Supplementary financing in Hong Kong’s mixed health care economy – Health Protection Scheme 2010

Professor Gabriel M LEUNG
Under Secretary for Food and Health
HKSAR Government
5 March 2011

Hong Kong Institute of Asia-Pacific Studies 20th Anniversary Conference, the Chinese University of Hong Kong
Macro-organisation of the HK Health System

Public Health

- Department of Health & Centre for Health Protection
  - Disease prevention and control (communicable and non-communicable diseases)
  - Elderly health
  - Health education
  - HIV/AIDS service
  - Maternal and child health
  - Port health
  - Student health
  - Tobacco control
  - Tuberculosis service

- General population

Personal Health Care

- Public
  - (Food and Health Bureau)

- Government general revenue
- Hospital Authority
  - 41 hospitals
  - GOPCs, SOPCs

- Minimal out of pocket fees (waived for the indigent)

- Employers
- Private insurers/MCOs

Private providers

- Western allopathic medicine (73%)
- Chinese medicine (14%)
- Dental medicine (10%)
- Laboratories (3%)

- Mostly individuals from middle and upper socioeconomic strata (except for Chinese medicine use)

Market share

- Inpatient (bed-days) (admission)
  - Public: 90%
  - Private: 10%
  - 80%
  - 20%

- Overall outpatient incl. TCM
  - Specialist: 30%
  - Public: 70%
  - Private: 30%
  - TCM: 50%
  - 70%

- GP: 50%
- 70%
Health spending by financing source

Source: Hong Kong’s Domestic Health Accounts 1989/90 – 2006/07
## Total Health Expenditure by Financing Source, 1989/90-2006/07 (HK$ Million)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>7,749</td>
<td>15,844</td>
<td>25,316</td>
<td>35,800</td>
<td>39,152</td>
<td>37,094</td>
<td>36,930</td>
<td>37,417</td>
<td>9.7%</td>
</tr>
<tr>
<td>PHI</td>
<td>2,338</td>
<td>3,622</td>
<td>6,015</td>
<td>8,198</td>
<td>8,117</td>
<td>8,434</td>
<td>9,057</td>
<td>9,786</td>
<td>8.8%</td>
</tr>
<tr>
<td>Individually purchased PHI</td>
<td>263</td>
<td>419</td>
<td>1,336</td>
<td>2,188</td>
<td>2,721</td>
<td>3,284</td>
<td>3,663</td>
<td>4,213</td>
<td>17.7%</td>
</tr>
<tr>
<td>Employer-provided PHI</td>
<td>2,075</td>
<td>3,204</td>
<td>4,680</td>
<td>6,010</td>
<td>5,396</td>
<td>5,150</td>
<td>5,395</td>
<td>5,573</td>
<td>6.0%</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>9,202</td>
<td>14,332</td>
<td>18,963</td>
<td>21,347</td>
<td>20,847</td>
<td>22,114</td>
<td>23,753</td>
<td>26,451</td>
<td>6.4%</td>
</tr>
<tr>
<td>Others</td>
<td>370</td>
<td>375</td>
<td>993</td>
<td>928</td>
<td>571</td>
<td>620</td>
<td>903</td>
<td>1,394</td>
<td>8.1%</td>
</tr>
<tr>
<td>Total</td>
<td>19,659</td>
<td>34,173</td>
<td>51,288</td>
<td>66,273</td>
<td>68,687</td>
<td>68,263</td>
<td>70,643</td>
<td>75,048</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

Source: Hong Kong’s Domestic Health Accounts 1989/90 – 2006/07
Health spending by healthcare function and financing source (2006/07)

- Inpatient curative care: 69% Public, 31% Private
- Day patient hospital services: 86% Public, 14% Private
- Ambulatory services: 33% Public, 67% Private
- Home care: 94% Public, 6% Private
- Rehabilitative and extended care: 97% Public, 3% Private
- Long-term care: 83% Public, 17% Private
- Ancillary services to health care: 72% Public, 28% Private
- Medical goods outside the patient care setting: 8% Public, 97% Private
- Prevention and public health services: 93% Public, 7% Private
- Health programme administration and health insurance: 10% Public, 90% Private
- Investment in medical facilities: 63% Public, 37% Private

Source: Hong Kong’s Domestic Health Accounts: 2006/07
Hong Kong has spent relatively less on health compared to OECD countries

Source: OECD Health Data 2010, June 2010
Hong Kong’s Domestic Health Accounts: 2006/07
...although public spending is commensurate with the different levels of public revenue between countries.
Sources of Government Revenue

Notes:

- Indirect taxes include bets and sweeps tax, hotel accommodation tax, stamp duties, air passenger departure tax, duties, general rates, motor vehicle taxes, royalties and concessions, and tax-loaded fees and charges.
- Others include fines, forfeitures and penalties, loans, reimbursements, contributions and other receipts, utilities, fees and charges (excluding tax-loaded fees), and capital revenue (excluding land premium).

Source: Census and Statistics Department website
Hong Kong tax revenue compared to OECD economies in 2009

Notes:
- Profits Tax includes Profits and Capital Gains Taxes on enterprises.
- Personal Income Tax includes salaries tax, personal assessment and property tax.
- Social Security Tax includes all compulsory payments that confer an entitlement to receive a future social benefit. Hong Kong has a Mandatory Provident Fund Scheme that provides for retirement benefits. For OECD definitional purposes, this is not considered as a social security tax.
- Payroll tax includes taxes paid by employers, employees or the self-employed which do not confer entitlement to social benefits. There is no such tax in Hong Kong.
- Property-related Taxes include rates, stamp duties, and estate duty. (Estate Duty was abolished with effect from 11 February 2006)
- Consumption Tax includes taxes on all goods and services. In Hong Kong, it includes duties, bets and sweeps tax, hotel accommodation tax, air passenger departure tax and motor vehicle tax.
- In Hong Kong, Others refer to income from royalties and concessions.
- Figures for Hong Kong are in 2009/10.
- The OECD figure does not add up to 100% due to rounding.

Hong Kong Annual Digest of Statistics 2010, C&SD
A historical timeline of public consultations
Where are we now?

Healthcare Reform

Second Stage Public Consultation

Sustainable Healthcare System:
- Provide holistic primary care
- Provide more quality choices
- Provide lifelong health protection
- Continue partnership for health

First Stage Public Consultation

Promote public-private partnership

Enhance primary care

Develop electronic health record

Introduce supplementary financing

Strengthen healthcare safety net

My Health  My Choice
Population Coverage of PHI, 2005 to 2009

Need to Reform Healthcare System

- Strongly agree / agree: 66%
- Indifferent: 17%
- Strongly disagree / disagree: 11%
- Don't know / no comment: 6%

Source: Opinion Poll on Healthcare Reform and Financing, March to August 2008
Voluntary Private Health Insurance Preferred

Source: Opinion Poll on Healthcare Reform and Financing, March to August 2008
On the public revenue side, spending on health has been broadly commensurate. Without a major review and revamp of the public revenue model, there is limited scope to generate new resources for health.

Private insurance as a financing source has grown considerably, although adverse and risk selection remain unresolved. Many products are designed to take advantage of the public delivery system, exacerbating these abnormal economic forces.

First Stage Consultation (2008): Healthcare Service and Financing Reform

- The public support reform in general, but have reservations about mandatory supplementary financing
- Prefer voluntary private health insurance, and choice of private healthcare services according to one’s needs
- Want more choice and better protection beyond public healthcare services provided by the Government
Voluntary Health Protection Scheme (HPS)
- Standardise and regulate voluntary private health insurance by legislation for consumer protection
- Formulate HPS core requirements and specifications to address shortcomings of existing private health insurance
- Consider making use $50 billion fiscal reserve to provide incentives to HPS subscribers
Public Healthcare: Unwavering Government Commitment

4 Core Targets:
• Acute and emergency care
• Care for low-income and under-privileged groups
• Catastrophic illness requiring professional team work, advanced technology and high cost
• Training of healthcare professionals

* Recurrent expenditure on health as a share of the Government’s total recurrent expenditure
Health Protection Scheme: Voluntary and Government-Regulated

HPS benefits everyone

Healthcare system:
- More choices and better protection
- More sustainable development

Health Protection Scheme: Sustainable and reliable protection

Health Insurance:
- Accessible to all
- Guaranteed renewal
- Fully portable
- Transparent premium
- Consumer protection

Private healthcare:
- Increase capacity
- Quality assurance
- Healthy competition
- Transparent pricing
- Consumer confidence

Public healthcare:
- Safety net for all
- Queue relief
- Needy groups
- Acute & emergency care
- Catastrophic care
### Health Protection Scheme – What it is (is not)

<table>
<thead>
<tr>
<th>HPS is ...</th>
<th>HPS is not ...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A supplementary financing</strong> option for more effective use of private health expenditure, with a positive effect on the sustainability of long-term healthcare financing</td>
<td><strong>Not</strong> a panacea that can solve the long-term healthcare financing problem completely given its voluntary nature</td>
</tr>
<tr>
<td><strong>A regulated scheme</strong> to promote value-for-money services and enhance consumer protection in the private healthcare insurance and healthcare markets</td>
<td><strong>Not</strong> a reduction of public health expenditure or public healthcare services which remains the safety net for all</td>
</tr>
<tr>
<td><strong>A measure to facilitate</strong> healthcare service development, enhance service capacity, competition and transparency in private healthcare, relieve pressure on public system, and enhance sustainability of healthcare system</td>
<td><strong>Not</strong> a once-and-for-all scheme – it requires continued monitoring and adjustment, including the use of the $50 billion fiscal reserve set aside</td>
</tr>
<tr>
<td>Feature</td>
<td>Health Protection Scheme</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Guaranteed renewal for life</td>
<td>Yes</td>
</tr>
<tr>
<td>Coverage for pre-existing conditions</td>
<td>Increasing protection after waiting period</td>
</tr>
<tr>
<td>Portability of insurance policies</td>
<td>Yes</td>
</tr>
<tr>
<td>Upfront certainty of protection &amp; charges</td>
<td>Yes (packaged charging based on diagnosis-related groups (DRG))</td>
</tr>
<tr>
<td>High-Risk Pool reinsurance</td>
<td>Yes</td>
</tr>
<tr>
<td>No-claim discount</td>
<td>Yes</td>
</tr>
<tr>
<td>Premium adjustment</td>
<td>With published guidelines</td>
</tr>
<tr>
<td>Standardised terms and conditions</td>
<td>Yes</td>
</tr>
<tr>
<td>Govt-regulated claims arbitration mechanism</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Health Protection Scheme – Coverage

HPS Plans

- **Top-up**: Better amenities and higher benefit limits
- **Core requirements**
  - Hospital admissions or ambulatory procedures
  - Associated specialist services and advanced diagnostic imaging
  - Chemotherapy or radiotherapy for cancer
  - Specialist services and advanced diagnostic imaging in general
- **Top-up**: Other services not covered by Standard Plans, e.g., general out-patient, dental care, maternity, etc.
Insurer to offer renewal into HPS Plans

- Plan A
- Plan B
- Plan C

Standard Plan
- Core requirements

Standard Plan with top-up
- Core requirements
- Top-up components

Standard Plan with top-up
- Core requirements
- Top-up components
## Health Protection Scheme – Access for Higher Risk Groups

### Higher Risk Groups to Access HPS

<table>
<thead>
<tr>
<th></th>
<th>Lower risk / premium</th>
<th>Proposal</th>
<th>Higher risk / premium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Lower waiting period</td>
<td>Higher premium cap</td>
<td>Shorter period for full cover</td>
</tr>
<tr>
<td></td>
<td>Lower ratios for reimbursement</td>
<td>Lower reinsurance</td>
<td>Higher ratios for reimbursement</td>
</tr>
<tr>
<td></td>
<td><strong>x years</strong></td>
<td><strong>300% + 100%</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Longer waiting period</td>
<td>Capped at 3 times the published premium</td>
<td>Lower premium cap</td>
</tr>
<tr>
<td></td>
<td>Lower reinsurance</td>
<td><strong>Higher reinsurance</strong></td>
<td>Higher reinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>1-year waiting period; reimburse 25% in 2nd year; 50% in 3rd year; 100% after 3rd year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Set upper age limit for entry</td>
<td>65+ may join within 1st year with no cap on premium plus loading</td>
<td>Apply premium cap</td>
</tr>
<tr>
<td></td>
<td><strong>Apply premium cap</strong></td>
<td><strong>Higher reinsurance</strong></td>
<td></td>
</tr>
</tbody>
</table>

**My Health My Choice**
We propose that financial incentives (one-off or recurrent) be considered in the following three directions making use of the $50 billion fiscal reserve earmarked to support healthcare reform –

- **Protection for high-risk individuals**: Government injection into High-Risk-Pool where necessary to buffer the excess risks arising from a large number of high-risk individuals joining the HPS

- **Premium discount for new subscribers**: subsidies for new joiners during a limited period after HPS introduction to enjoy maximum no-claim discount, i.e. to receive 30% discount on Standard Plan premiums immediately upon joining

- **Savings for future premium**: encourage savings (through options below) by individuals for paying future premium at older age (say 65+)
  - Required in-policy savings: government subsidies for savings
  - Optional savings accounts: government subsidies for savings
  - Save on their own means: premium rebate based on insured length
Health Protection Scheme – Provider Payment

Reimbursement of medical fees

Scenario 1: Packaged charging

- Check private hospital for packaged charging
- Check insurer for coverage and co-payment
- Certain coverage and transparent co-payment upfront
- Insurer pays private hospital and charges patient for co-payment

Scenario 2: Itemized charging

- Check itemized benefit schedule of insurance plan
- Check with private hospital for medical fees
- Do not know in advance how much would be charged and how much extra payment needed
- Patient pays private hospital first, then gets reimbursement from insurer and foots the difference
### Health Protection Scheme – Proposed Supervisory Structure

- **Oversee scheme implementation and operation, and monitor achievement of scheme objectives**
- **Proposed supervisory structure:**
  - **Prudential regulation:** a regulator (Office of the Commissioner of Insurance) to supervise financial soundness and capability of insurers, ensure that they could discharge obligations to the insured, and oversee complaint handling mechanisms applicable to insurance in general.
  - **Quality assurance:** an authority (Department of Health+) to supervise quality and standards of hospital services, oversee hospital accreditation and clinical audits, collect benchmarking information and statistics, and carry out other quality assurance measures.
  - **Scheme supervision:** a new dedicated agency to supervise scheme implementation and operation - product registration, regulation of health insurance products, collecting pricing and costing information, compiling pricing and costing information of healthcare services, and administering claims arbitration mechanism.

- **Require legislative changes to support implementation of these supervisory functions.**
Healthcare Infrastructure & Manpower

- **Private healthcare capacity**
  - Implementation of the HPS requires corresponding expansion in the capacity of the private healthcare sector

- **Private hospital development**
  - Known/planned private hospital development expected to be able to meet increased demand
  - New private hospitals required to provide certain proportion of services based on packaged charging
  - Government to monitor demand for private healthcare services and ensure sufficient capacity to meet

- **Healthcare manpower planning**
  - Government will undertake manpower planning for various healthcare professions to assess training needs
  - Will take into consideration potential demand arising from expansion of the healthcare system and implementation of the healthcare reform initiatives