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Food and Health Bureau
19/F Murray Building
Garden Road
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Dear Sirs

Subject: Hong Kong Health Care Reform

This document is Mercer's response to your invitation to a 'wide range of stakeholders' to comment on your reform consultation document entitled "Your Health Your Life". Mercer is delighted for the opportunity to contribute to this critical debate for the Hong Kong Government at this phase of the process for health care reform.

Mercer is a global benefits consultancy that operates in both the public and private sectors to assist a range of stakeholders with the design, funding and delivery of health care, and other benefit programs. We are privileged to serve several health care systems around the world as we have global presence, a unique in-house healthcare actuarial expertise, and a developed service that can analytically describe and forecast the impact of multiple scenarios on the overall operating model at both an income and expenditure level of any health care system. (We have provided more details of who we are in Appendix A).

Here we restrict our comments to those of an experienced observer, although we are also an employer of reasonable size in the Hong Kong market. We don't believe it is our position to come down on the side of any one of the 6 financing proposals put forward by the Government in your consultation document. We can confirm, however, that, in our experience, these options do, at a high level, represent the range of 'normal' options that we find reforming systems investigating in the building of a future sustainable healthcare system,

The analytics of the challenge of sustainable funding, while delivering services in the best public interest, are very compelling. The fundamental challenges of health care for Hong Kong appear very similar to many of those of other areas of the world. These include:

- The escalation of chronic illnesses, in many cases linked to sedentary lifestyles.
- Rapidly increasing healthcare costs, driven by the 'normal suspects', increasing utilisation, an ageing population and advances in medical technology.
- A limitation on the number of trained healthcare professionals.
- A growing crisis in public healthcare funding caused by a demographic profile skewed towards retirees, at the expense of the working age population.

In light of this, our main comments can be described under four key headings that are written as questions, including broader reflections about reforms of delivery mechanisms, as this is the impact that this document had on us:

1. Does the scope of coverage of public funding have to include everything?
2. Can further clarity be given to the part efficiency improvement will play in managing future cost in both the public and private systems?
3. Is there perhaps a bigger tactical challenge than funding, in the supply of health care professionals able to meet the forecast demand?
4. What should be the strategic role of employers in financing healthcare costs?

We cover each of these in turn:

1. Does the scope of coverage of public funding have to include everything?

One of the key challenges facing all agencies charged with administering healthcare expenditure is to determine and communicate spending priorities. As we have considered the reform objectives, it is not clear to us the degree to which funding options that are potential 'half-way-houses', have been considered. For example: Has a model been considered that structures insurance, both social and private, to cover only 'critical illnesses' (the problem of any extensive/unexpected medical cost), leaving the individual to fund 'running costs' (e.g. Family Doctor visits, simple generic prescription drugs, basic diagnostic tests etc.,) as out of pocket? These may or may not include chronic disease management, and any specific acute on chronic conditions etc., depending on the length of the funding required beyond basic interventions.

Such an approach does not need to be in conflict with the desire, in the reforms to "Strengthen public healthcare safety net", as full public coverage can still be targeted to those most in need, avoiding difficult optics of being seen to 'penalise the poor' who get sick. Many better-off Hong Kong citizens, we believe, would be relatively comfortable with a model that requires a blend of out-of-pocket (or partially privately insured) expenses for managing the 'basics' and a wider 'insurance' for contributions to high cost/catastrophic treatments, before falling back on the safety net of the public system.

2. Can further clarity be given to the part efficiency improvement will play in managing future cost in both the public and private systems?

The reform document outlines the desire to introduce a number of delivery reforms which aim to maximise appropriate use of, and to some degree alleviate the funding pressure on, the system. These are the family doctor approach, a move adopted generally in systems to gate-keep and increase 'right-first-time' use, the introduction of electronic patient records (generally introduced for efficiency increase and to facilitate access to greater choice with the web-based record available easily to appropriately qualified individuals) and the promotion of health-keeping/risk reducing activities.

We fully support these mechanisms and our experience confirms, as your document outlines, the World Health Organization studies have shown that a stronger primary healthcare system results in improved population health outcomes at lower cost and greater user satisfaction. We believe, therefore, that t is important that these goals are realised to assist in the management of long term costs, particularly those associated with chronic illnesses. We do acknowledge, however, the implementation challenge of any of the above mechanisms and wondered:

- To what extent these reforms are expected to ameliorate the cost increase and therefore the subsequent funding requirement?

- Given the starting point for Hong Kong residents of unfamiliarity with the family doctor concept and use for preventive approaches and the practice of Doctor-hopping, what plans had been envisaged and costs forecast for implementing the Family Doctor and prevention concepts and familiarising the population with the purpose and benefits of their intended use? In our experience the Government should not underestimate the sustained effort required to educate the community, launch and build an effective primary care network and cost-effectively manage resources.

In light of this we suggest that the Government give strong consideration to establishing a return on investment (ROI) model to measure its return on primary care and on certain disease management programs consistent with experience in Singapore.

Furthermore, we wondered if there was also an opportunity to widen the number of initiatives on the delivery side. Most systems, especially in developed countries, suffer from significant wastage caused by inefficiency in both the public and private sectors. Examples include:

- Complex administration (characteristic of a system of mandatory private insurance from multiple sources or public health systems that feature multiple layers of government bureaucracy);
- Uncontrolled/unregulated health provider fees;
- Excessive use of certain diagnostics, treatments and prescription drugs;
- Limited use of evidence-based treatment protocols resulting in wrong/unnecessary treatment;
- Duplication of work due to limited integration in and between health care providers treating the same patient.

Left unchecked, these issues proliferate as health care becomes more complex, and erode the efficiency and effectiveness of the networks.

In our opinion, reforms of funding mechanisms are accepted best where they are seen to be supported by clear evidence of effort to avoid waste. Based on our view of the current situation in Hong Kong, we would suggest a few additional initiatives that may support the process:

- **Further mechanisms to ensure reasonable pricing of services.**

  It is a common trait of healthcare systems that feature both public and private stakeholders, especially where there is limited regulation, that providers will gravitate to the private system which is characterised by higher fee structures. Typically, variations in pricing within and between the public and private systems are explained either by mandated tariffs (public-private) or by the realities of market forces (private). It is evident that there is huge variation in the cost of services between providers in the private system and some of the pricing structures themselves lack transparency and any fundamental rationale. For example, physician fees and hospital expenses are higher for a patient in a single bed ward over a semi-private ward within the same hospital where there is no apparent rationale for this additional cost. Without full transparency or understanding of pricing arrangements, patients and insurers are, at times, unwittingly compelled to pay more than they need. Furthermore, these kinds of pricing arrangements make it difficult for employers to manage the costs of employer-sponsored health plans. We accept fully that it would neither be practical nor prudent to attempt to regulate all such cost variations out of existence. However, if there are significant anomalies, they should not be ignored.

- **Apply a common DRG model to all providers and standardise coding for all levels of recording activity and**

  A DRG (diagnosis-related group) model delivers a structure which can be easily tracked and any collated data analyzed. Similar to the Australian model, in addition to regular secondary to in-patient care and a casemix adjusted tertiary care charging model can be overlaid. This allows for clear pricing and negotiation on a clear number of tariffed/risk-adjusted activities and develops data which can be regularly benchmarked to highlight utilisation anomalies.

- **Make sure both the public and private systems include an element of consumerism.**

Experience shows that patients may not seek the most cost effective treatment if they do not have a financial stake in it. Furthermore, they may not understand and appreciate the cost of the treatment without personally incurring a portion of the expense. We lean towards some form of affordable health co-payment (likely with an out of pocket maximum to protect against individual financial hardship in the event of catastrophic conditions) to encourage patients to be wise consumers of health care. The judicious imposition of consumer co-payments is also calculated to moderate utilisation of healthcare services and reduce demand, particularly on primary care providers.

- **Consider the implementation of evidence based medicine for common illnesses where these are not in place.**

  In both the public and private system, where they don't exist, we recommend the adoption of treatment protocols so that money is not spent on interventions that are not expected to improve health outcomes. It is clear that 'good healthcare is also cheap healthcare' as consistent, accurate direction to the most appropriate and effective protocols results in a lowering of costs and an increase in compliance to regimes.

3. Is there perhaps a bigger tactical challenge than funding, in the supply of health care professionals able to meet the forecast demand?

Balancing the number of health professionals with populations and their needs is a consistent challenge. The required length of training and an increased demand for health services all over the world has simply reinforced the problem of a shortage of clinical and allied healthcare professionals in many countries. Shortage of clinical capacity increases waiting lists and, without a substantive increase in capacity and efficiency, this will only be exacerbated as the population ages and utilisation levels increase. The laws of supply and demand apply here too and the cost of healthcare practitioners including doctors, nurses and technical experts tends also to increase. There is also a parallel risk that, if the system efficiency and quality decreases (perceived or real), there may be a reduction in the attractiveness for investment by organisations worried about employee health.

In the case of Hong Kong, therefore, we wonder if the more significant challenge may be that, even if funding can be reformed and delivered, there may be insufficient capacity in appropriately trained health professionals, of all types, to meet the projected demands of the system. If this has not been considered in detail we recommend it is included in any future analysis of the impact of the reforms.

4. What should be the strategic role of employers in financing healthcare costs?

Employers in Hong Kong currently make an important contribution to the cost of the healthcare system. Within the non-government funded healthcare sector, 70% of costs are borne by consumers in the form of out-of-pocket costs and 28% are funded by private health insurance. Of this, 60% of private health insurance costs are funded by the corporate community.

The provision of health-related benefits assists employers with their talent management strategies, including both retention and attraction objectives, helps them differentiate their employer brand, maintain a productive workforce and contribute to society. The most prevalent form for corporate organisations supporting health is through the provision of private health schemes to employees and their dependents.

Regardless of the financing option chosen, for employers to continue to make this health care investment and for Hong Kong to maintain its position as an attractive business environment, it is important that:

1. Employer's financial contributions to health care (for example as a percentage of payroll) remain at a competitive level compared to other developed countries and remain appropriately tax-efficient

2. A feasible transition plan for employers who have a healthcare plan for their staff. Exemption should be considered for such employers.

Conclusions

Mercer is pleased to have had the opportunity to provide input into this critical reform process. The following summarizes our conclusions:

- We believe this reform process provides the Government with an opportunity to redefine the future of healthcare delivery and funding in Hong Kong. Philosophically, we support the view that neither individual residents nor individual employers should bear the risk of funding the health expenses associated with high cost catastrophic illness. Public provision or a pooling mechanism should be established to pool this risk.

- We would encourage proactive measures to ensure that both the public and private healthcare systems operate to strict efficiency measures thereby eliminating duplication and mismanagement of scarce financial resources and maximising the cost effectiveness of health expenditure in parallel to reforming the funding mechanisms;

- Government needs to project the future healthcare needs of the community and ensure adequate supply of required human resources and infrastructure thereby providing universal access to health providers at an acceptable cost;

- The Government should maintain the current principle of shared responsibility for health care and invest in long term culture change to change behaviour around family doctors and preventive care.

- The government should recognize the strategic interest of employers in the provision of healthcare benefits and consult with employers to build cost-effective and sustainable solutions;

- The health care model should be flexible to adapt to changes in health care. Developments such as non invasive surgeries, breakthrough prescription drugs and new diagnostics will dramatically change the face of health care; this new model must be flexible enough to respond quickly to such changes.

The Mercer Global Health & Benefits team would be pleased to review the above in more detail and also work with you to explore future public primary care models which we understand from the consultation document is a priority. We would also be pleased to discuss alternative premium rating and underwriting techniques as prerequisites for private insurance to ensure premiums are maintained at a competitive and equitable level..

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Yours sincerely,

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Appendix A - Information about Mercer

Mercer is a leading global provider of consulting, outsourcing and investment services, with more than 25,000 clients worldwide. Mercer consultants help clients design and manage health, retirement and other benefits and optimize human capital. The firm also provides customized administration, technology and total benefit outsourcing solutions. Mercer's investment services include global leadership in investment consulting and multi-manager investment management.

Mercer's global network of more than 18,000 employees, based in over 40 countries, ensures integrated, worldwide solutions. Our consultants work with clients to develop solutions that address global and country-specific challenges and opportunities.

Mercer's Health & Benefits business assists clients design, implement and actively manage benefit programs that retain cost control as a central feature – whilst integrating with the employers' need to offer benefits that are understood, valued and constitute part of the overall approach to Total Rewards. Such programs must also comply with local regulations.

We ensure that we leverage Mercer's substantial global resource base, comprising 3,530 health & benefit professionals, to the benefit of clients locally. Our global resources include a team of thought leaders tasked with promoting thought leadership into the regions and zones, plus numerous specialist resources including:

- 77 Health & Benefit Actuaries;
- 25 Performance and audit group resources;
- 15 Absence management specialists;
- 5 Behavioural health specialists;
- 3 Physical health specialists.

We are committed to a vision of a more rational health care market characterised by:

- Providers being rewarded for providing high quality, cost-effective care;
- Employees actively being encouraged to manage their own health and participate in the cost of healthcare through appropriate consumerism measures, and;
- Health plan underwriters engaging in fair pricing, cost transparency and greater accountability to the benefit of our clients. .

Our health government consulting unit focuses entirely on the unique and challenging needs of the public health care sector, providing a wide array of consulting services to government including varying levels of actuarial, clinical, financial, operational, systems, and strategic consulting assistance around public schemes

The company is a wholly owned subsidiary of Marsh & McLennan Companies, Inc., which lists its stock (ticker symbol: MMC) on the New York, Chicago and London stock exchanges.