## Chapter 6 REFORM HEALTHCARE FINANCING ARRANGEMENTS

### Increasing Government Funding

6.1 The Government will continue to be the major financing source for healthcare and will uphold the treasured principle that no one should be denied adequate healthcare through lack of means. To meet the increasing healthcare needs of the community and for reforming the healthcare system, the Government is committed to increasing recurrent government expenditure for health and medical services from 15% to 17% of overall recurrent government expenditure by 2011-12.

### The Need to Reform Financing Arrangements

6.2 Over the years, we have taken various measures to increase the efficiency and cost-effectiveness of the public healthcare system. Public healthcare services have sustained an efficiency gain of around 1% per year on average over the years. For example, the average in-patient length of stay in public hospitals has gradually been reduced from 10.0 bed-days in 2000-01 to 8.9 bed-days in 2006-07. As part of the Government's Enhanced Productivity Programme and Efficiency Savings Programme between 2000-01 and 2005-06, the Hospital Authority (HA) has also achieved efficiency savings of an aggregate total equivalent to 12% of its baseline subvention while maintaining services throughput. HA is also examining how to improve its internal resource allocation mechanism with a view to better allocating resources to meet services needs and to encourage efficiency and cost-effectiveness.

6.3 Looking forward, we will continue to take measures to enhance the efficiency and cost-effectiveness of the public sector as well as the healthcare system as a whole. These will include the fundamental and comprehensive service and market structure reforms set out in Chapter 2 to Chapter 4. However, even with increased government funding for healthcare and sustained efficiency enhancement of public healthcare services, government funding alone will not be sufficient to guarantee the sustainability of the healthcare system in the long run. Without reforming the healthcare financing arrangements, the increased government funding for healthcare is still expected to be outstripped by the projected healthcare needs of the community by around 2012.

6.4 The experience of other advanced economies also shows that total and public health expenditure may grow to as large as 8%-15% and 6%-8% of GDP respectively. It is not certain to what extent this experience is directly applicable to Hong Kong against our better record of containing public health expenditure and

enhancing efficiency of the healthcare system, but our projection based on this experience shows that our total and public health expenditure may grow to 9.2% and 5.5% of GDP respectively by 2033. It is thus clear that we need to reform the healthcare financing arrangements alongside the healthcare services.

**Consequences of Maintaining Existing Financing Model**

6.5 If we continue to maintain the existing financing model to finance public healthcare solely through government revenue, public expenditure on healthcare will have to increase at a much faster pace than the economy. As explained in Chapter 1, this could mean rising tax bills eroding Hong Kong's competitiveness or reduced funding affecting other areas of public services. If we increase tax rates, those within the tax net would have to contribute more towards maintaining the healthcare system. Given the narrow tax base for Salaries Tax and the progressive tax rates, only around one-third of the workforce pays Salaries Tax, and those with higher income contribute a higher proportion of their income than those with lower income.

6.6 Our analysis of the pros and cons of maintaining the existing financing model are set out in greater detail in Chapter 7. Based on the analysis, **we believe that maintaining the existing financing model is not a sustainable option**.

**Introducing Supplementary Financing for Healthcare**

6.7 With increased government funding continuing to be the major financing source, a solution to sustain financing for our healthcare system is to introduce supplementary financing for healthcare, to supplement government funding to cope with increasing healthcare needs, and also to sustain the following reform for the long-term –

(a) to continue to invest in better and more comprehensive primary care that improves the health of the community and reduces the need for more expensive hospital care in the long run;

(b) to continue to invest in newer and better medical technology that offer better diagnosis and treatment of illnesses and improve the quality of healthcare provided to our community;

(c) to support the reform of the healthcare market structure by enabling more individuals to be in a position to choose private healthcare and promoting healthy competition in quality and cost-effectiveness; and

(d) to strengthen the public healthcare safety net for those in need, and promote the concept of shared responsibility for improving health through partnership between the Government and individuals.

6.8 One thing is clear: supplementary financing is an essential component of the reform and concerns not only our present community but generations to come. What form the supplementary financing should take is thus an important decision to be taken by the community based on our societal values. Together we need to move towards a consensus on the form of supplementary financing for healthcare best-suited to the circumstances of Hong Kong, for the sake of both ourselves and our future generations.

**Overseas Experience**

6.9 We have examined the healthcare financing arrangements in a number of advanced economies. Different economies adopt different healthcare financing arrangements (see **Table 6.1**). These arrangements can broadly be classified by their financing sources and means into the following categories –

- General taxation
- Social health insurance
- Out-of-pocket payments (user fees)
- Medical savings accounts
- Voluntary private health insurance
- Mandatory private health insurance

6.10 The financing arrangements of all the advanced economies we have studied invariably involve a mix of the above financing sources in different proportion, and none amongst them adopts one single means as the sole source of financing. It is worth noting that –

(a) All the advanced economies we have studied have sales tax of varying degrees. In those economies where government revenue is the main source of healthcare expenditure, the applicable tax rates, especially personal income tax rates, are much higher than those in Hong Kong.

(b) Apart from those economies where government revenue is the main source of healthcare expenditure, regular contribution from individuals to healthcare on top of tax payment is common and takes the form of –

(i) social health insurance contributions;

(ii) private health insurance premium payments;

(iii) mandatory medical savings to be channelled into the healthcare system as payments of fees and charges for healthcare services; or

(iv) a combination of the above.

(c) Apart from the United States (where voluntary health insurance is the main financing source) and Singapore (where out-of-pocket payments, part of which is from medical savings accounts, are the main financing source), it is invariably the group in the population with higher income level and better means who contributes more, although in the case of mandatory private health insurance the contribution level (premium) within the contributing group is the same for all. What a contributor receives in return, however, differs among financing options. In economies where government revenue or social insurance is the main source of healthcare expenditure, the choices for "high-end contributors" are often the same as those who have not contributed. In the case of mandatory private health insurance (e.g. in Switzerland, which terms their system as "social insurance"), everyone contributes the same in return for the same basic insurance coverage, but those who can afford to contribute more voluntarily (e.g. by purchasing top-up insurance) will have more choices.

6.11 It is also important to note that there is no one-size-fits-all solution – the healthcare system of each economy has its own specific history and circumstances, reflecting its own societal values and its own specific solution. No one single model can be readily transplanted. There is also no magic or perfect solution – all financing arrangements for healthcare involve trade-offs between the pros and cons of different financing means, and ultimately it is each society's own choice, based on its own political, social and economic conditions, as well as the values and expectations of its members, as to what to gain and what to give up by adopting its own specific mix of financing arrangements.

**Table 6.1** Comparison of Healthcare Financing Sources of Hong Kong and Selected Economies

| Economy | General Taxation | Social Health Insurance | Out-of-Pocket Payments | Voluntary Private Health Insurance | Mandatory Private Health Insurance |
|---|---|---|---|---|---|
| Hong Kong | * | - | ✓ | ✓ | - |
| Australia | * | - | ✓ | ✓ | - |
| Canada | * | ✓ | ✓ | ✓ | - |

| Economy | General Taxation | Social Health Insurance | Out-of-Pocket Payments | Voluntary Private Health Insurance | Mandatory Private Health Insurance |
|---|---|---|---|---|---|
| Finland | ∗ | ✓ | ✓ | ✓ | - |
| United Kingdom | ∗ | - | ✓ | ✓ | - |
| Austria | ✓ | ∗ | ✓ | ✓ | - |
| Belgium | ✓ | ∗ | ✓ | ✓ | - |
| Japan | ✓ | ∗ | ✓ | ✓ | - |
| Korea | ✓ | ∗ | ✓ | ✓ | - |
| Netherlands | ✓ | ✓ | ✓ | ✓ | ∗ |
| Switzerland | ✓ | - | ✓ | ✓ | ∗(Note 1) |
| United States | ✓ | ✓ | ✓ | ∗ | - |
| Singapore | ✓ | - | ∗(Note 2) | ✓ | - |

∗ Major financing source
✓ Supplementary financing source

Note:
1. The mandatory private health insurance is termed as a social health insurance under Swiss law.
2. Singapore adopts a medical savings accounts scheme as part of its Central Provident Fund Scheme to finance out-of-pocket payments for healthcare.

## Supplementary Financing Options for Hong Kong

6.12 We have studied various possible options to provide supplementary financing for healthcare in Hong Kong, having regard to the experience of overseas economies. Each option has its own pros and cons and the choice between the options is very much a choice of the community reflecting its societal values. These options and their pros and cons are set out in detail in Chapter 8 to Chapter 13 –

(a) **Social health insurance (Chapter 8)**: to introduce an employment-based, income-linked contributory scheme to build up a common pool of funding for financing healthcare for the whole population. The contribution base can be wider than the tax net for Salaries Tax in Hong Kong, thereby enlarging the base for financing. Similar to tax, those with higher income will be required to contribute more under social health insurance towards healthcare for the whole population.

(b) **Out-of-pocket payments (Chapter 9)**: to increase user fees for public healthcare services thereby effectively reducing the level of subsidization. Only those who use public healthcare services would pay more; and the more one uses public healthcare services, the more one pays.

(c) **Medical savings accounts (Chapter 10)**: to introduce a mandatory scheme requiring savings (with the option to invest) by a specified group of the population to cover their own medical expenses (including insurance premium if they take out private health insurance), with a view to building up individuals' source of funding available for their own future healthcare and encouraging them to use healthcare services other than high-subsidized public sector ones, thereby reducing the pressure on the public healthcare system. One possible way of defining the specified group is by income level, i.e. those in the working population who are above a certain income level will have to participate in the scheme.

(d) **Voluntary private health insurance (Chapter 11)**: encourage individuals to take out voluntary private health insurance that provides more choices of and greater accessibility to private healthcare services, thereby reducing the pressure on the public healthcare system and in turn public health expenditure. The choice of taking out insurance is voluntary either by individuals for their own individually-purchased medical insurance or by employers as group medical insurance for their employees whilst they are under their employment.

(e) **Mandatory private health insurance (Chapter 12)**: to introduce a mandatory insurance scheme, on a population-wide basis or confined to a specified group, regulated by the Government and operated by private insurance companies. The insurance is regulated to offer no exclusion of medical conditions with guaranteed continuity, and charge community-rated premium (i.e. same level of premium for the same level of protection and the same variety of choices for all participants irrespective of age, gender, other risk factors, and income level) so as to ensure effective pooling and sharing of the healthcare risks for individuals. Those without the means may be assisted by the public purse (under the population-wide scenario) or may not be required to join (under the specified group scenario).

(f) **Personal healthcare reserve (Chapter 13)**: to introduce a scheme requiring a specified group of the population to deposit part of their income into a personal account, for both subscribing to a mandatory regulated medical insurance for protection before and after retirement, and for accruing savings (with the option to invest) to meet healthcare expenses including insurance premium after retirement. The scheme involves a combination of mandatory savings and insurance. The insurance premium for everyone in the group would be the same regardless of difference in income level, in return for the same level of protection and variety of

choices. The amount of savings, however, would differ among individuals according to income levels.

6.13 During this first stage consultation, we would like to set out all the supplementary financing options and engage the public and stakeholders in deliberating the pros and cons of these options. We have an open mind on the supplementary healthcare financing options to be adopted and would like to seek the views of the public through the first stage consultation, with a view to putting forward concrete recommendations in the second stage consultation.

**Comparison between the Financing Options**

6.14 Having regard to both local and overseas experience, we have assessed the pros and cons of the various financing options as supplementary financing for healthcare in Hong Kong. In particular, it is worth noting that each of these options has its own advantages and disadvantages, and inevitably involves a trade-offs in the following aspects –

(a) **Financial stability and sustainability**: to what extent the supplementary financing option can provide a stable and sustainable source of financing to supplementary government funding, meet the long-term needs of the community, and ensure the long-term sustainable development of the healthcare system (e.g. investment in new medical technology, training of professional manpower, continued improvement in quality of healthcare)?

(b) **Accessibility of healthcare**: the public healthcare system seeks to provide the community with equitable access to the same basic level and standard of healthcare based on needs, through queuing and triage or other allocation mechanisms as necessary. Should the supplementary financing continue to finance services under this arrangement? Or should it enable or facilitate more choice of and better access to services for those who can afford and reduce the queues for public healthcare services, thereby also benefiting those who have to rely on basic standard healthcare?

(c) **Pooling and sharing of risk**: should the supplementary financing option pool the financial risk arising from healthcare needs of individual members of the society, such that the risk of those with higher health risk (e.g. the elderly, those with chronic diseases, and those with hereditary illnesses) or struck by unfortunate events requiring healthcare (e.g. those struck by accidents or catastrophic diseases) can be effectively shared out among the population?

(d) **Wealth re-distribution**: bearing in mind that the funding allocated from the public purse to public healthcare services is already a form of wealth re-distribution, should the supplementary financing option further reinforce this by seeking a greater proportion of financing from those with higher-income to subsidize more the lower-income using some form of tax or similar arrangements?

(e) **Choice of services**: to what extent the supplementary financing option induces the development of more personalized choice of services that tailor to the needs and preferences of individuals (e.g. the choice of healthcare services from the public or private sectors, the choice of healthcare providers or doctors, the choice of better amenities, or the choice on timing of treatment, the choice of alternatives in treatment)?

(f) **Market competition and efficiency**: to what extent the supplementary financing option can bring about more healthy competition in the healthcare market and greater transparency of cost/price and quality of services, among healthcare providers and between the public and private sectors, with a view to driving greater efficiency and cost-effectiveness of services?

(g) **Utilization and cost control**: to what extent the supplementary financing option promotes judicious use and cost competitiveness of healthcare, and has in it inherent mechanisms to exert effective control over excessive utilization and cost-escalation of healthcare services (e.g. as a result of moral hazards under a third-party-pay system, or price inflation due to increasing demand for healthcare services)?

(h) **Overhead costs**: how expensive the supplementary financing option would be in terms of overhead costs, such as the varying degree of administration and transaction costs for the purpose of collection of contributions from individuals, allocation of funding or payments to healthcare services and providers, and/or provision of healthcare services to individuals, as well as regulatory cost if a new regulatory regime is required?

6.15 A summary of the different attributes of these financing options as supplementary financing is set out in **Table 6.2** from the next page onward.

**Table 6.2** Comparison of supplementary financing options with existing financing model

| | **Financing sustainability** |
|---|---|
| **Government funding (existing model)** | Not sustainable in the long-term given the low tax rates and narrow tax base of Hong Kong, especially at times of fiscal deficits, which means taxpayers have to pay higher taxes to sustain the system. Increasing public healthcare expenditure may crowd out other areas of public services. |
| **Social health insurance** | Quite stable source of financing given that the social health insurance contributions are earmarked for healthcare. However, may not be sustainable in the long-term due to a shrinking workforce in the face of population ageing. Stability and sustainability also in question at times of economic downturn when contributors would have less ability to pay. Contribution rate will have to increase in future for it to be sustainable. If employers are required to contribute, labour costs will increase, which will impact on our competitiveness and economic performance. |
| **Out-of-pocket payments** | Not sustainable as a financing source as it depends heavily on individuals' ability to pay, and the need to provide safety net for those who could not afford to pay may in turn offset the availability of financing from fee revenues. |
| **Medical savings accounts** | Secure a sizeable and sustained source of ***potential*** financing by individual savings. But injection of financing into the healthcare system remains individuals' choice and can be unstable and unpredictable. There will also be a group of account holders who do not have adequate medical savings and may have to rely on subsidized public healthcare services. |
| **Voluntary private health insurance** | Not a stable or sustainable financing source as taking out voluntary insurance remains individuals' choice and affordability. Unlikely to become a significant source of financing. Premium also fluctuates and likely to increase over time. |
| **Mandatory private health insurance** | Quite a stable financing source but premium will increase in future for it to be sustainable. It can help to support healthcare reform by improving market structure and driving greater efficiency of healthcare, thereby contributing to long-term sustainability. Complement market reform. |
| **Personal healthcare reserve** | Provide a sustainable source of ***potential*** financing by individual savings while ensuring a stable injection of financing into the healthcare system through mandatory insurance. Premium will increase over time, but will be affordable to more individuals because of savings. However, there remains a group of account holders who do not have adequate medical savings and may have to rely on subsidized public healthcare services. Complement market reform. |

**Table 6.2** Comparison of supplementary financing options with existing financing model (cont'd)

| | **Accessibility of healthcare** |
|---|---|
| **Government funding (existing model)** | Accessibility based on needs, through triage and queuing, or other allocation mechanisms. Everyone in the society has equitable access to subsidized public healthcare services. |
| **Social health insurance** | Accessibility depending on design. Equitable access for all if availability of subsidized healthcare services is universal and extends to people who are not in the workforce. |
| **Out-of-pocket payments** | Accessibility based on affordability to pay user fees. Low-income and under-privileged groups and the high-risk groups (who tend to use more healthcare services) pay proportionally more user fees to access needed healthcare, unless safety net measures are correspondingly strengthened. |
| **Medical savings accounts** | Accessibility based on availability of savings. Heavy users will use more from the savings, and those with low income and less savings might not have enough savings to access healthcare other than subsidized public services through triage, queuing or other allocation mechanisms. |
| **Voluntary private health insurance** | Accessibility based on affordability to pay insurance premium. Better access to healthcare for those who have the means to purchase the insurance and who are not deterred from taking out voluntary insurance due to risk-selection. For high-risk individuals who are often denied access to insurance, or for those to whom premium is too high to be affordable, access to healthcare is limited to subsidized public services through triage, queuing or other allocation mechanisms. |
| **Mandatory private health insurance** | Accessibility depending on design (e.g. for the population group mandated to take out insurance, whether it is universal or otherwise). Better access to healthcare for those who are subject to the mandatory insurance. Access to the insurance guaranteed irrespective of age, gender and health risks. High-risk individuals are guaranteed access to mandatory insurance. For the uninsured who cannot afford, access to healthcare is limited to subsidized public services through triage, queuing or other allocation mechanisms. |
| **Personal healthcare reserve** | Accessibility depending on design. Better access for those insured and those with savings. High-risk individuals are guaranteed access to mandatory insurance. For those uninsured and without savings who cannot afford, access to healthcare is limited to subsidized public services through triage, queuing or other allocation mechanisms. |

**Table 6.2** Comparison of supplementary financing options with existing financing model (cont'd)

| | Risk-pooling/sharing | Wealth re-distribution |
|---|---|---|
| **Government funding (existing model)** | Effective risk-sharing. But the effect reduces as public healthcare system over-stretched to provide comprehensive healthcare for the whole population rather than targeting higher risks and more costly services. | Progressive (i.e. the high-income groups pay more and subsidize the low-income groups) under current tax system which has a very narrow tax base for personal income tax. |
| **Social health insurance** | Effective risk-sharing. Same as government revenue above. | Progressive (i.e. the high-income groups pay more and subsidize the low-income groups), but contribution is confined to the working population. Those with higher income contribute proportionally more to social health insurance. |
| **Out-of-pocket payments** | No risk-pooling. Those with illnesses will have to bear their own financial risks. | Regressive (i.e. the high-income and low-income groups pay the same amount of increased fees) unless accompanied by strengthened safety net measures. User fees have a much greater impact on the low-income families and under-privileged groups, and the high-risk groups who tend to be heavy users of healthcare services. Thus unhealthy individuals will pay more while healthy individuals will be less affected. |
| **Medical savings accounts** | No risk-pooling. Can result in very diverse impact: medical savings inadequate for those with catastrophic or chronic illnesses but surpluses for those who are relatively healthy, with medical savings going to their estates. | Not applicable because medical savings accounts do not pool funds or risks so they do not redistribute between rich and poor or healthy and sick. Higher income individuals will have more savings in their account compared to lower income individuals but adequacy of savings would ultimately depend on the individuals' healthcare utilization pattern and volume. |
| **Voluntary private health insurance** | Some degree of risk-pooling. But pooling effect limited by small pool-size (of individual insurance schemes), risk- selection (high-risk individuals are often denied access to voluntary insurance due to rejection of application, exclusions of pre-existing medical conditions, or prohibitive premiums) and anti-selection (tendency that those who get insured are those who are more likely to claim insurance). | Not applicable because participation in insurance is voluntary and there is no redistribution of wealth. Insurance premium is not based on income but on age, gender and health risks. Thus unhealthy individuals or those with higher health risks pay more. However, lower-income families would not opt to be in the system since they usually cannot afford voluntary insurance. |
| **Mandatory private health insurance** | Effective risk-sharing through mandatory participation thereby avoiding risk selection; community-rated premium and regulated insurance thereby enabling all to access insurance irrespective of age, gender and health risks. | Regressive (i.e. the high-income do not subsidize the low-income). Mandatory insurance premium is not based on income and is usually community-rated (every insured person pays the same premium for the same insurance plan offered by the same company irrespective of age, gender and health risks). Thus unhealthy individuals or those with higher health risks (not necessarily low-income) are subsidized by healthy ones or those with lower health risks (not necessarily high-income). But some progressive effect if applied to relatively higher income groups, by reducing pressure on public healthcare system that serves as healthcare safety net for the low-income and under-privileged groups. |
| **Personal healthcare reserve** | Effective risk-sharing. Same as mandatory private health insurance above. | Regressive (i.e. the high-income do not subsidize the low-income). Same as mandatory private health insurance, unhealthy individuals or those with higher health risks (not necessarily low-income) are subsidized by healthy ones or those with lower health risks (not necessarily high-income). But some progressive effect if applied to relatively higher income groups. |

**Table 6.2** Comparison of supplementary financing options with existing financing model (cont'd)

| | Choice of services | Market competition/efficiency |
|---|---|---|
| **Government funding (existing model)** | Little choice of services under tax-funded public healthcare system. | Continued domination of public healthcare sector. Little effective competition between public and private sectors and among healthcare providers. No extra incentive for efficiency drive. |
| **Social health insurance** | Some choice of services if the insurance procures both public and private healthcare services. | Competition enhanced through procurement of services under insurance from both public and private sectors. But scope of competition limited by procurement or reimbursement rules. |
| **Out-of-pocket payments** | Some choice of services for those who are willing to pay. Choice of services limited by affordability of user fees which could be very high if there is no subsidy or insurance coverage, especially for the high-risk groups. | No enhancement to competition or efficiency through increasing public user fees since it is not feasible to increase public fees to a level that is high enough to be comparable to the private sector and thus facilitating a meaningful competition. |
| **Medical savings accounts** | Some choice of services as medical savings can be used to pay for public or private sector services and will enhance the affordability of individuals for healthcare services to some extent. | Competition enhanced through enabling individuals to access public and private healthcare services. But competition and efficiency drive limited by insufficient transparency on cost/price and quality of healthcare services. Individuals likely to be in a disadvantaged position to bargain on price for healthcare. |
| **Voluntary private health insurance** | More choice of services in both the public and private sectors. Insurance plan at individuals' own choice and according to their affordability. | Competition enhanced through free choice of services from healthcare providers under insurance. But competition and efficiency drive limited by moral hazards under a third-party-pay insurance (the tendency of providers to over-supply and insured to over-use healthcare services under insurance), and also limited by insufficient transparency on cost/price and quality of healthcare services. |
| **Mandatory private health insurance** | More choice of services in both the public and private sectors. Individuals who can afford can choose top-up insurance plans to suit their own needs. | Competition enhanced through free choice of services from healthcare providers under insurance. With bigger insured pool, insurers have greater market power to drive transparency, efficiency and cost-effectiveness in healthcare services. |
| **Personal healthcare reserve** | Choice of services in both the public and private sectors. Combination of medical savings accounts and mandatory private health insurance will reap the benefits of both affordability through savings and risk-pooling through insurance. | Competition enhanced by enabling individuals to access public and private healthcare services through both insurance and savings. Insurers under regulation and with a sufficiently large guaranteed pool of insurees will have more bargaining power to drive transparency, efficiency and cost-effectiveness in healthcare services. |

**Table 6.2** Comparison of supplementary financing options with existing financing model (cont'd)

| | Utilization/cost control | Overhead cost |
|---|---|---|
| **Government funding (existing model)** | Effective utilization control through rationing of healthcare according to clinical needs. Effective cost-control through global budget and subvention control for public healthcare. | Low overhead costs as costs for healthcare services are directly paid by government through global budget. But administration costs are required for administering safety net mechanisms. |
| **Social health insurance** | Utilization control may not be effective given increased demands from the insured for more and better healthcare to maximize the return on their contribution, and the need to cover private sector services on a more readily available basis. | Moderate overhead costs for collection of contribution and administration of claims payout under insurance, especially if the private sector healthcare is involved. New infrastructure has to be set up since there is no existing social insurance system in Hong Kong. |
| **Out-of-pocket payments** | Very effective utilization and cost control as the cost for usage of healthcare services directly borne by the users and healthcare providers are more cost conscious if their patients are bearing the cost. But can result in "inverse care law", that is, healthcare is less accessible to those more in need because of less affordability. | Low overhead costs as costs for usage of healthcare services directly borne by the users. But administration costs are required for administering safety net mechanisms. |
| **Medical savings accounts** | Utilization and cost control is effective to some extent, as cost for usage of healthcare services directly borne by the users. However, there is also the propensity for account holders to spend the locked-up savings. | Moderate overhead costs for collection, accrual and disbursement of savings. Can be reduced by using MPF framework for the collection and accrual of savings. Administration costs for disbursements for medical expenses similar to claims processing for insurance. |
| **Voluntary private health insurance** | Little control on both utilization and cost given moral hazards and limited bargaining power of individual insurance companies on healthcare costs. Can result in increasing premium to keep up with increasing healthcare and insurance costs. | High overhead costs for administration of claims payout and other costs including underwriting, marketing, commissions and insurance profits. |
| **Mandatory private health insurance** | Little control on utilization and costs. But with bigger insured pool (compared to voluntary insurance), insurers can institute control measures to curb moral hazards and have greater bargaining power on healthcare costs. | Moderate overhead costs as underwriting, marketing and other insurance costs can be reduced through mandatory participation and regulated products. Administration costs for claims payout still required. Additional costs for regulatory regime. |
| **Personal healthcare reserve** | Little control on utilization and costs. But same as mandatory private health insurance, with bigger insured pool, insurers can institute control measures to curb moral hazards and have greater bargaining power on healthcare costs. | Moderate overhead costs similar to medical savings accounts and mandatory private health insurance. |

**Financial Incentives for Supplementary Financing**

6.16 As the Financial Secretary has announced in the 2008-09 Budget Speech, after the supplementary financing arrangements have been finalized for implementation after consultation, the Government will draw $50 billion from the fiscal reserve for taking forward the healthcare reform. This demonstrates the Government's commitment to share the responsibility for healthcare financing together with the community, and to increase the resources available to individual members of our community for healthcare. It can be used, for instance, to provide each participant in a contributory supplementary financing scheme with individual start-up capital.

6.17 In this regard, we will further examine how financial incentives can be provided to participants in a supplementary financing scheme, after receiving views during the first stage consultation, when developing detailed proposals for the supplementary financing arrangements. The financial incentives for participants in a supplementary financing scheme may take different forms, either available to participants individually or collectively, depending on the financing option(s) to be adopted. For instance –

(a) **Tax incentives**: tax incentives can take the form of a tax allowance or tax deduction for contributions made by individuals to social health insurance, for premium paid by individuals for voluntary or mandatory private health insurance, or for savings by individuals to their own medical savings accounts or personal healthcare reserve.

(b) **Start-up capital**: this can take the form of injection of a one-off lump-sum to individual medical savings accounts or personal healthcare reserve as seed money, or as a one-off reserve for a mandatory private insurance scheme or social health insurance scheme to reduce premium for participants and provide buffer for insuring individual high-risk participants.

(c) **Direct subsidization**: this can take the form of subsidization for individuals' contributions to social health insurance, subsidization for individuals' premium for private health insurance, or as contributions to individuals' medical savings accounts or personal healthcare reserve.

6.18 The public healthcare system will also continue to provide an available and accessible safety net for these participants who are taking a greater share of

responsibility for their own healthcare. This is particularly important to cater for the unfortunate event of a deterioration of their financial means.

**Enhancing Capacity of the Healthcare System**

6.19 If any of the above financing options to provide supplementary financing (except the model of continuing to rely on government funding) is adopted, it is likely to generate a greater demand for alternative choice of services apart from highly-subsidized public services. For instance, the social health insurance, voluntary private health insurance, and mandatory private health insurance are likely to generate extra demand for services from the private healthcare sector. Even increase in user fees for public services, and introduction of medical savings accounts are likely to drive or entice individuals to use private services more. In most cases, the supplementary financing will provide those subject to the scheme with the financing means to seek private services.

6.20 We thus expect that there would be an increase in demand for healthcare services in the private sector if supplementary financing to government funding is introduced. The extent of the increase will depend on the financing options adopted and also the detailed design of the financing arrangements. With a view to cater for the likely surge in demand and redressing the public-private imbalance, we intend to explore the following measures to further strengthen the capacity of the private sector to cope with the anticipated increase in demand –

(a) For the short and medium term, we will **pursue public-private partnership (PPP) initiatives**, e.g. PPP hospitals and other PPP models for the provision of hospital services, with a view to enhancing the capacity of the private sector and availability of private services.

(b) For the longer term, market force will drive the expansion of the private sector, and we will consider **policy measures to facilitate development of the private sector**, e.g. explore leasing out of vacant public premises or making sites available for private hospital development.

6.21 Meanwhile, some patients who have the financing means may still choose to turn to the public hospitals for services for a variety of reasons, e.g. confidence in the public system, or for complex illnesses (e.g. catastrophic or chronic illnesses) requiring costly treatment costs or procedures not readily available in the private sector. It is therefore necessary for the public sector to also allow some capacity to provide more personalized services to these patients. These patients are able to

afford and are likely to demand more choice of services and better amenities than those offered by public general wards.

6.22 **We therefore propose the public sector to increase moderately the capacity of its private services operating on a full cost-recovery basis.** The provision of such services would relieve the overall capacity constraint of the healthcare system in meeting the surge in demand for private healthcare services. The full-cost-recovery services would also provide a useful benchmark for comparison with the private sector on efficiency and cost-effectiveness. **At the same time, the provision of such private services must not be done at the expense of highly-subsidized public services provided to the general public.** On the contrary, the provision of such private services should help bring in additional financing into the public healthcare system and relieve its financial burden.

6.23 More fundamentally, we also need to address the issue of healthcare manpower planning, with a view to ensuring that there is sufficient manpower supply of different healthcare professionals to support the sustainable development of the healthcare system in the long run, in both the public and private sectors. As a first step, we will need to carefully examine the forecast of manpower requirements taking into account the overall healthcare needs of the population as well as foreseeable increase in demand in both the public and private sectors, with a view to ensuring that there is education and training capacity for an adequate supply of various healthcare professionals.