Healthcare Policy Forum's response to the consultation document, "My Health, My Choice – Healthcare Reform Second Stage Public Consultation Document"

Healthcare reform objectives that we endorse

- We start with an enunciation of the objectives of healthcare reform that we endorse:
  - containing the costs of care (as we believe that, given the omnipresence of resource scarcity, the healthcare system must possess a built-in mechanism for spending control.)
  - enhancing the quality of care (as we believe that the purpose of a healthcare system is to maximize people's healthcare gain, the system must have the capacity to provide care of good quality.)
  - improving access to care for all (as we are committed to the value of equal access to healthcare)

The voluntary health protection scheme (HPS) as we understand it

- Based on the consultation document, we understand that the purpose of the second stage consultation "My Health, My Choice" is to propose a voluntary health protection scheme (HPS).
- HPS is a scheme for standardizing and regulating voluntary private health insurance, aiming to ensure the quality and value-for-money of private healthcare services and private health insurance.
- HPS - standardized voluntary private health insurance - is proposed by the government as an option for reforming healthcare financing. It is considered as a supplementary healthcare financing arrangement.
- The government's choice of supplementary financing option is based on its understanding of public opinions that 1) the public have reservations about mandatory supplementary financing options in general and 2) the public prefer greater voluntary choice for individualized healthcare and voluntary private health insurance.
- The government proposes to use the $50 billion earmarked fiscal reserve to support healthcare reform by providing financial subsidies for the uptake of private health insurance.
- By ensuring value-for-money private health insurance and providing financial subsidies, the government seeks to encourage those who are able and willing to pay to subscribe to private health insurance and use private healthcare on a sustained basis as an alternative to public healthcare.
- Through this, the government claims that the pressure on the public healthcare system can be eased.
- The government also claims that HPS can enhance the long-term sustainability of Hong Kong's healthcare system.

The problem of the voluntary health protection scheme (HPS) as we see it

- We see no problem in the government pursuing a policy to regulate the private health insurance market and the private healthcare market in order to protect consumer/patient interests for the following reasons:
  - Intervening into the market when market failure occurs is one of the important functions of government.
  - And, it is well established that market forces do not work well in the healthcare insurance market and the healthcare market.
- We see problems however in the government adopting private healthcare insurance as a healthcare financing reform option and providing financial subsidies to encourage the uptake of private healthcare insurance for the following reasons:

- dubious understanding of public opinions
  - The government's understanding of public opinions on private insurance on which the proposal of HPS is based appears to be dubious. The findings of one of the focus group researches committed by the government indicate that voluntary private insurance was next to the least preferred option among middle-class focus group participants and was the least preferred option among participants with chronic illnesses. Instead, the research indicates that a "more progressive taxation system is preferred to the new supplementary financing options" among all focus group discussion participants.[1]
- inefficiency and cost-inflation of private insurance
  - The government's faith in the capacity of private insurance to enhance the long-term sustainability of Hong Kong's healthcare system is misplaced. Private insurance is not a measure to contain costs or to enhance efficiency or to deal with population ageing. International experience indicates that health systems relying more on private insurance to fund healthcare tend to be more expensive but lacking in evidence of improved health outcomes, whereas systems confining private insurance to the periphery tend to be more able to keep healthcare costs under control.[2]
- harming rather than helping the public healthcare system
  - The government's belief in the capacity of private insurance to ease pressure on the public healthcare system is also misplaced. International evidence shows that private healthcare is not only unlikely to help the public healthcare system but may actually harm the system in time.[3]
- injustice in using public money
  - The government's proposal to use public money to subsidize the purchase of private insurance raises the issue of justice. Justice demands that everyone be treated equally unless there are good reasons for doing otherwise. However, as the higher one's income, the more likely one can afford and will purchase private insurance, the government's proposal amounts to saying that the higher one's income, the more likely one can enjoy the privilege of better healthcare choices and protection supported by taxpayers' money. It is counter-intuitive that "earning more" or "being richer" is a good reason for deserving a greater share or higher priority in the use of public money.[4]

The objections we raise to the voluntary health protection scheme (HPS)

- Given the healthcare reform objectives we endorse, we fully support the government's objectives to 1) ease the pressure on the public system and 2) enhance the long-term sustainability of Hong Kong's healthcare system.
- Nonetheless, given the available research evidence mentioned earlier, we do not agree that private healthcare insurance is a correct policy tool for achieving the two objectives above.
- On the ground of justice, we also oppose using public money to subsidize the uptake of private insurance. The government's proposal will only move our healthcare system in the

[1] For more discussion on this, see our article entitled "*Findings of Government-Commissioned Opinion Poll on Healthcare Reform & Funding – Omitting Inconvenient Truths?*" in Appendix 1.

[2] For further elaboration on this, see our article entitled "*Sustaining the healthcare system by private insurance?*" in Appendix 2.

[3] For more on this, see our article entitled "*Helping or harming the public healthcare system?*" in Appendix 3.

[4] For more discussion on the issue of injustice of the government's proposal, see our article entitled "*The injustice of proposed private healthcare insurance scheme*" in Appendix 4.

direction of greater inequality in the access to healthcare, which goes against the fundamental value of equal access to healthcare of public healthcare systems in many advanced countries. We find subsidizing this greater inequality by public money unacceptable.

- Notwithstanding our objections, we have no intention to call for an overhaul of HPS.
- We agree that the government should take an active role in regulating the private insurance market and the private healthcare market for better consumer and patient protection.
- What we disagree with is adopting private insurance as a policy tool for reforming healthcare financing and using public money to support the uptake of private insurance.

The possible ways forward

- We propose that HPS should be re-conceptualized as a consumer/patient protection policy rather than a healthcare financing reform policy.
- As regards healthcare financing reform, given the government's objectives of enhancing the long-term sustainability of Hong Kong's healthcare system and easing the pressure on the public healthcare system, we believe the two following research findings may provide some pointers on possible directions:
  - "There is a consensus among most health economists, although the evidence base is incomplete, that single pipeline funding enables effective cost control. Thus, those countries which are single-pipeline financed by taxation can, by control of public expenditure limit cost inflation better than countries where funding is fragmented (for example, the USA). Once funding is fragmented, direct control of one pipeline tends to be compensated by inflation in funding via another."[5]
  - "... a resort to private finance is, on balance, more likely to harm than help publicly financed systems ... For those who would seek to improve publicly financed systems, the locus of reform efforts must remain the public system itself."[6]
- These two pieces of findings suggest that a more effective and efficient use of the $50 billion fiscal reserve would be to use it on improving the current tax-based public healthcare system rather than on supporting the uptake of private healthcare insurance.
- Such a use of the fiscal reserve can at same time meet the requirement of justice as the improved public healthcare system can be enjoyed by all.
- One innovative supplementary healthcare financing option is to use the $50 billion fiscal reserve to set up a public healthcare foundation for generating income. The income generated each year is then to be used to finance the public healthcare system.
- Alternatively, part of the income generated can be saved up and re-invested into the foundation for generating additional income. This way, the foundation will be like a medical savings account of the society as a whole, which is also a way of coping with population ageing.
- Depending on the soundness of the government's financial position and the level of financial reserves, more money can be earmarked for healthcare financing and put into the foundation in the future.
- Admittedly, all these suggestions are very preliminary, but they appear to provide a promising way forward.

Healthcare Policy Forum
3 December 2010

---

[5] A. Maynard. 2001. Ethics and health care "underfunding". *Journal of Medical Ethics* 27: p. 225.

[6] Carolyn H. Tuohy, Colleen M. Flood, and Mark Stabile. 2004. How does private finance affect public health care systems? Marshaling the evidence from OECD nations. *Journal of Health Politics, Policy, and Law* 29(3): p. 393.

Endorsed by:

1. Mr George Cautherley
   (Convenor, Healthcare Policy Forum; Vice-Chairman, Hong Kong Democratic Foundation)

2. Mr Richard Tsoi
   (Deputy Convenor, Healthcare Policy Forum; Convenor, Power for Democracy)

3. Prof Peter P. Yuen
   (Dean, College of Professional and Continuing Education, The Hong Kong Polytechnic University)

4. Prof Joseph Cheng Yu-shek
   (Executive Committee Member, Power for Democracy)

5. Dr Fernando Cheung Chiu-hung
   (Lecturer, Department of Applied Social Sciences, Hong Kong Polytechnic University; Chairperson, The Forthright Caucus)

6. Mr Tim Pang Hung-cheong
   (Community Organizer, Society for Community Organization)

7. Mr Alan Leong
   (Legislative Councillor – Kowloon East, Civic Party)

8. Dr Kwok Ka-ki
   (Convenor, Caring Hong Kong)

Findings of Government-Commissioned Opinion Poll on Healthcare Reform & Funding – Omitting Inconvenient Truths?

To prevent oneself from being deceived by statistics, "about the first thing to look for is bias", advises Darrell Huff in his now classic book *How to Lie with Statistics*. Bias can be conscious or unconscious. Conscious bias may be "selection of favourable data and suppression of unfavourable(*sic.*)". Huff's advice applies to the reading of reports of all kinds, we believe.

Thus, when the recently released *Report on First Stage Public Consultation on Healthcare Reform* says two surveys and two focus group researches had been conducted to garner the public's views on healthcare reform and yet only three were made reference to in the chapter on public responses to healthcare financing reform, our attention was naturally drawn to the omitted one – the focus group research conducted by an academic at the Hong Kong Polytechnic University.

Admittedly, data relevance or quality may be the reason for the omission of the particular focus group research. However, after going through the research, it appears that this is not the case

Citing one of the surveys, the government says in the *Report* that voluntary healthcare insurance (VHI) was ranked by the public as the most preferred supplementary healthcare financing option. The level of support was even higher among high and middle-income groups. By contrast, the omitted focus group research found that although there was no overwhelming support for any supplementary healthcare financing option, VHI was next to the least preferred option among middle class focus group participants and was the least preferred option among participants with chronic illnesses. Two further related findings from this focus group are interesting to note: (1) some well-educated middle class focus group participants were skeptical about earlier survey findings which indicated that "most middle-class residents of Hong Kong preferred voluntary health insurance to other financing options". They "believed respondents in the survey were provided with limited information or inadequate explanations of the six financing options." (2) most focus group participants with chronic illnesses strongly advised the government not to implement the VHI option as they believed that insurance companies would be the primary beneficiaries.

The government says, by citing the same survey, that social health insurance (SHI) was relatively less favoured across all segments. It also says, by citing another focus group research, that "there was considerable concern that SHI would impose extra financial burden to (*sic.*) the working population". The omitted focus group research, however, found that most middle class focus group participants showed particular interest in SHI and their attitude was generally supportive. The same participants also seemed not to resist the idea of wealth redistribution behind social health insurance because of the wide gap between rich and poor. In fact, relatively few of them mentioned any drawbacks of SHI. Likewise, SHI was generally accepted by participants with chronic illnesses.

The government says, by citing the same survey again, that "tax increase consistently received the least support" and "higher income groups were less in favour of tax increase". Yet, the omitted

focus group research found that a "more progressive taxation system is preferred to the new supplementary financing options" among all participants. Tax increase, "through direct or indirect means, is the preferred option of many middle-class participants, if the tax base can be broadened to put more pressure on the highest-income groups." The middle-class participants at the same time "felt very strongly that the existing taxation system has placed an undue burden on the middle class" and believed that "taxation was an equitable means of health-care financing only if the taxation system is truly progressive." The views of participants with chronic illnesses on tax increase were similar to those of the middle-class participants. They agreed that "the financial burdens on the middle class are disproportionate."

Several other findings of the omitted focus group research are also worth noting and pondering. It was found that given sufficient explanation, most participants could understand the social values underlying different healthcare financing options, namely, equity, wealth redistribution, risk-sharing, and freedom of choice. Most importantly, it appears that the participants did not feel that these values are necessarily mutually exclusive.

On equity, many high income and upper-middle income participants were supportive of the value, and they endorsed the value in healthcare access and financing.

On wealth redistribution, "[m]any participants were willing to pay more tax or to participate in a social insurance scheme to ensure equal access to health care for the elderly and the poor."

Though the same research does point out that participants might shift their commitment to such values if their interests were to be affected, taking all findings as a whole, it is not illegitimate to conclude that participants were not categorically opposed to equity, wealth redistribution, and tax increases.

This leads us to cast doubt on the government's general observation regarding the public's views on healthcare financing reform in the Executive Summary of the *Report*, that "while the public was generally receptive to the notion that the less-fortunate should be protected by the healthcare system and helped by the better-off, many considered that the current public healthcare system funded by taxpayers had already catered for the low-income and underprivileged, and tended to favour proposals catering for individuals' healthcare needs rather than pooling resources to subsidize the population as a whole." In light of the findings of the omitted focus group research, we suspect that given sufficient deliberation and balanced policy design, Hong Kong people are not unwilling to accept a healthcare financing arrangement based on a progressive taxation system.

To be fair, the government did hint at the presence of a whole host of alternative views in the *Report* by using phrases such as "some others pointed out" or "some others said". And it is mainly behind such phrases that the afore-mentioned research findings were fleetingly mentioned. This begs the question of why the research findings, which were from one of the government's own sponsored studies, had not been given as much attention as those of the other three government studies. Echoing Darrell Huff, one cannot but wonder whether the slight was conscious or unconscious.

Sustaining the healthcare system by private insurance?

Regulating the private health insurance market and industry to protect consumer interests would seem uncontentious as a public policy objective. What would be contentious is using private insurance as a policy tool to "enhance the long-term sustainability of our healthcare system" through encouraging the uptake of private insurance with public subsidies. For this policy tool to have a chance of helping sustain the healthcare system, apart from bringing more private funding to the system, private insurance must at least be able to contain healthcare costs and improve the quality of care. If not, the "alleged" runaway costs now blamed on the public healthcare system can similarly break the private purse. The government's faith in the cost-containing and quality-enhancing capability of private insurance however appears misplaced.

Australia, like Hong Kong, introduced a policy in 1998 to proactively encourage the uptake of private healthcare by providing a 30% subsidy on premiums to ease pressures on the public system and to contain healthcare costs. Notwithstanding the fact that Australian private healthcare insurance is highly regulated and premium increases require government approval, premium rises have been well above general inflation since the introduction of the policy. According to official statistics, annual increases in premiums averaged over 6% between 2002 and 2009. The projection is that premium increases higher than general inflation will continue. Meanwhile, Australia's total healthcare expenditures have risen with the increase in private insurance coverage. According to OECD data in 2005, the country's rate of increase in total healthcare expenditures was higher than other advanced countries.

Leonie Segal, Deputy Director at the Centre for Health Economics, Monash University argues that the private insurance policy has made the healthcare system less rather than more efficient, and calls for a total overhaul of the policy to transfer the insurance subsidy to the public system instead.

The Australian case is in fact not atypical. It simply confirms the empirical observation that health systems relying more on private insurance to fund healthcare tend to be more expensive but lacking in evidence of improved health outcomes, whereas systems confining private insurance to their periphery tend to be more able to keep healthcare costs under control.

The costliness of private insurance lies less in moral hazard – over utilization and over treatment – than it is commonly believed. All forms of healthcare insurance – private or public (tax-based or social insurance) – are subject to moral hazard so long as they are third-party paying systems. What makes private insurance more expensive than a public system is its lack of cost-containing measures and capability. As governments are in control of a single pool of funding in public systems, they have greater bargaining powers vis-à-vis healthcare providers and hence greater ability to exercise cost and quality control than private insurance systems. Cost measures like global budgets and price regulation used in public systems are absent in private insurance systems.

It has always been argued that competition in private insurance market can help contain costs and keep premiums low. However, market force does not necessarily work. Because of information asymmetry, the public may have difficulty in comparing insurance products, the performance of different insurers as well as the quality of care of different providers. The transaction costs of switching insurance plans across different insurers may be high. Also, as noted above, insurers may be simply unable to compete on premium prices as they lack bargaining powers to negotiate with healthcare providers on prices and quality.

High overhead costs are another major factor accounting for the costliness of systems replying more private insurance. The costs may also further limit insurers' ability to compete on premium prices. Marketing, underwriting, billing, claims administration, dispute arbitration, and contracting with providers have to be paid for on the part of insurers though all these activities contribute to no one's health. In public systems, most of these activities do not exist. In the United States, according to an OECD study, the administrative cost of private insurers is about 11.7% while the corresponding costs of the public programmes Medicare and Medicaid are only 3.6% and 6.8% respectively. Likewise, in Australia, the administrative cost of the public system is about 3.7% while that of the private insurance industry averages about 11.1%. Similar levels of administration costs of private insurers are found in other OECD countries: Netherlands (10.4%), Canada (13.2%), Ireland (9.7%) and Germany (14%). The figures do not necessarily suggest mismanagement in the private insurance industry but simply that room for cutting administration cost in the long run is limited and that at the same level of healthcare output, systems with a greater private insurance presence are bound to be more expensive.

The OECD concludes in a country report regarding the experience of Australia that: "Private funds have not effectively engaged in cost controls. They seem to have limited tools and few incentives to promote cost-efficient care". One may try to argue that the Australian experience is not directly transferable to Hong Kong. Yet, it is difficult to avoid the following general conclusion in another study summarizing OECD experience: "It is important to be realistic about the potential benefits of competitive [private healthcare insurance] markets and what they mostly likely will not achieve. For example, cost-containment within health system is often best achieved through means other than an expansion of private health insurance's role."

The challenge that confronts the Government is to demonstrate convincingly to the community that its voluntary private insurance package contains unique elements that can protect against the negative outcomes that have been the experience of publicly subsidized health insurance in other jurisdictions so far.

Hong Kong Democratic Foundation/
Healthcare Policy Forum
25 October 2010

Helping or harming the public healthcare system?

The proposed private healthcare insurance scheme will benefit everyone, says the SAR government. The proposed scheme will benefit not only people who can afford private healthcare insurance (PHI) but also those who cannot, as well as the insurance industry. According to the government, the objective of the scheme which is relevant to those who cannot afford private healthcare insurance is this: through encouraging the uptake of PHI, the pressure on and thus the waiting lists in the public healthcare system can be eased. For those who cannot afford PHI then, it is entirely legitimate to ask whether the promise can be delivered, particularly when the uptake of PHI is going to be subsidized by public money. Given international experience, we are concerned that not only is PHI not likely to help the public healthcare system, but it may actually harm the system in time.

Indeed, one of the consultancy reports committed by the government has provided some evidence in this regard. Reviewing related literature, the consultancy reports that "there is as yet no concrete evidence" that PHI can relieve pressure on public hospitals. Citing Australia's PHI experience as an example, the consultancy says that the conclusions from different academic studies on the topic are mixed. Summarizing the findings of an OECD study on PHI, the consultancy writes: "PHI has not significantly assumed financing burdens from the public sector. Cost shifting from publicly to privately financed providers in systems with duplicate PHI has remained small."

In addition to the government consultancy's research findings just cited, we would like to supplement a couple of others here. Regarding Australia's experience, a study by an academic at La Trobe University is worth noting. The study concludes that it "has confirmed the findings of previous overseas studies that suggest that increased private sector activity is associated with increased public sector waiting times, the reverse of the rhetoric supporting policies to increase support for the private sector in order to 'take the burden off the public sector'." This study at the same time echoes the view of the Canadian Health Services Research Foundation that the hypothesis of reducing waiting time in the public sector through expanding the private sector is a "myth".

Concerning the experience of OECD nations, another study on five OECD nations by academics at the University of Toronto is equally important not to miss. It says: "International evidence ... provides no grounds for believing that the existence of a privately insured sector parallel to the public sector reduces overall waiting lists or times." "Waiting lists for publicly financed services are likely to respond to infusions of public, not private, finance." "**Indeed, a resort to private finance is, on balance, more likely to harm than help publicly financed systems** ... For those who would seek to improve publicly financed systems, the locus of reform efforts must remain the public system itself."

The findings that PHI cannot help but may in fact harm the public system are not difficult to explain. In the short to medium run, the supply of crucial medical resources, in particular medical personnel, is constrained and highly inelastic. Expanding the private sector will only draw resources out of the public sector and thereby reduce its capacity. Greater competition for limited

supplies of medical resources between the two sectors will also bid up the prices of these resources. Cost inflation will result.

The private sector has an incentive to "cherry pick" the most profitable cases and less complicated cases while referring less profitable and more complicated cases to the public sector. If private wards and care services are available in the public sector, such perverse incentives will be further enhanced. Patients with PHI in this situation will also have an incentive to use private facilities in the public hospitals for more complicated illnesses. Given the general lack of critical-care facilities in private hospitals, public hospitals at the same time have to serve as a backup for all serious adverse contingencies in private hospitals. In the end, as an academic writes in the context of Australia, "nearly all emergencies and most of the oldest, poorest and sickest patients will be cared for publicly". There is evidence in Britain that length of stay in public hospitals is longer in areas with high levels of private inpatient services. Data from Australia also suggest that average complexity of cases is higher in public than in private hospitals. With shrunken capacity but increasing complexity of cases, that pressures on public hospitals will increase rather than reduce should be expected.

In systems where doctors can practise in both the public and private sectors simultaneously, there is yet another perverse incentive which bears on the length of waiting lists in the public sector. As payment levels are in general higher in the private sector, doctors may have an incentive to maintain lengthy waits or manipulate waiting lists in the public sector in order to increase demand for their private practice. Indeed, the OECD study studied by the government consultancy mentions this particular issue, as it writes: "In some countries, incentives created by higher payment levels in PHI markets have also encouraged providers to maintain long queues in the public system or refer patients to owned private facilities in order to sustain their private practice."

The government consultancy projects that PHI would relieve the patient load of public hospitals. However, it seems that its projection has neither modeled in the shift of medical personnel between the public and private sectors nor the long term supply of medical personnel. It is also unclear whether the projection has taken into account the perverse incentives of providers mentioned above – the perverse incentives of cherry picking and maintaining lengthy waits.

In the government consultation document, only the issue of healthcare manpower is discussed. There is no mention of the two perverse incentives of providers. The government even indicated recently that doctors might be allowed to practise in the private and public sectors simultaneously and expanding private facilities in public hospitals. All these add to our worry that the proposed private healthcare insurance scheme will only benefit people who can afford PHI and the insurance industry at the expense of the public system. The case that the proposed scheme will benefit everyone remains to be made by the government.

Hong Kong Democratic Foundation/
Healthcare Policy Forum
10 October 2010

The injustice of the proposed private healthcare insurance scheme

In the recently-released healthcare financing consultation document, the government says it has listened carefully to society's views: that people value "voluntary choice for public or private healthcare" and that they want "more choices and better protection in private healthcare". In the government's perception, citizens are all classical utility maximizers – they all want to maximize their own healthcare choices and protection through being able to switch between the public and private healthcare sectors at wish. How far this understanding of citizens' preference on healthcare is accurate we do not know. There must however be not a few people who treasure the public healthcare system and its underlying principle of equal access to healthcare, and as many who do not wish to count on the private sector.

Be that as it may, the government says it can play an "active role" in helping maximize citizens' choices and protection. The proposed private healthcare insurance (PHI) scheme is said to gear towards providing us with "better choices for lifelong protection". The government claims that it will be our "lifelong health partner" and will consider providing financial subsidies to assist us to uptake PHI so that we will have more choices and better life-long protection.

Nominally, the scheme and the subsidies are for every citizen. But the truth is that not every citizen can afford PHI. The "we" in the PHI scheme does not really include everyone. The government knows well that the PHI scheme and the subsidies are in fact for those who are able to pay for PHI only. Specifically, according to a consultancy report commissioned by the government, the scheme actually targets individuals with monthly incomes over $10,000 and those who currently have PHI. Official statistics have shown that the higher one's income, the more likely one can afford and will purchase PHI. Under the proposed scheme therefore, it becomes that the higher one's income, the more likely one can enjoy better healthcare choice and protection, the privilege being supported by taxpayers' money. In short, the PHI scheme provides disproportionate benefits to those on higher incomes. This raises the issue of justice in using public money.

Justice demands that everyone be treated equally unless there are good reasons for doing otherwise. Applying this principle to our context means that the better healthcare choice and protection supported by government subsidies should be made available to every citizen unless there are justifiable reasons for conferring the benefit on high-income people only. In theories of justice, two common arguments for differential treatments are needs and merits. But neither needs nor merits justify giving more publicly-supported benefits to high-income people in our case. There is no reason why the need of those on high incomes for quality healthcare protection should or could trump the same need of others and can have greater claims on public money. Likewise, it is counter- intuitive that people on higher incomes deserve better healthcare protection and more government subsidies simply because they earn more.

Quite the contrary, our moral intuition enjoins that given the same healthcare need, no individual's need should have higher priority or a greater claim on public money over the need of others. In this connection, it is worth recalling that equal access to healthcare – healthcare

distributed on the ground of healthcare need only – is the fundamental value of public healthcare systems in many advanced countries. In our view, instead of supporting high-income people to purchase PHI, a just use of public money should be on improving the public healthcare system so that better protection can be enjoyed by every citizen.

Even if the government thinks it has good reasons for giving PHI subsidies to the relatively well-off, there is little explanation for such a position in the consultation document. The only guiding value for using public money is "cost-benefits" – that public money should be used to achieve the objectives of the PHI scheme in the most cost-effective way. The government is however totally silent on the justice of the objectives now proposed. As it stands, the PHI scheme will only move our healthcare system in the direction of greater inequality. Those on higher incomes will have improved access to healthcare – they will be able to access both private and public healthcare as suits their needs. Such inequality is now being advocated and proposed for institutionalization by our government, using public money!! The government may reply that the relatively less well-off will also benefit as the PHI scheme relieves pressures on the public system. Even if this projection is correct, which we have ground to doubt very much, the problem of inequality in the access to healthcare supported by taxpayers' money remains. We await the government's engagement on the fairness of its proposed scheme.

Hong Kong Democratic Foundation/
Healthcare Policy Forum
17 October 2010