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To whom it may concern:

Please see attached a paper on Hong Kong's healthcare reform. The paper was submitted as an assignment for one of my classes, and does not represent the view of my university.

Thank you.

Regards,
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Policy Memo - Aging & MSAs.pdf

Policy Memo

Hong Kong's Health Care Financing Reform: The Implications of Medical Savings Accounts on the Elderly

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11 March, 2008

Summary

The Medical Savings Accounts (MSAs) scheme has a strict structure that increases the likelihood of cream skimming. Patients who are wealthier and healthier will seek health services from the private sector, and patients who are poorer and sicker will remain in the public sector. Whether cream skimming will lead to favorable or unfavorable outcomes for patients and the health system depends on the government's actions in the implementation of MSAs. To ensure equal or better services for everyone under the scheme, decision makers should carefully perform risk adjustment and examine potential consequences on patients who remain in the public sector before implementing the scheme. Since the prospect of living a healthy old age with greater financial capacity is a major incentive for Hong Kong citizens to cooperate with the reform, special attention should be paid on MSAs' impacts on elderly health services.

Background

Hong Kong has a relatively equitable healthcare system supported by both public and private health services providers. The public sector is mainly funded by the government's general revenues where the government subsidizes on average 95% of the total costs of public healthcare. [1] The tax-based health financing system has proven successful in serving as a safety net for citizens. The private health sector is financed mainly through out-of-pocket household expenditure by individuals. Generally, the cost of public health services is kept low so that no individual has to reduce the use of health services due to an inability to pay. As a result, Hong Kong citizens tend to over-rely on the public health sector regardless of their ability to pay for private care.

Apart from the imbalance between the utilization of public and private sectors, population aging has been adding burden to public healthcare financing in Hong Kong in the past decade. The proportion of the population aged 65 and over is projected to rise from 12% in 2006 to 26% in 2036.[2] Such an increase in elderly population suggests not only an increased demand for chronic

disease management, but also a shrinking tax-paying population that supports the current system. It has been projected that the elderly dependency ratio will increase from 161 per 1000 persons in 2003 to 428 in 2033.[3] Researchers have also estimated the total health expenditure will increase from 5.5% GDP in 2001/02 to 9.3% GDP in 2030, which translates into 26.5% of government expenditure.[4]

Proposal

The Bauhinia Foundation Research Centre (BFRC), a policy think tank in Hong Kong, published a consultation document regarding the development and financing of Hong Kong's future healthcare in August 2007. BFRC discusses the implementation of a MSAs financing model that supplements the current tax-based financing system. All Hong Kong citizens will be eligible to participate in the proposed MSAs scheme. Participation will be mandatory for people whose monthly income reaches a certain amount. Participants have to contribute 1-5% of their monthly income to MSAs for healthcare use on themselves or immediate family members. Before the age of 65, participants can use their MSAs funds to pay for government-approved major illness insurance plans, public health services, and also health services from private practice doctors who adopt the family medicine concept for designated services. After the age of 65, participants can use their funds to purchase any health services, and also government-approved insurance and long-term care (LTC) plans. People enrolled in MSAs have access to health services with different levels of government subsidy.

Analysis

While BFRC specifically states that promoting the financial sustainability of the public sector should be the key concern in the healthcare reform, the reform proposal frames the new financing model as a means to enhance Hong Kong citizens' choices and responsibilities toward healthcare and a healthy old age with greater financial capacity.

Although the MSAs scheme encourages health maintenance that leads to healthy old age, it is not likely the most vulnerable population will benefit. Low-income earners or their representatives generally do not support the scheme. This statement is supported by the fact that BFRC had to raise the minimum level of monthly income for mandatory enrollment to the current proposed level after it published its preliminary report for public feedbacks earlier in 2007. Despite the fact that everyone is eligible to participate in MSAs, people who are unemployed, severely poor and sick might not want to sign up for MSAs voluntarily and contribute funds to the account regularly. These non-MSAs participants will not be able to take advantage of the scheme's major benefit of purchasing government-subsidized health maintenance programs that are currently unsubsidized at all. The programs include wellness promotion, health screening, and prevention services. Therefore, the most vulnerable populations can always only return to the public sector for treatments when health problems arise.

Besides being unable to provide better care for the most vulnerable populations, the scheme is also not paying special attention to participants who are prone to be socially disadvantaged. Firstly, a problem of gender disparity exits because men are more likely to have accumulated more funds in their MSAs than women over their working years,[5] but the average medical expenditures are not necessarily significantly different between men and women. Secondly, since MSAs funds can be used to cover immediate family members, a problem of marital status disparity exists for unmarried elders, who have one fewer source of financial support from spouses. This phenomenon is also applicable to same-sex elderly couples in Hong Kong where same-sex marriage is not legalized. If the scheme can address these disparity issues, it will outperform other social welfare programs that often contain some discriminatory characteristics that make them less efficient in providing services to people with greater needs.

The aforementioned examples suggest that there are certain populations who might be compelled to be more financially risk adverse at present time under the strict structure of MSAs. This is a drawback of the scheme because people might reduce their utilization of subsidized private services and health maintenance programs, or even proper health treatments at times of illnesses in order to save funds for post-retirement. Such behaviors significantly impair their potential of healthy aging, and can actually reduce their financial capacity because they are at higher risks of developing major or chronic diseases that require expensive treatments. Therefore, the strict structure of MSAs might defeat the scheme's purpose to encourage healthy aging, unless sufficient outreach efforts are available to prevent these adverse behaviors.

MSAs' impacts on healthcare for existing elderly patients should do more good than harm. Due to the shift of MSAs participants to the private sector influenced by the government's subsidization, patients load in the public sector will decrease. Public healthcare providers will be able to reduce waiting time and allocate more physician time to each patient. An average elderly patient, who is likely to fall under the low-income group that normally seeks public health services, will be able to receive better public care. In addition, aging population is associated with increasing cognitive impairment and geriatric depression in Hong Kong.[6] Because mental health services are usually not covered by private insurance companies, or privately provided mental health services are often unaffordable[7], the MSAs scheme provides the means for elderly patients to access mental health services at affordable costs. However, it is also possible that people outside the MSAs pool will have to pay at a higher price for private insurance and services because employed individuals are healthier than people outside the pool on average. Higher private costs will shift some people back to the public sector. People who should originally be able to finance healthcare independently will now share government's resources with some deserving populations in society including the elderly.

Whether the scheme will lead to a detrimental two-tier health system or a less unbalanced system between the public and private sectors than that of today depends on how carefully the government is able to perform risk adjustment and how accurately it is able to predict the flow of patients across sectors. If under cream skimming, a two-tier system is created that only wealthier and healthier people will shift out to the private sector, public financing system might become unsustainable as the public sector will then have to take care of the poorest and sickest patients. The government will have to face much higher average per-patient costs but relatively stable average per-patient revenue. On the flip side, cream skimming can, in a way, alleviate the current imbalance problem between the two sectors.

The reform proposal provides no pooling across populations. However, it is not the intent of this proposal to allocate resources to areas of the greatest need in the community. Instead, it aims to increase individual awareness and responsibility toward personal health and financial capacity at old age. To evaluate the proposal's health impacts on existing elderly patients, the percentages of patients who are above age 65 and have received care from public service providers should be compared before and after MSAs implementation. Elders belong to the less financially sufficient populations whether or not they have been enrolled in MSAs. They might not be able to afford private care even with government's subsidization. If the percentage of elderly patients seeking care from public providers increases, it is an indication that elderly patients are receiving more benefits than other age-groups under the implementation of MSAs. Unfortunately, it is difficult to assess the change in quality of care for future elderly unless a large-scale longitudinal study is conducted. We can only hope that with increased financial capacity and better health at old age that are achieved through proper health maintenance efforts, MSAs scheme can alleviate psychological distress associated with major or chronic diseases at old age for both the elders and their families.

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