Healthcare Reform in Hong Kong:
Supplementary financing in a mixed health care economy

Mr. Chris Sun
Head, Healthcare Planning and Development Office
Food and Health Bureau
HKSAR Government
7 March 2013
Agenda

1. Background
2. Health Protection Scheme
3. Overseas experience
4. Read-across Implications
5. Way forward
Today’s flow

• Presentation 20-25 minutes
• Questions and Answers 20-25 minutes
Agenda

1. Background
2. Health Protection Scheme (HPS)
3. Overseas experience
4. Read-across Implications
5. Way forward
Macro-organisation of the HK Health System

System

Funding sources

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

Providers

Hospital Authority
- 41 hospitals
- GOPCs, SOPCs
  (predominantly Western allopathic medicine)

Consumers

General population

Public Health

Personal Health Care

Public
(Food and Health Bureau)

Government general revenue

Hospital
Authority

Private

Employers

Individuals

Private insurers/MCOs

Market share

Inpatient # (bed-days)
(admission)

Outpatient (incl. TCM)@

90%
80%
30%

Universal coverage

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

Sources: * Hong Kong’s Domestic Health Accounts 2009/10
# Hospital Authority and Department of Health, 2010
@Thematic Household Survey in 2011
Public Private Imbalance

Source:
(1) Health expenditures as a % of GDP: Hong Kong’s Domestic Health Accounts: 2009/10
(2) Inpatient (secondary & tertiary care): “Public-private share by in-patient bed day occupied in 2010” from HA and Dept of Health
<table>
<thead>
<tr>
<th>Service</th>
<th>Fees</th>
<th>Cost</th>
<th>Subsidized Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>$100 per attendance</td>
<td>$700</td>
<td>86%</td>
</tr>
<tr>
<td>In-patient (general acute beds)</td>
<td>$100 per day</td>
<td>$3,790</td>
<td>97%</td>
</tr>
<tr>
<td>In-patient (convalescent, rehabilitation, infirmary &amp; psychiatric beds)</td>
<td>$68 per day</td>
<td>$1,460</td>
<td>95%</td>
</tr>
<tr>
<td>Specialist out-patient</td>
<td>$100 (1st attendance)</td>
<td>$530</td>
<td>81%-89%</td>
</tr>
<tr>
<td></td>
<td>$60 (subsequent attendance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist out-patient (drug)</td>
<td>$10 per drug item</td>
<td>$120</td>
<td>92%</td>
</tr>
<tr>
<td>General out-patient</td>
<td>$45 per attendance</td>
<td>$250</td>
<td>82%</td>
</tr>
</tbody>
</table>
How we compare with other jurisdictions

Source: OECD.Stat website, Global Health Expenditure Database and Hong Kong’s Domestic Health Accounts: 1989/90 – 2009/10

Note
The ratio of Hong Kong’s public health expenditure to GDP should also be considered in conjunction with its low tax regime and stringent control on government expenditure for the sake of fiscal prudence. The public health expenditure as percentage of total tax revenue in Hong Kong is comparable to other economies somewhere in the middle amongst the economies under comparison. This reflects the Government’s ongoing commitment to healthcare.
Our population is ageing markedly

Note
Our population is expected to remain on an ageing trend. The proportion of the population aged 65 and over is projected to rise markedly from 13% in 2011 to 30% in 2041. On the other hand, the proportion of the population aged under 15 is projected to drop from 12% to 9% during the projection period.

The changing age structure of the projected population can also be seen from variation in the elderly dependency ratio. This is defined as the number of persons aged 65 and over per 1 000 population aged between 15 and 64. The ratio is projected to increase from 177 in 2011 to 497 in 2041.

Source: Hong Kong Population Projections, 2012-2041, Census and Statistics Department
HK’s health expenditure projected to continue to rise as a share of the economy

Health expenditure as % of GDP 1990 - 2033

Past Health expenditure in HK in 1990 - 2004

Projection Health expenditure in HK in 2005 - 2033

Total health expenditure

Public health expenditure

Private health expenditure

Source: Hong Kong’s Domestic Health Accounts: 1990 - 2004
Financial projection of Hong Kong’s total expenditure on health from 2004 to 2033
Healthcare Reform: A historical timeline of public consultations

1985
1993
1999
2000
2005
Mar 2008
Dec 2008
Jul 2010
## Total Health Expenditure by Financing Source, 1989/90-2009/10 (HK$ Million)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>7,749</td>
<td>18,657</td>
<td>31,671</td>
<td>39,152</td>
<td>36,934</td>
<td>38,828</td>
<td>41,257</td>
<td>43,823</td>
<td>9.0%</td>
</tr>
<tr>
<td>PHI</td>
<td>2,312</td>
<td>4,132</td>
<td>7,743</td>
<td>8,110</td>
<td>9,022</td>
<td>10,883</td>
<td>11,847</td>
<td>12,636</td>
<td>8.9%</td>
</tr>
<tr>
<td>Individually purchased PHI</td>
<td>263</td>
<td>480</td>
<td>1,961</td>
<td>2,721</td>
<td>3,663</td>
<td>4,721</td>
<td>5,417</td>
<td>6,041</td>
<td>17.0%</td>
</tr>
<tr>
<td>Employer-provided PHI</td>
<td>2,049</td>
<td>3,652</td>
<td>5,782</td>
<td>5,388</td>
<td>5,359</td>
<td>6,162</td>
<td>6,430</td>
<td>6,595</td>
<td>6.0%</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>9,212</td>
<td>15,948</td>
<td>21,952</td>
<td>21,006</td>
<td>23,712</td>
<td>27,440</td>
<td>29,028</td>
<td>30,961</td>
<td>6.2%</td>
</tr>
<tr>
<td>Others</td>
<td>370</td>
<td>744</td>
<td>870</td>
<td>568</td>
<td>903</td>
<td>1,750</td>
<td>1,557</td>
<td>1,301</td>
<td>6.5%</td>
</tr>
<tr>
<td>Total</td>
<td>19,643</td>
<td>39,481</td>
<td>62,236</td>
<td>68,835</td>
<td>70,571</td>
<td>78,901</td>
<td>83,690</td>
<td>88,721</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

Source: Hong Kong’s Domestic Health Accounts 1989/90 – 2009/10
Healthcare Reform: Enhancing Services on a Sustainable Basis

**Healthcare Reform**

- **Health Protection Scheme**
  - **Second Stage Public Consultation**
    - Introduce supplementary financing
    - Strengthen healthcare safety net
    - Promote public-private partnership
    - Enhance primary care
    - Develop electronic health record

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

*My Health  My Choice*
Agenda

1. Background
2. Health Protection Scheme (HPS)
3. Overseas experience
4. Read-across Implications
5. Way forward
HPS Objectives

- More consumer choice
- Reduce public waiting time
- Sustained insurance protection at old-age
- Consumer protection & market transparency
Key HPS Features

**Benefit Coverage**
- Benefit Limits
  - itemized
  - packaged charging
- Benefit Charge
  - inpatient (ward level)
  - ambulatory procedures

**Benefit Charge**

**Operational Rules**
- Claims Dispute Resolution Mechanism
- Portability
- Standardized policy terms and conditions

**Underwriting Rules**
- High Risk Pool
  - Premium loading capped at 200%
- Covering pre-existing conditions
- Age-banded premium
- Guaranteed acceptance and lifetime renewal

**Minimum Requirement Approach**

**No-claim discount**

**Savings for future premium**
# Value-added for the Consumers

<table>
<thead>
<tr>
<th>Current market</th>
<th>HPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncertainty of coverage and policy terms</td>
<td>✓ <strong>Minimum requirements and standardized terms and conditions</strong></td>
</tr>
<tr>
<td>Uncertainty of claims outcome</td>
<td>✓ <strong>Price transparency (e.g. quotation)</strong></td>
</tr>
<tr>
<td>Exclusion of pre-existing conditions</td>
<td>✓ <strong>Guaranteed acceptance, time-limited exclusion, premium loading capped at 200%</strong></td>
</tr>
<tr>
<td>No guarantee on policy renewal</td>
<td>✓ <strong>Guaranteed renewal for life</strong></td>
</tr>
<tr>
<td>Lack of transparency on insurance premium adjustment</td>
<td>✓ <strong>Transparency on premium; easy comparison between Standard Plans</strong></td>
</tr>
<tr>
<td>Unnecessary overnight hospital stay</td>
<td>✓ <strong>Cover ambulatory procedures</strong></td>
</tr>
<tr>
<td>Re-underwriting if changing insurer</td>
<td>✓ <strong>Individual to individual portability</strong></td>
</tr>
<tr>
<td>No guarantee to stay on after retirement</td>
<td>✓ <strong>Group to individual portability</strong></td>
</tr>
</tbody>
</table>
Agenda

1. Background of HK healthcare development
2. HPS Product Features
3. Overseas experience
4. Read-across Implications
5. Way forward
Overseas experience

International research was conducted for:
1. Australia
2. Ireland
3. the Netherlands
4. Switzerland
5. US: focus is on current health reforms
## Role of PHI and Key Features

<table>
<thead>
<tr>
<th>Role of PHI</th>
<th>Australia</th>
<th>Ireland</th>
<th>Netherlands</th>
<th>Switzerland</th>
<th>US</th>
<th>Hong Kong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage as % of population</td>
<td>Voluntary</td>
<td>Voluntary</td>
<td>Mandatory &amp; Voluntary</td>
<td>Mandatory &amp; Voluntary</td>
<td>Mandatory</td>
<td>Voluntary supplementary</td>
</tr>
<tr>
<td>PHI Expenditure as % of healthcare financing</td>
<td>47% (for hospital treatment)</td>
<td>47%</td>
<td>~100%</td>
<td>~100%</td>
<td>65% (prior to PPACA)</td>
<td>41%</td>
</tr>
<tr>
<td>Product Regulation by Law</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Premium Regulation by Law</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>All PHI Products subject to same regulatory standards?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Minor differences for large group plans</td>
<td>n/a</td>
</tr>
<tr>
<td>Financial Incentives</td>
<td>✓ (means tested)</td>
<td>✓</td>
<td>✓ (means tested)</td>
<td>✓ (means tested)</td>
<td>✓ (means tested)</td>
<td>✗</td>
</tr>
<tr>
<td>Government led alternative dispute resolution mechanism</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Industry-run</td>
</tr>
</tbody>
</table>

### Notes
- Voluntary supplementary
- Mandatory & Voluntary supplementary
### Product Regulation

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>Ireland</th>
<th>Netherlands</th>
<th>Switzerland</th>
<th>US</th>
<th>HK HPS (as in 2nd Stage Consultation Document)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guaranteed issuance</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓ Up to 65</td>
</tr>
<tr>
<td>Guaranteed renewal</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Must cover pre-existing conditions?</td>
<td>✓ (Except during waiting periods)</td>
<td>✓ (Except during waiting periods)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓ Except during waiting periods</td>
</tr>
<tr>
<td>Minimum benefit coverage</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓ (except for Group &amp; some grandfathered plans)</td>
</tr>
<tr>
<td>Restrictions on cost-sharing</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Standardised terms</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>not required as mandatory plans are identical</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Implications from overseas experience

1. HPS goals are consistent with PHI goals in the countries studied
2. Most features of the HPS are consistent with the countries studied
3. Common overseas practice to require all PHI products to comply with regulatory requirements
4. Statutory minimum requirements are broad
5. Cost sharing (out-of-pocket costs) is often regulated in order to protect members
6. Medical inflation and demand pressures are real risks which must be managed and monitored
7. Financial Incentives / Disincentives are widely offered, but must be well designed to be effective.

8. Some features not supported by evidence: no claims discount, savings accounts.

9. PHI reform requires a clear vision of public and private sector roles in health care delivery.

10. Market transparency is critical for competition, consumer protection and optimal regulation.

11. PHI reform is an incremental process requiring long-term commitment and ongoing oversight.

12. A government-led claims dispute resolution system is desirable.
Read across Implications

1. Private healthcare capacity
2. Healthcare manpower
3. Public-private dynamics
4. Medical inflation
5. Equity, efficiency and choice
Agenda of today

1. Background of HK healthcare development
2. HPS Product Features
3. Overseas experience
4. Read-across Implications
5. Way forward
Way Forward

1. Right touch regulatory regime: Legislation? Self regulation?
2. Affordability vs comprehensiveness
3. HPS Standard Plan
4. High Risk Pool
5. Operational Rules
6. Migration
7. Use of public subsidy
Questions and Answers