Health Care Financing Reform in Hong Kong

Peter P. Yuen, PhD
Professor and Dean
College of Professional & Continuing Education
The Hong Kong Polytechnic University
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 Policies 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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>6,019,900</td>
<td>6,311,000</td>
<td>6,787,000</td>
<td>6,970,000</td>
<td>7,039,000</td>
<td>7,067,800</td>
</tr>
<tr>
<td><strong>Elderly population</strong></td>
<td>9%</td>
<td>10%</td>
<td>11.4%</td>
<td>12%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Population units: (elderly*4)</strong></td>
<td>7,645,273</td>
<td>8,204,300</td>
<td>9,108,154</td>
<td>9,489,288</td>
<td>9,573,070</td>
<td>9,824,242</td>
</tr>
<tr>
<td><strong>Pop units/HA Doctor</strong></td>
<td>3,063</td>
<td>2,520</td>
<td>2,043</td>
<td>1,937</td>
<td>1,916</td>
<td>1,861</td>
</tr>
<tr>
<td><strong>Pop units/HA nurse</strong></td>
<td>462</td>
<td>440</td>
<td>462</td>
<td>493</td>
<td>498</td>
<td>495</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Population</td>
<td>6,019,900</td>
<td>6,311,000</td>
<td>6,787,000</td>
<td>6,970,000</td>
<td>7,039,000</td>
<td>7,067,800</td>
</tr>
<tr>
<td>Gen Beds</td>
<td>23,299</td>
<td>25,177</td>
<td>29,022</td>
<td>20,225</td>
<td>20,180</td>
<td>20,516</td>
</tr>
<tr>
<td>Patient Days</td>
<td>4,995,104</td>
<td>5,384,353</td>
<td>6,744,886</td>
<td>5,230,343</td>
<td>5,220,389</td>
<td>5,314,224</td>
</tr>
<tr>
<td>No of Doctors</td>
<td>2,496</td>
<td>3,255</td>
<td>4,458</td>
<td>4,898</td>
<td>4,966</td>
<td>5,278</td>
</tr>
<tr>
<td>Beds/Doc</td>
<td>9.3</td>
<td>7.73</td>
<td>6.51</td>
<td>5.75</td>
<td>4.06</td>
<td>3.90</td>
</tr>
<tr>
<td>Patient Days/Doc</td>
<td>2,001</td>
<td>1,654</td>
<td>1,513</td>
<td>1,077</td>
<td>1,051</td>
<td>1,006</td>
</tr>
</tbody>
</table>
# Total Workload

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

Tax $36B+

HA

QEH
KWH
QMH
TMH
PWH

HK Residents

$100 per day All inclusive

$100 per day All inclusive

$100 per day All inclusive

$100 per day All inclusive
Remedies: Change the Funding Model to Money Follow Patients

Government

$0

QEH
KWH
QMH
TMH
PWH
PMH

Patients

Fund Holder

Tax $30B+
• 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
Questions