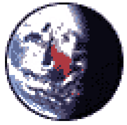

10/04/2008 12:36

To <bestrong@fhb.gov.hk>
cc
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Subject Healthcare financing reform

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My comments/proposals on healthcare financing reform:--
Headlines :-
1. Strong objection to mandatory medical saving
2. Can wait 3 years to verify the projected $58.5B figure for 2010
3. Current approach to medical treatment as cause of soaring cost
4. The books of HA (Hospital Authority) should be accessible to public for scrutiny or go through independent auditing
5. I propose the following low-burden semi-mandatory insurance plan
6. The limitation of insurance
7. On sustainability

1. MPF has already freezed an accumulated income equal to 14% of national annual income(GDP). As if this is not enough the government is proposing a mandatory medical saving. Implementing the mandatory medical saving will squeeze disposable income further and harm persona l spending/investment and retail business. It also violates one's basic right to handle his/her own money. It's a bad proposal which must not be allowed.

2(i):-There is some data missing from the consultation documents, namely the public health expenditures for the past 3 years (2005,2006,2007). The government has answered to a recent enquiry by Dr. Hon. Yeung Sum dated 20 Feb 2008 that the figures will not be available 'til 2009. As the data are relevant to the present discussion, the government should disclose the estimated figures.

2(ii):- Owing to great fiscal surplus in recent years, there is, despit e the pushing of the government, no immediate urgency to finalize decision this year or even the next couple of years. People can afford to wait for 2-3 years to verify the situation is as bad as predicted (public health expenses reaching $58.5B in 2010). The smoking ban and other pro-health measures may alter the trend of health. Cost control will hinder the inflation.

3. The government is making predictions about the trend of public health expenditure based on the conventional approach to medical treatment which is seldom nutritional and which often does not alt er or reverse the underlying chronicity or root cause (although there is some sign of change in past few years). Evidence indicates that most chronic or aging-associated diseases are caused by nutritional deficiencies, inactivity and 'sunlessness', and toxin and free radical and stress. If the government can get everyone to take responsibilty for his own health, the incidence of these chronic diseases may be slashed by half or more thus solving the financing problem. The government is suited to do large-scale experiments on nutritional remedies to verify their healing properties.

4. &n bsp; People may be interested in the breakdown of its annual expenditure on wage, equipment and drugs and of its income.
Has its austerity measures already retarded the 'medical inflation' ?

5. If a mandatory or universal-participation insurance scheme is deemed inevitable, I propose the following low-burden semi-mandatory version:-

headlines :-- (i) Semi-mandatory=very compelling;
(ii) Added MPF option: see also (vii);
(iii) No age discrimination: see also (iV);
; (iv) Premium schedule;
(v) Coverage (HA)(SOPD)(GOPD)(GP): see also (vi);
(vi) Private hospital care and private specialist clinics also subsidized;
(vii) Net impact often only about 1-2% of gross hous ehold income;
(viii) Financial outcome for respective parties;
(ix) Can be continued even if fails;

5(i) 'Semi-mandatory' means all are strongly requested to join but those who refuse can still enjoy HA services but at a rate called the "uninsured rate schedule for local citizens". This is a flat bed rate of $1000 per day (large ward) plus uni nsured special fees for special items. There is compelling economic reason to join.

5(ii) Participants can opt to reduce his/her MPF donation by 1%. This will release more usable money. See attached table of net extra expenses for opters. The option is essential for the success of the insurance plan.

5(iii) There is no progressively increasing premium rate as an individual's age advances. The elderly who are more well off have to pay a very light premium. (see 5(iv))

5(iv) Premium Schedule :---

----This is a low-burden extensive-base scheme which can muster >= $11B/yr.

----Approximate fee schedule :-

Standard Rate (>=10k earners): $230/$150 (employee/employer)
(can muster = 1.75M(wage-earners) x 380 x12 = $7.98B/yr);

Discounted Rates for lower-income earners :-

---8k-9.999k : $160/$100
(can muster = 0.478M x 260 x12 = $1.491B/yr);

&nbs p; ---5k-7.999k : $100/$80
(can muster = 0.658M x 180 x 12 = $1.421B/yr);

---<5k : $20/$20
(Note the burden to employers is kept to the minimum)

Dependants : also require a premium :-
Wife is dependent if FT housewife. Her spouse is required
; to pay $60 (if >=12k), $40 (if 8k-12k), $0(if <8k).
Children as dependants : $25 per head.

Elderly : the elderly group then is the middle-agers now, who often practice saving. Elderly contribution should not be dismissed as insignificant since it alone may muster $0.5B annually then:-
&n bsp; Pensioners $50/month; others $40 (if saving >$100k), $0 (if saving < $100k).

PA household : $20 per head or waived.

Multiple-employers workers require special calculations.
eg. if earns 6k+8k 2 employers, worker pays $230, the 2 employers pay $100, $80. If 10k+12k+5k, worker pays $230, the 3 employers pay $160, $160, $80. Or 15% discount to these employers. If 3k+4k, worker=$100, the 2 employers = $20,$20.

Unemployed persons : $30 or waived.

5(v)a. Coverage for HA in-treatment:-
Insurance payers or dependants pay out-of-pocket a flat bed rate of
$150 per day(large ward) plus "insured special fee for special items".
The insurance company will cover the difference between the "uninsured
rate" (see 5i above) and the "insured bed rate", ie $1000 - $150
&nbs p;   =$850 per day plus the difference between the "uninsured special fee"
and the "insured special fee". PA recipients and low-income people can
seek further subsidy.

b. Coverage for government Specialist Clinics :-
Also covered by the insurance company using the same principles stated
above. The Government will take care of the rest of the expenditure of
such clinics.

c. Govt GOPD and private GP care also covered by insurance:-
--govt GOPD : uninsured rate = $100, insured rate=$35. Insurance
pays $100-$35=$65 per visit. The government takes care of the
remainder.
--GP visits : insurance covers 10% of fee; Govt also subsidizes 10%.
GP patient pays 80% of fee. Cap on subsidy.

5(vi) :- Private hospital in-treatment and private specialist clinics also
sponsored (directly by the Government):-
Here's the crucial link !
Scheme participants who find the waiting time under HA too long or
&n bsp;   who simply favor private hospital from the start can opt to be treated
in the private sector but are required to pay 75-90% of the private
fee(lower income higher subsidy, higher income lower subsidy), and the
Government will cover the rest of the fee, with cap on subsidy.
The private vs. public imbalance can be ameliorated. The middle- or
high-income earners will be pursuaded to join the scheme to enjoy the
perennial discount offer. The middlelow income group or the general
public who have saved up some money may now be able to afford
private treatment due to the discount, thus easing HA of its strain.
The Government's extra expenses is about $8B-$9B per year. However
the purpose may be defeated by greedy price mark-ups.
Also private labs:- government subsidizes 10% of the lab fee (with
cap on subsidy) for middle-agers aged 35 to 55 (about 1.76mllion persons)
whose health is often sub-optimal.

5(vii) :- If joiners opt to reduce their MPF donation by 1 %, the net impact of the
scheme to individuals and households is small as shown by the attached
table of net extra expenses for opters, which is often 1-2% of gross
household income or less.

5(viii) :- Financial outcome for respective parties :-
HA :- hospital and SOPD and GOPD income received from the above
insurance fund and from "oop" payments = about $15B- $16B /yr.
Government covers the remainder of the expenditure.
Government :- subsidizes HA hospital care, govt SOPD, private hospital
&nbs p;   treatment, private specialist care, govt GOPD, private GP care, and
private lab fees. Total expenditure about $31B/yr.
Lowest-income 2 child familty:-
for a 5k+3k+2 childrn family, net extra expenses= $120;
4k+2k+2 childrn =$90;
6k+4k+2 childrn = $110;
&nb sp; 5k+0k+2 childrn = $100. All can seek PA .
Other households : see attached table.
Private sector :- all benefit from increased demand resulting from
subsidy. Individuals can add voluntary medical insurance to
increase coverage to a further degree. Purpose of subsidy
may be defeated by greedy price mark-ups.

5(ix) :- The standard rate can be adjusted every 3 years or so. The scheme
&nb sp; can be continued even if it fails, the deficit then covered by increase
in taxation. The insurance scheme itself will create jobs, and its good
exceeds its bad if it is run by an efficient company.

6. The limitation of insurance :-
The principle of insurance is such that it only makes economic sense if
the mishap to be covered has such a low rate of incidence that most
subscribers will not encounter it during their lifetime or the period of
subscription, such as cover for serious (traffic) injury that results in severe
disability. Suppose that such a mishap happens with a chance of 1 in 10,000
&nbs p; and its treatment and aftermath costs one million dollars. If all subscribe, the
premium is only $100/yr or $8.3/month. Add the admin charge, it may be just
$9/month which may be worthwhile given the possibility that you may have
to spend a million dollars if you are the victim. However if medical insurance
intends to grant cover to old age, there will be a big problem as time goes on,
because most if not all subscribers will eventually encounter the mishap, and
the premium rate will skyrocket and the scheme crash. The dire prospect may
be overcome by adopting measures that can reverse the trend of health.

7. On sustainability:-
All methods aimed at financing are not sustainable if medical treatment does
&nbs p; not alter or reverse chronicity or if the root case of disease is not addressed
and eliminated or if there is no reversal of the trend of health. The scheme
proposed in (5) above is light burden for all and yet can generate $11B/yr
because the financial burden is borne more evenly and justly by all members
of the community. With such an auxiliary fund, and with cost control and
more vigorous experiment-backed pro-health measures, the financing problem
may be significantly relieved.

Please publish the article . Keep anonymous.

The table of net extra expenses for opters (large jpeg file) will be sent by a separate e-mail or by paper mail.

&n bsp;

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Net Extra Expenses for Optero (absolute amount and as % of gross income)

		Man earns – 6K			8K			10K			15K			20K		
SINGLETON		100-60 = 40 (0.7%)			160-80 = 80 (1%)			230-100 = 130 (1.3%)			230-150 = 80 (0.53%)			230-200 = 30 (0.15%)		
		0 child	1	2	0 child	1	2	0 child	1	2	0 child	1	2	0 child	1	2
WIFE earns	0K (FT HW)	40 (0.7%)	65 (1.1%)	90 (1.5%)	160-80 +40 = 120 (1.5%)	145 (1.81%)	170 (2.12%)	230-100+ 40 = 170 (1.7%)	195 [illegible] 1.95 ([illegible]%)	220 (2.2%)	230-150+ 60 = 140 (0.93%)	165 (1.1%)	190 (1.3%)	230-200+ 60 = 90 (0.45%)	115 (0.58%)	140 (0.7%)
	6K	100-60 + 100-60 = 80 (0.67%)	105 (0.9%)	130 (1.1%)	160-80+ 100-60 = 120 (0.86%)	145 (1.04%)	170 (1.21%)	230-100+ 100-60 = 170 (1.06%)	195 (1.22%)	220 (1.38%)	230-150+ 100-60 = 120 (0.57%)	145 (0.69%)	170 (0.81%)	230-200+ 100-60 = 70 (0.27%)	95 (0.37%)	120 (0.46%)
	8K	100-60 + 160-80 = 120 (0.86%)	145 (1%)	170 (1.2%)	160-80+ 160-80 = 160 (1%)	185 (1.16%)	210 (1.31%)	230-100+ 160-80 = 210 (1.17%)	235 (1.3%)	260 (1.44%)	230-150+ 160-80 = 160 (0.7%)	185 (0.8%)	210 (0.91%)	230-200+ 160-80 = 110 (0.39%)	135 (0.48%)	160 (0.57%)
	10K	100-60 + 230-100 = 170 (1.06%)	195 (1.22%)	220 (1.38%)	160-80+ 230-100 = 210 (1.17%)	235 (1.3%)	260 (1.44%)	230-100+ 230-100 = 260 (1.3%)	285 (1.42%)	310 (1.55%)	230-150+ 230-100 = 110 (0.44%)	135 (0.54%)	160 (0.64%)	230-200+ 230-100 = 60 (0.2%)	85 (0.28%)	110 (0.37%)
	15K	100-60 + 230-150 = 120 (0.57%)	145 (0.69%)	170 0.8%	160-80+ 230-150 = 160 (0.7%)	185 (0.8%)	210 (0.91%)	230-100+ 230-150 = 210 (0.84%)	235 (0.94%)	260 (1.04%)	230-150+ 230-150 = 160 (0.53%)	185 (0.62%)	210 (0.7%)	230-200+ 230-150 = 110 (0.31%)	135 (0.39%)	160 (0.46%)
	20K	100-60 + 230-200 = 70 (0.27%)	95 (0.37%)	120 (0.46%)	160-80+ 230-200 = 110 (0.39%)	135 (0.48%)	160 (0.57%)	230-100+ 230-200 = 160 (0.53%)	185 (0.62%)	210 (0.7%)	230-150+ 230-200 = 110 (0.31%)	135 (0.39%)	160 (0.46%)	230-200+ 230-200 = 60 (0.15%)	85 (0.23%)	110 (0.28%)

Premium Schedule:-
- ≥ 10k 230/130
- ≥ 8K–9.99K 160/100
- 5K–7.99K 100/80
- < 5K 20/20

Dependants: Child: 25/child
wife (HW,):-
- Husbd ≥ 12k 60
- 10–12K 40
- 8–10K 40
- < 8K 0

Elderly:-
- pensioner 50
- non-pensioner
  - saving > 100k 40
  - < 100k 0

PA: 20/head or waived.