香港保險顧問聯會
THE HONG KONG CONFEDERATION
OF INSURANCE BROKERS

BY FAX (2102 2525) AND BY MAIL

Our Ref: IS0806051

13 June 2008

Food and Health Bureau
19/F Murray Building,
Garden Road,
Central,
Hong Kong

Dear Sir/Madam,

Re: "Your Health Your Life" Healthcare Reform Consultation Document

We are pleased to submit herewith our response to the above-mentioned consultation for your consideration.

There is no objection to our views being published or publicized for public discussion and debate, and we look forward to hearing from the Government on the next round of consultation.

Thank you for your attention.

Yours faithfully,

Eric Lee
Secretary-General & Registrar

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THE HONG KONG CONFEDERATION
OF INSURANCE BROKERS

Response to the "Your Health Your Life"
Healthcare Reform Consultation Document

13 June 2008

Introduction

The Hong Kong Confederation of Insurance Brokers ("CIB") is a professional association and self-regulatory body of insurance brokers authorized by the Insurance Authority. Incorporated in 1993, CIB currently represents 249 corporate member firms of insurance brokers.

CIB responded in October 2005 to the "Discussion Paper on the Future Service Delivery Model for our Health Care System", where it believed that the financing model and the service delivery model being intertwined, any reform should involve both.

Publication of the "Your Health Your Life" Healthcare Reform Consultation Document is most welcomed. It brings forward ideas and initiatives on healthcare financing that are comprehensive, insightful and thought-provoking.

As envisioned in the Document, this consultation exercise aims to gather views on providing better care, more choice, healthcare protection and peace of mind, and promoting partnership for health. It is also pointed out that it is important to examine how the financing of services will drive the interaction between different service providers, and how available resources are channelled into the system.

CIB is in full support to the motions to:

- Shift the emphasis from curative to preventive, from secondary to primary healthcare; and
- Develop community-wide electronic health record.

CIB is also pleased to contribute to the discussion and debate by putting forward a healthcare financing model.

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The Model

1. This model is worked out along the line of the long-established healthcare policy that no one should be denied adequate healthcare through lack of means.

2. Its formulation leverages upon the six financing options and various considerations and proposals included in the Document.

3. It however aims not to be a supplementary financing model itself for making up projected deficit in the public healthcare system. It aims to re-route the available resources to actually provide the means to citizens to choose and to access to the adequate healthcare.

4. The form and substances of this model are that there are:

- a basic model of holistic healthcare;
- a healthcare voucher scheme;
- a top-up MPF contribution;
- a mandatory medical insurance system;
- a supplementary safety net supported by the Samaritan Fund;
- a full-cost-recovery fee schedule for public hospitals and clinics.

5. The basic model of holistic healthcare:

5.1 It is to define the "adequate healthcare" referred to in the long-established healthcare policy of the Government.

5.2 Its development is by the Government in consultation with and involvement of the medical and other healthcare professionals.

5.3 It should cover the essential elements of primary and secondary care, including preventive as well as curative services.

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5.4 It is similar to, but more than, the concept of the basic models of primary care services proposed in the Document (paragraphs 2.11 – 2.13).

5.5 In its presently proposed form in the Document, the basic models are to cover the primary care services only. This puts some substances into the foresaid long-established healthcare policy, but the further and important step shall be taken to define in full what constitutes "adequate" healthcare. This has to be in a holistic approach.

6. The healthcare voucher scheme:

6.1 It is a scheme of non-means-test community-wide Government subsidy to provide to individual citizens the means for accessing to healthcare services.

6.2 The philosophy behind this scheme is that the citizens know best of taking care of their health needs. What they may be lacking is the financial means.

6.3 The scheme is to financially empower citizens to choose and to buy from the public or the private sectors the healthcare services they are in need.

6.4 It is in line with the proposal in the Document of Government subsidizing individuals to receive preventive care (paragraphs 2.16) that the funds are designated in the usage, but this scheme means a bigger step be taken.

6.5 The non-means-test feature removes any stigmatization on the underprivileged and minimizes the implementation cost.

6.6 The community-wide feature ensures an equitable redistribution of wealth when all individuals are given the voucher of the same value.

6.7 There need not be another institution to administer the voucher scheme. The MPF system can be leveraged upon for granting the funds.

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6.8 In the form of an annual credit to the MPF accounts, as illustrated by the grant to low-income group in the recent budget of the Government, the fund granted under the voucher scheme is earmarked for paying for mandatory medical insurance.

6.9 The scheme is funded not from extra allocation from the general revenue of the Government. It is by diverting a part of the recurrent subvention and funding for the operations of the Hospital Authority and the Government clinics.

6.10 That is to say, the public healthcare expenditure will be changed from subsidising the supply to subsidising the demand.

6.11 Government funding is the first layer of financing source for healthcare. Two figures would illustrate the likely value of the voucher:-

(i) The per capita public health expenditure at HK$5,600 (in 2005 dollar) as quoted in Table 1.2 of the Document.

(ii) The per capita share of the recurrent Government subvention to the Hospital Authority at around HK$3,900. (Recurrent subvention to the Hospital Authority at HK$27,182 million in 2006/07.)

7. The top-up MPF contribution:

7.1 It is a MPF contribution in addition to the current 5-5% being made by employees and employers.

7.2 Both eligible employees and employers are to make this additional contribution as a top-up.

7.3 The fund is earmarked as reserves for healthcare expenditure that can be deployed pre or post retirement.

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8. The mandatory medical insurance system:

8.1 Insurance is the most appropriate financial vehicle to spread the financial risk associated with healthcare expenditure faced by individuals, so that they can transfer the risk to the insurance companies at a relatively low cost.

8.2 It is an indemnity-based medical insurance providing coverage, with limits of indemnity, for the itemized healthcare services as defined in the basic model of healthcare, i.e. the "Act" cover.

8.3 The premium of this mandatory medical insurance is paid by the fund provided by the healthcare voucher.

8.4 When there is a difference between the premium and the healthcare voucher, in case it is a savings in premium, the surplus is retained in the respective MPF account of the individuals as personal reserves to meet future healthcare expenditure; in case it is a shortfall, the individuals may either use the reserves saved or built in previous years, or pay out of pocket, or apply to the Samaritan Fund for means-test subsidy.

8.5 The medical insurance is underwritten by authorized medical insurers in Hong Kong and the coverage is regulated, for example,

- Limited to healthcare services supplied geographically in Hong Kong;
- Guaranteed acceptance;
- Portable between insurers;
- Minimal exclusions (e.g. cosmetic surgeries/treatment);
- Requiring co-payment when consuming healthcare services.

8.6 The private sectors shall retain business autonomy:

- Insurance is a financial instrument for risk transfer. Insurers invest capital to run the business according to their respective models, inter alia, business

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acquisition, claims payment, and reserves. They receive premium in exchange for paying claims incurred and earning surplus remained.

- Pricing autonomy is the key indicator of free market competition which will encourage and entail efficiency and innovation. Any attempt by the Government to fix the price will only distort either the supply or the demand and induce resource misallocation and wastage.

- In the insurance market, premium level is driven by competition, and always the consumers benefit from it – lower price and better service.

- Striving for survival in a competitive market, players in the insurance market will minimize their operational cost including administration and business acquisition, hence promote efficiency.

- Premium level also signifies the extent of health risk. The potential of enjoying lower premium rate is a key driver for individuals improving and maintaining healthy life.

- Except for ensuring solvency of insurers, there is no justification for regulating how insurers allocate the premium received. When the Government hands out monies to CSSA recipients to buy foods and clothes, it imposes no regulation on suppliers of the foods or clothes. There is no good reason to treat insurers, the supplier of risk transfer service, differently.

- Other than being subject to solvency requirements, insurers enjoy higher flexibility and motivation than statutory bodies to efficiently invest premium receipts to maximize returns, hence more room for competitive premium reduction and another boost to the development of financial market in Hong Kong.

- The Swiss model does not regulate the premium level either. Premiums vary among insurance companies, albeit it is required that the rate be

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identical within the same company for all insured persons of the same age group.

8.7 Top-up voluntary insurance is allowed and encouraged with financial incentives (such as tax credits) that individuals can pay out of pocket to extend and enrich the insurance cover, e.g. worldwide coverage, higher limits of indemnity, lower co-payment. Insurance companies are allowed to apply a different rate to different insured persons for this voluntary part within the same company.

8.8 Currently there are more than a million people, mostly employees and some of their family members, being insured under voluntary group medical insurance. Employers or various organizations like churches or schools, can be encouraged to sponsor the purchase of the mandatory medical insurance with voluntary top-up, so as to leverage further on the bargaining power of a group scheme for better terms in both premium and coverage.

8.9 There shall be an opt-out or grandfathering arrangement, like the exemption of ORSO Schemes under the MPF, that people who are having any existing voluntary medical insurance policies which are with better coverage than the mandatory scheme may be exempted from such mandatory scheme.

8.10 The Insurance Companies Ordinance has to be amended to classify medical insurance as a separate class of business, subject it to a common set of solvency and reporting requirements. Currently, insurers writing medical insurance are subject to two different sets of requirements, one for long-term insurance business and the other for general insurance business.

9. The supplementary safety net supported by the Samaritan Fund:

9.1 The Samaritan Fund is deployed to provide the last resort for healthcare financing, and it is on a means-test basis.

9.2 It is for subsidizing people who have passed the means-test for

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- The co-payment payable under the mandatory medical insurance;
- The premium shortfall of the mandatory medical insurance;
- The excess payment for healthcare service above the limit of indemnity of the mandatory cover, provided that the service providers are charging not more than that specified in the fee schedule of the public sector; and
- The healthcare services fallen outside the basic models of holistic healthcare services.

9.3 The $50 billion earmarked from the fiscal reserves by the Financial Secretary shall be the seed monies to build up this fund through appropriate investment.

10. The full-cost-recovery fee schedule for public hospitals and clinics:

10.1 This is to help strike the balance of utilization between the public and private healthcare sectors.

10.2 When individuals are subsidized through the healthcare voucher system and are empowered financially to choose public or private healthcare service, they should be paying full fees when they elect the public sector; otherwise, they will be double subsidized.

10.3 The Hospital Authority shall formulate a full-cost-recovery fee schedule with itemized services and fees.

10.4 This fee schedule will facilitate insurers to assess the risk exposure and to price the mandatory medical insurance.

10.5 Also given this benchmark for comparison, the private healthcare sector will be able to compete for market share with the public healthcare sector.

10.6 Individuals will be able to ask, compare and choose the needed healthcare services between the public and the private sectors.

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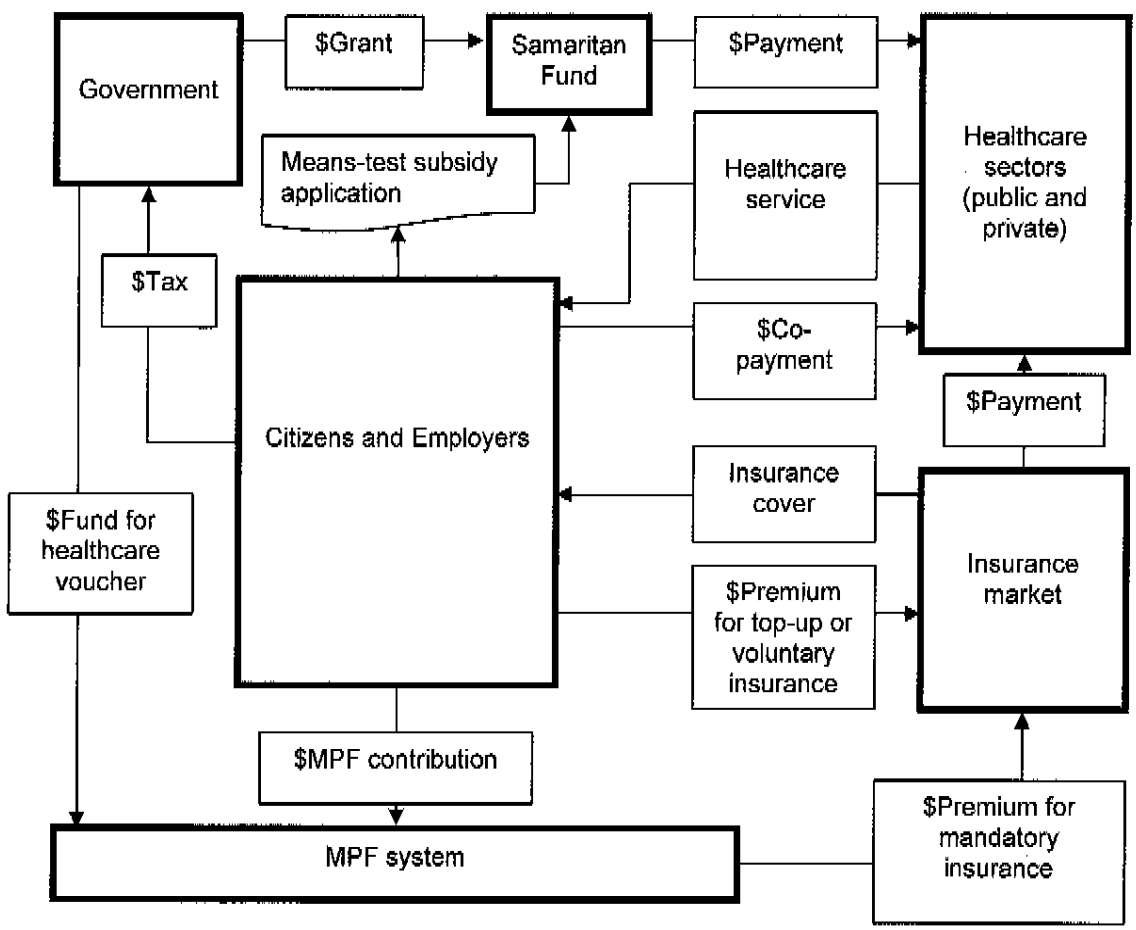
10.7 The Hospital Authority will recoup the full cost for emergency treatments of victims in work or traffic accidents when these are now heavily subsidized without a good reason. It will be equitable when the subrogation mechanism works among the three mandatory insurance systems, medical, employees' compensation and motor that, careless employers and car owners will ultimately be funding such cost.

11. Chart to illustrate how resources are channelled through the healthcare system under the Model:



CIB is most pleased to put forward this financing model as our response to the consultation, and looks forward to participating in the next round of consultation.

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