in the North Lantau Hospital project. For the purchase of service schemes, the role of purchaser rather than provider of clinical services is new to HA, and contracts involving the provision of such services have to be managed carefully to ensure that public money is well-spent. Care must also be taken to achieve a fine balance and not to attract patients who would have otherwise opted for private sector service to join the public service waiting list because they could use private sector services at a subsidized rate by so doing.

3.9 In PPP hospital development projects, land is involved and arrangements have to be put in place to ensure that the premium or rental charged for the use of such valuable public resources would be fair to both the private hospital concerned and to the community. As for engaging private sector doctors to work in public hospitals part time, HA is now contracting a small number of private sector doctors to address the shortage of human resources in some specialties. Where there is room for the engagement of more private sector doctors, more flexible arrangements will be considered to attract them to serve in public hospitals. The proposed centres of excellence have received general support and the projects will be taken forward after detailed plans have been developed in consultation with the parties involved.

Chapter 4 DEVELOP ELECTRONIC HEALTH RECORD SHARING

Better Access to Patient Records with Consent

4.1 In *Building a Healthy Tomorrow*, we recommended that, in order to facilitate the best use of resources and provide the framework necessary for the transition of patients between different levels of care and between the public and private sectors, it is essential to develop a system which enables better access to patients' records with the patients' consent. Our long-term vision is to develop a territory-wide information system for healthcare professionals in both public and private sectors to enter, store and retrieve patients' medical records, subject to authorization by the patients.

4.2 While there is no universally applicable definition, an electronic health record (eHR) usually refers to a record in electronic format containing health-related data of an individual stored and retrieved for healthcare-related purposes. An eHR encompasses general personal particulars (e.g. name, identification, date of birth, contacts, insurance enrolment, organ donation preference, etc.), personal health-related information (e.g. weight, height, blood type, diet, exercise habits, smoking habits, etc.), as well as medical records (e.g. diagnosis, prescriptions, test results and discharge summary), from different sources and locations. An eHR system coordinates the storage and retrieval of, as well as access to, individual eHR electronically.

Objectives of eHR Sharing

4.3 The development of a territory-wide eHR system is fundamental to enhancing continuity of care as well as better integration of different healthcare services for the benefits of individual patients. It also facilitates the implementation of various reforms including enhancement of primary care in both the public and private sectors as well as development of public-private partnership in provision of services.

4.4 To achieve our long-term vision, the Government will take the lead in the development of a territory-wide eHR sharing infrastructure, with a view to achieving the following objectives –

(a) **Improve Efficiency and Quality of Care**: by providing healthcare professionals with timely access to comprehensive medical information of patients, and enhance cost-efficiency by minimizing duplicate investigations and treatments.

(b) **Improve Continuity and Integration of Care**: by providing family doctors with access to lifelong health records of individual patients for holistic care and facilitating referral and follow-up of cases between different levels of care.

(c) **Enhance Disease Surveillance**: by allowing prompt provision of anonymous data for disease surveillance and by facilitating the compilation of health statistics to support policy formulation and conducting of researches for medical purposes.

(d) **Redress Public-Private Imbalance**: by enabling patients to freely choose between public and private services without worrying about the transfer of their medical records, and facilitating other public-private partnership in healthcare.

Progress to Date

4.5 To achieve the above, the Secretary for Food and Health has appointed a Steering Committee on Electronic Health Record Sharing (the Steering Committee), chaired by the Permanent Secretary for Food and Health (Health) and comprising members from the healthcare professions in both the public and private sectors, in order to provide the steer, build consensus and gather expertise for the initiative. The Steering Committee aims at devising a strategy and plan for the overall development of a territory-wide eHR system for the sharing of health records of individuals within the healthcare system subject to conditions such as the record subjects' consent. To take forward the initiative, the Steering Committee has set out a number of guiding principles. It has also identified a number of fundamental issues relating to the development of an eHR sharing infrastructure, such as its institutional set-up, the legal implications and privacy concerns, as well as its technical standards etc. It has therefore set up three working groups to specifically address these issues.

4.6 The development of a territory-wide eHR system is a long-term initiative involving significant changes in both the public and private sectors. Lessons of similar initiatives in other economies have taught us that it is not just an IT project involving substantial investment in software development and hardware deployment, but also, and indeed more importantly, a process of re-engineering requiring significant changes in the mindset of healthcare providers and their way of delivering healthcare. The initiative will thus have to proceed step-by-step with the engagement of the healthcare professions from the outset. It will not be a

single one-off project but rather a series of co-ordinated projects and the eHR system will be under continuous development and evolution.

Way Forward on eHR Sharing

Overall Work Programme

4.7 The current plan of the Steering Committee is to put forward in 2008 its initial recommendations for a work programme including pilot projects that would pave the way for the ultimate goal of developing a territory-wide eHR sharing infrastructure. The recommendations are intended to cover the overall strategy for the further development of the eHR system in both the public and private sectors, and the necessary components to enable eHR sharing between different healthcare providers especially between public and private sectors. The recommendations will also include the way forward on institutional arrangements, legal framework as well as technical standards.

Financing for the eHR System

4.8 The development of the eHR system especially the sharing infrastructure would require substantial capital investment for development as well as recurrent cost for operation. The continued development and upgrading of the eHR system would also require future re-investment. The sustainability of such a system would thus require sorting out the financing for the system, both for the initial start-up cost as well as long-term operation and re-investment.

4.9 To kick-start the initiative, the Government will consider financing the capital cost for the development of the eHR sharing infrastructure, as well as to make available existing systems and know-how in the public sector at minimal or no cost for further development and deployment in the private sector. We will also consider other possible capital financial assistance to facilitate the deployment of eHR system in the private sector, specifically for private healthcare providers who are involved in various public-private partnership initiatives including those who are providers of purchased services (e.g. doctors who provide primary care purchased by the Government from the private sector), other publicly subsidized healthcare (e.g. family doctors who provide preventive care subsidized by the Government), as well as shared care programmes (e.g. shared care of chronic patients between public hospitals and private doctors).

Public Education on Health Record Sharing

4.10 At present, not all patients are aware of their right to access their own health records and the benefits of health record sharing. For the eHR system to be successful and gain community support, the public and private sectors should collaborate in doing more public education on the advantages of sharing of health records, and the benefits of an eHR system with sharing capabilities. We will continue to consider ways to promote the benefits of health record sharing and instil a patient-oriented culture of sharing patients' records for the purpose of better healthcare.

Chapter 5 STRENGTHEN PUBLIC HEALTHCARE SAFETY NET

The Public Healthcare Safety Net

5.1 The current public healthcare system serves as an essential safety net for the population, especially those who lack the means to pay for their own healthcare. We need to improve the existing safety net provided by the public healthcare system, in order to maintain and improve the coverage and quality of healthcare services provided for those in need. In particular, we must continue to maintain our long established policy that no one should be denied adequate healthcare through lack of means by ensuring that the public healthcare system can continue to serve those who cannot afford private healthcare services.

5.2 To do so, the Government will continue to provide highly-subsidized public healthcare services to the population. The current fee waiver mechanism and other financial assistance schemes for certain self-financed drug items (SFIs) and privately-purchased medical items (PPMI) through the Samaritan Fund will continue to be available as a safety net for CSSA recipients and low-income families as at present. We will consider streamlining the current fee waiver mechanism and other financial assistance schemes with a view to rationalizing and simplifying the application and administration procedures for those in need.

5.3 If we can successfully reform the current market structure and financing arrangements to effectively reduce the pressure on the public healthcare system, we envisage that there should be room for improving the safety net under the public healthcare system, in terms of both coverage and quality of services. Our proposals for improving the public healthcare safety net are set out in the ensuing sections.

Improve the Public Healthcare Safety Net

5.4 If pressure on public hospitals is reduced and resources in the public healthcare system are freed-up, we may consider improving services in the public healthcare system in the following ways –

(a) **Reduce waiting time of public hospital services**: the freed-up resources could be used to reduce waiting time of existing services (e.g. queues for specialist out-patient services). This could be done either through strengthening the existing services provision after the demand pressure on services has been reduced, or through using the extra resources to purchase

services from the private sector (see Chapter 3 on purchase of services as part of public-private partnership).

(b) **Improve the coverage of standard public services**: the current drug formulary as well as the lists of self-financed items or privately-purchased medical items are reviewed from time to time. The freed-up resources would allow room for further improvement to the coverage of these drugs and items. Certain items whose effects are proven can be considered for inclusion as standard services, or be subsidized for patients.

(c) **Explore the idea of a personal limit on medical expenses**: The freed- up resources would allow public hospitals to procure new equipment, to upgrade or replace existing equipment with a view to improving services. Freed-up public hospital resources would also provide room for considering improvements to the current safety net and financial assistance mechanisms, for instance, by catering more to the needs of families with patients struck by complex illnesses (e.g. catastrophic or chronic illnesses) requiring costly treatment. We may explore the idea of introducing a limit on medical expenses for individual patients as part of the safety net mechanism to protect these families against financial ruin. The concept is to set a limit on the proportion of annual household income spent by a family for secondary healthcare in public hospitals, beyond which financial assistance would be provided. Depending on views received during the public consultation towards the proposals, this concept of spending limit of medical expenses can be further developed.

(d) **Inject funding into the Samaritan Fund**: part of the freed-up resources can be injected into the Samaritan Fund as extra funding to finance those who need but lack the means to use certain medical treatment which are not included as standard services.

Rationalize Public Fee Structure

5.5 For reasons detailed in Chapter 9, we believe that it would not be feasible or desirable to rely on increases in fees and charges for public services as a means of providing a significant source of financing for healthcare. We believe that in parallel with improving the public healthcare safety net, there should be scope for reviewing the current fee structure for public healthcare services to ensure that they remain accessible and affordable. In this connection, we consider that any future review of fees and charges for public services should be undertaken based on the following principles –

(a) **Resource prioritization**: the structure and level of the fees should aim at targeting resources at priority service areas of the public healthcare system. In particular, the level of subsidization for different services should take into account the priority of the services.

(b) **Affordable services**: the fees should have regard to affordability of patients in general, having regard to both level of fees and frequency of utilization. The low-income families and under-privileged groups should be covered by the safety net mechanism for financial assistance.

(c) **Judicious and appropriate use**: the fees should be conducive to encouraging judicious and appropriate use of public healthcare services by patients, so as to ensure that services are accessible by and available to those in need.

(d) **Shared responsibility**: the fees should instil a sense of shared responsibility for health – the Government continues to provide a comprehensive healthcare safety net for the whole population, while individuals also take a share of responsibility for their own healthcare.

5.6 Irrespective of any rationalization, we expect public healthcare services to remain highly-subsidized overall and government funding will continue to be the primary funding source for the public healthcare system. In particular, we expect that the public healthcare system will have to continue to serve as an effective safety net by continuing to provide highly-subsidized healthcare services that entail high cost and pose huge financial risks to individuals beyond their means, such as the treatment of catastrophic illnesses and chronic diseases.

Chapter 6 REFORM HEALTHCARE FINANCING ARRANGEMENTS

Increasing Government Funding

6.1 The Government will continue to be the major financing source for healthcare and will uphold the treasured principle that no one should be denied adequate healthcare through lack of means. To meet the increasing healthcare needs of the community and for reforming the healthcare system, the Government is committed to increasing recurrent government expenditure for health and medical services from 15% to 17% of overall recurrent government expenditure by 2011-12.

The Need to Reform Financing Arrangements

6.2 Over the years, we have taken various measures to increase the efficiency and cost-effectiveness of the public healthcare system. Public healthcare services have sustained an efficiency gain of around 1% per year on average over the years. For example, the average in-patient length of stay in public hospitals has gradually been reduced from 10.0 bed-days in 2000-01 to 8.9 bed-days in 2006-07. As part of the Government's Enhanced Productivity Programme and Efficiency Savings Programme between 2000-01 and 2005-06, the Hospital Authority (HA) has also achieved efficiency savings of an aggregate total equivalent to 12% of its baseline subvention while maintaining services throughput. HA is also examining how to improve its internal resource allocation mechanism with a view to better allocating resources to meet services needs and to encourage efficiency and cost-effectiveness.

6.3 Looking forward, we will continue to take measures to enhance the efficiency and cost-effectiveness of the public sector as well as the healthcare system as a whole. These will include the fundamental and comprehensive service and market structure reforms set out in Chapter 2 to Chapter 4. However, even with increased government funding for healthcare and sustained efficiency enhancement of public healthcare services, government funding alone will not be sufficient to guarantee the sustainability of the healthcare system in the long run. Without reforming the healthcare financing arrangements, the increased government funding for healthcare is still expected to be outstripped by the projected healthcare needs of the community by around 2012.

6.4 The experience of other advanced economies also shows that total and public health expenditure may grow to as large as 8%-15% and 6%-8% of GDP respectively. It is not certain to what extent this experience is directly applicable to Hong Kong against our better record of containing public health expenditure and

enhancing efficiency of the healthcare system, but our projection based on this experience shows that our total and public health expenditure may grow to 9.2% and 5.5% of GDP respectively by 2033. It is thus clear that we need to reform the healthcare financing arrangements alongside the healthcare services.

Consequences of Maintaining Existing Financing Model

6.5 If we continue to maintain the existing financing model to finance public healthcare solely through government revenue, public expenditure on healthcare will have to increase at a much faster pace than the economy. As explained in Chapter 1, this could mean rising tax bills eroding Hong Kong's competitiveness or reduced funding affecting other areas of public services. If we increase tax rates, those within the tax net would have to contribute more towards maintaining the healthcare system. Given the narrow tax base for Salaries Tax and the progressive tax rates, only around one-third of the workforce pays Salaries Tax, and those with higher income contribute a higher proportion of their income than those with lower income.

6.6 Our analysis of the pros and cons of maintaining the existing financing model are set out in greater detail in Chapter 7. Based on the analysis, **we believe that maintaining the existing financing model is not a sustainable option**.

Introducing Supplementary Financing for Healthcare

6.7 With increased government funding continuing to be the major financing source, a solution to sustain financing for our healthcare system is to introduce supplementary financing for healthcare, to supplement government funding to cope with increasing healthcare needs, and also to sustain the following reform for the long-term –

(a) to continue to invest in better and more comprehensive primary care that improves the health of the community and reduces the need for more expensive hospital care in the long run;

(b) to continue to invest in newer and better medical technology that offer better diagnosis and treatment of illnesses and improve the quality of healthcare provided to our community;

(c) to support the reform of the healthcare market structure by enabling more individuals to be in a position to choose private healthcare and promoting healthy competition in quality and cost-effectiveness; and

(d) to strengthen the public healthcare safety net for those in need, and promote the concept of shared responsibility for improving health through partnership between the Government and individuals.

6.8 One thing is clear: supplementary financing is an essential component of the reform and concerns not only our present community but generations to come. What form the supplementary financing should take is thus an important decision to be taken by the community based on our societal values. Together we need to move towards a consensus on the form of supplementary financing for healthcare best-suited to the circumstances of Hong Kong, for the sake of both ourselves and our future generations.

Overseas Experience

6.9 We have examined the healthcare financing arrangements in a number of advanced economies. Different economies adopt different healthcare financing arrangements (see **Table 6.1**). These arrangements can broadly be classified by their financing sources and means into the following categories –

- General taxation
- Social health insurance
- Out-of-pocket payments (user fees)
- Medical savings accounts
- Voluntary private health insurance
- Mandatory private health insurance

6.10 The financing arrangements of all the advanced economies we have studied invariably involve a mix of the above financing sources in different proportion, and none amongst them adopts one single means as the sole source of financing. It is worth noting that –

(a) All the advanced economies we have studied have sales tax of varying degrees. In those economies where government revenue is the main source of healthcare expenditure, the applicable tax rates, especially personal income tax rates, are much higher than those in Hong Kong.

(b) Apart from those economies where government revenue is the main source of healthcare expenditure, regular contribution from individuals to healthcare on top of tax payment is common and takes the form of –

(i) social health insurance contributions;

(ii) private health insurance premium payments;

(iii) mandatory medical savings to be channelled into the healthcare system as payments of fees and charges for healthcare services; or

(iv) a combination of the above.

(c) Apart from the United States (where voluntary health insurance is the main financing source) and Singapore (where out-of-pocket payments, part of which is from medical savings accounts, are the main financing source), it is invariably the group in the population with higher income level and better means who contributes more, although in the case of mandatory private health insurance the contribution level (premium) within the contributing group is the same for all. What a contributor receives in return, however, differs among financing options. In economies where government revenue or social insurance is the main source of healthcare expenditure, the choices for "high-end contributors" are often the same as those who have not contributed. In the case of mandatory private health insurance (e.g. in Switzerland, which terms their system as "social insurance"), everyone contributes the same in return for the same basic insurance coverage, but those who can afford to contribute more voluntarily (e.g. by purchasing top-up insurance) will have more choices.

6.11 It is also important to note that there is no one-size-fits-all solution – the healthcare system of each economy has its own specific history and circumstances, reflecting its own societal values and its own specific solution. No one single model can be readily transplanted. There is also no magic or perfect solution – all financing arrangements for healthcare involve trade-offs between the pros and cons of different financing means, and ultimately it is each society's own choice, based on its own political, social and economic conditions, as well as the values and expectations of its members, as to what to gain and what to give up by adopting its own specific mix of financing arrangements.

Table 6.1 Comparison of Healthcare Financing Sources of Hong Kong and Selected Economies

Economy	General Taxation	Social Health Insurance	Out-of-Pocket Payments	Voluntary Private Health Insurance	Mandatory Private Health Insurance
Hong Kong	*	-	✓	✓	-
Australia	*	-	✓	✓	-
Canada	*	✓	✓	✓	-

Economy	General Taxation	Social Health Insurance	Out-of-Pocket Payments	Voluntary Private Health Insurance	Mandatory Private Health Insurance
Finland	∗	✓	✓	✓	-
United Kingdom	∗	-	✓	✓	-
Austria	✓	∗	✓	✓	-
Belgium	✓	∗	✓	✓	-
Japan	✓	∗	✓	✓	-
Korea	✓	∗	✓	✓	-
Netherlands	✓	✓	✓	✓	∗
Switzerland	✓	-	✓	✓	∗(Note 1)
United States	✓	✓	✓	∗	-
Singapore	✓	-	∗(Note 2)	✓	-

∗ Major financing source
✓ Supplementary financing source

Note:
1. The mandatory private health insurance is termed as a social health insurance under Swiss law.
2. Singapore adopts a medical savings accounts scheme as part of its Central Provident Fund Scheme to finance out-of-pocket payments for healthcare.

Supplementary Financing Options for Hong Kong

6.12 We have studied various possible options to provide supplementary financing for healthcare in Hong Kong, having regard to the experience of overseas economies. Each option has its own pros and cons and the choice between the options is very much a choice of the community reflecting its societal values. These options and their pros and cons are set out in detail in Chapter 8 to Chapter 13 –

(a) **Social health insurance (Chapter 8)**: to introduce an employment-based, income-linked contributory scheme to build up a common pool of funding for financing healthcare for the whole population. The contribution base can be wider than the tax net for Salaries Tax in Hong Kong, thereby enlarging the base for financing. Similar to tax, those with higher income will be required to contribute more under social health insurance towards healthcare for the whole population.

(b) **Out-of-pocket payments (Chapter 9)**: to increase user fees for public healthcare services thereby effectively reducing the level of subsidization. Only those who use public healthcare services would pay more; and the more one uses public healthcare services, the more one pays.

(c) **Medical savings accounts (Chapter 10)**: to introduce a mandatory scheme requiring savings (with the option to invest) by a specified group of the population to cover their own medical expenses (including insurance premium if they take out private health insurance), with a view to building up individuals' source of funding available for their own future healthcare and encouraging them to use healthcare services other than high-subsidized public sector ones, thereby reducing the pressure on the public healthcare system. One possible way of defining the specified group is by income level, i.e. those in the working population who are above a certain income level will have to participate in the scheme.

(d) **Voluntary private health insurance (Chapter 11)**: encourage individuals to take out voluntary private health insurance that provides more choices of and greater accessibility to private healthcare services, thereby reducing the pressure on the public healthcare system and in turn public health expenditure. The choice of taking out insurance is voluntary either by individuals for their own individually-purchased medical insurance or by employers as group medical insurance for their employees whilst they are under their employment.

(e) **Mandatory private health insurance (Chapter 12)**: to introduce a mandatory insurance scheme, on a population-wide basis or confined to a specified group, regulated by the Government and operated by private insurance companies. The insurance is regulated to offer no exclusion of medical conditions with guaranteed continuity, and charge community-rated premium (i.e. same level of premium for the same level of protection and the same variety of choices for all participants irrespective of age, gender, other risk factors, and income level) so as to ensure effective pooling and sharing of the healthcare risks for individuals. Those without the means may be assisted by the public purse (under the population-wide scenario) or may not be required to join (under the specified group scenario).

(f) **Personal healthcare reserve (Chapter 13)**: to introduce a scheme requiring a specified group of the population to deposit part of their income into a personal account, for both subscribing to a mandatory regulated medical insurance for protection before and after retirement, and for accruing savings (with the option to invest) to meet healthcare expenses including insurance premium after retirement. The scheme involves a combination of mandatory savings and insurance. The insurance premium for everyone in the group would be the same regardless of difference in income level, in return for the same level of protection and variety of

choices. The amount of savings, however, would differ among individuals according to income levels.

6.13 During this first stage consultation, we would like to set out all the supplementary financing options and engage the public and stakeholders in deliberating the pros and cons of these options. We have an open mind on the supplementary healthcare financing options to be adopted and would like to seek the views of the public through the first stage consultation, with a view to putting forward concrete recommendations in the second stage consultation.

Comparison between the Financing Options

6.14 Having regard to both local and overseas experience, we have assessed the pros and cons of the various financing options as supplementary financing for healthcare in Hong Kong. In particular, it is worth noting that each of these options has its own advantages and disadvantages, and inevitably involves a trade-offs in the following aspects –

(a) **Financial stability and sustainability**: to what extent the supplementary financing option can provide a stable and sustainable source of financing to supplementary government funding, meet the long-term needs of the community, and ensure the long-term sustainable development of the healthcare system (e.g. investment in new medical technology, training of professional manpower, continued improvement in quality of healthcare)?

(b) **Accessibility of healthcare**: the public healthcare system seeks to provide the community with equitable access to the same basic level and standard of healthcare based on needs, through queuing and triage or other allocation mechanisms as necessary. Should the supplementary financing continue to finance services under this arrangement? Or should it enable or facilitate more choice of and better access to services for those who can afford and reduce the queues for public healthcare services, thereby also benefiting those who have to rely on basic standard healthcare?

(c) **Pooling and sharing of risk**: should the supplementary financing option pool the financial risk arising from healthcare needs of individual members of the society, such that the risk of those with higher health risk (e.g. the elderly, those with chronic diseases, and those with hereditary illnesses) or struck by unfortunate events requiring healthcare (e.g. those struck by accidents or catastrophic diseases) can be effectively shared out among the population?

(d) **Wealth re-distribution**: bearing in mind that the funding allocated from the public purse to public healthcare services is already a form of wealth re-distribution, should the supplementary financing option further reinforce this by seeking a greater proportion of financing from those with higher-income to subsidize more the lower-income using some form of tax or similar arrangements?

(e) **Choice of services**: to what extent the supplementary financing option induces the development of more personalized choice of services that tailor to the needs and preferences of individuals (e.g. the choice of healthcare services from the public or private sectors, the choice of healthcare providers or doctors, the choice of better amenities, or the choice on timing of treatment, the choice of alternatives in treatment)?

(f) **Market competition and efficiency**: to what extent the supplementary financing option can bring about more healthy competition in the healthcare market and greater transparency of cost/price and quality of services, among healthcare providers and between the public and private sectors, with a view to driving greater efficiency and cost-effectiveness of services?

(g) **Utilization and cost control**: to what extent the supplementary financing option promotes judicious use and cost competitiveness of healthcare, and has in it inherent mechanisms to exert effective control over excessive utilization and cost-escalation of healthcare services (e.g. as a result of moral hazards under a third-party-pay system, or price inflation due to increasing demand for healthcare services)?

(h) **Overhead costs**: how expensive the supplementary financing option would be in terms of overhead costs, such as the varying degree of administration and transaction costs for the purpose of collection of contributions from individuals, allocation of funding or payments to healthcare services and providers, and/or provision of healthcare services to individuals, as well as regulatory cost if a new regulatory regime is required?

6.15 A summary of the different attributes of these financing options as supplementary financing is set out in **Table 6.2** from the next page onward.

Table 6.2 Comparison of supplementary financing options with existing financing model

	Financing sustainability
Government funding (existing model)	Not sustainable in the long-term given the low tax rates and narrow tax base of Hong Kong, especially at times of fiscal deficits, which means taxpayers have to pay higher taxes to sustain the system. Increasing public healthcare expenditure may crowd out other areas of public services.
Social health insurance	Quite stable source of financing given that the social health insurance contributions are earmarked for healthcare. However, may not be sustainable in the long-term due to a shrinking workforce in the face of population ageing. Stability and sustainability also in question at times of economic downturn when contributors would have less ability to pay. Contribution rate will have to increase in future for it to be sustainable. If employers are required to contribute, labour costs will increase, which will impact on our competitiveness and economic performance.
Out-of-pocket payments	Not sustainable as a financing source as it depends heavily on individuals' ability to pay, and the need to provide safety net for those who could not afford to pay may in turn offset the availability of financing from fee revenues.
Medical savings accounts	Secure a sizeable and sustained source of ***potential*** financing by individual savings. But injection of financing into the healthcare system remains individuals' choice and can be unstable and unpredictable. There will also be a group of account holders who do not have adequate medical savings and may have to rely on subsidized public healthcare services.
Voluntary private health insurance	Not a stable or sustainable financing source as taking out voluntary insurance remains individuals' choice and affordability. Unlikely to become a significant source of financing. Premium also fluctuates and likely to increase over time.
Mandatory private health insurance	Quite a stable financing source but premium will increase in future for it to be sustainable. It can help to support healthcare reform by improving market structure and driving greater efficiency of healthcare, thereby contributing to long-term sustainability. Complement market reform.
Personal healthcare reserve	Provide a sustainable source of ***potential*** financing by individual savings while ensuring a stable injection of financing into the healthcare system through mandatory insurance. Premium will increase over time, but will be affordable to more individuals because of savings. However, there remains a group of account holders who do not have adequate medical savings and may have to rely on subsidized public healthcare services. Complement market reform.

Table 6.2 Comparison of supplementary financing options with existing financing model (cont'd)

	Accessibility of healthcare
Government funding (existing model)	Accessibility based on needs, through triage and queuing, or other allocation mechanisms. Everyone in the society has equitable access to subsidized public healthcare services.
Social health insurance	Accessibility depending on design. Equitable access for all if availability of subsidized healthcare services is universal and extends to people who are not in the workforce.
Out-of-pocket payments	Accessibility based on affordability to pay user fees. Low-income and under-privileged groups and the high-risk groups (who tend to use more healthcare services) pay proportionally more user fees to access needed healthcare, unless safety net measures are correspondingly strengthened.
Medical savings accounts	Accessibility based on availability of savings. Heavy users will use more from the savings, and those with low income and less savings might not have enough savings to access healthcare other than subsidized public services through triage, queuing or other allocation mechanisms.
Voluntary private health insurance	Accessibility based on affordability to pay insurance premium. Better access to healthcare for those who have the means to purchase the insurance and who are not deterred from taking out voluntary insurance due to risk-selection. For high-risk individuals who are often denied access to insurance, or for those to whom premium is too high to be affordable, access to healthcare is limited to subsidized public services through triage, queuing or other allocation mechanisms.
Mandatory private health insurance	Accessibility depending on design (e.g. for the population group mandated to take out insurance, whether it is universal or otherwise). Better access to healthcare for those who are subject to the mandatory insurance. Access to the insurance guaranteed irrespective of age, gender and health risks. High-risk individuals are guaranteed access to mandatory insurance. For the uninsured who cannot afford, access to healthcare is limited to subsidized public services through triage, queuing or other allocation mechanisms.
Personal healthcare reserve	Accessibility depending on design. Better access for those insured and those with savings. High-risk individuals are guaranteed access to mandatory insurance. For those uninsured and without savings who cannot afford, access to healthcare is limited to subsidized public services through triage, queuing or other allocation mechanisms.

Table 6.2 Comparison of supplementary financing options with existing financing model (cont'd)

	Risk-pooling/sharing	Wealth re-distribution
Government funding (existing model)	Effective risk-sharing. But the effect reduces as public healthcare system over-stretched to provide comprehensive healthcare for the whole population rather than targeting higher risks and more costly services.	Progressive (i.e. the high-income groups pay more and subsidize the low-income groups) under current tax system which has a very narrow tax base for personal income tax.
Social health insurance	Effective risk-sharing. Same as government revenue above.	Progressive (i.e. the high-income groups pay more and subsidize the low-income groups), but contribution is confined to the working population. Those with higher income contribute proportionally more to social health insurance.
Out-of-pocket payments	No risk-pooling. Those with illnesses will have to bear their own financial risks.	Regressive (i.e. the high-income and low-income groups pay the same amount of increased fees) unless accompanied by strengthened safety net measures. User fees have a much greater impact on the low-income families and under-privileged groups, and the high-risk groups who tend to be heavy users of healthcare services. Thus unhealthy individuals will pay more while healthy individuals will be less affected.
Medical savings accounts	No risk-pooling. Can result in very diverse impact: medical savings inadequate for those with catastrophic or chronic illnesses but surpluses for those who are relatively healthy, with medical savings going to their estates.	Not applicable because medical savings accounts do not pool funds or risks so they do not redistribute between rich and poor or healthy and sick. Higher income individuals will have more savings in their account compared to lower income individuals but adequacy of savings would ultimately depend on the individuals' healthcare utilization pattern and volume.
Voluntary private health insurance	Some degree of risk-pooling. But pooling effect limited by small pool-size (of individual insurance schemes), risk- selection (high-risk individuals are often denied access to voluntary insurance due to rejection of application, exclusions of pre-existing medical conditions, or prohibitive premiums) and anti-selection (tendency that those who get insured are those who are more likely to claim insurance).	Not applicable because participation in insurance is voluntary and there is no redistribution of wealth. Insurance premium is not based on income but on age, gender and health risks. Thus unhealthy individuals or those with higher health risks pay more. However, lower-income families would not opt to be in the system since they usually cannot afford voluntary insurance.
Mandatory private health insurance	Effective risk-sharing through mandatory participation thereby avoiding risk selection; community-rated premium and regulated insurance thereby enabling all to access insurance irrespective of age, gender and health risks.	Regressive (i.e. the high-income do not subsidize the low-income). Mandatory insurance premium is not based on income and is usually community-rated (every insured person pays the same premium for the same insurance plan offered by the same company irrespective of age, gender and health risks). Thus unhealthy individuals or those with higher health risks (not necessarily low-income) are subsidized by healthy ones or those with lower health risks (not necessarily high-income). But some progressive effect if applied to relatively higher income groups, by reducing pressure on public healthcare system that serves as healthcare safety net for the low-income and under-privileged groups.
Personal healthcare reserve	Effective risk-sharing. Same as mandatory private health insurance above.	Regressive (i.e. the high-income do not subsidize the low-income). Same as mandatory private health insurance, unhealthy individuals or those with higher health risks (not necessarily low-income) are subsidized by healthy ones or those with lower health risks (not necessarily high-income). But some progressive effect if applied to relatively higher income groups.

Table 6.2 Comparison of supplementary financing options with existing financing model (cont'd)

	Choice of services	Market competition/efficiency
Government funding (existing model)	Little choice of services under tax-funded public healthcare system.	Continued domination of public healthcare sector. Little effective competition between public and private sectors and among healthcare providers. No extra incentive for efficiency drive.
Social health insurance	Some choice of services if the insurance procures both public and private healthcare services.	Competition enhanced through procurement of services under insurance from both public and private sectors. But scope of competition limited by procurement or reimbursement rules.
Out-of-pocket payments	Some choice of services for those who are willing to pay. Choice of services limited by affordability of user fees which could be very high if there is no subsidy or insurance coverage, especially for the high-risk groups.	No enhancement to competition or efficiency through increasing public user fees since it is not feasible to increase public fees to a level that is high enough to be comparable to the private sector and thus facilitating a meaningful competition.
Medical savings accounts	Some choice of services as medical savings can be used to pay for public or private sector services and will enhance the affordability of individuals for healthcare services to some extent.	Competition enhanced through enabling individuals to access public and private healthcare services. But competition and efficiency drive limited by insufficient transparency on cost/price and quality of healthcare services. Individuals likely to be in a disadvantaged position to bargain on price for healthcare.
Voluntary private health insurance	More choice of services in both the public and private sectors. Insurance plan at individuals' own choice and according to their affordability.	Competition enhanced through free choice of services from healthcare providers under insurance. But competition and efficiency drive limited by moral hazards under a third-party-pay insurance (the tendency of providers to over-supply and insured to over-use healthcare services under insurance), and also limited by insufficient transparency on cost/price and quality of healthcare services.
Mandatory private health insurance	More choice of services in both the public and private sectors. Individuals who can afford can choose top-up insurance plans to suit their own needs.	Competition enhanced through free choice of services from healthcare providers under insurance. With bigger insured pool, insurers have greater market power to drive transparency, efficiency and cost-effectiveness in healthcare services.
Personal healthcare reserve	Choice of services in both the public and private sectors. Combination of medical savings accounts and mandatory private health insurance will reap the benefits of both affordability through savings and risk-pooling through insurance.	Competition enhanced by enabling individuals to access public and private healthcare services through both insurance and savings. Insurers under regulation and with a sufficiently large guaranteed pool of insurees will have more bargaining power to drive transparency, efficiency and cost-effectiveness in healthcare services.

Table 6.2 Comparison of supplementary financing options with existing financing model (cont'd)

	Utilization/cost control	Overhead cost
Government funding (existing model)	Effective utilization control through rationing of healthcare according to clinical needs. Effective cost-control through global budget and subvention control for public healthcare.	Low overhead costs as costs for healthcare services are directly paid by government through global budget. But administration costs are required for administering safety net mechanisms.
Social health insurance	Utilization control may not be effective given increased demands from the insured for more and better healthcare to maximize the return on their contribution, and the need to cover private sector services on a more readily available basis.	Moderate overhead costs for collection of contribution and administration of claims payout under insurance, especially if the private sector healthcare is involved. New infrastructure has to be set up since there is no existing social insurance system in Hong Kong.
Out-of-pocket payments	Very effective utilization and cost control as the cost for usage of healthcare services directly borne by the users and healthcare providers are more cost conscious if their patients are bearing the cost. But can result in "inverse care law", that is, healthcare is less accessible to those more in need because of less affordability.	Low overhead costs as costs for usage of healthcare services directly borne by the users. But administration costs are required for administering safety net mechanisms.
Medical savings accounts	Utilization and cost control is effective to some extent, as cost for usage of healthcare services directly borne by the users. However, there is also the propensity for account holders to spend the locked-up savings.	Moderate overhead costs for collection, accrual and disbursement of savings. Can be reduced by using MPF framework for the collection and accrual of savings. Administration costs for disbursements for medical expenses similar to claims processing for insurance.
Voluntary private health insurance	Little control on both utilization and cost given moral hazards and limited bargaining power of individual insurance companies on healthcare costs. Can result in increasing premium to keep up with increasing healthcare and insurance costs.	High overhead costs for administration of claims payout and other costs including underwriting, marketing, commissions and insurance profits.
Mandatory private health insurance	Little control on utilization and costs. But with bigger insured pool (compared to voluntary insurance), insurers can institute control measures to curb moral hazards and have greater bargaining power on healthcare costs.	Moderate overhead costs as underwriting, marketing and other insurance costs can be reduced through mandatory participation and regulated products. Administration costs for claims payout still required. Additional costs for regulatory regime.
Personal healthcare reserve	Little control on utilization and costs. But same as mandatory private health insurance, with bigger insured pool, insurers can institute control measures to curb moral hazards and have greater bargaining power on healthcare costs.	Moderate overhead costs similar to medical savings accounts and mandatory private health insurance.

Financial Incentives for Supplementary Financing

6.16 As the Financial Secretary has announced in the 2008-09 Budget Speech, after the supplementary financing arrangements have been finalized for implementation after consultation, the Government will draw $50 billion from the fiscal reserve for taking forward the healthcare reform. This demonstrates the Government's commitment to share the responsibility for healthcare financing together with the community, and to increase the resources available to individual members of our community for healthcare. It can be used, for instance, to provide each participant in a contributory supplementary financing scheme with individual start-up capital.

6.17 In this regard, we will further examine how financial incentives can be provided to participants in a supplementary financing scheme, after receiving views during the first stage consultation, when developing detailed proposals for the supplementary financing arrangements. The financial incentives for participants in a supplementary financing scheme may take different forms, either available to participants individually or collectively, depending on the financing option(s) to be adopted. For instance –

(a) **Tax incentives**: tax incentives can take the form of a tax allowance or tax deduction for contributions made by individuals to social health insurance, for premium paid by individuals for voluntary or mandatory private health insurance, or for savings by individuals to their own medical savings accounts or personal healthcare reserve.

(b) **Start-up capital**: this can take the form of injection of a one-off lump-sum to individual medical savings accounts or personal healthcare reserve as seed money, or as a one-off reserve for a mandatory private insurance scheme or social health insurance scheme to reduce premium for participants and provide buffer for insuring individual high-risk participants.

(c) **Direct subsidization**: this can take the form of subsidization for individuals' contributions to social health insurance, subsidization for individuals' premium for private health insurance, or as contributions to individuals' medical savings accounts or personal healthcare reserve.

6.18 The public healthcare system will also continue to provide an available and accessible safety net for these participants who are taking a greater share of

responsibility for their own healthcare. This is particularly important to cater for the unfortunate event of a deterioration of their financial means.

Enhancing Capacity of the Healthcare System

6.19 If any of the above financing options to provide supplementary financing (except the model of continuing to rely on government funding) is adopted, it is likely to generate a greater demand for alternative choice of services apart from highly-subsidized public services. For instance, the social health insurance, voluntary private health insurance, and mandatory private health insurance are likely to generate extra demand for services from the private healthcare sector. Even increase in user fees for public services, and introduction of medical savings accounts are likely to drive or entice individuals to use private services more. In most cases, the supplementary financing will provide those subject to the scheme with the financing means to seek private services.

6.20 We thus expect that there would be an increase in demand for healthcare services in the private sector if supplementary financing to government funding is introduced. The extent of the increase will depend on the financing options adopted and also the detailed design of the financing arrangements. With a view to cater for the likely surge in demand and redressing the public-private imbalance, we intend to explore the following measures to further strengthen the capacity of the private sector to cope with the anticipated increase in demand –

(a) For the short and medium term, we will **pursue public-private partnership (PPP) initiatives**, e.g. PPP hospitals and other PPP models for the provision of hospital services, with a view to enhancing the capacity of the private sector and availability of private services.

(b) For the longer term, market force will drive the expansion of the private sector, and we will consider **policy measures to facilitate development of the private sector**, e.g. explore leasing out of vacant public premises or making sites available for private hospital development.

6.21 Meanwhile, some patients who have the financing means may still choose to turn to the public hospitals for services for a variety of reasons, e.g. confidence in the public system, or for complex illnesses (e.g. catastrophic or chronic illnesses) requiring costly treatment costs or procedures not readily available in the private sector. It is therefore necessary for the public sector to also allow some capacity to provide more personalized services to these patients. These patients are able to

afford and are likely to demand more choice of services and better amenities than those offered by public general wards.

6.22 **We therefore propose the public sector to increase moderately the capacity of its private services operating on a full cost-recovery basis.** The provision of such services would relieve the overall capacity constraint of the healthcare system in meeting the surge in demand for private healthcare services. The full-cost-recovery services would also provide a useful benchmark for comparison with the private sector on efficiency and cost-effectiveness. **At the same time, the provision of such private services must not be done at the expense of highly-subsidized public services provided to the general public.** On the contrary, the provision of such private services should help bring in additional financing into the public healthcare system and relieve its financial burden.

6.23 More fundamentally, we also need to address the issue of healthcare manpower planning, with a view to ensuring that there is sufficient manpower supply of different healthcare professionals to support the sustainable development of the healthcare system in the long run, in both the public and private sectors. As a first step, we will need to carefully examine the forecast of manpower requirements taking into account the overall healthcare needs of the population as well as foreseeable increase in demand in both the public and private sectors, with a view to ensuring that there is education and training capacity for an adequate supply of various healthcare professionals.

Chapter 7 CONSEQUENCES OF MAINTAINING EXISTING FINANCING MODEL

Existing Financing Arrangements

7.1 In the case of Hong Kong, to maintain the existing financing arrangements would mean continuing to rely on government revenue to meet the increasing expenditure required to meet healthcare needs. Unless we are prepared to accept significant deterioration in the level and quality of healthcare offered by the public hospital system (see Chapter 1), this would mean that additional revenue will have to be raised by one or more of means such as increasing tax rates, broadening tax base and increasing non-tax revenue, assuming that we cannot substantially cut into other areas of public expenditures.

Financing Implications

7.2 It is estimated that, if any extra funding required for public healthcare under the current healthcare system were to be met in full by government revenue, our total public expenditure would have to be increased to 22.1% of GDP and the share of public expenditure for health in the total public expenditure would be increased to 24.8% in 2033.

7.3 Meeting the increased public expenditure requires an increase in government revenue, which could mean substantial increases in Salaries Tax and/or Profits Tax rates, unless we introduce new sources of revenue including broadening tax base or increasing non-tax revenue. The expansion of total public expenditure would also be contrary to the existing policy of limiting total public expenditure to below 20% of GDP.

7.4 On the other hand, if the total public expenditure is to be kept below 20% of GDP, public health expenditure would take up 27.3% of total public expenditure in 2033, at the expense of funding for other public services (e.g. the share of funding for education, social welfare or security, which account for some 23.8%, 17.6% and 11.8% of recurrent government expenditure in 2008-09, may have to be reduced).

Overseas Experience

7.5 Direct funding from government revenue for healthcare is the predominant means of financing in Australia, Canada, Finland and the UK, apart from Hong Kong. In the case of all these advanced economies, they have much higher personal income tax rates, ranging from 40.0% to 48.8% excluding social security contributions, compared with 16.0% in Hong Kong (standard rate of Salaries Tax in

2007-08). All of these economies have sales tax as a source of revenue. Their public expenditure as a percentage of GDP is also much higher, ranging from 34% to 51%, compared with 19.7% in Hong Kong (in 2004-05).

7.6 In all these economies, similar to the case of Hong Kong, invariably a major challenge to the publicly-funded healthcare system is the rise in the cost of healthcare services, due to both ageing population and advances in medical technology. This is further aggravated in the case of Canada where a fee-for-service model[7] is adopted which renders control in utilization and cost much more difficult. In face of the challenge, the economies have responded differently.

7.7 Canada has been debating the merit of expanding the private sector by allowing more provisions of services by private healthcare providers and a greater share of private health insurance in financing, with little consensus for action. In the case of Australia, the government has responded by encouraging the public to take out private health insurance with a view to reducing demand on public hospitals (see Chapter 11), with some success but also leaving some questions to be answered on the long-term viability of this approach.

7.8 The UK responded by significantly expanding public spending on healthcare, largely because of the recognition that healthcare in UK has been under-funded in comparison with most other Western European countries in at least the last two decades. There are however concerns on the ability of the government to sustain the level of spending on healthcare, when faced with the prospect of big budget deficit.

Advantages of Existing Financing Model

7.9 The current financing system has the following advantages –

(a) **Equitable healthcare**: a publicly-funded healthcare system provides every member of the public with equitable access to the same level and standard of healthcare services at the same highly-subsidized rate regardless of means, through queuing, rationing, or triage on the basis of clinical needs, or a mix of these.

[7] Fee-for-service in healthcare services or health insurance context means that doctors and other healthcare providers receive a fee for each service provided, such as a consultation, test, procedure, or other episode of administering healthcare service. Fee-for-service health insurance typically allows patients to obtain care from doctors or hospitals of their choosing, but in return for this flexibility they may pay higher copayments or deductibles.

(b) **Simple and low-cost administration**: with well-established mechanisms for the collection of tax and adjustment of tax rates, financing healthcare by increasing the existing types of taxes is simpler to administer and incurs less extra cost, unless new types of taxes were to be introduced.

(c) **Wealth re-distribution**: financing healthcare by tax revenue has the effect of requiring taxpayers with higher income to subsidize the healthcare for the rest of the population. It should however be noted that the current public healthcare system funded by government revenue already achieves a significant degree of wealth re-distribution, and it is for consideration if it would be necessary to achieve further wealth re-distribution through the supplementary financing.

Shortcomings of Maintaining Existing Financing Model

7.10 Relying on government revenue as the sole financing for healthcare has the following shortcomings –

(a) **Rising tax bills and expanding government budget**: financing healthcare solely with government revenue will eventually result in continued increase in tax rates and expansion of public expenditure in the economy, departing from the small government principle and low tax regime, which are key to our competitiveness. Our Salaries Tax already rests on a relatively narrow tax base. Our reliance on Profits Tax is already high compared to OECD countries, and headline corporate tax rate in many economies, including our main competitors, has been decreasing. Any increase in Profits Tax rate will adversely affect Hong Kong's competitiveness. It is doubtful if it would be viable to raise the rates of existing taxes to a significant extent in order to meet the increasing healthcare expenditure. Meanwhile, no consensus has been reached in previous consultation to broaden the tax base.

(b) **Increasing burden on future generations**: the tax burden on the future generation would become greater as Hong Kong's demography changes to a smaller working population supporting a larger elderly population. The share of government expenditure on healthcare that each taxpayer would have to shoulder in twenty years' time would be much larger than that of the taxpayer today, when on the one hand public health expenditure is projected to increase significantly in real terms at a much faster pace than the economy, and on the other hand the proportion of labour force in the population is projected to continue to shrink.

(c) **Encourage over-reliance on highly-subsidized public healthcare and aggravate public-private imbalance**: even putting aside financial affordability, relying solely on government revenue to finance healthcare would mean perpetuating the current public-dominance in provision of hospital services, and in turn the current structural imbalance between the public and private healthcare sectors. The continued provision of highly-subsidized public healthcare services would inevitably encourage further reliance on public healthcare services, further expanding the share of public sector in the healthcare market, and further aggravating the public-private imbalance and not conducive to stimulating healthy competition in the market.

(d) **Lack incentives for judicious use of highly-subsidized public healthcare and not conducive to enhancing public sector efficiency and cost-effectiveness**: the continued highly-subsidized healthcare services offered by the public system would not provide enough incentives for judicious use of such services. With healthcare services provided predominantly by the public system financed by government revenue on a block-grant approach, and with virtually no competition from the private sector, there is no added incentive for the public sector to drive for even greater cost efficiency and cost-effectiveness.

(e) **Inadequate choice in healthcare services**: healthcare services provided by the public healthcare system financed by government revenue are supply-controlled, and will inevitably involve queuing and waiting for healthcare services, as well as allocation of services based on clinical needs assessed according to established criteria and protocols. In providing equitable access, a tax-funded healthcare system can only provide services within prescribed scopes, including specified formulary, to eligible members of the public. It will therefore limit choices and thus competition between the public and private sectors in providing healthcare services.

(f) **Unsustainable financing**: the current tax-base is narrow and government revenue is relatively dependent on economic cycles. It would not be sustainable to continue to increase the share of health expenditure in government budget without limit, and the limit will be affected by the economic performance of Hong Kong.

Chapter 8 SUPPLEMENTARY FINANCING OPTION (1) - SOCIAL HEALTH INSURANCE

Social Health Insurance as Supplementary Financing

8.1 Social health insurance refers to mandatory contributory schemes, usually employment-based and income-linked, i.e. financed by the working population and, in most cases, by employers as well. It may be centrally administered by a single statutory insurer, as with the National Health Insurance system of Korea, whereby subsidized healthcare is generally available to the whole population; or administered by multiple sickness funds, membership and contribution rate of which are determined by occupational groups, as with the system in Austria and Japan. Individuals in employment with remuneration above a certain level are usually required to contribute a certain percentage of their income to a social health insurance fund designated for healthcare use for the general population. Employers may be required to contribute a matching or different percentage.

Financing Implications

8.2 Introducing some form of social health insurance as a source of supplementary financing is similar to raising Salaries Tax in effect, but the number of contributors involved would be larger, depending on where the contribution line is drawn.

8.3 If a social health insurance is applied to those earning monthly income of $5,000 or more (some 80% of the working population) and capped at $20,000 (i.e. those earning $20,000 or more will only be required to contribute at $20,000 income level), we estimate that a contribution at 3% to 5% of monthly income will provide sufficient supplementary financing for healthcare up to around 2025 to 2027.

Overseas Experience

8.4 Social health insurance is the primary source of healthcare funding in Austria, Belgium, Japan, Korea and the Netherlands (before the more recent reform to introduce a mandatory private health insurance). Funding from general taxation is required at varying degrees to top up and meet the requirement for healthcare services. With the exception of Korea, all these economies have a much higher total health expenditure as a percentage of GDP (ranging from 8% to 10%, compared to 5.2% in Hong Kong), and public health expenditure accounts for a relatively large proportion of total healthcare expenditure (at least 60% and well over 70% in some cases, compared to 55% in Hong Kong).

8.5 In all these economies, an ageing population as well as increase in healthcare utilization and costs have posed significant challenges to the financial sufficiency and sustainability of the healthcare system, especially in those which have adopted a fee-for-service system (e.g. Belgium and Japan). For instance –

(a) In Belgium, the fee-for-service payment system for providers, low co-payment for patients and lack of primary care provider as a gate-keeper for specialist/hospital care have made the healthcare system vulnerable to inefficiency, over-supply and over-use of healthcare.

(b) In Finland, where general taxation is the primary financing source and social health insurance is a secondary source, ageing population is posing a challenge to the healthcare system, and there is pressure for pursuing structural reforms in order to ensure financial sustainability.

(c) In Japan, the out-patient and in-patient utilization per capita per year is twice and four times the average among OECD countries. Meanwhile, the ageing population has caused serious financing problem for the social health insurance system due to slow growth of revenue amidst increasing spending pressure due to ageing.

(d) In Korea, the National Health Insurance has experienced serious deficits for a mix of reasons. At end 2001, deficits had reached a fifth of total NHI expenditures for the year. There is also inappropriate use of healthcare leading to extra burden on the insurance system.

8.6 In response to these challenges, the governments have employed various types of cost-control, budget-control and utilization-control measures, as well as revenue-raising measures such as increasing contribution rates and charges or co-payments, to control or meet the rising health bill. Some (e.g. the Netherlands) have also turned to reforming the market structure and financing arrangements.

8.7 In the case of the Netherlands, the government has in recent years embarked upon a series of reforms which reduces the role of the government by introducing a compulsory health insurance scheme operated by private health insurance companies. The scheme charges community-rated premium and is funded by the premium revenues, an income-related contribution, and government contribution. The premium-paying part is effectively a mandatory private health insurance scheme for the whole population (see Chapter 12), while the part of the scheme financed by income-related contribution and government contribution is

essentially a social health insurance for subsidizing the children's premium and to compensate insurers for financial disadvantages in insuring high-risk individuals.

Advantages as Supplementary Financing

8.8 Introducing social health insurance as supplementary financing for healthcare has the following advantages –

(a) **Equitable healthcare**: like taxation, a healthcare system funded by social health insurance can provide every member of the public with equitable access to the same level and standard of healthcare services.

(b) **More stable financing**: a social health insurance, funded by a large proportion of the working population than the existing tax base for Salaries Tax and with contributions dedicated to funding healthcare services, can provide a relatively more stable source of financing than raising Salaries Tax. However, at times of economic downturn when the working population can ill-afford the contribution level, financial sustainability of social health insurance schemes can still be a problem.

(c) **Wealth re-distribution**: like taxation, financing healthcare by social health insurance also has the effect of requiring those with higher income to subsidize healthcare for the population.

(d) **Some choice of services**: unlike using government revenue to fund healthcare services provided by the public healthcare system, social health insurance can be designed to provide some choice of healthcare services in either the public or the private sector through purchase and subsidization of services.

Disadvantages as Supplementary Financing

8.9 Introducing social health insurance as supplementary financing for healthcare has the following disadvantages –

(a) **A new hypothecated tax**: a social health insurance scheme is in effect an extra tax on the working population to finance the healthcare for the whole population.

(b) **Increasing burden on future generations**: like tax, social health insurance funded by contributions from the working population will become an

increasing burden on the future generations as Hong Kong's demography changes to a smaller working population supporting a larger elderly population.

(c) **Encourage over-reliance on highly-subsidized healthcare and lack incentives for its judicious use**: with healthcare services highly-subsidized by social health insurance as third-party-funding, there is little incentive for individuals to use healthcare services in a judicious manner.

(d) **Difficult to control healthcare utilization, and prone to excessive utilization of services**: financing healthcare services provided by both public and private sectors with social health insurance would make control over the utilization and costs of healthcare services very difficult, unless supplemented with usage quotas or other supply-control measures. The high-subsidization level may also create incentives for healthcare providers to provide excessive healthcare and for individuals to overuse healthcare services when they are more readily available through the social health insurance. The alternative will be to apply stringent control on both the provision and price of healthcare services in both the public and private sectors to be funded by social health insurance, effectively merging the private sector into the public system.

(e) **Increasing contribution rate**: the contribution rate would have to be increased in future to meet the rising healthcare expenditure due to an ageing population and medical inflation in addition to likely increases in utilization of healthcare. An alternative is to require a higher contribution rate upfront in order to build up a reserve in the social health insurance to meet future increase in healthcare expenditure.

(f) **Incur administration cost**: introducing social health insurance would be like introducing a new type of tax, and would require the establishment of a new mechanism for the collection of contributions to the insurance. If the insurance covers services by private sector providers apart from public services providers, extra administration cost will be involved for reimbursement of fees for healthcare services.

(g) **Choice of services are prescribed or limited**: while social health insurance may provide individuals with some choice of healthcare services in both the public and private sectors, the need to maintain equity and cost control would require that only specified services subject to prescribed standards would be funded by social health insurance, with little choice for

additional services or extra amenities. Individuals can only access services outside the scope of the social health insurance or get extra amenities through their own funds or privately-purchased health insurance.

Chapter 9 SUPPLEMENTARY FINANCING OPTION (2) - OUT-OF-POCKET PAYMENTS

Out-of-Pocket Payments as Supplementary Financing

9.1 Public healthcare services in Hong Kong are highly subsidized, and out-of-pocket payments in the form of public fees amount to a very small portion (about 5%) of the cost. On the other hand, private services are unsubsidized, and thus out-of-pocket payments in the form of either fees for private healthcare services or co-payment for insurance remain a major source of financing for private services apart from insurance pay-outs from insurance premium of voluntary health insurance (either employer-provided or individually-purchased).

9.2 Irrespective of the main financing sources, out-of-pocket payments remain an important and effective means of encouraging responsible and judicious utilization of healthcare services, especially for services that are prone to inappropriate use or abuse. Requiring a certain level of fees and charges for public services will also help to bring home the message that health is a shared responsibility between the individual and the public healthcare system.

9.3 Relying on out-of-pocket payments to become a bigger supplementary financing source effectively means reducing the overall level of subsidization and increasing fees for public healthcare services. In practice, the level of subsidies of individual healthcare services would have to be adjusted having regard to the affordability of the fees, the likely frequency of utilization, the level of cost, as well as the need to encourage judicious and responsible use of subsidized public healthcare services by members of the public. At the same time, in order to uphold our establish healthcare policy that no one should be denied adequate healthcare through lack of means, a strengthened financial assistance mechanism would be needed to cater for those who cannot afford the increased fees.

9.4 In theory, it may be possible to consider applying means-test in charging for public healthcare services, so that those who have the means will be required to pay higher fees and receive lower subsidies. In practice, however, this would be difficult to implement given the huge amount of resources involved in administering the means-test. Another theoretical possibility is to apply a tight supply-control and quality differential between public and private healthcare services, such that those who cannot afford to wait, or desire alternative services with better quality and can afford to pay would shift to the private sector and thereby paying for their own healthcare. However, this would cause those who

need to stay on the public healthcare system to suffer both in terms of waiting time and quality of services. Such control is therefore not a tenable option.

Financing Implications

9.5 It is estimated that, to become a supplementary financing source that could provide the extra resources needed to meet the population's healthcare needs of the population, the level of subsidization in overall will have to be reduced from 95% at present to around 80% and 60% in 2020 and 2030 respectively. This would mean at least a respective four-fold and eight-fold increase in public fees. This estimation is based on the assumption that the current utilization of public healthcare services remains unchanged, the costs of public healthcare services remain the same, and has not taken into account the need to provide financial assistance to those who may not be able to afford the increased level of fees.

9.6 If public fees were increased substantially, it is likely that a significantly larger proportion of patients would not be able to afford the fees and would have to rely on the financial assistance mechanisms as a safety net. These include those in the low-income group, chronic patients, and patients who require lengthy and/or costly treatment, etc. A preliminary estimation suggested that, if public fees were to be increased to some 10% cost-recovery, around one-third of the revenue may be foregone by way of fee waiver as financial assistance to the low-income and under-privileged groups under the current fee waiver criteria. In other words, increasing the public fees and lowering the level of subsidization do not necessary mean that revenue would be recovered proportionally.

Overseas Experience

9.7 Direct out-of-pocket payments for fees and charges for healthcare services, including co-payment required under health insurance schemes, is a means of financing that exists to varying extent in all economies irrespective of the predominant source and means of financing for healthcare. It is worthwhile to note that even in the UK, where healthcare is predominantly provided by the tax-funded National Health Service with a very small private sector and services are subject to budget-control and supply-control, out-of-pocket payments still amount to approximately some 12% of total health expenditure. In other economies where healthcare is financed by social health insurance or mandatory private health insurance, the proportion of out-of-pocket payments is even higher.

9.8 Meanwhile, in all the advanced economies we have studied, irrespective of the financing source and means, a key feature is the provision of a safety net for the

under-privileged to continue to access healthcare. Some examples of the different approaches adopted are as follows –

(a) In economies where government revenue is the main source of financing and public healthcare system is the main service provider (e.g. Australia, Canada, Finland, and the UK), the safety net usually takes the form of provision of services free-of-charge or at very low fees by the government-funded public healthcare system to the low-income and under-privileged groups.

(b) In economies where healthcare is financed by social health insurance (e.g. Austria, Belgium, Japan and Korea), the safety net is funded by the social health insurance itself, or in some cases through specific tax-funded government programmes.

(c) In Switzerland where mandatory private health insurance is implemented, the insurance premium of the low-income and underprivileged groups are paid for or subsidized by the government using tax revenue.

(d) Under the mandatory private health insurance implemented in the Netherlands, a social health insurance and government funded component are specifically included to cover children's premium in full.

Advantages as Supplementary Financing

9.9 Increasing public fees with a view to providing a supplementary source of financing has the following advantages –

(a) **Encourage judicious use of healthcare**: as individual patients have to bear the extra cost for healthcare (on top of any government subsidies or insurance payout), increasing user fees will have a direct impact in encouraging individuals to be more judicious and responsible in using subsidized healthcare services, especially through reducing the level of subsidization for services which are more easily prone to abuse or inappropriate use.

(b) **Instil sense of self-responsibility for health**: increasing an individual's share of contribution to his own healthcare will instil a sense of self-responsibility for his own health and will help encourage individuals to adopt healthier lifestyle and take greater care of their own health.

Disadvantages as Supplementary Financing

9.10 On the other hand, increasing public fees has the following disadvantages –

(a) **No risk-pooling and disproportionate burden on low-income, under-privileged and high-risk groups**: this is because the utilization profile of hospital care is highly skewed, i.e. a small proportion of high-risk individuals utilize the majority of healthcare, while the rest of the healthier population utilize a relatively small proportion of hospital care. Raising fees and charges of public services substantially would thus have a disproportionate effect on the heavy users of healthcare services. These include those in the high-risk groups, e.g. chronic patients and the elderly, who are more likely to have to rely on public services, as well as patients from middle-income families struck by complex illnesses (e.g. catastrophic or chronic illnesses) involving extensive and costly treatments, who may also need to turn to the public sector.

(b) **Cannot provide a significant source of supplementary financing**: narrowing the gap between the fee levels of the public and private sectors would divert some patients, probably those with better means, to the private sector. Meanwhile, those who do not have the means would continue to use public service and rely on the safety net. Given the need to provide financial relief for those who cannot afford the user fees for healthcare, especially for the low-income and under-privileged groups, increase in user fees for public services does not necessarily guarantee a proportionate increase in supplementary financing for the public healthcare system.

(c) **Increase cost for administering safety net mechanisms**: increase in user fees will result in a greater proportion of users requiring financial assistance from the safety net mechanisms including waiver mechanism for public fees. The resultant administrative workload and cost could be significant.

Chapter 10 SUPPLEMENTARY FINANCING OPTION (3) - MEDICAL SAVINGS ACCOUNTS

Medical Savings Accounts as Supplementary Financing

10.1 Medical savings accounts are mandatory employment-based and income-linked individual savings accounts which accrue contributions from an individual's income with investment return to pay for the fees charged for healthcare services he/she consumes. Each individual in employment with remuneration above a certain level is required to save up a certain percentage of his regular income in his individual medical savings account. In short, medical savings accounts serve the purpose of enabling individuals to build up a healthcare reserve fund of their own over time to pay for their future healthcare needs, and the fund can go to their estates if unused.

10.2 Medical savings accounts underwrite part of the financial risks of individuals for their own healthcare needs over time, when they would be able to have a reserve fund to meet such needs, especially after retirement when the individual is likely to have to spend more on healthcare but may not have a regular income. For society as a whole, medical savings accounts provide a mechanism where the working population saves for its own future healthcare needs, thereby reducing the pressure on the public healthcare system in the future and in turn the economic and financial burden on future generations.

10.3 Medical savings accounts, however, do not provide for risk sharing or risk pooling among individuals. Medical savings accounts by themselves also do not help generate additional funding that will go into the healthcare system. The funds remain in the individual's account and will only go into the healthcare system when healthcare services are used, and only if the fee for using such services is more than nominal.

Financing Implications

10.4 As healthcare needs differ among individuals, the financial impact of medical savings accounts on individuals can vary significantly. Those who need to use healthcare services substantially (such as patients who need long-term medication) or those who need to use costly healthcare services (such as patients who are struck by catastrophic illnesses or requiring complicated surgery or treatments) may not have sufficient savings in the account to cover their healthcare expenses and may have to fall back on the safety net. Patients with savings may also choose to use highly-subsidized public healthcare services and allow the

savings to remain unused in their accounts. On the other hand, those who stay healthy throughout their lives without requiring long period of care would leave behind sizeable savings unused for healthcare purposes.

10.5 To study the implications of a medical savings account scheme, we have commissioned an actuarial simulation of individuals' savings and medical expenses, and estimated the average amount of savings accrued when an individual reaches age 65, and the probability that he/she would have enough savings in the medical savings account to meet his/her own medical expenses after 65 until death.

10.6 **Table 10.1** shows the estimated figures for individuals within the age group of 20-29 who start saving a rate of 3% of their income (capped at $20,000) until 65 for meeting their future healthcare needs, and that 15% of the savings will be used before 65. The actuarial simulation takes into account salary progression and labour participation rates, and assumes a real investment return of 3%, real annual medical inflation of 3%, and medical expenses at around 20% of public healthcare cost for both in-patient and out-patient services (i.e. healthcare services subsidized at 80% level).

Table 10.1 Estimated amount of medical savings for individuals who start saving at age 20-29 at **3%** saving rate

Monthly income groups (range of initial income)	Average accrued savings at age 65	Average post-65 medical expenses	Average account balance at death	% of account holders with sufficient savings to meet post-65 medical expenses
Lowest 30% of income earners (below $7,650)	$151,000	$520,000	-$362,000	28%
30th to 80th percentile of income earners ($7,650 - $14,499)	$236,000	$575,000	-$295,000	40%
Highest 20% of income earners ($14,500 or above)	$350,000	$582,000	-$124,000	58%

10.7 On the other hand, **Table 10.2** shows the estimated figures for individuals within the age group of 20-29 who start saving a rate of 5% of their income under the same set of assumptions as above. As clearly shown by the figures, the sufficiency of the estimated savings would improve significantly across-the-board at a higher saving rate.

Table 10.2 Estimated amount of medical savings for individuals who start saving at age 20-29 at **5%** saving rate

Monthly income groups (range of initial income)	Average accrued savings at age 65	Average post-65 medical expenses	Average account balance at death	% of account holders with sufficient savings to meet post-65 medical expenses
Lowest 30% of income earners (below $7,650)	$252,000	$520,000	-$211,000	47%
30th to 80th percentile of income earners ($7,650 - $14,499)	$393,000	$575,000	-$55,000	62%
Highest 20% of income earners ($14,500 or above)	$583,000	$582,000	$234,000	80%

10.8 The actuarial simulation indicates that a medical savings account scheme involving savings alone may not be an adequate source of supplementary financing due to the very different healthcare utilization patterns among different individuals. This, coupled with the variations in income profile, could lead to very different levels of savings, resulting in a significant proportion of individuals still relying on the public healthcare safety net while some would have accrued sizeable savings in their account without the need to spend it.

Overseas Experience

10.9 The medical savings accounts arrangement is adopted by Singapore, where the subsidy rate of public service is not as high as that in Hong Kong. The subsidy rates are 80% for "C" class wards, 65% for "B2" class wards, and 20% for "B1" class wards. There is no subsidy for the private "A" class wards. The unsubsidized portion of the hospital charges is paid out-of-pocket by the patient or by insurance if the patient has such coverage.

10.10 In Singapore, where the medical savings account scheme is called Medisave, the government has in place a mechanism to provide a limited extent of risk pooling through the setting up of a catastrophic health insurance scheme (the Medishield scheme). The objective of the scheme is for all Medisave account holders and their dependents up to 85 years old to share out the risk of catastrophic illnesses. Premiums for the insurance are paid through the Medisave. Unless Medisave account holders choose to opt out of the scheme, they will automatically be covered by the insurance.

Advantages as Supplementary Financing

10.11 Introducing medical savings accounts as a supplementary financing arrangement has the following advantages –

(a) **Saving for own use**: medical savings accounts are more desirable from an individual's point of view in that the savings remain the individual's own assets, which, if not used by himself/herself (and his/her family members subject to scheme design), are left to his/her estates. Saving for one's future is a concept well accepted in Hong Kong.

(b) **Saving for individuals to meet future medical needs**: medical savings accounts enable an individual to spread out his financial risks due to poor health over time, by saving up to meet future medical needs. This is particularly useful after retirement, when the individual is likely to have to spend more on healthcare but is no longer getting any regular income.

(c) **Reduce the financial burden on future generations**: given our demographic changes in the coming decades, we are likely to have a smaller working population to support a growing elderly population. Medical savings accounts could reduce the financial burden on our future generations. However, to enable savings in medical savings accounts to be channelled into the healthcare system to reduce the reliance on the public purse, there has to be a larger range of private sector services from which patients with savings can choose, and there would also be a need for public fees to be increased.

(d) **Instil sense of self-responsibility for health**: by requiring an individual to save for his own healthcare, medical savings account will help instil a sense of self-responsibility for health, and encourage individuals to adopt a healthier lifestyle and take better care of their own health.

(e) **Promote judicious use of healthcare services**: as individual patients have to use their own savings for healthcare (on top of any government subsidies or insurance payout), medical savings accounts may also have an effect in encouraging individuals to be more judicious and responsible in using subsidized healthcare services, especially if they are required to pay a higher level of payment for services which are more prone to inappropriate use or abuse.

Disadvantages as Supplementary Financing

10.12 Introducing medical savings accounts as a supplementary financing arrangement has the following disadvantages –

(a) **No risk-pooling**: pure medical savings do not pool the health risks among the population, and could still be inadequate to cover the medical expenses of those heavy users requiring more healthcare. As in the case of Singapore, it would be necessary to supplement the scheme with some form of insurance so that every patient who has savings is protected while the unfortunate minority who have to pay out huge medical expenses are covered to some extent by the insurance.

(b) **Not a guaranteed source of supplementary financing**: while medical savings accounts will accumulate over time a sizeable pool of savings that could potentially be tapped to finance healthcare, the use of such savings is up to the individual. There is little predictability on when and how the savings would be used, and thus the amount of additional finance that can be secured for healthcare is uncertain. As our actuarial simulation shows, the usage pattern of savings can be very diverse among individuals. This is especially the case if public healthcare services remain highly-subsidized at the current level (95% subsidized), where the account holders would have strong incentives to continue using public services, in which case the savings would not relieve the pressure on the public healthcare system. This contrasts with the situation in Singapore, where the highest subsidization for public healthcare services is only 80% and the savings would at least provide funding to cover 20% of the cost.

(c) **Does not in itself support market reform especially in redressing public-private imbalance**: medical savings accounts on its own, coupled with the current highly-subsidized public healthcare system, provides little incentive to make more use of private services. This not only casts doubt on the ability of medical savings accounts to provide supplementary financing for healthcare, but also renders it unable to support the necessary market reforms to the healthcare system, especially those aimed at redressing the public-private imbalance.

(d) **Use of savings before retirement defeat the purpose of saving for future medical expenses**: medical savings accounts are intended to provide savings to meet future healthcare needs. Allowing the use of savings before retirement could easily deplete savings and would defeat the purpose of medical savings accounts. To cater for frequent withdrawals

from medical savings accounts to meet unpredictable healthcare expenses from time to time, savings would have to be invested in assets with high liquidity and low volatility, thereby foregoing the upsides of long-term investment, making medical savings accounts a less attractive proposition.

(e) **Incur administration cost**: the accrual of savings and the subsequent disbursement of the savings for healthcare expenses will entail administration costs. The administration costs for collection of savings can be minimized by making use of the established MPF framework, where there is synergy and economy of scale. However, the administration costs for disbursement of medical expenses are unavoidable and is similar to the administration costs for processing claims payouts under health insurance (be it social insurance, voluntary insurance or mandatory insurance).

(f) **Locking up huge pool of funding**: if the contribution is set at a relatively higher level to ensure a greater degree of sufficiency and alternative usage such as investment is not allowed, medical savings accounts will lock up a huge pool of idle funding.

Chapter 11 SUPPLEMENTARY FINANCING OPTION (4) - VOLUNTARY PRIVATE HEALTH INSURANCE

Voluntary Private Health Insurance as Supplementary Financing

11.1 Voluntary private health insurance includes both employer-provided medical benefits and individually-purchased medical insurance. In the case where individuals take out health insurance on their own, the premium is assessed on the basis of their health risk, based on their age, gender and other health-related factors. Under-writing and other measures such as health checks are often required in order to assess the health risks more accurately, adding to the cost of taking out insurance. In the case of schemes tailored for specific groups such as group policies taken out by employers for the employees of a company, the premium is rated on the basis of the profile of members of the group.

11.2 However, it is difficult for an insurer to determine the health risk of an individual with complete accuracy. A major factor that affects the premium and viability of voluntary private health insurance is anti-selection (or adverse selection)[8], i.e. the tendency of those with higher risk who are likely to benefit to take out insurance, leading to higher premium, which in turn further deter those with lower risk from staying insured. Risk-selection[9] by insurers, such as exclusion of pre-existing medical conditions or increasing the premium for those with claims, is thus common and has the effect of excluding those with high risks from getting insured.

11.3 Another major factor that affects voluntary private health insurance is moral hazards, i.e. the tendency for providers to over-supply and over-charge and patients to over-use and over-claim healthcare services under insurance, which would lead to increasing premium. This is particularly the case for services which are less risk-based and more prone to inappropriate use or abuse, e.g. out-patient services and diagnostic tests. Requirement of co-payment or deductible is often employed as a means to curb moral hazards, but this may also reduce the

[8] Anti-selection, or adverse selection, in the context of insurance, is the situation where, because the insurer does not have perfect information to assess the precise risks of each individual, those with risks higher than that priced under an insurance are more likely to self select to take out the insurance, resulting in the insured gaining an undue advantage over the insurer. In economic terms, this represents a market failure due to information asymmetries between the insurer and the insured that prevent the risks from being fairly and accurately priced.

[9] Risk-selection means the insurers tries to select only those with low risk to insure while rejecting the high-risk individuals, in order to keep the overall risk level of an insurance scheme at a lower and manageable level, and at the same time avoid insuring high risks which may be difficult to price due to anti-selection and other information asymmetries.

attractiveness of a voluntary medical insurance policy, especially when companies compete on the basis of terms and premium in a free and unregulated market.

11.4 As a result of these factors, where the premium is individually-rated, cherry-picking is common in that insurers would tend to favour less risky clients. Persons with relatively higher health risk, including the chronically-ill, the elderly, those with previous illnesses that may recur, and those with family members having illnesses that may be hereditary, would usually find it more expensive, or not possible at all, to get insured in a free market where insurance companies operate for profits. It is also not uncommon for individuals who get certain illnesses with a likelihood of recurrence to have their insurance premium increased subsequent to their illnesses. Even for group insurance policies, it is not uncommon to exclude pre-existing medical conditions for the purpose of cost control.

Financing Implications

11.5 In Hong Kong, voluntary private health insurance, including both employer-provided medical benefits and individually-purchased medical insurance, is already a supplementary source of financing under the current system. It accounts for some 12.5% of total health expenditure in 2004/05 (employer-provided medical benefits account for some 7.6% and individual-purchased medical insurance account for 4.8%), or 27.6% of private health expenditure. The share of voluntary private health insurance in Hong Kong as a source of funding in total health expenditure is relatively high among advanced economies except when compared with the United States.

11.6 To rely solely on voluntary private health insurance as a source of supplementary financing to provide the extra health expenditure required to meet the needs of the community (on the assumption that the insured will either use private services or pay full cost for using public services), it is estimated that the amount of financing from insurance will have to at least triple to provide around 34% of the total health expenditure in 2033 or 53% of private health expenditure. It is difficult to envisage any viable scheme that could expand the current voluntary insurance market by that magnitude, an on a voluntary basis.

Overseas Experience

11.7 Voluntary private health insurance exists at varying degree in almost all the advanced economies we have studied. However, it serves as a major financing source only in the case of the United States. It has also been proactively promoted

as a means of addressing financing challenges to the tax-funded public hospital system in Australia.

The United States

11.8 In the US, voluntary private health insurance is the predominant means of healthcare financing. The safety net is provided through two programmes: (i) the Medicaid programme which is a tax-funded scheme to provide a minimum set of services for the low-income groups and needy families; and (ii) the Medicare programme which is a social health insurance funded by payroll taxes to provide health insurance for the elderly and the disabled. For those outside the safety net coverage, their access to healthcare depend heavily on their private insurance coverage, and in turn their ability to pay the premium if they do not have any or adequate employer-provided medical insurance, which can be expensive to the lower income or those with pre-existing medical conditions. It has been estimated that some 46 million (16%) of the population in the US are without health insurance coverage.

11.9 A major problem that has arisen in the US is the escalation of healthcare cost and in turn insurance premium, with spending largely driven by the demand of the patients who want the latest and the best treatment after having paid the insurance premium. This has resulted in rapidly growing total health expenditure – over the past 20 years, the total health expenditure in the US as a percentage of GDP has increased from 10.2% in 1986 to 15.3% in 2005.

11.10 Another problem is the financial sustainability of the Medicare and Medicaid programmes. The actuaries who track the costs of the programmes have estimated that the funding from payroll taxes is inadequate to fund the Medicare programme as the working population is not growing as fast as the elderly population. Reform to the healthcare system, especially on financing these programmes as well as to provide coverage for the uninsured, remains a controversial issue in the US.

Australia

11.11 In Australia, where the government budget is the primary source of funding, voluntary private health insurance is strongly encouraged by the government and plays a supplementary role.

11.12 The Australian government emphasizes the role of private health insurance as a means of reducing demand on public hospitals and thereby diminishing cost pressures on the public healthcare system. It therefore tightly regulates private

health insurance funds' offers and activities in an attempt to maintain broad participation in the private health insurance market across different risk cohorts. For example, private health insurance funds have to accept all applicants within certain membership categories. Risk selection/discrimination on the basis of gender, age, health status etc. is prohibited. Premiums are community-rated for each product and the funds cannot refuse renewal of insurance policies. It should also be noted that out of the 38 registered private health insurance funds operating in Australia, only 6 of them are for-profit organizations.

11.13 Since the Australian Government attaches much importance to private insurance, it is very much concerned with drops in the level of private health insurance uptake, or membership as it is termed in Australia. The Australian Government therefore also implements a number of 'carrot and stick' policies to boost the uptake of private health insurance and maintain it at a level that can sustain a private healthcare market which is capable of reducing demand on the public healthcare system. The most effective of these include –

(a) a 30% rebate of the premium offered by the government (and an even higher rebate for the elderly);

(b) "Lifetime Health Cover", which requires Health funds to apply the same base premiums, calculated at age 30, as long as individuals take out insurance cover before 30 and remain insured thereafter. Insurers can apply premium increase to individuals buying health coverage after age 30 that equal to 2% of the base premium per each year of age above 30, with a maximum increase of 70%; and

(c) levying a surcharge of 1% on the taxable income of individuals in the highest income band who have failed to take up private hospital insurance.

11.14 While the taking up of health insurance in Australia is not compulsory, with government interventions in the Australian private health insurance market and the carrots and sticks provided, the take up of health insurance in Australia by individuals is very different from that of people in the US or in any other economy where the government does not proactively implement measures to maintain a high take-up rate. In many respects, the Australian-style voluntary private health insurance scheme is more similar to the mandatory private health insurance schemes adopted by Switzerland and the Netherlands.

11.15 Like the mandatory schemes in Switzerland and the Netherlands, private health insurance in Australia is useful in improving individual choice. Those who

have private insurance cover can use a greater variety of providers (public or private hospitals and doctors of their choice) than patients relying solely on Medicare, Australia's publicly funded healthcare system. One considerable advantage of private health insurance with hospital cover is that it may allow flexibility over the timing of care, and access to more timely care, particularly for elective surgery. This is a significant advantage in Australia where public hospital patients have to endure long waiting times for elective surgery. The Australian public hospital system guarantees access to care in case of catastrophic or life-threatening conditions. However, access to elective surgeries is rationed, with priority for admission assigned on the basis of need.

11.16 Private health insurance is being developed in Australia as an increasing source of financing apart from government funding especially for private hospital activity - it accounts for some 6.7% of the total health expenditure of Australia in 2004 or some 20.4% of the private health expenditure. It has contributed finances to the development of a large private hospital sector and has helped to fill its capacity. The pros of the Australian-style voluntary private health insurance are that it not only provides a supplementary source of funding, but also more choice for patients with a vibrant private medical sector that shares out the demand of the public healthcare system. The Australian experience, however, also indicates that the problem of how to maintain a sizeable take-up rate must be resolved for private health insurance to function well and be sustained in the long run.

Advantages as Supplementary Financing

11.17 Providing incentives for the taking out of voluntary private health insurance (e.g. tax deduction) with a view to providing a supplementary source of financing has the following advantages –

(a) **Individuals' choice to reduce financial risk**: it remains an individual's choice to take out voluntary private health insurance. Through the insurance and premium payment, the insured can effectively off-load a substantial portion of his financial risks arising from falling ill. Private health insurance can be an effective and efficient means to provide risk-pooling for an individual's health risks, provided that issues such as anti-selection and moral hazards can be effectively addressed.

(b) **More choice of services**: private health insurance provides an individual with more choice of healthcare services. It not only provides individuals with a choice of healthcare services from both the public and private sectors, but also allows an individual to customize the scope of services, the

level of benefits, and the class of amenities to be covered by the insurance according to his own choice.

Disadvantages as Supplementary Financing

11.18 On the other hand, relying on voluntary private health insurance as a supplementary source of financing has the following disadvantages –

(a) **Expensive for the high-risk groups**: under a voluntary insurance scheme, the insurance premium for the high-risk groups such as those with chronic illness, the elderly, those with pre-existing medical conditions, or those with risks of hereditary illnesses can be very expensive.

(b) **Costly premium due to anti-selection**: under a voluntary insurance scheme, there can be a significant degree of anti-selection. If the insured pool is small as with the case of most voluntary health insurance schemes at present, the effect of anti-selection and the cost of underwriting to avoid such would also lead to more costly insurance premium.

(c) **Coverage may exclude pre-existing medical conditions**: exclusion of pre-existing medical conditions is often employed as a means of avoiding anti-selection under a voluntary insurance scheme. This makes it even harder for those already with illnesses to get insured. Reportedly there are disputes between insurers and insurees over the exact coverage and the exclusion of the insurance, especially when the exclusion is based on self-declaration.

(d) **No guarantee of continuity especially at old age**: voluntary private health insurance for individuals rarely provides guarantee on premium or renewal. Insurance premium will usually increase with age as health risks increase. It is also often the case that those having insurance claims for illnesses may have their premium increased, sometimes to an unaffordable level. Reportedly some may also have their insurance policies terminated. In addition, medical insurance provided by employers for their employees will usually cease coverage once the employees leave employment (e.g. on changing jobs or after retirement).

(e) **Little protection for consumers if unregulated**: currently voluntary private health insurance policies are not subject to regulation on their terms and coverage. Individual insurees are also often at a disadvantaged position

vis-à-vis insurers as they would be less capable of understanding the legal terms of insurance as well as defending their contractual rights.

(f) **Little control on healthcare utilization and costs**: without a regulatory framework, it is difficult to control utilization and costs of healthcare services including those in the private sector under a voluntary private health insurance.

(g) **May encourage tendency to overuse healthcare**: given the potential for moral hazards, voluntary private health insurance may encourage the tendency to overuse healthcare, when providers and patients may have the incentives to over-supply and over-use healthcare. The rapidly increasing healthcare costs and insurance premium in the US is a case in point.

(h) **Increasing premium over time**: The increase in utilization particularly the excessive use of healthcare due to moral hazards will increase insurance premium over time. The lack of effective benchmarking of healthcare price and cost would also contribute to increasing premium. For individuals, the premium will also increase over time as they get older or if chronic or other illnesses occur to them.

(i) **Not helping individuals to save to meet future healthcare needs**: while some insurance plans provide a savings component, voluntary health insurance in general does not provide reserve funding for individuals to meet their future healthcare needs. If we rely on voluntary health insurance as supplementary financing, as the healthcare needs of the population increase, the amount of financing expected from voluntary health insurance will increase as well.

(j) **Incur administration and other insurance costs**: apart from the administration costs for underwriting, private health insurance would also incur administration costs for claims processing and reimbursement, as well as commissions for agents and profits for insurers. On average, the claims payout from voluntary private health insurance currently in the market amount to some 70% of the amount of premium paid, the rest being costs and profits or sums set aside for meeting future liabilities.

(k) **Not relieving the pressure on the public healthcare system**: at present in Hong Kong, even for those with voluntary private health insurance (both employer-provided and individually-purchased), it is estimated that some 62% of their in-patient needs are still being met by the public hospitals. A

possible reason is the significant price differential between the public and private sectors, and the residual financial risks (i.e. the payment that the insured has to make after the insurance benefit limit has been reached) even with insurance. If the insured goes to public hospitals, the insured will be sure that they would not need to pay for any co-payment, and the insurers will only need to pay the highly-subsidized fees ($100 per day). Reportedly some insurance even offer cash allowance for the insured if they choose services from public hospitals. Thus for acute care and other healthcare services where there are relatively higher priorities and shorter queues in public hospitals, there is still significant incentives for the insured to go to public hospitals instead of private ones (and for the insurers to encourage them to do so), and in those cases the voluntary insurance would not provide any additional supplementary financing for those services.

(l) **Unpredictable and inadequate supplementary financing**: it would be difficult to predict the amount of financing that would be available through voluntary private health insurance, especially as the taking out of private health insurance could be subject to economic cycles. Even with financial incentives such as tax deduction, the size of private health insurance is also unlikely to increase to such a size that can provide an adequate source of supplementary financing. For comparison, in Australia where the Government has proactively promoted voluntary private health insurance, it still amounts to only 6.7% of financing for the total health expenditure or 20.4% of private health expenditure.

Chapter 12 SUPPLEMENTARY FINANCING OPTION (5) - MANDATORY PRIVATE HEALTH INSURANCE

Mandatory Private Health Insurance as Supplementary Financing

12.1 Mandatory private health insurance is where private health insurance, instead of being taken out voluntarily by individuals in the population, is mandated to be taken out by law usually on a population-wide basis. The scope of coverage and level of benefits of mandatory private health insurance is specified by law usually in the form of a statutory minimum level of coverage and benefits. Premium for mandatory private health insurance is usually community-rated, i.e. all the insured irrespective of age, gender and health conditions are charged the same premium for the same insurance plan of the same coverage and benefits. Premium for the low-income and under-privileged is usually paid for or subsidized by the Government.

12.2 A key difference between mandatory private health insurance and social health insurance is that the former does not involve direct income re-distribution, i.e. the high-income does not subside the low-income through the insurance. On the other hand, income re-distribution is a hall-mark of almost all social health insurance schemes with contributions linked to income level.

12.3 Mandatory private health insurance usually provides broad coverage for essential healthcare services ranging from in-patient services, out-patient services (specialist out-patient services and general out-patient services) to prescription drugs, as well as other related healthcare services. The level of benefits is usually only at a basic level, e.g. covering in-patient services at a lower class of amenities, and covering out-patient services at average fees requiring co-payment. Individuals who want coverage for services beyond the scope of the mandatory insurance or want a better level of benefits (e.g. higher benefit levels for in-patient coverage, better class of amenities for in-patient services, higher reimbursement limits for out-patient services, etc.) may purchase top-up insurance on a voluntary basis.

12.4 As in the case of voluntary private health insurance, mandatory private health insurance provides the insured with choice of healthcare services in both the public and private sectors. Unlike voluntary private health insurance, however, mandatory private health insurance effectively prevents risk-selection by the insurers (e.g. the insurers select only those with low risk to insure while rejecting the high-risk individuals) and anti-selection (whereby high-risk individuals intentionally take out insurance while low-risk individuals opt out of the scheme),

by creating a pool sufficiently large for any risk to be effectively shared out and by having in place regulatory measures to ensure such. This allows all citizens to be insured regardless of risk levels, and ensures that everyone except those in need of government subsidies would be paying an equal share of the premium.

12.5 Increase in healthcare utilization and cost due to abuse remain a key factor in driving up the premium for mandatory private health insurance. Thus mandatory private health insurance schemes are almost invariably accompanied by various control measures aimed at controlling healthcare utilization and cost.

Financing Implications

12.6 We estimate that for a mandatory private health insurance scheme, if introduced in Hong Kong on a population-wide basis to provide benefit coverage at around 40% of the cost of public healthcare services (i.e. the insurance would pay around 40% of the cost of public healthcare services irrespective of whether the insured uses public or private services), the monthly insurance premium would initially be some $160 per person, and the insurance scheme would be able to provide extra funding equivalent to around 17% of the total health expenditure. The premium will increase to around $240 and $330 in 2015 and 2023 respectively, as the age profile of the population changes to one with a larger elderly population. This is on the assumption that the scheme applies to every individual in the whole population, irrespective of their age and employment status, and has not taken into account the affordability of the low-income and under-privileged groups. If the low-income and under-privileged groups are to be exempted from the mandatory private health insurance scheme, the premium will need to be higher in order to provide the same level of supplementary financing.

12.7 In principle, it is also possible to apply the mandatory private health insurance scheme to a specified group of the population, e.g. the working population, and provide better benefit coverage that can cover charges for private hospital services. In this regard, we have estimated that a mandatory private health insurance scheme that provides benefits at around 80th percentile of current private hospital charges at the general ward level[10], if applied to those in the working population aged from 18 to 64 with monthly income $10,000 or above, the community-rated premium will be around $290 per person per month, and the insurance scheme would be able to provide extra funding equivalent to around 5% of the total health expenditure. The premium will increase to around $340 and $430 in 2015 and 2023 respectively. If the scheme is applied to this group of

[10] In other words, based on current utilization profile, the benefit limits of the insurance would be able to cover private hospital admissions at general ward level in 80% of cases without the need for top-up.

working population plus the whole elderly population (aged 65 or above), the community-rated premium will be much higher at around $710 per person per month, due to the much older age profile of the participants.

Overseas Experience

12.8 Mandatory private health insurance is implemented on a population-wide basis in Switzerland[11] and the Netherlands[12]. The law in these countries mandates the taking out of private health insurance of a prescribed minimum level of coverage. There is a legal obligation for insurance companies to accept anyone purchasing compulsory health insurance from them. In Switzerland, these insurance companies are not allowed to make profits from their compulsory health insurance activities. However, they are at liberty to offer their members a variety of other insurance products, like supplementary health insurance, life and accident insurance products that are profit-making.

12.9 Premium for the compulsory level of coverage is the same for everyone who takes out the same insurance plan, irrespective of age, gender and medical conditions. The governments in Switzerland and Netherlands subsidize compulsory health insurance premiums on a means-tested basis through allocations from general taxation. Premium subsidies vary according to the income and asset of the insured person. In the Netherlands, the government and a social health insurance mechanism involving income-related contributions from the working population pay for the premium of children up to age 18. In Switzerland, most of the insurance policies require a deductible from the insured and in addition to the deductible, there is a co-payment for all services covered by compulsory health insurance, to be paid by patients out-of-pocket. In the Netherlands, whether deductible and co-payments have to be paid by the insured depends on the plan chosen.

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[11] What the Swiss law terms as a social health insurance is in fact mandatory taking out of private health insurance that are managed by private insurance companies. The insurance is mandatory for the whole population and low-income families are subsidized by the government. Premiums of the mandatory insurance are community-rated and the insurers are not allowed to make profits from the compulsory insurance.

[12] The Netherlands implemented a mandatory private health insurance scheme in January 2006 under a major healthcare reform. The mandatory insurance is managed by private insurers and is financed by community-rated premiums as well as by income-related contributions that are meant for covering children's premiums and for risk adjustment among insurance companies. Prior to the reform, the major financing source was social health insurance, participation of which was compulsory for people with income lower than a certain level, while higher income people took out voluntary private health insurance.

12.10 Under the mandatory private insurance system, insurers are the purchasers of healthcare services on behalf of the insured and are generally in a strong position to derive optimum return from the payouts to the care providers. In Switzerland, payments to healthcare providers are negotiated between service providers/associations of service providers and associations of health insurance funds. In the Netherlands, insurers enter into contract with hospitals and doctors. The insured can choose to receive care from non-contracted care providers but they may not receive full reimbursement in these cases.

12.11 Both Switzerland and the Netherlands have in place measures to ensure that insurance companies are able to meet their financial commitments to the insured. In Switzerland, the compulsory health insurance is funded mainly through premium revenues. To ensure that companies with high-risk enrolees are not at a disadvantage, insurance companies in Switzerland formed an organization to make risk-adjustment and transfers between companies based on the age and gender of the insured people. In the Netherlands, the compulsory health insurance is funded through premium revenues (45%), an income-related contribution (50%), and government contribution (5%). The income-related contributions are collected by the Inland Revenue Service from the insured and deposited in a Health Insurance Fund together with the government contribution. The Health Insurance Fund is used to pay insurers the children's premiums and to compensate insurers for any financial disadvantage they incur in insuring high-risk individuals. Dutch law also provides for the disbursement of public funds if an insurer is unable to meet its financial commitments.

Advantages as Supplementary Financing

12.12 Introducing mandatory private health insurance with a view to providing a supplementary source of financing has the following advantages –

(a) **Guaranteed risk-pool and avoid risk-selection/anti-selection**: a mandatory private health insurance can prevent risk-selection by insurers or anti-selection by individuals by guaranteeing a large insured base with largely predictable risk profile for effective risk-pooling, thereby allowing the risk to be effectively pooled among the insured population. The huge insured-base offers guarantee to the insurance industry to ensure that such insurance is viable.

(b) **Guaranteed acceptance and continuity**: being mandatory, a health insurance scheme can be required to accept all insurees, not to exclude any pre-existing medical conditions, and thereby enabling the high-risk groups

including chronic patients, the elderly or individuals with other risk factors to get insured. It would also allow individuals to stay insured even after they have been struck by catastrophic or chronic illnesses, thereby enjoying continued protection.

(c) **Enable affordable community-rated premium**: because of the large size of the insured pool and the consequential capacity of the pool to absorb the impact of high level payouts incurred by high-risk individuals, a mandatory health insurance scheme can be required to charge the same premium for the same insurance plan for all participants, thereby making it possible for all persons, regardless of their health condition, age and other attributes, to be insured at a reasonable premium level, and making the insurance affordable even to the high-risk groups.

(d) **Lower insurance cost and lower healthcare cost**: with mandatory and universal participation, mandatory private health insurance obviates the need for underwriting as well as extensive marketing, thereby reducing the cost for the insurance as compared to voluntary private health insurance. With a much larger insured base compared to voluntary private health insurance, mandatory private health insurance also enables insurers to be in a better position to negotiate with healthcare providers on the price, thereby increasing competition and driving down healthcare costs.

(e) **Enhance consumer protection through regulated insurance**: mandatory private health insurance would have to be regulated to ensure that they provide better terms and other benefits as set out above. Such regulatory activities can also ensure better consumer protection.

(f) **More choice of services**: like voluntary private health insurance, mandatory private health insurance also provides an individual with more choice of healthcare services. Although the basic level of benefits under the mandatory insurance plan is the same for all, the insured would still enjoy greater freedom in choice of services (e.g. provider, timing of treatment, etc.). Individual may also customize the scope of services, the level of benefits, and the class of amenities according to his own choice through purchasing top-up insurance offered as options on top of the mandatory insurance.

(g) **Relieving the pressure on the public healthcare system**: similar to a social health insurance, a mandatory private health insurance can provide coverage for healthcare services in both the public and private sectors, and

insurers can be required by law to cover the cost for services provided by the private and public sectors alike, thereby relieving the financing pressure on the public healthcare system.

(h) **Stable financing**: with a guaranteed and predictable participation, a mandatory private health insurance would provide a stable source of supplementary financing for healthcare.

Disadvantages as Supplementary Financing

12.13 Introducing mandatory private health insurance with a view to providing a supplementary source of financing has the following disadvantages –

(a) **Incur administration and other insurance costs**: although the costs for underwriting and commissions could be reduced, a mandatory private health insurance would still incur administration costs for claims processing and reimbursement. Such costs are unavoidable if choice of services is to be provided.

(b) **Regulatory costs**: the government will need to put in place stringent regulatory measures including a cap on insurance administration cost for mandatory private health insurance, which means intervention in the currently free market of voluntary private health insurance.

(c) **Not helping individuals to save to meet future healthcare needs**: mandatory private health insurance in itself does not provide reserve funding for meeting future healthcare needs, unless additional arrangements are made to obtain reserve funding for individuals when they cease employment.

(d) **May encourage tendency to overuse healthcare**: like voluntary private health insurance and other third-party-pay financing options, mandatory private health insurance is also susceptible to moral hazards, and may encourage the tendency to overuse healthcare, when providers and patients may have the incentives to over-supply and over-use healthcare. However, the large pool size and the uniform structure and coverage of a mandatory insurance scheme would allow better control of utilization through design of the scheme in terms of coverage (e.g. to cover services less easily abused) and other rules for claims (e.g. by requiring higher co-payment or deductible for services that may be subject to abuse) to minimize the potential of abuse or overuse.

(e) **Increasing premium over time**: while the utilization and costs of healthcare services including those in the private sector under a mandatory private health insurance scheme would be under better control, premium for a mandatory private health insurance would still go up as the healthcare needs of the insured population increase, due to an ageing population and medical inflation.

Chapter 13 SUPPLEMENTARY FINANCING OPTION (6) - PERSONAL HEALTHCARE RESERVE

Personal Healthcare Reserve as Supplementary Financing

13.1 With a view to inducing changes in the healthcare system that would enhance its long-term sustainability, and having regard to the experience of overseas economies over different financing options, we have also explored the option of a Personal Healthcare Reserve (PHR) Scheme as an additional financing option in the context of Hong Kong's healthcare system. PHR seeks to combine the desirable features of medical savings accounts and regulated private health insurance, while allowing room for a certain level of subsidization by the Government.

13.2 The basic concept of a PHR is to require those above a certain income level in the working population to deposit a fixed percentage of their income to their own PHR account for the purpose of financing their own healthcare, with the following features –

(a) **Health protection scheme**: the PHR will serve as a healthcare protection scheme for its participants both during their working life and after their retirement[13], by affording them the following two layers of protection –

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[13] For instance, if a PHR scheme is applied to those in the working population aged 18-64 with income above a certain specified level, it is envisaged that an individual will save and use the deposit under the PHR scheme as follows –

(1) <u>During age 18-64</u> –
   a. the individual will save a fixed percentage of his/her income to his/her PHR account for as long as he/she is employed with income above the specified level;
   b. the individual will stop saving to his/her PHR account when he/she ceases employment (e.g. change jobs or stop working), or when his/her income is below the specified level;
   c. the individual will be required to subscribe to a regulated medical insurance scheme and the premium will be deducted from the deposit in his/her PHR account, for as long as there is still deposit, even while he/she may be out of employment temporarily;
   d. the individual will no longer be required to subscribe to the regulated medical insurance scheme after he/she has exhausted the deposit in his/her PHR account, say when he/she has ceased employment for a long period, though he may continue to subscribe the insurance on a voluntary basis using his own funds; or
   e. the remaining deposit will be accrued in the individual's PHR account through investment for meeting his/her future healthcare needs, and the deposit could not be used before 65 for purposes other than paying for the regulated medical insurance premium.

(2) <u>Age 65 and after</u> –
   a. the individual will no longer be required to save his/her income to his/her PHR account even if he may still remain in employment with income above the specified level;

(i) to use part of the PHR deposit to subscribe to a compulsory regulated medical insurance scheme (see sub-paragraph (c) below) to provide basic and continuous healthcare protection at all ages, both **before and after retirement**[13]; and

(ii) to accrue the remaining deposit in the PHR account through investment, to meet one's own future healthcare needs and pay for healthcare expenses **after retirement**[13] (including insurance premium, insurance co-payment and other out-of-pocket healthcare expenses).

(b) **Scope of application**: the PHR scheme is intended to apply to those whose income is above a certain level. The Scheme will allow these participants the option to extend voluntarily the protection offered by the Scheme to their family members.

(c) **Regulated medical insurance**: all PHR holders with deposit in their PHR account (including those who are no longer required to save, such as those after their retirement) will be required to subscribe to a regulated medical insurance scheme. This scheme addresses a substantial number of shortcomings of voluntary private health insurance in the following ways –

(i) **Flat rate premium for all ages**: the basic insurance will be regulated to charge community-rated premium for all participants irrespective of age, gender and health conditions. The flat premium rate for the basic insurance would mean that the insured who suffered from illnesses would not have their insurance premium drastically increased after major claims. This would enable the high-risk population (e.g. patients with chronic illnesses or elderly patients) to get and stay insured. The cost for the basic insurance may also be subject to regulation for it to operate solely on a cost-recovery basis. This together with the large insurance pool would ensure a premium that is lower in general than that of voluntary medical insurance of similar

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b. the individual will be required to subscribe to a regulated medical insurance scheme and the premium will be deducted from the deposit in his/her PHR account, for as long as there is still deposit;
c. the individual will also be able to use the deposit in his/her PHR account to pay for other day-to-day medical expenses, and any remaining deposit will continue to be accrued in his/her PHR account with investment; and
d. the individual will no longer be required to subscribe to the regulated medical insurance scheme after he/she has exhausted the deposit in his/her PHR account, but depending on the design of the scheme he/she may be allowed to continue to subscribe to the insurance voluntarily using his/her own funds.

coverage currently available in the market.

(ii) **Essential and continuous coverage at all ages**: the insurance can be regulated to provide its participants with no exclusion of pre-existing medical conditions, guaranteed acceptance and renewal, portability between employment, and continuity beyond retirement age. Various coverage designs are possible, for instance:

- essential in-patient services only;
- essential in-patient services and long-term medications;
- essential hospital and specialist services as well as long-term medications, specialized drugs; or
- essential treatment for catastrophic illnesses.

The scope of services and level of benefits to be covered by the basic insurance will be subject to further design having regard to the views of the community on this supplementary financing option, as well as what essential services they would like to see protected by insurance. In this regard, it is not recommended to cover general out-patient services under the regulated medical insurance. This is because the risk of requiring such services is rather evenly spread among the vast majority of the population (i.e. most individuals would be using such services), and thus there is little risk-sharing effect in subscribing an insurance to cover such services. Such services are also relatively more affordable to the public, and for which voluntary top-up insurance can be purchased as necessary.

Claims payouts under the regulated medical insurance for healthcare services may be subject to co-payment or deductibles as appropriate to ensure judicious and responsible use of healthcare. Insurance companies may offer on profit-making basis different optional top-up insurance for participants to choose to suit their needs.

(d) **Government financial incentives**: as mentioned in paragraphs 6.16-6.17, the Government will examine, inter alia, how financial incentives can be provided for the participants of the PHR scheme, in return for their taking a greater share of responsibility for their own healthcare. The financial incentives may take different forms, for example, tax deduction for deposits made to PHR account (for oneself and for family members), or one-off government contribution to PHR account as start-up capital. The

form and amount of the financial incentives will be subject to further design.

(e) **Choice of healthcare services**: The PHR scheme will enable its participants to have a choice of various personalized healthcare services in the private sector, through the regulated medical insurance and any top-up insurance individuals may choose on their own. The participants may also choose healthcare services in the public sector, in which case the insurance will be charged the full cost for the public services used, subject to any applicable co-payments or deductibles, in the same way as the insurance would be charged for private sector services used by the insured. The participants may choose to use private services in public hospitals, or they may access general class public services, in the same manner as with other uninsured patients, through the same queuing and triage mechanisms. The former services are currently charged on a full-cost-recovery basis. If they choose the latter services, they will only need to pay out-of-pocket the standard fees of public hospital services. Since the participants have been insured up to a certain level that enables them to afford private sector service, in the case of choosing public sector service they may still prefer private services in public hospitals to general class services.

(f) **Public healthcare safety net**: if a participant in the PHR scheme uses public services and the cost exceeds the applicable benefit limits of the insurance, or if the participant has already exhausted the benefit limits of his/her insurance, the cost would continue to be borne by the public sector.

(g) **Second safety net**: consideration may also be given to introducing a second safety net for participants in the PHR scheme, by allowing an individual participant who has used healthcare services beyond his/her insurance benefit limit to access private services in the public sector at a lower rate, e.g. a rate set at a certain percentage of the cost or a rate capped at a certain percentage of the participant's household income. This second safety net provides those participants in the PHR scheme who have taken a greater share of responsibility for their own healthcare needs through supplementary financing, but who have unfortunately exhausted their insurance (e.g. due to catastrophic or complex illnesses requiring costly treatment) an extra option to access private services provided by the public sector with more choice and better amenities at lower fees than normally charged, apart from reverting to the basic safety net of general class public services.

13.3 The concept of a PHR comprising a combination of a savings component and an insurance component and involving a specified group of the population is a new concept. We propose this concept in the light of experience of savings schemes and insurance schemes in overseas economies, and having regard to our own circumstances, especially the need to reform our own healthcare system to address the public-private imbalance, the limited choice in healthcare for the community, and inadequate healthy competition in the healthcare market. We believe that the PHR concept is a worthwhile concept to explore to address the need for supplementary financing, as well as to drive the market structure reform to the healthcare system.

Financing Implications

13.4 It is worth emphasizing again that the concept of a PHR scheme is explored as a **supplementary financing**, i.e. financing means for healthcare to supplement government funding which will continue to increase and will remain the primary funding source for healthcare. In particular, the public healthcare system will continue to be funded predominantly by government funding and will continue to provide a safety net (see Chapter 5) for the population, under the policy that no one should be denied adequate healthcare through lack of means.

13.5 The supplementary financing that could be made available through the PHR scheme, which in turn affects its viability, depend on the following design parameters of the Scheme –

(a) **Size of PHR population**: The greater the size of the population to which the PHR scheme is applied, the larger the reserve as potential financing for healthcare from the individual participants, and also the bigger the base for the regulated medical insurance which could ensure effective pooling of risks and lower insurance premium. The size of the PHR population is determined by the criteria defining mandatory participation in the PHR scheme.

For example, if the scheme were to apply to those in the present working population earning a monthly income at a certain level or above, the number of mandatory participants in the PHR scheme would be as follows –

Monthly income	Number of mandatory participants
$10,000 or above	1.70 million
$12,000 or above	1.39 million
$15,000 or above	1.07 million

(b) **Rate of deposit to PHR**: the higher the rate, the larger the reserve available to individual participants to finance their own healthcare, and also the greater the security of financing available to meet healthcare needs after retirement. On the other hand, to avoid the building up of excessive reserve, the deposit could be subject to a cap, i.e. a maximum income for deposit.

For example, for an individual who started contribution at the age of 25, the amount of deposit that would be accrued in his/her reserve by the age of 65 taking into account salary progression (based on the salary progression factor of a male worker at different age from 25 to 64) and assuming no withdrawal from reserve before 65 (in today's dollar terms, excluding inflation, at 3% real investment return, and monthly income for contribution capped at $30,000) is estimated as follows –

Starting monthly income	Accrued savings between age 25 to 65 at contribution rate		
	3%	4%	5%
$10,000	$525,000	$699,000	$874,000
$12,000	$624,000	$832,000	$1,040,000
$15,000	$747,000	$996,000	$1,245,000

(c) **Coverage of regulated insurance**: a major part of an individual's PHR deposit will be channelled into the healthcare system to fund his own healthcare through the mandatory regulated medical insurance. The design of the regulated medical insurance and in turn its premium will thus determine to a large extent the amount of supplementary financing that would be made available through the PHR scheme, and the amount of reserve left in the individuals' PHR account for future use.

We have conducted an actuarial study on the level of premium for a mandatory insurance scheme with the features in paragraph 13.2(c) above, covering in-patient services, specialist out-patient services, and long-term

western medications (e.g. those for chronic illnesses), and with benefit coverage pitched at 80th percentile of the current benefit levels of private medical insurance claims (i.e. 80% of claims for private in-patient services at the general ward level would be within the benefit limits of the insurance). Assuming that the PHR scheme is applied to those in the working population with income above a certain level, and all participants (including the working population below age 65 with income above a certain level, plus those retired persons who have joined the PHR scheme before age 65 and have positive savings in the PHR) subscribe to the regulated medical insurance, the estimated premium level and the resultant amount of accrued deposit in the PHR at age 65 of an individual who started contribution at age 25 (same assumptions as in (b) above) are as follows –

Starting monthly income (no. of scheme participants)	Initial monthly premium*	Accrued savings between age 25 to 65 at different contribution rate (after premium deduction)		
		3%	4%	5%
$10,000 (1.70 million)	$293	-$206,000	-$31,000	$144,000
$12,000 (1.39 million)	$296	-$114,000	$94,000	$302,000
$15,000 (1.07 million)	$300	-$1,000	$248,000	$496,000

*Note: premium level is affected by number of participants – in general a smaller number of participants will result in a higher premium level.

It should be noted that –

(i) If government subsidies are provided as financial incentives to participants in the PHR scheme (see paragraph 13.2(d) above), the amount of the accrued savings is expected to be higher.

(ii) The initial premium is expected to be higher if the scheme is applied to those with a higher income who constitute a smaller size of mandatory participants with different age profile.

(iii) The premium is expected to increase over the years due to the increasing age profile of the participants in the insurance and rising medical costs. The premium progression will also be affected by

changes in utilization.

(iv) It is expected that at a lower contribution rate, those with lower income may not be able to accrue sufficient deposit in their PHR accounts to continue to purchase the regulated medical insurance for a very long period due to increasing premium (shown as deficit above).

(v) If the regulated medical insurance is designed with less coverage and hence lower premium, the amount of accrued deposit in the PHR account will be larger, though at the same time the PHR scheme would provide less amount of supplementary financing for healthcare, and the benefits offered by the scheme to the insured would also be less.

13.6 We have estimated that, if the PHR scheme were to be implemented in 2011 and applied to the 1.70 million working population currently with monthly income at $10,000 or above, initially the scheme should be able to provide some $6.0 billion supplementary financing for healthcare, amounting to 10% of government budget on health. The amount and proportion of supplementary financing would gradually increase as the insured population becomes older and takes up a greater share of the healthcare needs of the population. It is expected that by 2033, PHR could provide supplementary financing representing an extra 22% on top of government budget on health. This has not discounted any financial incentives that may be provided by the Government to the participants.

13.7 For individual participants, the PHR scheme would enable them to have medical insurance protection and choice of services both before and after retirement. Since most individuals' salary should increase over their working life, it is expected that the amount of reserve of individual participants would enable them to enjoy the benefits of continued insurance coverage for a substantial period after retirement. For those whose salary stayed at the minimum level throughout their working life, they may have a smaller reserve that could not last for long. It remains possible that individual participants may not have sufficient reserve to last until their death. For these individuals, the insurance scheme could be designed to allow them to continue to purchase the insurance using their own resources, and the community-rated premium design of the insurance would make it affordable to them even at an advanced age. For those who do not want to continue to purchase the insurance or who do not have the means to do so, the public healthcare system will continue to serve as a safety net for them.

Overseas Experience

13.8 In Singapore where a medical savings account scheme (the Medisave) has been implemented, the government has introduced an insurance scheme for catastrophic illnesses (the Medishield) in order to enhance the risk-pooling effect of the arrangement. The Medishield premium is to be paid using savings in the medical savings accounts. Participation in Medishield is voluntary in principle, though in practice under an opt-out arrangement where participation is automatic unless the individual chooses to stay out of the scheme, very few people are not covered by the insurance. The high level of co-payment (at least 20%) in Singapore's public healthcare services also makes the catastrophic insurance more attractive. It should be noted that the premium of the Medishield scheme is not community-rated, but increases with age.

13.9 While mandatory health insurance is implemented on a population-wide basis in Switzerland and the Netherlands, the concept of a PHR, on the other hand, is to apply the scheme only to those who can better afford contributions. This is not dissimilar to the insurance scheme promoted in Australia. Although the insurance scheme in Australia is in principle a voluntary insurance scheme, various policy measures are put in place with a view to ensuring high penetration of the insurance scheme among those who can afford it.

Advantages as Supplementary Financing

13.10 We believe that the PHR scheme can bring benefits to everyone in the community in the following ways –

(a) **For those who have joined the PHR scheme**:

(i) **Continued protection:** the PHR scheme will provide individual participants with guaranteed insurance both before and beyond retirement, and at the same time a means for them to accrue savings through investments for their own healthcare needs after retirement.

(ii) **Better insurance and choice**: the regulated medical insurance provides community-rated premium with no exclusion of pre-existing medical conditions for everyone who joins through effective pooling of risks, and will enable participants to access a greater variety of more personalised choices for healthcare services in both private and public sectors apart from the government-funded safety net.

(iii) **Safety net**: the public healthcare safety net will remain available to the

participants in the PHR scheme at all times. Consideration could also be given to providing them with a second safety net through the public healthcare system so that they would have an extra option should they fall through their insurance for instance due to complex illnesses requiring costly treatment.

(b) **For those who have <u>not</u> joined the PHR scheme**:

(i) **Improved public services and safety net**: the PHR scheme will enable a substantial portion of the population to meet their healthcare needs through insurance-paid healthcare in the private sector (or private services offered by the public sector which will be charged at-cost), thereby relieving the pressure on the public healthcare system. This would help shorten the existing queues and waiting time in public hospitals, and make public healthcare services more accessible to those who have to rely on the public healthcare safety net. Reduced pressure on the public healthcare system would allow resources to be devoted to the priority areas of public healthcare services, including those for the low-income families and under-privileged groups. It would also allow room for improving standard public services and extending the safety net.

(c) **For the healthcare system as a whole**:

(i) **Sustainability**: the PHR scheme will secure a substantial pool of funding that can be tapped as supplementary financing source apart from government funding to finance future healthcare, thereby reducing the demand on future public expenditure and burden on future generations, and sustaining the continued development of the healthcare system, including continued investment in medical technology and training of healthcare manpower.

(ii) **Stability**: at times of economic downturn, the savings (for those after retirement) and the insurance (for all) can help sustain the participants with healthcare protection, without having to offload all the pressure for healthcare onto the public healthcare safety net.

(iii) **Address public-private imbalance**: by ensuring that a substantial portion of the population would have the means to access private healthcare services through effective risk-pooling, the scheme could help redress the current public-private imbalance and promote healthy

competition between the two sectors.

13.11 Introducing the PHR scheme would combine some of the advantages of mandatory health insurance and medical savings accounts as set out in paragraph 10.11 and paragraph 12.12 respectively. Moreover, the PHR scheme would also have the following additional advantages not available through either medical savings accounts or mandatory health insurance alone –

(a) **Complementary savings and insurance**: the regulated medical insurance could address the disadvantage of not having any risk-pooling under a pure savings scheme, and provides a way to making use of regular and predictable withdrawal of savings to provide healthcare protection before retirement without having to forego the benefits of accruing reserve in the PHR account through investments. At the same time, the reserve account could address the disadvantage of mandatory private health insurance that does not make provision for future healthcare needs, and would allow the insurance protection to continue even if the participant is temporarily out of employment.

(b) **Sustainable and stable financing**: with a guaranteed and predictable participation, and the feature of saving for future healthcare needs, the PHR deposits together with the regulated medical insurance would provide a stable and sustainable source of supplementary financing for healthcare.

Disadvantages as Supplementary Financing

13.12 The concept of a PHR scheme has its share of disadvantages, some of which are inherited from those of medical savings accounts and voluntary/mandatory private health insurance –

(a) **Incur administration costs and other costs for both insurance and savings**: the contribution to the PHR accounts, the regulated medical insurance, and disbursement of reserve from the PHR accounts to pay for healthcare expenses will all entail administration costs. The administration costs for the collection of deposit and administration of PHR accounts can however be minimized by making use of the established MPF framework, where there would be synergy and economy of scale, and measures are already being taken to reduce the administration costs of the MPF. The administration costs of the insurance can be reduced by regulating the insurance to control administration costs and to ensure that it operates on a

cost-recovery basis, provided there is a sufficiently large pool to achieve economy of scale in administration. The administration cost for disbursement of medical expenses is unavoidable, but there would be synergy if the disbursement is to be administered by the insurer alongside processing of insurance claims.

(b) **Regulatory costs**: the government will need to put in place stringent regulatory measures for both the PHR accounts operation and the regulated medical insurance. The regulatory costs for the PHR accounts operation could be minimized by making use of the established MPF framework, without having to set up an extra layer of regulatory framework. However, regulation of medical insurance will still require a separate regulatory framework, which also entails cost and intervention in the currently free market of voluntary private health insurance.

(c) **May encourage tendency to overuse healthcare**: like other financing options involving insurance or other third-party-pay, the PHR scheme may also have the effect of encouraging a tendency to overuse healthcare. As in the case of mandatory health insurance, however, the behaviour of the insured under a mandatory insurance scheme can be better controlled through design of the scheme in terms of coverage (e.g. to cover services less easily abused) and other rules for claims (e.g. by requiring higher co-payment or deductible for services that may be subject to abuse) to minimize the potential of abuse or overuse.

(d) **Increasing premium over time**: notwithstanding the putting in place of control measures including co-payment or deductible or other measures, the utilization and costs of healthcare services may still increase as a result of the introduction of the regulated medical insurance, partly because of the heightened expectations for healthcare under the insurance, and partly because of the incentives of the private sector to over-supply healthcare services. Even if the healthcare utilization and cost could be effectively controlled, the premium for the insurance would still escalate as the healthcare needs of the insured population increase, due to ageing population and medical inflation.

Chapter 14 BUILDING A HEALTHY TOMORROW

Success Criteria of Reform

14.1 The previous chapters set out our proposals to reform the healthcare system to serve better the community. We intend to measure the success of healthcare reform by how well we achieve the following –

(a) **For the public/patients** –

(i) ensure that public healthcare services remain affordable and accessible and continue to provide a sustainable safety net;

(ii) improve the quality and value-for-money of healthcare services in both the public and private sectors;

(iii) provide more personalized choice of services in both the public and private sectors;

(iv) promote a culture of shared responsibility for personal health and put greater emphasis on healthy lifestyle and preventive care; and

(v) build in incentives and safeguards that promote judicious and appropriate use of healthcare services.

(b) **For the healthcare providers/workers** –

(i) ensure that professional standards and skills, quality of care, as well as healthcare facilities and technology continue to keep pace with international development;

(ii) continue to uphold high standards of professional conduct and ethics through the professional regulatory framework and peer monitoring;

(iii) promote healthy competition and collaboration between the public and private sectors in the market that can further enhance professional quality and cost-effectiveness of services; and

(iv) provide a vibrant healthcare market and a working environment conducive to the provision of better healthcare services.

(c) **For the healthcare system as a whole –**

(i) improve the health of our community continuously through more efficient and cost-effective healthcare, with more emphasis given to primary care, especially preventive care;

(ii) ensure sustainable development of the healthcare system by overcoming the structural and financing challenges it faces;

(iii) continue to provide a safety net of healthcare for the low-income and under-privileged groups as well as others in need; and

(iv) ensure the effective and efficient functioning as well as healthy development of the healthcare market.

Areas to be Further Considered

Institutional Changes

14.2 We anticipate that the implementation of the reform will entail changes to the institutional arrangements under the current healthcare system, especially in supporting the reforms to the service delivery models as well as financing arrangements. We will consider the necessary changes after finalising the reform proposals for implementation. In principle, we envisage a need to distinguish the following roles within the healthcare system –

(a) **Policy maker**: to formulate health policies and allocate public funds to implement such policies.

(b) **Professional regulator**: to regulate the professional standards and conduct of the healthcare professions, including professional ethics.

(c) **Professional development and training institution**: to provide the necessary training and support the continued development of healthcare professionals.

(d) **Service standards setting body**: to set the standards for healthcare services including the quality and content of publicly-funded or subsidized healthcare services.

(e) **Service purchaser**: to purchase publicly-funded or subsidized healthcare services from service providers, or in the case of insurance, to purchase healthcare services for the insured from both public and private services providers.

(f) **Service provider**: to provide healthcare services up to purchasing standards while subject to regulation on professional standards and conduct.

(g) **Service monitor and auditor**: to audit publicly-funded, subsidized or third-party purchased healthcare services provided by service providers to ensure compliance with service standards and value-for-money.

(h) **Insurance regulator**: to regulate medical insurance offered by insurance companies for the protection of consumers.

Healthcare Manpower Planning

14.3 Following the reform and financing proposals, the Government will need to examine the issue of healthcare manpower planning, with a view to ensuring that there is sufficient manpower supply of different healthcare professions to support the sustainable development of the healthcare system in the long run, both in the public and private sectors.

Long-Term Funding Arrangement for Hospital Authority

14.4 As a result of the reform and financing proposals, particularly the proposal to redress the public-private imbalance and the introduction of supplementary financing, the Government will need to examine the long-term funding arrangement for the Hospital Authority. The purpose is to ensure sufficient funding for public healthcare services having regard to the target services provided and population served, so as to ensure that the public healthcare system and safety net services will continue to improve in quality.

Specific Areas of Healthcare Services

14.5 After finalising the reform and supplementary financing proposals to be taken forward, we shall further examine the necessary policies and measures to develop and enhance specific areas of healthcare services, including mental health services, dental services, Chinese medicine, infirmary services and long-term medical care.

Chapter 15 WAY FORWARD

Two-Stage Consultation

15.1 Health is important for every one of us. Building a healthcare system that can continue to keep us, our families, and our future generations healthy is therefore our shared responsibility. Now is the time for us to collectively consider how best to overcome the challenges to our healthcare system and strive for a consensus on the actions that need to be taken to ensure its sustainability. This consultation document has set out the problems and our proposals to address them. We need your support and constructive views to take them forward. This consultation exercise concerns every one of us and our future generations. Please share with us your thoughts and views.

15.2 Please give us your support and constructive views to turn our vision into reality. Please send us your views on this consultation document **on or before 13 June 2008** through the contact below. Please indicate clearly if you do not want your views to be published or if you wish to remain anonymous when your views are published. Unless otherwise specified, all responses will be treated as public information and may be publicized in the future.

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15.3 On the basis of the views received during the first stage consultation, we will formulate detailed proposals for the reform including those of supplementary financing arrangements. We will then consult you further at the second stage consultation.

APPENDIX A GLOSSARY OF TERMS

Acute Medicine / Acute Care	Refers to the immediate and early specialist management of patients with a wide range of medical conditions who present in hospital as emergencies.
Ambulatory Care	Medical care (including diagnosis, observation, treatment and rehabilitation) that is provided on an out-patient basis. This care is particularly given to patients who are mobile (ambulatory) and not confined to hospital.
Anti-selection / Adverse Selection	In the context of insurance, anti-selection or adverse selection refers to a situation whereby individuals with higher risks are more likely to take out insurance, resulting in the insured having a higher chance of making claims for the insurance benefits.
Benefit Limits	The maximum amount that the insurance company will pay out to an insured person who makes a claim for a particular item covered by the insurance package.
Benign Prostatic Hyperplasia Surgery	A surgery that involves removing part of the prostate (a gland within the male reproductive system) that is pressing against the urethra (the tube that excretes urine from the bladder to the outside of the body) and restricting the flow of urine. Benign prostatic hyperplasia is a non-malignant (non-cancerous) enlargement of the prostate gland, making urination difficult and painful and in extreme cases, completely impossible. It often occurs in older men.
Cataract Surgery	Removal of the clouded lens of the eyes (the cataract) in its entirety by surgery.
Catastrophic Illness	A severe illness that is life-threatening or may lead to serious disability. Such illnesses usually require prolonged hospitalisation or recovery, and involve high costs for medical care.
Chemotherapy	Drug treatment to kill cancer cells.
Chiropractors	Health professionals who seek to diagnose, treat, correct, and prevent neurological, skeletal, or soft tissue dysfunction by employing manual therapies.
Chronic Disease	A disease that is long-lasting or recurrent, and with slow progression. Examples of chronic diseases include diabetes and arthritis (a condition where there is damage caused to the joints of the body).

Clinical Protocols	Precise and detailed plans for the study or treatment of a medical problem or disease. They provide the standards in which healthcare providers can follow in their daily practice.
Colorectal Cancer	Cancer that starts in the large intestine (colon) and/or the rectum (end of the colon).
Communicable Diseases	Diseases that can be transmitted directly or indirectly from one person to another. Examples include influenza, tuberculosis (TB), dengue fever and hepatitis B.
Community-rated Premium	All the insured persons pay the same premium rate for the same insurance plan irrespective of age, gender and medical conditions.
Continuity of Care	Care is provided to a patient by the same service provider over a period of time. Even if different service providers are involved in the care, they communicate with each other to coordinate healthcare, so that the care provided to the patient is continuous and not being disrupted by any changes in service providers or places of care.
Convalescent Care	Nursing care or therapeutic services for patients to help them to recuperate and recover after a surgery or serious illness.
Co-payment	An amount that a patient has to pay as his/her share of the cost of health services received.
Cost-effectiveness	The minimal expenditure of financial and other resources necessary to achieve the appropriate healthcare result.
Curative Care	Healthcare services that are concerned with treatment of acute episodic illness and injury.
Deductible	Deductible (also called "excess") refers to the initial portion of any insurance claim that is not covered by the insurance provider. It is normally quoted as a specified dollar amount or a percentage of the claim amount that must be paid by the policyholder before the benefits of the policy can apply.
Disease Surveillance	The continuing collection and analysis of information of all aspects related to the occurrence of a disease that is pertinent to effective control of the disease.
Doctor-shopping	Refers to patients going to numerous different doctors to seek investigation and treatment for the same health conditions.

Domestic Health Accounts (DHA)	A set of descriptive account that traces all the financial resources that flow through Hong Kong's health system over time. It is compiled according to the International Classification for Health Accounts (ICHA) Framework developed by Organisation for Economic Co-operation and Development (OECD) to describe systematically the totality of health expenditure flows in both government and non-government sectors.
Efficiency	A proper allocation of services such that waste and unnecessary use of medical services are minimized.
Elderly Dependency Ratio	Refers to the number of persons aged 65 and above per 1,000 persons aged between 15 and 64.
Employer-provided Medical Benefits	Healthcare services provided by employers to their employees (often including employees' dependents as well) usually through a group-based health insurance arrangement. Employers may also provide staff medical benefits in the form of medical fee reimbursement.
Equitable Access (to healthcare services)	A fair opportunity to use healthcare services.
Family-doctor Model	A model in which a personal doctor, who can be a general practitioner, a family medicine specialist or any other specialist, provides primary care to patients and refers them to other healthcare services when necessary.
Family Medicine	The medical specialty that provides continuing, comprehensive healthcare for the individual and family irrespective of age, gender and illness. The core role of family medicine is in the provision of primary care, that is, in promoting health, preventing disease and providing curative or palliative care to patients in the community.
Fee-for-service	Refers to a payment method for healthcare whereby doctors and other healthcare providers receive a fee for each service provided, such as a consultation, test, procedure, or other episode of administering healthcare service.
Gamma Knife	A neurosurgical device used to treat brain tumours with radiation therapy.
Geriatric Assessment	An evaluation of an elderly person's physical, mental and psycho-social health conditions as well as his/her ability to perform the basic activities of daily living such as dressing and bathing.
Global Budget	An aggregate cash sum, fixed in advance, intended to cover the total cost of a service, usually reserved one year before.

Gross Domestic Product (GDP)	GDP is a way of measuring the size of an economy. It is a measure of the total value of production of all resident producing units of a country or territory in a specified period, before deducting allowance for consumption of fixed capital.
Gynaecology	The specialty that deals with health of the female reproductive system.
HA Drug Formulary	A reference guide produced by the Hospital Authority (HA) in 2005 to standardize drug policy and utilization across public hospitals and clinics. Drugs that are listed in the Drug Formulary are charged at a standard fee that is heavily subsidized regardless of the actual costs of the prescriptions. Drugs not listed in the Drug Formulary have to be purchased at cost by the patients.
Haemodialysis	A method for removing waste materials, such as urea, in the blood by taking blood from the body to be cleaned in a filter known as a dialyser (artificial kidney), for patients with kidney failure.
Hereditary Illness	An illness or disorder that is passed genetically from the biological parents to offspring.
Holistic Care	A philosophy of healthcare that views the physical, psychological, social and spiritual aspects of a person as all important in the provision of care.
Immunosuppressant Treatment	Drugs or therapy that are used to prevent rejection of transplanted organs and tissues, and to treat autoimmune diseases (i.e. diseases that are caused by attacks of cells, tissues and organs of a person's body by his/her own immune system) such as rheumatoid arthritis, which is a disorder that causes the body's immune system to attack the bone joints.
Individual Medical Insurance	Private health insurance purchased on an individual rather than on a group basis. Premium of an individual medical insurance is usually determined according to the insured individual's age and health risks.
Infirmary Services	Intensive nursing and personal care services that are provided to persons with severe physical and/or mental disability on an in-patient basis. Infirm persons include those who are constantly bed-bound and are fully dependent on others in carrying out activities of daily living.
Inflation	The amount by which prices increase from one year to the next.
Information Asymmetries	A state when one party to a transaction has more or better information than the other party.

Integration of Care	The provision of care that involves collaboration and coordination, joint planning and shared activity between healthcare providers across all settings to ensure consistent and comprehensive care over time.
International Classification for Health Accounts (ICHA) Framework	A framework developed by Organisation for Economic Co-operation and Development (OECD) to trace all the financial resources that flow through a health system over time. In the framework, health expenditures are classified according to three dimensions: health financing sources; healthcare providers; and healthcare functions. Many countries have compiled their own National Health Accounts (NHA) using this framework, which allows for international comparison of healthcare financing and expenditure.
Inverse Care Law	Proposed by a British doctor, Professor Julian Tudor Hart in 1971, the law states that "the availability of good medical care tends to vary inversely with the need of the population served." In other words, those who need medical care the most are least likely to receive it; conversely, those with the least need of healthcare tend to use health services more.
Labour Force Participation Rate	Labour force participation rate refers to the proportion of labour force in the population aged 15 and over. It is a measure of the propensity of the persons of working age to be economically active.
Means-test	A process undertaken to assess an applicant's income or wealth to determine whether he/she is eligible to receive certain types of benefits from the Government.
Medical Centres of Excellence	Specialty medical centres that deliver quality tertiary and specialised healthcare services and treatments by top-notched medical professionals.
Medical Inflation	The increase in costs/prices of medical goods and services. Medical inflation is mainly due to advances in medical technology and relative price movement in the supply of health services, which are distinct from the effects of demographic changes on medical utilization. For example, new medical technologies may increase demand by increasing the variety and quality of products, which in turn will drive up the medical cost.
Moral Hazard	A situation where the existence of insurance changes the behaviour of an insured party and/or service provider, such as resulting in the insured person over-using an insured service or the service provider over-supplying the service. Moral hazard arises when the insured persons or service providers do not have to bear the full costs of their actions under the insurance coverage, and thus have a tendency to act less carefully than they otherwise would.

Multi-partite	Involving more than two parties working in co-operation.
Neuroscience	Refers to the scientific study of the nervous system. It covers a range of activities, from scientific experimentation to diagnostic investigation and medical treatment for diseases that are related to neurological disorders, such as Alzheimer's disease, stroke, brain tumour and brain injury.
Nominal Fee	Fee that involves only a very small amount of money.
Notional Waiting Time	The estimated length of time between registering for a certain service and the actual receipt of the service.
Obstetrics	The specialty that deals with the care of a woman and her offspring during pregnancy, childbirth and the postnatal period.
Oncology	The specialty that deals with the medical treatment of tumours, in particular malignant tumours, i.e. cancer.
Optometrists	Health professionals trained to provide comprehensive eye and vision care, such as eyesight correction and diagnosis of common conditions related to the eyes or vision. They are not medical doctors but may refer patients to an ophthalmologist (who is a medical doctor specializes in eye care) for treatment when needed.
Optometry	A healthcare profession that is concerned with eyes and related structure, vision, and visual system.
Orthopaedics	The specialty that deals with the medical treatment for injury, illness and other disorders concerning the muscles and skeletal system.
Out-of-pocket Payments	Expenditures paid directly by individuals for health services at the point of use. They are often referred to as user fees or co-payments.
Paediatrics	The specialty that deals with the medical care of infants, children and adolescents.
Pre-existing Medical Conditions	Refer to medical conditions that have been diagnosed or are being investigated or treated for, or ongoing medical conditions of which an insured person is aware before he/she takes out an insurance plan.
Preventive Healthcare	A scope of healthcare services that aims at preventing diseases or injury.

Primary Healthcare	According to the World Health Organization's definition, primary healthcare is essential healthcare made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable. It constitutes the first element of a continuing healthcare process and includes public education of prevailing health problems, adequate food supply and proper nutrition, safe drinking water and basic sanitation, maternal and child healthcare (including family planning), immunization, treatment of common diseases and injuries, and the provision of essential drugs. This discussion paper mainly refers to the healthcare services component of primary healthcare, which includes preventive, curative and rehabilitative services provided by medical doctors (in particular, general practitioners), dentists, nurses, pharmacists, and allied health professionals.
Primary Medical Care / Primary Care	Refers to the medical part of primary healthcare. It is the first point of contact that patients made with their doctors, such as general practitioners. It covers curative and preventive care, continuing care, health promotion and education, as well as referral to specialists.
Primary Prevention	Healthcare activities that aim at avoiding the development of a disease or injury. Most population-based health promotion and disease prevention activities such as public education to minimize falls and vaccinations are primary preventive measures.
Private Health Expenditure	Health expenditure financed by private sector (e.g. employer-provided medical benefits, private health insurance, and private household out-of-pocket expenditure).
Private Health Insurance	Medical insurance offered by private insurance companies. It is either purchased on an individual basis or group-purchased by employers as staff medical benefits.
Privately-purchased Medical Items (PPMI)	Medical items that are not covered by the subsidized medical fees of the Hospital Authority and so are required to be purchased by the patients on their own. These include prostheses and consumables, items purchased by patients for home use such as wheelchairs and home use ventilators, as well as costly medical procedures not available in public hospitals, such as gamma knife surgery and harvesting of bone marrow outside Hong Kong.
Public Health Expenditure	Health expenditure financed by public sector (e.g. the Government, and statutory organisations managing social health insurance).

Public-private Partnership (PPP)	A business relationship between the public and private sectors whereby there is a contractual arrangement in which infrastructure or services that are traditionally provided by the public sector are being undertaken by the private sector.
Radiographers	Healthcare professionals who use radiation technology such as X-rays and CT scans to create medical images of the body to help doctors diagnose and treat illness and injury.
Radiography	A discipline in health sciences that is concerned with the use of radiation technology such as X-rays for diagnostic or therapeutic purposes.
Radiosurgery	A procedure which allows non-invasive brain surgery, i.e. without actually opening the skull, by means of radiation.
Real Terms	After removing the effect of inflation. For example, real GDP growth is the increase in the value of GDP after discounting the effect of inflation.
Recurrent Cost	Ongoing expense of operating a service, such as expenditure on salaries, utilities, and in the case of a medical service, the purchase of medical supplies.
Renal Replacement Therapy	A treatment to replace the function of the kidney for patients with kidney failure. An example is haemodialysis, which is a method for removing waste materials, such as urea, in the blood by taking blood from the body to be cleaned in a filter known as a dialyser (artificial kidney).
Risk-adjustment	A method for setting insurance premiums or payments to account for differences in individuals (e.g. age, gender, income and type of illness needing treatment) that are likely to affect their use of healthcare services and the associated costs.
Risk Pooling	Spreading the loss incurred by a few over a larger group, so that each individual group members' losses are limited to the average loss (premium payments) rather than the potentially larger actual loss that might be sustained by an individual.
Risk Selection	A process whereby an insurer tries to attract people with a low risk of health problems but deter people with a high health risk in order to increase profits.
Risk Sharing	Sharing with another party the burden of loss or benefit of gain from a particular risk. Risk sharing can be carried out through insurance or other agreements.

Safety Net (in the context of the public healthcare system in Hong Kong)	To safeguard and promote the general public health of the community as a whole and to ensure the provision of medical and health facilities for the people of Hong Kong, including the provision of public assistance to help a person meet his basic and special medical needs in cases where he does not have the means to access them as well as to protect him from undue financial burden.
Samaritan Fund	A charitable fund established by resolution of the Legislative Council in 1950. It is currently administered by the Hospital Authority and is financed by donations and government grant. The Fund provides financial assistance to needy patients who require Privately-purchased Medical Items (PPMI) or new treatment technologies that are not subsidized by the public healthcare system.
Secondary Care	Secondary care refers to specialist medical care and hospital care. Secondary care services include acute and convalescent in-patient care, day surgery, specialist out-patient, and Accident and Emergency services.
Secondary Prevention	Healthcare activities that aim at early detection of disease, thereby increasing opportunities for interventions to prevent progression of the disease. Health check-ups (e.g. blood pressure assessment) and disease screening, such as Pap smear (a test to screen for cervical cancer), followed by necessary interventions after making the diagnosis, are examples of secondary preventive measures.
Self-financed Drug Items (SFIs)	Drugs that are not listed in the HA Drug Formulary and thus have to be purchased at cost by the patients. Patients in need may receive a partial subsidy or even full financial support from the Samaritan Fund for their expenses on self-financed drugs.
Social Health Insurance	Medical insurance that are mandated by law and managed by statutory sickness funds or by a government agency, and of which contributions are usually employment-based and levied as a proportion of an employee's salary. Employees and their employers usually share the contributions.
Tertiary Care	Tertiary care refers to highly complex and costly hospital care, usually with the application of advanced technology and multi-disciplinary specialized expertise. Examples of tertiary care services include organ transplants.
Therapeutic Products	Therapeutic products refer to pharmaceutical products, biological products (including vaccines and products intended for transfusion), and medical devices for the treatment of medical conditions.

Third-party-pay / Third-party-funding	The source of payment or funding to cover the charges of a medical service comes from a third party rather than from the service user, for example, from an insurance company, an employer, or the Government.
Total Health Expenditure	The aggregate of public and private health expenditures. Under the Domestic Health Accounts (DHA) framework, health expenditures consist of all expenditures or outlays for medical care, disease prevention, health promotion, rehabilitation, long-term care, community health activities, health administration and regulation, and capital formation with the predominant objective of improving health.
Total Public Expenditure	The aggregate of operating expenditure and capital expenditure incurred by the public sector. In Hong Kong, total public expenditure is government expenditure plus expenditure (operating and capital) of the Trading Funds and the Housing Authority.
Triage	The sorting out and classification of casualties to determine the priority of need and proper place of treatment.
Value-for-money	Achieving the desired outcome at the best possible price.
Voucher	A kind of coupon with a prescribed purchasing power, over a specified service.

APPENDIX B HONG KONG'S CURRENT HEALTHCARE SYSTEM

Introduction

B.1 Over the years, Hong Kong has developed a highly efficient healthcare system and achieved impressive health outcomes for its population. Hong Kong is among the best in the world in terms of life expectancy and infant mortality rate which are commonly used population health indicators. The standard and quality of care of our system enjoys renowned international standing, stays at the forefront of advances in medical technology, and compares favourably with other advanced economies.

B.2 The highly subsidized public hospital system provides the Hong Kong population with equitable access to healthcare services with well recognized quality at very affordable price, underpinned by our long-established healthcare policy that "no one should be denied adequate healthcare through lack of means". The public sector also provides comprehensive public health programmes and serves essential public health functions including preventing and preparing against communicable diseases. The private sector provides the public with a variety of choice of different healthcare services, including affordable primary medical care as well as a range of specialist and hospital care.

B.3 The two sectors complement each other in that the private sector is the major provider of primary healthcare while the public sector is the predominant provider of secondary and tertiary healthcare services. About 70% of the out-patient consultations are provided by the private sector, while over 90% of the in-patient services (in terms of the number of bed days) are provided by public hospitals.

B.4 The system is supported by teams of dedicated healthcare professionals including doctors, nurses and other allied health professionals with high professional and ethical standards. They are provided with high standard and internationally recognized training and continuing education by well-established institutions, including universities and other education and training institutions for doctors, nurses and allied health professionals, and the 15 Medical and Dental Colleges of the Hong Kong Academy of Medicine. There are also professional bodies which play their parts in the regulation of professional standards.

Primary Healthcare Services

B.5 Primary healthcare is the first point of contact individuals and their

families have with a continuing healthcare process, which aims at improving their health condition and preventing diseases in general, and reducing the need for more intensive medical care. Primary care includes a range of services relating to health promotion and disease prevention, curative medical care, and community-based healthcare. Another important component of primary healthcare is the provision of public health functions that aim at protecting the health of the population on the whole, and which include disease surveillance and control of communicable diseases, public health regulation and licensing, port health measures, and tobacco control. In Hong Kong, these public health functions are mainly performed by the Department of Health (DH).

Preventive Care

B.6 Most of the health promotion and disease prevention services are provided by DH. These include the Central Health Education Unit, Maternal and Child Health Centres that provide family health services and immunization services for young children, student health services, and elderly health services provided through Elderly Healthcare Centres and Visiting Health Teams. These services are provided either free of charge or for a nominal fee.

Curative Care

B.7 For curative services, the majority in the community seek out-patient services from the private sector, provided by around 6 000 doctors in private practice and some 160 registered private clinics. Patients are free to choose their private doctors and "doctor-shopping" is a fairly common phenomenon for patients in search of a quick cure. Having a family doctor to provide a continuity of care is hitherto not common. For patients who may not be able to afford private care, subsidized care is available at 75 public general out-patient clinics (GOPCs) operated by the Hospital Authority (HA). However, patients cannot choose their doctors in the GOPCs. There were around 4.9 million visits at GOPCs in 2006, with government funding of $1.3 billion.

B.8 Chinese medicine practitioners are the principal alternative primary care provider in Hong Kong outside the mainstream western medicine system. Many patients use both systems in parallel, taking western medicine to suppress symptoms and Chinese medicine to restore the body to its natural balance. In 2006, there were 5 268 registered and 2 897 listed Chinese medicine practitioners in private practice. HA also operates eight Chinese medicine clinics with a subvention of $32.4 million. There were 132 000 visits to these clinics in 2006, and the fee charged to patients is $120 per visit.

B.9 It has been estimated that there are about 27 million and 6 million attendances at western medicine private practitioners' clinics and Chinese medicine private practitioners' clinics respectively each year.

Community-Based Healthcare

B.10 HA operates community health services to provide outreach medical, nursing and allied health services to support discharged patients for rehabilitation in the community. These include community nursing services, community geriatric assessment teams, community psychiatric teams and nursing services, and community allied health services. Over 80% of the community nursing patients are elders. However, these services cover only patients discharged from the public hospitals. To enhance medical care for residential care homes for the elderly, visiting medical officers are deployed under the supervision of community geriatric assessment teams to provide weekly on-site medical visits covering over 200 residential care homes for the elderly. HA's expenditure on community health services was $600 million in 2005/06.

Secondary and Tertiary Healthcare Services

B.11 Secondary healthcare encompasses specialized ambulatory medical services and general hospital care that are curative in nature. It is provided by medical specialists, usually in the hospital setting, but some specialist services are also provided in the community. Secondary care services include acute and convalescent in-patient care, day surgery, specialist out-patient, and Accident and Emergency services.

B.12 Tertiary healthcare, on the other hand, refers to highly complex and costly hospital care, usually with the application of advanced technology and multi-disciplinary specialized expertise. Tertiary care services are usually required by patients with complicated but relatively less common diseases or are suffering from catastrophic injuries or illnesses. Some examples of tertiary care services are organ transplants and radiosurgery of the brain including the use of Gamma Knife.

B.13 In contrast with curative primary care, the public sector is the predominant provider of secondary and tertiary care in Hong Kong. Apart from GOPCs, HA also manages all the public hospitals in Hong Kong. As at end 2006, there were 39 public hospitals with a total of 27 755 hospital beds as compared to 3 124 beds provided by 12 private hospitals.

Specialist Out-Patient Service

B.14 Besides primary care, a sizable proportion of the 6 000 private doctors and 160 registered private clinics are also providing non-subsidized specialist care in the community. However, it has been difficult to differentiate between private primary care and specialist attendances in household surveys and so the exact numbers of the respective consultation in the private sector are not known.

B.15 Public hospitals also operate specialist out-patient clinics (SOPCs) that provide heavily subsidized specialist care. In 2006, there were almost 6 million specialist out-patient attendances and about 1.9 million allied health out-patient attendances in public hospitals and about $5.6 billion were allocated for the provision of such services.

B.16 Many of the patients have been attended to at the SOPCs for years even though their medical conditions have long been stabilized and no longer require specialist care. It seems that patients requiring long-term medication have remained within the public SOPCs system where the drugs are highly subsidized. Since many of the stabilized cases are not discharged back to the primary care doctors, there is an accumulation of cases resulting in long waiting lists. To handle the situation, a triage system is implemented to screen new referrals so that patients requiring more urgent medical attention could be given earlier clinic appointments.

In-Patient Service

B.17 In-patient services are provided to patients who require intense therapy for their medical condition. Most of the tertiary care services are provided in major acute hospitals in the public sector besides the provision of secondary care in a comprehensive range of medical and surgical specialties. Private hospitals, on the other hand, provide mostly secondary care in the specialty of medicine, obstetrics and gynaecology, and surgery.

B.18 In the past before the setting up of HA, private hospital treatment was often the choice for those who could afford them. However, improvement in public hospital services since the establishment of the HA in 1990 has substantially narrowed the quality gap between the public and private sectors. Currently, over 80% of patients requiring hospitalisation turn to public hospitals with the expectation that they will receive highly subsidized, low price and high quality service. The total number of public hospital admissions has increased by 76% from 0.64 million in 1990 to 1.13 million in 2005/06, with a budget of $16.8 billion being allocated for public in-patient services. In contrast, the number of patients treated in private hospitals was only 0.28 million in 2006. In terms of the number of bed

days, the market share of the private hospital is less than 10% for in-patient services.

B.19 The current hospital utilization pattern reflects a huge imbalance in the market share between the public and private hospitals. The capacity of public hospitals is overstretched and there are long waiting lists for some elective surgery, such as cataract surgery. This is an unhealthy situation and is unlikely to be sustainable in the long run.

Accident and Emergency Services

B.20 15 of the public hospitals are major acute hospitals providing Accident and Emergency (A & E) services. While most of the private hospitals are equipped with 24-hour out-patient clinics, these clinics are not meant to provide the same kind of emergency services rendered at the A & E departments of public hospitals. The public A & E services provide emergency care to those in need of acute treatment, offer emergency life support to the critically ill, and manage disasters that bring in massive casualties. In 2006, the A & E departments of public hospitals had about 2 million attendances, or 5 558 attendances per day. About $1.5 billion were allocated for the provision of such services.

B.21 However, it has been found that a sizeable number of patients attending the A & E departments do not actually need such services. A & E patients are triaged according to their medical conditions into five different categories, namely, Critical (Category 1), Emergency (Category 2), Urgent (Category 3), Semi-urgent (Category 4), and Non-urgent (Category 5). Patients with more urgent conditions are given priority. Categories 4 and 5 are non-emergency cases that should have been treated by primary care providers, but they have instead constituted a majority of the A & E attendances.

Subsidization and Fee Structure

Public Healthcare Services

B.22 The subsidy level of public healthcare in Hong Kong is amongst the highest in developed economies, at over 95% of the cost across-the-board for public hospital services. The subsidy for in-patient care is particularly high, reaching 97% of cost. On average, subsidized patients pay less than 5% of the cost for the use of public hospital services.

B.23 Due to the high subsidy, fees and charges of public healthcare services are extremely low. The fee structure and subsidy level of subsidized services at public hospitals and clinics are summarized in Table B.1. Notwithstanding an additional

charge of $50 admission fee for the first day of hospitalization, patients only have to pay $100 per day for in-patient care although the average cost is $3,290 per day. The fee is a flat-rate inclusive of doctor consultations, drugs, diagnostic tests, treatment procedures, accommodation and food. There are no additional charges when a patient undergoes a surgical operation or utilizes intensive care even though the actual costs of these services are extremely high. For example, the cost of liver transplant operation is $540,000, excluding the post-operative follow-up and the immunosuppressant treatment but the user fee is the same as any other in-patient care, that is, $100 per day.

Table B.1 Fee structure and subsidy level of public hospitals and clinics (2006/07)

Public Hospitals and Clinics	**User Fees ($)**	**Cost ($)**	**Government Subsidy (%)**
In-patient (ward level - per day)	100	3,290	97.0
Accident & Emergency (per visit)	100	700	85.7
Specialist Out-Patient (per visit)			
- first visit	100	740	86.5
- subsequent visits	60		91.9
General Out-Patient (per visit)	45	260	82.7

Note: In-patient cost represents general in-patient services, excluding infirmary, mentally handicapped and psychiatric services.
Source: Data from Hospital Authority.

B.24 As for out-patient care, the subsidized fees are $100 for each A & E attendance, $60 for each specialist out-patient consultation although the fee for the first attendance is $100, and $45 for each general out-patient consultation. The fees are inclusive of all diagnostic tests and treatment procedures. Drugs prescribed at the A & E and GOPCs are also included in the fees while drugs prescribed at the SOPCs that are listed in HA Drug Formulary are charged at $10 per drug item regardless of the actual costs of the prescriptions. Drugs not listed in the Drug Formulary have to be purchased at cost by the patients.

B.25 There is generally no differentiation in the class of wards offered in public hospitals apart from a small number of private wards. Less than 400 private beds are made available in public hospitals. The private fees are $3,900 per day for a bed in a first class ward and $2,600 per day for second class beds, inclusive of accommodation and food, drugs, and certain diagnostic tests. In-patient doctor consultation fees and surgical operations are charged separately, ranging from

$3,900 for minor operation to $300,000 for ultra-major operations. Over 60% of the private bed days are occupied by serving or retired civil servants or HA staff, who generally pay only a nominal fee for the services.

Pros and Cons of the Current Fees Structure

B.26 The current flat-rate fees structure of public healthcare is simple for patients to understand and easy to be administered by the hospitals. The high level of subsidy for all public patients regardless of their ability to pay also ensures universal access to healthcare. However, the heavily subsidized flat-rate fees are not conducive to responsible use of public resources. For example, as mentioned earlier, many chronically-ill patients who consult private doctors also register themselves at SOPCs to get access to the highly subsidized drugs, leading to wastage of resources and overstretching of public healthcare services.

B.27 Furthermore, since there is no differentiation of ward classes (except the $100 public beds and $2,600 or $3,900 private beds, with nothing in between), there is no choice for patients who prefer to patronize public hospitals but who can afford and are willing to pay a bit more for better amenities.

Safety Net Measures

B.28 Despite the low fee levels, various safety net measures have been put in place for public healthcare services. Recipients of Comprehensive Social Security Assistance (CSSA) are exempted from payment of public fees and charges. In addition, there is a medical fee waiver mechanism for other under-privileged groups, including low-income patients, chronically ill patients and elderly patients in economic hardship.

B.29 For non-CSSA individuals, two financial criteria need to be met: (i) having a monthly household income not exceeding 75% of the Median Monthly Domestic Household Income (MMDHI) applicable to the patient's household size, and (ii) the value of the patient's household asset, excluding owner-occupied residential property, is within a certain limit applicable to their household size. The asset limit is higher for households with elderly members. Patients whose monthly household income does not exceed 50% MMDHI and who pass the asset limit test may receive full waiver of their fees and charges. Applicants who do not satisfy the financial criteria may still apply for a fee waiver and the Medical Social Workers will assess their applications taking into account non-financial criteria.

B.30 The Samaritan Fund is a charitable fund set up since 1950, administered by the Hospital Authority, and financed by donations and government grant. The

objective of the Fund is to provide financial assistance to needy patients who require privately-purchased medical items (PPMI) (e.g. prostheses and consumables, items that are implanted or used only once, items purchased by patients for home use such as wheelchairs and home use ventilators), costly new technologies not provided for in public hospitals (e.g. gamma knife surgery), harvesting of marrow outside Hong Kong for marrow transplant, and drugs that are proved to be of benefits but are extremely costly to be provided as part of the standard subsidized public healthcare services (e.g. self-financed drug items (SFI) such as growth hormone and interferon). The basic philosophy is to ensure that no one would be prevented, through lack of means, from obtaining adequate medical treatment.

B.31 Application for financial assistance under the Samaritan Fund is subject to assessment of financial condition of the patient's family. For non-drug items, for patients whose monthly family income is equal to or below the MMDHI corresponding to the patient's household size, and when the family's liquidable savings is equal to or below two times the cost of the item concerned, full assistance would be considered. For patients with more liquidable savings, partial/full assistance may be considered having regard to the proportion of the cost which the patient/family could contribute, and other special circumstances faced by the patient. For drug items, the level of subsidy would be assessed on the basis of the patients' household disposable financial resources (DFR), i.e. the amount of their household disposable income and disposable capital. Patients are required to contribute to the cost of the drugs from their DFR, at a level determined on the basis of a sliding scale.

Private Healthcare Services

B.32 There is no government subsidy for healthcare provided by the private sector. Fees in the private sector are not regulated and there are no requirements for private healthcare providers to divulge their fees and charges. Some private hospitals have taken the initiative to increase the transparency by displaying information about their fees schedule. However, the information mainly pertains to the daily fees for the various types of wards and the fees for packaged services such as maternity package. Other itemized charges that could affect the size of the medical bill, such as the operating theatre expenses, charges for diagnostic and treatment procedures, are not all listed.

B.33 Fees charged by private doctors for out-patient services vary a lot, usually from about $100 to $250, or more for a specialist consultation. In some cases, these fees include the cost of medicine, but separate charges are often made. Patients also have to pay extra for diagnostic tests and treatment procedures.

B.34 The charges in private hospitals vary from $350 a day for a bed in a general ward to $900 or more for a higher class ward. In addition, patients have to pay for all services, such as medicines and dressings, besides daily doctor consultation fees. Diagnostic tests, surgical operations and treatment procedures are also charged separately and on an itemized basis.

Healthcare Manpower and Training

B.35 Under existing legislation, 12 types of healthcare professionals are required to be registered with their respective boards or councils before they are allowed to practise in Hong Kong. As at December 31, 2006, the professionals registered with their respective boards and councils numbered: 11 739 doctors, 1 976 dentists, 5 336 Chinese medicine practitioners, 36 444 nurses (including registered and enrolled nurses), 4 648 midwives, 1 649 pharmacists, 90 chiropractors, 2 034 physiotherapists, 1 225 occupational therapists, 2 584 medical laboratory technologists, 1 925 optometrists and 1 605 radiographers.

Doctors

B.36 The University of Hong Kong and the Chinese University of Hong Kong provide basic training of doctors. They took in 126 and 130 medical students respectively in 2006. During the year, nine medical graduates with professional qualifications obtained outside Hong Kong passed the licensing examination conducted by the Medical Council of Hong Kong. The Hong Kong Academy of Medicine is an independent statutory body with the authority to approve, assess and accredit specialist training within the medical and dental professions. Its 15 colleges conduct training and examinations to award specialist qualifications to qualified candidates.

Dentists

B.37 Training in dentistry is available at the University of Hong Kong, which enrolled 53 dental students in 2006. During the year, six candidates who completed their dental training outside Hong Kong passed the licensing examination conducted by the Dental Council.

Chinese Medicine Practitioners

B.38 Three local universities offer full-time undergraduate degree courses in Chinese medicine. In 2006, 83 full-time local Chinese medicine graduates who passed the licensing examination were registered as Chinese medicine practitioners.

Allied Health Professionals

B.39 For allied health professionals, degree programmes in the areas of medical laboratory science, physiotherapy, occupational therapy, optometry and radiography were offered by the Hong Kong Polytechnic University, with an enrolment of 35, 61, 44, 37 and 35 students respectively in 2006.

Nurses

B.40 The University of Hong Kong, the Chinese University of Hong Kong and the Hong Kong Polytechnic University provide basic training of Registered Nurses. 553 nursing students were recruited into their four-year general nursing degree programmes in 2006. Furthermore, three-year higher diploma nursing programmes are offered by the Hong Kong Polytechnic University and HA, with an enrolment of 120 for the former while 105 Registered Nurses graduated from the course run by HA in 2006. In addition, the Hong Kong Sanatorium and Hospital Limited provides basic training of Enrolled Nurses. It has recruited 83 student pupils into its two-year certificate nursing programme.

APPENDIX C HONG KONG'S CURRENT HEALTHCARE FINANCING ARRANGEMENTS

Public and Private Healthcare Expenditures

C.1 Apart from the dedication of our healthcare professionals, the current healthcare system is also the cumulative result of continued substantial investment by the society in healthcare over the past two decades. According to the Domestic Health Accounts (DHA)[14], Hong Kong's total health expenditure amounted to some $68 billion in 2004/05, with $37 billion being public or government expenditure and $31 billion being private expenditure. This expenditure has been on constant rise over the past two decades. During the period 1989/90 to 2004/05 –

(a) total health expenditure increased by over 2.5 times at an average annual growth rate of 8.7%, its share of Gross Domestic Product (GDP) rose from 3.5% to 5.2%;

(b) the government's share of this expenditure also rose from 40% to 55% in the same period, which means that private share of the expenditure has decreased from 60% to 45% during this period; and

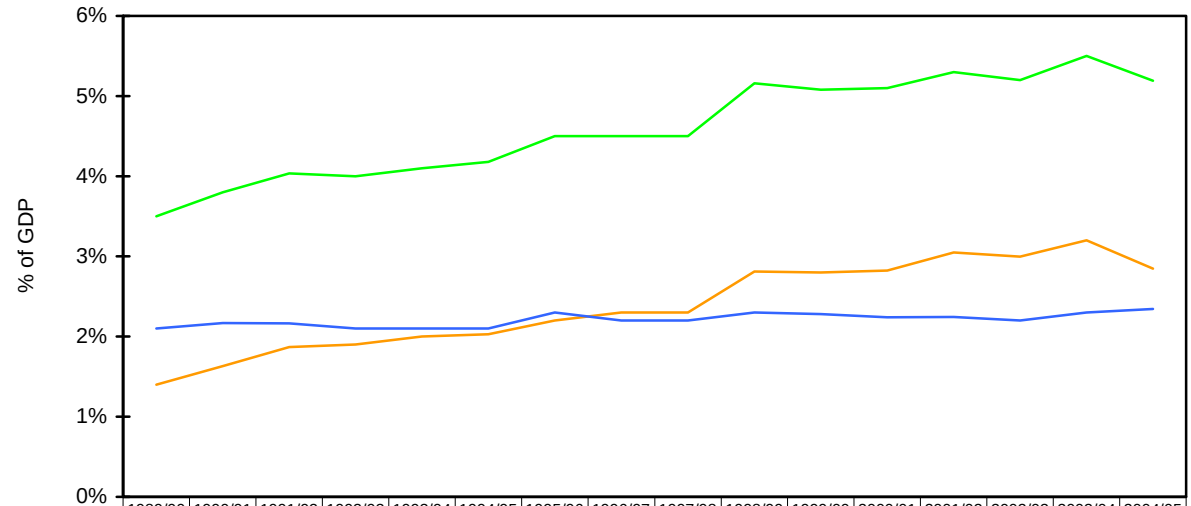
(c) public health expenditure has increased 3.8 times at an average annual growth rate of 11.0%, its share of the total health expenditure increased from 40% to 55%[15], and its share of GDP doubled from 1.4% to 2.8%.

C.2 The public health expenditure constituted 14.5% of total public expenditure in 2004/05, or 2.8% GDP. Overall, the government is spending around 10% of its funding for healthcare in primary care while about 80% of the healthcare budget (or some $30 billion in 2007/08) are being injected into the public hospital system. Despite this funding level, the HA is facing considerable pressure to balance its budget. A major contributing factor is the heavy subsidization for public hospital services.

[14] A series of accounts compiled over the years in accordance with the International Classification for Health Accounts (ICHA) Framework developed by the Organisation for Economic Cooperation and Development to keep track of Hong Kong's health spending and to allow for international comparison.

[15] Based on Domestic Health Accounts of Hong Kong.

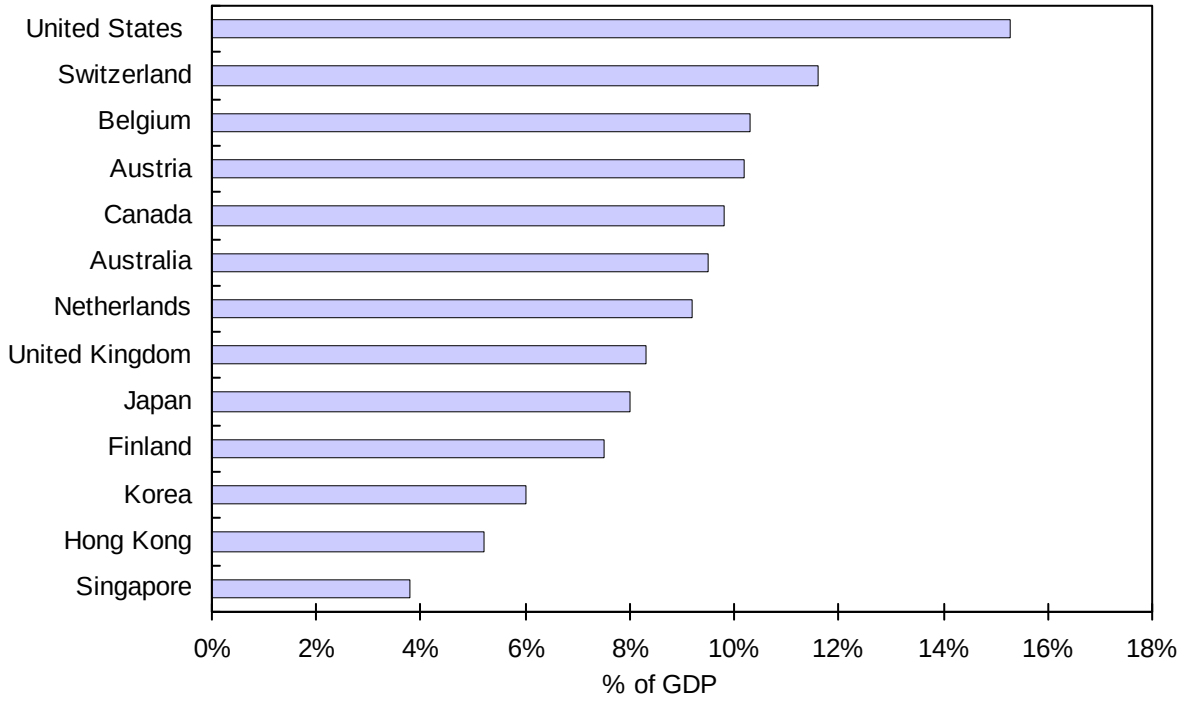
Figure C.1 Public and private health expenditure as percentage of GDP, 1989/90 – 2004/05



	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05
Public	1.4%	1.6%	1.9%	1.9%	2.0%	2.0%	2.2%	2.3%	2.3%	2.8%	2.8%	2.8%	3.0%	3.0%	3.2%	2.8%
Private	2.1%	2.2%	2.2%	2.1%	2.1%	2.1%	2.3%	2.2%	2.2%	2.3%	2.3%	2.2%	2.2%	2.2%	2.3%	2.3%
Total	3.5%	3.8%	4.0%	4.0%	4.1%	4.2%	4.5%	4.5%	4.5%	5.2%	5.1%	5.1%	5.3%	5.2%	5.5%	5.2%

Source: Hong Kong's Domestic Health Accounts: 1989/90 – 2004/05.

Figure C.2 Healthcare expenditure as percentage of GDP in Hong Kong and selected economies, 2005



Note: Figures are of 2005, except Australia, Hong Kong, Japan, Netherlands and Singapore, which are of 2004.

Source:
1. All figures from OECD Health Data 2007 (Oct 2007) unless otherwise specified.
2. Hong Kong figure from Hong Kong's Domestic Health Accounts: 1989/90 - 2004/05.
3. Singapore figure from Singapore Ministry of Health.

Current Financing Arrangements

C.3 The current situation of healthcare financing in Hong Kong is as follows –

(a) Total health expenditure amounts to some $68 billion (Table C.1) or 5.2% of GDP (Figure C.1) in 2004/05, of which public and private health expenditures amount to some 55% and 45% respectively (Figure C.7).

(b) Public health expenditure comes all from the government budget, about 80% of which is allocated to the public hospital system, which dominates over 90% of the market for in-patient services (by number of bed days).

(c) The comprehensive range of public healthcare services is highly-subsidized by the Government at some 95% of the overall cost. The actual level of subsidization varies across different services, with the highest level of subsidization for in-patient services at around 97%.

(d) About 10% of public health expenditure is spent on primary care. The funding is mainly for preventive public health services including disease prevention and health education, and for curative general out-patient services targeting the low-income families and under-privileged groups (including the chronically-ill and poor elders).

(e) Private healthcare services are paid for mostly by out-of-pocket payments, accounting for some 70% of private health expenditure (in 2004/05). By comparison, employer-provided medical benefits and individual voluntary medical insurance are relatively small financing sources, at 17% and 11% respectively (in 2004/05).

(f) Private hospitals provide less than 10% of in-patient services (in terms of bed days), which are unsubsidized (except for certain institutional/day-time long-term medical/nursing care) and patients have to bear the full-cost for using private services. Such services account for 16% of private health expenditure. A relatively greater proportion of private in-patient services is financed by employer-provided medical benefits and individual voluntary medical insurance at 35% and 18% respectively, while out-of-pocket payments account for some 34%.

(g) About 70% of ambulatory care (by number of consultations, either primary curative care or specialist out-patient services) is provided by the private sector. There is no statistics available on how much of the ambulatory care is for primary care. Such services account for 41% of

private health expenditure, and are paid for by out-of-pocket payment (75%), employer-provided medical benefits (19%), and individual voluntary medical insurance (6%). The remaining is institutional or day-time long-term medical and nursing care subsidized by the Government.

(h) Most members of the public can afford their own primary care from private practices, but they mostly pay for curative care rather than for preventive care.

(i) Other than voluntary private savings and insurance, there are no other mandatory or prescribed financing arrangements in place to meet future healthcare needs.

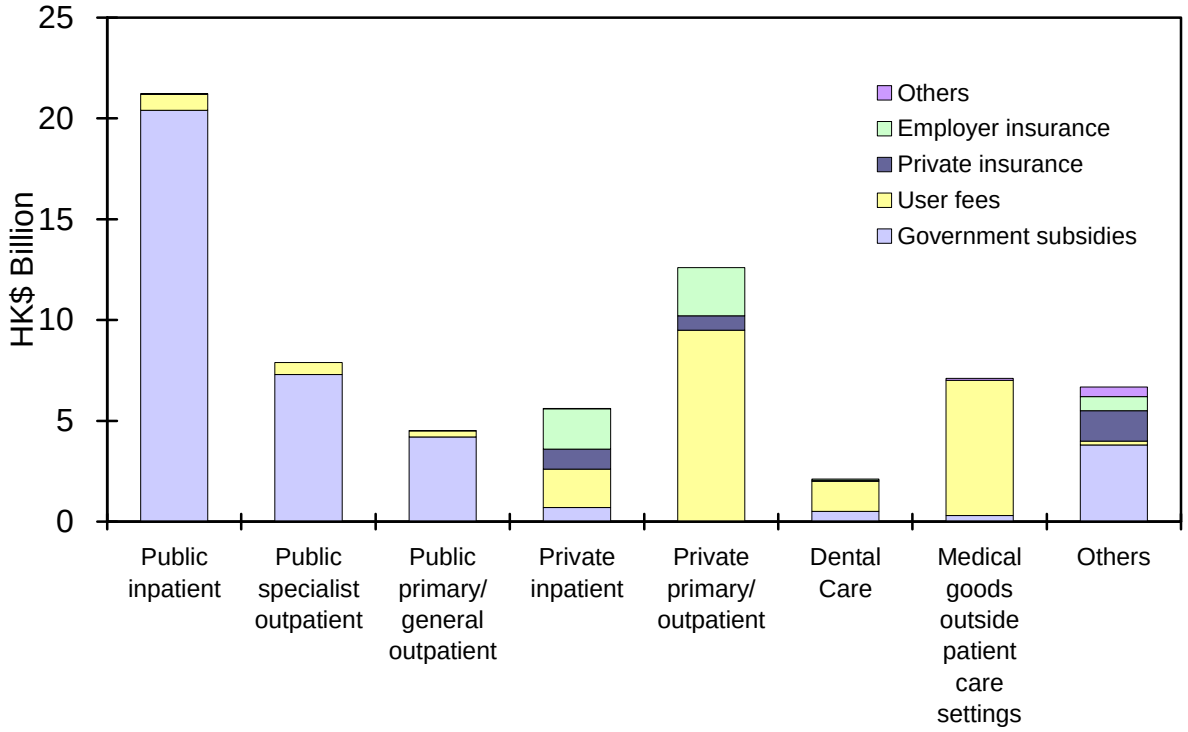
Table C.1 Total health expenditure of Hong Kong in 2004/05 by financing source and function (HK$million)

	Gov't subsidies	User fees/ out-of-pocket	Employer insurance	Private insurance	Others (note 4)	Total
Public in-patient (note 5)	20,433	780 (note 3)	-	-	21	21,234
Public specialist out-patient	7,263	613 (note 3)	-	-	-	7,875
Public primary care/general out-patient	4,219	322 (note 3)	-	-	17	4,557
Private in-patient	743 (note 2)	1,902	1,992	1,021	14	5,672
Private primary care/out-patient (note 1)	2 (note 2)	9,453	2,402	721	7	12,585
Dental care	482	1,490	58	44	9	2,084
Medical goods outside patient care settings	272	6,736	-	-	97	7,105
Others (including ancillary medical services, investment and administration)	3,766	249	715	1,498	466	6,695
Total	37,179	21,545	5,168	3,284	631	67,807

Note:
1. Private out-patient include both specialist and general out-patient.
2. Include subsidized institutional/day-time long-term medical/nursing care.
3. Include private and employer insurance for which there are no separate statistics.
4. Include non-profit institutions serving households, corporations and non-patient care related revenue.
5. Include in-patient curative care, in-patient rehabilitative care, in-patient and institutional long-term care, and day patient hospital services.

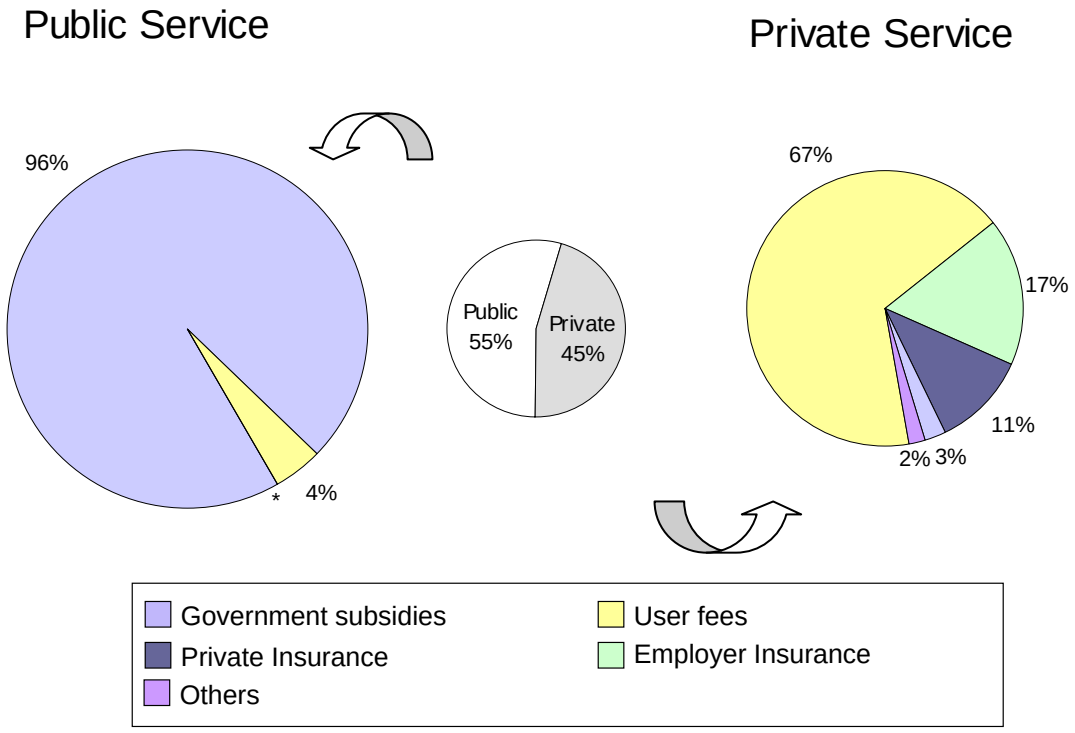
Source: Hong Kong's Domestic Health Accounts: 2004/05

Figure C.3 Total health expenditure in 2004/05 by financing source



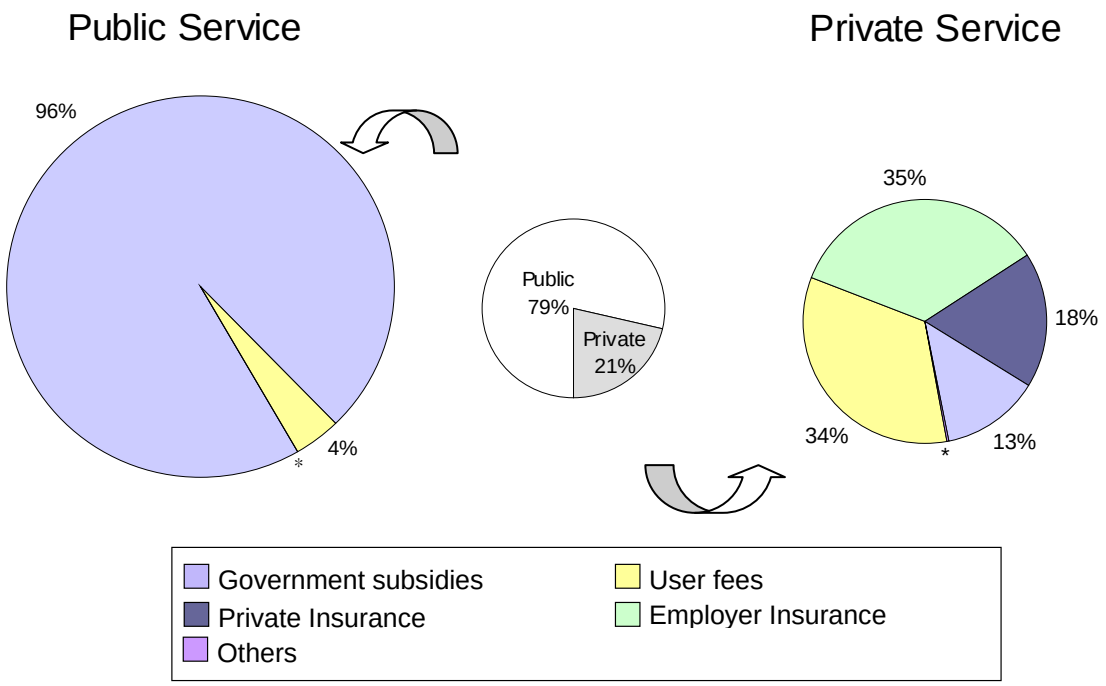
Source: Hong Kong's Domestic Health Accounts: 2004/05 and 2004/05 HA costing.

Figure C.4 Total health expenditure in 2004/05 by public and private services



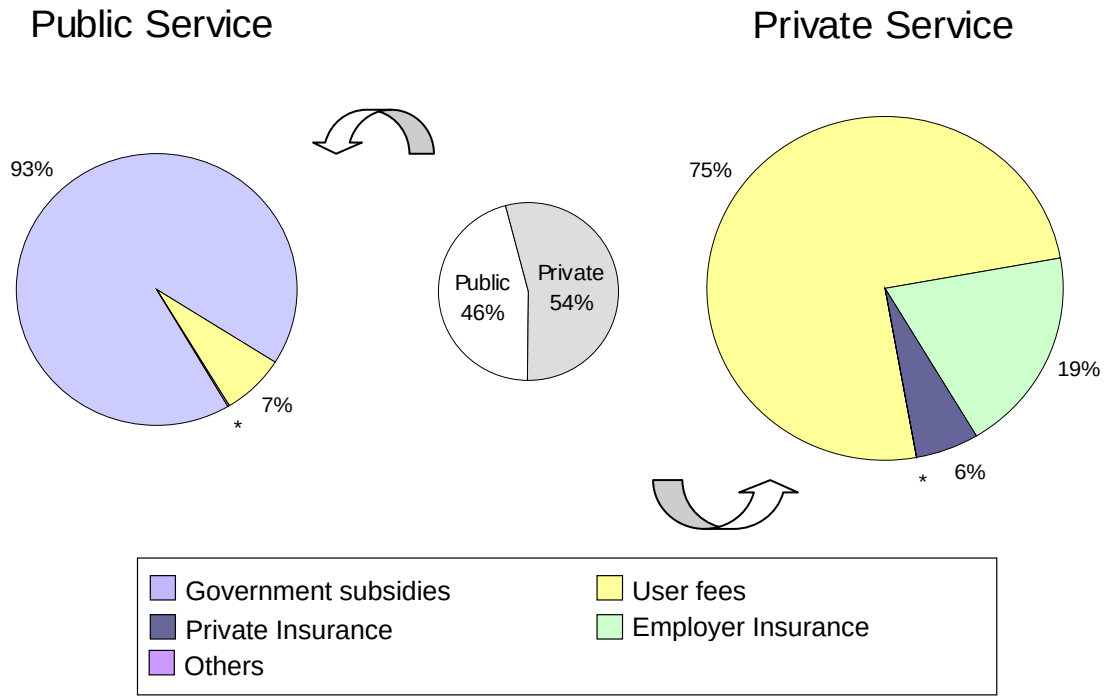
Note: * figures smaller than 0.1%
Source: Hong Kong's Domestic Health Accounts: 2004/05 and 2004/05 HA costing.

Figure C.5 Expenditure of in-patient services in 2004/05 by public and private services



Note: * figures smaller than 0.1%
Source: Hong Kong's Domestic Health Accounts: 2004/05 and 2004/05 HA costing.

Figure C.6 Expenditure of out-patient services in 2004/05 by public and private services



Note: * figures smaller than 0.1%
Source: Hong Kong's Domestic Health Accounts: 2004/05 and 2004/05 HA costing.

Public Funding Source

C.4 Public healthcare is predominantly funded by the Government through general taxation. However, Hong Kong has one of the lowest tax regimes among developed economies. There is no sales tax and the highest progressive rate for Salaries Tax is only 17% (for the financial year 2007/08). Salaries tax is further capped by a standard rate of 16% (for the financial year 2007/08) and will not exceed the amount charged by applying the standard rate to the net total work-related income.

C.5 We also have a very narrow tax base. Only 19% of the whole population is paying Salaries Tax. More than half of the population are not working and so do not have to pay Salaries Tax even if they have income from other sources. Even among the working population, most do not have to pay Salaries Tax because of the high tax threshold arising from the various tax allowances such as child allowance, dependent parent allowance, etc. Of the 3.5 million working population, only 37% are paying Salaries Tax.

Private Funding Source

C.6 Private healthcare is predominantly (about 70%) funded by out-of-pocket payments. Only about 28% of the private funding comes from private health insurance, with 17% being employer-provided medical benefits schemes and 11% being individual voluntary medical insurance. Nevertheless, there has been an increase in the share of private insurance in private funding, from 21% in 1989/90.

C.7 Private hospitals provide less than 10% of in-patient services in terms of bed days, which account for 16% of private health expenditure. A relatively greater proportion of private in-patient services is financed by employer-provided medical benefits and individual voluntary medical insurance at 35% and 18% respectively, while out-of-pocket payment account for some 34%.

C.8 About 70% of out-patient consultations are provided by the private sector, which account for 41% of private health expenditure, and are paid for by out-of-pocket payment (75%), employer-provided medical benefits (19%), and individual voluntary medical insurance (6%).

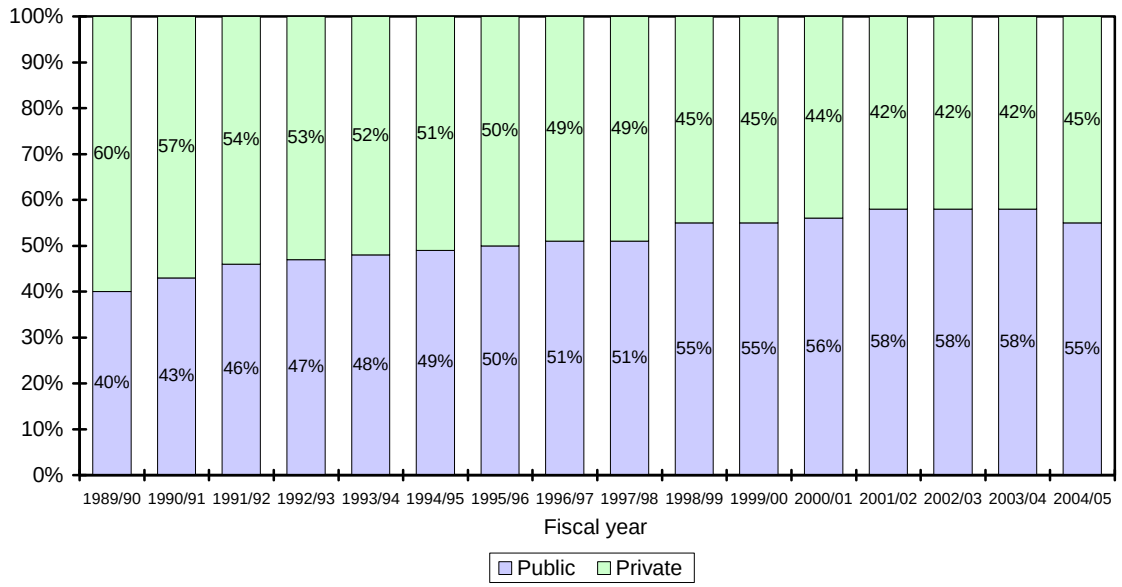
C.9 The current financing arrangements directly or indirectly contributed to the following phenomena in our healthcare system –

(a) The high level of subsidies for public hospital services channels patients into the public hospital system and is not conducive to judicious use.

(b) To some extent, the lack of certainty over the amount of charges for private hospital service also discourages members of the public from using such service.

(c) The share of public healthcare expenditure as a percentage of total healthcare expenditure has continued to rise over the years (See Figure C.7).

Figure C.7 Public and private share of total health expenditure, 1989/90 – 2004/05



Source: Hong Kong's Domestic Health Accounts: 1989/90 – 2004/05

APPENDIX D COMPARISON WITH OVERSEAS ECONOMIES' HEALTHCARE FINANCING ARRANGEMENTS

Table D.1 Comparison of Healthcare Systems in Selected Economies – Part I

	Hong Kong	Australia	Canada
Predominant funding source	General taxation	General taxation	General taxation
Main tax	Income tax 16%; Sales tax: Nil	Income tax 47%; Sales tax 10%	Income tax 46.4%; Sales tax 7-17%
Major scheme	Hospital Authority	Medicare	Medicare
Contributions for major scheme	N/A	Medicare Levy: 1.5% income; Medicare Levy Surcharge for high income earners with no private hospital insurance: 1% income	Health premiums (only in British Columbia, Alberta and Ontario) - e.g. Alberta: C$44 (HK$234) or C$88 (family) per month, with the elderly exempted
Population coverage	Universal	Universal	Universal
Service coverage	Not defined - comprehensive	Defined - only services and drugs listed in benefits schedules	Defined in Canada Health Act as essential or medically necessary services
Service exclusions	Drugs not in the HA Drug Formulary and some medical devices	Dental, ambulance, home nursing, allied health, visual & hearing aids, prosthetic, service not medically necessary	Dental, ambulance, prescription drugs, visual aids
Providers of subsidized care	Public providers only; Patients have no choice of doctors	Public or private providers; Public inpatients have no choice of hospital doctors	Private or public providers; Patients can choose both providers and doctors

Note: Income tax refers to top marginal rates of personal income tax **excluding** employee social security contribution. For the case in Hong Kong, the maximum personal income tax is subject to a cap of 16.0%, which is known as the standard rate.

	Finland	United Kingdom	Singapore
Predominant funding source	General taxation	General taxation	Out-of-pocket payment
Main tax	Income tax 48.8%; Sales tax 22%	Income tax 40%; Sales tax 17.5%	Income tax 21%; Sales tax 5%
Major scheme	Municipal healthcare; National Health Insurance (NHI)	National Health Service (NHS)	Medisave (compulsory medical savings accounts); Medishield (voluntary health insurance)
Contributions for major scheme	Municipal healthcare: N/A; NHI (social insurance): around 4%* of income without ceilings	N/A	Medisave: 6.5-9%* of income with account cap S$33,500 (HK$173,092); Medishield: S$30-705 (HK$155-3,640) annual, according to age bands
Population coverage	Universal (including NHI)	Universal	Medisave: account holders and their family; Medishield: individuals up to age 85
Service coverage	Municipal healthcare: not defined - comprehensive; NHI: outpatient drugs, occupational healthcare, private outpatient care, cash benefits for sickness, maternity and parental care of a sick child	Not defined – comprehensive	Medisave and Medishield: inpatient, day surgery, dialysis and chemotherapy; New inclusion for Medisave: outpatient care for selected chronic diseases
Service exclusions	-	Drug not in the NHS drug lists	Most of the outpatient services
Providers of subsidized care	Municipal healthcare: public providers only; Patients have no choice of doctors or hospitals; NHI: private clinics and pharmacies	NHS providers only; Patients have no choice of doctors	Public providers only, no choice of doctors; Patients using Medisave and Medishield can choose public or private services but coverage is up to public B2 or C class level

* Contributions shared by employers and employees

	Austria	Belgium	Japan
Predominant funding source	Social health insurance	Social health insurance	Social health insurance
Main tax	Income tax 42.7%; Sales tax 20%	Income tax 46.5%; Sales tax 21%	Income tax 47.1%; Sales tax 5%
Major scheme	Statutory sickness funds	Statutory sickness funds	Statutory sickness funds
Contributions for major scheme	6.4%-9.1% of salary* with ceilings	Employees 3.55% of salary; Employers 3.80% of employee's salary; Self-employed 3.20%; No ceilings	Kumiai (corporate managed): 3-9.5%* of income; Seikan (for SMEs): 8.5%*; Kokuho (public): based on household income and asset (average 10.2%); Elderly insurance: contributions from sickness funds and govt subsidy
Population coverage	Working population & their dependents; Welfare recipients not covered but receive health services directly from the government	Universal; Government pays to sickness funds for healthcare of welfare recipients, the elderly and other vulnerable groups who pay no contributions	Kokuho is for self-employed, unemployed, small business and retirees; Together, the 4 schemes cover the whole population
Service coverage	Comprehensive, including long-term nursing care and cash benefits for sickness and maternity	Defined in nationally set fee schedule – curative medical care and dental care only; Preventive care and health promotion are tax-funded	Defined in nationally set fee schedule, including most dental care; Kumiai and Seikan: also include cash benefits for sickness & maternity
Service exclusions	-	Services not listed in the fee schedule, e.g. cosmetic surgery	Abortion, cosmetic surgery, traditional medicine, some high-tech procedure
Providers of subsidized care	Public or private providers contracted by the sickness funds; GP referral for inpatient care	Public or private providers; Patients have choice of doctors and hospitals	Mostly private providers

* Contributions shared by employers and employees

	Korea	The Netherlands	Switzerland
Predominant funding source	Social health insurance	Private health insurance + Social insurance	Private health insurance
Main tax	Income tax 35.5%; Sales tax 10%	Income tax 52%; Sales tax 19%	Income tax 37.8%; Sales tax 7.6%
Major scheme	National Health Insurance (NHI)	Health Insurance Act (compulsory health insurance)	Health Insurance Act (compulsory health insurance) - private but termed as social insurance in Swiss law
Contributions for major scheme	4.77%* of salary with ceiling	Community-rated premiums, average annual EUR1,050 (HK$10,850); Premiums of children aged 18 or below are covered by public funds; Income-related contribution of 4.4% or 6.5% up to EUR1,950 per year (HK$20,148)	Community-rated premiums, average CHF184-398 (HK$1,213-2,623) per month; No profit allowed from the compulsory insurance
Population coverage	Working population & their dependents; Needy families are covered by tax-funded programme with free insurance benefits same as those of NHI	Universal but individually insured; Obligatory acceptance of all applications; Income-related contribution is for covering risk adjustment and children's premium	Universal but individually insured; Obligatory acceptance of all applications; Risk adjustments among insurance companies
Service coverage	Comprehensive, including dental, oriental medicine, and cash benefits for funeral	Defined and uniform basic coverage; Comprehensive (includes dental care for children and young people up to age 22); World-wide coverage	Defined and uniform basic coverage; Comprehensive, including long-term nursing care and disease-related dental care
Service exclusions	Services not medically necessary, amenities, assisted reproduction, new medical technology, dental prosthesis, drugs without prescription	Hospital care exceeding 365 days, and vaccinations, which are covered under a separate long-term care social insurance (contribution rate is 13.45% of income)	Routine dental care, complementary medicine, drugs not listed in the approved list, services not medically necessary
Providers of subsidized care	Mostly private providers; Patients have choice of western or oriental medicine	Mostly private providers; Contracted by insurance companies	Public or private providers; Patients can choose doctors or take up managed care packages

* Contributions shared by employers and employees

	The United States
Predominant funding source	Private health insurance
Main tax	Income tax 41.3%; Sales tax varies by states (some states do not have sales tax while others ranged from 2.9 to 7.25%)
Major scheme	Voluntary private health insurance; Medicare (Social health insurance); Medicaid (General taxation)
Contributions for major scheme	Majority of private health insurance are group-purchased by employers; Medicare: 2.9%* of salary; Medicaid: N/A
Population coverage	Private health insurance: mostly working population; Medicare: retirees aged 65 and above and some disabled people; Medicaid: poor elderly and disabled people, poor family with children
Service coverage	Medicare: inpatient, skilled nursing facilities, home healthcare, hospice and inpatient drugs; Medicaid: Basic health and long term care
Service exclusions	Medicare: A&E, outpatient, day surgery, tests and outpatient drugs – these are covered under voluntary plans with monthly premiums
Providers of subsidized care	Private providers

* Contributions shared by employers and employees

Table D.1 Comparison of Healthcare Systems in Selected Economies – Part II

	Hong Kong	Australia	Canada
Subsidy level	Specialist outpatient: 92% cost; General outpatient: 83% cost; Inpatient: 97% cost	Outpatient: 85% scheduled fees; Inpatient: 75-100% scheduled fees	100% for medical services; Nil for prescription drugs
User fees or copays (outpatient)	Specialist: HK$60; GP: HK$45; A&E: HK$100	15% scheduled fees + remaining balance charged by doctors (can't pay through private insurance)	Nil
User fees or copays (inpatient)	HK$100 per day inclusive of food & lodging	Public patients: Nil; Private patients: 25% of scheduled fees + remaining balance + charges for food & lodging	Nil
User fees or copays (prescription drugs)	HK$10 per item (only for specialist outpatient drugs)	Up to A$30.70 (HK$202) per item; A$4.90 (HK$32) for concession card holders	Full fees
Safety net	Exemptions for welfare recipients; Means-tested fee waiver system with household size-adjusted asset and income limits: income below 75% of median monthly household income, with higher asset limits for elderly patients	Outpatient: 100% subsidy for scheduled fee if copays reach A$358.90 (HK$2,355) in a year; Prescription drugs: concessionary rate of A$4.90 if copays exceed A$1,059 (HK$6,967) in a year; Waived if concessionary copays exceed A$274.40 (HK$1,805) in a year	Pharmacare: provincial drug subsidies for elderly people and welfare recipients
Private health insurance	Not regulated	Community-rated premiums; Obligatory acceptance of all applications; Premium surcharge imposed on young people who take out private insurance after age 30, to protect against adverse selection	Premium not regulated; Can only cover services not covered by Medicare

	Finland	United Kingdom	Singapore
Subsidy level	Municipal healthcare: almost 100%; NHI: 15-58% of fees	100% cost for most services	No direct subsidy to Medisave and Medishield schemes; B2 class ward: 65% cost; C class ward: 80% cost
User fees or copays (outpatient)	Municipal healthcare: nominal; NHI: Deductible EUR13 (HK$142) + 60% copays for consultation, 75% for treatment and test	Nil for most services; Nominal fees for ophthalmic and dental services	Medisave withdrawal limit for selected chronic diseases: S$300 (HK$1,549) per year but for each bill, patients have to pay the first S$30 and 15% of the balance; Medishield: N/A
User fees or copays (inpatient)	Municipal healthcare: up to 80% of income for patients aged ≥ 18 if stay is longer than 3 months; NHI: N/A	Mostly nil; Charges levied on insurance companies for road traffic accident patients	Medisave withdrawal limits: daily charges S$400 (HK$2,067), surgical charges S$150-5000 (HK$775-25,833); Medishield: deductible at least S$1,000 (HK$5,163) per year + 10-20% copays; claims limit S$50k (HK$258,153) per year, S$200k (HK$1.03 million) lifetime
User fees or copays (prescription drugs)	NHI: 42% of fees (for outpatient drugs only)	Nominal fees	Withdrawal and claims limits as above
Safety net	Non-means-tested annual ceiling on public user fees and NHI copays; Chronic patients: reduced deductible for drugs EUR4 (HK$44) + 75% or 100% reimbursement	Exemptions for welfare recipients, children, pregnant women and new mothers, and patients with selected medical conditions	Medifund: means-tested government endowment fund to assist public patients who cannot afford copays
Private health insurance	Premium not regulated	Premium not regulated	Premiums of approved insurance plans can be paid using Medisave

	Austria	Belgium	Japan
Subsidy level	Contracted providers: unclear; Non-contracted providers: 80% of contracted fees	Outpatient: 60-70% scheduled fees; Drugs: Nil for the self-employed; 0-100% for others depending on the drug's therapeutic value	Varies depending on sickness funds
User fees or copays (outpatient)	Contracted providers: fixed sum for 1st consultation in a given quarter of the year; Non-contracted providers: 20% of contracted fees + remaining balance	GP: 30% scheduled fees; Specialist: 40% scheduled fees	20-30% scheduled fees with monthly cap per household: ¥63,600 (HK$4,270); Elderly copays: 10% scheduled fees, monthly inpatient cap ¥24,600 (HK$1,652), monthly outpatient cap ¥8,000 (HK$537)
User fees or copays (inpatient)	Deductibles EUR10-15 (HK$110-165) per day for the 1st 28 days + 10-20% copays	Separate flat rate statutory copays for hospitalization, drugs and diagnostic tests or radiology	
User fees or copays (prescription drugs)	EUR4.45 (HK$49) per item; 10-20% for therapeutic products	Self-employed: full costs; Others: 0-100% costs depending on subsidy level	
Safety net	Means-tested exemptions on copays	Vulnerable groups: exempt if copays exceed EUR450 (HK$4,926) in a year; Others: tax deductible if copays exceed thresholds (income-based)	Lower monthly cap for low-income family: ¥35,400 (HK$2,377)
Private health insurance	Premium not regulated	Premium not regulated	Premium not regulated

	Korea	The Netherlands	Switzerland
Subsidy level	Outpatient: varies depending on the type of clinic/hospital; Inpatient: 80% of scheduled fees	55% of the Health Insurance Act revenues are from government subsidy (5%) and the income-related contribution (50%)	N/A for private insurance, but government subsidizes the capital costs and at least 50% of the running cost of subsidized hospitals
User fees or copays (outpatient)	Clinic: min. 3000 won (HK$25); If bill exceeds 15,000 won (HK$126), 30% of scheduled fees; Hospital: 40% or 50% of scheduled fees	Not stipulated, depend on the plans opted for (benefits-in-kind or reimbursement, level of deductibles, etc.)	Deductible (for adults only): CHF300-2500 (HK$1,970-16,411) per year; 10% copay with annual cap CHF700 (HK$4,594) for adults; Cap for children is halved; If several children of a family are insured by the same company, their total copay cannot exceed twice the children cap
User fees or copays (inpatient)	20% of scheduled fees		
User fees or copays (prescription drugs)	For drugs with prescription: 20% for people aged 65 or above, 30% for people aged below 65		
Safety net	Reimburse 50% of the exceeded amount if copays exceed 1.2 million won (HK$10,117) in 30 days; Exempt if exceed 3 million won (HK$25,292) in 6 months	No-claim reimbursement for adults with annual claims below EUR255 (HK$2,635) (to be abolished with effect from 01 January 2008); Means-tested premium subsidy up to EUR1,050 (HK$10,846)	Means-tested premium subsidy varies by region (e.g. for premiums exceeding 10% of household income); Welfare recipients' premiums are paid by the government
Private health insurance	Premium not regulated	Voluntary top-up plans not regulated	Voluntary top-up plans not regulated

	The United States
Subsidy level	Medicaid: almost 100%
User fees or copays (outpatient)	Medicare: 20% of scheduled fees + annual deductible of US$100 (HK$780); Medicaid: Nominal copay US$0.5-3 (HK$4-23)
User fees or copays (inpatient)	
User fees or copays (prescription drugs)	
Safety net	Medicaid: No copay for A&E, family planning and hospice care; Copay exempted for children, pregnant women and elderly or disabled welfare recipients
Private health insurance	Premium (including voluntary top-ups for Medicare) not regulated; Annual premium for voluntary top-ups for Medicare US$1,000-3,500 (HK$7,800-27,300)

Table D.2 Comparison of healthcare expenditure and source of financing in Hong Kong and selected economies

Economy	Total health expenditure as a % of GDP [1]	Public health expenditure as a % of GDP	Source of financing				Per capita health expenditure at purchasing power parity [2]	Public expenditure as a % of GDP [3]	Highest personal income tax [4]	Sales tax [5]	Public health expenditure as a % of total tax revenue [6]
			Public		Private						
			General taxation	Social health insurance	Private health insurance	Out-of-pocket payments/ others sources					
Hong Kong	5.2	2.8	**54.8%**	-	12.4%	32.7%	1,666	19.7	16.0%	-	23.6
Australia	9.5	6.4	**67.5%**	-	6.7%	25.8%	3,128	34.4	47.0%	10%	20.6
Canada	9.8	6.9	**68.8%**	1.5%	12.9%	16.8%	3,326	39.3	46.4%	7-17%	20.7
Finland	7.5	5.9	**61.1%**	16.6%	2.3%	20.0%	2,331	50.5	48.8%	22%	13.4
United Kingdom	8.3	7.2	**87.1%**	-	1.0%	11.9%	2,724	44.5	40.0%	17.5%	19.7
Austria	10.2	7.7	29.7%	**46.0%**	5.2%	19.1%	3,519	49.9	42.7%	20%	18.3
Belgium	10.3	7.4	4.2%	**63.3%**	5.1%	27.4%	3,389	49.9	46.5%	21%	16.3
Japan	8.0	6.6	15.9%	**65.9%**	0.3%	17.9%	2,358	38.1	47.1%	5%	25.1
Korea	6.0	3.2	11.9%	**41.1%**	3.4%	43.6%	1,318	28.9	35.5%	10%	12.5
Netherlands	9.2	5.7	2.8%	**59.5%**[7]	19.0%	18.7%	3,094	45.5	52.0%	19%	15.2
Switzerland	11.6	6.9	17.2%	**42.5%**[8]	8.8%	31.5%	4,177	36.3	37.8%	7.6%	23.2
United States	15.3	6.9	32.1%	12.9%	**36.6%**	18.4%	6,401	36.6	41.3%	2.9-7.25%	25.3
Singapore	3.8	1.3	25.5%	9.2%[9]	-	**65.3%**[9]	1,180	15.6	21.0%	5%	7.2

Table D.2 Comparison of healthcare expenditure and source of financing in Hong Kong and selected economies (cont'd)

Note: Figures were extracted from the OECD Health Data 2007 (Oct 07), National Accounts of OECD Countries, volume 2, OECD 2007, OECD Tax Database (accessed 10 Dec 2007), the World Health Organization – National Health Accounts Series, and the Hong Kong's Domestic Health Accounts: Estimates of Domestic Health Expenditure, 1989/90-2004/05, unless otherwise specified.

1. Figures for Singapore (2004 figure) were provided by the Singapore Ministry of Health.
2. Figures for Hong Kong (2004/05 figure) were compiled using the purchasing power parity conversion rate from the World Development Indicators 2006.
3. Figures for Hong Kong (2004/05 figure) and Singapore (2005 figure) were compiled respectively from Hong Kong Annual Digest of Statistics 2006 and Yearbook of Statistics Singapore.
4. Income tax refers to top marginal rates of personal income tax exclusive of employee social security contribution. For the case in Hong Kong, the maximum personal income tax is subject to a cap of 16.0%, which is known as the standard rate. Figures for Singapore were provided by the Singapore Ministry of Health.
5. Figures for Canada and Singapore (2005 figure) were provided by the Health Canada and Singapore Ministry of Health respectively. In United States, some states do not have sales tax while others ranged from 2.9 to 7.25%.
6. Figures for Singapore (2004 figure) were provided by the Singapore Ministry of Health.
7. Figure is as of 2004 extracted from OECD Health Data (Oct 2006). However, it should be noted that for the Netherlands, there have been new developments since then. The Netherlands implemented a mandatory private health insurance scheme in January 2006 under a major healthcare reform. The mandatory insurance is managed by private insurers and is financed by community-rated premiums as well as by income-related contributions that are meant for covering children's premiums and for risk adjustment among insurance companies. Prior to the reform, the major financing source was social health insurance, participation of which was compulsory for people with income lower than a certain level, while higher income people took out voluntary private health insurance.
8. What the Swiss law terms as a social health insurance is in fact mandatory taking out of private health insurance that are managed by private insurance companies. The insurance is mandatory for the whole population and low-income families are subsidized by the government. Premiums of the mandatory insurance are community-rated and the insurers are not allowed to make profits from the compulsory insurance.
9. The figure under social health insurance in Singapore refers to the Medisave, Medishield and Eldershield schemes. However, Medisave is an individual medical savings accounts scheme which does not involve direct income redistribution that is a hall-mark of social health insurance, whereas Medishield and Eldershield are voluntary taking out of private health insurance and long-term care insurance respectively. Also, the figure under out-of-pocket payments for Singapore has included private health insurance (other than Medishield) and employer provided medical benefits.

APPENDIX E THE HEALTH AND MEDICAL DEVELOPMENT ADVISORY COMMITTEE

The Health and Medical Development Advisory Committee (HMDAC) is an advisory body, chaired by the Secretary for Food and Health and comprising 12 non-official members and one ex officio member, tasked to review and develop the service model for healthcare in both the public and private sectors, and to propose long-term healthcare financing options. The Working Group on Healthcare Financing under the HMDAC was set up in October 2005 to examine specifically the financing aspect of the healthcare system in the light of the long-term service delivery model.

The HMDAC issued the discussion paper "*Building a Healthy Tomorrow*" in July 2005 for public consultation. It puts forth a host of recommendations for the future service delivery model for our healthcare system, covering primary medical care, hospital services, tertiary and specialized services, elderly, long-term and rehabilitation care, as well as other related issues including private-public sector collaboration and infrastructural support for public discussion, with a view to building a sustainable system that is accessible and affordable by every member of the community.

This consultation document is building on the HMDAC discussion paper "*Building a Healthy Tomorrow*" and is developed on the basis of the recommendations of HMDAC.

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