For discussion on
19 March 2012

Legislative Council Panel on Health Services
Subcommittee on Health Protection Scheme

Roles of Public Funding and Health Insurance in Financing Healthcare Services

PURPOSE

This paper gives an overview of the roles of public funding and health insurance in financing healthcare services. It also examines the advantages and disadvantages of a Government funding model, and that of a voluntary and government-regulated private health insurance (PHI) model.

THE EXISTING HEALTHCARE SYSTEM

2. Hong Kong's healthcare delivery system is characterized by its dual public and private healthcare sectors. Both sectors cover the various levels of care from primary to the more specialised secondary and tertiary care. The public sector is the predominant provider of secondary and tertiary healthcare services. Around 90% of in-patient services (in terms of number of bed days) are provided by public hospitals. There are around 27 000 hospital beds in public hospitals, accounting for about 87% of total hospital beds in Hong Kong. The private sector is the major provider of primary healthcare services, with about 70% of out-patient consultations being taken care of by private medical practitioners.

3. The public healthcare system is the cornerstone of our healthcare system, acting as the safety net for all so that no one should be denied adequate healthcare through lack of means. Over the years, the Government has made substantial and sustained investment to improve our public healthcare services. We have progressively achieved a substantial increase in recurrent health expenditure from $31.6 billion in 2007-08, by over 40%, to almost $45 billion in the 2012-13 Estimates, in line with the Chief Executive's target to increase recurrent expenditure on health to 17% of total government recurrent expenditure.

4. The Government's commitment to public healthcare remains strong and unchanged, and will be strengthened on a continuous basis while taking forward healthcare reform. Apart from increase in recurrent government expenditure on health, we have made continuous efforts to deploy resources for expanding our public healthcare infrastructure, building new hospitals and improving existing hospital facilities. Projects currently underway include construction of the North Lantau Hospital Phase One, and improvement works for Tseung Kwan O Hospital, Yan Chai Hospital and the Caritas Medical Centre. We have also reserved funding for construction of the Tin Shui Wai Hospital and the Centre of Excellence in Paediatrics at Kai Tak which will serve the whole territory, expansion of the United Christian Hospital and redevelopment of Kwong Wah Hospital and Queen Mary Hospital. In addition to capital works projects on hospitals, in the past few years, the Government has continued to provide Hospital Authority with around $500 million each year for acquisition and upgrading of its medical equipment.

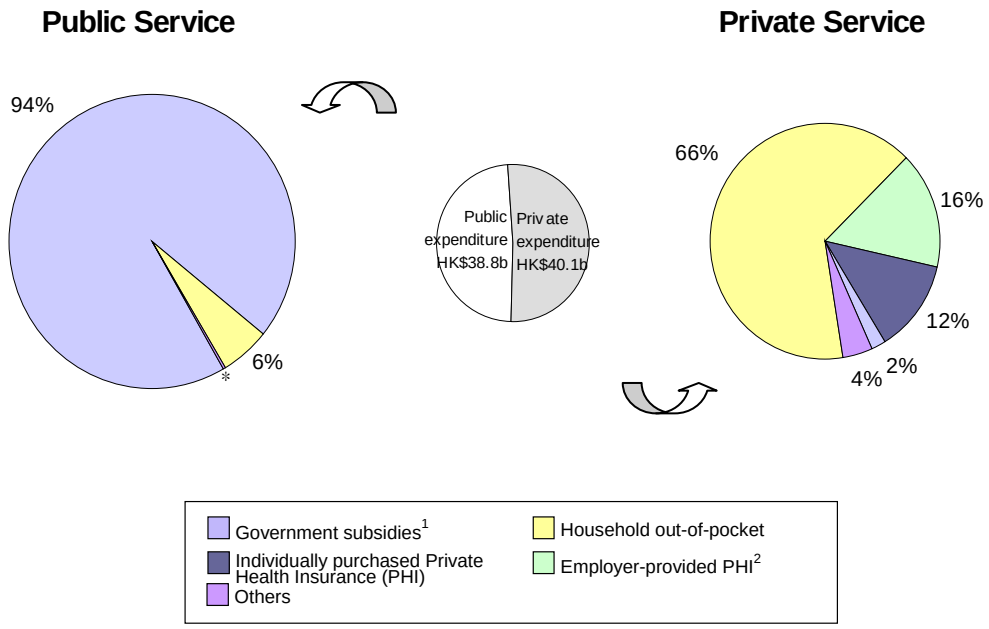
5. Alongside with a robust and strengthened public healthcare system, the private healthcare sector plays a complementary role to public healthcare services by offering an alternative to those who could afford and are willing to seek private services for a variety of reasons, including choices over doctors and amenities, immediate access to treatment with shorter waiting time, in particular for elective procedures, and personalized service and arrangement that suits different needs and preferences. At present, there are twelve private hospitals providing in total around 4 000 private hospital beds. The total number of private hospital inpatients treated in 2010 was about 382 800.

EXISTING FINANCING OF HEALTHCARE SERVICES

6. The public and private healthcare services each account for roughly equal amount of health expenditure, reaching $38.8 billion and $40.1 billion in 2007-08[1] respectively. Public healthcare services were almost fully financed by public funding from government budget – only about 6% came from out-of-pocket household expenditure and the remaining 94% of the cost was financed by government funding. Private healthcare services were mainly financed by out-of-pocket household payment (66%) and insurance pay-out (28%) (**Chart**).

[1] Source: Hong Kong's Domestic Health Accounts as at 2007-08.

Chart Total health expenditure in 2007-08 by financing source of public and private services



Note: * figures smaller than 0.1%
[1] include expenditure on civil servant and Hospital Authority staff medical benefit
[2] exclude expenditure on civil servant and Hospital Authority staff medical benefit
Source: Hong Kong's Domestic Health Accounts: 2007-08

7. With regard to the financing role of PHI, it is worth noting that PHI is a sizeable and growing healthcare financing source in Hong Kong. According to the Thematic Household Survey (THS) conducted by the Census and Statistics Department (C&SD) in 2009, there were around 2.56 million people covered by PHI (slightly more than one third of Hong Kong's population). PHI has been playing an increasingly significant role in financing health expenditure — the overall share of PHI in healthcare financing increased from 11.9% to 13.8% from 1989-90 to 2007-08[2]. The financing role of PHI varied with the type of health expenditure. On private inpatient care, PHI was the major financier, accounting for 55% of expenditure involved in 2007-08. As regards private outpatient care, the financing share of PHI was at a relatively smaller proportion of 24.2%.

8. It is observed that people covered by PHI have a higher tendency to use private hospitals for inpatient care. As estimated by a consultant commissioned by the Food and Health Bureau in 2010, for people covered by PHI, 63% of the hospital admissions pertained to the

[2] Source: Hong Kong's Domestic Health Accounts as at 2007-08.

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private sector. For people without PHI cover, only 10% of the admissions pertained to the private sector. Notwithstanding the above, over one third of the admissions of people covered by PHI still pertained to the public sector. There are various reasons for this, including emergency cases and cases requiring inter-disciplinary care (which are usually treated at public hospitals), avoidance of out-of-pocket payment when the insurance protection is insufficient to cover all the private hospital expenses, and budget uncertainty when the insured cannot ascertain the out-of-pocket payment in advance to receiving treatments.

ADVANTAGES AND DISADVANTAGES OF HEALTH FINANCING MODELS

9. In 2008 and 2010, we conducted two stages of public consultation on healthcare reform with a view to developing supplementary financing options and enhancing the long-term sustainability of our healthcare system. We examined in detail the advantages and disadvantages of a Government funding model (i.e. rely on government revenue to meet the increasing expenditure required to meet healthcare needs), and that of a voluntary and government-regulated PHI model, namely the Health Protection Scheme (HPS). The advantages and disadvantages of these two models are summarised in the ensuing paragraphs.

Advantages and Disadvantages of Government Funding Model

10. The Government funding model has the following advantages –

(a) **Equitable healthcare**: a publicly-funded healthcare system provides every member of the public with equitable access to the same level and standard of healthcare services at the same highly-subsidized rate.

(b) **Simple and low-cost administration**: with well-established mechanisms for the collection of tax and adjustment of tax rates, financing healthcare by increasing the existing types of taxes is simpler to administer and incurs less extra cost.

(c) **Wealth re-distribution**: financing healthcare by tax revenue has the effect of requiring taxpayers with higher income to subsidize

the healthcare for the rest of the population.

11. On the other hand, relying predominantly on government revenue to finance healthcare has the following disadvantages –

(a) **Inadequate choice in healthcare services**: healthcare services provided by the public healthcare system financed by government revenue are supply-controlled, and will inevitably involve queuing and waiting for healthcare services, as well as allocation of services based on clinical needs assessed according to established criteria and protocols. In providing equitable access, a tax-funded healthcare system can only provide services within prescribed scopes, including specified formulary, to eligible members of the public. It will therefore limit choices and thus competition among service providers.

(b) **Lack of incentives for judicious use of highly-subsidized public healthcare and not conducive to enhancing public sector efficiency and cost-effectiveness**: the continued highly-subsidized healthcare services offered by the public system would not provide enough incentives for judicious use of such services. With virtually no competition from the private sector, there is no added incentive for the public sector to drive for even greater cost efficiency and cost-effectiveness.

(c) **Encourage over-reliance on highly-subsidized public healthcare**: relying predominantly on government revenue to finance healthcare would mean further expansion of the share of public sector in the healthcare market. This is not conducive to stimulating healthy competition in the market.

(d) **Unsustainable financing**: the current tax-base is narrow and government revenue is relatively dependent on economic cycles. It would not be sustainable to continue to increase the share of health expenditure in government budget without limit, and the limit will be affected by the economic performance of Hong Kong.

(e) **Rising tax bills and expanding government budget**: financing healthcare predominantly with government revenue will eventually result in continued increase in tax rates and expansion of public expenditure in the economy, departing from the small government principle and low tax regime, which are key to our competitiveness. It is doubtful if it would be viable to raise the rates of existing taxes to a significant extent in order to meet the increasing health expenditure. The tax burden on the future generation would become greater as Hong Kong's demography changes to a smaller working population supporting a larger elderly population.

Advantages and Disadvantages of Voluntary and Government-Regulated PHI Model

12. A voluntary and government-regulated PHI model — the HPS — was proposed in the Second Stage Public Consultation on Healthcare Reform in 2010. The advantages of this model are –

(a) **Enhance consumer protection**: under the HPS, participating insurers are required to offer standardised health insurance plan(s) providing the subscribers with benefit coverage and reimbursement levels that would enable them to access general ward class of private healthcare services when needed. Key features of the HPS plans such as no turn-away of subscribers and guaranteed renewal for life; covering pre-existing medical conditions subject to waiting period; accepting high-risk groups through high-risk pool mechanism; and transparent insurance costs including claims and expenses, etc., are designed to offer better protection, value-for-money services to consumers, as well as an alternative to those who are willing and may afford to pay for private healthcare services.

(b) **More choice of services**: PHI provides an individual with more choice of healthcare services. Although the basic level of benefits of the standard plan(s) under the HPS is the same for all, the insured would still enjoy greater freedom in choice of services (e.g. provider, timing of treatment, etc.). Individual may also customize the scope of services, the level of benefits,

and the class of amenities according to his own choice through purchasing optional top-up/add-on coverage.

(c) **Individual's choice to reduce financial risk**: it remains an individual's choice to take out voluntary PHI. The insured can effectively off-load a substantial portion of his financial risks arising from falling ill. PHI could be an effective means to provide risk-pooling for an individual's health risks once issues such as anti-selection and moral hazards are effectively addressed.

(d) **Strengthening the role of private sector alongside public system**: by continuously inducing greater transparency and competition as well as protecting consumer interests in the PHI and private healthcare services, the HPS should facilitate the public's sustained access to value-for-money private healthcare services and enhance their ability to get health insurance protection through PHI on a long-term basis. It should also better ensure that private health funding is channelled to meet healthcare needs of the population effectively and efficiently, which in turn should serve as a catalyst to further mobilize private financing for healthcare in the future.

(e) **Relieving pressure on the public healthcare system and enhancing long-term sustainability of healthcare system**: by making PHI more affordable and private healthcare services a more attractive option to the public, and by maintaining its attraction and affordability into the future as the population ages and as the insured get older, the HPS should help divert to the private healthcare sector some of the healthcare needs that would otherwise have to be met by the public healthcare system. With more people choosing value-for-money private services through the HPS, the HPS can help ease the pressure of the public system, so that the public healthcare services could strengthen its role to focus resource on targeted services areas and population groups, namely (i) acute and emergency care; (ii) low income and under-privileged groups; (iii) illnesses that entail high costs, advanced technology and multi-disciplinary professional team

work; and (iv) training of healthcare professionals.

13. A voluntary and government-regulated PHI model has the following disadvantages –

(a) **Regulatory capacity and costs**: the current regulatory regime for insurance focuses on solvency of insurers and does not extend to product or premium regulation. The current insurance regulatory regime will have to be revamped to cater for the requirements of the HPS and to accord better protection to those who choose to take out PHI. The HPS will require much stronger regulatory involvement on the part of the Government in terms of regulatory capacity, infrastructure and expertise.

(b) **Incur administration costs**: if compliance with the HPS requirements involves substantial administrative works for insurance companies, the premium may have to be increased to compensate for the higher administrative cost or else the insurance companies may refrain from participating in the HPS if such overhead cost is prohibitive.

(c) **Less stable financing**: compared with the Government funding model, financing by voluntary PHI is less stable as the amount of financing would depend on the financial strength of individuals, which in turn could be subject to factors such as economic cycles.

(d) **May encourage tendency to overuse healthcare**: PHI is susceptible to moral hazards and may encourage the tendency of patients to overuse healthcare, since a third party (i.e. insurers) will bear the cost of utilizing healthcare services. However, the uniform structure and coverage of standard plan(s) under the HPS would allow better control of utilization through design of the scheme in terms of coverage (e.g. to cover services less easily abused) and other rules for claims (e.g. by requiring co-payment or deductible for services that may be subject to abuse) to minimize the potential of abuse or overuse.

(e) **Concern over premium increase over time**: while the utilization and costs of healthcare services including those in the private sector under the HPS would be under better control, premium may still go up as the healthcare needs of the insured population increase, due to an ageing population and medical inflation. This concern could be alleviated through greater certainty and transparency over payment and claims, the proposed age-banded, transparent premium schedule and the development of a suitable premium adjustment mechanism under the HPS.

ADVICE SOUGHT

14. Members are invited to note the contents of the paper.

Food and Health Bureau
March 2012