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ACTUARIAL SOCIETY of HONG KONG
香港精算學會

Dr. York Chow, SBS, JP
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By Fax (2102 2525) and Post

Dear Dr. Chow,

Comments on Hong Kong Government "Healthcare Reform Consultation Document – Your Health, Your Life"

The government needs to be applauded for tackling this thorny issue after several attempts over the last decade. The current proposals suggest that changes to the existing system will be implemented in the foreseeable future.

As actuaries we do not aim to comment on the political content of the proposal: we accept the framework of existing principles namely that the government shall –

(a) Uphold Hong Kong's long- established healthcare policy that no one should be denied adequate healthcare through lack of means;
(b) Ensure that necessary healthcare services remain accessible and affordable to the community;
(c) Maintain the public healthcare system as a safety net for the low- income and under- privileged groups and those in need; and
(d) Upkeep the professional standards and conduct of the healthcare professions.

At this first stage consultation, we would like to consult you on –

(a) Key principles and concepts of our service reform proposals; and
(b) Pros and cons of possible supplementary financing options.

The question posed has many actuarial implications, notably the latter part.

There are two parts to a healthcare reform program:

(i) Service improvement with cost control; and
(ii) Cost distribution (financing).

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Reading the document, one gets the impression that the government's main target is on the latter, i.e., to contain the public expenditure on healthcare, not the quality or the efficiency of healthcare in Hong Kong.

1. Service improvement with cost control

This is elaborated on in chapters 2 to 5 of the consultation document. The following general comments should be noted:

(i) One would have thought that number of doctors and hospital beds per 10,000 population (as given in the Legco research report 2006) and average waiting time for certain surgical procedure would be better indicators of the quality of healthcare of a society than "total healthcare expenditure as a % of GDP" as given in this document.

(ii) It is the total healthcare cost, not just the public healthcare expenditure that this healthcare reform should be concerned about. Introduction of family doctor system and contracting surgical procedure to private hospitals might lead to better utilization of our resources and lower ultimate cost, but there are other possibilities that should be explored.

(iii) Listed below are some possibilities that can be explored (not intended here as recommendations or endorsements).

- Importing doctors, herbalists and/or paramedics from other countries (such as China, India, the Philippines, etc.) to work in public hospitals
- Promoting managed-care facilities
- Government negotiating service providers' fees for registration of government-approved health insurance programs, family doctor system, etc.
- Contracting out certain long-term care across the border

Specific comments to the individual measures proposed are listed hereunder:

Chapter 2: Enhance Primary Care

We concur that strengthening of the Primary Care segment should result in better and more efficient utilisation of resources and help with controlling cost. The following should be considered inter alia:

- It needs to be determined what choice the patient should have. The proposed family doctor register might be too weak an approach to result in real cost control.
- It needs to be ensured that it does not preclude efficient and effective involvement of insurers and other payers
- For preventative care subsidization might not be the right answer. Experience overseas suggests that charging for non-usage can be more effective.
- Similarly, rewarding of healthy behaviour (e.g. cessation of smoking, weight loss) could be incorporated into such a system.

Chapter 3: Promote Public-Private Partnership in Healthcare

We concur that there is significant scope for enhancing the partnership between the public and the private sector. A major impediment in the current utilisation of the private sector is the lack of transparency in its charging structure. Experience from overseas would suggest that advanced systems rely on regulation of fees, separation of doctor services and dispensation of drugs, regulation on usage of generic drugs, etc. In most systems there is a mechanism in place to negotiate fees to ensure the private sector can make money and return on capital.

Chapter 4: Develop Electronic Health Record (eHR) Sharing

We support this concept strongly and suggest some further areas:

- Use also for more general research (not just disease surveillance) -
  - For input into clinical protocols
  - Comparing with other populations
  - Efficiency of treatments etc
- Availability to authorized 3rd parties for research (on a de-identified basis) e.g. insurers for pricing, medical technology for product info, etc.;
- Needs to include pharmaceutical benefits (including possibly TCM);
- Links to payment systems, which are a major source of "friction costs" in insurance and medical savings account processes; and
- Links to insurance records.

Chapter 5: Strengthen Public Healthcare Safety Net

We believe that in a properly designed insurance scheme the role of such a safety net could be limited. As is it will always be difficult to ensure that mechanism is not abused. In that context it is important not to create/continue the situation where the insured patients choose to use (subsidized) public services and not use insurance to

- Save insurance co-payments;
- Not use up part of insurance limits; and
- Limit future premium increases.

2. <u>Cost distribution (financing)</u>

This is dealt with in Chapters 6 to 13 of the consultation document.

It is well known that long-term economic projections are fraught with danger and this document seems to use a 25-year projection under one set of assumptions. The actuarial profession today seldom uses one set of assumptions for this kind of projection. One invariably does the projections under various different scenarios. What with Hong Kong's highly mobile population (high-pay expatriates, low-pay domestic workers, migrant population from China, etc.) and a trend towards longer working life beyond age 65 throughout the world, the society needs to have a better picture of Hong Kong's

demographic profile under different scenarios, some of which may be controllable to some degree by the government.

The consultation document quickly arrives at the conclusion that the current system is unsustainable. In this context it cites the narrow tax base of Hong Kong, which considering revenue from horse betting, land sales, etc. is not so narrow after all.

The consultation document then goes on to compare 6 alternative financing options. Hong Kong has enough qualified consultants to do the numbers. The government should postulate a number of scenarios and ask the consultants to show how each sub-group of the society is affected by each of the financing options under each scenario.

We also note that in most of the projections, caps on relevant income for the projections have been used. Although this approach is consistent with the current determination of MPF contribution levels, we do not endorse its automatic use in considering financing of health care.

We would like to comment on a few issues specifically:

Chapter 7: Consequences of Maintaining Existing Financing Model

Undoubtedly spending will go up – the only question is how much of the payments should be via government and in what form (funded hospitals, vouchers, payments to providers). This begs the question:

- Is there really anything wrong with higher public spending?
- Is it practical to continue to want better lifestyles and public services without a corresponding increase in tax (in various forms)?
- How do current and projected demographics of HK compare e.g. wide gap between poor and rich (and super-rich), large middle class that pays no tax,…

Chapter 8: Supplementary Financing Option (1) – Social Health Insurance

We do not necessarily consider the arguments against such a system compelling.

- Why cap the relevant income for contributions at $20k pm? There is no reason that the wealthier should not contribute more in dollar terms. Although this matches the way MPF is structured, it makes little sense when the objective is to have the wealthy subsidise costs for the poor.
- Is extra tax really a disadvantage? Whether the extra cost is forced savings, insurance premiums, higher tax or social insurance really is just a matter of different means of funding.
- To avoid a burden on future generations (8.9(b)) it should be properly funded i.e. contributions should reflect lifetime costs not just current year costs.

We do believe that a properly structured commercial system can achieve better long-term results for the community than public services. This requires a system that

rewards private providers and insurers that innovate with community interests in mind and that provides private industry with the flexibility (under appropriate governance) to implement improvements.

Chapter 9: Supplementary Financing Option (2) – Out of pocket payments

We agree that out-of-pocket payments cannot be a sustainable solution notably as they lack the characteristics of risk pooling. However, a certain element of it is desirable to manage utilisation better.

- Although raising fees would lead to an increase in fee waivers or other subsidization, increasing fees is important for a number of reasons –
  - To ensure that users understand the true cost of services;
  - To provide the right incentives for users to consider the value of the service versus the cost (and drive healthy behaviour); and
  - To ensure appropriate competition allowed between private and public services (if public cheaper and reasonable, users will drift to it and insurers will continue to encourage usage of public services).

Chapter 10: Supplementary Financing Option (3) – Medical Savings Accounts

We agree that Medical Savings Accounts (MSA) cannot be a sustainable solution notably as they lack the characteristics of risk pooling. However, they could still play an important supplementary financing role as –

- A significant part of health care costs can be well planned for and insurance is not required or effective – e.g. regular checkups, preventative services, a relatively standard level of yearly care – MSA are a better solution than insurance for this because –
  - Lower friction costs typically (no capital, underwriting, etc); and
  - Drives incentives most effectively to not overuse because unused remains in the hands of the individual (not the insurer)

MSA are not sufficient on their own because –

- Some will need more than their accumulated balance because of short-term unexpected health events – a natural solution is insurance beyond the MSA.
- Most health care costs are incurred in later years of life - pre-funding alone cannot solve this.

Chapter 11: Supplementary Financing Option (4) – Voluntary Private Health Insurance

We agree that this can only serve as top-up mechanism, not solve core issues. The current regulation treats health insurers like property-casualty insurers.

Prudential regulation could be improved to recognise the need for pre-funding for steeply increasing morbidity. This would need to come with regulation on valuation

of liabilities etc.. The current system lacks the guarantee of continuity as commented on in the consultation paper – this could be overcome by regulations requiring renewal by insurers once coverage was accepted. This is not unusual in life and medical insurance regulation in other parts of the world but again, needs appropriate internal prudential controls to ensure adequate long-term pricing and sustainable claims-paying ability.

With significant incentives, take-up can be raised e.g. Australia has about 44% (Source: PHIAC website, Dec 2007) take-up based on tax disincentives if not purchased, increasing premium loadings with age for take-up at a later age and government partial contribution.

- Incentives could be –
  - Tax deduction for employer who provides for employees and their families;
  - Tax deduction for individual who purchases;
  - Government partial contribution; and
  - Offsets against any mandatory insurance requirements or medical savings account contribution requirements.

Chapter 12: Supplementary Financing Options – Mandatory Private Health Insurance

Overseas experience suggests that this can be a very effective system. Pooling mechanisms ensure that cost of chronic experience and imbalance between portfolios (e.g. age distribution) is shared across insurers. Multiple insurers can create better innovation and more competitive pricing, services.

Flexibility of coverage can allow for personal situation of the insured such as the accumulated personal health reserve, individual insurance, ability to personally fund deductibles, etc..

Chapter 13: Supplementary Financing Options (6) – Personal Healthcare Reserve

This seems to be the scenario favoured in this consultation paper. We will not comment in detail, but feel that there could be variations to the proposal.

- It could be compulsory to provide for immediate family members (unless they also have separate membership – with Hong Kong's dearth of children a government-sponsored children's PHR could be conceivable).
- Insurance could include rating elements beyond pure community rating -
  - Age and gender; and
  - To reward responsible behaviour ("preferred lives").

As the PHR is funded via a fixed percentage of salary, the lower income groups will likely fall back into the subsidized public health system when their PHR is exhausted

at older ages. This needs to be considered when modelling the financial impact of such a system.

Chapter 14: Building a Healthy Tomorrow

The consultation document lists out ambitious targets, notably

- The promotion of a culture of shared responsibility for personal health and greater emphasis on healthy lifestyle and preventive care.

We believe that better financial incentives and disincentives both for consumers and providers have to be incorporated to achieve this.

- Promote healthy competition and collaboration between the public and private sectors in the market that can further enhance professional quality and cost-effectiveness of services

We believe collectively agreed (but not mandatory) standard fee schedules and transparency of charging will be needed to achieve this.

- Improve the health of our community continuously through more efficient and cost-effective healthcare, with more emphasis given to primary care, especially preventive care

We believe that more specific incentives and disincentives are needed to achieve this.

Ultimately, the consultation paper is particularly concerned with the post-retirement funding of health care costs. Implicitly it suggests that current MPF funding will be insufficient to pay for non-subsidised health care cost post-retirement. Clearly, risk pooling combined with further old-age funding mechanisms will be a preferred option and likely the insurance industry will play a dominant role in this as it already does in the retirement savings system.

We note that another option to consider is the more explicit separation of the long-term savings requirements for health care costs in later life from the short-term funding mechanism. The contributions for longer term health savings could be readily incorporated into the existing MPF system with no amendment. This would require, however, more structure around retirement incomes policy to ensure that on retirement the individual either purchased insurance or retained some of the accumulated funds for meeting health care costs, rather than spending the balance at retirement as is possible today. This alternative has advantages as follows –

- Lower implementation costs
- Avoidance of part of the problem of "locked up funds" - as described in the consultation paper - as the MPF assets are typically fully invested for the longer-term
- Better incentives to the health user for managing short-term care costs because "excess" balances could be used for reimbursements, withdrawals or

payment of short-term insurance premiums could be incorporated into a medical savings account that focused on the short-term needs.

Linkage to the MPF system does entail certain risks:

- Preferential access to this new market segment for incumbent MPF providers and thus potentially limited competition
- Danger of multiple regulators e.g. an insurer could be regulated for Pensions, PHR, life insurance, health insurance, medical services, all with separate regulators irrespective of links between them.

We will be pleased to provide further comments and suggestions in the second round of this consultation process.

Meanwhile should you need any clarification on the above, please do not hesitate to contact the undersigned at tel: 9190 8822 or email: peterluk@peterluk.com.

Yours sincerely,

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