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Health Care Financing Reform in Hong Kong

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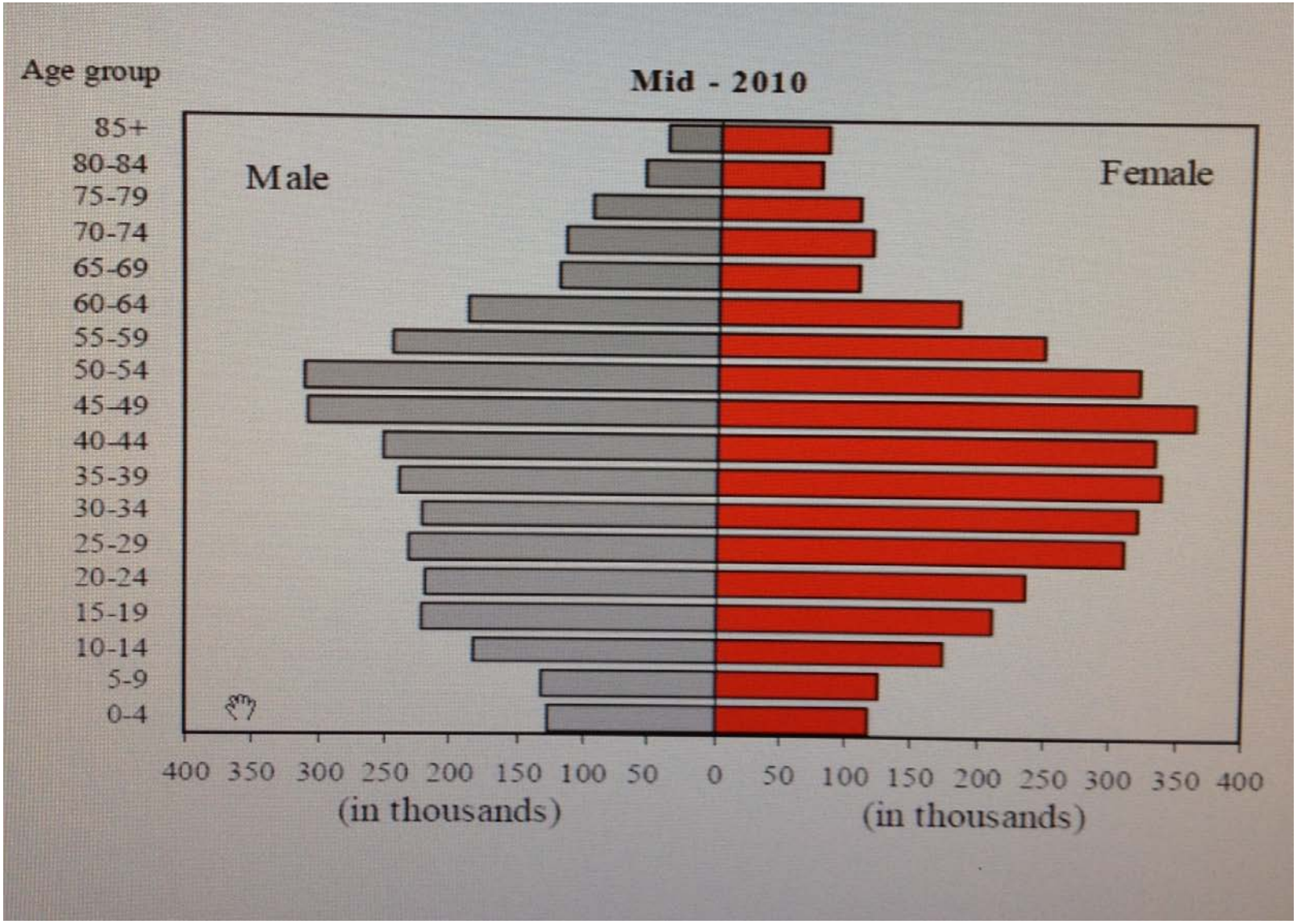
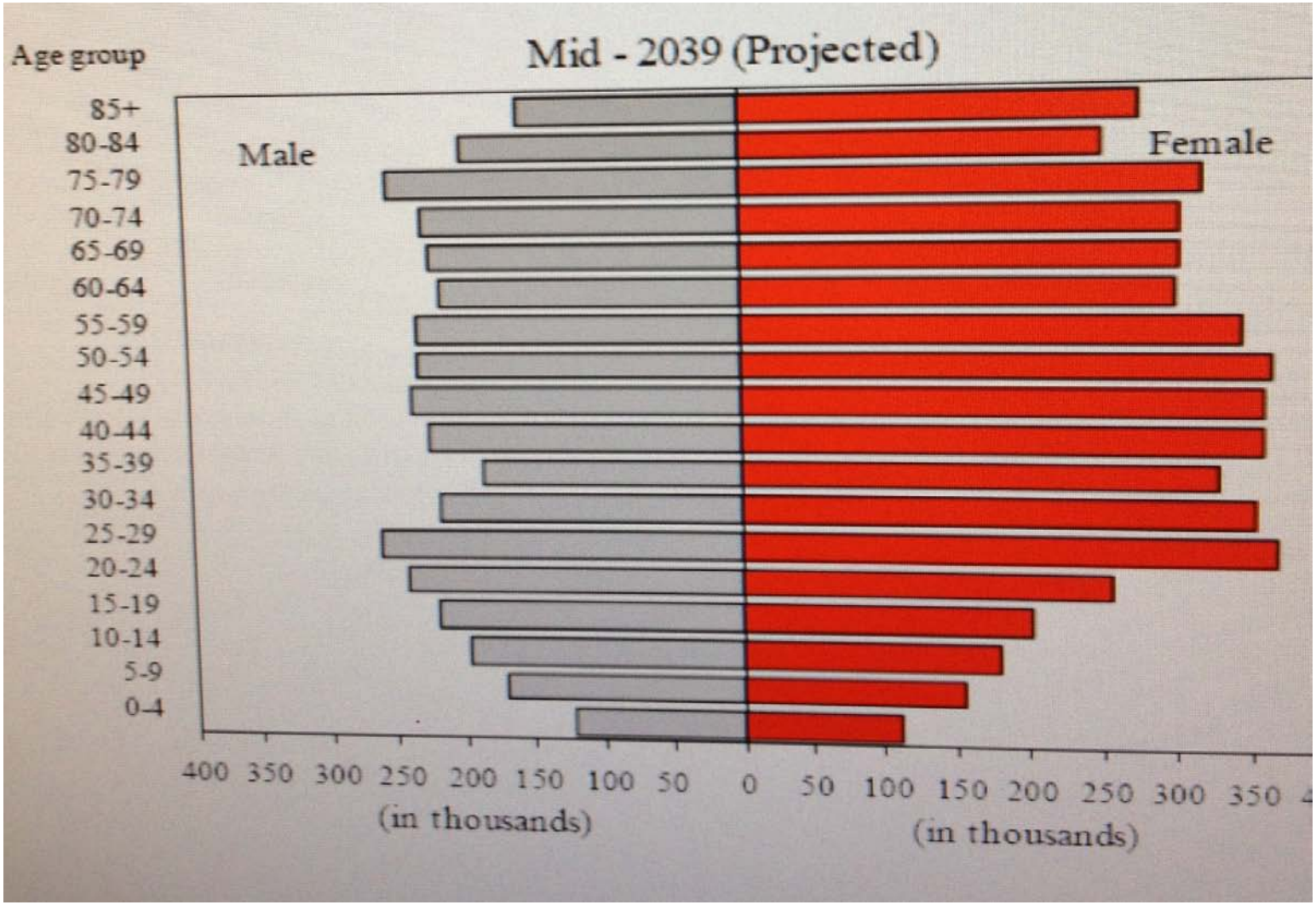
Why Reform?

- Aging population
  - Elderly dependency ratio :
    - Now 170/1,000
    - 2033 428/1,000
- Elderly health care expenses 4 times non-elderly person
- Most elderly do not pay income tax or have private insurance

Changing Age Structure: Now



Changing Aging Structure: In 30 years time



Government's 6 Reform Options

1. Social health insurance
2. Raise users' fees in public hospitals
3. Medical savings accounts
4. Voluntary private health insurance*
5. Mandatory private health insurance
6. Personal health care reserve (mandatory savings + insurance)

*Government preferred option

Existing Voluntary Private Health Insurance in Hong Kong

- No government subsidy
- Under-regulated
- Excludes persons pre-existing conditions
- Prohibitively expensive for elderly
- Many cost effective services are not covered : prevention and early detection services
- Many plans do not offer adequate protection in the event of major illness

2011 Employees' Insurance Benefit Survey: Benefit Provision (Siu & Yuen 2011)

Surveyed 409 companies, 35,678 employees

- 37% of the employers provide hospitalization benefits
- 33% of the employers provide outpatient benefits
  - Maximum number of outpatient visits for general staff: 30 (median) – **way too high**

Premium for Hospitalization vs Outpatient Plans

- Hospitalization: Annual Premium per insured for General Staff: $912(median)
- Outpatient: Annual Premium per insured for General Staff: $1,623 (median)

Private Health Insurance Polices and Private Hospital Days

- Close to 3 million persons (~40%) in HK are covered by some form of private health insurance;
- Over 90% of patient days are in public hospitals
- The majority of the plan-holders go to public hospitals in the event of major illness

Australian Private Health Insurance and Private Hospitals

- Around 40% population has private health insurance
- Premium is fixed for life according to the age of joining – otherwise 2% increase for every year from age 30
- Private hospitals treat 4 out of 10 admitted patients
- Private hospitals performs 57% of all surgeries

Government's Proposed Health Protection Scheme (HSP) 2011

- Voluntary private health insurance
- Government regulated
  - Lifetime coverage
  - No refusal
  - Guidelines on premium, coverage, transparencies, providers requirements
  - Arbitration procedures
- Some subsidies as incentives

Benefits

- Hospitalization and some day procedures
- General ward class
- There will be Deductibles and Co-payments (eg deductible $10K; 20% co-payment for 1st $10K and 10% for the rest)
- General outpatient services excluded
- Prevention early detection services excluded

Subscribers

- Group and Individuals
- Can migrate from existing plans
- Portability – can switch plans
- No refusal but premium could be high
- Pre-existing conditions delay and reduced benefits (25% after 2nd year; 50% after 3rd year)
- Maximum entry age : 65, and guaranteed renewal for life

Premium

- Vary with age
- Premium can be increased because of medical inflation, utilization and age of the subscriber
- Premium can be lowered with deductible
- Maximum loading for high risk individuals is 3 times the normal premium for that age

Administration

- Private insurance companies can participate if they wish to abide by the rules
- The Scheme will be supervised by Commissioner of Insurance (maybe later by an Independent Insurance Authority)
- Dept of Health will be responsible for QA of participating hospitals

- Government provides subsidies for the high risk pool
- Payment to providers using DRG’s (package price) for common conditions and fixed fee schedules for other procedures

Comparing HSP with the majority of Existing Employers' Sponsored Plans

Existing Plans (General Staff; Median)

- Daily Rm & Board $525
- Daily Doctor's fee $500
- Max Limit of days/disability 60

HSP

- Daily Rm & Board $550
- Daily Doctor's fee $650
- 180 days total

Existing Plans

- Surgical limit
  - Surgeon’s fee for complex procedures $33,000
  - Anaesthetist’s fee $9,983
  - Operating theatre $9,900

HSP

- Surgical limit
  - $50,000

Premium

Existing Plans

- Annual Premium per staff $912

HSP

- Annual Premium with $10K deductible
  - 30-34: $1,290
  - 40-44: $2,000
  - 50-54: $2,710
  - 60-64: $4,070

Implications

- The hospitalization benefits provided by HSP are comparable to the majority of the existing plans
- The Premium of HSP appears to be much higher than existing plans
- Many employers will therefore not choose to migrate

Individual Subscribers

- Not attractive to elderly
  - No income
  - Premium 3.8X persons in their 30's
  - High risk another 3X (~ 10X healthy 30's)
  - $10K deductible plus co-payment for every hospital stay

Results of Simulation (Mercer 2011): (1)Healthy, (2) Average, (3)Sick Families

(1) Healthy Family : **better-off without HSP**

- No insurance – medical costs $53,000
- With HSP – premium $36,000 + $53,000

(2) Average Family: **about the same with HSP**

- No insurance – medical costs $137,000
- With HSP – premium $36,000 + out-of-pocket $94,000

(3) Sick Family: **will benefit from HSP, but with $300K out-of-pocket payment**

- No insurance – medical costs $623,000
- With HSP – premium $36,000 + out-of-pocket $301,000

Solution to Health Care Financing?

- Not attractive to Employers
- Not attractive to the elderly
- Cannot effectively tackle the Aging problem:
  - Pay-as-you-go scheme; few working-age people supporting growing elderly population

Spending the $50B

- The most pressing problems -- cataract surgery, cholecystectomy, PCTA, hip replacement, dementia-- happen mostly to the elderly population
- Elderly will most likely not buy insurance even though there are money set aside to help them
- Spending $50B to help the population to get private health insurance does not ease the problem

Way Forward

- Regulate but no subsidy
- Should be a Self-financing scheme similar to MediShield in Singapore
- Use the $50B to set up a Government Savings Account to deal with the most pressing problems of the elderly
- The fund needs to be replenished whenever Government has substantial surplus

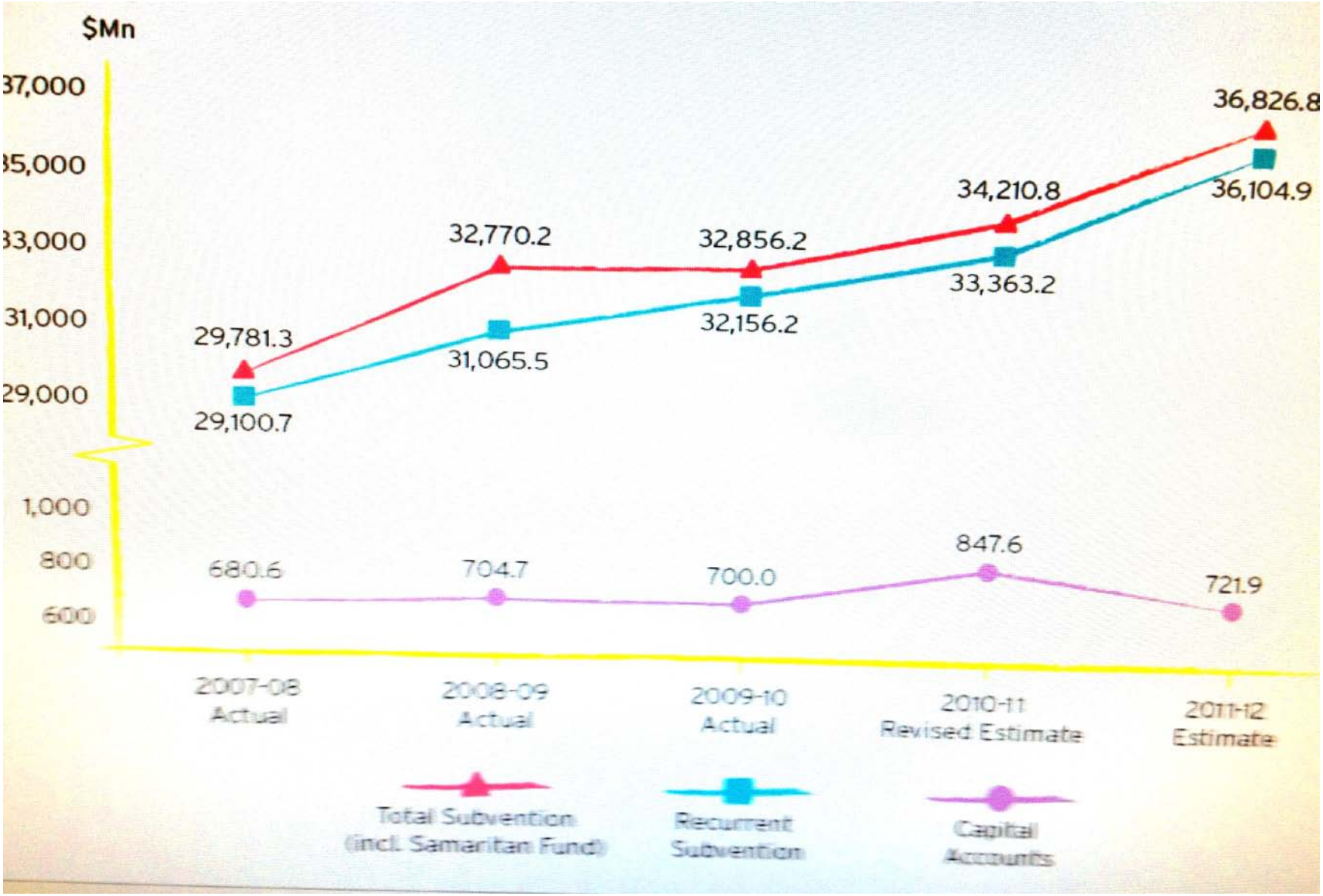
A Government Savings Fund for Aging
How Much?

- MPF contributions (10% of salary) : $37B (2010)
- Proposed medical savings account: 3% of salary – $11B
- Government should set aside from surplus an average of $10B per year to cope with the medical and long-term care expenses relating to population aging
- The $50B can be the first instalment

How should We Use the Money from the Government Savings Account?

- Just give to the Hospital Authority?
- Will the HA spend it wisely?
- Has HA been spending money wisely?
- Is the popular perception that HA is underfunded and HA doctors' overworked correct?

Government Subvention to HA



Recurrent per capita subvention 2011

- Population in 2011: 7,071,576
- Elderly %: 13.3
- Population units (elderly X4): 9,893,134
- Government recurrent subvention: $36B
- Annual Per capita for non-elderly: $3,639
- Annual Per capita for elderly: $14,556

Doctors, Nurses & Population

Year	1993	1996	2002	2005	2007	2010
Population	6,019,900	6,311,000	6,787,000	6,970,000	7,039,000	7,067,800
Elderly population	9%	10%	11.4%	12%	12%	13%
Population units: (elderly*4)	7,645,273	8,204,300	9,108,154	9,489,288	9,573,070	9,824,242
Pop units/HA Doctor	3,063	2,520	2,043	1,937	1,916	1,861
Pop units/HA nurse	462	440	462	493	498	495

Public Hospitals' Doctor's Workload

Year	1993	1996	2002	2005	2007	2010
Population	6,019,900	6,311,000	6,787,000	6,970,000	7,039,000	7,067,800
Gen Beds	23,299	25,177	29,022	20,225	20,180	20,516
Patient Days	4,995,104	5,384,353	6,744,886	5,230,343	5,220,389	5,314,224
No of Doctors	2,496	3,255	4,458	4,898	4,966	5,278
Beds/Doc	9.3	7.73	6.51	5.75	4.06	3.90
Patient Days/Doc	2,001	1,654	1,513	1,077	1,051	1,006

Total Workload

Year	1993	1996	2002	2005	2007	2010
Gen OPD visits	760,145	754,572	887,328	5,179,203*	4,842,247	4,700,543
A&E visits (2.65*GOPD)	1,492,637	1,979,212	2,522,972	2,019,451	2,052,774	2,214,422
SOPD visits (3.26*GOPD)	4,420,542	6,119,560	5,,943,653	6,018,338	6,005,257	6,392,410
Patient days (15.53*GOPD)	4,995,104	5,384,353	6,744,886	5,230,343	5,220,389	5,314,224
Total Work Units	96,700,564	109,568,252	130,146,269	111,377,757	110,931,877	166,751,881
No of Doctors	2,496	3,255	4,458	4,898	4,966	5,278
Work Units/ Doctor	38,742	33,661	29,193	22,739	22,338	31,594

Observations

- Inpatient workload for has been on the decline
- Despite Outpatient Workload is on the increase, average workload for doctors has been consistently decreasing
- Overall age-adjusted population to doctor ratio is much better now than ever before
- Overall age-adjusted population to nurse ratio is worse-off than before

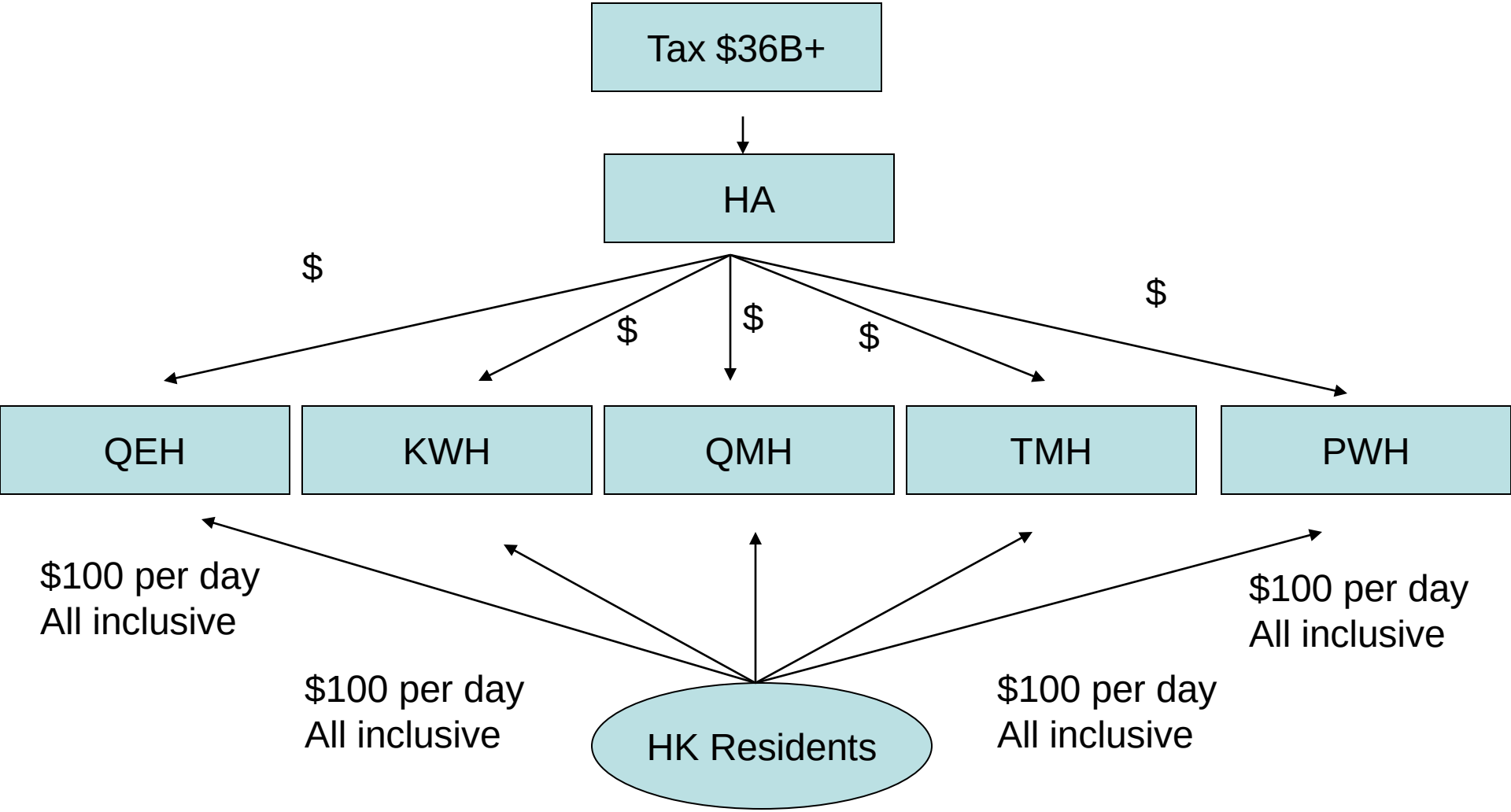
- My evidence does not support that the generally held perception that HA is underfunded
- My evidence does not support the generally held perception that our doctors are overworked

- While mortality indicators are on the decline, we have no data on quality of care and quality of life of patients
- Anecdotal evidence -- long waiting lists, frequent medical blunders – suggests problems
- HA’s efficiency appears to be on the decline

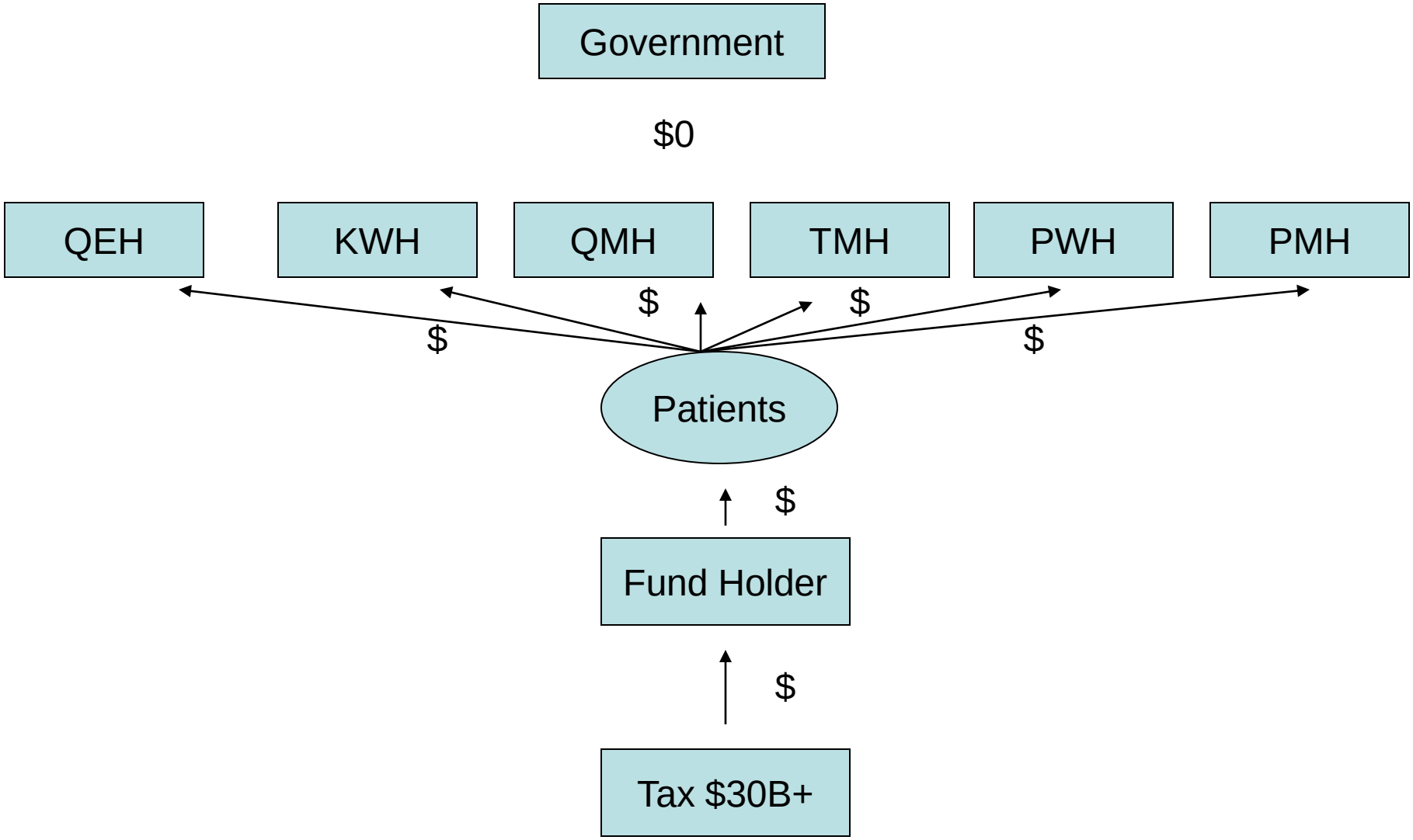
Why?

- Perverse incentives systems
- Money does not follow patients
- Money goes to hospitals at beginning of the year regardless of workload, outcome
- Good care attract more patients but not resources
- Poor care deter patients but resource level is the same

The HA Funding Model



Remedies: Change the Funding Model to Money Follow Patients



- There appears to be something wrong with the resource allocation system/incentive system within HA
- This needs to addressed before committing more resources to HA

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Questions