

Research Brief

Issue No. 3
2017 – 2018

Health insurance for individuals in Hong Kong

July 2018

In parallel with growing health consciousness in society, the proportion of local population covered by individual-based health insurance has surged from 20% to 34% within a decade. Market premium has almost tripled to HK\$10.3 billion in 2016.

While almost all of the insurance policies covered inpatient care, less than three-fifths of the insured persons received such care in private hospitals. The hesitation to patronize private hospitals could be attributable in part to caveats in existing products such as a lack of premium transparency and budget certainty.

Robust penetration of health insurance so far has limited diversion effect in the overall healthcare system, partly due to higher administration cost in running the individual-based health insurance system. The public healthcare system remains highly congested, handling 82% of inpatient admissions in 2016.

While the newly added 10 minimum requirements may help enhance quality and transparency of certified plans under the Voluntary Health Insurance Scheme ("VHIS"), the stock of existing policies remains "lightly regulated". Coupled with the omission of high-risk pool and expectation of higher insurance premium, the policy target to cover 1.5 million people under VHIS within three years seems to be quite challenging.

The subject of health insurance falls within the policy area of the Panel on Health Services. An amendment bill on the Inland Revenue Ordinance to offer tax incentives for purchase of health insurance was gazetted on 18 May 2018.



**Research Office
Legislative Council Secretariat**

1. Introduction

1.1 The healthcare system in Hong Kong presents a real conundrum to the Government. On the one hand, Hong Kong should be proud of its accessible and affordable public healthcare services, contributing to the longest life expectancy of local citizens in the world since 2011.¹ On the other hand, longer waiting queues and rising incidence of sentinel events in recent years have decreased the level of satisfaction among the public with the healthcare services provided by the Hospital Authority ("HA").² In particular, there are concerns over inadequate resources allocated to the public healthcare system relative to the growing demand amidst an ageing society.³

¹ The average life expectancy at birth in Hong Kong has lengthened by a total of about four years since 2000, to 81.7 years for males and 87.7 years for females in 2017. Hong Kong has surpassed Japan to have the longest life expectancy for both sexes in the world since 2011. See Census and Statistics Department (2017b) and World Health Organization (2018).

² As an illustration, the average waiting time for semi-urgent cases for accident and emergency services of HA has lengthened by 54% to 114 minutes during 2010-2017, whereas the number of sentinel events of HA has increased by 21% to 40 cases over the same period. Within a scale of 0 (least satisfied) to 10 (most satisfied), public satisfaction of the public healthcare system has declined steadily from 6.5 in 2014 to 5.9 in 2017. For details, see Food and Health Bureau (2018b), Hospital Authority (2018a) and Chu Hai College for Higher Education (2018).

³ Indicating the imbalance in the public healthcare system, the Government estimated that there was a shortage of 300 doctors and 600 nurses in public hospitals in 2016-2017. Despite a forecast increase in public spending on health by 9% in the 2018-2019 Budget, its share in total public spending will decline to 13%, from a peak of 15% in 2015-2016. See Food and Health Bureau (2017a).

1.2 To relieve the pressure on the public sector and to broaden the source of healthcare financing, the Food and Health Bureau ("FHB") will launch the Voluntary Health Insurance Scheme ("VHIS") in early 2019, offering tax incentives of HK\$8,000 for individuals to purchase eligible insurance products. Yet there are doubts over how far the new initiative could address the structural imbalance in the healthcare system. This Research Brief focuses on the individual-based health insurance ("IHI") segment, beginning with a review of its recent market developments and its implications for the overall healthcare system. It then discusses the key features of VHIS and its major implementation issues.

2. Recent developments in the health insurance market for individuals

2.1 Local health insurance market comprises two distinct segments, namely individual-based policies purchased by consumers and group-based policies offered by employers to their employees.⁴ For the former, reimbursement of the expense for inpatient care is the most common feature, while the latter is more broad-based usually covering out-patient care as well. According to FHB, the health insurance market is "lightly regulated in Hong Kong", subject only to the prudential regulation under the Insurance Companies Ordinance. Health insurers generally have a large degree of freedom in the design and marketing of health insurance products.⁵

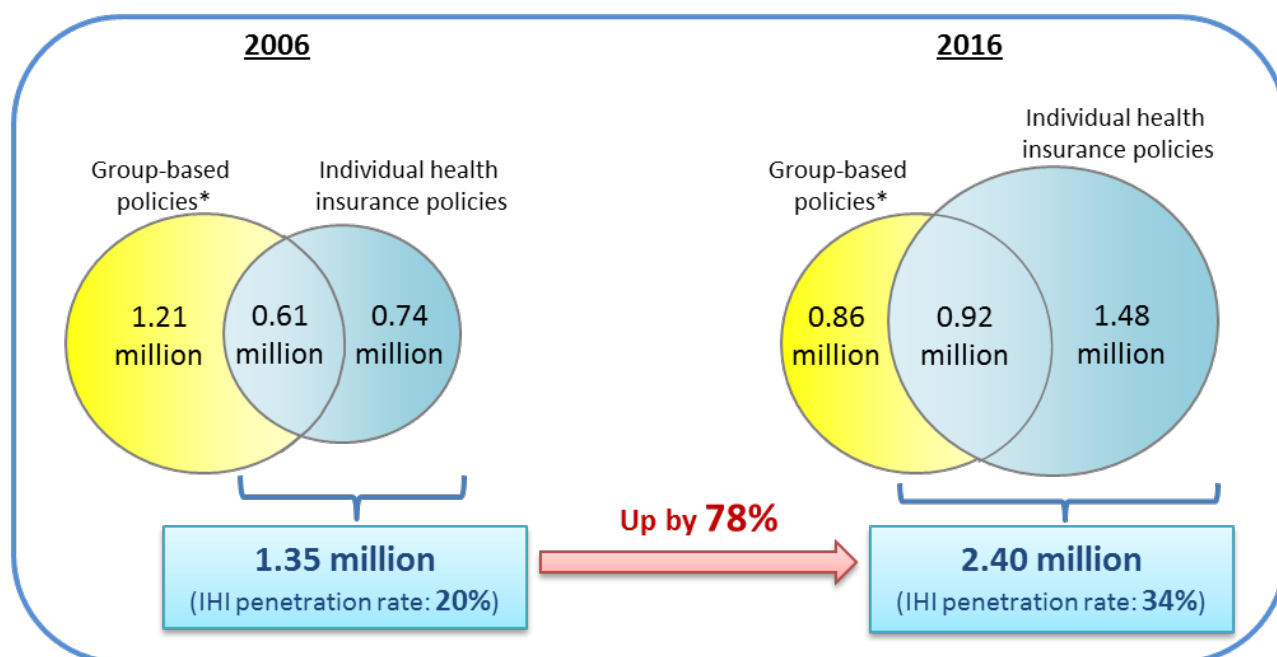
2.2 In parallel with growing health consciousness and increased affluence in society, sales of overall health insurance products have exhibited robust growth over the past decade. According to the Census and Statistics Department ("C&SD"), as many as 3.26 million people or 47% of local population were protected by health insurance in 2016, comprising 1.48 million people with IHI policies only, 0.86 million with group-based policies only and 0.92 million with both types of policies.⁶ While the insured population in the group-based segment hovered around 1.8 million in 2016, that in the individual-based segment has surged by 78% over the past decade to 2.4 million in 2016 (**Figure 1**).

⁴ IHI products can be further divided into four broad types, namely (a) hospital insurance reimbursing hospitalization cost; (b) out-patient insurance reimbursing treatment cost in doctor consultation at clinics; (c) hospital cash insurance offering income protection to policy holders which may not be related to inpatient cost; and (d) critical illness insurance offering a lump-sum amount of cash to policy holders upon confirmation of critical illness which may be unrelated to treatment cost. See Food and Health Bureau (2010).

⁵ Food and Health Bureau (2014 and 2017b).

⁶ The survey was taken between October 2016 and January 2017, covering 10 100 households. For presentational convenience, this survey period stands for the reference year 2016 throughout this brief. Likewise, another survey in this series conducted between November 2005 and March 2006 stands for the year 2006 for comparison. See Census and Statistics Department (2007 and 2017a).

Figure 1 – Local population covered by health insurance policies, 2006-2016



Note: (*) Group-based schemes refer to health insurance provided by employers to their employees in the private sector in 2016. For the 2006 figure, it also covered medical benefits provided by employers in the public sector, as breakdowns are not available.

Data source: Census and Statistics Department.

2.3 As this short note focuses on the individual-based segment of the health insurance market only, it will leave out the group-based segment in discussion unless necessary. More specifically on the penetration ratio of IHI products in local population, it has surged from 20% to 34% during 2006-2016. Matching with a total of 3.25 million IHI policies as enumerated by the Hong Kong Federation of Insurers ("HKFI") in 2016, this suggests that some insured persons may be holding multiple IHI policies.⁷

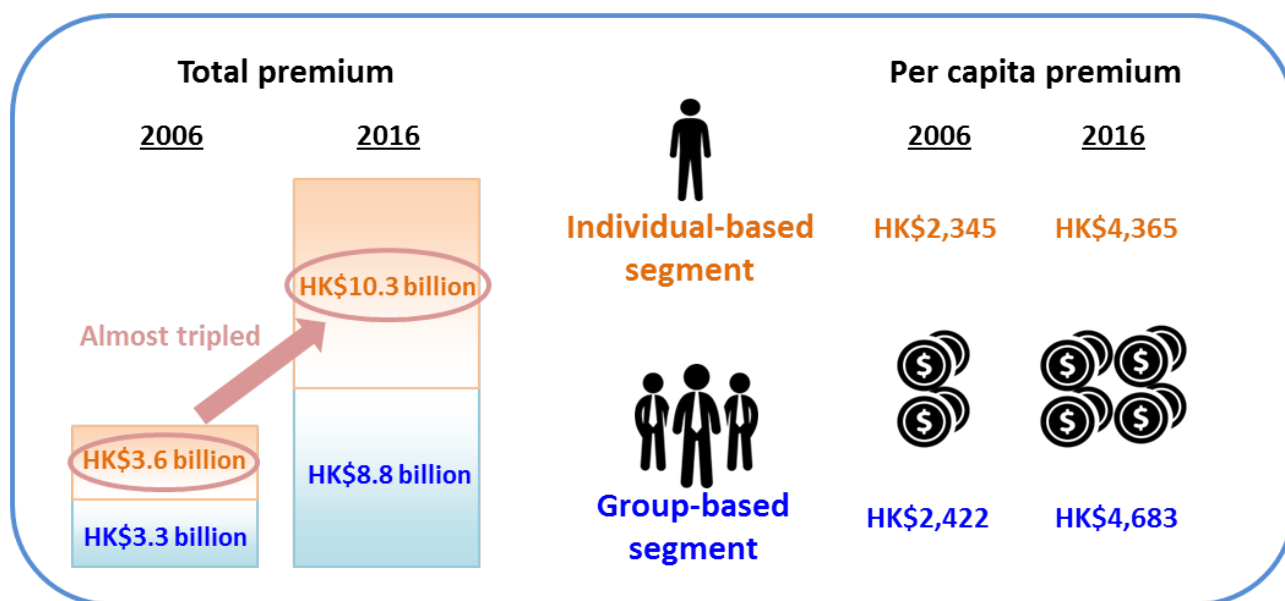
2.4 On the size of the health insurance market, total premium revenue of the individual-based segment has almost tripled within 10 years to HK\$10.3 billion in 2016, so did the group-based segment to HK\$8.8 billion.⁸ As regards per capita premium, it has increased by 86% to HK\$4,365 for the individual-based segment in 2016, and by 93% to HK\$4,683 for the group-based segment (**Figure 2**). Both were faster than concurrent consumer price inflation of 38% in Hong Kong.⁹

⁷ Census and Statistics Department (2007 and 2017a) and Hong Kong Federation of Insurers (2017b).

⁸ Hong Kong Federation of Insurers (2017b), 香港保險業聯會 (2017) and PriceWaterhouseCoopers (2013).

⁹ While there are no official statistics on medical cost inflation in Hong Kong, HKFI indicated that it was "in the range of 8% to 10%" annually. See Hong Kong Federation of Insurers (2015).

Figure 2 – Total premium and per capita premium of the health insurance market in Hong Kong, 2006-2016



Data sources: Hong Kong Federation of Insurers and PriceWaterhouseCoopers.

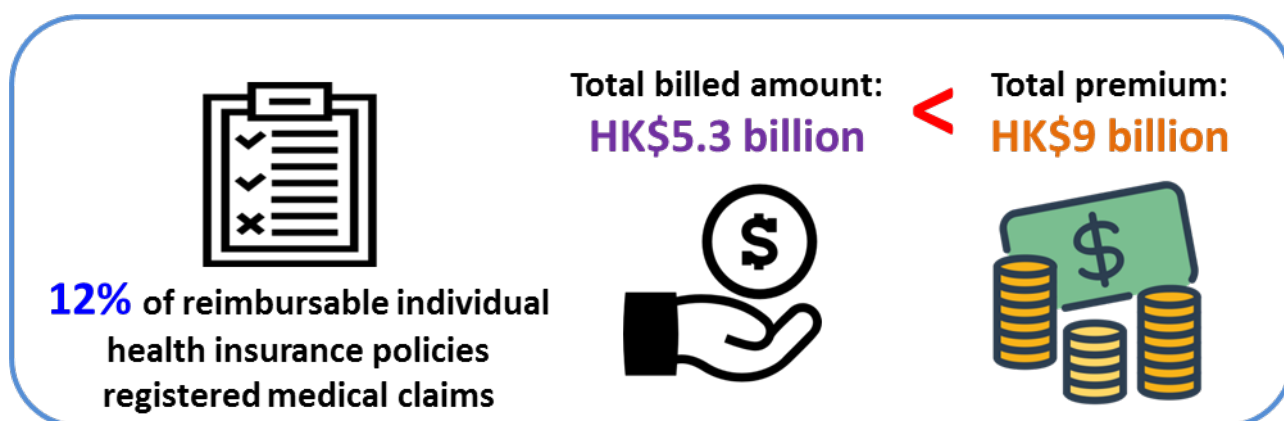
2.5 Inpatient care is almost a must-have feature in IHI policies, covering 99% of the insured population, according to C&SD. This is however not the case for out-patient care, which covered just about 10% of the insured persons. More specifically on the pattern of medical claims of insured population in the individual-based segment, the following salient points are noted:

- (a) **Incidence rate of curative care:** According to C&SD, about 19% of insured persons with IHI coverage only consulted doctors within the month before enumeration in 2016, and 10% were hospitalized within the year before enumeration.¹⁰ These were broadly similar to the respective incidence rates of 21% and 9% for the uninsured population;
- (b) **Annual medical claims:** Based on statistics of HKFI, about 12% of reimbursable IHI policies came up with medical claims in 2015. Although the total billed amount had increased by 50% in three years to HK\$5.3 billion in 2015, this was still far below the premium revenue of around HK\$9 billion in the same year (**Figure 3**).¹¹

¹⁰ This refers to those individuals covered by IHI policies only. For those persons covered by both IHI and medical benefits provided by employers, 26% had consulted doctors and 10% had been hospitalized over the same period. See Census and Statistics Department (2017a).

¹¹ In 2015, there were 270 400 cases of medical claims, representing about 12% of 2.2 million reimbursable IHI policies. With a per capita premium of HK\$4,055 in 2015, this gave rise to an estimated total premium of around HK\$9 billion for the year. See Hong Kong Federation of Insurers (2017a) and 香港保險業聯會 (2017).

Figure 3 – Medical claims and billed amount in reimbursable IHI segment in 2015



Data source: Hong Kong Federation of Insurers.

As residual of premium after claims is largely administration cost of insurers, the cost ratio of two-fifths in the individual-based segment appears to be on the high side.¹² The consultants appointed by FHB to study the local health protection scheme in Hong Kong remarked that the local individual-based market "is not very efficient in funding health care costs" by the global standard.¹³ Likewise, the Government also noted that the profit margin of the individual-based segment was "relatively more decent" than the group-based segment.¹⁴ Nevertheless, health insurers responded that 75% of premium revenue was used to settle medical bills when both segments were taken together;¹⁵

¹² Administration cost of private health insurance covers expenditure on sales and enrolment of policy service (e.g. commissions paid to insurance agents), claim adjudication, actuarial functions, legal support services, investment functions, corporate overheads, risk charges, etc. See Organisation for Economic Co-operation and Development (2013).

¹³ According to the consultancy report, the share of health insurance premium in the individual-based segment used for direct funding of healthcare cost averaged at 57% during 2004-2011 in Hong Kong. This was far lower than the respective ratio of 85% in Australia and 88% in Ireland in 2010 which were also predominantly individual-based markets. To a certain extent, this could be attributable to the fact that a lion share of 95% of IHI products in Hong Kong were sold through insurance agents or brokers. For details, see PriceWaterhouseCoopers (2013).

¹⁴ For the group-based segment in Hong Kong, the average share of health insurance premium used for direct funding of healthcare cost was much higher at 82% during 2004-2011, partly because of "better bargaining power" of bigger employers relative to insurers. See Food and Health Bureau (2010) and PriceWaterhouseCoopers (2013).

¹⁵ HKFI stated that "according to the 2013 statistics, for every \$100 premium paid by a policy holder (both individual and group indemnity plans), \$75 was used to settle medical bills". While HKFI also opined that inclusion of hospital cash allowance plans had distorted the average figure in the individual-based segment, FHB felt that "this does not alter the broad picture" in view of "limited market share of hospital cash products" in the individual-based segment. See Hong Kong Federation of Insurers (2015) and Food and Health Bureau (2010).

- (c) **Reimbursement by type:** Inpatient care accounted for the largest share of 65% of the overall caseload of medical claims in 2015, while the rest was out-patient consultation. The average billed amount of inpatient claim was HK\$29,900 in 2015, far more than that of HK\$880 for out-patient claim;
- (d) **Reimbursement ratio:** On average, IHI insured persons could be reimbursed 77%-85% of the billed amount of their inpatient care from insurers in 2015, depending on the accommodation grade in hospitals.¹⁶ In other words, insured persons still need to foot 15%-23% of the bills of hospitalization. However, there are no statistics on reimbursement ratio on out-patient consultation;
- (e) **Type of hospitals:** According to C&SD, some 57% of the inpatients covered by IHI policies only were treated in private hospitals in 2016, almost 10 times the respective figure of 6% for those uninsured persons.¹⁷ That said, 43% of these insured persons were still treated in more congested HA hospitals. FHB attributed this phenomenon to caveats of existing IHI products, including (i) absence of premium and product transparency; (ii) uncertainties over eligibility of medical claims for reimbursement; (iii) uncertainties over the ratio of reimbursement; and (iv) implications of medical claims on policy premium upon renewal.¹⁸

Health insurers nevertheless responded that "88% of reimbursed claim cases took place in private hospitals or private day case centres".¹⁹ To a certain extent, this paradox could be reconciled by the fact that most (92%) of those insured persons with IHI policies only and receiving inpatient care in HA hospitals did not claim any reimbursement of medical expense from health insurers, according to statistical breakdowns of C&SD.²⁰ Conceivably, these could be

¹⁶ The reimbursement ratio bore a negative relationship with the accommodation grade in 2015, rising from 77% for private rooms, 80% for semi-private rooms, 83% for ward and 85% for day case. The average billed amount for these four grades of accommodation was HK\$95,600, HK\$42,900, HK\$34,600 and HK\$9,400 respectively. See Hong Kong Federation of Insurers (2017a).

¹⁷ For those persons with both IHI insurance and employers' medical benefits, a larger proportion of 61% stayed in private hospitals for treatment. Figures from C&SD are slightly adjusted to take into account those inpatients receiving treatment in both private hospitals and HA hospitals during the year before enumeration. See Census and Statistics Department (2017a).

¹⁸ Food and Health Bureau (2010 and 2014).

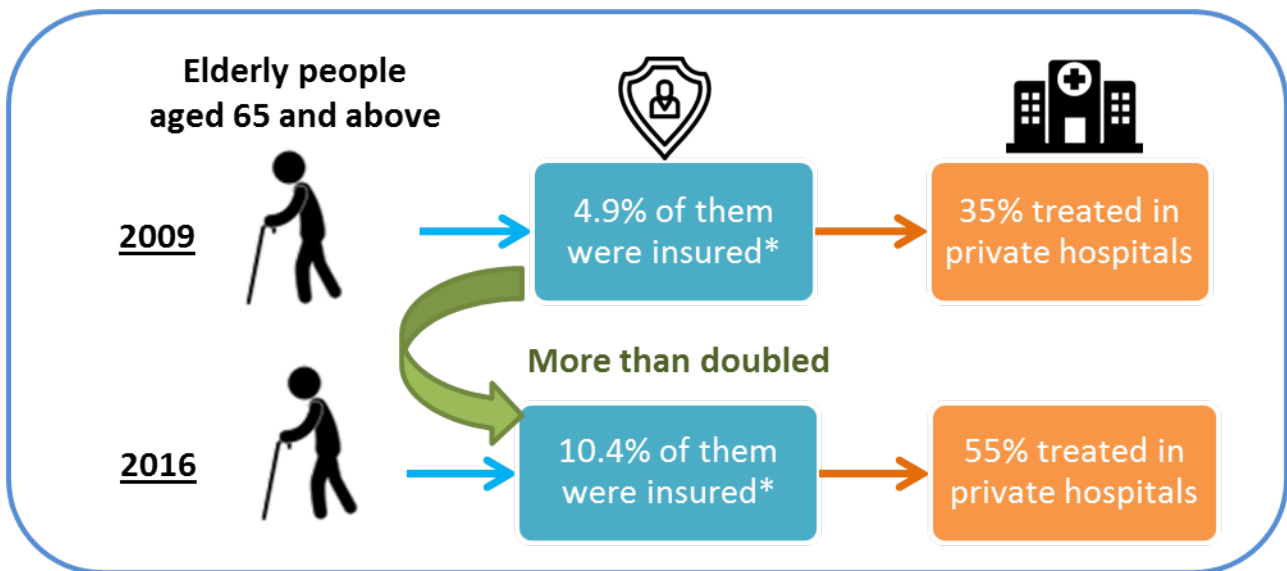
¹⁹ Hong Kong Federation of Insurers (2015).

²⁰ Based on statistical breakdowns obtained from C&SD, there were 124 800 persons covered by IHI policies only and were admitted into HA hospitals in 2016. Yet 114 500 of such insured inpatients did not make any medical claims for reimbursement from the health insurers.

related to concerns over the implications of medical claims on renewal premium on the one hand, and more affordable inpatient care in HA hospitals on the other; and

- (f) **Hospitalization of insured elderly persons:** More specifically for elderly persons aged 65 and above, the penetration ratio of IHI policies has more than doubled from 4.9% in 2009 to 10.4% in 2016. For these insured elderly with IHI policies only, 55% of them were treated in private hospitals in 2016, up from 35% in 2009. This suggests that IHI policies help divert some elderly patients to private hospitals, although the magnitude of such diversion effect is still rather modest at present (**Figure 4**).²¹

Figure 4 – IHI penetration and hospitalization of elderly population, 2009-2016



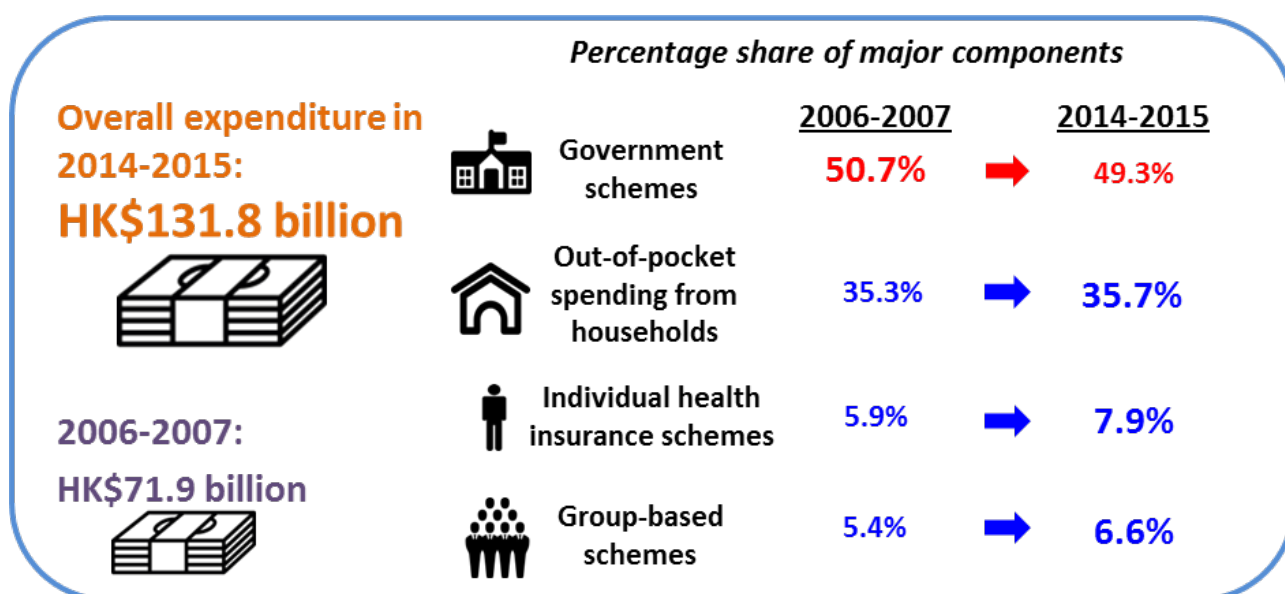
Note: (*) Proportion of elderly population covered by IHI policies.
Data source: Census and Statistics Department.

²¹ The proportion of elderly people in the local population has increased from 12.4% to 15.9% during 2006-2016, and is expected to rise further to 23% in 2026. At present, elderly people accounted for 42.5% of inpatient admission of HA hospitals and 48.6% in the total cost of HA. See Food and Health Bureau (2018b).

3. Health insurance and resource balance in the overall healthcare system

3.1 On the expenditure side, annual healthcare spending from IHI insurers has witnessed significant growth in recent years. Based on the most recent statistics on domestic health accounts, current health expenditure from IHI schemes had surged by 146% in eight years to HK\$10.3 billion in 2014-2015, almost doubling the respective growth of 83% in total current health expenditure and outpacing all other major components (**Figure 5**).²²

Figure 5 – Current health expenditure in Hong Kong and its major components by percentage distribution, 2006-2007 and 2014-2015



Data source: Food and Health Bureau.

3.2 In spite of this visible pick-up, IHI still plays a rather modest role in overall healthcare financing in Hong Kong, in the light of the following considerations:

- (a) **Small share in overall healthcare spending:** Whereas the share of individual-based insurance funds in total current health expenditure has risen from about 6% in 2006-2007 to 8% in 2014-2015, it was just around one-fifth of out-of-pocket spending from households (36%) and one-sixth of government spending (49%);

²² Domestic health accounts show the flows of healthcare funds provided by various sources (e.g. government, firms and households) and how these funds are spent on healthcare services provided by various entities (e.g. hospitals, clinics and pharmacies). It takes a long lead time of about three years to compile statistics on domestic health accounts, however. See Food and Health Bureau (2018a).

- (b) **Muted effect on out-of-pocket spending of households:** Contrary to expectation, increased pay-outs from health insurance funds had not reduced the burden of out-of-pocket healthcare spending of households. The absolute amount of such spending from households continued to increase steeply over the past eight years, with its relative share in total health expenditure edging up from 35% to 36%; and
- (c) **Limited diversion effect from the public sector:** While the relative contribution of the Government in overall healthcare financing had fallen by 1.5 percentage points between 2006-2007 and 2014-2015, this was smaller than the concurrent rises by 2.0 percentage points in the spending from IHI segment and by 1.2 percentage points from the group-based insurance segment. This magnitude of diversion from the public sector to the private sector seemed to be disproportionately small.²³

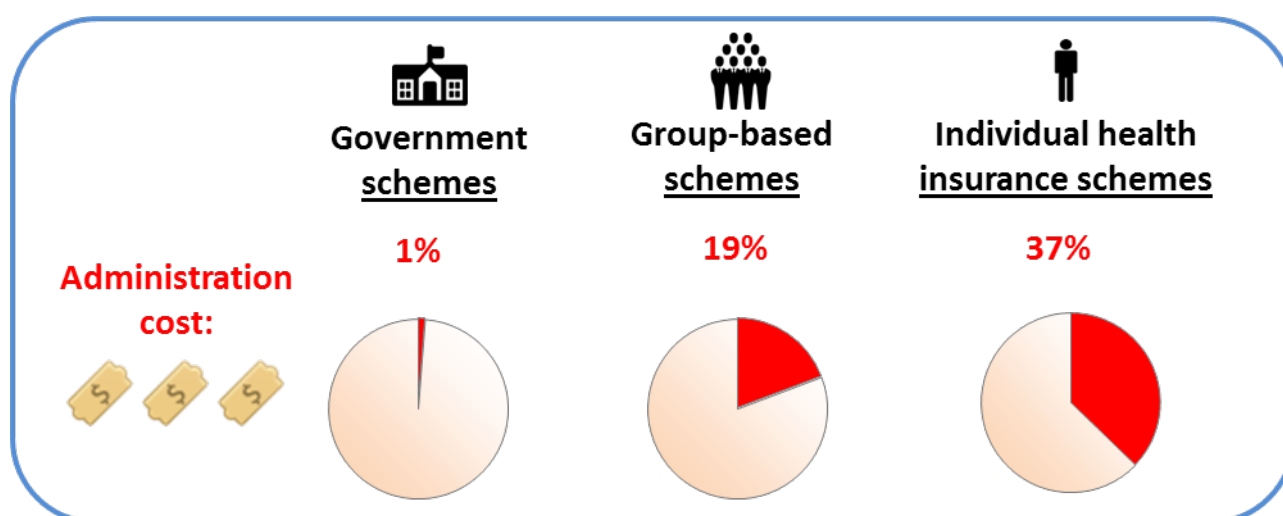
This moderate substitution effect could be partly attributable to higher administration cost in running the IHI system, which took up as much as HK\$3.9 billion or 37% of its total spending in 2014-2015, contrasted against the administrative cost of just 1% borne by the Government in running the public healthcare system (**Figure 6**).²⁴ According to a recent global study published by the Organisation for Economic Co-operation and Development ("OECD") in 2017, administrative costs of private health insurance schemes are generally and "significantly higher than those in public systems", partly due to a lack of economies of scale and inclusion of the profitability factor.²⁵ It seems that Hong Kong is not an exception to this rule.

²³ The diversion effect is also small when a longer duration between 1997-1998 and 2014-2015 is taken for comparison. Over this 17-year period, while the share of IHI schemes in overall healthcare financing had risen from 3.2% to 7.9% and that of the group-based schemes from 3.8% to 6.6%, the share of government schemes had fallen from 51.2% to 49.3% only. See Food and Health Bureau (2018a).

²⁴ Food and Health Bureau (2018a).

²⁵ For instance, the administrative cost of voluntary private insurance scheme as a whole was 32% of its healthcare spending in Spain, 32% in the United Kingdom and 21% in France in 2014, contrasted against the respective cost ratio of 1.9%, 1.5% and 4.1% in the financing of public healthcare systems in these three places. For details, see Organisation for Economic Co-operation and Development (2017).

Figure 6 – Administration cost of healthcare financing schemes in 2014-2015*



Note: (*) Most recent statistics from the domestic health accounts.
Data source: Food and Health Bureau.

3.3 Turning to the delivery of healthcare services by sector, it has been hoped that increased insurance coverage in both segments²⁶ could boost the supply of healthcare services in the private sector, which in turn could alleviate the burden of the public sector.²⁷ While there was noticeable service expansion in the private sector, it was still not fast enough to keep pace with the overall healthcare demand, resulting in enlarged curative burden in the public sector. **First**, the share of private hospitals in the total number of inpatient discharges declined from 20% to 18% during 2006-2016 (**Figure 7**).²⁸ **Secondly**, although the private sector held a dominant share in out-patient care which are more affordable to the general public, its share likewise fell from 71% to 68% during 2006-2016.²⁹ This is somewhat in line with the study findings of OECD, highlighting that private health insurance has an "overall limited contribution" to containment in the public cost, partly because insured persons "continue to utilise the public system for the most expensive services".³⁰

²⁶ Taking into account both segments and bearing in mind certain data limitation in the earlier years, overall penetration ratio of health insurance in the local population has risen from 38.5% in 2006 to 47% in 2016.

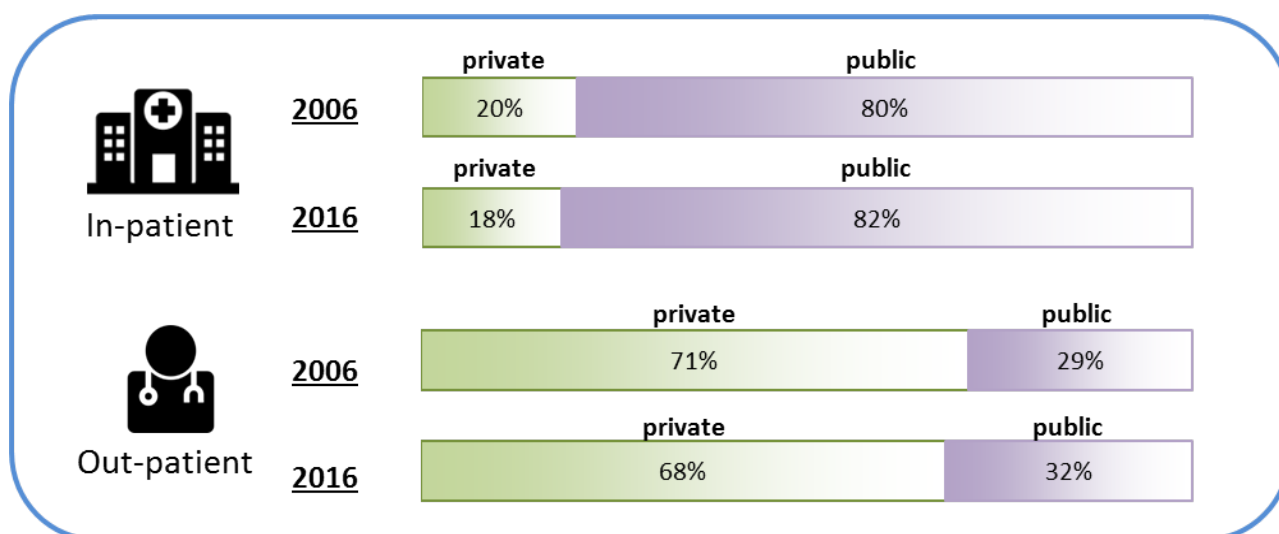
²⁷ Food and Health Bureau (2008a).

²⁸ Excluding nursing homes and hospitals in correctional institutions, inpatient discharges (including deaths) from private hospitals have increased by a total of 39% to 0.39 million during 2006-2016, slower than the respective growth of 52% to 1.73 million from public hospitals. See Census and Statistics Department (2017b).

²⁹ Census and Statistics Department (2017a).

³⁰ Organisation for Economic Co-operation and Development (2004).

Figure 7 – Provision of local healthcare services by sector, 2006-2016



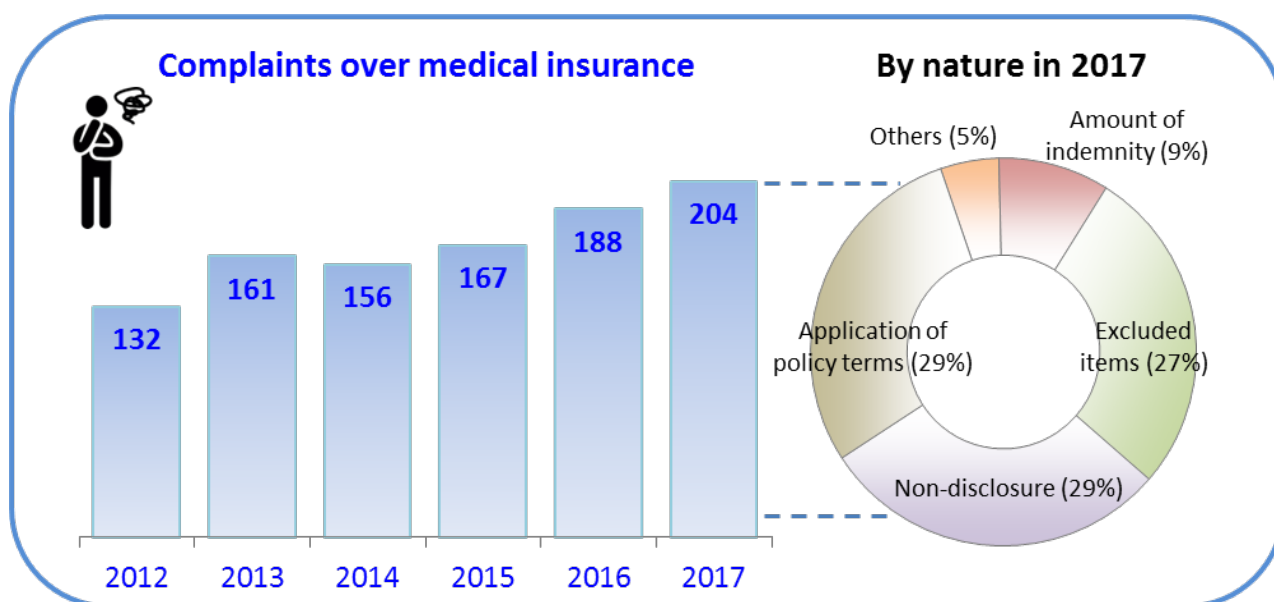
Data source: Census and Statistics Department.

3.4 In its review of IHI products in 2014, FHB noted a host of drawbacks which have discouraged the insured population from using private healthcare services, such as declined coverage of vulnerable persons, exclusion of pre-existing conditions and no guaranteed renewal of policies. As a matter of fact, the drawbacks of IHI products are also reflected in the number of complaints lodged to the Insurance Complaints Bureau. During 2012-2017, complaints on medical insurance have gone up visibly by 55% to 204 cases.³¹ Moreover, medical insurance has continuously been the largest source of complaints, accounting for 50% of overall caseload in 2017.³² Within the concluded complaint cases over medical insurance in 2017, "non-disclosure" and "application of policy terms" were the two largest types, each with a share of 29%. This was followed by "excluded items", with a share of 27% (**Figure 8**).

³¹ Closed complaint cases after handling. See the Insurance Complaints Bureau (2018).

³² For the second-placed travel insurance, it had only 82 concluded cases in 2017, with a share of 20%.

Figure 8 – Complaints over medical insurance*, 2012-2017



Note: (*) Concluded cases.

Data source: Insurance Complaints Bureau.

4. Voluntary Health Insurance Scheme

4.1 After many rounds of consultations lasting for almost a decade, FHB announced policy details of VHIS in March 2018, taking a non-legislative approach to certify those IHI plans meeting prescribed minimum standards.³³ On 18 May 2018, the Inland Revenue (Amendment) (No. 4) Bill 2018 was gazetted, offering tax deductions to insured persons under VHIS. Here are the key features of VHIS:

- (a) **Minimum product requirements:** There will be two types of Certified Plans, namely the **Standard Plans** providing basic protection and **Flexi Plans** providing enhanced benefits. Ten minimum requirements are laid down for better consumer protection, such as guaranteed renewal up to 100 years old;³⁴

³³ After two rounds of public consultations on healthcare reform in March 2008 and October 2010, the Government concluded that the public had expressed reservations over mandatory measures on healthcare financing. It then launched another round of public consultation on VHIS in December 2014 and concluded in 2017 that there was broad support for the concept and policy objectives of the proposed VHIS. For details, see Food and Health Bureau (2014).

³⁴ The 10 minimum requirements are (i) guaranteed renewal up to 100 years old; (ii) no "lifetime benefit limit"; (iii) extended coverage of hospitalization and prescribed ambulatory procedures; (iv) coverage of prescribed advanced diagnostic imaging test and non-surgical cancer treatment; (v) budget certainty; (vi) standardized policy terms and conditions; (vii) premium transparency; (viii) minimum benefits limits; (ix) cost-sharing restriction; and (x) coverage of pre-existing conditions. See Food and Health Bureau (2017b and 2018d) and Legislative Council Secretariat (2018).

- (b) **Estimated annual premium:** Insurance premium of certified plans under VHIS will vary with age and will be determined by the market. While annual average premium for the Standard Plans was reportedly around HK\$4,800 initially, some health insurers expect that such premium could exceed HK\$5,000 in 2019.³⁵ This is noticeably higher than the average annual premium of HK\$4,365 for existing IHI products in 2016, partly due to prescription of minimum requirements under VHIS;
- (c) **Tax deduction of HK\$8,000:** To provide an added incentive for the public to purchase Certified Plans, annual tax deduction of up to \$8,000 will be provided for premium paid by each insured person and his/her dependants, without a cap on the number of dependants that are eligible for tax deduction;³⁶
- (d) **Voluntary approach in regulation:** Instead of a legislative approach, health insurers are not mandatorily required to issue Certified Plans to consumers. Moreover, they can continue to sell non-compliant IHI plans to consumers, though they will not be eligible for tax deduction. However, for those insurers joining VHIS, they must make available the Standard Plans to their customers; and
- (e) **Setting up VHIS Office:** The Government is amending the Inland Revenue Ordinance to introduce tax deduction under VHIS. Subject to the passage of the Amendment Bill, VHIS is scheduled for implementation by early 2019. FHB will set up a VHIS office to certify VHIS-compliant products and engage key stakeholders.

4.2 The policy objectives of VHIS are to enhance "accessibility, quality and transparency" of health insurance products on the one hand, and strengthen consumer confidence in exercising their insurance coverage to patronize private healthcare services on the other.³⁷ While FHB admits that VHIS acts as "voluntary supplementary financing", it also has high hope that it could alleviate "the long-term pressure on the public healthcare system". FHB estimates that about 1.5 million

³⁵ Health insurers indicated that the estimated premium in 2019 need to take into account medical cost inflation of around 5-6% annually. For details, see Food and Health Bureau (2018c) and 信報 (2018).

³⁶ The exact amount of tax concessions hinges on the income level and the insurance premium of the policyholder. For instance, the tax concession could be as much as HK\$1,360 each year if a high-income earner who is subject to a tax rate of 17% for maximum income band and purchases a VHIS policy worth of HK\$8,000. However, for a low-income earner subject to a tax rate of just 2% purchasing VHIS policy worth of HK\$2,000, the amount of reduced tax payment could be just HK\$40.

³⁷ Food and Health Bureau (2018d).

people will join VHIS by the third year of implementation, and two-thirds of them are taxpayers with forgone tax revenue of about HK\$800 million.³⁸

4.3 However, there are concerns in the community whether VHIS can achieve the stated objectives. **First**, the regulatory regime is entirely voluntary and is confined to certified plans under VHIS. For the existing stock of non-compliant policies in the market, they are still "lightly regulated". Health insurers can continue to sell such products, without addressing the product caveats discussed above.³⁹ **Secondly**, two important product features namely "guaranteed acceptance" under the high risk pool ("HRP")⁴⁰ and "portable insurance policy",⁴¹ are not included as minimum requirements of VHIS after the public consultation concluded in 2017. These exclusions undermine the overall attractiveness of VHIS.⁴² **Thirdly**, the minimum requirements laid down in certified plans are not entirely new, as some of them are already seen in existing IHI products. Coupled with expectation of higher premium of certified plans, there are doubts whether VHIS are attractive to members of the public.⁴³ **Fourthly**, as health insurers have limited incentives to accept high-risk individuals who may then have to continue to stay in the public healthcare system, it undermines the policy objective to improve the structural imbalance in the healthcare system.⁴⁴ **Fifthly**, it appears that there is no specific provision under VHIS to address the issue of high administration cost in running the IHI system in Hong Kong as discussed above, precipitating concerns whether it could effectively improve the structural imbalance in the overall healthcare system.⁴⁵

³⁸ Food and Health Bureau (2018c).

³⁹ Legislative Council Secretariat (2017).

⁴⁰ In the public consultation on VHIS launched in December 2014, FHB proposed establishing HRP to enable high-risk individuals (e.g. persons with chronic illness, the elderly, those with pre-existing conditions) to purchase certified plans, subject to a loaded premium of 200% of the standard premium. HRP would involve government subsidy, with an estimated total cost of HK\$4.3 billion at 2012 constant prices within a 25-year period. However, FHB deferred the HRP proposal in January 2017, citing "diverse views" received in consultation and concerns over "using public money to help such high-risk individuals to purchase private hospital insurance". For details, see Food and Health Bureau (2014 and 2017b).

⁴¹ In the same consultation exercise, the Government proposed insurance policy could be transferable across insurers, provided that claims had not been made in three years before the transfer.

⁴² Legislative Council Secretariat (2018).

⁴³ According to an opinion survey covering 1 793 respondents conducted in 2014-2015, two-thirds of respondents said that they did not have the intention of subscribing to VHIS. While 26.5% of the respondents said that they were "already insured in the private market and no intention to switch (to VHIS)", 26.1% cited "high premium" as the reasons for not subscribing to VHIS. See He (2017).

⁴⁴ Legislative Council Secretariat (2018).

⁴⁵ 明報 (2018).

5. Observations

5.1 The following observations can be made from the above analysis:

- (a) **Robust penetration of individual-based health insurance:** In parallel with growing health consciousness in society, the number of local people covered by IHI schemes has surged by 78% within a decade to 2.4 million in 2016, with a leap in the penetration ratio from 20% to 34%. Market premium for this segment has almost tripled to about HK\$10.3 billion in 2016;
- (b) **Hesitation to receive inpatient care at private hospitals:** However, less than three-fifths (57%) of the insured people covered by IHI policies only were treated in private hospitals, indicating a general hesitation amongst IHI policy holders. This could be partly attributable to caveats of existing IHI products in the market, including a lack of budget certainty, declined coverage of pre-existing conditions, no guaranteed renewal of policies, frequent reports of disputes and complaints over insurance claims;
- (c) **Limited diversion effect in overall healthcare financing:** While the share of IHI funds in overall healthcare expenditure has risen from 6% in 2006-2007 to 8% in 2014-2015, it was still far behind the respective proportions of government spending and out-of-pocket spending from households. The diversion effect in healthcare spending from the public sector to private sector is disproportionately small, partly attributable to higher administration cost in running the IHI system. In 2014-2015, the ratio of administrative cost was 37% in the IHI schemes, contrasted against just 1% borne by the Government in running the public healthcare system;
- (d) **Still congested public healthcare system:** While increased insurance coverage in both segments has contributed to service expansion in the private sector, it was not fast enough to keep pace with the overall healthcare demand. During 2006-2016, the share of private sector in the total number of inpatient discharges declined from 20% to 18%, so did the share in out-patient care from 71% to 68%. The public healthcare system remains highly congested; and

- (e) **Challenges faced by VHS:** VHS is scheduled for implementation by early 2019, with 10 minimum product requirements and tax deduction of up to HK\$8,000 for each person insured under the Certified Plans. However, (i) the adoption of a voluntary approach; (ii) exclusion of HRP from product requirements; and (iii) envisaged higher annual premium may limit its appeal to the general public, making it challenging to hit the policy target of reaching 1.5 million people in three years.

Research Office
Information Services Division
Legislative Council Secretariat
3 July 2018
Tel: 2871 2125

Research Briefs are compiled for Members and Committees of the Legislative Council. They are not legal or other professional advice and shall not be relied on as such. Research Briefs are subject to copyright owned by The Legislative Council Commission (The Commission). The Commission permits accurate reproduction of Research Briefs for non-commercial use in a manner not adversely affecting the Legislative Council, provided that acknowledgement is made stating the Research Office of the Legislative Council Secretariat as the source and one copy of the reproduction is sent to the Legislative Council Library. The paper number of this issue of Research Brief is RB03/17-18.

References

1. Census and Statistics Department. (2007) *Thematic Household Survey #30 on Provision of Medical Benefits by Employers and Companies and Coverage of Medical Insurance Purchased by Individuals*. Available from: <https://www.statistics.gov.hk/pub/B11302302007XXXXB0100.pdf> [Accessed June 2018].
2. Census and Statistics Department. (2017a) *Thematic Household Survey #63 on Provision of Medical Benefits by Employers and Companies and Coverage of Medical Insurance Purchased by Individuals*. Available from: <https://www.statistics.gov.hk/pub/B11302632017XXXXB0100.pdf> [Accessed June 2018].
3. Census and Statistics Department. (2017b) *Annual Digest of Statistics (2017 Edition)*. Available from: <https://www.statistics.gov.hk/pub/B10100032017AN17B0100.pdf> [Accessed June 2018].
4. Chu Hai College for Higher Education. (2018) *Press release on Happiness Index in 2017*. Available from: https://fob.chuhai.edu.hk/wp-content/uploads/2017/11/Annual-Happiness_Press-Release_2017-both-languages_final.pdf [Accessed June 2018].
5. Food and Health Bureau. (2008a) *Your Health Your Life, Healthcare Reform Consultation Document*. Available from: https://www.fhb.gov.hk/beStrong/files/consultation/Condochealth_full_eng.pdf [Accessed June 2018].
6. Food and Health Bureau. (2008b) *Your Health Your Life, Report on First Stage of Public Consultation on Healthcare Reform*. Available from: http://www.fhb.gov.hk/beStrong/files/consultation/HCR_Report_eng.pdf [Accessed June 2018].
7. Food and Health Bureau. (2010) *My Health My Choice, Healthcare Reform Second Stage Consultation Document*. Available from: http://www.myhealthmychoice.gov.hk/pdf/consultation_full_eng.pdf [Accessed June 2018].
8. Food and Health Bureau. (2011) *My Health My Choice, Healthcare Reform Second Stage Public Consultation Report*. Available from: http://www.myhealthmychoice.gov.hk/pdf/report/full_report_eng.pdf [Accessed June 2018].

9. Food and Health Bureau. (2014) *Consultation Document on Voluntary Health Insurance Scheme*. Available from: https://www.vhis.gov.hk/doc/en/full_consultation_document/consultation_full_eng.pdf [Accessed June 2018].
10. Food and Health Bureau. (2017a) *Report of the Strategic Review on Healthcare Manpower Planning and Professional Development*. Available from: https://www.fhb.gov.hk/en/press_and_publications/otherinfo/180500_sr/srreport.html [Accessed June 2018].
11. Food and Health Bureau. (2017b) *Voluntary Health Insurance Scheme, Consultation Report*. Available from: <https://www.legco.gov.hk/yr16-17/english/panels/hs/papers/hs20170116-rpt201701-e.pdf> [Accessed June 2018].
12. Food and Health Bureau. (2018a) *Estimate of Domestic Health Expenditure, 1989/90 – 2014/15 (SHA 2011)*. Available from: <http://www.fhb.gov.hk/statistics/en/dha.htm> [Accessed June 2018].
13. Food and Health Bureau. (2018b) *Replies to initial written questions raised by Finance Committee Members in examining the Estimates of Expenditure 2018-19*. Available from: https://www.legco.gov.hk/yr17-18/english/fc/fc/w_q/fhb-h-e.pdf [Accessed June 2018].
14. Food and Health Bureau. (2018c) *Voluntary Health Insurance Scheme – Inland Revenue (Amendment) (No.4) Bill 2018*. Available from: https://www.legco.gov.hk/yr17-18/english/bills/brief/b201805181_brf.pdf [Accessed June 2018].
15. Food and Health Bureau. (2018d) *Voluntary Health Insurance Scheme, official website*. Available from: https://www.vhis.gov.hk/en/welcome_message/index.html [Accessed June 2018].
16. He Jingwei Alex. (2017) *Introducing Voluntary Private Health Insurance in a Mixed Medical Economy: Are Hong Kong Citizens Willing to Subscribe?* Available from: <https://www.ncbi.nlm.nih.gov/pubmed/28841880> [Accessed June 2018].
17. Hong Kong Federation of Insurers. (2012) *HPS Proposition for HKFI*. Available from: http://www.luahk.org/www/Attach/member/download/HKFI_Elaine%20Chan_final.pdf [Accessed June 2018].

18. Hong Kong Federation of Insurers. (2015) *Position Paper on Consultation on Voluntary Health Insurance Scheme (VHIS)*. Available from: http://www.legco.gov.hk/yr14-15/chinese/panels/hs/hs_hps/papers/hs_hpscb2-1098-1-ec.pdf [Accessed June 2018].
19. Hong Kong Federation of Insurers. (2017a) *Medical Claims Statistics, Various Years*. Available from: <https://www.hkfi.org.hk/#!/resources-centre/medical-claims-statistics> [Accessed June 2018].
20. Hong Kong Federation of Insurers. (2017b) *Medical Market Development and Outlook: VHIS and Beyond*. Available from: http://www.actuaries.org.hk/upload/File/ASHK%20Healthcare%20Seminar%20017/02_ElaineChan.pdf [Accessed June 2018].
21. Hospital Authority. (2012) *Strategic Service Framework for Elderly Patients*. Available from: <http://www.ha.org.hk/ho/corpcomm/Strategic%20Service%20Framework/Elderly%20Patients.pdf> [Accessed June 2018].
22. Hospital Authority. (2017) *Innovating for Better Care, Strategic Plan 2017-2022*. Available from: http://www.ha.org.hk/haho/ho/ap/HA-SP_1.pdf [Accessed June 2018].
23. Hospital Authority. (2018a) *Annual Report on Sentinel and Serious Untoward Events, October 2016 – September 2017*. Available from: <https://www.ha.org.hk/haho/ho/psrm/E-SESUE1617.pdf> [Accessed June 2018].
24. Hospital Authority. (2018b) *Hospital Authority Statistical Report 2016-2017*. Available from: http://www.ha.org.hk/haho/ho/stat/HASR16_17.pdf [Accessed June 2018].
25. Insurance Claims Complaints Bureau. (2018) *Statistics*. Available from: <http://www.icb.org.hk/en/statistics.html> [Accessed June 2018].
26. Legislative Council Secretariat. (2015) *Updated background brief on Voluntary Health Insurance Scheme*. LC Paper No. CB(2)598/14-15(01).
27. Legislative Council Secretariat. (2016) *Report of the Subcommittee on Health Protection Scheme*. LC Paper No. CB(2)1915/15-16.
28. Legislative Council Secretariat. (2017) *Minutes of meeting Panel on Health Services held on 16 January 2017*. LC Paper No. CB(2)1370/16-17.

29. Legislative Council Secretariat. (2018) *Updated background brief on Voluntary Health Insurance Scheme*. LC Paper No. CB2/1022/17-18(04).
30. Organisation for Economic Co-operation and Development. (2004) *Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems*. Available from: <https://www.oecd.org/els/health-systems/33698043.pdf> [Accessed June 2018].
31. Organisation for Economic Co-operation and Development. (2013) *Guidelines to improve estimates of expenditure on health administration and health insurance*. Available from: <https://www.oecd.org/els/health-systems/Improving-Estimates-of-Spending-on-Administration.pdf> [Accessed June 2018].
32. Organisation for Economic Co-operation and Development. (2017) *Tackling Wasteful Spending on Health*. Available from: <http://www.quotidianosanita.it/allegati/allegato3684537.pdf> [Accessed June 2018].
33. PricewaterhouseCoopers. (2013) *Consultancy Study for the Health Protection Scheme, Final Report*. Available from: https://www.vhis.gov.hk/doc/en/information_centre/hps_consultancy_report.pdf [Accessed June 2018].
34. World Health Organization. (2010) *Administrative costs of health insurance schemes: exploring the reasons for their variability*. Available from: http://www.portal.pmnch.org/health_financing/documents/cov-dp_e_10_08-admin_cost_hi/en/ [Accessed June 2018].
35. World Health Organization. (2018) *Life expectancy and Healthy life expectancy, Data by country*. Available from: <http://apps.who.int/gho/data/view.main.SDG2016LEXv?lang=en> [Accessed June 2018].
36. 《自願醫保平均保費勢破 5000 目標明年 4 月推醫生：加保費不加保障不公平》，《明報》，2018 年 3 月 2 日。
37. 《自願醫保享扣稅一人最多慳千三》，《信報》，2018 年 3 月 1 日。
38. 《自願醫保明年 4 月推出 料可賠八成》，《信報》，2018 年 3 月 2 日。

39. 《住院照腸鏡胃鏡 貴診所兩三倍 保險聯會籲考慮需要 醫生：高風險者要入院》，《明報》，2017年6月7日。
40. 《社評：自願醫保大變樣 高官一語露真相》，《明報》，2018年3月2日。
41. 香港保險業聯會：《醫療保險的理賠情況及如何進行精明索償－香港醫療福利展望座談會 2017》，2017年10月。
網址：https://drive.google.com/drive/folders/0B2bL2rGc_HeZZDQtc3BXYnlXdTQ
[於2018年6月登入]。
42. 《買醫保人數料雙位增長》，《信報》，2018年3月19日。