Development and Financing of Hong Kong’s
Future Health Care

Final Report

The Bauhinia Foundation Research Centre
Health Care Study Group

August 2007
Hong Kong
Contents

I. INTRODUCTION.................................................................................................................. 2
   The Need for Reform ........................................................................................................... 2
   Focus of the Health Care Study Group ............................................................................... 3
   Goals and Principles of the Health Care Study ................................................................. 4

II. HONG KONG’S HEALTH CARE DELIVERY AND FINANCING......................... 6
   Overview of Past Reform Initiatives .................................................................................. 8
   Pressure Points and Key Concerns ................................................................................... 10

III. GUIDING PRINCIPLES OF REFORM................................................................. 14

IV. OPTIONS FOR CHANGE............................................................................................. 15
   The Tax-Based Model ....................................................................................................... 15
   The Social Health Insurance Model .................................................................................. 16
   The Voluntary Private Health Insurance Model ............................................................. 16
   The Medical Savings Model ............................................................................................ 17
   Findings .......................................................................................................................... 17

V. THE PROPOSAL: A NEW HEALTH CARE MODEL..................................... 18
   Three Pillar Framework ................................................................................................... 19
   Enhanced Primary Health Care ...................................................................................... 23

VI. COMPARISON OF DIFFERENT FINANCING APPROACHES...................... 24

VII. MERITS OF MEDICAL SAVINGS ACCOUNT............................................... 26

VIII. INSTITUTIONAL ARRANGEMENTS............................................................... 30

IX. CONCLUSION........................................................................................................... 33

APPENDICES
   I HEALTH CARE STUDY GROUP: MEMBERSHIP AND TERMS OF
      REFERENCE..................................................................................................................... 35
   II KEY STAKEHOLDER COMMENTS, QUESTIONS AND SUBMISSIONS
      ON PRELIMINARY REPORT......................................................................................... 37
I. INTRODUCTION

Health systems in many parts of the world are facing increasing challenges to improve access, enhance quality and to hold down rising health care costs and spending. People and decision makers are demanding better value, coordinated health care, focus on wellness and prevention, reduced waiting time and access to information. Many governments are either contemplating or implementing initiatives to reform their health care systems to respond to changing needs and demands.

2. Hong Kong’s health system is the envy of many people throughout the world. It leads many others with some of the best vital statistics and performance measures. Particularly noteworthy are the low infant mortality rate, long average life expectancy at birth, well-trained health and medical professionals and low out-of-pocket payments in using public health care services.

The Need for Reform

3. Yet, like many others, Hong Kong’s health system is fragmented and not patient centred. There is little focus on integrating primary and secondary care. It also faces the following challenges:

(a) **Rising morbidity rate for certain common diseases** – Despite impressive health indicators in terms of life expectancy and infant mortality rate, the morbidity rate for certain common illnesses, such as diabetes mellitus and the different kinds of cancer which are the number one killers in Hong Kong, are rising. Long waiting lists, stress of modern life, underdevelopment of preventive and primary care, have contributed to a worsening of this rising trend.

(b) **Limited and inadequate capacity to respond to changes in the demographic structure** – The changing demographic structure arising from low birth rate, a shrinking labour force and rising proportion of retired elderly persons will bring differential medical needs amongst the different age groups of the elderly population. There is increased dependency ratio with the shrunken workforce. The current health system’s capacity to deal with these emerging needs and demands is limited and inadequate.

(c) **Under-development of preventive care** – The system has been criticized as too compartmentalized, resulting in poor coordination and workload imbalance between the public and private sectors as well as between primary and secondary/tertiary care sectors. Among users, there is an over-reliance on treatment and insufficient emphasis on prevention and personal health.

(d) **Low health awareness** – The public’s over-reliance on treatment and tendency to go for quick fixes suggest that there is much that must be done in instilling a sense of self-responsibility for one’s own health, in strengthening the focus on health and wellness and in promoting proper health seeking behaviours and lifestyles.
Improving the quality of care – The two preceding challenges suggest that improved quality of care in areas such as greater efficiency, more responsive patients care, accelerated adoption of innovative interventions and preventive measures, more judicious use of health care resources and strengthened systems management and performance should be key focuses of future health care development.

4. Previous reform proposals are testimony to the concerns and need to develop a responsive and sustainable health care system for all. But the concept that health care is a common good and that health care resources should be protected, like the environment, from wrongful and wasteful use in order to be sustainable has not been previously highlighted. There was little emphasis on encouraging self-responsibility, improving people’s health seeking behaviour and promoting proper use of health care resources. There was little attention given to influencing provider and government behaviours to achieve equitable, efficient and effective health care for all.

5. Developing a sustainable and responsive health system has been a clearly articulated goal. But what was to drive the development and financing of a sustainable and responsive system was not made explicit. Although financing plays a significant part and is a necessary condition for better health, other critical factors include societal values, people behaviours, and clear system goals and health targets. There is also need for a system of integrated institutional arrangements and payment incentives to drive service delivery and promote proper behaviours. Without these, simply having more money for health may actually do more harm than good. Sustainability should be about value and behavioural changes as well as effective institutional arrangements, not just financing.

Focus of the Health Care Study Group

6. This study aims to propose a way forward to strengthen the responsiveness and sustainability of the Hong Kong health system so that it will continue to safeguard and enhance people’s health, meet patients’ changing needs and expectations and be prepared for future rising costs of care. The Bauhinia Foundation Research Centre appointed a Health Care Study Group in August 2006 to undertake the study with support from consultants. The membership and terms of reference of the Study Group are set out in Appendix I of this report.

7. The Study Group deliberated in detail the various issues relating to improving the effective functioning and enhancing the future sustainability of the Hong Kong health system. It also considered, among others, the following issues and concerns:

(a) the need for provision of essential services and a health care safety net for Hong Kong Society;

(b) the promotion of health and wellness for all;

(c) the viability of various financing options for assuring equitable access for all;

---

(d) the values and behaviours needed to underpin responsive service delivery and responsible utilization of the Hong Kong health care system; and

(e) the institutional arrangements required for an equitable, efficient and effective and quality health care system to achieve successful transformation.

Goals and Principles of the Health Care Study

8. Having taken into consideration feedback and submissions from the public engagement exercise after the release of its preliminary report and from meetings with key stakeholders (see Appendix II for the list of comments and suggestions), the Study Group reconfirmed that there is a need to put the patient at the centre of all our deliberations and proposals. The primary concern of our Study Group was to go beyond the issue of money and financing alone and focus on the health and wellness of our society as a whole. We believe that Hong Kong’s future health care development should aspire to attain the following goals:

(a) achieving better health and wellness with emphasis on prevention and joint responsibility;

(b) improving quality of care through enhanced service delivery, especially for the elderly and those with chronic diseases; and

(c) promoting system sustainability and effectiveness by changing individual behaviour, government behaviour and provider behaviour.

9. To achieve the aforementioned goals, the study will adhere to the following core values in developing recommendations and proposals:

(a) *Equity and accessibility* – The current tax-based health care financing system should continue to be the equitable and risk pooling mechanism that provides the safety net protection for Hong Kong residents. The new system should enhance the intergenerational equity in financing health care. It should also improve access to health care through enhanced primary health care services and adoption of new evidence-based drugs and technology.

(b) *Mutual care and joint responsibility* – There should be a strong focus on behavioural modification of users, providers and the Government to promote mutual care and joint responsibility within our health care system. There should be greater public participation and engagement to improve personal health and the system’s performance.

(c) *Efficiency* – Health care is a valuable societal resource. Early prevention should be promoted to reduce the need for care. Resource wastage should be reduced to the minimum. Better coordination in program management, more appropriate use of state of the art technological innovations, and
better integration of the public/private interface can result in more efficient and effective use of our valuable health care resources.

(d) *Quality* – There should be a strong emphasis on continuous improvement in quality of care based upon defined standards and a holistic view of care, and with care provided by registered or accredited providers.

(e) *Choice* – There should be greater transparency in the system to enhance patient choice and to foster personal responsibility for health. A systematic approach to promoting and developing public-private cooperation should be emphasized and offered as additional choice.
II. HONG KONG’S HEALTH CARE DELIVERY AND FINANCING

10. Hong Kong has a rather simple system of financing and delivery of health care (see Figure 1 below). The public sector is a tax-based budget funded system in which the Government subsidizes on average 95 percent of the total costs of care. The private sector is privately funded although nearly 3 million individuals have some form of health insurance cover, which is either self-purchased or employer-sponsored. The two sectors interface or collaborate infrequently. User choice is limited to either public or private sector care.

11. Outpatient care, mostly primary health care, is provided predominantly by private general practitioners, who provide over 70 percent of all outpatient consultations. Public general outpatient clinics provide approximately 15 percent of all outpatient consultations at a subsidized rate to mostly those with low income and patients with chronic conditions. The remaining 15 percent of outpatient visits are provided by private practitioners of alternative medicine, in which traditional Chinese medicine practitioners constitute the largest group. Expenditure on outpatient services constitutes around 50 percent of the total health care expenditure. Roughly 75 percent of outpatient expenditure is financed by out-of-pocket payments, with the remaining financed by employers or insurance³.

---

12. The bulk of specialist and inpatient care, mostly secondary and tertiary care, is financed and delivered through the public sector. The Hospital Authority owns and manages over 40 public health care institutions, and provides over 90 percent of all hospital beds in Hong Kong. Institutions under the Hospital Authority provide a comprehensive range of services at a heavily subsidized rate. The Hospital Authority receives over 90 percent of its income from the Government’s general revenue. Presently, private hospitals deliver roughly 6 percent of total inpatient care.

13. All Hong Kong residents are eligible to receive care from public hospitals and clinics at a heavily subsidized rate. Patients in public hospitals pay a fixed per diem fee of HK$100, which is less than 4 percent of the actual average cost of a patient day in an acute public hospital. The per diem fee is all-inclusive with the exception of a short list of the “Privately Purchased Medical Items (PPMI)” and drugs not included in the Hospital Authority’s Drug Formulary, for which patients have to pay the full cost separately.

14. The system, whereby the bulk of hospital services is funded by the Government and delivered by public hospitals and the bulk of general outpatient care is funded and delivered privately, has not changed much since the 1950’s. This arrangement has been criticized as too compartmentalized, resulting in poor coordination and workload imbalance between the public and private sectors as well as between primary and secondary/tertiary care sectors, and not sustainable in the long run.

15. Within the public hospital system, all health care providers are compensated on a fixed salary basis. Funding from government to the Hospital Authority has been mostly historically and facility based, recently moving towards more population based. Money does not follow patients.

16. There is insufficient financial incentive for public health care providers to be responsive to patients’ needs. Disincentives within the system are extensive, e.g. units that serve patients well will attract more patients, who will not bring in more resources. Despite these disincentives, quality of care in public hospitals generally improved after the establishment of the Hospital Authority, but spending also went up considerably. Waiting time for some non-urgent conditions, however, has worsened significantly in recent years.

17. Government total spending on health in 2001/2 was $39.1 billion, around 14.5 percent of total government expenditure. Around 90 percent of public sector health care funding goes to the Hospital Authority. Private expenditure on health services is roughly the same as that of government health expenditure.

18. Hong Kong has no compulsory health insurance or medical savings contributions. Public hospital services are financed almost entirely through government general revenue, despite the fact that tax rates in Hong Kong are amongst the lowest in the world, and the

---

percentage of tax payers is also low by industrialized countries’ standards. Private hospital services are financed through direct payment or private health insurance.

**Overview of Past Reform Initiatives**

19. While many countries in the Far East implemented substantive reforms in their health care financing systems in the 1980’s and 1990’s, Hong Kong did not. Singapore, for example, introduced medical savings accounts and major illness insurance in the eighties; South Korea and Taiwan both established national health insurance systems in the eighties and nineties respectively. These reforms aim to provide universal access to health care services and at the same time move the system away from being too reliant on general taxation to finance health care.

20. In Hong Kong, the major health care system reform initiative in the 1980’s to 1990’s was the formation of the Hospital Authority in 1990. The Hospital Authority exercise was not a health care financing reform measure. It restructured public hospitals under a corporate management framework to modernize care but did not implement any substantive change in the way hospital services are financed. The financing of hospital services remains primarily tax-based. There were no attempts to introduce competition to or within the massive public hospital system either.

21. With the long-term sustainability of the system being in question, suggestions for the reform of the health care financing system resulted in the publication of a number of consultation documents: *Towards Better Health*, *Improving Hong Kong’s Health Care System: Why and For Whom*, *Lifelong Investment in Health*, and *Building a Healthy Tomorrow*. The major proposals in these documents and their implementation status are as follows:

(a) *Towards Better Health*

The first consultation on health care financing reform took place in the early nineties. A consultation paper entitled *Towards Better Health* (often referred to as the “rainbow document” because of the design of the cover) was published in 1993. The paper proposed five reform options: (i) charging a higher co-payment based on a percentage of actual operating cost; (ii) the introduction of more expensive semi-private beds and other charges in public hospitals; (iii) encouraging more private health insurance through government registration of suitable plans; (iv) compulsory health insurance for all; and (v) having a core and non-core list for public hospital services.

---


10 Harvard Team 1999. *Improving Hong Kong’s Health Care System: Why and For Whom?* HKSARG Printing Department


hospitals, in which interventions not on the core list would have to be charged the full cost.

With the exception of the introduction of semi-private beds and the registration of private health insurance plans, all other reform options were poorly received by the public and most of the other stakeholders. However, the registration of private health insurance plans was never pursued. Semi-private beds were introduced as pilot schemes in selected hospitals. Even though they proved to be very popular with patients, perhaps due to opposition from private hospitals, the plan never went beyond the pilot stage.

(b) The Harvard Report

In November 1997, Government commissioned the School of Public Health of the Harvard University to re-examine the health care financing question. The Harvard Team put forward a number of financing options and recommended compulsory health insurance (the Health Security Plan (HSP)), savings and insurance for long-term care (MEDISAGE), and breaking up the giant Hospital Authority into twelve to eighteen regionally based “Health Integrated Systems” (HIS) as the way forward, along with a number of other suggestions for reforming the health care delivery and policy-making system.

The Harvard Report was extensively debated, but in the end, there was not much support for compulsory health insurance. Various surveys of the general public showed that less than 24 percent of those surveyed supported compulsory health insurance.

(c) Lifelong Investment in Health

A government consultation document (the third within a ten-year period) entitled Lifelong Investment in Health was issued towards the end of 2000. Noting that there was not much support for compulsory health insurance, the document put forward a medical savings proposal, termed Health Protection Account (HPA), requiring working persons reaching a certain age to contribute 1 to 2 percent of their earnings, which will be used to pay for health services in public hospitals after the age of 65.

The highly restrictive nature of the proposed plan did not receive support from the public or other stakeholders. Low income persons, who already had problems making ends meet, naturally opposed it, as the plan would further reduce their take home pay. The middle class and persons of higher
income felt that they were asked to contribute, on the top of their regular
tax contributions, to a system without any promise of getting better service
or more choice in return.

There were also doubts about whether the one percent of earnings
contribution to the medical savings account of the ordinary working
persons would be able to make any meaningful difference to the overall
health care financing picture\textsuperscript{16}. For persons of higher earnings, a large
amount of money would be locked up in their HPA, as they could not use it
to purchase private health care services.

\textit{(d) Building a Healthy Tomorrow}

In 2005, Government, through the Health and Medical Development
Advisory Committee, published a discussion paper on the future service
delivery model. While the paper did not contain specific proposals for
financing reforms, it re-emphasized the importance of primary care and the
role of family doctor, and defined more clearly the role of the public sector:
acute and emergency services, services for the low income groups,
catastrophic illnesses, and the training of health care professionals.

22. Public reactions to the main proposals of the previous consultation papers
unmistakably suggest the preference for incremental changes to the status quo, and that the
majority prefers to preserve the present tax-based financing system as the major source of
health care financing.

\textbf{Pressure Points and Key Concerns}

23. In spite of its many strengths and well-endowed financing provision at the moment,
Hong Kong’s health care system is stressed. There are excessive work loads, rising staff
shortages and worsening waiting times in the public sector. The private sector has limited
hospital capacity and can be easily affected by changes in the dominant and highly
subsidized public sector.

24. Like most developed economies in the world, escalating health care needs and
demand will pose a serious threat to the sustainability and responsiveness of our health
care system. According to the Hong Kong Census and Statistics Department, the
population is expected to remain on an ageing trend. The proportion of the population
aged 65 and over is projected to rise markedly, from 12 percent in 2006 to 26 percent in
2036, though the rise will be gradual up to around 2016 (when the proportion will reach
15 percent) and will pick up at a much faster pace thereafter. The elderly and overall
dependency ratios will also increase significantly during this period\textsuperscript{17}.

25. Maintaining the status quo is clearly not the answer to meeting users’ needs,
demands and expectations in future. What should be done to better prepare for the future?

\textsuperscript{17} Demographic Statistics Section, 2007. \textit{Hong Kong Population Projections 2007-2036}. Hong Kong
SARG: Census and Statistics Department.
Four problems are particularly noteworthy and should be the key concerns in reforming Hong Kong’s health care system:

(a) **Insufficient emphasis on prevention and personal health**

The provision of primary health care in Hong Kong is not well organized. Services tend to be episodic and treatment-oriented, lacking in continuity and sparse in prevention. An integrated multidisciplinary team approach, involving dentists, nurses, pharmacists, allied health professionals such as physiotherapists and occupational therapists working together with registered, accredited primary care doctors with training in family medicine in community health centers, to deliver holistic family-medicine-oriented primary health care is rare. In addition, there is little communication between Chinese and western medicine although the majority of the population uses both and better integration would enhance patient centred care.

Patients’ culture and health seeking behaviour tend to focus more on finding quick fixes than on prevention or adopting healthy lifestyles. The public has insufficient appreciation and emphasis on primary health care. Maintaining regular access to a doctor is also not common even though when a patient builds a continued relationship with the same doctor, the result is enhanced care, increased trust, and patient adherence to treatment regimens. There is an over-reliance on treatment and a tendency to shop for doctors and to place more value on expensive secondary or tertiary health care.

(b) **Imbalance between public and private sectors in secondary and tertiary care**

The public health care sector currently accounts for over 90 percent of total secondary and tertiary care. Its subsidy from the Government is huge, around 95 percent. That means low out-of-pocket payment for users. This imposes enormous pressures on public facilities and leads to long waiting time for patients, long waiting lists and increased workload for staff.

The public’s over-reliance on the public sector perpetuates dominance of the public sector which leaves little room for the private sector to innovate or for new players to enter the market. A more level playing field between the public and private sectors has yet to be fully realized in order to bring about better utilization of resources and overall improvement of our health system.

(c) **Sustainability of society’s health care resources in question**

With Hong Kong providing access to reasonably high quality health care to all of its residents at an affordable price, the sustainability of the system has been questioned by many. The aging of the population, aspirations for new technology and new drugs, adherence to the principles of a small government and low tax regime, and the unlikely change in magnitude in
future Government funding will stretch resources and impose increasing pressures on the public health care system (see Figure 2). This raises serious questions about the future sustainability of Hong Kong’s health care system if it remains unchanged.

**Figure 2 – Pressure Points on Public Health Care System**

The doubtful future financial sustainability of the public health care sector is discernible from another dimension. Unless changes are made, Hong Kong’s health expenditure, at 5.5 percent of Gross Domestic Product (GDP) in 2001/02, is estimated to increase to 7.5 percent by 2020 and 9.3 percent by 2030 (see Figure 3). The 2001/02 public sector expenditure constituted 57 percent of total health care expenditure or 3.1 percent of GDP. If this proportion remains constant in the future, public sector health expenditure may increase to 4.3 percent and 5.3 percent of GDP by year

<table>
<thead>
<tr>
<th></th>
<th>2001/02</th>
<th>2020</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Total Health Expenditure in GDP</td>
<td>5.5%</td>
<td>7.5%</td>
<td>9.3%</td>
</tr>
<tr>
<td>% of Public Health Expenditure in GDP</td>
<td>3.1%</td>
<td>4.3%</td>
<td>5.3%</td>
</tr>
<tr>
<td>% of Government Expenditure</td>
<td>14.5%</td>
<td>21.5%</td>
<td>26.5%</td>
</tr>
</tbody>
</table>

**Figure 3 – Health Expenditure in Hong Kong**

Source: Domestic Health Accounts 2001/02 and health care expenditure projection study by Gabriel Leung, 2006. Bauhinia assumptions: Government expenditure in 2020 and 2030 assumed to be 20% of GDP (maximum). Public health expenditure as proportion of total health expenditure in 2020 and 2030 assumed to remain constant at 57%.

2020 and 2030 respectively. However, assuming future Government expenditure will remain at 20 percent of GDP and allocation to public sector health care remain at 17 percent of total Government expenditure because of other competing demands, the public sector’s GDP share for health will at most be 3.4 percent.

By years 2020 and 2030, health care’s share of Government expenditure is projected to increase to 21.5 and 26.5 percent respectively. These percentages will mean cuts into other areas by a wide margin which is not likely to be acceptable to the community. This suggests that Government cannot afford to continue with the present system: it is not going to be sustainable in the future.

(d) Intergenerational equity not fully addressed

Hong Kong’s current tax-based health care financing system, essentially a pay-as-you-go system,\(^{19}\) has many benefits (see paragraph 25 below) and has always served as the safety net for its residents. This system of health care financing should be preserved so that no one should be deprived of essential health care because of the lack of means. Moreover, there is a strong demand from society that this safety net, which has been available to them for a long time, should continue so that they are protected from traumatic financial consequences in the event of major illnesses.

But as Hong Kong’s population structure changes, health care costs will increase steadily. The current pay-as-you-go system will incur a huge increase in future burden of these costs. That is, the burden of paying for health care of the elderly as the dependency ratio increases will be passed onto the shoulders of the younger generations of tax payers. This means that the tax-based financing approach will become increasingly non-viable if it is Hong Kong residents’ choice that taxes should not be increased to meet increasing health care costs. The issue of intergenerational inequity of burdens will become more severe in the future and pressure on the tax-based health care financing system may become insurmountable. What is needed is an equitable and effective way to pre-fund the health care spending of the elderly to enable them to achieve a healthy, independent old age before they get old.

---

\(^{19}\) In this type of system, money is collected from many individuals during a given year and spent on some of the individuals during that year. In itself, it is a form of risk pooling and is well known in health economics for its moral hazard problems.
III. GUIDING PRINCIPLES OF REFORM

26. Hong Kong’s health care system must change if it is to remain a sustainable and responsive system. Hong Kong’s future health system should aim to improve intergeneration equity, cherish health care resources as a common good, reduce waste, improve quality, enhance choice, achieve early prevention and detection of illness, raise awareness and promote mutual care and responsibility. Towards these goals, proper user, provider and government behaviours should be nurtured to drive the health system’s effectiveness and sustainability.

27. We propose that the following be the guiding principles, underpinned by equity, accessibility, efficiency, quality, choice, mutual care and joint responsibility as core values, for reforming Hong Kong’s health system:

(a) *Change of individual behaviours*, to include

(i) greater self-responsibility for one’s own health;
(ii) greater awareness of primary health care;
(iii) more emphasis on prevention to reduce the need for care;
(iv) change in health seeking behaviour;
(v) judicious use of health care services; and
(vi) early planning for health care financing after retirement for a healthy old age.

(b) *Change of Government behaviours*, to include

(i) increasing public emphasis on primary health care (e.g. use of family doctors, development of individual health portfolios, and person/patient centred care supported by electronic patient records) through education, community promotions and funding support;
(ii) maintaining a safety net in health care for the grassroots and the middle class who choose to use public services; and
(iii) encouraging users to seek more choice and better services through shared responsibility.

(c) *Change of service providers’ behaviours*, to include

(i) enhancing service standards, increasing fee transparency and improving efficiency;
(ii) promoting competition and cooperation between public and private sectors to address the imbalanced situation; and
(iii) setting key performance measures and providing incentives for performance and enhanced quality of care.
IV. OPTIONS FOR CHANGE

28. Reforming the health care system must be about improving performance and incentives to enhance and sustain people’s health. This involves making effective changes in the governance, management and delivery arrangements as well as the financing mechanisms in order to make it happen.

29. Internationally, health care systems’ governance, management and delivery arrangements are converging and following similar development trends, even though individual nations develop their own composite systems to reflect their socioeconomic and political attributes and aspirations. Thus health care financing mechanisms are variable among different economies. However there are principally only four major approaches to health care financing:

(a) taxation
(b) social insurance
(c) private insurance
(d) medical savings schemes

Such approaches are not mutually exclusive. The basic features as well as the pros and cons of each approach are summarized below.

The Tax-Based Model

30. Health care services are predominantly funded by general government revenue which tends to rely heavily on income tax, corporate profit tax, and indirect taxes. Non-publicly funded services are largely financed by out-of-pocket payments and/or private insurance plans. Countries and regions that rely mainly on taxes to finance their health care system include UK, Sweden, and to a large extent Hong Kong (mainly public hospital services). Under such systems, governments allocate funds to a health/hospital authority, which in turn funds public hospitals. Patients can utilize services provided in the public sector at a highly subsidized rate.

31. The advantages of financing health care with taxes include: low administration costs and equal access to publicly funded services by every member of the community. The frequently cited disadvantages of tax-based systems include: availability of funds is highly susceptible to the performance of the general economy; many other services compete for general tax funds; the difficulties associated with raising taxes to meet increasing health care requirements; publicly funded services are often not consumer-oriented; and the tax-based system is basically a “pay-as-you-go” system, which does not address the aging population situation and the intergeneration equity question – the shrinking percentage of younger tax payers, resulting in a much higher tax rate for the next generation in order to pay for the health care services of the elderly.
The Social Health Insurance Model

32. Social insurance schemes are always compulsory contributory schemes. Under such schemes, all working persons are required to contribute, to a health insurance fund, a certain percentage of their income (normally with employers also contributing). The insurance fund is often administered by a body at arm’s length from government. Community rating (i.e. premiums are not related to the health status of the individual) and universal coverage are always practised in social insurance systems. Services rendered by public and private providers are reimbursed by the social insurance fund. Countries and regions that rely mainly on social insurance to finance health care include Japan, Taiwan, South Korea, Germany and Canada. The schemes in the Netherlands and Switzerland are also social insurance schemes, with participation from private insurance organizations.

33. The advantages of social insurance systems include: a higher degree of financial transparency regarding the sources and uses of funds; raising premiums to meet rising requirements is relatively easier than raising taxes; and services tend to be more responsive to the needs of the consumers than tax-based systems as most insurance systems pay providers on a “money follows patients” basis. The drawbacks of such schemes include: higher administration costs associated with collection and disbursement; problems of moral hazards which will lead to more unnecessary utilization if not well-managed; and, as in the case of tax-based systems, social insurance systems are also “pay-as-you-go” systems, which do not address the problems of aging and intergeneration equity.

The Voluntary Private Health Insurance Model

34. Unlike social health insurance, private health insurance is generally purchased on a voluntary basis, either by individuals or by groups (mostly employers). The premium varies depending on the benefits and the health condition of the insured (known as experience rating). Consequently, the elderly and persons with existing medical conditions are required to pay prohibitively high premium.

35. The USA is the only industrialized country which relies mainly on private insurance to finance its health care services. The majority of the working population obtains insurance coverage through employment. The US government has two tax-funded insurance programs, the MEDICAID and the MEDICARE, to pay for the health care services of the low income and the elderly.

36. Private health insurance also plays an important role in some countries such as Australia. In Australia, which has a compulsory national insurance scheme, private health insurance is voluntary but regulated. Registered plans must practise community rating. The Government provides financial incentives for people to purchase registered private health insurance plans – private insurance policy holders receive 30 percent rebate on their compulsory national health insurance levy.

37. Private insurance provides benefits such as choice of doctors in the private sector, choice of private hospitals and the more flexible scheduling of care for non-urgent conditions. The advantages of private health insurance include: greater choice to consumers in terms of plans and providers; and services tend to be more consumer-oriented for those with adequate insurance coverage. The disadvantages include: high
administration costs; more unnecessary utilization if not well managed; the unemployed, the elderly, and persons with chronic conditions are often unable to obtain coverage in voluntary schemes.

**The Medical Savings Model**

38. Unlike insurance models, in which contributions from participants go into a pool to pay for the expenses incurred by all within the same year, medical savings models create individual savings accounts where contributions accumulate over time. From a risk pooling standpoint, medical savings accounts are just a different way of pooling financial risk. Instead of taking a pool of funds across many individuals in one year, medical savings accounts take the pool of funds over many years for one individual.

39. Contributions to the savings accounts are normally compulsory. Medical savings accounts is a relatively new idea which attempts to address the aging population and the intergeneration equity question – each person saves up for his/her medical needs after retirement, and will not be a burden to the next generation. Singapore is the first country to adopt this system. Medical savings schemes are also found in China and the United States.

40. The advantages of the medical savings model include: higher degree of acceptability (contributions do not disappear into a black hole as in insurance premium or taxes but will remain in the participant’s account); it is the only effective way to address the intergeneration equity problem; it empowers patients and can foster behaviour change of participants; and participants might use health care services more judiciously with money in their savings account than under insurance or tax-financed situations. The disadvantages of savings schemes include: the lack of adequate funds, especially during the early years, to finance major or catastrophic illnesses if not covered by suitable insurance products and/or government underwriting the risk with general revenue; and high administration costs associated with collection, fund management, and disbursement. Moreover, by establishing savings accounts alone without other funding (e.g. tax-based) is not a total approach to any health care financing system.

**Findings**

41. None of the financing approaches examined above is a perfect solution to the health care system that adopts it. When societies are becoming more complex and pluralistic, a single source of health care financing is unlikely to be adequate to meet the diversified needs of any health care system over time. And, since Hong Kong’s health care reform needs to meet a complex set of constantly changing needs and expectations of users, providers and related stakeholders, a pluralistic model is needed.
V. THE PROPOSAL: A NEW HEALTH CARE MODEL

42. Based on the analysis of various health care financing options, and on the premise that the present tax-based system of financing health care will be preserved and Government’s commitment to public health care spending will remain at 17 percent of total Government spending, the Study Group proposes a new health care model with a three pillar framework (see Figure 4) that encompasses, in brief, the following features and objectives:

Figure 4 – The Proposed New Health Care Model

(a) Evidence-based or beneficial essential items will always remain as heavily subsided Pillar 1 services and will constitute the bedrock of the Hong Kong health care safety net for all.

(b) Creation of a new Pillar 2 is to strengthen preventive health services and to ensure access to quality care in old age. It seeks, through providing incentive for Hong Kong residents to participate in a medical savings account scheme, to instill a sense of joint responsibility among individuals for behaviour modification, to promote increased awareness for maintaining their health, by making better use of primary health care and by early planning for post-retirement or after age 65 health care needs.

(c) The difference between Pillars 1 and 2 can be construed as a difference in government subsidy to support individuals to assume a greater role in looking after one's health and well being. It implies both financial incentive and positive action to promote prevention, wellness and quality of life into old age, thus resulting in a healthier old age after retirement.
(d) Through institutional arrangements, such as a health commission, there should be more transparency in decision making so that key performance measures can be introduced and the Government can provide breakdown in funding. The information and transparency (on items such as waiting times, contents of Pillars 1 and 2, and levels of subsidy for specific treatments and drugs under Pillar 2) will help establish credibility and integrity of the new arrangements.

Three Pillar Framework

43. The three pillar framework is to meet the pluralistic needs of the Hong Kong society. It aims to institutionalize the safety net for Hong Kong residents, enhancing financing capacities and user options, and encouraging proper user, provider and government behaviours to strengthen system performance and sustainability. There will be a clear delineation of the purchaser and provider functions that empowers the purchaser to commission or negotiate contracts with providers, in both the public and private sectors, to deliver services that optimize value for money spent and enhance proper use and access to both Pillar 1 and Pillar 2 services for users.

44. The three pillars are to comprise:

(a) **Pillar 1 services**, which will continue to have high Government subsidy ranging from 85 to 100 percent, serving as the safety net for Hong Kong residents, are fundamentally essential health care services that are currently provided in the public system, including items paid for by the Samaritan Fund (a special Government fund to pay for privately purchased medical items in public hospitals for those who need them but could not afford them). The list of services to be included under this category should be reviewed and updated regularly to ensure that effective interventions are accessible to the low income group.

(b) **Pillar 2 services**, which will be funded jointly by users and Government, are enhancements of Pillar 1 services, including innovative long-term care services. The level of subsidy from Government for these services will be, on the average, 50 percent. As a general guideline to ensure fairness to those without the means to purchase Pillar 2 services, the Government subsidy in dollar terms for a Pillar 2 service should normally not be more than that for an equivalent Pillar 1 service. Under special circumstances, Government (or its designated body) may deviate from this guideline (e.g., for new drugs that are medically indicated and supported by evidence). Developing detailed arrangements will take time and need to be cognizant of this basic fairness principle.

(c) **Pillar 3 services**, which will have no Government subsidy, are self-financed or self-pay items that users have total choice of use but are wholly responsible for payment of, through either personal savings or private insurance.
We propose that Pillar 1 and Pillar 2 services be structured as follows:

(a) **Pillar 1 services**

Pillar 1 services are to address the basic health care needs of Hong Kong residents, to provide cost-effective interventions to safeguard and promote individual and population health, to provide for early detection and screening of diseases and disabilities, and to give Hong Kong residents the assurance of accessing essential services without financial worries.

Pillar 1 services would cover services currently provided in the public sector, including in-patient and out-patient services provided by the Hospital Authority and primary health care services provided by the Department of Health. The scope and quality of Pillar 1 services should not be less than what people are getting today. They are and should continue to be the keystones of the Hong Kong health system.

(b) **Pillar 2 services**

Pillar 2 will promote preventive care, health awareness, personal individual responsibility and improved access. It aims to provide more options for users, in terms of treatment, drugs, providers, and amenities, through shared responsibility on top of the existing heavily-subsidized safety net in health care.

Pillar 2 is also about modifying patient behaviour and culture. It will encourage users to adopt proper health seeking behaviour, demonstrate self-responsibility for their own health whilst providing more choice and making efficient use of health care services.

In addition, Pillar 2 will strengthen primary health care by promoting better health for all and disease management. This will include subsidizing disease prevention and screening, thereby decreasing reliance on treatment. The difference between Pillars 1 and 2 can be construed as a difference in government subsidy to support individuals to assume a greater role in looking after their own health and well being. It implies both financial incentive and positive action to promote prevention, wellness and quality of life into old age, thus resulting in a healthier old age after retirement. It prepares individuals to plan and build up the financial capacity to access and pay for post-retirement or after age 65 health care needs. To achieve this objective it is necessary to introduce a new form of financing to pay for Pillar 2 services. By offering enhanced and value added services, Pillar 2 will provide incentives for individuals to take up shared responsibility and engage in planning and saving for post-retirement.

We propose that there can be three types of Pillar 2 services, classified as follows:
(i) *Extended primary health care* that comprises –

- initiation of family doctor services through, for example, a Health Assessment Consultation (HAC) offered to newborns and their mothers to initiate an individual health portfolio and to encourage the establishment of a continued relationship with a family doctor. It is suggested that the Government consider funding a scheme to activate a health portfolio account for each newborn and mother and to cover the needed expenses of the HAC that should help the mother better understand preventive health care and family medicine and provide appropriate health advice to the child later on;
- additional evidence-based, age-specific health screening or assessment and early detection services;
- disease management programs that use established or approved cost-effective interventions or care for designated medical conditions; and
- enhanced access to providers – public (Department of Health, Hospital Authority) as well as private practice doctors who adopt the family medicine concept – for designated services.

(ii) *Long-term medically supervised care*, subject to policy scrutiny based on criteria such as scope, scale, standards and location of services, that includes –

- dependency care;
- special accommodation and amenities that improve access to long-term care in old age;
- hospice and palliative care;
- maintenance rehabilitation that includes long-term inpatient rehabilitation, centre-based rehabilitation, or community rehabilitation; and
- visiting medical and nursing care.

(iii) *Extended secondary and tertiary care* could include –

- choices offered to patients to improve their accessibility to new diagnostic and treatment methods or modalities, including laboratory tests, radiological examinations, interventional procedures, drugs, consumables, prostheses, and other treatment accessories and appliances, where clinical evidence of a clear advantage over conventional diagnostic and treatment methods is not yet fully established but emerging and is not provided under Pillar 1 services – this category may include a wide range of products and services such as:
Privately Purchased Medical Items and self-financing items, e.g., drugs and special surgical consumables outside the normal clinical indications provided under Pillar 1 services, e.g. non-standard or special joint prostheses;

choice and access to emerging diagnostic and treatment methods, particularly those procedures where clinical benefit is marginal or evidence of advantage is still being established, e.g. minimally-invasive surgery for conditions that has not yet demonstrated clear advantage over traditional open surgery;

special type of surgery not covered under Pillar 1 services, e.g. bariatric surgery for morbid obesity; and

new technology still under evaluation, e.g. robotic surgery;

improved amenities; and

shorter waiting time for non-urgent conditions.

(c) Pillar 3 services

Pillar 3 services are private sector services not subsidized by Government. They include mainly general outpatient treatment which should remain primarily the responsibility of individuals. They also include interventions, care or services the lack of which should not cause significant adverse health consequences to individual patients or society and therefore will not be subsidized by the Government. Examples of such Pillar 3 services could include lifestyle enhancement or maintenance, cosmetic procedures, non-standard formulary drugs, assisted reproduction, some dental care, and eye glasses.

Some users may choose to go to the private sector for treatments or services covered by Pillar 1 or 2. In such cases, they will need to meet the full costs of such services on their own.

46. We envisage that the determination of the scope of services that should go into Pillars 1 and 2 may at times be contentious. We therefore recommend that a designated body be responsible for making such determination, and that refinements should be made continuously, especially when Pillar 2 services should shift to Pillar 1, taking into consideration availability of new clinical evidence, changing needs and requirements arising from demographic and epidemiologic transitions, technological advancements, societal values or preferences as may be collected through public consultations, and Government’s financial position.
Enhanced Primary Health Care

47. We recognize the need to strengthen and sustain the successful provision of primary health care in Hong Kong in order to achieve a high performing health care system. Accordingly, we propose that the following be considered and implemented as integral components of the reform initiatives:

(a) *promote establishment of community-wide networks* delivering holistic primary health care through integrated multidisciplinary teams that involve Chinese Medicine practitioners, dentists, nurses, pharmacists and other allied health professionals working together with registered, accredited primary care doctors;

(b) *establish a primary care doctor’s register* – this initially can include any medical doctor or dentist who is committed to and declares to practise family medicine, although certification requirements can be enforced over time based on peer opinion, patient expectations and by evolution; there should be a Primary Care Doctor’s Register under the Medical Council of Hong Kong similar to the existing Specialist’s Register;

(c) *implement quality assurance mechanisms of the accredited registered service providers* through audit (which can be self audit, peer audit or audit by an accredited organization or body); this would be a requirement for those service providers who participate in future Government subsidized shared-care extended primary health care programs;

(d) *emphasize a life-course-approached health screening program* – health screening or assessment programs during the life course of an adult could be funded based on medical evidence and professional consensus, with possibly different levels of subsidies offered by Government;

(e) *develop an integrated seamless primary, preventative, and secondary care system of delivery, augmented by portable electronic medical records*, so that the primary health care provider may play an effective role in facilitating the users in accessing appropriate care and in interacting with specialists when needed in managing chronic diseases. Data obtained from the proposed Health Assessment Consultation (HAC) can be optimally a first entry into such portable electronic medical records; and

(f) *provide resource and funding to train* family doctors, nurses and other health care personnel and upgrade the standard of primary health care in Hong Kong.
VI. COMPARISON OF DIFFERENT FINANCING APPROACHES

48. Based on an evaluation of existing health financing approaches elsewhere and an analysis of the needs of Hong Kong’s health care system as well as the pros and cons of its current tax-based health financing mechanism, we conclude that Hong Kong has an efficient and effective tax-based financing approach to provide for people’s needs for essential health care or Pillar 1 services. But the capacity to provide for major expansions in health care services will be limited. It will incapacitate the Government’s financial position if it is to subsidize all of Hong Kong’s future health care needs. And Hong Kong’s public health care system will be unsustainable if no new financing sources are brought into the system.

49. The study group recommends that, in addition to the tax-based financing system, a medical savings account (MSA) scheme would be needed to ensure that Hong Kong residents would accumulate some savings to contribute to their future health care needs, especially after they have reached retirement age. Such a scheme should be mandatory for those in employment, subject to a minimum qualifying income. While Pillar 1 services provide a safety net for essential health care services, it is crucial that Hong Kong people should also develop the awareness, responsibility and incentive to look after their personal health, especially in disease prevention and detection and during old age. This behavioural change is essential. If there is indiscriminate and insatiable use of health care services, no matter how much funding and resource is available, this will become exhausted.

50. We have carefully examined the desirability of insurance (both private and social insurance) in lieu of compulsory savings. While insurance provides risk pooling, which is extremely important in protecting individuals in the event of catastrophic episodes, some existing private insurance products in Hong Kong tend to have the following drawbacks:

(a) premium is often unpredictable, and can vary quite significantly from year to year depending on medical inflation and the number of claims of the previous year;

(b) premium increases can be very substantial with age and for persons with pre-existing conditions;

(c) premium for products that provide reasonable protection can be prohibitively high for persons aged 65 and above;

(d) products with low premium do not provide adequate protection;

(e) prevention and early detection services are often not covered;

(f) there is risk selection; e.g., mental health and congenital illnesses (which lack clear definition) are not covered; and

(g) administration and agency fees are high so the actual funds available to the service provider are very much discounted.
51. Furthermore, utilization under insurance always tends to increase as a result of moral hazards (i.e. no incentives for providers or consumers to use resources judiciously). Insurance financing, even for compulsory social health insurance, is “pay-as-you-go” (i.e. the younger working population contributes but the retired population does not) and does not address the question of intergeneration equity (i.e. the younger generation will have to contribute a much higher percentage of their income as the percentage of the elderly population increases).

52. We have also considered an income-related hypothecated health tax option. This option can provide substantial funding with a high degree of certainty. The associated administration costs will be low. It will also provide considerable risk pooling, and therefore can be structured to provide coverage for the elderly. However, such form of financing may not receive wide public acceptance because it is perceived as regressive taxation. Moreover, it does not promote the concept of personal responsibility and judicious use of services. Like insurance, tax systems are “pay-as-you-go” systems, and are inefficient in dealing with the intergeneration equity issue.
VII. MERITS OF MEDICAL SAVINGS ACCOUNTS

53. In comparison, mandatory savings is better able to promote behavioural change to achieve better health and system sustainability without some of the drawbacks of medical insurance or hypothecated tax:

(a) Contributions to medical savings are predictable.

(b) Contributors accumulate funds during their working life for uses to promote greater health responsibility and to achieve a more healthy old age.

(c) Contributors can use funds in the account to purchase preventive health care services and approved insurance plans which provide coverage for catastrophic illnesses, hospitalization beyond age 65, and long-term care.

(d) Contributors generally have greater incentive to use health services more judiciously with money in their own medical saving accounts.

(e) Medical savings addresses the question of intergeneration equity, which is particularly important for communities like Hong Kong where the percentage of the elderly population is expected to increase from the current 12.1 percent to 26.3 percent in 2036.\(^{20}\)

54. Based upon careful comparisons, we propose that a mandatory medical savings account (MSA) be considered as a supplemental financing scheme to be added to Hong Kong’s successful tax-based financing system. We are of the opinion that the scheme will offer more benefits to the people of Hong Kong.

55. The essential features of the MSA scheme are:

(a) Underpinning philosophy

(i) To foster desirable health seeking behaviour and to emphasize prevention to achieve better health and more judicious use of health care resources.

(ii) To promote a greater sense of health awareness and responsibility.

(iii) To guarantee access to long-term care and to bring about a healthy old age.

(iv) To provide greater choice to consumers for selected services including management of certain chronic diseases, and the use of emerging medical technology.

(v) To supplement tax-based financing to maintain the effectiveness and sustainability of the current system which is likely to be inadequate in the longer term because of:

• aging population: increasing elderly population and a shrinking tax-paying population;
• new technology and new drugs; and
• Hong Kong remaining as a low-tax regime.

(b) Benefits to holders

Under this scheme, MSA account holders:

(i) will receive substantial Government subsidy when purchasing Pillar 2 services which include wellness promotion, health screening and prevention (currently these services are not subsidized at all);

(ii) can choose their preferred providers from a list of Government approved providers, including those in the private sector;

(iii) will be able to obtain prompt treatment from accredited registered private sector providers using funds from the account at a subsidized rate;

(iv) can choose to use the funds in their account to pay for Pillar 1 services, privately purchased medical items, and drugs outside the public hospital general formulary when receiving care in public hospitals;

(v) can also use funds in the account to purchase government approved health insurance plans;

(vi) will receive tax exemption for their contribution to the account; and

(vii) will acquire strengthened financial capacity to purchase health care services upon retirement, when their health care needs are greatest, as funds in the MSA will grow over their working life.

(c) Fund usage

Funds in the MSA can be used to pay for:

(i) Fees and charges under Pillar 1.

(ii) Subsidized services under Pillar 2. Only MSA holders will be entitled to the Government subsidy.

(iii) Pillar 3 services (without subsidy) after age 65.

(iv) Government-approved medical insurance plans where available, e.g. hospitalization plans after age 65, long-term care plans, and possibly major illness plans before age 65. Local insurance companies have expressed interests to develop such products.
(d) Participants

(i) All residents of Hong Kong are eligible to participate in the scheme. It will be mandatory for those in employment, subject to a minimum qualifying income.

(ii) Contributing participants can pay for health care expenses of approved services incurred by immediate family members using his/her own MSA.

(e) Administration

(i) The existing MPF system will be used – to collect contributions from participants and to enforce contributions – in order to minimize setup and future transaction costs. Public concerns over the high management fees associated with MPF funds are noted. Such fees are expected to come down as the system matures and with reforms aiming at injecting a greater degree of competition within the system.

(ii) Different fund management modes should be made available, giving choice to participants regarding risk, return and administration fees.

(iii) A new agency will be set up to handle disbursements. It will deduct funds from the individual accounts for treatments/services rendered to participants. Insurance companies may be interested to offer this service. Existing disbursement systems used by the insurance industry can be adopted or used for this purpose.

(f) Contributions

(i) For the scheme to be viable, the mandatory contribution rate for those in employment should be between 1 and 5 percent. We would recommend 3 percent.

(ii) Exemptions will be made for the very low income earners, and a contribution ceiling will be set for the high income earners. Under current MPF regulations, the minimum and maximum levels of income are $5,000 and $20,000 per month respectively. For medical savings purposes, the minimum level of monthly income can be adjusted upward to $8,000, taking into consideration social concerns and public opinion.

(iii) Voluntary contributions from employers are encouraged, especially for those who are not already providing health insurance or retirement plans for their employees.

(iv) Voluntary monthly or ad hoc top-ups are permitted to encourage faster buildup of savings in the account.
(v) To prevent excessive buildup of account balance and use of subsidies, and possibly tax evasion, a maximum total contribution limit will be set for each account.

(g) Withdrawals

(i) Funds in the MSA can be withdrawn to pay for approved services consumed by the account holder and his/her immediate family members.

(ii) Unspent balance in the account will be treated as part of the participant’s estate upon death.

56. It is also our recommendation that Government should encourage employers, large and small, to take better care of their employees by taking out appropriate medical insurance policies. The co-sharing of burden between employees and employers is a key to success in funding health care services.
VIII. INSTITUTIONAL ARRANGEMENTS

57. To accomplish the reform objectives, to optimize the use of the pooled financial resources and to ensure sustained effective health care system performance, it is necessary to have in place integrated and effective institutional arrangements to carry out the essential functions of the health care system. There are four principal health care system functions that should be effectively organized and with decision making transparent, participatory and inclusive, involving key stakeholders throughout the entire process. These functions should be carried out by designated bodies with clear demarcation of roles and responsibilities:

(a) **Stewardship**

Good health system stewardship can be an effective approach to help government health bureaus achieve the main goals of health systems. The three basic tasks that contribute to effective stewardship include: formulating health policy by defining vision and direction for the health system, exerting influence through regulation, and using objective data and information to identify issues confronting the system, to monitor and assess its performance. Such an approach can help build up a stronger intersectoral partnership and secure political commitment from related organizations or parties to enhance the health system’s effective functioning and performance.

The establishment of a designated body, e.g. a health commission, is recommended to advise the Government on the strategic and policy directions, health standards, the contents of Pillars 1 and 2 services, and to collect statistics and information. Membership of this body should be inclusive and involve participation and representation of key stakeholders, including patient and consumer groups. In addition, decision making should be transparent and public opinion tapped in formulating its recommendations and proposals. Key performance measures may be introduced to improve transparency.

(b) **Purchasing**

The purchaser functions should be separate from the provider functions. The concept of a clear delineation and separation of the purchaser and provider roles in health care takes on many different forms or strategies today, ranging from contracting to outsourcing and from practice-based commissioning to performance-based management. But the underlying principle is one of optimizing value for money spent and ensuring efficient and effective use of health care resources and enhancing the performance of the health system. Research has shown that purchasers can play a significant role in driving quality improvement in health care.

---


30
We envisage that the delineation and separation of the purchaser and provider roles will not only create more competition for public sector providers but also more opportunities for private sector providers to participate in the care of patients receiving services under either Pillar 1 or 2. The purchasing agency would have the authority to direct patients to the private sector providers as long as standard and cost specifications are met. This would create a better public and private balance for improving service standards, quality and accessibility. For patients, this should mean improved access to quality health care.

We recommend that an agency or unit should be responsible for the purchaser functions for the public sector, including deciding on the scope and level of services to be publicly funded (e.g. quantities); the fee schedule (i.e. discount/subsidy rates) for different service types and user groups; the appropriate payment methods to providers; and approving subcontracting to the private sector. The purchasing agency would monitor the performance and quality compliance of the provider in accordance with agreed standards and other terms and conditions. A performance framework which emphasizes quality of care and greater efficiency in the health care system could be created.

(c) Disbursement

The administrative costs of collecting the MSA contributions can be expensive. To avoid the expensive start up costs and to spread the requisite cost of the collection functions, we propose that the existing mandatory provident fund system be used to collect the MSA contributions from participants. This should be a win-win situation whereby the unit administrative costs could be lowered for all parties.

A new agency should be set up to handle the disbursements and be responsible for receiving, adjudicating, and processing accounts for all treatment expenses associated with claims and for processing a variety of payments by deducting funds from the participants’ individual MSA accounts. The cooperation and services of the insurance industry should be sought.

(d) Delivery of care

The delivery of health care relies on both private and public sector providers. For government funded or subsidized services, the main provider is the Hospital Authority. But this could also include the Department of Health, accredited and registered private hospitals, clinics, laboratories and medical practitioners which offer services under Pillar 1 or 2 as directed by the purchaser.

Providers or provider organizations should be entities independent from the purchaser. With this separation, public sector providers should become more attracted to collaborate with private sector providers to either improve
access or offer a broader variety of services for patients. Hence, this should create more opportunities to forge new public-private collaboration and partnerships to improve patient access to Pillars 1 and 2 services.
IX. CONCLUSION

58. We propose that the development and financing of Hong Kong’s future health care be focused on achieving the following goals:

(a) achieving better health and wellness with emphasis on prevention and joint responsibility;

(b) improving quality of care through enhanced service delivery, especially for the elderly and those with chronic diseases; and

(c) promoting system sustainability and effectiveness by changing individual behaviour, government behaviour and provider behaviour.

59. To achieve the goals and core principles of equity, accessibility, mutual care and joint responsibility, efficiency, quality and choice, we recommend the following integral components of the reform agenda of the Hong Kong health system:

(a) **The three pillar framework health care model** that preserves our existing strengths and achieves our reform objectives.

(b) A new financing model, which involves the introduction of a medical savings scheme, to supplement the existing tax-based financing system, to strengthen users’ financial capacity and to enhance users’ choice and responsibility.

(c) Enhanced institutional arrangements that improve quality and access, optimize value for money spent and promote health and wellness.

60. Our foregoing recommendations are based on the recognition that an effective and sustainable health system must go beyond just mobilizing additional funds for health services provision, it needs to also ensure that the financing approach offers proper incentives for users to use health care appropriately and for the Government and providers to fund and provide the needed health care efficiently and effectively. Equally important, there must be effective institutional arrangements in place to drive the reform and lead the health system to achieve sustainable equitable and efficient health care for all.

61. While we believe that our proposals should be implemented in total, it is not necessary that they be implemented at the same time. As health care and health care reform are complex issues, further debate and deliberations are inevitable. We hope that our proposals will stimulate informed discussions and facilitate a shared decision on the best way forward.

62. After the release of the preliminary findings of this study, we have conducted and participated in numerous public and media forums to present the proposals and respond to public and key stakeholder queries and concerns (see Appendix II). Our understanding from this process is that there is popular consensus and a sense of urgency that something should be done about improving the existing health care system. However, it is also clear that an incremental approach to reform is preferred over a big-bang approach.
Therefore we recommend that a staged approach be adopted for Hong Kong’s health system reform. To put policies into action will require that details be worked out in advance. The reform should start with changes where consensus and the likely improvements are strongest and where requirements for successful implementation are least disruptive. Towards this end, we propose that institutional reforms be implemented before the financing reforms. That is, the stewardship role should be strengthened, the purchaser and provider roles clearly delineated, primary health care enhancement expedited, greater public and patient engagement with health and health care be promoted and more public-private partnerships forged quickly. These can take place with incremental change within the existing system infrastructure. However, in the longer-term stronger institutional change will be needed to take forward these initiatives. Further reform, such as the MSA scheme, can be rolled out later, in line with public and key stakeholder input and support.
### Membership and Terms of Reference

**Membership**

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>陳德霖先生 (召集人)</td>
<td>智經研究中心主席</td>
</tr>
<tr>
<td></td>
<td>Mr Norman Chan</td>
<td>Chairman and Director, Bauhinia Foundation Research Centre (till</td>
</tr>
<tr>
<td></td>
<td>(Convenor</td>
<td>30\textsuperscript{th} June 2007)</td>
</tr>
<tr>
<td></td>
<td>(Convenor till</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30\textsuperscript{th}</td>
<td></td>
</tr>
<tr>
<td></td>
<td>June 2007)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>李國棟醫生 (召集人)</td>
<td>智經研究中心顧問</td>
</tr>
<tr>
<td></td>
<td>Dr Donald Li (Convenor</td>
<td>Adviser (till 30\textsuperscript{th} June 2007) and Director (with</td>
</tr>
<tr>
<td></td>
<td>with effect from 1\textsuperscript{st}</td>
<td>effect from 1\textsuperscript{st} July 2007), Bauhinia</td>
</tr>
<tr>
<td></td>
<td>July 2007)</td>
<td>Foundation Research Centre</td>
</tr>
<tr>
<td>3</td>
<td>鄭國成醫生</td>
<td>九龍醫院行政總監</td>
</tr>
<tr>
<td></td>
<td>Dr Derrick Au</td>
<td>Hospital Chief Executive, Kowloon Hospital</td>
</tr>
<tr>
<td>4</td>
<td>陳鉅源先生</td>
<td>新鴻基地產發展有限公司執行董事</td>
</tr>
<tr>
<td></td>
<td>Mr Thomas Chan</td>
<td>Executive Director, Sun Hung Kai Properties</td>
</tr>
<tr>
<td>5</td>
<td>鄭崇羔醫生</td>
<td>香港浸會醫院董事會主席</td>
</tr>
<tr>
<td></td>
<td>Dr Charles Cheng</td>
<td>Chairman, Board of Directors, Hong Kong Baptist Hospital</td>
</tr>
<tr>
<td>6</td>
<td>莊結儀女士</td>
<td>三十會執委會成員</td>
</tr>
<tr>
<td></td>
<td>Ms Rachel Chong</td>
<td>Core Member of 30SGroup</td>
</tr>
<tr>
<td>7</td>
<td>鍾惠玲博士</td>
<td>再生會榮譽主席</td>
</tr>
<tr>
<td></td>
<td>Dr Margaret Chung</td>
<td>Founder and Honorary Chairperson, Regeneration Society</td>
</tr>
<tr>
<td>8</td>
<td>葛菲雪教授</td>
<td>香港中文大學公共衛生學院院長及教授</td>
</tr>
<tr>
<td></td>
<td>Prof Sian Griffiths</td>
<td>Director, School of Public Health, The Chinese University of Hong</td>
</tr>
<tr>
<td></td>
<td>(President</td>
<td>Kong</td>
</tr>
<tr>
<td>9</td>
<td>許曉暉女士</td>
<td>金融界</td>
</tr>
<tr>
<td></td>
<td>Ms Florence Hui</td>
<td>Financial Services</td>
</tr>
<tr>
<td>10</td>
<td>李國麟博士</td>
<td>香港公開大學護理學課程主任</td>
</tr>
<tr>
<td></td>
<td>Dr Joseph Lee</td>
<td>Assistant Professor of Nursing, The Open University of Hong Kong</td>
</tr>
<tr>
<td>11</td>
<td>李伯偉先生</td>
<td>醫院管理局總藥劑師</td>
</tr>
<tr>
<td></td>
<td>Mr Lee Pak Wai</td>
<td>Chief Pharmacist, Hospital Authority</td>
</tr>
<tr>
<td>12</td>
<td>沈茂輝先生</td>
<td>香港工間專業聯會醫療委員會主席</td>
</tr>
<tr>
<td></td>
<td>Mr Michael Somerville</td>
<td>Chairman, Health Care Committee, Business &amp; Professionals</td>
</tr>
<tr>
<td></td>
<td>(President</td>
<td>Federation of Hong Kong</td>
</tr>
<tr>
<td>13</td>
<td>鄧惠瓊教授</td>
<td>香港醫學專科學院主席</td>
</tr>
<tr>
<td></td>
<td>Prof Grace Tang</td>
<td>President, Hong Kong Academy of Medicine</td>
</tr>
</tbody>
</table>
Health care reform has been on the government agenda for many years but public support for the various previous proposals has not been strong. There is now again a surging sense of urgency that the health care system should undertake both provision and financing reforms to ensure that health care continues to be accessible and affordable to people. Hence, Hong Kong needs an overarching review of its future health care reform needs and options in order to develop an integrated policy to guide health care’s future development and financing.

The Health Care Study Group, having regard to the above and taking into consideration policy gaps and issues that must be addressed in order to meet the future health care delivery and financing requirements of Hong Kong residents, in particular those of the elderly, undertakes to:

(1) review, discuss and articulate the objectives and attributes of an appropriate system of health care delivery and development for Hong Kong;

(2) identify incentive systems that induce and enhance desired health care stakeholder behaviour;

(3) propose a financing model, including payment options and funding mechanisms, that promotes the development of an efficient, responsive and financially sustainable health care system for Hong Kong; and

(4) propose appropriate institutional arrangements conducive to effective implementation of the preferred health care system.
Appendix II

Key Stakeholder Comments, Questions and Submissions on Preliminary Report

During the course of the study, especially after the release of the Preliminary Report and in a Health Care Reform Forum held on 23 June to gauge the different views of the stakeholders, the Centre has received feedback and submissions from both individuals and organizations through different channels. Our responses to the following key stakeholder comments and questions have been incorporated in the Final Report and reflect changes made to the Preliminary Report.

<table>
<thead>
<tr>
<th>Comment or Question</th>
<th>Study Group Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>On highlight of the Report:</strong></td>
<td><strong>and Changes Incorporated in Final Report</strong></td>
</tr>
<tr>
<td>1. What are the challenges to Hong Kong’s health care system?</td>
<td>The key challenges include:</td>
</tr>
<tr>
<td></td>
<td>(a) rising morbidity rate for certain common diseases;</td>
</tr>
<tr>
<td></td>
<td>(b) limited and inadequate capacity to respond to changes in the demographic structure;</td>
</tr>
<tr>
<td></td>
<td>(c) under-development of preventive care;</td>
</tr>
<tr>
<td></td>
<td>(d) low health awareness and personal responsibility in health care;</td>
</tr>
<tr>
<td></td>
<td>(e) continuous improvement of the quality of care.</td>
</tr>
<tr>
<td>2. What are the ultimate goals of reform?</td>
<td>The goals of the reform are to:</td>
</tr>
<tr>
<td></td>
<td>(a) achieve better health and wellness;</td>
</tr>
<tr>
<td></td>
<td>(b) improve quality of care; and</td>
</tr>
<tr>
<td></td>
<td>(c) promote system sustainability and responsiveness.</td>
</tr>
<tr>
<td>3. What core values are you advocating?</td>
<td>The core values underpinning the proposed reform are: equity, accessibility, efficiency, quality, choice, mutual care and joint responsibility.</td>
</tr>
<tr>
<td>4. What are the guiding principles in your proposal for reform?</td>
<td>The guiding principles are:</td>
</tr>
<tr>
<td></td>
<td>(a) change of individual behaviours;</td>
</tr>
<tr>
<td></td>
<td>(b) change of Government behaviours; and</td>
</tr>
<tr>
<td></td>
<td>(c) change of service providers’ behaviours.</td>
</tr>
</tbody>
</table>


On the Three Pillar Framework:

5. The definitions of the Pillars 1 and 2 services are not clear, and this casts doubt on the feasibility of the three pillar framework. There has also been a concern about the range of service items to be covered by the two pillars.

The Three-pillar Framework is to meet the pluralistic needs of the Hong Kong society. It is about institutionalizing the safety net for Hong Kong residents, enhancing financing capacities and user options, and encouraging proper user, provider and government behaviours to strengthen system performance and sustainability. It is a system that increases competition, choice and capacity as well as increasing carer support and responding to the consumer voice.

Creation of a new Pillar 2 is to strengthen preventive health services and to ensure access to quality care in old age. The difference between Pillars 1 and 2 can be construed as a difference in government subsidy to support individuals to assume a greater role in looking after one's health and well being. It implies both financial incentive and positive action to promote prevention, wellness and quality of life into old age, thus resulting in a healthier old age after retirement.

We propose that Pillar 1 will remain as a safety net, and its scope and services will not be less than what people are getting today.

Evidence-based or beneficial essential items will always remain as heavily subsided Pillar 1 services. We also propose that the quality of Pillar 1 services and the adequacy of the Samaritan Fund should be kept under regular review to ensure responsiveness to society’s needs.

We propose that there will be a clear delineation of the purchaser and provider functions that empowers the purchaser to commission or negotiate contracts with providers, in both the public and private sectors, to deliver services that optimize value for money spent and enhance proper use and access to both Pillar 1 and Pillar 2 services for users.

We envisage that the determination of the
scope of services that will be covered by Pillars 1 and 2 may at times be contentious. We therefore recommend that a designated body (operating in a transparent manner with the stakeholders as members) be set up to make decisions about priorities taking into consideration the continuous changing needs and expectations arising from demographic, medical and technological changes as well as the Government’s fiscal position.

Through this institutional arrangement, there should be more transparency in decision making so that key performance measures can be introduced and the government can provide breakdown in funding.

On the Medical Savings Account scheme:

7. What are the purposes and underlying principles of the Medical Savings Account (MSA) scheme?

MSA is about early planning for health care financing after retirement as well as shared responsibility for maintaining one’s own health. Account holders may use the funds to pay for Pillars 1 and 2 services when they are in need of health care services, including wellness check-ups.

While Pillar 1 services provide a safety net for essential health care services, it is crucial that Hong Kong people should also develop the awareness, responsibility and incentive to look after their personal health, especially in disease prevention and detection and during old age.

This behavioural change is essential. If there is indiscriminate and insatiable use of health care services, no matter how much funding and resource is available, this will become exhausted.

The underpinning philosophy is to:

(a) foster desirable health seeking behaviour and to emphasize prevention to achieve better health and more judicious use of health care resources;

(b) promote a greater sense of health
8. **Mandatory contributions would further reduce the take-home pay of the low income earners, if those earning $5,000 or above are required to make contributions.**

We now propose that the minimum level of monthly income should be adjusted upward to $8,000, taking into consideration social concerns and public opinion. Voluntary contributions from employers, however, are encouraged, especially for those who are not already providing health insurance or retirement plans for their employees.

9. **The minimum account balance requirement should be eliminated.**

We have eliminated the minimum account balance requirement in our proposals.

10. **Low cost fund holders of the MSA should be available**

We have proposed that different fund management modes should be made available, giving choice to participants regarding risk, return and administration fees.

**On health insurance and the health care tax options:**

11. **It is considered that MSA cannot result in risk pooling, and the MSA balance would be quickly depleted as the treatments for catastrophic illnesses could be very costly.**

We would like to emphasize that the current safety net is preserved as those participating in MSA can still utilize public medical services. We have carefully examined the desirability of
Kong should instead launch health care insurance plans at the community level, or allow those contributing to MSA to use the MSA funds to take out insurance cover. Have you considered the desirability of insurance versus compulsory savings?

insurance in lieu of compulsory savings. While insurance provides risk pooling, which is extremely important in protecting individuals in the event of catastrophic episodes, it does not promote judicious use of services and is unable to address the intergeneration equity problem.

Some existing products in Hong Kong tend to have the following drawbacks: premium is often unpredictable, and can vary quite significantly from year to year; premium increases can be very substantial with age and for persons with pre-existing conditions; premium for products that provide reasonable protection can be prohibitively high for persons of age 65 and above; products with low premium often do not provide adequate protection; prevention and early detection services are generally not covered; and administration fees can be high.

12. What insurance products will Pillar 2 money be allowed to purchase?

We propose that Pillar 2 money will be allowed to purchase Government-approved medical insurance plans where available, e.g. hospitalization plans after age 65, long-term care plans, and possibly major illness plans before age 65. Local insurance companies have expressed interests to develop such products.

13. What about an income-related health tax option to financing Hong Kong’s health care?

We have also considered an income-related hypothecated health tax option. This option can provide substantial funding with a high degree of certainty. The associated administration costs will be low. It will also provide considerable risk-pooling, and therefore can be structured to provide coverage for the elderly and for catastrophic illnesses.

Such form of financing, however, may not receive wide public acceptance. And, it does not promote the concept of personal responsibility and judicious use of services. Like insurance, tax systems are “pay-as-you-go” systems, and are inefficient in dealing with the intergeneration equity issue.
On primary health care:

14. The primary health care team should incorporate Chinese Medicine practitioners as members.

We propose that the Government promote establishment of community-wide networks that deliver holistic primary health care through integrated multidisciplinary teams that involve Chinese Medicine practitioners, dentists, nurses, pharmacists and other allied health professionals working together with registered, accredited primary care doctors.

15. There should be support and funding for training of primary health care providers.

We propose that Government provide resource and funding to train family doctors, nurses and other health care personnel and upgrade the standard of primary health care in Hong Kong.

On institutional arrangements:

16. What is being proposed to improve the efficiency of the existing health care system?

One of our reform proposals – a clear delineation of the purchaser and provider functions – aims at driving better efficiency and quality of the service providers. We envisage that the delineation and separation of the purchaser and provider roles or functions will not only create more competition for public sector providers but also more opportunities for private sector providers to participate in the care of patients receiving services under either Pillar 1 or 2.

This purchasing framework will allow patients to be directed to the private sector providers in as long as standard and cost specifications are met. This should create improved public and private balance for enhanced service standards, quality and accessibility. For patients, this should mean improved access to quality health care.

17. Who will be the purchaser?

We propose that an agency or unit should be responsible for the purchasing functions for the public sector. The purchasing agency should monitor the performance and quality compliance of the providers in accordance with agreed standards, terms and conditions.
18. Should insurers be considered as possible disbursement agents? We propose that a new agency be set up to handle the disbursements and the cooperation and services of the insurance industry should be sought.

On implementation of the reform:

19. There are concerns about the delay of the reform as the recommendations will require that the Government work out a lot of details in order to make them work. While we believe that our recommendations should be implemented in total, we also feel that it is not necessary that they be implemented at the same time. To make it happen, we recommend that a progressive approach in stages be adopted for Hong Kong’s health system reform.