Healthcare Financing Submission to the Hong Kong SAR Government

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What We Agree

The Consultation Document on healthcare financing urged the strengthening of primary healthcare and preventive efforts and the introduction of electronic medical records for patients that will be used throughout the territory by both private and public healthcare givers. The Centre for Public Policy Studies at Lingnan University supports these proposals.

Our Greatest Worry: A Premium Cost Spiral

However, we find the government's listing of the policy options for supplementary financing unenlightening. The most worrying thing about the options is that they generally reflect a lack of understanding of human nature and how incentives work. When it comes to preventive care the Consultation Document mainly relies on an improved primary care sector and public education. But financial incentives do play an important role too. The failure of the Consultation Document to come to terms with the need to raise healthcare charges to a reasonable level and thus motivate people to adopt a healthy lifestyle is disappointing. The Consultation Document does recognize that low charges tend to cause misuse and waste, but simply ignores the need to raise charges to a more reasonable level.

We are supportive of the need for risk-pooling. But risk-pooling does not imply we need to collect insurance premiums. A flat-rate insurance premium is regressive. With increasing income disparity in Hong Kong we recommend paying for the cost of insurance through taxes. This is simpler and will save administrative cost.

On the other hand, maintaining low charges on services will produce perverse incentives on utilization of public services. We argue that claims for private services rendered need to be regulated because in the absence of such regulation caregivers are likely to raise charges and render more services than are optimal. This will push up costs and put pressure on premiums.

A Charge and Cap Plan

Just as the National Health Insurance scheme in Taiwan found it necessary and appropriate to introduce co-payments we consider it imperative to raise health service charges to a more reasonable level. Co-payments serve to discourage over-utilization of services. Typically co-payments would cover at least 10%, and often 20% or more of true costs. Charges much lower than 10% of true costs are obviously too low. Totally free services will always invite misuse and waste. Although we recommend raising charges to a more reasonable level and not exempting anyone completely, we also any individual's payments for higher charges be capped at some percentage.

We propose that the Government take the prerogative to set *standard charges for standard healthcare services* that are provided publicly. An insured person may use the services of private caregivers. But if the private caregiver charges more, he must be willing to pay for any excess out of his own pocket, as the caregiver can only claim compensation for the standard charge from the government, which is the insurer for basic healthcare. Under our proposal, the caregiver can claim compensation for the standard charge from the government AFTER an individual has paid beyond an annual deductible, which is initially set at $5000.

Fixing Standard Fees for Covered Services

Without a standardized price schedule that is set by the government, there will be a tendency for caregivers to charge excessively and to provide excessive services, especially when the patient is insured. In the end, insurance premiums will be driven up, and people will be paying too much for services that they do not need. In February 2008 the Hospital Authority introduced a new Cataract Surgeries Programme under which a fixed subsidy of $5,000 will be provided for each cataract surgery performed by participating private ophthalmologists, who may charge more thus requiring patients to co-pay an amount no more than $8,000. This is a good beginning. We think preempting the private sector for pricing standard services is necessary. Just as in the cataract plan, the private sector should be allowed to charge more if the patient is prepared to pay with his own funds that are not counted as eligible toward the annual deductible.

An Efficient Way of Protecting the Poor

Although we recommend excluding the very poor from insurance premiums, we deem it imperative that even the poor should pay their fair share of healthcare charges up to a point.

For the eligible poor, who pass a means test or who are CSSA recipients, we recommend giving each person a healthcare coupon, worth $2000 per year to start with. Besides, we will recommend that charges be *halved* for them. If at the end of a year any funds are left they can be available for their free disposal or for setting aside in a *medisave account.* Given the healthcare coupon, the maximum extra cost on these poor people is only $500 per year.

For the average person, before he reaches 50, we will recommend that the “annual deductible” for the “excessive burden insurance” be set at $5000 a year. This means that he will have to be responsible for the first $5000 of eligible standard healthcare services for the year. Beyond $5000 all eligible costs will be covered by public funds. Because older people typically consume more healthcare services, older people will be responsible for a higher level of their healthcare expenditures.

An Annual Deductible that Increases with Age

We recommend gradually raising the annual deductible for those past the age of 50 to a maximum of $15000 a year. This will serve two purposes. One is that we can provide better services more promptly for them because we will have more resources. The other is that it serves as a warning to the young, advising them that they should take preventive care and adopt a more healthy lifestyle from an early age.

For the poor past the age of 50, the yearly healthcare allowance will also be increased along with the spending limits(annual deductible). The annual spending limit will be set at $7500, while maximum healthcare coupon will be set at $6000. Just as recommended earlier, any funds from the allowance that has not been spent for the year will be available at their disposal or for putting into a medisave account.

Voluntary Medisave Account and the Lifetime Healthcare Supplement

Now we will discuss the medisave account. We recommend that the government provide incentives for people to put money into the medisave account. In the liberal spirit, we will not recommend mandatory medisave account contributions.

We recommend that the government match deposits into the medisave account with a *conditional government-funded deposit* called the Lifetime Healthcare Supplement. An individual may draw the government-funded portion only with an equal contribution from his own pocket or from the medisave account, to spend on healthcare that is not covered in the standard basic care package, such as very expensive frontier medical treatments. He can do so any time in his life. But if he is over 65, he will also be allowed to spend the medisave funds on standard services.

The total amount of conditional government-funded deposit is $300,000, which sets a limit to the contingent liability of the government. This arrangement is better than treating medisave contributions as deductible from taxable income, because the poor may not have taxable income and would not benefit from tax allowances. Moreover, tax deductibility immediately reduces government revenues. The Lifetime Healthcare Supplement on the other hand is only a contingent liability and may not be a government expenditure at all. In the event that an individual dies the conditional government-funded deposit will be returned to the public coffers, while private contributions will be treated as his estate.

The Lifetime Healthcare Supplement is also limited for the life time. This means that if someone has drawn funds from it early in his life, less will be available in the rest of his life. This will provide an incentive for people to conserve funds. Because of this, and because of the matching feature, there is a good possibility that many Hong Kong citizens may never use or may use only a portion of the funds for their entire lives. The LHS provides an excellent incentive for medical savings. If people have accumulated $300,000 of medical savings, it means that they will have a total of $600,000 to pay for costly healthcare that may not be covered in the standard public healthcare plan.

Conclusions: A Hybrid Healthcare Funding Plan Requiring No Mandatory Contributions

Our proposal actually combines tax financing, user charges, and risk pooling. The Lifetime Healthcare Supplement can be set at a level that the government feels comfortable. This limits the exposure to cost pressures from technological advance. The Annual Deductibles or spending limits can be set at a level that balances the individual's need for financial risk protection against the need for resources to provide quality care. There will be no need for any mandatory contributions and no need to set up a new regulatory body like the MPF Authority. Mandatory contributions will end up eroding our competitiveness and undermining the responsibility system. Any extra administrative costs will be minimal, particularly after the electronic filing system has been set up. We believe that the hybrid system that we are recommending is the best system for Hong Kong. Our hybrid plan represents a logical extension of the present system. A similar version of it is already in operation and is doing well in Taiwan. But whereas Taiwan introduces a new earmarked tax, and charges excessively low outpatient fees, we would recommend doing without such new forms of taxes and maintaining reasonable outpatient charges and drug charges too.

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