

## EXECUTIVE SUMMARY

### Preamble

We want a healthcare system that makes our community healthier and continues to improve the quality of care. To do so, we need to reform our system to make it sustainable and more responsive to the increasing needs of the community. Everyone in the community is a stakeholder. Further to “Building a Healthy Tomorrow”<sup>1</sup> for public discussion on the future service delivery model of our healthcare system, we are now initiating a two-stage public consultation to engage **YOU** the stakeholder in taking forward the reform.

2. At this first stage consultation, we would like to consult you on –
  - (a) the key principles and concepts of our service reform proposals; and
  - (b) the pros and cons of possible supplementary financing options.
3. On the basis of the views received during the first stage consultation, we will formulate detailed proposals for the reform including those of supplementary financing arrangements. We will then consult you further at the second stage consultation.

### Our Vision for the Healthcare System

4. **Our vision is to achieve a healthcare system that improves the state of health and quality of life of our people, and provides healthcare protection for every member of the community.**
5. **We want to reform the healthcare system so that it can develop on a sustainable basis and keep up with medical technology advances to –**
  - (a) **provide you with access to lifelong, comprehensive and holistic primary care, with emphasis on health-improving preventive care;**
  - (b) **provide you with more choice of quality, efficient and cost-effective healthcare in both the public and private sectors;**

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<sup>1</sup> Discussion paper issued by the Health and Medical Development Advisory Committee (HMDAC) in July 2005 on the future service delivery model of our healthcare system.

- (c) **provide you with healthcare protection and peace of mind in case you are struck by illnesses that need costly treatment; and**
  - (d) **continue the partnership between the Government and you in sharing the financial commitment for your better health.**
6. **In reforming the healthcare system, we shall –**
- (a) **uphold our long-established healthcare policy that no one should be denied adequate healthcare through lack of means;**
  - (b) **ensure that necessary healthcare services remain accessible and affordable to the community;**
  - (c) **maintain the public healthcare system as a safety net for the low-income and under-privileged groups and those in need; and**
  - (d) **upkeep the professional standards and conduct of the healthcare professions.**
7. **To reform the healthcare system, the Government is committed to increasing recurrent government expenditure for medical and health services from 15% to 17% of overall recurrent government expenditure by 2011-12.**

### **We Need to Change – To Change for You**

8. Everyone wants to stay healthy. Everyone wants a healthcare system that improves our health, offers quality healthcare services, both preventive and curative, and protects us against illnesses requiring costly treatment (e.g. complex or chronic conditions). However, unless we reform our current system promptly, it will not be able to continue to provide you with the necessary healthcare in the future. If nothing is done, the community as a whole including you will suffer. Let us explain why.

### ***Public Hospital Services at Risk***

9. The proportion of elderly people in our community will double from 1 in 8 in 2007 to 1 in 4 by 2033. There are also signs of increasing occurrence of certain lifestyle-related diseases. Both factors will cause the healthcare needs of our community to increase significantly. The waiting queues for public hospital services, especially non-urgent and/or elective surgeries and specialist out-patient

services will thus become longer because of these factors, if we do not reform our system to address them. If we do nothing, there is a real risk that the level and quality of services in public hospitals will decline, for instance –

- (a) occupancy in public in-patient wards for major specialties could reach congestion (over 90% occupancy) within the next three years, and saturation (100% occupancy) by 2012 for Medicine specialty, and by 2015 for Oncology specialty;
- (b) the waiting time of new cases for specialist out-patient services in all specialties could be tripled by 2012, e.g. the notional waiting time for new cases for surgery would increase from 31 weeks in 2006 to 96 weeks by 2012, and the follow-up interval for old cases would also increase significantly;
- (c) the waiting time for various special services could increase significantly, e.g. there would be around 22% or 2,000 patients who might not receive sufficient renal replacement therapy in public hospitals by 2015 due to waiting time; and
- (d) the waiting time for non-urgent surgery could lengthen significantly, e.g. waiting time would increase from three years in 2006 to six years in 2015 for cataract surgery, and from 2-3 years in 2006 to 4-5 years in 2015 for benign prostatic hyperplasia surgery.

10. As mentioned in paragraph 7 above, we will increase the funding for public healthcare, and these situations will be alleviated to some extent. The public healthcare system has over the years sustained efficiency gain of around 1% per year on average. 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. We will also take forward various reform to healthcare services and market structure, with a view to enhancing the quality of healthcare services (details are set out in paragraph 19-22 below). However, even with increased government funding, and even with sustained efficiency gain and service enhancement of the public healthcare system, we can only defer but not resolve the problem of declining level and quality of services.

### ***Rising Tax Bills or Less Funding for Other Public Services***

11. Ageing population and rising medical costs brought about by advances in medical technology will cause health expenditure to increase rapidly and at a much faster pace than our economy –

		<b>In year 2004</b>	<b>In year 2033</b>	<b>Increased by</b>	<b>Annualised growth rate</b>
<b>Population</b>		6,783,500	8,384,100	24%	0.7%
<b>Economic growth (GDP)</b>	total (\$billion in 2005 dollar)	1,287	3,413	165%	3.4%
	per capita (\$ in 2005 dollar)	189,700	407,100	115%	2.7%
<b>Total health expenditure</b>	as % of GDP	5.3%	9.2%	74%	2.0%
	total (\$billion in 2005 dollar)	67.8	315.2	365%	5.4%
	per capita (\$ in 2005 dollar)	10,000	37,600	276%	4.7%
<b>Public health expenditure</b>	as % of GDP	2.9%	5.5%	90%	2.2%
	total (\$billion in 2005 dollar)	37.8	186.6	394%	5.7%
	per capita (\$ in 2005 dollar)	5,600	22,300	298%	4.9%
<b>Share of public health expenditure in total health expenditure</b>		55.7%	59.2%	-	-

12. If we do not reform the healthcare system and its financing arrangements, and need to meet the increasing public health expenditure by the public purse to avoid the level and quality of public services from declining, you will be affected by either of the following situations –

- (a) **Rising tax bills:** to meet the increasing public health expenditure by government funding, total public expenditure would have to be expanded to 22% of GDP by 2033. To fund such a required increase in public expenditure could mean substantial increase in Salaries Tax and/or Profits Tax. This would depart from the principle of small government and low-tax regime, and erode Hong Kong's economic competitiveness; or
- (b) **Reduced funding for other public services:** if total public expenditure is to be kept below 20% of GDP, public health expenditure would increase from 14.7% of total public expenditure in 2004 to 27.3% in 2033, at the expense of funding for other public services (e.g. the share of funding for education, social welfare or security, which account for

some 23.8%, 17.6% and 11.8% of recurrent government expenditure in 2008-09, may have to be reduced).

### *Limited Alternative Choice to Public Hospital Services*

13. At present, even if you want to avoid the long waiting queues, you may not have much choice other than unsubsidised and more costly private hospital and specialist services. There is significant public-private imbalance in our healthcare system where the public sector dominates in-patient care while the private sector provides the majority of out-patient care. This has resulted in limited choice for you as well as inadequate competition and collaboration among healthcare providers in both the public and private sectors.

### *Present Safety Net Not Wide Enough*

14. The present public healthcare safety net does not sufficiently cater for patients struck by illnesses requiring costly treatment. This is especially the case for a patient who comes from a middle-income family which does not meet the means-testing criteria under the current fee waiver and financial assistance mechanisms.

### *Insufficient Emphasis on Holistic Primary Care*

15. Better primary care will mean better health for you and everybody in the community and less chance that you will need to go for hospital care. Eventually, this will mean reduced demand for hospital care. However, there is at present insufficient emphasis by both patients and healthcare providers on holistic primary care and wellness promotion.

### *Limited Continuity and Integration of Care*

16. At present, not enough attention is being given to the development of long-term doctor-patient relationships and effective interface between different healthcare providers at different levels of care, which are essential for providing better quality of care.

## **Healthcare Reform Proposals**

17. To achieve our vision of a healthcare system that makes our community healthier and to address the above challenges to the system, we plan to undertake the following reform –

- (a) **Enhance primary care** to put greater emphasis on preventive care, reduce the need for hospital care, improve the health of our community, and contain the overall healthcare needs and expenditure of our community in the long run. (See Chapter 2)
- (b) **Promote public-private partnership in healthcare** to provide more choice of quality, efficient and cost-effective services and promote further healthy competition and collaboration between the public and private sectors in providing healthcare services. (See Chapter 3)
- (c) **Develop electronic health record sharing** to allow individuals' health records to follow them wherever they go for healthcare to improve the quality of healthcare for the public and provide the necessary infrastructure to support the healthcare reform. (See Chapter 4)
- (d) **Strengthen public healthcare safety net** to retain and improve the current public healthcare safety net for the low-income families and underprivileged groups, while strengthening the safety net for patients struck by illnesses requiring costly healthcare. (See Chapter 5)
- (e) **Reform healthcare financing arrangements** to provide supplementary financing, apart from increased government funding, to ensure the sustainable development of the healthcare system and support the reform of the healthcare market. (See Chapter 6 to Chapter 13)

18. These reform proposals form an integral package and complement each other. To meet the challenges to the healthcare system, not only do we need to introduce reforms to the existing healthcare service and market structure, but we also need to reform the financing arrangements in support of the service reforms. The reforms would also require continued improvement in the light of outcomes and experience in the years ahead.

### **Enhance Primary Care**

19. Effective primary care will help improve the health of individuals in our community and reduce the need of the community for hospital care. Primary care is not just about the curing of episodic illnesses, but should provide continuous, comprehensive and holistic (whole-person) healthcare. It also puts emphasis on preventive care that promotes the well-being and improves the quality of life of individuals. To enhance primary care in Hong Kong, we propose the following –

- (a) **Develop basic models for primary care services:** as the basic standard for different age/gender groups with emphasis on preventive care, for reference by both healthcare professionals and individuals.
- (b) **Establish a family doctor register:** to register private doctors who serve as family doctors and provide comprehensive primary care to patients, for reference by individuals who wish to receive such care.
- (c) **Subsidize individuals for preventive care:** to subsidize individuals of different target age/gender groups to undertake preventive care through private family doctors. The basic models developed above could serve as a reference for these family doctors.
- (d) **Improve public primary care:** to purchase primary care services from the private sector and incorporate preventive care in the public clinics for low-income families and under-privileged groups.
- (e) **Strengthen public health functions:** strengthen public health education, healthy lifestyle promotion, disease prevention, as well as development of and standard-setting for primary care services.

### **Promote Public-Private Partnership in Healthcare**

20. Public-private partnership (PPP) is collaboration between the public and private sectors to provide healthcare infrastructure or services. PPP offers greater choice of services for individuals in the community, promotes healthy competition and collaboration among healthcare providers, makes better use of resources in both the public and private sectors, benchmarks the efficiency and cost-effectiveness of healthcare services, and facilitates cross-fertilization of expertise and experience between medical professionals. To promote PPP, we will explore the following initiatives through pilot projects progressively –

- (a) **Purchase primary care from the private sector and subsidize individuals to undertake preventive care in the private sector,** as mentioned in paragraphs 19(c) & 19(d) above.
- (b) **Purchase hospital services from the private sector,** especially those in low-priority areas of the public healthcare system such as non-urgent and/or elective procedures.
- (c) Pursue PPP in hospital development which could take the form of

co-location of public and private hospital facilities at the same site to enable co-ordinated planning and shared use of facilities.

- (d) **Set up multi-partite medical centres of excellence** to draw together top expertise of the relevant specialties locally and overseas, and participation of experts both in the public and private sectors.
- (e) **Engage private sector doctors to practice in public hospitals**, particularly in tertiary and specialized services, on a part-time basis, to facilitate cross-fertilization of expertise and experience.

### **Develop Electronic Health Record Sharing**

21. The development of a territory-wide electronic health record (eHR) infrastructure is essential to enhancing continuity of care as well as better integration of different healthcare services for the benefits of individual patients. It also provides the infrastructure to support the healthcare reform especially in the areas of primary care and public-private partnership. The Hospital Authority has already established an eHR system that we can leverage on. To take forward the initiative, the Government will take the lead. We have set up a Steering Committee on Electronic Health Record Sharing comprising members from the healthcare professions in both the public and private sectors. The Steering Committee's work will include the following –

- (a) **Consider funding the capital cost for development** of the eHR sharing infrastructure.
- (b) **Make available public sector know-how** for further development and deployment of eHR systems in the private sector.
- (c) **Consider other financial assistance** to facilitate the development and deployment of eHR system in the private sector.
- (d) **Consider ways to promote the benefits** of health record sharing to patients and providers.

### **Strengthen Public Healthcare Safety Net**

22. The public healthcare system will continue to serve as an essential safety net for the population, especially for those who lack the means to pay for their own healthcare. The current fee waiver mechanism and other financial



assistance schemes will continue to be available as a safety net for CSSA recipients, low-income families and under-privileged groups as at present. If we can reform the financing arrangements to relieve the strain on resources for the public healthcare system, there should be room for strengthening the public healthcare safety net. Specifically, we propose to consider the following –

- (a) **Reduce waiting time of public hospital services** through strengthening existing service provision or purchasing services from the private sector.
- (b) **Improve the coverage of standard public services** especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment.
- (c) **Explore the idea of a “personal limit on medical expenses”** beyond which financial assistance would be provided to protect individual patients against financial ruin due to illnesses requiring costly treatment.
- (d) **Inject funding into the Samaritan Fund** as extra funding to finance those in need of but lack the means to obtain certain medical treatment outside the standard public services.

### **Reform Healthcare Financing Arrangements**

23. As mentioned in paragraph 9 above, even though we will increase government funding, continue to enhance efficiency and reform healthcare services and the market structure, we still cannot guarantee the sustainability of our healthcare system in face of the challenges posed by the ageing population and rising medical costs. The experience of other advanced economies also shows that their 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. However, our projection based on this experience shows that, without reform, our total and public health expenditure may grow from 5.3% and 2.9% of GDP respectively in 2004, to as large as 9.2% and 5.5% of GDP respectively by 2033.

24. It is clear that we need to reform the healthcare financing arrangements, in addition to healthcare services and market structure reforms. With increased government funding continuing to provide a major financing source,

what we need is a supplementary financing source for healthcare to supplement government funding to cope with increasing healthcare needs, and to sustain the reform as set out in paragraphs 19-22 above, with a view to improving healthcare services.

### **Supplementary Financing Options for Hong Kong**

25. Apart from examining the option of maintaining the existing financing model, i.e. to continue to meet increasing health expenditure by government revenue including increasing tax, we have studied various options to provide supplementary financing for healthcare in Hong Kong, having regard to experiences of overseas economies. During this first stage consultation, we do not recommend any particular option and would like to seek your views on the pros and cons of the following six options for providing supplementary financing for healthcare –

- (a) **Social health insurance:** to require the workforce to contribute a certain percentage of their income to fund healthcare for the whole population.
- (b) **Out-of-pocket payments (user fees):** to increase user fees for public healthcare services.
- (c) **Medical savings accounts:** to require a specified group of the population to save to a personal account for accruing savings (with the option to invest) to meet their own future healthcare expenses, including insurance premium if they take out private health insurance.
- (d) **Voluntary private health insurance:** to encourage more individuals to take out private health insurance in the market voluntarily.
- (e) **Mandatory private health insurance:** to require a specified group of the population to subscribe to a regulated private health insurance scheme for their own healthcare protection.
- (f) **Personal healthcare reserve:** to require a specified group of the population to deposit part of their income into a personal account, both for subscribing to a mandatory regulated medical insurance before and after retirement, and for accruing savings (with the option to invest) to meet their own healthcare expenses including insurance premium after retirement.

26. 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 on the following –

- (a) **Financial stability and sustainability:** we all hope that our healthcare system can sustain quality healthcare services for the community and our future generations. Is the supplementary financing option able to ensure stable financing for the sustainable development of the healthcare system?
- (b) **Accessibility of healthcare:** if you are contributing to supplementary financing, do you want your contribution to go to funding healthcare for everyone in the community including yourself through queuing and triage as necessary, or do you want your contribution to provide you with better access to healthcare?
- (c) **Pooling and sharing of risk:** do you want your financial risk arising from illnesses to be pooled or shared out with others, so that when you become ill you would be subsidized by the healthy, the corollary being that when you are healthy you will have to subsidize the unhealthy ones?
- (d) **Wealth re-distribution:** current public healthcare services funded by tax-payers are already a form of wealth re-distribution. How far do you think supplementary financing should further require those with higher income to pay more for healthcare subsidizing those with lower income? Or do you think supplementary financing for healthcare should not be generated through a form of tax or similar systems?
- (e) **Choice of services:** is the supplementary financing option able to bring about more choice of personalized healthcare services tailored to your own preferences (e.g. choice of doctors/providers, amenities of care, or options for treatment)?
- (f) **Market competition and efficiency:** is the supplementary financing able to bring about a market system that drives competition among healthcare providers and enhance price transparency, quality, efficiency and cost-effectiveness of healthcare services?
- (g) **Utilization and cost control:** the excessive use and increasing cost will lead to ever more costly healthcare for the community as a whole. We

need a mechanism that can inherently encourage judicious use of healthcare resources and contain the cost of healthcare. Does the supplementary financing arrangement have such an effect?

- (h) **Overhead cost:** options that offer certain benefits such as more choice or greater competition (e.g. insurance or savings) entail administration or other transaction costs. How expensive is the supplementary financing option's overhead costs?

27. It is important to note that there is no perfect option that can offer us the best in all aspects – every option will involve trade-offs between the above considerations. Overseas experience also suggests that the healthcare system and financing arrangements of each economy has its own specific history and circumstances requiring its own solution. No one single model can be readily transplanted.

28. An assessment and comparison based on the considerations in paragraph 26 above of the existing financing model and the various supplementary financing options in a number of aspects (accessibility of healthcare, choice of services, market competition/efficiency, financing sustainability, utilization/cost control, overhead cost, risk-pooling/sharing, and wealth re-distribution) is summarized in **Table 1** (page *xvi*). An analysis of the different contributors under different financing options and the impact of the options on different groups of the community are in **Table 2** (page *xviii*). A summary of the pros and cons of all the financing options is in **Table 3** (page *xxi*).

### **Financial Incentives for Supplementary Financing**

29. As the Financial Secretary has announced in the 2008-09 Budget Speech, after the supplementary financing arrangements have been finalised 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.

30. 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 may take different forms, depending on the supplementary financing option to be adopted. These may include, for instance, tax deduction, start-up capital, or other forms of direct subsidization.

31. The public healthcare system will also continue to provide an available and accessible safety net for the community as a whole. This safety net will still offer protection to those who are taking a greater share of responsibility for their own healthcare when they are in need.

### **We Need Your Support**

32. Please give us your support and constructive views to turn our vision into reality. Please send your views on this consultation document to us **on or before 13 June 2008** through the contact below. Please indicate if you do not want your views to be published or if you wish to remain anonymous. Unless otherwise specified, all responses will be treated as public information and may be publicized in the future.

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**Table 1** Comparison of different supplementary financing options and existing financing model

	<b>Financing sustainability</b>	<b>Accessibility of healthcare</b>	<b>Risk-pooling/ sharing</b>	<b>Wealth re-distribution</b>
<b>Government funding (existing model)</b>	Subject to fluctuations of fiscal position; unsustainable in the long-term	Accessibility based on needs (through triage and queuing)	Effective risk-sharing (healthy subsidize unhealthy)	High-income pay more and subsidize low-income
<b>Social health insurance</b>	Quite stable but unsustainable with shrinking workforce; require higher contribution rate as utilization increases to be sustainable	Accessibility depending on design (whether population coverage is universal or not)	Effective risk-sharing (healthy subsidize unhealthy)	High-income pay more and subsidize low-income
<b>Out-of-pocket payments</b>	Unsustainable	Accessibility based on affordability to pay user fees (heavy users pay more)	No risk-pooling (unhealthy pay more)	High income and low-income pay the same
<b>Medical savings accounts</b>	Secure a sizeable and sustainable potential source of financing, but injection of financing unstable and unpredictable	Accessibility based on availability of savings (heavy users will use more from the savings)	No risk-pooling	Not applicable
<b>Voluntary private health insurance</b>	Subscription unpredictable and financing unstable; unlikely to be a sizeable and sustainable supplementary financing source	Accessibility based on affordability to pay insurance premium (better access for those insured)	Some degree of risk-pooling (unhealthy or higher-risk pay more)	Not applicable
<b>Mandatory private health insurance</b>	Quite stable; require higher premium as utilization increases to be sustainable	Accessibility depending on design (whether population mandated to take out insurance is universal or not)	Effective risk-sharing (healthy subsidize unhealthy)	High-income and low-income, regardless of risk profile, pay the same
<b>Personal healthcare reserve</b>	Sustainable source of financing through savings; stable injection of savings into the healthcare system through insurance	Accessibility depending on design (better access for those insured and for those with savings)	Effective risk-sharing (healthy subsidize unhealthy)	High-income and low-income, regardless of risk profile, pay the same

**Table 1** Comparison of different supplementary financing options and existing financing model (cont'd)

	<b>Choice of services</b>	<b>Market competition/ efficiency</b>	<b>Utilization/cost control</b>	<b>Overhead cost</b>
<b>Government funding (existing model)</b>	Little choice	Not enhancing competition or efficiency drive	Effective through supply and budget control	Low
<b>Social health insurance</b>	Some choice	Some competition through procurement of services from different providers	May not be effective due to increased demands from contributors	Moderate
<b>Out-of-pocket payments</b>	Some choice	Not enhancing competition or efficiency	Very effective but can result in healthcare less available to those more in need	Low
<b>Medical savings accounts</b>	Some choice	Some enhancement of competition and efficiency	Control effective to some extent when cost is borne by patients	Moderate, but can be reduced by using MPF framework; disbursement admin. cost still required
<b>Voluntary private health insurance</b>	More choice	Some enhancement of competition and efficiency	Little control	High
<b>Mandatory private health insurance</b>	More choice	Enhance competition and efficiency if insured pool is large; support market reform	Little control, but insurers with bigger pool in better position to control moral hazards and bargain fees	Moderate
<b>Personal healthcare reserve</b>	More choice	Enhance competition and efficiency if insured pool is large; support market reform	Little control, but insurers with bigger pool in better position to control moral hazards and bargain fees	Moderate, but can be reduced by using MPF framework; admin. cost for claims processing still required

**Table 2** Summary of contributors of supplementary financing options and existing financing model and their impacts on different groups

	<b>Contributors</b>	<b>Impacts on Different Groups</b>
<b>Government funding (existing model)</b>	<ul style="list-style-type: none"> <li>• Taxpayers (higher income pay more)</li> </ul>	<ul style="list-style-type: none"> <li>• Everyone in the community access subsidized healthcare equitably by queuing and triage</li> <li>• Those who can afford to pay but cannot afford to wait can resort to unsubsidized private healthcare</li> <li>• Low-income and under-privileged continue to be taken care of by public system funded by taxpayers</li> <li>• Unsustainable financing will cause everyone especially the high-risk groups (chronic patients, the elderly, etc.) who need to rely on the public system to suffer in the long-run</li> </ul>
<b>Social health insurance</b>	<ul style="list-style-type: none"> <li>• Working population (higher income pay more)</li> <li>• Employers (if they are required to contribute)</li> <li>• Taxpayers (for public healthcare system)</li> </ul>	<ul style="list-style-type: none"> <li>• Everyone in the community provided with subsidies for healthcare equitably through social insurance</li> <li>• Some extra choice of private services for those who can afford higher co-payment</li> <li>• Low-income and under-privileged subsidized by contributions from high-income</li> <li>• Overall utilization increase will require the contributors to pay more</li> </ul>
<b>Out-of-pocket payments</b>	<ul style="list-style-type: none"> <li>• Patients who need to use healthcare (heavier users pay more)</li> <li>• Taxpayers (for public healthcare system)</li> </ul>	<ul style="list-style-type: none"> <li>• Healthier individuals in the community will not need to pay more</li> <li>• Those who can afford to pay can resort to unsubsidized private healthcare</li> <li>• The high-risk groups (chronic patients, the elderly, etc.) in heavy need of healthcare will pay substantially more</li> <li>• Low-income and under-privileged continue to be taken care of by public system funded by taxpayers</li> <li>• Unsustainable financing will cause everyone especially the high-risk groups who need to rely on the public system to suffer in the long-run</li> </ul>
<b>Medical savings accounts</b>	<ul style="list-style-type: none"> <li>• A specified group of the population subject to medical savings accounts (depending on design, higher income will save more for their own accounts)</li> <li>• Employers (if they are required to contribute)</li> <li>• Taxpayers (for public healthcare system)</li> </ul>	<ul style="list-style-type: none"> <li>• Those who save will have financing to meet their future healthcare needs especially after retirement</li> <li>• Those with illnesses requiring costly treatment will unlikely have enough savings to meet their healthcare needs and will fall back on safety net</li> <li>• Those relatively healthier will have less healthcare needs and will accrue a sizeable savings to be left to their estates</li> <li>• Low-income and under-privileged continue to be taken care of by public system funded by taxpayers</li> <li>• Medical savings unlikely to reduce demand for public healthcare services significantly and will not be funding public system, and thus unlikely to benefit those who need to rely on public system especially the high-risk groups, and the low-income and underprivileged groups</li> </ul>



**Table 2** Summary of contributors of supplementary financing options and existing financing model and their impacts on different groups (cont'd)

	<b>Contributors</b>	<b>Impacts on Different Groups</b>
<b>Voluntary private health insurance</b>	<ul style="list-style-type: none"> <li>• Those who buy insurance voluntarily (higher-risk pay higher premium)</li> <li>• Employers (those who provide medical insurance for their employees)</li> <li>• Taxpayers (for public healthcare system)</li> </ul>	<ul style="list-style-type: none"> <li>• The insured will enjoy protection for their health risks and access to private healthcare services</li> <li>• The high-risk groups (chronic patients, the elderly, etc.) unlikely to be able to get insured or have to pay expensive premium</li> <li>• Low-income and under-privileged continue to be taken care of by public system funded by taxpayers</li> <li>• The insured will have better access to more choice of healthcare services while the choice of services will not be enhanced for the uninsured</li> <li>• The shift of some of the insured to the private sector may reduce pressure on public system and benefit those who need to rely on it especially the high-risk groups, and the low-income and under-privileged groups, but extent of the shift likely to be limited</li> <li>• Utilization increase by participants will cause higher premium</li> <li>• Unsustainable financing will cause the uninsured especially the high-risk groups who need to rely on the public system to suffer in the long-run</li> </ul>
<b>Mandatory private health insurance</b>	<ul style="list-style-type: none"> <li>• A specified group of the population subject to mandatory insurance (depending on design, everyone pays the same insurance premium)</li> <li>• Others who buy the insurance voluntarily (depending on design)</li> <li>• Employers (those who provide medical insurance for their employees)</li> <li>• Taxpayers (for public healthcare system)</li> </ul>	<ul style="list-style-type: none"> <li>• The insured will enjoy protection for their health risks which are shared out with other insured, and access to private healthcare services</li> <li>• The high-risk groups (chronic patients, the elderly, etc.) will be able to enjoy healthcare protection through community-rated premium, and regulated terms including no exclusion of pre-existing medical conditions and continuity of insurance</li> <li>• Low-income and under-privileged continue to be taken care of by public system funded by taxpayers</li> <li>• The insured will have better access to more choice of healthcare services while the choice of services will not be enhanced for the uninsured</li> <li>• The shift of the insured to the private sector or requiring the insurance to pay for public services will reduce pressure on public system and benefit those who need to rely on it including the high-risk groups, and the low-income and under-privileged groups. Extent of the shift likely to be much larger than in the case of voluntary insurance</li> <li>• Utilization increase by participants will cause higher premium</li> </ul>

**Table 2** Summary of contributors of supplementary financing options and existing financing model and their impacts on different groups (cont'd)

	<b>Contributors</b>	<b>Impacts on Different Groups</b>
<b>Personal healthcare reserve</b>	<ul style="list-style-type: none"> <li>• A specified group of the population subject to personal healthcare reserve (depending on design, higher income will save more for their own accounts, but everyone pays the same insurance premium)</li> <li>• Employers (if they are required to contribute or those who provide medical insurance for their employees)</li> <li>• Taxpayers (for public healthcare system)</li> </ul>	<ul style="list-style-type: none"> <li>• Those who participate will have financing to meet their future healthcare needs especially after retirement, and will also enjoy protection for their health risks which are shared out with other insured, and access to private healthcare services through insurance</li> <li>• The high-risk groups (chronic patients, the elderly, etc.) will be able to enjoy healthcare protection through community-rated premium of the insurance, and regulated terms including no exclusion of pre-existing medical conditions and continuity of insurance</li> <li>• Low-income and under-privileged continue to be taken care of by public system funded by taxpayers</li> <li>• The insured will have better access to more choice of healthcare services while the choice of services will not be enhanced for the uninsured</li> <li>• The shift of the participants to the private sector or requiring the insurance to pay for public services will reduce pressure on public system, and benefit those who need to rely on it including the high-risk groups and the low-income and under-privileged groups</li> <li>• Utilization increase by participants will cause higher premium</li> <li>• The building up of a source of financing to meet the future healthcare needs of the participants will reduce future burden on the public system and benefit those who need to continue to rely on it including the high-risk groups and the low-income and under-privileged groups</li> </ul>

**Table 3** Summary of pros and cons of supplementary financing options and existing financing model

	<b>Advantages</b>	<b>Disadvantages</b>
<b>Government funding (existing model)</b>	<ul style="list-style-type: none"> <li>• Equitable healthcare</li> <li>• Simple administration and lower administration cost</li> <li>• High-income to subsidize low-income</li> </ul>	<ul style="list-style-type: none"> <li>• Rising tax bills and expanding government budget</li> <li>• Increasing burden on future generations of a shrinking workforce</li> <li>• Encourage over-reliance on highly-subsidized public healthcare</li> <li>• Further aggravate public-private imbalance and insufficient competition between the two sectors</li> <li>• Lack incentives for judicious use of highly-subsidized public healthcare</li> <li>• Not conducive to enhancing public sector efficiency and cost-effectiveness</li> <li>• Inadequate choice in healthcare services</li> <li>• Unsustainable financing</li> </ul>
<b>Social health insurance</b>	<ul style="list-style-type: none"> <li>• Equitable healthcare</li> <li>• More stable financing</li> <li>• High-income to subsidize low-income</li> <li>• Some choice of services: can cover both public and private services depending on design</li> </ul>	<ul style="list-style-type: none"> <li>• A new hypothecated tax</li> <li>• Increasing burden on future generations of a shrinking workforce</li> <li>• Encourage over-reliance on highly-subsidized healthcare</li> <li>• Lack incentives for judicious use of highly-subsidized healthcare</li> <li>• Difficult to control healthcare utilization</li> <li>• May encourage tendency to overuse healthcare</li> <li>• Increasing contribution rate due to ageing population and shrinking working population</li> <li>• Incur administration cost</li> <li>• Prescribed choice of healthcare services</li> </ul>
<b>Out-of-pocket payments</b>	<ul style="list-style-type: none"> <li>• Effective means to encourage judicious use of healthcare</li> <li>• Instil sense of self-responsibility for health</li> </ul>	<ul style="list-style-type: none"> <li>• No risk-pooling and disproportionate burden on low-income and under-privileged groups</li> <li>• Cannot provide a significant source of supplementary financing</li> <li>• Increase cost for administering safety net mechanisms</li> </ul>
<b>Medical savings accounts</b>	<ul style="list-style-type: none"> <li>• Saving for own use</li> <li>• Saving for individuals to meet future medical needs</li> <li>• Reduce burden on future generations</li> <li>• Instil sense of self-responsibility for health</li> <li>• Promote judicious use of healthcare services</li> </ul>	<ul style="list-style-type: none"> <li>• No risk-pooling</li> <li>• Not a guaranteed source of supplementary financing</li> <li>• Does not in itself support market reform especially redressing public-private imbalance</li> <li>• Use of savings before retirement defeats purpose of saving for future medical expenses</li> <li>• Incur administration cost</li> <li>• Lock up huge pool of funding</li> </ul>

**Table 3** Summary of pros and cons of supplementary financing options and existing financing model (cont'd)

	<b>Advantages</b>	<b>Disadvantages</b>
<b>Voluntary private health insurance</b>	<ul style="list-style-type: none"> <li>• Individuals' choice to pool risk</li> <li>• More choice of services</li> </ul>	<ul style="list-style-type: none"> <li>• Expensive for the high-risk groups</li> <li>• Costly premium due to anti-selection (tendency that those who take out insurance are those who are more likely to claim insurance)</li> <li>• Coverage may exclude pre-existing medical conditions</li> <li>• No guarantee of continuity especially at old age</li> <li>• Little protection for consumers if unregulated</li> <li>• Little control on healthcare utilization and costs</li> <li>• May encourage tendency to overuse healthcare</li> <li>• Increasing premium over time due to individuals' age and health conditions</li> <li>• Not helping individuals to save to meet future healthcare needs</li> <li>• Incur administration and other insurance costs</li> <li>• Not relieving the pressure on the public healthcare system</li> <li>• Unpredictable and inadequate supplementary financing</li> </ul>
<b>Mandatory private health insurance</b>	<ul style="list-style-type: none"> <li>• Guaranteed risk-pool and avoid risk-selection/anti-selection</li> <li>• Guaranteed acceptance and continuity</li> <li>• Enable more affordable community-rated premium</li> <li>• Enhance consumer protection through regulated insurance</li> <li>• More choice of services</li> <li>• Relieve the pressure on the public healthcare system</li> <li>• Stable financing</li> </ul>	<ul style="list-style-type: none"> <li>• Incur administration and other insurance costs</li> <li>• Regulatory costs</li> <li>• Not helping individuals to save to meet future healthcare needs</li> <li>• May encourage tendency to overuse healthcare</li> <li>• Increasing premium over time due to increasing age profile of insured population</li> </ul>
<b>Personal healthcare reserve</b>	<ul style="list-style-type: none"> <li>• Benefits of medical savings accounts and mandatory private health insurance as above</li> <li>• Complementary savings and insurance: provide both risk-pooling and savings for the future</li> <li>• Relieve the pressure on the public healthcare system</li> <li>• Sustainable and stable financing</li> </ul>	<ul style="list-style-type: none"> <li>• Incur administration and other costs for both insurance and savings</li> <li>• Regulatory costs</li> <li>• May encourage tendency to overuse healthcare</li> <li>• Increasing premium over time due to increasing age profile of insured population</li> </ul>