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Subject comments on 'Your Health, Your Life: Healthcare Reform Consultation Document'

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Dear Dr Chow,

The attached is my comments on the document.

K L Wong

healthcare reform 2008_03_16.doc

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16 March 2008

Moving towards Fees Schedules and Subsidisation model:
a response to the Food and Healthcare Bureau proposal 2008

1 General Comments

1.1 The Bureau is to be commended to have put forward this innovative document, 'Your Health, Your Life: Healthcare Reform Consultative Document ', that utilises actuarial concepts and model in estimating the future demand and supply of healthcare services in the future.

1.2 The proposal attaches a comprehensive survey of the system of healthcare financing and their projected challenges in a number of countries. This serves as a very important platform to discuss about the future Hong Kong model.

1.3 The division of primary healthcare and referred healthcare is extremely important in the delivery of healthcare services.

1.4 One of the six models proposes the use of combined healthcare saving and insurance probably provides sustainability and will be discussed in more details.

2 Entrenched principles

2.1 All the eligible residents of HKSAR are covered for essential healthcare services that include in-patient and ambulatory healthcare services.

2.2 The healthcare services should include medical, dental and ancillary services.

2.3 Premium services are not covered.

2.4 Healthcare services consumers can determine their own healthcare service providers, public or private. This should promote competition for private and public healthcare service providers, and intra public clusters healthcare service providers.

2.5 The model should be sustainable especially in the context of an ageing population.

2.6 Tax burden should be equitably distributed.

2.7 Subsidisation cannot be limitless but allocation should be equitable.

3 Principles for Fees Schedules & Subsidisation Model

3.1 Any form of insured or subsidised services relies on fees schedules.

3.2 The fees schedules must be equitable and seen to be equitable.

3.3 Minimise abuses or excessive utilisation of services.

3.4 Only essential services should be provided at subsidised level.

3.5 Subsidisation is not limitless and needs to be controlled.

3.6 Ceiling should be set for different income groups.

3.7 Two separate structures are to be established for determination of Fees Schedules & Subsidisation Model.

4 Fees Schedules

4.1 Classified Healthcare Services into 4 Categories: Consultation Services (Preventive & Curative), Drug Charges, Laboratory Charges, Medical Appliances Charges.

4.2 Determine within each category, four scales/levels of charges for reimbursement:

- 4.2.1 Essential services without need for authorisation.
- 4.2.2 Services requiring authorisation for specific indications.
- 4.2.3 Services requiring special review and approval.

4.2.4 Services that are not subsidised or controlled.

4.3 Determine co-payment or other measures to minimise abuse or abnormal utilisation.
4.4 Review and audit of services that require authorisation, special review or approval.
4.5 Negotiation with insurance corporations about insurance premium, coverage and reimbursement at certain time period (? five yearly)(? by tender).

5 Subsidisation Bureau
5.1 This is established to evaluate, control and conduct of subsidies.
5.2 Determine income/asset classes on year-to-year basis.
5.3 Determine level of subsidisation to each income/asset classes.
5.4 Determine healthcare expenditure ceilings for each income/asset classes.
5.5 Apply and review means tests for healthcare consumers that exceed the ceiling.
5.6 Review of cases for possibility of abuses or abnormal utilisation.
5.7 Receive and approve applications to opt out of public insurance arrangements.
5.8 What to cover, extent of cover and level is a political process and subjected to financial constraints. This can be determined on a year-to-year basis

6 Comment on Combined Savings (investment) and Insurance
6.1 This provides resources (in the form of investment returns/savings) for insurance at an age when the income is insufficient to finance any insurance scheme. This is especially so in the group of people who may not enough savings to finance their own insurance and high demand for healthcare services when they age.
6.2 This proposed scheme is provided on a household basis and from householder(s) with continuing income.
6.3 The scheme can run into continuing financing problem if the income and/or investment returns are not sufficient and when the householder(s) has/have changing financial circumstances.
6.4 Proposed considerations

6.4.1 Insurance scheme for basic services is provided on an individual basis, i.e. every HKSAR resident is covered.

6.4.2 Insurance scheme is negotiated with insurance premium payable to the insurance corporation on an individual basis.

6.4.3 The amount of such insurance scheme will be subsidised by the government according to income classes and reviewable year-on-year, e.g. residents with no income (children & aged) 100% by government and above an annual income level 0%.

6.4.4 If the amount deducted from contribution exceeds the insurance income, this residual amount will be deposited into a savings/investment account to be used after the proposed age of 65 years to finance the future insurance premium. Shortfalls will be financed by government contribution (recurrent government revenue and concurrent tax reform).

6.4.5 People with existing insurance scheme can opt out of the proposed (government negotiated) scheme. The equivalent amount of insurance premium will be reimbursed to the person. The person can elect to deposit the amount in the savings account.

6.4.6 Premium insurance schemes can be considered or encouraged with possibility of tax rebate.

6.4.7 Extra savings is also encouraged with possibility of tax deduction as incentives.

6.4.8 The use of healthcare savings outside healthcare services can be reviewed regularly some time after introduction, e.g. five yearly.

6.4.9 If mandatory insurance schemes and/or mandatory healthcare savings is approved, a separate structure to negotiate, supervise and regulate the insurance and investment schemes is required to allay fears that the government is inefficient in making investment decisions and allocation of resources.

6.5 Operational proposal

6.5.1 People with the insurance scheme can choose their own healthcare service providers within the terms of the insurance on reimbursement.

6.5.2 People can choose their own public healthcare service providers as well with no restriction to specific cluster. This will promote inter-cluster competition within the public healthcare services

6.5.3 The Hospital Authority will collect the same reimbursement amount from the patient. The anticipated increase in income collected will be deducted from yearly allocation from the government.

6.5.4 The savings from the public healthcare budget will be used in financing the insurance schemes.

6.5.5 If there is additional fiscal surplus year-on-year, amount will be paid into healthcare savings account of each individual.

6.5.6 Adjustment and allocation should be phased in and not introduced out-right. A steerng committee should eb set up to implement and monitor the proposal.

7 Concurrent Tax Reforms to finance Healthcare Reforms

7.1 Any of these healthcare financing proposals can co-exist with tax reforms that increase the government's revenue towards healthcare. The tax collected will be ear-marked for healthcare financing.

7.2 Increase marginal tax for high income earners and corporates with extremely high profits

7.3 Capital gain tax for investment properties.

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