Chapter 5 – Options for Financing Health Care Service

The Challenge

105. At present, about 94% of the hospital services rendered to the local population are provided by the public sector. It is important for the benefit of the whole community that we must have a financially sustainable public hospital system. At a charge of $68 per bed per day in a general ward and $44 per specialist out-patient attendance, the public health care services are currently heavily subsidised by general revenue. Fee income accounts for only about 2.5% of the Hospital Authority's recurrent operating expenses. In 2000-01, the public sector health care recurrent allocation amounts to $30.8 billion, taking up 14.7% of the total recurrent public expenditure.

106. We expect the health cost to continue to grow, and this pressure is not only confined to Hong Kong but is common to many other health care systems. First, the population is aging. At present, 11% of our population are at 65 or above. We expect this figure to increase to 15% in 2019 and to 20% in 2029. Older individuals have a greater cumulative risk of chronic illness and disability, requiring more intensive medical and rehabilitative services. About 46% of the bed days in public hospitals are now taken up by persons at 65 or above. Technological advances enable health systems to treat illnesses and disabilities hitherto to which no curative option was available; and community aspirations add further pressure to cost. New technologies are generally labour intensive and tend to be financially expensive and need to be managed to ensure they are appropriately applied,

effectively used and financially accessible. With a robust mechanism for technology management, we anticipate that new technologies in the coming years can be maintained at a cost-increase of approximately 1% per annum, but this is probably a conservative estimate. People always tend to ask for more and better health care services as society gets more affluent. Some overseas studies have shown that when per capita GDP increases by 1%, health care expenditure per capita increases by 1.67%.

107. The Harvard consultants have pointed out that the long term financial sustainability of our current health care system is highly questionable. They predict that public health care recurrent expenditure, as a percentage of the total recurrent public expenditure, would increase from the current 14.7% in 2000 to as much as 28.4% by 2016, based on an annual 3% real GDP growth rate. While the situation may not turn out to be as predicted, especially as the Hospital Authority has already implemented many programmes to enhance productivity and reduce cost, the growth trend is however unmistakable. To expect such a major increase in the allocation of public revenue to health care will not be realistic as it will mean corresponding major reductions in other equally deserving public programmes, such as education, welfare and infrastructure. On the other hand, inadequate funding to the public health care sector will hurt the lower income groups, who have to depend on public sector health care services. Generally, as the population ages and the percentage of younger (and working) people declines, a financing model based on inter-generational subsidisation, that is, with the younger people paying taxes and contributing to the health care of their elders, has fundamental difficulties regarding long term viability.

108. This chapter looks at how to identify and obtain supplementary funding to finance the public health care system.

Objective

109. One fundamental role of the public health care system in Hong Kong is to protect the citizens from potentially huge financial risks arising from catastrophic or prolonged illness. To fulfil this role, the public health care system must remain accessible to all, affordable by individuals, and of a high standard. We shall continue to invest in the public health care service and ensure that it provides protection for the citizens from potentially huge financial risks, but in the light of the rapidly rising cost, we need to identify supplementary funding sources to ensure the system's financial sustainability in the long term.

Strategic Directions

110. To achieve our objective, we propose to pursue the following strategic directions :-

(a) Reduce costs and enhance productivity;
(b) Revamp public fees structure; and
(c) Establish Health Protection Accounts.

Reduce Costs

111. We always believe that the first place to look for new resources is from within the organisation. Reducing costs and enhancing productivity can yield significant savings for re-

deployment, and this effort must be a continuous one. The reforms to the delivery system described in Chapter 3 will help slow down the increase in total health care costs in the long term. In the interim, the public sector has different cost containment mechanisms that will help produce savings and keep the total costs down. These mechanisms include :-

(a) rationalisation of service delivery network to minimise duplication – The Hospital Authority at present organises its public hospital services by eight hospital clusters, with hospitals and facilities within each cluster complementing each other. The Authority is taking active steps to enhance and enforce this cluster concept, and to take this a step further by developing an integrated community-based health system, incorporating primary medical care and strategies of partnerships with private health care providers, welfare services and community organisations;

(b) improvement of productivity and operational efficiency through service re-design and process re-engineering – The Hospital Authority has pursued a programme of productivity gain initiatives since its establishment, and has so far achieved an accumulated savings of 9% of its recurrent operating cost. These efforts will continue;

(c) structured management of health care technology to ensure cost effectiveness – The Hospital Authority will strengthen its established mechanisms to consider the desirability, appropriateness and effectiveness in the

introduction and diffusion of new technologies in the service;

(d) development of guidelines and protocols to guide appropriate application and ultilisation of investigations and services – The Hospital Authority will expedite efforts in this respect, which will also help improving the overall quality of service; and

(e) appropriate pricing of public services to influence both provider and patient behaviour - pricing has always been an effective tool in influencing health-seeking and health-giving decisions. Cost could be better managed as a result of more appropriate use. This will be discussed further in subsequent paragraphs.

Revamp Fees Structure

112. The financial pressure on the public health care system is further aggravated by the fact that funds available are not sufficiently well targeted in terms of service provision or population groups. These problems have arisen because of our current fees structure. Recipients of comprehensive social security assistance can apply to have their medical fees waived, but apart from this, our existing fees structure does not distinguish the rich from the poor. The huge subsidy invested in the system, plus the improving standards, have attracted to the public sector a substantial number of patients who can afford to pay more. In short, as a result of the present fees structure, we have not been able to prioritise our resources to areas of greatest needs.

Proposal

113. We propose to carry out a full-scale review of our fees structure. We have no intention of reducing Government commitment to the financing of the public health care system, and indeed, we would expect the allocation from General Revenue to continue to increase in future, having regard to community needs and economic growth. The aim of the review is to examine how to target our subsidy to various services in the most appropriate manner. We believe that public funds should be channeled to assist lower income groups and to services of major financial risks to patients. The review should also examine how the relative priorities of services provided may be reflected in the subsidy level and how inappropriate use and misuse of services can be minimised. Following the review and the consequent revision of the fees structure, charges will continue to be affordable but could be effective in influencing patient behaviour to minimise inappropriate use and misuse. The revised fees structure will also influence the distribution of workload between the public and private sectors.

114. We propose that whatever the revisions, the fees must be set at a level generally affordable by individual patients. We are aware that there are always patients who cannot afford even a highly subsidised fee. We propose that we must continue to uphold our long-held policy of ensuring that no one is denied adequate medical care because of insufficient means. In addition to the first safety net provided by Government, namely, the allocation from General Revenue to provide heavy subsidies to the public health care sector, we should build up a second safety net,

similar to the existing Samaritan Fund, to assist those who have insufficient earnings or who have difficulty to pay for even the heavily subsidised services because of serious or chronic illnesses. Patients eligible can apply for full or partial subsidy.

Implementation

115. We shall immediately proceed to conduct a detailed study of the fees structure and how it can be restructured to reflect the objective of targeting the public subsidies at areas of greatest needs. The study will include an evaluation of the impact of the restructured fees and charges on utilisation and on the financially vulnerable. We estimate that the study will take about 18 months to complete.

Establish Health Protection Accounts

116. For the longer term, the Harvard consultants recommended to establish a Health Security Plan with mandatory contribution of 1.5% to 2% of the salaries from the working population to pay for large medical expenses. This proposal is based on the risk-pooling concept, spreading the financial risks arising from serious illnesses among the entire population and relying on substantial copayments and deductibles as demand management tools to maintain its financial viability. This proposed Health Security Plan have not been well received by the local community. It has also been pointed out that while the concept of risk-pooling is appealing, it involves inter-generation subsidisation; and given the aging population and the declining percentage of young people in Hong Kong, such an approach will put undue funding pressure on future generations. The adequacy of the levels of contribution has not been studied, and

with a smaller proportion of the population in actual employment as the population ages, premium will inevitably rise. In view of the public sentiment, and a probable scenario in the future of having to raise the premiums and/or increase copayments (user fees) substantially to maintain the financial viability of the system, we do not recommend to pursue further this proposal of Health Security Plan.

117. We have also considered the pros and cons of promoting a scheme of voluntary insurance as the main source of supplementary funding to the health care system. At present, the low levels of public sector fees have been regarded as the main disincentive to the expansion of voluntary insurance. To induce the public to purchase private insurance will require substantial increases in public sector fees. Furthermore, as long as purchase is voluntary, there will be population groups who will not have insurance protection either because of their own choice or because they are rejected by the insurance companies. These population groups could suffer substantial financial risks arising from illness under such a scheme.

118. The above said, we would like to emphasise that we recognise the potential contribution of voluntary insurance as one of the sources of supplementary funding of the health care system and that it could provide greater choice. While we shall recommend to establish a savings scheme, as described below, as the principal supplementary source of funding for the longer term, we encourage the medical insurance sector to create new health products and devise attractive packages for the public to consider. We are confident that there would be a market for these products and packages in certain sectors of the population.

Proposal

119. To reduce the burden on our next generations and to strengthen the long term financial sustainability of the public health care system, we propose to introduce medical savings through a scheme of Health Protection Accounts as the principal supplementary funding source for health care services in the longer term. We propose that this scheme should comprise the following features :-

(a) This will be a mandatory contributory scheme, with every individual putting approximately 1 to 2% of the earnings to a personal account, from the age of 40 to 64, to cover the future medical needs of both the individual and the spouse. The savings will attract investment returns.

(b) The savings cannot normally be withdrawn until the person reaches the age of 65 (or earlier in case of disability). Upon withdrawal, the savings can be used either to pay for medical and dental expenses at public sector rates, or to purchase medical and dental insurance plans from private insurers.

(c) If the person chooses services in the private sector, the person will still be reimbursed only at the public sector rates from the accumulated savings. The price difference will have to be met either from the person's own means outside the savings account or from the entitlement of private insurance.

(d) In the case of the death of an individual, any unspent savings left in the account will be passed on to the surviving family.

120. This Health Protection Account is designed to assist individuals to continue to pay for heavily subsidised medical services after retirement, and not to shift the burden to the next generations. In order to keep the savings rate to an affordable minimum, we have therefore proposed to limit the withdrawal by the individual to until age 65 and above and to reimburse the individual only at public sector rates. For those patients who prefer private sector services, the savings will help meeting the medical bills. We estimate that for a family at median income level, the couple will be able to pay for, based on the territory's average utilisation rate, their medical expenditure at public sector rates up to the average life expectancy age. For those patients who have managed to save very little or who have already exhausted their savings because of frequent sickness, they will have the assistance of the second safety net provided by Government.

121. While the above proposed Health Protection Accounts will assist individuals to pay for their medical needs, a small group of our population will require, in addition to medical treatment, long term nursing care. This group of people, while medically in stable conditions, suffer from various degree of disability and require multi-services, from health care professionals to personal care helpers, to assist them either to live in the community or in nursing homes. Prolonged long term care is expensive, and will become a heavy burden on the recipients and their families. The Harvard consultants recommended to establish a separate personal savings account, called MEDISAGE, with contributions

from the individual at the rate of 1% of the salary, to purchase long term care insurance upon retirement. Both the contribution and the purchsae of insurance would be compulsory.

122. This proposed MEDISAGE scheme has been well received by the community. The two principles underlying the scheme are self-responsibility (savings) and risk-pooling (insurance), which we support. However, as long term care insurance is not well developed in Hong Kong, we would require to conduct more in-depth studies of the different options for long term care and the detailed features of such a scheme, including the rate of contributions, the services to be included in the scheme, and whether or not the purchase of insurance should be mandatory or voluntary. We propose to proceed with a study immediately and we may suggest modifications to the MEDISAGE proposal, subject to the findings of the study.

Implementation

123. Subject to the community's views on our proposals, we shall commission in 2001-02 a study on Health Protection Accounts, which will examine in detail the merits of such a scheme and its feasibility for application in Hong Kong. We expect that the study will take about 18 months to complete, and we shall consult the public on the study findings and recommendations. In parallel, we shall carry out a detailed study on the long term care needs of our population and how best to finance and provide these services. We expect to have a report of the study in 2003, and we shall consult the public on the recommended way forward.