TIME FOR DECISION

Michael Somerville
Chairman, BPF Health Care Committee

Thank you for giving me the opportunity to share some thoughts with you on Health Care Reform. It is a daunting task.

Health Care structure delivery and financing are complex with many competing often conflicting interests and objectives – secondary versus primary, specialist versus general, equity versus choice, quality versus cost, modern technology versus tried experience, prevention versus cure, traditional versus western, private versus public. It is a veritable Tower of Babel.

No two systems in the developed world are the same, even broadly similar. Each is a product of that community's history, social ethics and economics. None is perfect and lessons to are be learnt from mistakes rather than copying success. Yet there are common themes which should influence our thinking. The consultation document outlines some of these but I have provided hard copies of this comprehensive comparison of key features which you may find helpful as a benchmark for testing your own thoughts. Highlighted are four common elements of special relevance for Hong Kong (single system, standard fees, co payment, cost problems).

HONG KONG SITUATION

Turning to our own Hong Kong system. It is like the curates egg – excellent in parts. But it is has serious flaws.

So what are these flaws? In essence we have a two tier system or, even worse, two separate systems. With acknowledgments and apologies to the Harvard team, whose illustration I have partly plagiarised it looks something like this. A highly regulated highly centralised, virtually free public hospital system in which the public provider is wholly financed by government. On the other hand a largely unregulated free market fee for service primary care system predominately private sector provided without coordination of priorities, or any control of affordability or pricing. The two systems are compartmentalised living almost in separate worlds. The public system is transparent, of assured quality, is low cost but it is losing resources. The private is opaque of variable quantity and cost and has limited resources.

This is a two tier system of health care, even two distinct systems of health care. No other developed country has this – all have unified systems. It is essential that over time we move to one system, with unified coordination and control.

IF IT WORKS WHY CHANGE

Many people still say that for all the flaws the current system delivers good quality health care at a comparatively low cost to the community. If it works why change?

DISCUSS

THE GOVERNMENT PAPER

Also some briefs comments on the Government's consultation paper.

DISCUSS

Let me then recap. There are 4 principal reform issues.

Balance
Coordination
Governance
Finance

REFORM ISSUES

Balance

I have already addressed the current imbalance, which is heavily weighted to hospital care. Primary care and prevention which should be the foundation of any modern health system lack focus and structure.

Coordination

There is little coordination between the two tiers I have illustrated, even between different elements. A common EHR electronic health record highlighted in new consultation document is an excellent and major initiative. However it is but a tool albeit and essential tool the effectiveness of which depends on its use and management.

Governance

This is an absolutely key issue and one which so far there has been great reluctance to confront. It is my view and indeed the view of BPF that the corollary of any move by government to introduce supplementary financing must be to take a grip of the private sector delivery of health care and its pricing to make it much more transparent and affordable especially to the middle class who are the main victims of our current two tiered system. Expecting to obtain their support without clearly articulating the improvement not only of choice but more importunately of affordability is lost cause. The concept of achieving this through gate keeping is fine in itself but unless government manages the system formally through regulation, registration and above all the financial leverage of incentives and subsidies it will not work.

Finance

The consultation paper goes into considerable detail on the long term financial unsustainability. I will not repeat the numbers in detail. There are those in the community who doubt the projection and claim that the cost of ageing is overstated, or that we can continue to fund health care predominately through taxation if we beef up our cost control, replace expensive older techniques with cheaper modern technology (key hole surgery for example), and give greater priority to health care in allocating funds. This is debatable but to me the reality remains that if we are to have a public/private health care system in the future that lives up to community expectations on quality and service standards it requires more resource and some major changes in the way health care is bought.

Supplementary funding and redirecting tax based government funding from producer to purchaser funding are the tools to facilitate structural change, promote primary and preventive care, spread the burden and create choice, while co payment encourages self responsibility.

Recent history has starkly highlighted the volatility and instability of a system based just on current tax revenues. In short we need a better balanced funding mix.

This leads on to the core essence of what I want to share with you today. That is the essential guiding principles which should act as benchmarks against which the funding options must be judged. We must not lose sight of the fact that any supplementary funding system we choose will have very long term and

major implications for the structure of our health care system in the future. We do not want to repeat the mistake of creating a lopsided system.

These guiding principles can be divided between those that have overwhelming support and those more controversial on which the community is divided.

GUIDING PRINCIPLES

AVAILABILITY OF HEALTH CARE TO ALL

On the face of it we all support this concept. The definition currently in use is that none shall be denied adequate health care through lack of means. I prefer a more positive statement of the principle by stating that adequate health care must be available to all in the community regardless of their financial circumstances.

In practice, I am really concerned that we may be moving in the direction of creating a system which perpetuates giving one section of the community a better deal than the rest. If you limit the participation in a publicly sponsored funding scheme to a section of the community giving them more freedom of choice to purchase services from either the public or private sector, then you are inevitably creating a preferred class of customer. Whatever the policy makers may say is the intention, ultimately those who pay more in a public system will demand and get priority. This fear that we might end up exchanging one two tier system for another was a key concern expressed at a recent Hong Kong University forum, with several overseas speakers expressing this succinctly with the statement “a separate system for the poor is a poor system”.

SELF RESPONSIBILTY

Notwithstanding the fierce determination in our community to hang on to free lunches wherever possible there does seem to be broad acceptance that we should foster self responsibility and that this is best achieved by some form of co payment preferably out of pocket co payment, perhaps with some element of capping. As I have already mentioned virtually every other system in the developed world applies this principle.

RISK POOLING

To my mind, no major source of funding health care is viable unless it is significantly risk pooled. By risk pooling I mean simply the sharing of health (and accidental injury) expense between the fit and the unwell and to a degree between generations. As a member of the Bauhinia Health Care group, my principle reservation with their proposals was the virtual absence of a risk pooling mechanism. It is encouraging that this issue has been given much more weight in the current consultation document.

Now to the more controversial guiding principles.

EQUITY

On the face of it we all want to see a fair and equitable system but we also seek wider choice at least for some in the community. Are these in reality compatible? It’s like opportunity, unless we are committed to equal opportunity, modern societies almost universally cry foul. For my part in choosing between options or suggesting amendments to options my vote goes to those that target the community as a whole. This is and has been a key element in BPF’s reservations about employment based funding. The world’s leading employment based health care system, that of the USA, is the least equitable.

WEALTH DISTRIBUTION

With 50% or more of our health care costs being funded through general taxation we already call upon the rich to subsidise the poor. There are those that feel that all health funding should follow this principle. It is up to employers to decide how far they have sympathy with this approach.

MANDATORY/VOLUNTARY

A middle class survey of the consultation paper options, reported last week, reveals a strong majority against mandatory funding and a majority in favour of voluntary insurance. Frankly I do not think we have any option. Any principle and formal public funding mechanism must be mandatory. This does not for example preclude voluntary insurance as part of the funding regime for health care but this cannot meet the criteria of a public funding system. The key reasons for this are that its risk pooling is limited and exclusive and that it does not provide a level playing field of benefits.

MONEY FOLLOWS PATIENT

This is not strictly a guiding principle but the issue of financing flows is a fundamental element in any health funding mechanism. Unfortunately it is barely covered in the consultative paper. Our current public system is producer funded. This effectively rations health care by cost, constricts quality and competition or choice. Many claim that purchaser funding enhances efficiency and value through competition and choice. That is debatable. A mixed approach seems to be the best option.

THE SIX SUPPLEMENTARY FINANCING OPTIONS

So having outlined the guiding principles at any rate as I see them, I feel I am obliged to comment on how the six financing options articulated by government stack up.

But let me make two caveats. First it does not seem to me that the options as outlined are mutually exclusive – although one may become the preferred choice there is almost certainly room in the funding mix for all or most of these approaches. Secondly my comments are personal as the study group which I chair has not yet deliberated on them. This is a briefing not a sales pitch so please take these comments for what they are – one person's perspective.

SOCIAL HEALTH INSURANCE

This is the predominant approach of most developed countries 'systems' but it does not have to be earnings or employment linked as the consultation paper suggests. For those who feel that our current system already provides adequate earnings related redistribution a centrally administered social insurance system can be based on a standard insurance benefit with a standard community wide risk pooled rate and subsidies for low income groups. Taiwan is an example of this. In effect social insurance can be a government arranged insurance scheme.

OUT OF POCKET

Many of us still believe that the current charges at public hospitals are too low and make any realistic pricing level playing field with the private sector very hard to achieve. I for one would strongly support some increase, preferably in combination with annual capping of costs especially for chronic sufferers. The concept of capping is mentioned briefly in the consultation document but deserves more emphasis. Out of pocket should always be an element of a funding system, if only to inhibit over usage, but it currently represents too high an element of total health funding and cannot be a main source of supplementary funding.

MEDICAL SAVINGS

I don't have a problem with the concept of medical savings but they are not risk pooled nor are they really a funding mechanism for health care per se. Except to the extent that they may be used to pay insurance premiums they are only a way of facilitating out of pocket expenses.

I am also concerned that the nexus between old age and payment for health care 30 years hence is so unclear that any savings scheme is pure conjecture. Will 65 still represent retirement age in 2033? Will those in their 70's be economically active (as some of us are today!). Will our aged population be predominately poor or more able to fend for themselves? Will our community expect them to bear their own costs?

VOLUNTARY HEALTH INSURANCE

I have already stated my view on this. I believe that employers and the insurance industry have a big role to play in promoting wider use of voluntary health insurance and in building a medical insurance industry better able to influence or even to participate in, providing quality health care. But this is not a viable source of a publicly sponsored supplementary funding mechanism.

MANDATORY HEALTH INSURANCE

I and I believe BPF still support this approach but because supplementary funding must support the shift in emphasis to primary and preventative care, these should feature in any standard insurance package.

PERSONAL HEALTH CARE RESERVE

Because this is clearly Government's preferred option it deserves particularly close examination. My own core concern is that, as presented, it only addresses part of the working population and as such may fuel that two tier approach to future health care that has worried many. I would feel much more comfortable if the insurance element at least could be more broadly based across the community. I also wonder about the position of dependants under such as a scheme.

So we are faced with trying to make a choice between a number of funding options each of which has its pros and cons, none being a perfect solution for Hong Kong or perhaps to recommend some amendment or different approach.

Which ever funding solution is finally selected, there are major implications for employers and the business community. The debate on financing has dragged on for many years and now is the time for your constructive and positive contribution to finding a sensible working solution for Hong Kong.

EMPLOYMENT RELATED ISSUES

Lastly I would like to take a few moments to identify and comment on some issues which most specifically impact employers. Those I have shown here are, I think, the most important and are interlinked.

The first and most important of these must be the issue of mandatory contribution to funding by employers. In the consultation paper only the first option – social insurance - employer contribution. You will also be aware that the Bauhinia Group, in its proposals, specifically recommended against mandatory employer contribution because of the negative potential impact on existing employer benefits and employer funded voluntary insurance. There is however continuing pressure from many quarters to mandate employer contribution. Employers, in particular needs to articulate a clear and well argued stance on this issue. Is it compatible, for example, with the principle of self responsibility? What is the justification for substituting, in effect, general taxation by hypothecated employer taxation?

Next is the concept of employment based funding which is closely allied to employee mobility, both within and outside our borders, and to the breakdown in life time employment with one employer? Whilst this form of funding historically has been the norm, there is a clear trend to abandon this approach, notably in the US. In Hong Kong we have the added problem of a narrowing dependency ratio. You will surely wish to examine this.

Existing employer funded medical benefits and insurance represent a major funding source and delivery vehicle for healthcare particularly primary care. Preserving, indeed growing, this area is vital to a stable health care system. How then do new funding proposals impact this? Is there a danger of employers dumbing down their benefits as happened with MPF? How can this be addressed?

Finally, I am sure you will wish to consider the implications for SMEs, which constitute a major part of our business community.

As with everything associated with health care these are complex issues and if BPF can help you in considering them we will be happy to try and do so.

This brings me to my last slide.

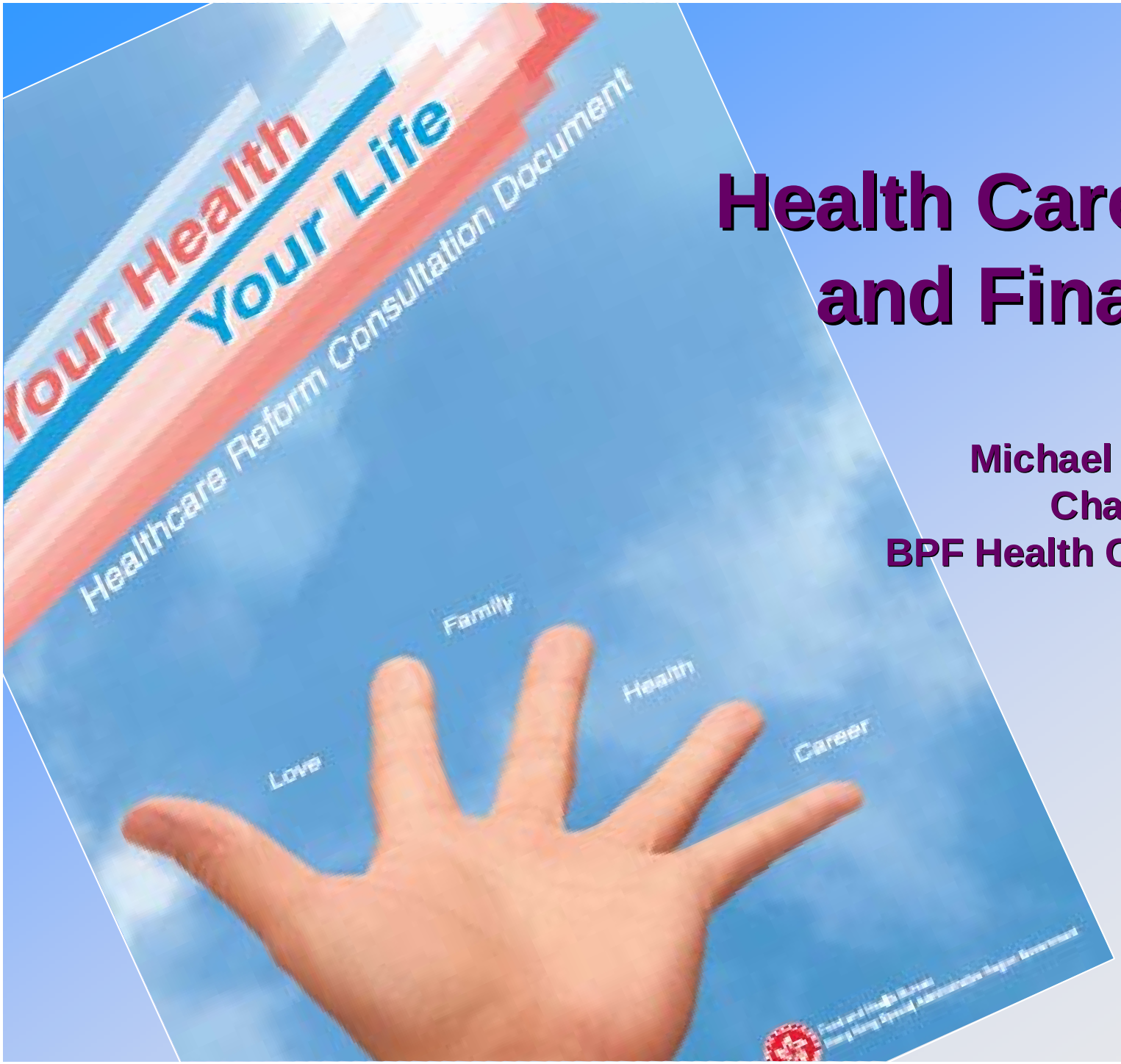
After nearly 20 years of indecision and abortive initiatives health care reform is at last at the top of government's agenda,

Our Chief Executive has expressed his determination to find solutions during his present term of office.

With so many conflicting interests at stake no solution will be an easy sell. With a thousand reasons why we should not do things, there is great need for constructive input putting the overall community's interest first.

Above all however this is the

TIME TO DECIDE



Health Care Reform and Financing

Michael Somerville
Chairman
BPF Health Care Committee

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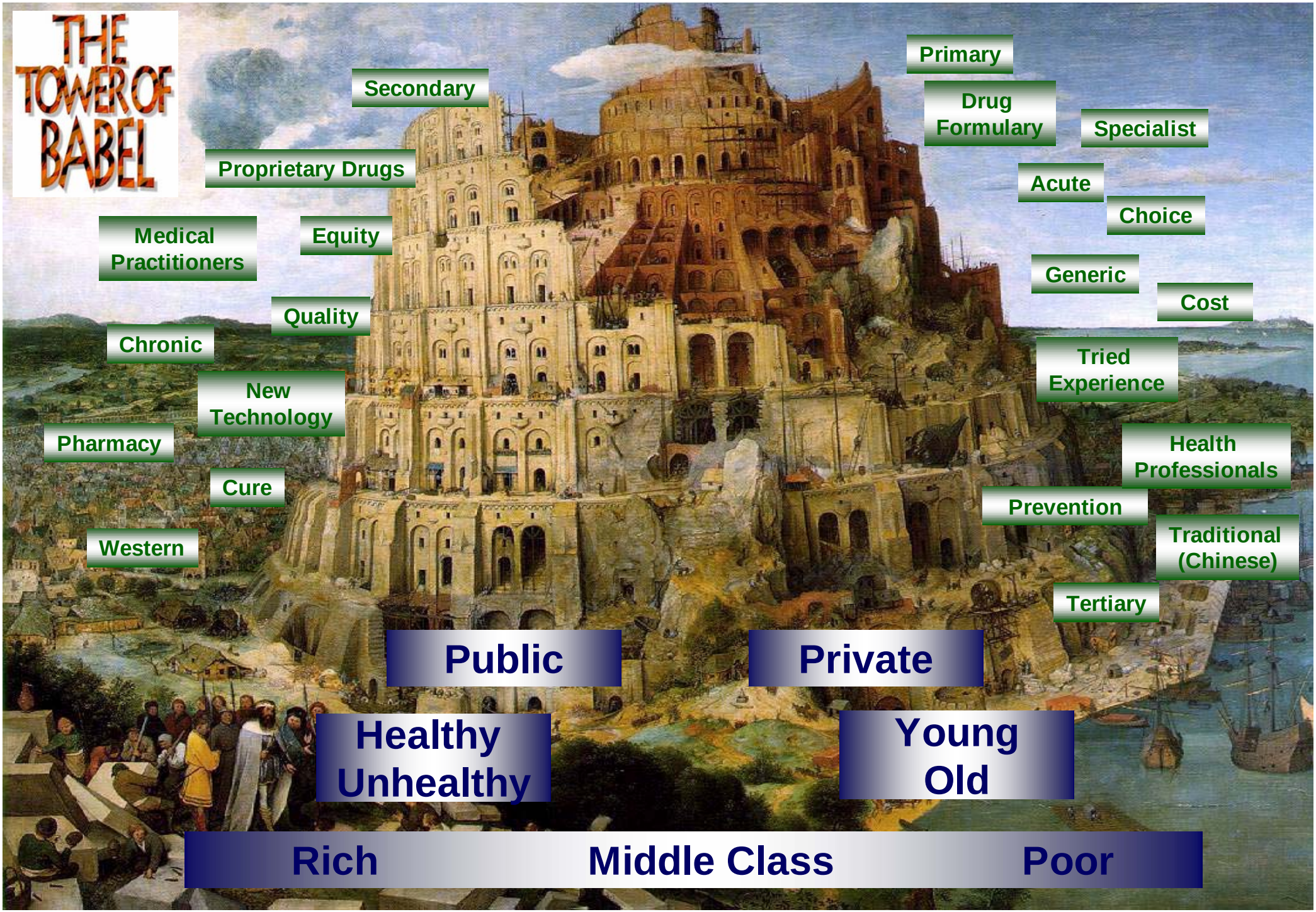
THE TOWER OF BABEL
Primary
Secondary
Drug Formulary
Specialist
Proprietary Drugs
Acute
Choice
Medical Practitioners
Equity
Generic
Cost
Quality
Chronic
Tried Experience
New Technology
Pharmacy
Health Professionals
Cure
Prevention
Traditional (Chinese)
Western
Tertiary
Public
Private
Healthy Unhealthy
Young Old
Rich
Middle Class
Poor

Comparing Health Care System

	Australia	Canada	Finland	UK	Austria	Belgium	Japan	Korea	Netherlands	Switzerland	Singapore*	HK
Universal												
Primary	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Secondary	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
General tax	✓	✓	✓	✓	X	X	✓	✓	✓minor	✓	✓	✓
Social insurance	✓	✓ states	✓	✓	✓	✓	✓	✓	✓	✓	X	X
Savings account (MSA)	X	X	X	X	X	X	X	X	X	X	✓	X
Contributed by												
- Taxpayers	✓	X	✓	✓	X	X	X	✓	X	X	✓	✓
- Employers	X	X	✓	✓	✓	✓	✓	✓	X	X	✓	X
- Employees	X	X	✓	✓	✓	✓	✓	✓	✓	X	✓	X
- Self employed	X	X	✓	✓	voluntary	✓	✓	X	✓	X	✓	X
- Young	X	X	✓	X	?	X	X	X	X	X	X	X
- Pensioners	X	X	?	X	?	X	✓	X	✓	X	X	X
- All residents	X	✓	X	X	X	X	X	X	✓	✓	X	X
Private insurance												
- Mandatory	X	✓	X	X	✓	X	X	X	✓	✓	X	X
- Mandatory / Supplement	X	X	X	X	✓voluntary	X	X	X	X	X	MEDISAVE	X
- Voluntary	✓ tax credit	✓	✓small	✓	✓	✓	X	X	✓	✓	✓	✓
Standard fees	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓ partial	X
Public / private choice	✓	✓	✓	✓	✓	✓	✓	✓	All private	✓	✓	X
Copayment	✓	✓ drugs	✓	X	✓	✓	✓	✓	✓	✓	✓	✓ minimal
Fee capping	✓	X	✓	X	X	X	✓	✓	X	X	✓	X
Government safety net subsidy	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	MEDIFUND	✓
Cost control problem	✓	✓✓	✓ drugs	✓	✓	✓	✓✓	✓	X	✓	✓	✓

** Singapore savings account MEDISAVE is funded by a compulsory 10 → 34.5% of wages shared between employers and employees. Withdrawals can contribute to hospital based bills up to set limits only. The only country to have implemented MSA.*

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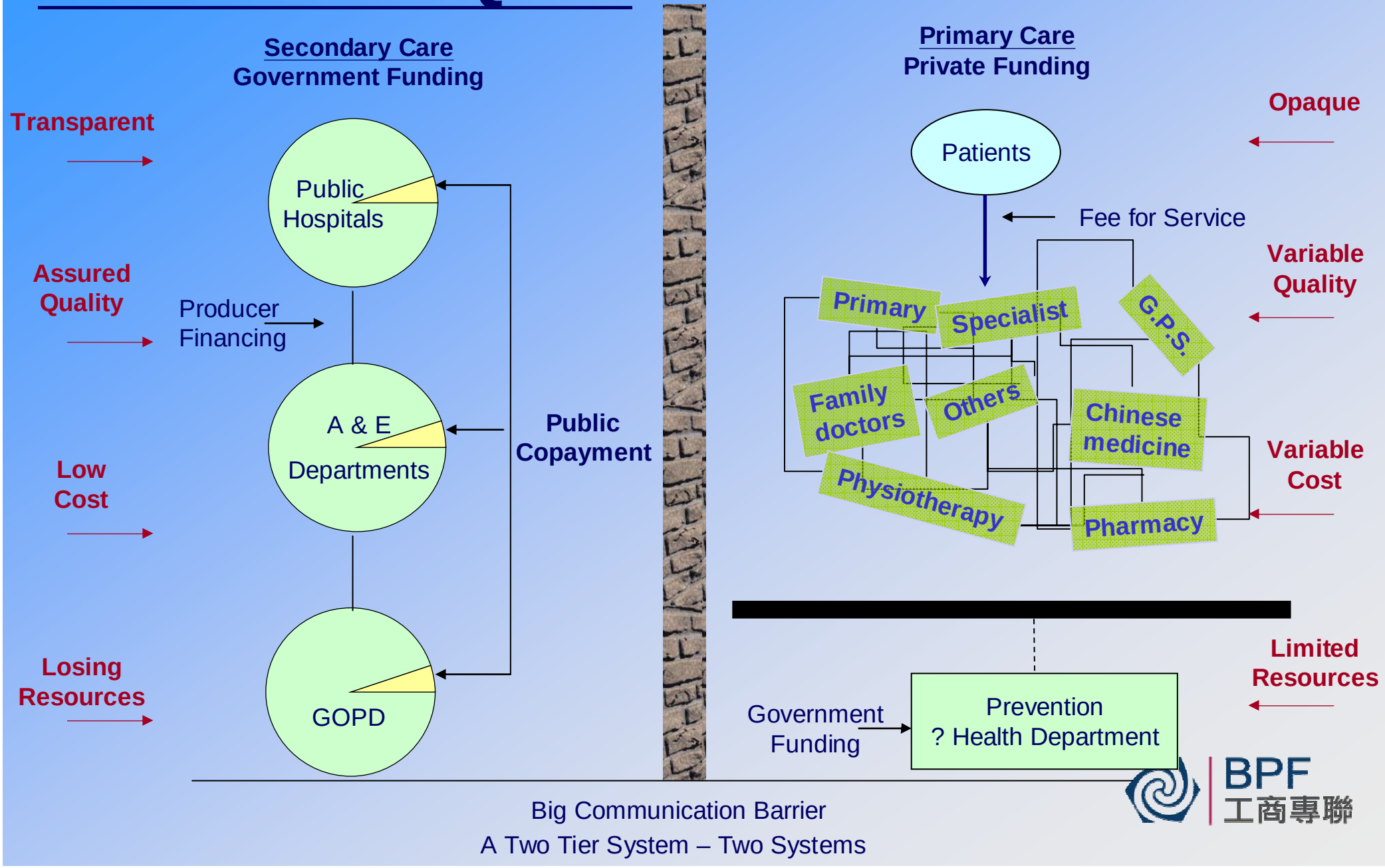
The "Status Quo"



But Many Think It Works – So Why Change It?

- The status quo is unsustainable
  - Growing pressure on public purse
  - Instability of publicly funded hospitals
  - Emphasis on primary care / prevention
  - Middle class main victims
- Beneficiaries of Change
  - Consumers
  - The medical profession
  - The economy
- If so many gain, why no progress?
  - Vested interests
  - The medical profession
  - Legco
  - Fear
  - Ignorance

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The Government Paper

- Excellent for discussion
- Long and complex
- Draws public debate to financing at the expense of debating delivery and governance
- Some issues unclear:
  - the “now” problems that need fixing now
  - how to achieve?
  - consumer benefit?
  - how does financing support change?

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Four Key Reform Issues

- Balance
- Coordination
- Governance
- Financing

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Four Key Reform Issues

- Balance
  - Taking pressure off public hospitals
  - Emphasis on primary care / prevention
  - Enhancing private sector role
- Coordination
  - Gatekeeping
  - Linking private / public
  - Joint venture – PPP
  - Electronic patient record - EPR

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Four Key Reform Issues

- Governance
  - This is the key
  - Managing priorities
  - Quality control
  - Cost control
  - Pricing
  - Human resources
- Financing
  - Facilitate structural change
  - Empower user
  - Spread burden
  - Equity
  - Stability

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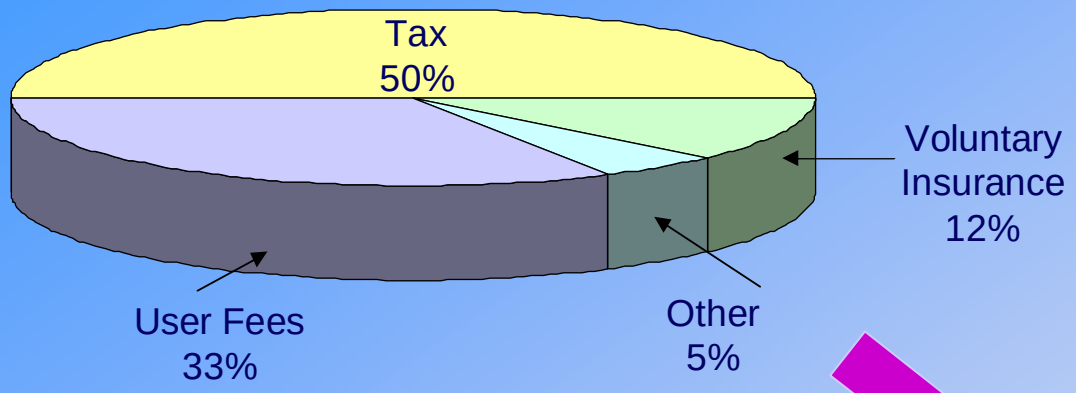
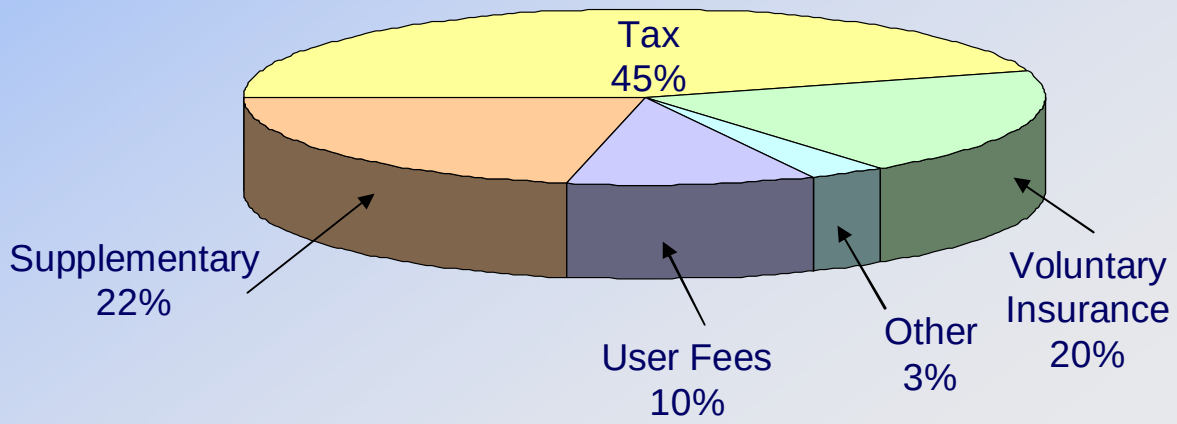
The Funding Mix

Now



Future



Towards a Better Balance

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Guiding Principles
“Values are the Key”

Generally Accepted

1. Availability of Healthcare to All
2. Self Responsibility
3. Risk Pooling (Capping)

Controversial

1. Equity
2. Wealth Redistribution
3. Mandatory/ Voluntary
4. Money Follows Patient

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The Financing Options

1. Social Health Insurance
2. Out of Pocket
3. Medical Savings
4. Voluntary Health Insurance
5. Mandatory Health Insurance
6. Personal Health Care Reserve

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1. Social Health Insurance

- Does not have to be employment / earnings based
- Taiwan
- A mainstream option

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2. Out of Pocket

- Increase public fees
- Level playing field
- Capping
- Not mainstream option

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3. Medical Savings

- Not funding per se
- Not risk pooled
- Doubtful saving adequacy
- Not mainstream option on own

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4. Voluntary Health Insurance

- Essential funding element
- No universal risk pool
- Not mainstream option

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5. Mandatory Health Insurance

- Risk pooled
- Community wide
- Relatively simple
- No direct support to primary care
- A mainstream option

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6. Personal Health Care Reserve

- Hybrid preferred by Government
- Some attractive features
- Complex administration
- Employment based
- Dependents / spouses?
- Preferred class?
- Fuels two tier system
- Mainstream option, if amended

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To Summarise

- Structure / governance are key
- Risk pooled supplementary financing essential
- Must be mandatory
- Community wide is the goal
- Government funding can be rerouted
- Employment based / partial community solutions are “short term”
- Out of pocket / voluntary insurance remain important

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Some Employment Related Issues

- Employer Contribution (Health / Retirement)
- Employment Based Funding
- Collection Agents
- Employee Mobility
- Employee (And Family) Medical Benefits
- Impact on SMEs

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TIME TO DECIDE