

Development and Financing of Hong Kong's Future Health Care

Report on Preliminary Findings

Presented

by

The Bauhinia Foundation Research Centre

Health Care Study Group

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Hong Kong

Health care systems in many parts of the world are facing increasing challenges to improve access, enhance quality and to hold down rising health care costs and spending. People and decision makers are demanding better value, coordinated health care, focus on wellness and prevention, reduced waiting time and access to information. Many governments are contemplating or implementing initiatives to reform their health care delivery and financing systems to respond to changing needs and demands.

2. Hong Kong’s health care is the envy of many people throughout the world. It leads many health care systems with some of the best vital statistics and performance measures. Particularly noteworthy are the low infant mortality rate, long average life expectancy at birth, well-trained health and medical professionals and low out-of-pocket payments in using public health care services.

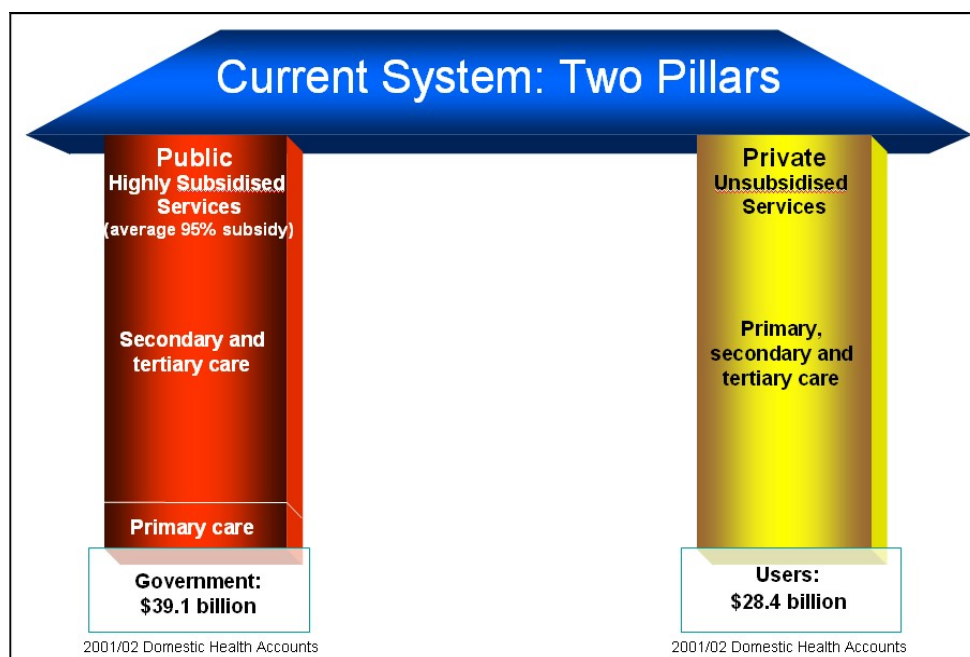
3. Yet, Hong Kong is facing many of the same problems other health care systems are facing. Health care reform proposals in the past are testimony to the concerns and need to develop a responsive and sustainable health care system for the people of Hong Kong.

4. This study aims to propose a way forward to strengthen the Hong Kong health care system to continue to safeguard and enhance people’s health, to meet patients’ changing needs and expectations and to be prepared for future rising costs of care. A Health Care Study Group was formed by the Bauhinia Foundation Research Centre in August 2006 to undertake the study with support from consultants. The membership and terms of reference of the Study Group are set out in **Appendix I** of this report.

Hong Kong’s Health Care Delivery and Financing

5. Hong Kong has a rather simple system of financing and delivery of health care (see Figure 1). Outpatient care, mostly primary health care, is provided predominantly by private

Figure 1 – Hong Kong’s Current Health Care System



general practitioners, who provide over 70 percent of all outpatient consultations. Public general outpatient clinics provide approximately 15 percent of all outpatient consultations at a subsidized rate to mostly those with low income and patients with chronic conditions. The remaining 15 percent of outpatient visits are provided by private practitioners of alternative medicine, in which traditional Chinese medicine practitioners constitute the largest group. Expenditure on outpatient services constitutes around 50 percent of the total health care expenditure. Roughly 75 percent of outpatient expenditure is financed by out-of-pocket payments, with the remaining financed by employers or insurance¹.

6. The bulk of specialist and inpatient care, mostly secondary and tertiary care, is financed and delivered through the public sector. The Hospital Authority owns and manages over 40 public health care institutions, and provides over 90 percent of all hospital beds in Hong Kong. Institutions under the Hospital Authority provide a comprehensive range of services at a heavily subsidized rate. The Hospital Authority receives over 90 percent of its income from the Government's general revenue. Presently, private hospitals deliver roughly 6 percent of total inpatient care².

7. All Hong Kong residents are eligible to receive care from public hospitals and clinics at a heavily subsidized rate. Patients in public hospitals pay a fixed per diem fee of HK\$100, which is less than 4 percent of the actual average cost of a patient day in an acute public hospital. The per diem fee is all-inclusive with the exception of a short list of the "Privately Purchased Medical Items (PPMI)" and drugs not included in the Hospital Authority's Drug Formulary, for which patients have to pay the full cost separately³.

8. The system, whereby the bulk of hospital services is funded by the Government and delivered by public hospitals and the bulk of general outpatient care is funded and delivered privately, has not changed much since the 1950's. This arrangement has been criticized as too compartmentalized, resulting in poor coordination and workload imbalance between the public and private sectors as well as between primary and secondary/tertiary care sectors, and not sustainable in the long run⁴.

9. Within the public hospital system, all health care providers are compensated on a fixed salary basis. Funding from government to the Hospital Authority has been mostly historically and facility based, recently moving towards more population based. Money does not follow patients.

10. There is insufficient financial incentive for public health care providers to be responsive to patients' needs. Disincentives within the system are extensive, e.g. units that serve patients well will attract more patients, who will not bring in more resources. Despite these disincentives, quality of care in public hospitals generally improved after the

¹ Health Welfare and Food Bureau 2007. <http://www.hwfb.gov.hk/statistics/en/dha.htm/>

² Health Welfare and Food Bureau 2007. <http://www.hwfb.gov.hk/statistics/en/dha.htm/>

³ Hospital Authority 2007. <http://www.ha.org.hk/>

⁴ Harvard Team 1999. *Improving Hong Kong's Health Care System: Why and For Whom ?* HKSARG Printing Department; Leung G. 2006. Hong Kong's health spending – 1989 to 2033. *Proceedings of the Hospital Authority Convention 2006*.

establishment of the Hospital Authority, but spending also went up considerably⁵. Waiting time for some non-urgent conditions, however, has worsened significantly in recent years.

11. Government total spending on health in 2001/2 was \$39.1 billion, around 14.5 percent of total government expenditure. Around 90 percent of public sector health care funding goes to the Hospital Authority. Private expenditure on health services is roughly the same as that of government health expenditure.

12. Hong Kong has no compulsory health insurance or medical savings contributions. Public hospital services are financed almost entirely through government general revenue, despite the fact that tax rates in Hong Kong are amongst the lowest in the world, and the percentage of tax payers is also low by industrialized countries' standards. Private hospital services are financed through direct payment or private health insurance.

Overview of Past Reform Initiatives

13. While many countries in the Far East implemented substantive reforms in their health care financing systems in the 1980's and 1990's, Hong Kong did not. Singapore, for example, introduced medical savings accounts and major illness insurance in the eighties (Lim 1998); South Korea and Taiwan both established national health insurance systems in the eighties and nineties respectively⁶. These reforms aim to provide universal access to health care services and at the same time move the system away from being too reliant on general taxation to finance health care.

14. In Hong Kong, the major health care system reform initiative in the 1980's to 1990's was the formation of the Hospital Authority in 1990. The Hospital Authority exercise was not a health care financing reform measure. It merely restructured public hospitals under a corporate management framework without implementing any substantive change in the way hospital services are financed. The financing of hospital services remains primarily tax-based. There were no attempts to introduce competition to or within the massive public hospital system either.

15. With the sustainability of the system being questioned, attempts to reform the health care financing system resulted in the publication of a number of consultation documents: *Towards Better Health*⁷, *Improving Hong Kong's Health Care System: Why and For Whom*⁸ (Harvard Team 1999), *Lifelong Investment in Health*⁹, and *Building a Healthy Tomorrow*¹⁰.

⁵ Yuen, P P, Lo, C W H. 2000 Alternative delivery systems for public service in Hong Kong: the Hospital Authority vs. the Housing Authority. *International Review of Public Administration*, 5, 2, 55-66.

⁶ Kwon, S. 2000. Health care financing and delivery for the poor in Korea. *International Review of Public Administration*, 5, 2, 37-45; Hwang, YS., and Hill, M. 1997. The 1995 health reforms in Taiwan – An analysis of the policy process. *Hong Kong Public Administration*, 6, 2, 79-96.

⁷ Health and Welfare Branch 1993. *Towards Better Health*. Hong Kong: Printing Department of the Hong Kong Government.

⁸ Harvard Team 1999. *Improving Hong Kong's Health Care System : Why and For Whom ?* HKSARG Printing Department

⁹ Health and Welfare Bureau 2000. *Lifelong Investment in Health: Consultation Document on Health Care Reform*. Hong Kong: Printing Department of the Government of the Hong Kong Special Administrative Region.

¹⁰ Health and Medical Development Advisory Committee 2005. *Building a Healthy Tomorrow: Discussion Paper on the Future Service Delivery Model for our Health Care System*, Health, Welfare and Food Bureau.

The major proposals in these documents and their implementation status are as follows:

(a) *Towards Better Health*

The first consultation on health care financing reform took place in the early nineties. A consultation paper entitled *Towards Better Health* (often referred to as the “rainbow document” because of the design of the cover) was published in 1993. The paper proposed five reform options: (i) charging a higher co-payment based on a percentage of actual operating cost; (ii) the introduction of more expensive semi-private beds and other charges in public hospitals; (iii) encouraging more private health insurance through government registration of suitable plans; (iv) compulsory health insurance for all; and (v) having a core and non-core list for public hospitals, in which interventions not on the core list would have to be charged the full cost.

With the exception of the introduction of semi-private beds and the registration of private health insurance plans, all other reform options were poorly received by the public and most of the other stakeholders¹¹. For some reasons, the registration of private health insurance plans was never pursued. Semi-private beds were introduced as pilot schemes in selected hospitals. Even though they proved to be very popular with patients, perhaps due to opposition from private hospitals, the plan never went beyond the pilot stage.

(b) *The Harvard Report*

In November 1997, Government commissioned the School of Public Health of the Harvard University to re-examine the health care financing question. The Harvard Team put forward a number of financing options and recommended compulsory health insurance (the Health Security Plan (HSP)), savings and insurance for long term care (MEDISAGE), and breaking up the giant Hospital Authority into twelve to eighteen regionally based “Health Integrated Systems” (HIS) as the way forward, along with a number of other suggestions for reforming the health care delivery and policy-making system (Harvard Team 1999).

The Harvard Report was extensively debated, but in the end, there was not much support for compulsory health insurance. Various surveys of the general public showed that less than 24 percent of those surveyed supported compulsory health insurance¹².

(c) *Lifelong Investment in Health*

A government consultation document (the third within a ten-year period) entitled *Lifelong Investment in Health* was issued towards the end of 2000. Noting that there was not much support for compulsory health insurance, the document put forward a medical savings proposal, termed Health Protection Account (HPA), requiring

¹¹ Gauld, R., & Gould D. 2002. *The Hong Kong Health Sector*. HK: Chinese University Press, p.123-125.

¹² Gauld, R., & Gould D. 2002. *The Hong Kong Health Sector*. HK: Chinese University Press, p.134-138.

working persons reaching a certain age to contribute 1 to 2 percent of their earnings, which will be used to pay for health services in public hospitals after the age of 65¹³.

The highly restrictive nature of the proposed plan did not receive support from the public or other stakeholders. Low income persons, who already had problems making ends meet, naturally opposed it, as the plan would further reduce their take home pay. The middle class and persons of higher income felt that they were asked to contribute, on the top of their regular tax contributions, to a system without any promise of getting better service or more choice in return.

There were also doubts about whether the one percent of earnings contribution to the medical savings account of the ordinary working persons would be able to make any meaningful difference to the overall health care financing picture¹⁴. For persons of higher earnings, a large amount of money would be locked up in their HPA, as they could not use it to purchase private health care services. The unspent portion of the HPA would be of little use to the account holder, the government or the Hospital Authority.

(d) *Building a Healthy Tomorrow*

In 2005, Government, through the Health and Medical Development Advisory Committee, published a discussion paper on the future service delivery model. While the paper did not contain specific proposals for financing reforms, it re-emphasized the importance of primary care and the role of family doctor, and defined more clearly the role of the public sector: acute and emergency services, services for the low income groups, catastrophic illnesses, and the training of health care professionals.

16. Public reactions to the main proposals of the previous consultation papers unmistakably suggest the preference for incremental changes to the status quo, and that the majority prefers to preserve the present tax-based financing system as the major source of health care financing.

Pressure Points and Key Concerns

17. In spite of its many strengths and well-endowed financing provision at the moment, Hong Kong's health care system is stressed. There are excessive work loads, rising staff shortages and worsening waiting times in the public sector. The private sector has limited hospital capacity and can be easily affected by changes in the dominant and highly subsidized public sector. Maintaining the status quo is clearly not the answer to meeting users' needs, demands and expectations in future.

18. What should be done to better prepare for the future? Three problems are particularly noteworthy and should be the key concerns in reforming Hong Kong's health care system:

¹³ Health and Welfare Bureau 2000. *Lifelong Investment in Health: Consultation Document on Health Care Reform*. Hong Kong: Printing Department of the Government of the Hong Kong Special Administrative Region, p. 56.

¹⁴ Gauld, R., & Gould D. 2002. *The Hong Kong Health Sector*. Hong Kong: Chinese University Press, p.160.

(a) Insufficient emphasis on primary health care

The provision of primary health care in Hong Kong is not well organized. Services tend to be episodic and treatment-oriented, lacking in continuity and sparse in prevention. An integrated multidisciplinary team approach, involving dentists, nurses, pharmacists, allied health professionals such as physiotherapists and occupational therapists working together with registered, accredited primary care doctors with training in family medicine in community health centres, to deliver holistic family-medicine-oriented primary health care is rare.

Patients' culture and health seeking behavior tend to focus more on finding quick fixes than on prevention or adopting healthy lifestyles. The public has insufficient appreciation and emphasis on primary health care. There is a tendency to fall back on expensive secondary or tertiary health care.

(b) Over-reliance on public sector in secondary and tertiary care

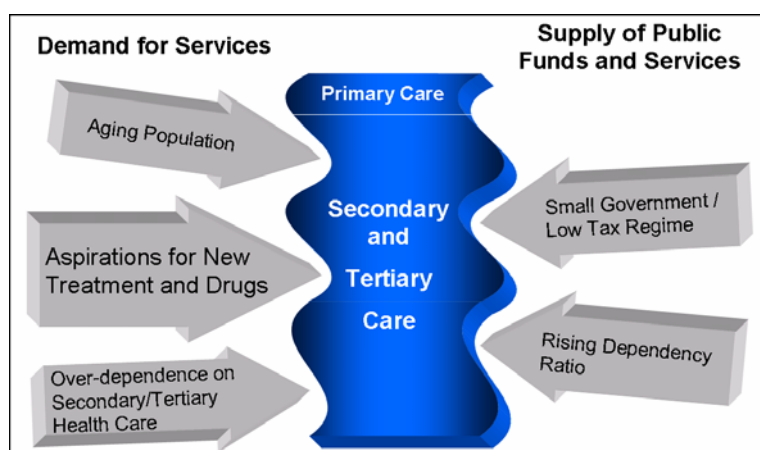
The public health care sector currently accounts for over 90 percent of total secondary and tertiary care. Its subsidy from the Government is huge, around 95 percent. That means low out-of-pocket payment for users. This imposes enormous pressures on public facilities and leads to long waiting times for patients and increased workload for staff.

The public's over-reliance on the public sector perpetuates dominance of the public sector which leaves little room for the private sector to innovate or for new players to enter the market. A more level playing field between the public and private sectors has yet to be fully realized.

(c) Financial sustainability of public health care system

With Hong Kong providing access to reasonably high quality health care to all of its residents at an affordable price, the sustainability of the system has been questioned by many. The aging of the population, aspirations for new technology and new drugs, adherence to the principles of a small government and low tax regime, and the unlikely change in magnitude in future Government funding will stretch resources and impose increasing pressures on the public health care system (see Figure 2). This

Figure 2 – Pressure Points on Public Health Care System



raises serious questions about the future sustainability of Hong Kong’s health care system if it remains unchanged.

The doubtful future financial sustainability of the public health care sector is discernible from another dimension. Unless changes are made, Hong Kong’s health expenditure, at 5.5 percent of Gross Domestic Product (GDP) in 2001/02, is estimated to increase to 7.5 percent by 2020 and 9.3 percent by 2030¹⁵ (see Figure 3). The 2001/02 public sector expenditure constituted 57 percent of total health care expenditure or 3.1 percent of GDP. If this proportion remains constant in the future, public sector health expenditure may increase to 4.3 percent and 5.3 percent of GDP by year 2020 and 2030 respectively. However, assuming future Government expenditure capped at 20 percent of GDP and allocation to public sector health care capped at 17 percent of total Government expenditure, the public sector’s GDP share for health will at most be 3.4 percent.

Figure 3 – Health Expenditure in Hong Kong

	2001/02	2020	2030
% of Total Health Expenditure in GDP	5.5%	7.5%	9.3%
% of Public Health Expenditure in GDP	3.1%	4.3%	5.3%
% of Government Expenditure	14.5%	21.5%	26.5%

*Source: Domestic Health Accounts 2001/02 and health care expenditure projection study by Gabriel Leung, 2006.
Bauhinia assumptions: Government expenditure in 2020 and 2030 assumed to be 20% of GDP (maximum).
Public health expenditure as proportion of total health expenditure in 2020 and 2030 assumed to remain constant at 57%.*

By years 2020 and 2030, health care’s share of Government expenditure is projected to increase to 21.5 and 26.5 percent respectively. These percentages will exceed Government’s health care cap of 17 percent by a wide margin, suggesting that Government cannot afford to continue with the present system: it is not going to be sustainable in the future.

19. Yet, Hong Kong’s health care system has always served as a strong safety net for its residents. This should be preserved as *no one should be deprived of essential health care because of the lack of means*. Moreover, there seems to be strong demand from the middle income group that this safety net, which has been available to them for a long time, should continue so that they are protected from traumatic financial consequences in the event of major illnesses.

Guiding Principles for Reform

20. Hong Kong’s health care system must change if it is to remain sustainable. There is a need for both providers and users to use resources more efficiently and effectively, for the system to provide better quality and more choice for users, and for users to be better prepared

¹⁵ Leung G. 2006. Hong Kong’s health spending – 1989 to 2033. *Proceedings of the Hospital Authority Convention 2006*.

financially to take advantage of new services and to pay the rising health care costs, especially after retirement and during old age.

21. Accordingly, we propose the following guiding principles for reforming Hong Kong's health care system:

- (a) Change of individual behaviours
 - (i) Greater self-responsibility for one's own health.
 - (ii) Enhancement of primary health care.
 - (iii) More emphasis on prevention.
 - (iv) Judicious use of hospital services.
 - (v) Early planning for health care financing after retirement.

- (b) Change of Government behaviours
 - (i) Increase public emphasis on primary health care (e.g. use of family doctors and development of individual health portfolios) through education, community promotions and funding support.
 - (ii) Maintain a safety net in health care for the grassroots and the middle class.
 - (iii) Encourage Hong Kong people to seek more choice and better services through shared responsibility.

- (c) Change of service providers' behaviours
 - (i) Enhance service standards, increase fee transparency and improve efficiency.
 - (ii) Promote competition and cooperation between public and private sectors to address the imbalanced situation.

Options for Change

22. Reforming the health care system must be about improving performance and incentives to enhance and sustain people's health. This involves making effective changes in the governance, management and delivery arrangements as well as the financing mechanisms in order to make it happen.

23. Internationally, health care systems' governance, management and delivery arrangements seem to be converging in character and following similar development trends even though they continue to reflect their socioeconomic and political attributes as well as aspirations. Health care financing mechanisms, however, vary more widely among different economies. But there are principally only four major approaches to health care financing – namely the “Tax-based Model”, the “Social Insurance Model”, the “Private Insurance Model”, and the “Medical Savings Model”. The basic features as well as the pros and cons of each approach are summarized below.

The tax-based model

24. Health care services are predominantly funded by general government revenue which tends to rely heavily on income tax, corporate profit tax, and indirect taxes. Non-publicly funded services are largely financed by out-of-pocket payments and/or private insurance plans. Countries that rely mainly on taxes to finance their health care system include UK,

Sweden, and to a large extent Hong Kong (mainly public hospital services). Under such systems, governments allocate funds to a health/hospital authority, which in turn funds public hospitals. Patients can utilize services provided in the public sector at a highly subsidized rate.

25. The advantages of financing health care with taxes include: low administration costs and equal access to publicly funded services by every member of the community. The frequently cited disadvantages of tax-based systems include: availability of funds is highly susceptible to the performance of the general economy; many other services compete for general tax funds; the difficulties associated with raising taxes to meet increasing health care requirements; publicly funded services are often not consumer-oriented; and the tax-based system is basically a “pay-as-you-go” system, which does not address the aging population situation and the inter-generation equity question – the shrinking percentage of younger tax payers, resulting in a much higher tax rate for the next generation in order to pay for the health care services of the elderly.

The social health insurance model

26. Social insurance schemes are always compulsory contributory schemes. Under such schemes, all working persons are required to contribute, to a health insurance fund, a certain percentage of their income (normally with employers also contributing). The insurance fund is often administered by a body at arm’s length from government. Community rating (i.e. premiums are related to income and not related to the age and health status of the individual) and universal coverage are always practised in social insurance systems. Services rendered by public and private providers are reimbursed by the social insurance fund. Countries that rely mainly on social insurance to finance health care include Japan, Taiwan, South Korea, Germany and Canada.

27. The advantages of social insurance systems include: a higher degree of financial transparency regarding the sources and uses of funds; raising premiums to meet rising requirements is relatively easier than raising taxes; and services tend to be more responsive to the needs of the consumers than tax-based systems as most insurance systems pay providers on a “money follows patients” basis. The drawbacks of such schemes include: higher administration costs associated with collection and disbursement; more unnecessary utilization if not well-managed; and, as in the case of tax-based systems, social insurance systems are also “pay-as-you-go” systems, which do not address the problems of aging and inter-generation equity.

The private health insurance model

28. Unlike social health insurance, private health insurance is generally purchased on a voluntary basis, either by individuals or by groups (mostly employers). The premium varies depending on the benefits and the health condition of the insured (known as experience rating). Consequently, the elderly and persons with existing medical conditions are required to pay prohibitively high premium.

29. The USA is the only industrialized country which relies mainly on private insurance to finance its health care services. The majority of the working population obtains insurance coverage through employment. The US government has two tax-funded insurance programs,

the MEDICAID and the MEDICARE, to pay for the health care services of the low income and the elderly.

30. Private health insurance also plays an important role in some countries such as Australia. In Australia, which has a compulsory national insurance scheme, private health insurance is voluntary but regulated. Registered plans must practise community rating. The Government provides financial incentives for people to purchase registered private health insurance plans – private insurance policy holders receive 30% rebate on their compulsory national health insurance levy.

31. Private insurance provides benefits such as choice of doctors in the private sector, choice of private hospitals and the more flexible scheduling of care for non-urgent conditions. The advantages of private health insurance include: greater choice to consumers in terms of plans and providers; and services tend to be more consumer-oriented for those with adequate insurance coverage. The disadvantages include: high administration costs; more unnecessary utilization if not well-managed; the unemployed, the elderly, and persons with chronic conditions are often unable to obtain coverage in voluntary schemes.

The medical savings model

32. Unlike insurance models, in which contributions from participants go into a pool to pay for the expenses incurred by all within the same year, medical savings models create individual savings accounts where contributions accumulate over time. Contributions to the savings accounts are normally compulsory. Medical savings accounts attempt to address the aging population and the inter-generation equity question – each person saves up for his/her medical needs after retirement, and will not be a burden to the next generation. Singapore is the first country to adopt this system. Medical savings schemes are also found in China and the United States.

33. The advantages of medical savings model include: higher degree of acceptability (contributions do not disappear into a black hole as in insurance premium or taxes but will remain in the participant's account); it is the only effective way to address the inter-generation equity problem; it empowers participants; and participants might use health care services more judiciously with money in their savings account than under insurance or tax-financed situations. The disadvantages of savings schemes include: the lack of risk pooling which could result in rapid drawdown of account balance of a participant in the event of catastrophic illnesses (this can be remedied by allowing the use of funds in the account to purchase catastrophic insurance and/or government underwriting the risk with general revenue); and high administration costs associated with collection, fund management, and disbursement.

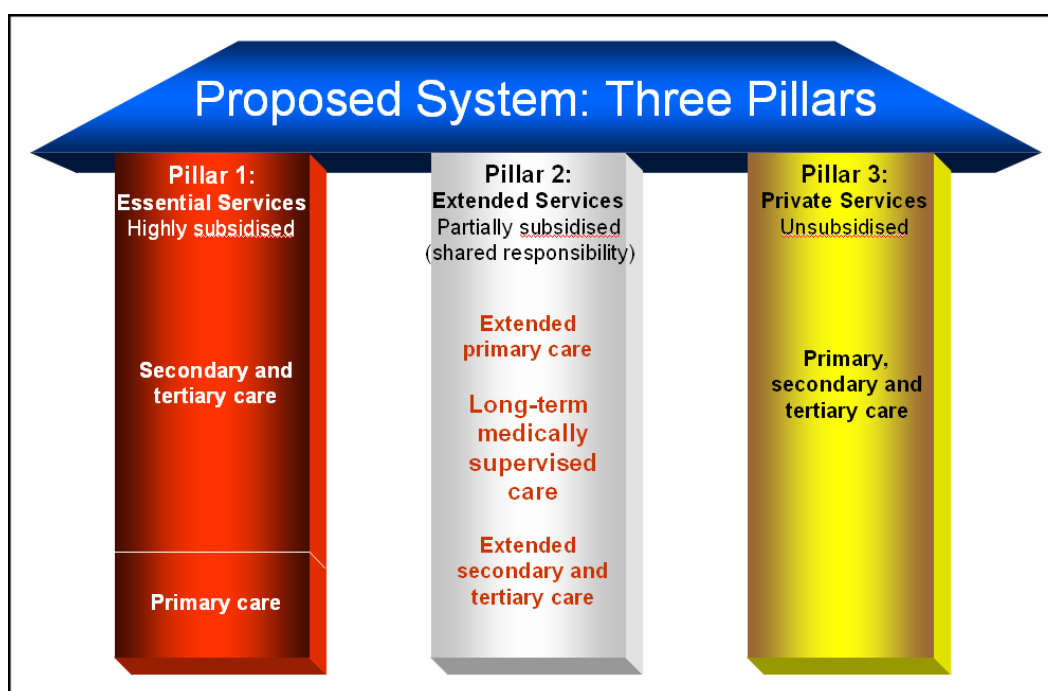
Findings

34. None of the financing approaches examined above is a perfect solution to the health care system that adopts it. When societies are becoming more complex and pluralistic, a single source of health care financing is unlikely to be adequate to meet the diversified needs of any health care system over time. And, since Hong Kong's health care reform needs to meet a complex set of constantly changing needs and expectations of users, providers and related stakeholders, a new model is needed.

The Proposal: A New Health Care Model

35. Based on the analysis of various health care financing options, and on the premise that the present tax-based system of financing health care would be preserved and Government's commitment to public health care spending capped at 17 percent of total Government spending, the Study Group proposes a new health care model with a three pillar framework (see Figure 4).

Figure 4 – The Proposed New Health Care Model



Three Pillar Framework

36. The three pillar framework will include: (a) Pillar 1 services, which will continue to have high Government subsidy ranging from 85 percent to 100 percent and will serve as the safety net for Hong Kong residents, are fundamentally essential health care services that are currently provided in the public system; (b) Pillar 2 services, which will have lower Government subsidy of an average of, say, 50 percent (subject to the subsidy for any service in dollar terms not exceeding that for the equivalent Pillar 1 service), are either extensions or enhancements of Pillar 1 services, including innovative long-term care services; and (c) Pillar 3 services, which will have no Government subsidy, are self-financed or self-pay items that users have total choice of use but are wholly responsible for payment of, through either personal savings or private insurance.

37. We propose that Pillar 1 and Pillar 2 services be structured as follows:

(a) Pillar 1 services

Pillar 1 services are to address the basic health care needs of Hong Kong residents, to provide cost-effective interventions to safeguard and promote individual and population health, to provide for early detection and screening of diseases and

disabilities, and to give Hong Kong residents the assurance of accessing essential services without financial worries.

It is envisaged that Pillar 1 services would basically cover services currently provided in the public sector, including in-patient and out-patient services provided by the Hospital Authority and primary health care services provided by the Department of Health. The scope and quality of Pillar 1 services should not be less than what people are getting today.

(b) Pillar 2 services

Pillar 2 services are either extensions or enhancements of Pillar 1 services. They are to provide choice for patients in terms of treatment, drugs, providers as designated, and amenities. They should include (i) extended primary health care; (ii) long-term medically supervised care; and (iii) extended secondary and tertiary care as follows. It is necessary to introduce a new form of financing to pay for Pillar 2 services:

- (i) Extended primary health care could comprise –
 - a Health Assessment Consultation (HAC) offered to newborns and their mothers to initiate an individual health portfolio and to encourage the establishment of a continued relationship with a family doctor – it is suggested that the Government consider funding a scheme to activate a health portfolio account for each newborn and mother and to cover the needed expenses of the HAC that should help the mother better understand preventive health care and family medicine and provide appropriate health advice to the child later on;
 - evidence-based, age-specific health screening or assessment;
 - disease management programs that use established or approved cost-effective interventions or care for designated medical conditions ; and
 - providing choice of providers – public (Department of Health, Hospital Authority) as well as private practice doctors who adopt the Family Medicine concept – for designated services.
- (ii) Long-term medically supervised care could include special accommodation and amenities for long term care, hospice and palliative care, long-term inpatient rehabilitation, centre-based rehabilitation, or community rehabilitation – the provision of special accommodation with partial public subsidy should be subject to policy scrutiny based on criteria such as scope, scale, standards and location of services.
- (iii) Extended secondary and tertiary care could include –
 - choices offered to patients to improve their accessibility to new diagnostic and treatment methods or modalities, including laboratory tests, radiological examinations, interventional procedures, drugs, consumables, prostheses, and other treatment accessories and appliances, where clinical evidence of a clear advantage over conventional diagnostic and treatment methods is

not yet fully established but emerging and is not provided under Pillar 1 services – this category may include a wide range of products and services such as:

- ◆ some of the existing Privately Purchased Medical Items and self-financing items;
- ◆ selected minimally invasive surgery and interventional procedures where clinical benefit is marginal or evidence of advantage is still being established, e.g. laparoscopic surgery for conditions that has not yet demonstrated clear advantage over traditional open surgery;
- ◆ special surgical consumables outside the normal clinical indications provided under Pillar 1 services, e.g. non-standard or special joint prostheses;
- ◆ special type of surgery not covered under Pillar 1 services, e.g. bariatric surgery for morbid obesity; and
- ◆ new technology still under evaluation, e.g. robotic surgery;
- improved amenities; and
- shorter waiting time for non-urgent conditions.

(c) Pillar 3 services

Pillar 3 services are private sector services not subsidized by Government. They include mainly general outpatient treatment which should remain primarily the responsibility of individuals. They also include interventions, care or services the lack of which should not cause significant adverse health consequences to individual patients or society and therefore will not be subsidized by the Government. Examples of such Pillar 3 services could include lifestyle enhancement or maintenance, cosmetic procedures, non-standard formulary drugs, assisted reproduction, some dental care, and eye glasses.

Some users may choose to go to the private sector for treatments or services covered by Pillar 1 or 2. In such cases, they will need to meet the full costs of such services on their own.

38. We envisage that the determination of the scope of services that should go into Pillars 1 and 2 may at times be contentious. We therefore recommend that a designated body be responsible for making such determination, and that refinements should be made continuously taking into consideration changing needs and requirements arising from demographic and epidemiologic transitions, technological advancements, societal values or preferences as may be collected through public consultations, and Government's financial position.

Enhanced Primary Health Care

39. We recognize the need to strengthen and sustain the successful provision of primary health care in Hong Kong in order to achieve a high performing health care system. Accordingly, we propose that the following be considered and implemented as integral components of the reform initiatives:

- (a) promote establishment of community-wide networks delivering holistic primary health care through integrated multidisciplinary teams that involve dentists, nurses, pharmacists and other allied health professionals working together with registered, accredited primary care doctors;
- (b) establish a primary care doctor's register – this initially can include any medical doctor or dentist who is committed to and declares to practise family medicine, although certification requirements can be enforced over time based on peer opinion, patient expectations and by evolution; there should be a Primary Care Doctor's Register under the Medical Council of Hong Kong similar to the existing Specialist's Register;
- (c) implement quality assurance mechanisms of the accredited registered service providers through audit (which can be self audit, peer audit or audit by an accredited organization or body); this would be a requirement for those service providers who participate in future Government subsidized shared-care extended primary health care programs;
- (d) emphasize a life-course-approached health screening program – health screening or assessment programs during the life course of an adult and elderly person could be funded based on medical evidence and professional consensus, with possibly different levels of subsidies offered by Government; and
- (e) develop an integrated seamless primary, preventative, and secondary care system of delivery, augmented by portable electronic medical records, so that the primary health care provider may play an effective role in facilitating the users in accessing appropriate care and in interacting with specialists when needed.

Medical Savings Account

40. Based on an evaluation of existing health financing approaches elsewhere and an analysis of the needs of Hong Kong's health care system as well as the pros and cons of its current tax-based health financing mechanism, we conclude that Hong Kong has an efficient and effective tax-based financing approach to provide for people's needs for essential health care or Pillar 1 services. But the capacity to provide for health care services will be limited. It will incapacitate the Government's financial position if it is to subsidize all of Hong Kong's future health care needs. And Hong Kong's public health care system will be unsustainable if no new financing sources are brought into the system.

41. It is considered that, in addition to the tax-based financing system, a medical savings account (MSA) scheme would be needed to ensure that Hong Kong residents would accumulate some savings to meet their future health care needs, especially after they have reached retirement age. Such a scheme should be mandatory for those in employment, subject to a minimum qualifying income. While Pillar 1 services provide a safety net for essential health care services, it is crucial that Hong Kong people should also take some responsibility in taking care of their personal health, especially in disease prevention and detection and during old age.

42. We propose that a medical savings account (MSA) be considered as a supplemental financing scheme to be added to Hong Kong's successful tax-based financing model. The essential features of this scheme are outlined below:

(a) Underpinning philosophy

- (i) Tax revenue will continue to be the major source of financing for Pillar 1 services.
- (ii) Tax-based financing is likely to be inadequate in the longer term because of:
 - aging population: increasing elderly population and a shrinking tax-paying population;
 - new technology and new drugs; and
 - Hong Kong remaining as a low-tax regime.
- (iii) A medical savings account (MSA) scheme for individuals is proposed to supplement tax-based financing.
- (iv) Resources from the MSA will primarily cover health care services for the elderly and new technology.
- (v) The extra resources will also be used to provide greater choice to consumers for selected services and to foster the consumption of certain cost-effective health care services, especially during old age – Pillar 2 services.
- (vi) A sense of responsibility of one's own health will be instilled through participation in the MSA scheme.

(b) Benefits

Funds in the MSA can be used to pay for:

- Fees and charges under Pillar 1.
- Subsidized services under Pillar 2.
- Pillar 3 services (without subsidy) after age 65.
- Government-approved medical insurance plans, e.g. hospitalisation plans after age 65, long-term care plans, and possibly major illness plans before age 65.

(c) Participants

- (i) All residents of Hong Kong are eligible to participate in the scheme. It will be mandatory for those in employment, subject to a minimum qualifying income.
- (ii) Contributing participants can pay for health care expenses of approved services incurred by immediate family members using his/her own MSA.

(d) Administration

- (i) The existing MPF system will be used – to collect contributions from participants and to enforce contributions – in order to minimize setup and future transaction costs.

- (ii) Funds in the MSAs would be allowed to be invested in the more conservative MPF funds (conservative investment is preferred in view of the nature and uncertain timing of withdrawals).
 - (iii) A new agency will be set up to handle disbursements. It will deduct funds from the individual accounts for treatments/services rendered to participants.
- (e) Contributions
- (i) For the scheme to be viable, the mandatory contribution rate for those in employment should be between 1 and 5 percent.
 - (ii) Exemptions will be made for the very low income earners, and a contribution ceiling will be set for the high income earners (similar to the current MPF regulations, the amount of mandatory contributions will be subject to the minimum and maximum levels of income which are \$5,000 and \$20,000 per month respectively).
 - (iii) Voluntary contributions from employers are encouraged, especially for those who are not already providing health insurance or retirement plans for their employees.
 - (iv) Voluntary monthly or ad hoc top-ups are permitted to encourage faster buildup of savings in the account.
 - (v) To prevent excessive buildup of account balance and use of subsidies, and possibly tax evasion, a maximum total contribution limit will be set for each account.
- (f) Withdrawals
- (i) To ensure availability of funds for post-retirement, a minimum balance per account will be set. Other than for approved exceptions, e.g. certain major illnesses and evidence-based health assessments, account holders cannot use the balance before age 65 if it is below the set minimum level.
 - (ii) Unspent balance in the account will be treated as part of the participant's estate upon death.

43. It is also our recommendation that Government should encourage employers, large and small, to take better care of their employees by taking out appropriate medical insurance policies. The co-sharing of burden between employees and employers is a key to success in funding health care services.

Institutional Reform

44. To accomplish the reform objectives and to ensure sustained effective health care system performance, it is necessary to have in place appropriate and effective institutional arrangements to carry out all of the essential functions of a health care system. There are four principal health care system functions that should be effectively organized and carried out by designated bodies with clear demarcation of roles and responsibilities: (a) stewardship, (b) purchasing, (c) disbursement, and (d) delivery.

(a) Stewardship

A designated body, e.g. a health commission, should be established to advise the Government on the strategic and policy directions, health standards, the contents of Pillars 1 and 2 services, and to collect statistics and information.

(b) Purchasing

An agency or unit should be responsible for the purchaser functions for the public sector, including deciding on the scope and level of services to be publicly funded (e.g. quantities); the fee schedule (i.e. discount/subsidy rates) for different service types and user groups; the appropriate payment mechanism to different providers for different service types; and approving sub-contracting to the private sector. These purchaser functions should be separate from the provider functions. The concept of the purchaser and provider split in health care is described in **Appendix II** of this report.

(c) Disbursement

The existing mandatory provident fund system is proposed to be used to collect contributions from participants of our proposed medical savings account scheme. A new agency will need to be set up to handle disbursements. It will deduct funds from the individual accounts for treatments/services rendered to participants.

(d) Delivery of care

The delivery of health care relies on both private and public sector providers. For government funded or subsidized services, the main provider is the Hospital Authority. But this could also include the Department of Health, accredited and registered private hospitals, clinics, laboratories and medical practitioners which offer services under Pillar 1 or 2 as directed by the purchaser. Providers or provider organizations should, however, be entities independent from the purchaser.

Conclusion

45. We recommend:

- (a) A new three pillar framework health care model that preserves our existing strengths and achieves our reform objectives.
- (b) A new financing model, involving the introduction of a medical savings scheme, that strengthens users' financial capacity and enhances users' choice.
- (c) Enhanced institutional arrangements that improve quality and access, optimize value for money and promote health and wellness.

The Bauhinia Foundation Research Centre Health Care Study Group

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Terms of Reference

Health care reform has been on the government agenda for many years but public support for the various previous proposals has not been strong. There is now again a surging sense of urgency that the health care system should undertake both provision and financing reforms to ensure that health care continues to be accessible and affordable to people. Hence, Hong Kong needs an overarching review of its future health care reform needs and options in order to develop an integrated policy to guide health care's future development and financing.

The Health Care Study Group, having regard to the above and taking into consideration policy gaps and issues that must be addressed in order to meet the future health care delivery and financing requirements of Hong Kong residents, in particular those of the elderly, undertakes to:

- (1) review, discuss and articulate the objectives and attributes of an appropriate system of health care delivery and development for Hong Kong;
- (2) identify incentive systems that induce and enhance desired health care stakeholder behaviour;
- (3) propose a financing model, including payment options and funding mechanisms, that promotes the development of an efficient, responsive and financially sustainable health care system for Hong Kong; and
- (4) propose appropriate institutional arrangements conducive to effective implementation of the preferred health care system.

The Concept of Purchaser and Provider Split (PPS) in Health Care

Overview

1. The separation of the purchaser and provider functions is not new in health care, especially in the private sector. All funders of health care, including medical insurers and employers who offer health insurance coverage to their members, have performed the purchaser role to some extent. The concept of Purchaser-Provider Split is more of a recent phenomenon in publicly funded systems, such as the NHS in the UK, which made this concept more pronounced when it introduced in the 1990s the GP fundholding concept to put in practice the principles of purchaser-provider split.

Defining Purchaser-Provider Split (PPS)

2. Purchaser provider split can be defined as an arrangement where the purchaser is the agent who decides on behalf of users what care and services will be delivered and the provider is the agent who delivers to the users the agreed outputs or outcomes. Through this arrangement the service delivery outcomes are defined and made explicit in contracts or service agreements.

3. The purchase-provider split was initially created to stimulate the development in the public sector of an internal market, where purchasers bought health care services from providers. The intent was to introduce market incentives in order to increase efficiency at the secondary and tertiary care levels and to make explicit the accountability for better health outcomes.

4. The purchasers were to represent the local population, and to act as patient representatives as well-informed buyers of specialized care and to be financially responsible. The purchasers through a democratic decision-making process would challenge the prevailing patterns of resource distribution between primary and secondary health care and clearly specify what was expected of the providers. The Primary Care Trust's fund holding role in the NHS in the 1990's was an example of such an arrangement.

5. But the effects of an internal market, as demonstrated in the NHS experience, never evolved fully, particularly in communities or specialties where there were only one or a small handful of providers. The arrangement in NHS today takes the form of health services commissioning in which purchasers and providers are to learn more about each other, develop partnerships, collaborations and work closely together in shaping services to address users' health care needs and expectations.

The Key Players

6. Although the concept refers to the purchaser and provider, there are in practice four key players whose roles may be described as follows:

- (a) **Funders** who are responsible for acquiring and distributing funds to purchasers. The funder may formulate specific policies and priorities, monitor

purchaser performance, and administer any regulations concerning purchaser-provider relationships.

- (b) **Purchasers** who evaluate the health care requirements and ascertain opportunities for improving health of the community. They set priorities, develop specifications, and enter into agreements with providers for the delivery of services. The range of services for which purchasers are responsible and the degree of risk may vary.
- (c) **Providers** who deliver services against service agreements and requirements are accountable to purchasers for the quality and quantity of services provided.
- (d) **Owners** who are responsible for protecting the integrity of the human, financial, and physical assets in public sector providers and for the role of ensuring a suitable return on government resources.

Overseas Experience

7. The key features and experience of purchasing and providing health care in five overseas countries – New Zealand, Australia, Finland, the United Kingdom and the United States – are presented below for reference (also see Figure 1 at the end of this paper for a summary of the practices and experiences in these countries).

8. In Australia, New Zealand and the United Kingdom the purchasers are appointed and funded by central or state governments. In Finland, accountability is exercised through local government and the funds are generated from central taxation supplemented by local taxation. In the United States, managed care organizations are commercial companies with boards of directors accountable to shareholders. In these countries, the boards of purchasing agencies explain for the community who is responsible for any deficiencies.

9. The scope of purchasing duties varies widely among the five countries. The greatest extent for the purchaser is in New Zealand, where the regions procure all health and social services, including homemaker services, as well as handling disability benefits.

10. The split between purchaser and the provider seems to be more comprehensive outside the United Kingdom. In the United Kingdom, the purchasers and providers are compelled together in a “managed market,” in which each organization’s decisions and activities are restrained by the outcome it has on the other.

- (a) The funder of health care is the central department, the NHS Executive. Unified purchasing health authorities are funded on a capitation basis, general practitioner fundholders also receive funds, and NHS trusts receive funds partly on the basis of population and partly according to bed numbers.
- (b) The providers are required to set prices for their services that are the same as their exact cost. Furthermore, they may not cross subsidize services in which income does not cover cost by using excess income from other parts of the organization.

- (c) Arguably this feature of the UK reforms prevents the operation of a true market in health care: providers have no incentive to promote innovative and perhaps cheaper services that might attract income and strengthen the provider organization as a whole. By the same argument purchasers also are unlikely to shop around for the best value for money and are locked into contracts with relatively few providers. This system has created a mountain of red tape, which is costly and time-consuming.
- (d) The Healthcare Commission was formed in 2004 to assess and report the performance of NHS and independent health care organizations to ascertain that they are providing a high standard of care and continuously improving their services and the systems within their institutions. Government funding and allocation is based on their assessment report.

11. The level of Government influence in the taxation based services varies from strong in the United Kingdom and Australia to weak in Finland, where the influence of 450 municipalities is dominant.

12. All use contracts to negotiate the affiliation between purchasers and providers. They have very distinct features, from legally enforceable and price sensitive in the United States to annual contracts about the scale and nature of services with price equaling to cost in the United Kingdom. The nature of agreements has great implications for the degree to which health care can function.

13. One greatly noticeable consequence of these reforms has been their reliance on information for contract requirements and monitoring. All five countries put a prominent value on getting the right balance between detail and precision in one aspect, and controlling the unavoidable increase in operation cost in the other.

14. In all five countries affordability of health care is imperative. The reforms are meant to handle supply and demand, and the issue of affordability.

Pros and Cons of Purchaser Provider Split

15. The advantages of PPS could include:
- (a) The purchaser would look for cost efficiency and value for money. As a result, the providers will need to exercise fiscal discipline and have full knowledge of their costs.
 - (b) The purchaser can expect standard quality services and outcomes from the providers as a strict condition for purchase. In reaction, the providers will need to have continuous quality improvement and outcome studies.
 - (c) There could be internal competition among the public providers and clusters for cost efficiency and quality.
 - (d) The purchaser has choice and can also purchase services from the private sector. The public and private providers may have to establish their

competitive advantages. And, competition could enhance the quality of services regardless of whether it is public or private.

- (e) The purchaser can also establish target subsidies for certain high cost disease treatments to ensure the provider will continue to provide adequate quality of care.
- (f) The cost of activities, such as training of medical graduates, could be isolated and separate funding from Government sought.

16. Some constraints of PPS

- (a) There may be additional costs incurred in the administration of such a program, although early experience from other countries seems to suggest that no significant additional increase in costs is incurred as a result of the split.
- (b) If the purchaser can also procure services from the private sector, patients may shift to private sector and as a result, public services may suffer without adequate funding for development and improvement of their services.
- (c) The public health care system which has not changed for many years may not be ready for PPS arrangement, and may result in providing poor quality services due to system change for cost efficiency in their services.

Figure 1 - Key Features of Purchasing and Providing Health Care in Five Selected Countries

	Purchasing Organizations	Board	Range of Purchaser Responsibilities	Separation of purchaser and provider	Degree of central policy direction	Contract mechanism	Resource Context	General Practitioner Purchase	Experience
New Zealand	Separate public authorities accountable to ministers (separate minister for provider organization)	Political appointees	All health services, including nursing home care	Near total	Slight	Contracts are legal, volume specifications not yet sophisticated; prices does not equal cost	No growth	Planned, most services	Since July 1993
Australia	Public authorities accountable to state and commonwealth ministers; purchaser-provider separation by “Chinese walls”	Political appointees	Most secondary and tertiary and community health services	Planned in two states (1995/6)	Direct guidance, plus Commonwealth also purchases in parallel	Shadow contracts 1994/5; price does not equal cost	No growth	(South Australia) planned, (Western Australia) most services	WA – 1993; SA - 1995
Finland	Separate local authorities [450 municipalities (5,000 – 40,000 population each) also purchase civic and welfare services]	Elected	Most health and welfare	Near total	Slight	Volume specifications are block, and cost and volume contracts price does not equal cost	No growth	Yes, all services	From 1995, Gradual implementation over next 14 months
United Kingdom	Separate public authorities accountable to ministers via central management executive, also general practitioner fund holders	Non-executive appointees and executive directors	Most tertiary, all secondary, some primary, and all community services	Different organizations closely bound together	Pronounced	Volume specifications are block (mostly, but some are costs and volume), not legal, but quite sophisticated; price equals cost	Some growth	Yes, partial scheme (roughly 30% of population covered)	Three years
United States	Separate commercial organizations insuring up to half a million people and contracting with range of preferred providers for all health care	Shareholders in profit or not for profit organizations	All health services, including nursing home care	Total	None (but fiscal measures)	Very sophisticated; legal contracts price does not equal cost	Growth	No, but GPs have financial stake in purchasing	Many years

Source: Mason, Alastair and Morgan, Kieran 1995. Purchaser-provider: the international dimension. *British Medical Journal*, 28 January, Vol. 310, pp 231-235.

Response to Public Concerns over Health Care Proposals

The preliminary findings of “Development and Financing of Hong Kong’s Future Health Care” released on 6 June 2007 have led to a community-wide discussion on Hong Kong’s future health care development.

Since its release, the Centre has received feedback from both individuals and organizations through different channels. Before finalizing the final report, a Health Care Reform Forum was held on 23 June to gauge the different views of the stakeholders.

The following is an analysis of the feedback received together the Centre’s response:

Concern (A): There are considerable concerns about the withdrawal of funds from the proposed Medical Savings Accounts (MSA). Some are concerned that the MSA funds can only be withdrawn after the age of 65 unless under exceptional circumstances (e.g. major illnesses) or with prior approval. This requirement is considered too restrictive and inflexible.

Response (A): This is a misunderstanding of our proposal. According to our preliminary report, account holders can use funds in the MSA to pay for fees and charges under Pillar 1 and subsidized services under Pillar 2 before age 65. They may use the balance to purchase private services (Pillar 3) as well after 65.

To ensure availability of funds for post-retirement, we propose in our preliminary report that a minimum balance per account be set. But even if the balance is below the minimum level, account holders can use the funds before 65 for approved exceptions (i.e. certain major illnesses). In light of the feedback received, we are considering whether we can do away with the minimum balance requirement altogether to allow greater flexibility in the use of MSA funds.

Concern (B): Medical savings would further reduce the take-home pay of the low income earners, if those earning \$5,000 or above are required to make contributions.

Response (B): MSA is about early planning for health care financing after retirement as well as shared responsibility for one’s own health. Account holders may use the funds to pay for Pillars 1 and 2 services when they are in need of health care services.

On the minimum level of income, we are considering whether, in light of the feedback received, we should allow those earning less than \$10,000 to contribute on a voluntary basis to relieve their financial burden.

Concern (C): It is considered that MSA cannot result in risk pooling, and the MSA balance would be quickly depleted as the treatments for catastrophic illnesses could be very costly. Hong Kong should instead launch health care insurance plans at the community level, or allow those contributing to MSA to use the MSA funds to take out insurance cover.

Response (C): We would like to emphasize that the current safety net is preserved as

those participating in MSA can still utilize public medical services. One of the major concerns expressed at the Health Care Reform Forum organized by the Centre related to the high medical costs in cases of catastrophic illnesses. In light of the feedback received, the Centre is exploring the viability as well as pros and cons of including an insurance cover for catastrophic illnesses for those contributing to MSA. Part of the MSA balance will be used to pay the premium. Given the size of the insured population, there is a possibility that the premiums can be kept low. We have been in touch with the insurance sector to explore the possibility of developing a low-cost package for the MSA holders.

Concern (D): Some consider that the definitions of the Pillars 1 and 2 services are not clear, and this casts doubt on the feasibility of the three-pillar framework. There has also been a concern about the range of service items to be covered by the two pillars.

Response (D): The three-pillar framework is a new health care model developed by the Study Group based on its analysis of the existing health care system. This is a conceptual framework which aims to provide more choice and better quality services through shared responsibility on top of the existing heavily-subsidized ‘safety net’ in health care. The objective is to modify patient behaviour and culture.

We propose that Pillar 1 will remain as a safety net, and its scope and services should not be less than what people are getting today. The bulk of the Pillar 2 services should cover extended services in primary health care, shifting emphasis from treatment to prevention, promoting family doctor services, offering choice in long-term medical care as well as affording emerging medical technology.

While working on further details of the Pillar 1 and 2 services, we hope that there will be more discussion on the pros and cons of the concept. We envisage that the determination of the scope of services that will be covered by Pillars 1 and 2, though strictly evidence-based, may at times be contentious. We therefore recommend that a designated body (operating in a transparent manner with the stakeholders as members) be set up to make such decisions taking into consideration the continuous changing needs and expectations arising from demographic, medical and technological changes as well as the Government’s fiscal position.

Concern (E): There is also a concern about the efficiency of the existing health care system.

Response (E): One of our reform proposals – the Purchaser/Provider Split (PPS) – aims at driving better efficiency and quality of the service providers. Under the concept of PPS, the purchaser would look for cost efficiency and value for money. As a result, the providers will need to exercise fiscal discipline and have full knowledge of their costs. There would also be competition among the service providers as the purchaser can purchase services from the public and the private sectors as and where appropriate.

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