Healthcare consultation: consensus on objectives shows way forward

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The Government has made people aware of the necessity and issues of healthcare reform and, at least on the objectives, there is broad consensus. When issues and goals are clear, solutions are but a step away.

The future system, it is broadly agreed, should ensure cost-effectiveness, improve the balance between the public and private healthcare sectors, and provide risk-pooling for all[1]. This calls for engaging the public and private sectors in the same level playing field providing universal health insurance, as outlined below.

Every person would have to be insured for healthcare, choosing from a small number of networks of providers. All networks provide comprehensive coverage, but at varying levels of service, e.g. the Hospital Authority would offer the same level of service it does now. No filing of claims is necessary, given the comprehensive coverage subject to gatekeeping by networks on services.

So that competition is on equal footing, the premium charged by the Hospital Authority should include imputed costs of land and capital. The other networks, each a union of doctors' clinics and hospitals, offer levels of service and at premiums that cater to different market segments.[2] At least initially, some networks would have to purchase inpatient service from the Hospital Authority, where hospital beds are now concentrated.[3]

As always, market competition would produce the balance among providers that is most cost-effective for the community as a whole[4]. Just as providers would share patient data electronically, so patients should have better access to information for making choices

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[1] Currently risk-sharing is available in government-funded healthcare. Within the private sector, it is available in private health insurance but only to a limited extent because of risk-selection by insurers and high costs due to small market size.

[2] The network(s) most directly in competition with the Hospital Authority will likely charge a premium narrowly above that by the Hospital Authority, in return for providing patients with more personal service, choice of doctor, shorter waiting time, etc.

[3] To relieve the current capacity constraint, the Government has undertaken to set aside more land for building hospitals. Where warranted, it should allow existing public hospitals to be privatized.

[4] The Hospital Authority (HA) has provided the bulk of healthcare in Hong Kong. In 2004/05, the public sector accounted for 54% of total health expenditure, but provided over 90% of inpatient services and about 70% of ambulatory care. Yet only by putting both the public and private sector providers on the same level playing field and giving the money to patients for them to choose (i.e. "money follows the patient") would the mix of providers be most cost-effective for the community as a whole. That mix may entail an expansion or contraction of the HA.

as consumers[5]. On the other hand, providers cannot turn away patients.[6]

Co-payments[7] borne by patients, together with gate-keeping by doctors at primary level in all networks, would prevent wasteful use of services. Co-payments and gate-keeping should also be conducive to better preventive care, saving future healthcare costs.

But costs would still likely go up, due to population aging and technological advances. On the question of who pays, public response to the consultation exercise indicates that the middle class, not to mention low-income earners, understandably resist taking on a greater share of the cost burden[8] – even though the escalation of healthcare subsidy had provided improved service at public hospitals and so reduced out-of-pocket medical expenses for many.

A compromise approach is to cap the growth of but not roll back public healthcare expenditure. Currently that expenditure translates into benefits that vary with income level, Subsidy ranges, on average, from almost 100% for the poor, who rely almost totally on the Hospital Authority, to near zero for the rich, who mostly patronize private providers. These different extents of subsidy[9] can be applied to the premiums payable under the new system. This way, no income group would be worse off. Then, once future total public healthcare expenditure (equal to total subsidies[10]) exceeds a certain percentage of total government

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[5] Such information might include brief diagnoses, the names and nature of drugs prescribed, and the relative sizes of the administrative costs of all networks for comparison, etc.

[6] As in Switzerland and the Netherlands, there should be mechanisms for adjustment of premium income among the networks taking into account how many high-risk patients each has. Also, the network from which a patient is switching out of might be levied a certain amount. The patient who makes the switch, too, might be required to pay an administrative fee.

[7] Co-payments here includes also deductibles and user fees. It would be better if all the non-premium out-of-pocket payments by patients are uniformly expressed as a percentage of the medical bill, rather than being a diverse array of individual amounts that have to be individually set. Administration would be simplified and patients would have a better grasp of the relative magnitude.

[8] The supplementary financing options proposed in the government consultation document, with the exception of the mandatory savings accounts, all involve an immediate roll back of benefits that the middle class is already receiving. (Poor people already on social security will not be affected by such roll back of subsidy, because the resultant shortfall would be paid for by social security.) It is understandable that such roll back would be resisted, since the widening of Hong Kong's rich-poor gap in recent years had adversely affected many in the middle and lower income groups.

[9] If this set of figures are not available currently, they can be easily estimated with the help of a survey.

[10] Currently, public healthcare expenditure is basically the expenditure of the Hospital Authority (HA). But under the new system, the former will basically consist of total healthcare subsidies, while the HA will become self-financing. The HA will be the market leader and charge a premium on full cost recovery basis. Other networks will set their premiums relative to the HA's premium. As for subsidies, the maximum subsidy per person, that for the low income group who rely almost totally on the HA right now, will be the lowest available premium – likely to be the one charged by the HA. Other levels of subsidy will be determined with reference to the set of figures referred to in Footnote

expenditure, the difference would have to be made up by increases in co-payments[11].

Instead of burdening the next generation with our post-retirement medical costs, people should be encouraged to opt for paying a higher level of premium such that anyone who has paid the higher premium through age 65 would not have to pay premiums thereafter[12]. The $50bn set aside in this year's Budget would be used to provide incentive for people to choose this alternative.[13]

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[11] Consideration should be given to allowing healthcare subsidy to grow mildly faster than total government expenditure, instead of capping that growth outright. A principal justification for subsidizing healthcare from public revenue is that market forces have wrought a large rich-poor gap in Hong Kong and, for the sake of social cohesion, the rich, who are paying just a modest rate of tax, should pay towards mitigating the hardships caused. Also, even though only a relatively low proportion of the population pay taxes, much of Hong Kong's public revenue derives from appreciating property values, to which everyone contributed.

In the main, though, the expansion of healthcare subsidy should be curtailed at some point. Escalating medical costs should be taken into account in individual spending decisions, and Hong Kong's tradition of each person paying for his own is a worthy one to preserve. Thus it is also suggested, for instance, that premiums for chiidren should be paid by the parents themselves (unlike in the Netherlands).

The social security system should be further rationalized. Its database can interface with that of the income taxation system to provide integrated information on personal means. Through more interfacing of systems, such information should then be accessible to the healthcare accounts system, so that premiums and co-payments can be paid for by social security in amounts that match objectively determined needs in each individual case.

[12] This should be easier for the public to accept than the Medical Savings Accounts option in the consultation document, and also easier to administer.

[13] The public can be allowed to choose between one of two incentives: (1) cash upon retirement – to encourage low-income earners to pay out-of-pocket for the difference in premium even when the regular premium is already paid for them by social security, and (2) a discount to the higher premium – to provide incentive to the middle class .