



# My Health My Choice

Healthcare Reform Second Stage Consultation Document



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# **My Health My Choice**

Healthcare Reform  
Second Stage Public Consultation  
Consultation Document

Food and Health Bureau  
Hong Kong Special Administrative Region Government  
October 2010

## KEY TERMS

<b>Term</b>	<b>Description</b>
Health Protection Scheme (HPS)	A standardized and regulated framework for health insurance proposed by the Government for the second stage public consultation on healthcare reform.
Core requirements and specifications under the HPS	Requirements and specifications standardized under the HPS that all health insurance plans to be offered under the HPS are required to meet.
Health insurance plans under the HPS (HPS Plans)	Health insurance plans that meet the core requirements and specifications under the HPS to be offered by insurers. These include Standard Plans and other health insurance plans that provide top-up benefits and add-on components over and above the Standard Plans.
Standard Health Insurance Plans (Standard Plans)	Standardized health insurance plans that are offered by insurers strictly in accordance with the core requirements and specifications under the HPS without any top-up benefits and add-on components.
Top-up benefits and add-on/additional components	Top-up benefits or add-on components that insurers may choose to offer beyond the core requirements and specifications under the HPS, e.g. higher benefit limits, better service class, broader service coverage such as general out-patient consultation.
Diagnosis-related groups (DRG)	A method of classifying medical conditions requiring hospital admissions or ambulatory procedures by diagnosis and complexity that can be used as a basis for costing or charging for medical services.

## ABBREVIATIONS

CHC	Community Health Centre
DH	Department of Health
DHA	Domestic Health Accounts
DRG	Diagnosis-related groups
eHR	Electronic health record
FHB	Food and Health Bureau
HA	Hospital Authority
HMDAC	Health and Medical Development Advisory Committee
HPS	Health Protection Scheme
OCI	Office of the Commissioner of Insurance
PCO	Primary Care Office
PHI	Private health insurance
PPP	Public-private partnership
WGPC	Working Group on Primary Care

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## MESSAGE FROM DR YORK Y N CHOW, GBS, JP, SECRETARY FOR FOOD AND HEALTH

Dear Citizens,

An effective and sustainable healthcare system requires close monitoring and steering by the Government. It needs to ensure equitable access and provide safety net for all, through a robust public system supported by public funding. It also needs to provide adequate choices for you, our fellow citizens, through a private sector that is equally professional and transparent to consumers in both quality and service fees.



Our current healthcare system in Hong Kong is highly rated internationally, but we need to continue to refine and develop our monitoring and steering mechanisms for the service capacity, market coverage, professional development and financial sustainability of our healthcare system. That is the essence of the healthcare reform we are embarking on.

It has been two years since we first launched the healthcare reform and consulted your views on the comprehensive package of reform proposals in 2008. With your support in the first stage public consultation, we have been enhancing public healthcare services and taking forward the service reform proposals making use of the increased budget for health.

Since 2007/08, we have increased our budget for health from \$30.5 billion to \$36.9 billion and invested over \$15 billion in healthcare infrastructure and safety net. Making use of the increased resources, we have built a solid foundation for the healthcare reform:

- (1) **Enhance Primary Care:** the Primary Care Working Group comprising primary care practitioners from both the public and private sectors has formulated an overall primary care development strategy for Hong Kong which the newly established Primary Care Office will be taking forward.
- (2) **Promote Public-Private Partnership (PPP):** a number of pilot projects to deliver healthcare services through PPP are already underway and we set to further expand the scope. We will also facilitate the private sector to expand capacity through encouraging development of private hospitals.
- (3) **Develop Electronic Health Record (eHR) Sharing:** the eHR Office together with the IT experts from the Hospital Authority (HA) is working closely with the private sector to implement the eHR Programme to provide a sharing infrastructure bridging the public and private sectors.

- (4) **Strengthen Public Healthcare Safety Net:** to improve public healthcare services, we have increased the subvention for HA from \$28.0 billion to \$32.7 billion and will further increase it next year. We have also injected \$1 billion into the Samaritan Fund to help those in need.

It is time we move on to the next stage of the healthcare reform. We have listened carefully to your views: you value your voluntary choice for public or private healthcare; you treasure the public healthcare system as the equitable safety net; and yet you want more choices and better protection in private healthcare. We believe the Government can play an active role.

We have thus formulated proposals for a Health Protection Scheme (HPS), a scheme for standardizing and regulating voluntary private health insurance, that aims to provide you with better choices for lifelong protection. We will also be your lifelong health partner by proposing financial subsidies that invest together with you in your long-term health protection.

We will continue to uphold the public healthcare system as the safety net for the whole population. By enabling more people to access private healthcare, the HPS will relieve the pressure on the public healthcare system so that it could better focus its resources on target service areas and population groups, especially low-income families, under-privileged groups and other needy patients.

The proposed HPS would thus benefit everyone, both those opting for private healthcare and those taken care of by the public system. It would also complement the service reforms underway and help enhance the long-term sustainability of our healthcare system.

I would like to take this opportunity to express my appreciation of the contribution by members of the Health and Medical Advisory Committee and its Working Group on Healthcare Financing, as well as members of the Consultative Group on Voluntary Supplementary Financing Scheme, who have played a pivotal role in the formulation of the proposals for the HPS for consultation.

We are committed to joining hands with you in tailoring the HPS to the benefits of all. We look forward to receiving your views and suggestions in this second stage public consultation on the healthcare reform.



Dr York Y N CHOW  
Secretary for Food and Health  
October 2010

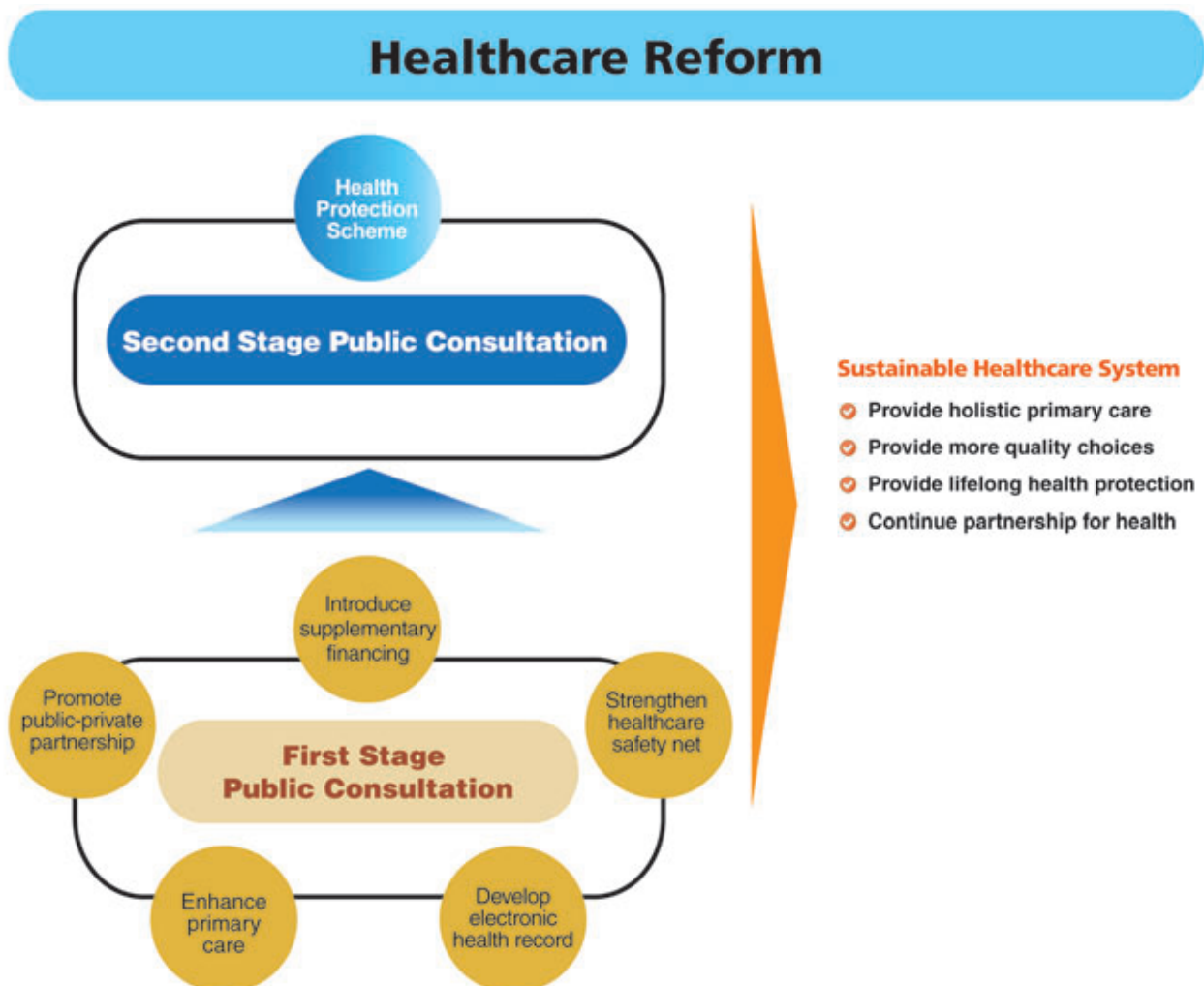


## EXECUTIVE SUMMARY

### Healthcare Reform

We put forward a comprehensive package of proposals to reform the healthcare system in the **Healthcare Reform Consultation Document “Your Health, Your Life” in March 2008**. These include four **healthcare service reform proposals** to enhance primary care, promote public-private partnership in healthcare, develop electronic health record sharing, and strengthen public healthcare safety net, and a **healthcare financing reform proposal** to consider introducing **supplementary healthcare financing** via six possible **supplementary financing options**.

2. We conducted the **first stage public consultation** on healthcare reform in March to June 2008 and published the consultation report in December 2008. Building on the views received, we are **improving public healthcare** and **taking forward the service reforms**, making use of the **increasing government budget for health**. We have also formulated a *voluntary* **Health Protection Scheme (HPS)** as the next step in healthcare reform. This document mainly sets out our proposals for the Health Protection Scheme to initiate the **second stage public consultation** on healthcare reform.



## First Stage Public Consultation (Chapters 1 & 2)

3. The first stage public consultation reflected a widely shared concern over the **long-term sustainability of our healthcare system**. The community recognized the imminent need to take forward **comprehensive reform to our healthcare system** to meet the challenges of a **rapidly ageing population** and **rising medical costs**. There was a broad community consensus to **take forward the healthcare service reform proposals**.

4. The majority of the public agreed that **reform of both service delivery and financing arrangements would be needed**. However, the public expressed **divergent views over the supplementary financing options** put forth. They expressed **reservations against mandatory supplementary financing options** in general. A greater proportion of the public **preferred voluntary choice for individualised healthcare** and **favoured voluntary private health insurance**.

5. **The Government's commitment to healthcare is set to continue to increase** as we reform our healthcare system based on the community's views. We will **continue to uphold the public healthcare system as the safety net for the whole population**. The Government's annual recurrent expenditure on health has increased from \$30.5 billion in 2007-08 to \$36.9 billion in 2010-11. We aim to **increase the health budget to 17% of the Government's recurrent expenditure in 2012**.

## Second Stage Public Consultation (Chapter 3)

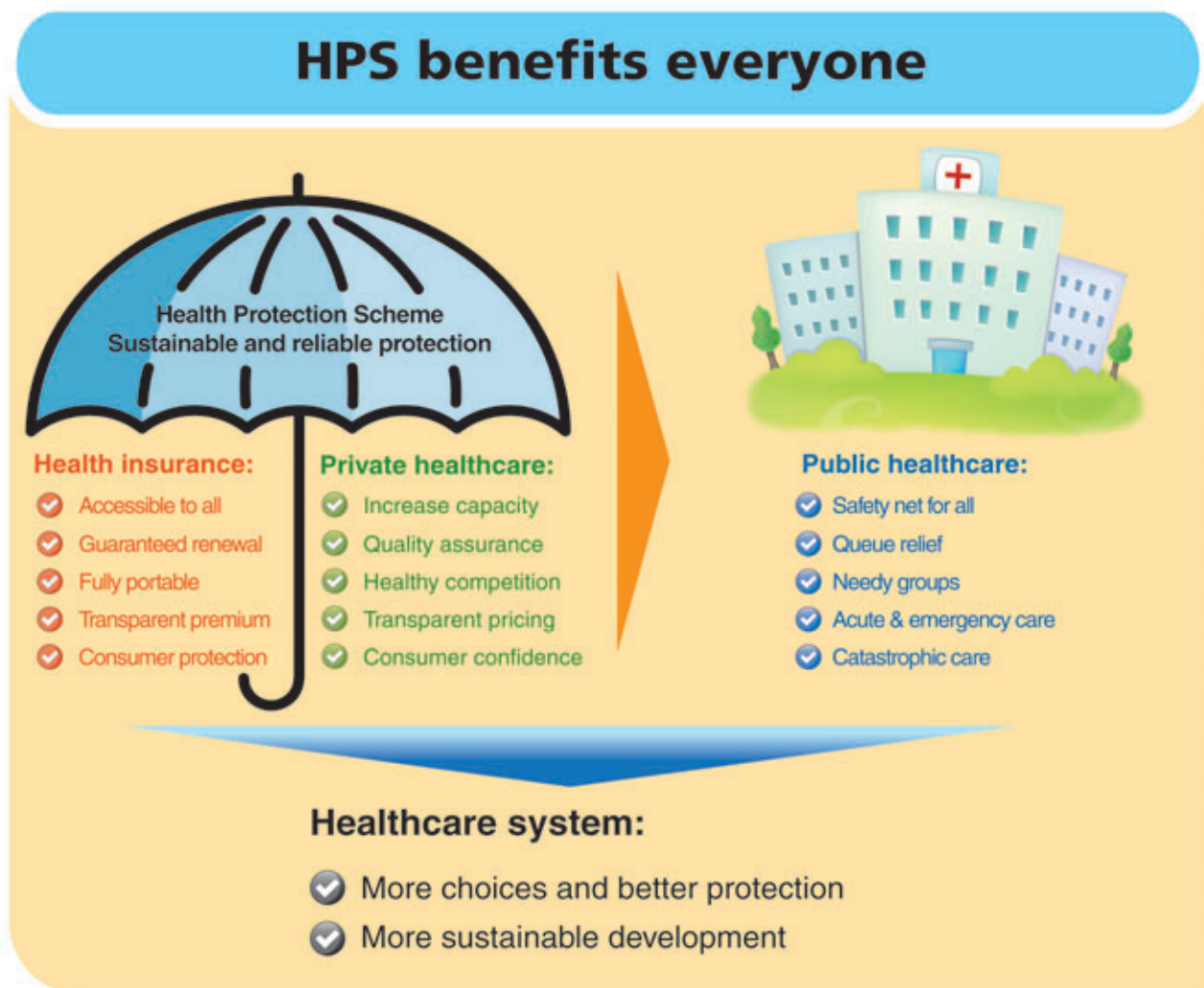
6. The Government is committed to continuing to engage the community and take forward **healthcare reform through a step-by-step approach**, with a view to **enhancing the long-term sustainability of our healthcare system**. As announced in the 2009-10 Policy Address, the Government would put forward a **voluntary supplementary healthcare financing scheme** for the **second stage public consultation** based on the following principles –

- (a) **Supplementary financing:** public funding will remain the main funding source for healthcare supplemented by private funding;
- (b) **Voluntary participation:** the Scheme will be based on voluntary participation by those who are able and willing to afford;
- (c) **Wider choice:** the Scheme will provide consumers with more choices of value-for-money healthcare services with quality assurance;
- (d) **Continuous protection:** the Scheme will be designed to provide continuous protection for participants into their older ages; and
- (e) **Consumer interests:** the Scheme will be standardized and regulated by the Government to safeguard consumer interests.

7. We propose to introduce a *voluntary* Health Protection Scheme that aims to better ensure the quality and value-for-money of private healthcare services and private health insurance. It takes a step in enhancing the long-term sustainability of the healthcare system by making private healthcare, and private funding as healthcare financing supplementary to public funding, more sustainable.

8. The proposed Health Protection Scheme also aims to ease the pressure on the public healthcare system, thereby benefitting those who depend on the public system for their healthcare. It does so by encouraging individuals who are able and willing to choose and pay for private healthcare to subscribe to private health insurance and enabling them to use private healthcare on a sustained basis as an alternative to public healthcare, which will still be available to all eligible Hong Kong residents.

9. The Government has pledged to draw \$50 billion from the fiscal reserve to support healthcare reform after the supplementary healthcare financing arrangements are finalized for implementation. We will consider making use of the \$50 billion to provide incentives to encourage the public to participate in the Health Protection Scheme on a sustained basis, thus relieving the long-term demand for public healthcare services.



## Proposed Voluntary Health Protection Scheme (Chapter 4)

### *Scheme Objectives*

10. The Government will regulate health insurance plans to be offered under the Health Protection Scheme to uphold the principles above. Our aim is to enhance **consumer protection, price transparency, quality assurance and market competition in the private health insurance and private healthcare service sectors**. The Health Protection Scheme is thus designed with the following objectives –

- (a) **Provide more choices with better protection to those who are able and willing to pay for private health insurance and private healthcare services.**
- (b) **Relieve public queues by enabling more people to choose private services and focus public healthcare on target service areas and population groups.**
- (c) **Better enable people with health insurance to stay insured and make premium payment at older age and meet their healthcare needs through private services.**
- (d) **Enhance transparency, competition, value-for-money and consumer protection in private health insurance and private healthcare services.**

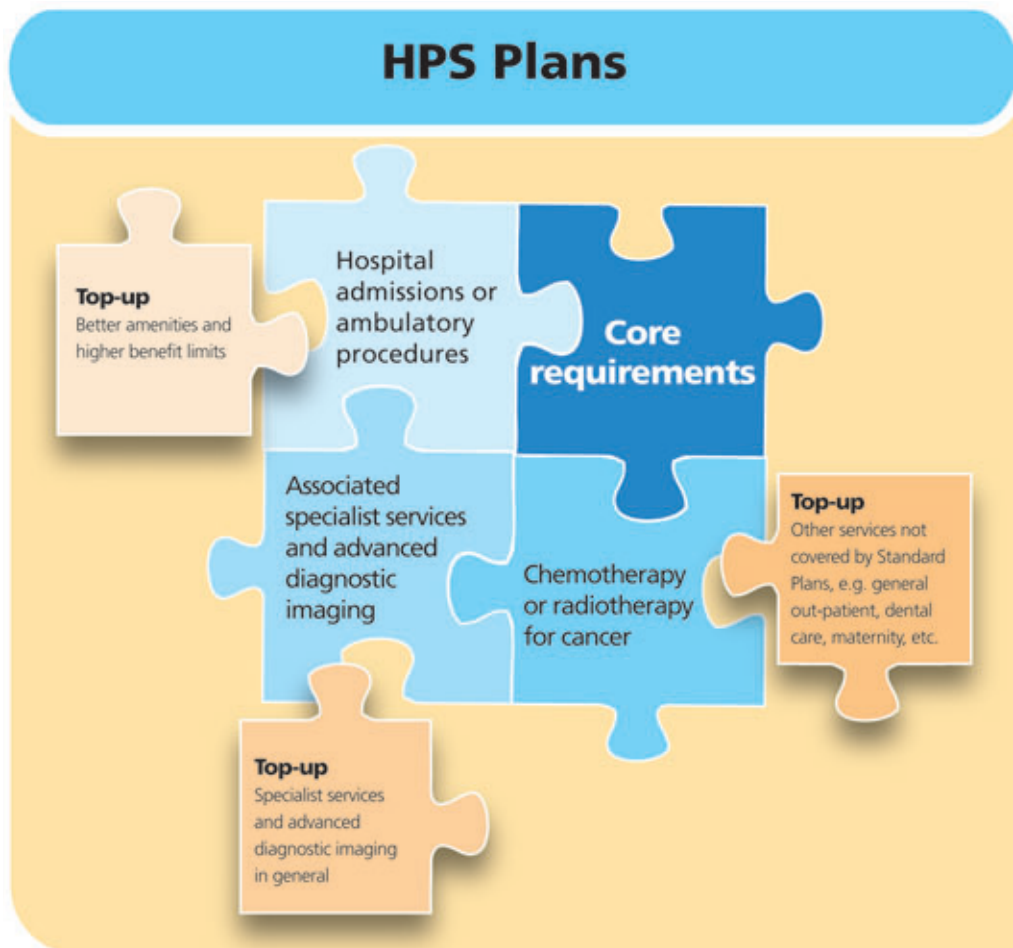
11. By enabling more people to use private healthcare on a sustained basis, the Health Protection Scheme will enable the public healthcare system to better focus on its target service areas, including **services for low-income families and under-privileged groups, acute and emergency care, and catastrophic and complex illnesses requiring high cost, advanced technology and multi-disciplinary professional team work** which may not be readily available or may entail very high cost in the private sector.

### *Scheme Concept*

12. **The Health Protection Scheme is proposed as a standardized and regulated framework for health insurance under its aegis.** Health insurance plans to be offered under the HPS (**HPS Plans**) are required to meet the **core requirements and specifications** for health insurance standardized under the HPS. Specifically, insurers participating in the HPS are required to offer standardized health insurance plans in accordance with the core requirements and specifications (**Standard Plans**). Participating insurers are also required to comply with scheme rules and requirements specified under the HPS.

13. **The HPS is designed to be modular:** while participating insurers are all required to offer Standard Plans which would attract government incentives, they are free to design appropriate health insurance plans of their own offering top-up benefits or integrating additional components beyond the core requirements and specifications to suit consumers' needs, e.g. better services and rooms and boards, or coverage of services not included in Standard Plans such as out-patient services. However, the top-ups or additions would not be eligible for government incentives under the HPS.

14. Individuals may **choose to subscribe to HPS Plans** offered by participating insurers on a voluntary basis. They will enjoy the **provisions under the HPS for consumer protection and other advantages offered by HPS Plans**, which are not available to private health insurance outside the HPS in general. Employers may also choose to make use of HPS Plans through their insurers when providing medical benefits to their employees.



### *Core Requirements and Specifications*

15. The core requirements and specifications for health insurance under the HPS will be set to ensure that HPS Plans can provide risk-pooling protection for unanticipated and costly healthcare. We propose to require HPS Plans to cover medical conditions requiring **hospital admissions or ambulatory procedures**, including the associated specialist out-patient consultations/investigations and advanced diagnostic imaging required for the admissions or procedures, and **chemotherapy or radiotherapy for cancer**.









16. The core specifications will set out the standardized policy terms and reimbursement levels (benefit limits) required under the HPS. We propose to set the benefit limits at a level that enables the insured to access affordable private healthcare for medical conditions requiring hospital admissions or ambulatory procedures. Insurers are free to offer top-up benefits exceeding the core specifications (e.g. better amenities, higher benefit limits, lower co-payments, etc.).

17. We propose **not to include primary care** as a core requirement under the HPS because private primary care is relatively more affordable, and the utilization of primary care is highly elective and more prone to moral hazards. For similar reasons, we propose **not to include specialist services and diagnostic imaging in general** that are not required for hospital admissions or ambulatory procedures, and **not to include maternity coverage**. Insurers are at liberty to offer add-on components covering these services.

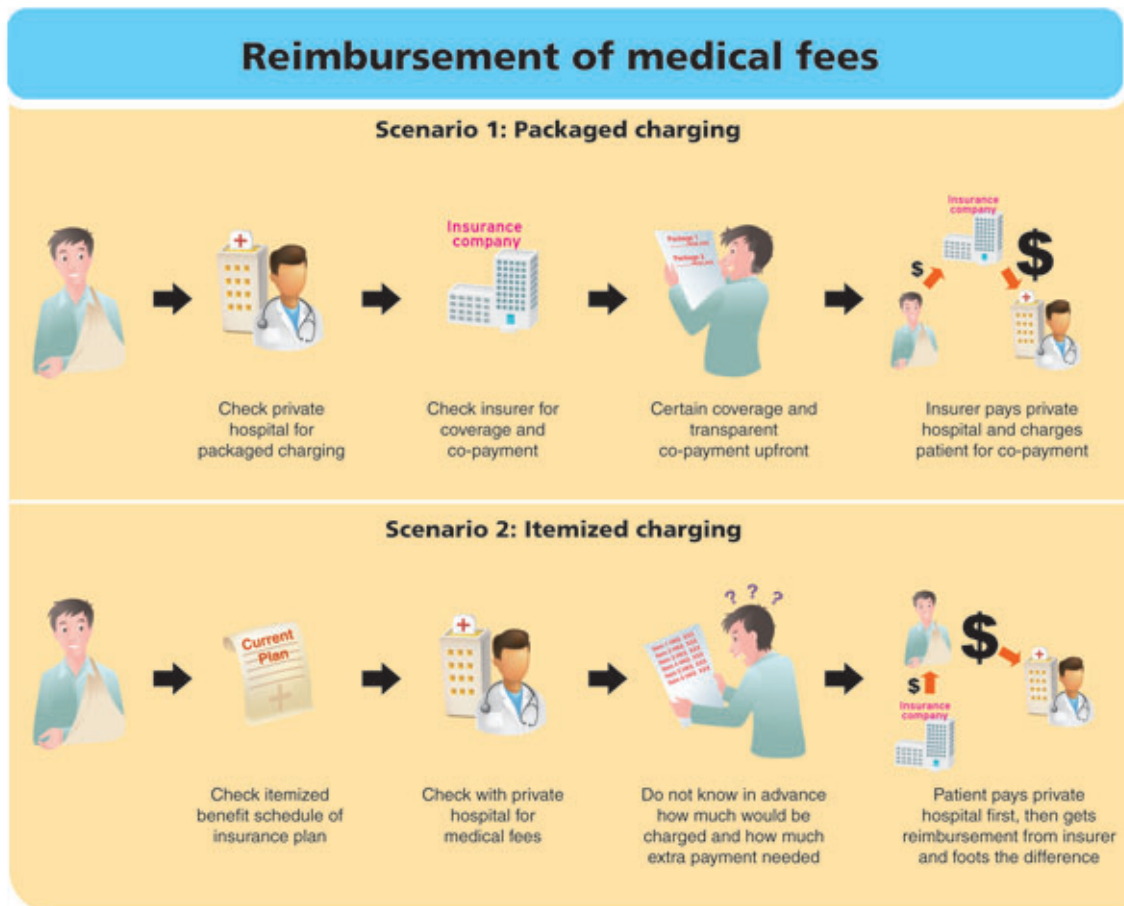
### Key Scheme Features

18. HPS Plans are required to provide a combination of key features that offer advantages over existing private health insurance products available in the market –

- **No turn-away of subscribers and guaranteed renewal for life**
- **Published age-banded premiums subject to adjustment guidelines**
- **Cover pre-existing medical conditions subject to waiting period and time-limited reimbursement limits\***
- **Cap premium plus high-risk loading at 3x published premium\***
- **Make higher risk groups insurable with High-Risk Pool reinsurance\***  
(\* see the next section on “Access for Higher Risk Groups”)
- **Offer no-claim discount up to 30% of published premiums**
- **Insurance plans portable between insurers and on leaving employment**
- **Transparent insurance costs including claims and expenses**
- **Standardized health insurance policy terms and definitions**
- **Government regulated health insurance claims arbitration mechanism**

<b>HPS provides better health insurance plans</b>		
<b>Key features</b>	<b>Current health insurance products in general</b>	<b>HPS Plans</b>
1. Is the plan regulated by the Government for consumer protection?		
2. Will there be checks to ensure that premium adjustment is reasonable?		
3. Can I switch my plan to another insurer with no loss in coverage?		
4. Can my plan continue after I retire with no loss in coverage?		

19. Another key feature of the HPS is to promote **transparent medical fees with packaged charging for common procedures**. Private hospitals would be encouraged to offer quality-assured, all-inclusive and condition-specific packaged services and pricing. HPS Plans would be required to set reimbursement levels based on packaged charging where available, thereby enhancing transparency and certainty of medical charges to the insured. This enhances market transparency and competition in private healthcare services and helps safeguard consumer interests in making use of such services.

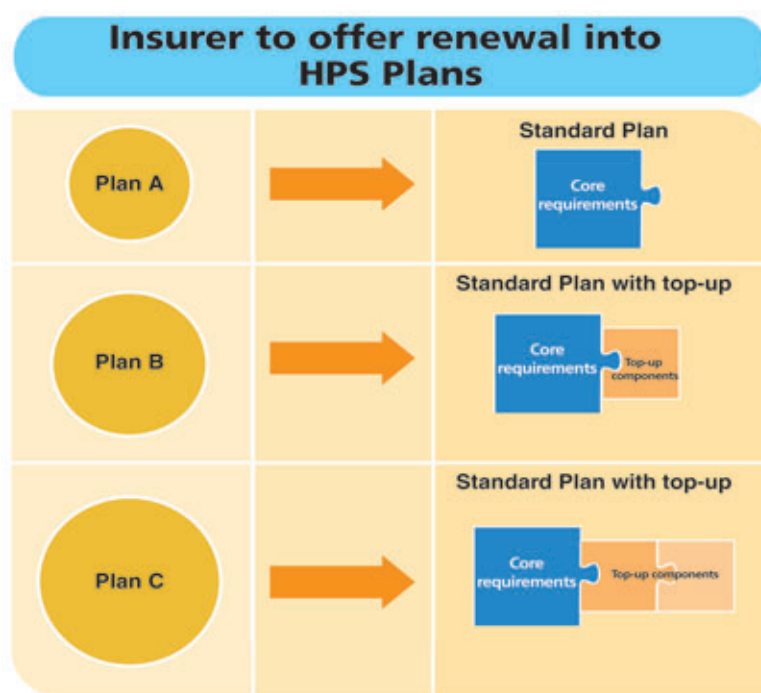


### *Migration of Existing Health Insurance*

20. The HPS is voluntary for individuals and employers with existing health insurance, who may choose whether to migrate to health insurance plans under the HPS. Based on discussion with the insurance industry, we propose to require insurers participating in the HPS to facilitate seamless migration of policy-holders from their existing health insurance policies to HPS Plans as follows –

- (a) **For existing individual policy-holders:** participating insurers will be required to offer them an option to renew their existing health insurance policies to an appropriate HPS Plan which must meet or exceed the requirements for Standard Plans with no less coverage and benefits and without undergoing re-underwriting, and to enjoy advantages offered by the HPS including pre-existing conditions coverage subject to waiting period, portability, no-claim discount, etc.

- (b) **For existing group policy-holders (mainly employers):** participating insurers will be required to offer them upon renewal an option to switch to an appropriate tailor-made HPS Plan which must meet or exceed the requirements for Standard Plans that provides no less coverage and benefits and meets the core requirements and specifications under the HPS. The insurers may offer top-up components to suit individual employers' needs.



### *Access for Higher Risk Groups*




21. In formulating the proposals for the HPS, we have identified a number of key issues on the HPS design concerning how individuals with higher risk should be able to subscribe to health insurance. Our proposals are set out below –

- (a) **How pre-existing conditions should be covered in health insurance?** The HPS requires health insurance to cover pre-existing medical conditions that are usually excluded by existing health insurance. A waiting period and reimbursement ratios are needed to minimize anti-selection. We propose to start coverage of pre-existing conditions after a one-year waiting period, and provide reimbursement of 25% in the second year, 50% in the third year, and 100% after three years.
- (b) **How high-risk individuals may subscribe to health insurance?** High-risk individuals often cannot get health insurance now or the premium can be prohibitively high. The HPS requires insurers to insure them with premium plus high-risk loading not exceeding a certain level. We propose to cap the premium plus loading to be paid by high-risk individuals at three times the published premiums for Standard Plans.



- (c) **How individuals already at older age may also get health insurance?** Existing health insurance usually set an age limit beyond which entry would be denied. The HPS aims to facilitate access by the higher risk groups but allowing entry at all ages may introduce excessive risks to HPS Plans. On balance, we propose to require insurers to allow people aged 65+ to subscribe to HPS Plans within the first year of introduction, but with no cap on their premium plus loading.

## Higher Risk Groups to Access HPS

	Lower risk / premium Lower accessibility	Proposal	Higher risk / premium Higher accessibility
1. How long should people with pre-existing conditions wait to be covered? 	Longer waiting period Lower ratios for reimbursement	<b>1-year waiting period; reimburse 25% in 2nd year; 50% in 3rd year; 100% after 3rd year</b>	Shorter period for full cover Higher ratios for reimbursement
2. How much more premium should people with higher risks pay? 	Higher premium cap Lower reinsurance	<b>Capped at 3 times the published premium</b>	Lower premium cap Higher reinsurance
3. How may the elderly get health insurance? 	Set upper age limit for entry	<b>65+ may join within 1st year with no cap on premium plus loading</b>	Apply premium cap Higher reinsurance

### *High-Risk Pool Reinsurance Mechanism*

22. To enable the higher-risk groups to have access to health insurance while ensuring the financial viability of the health insurance plans under the HPS, it is necessary to introduce a **High Risk Pool (HRP)**, which is an industry reinsurance mechanism for insurers participating in the HPS to share out the high risks insured by their HPS Plans. All high-risk policies, defined as those policies with risk premium assessed to exceed the cap for premium with high-risk loading (i.e. three times the published premium of Standard Plans) will be put into the HRP.

23. The HRP is proposed to be a reinsurance mechanism operated by the industry and regulated by the Government, funded by the premium of high-risk policies (corresponding to Standard Plans) and reinsurance premium from participating insurers. Where necessary, injection by the Government would be considered in case the viability of the HRP is in jeopardy due to a large proportion of higher risk people joining health insurance plans under the HPS, when the HRP premium cannot meet the claims pay-out (see “Government Incentives” in paragraph 25(a) below).

### *Saving for Future Premium*

24. A key objective of the HPS is to encourage people with health insurance to stay insured at older age. However, age-banded premium for voluntary health insurance are bound to increase sharply with age of the insured as their health risk and healthcare utilization increase. One possible way that may help ensure that individuals can still afford continuous health protection under the HPS at older age when they need it most is to encourage savings for paying future premium. We thus propose the following options to encourage savings (see “Government Incentives” in paragraph 25(c) below) –

- (a) **Required in-policy savings:** HPS Plans will be required to incorporate a savings component, where the insured would pay a higher premium at a younger age to offset the premium increase at older age. Incentives via government contributions to the savings component of HPS Plans would be considered.
- (b) **Optional savings accounts:** individuals subscribing to HPS Plans will have an option to save to a savings account, and the accrued savings can be freely used on or after age 65. Incentives via government contributions to the savings account would be considered, but would be subject to the savings being used to pay HPS premium from age 65.
- (c) **Premium rebate for long-stay:** individuals subscribing to HPS Plans are not required to save, but may choose to save on their own means. Incentives via a premium rebate proportion to their length of staying insured under the HPS would be considered, provided that they continue to pay premium from age 65 using their own savings.

### *Government Incentives*

25. To achieve the objectives of the HPS, we propose that financial incentives making use of the \$50 billion fiscal reserve earmarked to support healthcare reform should be considered in the following directions –

- (a) **Protection for high-risk individuals:** to allow high-risk individuals to join HPS Plans without requiring other healthy insured to pay excessive premium, we propose to consider government injection into HRP where necessary, an industry-operated reinsurance mechanism for taking on high-risk individuals and sharing out their risks, to buffer the excess risk arising from the participation of high-risk individuals.
- (b) **Premium discount for new subscribers:** to attract individuals especially the young to join HPS Plans, we propose to consider government incentives for all new joiners of HPS Plans to enjoy maximum no-claim discount i.e. up to 30% discount on the Standard Plan premium immediately on joining. We propose to make this available for a limited period after the introduction of HPS.

- (c) **Savings for future premium** (see “Saving for Future Premium” in paragraph 24 above): to enable the insured to continue to afford health protection under the HPS at older age, we propose to consider government incentives for savings by individuals for paying future premium at older age (say 65 or above). We propose that the government incentives should be proportional to their length of continuously staying insured under the HPS and may be up to a certain percentage of their Standard Plan premium.

26. Upon receiving views in the public consultation over the proposed directions for considering financial incentives, we will formulate the details of the proposals for government incentives under the HPS, and work out the use of the \$50 billion fiscal reserve earmarked to support healthcare reform.

## **Supporting Infrastructure for Health Protection Scheme (Chapter 5)**

### *Private Healthcare Capacity and Manpower*

27. Implementation of the HPS will require corresponding expansion in the capacity of the private healthcare sector to cope with the potential increase in demand. We estimate that the known redevelopment projects of existing private hospitals and the development of new private hospitals under planning should be able to meet the projected demand for private healthcare services arising from the HPS. We shall continue to monitor the demand for private healthcare services and further consider ways to increase the capacity as necessary after the HPS is implemented.

28. We conduct manpower planning exercises on a regular basis for the various healthcare professions for the purpose of assessing the education and training needs for healthcare professionals. The exercise will take into account the potential demands for manpower increase, including expansion of the healthcare system to cater for demographic changes and implementation of the healthcare reform initiatives. The potential increase in demand for private healthcare services arising from the implementation of the HPS will be taken into consideration.

### *Requirements for Insurers and Providers*

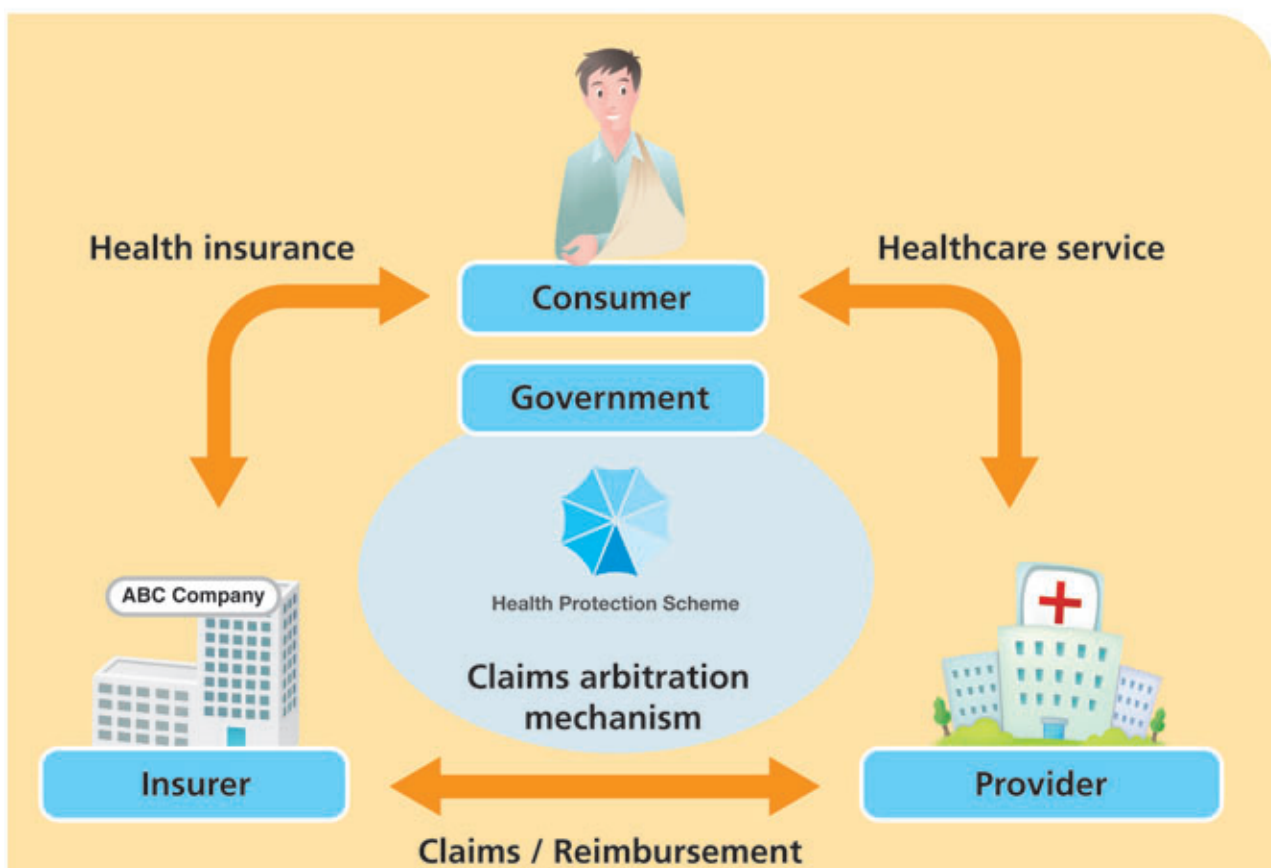
29. Implementation of the HPS requires participation of private health insurers and private healthcare providers. To this end, the proposals for the HPS are designed with a view to safeguarding consumer interests in private health insurance and private healthcare services, while ensuring that it should be practically feasible and financially viable to offer health insurance plans and provide private healthcare services under the HPS.

30. To ensure competition and choice under the HPS, there is a need for more interested private health insurers to participate and offer sufficient and attractive choices of health insurance plans under the HPS. The HPS is formulated taking into account the

views of the insurance industry, and we expect that private insurers in the insurance industry would be interested in participating in the HPS. However, should there be a general lack of interests from the industry in offering health insurance plans under the HPS, the Government will consider setting up its own mechanism to provide the public with more choices of health insurance plans.

31. For the implementation of the HPS, there is a need for private healthcare providers to provide services that meet the requirements under the HPS, especially healthcare services at packaged charging. To this end, for new private hospital developments at the four pieces of land earmarked for such, we shall design the development requirements taking into account the need to support the HPS, including service scope, price transparency, and the requirement to provide services at packaged charges. We will also explore ways to facilitate local private hospitals to provide healthcare services at packaged charging in accordance with the HPS through providing of necessary infrastructural support.

32. To safeguard consumer interests, a proposed requirement under the HPS is for private health insurers participating in the HPS and private healthcare providers providing services to the insured under the HPS (including private hospitals and their engaged or associated doctors) to participate in a **health insurance claims arbitration mechanism** to handle disagreements between patients, private insurers and/or private healthcare providers over health insurance claims. The arbitration mechanism will be regulated by the Government with a view to maintaining impartiality and ensuring consumer protection in the private health insurance and healthcare service markets.



## *Supervisory Structure*

33. To supervise effectively the implementation and operation of the HPS and to monitor the achievement of the objectives of the HPS in the private health insurance and private healthcare markets in Hong Kong, we propose a supervisory structure with separate agencies to perform the following essential functions –

- (a) **Prudential regulation:** the Office of the Commissioner of Insurance will continue to serve the functions of the prudential regulator to supervise, inter alia, the financial soundness of insurers participating in the HPS and to ensure their financial capability to discharge obligations to the insured, and to oversee any complaint handling mechanisms applicable to insurance in general.
- (b) **Quality assurance:** the Department of Health will be strengthened in its role as the regulatory and licensing authority for private hospitals to serve the functions of quality assurance, including to enforce the regulatory requirements and licensing conditions, to supervise the quality and standard of healthcare services provided, to oversee hospital accreditation and clinical audits, to collect service statistics and benchmarking information, and to administer other quality assurance measures. The professional regulation of healthcare professionals will continue to rest with the relevant statutory boards and councils.
- (c) **Scheme supervision:** a new dedicated agency is proposed to be established to supervise the implementation and operation of the HPS, including registering health insurance plans, administering the HPS core requirements, collecting information and statistics about private health insurance plans, compiling benchmarking information and service statistics of private healthcare services, compiling necessary pricing and costing information of private healthcare under the HPS, and administering mechanisms for consumer protection specific to the HPS including claims arbitration, complaint handling and case review.

34. Legislative change will be required to support the implementation of the above supervisory structure and functions. We will examine the detailed legislative requirements when finalizing the HPS proposal for implementation after consultation.

## **We Need Your Views**

35. We are consulting the public on our proposals to introduce the HPS and we would appreciate your views. Your support and views are important for us to find out the best way forward. Please send your views on this consultation document to us on or before 7 January 2011 through the contact below.

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36. 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.

### Part 1 : General Views

- 1.1 Do you support introducing the voluntary HPS providing health insurance standardized and regulated by the Government?
- 1.2 Do you support regulating health insurance plans under the HPS to provide protection and better choices to consumers?
- 1.3 Do you support increasing private healthcare sector capacity and strengthening quality assurance measures in support of the HPS?

### Part 2 : HPS Design

- 2.1 Do you agree with the proposals for allowing higher risk groups to access health insurance?
  - HPS Plans should cover pre-existing medical conditions after 1-year and provide 25% / 50% partial reimbursement in 2nd/3rd year, and full reimbursement after 3 years.
  - HPS Plans should accept high-risk individuals with premium plus high-risk premium loading not exceeding 300% of the published premium rate applicable.
  - HPS Plans should accept those aged 65 or above during the first year of introduction, but without being subject to cap on high-risk premium loading.
- 2.2 Which option to save for future premium do you prefer?
  - I. required to save as part of the health insurance policy to pay future premium
  - II. given an option to save to a medical savings account that can be used for any purpose; or
  - III. allowed to save on their own, with incentives provided for payment of premium from age 65.
- 2.3 Do you agree with the proposals to introduce packaged charging for private healthcare services, to require insurers to facilitate migration of existing health insurance, and to establish a government-regulated claims arbitration mechanism?

### Part 3 : Financial Incentives for HPS

- 3.1 Do you support government injection into the High-Risk Pool where necessary to protect high-risk individuals and avoid premium increases for the healthy under the HPS?
- 3.2 Do you support that there should be a no-claim premium discount up to 30% of premium for all new subscribers for a limited period after the introduction of the HPS?
- 3.3 Do you support that there should be rebate up to a certain percentage of savings used to pay Standard Plan premiums under the HPS on or after age 65?

### Background

1.1 The Health and Medical Development Advisory Committee (HMDAC) (see *Appendix E*) issued the discussion paper “*Building a Healthy Tomorrow*” in July 2005 on the future service delivery model for the healthcare system. The discussion paper surveyed the healthcare system and made a number of recommendations on how the service delivery model should be changed. The recommendations covered various aspects of the healthcare system including primary medical care, hospital services, tertiary and specialized services, elderly, long-term and rehabilitation care services, integration between the public and private sectors, and infrastructural support. They received broad support from the community and stakeholders.

1.2 Based on the recommendations by the HMDAC, the Government published the Healthcare Reform Consultation Document “*Your Health, Your Life*” on 13 March 2008 and put forward a comprehensive package of reform proposals to meet the challenges brought about by the changing demographic profile and rising medical costs. These include four proposals on healthcare service reform and a proposal for healthcare financing reform by considering the introduction of supplementary healthcare financing through six possible supplementary financing options. The Government conducted the first stage public consultation on the healthcare reform from March to June 2008 with a view to engaging the community and stakeholders and building a consensus to reform the healthcare system and enhance its sustainable development.

### Healthcare Reform Proposals

1.3 The Healthcare Reform Consultation Document “*Your Health, Your Life*” published in March 2008 put forward reform proposals that aim to enhance the long-term sustainability of the healthcare system including its financing through reforming the system in the following directions –

- (a) **Service reform:** to change the current service delivery model, which focuses on hospital care at present, and put greater emphasis on primary care especially preventive care, with a view to improving the overall population health and reducing downstream hospitalization needs.
- (b) **Market reform:** to change the current market structure where hospital care is provided predominantly by the public sector, with a view to providing more choices for the public, promoting efficient use of healthcare resources, and enhancing overall efficiency in both the public and private sectors.
- (c) **Financing reform:** to change the current healthcare financing arrangements by introducing supplementary financing in addition to existing financing sources, with a view to enhancing the sustainable development of the healthcare system

and complementing the service and market reforms.

### *Healthcare Service Reform*

1.4 The healthcare reform put forward four proposals for healthcare service reform that aim at reforming the service delivery and market structure of the healthcare system, with a view to addressing the various issues identified by the HMDAC -

- (a) **Enhance primary care:** to enhance the provision of accessible first contact care that is comprehensive, continuing, co-ordinated and person-centred in the context of family and community, and to put more emphasis on preventive care that promotes the well-being and improves the quality of life of individuals.
- (b) **Promote public-private partnership (PPP) in healthcare:** to foster collaboration between the public and private healthcare sectors in the provision of healthcare in order to encourage healthy competition and collaboration between public and private sectors, thereby providing more cost-effective services and greater choice of services.
- (c) **Develop electronic health record (eHR) sharing:** to develop a territory-wide patient-oriented eHR sharing system to enable sharing of patients' health records between healthcare providers in both the public and private sectors subject to patients' consent.
- (d) **Strengthen public healthcare safety net:** to strengthen the public healthcare system as an essential safety net for the population, especially for those who lack the means to pay for their own healthcare.

### *Healthcare Financing Reform*

1.5 At the same time, the Government also proposed to reform the current healthcare financing arrangements to complement the healthcare service reform. In particular, while maintaining tax-based public funding as the major financing source for healthcare services, we proposed to consider the introduction of supplementary financing to supplement public funding in meeting increasing healthcare needs and sustaining the development of the healthcare system. Six possible supplementary financing options were put forward for consultation –

- (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.

### **First Stage Public Consultation**

1.6 The first stage public consultation on healthcare reform was conducted from March to June 2008 through an extensive consultation programme with the community and stakeholders. The public and various stakeholders had put forward constructive views on both the service reform proposals and the supplementary financing options, which had helped us better understand their expectations for the Healthcare Reform. The report on the first stage public consultation summarizing the views received on the healthcare reform proposals was published in December 2008.

1.7 The public generally shared the view that ageing demographic profile of the population and rising medical costs due to advancement in medical technology would pose significant challenges to the healthcare system. The ageing population would lead to rapid increase in healthcare needs and service demands on the healthcare system, particularly the public system. The cost of healthcare would also likely continue to rise in view of the advancement of medical technology and medical inflation. Noting the significant public-private imbalance in our healthcare system, many expressed concerns that the continued growth in service demand could lead to deterioration of service quality and lengthening of waiting queue for highly-subsidized public healthcare services, where the elderly, chronic disease patients and the under-privileged group would likely be most affected.

1.8 There was a broad consensus among the public that there was an imminent need to take forward comprehensive reform of our healthcare system to enhance sustainable development to meet the challenges. The public generally supported that comprehensive reform on both the service delivery and financing arrangements would be needed to ensure the sustainability of the system and there was an imminent need to do so. Many of them advocated that the Government should take the lead and work out details of the reform proposals with stakeholders for building consensus.

## *Views on Healthcare Service Reform*

1.9 The first stage public consultation on healthcare reform reflected a broad consensus in the community over the healthcare service reform proposals. The public and various stakeholders called for early implementation of these reforms with a view to bringing about immediate improvements to the capacity and quality of healthcare services provided to the public at present.

1.10 The public generally agreed with the key concepts and directions for the service reform proposals. The public strongly urged the Government to allocate additional resources to take forward the inter-linked healthcare reform initiatives with a view to supporting the sustainable development of our healthcare system, including –

- (a) enhancing comprehensive, lifelong and holistic primary care services to put greater emphasis on preventive care, promote continuity of care, improve the health of the community and reduce the need for costly hospital care in the long run;
- (b) promoting PPP in providing cost-effective and quality healthcare services for the population to facilitate cross-fertilization of expertise and skills and enhance collaboration of healthcare professionals between the public and private sectors;
- (c) developing an eHR sharing system to enhance continuity of care, improve efficiency and quality of care, facilitate collaboration between healthcare professionals and enable better integration of healthcare services for the benefits of patients; and
- (d) strengthening public healthcare safety net to improve public healthcare services for patients, to focus public services in target service areas, and to provide enhanced protection to target population groups in need including the low-income families and under-privileged groups.

1.11 Based on the broad consensus reached in the first stage public consultation, the Government has been taking forward the healthcare service reform proposals through making use of the increasing government budget for health. The progress and way ahead of these service reform initiatives are set out in Chapter 2.

## *Views on Supplementary Financing Options*

1.12 As reflected in the first stage public consultation, the majority of the public agreed that the long-term sustainability of the healthcare system could not be adequately addressed without reforming the healthcare financing arrangements. There is a relatively small proportion of the public who disagreed that the need for changing the healthcare financing arrangements is imminent. Some of them considered that raising tax should also be an option, though opinion surveys showed that tax increase is least favoured among the public. Among those who agreed with the need for reform,

however, there were divergent views on how.

1.13 The public and stakeholders expressed divergent views over the six possible supplementary financing options. An analysis of their pros and cons was put forward to facilitate public discussion. There were views for or against each of the supplementary financing options –

- (a) **Social health insurance (mandatory contribution by the workforce):** social health insurance was relatively less favoured in opinion surveys similar to tax increase. Some respondents recognized the value of social health insurance in providing the community with equitable access to healthcare and as a form of wealth re-distribution. However, many respondents were against social health insurance as they considered it an alternative tax which would erode Hong Kong's competitiveness and pose an increasing burden on future generations in view of Hong Kong's demographic change.
- (b) **Out-of-pocket payments (increase user fees):** opinion surveys showed that fee increase received a fair amount of support especially among the middle to high income groups. Some respondents considered fee increase a simple, direct and efficient means to provide additional funding source for healthcare. Fee increases could encourage more judicious use of public healthcare services and instil a sense of self-responsibility for people's own health. Those who objected considered fee increase would pose greater direct burden to healthcare users and without risk-pooling the burden would fall mostly on those who were sick and needed help the most especially the under-privileged groups. They considered that the public healthcare safety net should be strengthened to protect the vulnerable groups.
- (c) **Medical savings accounts (mandatory savings for future use):** some respondents supported medical savings accounts on the ground that they favoured the concept of saving for one's own future needs. This option received relatively high support among others in opinion surveys. However, some respondents opposed medical savings accounts for its mandatory nature and many expressed concerns over the possibly high administrative cost. Some were concerned about the uncertainty of whether savings would be sufficient to meet one's future healthcare needs, while some recognized the deficiency of mere savings without risk-pooling in catering for future healthcare needs.
- (d) **Voluntary private health insurance:** the first stage public consultation reflected a relatively stronger preference among the public for voluntary private health insurance. Opinion surveys revealed that private health insurance was favoured as a voluntary supplementary financing option over other mandatory options. Respondents favoured voluntary private health insurance as it offered choices of insurance products and healthcare protection according to individual's needs. However, many respondents expressed dissatisfaction with the shortcomings of voluntary private health insurance in the current market such as

widely-practised exclusion of pre-existing medical conditions, inability of high-risk groups to get insurance, and lack of protection for consumers in health insurance claims. Most called for tighter regulation by the Government for better insurance products and consumer protection. Meanwhile, many pointed to the risk of voluntary private health insurance in leading to higher healthcare costs and utilization due to moral hazards and lack of proper control. Some considered it difficult to control healthcare costs under insurance-based financing and that over-reliance on voluntary private health insurance could lead to sharp increase in healthcare costs in the case of the United States.

- (e) **Mandatory private health insurance:** this option received moderate support in opinion surveys, but mixed views from respondents. Some respondents preferred it to voluntary insurance as it would accept all applicants regardless of their pre-existing medical conditions and provide continuity, portability and lifelong protection. Some favoured it as it would provide a guaranteed risk pool, thereby minimizing exclusion of coverage, enabling the same premium be charged for all participants, and allowing those with higher health risks to afford insurance coverage. Whilst recognizing its benefits, some respondents objected the scheme as it was mandatory in nature. Some suggested that health insurance, be it mandatory or voluntary, might encourage overuse of healthcare or abuse due to moral hazards if there was no proper control or safeguard. Some were concerned about the capability of the Government to effectively regulate the private health insurance and healthcare markets under a mandatory system. Business and employer groups were generally against implementing employment-based mandatory health insurance.
- (f) **Personal healthcare reserve (mandatory savings and insurance):** apart from the grounds for supporting or opposing either mandatory savings or mandatory insurance, some favoured the proposal as it could allow the advantages of the two types of schemes to complement each other and accommodate both current and future healthcare financing needs. Like other mandatory schemes, many respondents opposed it for its mandatory nature. Some were against this option recognizing that it would require very high level of contribution. Some were concerned about duplication with existing voluntary private health insurance already subscribed. Some expressed concerns over the likely high administrative costs for such a complex scheme bundling insurance and savings.

1.14 Notwithstanding the divergent views expressed on the six supplementary financing options, the views expressed by the public over supplementary healthcare financing reflected certain broad principles –

- (a) **Individual needs:** noting that public healthcare funded through government taxation could ensure equitable healthcare and achieve wealth re-distribution, most of the public considered that any supplementary healthcare financing should cater more to individual needs rather than further pooling resources to

subsidize the population as a whole.

- (b) **Voluntary participation:** while recognizing the need to address the long-term sustainability of healthcare financing and acknowledging the advantages of mandatory financing options, the majority of the public expressed reservations against mandatory financing options and preferred having their own voluntary choices of healthcare protection at this stage.
- (c) **Continuous protection:** many of the public recognized savings as an important factor for ensuring continuous healthcare protection that could sustain into their older age, while others recognized the need for some form of risk-pooling as part of any healthcare protection that would continue into the future in order to meet unanticipated and costly healthcare needs.
- (d) **Wider choices:** recognizing that the need for equitable and universal access to standard healthcare would be met by the tax-funded public healthcare system, the majority of the public was in favour of schemes that would provide them with better choices for seeking through voluntary means value-for-money private healthcare services.

### **Healthcare Reform Continues ...**

1.15 Building on the first stage public consultation and the service reforms being implemented (Chapter 2), the Government has examined the next step in healthcare reform needed to further our goal of enhancing the sustainable development of our healthcare system (Chapter 3). To this end, we have formulated in consultation with relevant stakeholders the proposals for voluntary Health Protection Scheme (HPS) (Chapter 4) and have identified a number of related issues on healthcare and supporting infrastructure that need to be addressed for the second stage public consultation (Chapter 5).

## Chapter 2 HEALTHCARE REFORM – PROGRESS TO DATE

2.1 The Government's commitment to healthcare is set to continue to increase as we reform the healthcare system based on the community's views. We will continue to uphold the public healthcare system as the safety net for the whole population. The Government's annual recurrent expenditure on health has increased from \$30.5 billion in 2007-08 to \$36.9 billion in 2010-11. We aim to increase the health budget to 17% of the Government's recurrent expenditure in 2012.

2.2 Following the first stage public consultation, the Government has been taking forward various healthcare service reform proposals which have broad support in the community, including enhancing primary care, promoting public-private partnership, development of electronic health record (eHR) sharing, and strengthening public healthcare safety net. The progress in taking forward these service reforms is summarized in the following sections.

### (1) Enhancing Primary Care

2.3 Effective primary care can often improve the health of individuals in the community, and reduce their need for more expensive medical services especially specialists and hospital services. However, holistic primary care, especially preventive care and wellness promotion, is not sufficiently emphasized at present. The Government has therefore proposed to enhance primary care by focusing on the provision of continuous, comprehensive and holistic primary healthcare services, with special emphasis on prevention.

#### *Primary Care Development*

2.4 Following the Chief Executive's announcement in the 2008-09 Policy Address that the Government would allocate resources to implement the proposals to enhance primary care, the Secretary for Food and Health reconvened the Working Group on Primary Care (WGPC) under the Health and Medical Development Advisory Committee (HMDAC) in October 2008 to provide strategic recommendations on enhancing and developing primary care in Hong Kong. The WGPC comprises representatives from medical professionals from the public and private sectors, academia, patient groups and other stakeholders. Three Task Forces were set up under the WGPC to study specific proposals set out in the consultation document, taking into account the views collected during the first stage public consultation on healthcare reform.

2.5 After extensive deliberations at both the Task Forces and other informal forums, the WGPC has formulated a set of initial recommendations in 2009 for the development of better primary care services in Hong Kong through the following three main areas of work –

- (a) developing primary care conceptual models and clinical protocols, especially for

the prevention and management of common chronic diseases, starting from hypertension (HT) and diabetes mellitus (DM), the two most common chronic diseases in Hong Kong, with a view to guiding the provision of enhanced primary care;

- (b) setting up a Primary Care Directory with a view to promoting enhanced primary care through the family doctor concept and adopting a multi-disciplinary approach, starting from the sub-directories for doctors and dentists; and
- (c) devising feasible service models to deliver enhanced primary care services in the community through pilot projects as appropriate, including the setting up of community health centres (CHCs) or networks.

#### (a) Conceptual Models and Clinical Protocols

2.6 After more than a year of extensive formal and informal discussion sessions among the WGPC and Task Force members and experts in the field, the primary care conceptual models and clinical protocols for HT and DM are being finalised for use as common reference by healthcare professionals. We aim to launch the first edition of the models and protocols within 2010-11. The strategies for promoting the clinical protocols to the public and healthcare professionals are also being developed. Next the WGPC and the relevant Task Force will start developing age group-specific models and protocols, e.g. children and elderly.

#### (b) Primary Care Directory

2.7 On the Primary Care Directory, members of the WGPC have agreed on the information to be provided in the Directory, as well as the criteria for entering and remaining in the Doctor and Dentist sub-directories at the initial stage of development of the Directory. We aim to launch the first edition of the Doctor and Dentist sub-directories within 2010-11. The Government will continue to work with the healthcare professionals, academia and relevant stakeholders to explore the enhancement in professional requirements for entering and remaining in the Directory in the future, and other issues such as training and manpower development of primary care providers. The sub-directories of Chinese medicine practitioners, nurses and other allied health professionals will be developed at a later stage.

#### (c) Community Health Centres and Networks

2.8 With regard to the primary care service delivery models, the Government is exploring various CHC pilot projects based on different models in consultation with healthcare professionals and providers from the public and private sectors, non-governmental organisations (NGOs) and the universities. Located in the community, CHCs aim to offer the public with one-stop, better co-ordinated, and more comprehensive primary care services.

## *Pilot Initiatives to Enhance Primary Care*

2.9 Since end 2008, the Government has taken forward, through the Department of Health (DH) and the Hospital Authority (HA), various initiatives in providing primary care and public health services, engaging different primary care professionals from the private sector and enhancing the involvement and collaboration of the private sector with the public sector. These include –

- Elderly Health Care Voucher Pilot Scheme
- Elderly Vaccination Subsidy Scheme
- Childhood Influenza Vaccination Subsidy Scheme

2.10 Besides, the Government has implemented a series of pilot projects through HA to strengthen chronic disease management in the primary care setting, some of which involve partnership between the public sector and the private sector and NGOs. These projects include –

- Multi-disciplinary Risk Factor Assessment and Management Programme (RAMP)
- Patient Empowerment Programme (PEP)
- Nurse and Allied Health Clinics (NAHC)
- Public-Private Chronic Disease Management Shared Care Programme
- Tin Shui Wai Primary Care Partnership Project

### (a) Multi-disciplinary Risk Factor Assessment and Management Programme (RAMP)

2.11 Under this programme, multi-disciplinary teams of healthcare professionals including nurses, dieticians and pharmacists are set up by HA in designated general out-patient clinics (GOPCs) to provide comprehensive health risk assessment for HT and DM patients, so that they can receive appropriate preventive and follow-up care.

2.12 The programme has been implemented in the Hong Kong East and New Territories East Clusters of HA since August 2009. It will be implemented in 23 GOPCs in six clusters (including Hong Kong East, Hong Kong West, Kowloon East, Kowloon Central, Kowloon West and New Territories East Clusters) in 2010-11, and will be extended to all seven clusters across the territory by 2011-12. A total of 144,500 patients are expected to benefit from the programme by 2012-13.

### (b) Patient Empowerment Programme (PEP)

2.13 HA has implemented this programme in collaboration with NGOs starting from March 2010 to improve chronic disease patients' knowledge on the diseases and enhance their self-management skill. A multi-disciplinary team comprising allied health professionals from HA develops appropriate teaching materials and aids for common chronic diseases (for example, HT, DM, chronic obstructive pulmonary disease, heart



disease, etc.), and provides training for frontline staff of the participating NGOs to facilitate the organisation of patient empowerment sessions.

2.14 The programme will be extended to all seven HA clusters by 2011-12, serving a total of 32,000 patients over 3 years.

(c) Nurse and Allied Health Clinics (NAHC)

2.15 NAHCs comprising HA nurses and allied health staff have been established by HA in selected GOPCs in its seven clusters starting from August 2009 to provide more focused care for high-risk chronic disease patients, including those who require specific care services for health problems or complications. These services include fall prevention, handling of chronic respiratory problems, wound care, continence care, drug compliance and supporting mental wellness for individual patients. The total number of attendances is expected to be 217,400 by 2011-12.

(d) Public-private Chronic Disease Management Shared Care Programme

2.16 The Shared Care Programme is a pilot project which offers additional choices to chronic disease patients currently under the care of the public healthcare system to have their conditions followed up by private doctors. Clinically suitable patients are identified by a multi-disciplinary risk assessment and management programme at special outpatient clinics and then invited to participate in the Shared Care Programme. The Government provides partial subsidy for patients to receive comprehensive management in the community, and supports the establishment of long-term partnership between patients and the doctors of their choice. The programme primarily targets DM and HT patients who are currently taken care of by the public healthcare system.

2.17 The programme is currently being piloted by HA in the New Territories East Cluster. Independent assessment bodies are engaged in the continuous evaluation of programme process and effectiveness. The Government will consider improving and extending the programme to other districts having regard to the initial experience. Resources have been reserved to benefit 22,000 patients by 2012-13 under the programme.

2.18 The above pilot projects aim at trying out different service models for enhancing primary care both within the public healthcare system and through partnership with the private sector and NGOs. The Government will continue to plan various pilot projects to foster the provision of CHC-type services or formation of CHC networks, and explore different models of service provision in consultation with the relevant stakeholders.

*Strategy for Primary Care Development*

2.19 The overall strategy for developing primary care in Hong Kong is an on-going and evolving strategy which emphasizes a step-by-step and consensus building approach to reforming the primary care system, and a virtuous cycle of pilot-evaluation-adjustment for the continuous development and implementation of specific initiatives and pilot projects. Based on the recommendations of the WGPC, we plan to publish a strategy

document by the end of 2010 to set out the overall strategy for primary care development in Hong Kong.

2.20 As part of the strategy, the Government will also launch a two-year advocacy campaign at the same time in partnership with healthcare professionals to raise public awareness of the importance of primary care in disease prevention and management, and encourage the public to adopt good primary care practices and a proactive approach in improving health.

2.21 A Primary Care Office (PCO) has been set up in DH in September 2010 to support and co-ordinate the long-term development of primary care in Hong Kong, the implementation of primary care development strategies and actions, and the co-ordination of actions among DH, HA, private healthcare sector, NGOs and other healthcare providers.

### *Way Ahead*

2.22 With the continuous evolution and implementation of the strategy for primary care development, we expect to see the following next steps in the course of enhancing primary care in Hong Kong –

- (a) We plan to launch the first editions of the primary care conceptual models and clinical protocols for DM and HT within 2010-11. Age group-specific primary care conceptual models and clinical protocols for children and the elderly will also be developed.
- (b) We plan to launch the first edition of the Doctor and Dentist sub-directories of the Primary Care Directory within 2010-11. The sub-directories of Chinese medicine practitioners, nurses and other allied health professionals will be developed at a later stage.
- (c) We will continue to take forward, through DH and HA, a series of pilot projects to enhance primary care, including various healthcare voucher and vaccination subsidisation schemes, the Shared Care Programme and other chronic disease management pilot projects that aim at trying out different models for enhancing primary care both within the public healthcare system and through public-private partnership.
- (d) We will continue to explore various CHC pilot projects based on different CHC-type models in consultation with healthcare professionals and providers from the public sector, private sector, NGOs, and the universities, to tie in with the different needs of the local communities where these pilot projects will be situated.

2.23 In terms of resources, the Government has been providing and will continue to provide financial support to the long-term task of developing primary care, where

necessary, having regard to the overall progress of healthcare reform including supplementary healthcare financing arrangements and the resources available for healthcare. An additional funding of more than \$4.1 billion has been allocated and earmarked for primary care and Public-Private Partnership (PPP) in Healthcare since 2008-09.

## **(2) Promoting Public-Private Partnership (PPP) in Healthcare**

2.24 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 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.

### ***PPP Pilot Projects and Initiatives***

2.25 To promote PPP in healthcare, the Government has implemented a number of PPP projects such as the Tin Shui Wai Primary Care Partnership Project under which primary care services are purchased from the private sector in Tin Shui Wai for specific patient groups under the care of public GOPCs, the Public-Private Chronic Disease Management Shared Care Programme, the purchasing of haemodialysis service from private centres for end stage renal disease patients currently under the care of public hospitals, and the Cataract Surgeries Programme where patients waiting for cataract surgeries in public hospitals receive partial subsidy to receive treatment in the private sector. Since the introduction of the Cataract Surgeries Programme in 2008, more than 10,000 patients have joined the programme and over 7,500 of them have already undertaken surgeries as at July 2010. HA's target is to provide additional 3,000 surgeries under the programme in 2010-11.

2.26 The Government has also implemented the Elderly Health Care Voucher Pilot Scheme, which is a three-year pilot scheme, starting from 1 January 2009. Under the Scheme, all citizens aged 70 or above are given annually five healthcare vouchers worth \$50 each through an electronic system to partially subsidise their use of primary care services in the private sector. The Scheme aims at implementing the "money-follows-patient" concept on a trial basis through the provision of partial subsidy to the elderly. It enables the elderly to choose private primary care services that best suit their needs in the community, thereby piloting a new model for subsidised primary care services in the future. It also lays the foundation for the future development of subsidisation schemes by vouchers for enhancing primary care services for specific age groups or disease groups.

2.27 Moreover, the Government introduced in 2008-09 a number of vaccination schemes through PPP. These included a childhood influenza vaccination subsidy scheme and a vaccination subsidy scheme for the elderly to increase the number of vaccination service providers and to offer more choices of providers to the public. The aim is to

encourage target groups to receive vaccination in the private sector to minimize the risk of infection of infectious diseases.

2.28 Building on the experience gained and the infrastructure established for taking forward the above PPP initiatives, the Government will continue to examine possible PPP initiatives with a view to making the best use of healthcare resources in the public and private sectors to deliver better healthcare services.

**Table 2.1** Summary of the pilot projects involving public-private-partnership in healthcare

<p><b>Cataract Surgeries Programme</b></p>	<p>The Cataract Surgeries Programme has been launched to shorten patients' waiting time on HA's queue for cataract surgeries.</p> <p>Eligible patients on HA's waiting queue for cataract surgeries are invited to participate in this Scheme.</p> <p>HA provides a one-off \$5,000 subsidy for participating patients to undergo cataract surgeries in the private sector, and any balance of the surgery fee will be borne by the patients concerned. Private surgeons may charge no more than \$13,000 for each surgery; the patients are thus required to co-pay at most \$8,000 for the cataract surgery performed. For eligible patients who are recipients of CSSA or from low-income families eligible for full medical waiver, they may have cataract surgeries performed in HA hospitals through additional operating sessions.</p>
<p><b>Tin Shui Wai Primary Care Partnership Project</b></p>	<p>The Tin Shui Wai (TSW) Primary Care Partnership Projects has been launched to test the use of PPP model and supplement the provision of public general out-patient services in the area.</p> <p>Under this Programme, eligible patients in TSW who have been under the care of HA's existing TSW GOPC are invited to participate. Those who choose to participate in this Scheme may enrol with a private medical practitioner in TSW who participates in this Scheme. They may seek up to 10 medical consultations with the private practitioners, and are required to pay a standard fee of \$45 per consultation, the same fee as attending HA's GOPC.</p>
<p><b>Haemodialysis Shared Care Programme</b></p>	<p>The Haemodialysis Shared-Care Programme has been launched to utilize spare capacity in the private sector in providing haemodialysis services.</p> <p>Under the Programme, eligible patients with end stage renal disease currently under the care of HA will be invited to participate. Qualified community haemodialysis providers in the private sector will provide haemodialysis treatment to patients who choose to participate. Patients participating in the programme will pay the community haemodialysis centre/private hospital a standard fee (\$80), the same as that for receiving haemodialysis treatment in HA hospitals.</p>
<p><b>PPP Project on Enhancement of Radiological Investigation Services</b></p>	<p>The purpose of the Project is to subsidise patients under the care of HA to receive radiological investigation service in the private sector as an additional choice for the patients, having regard to the spare capacity in the private sector to provide such service.</p> <p>Eligible patients will be invited to receive radiological imaging service through specified contracted private providers.</p>

<b>Elderly Health Care Voucher Pilot Scheme</b>	<p>During the three-year period of the Pilot Scheme, all elderly with HK Identity Card at or above the age of 70 are provided each year with five vouchers of \$50 each as partial subsidies for their receiving primary care services from private primary care providers enrolled under the Scheme (covering 9 healthcare professions including doctors, dentists, Chinese medicine practitioners, etc.).</p> <p>Eligible elderly may choose freely to use one or more of the vouchers to pay for primary care services they received from enrolled private primary care providers, but are required to pay any balance of the fees that may be charged by the providers on top of the voucher amount.</p>
<b>Elderly Vaccination Subsidization Scheme, Childhood Influenza Vaccination Subsidization Scheme and Human Swine Influenza Vaccination Subsidization Scheme</b>	<p>A number of vaccinations for certain high risk groups are recommended by Scientific Committees comprising relevant experts to minimize the risk of infection and hospitalization. In this regard, a number of vaccination subsidization schemes have been launched to subsidize eligible individuals receiving vaccination from private medical practitioners who are the predominant primary care providers for the population.</p> <p>Eligible individuals are provided a fixed amount of subsidies when they receive vaccination from a private medical practitioner enrolled under the schemes. The practitioner may charge extra fees for the vaccination which have to be paid by the individuals, subject to the extra fees being indicated upfront to the Government and on a poster in the clinic. In the case of Human Swine Influenza Vaccination, extra subsidies are provided for the injection costs and practitioners are encouraged not to charge extra. However, no restriction is set on charging co-payments.</p>
<b>Shared Care Programme</b>	<p>Currently, chronic disease patients who receive treatment at HA's Specialist Out-patients Clinics (SOPCs) and are clinically stable can be referred to neighbouring public GOPCs to follow up on their conditions. The Shared Care Programme provides additional choices of private services for these patients and allows patients to choose neighbouring private doctors of their choice to follow up on their conditions and receive partial subsidy for receiving comprehensive management. Doctors may charge the patient an extra fee that will have to be made transparent upfront to both the Government and the participating patients. The programme aims to establish long-term patient-doctor relationships in order to achieve the objective of continuous and holistic care. The public healthcare system will continue to provide support to participating patients.</p>

### *Centres of Excellence and Private Hospital Development*

2.29 The Government is also preparing for the establishment of multi-partite medical centres of excellence in the specialty areas of paediatrics and neuroscience in Hong Kong. They are part of the Government's pilot measures to promote excellence in medical specialties and PPP, as stated in the Chief Executive's 2008-09 Policy Address. The two centres will bring together professionals in the public, private and academic sectors from both within and outside Hong Kong to provide multi-disciplinary care for patients suffering from these complex diseases, and to conduct research and training in the two specialty areas of paediatrics and neuroscience.

2.30 In addition, as part of our healthcare reform initiatives to improve the long-term sustainability of our healthcare system, and in line with the Government's policy to promote and facilitate development of private hospital and medical services, the Government is promoting and facilitating private hospital development in order to address the imbalance between the public and private sectors in hospital services and to increase the overall capacity of the healthcare system in Hong Kong to cope with the

increasing service demand.

2.31 To this end, the Government has reserved four sites at Wong Chuk Hang, Tseung Kwan O, Tai Po and Lantau for private hospital development. For formulating suitable land disposal arrangement, the Government has invited local and overseas parties to express their interest in developing private hospitals at the reserved sites. We have received a total of 30 expression of interest submissions upon the deadline on 31 March 2010. We are considering the suggestions and views in the submissions received with a view to formulating the land disposal arrangements for the four reserved hospital sites, including the means and timing for land disposal, the detailed service and special requirements, and the land premium.

2.32 To ensure that the services provided by the new hospitals would be of good quality, cater for the needs of the general public, and help enhance the professional standards and ethics for furthering the development of medical services, the Government will formulate a set of special requirements for development of the sites, which cover the aspects of scope of service, price transparency, service standard, etc.

2.33 In respect of price transparency, the Government is considering requiring the private hospitals to be developed at the four sites to provide a certain volume of services through packaged charging, which should cover doctors' fees, maintenance fees, diagnostic procedures, surgical operations, etc. We believe such requirement could help enhance price transparency and hence provide incentives for the public to use private hospital services.

### **(3) Developing Electronic Health Record Sharing**

2.34 The territory-wide patient-oriented eHR sharing system connecting the public and private healthcare providers is an essential infrastructure for implementing the healthcare reform. The objective of an eHR sharing system is to enhance the continuity of care as well as better integration of different healthcare services for the benefits of individual patients. Participation in eHR sharing is voluntary and based on patients' express and informed consent. The Government has taken a leading role in eHR development given the multitude of healthcare providers involved and the importance of personal health data.

2.35 A dedicated eHR Office was set up under the Food and Health Bureau in July 2009 to steer and oversee the ten-year eHR Programme (from 2009-10 to 2018-19) with a view to ensuring coherent development in both the public and private sectors. The Government will leverage the successful experience and invaluable expertise of HA in developing its Clinical Management System (CMS) since 1995. The HA CMS is the largest integrated electronic medical/patient record (eMR/ePR) system in Hong Kong and has more than eight million medical records. The Government will make available HA's systems and know-how to facilitate the private sector in developing their eMR/ePR systems with sharing capabilities through different partnership initiatives such as the eHR

Engagement Initiative.

2.36 The eHR sharing system will bring about a host of benefits to the community through a healthier population and a reduction on secondary and tertiary care costs as a result of more effective and early treatment. Also, the system would enhance the availability and transparency of information through sharing of patient records between healthcare providers in both the public and private sectors, reduce the number of consultations, improve the accuracy of diagnosis and patient management through clinical decision support, minimise duplicate investigations and errors associated with paper records, enable disease surveillance, public health research and more effective policy formulation.

### *First Stage eHR Programme*

2.37 The objectives of the First Stage eHR Programme (from 2009-10 to 2013-14) are –

- (a) to set up the eHR sharing platform by 2013-14 for connection with all public and private hospitals;
- (b) to have eMR/ePR systems and other health information systems available in the market for private doctors, clinics and other health service providers to connect to the eHR sharing platform; and
- (c) to formulate a legal framework for the eHR sharing system to protect data privacy and system security prior to commissioning of the system.

2.38 The 10-year eHR programme is estimated to cost a total non-recurrent expenditure of \$1,124 million and an annual recurrent expenditure of around \$200 million. In July 2009, the Finance Committee of the Legislative Council approved a new capital commitment of \$702 million for implementing the First Stage eHR Programme.

2.39 With these funding, the eHR Office, under the guidance of the Steering Committee on eHR Sharing comprising members from both the public and private sectors, will spearhead and co-ordinate the ten-year programme which covers –

- (a) the eHR Core Infrastructure Architecture for the territory-wide eHR sharing platform;
- (b) the CMS Adaptation Modules and On-ramp Applications to private sector for developing their individual eMR/ePR systems;
- (c) standardisation of technical standards to facilitate accurate sharing of clinical data;
- (d) different partnership initiatives including eHR Engagement Initiative to invite partnership proposals that would contribute towards the development of eHR sharing system;

- (e) various engagement and briefing sessions with stakeholders and the public to raise public interests in and awareness of eHR; and
- (f) Privacy Impact Assessment, Privacy Compliance Audit, Security Risk Assessment and Security Audit and drafting of the necessary legislation to safeguard data privacy and ensure the integrity of the eHR sharing system.

### *Pilot Projects on eHR Sharing*

2.40 Prior to the implementation of the eHR sharing system in 2013-14, pilot partnership projects have been initiated to facilitate better collaboration on sharing of electronic medical records between the public and private healthcare sectors subject to patients' consent. The Public-Private-Interface Electronic Patient Record Sharing Pilot Project, which was first launched in 2006, will be expanded to NGOs to allow more patients and private healthcare providers to experience the sharing of electronic patient records. The Radiological Image Sharing Pilot Project, which was launched in 2009, will be extended to interested private healthcare providers for sending radiological images of enrolled patients to HA via electronic means.

### **(4) Strengthen Public Healthcare Safety Net**

2.41 The current public healthcare system serves as an essential safety net for the population, especially those who lack the means to pay for their own healthcare. The Government will continue to uphold the public healthcare system as the safety net for the whole population and to provide highly-subsidized public healthcare services targeting those in need. To strengthen this safety net to cope with the increasing service demand arising from the growing and ageing population, the Government has been increasing the funding for public healthcare service in recent years.

### *Improving Public Healthcare Services*

2.42 The Government has been increasing the financial provision for HA since 2007-08. The subvention of HA in 2010-11 is around \$32.7 billion, up from \$28.0 billion in 2007-08, representing an increase of 17% over that for 2007-08. Under the three-year funding arrangement for the HA starting from 2009-10, HA's recurrent subvention will be further increased in 2011-12. The additional provision allocated to HA will be used for implementation of a host of improvement measures, which include the following major items with respect to reducing waiting time of public hospital services and improving the coverage of standard public services –

- (a) expansion of service capacity in the Hong Kong East, Kowloon East and New Territories West Clusters through opening of additional beds and operating theatre suites;
- (b) enhancement of services for treatment of life-threatening diseases, including haemodialysis service, palliative care for patients with end stage renal diseases,



clinical oncology service, integrated cancer care and acute cardiac care;

- (c) introduction of a case management programme on cancer treatment;
- (d) enhancement of mental health services through new initiatives including introduction of the case management programme for persons with severe mental illness and enhanced assessment and treatment for persons with common mental disorders through the setting up of Common Mental Disorder Clinics and introduction of the Integrated Mental Health Programme;
- (e) expansion of the coverage of HA's Drug Formulary by including eight new drugs as standard drugs and expanding the clinical application of twelve drug classes;
- (f) strengthening the supply of nursing manpower through provision of nurse training places;
- (g) increasing the number of cataract surgeries; and
- (h) establishment of a specialist centre for joint replacement.

2.43 The Government also plans to increase the number of beds in public hospitals. The planned number of beds in public hospitals managed by HA is 27,041 by March 2011. A number of redevelopment/expansion projects of existing public hospitals and new public hospital projects are underway, including the expansion of the Tseung Kwan O Hospital, the North Lantau Hospital Phase 1 and the Tin Shui Wai Hospital. It is estimated that about 600 additional beds in public hospitals will be provided over the next few years.

### *Strengthening Safety Net Mechanisms*

2.44 Meanwhile, the current fee waiver mechanism and other financial assistance schemes for certain self-financed drug items and privately-purchased medical items through the Samaritan Fund will continue to be available to recipients of Comprehensive Social Security Assistance and low-income families. The Government will continue to monitor the use of the Fund and will inject additional money into the Fund where necessary (the Government has injected \$1 billion into the Fund in 2008-09 to cope with the projected requirements of needy patients).

2.45 At the same time, we are exploring with HA on other possible ways to further strengthen the safety net, especially for patients requiring costly treatment. This includes exploring the idea of providing a second safety net in the form of additional financial assistance for those patients requiring costly treatment when their medical expenses for public healthcare services exceed a certain proportion of their household income. The idea is to provide them with an additional protection against financial ruin when struck by catastrophic illnesses. We will also explore rationalization of the existing subsidization structure of public healthcare services with a view to ensuring that subsidies are accorded to those most in need.

### Next Step in Healthcare Reform

3.1 Based on the views received during the first stage public consultation, the Government is committed to taking forward healthcare reform through a step-by-step approach, with a view to building towards a consensus on the way forward within the community and arriving at measures to help enhance the long-term sustainable development of our healthcare system, so that it can continue to provide quality healthcare to the population as a whole. Following the first stage public consultation, the Government has made use of the increasing healthcare expenditure to improve public healthcare services and take forward service reform proposals.

3.2 Building on the first stage public consultation and the service reforms being implemented, we need to consider the next step in healthcare reform to further our goal to help enhance the long-term sustainability of our healthcare system. To complement the service reforms, we consider that there is a need to further carry out reform of the market structure in order to –

- (a) improve public-private market balance;**
- (b) provide more choices for the public;**
- (c) increase healthcare service capacity; and**
- (d) improve quality of care in general.**

3.3 In particular, in reforming the market structure while maintaining the public system as the safety net sector, we consider it important to reform the current private healthcare sector, which forms an important part of the healthcare system, with a view to enhancing the long-term sustainability of the healthcare system including its financing by finding ways to –

- (a) enhance efficiency of healthcare services;**
- (b) create and promote healthy competition;**
- (c) contain cost increase and medical inflation; and**
- (d) encourage savings among the population to meet future healthcare expenses.**

### Voluntary Supplementary Financing Scheme

3.4 The first stage public consultation reveals that there is a general preference of the public for reform proposals that: (i) cater for individual needs; (ii) allow voluntary participation; (iii) enable continuous healthcare protection; and (iv) protect consumer interests. Having regard to the views received during the first stage public consultation,

the Chief Executive announced in his 2009-10 Policy Address that the Government would be working on a supplementary healthcare financing scheme based on the following principles –

- (a) **Supplementary financing:** it should be supplementary to public funding which remains the main funding source for public healthcare;
- (b) **Voluntary participation:** it should be based on voluntary participation by those who are able and willing to afford;
- (c) **Wider choice:** it should provide consumers with more choices of value-for-money healthcare services;
- (d) **Continuous protection:** it should be designed to provide continuous protection for individuals into their older age; and
- (e) **Consumer interests:** it should be standardized and regulated by the Government to protect consumer interests.

3.5 We approached the task of designing a supplementary financing scheme that meets the above-mentioned principles by first examining the current markets of private health insurance and private healthcare services in Hong Kong. We have also examined their respective roles in supplementing and complementing the public healthcare system, especially in enabling the public healthcare system to focus on its target service areas and population groups. A succinct account of our studies is given in the following sections. For detailed analyses, please refer to *Appendix B* for Hong Kong's current private health insurance market, *Appendix C* for the current situation of the private healthcare sector, and *Appendix D* for overseas economies' experience in private health insurance.

### **Current Private Health Insurance and Private Healthcare Services**

3.6 The first stage public consultation reflected a relatively stronger preference among the public for choice of private healthcare services through voluntary private health insurance. The views expressed by the public in general showed that there was a general recognition of the respective roles played by the private healthcare sector and private health insurance. By and large the public especially those with better means were in favour of more choices of private healthcare services apart from public healthcare. Many considered that a greater role by private health insurance and private healthcare services could help address the financing issue.

3.7 This general preference of the public is echoed by the increasing popularity of private health insurance and its role as a source for financing private healthcare services –

- (a) **Private health insurance is an increasingly popular form of healthcare protection:** government statistics show that 2.4 million or 34% of the population in 2008 have private health insurance cover purchased individually or by their

employers (excluding civil service medical benefits and HA staff medical benefits), up from 2.2 million or 32% of the population in 2005 concentrating mostly in the working population (>50% for age 25-44, but only ~4% for age 65+) and higher income groups (>50% among those with monthly household income >\$30,000).

- (b) **Private health insurance is a sizeable and growing healthcare financing source:** government statistics show that private health insurance accounts for some \$9.8 billion or 13% of total health expenditure in 2006/07, an average annual growth rate of 6.9% in real terms since 1989/90. Individual private health insurance has been growing at a faster rate at 15.7% in real terms since 1989/90. Industry statistics also show that the total private health insurance premium has been growing from \$5.3 billion in 2004 to \$10.0 billion in 2009, an average annual growth rate of 15.1% in real terms.

3.8 However, as the first stage public consultation also reflected, the public expressed concerns over a number of shortcomings of current private health insurance and private healthcare services which, if left unchecked, would impede their confidence in these markets –

- (a) **Consumers are not satisfied with current private health insurance features:** many respondents in the first stage public consultation pointed to the various shortcomings of current private health insurance, e.g. excluding pre-existing medical conditions in individual plans, not accepting high-risk individuals, no guarantee on renewal, insurance plans not portable, lack of consumer protection, etc. An opinion survey commissioned by the Government in March 2010 shows that about 70% of respondents supported regulatory intervention by the Government to address these shortcomings.
- (b) **Private healthcare market and private health insurance can be more effective:** expenditure on private in-patient services accounts for 25% of all in-patient expenditure in 2006/07 (\$7.1 billion out of \$28.3 billion), half of which is supplied by private health insurance (\$3.5 billion). Yet only 18% and 10% of all in-patient services in terms of admissions and bed-days are provided by the private sector. The current markets of private health insurance and private healthcare are prone to demand-side and supply-side moral hazards which impose extra cost on all parties concerned. Possible abuses like unnecessary admissions/procedures, non-transparent and highly variable medical charges are often cited.

## **Public Healthcare System**

3.9 The feedback from the first stage public consultation regarding the public healthcare system is loud and clear: the public healthcare system, which offers equitable access to essential public healthcare services, is the cornerstone of our healthcare system. In this connection, we wish to stress that we will maintain our long-established healthcare

policy that no one should be denied adequate healthcare through lack of means. We will continue to uphold the public healthcare system as an equitable and accessible safety net for the population as a whole, not least low-income families and under-privileged groups as well as others in need. This is testified by the Government's aim to increase its recurrent expenditure on health as a share of government recurrent expenditure from 15% in 2007-08 to 17% by 2012. The increasing budget for health will further strengthen the provision of public funding as major financing source for public healthcare.

3.10 In parallel with taking forward healthcare reform initiatives, the Government will continue to improve public healthcare services, making use of the increasing government budget for health, focusing on the four target services areas and population groups as recommended by the HMDAC in its discussion paper "Building a Healthy Tomorrow" published in July 2005 –

- (a) **acute and emergency care;**
- (b) **healthcare or medical care for low-income and under-privileged groups;**
- (c) **illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and**
- (d) **training of healthcare professionals.**

3.11 The Government's commitment to healthcare is set to continue to increase as we reform the current healthcare system. The existing public healthcare system will continue to serve as a safety net to provide **equitable and accessible quality public healthcare services** to the entire population. Public funding will continue to be a major healthcare financing source for public healthcare. The Government will improve public services to meet the increasing needs of the public using the increasing government budget for health. The public healthcare system will focus on developing its four target services areas and strengthen the public healthcare safety net mechanism to provide protection to target groups in need.

3.12 Focusing on the target services areas allows public healthcare resources to be utilized in the most appropriate and efficient manner for those in need of public healthcare services. The increasing budget for health will also help sustain the public healthcare system in the years to come. As the population ages, however, the healthcare burden is likely to fall increasingly on the public system and the share of private healthcare, if left in its present condition, is expected to further shrink with escalating medical costs. This will inevitably stretch the resources and capacity of the public system, and eventually undermining its quality of care and ability to cater for the above target services areas. At the same time, this also means that resources and capacity in the private sector will not be utilized efficiently to meet the healthcare needs of the population.

## **The Case for Reforming the Private Sector**

3.13 The public healthcare system co-exists with the private healthcare sector in a dynamic healthcare system. The healthcare resources of the community are shared between the two sectors, and each shoulders its share of the healthcare needs of the population. The public system and in turn the healthcare system as a whole cannot be made sustainable over the long-run without ensuring that the private sector is sustainable (or alternatively without taking over the whole private sector). Thus apart from taking forward the service reforms and strengthening the public healthcare system, we need to enhance the sustainable development of the private healthcare sector.

3.14 In formulating proposals for the voluntary supplementary healthcare financing scheme, we have put particular emphasis on standardization and regulation of private health insurance and private healthcare services in order to address the shortcomings of the current private markets. In particular, we aim to safeguard the interests of consumers of private health insurance and private healthcare services, while strengthening the role of the private sector in meeting the healthcare needs of the population, alongside the public system.

3.15 From the perspective of the overall healthcare system, if the current private health insurance and private healthcare service markets are left as they are, it is questionable whether private funding for private health insurance and private healthcare services could sustain on a long-term basis. The following situations are likely to occur –

- (a) Moral hazards and lack of competition and price transparency in private health insurance and private healthcare services will likely result in more inefficient use of private healthcare financing and resources, further driving up medical costs, causing private medical charges and health insurance premium to spiral upwards and making private health insurance and private healthcare services less attractive and affordable over the long-run.
- (b) The coverage of the insured, the majority currently in the working population, is likely to lapse as they get older especially when they go into retirement, when they need health insurance protection the most, but, at the same time, their health insurance premium – aggravated by premium increase due to moral hazards and rising costs left unchecked – will become less affordable .
- (c) Some individuals who are willing and able to pay for affordable private health insurance and private healthcare services are likely to be deterred in making any long-term commitment to finance their own future healthcare through private health insurance without seeing a transparent and competitive market as well as certainty and predictability of future healthcare protection.
- (d) The existing deficiencies are likely to continue to skew and impair the development of both the private healthcare service and private health insurance markets, resulting eventually in the population’s healthcare burden increasingly

falling back on the public sector as the ultimate healthcare safety net for the ageing population.

3.16 By making private health insurance and private healthcare services an affordable and value-for-money choice, HPS will facilitate individuals who are willing and able to pay for private healthcare services to choose private services as an alternative to public services. This will help relieve the pressure on the public healthcare system, enable public healthcare resources to better focus on target services areas and target population groups, including the low-income families and under-privileged groups and others in need.

### Formulation of the Health Protection Scheme

4.1 The initiative to devise a voluntary supplementary financing scheme aims to take a first step in enhancing the long-term sustainability of our healthcare system. The idea is to devise a scheme based on voluntary participation, comprising both insurance and savings components, standardized and regulated by the Government, that can provide the public with affordable, value-for-money and quality-assured choice of private health insurance and private healthcare services.

4.2 To examine the feasibility of such a voluntary supplementary financing scheme, we have established the Consultative Group on Voluntary Supplementary Financing Scheme (see *Appendix F*) in November 2009 involving stakeholders of relevant sectors including the insurance sector, medical profession, employer groups, consumer representatives and patient groups to advise on the formulation of the scheme. We have also commissioned a series of consultancy studies focusing on different aspects of the scheme.

4.3 Based on the consultancy studies commissioned and advice of the Consultative Group, we have formulated the proposals for a Health Protection Scheme (HPS) as set out in this Chapter. An outline of the HPS is set out at *Appendix A*. Also included therein is an illustrative health insurance plan devised based on actuarial evaluation with benefit coverage and level designed at the level of median-priced private hospital services for medical conditions requiring hospital admissions or ambulatory procedures, with indicative premium level net of commission actuarially assessed shown for illustrative purpose.

4.4 The purpose of the illustrative plan is to illustrate the possible shape of an actuarially viable health insurance plan meeting the core requirements and specifications under the HPS. Actuarial evaluation shows that the premium required for such a health insurance plan to be offered under the HPS should be competitive vis-à-vis existing voluntary private health insurance products generally offered in the current market. However, the details of health insurance plans and premium to be charged will be subject to finalization of the HPS proposals for implementation and offer by insurers participating in the HPS.

### Scheme Objectives

4.5 The proposed *voluntary* HPS aims to enhance consumer protection, price transparency, quality assurance and market competition in the private health insurance and private healthcare markets. Specifically, the proposals for the HPS are formulated with the following objectives –

- (a) **To encourage taking-out of health insurance and savings by those among the**



**population who choose to, in order to:**

- (i) provide choices to those who are able and willing to pay for private healthcare and improve their sustained access to value-for-money and affordable private healthcare services; and**
  - (ii) in so doing, facilitate the greater use of private services as an alternative to public services.**
- (b) To improve transparency about service standards and price levels in the private health insurance and healthcare markets, in order to –**
- (i) encourage the development and offering of quality-assured, all-inclusive, condition-specific packaged services and charging for most medical conditions; and**
  - (ii) promote healthy market competition and enhance consumer protection and confidence.**

4.6 By enabling more people to use private healthcare on a sustained basis, the HPS also aims to better focus the public healthcare system on its target service areas, including services for low-income and under-privileged groups, acute and emergency care, and catastrophic and complex illnesses requiring high cost, advanced technology and multi-disciplinary professional team work which may not be readily available or may entail very high cost in the private sector.

## **Scheme Concept**

### *HPS Standard Plans and Top-up Components*

4.7 **The HPS is proposed as a standardized and regulated framework for health insurance under its aegis.** Health insurance plans to be offered under the HPS (**HPS Plans**) are required to meet the core requirements and specifications for health insurance standardized under the HPS. Specifically, insurers participating in the HPS are required to offer standardized health insurance plans in accordance with the core requirements and specifications (**Standard Plans**). Participating insurers are also required to comply with scheme rules and requirements specified under the HPS.

4.8 **The HPS is designed to be modular:** while participating insurers are all required to offer Standard Plans which would attract government incentives, they are free to design appropriate health insurance plans of their own offering top-up benefits or integrating additional components beyond the core requirements and specifications to suit consumers' needs, e.g. better services and rooms and boards, or coverage of services not included in Standard Plans such as out-patient services. However, the top-ups or additions would not be eligible for government incentives under the HPS.

4.9 Individuals may **choose to subscribe to HPS Plans** offered by participating insurers on a voluntary basis. They will **enjoy the provisions under the HPS for consumer protection and other advantages offered by HPS Plans**, which are not available to private health insurance outside the HPS in general. Employers may also choose to make use of HPS Plans through their insurers when providing medical benefits to their employees.

### *Core Requirements and Specifications*

4.10 All HPS Plans will have to meet the **core requirements and specifications under the Scheme** to ensure that they can provide basic and essential healthcare protection for the insured. The core requirements and specifications will include basic benefit coverage and limits set to ensure that the insured would be able to access affordable private healthcare for medical conditions requiring hospital admissions or ambulatory procedures. Insurers are free to offer top-up components exceeding the core requirements (e.g. better amenities, higher benefit limits, lower co-payments, etc.).

4.11 At the same time, HPS Plans and participating insurers would have to abide by rules and requirements specified under the HPS for the purpose of ensuring market competition, price transparency, quality assurance and consumer protection. These include, for instance, requirements for insurers to adopt standardized policy terms and definitions, to accept all applicants and cover all pre-existing conditions, to allow full portability between insurers, to participate in re-insurance or risk-equalization, to provide information on health insurance claims and costs, to standardize procedure coding and claims handling, and to participate in arbitration mechanism for claims.

### **Key Scheme Features**

4.12 The features of the HPS are designed with the aim to facilitate HPS subscribers to have access to affordable, quality-assured and value-for-money private healthcare services through enhancing consumer protection and confidence in both private health insurance and private healthcare markets. Many features are devised to address the perceived shortcomings of existing voluntary health insurance products such as uncertainty of coverage and policy terms, uncertainty of medical charges, exclusion of pre-existing conditions, no guarantee renewal of policies, lack of transparency on insurance premium adjustment and non-portability of insurance.

4.13 The key features of the HPS are summarized and compared with current market of voluntary private health insurance in Table 4.1. Further details of the scheme features are set out in the subsequent sub-sections. Many of the features are to be specified as core requirements and specifications of HPS Plans to be approved by the Government and offered by participating insurers under the HPS. Some of the features are to be specified as scheme rules and requirements under the HPS to be applied to participating insurers, with legislative backing as necessary and appropriate (see “*Supervisory Structure*” in Chapter 5).

**Table 4.1** Comparison of HPS Plans and products generally offered in the current market

Features	Health Insurance Plans to be offered under the Health Protection Scheme	Voluntary private health insurance currently offered in the market in general
<b>Benefit coverage</b>	<ul style="list-style-type: none"> <li>• <b>Core requirements (required):</b> medical conditions requiring hospital admissions or ambulatory procedures, and associated specialist services &amp; diagnostic imaging, chemotherapy or radiotherapy for cancer.</li> <li>• <b>Top-up components (optional):</b> higher benefit limits and/or broader service coverage (e.g. out-patient, dental, maternity, etc.).</li> </ul>	Range from providing only in-patient (i.e. hospital admission) coverage to covering in-patient, out-patient and other services.
<b>Benefit limits</b>	<ul style="list-style-type: none"> <li>• <b>Based on packaged charging for common procedures</b> according to standardized diagnosis-related groups (DRG).</li> <li>• <b>Lump-sum benefits for common procedures with packaged charging</b> to reduce charges uncertainty for patients.</li> <li>• Itemized benefit schedule available in the absence of packaged charging (e.g. complex or uncommon procedures).</li> <li>• <b>Basic benefit levels standardized</b> and adjusted to provide sufficient coverage for general-ward-class private healthcare.</li> </ul>	Offer itemized benefit schedules. Providers usually charge on an itemized basis and charges depending on actual utilization. Patients required to bear uncertain costs when the bill exceeds the benefit limits of individual items.
<b>Premium</b>	<ul style="list-style-type: none"> <li>• <b>Transparent age-banded premium</b> schedule for each individual plan.</li> <li>• <b>High-risk loading to be capped</b> below a certain proportion of premium (say 200%).</li> <li>• <b>Transparent guidelines for premium adjustment</b> based on claims and costs.</li> </ul>	Each insurer <b>free to set and adjust individual premium.</b>
<b>No-claim discount</b>	<ul style="list-style-type: none"> <li>• <b>Insurers to offer no-claim discount</b> up to a certain percentage of premium (say 30%).</li> </ul>	–
<b>Acceptance</b>	<ul style="list-style-type: none"> <li>• <b>Must accept all applicants</b> subject where necessary to underwriting and premium loading.</li> </ul>	<b>Typically apply exclusions or decline applications for high-risk individuals. No guaranteed acceptance</b> (up to individual insurers).
<b>Entry age</b>	<ul style="list-style-type: none"> <li>• <b>No limit on entry for those aged below 65.</b></li> <li>• <b>Those aged 65 or above can join the Scheme within the first year after launch</b> (but premium loading cap will not apply to them).</li> </ul>	<b>Usually limited to those below 65 or 70.</b>
<b>Pre-existing conditions</b>	<ul style="list-style-type: none"> <li>• <b>Accept pre-existing conditions</b> subject to waiting period and time-limited reimbursement limits, with full coverage thereafter.</li> </ul>	<b>Exclude all pre-existing conditions</b> in general for individuals (some group policies may accept pre-existing conditions subject to waiting period).
<b>Pooling of high-risk subscribers</b>	<ul style="list-style-type: none"> <li>• <b>High-Risk Pool (HRP) under HPS</b> funded by premium of high-risk policies and reinsurance premium from participating insurers to absorb risk of high-risk subscribers, with injection from the Government into the HRP where necessary.</li> </ul>	<b>Reinsurance</b> arranged by individual insurers in general.

Features	Health Insurance Plans to be offered under the Health Protection Scheme	Voluntary private health insurance currently offered in the market in general
Renewal	<ul style="list-style-type: none"> <li>• <b>Guaranteed renewal for life.</b></li> </ul>	<b>No guarantee for renewal</b> in general (some insurers offer guaranteed renewal up to certain age or for life).
Portability	<ul style="list-style-type: none"> <li>• <b>Fully portable</b> between insurers, on retirement or leaving employment.</li> <li>• Portability include <b>carrying-over of pre-existing condition coverage and no-claim discount.</b></li> </ul>	<b>Not portable</b> between insurers. Usually not portable when switching jobs or upon retirement (some insurers offer portable plans to retirees).
Transparency of insurance costs	<ul style="list-style-type: none"> <li>• <b>Insurers required to be transparent in insurance costs</b> including claims, administration and commission.</li> </ul>	<b>No transparency</b> on insurance costs in general.
Government regulation	<ul style="list-style-type: none"> <li>• <b>Standardized and regulated by the Government</b> to safeguard consumer interests.</li> </ul>	Insurance plans not regulated. Insurers subject to prudential regulation mainly for financial solvency.

### (a) Benefit Coverage

#### Existing health insurance

4.14 The benefit coverage of existing health insurance products varies, depending on providers and the nature of the products. The majority of current health insurance products provide in-patient (i.e. hospital admission) coverage with add-on options for additional coverage for out-patient and other medical services, as well as top-up options for better hospital amenities and higher benefit limits. Some existing health insurance products restrict coverage to in-patient admissions, thus causing unnecessary hospital admissions for procedures that could have been performed more cost-effectively in ambulatory settings. This would inevitably drive up claims and premium. The benefit limits of existing health insurance products also vary and in some cases might not provide adequate coverage for access to private healthcare services.

#### Proposals under the HPS

4.15 HPS Plans will be required to meet core requirements and specifications including benefit coverage and benefit limits for essential private healthcare services. The core requirements under the HPS are designed to enable the insured to have affordable and sufficient protection to access private healthcare service when needed. Specifically, we propose that HPS Plans should be required to provide coverage for –

- (a) **medical conditions requiring hospital admissions or ambulatory procedures** (covering procedures that can be performed in out-patient clinics or in day-hospitals so as to reduce costs and unnecessary admissions);
- (b) **specialist out-patient consultations and investigations that are associated with the required hospital admission or ambulatory procedure** (e.g. pre-admission diagnostic and post-discharge follow-up consultations);
- (c) **advanced diagnostic imaging (e.g. MRI, PET scan or CT scan) required for the**

**hospital admission or ambulatory procedure** necessitated by the diagnosed medical condition; and

(d) **chemotherapy or radiotherapy for cancer.**

4.16 We are keenly aware that the core requirements for HPS Plans have a direct bearing on premium levels to be charged by insurers. This is because the more services that are required to be covered as a must by health insurance plans under the HPS, the higher the premium. A balance has to be struck between what is necessary and what is desirable. We thus consider it reasonable to exclude services that are largely elective or relatively affordable from the core requirements, bearing in mind that the purpose of the HPS is to provide protection that enables access to essential private healthcare services when needed.

4.17 Insurers, however, are free to offer non-core items in the form of top-up components covering such services that individuals may purchase on an optional basis to suit their different needs –

- (a) **Primary care in general** (including general out-patient services and dental care): the main purpose of health insurance is to provide risk-pooling protection for uncertain and costly healthcare. We do not propose to require coverage for primary care as a must under the HPS because such services are relatively more affordable in Hong Kong, while their utilization is highly elective and more prone to moral hazards. Insurers may, as they do now, offer optional coverage for such services.
- (b) **Specialist consultation and investigation, as well as advanced diagnostic imaging in general** (i.e. services not associated with medical conditions requiring hospital admissions or ambulatory procedures): HPS Plans will be required to cover such services for medical conditions requiring hospital admissions and ambulatory procedures. We do not propose to require coverage for such services as a must under the HPS when there is no specific diagnosed medical condition requiring admission or procedure in order to reduce moral hazards. Insurers may offer top-up components to cover such services in general.
- (c) **Maternity coverage:** we do not propose to require HPS Plans to provide maternity coverage as a must because such coverage is highly elective and prone to anti-selection<sup>1</sup>, and due to its high costs would lead to high premium. Its inclusion as a must and the resulting high premium are likely to deter those who

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<sup>1</sup> Anti-selection, or adverse selection, in the context of insurance, is the situation where, because the insurer does not have perfect information to assess the precise risks of each individual, those with risks higher than that priced under an insurance are more likely to self select to take out insurance, resulting in the insured gaining an undue advantage over the insurer. In economic terms, this represents a market failure due to information asymmetries between the insurer and the insured that prevent risks from being fairly and accurately priced.

are single or who have no immediate plan to have children from buying HPS Plans. Given the need for maternity coverage is largely a matter of personal choice, we propose to leave maternity package as a top-up component for insurers to offer.

- (d) **Kidney dialysis:** at present the vast majority of patients having end-stage renal failure requiring kidney dialysis are under the care of public hospitals. As part of the healthcare reform and improvement of public healthcare, we have been enhancing renal services in public hospitals and piloting the purchase of haemodialysis services from the private sector for these patients. Given the small number of such patients and their high utilization of healthcare services, it would be more efficient and cost-effective for their healthcare needs to continue to be met by the public system, with services to be enhanced through private participation schemes such as the service purchasing scheme being piloted. We thus do not propose to require HPS Plans to cover kidney dialysis as a must.

4.18 Insurers are required to offer Standard Plans without any top-up benefits and/or components. Insurers are required to publish premium schedule for their Standard Plans, and accept applicants who choose to subscribe to Standard Plans only. Insurers may offer other HPS Plans with top-up benefits and/or components, but are required to publish premium schedule for these plans separately.

4.19 In view of the provision of Government subsidies under the HPS, if an HPS subscriber is also covered by other non-HPS products, the HPS Plans should be the last payer compared to other insurance covers (including travel, employee compensation).

### *(b) Benefit Limits*

#### Existing health insurance

4.20 Most existing health insurance products reimburse medical fees based on itemized benefit schedules specifying the benefit limits on individual chargeable items (e.g. room & board, surgeon's fees, anaesthetist's fees, operating theatre, doctor's visit, specialist fees, and other miscellaneous hospital expenses). Such benefit limits are usually applied on per episode (e.g. for one episode of hospital admission), per disability (e.g. for one medical condition requiring one or multiple episodes of hospital admission within 180 days) or per visit/consultation (some with limits on number of visits/consultations) basis. Some products also have benefit limits on overall claims per episode, per disability, per year or for the whole policy. The benefit limits vary between products and differentiate between private services for different classes of in-patient ward (e.g. general, semi-private and private ward).

#### Itemized charging and cost-uncertainty

4.21 The itemized benefit schedule and reimbursement arrangements of existing health insurance products stem from the prevailing practice in the current private healthcare market where providers usually charge on an itemized basis based on actual

utilization of the service items in individual cases, and where fees are charged separately by individual doctors and hospitals. Under such charging arrangements, patients bear the risk of uncertain costs to them and may need to pay an extra amount unknown and unforeseen in advance, when the actual charges due to utilization and other unpredictable circumstances exceed the benefit limits of individual items or the overall limits. The risk of uncertain costs is compounded by the highly variable charges by private doctors, where there is a general lack of transparent basis for comparison by patients and insurers alike.

4.22 Cost uncertainty is often cited as a main reason that people are deterred from making use of private healthcare services even when insured or from taking-out private health insurance at all, when the alternative of highly-subsidized public healthcare services charge very low fees and provide much greater certainty in terms of cost. Requiring insurers to provide higher benefit limits to further reduce cost uncertainty will inevitably result in higher premiums for all in order for the insurance products to be actuarially viable. Raising benefit limits alone may not help address the problem, given that high variability in charges for private medical services also contributes to the uncertainty.

#### DRG-based packaged charging

4.23 One possible solution to address cost uncertainty for medical services that have been tried with some success in various overseas economies is to introduce packaged charging for specific treatments or procedures categorised by “diagnosis-related groups” (i.e. DRG). The DRG is a way of classifying medical conditions requiring treatments or procedures in a hospital (both hospital admissions and ambulatory procedures) by diagnosis and complexity. It has been used as a basis for accounting for the costs for such treatments or procedures. Applying the DRG to charges for medical services means that a lump-sum packaged fee would be set for a certain medical condition requiring hospital admission or a certain ambulatory procedure, providing for varying degree of complexity of the condition or procedure.

4.24 Packaged pricing based on DRG is possible where a certain treatment or procedure is performed at a sufficiently high frequency allowing the variation in costs to be averaged out among different cases, or is relatively routine or standardized with low variation in actual utilization of medical services and in turn costs involved. It may not be feasible for all hospital admissions or ambulatory procedures, but where DRG packaged charging mechanism is in place, it will have the following impact –

- (a) provides cost transparency and certainty to users and financiers alike, whereby patients requiring specific treatment or procedures will know in advance the medical charges involved and, for those with health insurance, whether their insurance would be able to cover the charges in full or how much out-of-pocket payment would be required;
- (b) provides a transparent platform for comparison of costs and charges between different providers, for instance between different private hospitals or even

between public and private hospitals, thereby promoting competition in private healthcare services, and enabling monitoring and benchmarking of healthcare costs; and

- (c) gives impetus to providers to enhance their cost-efficiency and be vigilant in clinical standards and outcomes, by putting the onus on the providers to set prices having regard to costs and variations of such. Providers who fail to keep their costs under check or have relatively poorer clinical outcomes incurring extra costs will become less competitive.

4.25 Given the above, the introduction of DRG packaged charging will enhance certainty and transparency of charges for private healthcare services, which will bring significant benefits to consumers by way of **(a) enhancing pricing transparency and promoting healthy competition in the private healthcare service market; and (b) enabling more value-for-money services with better quality assurance and more efficient use of healthcare resources.**

4.26 Formulating DRG methodology and establishing mechanisms for their application to costing and charging require substantial efforts, expertise and investment. In Hong Kong, the Hospital Authority (HA) has already been adopting DRG methodology covering a comprehensive range of public medical services provided in public hospitals for its internal costing and resource allocation purposes. Given that the hospital services provided by HA encompass most if not all hospital admissions and ambulatory procedures that may be provided in the private healthcare sector, the DRG structure and methodology developed by HA can be adapted for application in the private health sector, utilizing the expertise already built up in HA without reinventing the wheel and duplicating the investment. However, much additional work would still be needed to establish the costing and pricing in the private sector based on DRG methodology, given that these are necessarily different from those in the public sector.

#### Proposals under the HPS

4.27 We propose to require HPS Plans as part of the core requirements and specifications to offer benefit coverage and benefit limits using DRG-based packaged charging. Specifically, where packaged charging is offered by one or more private healthcare providers for a certain treatment or procedure based on DRG, Standard Plans under the HPS will have to offer coverage based on packaged charging, i.e. insurers will set a lump-sum benefit level for the treatment/procedure of the insured for paying providers direct, subject to any co-payment that may be required under the Plans.

4.28 For treatment/procedure where packaged benefit limit is applicable, where the insured chooses a provider that offers packaged charging, the co-payment necessary will be the co-insurance required under the health insurance plan if the packaged price is within the packaged benefit limit under the plan, plus the price difference, if more experienced doctors and/or premium-priced hospitals are chosen and the packaged price is above the packaged benefit under the plan.



4.29 Where the insured chooses a provider that charges on an itemized basis for a treatment / procedure covered by packaged benefit limit under the plan, the insurer will reimburse up to the packaged benefit limit, and the co-payment necessary will be the co-insurance required under the health insurance plan plus any charges billed exceeding the packaged limit. With the transparent benefit level of the health insurance plans and the packaged pricing offered by some providers, patients will be able to make an informed choice of providers that suits their need while giving them greater cost-certainty.

4.30 The basic benefit levels for DRG-based packaged charging will be pitched at levels such that Standard Plans under the HPS will be able to provide full coverage (barring any co-payment that may be required under the plans) of the packaged charging at general-ward class offered by median-priced private hospitals for the required ambulatory procedure or hospital admission. Insurers may offer higher benefit levels to cater for consumers who want higher level of protection including access to premium-priced private hospitals and doctors or to better ward class of private services.

4.31 Standard Plans under the HPS will still need to offer itemized benefit schedules to cater for medical conditions where no private hospital offers packaged pricing, e.g. where this is considered not feasible due to the complexity of the treatments or procedures involved (and in turn high variability of costs). In such cases, Standard Plans under the HPS will provide reimbursement in the same way as with existing health insurance products. Standard Plans under the HPS will be required to offer minimum benefit limits as part of the core requirements which will be set at levels that aim to offer adequate coverage for median-priced private hospital services in most circumstances.

4.32 Insurers remain free to offer optional top-up components that offer better amenities of hospital services and higher benefit limits/levels, over and above the benefit limits/levels under the standardized core requirements, to suit different consumers' needs.

#### Importance of DRG-based packaged charging

4.33 DRG packaged charging practice is conducive to consumer protection and raises confidence in private healthcare markets, which is essential to achieving the key objectives of the HPS. From the perspective of the healthcare system as a whole, DRG-based packaged charging helps address the existing information deficiency in costing and pricing of both private health insurance and private healthcare markets. DRG-based packaged charging would thus help create and promote healthy competition in private healthcare services and facilitate comparison of pricing of private health insurance.

4.34 By providing greater transparency on medical charges and insurance claims, DRG-based package charging allows benchmarking and monitoring of healthcare costs, thus enabling a more vigilant check and control on healthcare cost increase. With better assurance on checks against future healthcare costs escalation, individuals who are willing and able to pay for additional choices of private services are more likely to be receptive to investing in financing their own healthcare through health insurance on a sustained basis, thereby helping enhance the long-term sustainability of private financing for in-patient

services through health insurance.

*(c) Co-payment*

4.35 For the purpose of cultivating shared responsibility, encouraging judicious use of healthcare and curbing moral hazards, we propose that co-payment should be included as core requirements for Standard Plans. Specifically, we propose that Standard Plans should be subject to a minimum co-insurance of 20% for claims up to \$10,000, 10% for the next \$90,000, no one after \$100,000.

4.36 Insurers may offer top-up components over and above their Standard Plans to cover co-insurance.

4.37 Meanwhile, applying higher levels of deductible can lower premiums across the board. We propose that insurers should be allowed to freely set different deductible levels to target different markets.

*(d) Premium setting, loadings and adjustment*

Existing health insurance

4.38 In the existing health insurance market, insurers are free to set and adjust premiums. Focus group studies indicated that the lack of assurance and control over future premium escalation is a major concern of people when subscribing to private health insurance. Increasing premium due to rising medical costs and claims combined with higher premium at older ages is one of the main reasons for people to lapse on their individual health insurance coverage. Some also pointed out the lack of guidelines or benchmarks governing the adjustment of premium. There have been calls for regulation over premium setting and adjustment, and transparency in insurance costs for health insurance.

4.39 Some insurers currently apply premium loadings to individual health insurance policies in accordance with their own underwriting criteria. In these cases, individuals who are considered higher risk by insurers will be charged premium loadings over and above the “normal” premium level. In some other cases, insurers may even refuse to accept higher-risk individuals and underwrite their risk. There have been concerns about access by higher-risk individuals to health insurance products, and transparency of underwriting criteria and application of premium loadings, especially when insurers may apply sky-high loadings to price out higher-risk individuals from getting health insurance protection.

Proposals under the HPS

4.40 To address these existing shortcomings, we propose to require insurers participating in the HPS to –

- (a) set and publish transparent premium schedules for all HPS Plans, which should

be age-banded in general with refinement as appropriate, and separate premium schedules for Standard Plans and other HPS Plans should be published for transparency;

- (b) accept all subscribers into any HPS Plans, subject to age limit in general and premium loading that may be applied to individual policies by underwriting based on transparent guidelines and criteria;
- (c) make known the reasons for assessing any premium loading to the subscriber concerned, who should be allowed to provide supporting evidence to request loading reduction;
- (d) limit the premium loading to a maximum of 200% of the published premium for Standard Plans, i.e. maximum premium to be charged is 3x published premium, subject to the HRP reinsurance mechanism;
- (e) provide transparent information on insurance costs including claims, administrative expenses and commissions, which will be a reference for formulating premium adjustment guidelines for HPS Standard Plans; and
- (f) adjust premium schedules, for HPS Standard Plans, having regard to the premium adjustment guidelines based on claims experience and insurance costs, and apply adjustment to all the insured without re-underwriting unless requested.

4.41 The above proposals aim to eliminate the existing practice of excluding or pricing out higher-risk individuals, and allowing them to purchase health insurance plans subject to a reasonable premium loading. The current proposal of maximum high-risk premium loading of 200% is proposed to cap the premium that higher-risk individuals need to pay for their health insurance coverage. At the same time, we have to avoid significant premium escalation for other HPS subscribers due to more high-risk individuals joining. To do so, there is a need to introduce HRP as an industry reinsurance mechanism to share out the high risks (see paragraphs 4.55-4.59 below). A maximum 200% loading is proposed having regard to actuarial evaluation on the viability of HRP.

#### *(e) No-Claim Discount*

##### Existing health insurance

4.42 No-claim discount (NCD) is a discount on premium offered by insurers to individuals who have not made any claim for the year. It is not often offered in existing health insurance products in the current market. NCD is a measure that aims to reward individuals who adopt a healthy lifestyle and maintain good health and thus not make any claims after purchasing health insurance. It also helps deter injudicious use of healthcare services which would increase claims and premium for all the insured.

### Proposals under the HPS

4.43 We propose to require participating insurers to offer NCD for HPS Plans to individuals who make no claim over a period of time, based on standardized rules and subject to a cap. Our proposal is to require insurers to offer 10% NCD on the published premium for their Standard Plans for each year in which an insured individual has not made any claims, up to a maximum of 30% for three consecutive years without claims. The discount will reset to 0% at next policy renewal upon making a claim.

4.44 Insurers may offer deeper NCD for Standard Plans than the required level, e.g. insurers may offer full 30% NCD upfront to attract healthy individuals to join. Insurers are at liberty to decide whether and how to offer NCD for top-up components and charge higher premium, provided that the premium of the Standard Plans with top-up components will not be lower than the corresponding published premium for the Standard Plans.

#### *(f) Acceptance and Entry Age of Subscribers*

### Existing health insurance

4.45 For the purpose of risk management, current private health insurance products usually do not accept those above a certain age (e.g. 65 or 70). In general, the health risks of a person increase with his/her ages and variations of health risks between individuals also become more significant. Accepting them as new joiners into any health insurance pool may possibly introduce excessive risks to the pool disproportional to the premium charged especially given the very likely risk of anti-selection. Doing so may result in escalating premium for all the insured; or worse, undermine the viability of the insurance pool.

### Proposals under the HPS

4.46 In an ideal situation, individuals should join health insurance at younger age and stay on for continued protection at older age. However, we recognize that those who are already at older age do not have the chance to join HPS Plans when they were young and enjoy their enhanced protection. We need to balance allowing individuals at older age (say aged 65 or above) to have the choice to subscribe to HPS Plans, against causing premium escalation for all the insured (including young and healthy subscribers) due to the excessive risks introduced by their participation.

4.47 We propose that participating insurers should accept all subscribers subject to age limit in general. We further propose allowing those aged 65 or above to join within the first year after the introduction of the HPS. This would provide them with an opportunity, albeit a limited one, to get health insurance coverage under the HPS. However, it may not be viable to extend the high-risk premium loading cap (see paragraph 4.40(d) above) to them, as that might undermine the viability of the HRP.

## **(g) Pre-existing Conditions**

### Existing health insurance

4.48 Most current health insurance products for individuals in general do not cover pre-existing medical conditions, i.e. any medical conditions that exist before a person subscribed to a health insurance would not be covered by the insurance. Given the large pool size and more balanced risk profile of group policies taken out by employers, some insurers may cover pre-existing conditions of employees under group policies, in some circumstances subject to waiting period.

4.49 Exclusion of pre-existing conditions is commonly used by health insurers as a tool in the current health insurance market to reduce risk exposure and manage the risk-profile of their risk pool. However, previous public consultations indicated that the public were concerned about the exclusion of pre-existing conditions because it would severely restrict the access of higher-risk patients to health insurance protection and undermine the risk-pooling function of private health insurance.

4.50 At the same time, we need to balance requiring HPS Plans to cover pre-existing medical conditions, against introducing excessive risks into these plans undermining their viability, especially given the risk of anti-selection. Taking on too many pre-existing medical conditions will likely result in rising claims and escalating premium, discouraging the healthy to join the HPS and undermining its financial viability.

4.51 Possible ways to manage the excess risks due to coverage of pre-existing medical conditions include applying a **waiting period** (i.e. the insured will have to wait for a certain period before their pre-existing medical conditions will be covered by the insurance) and **partial reimbursement** (i.e. the insurance will reimburse claims related to the pre-existing medical conditions only up to a certain reimbursement ratio).

### Proposals under the HPS

4.52 The HPS aims to eliminate strict exclusions commonly applied in existing health insurance policies, thus allowing higher-risk individuals to have access to HPS Plans. In line with the objectives of the HPS, HPS Plans should enhance access to health insurance protection by the public including those with higher-risk profiles.

4.53 We thus propose to require all HPS Plans to accept pre-existing medical conditions, subject to a one-year waiting period (i.e. pre-existing medical conditions will not be covered in the first year), a reimbursement ratio of 25% in the second year and 50% in the third year for the pre-existing conditions. The pre-existing medical conditions will thus be covered for partial reimbursement after one year, and for full reimbursement after three years. There would be no exclusion of congenital conditions, sexually transmitted diseases, mental illnesses, and psychiatric problems.

4.54 The current proposal to require participating insurers to accept pre-existing conditions subject to standardized rules on waiting period and reimbursement limits is an

improvement over existing health insurance which generally exclude all pre-existing medical conditions. However, to ensure the viability of HPS Plans, an HRP reinsurance mechanism will be required to share out the risk of higher-risk subscribers under HPS (see below).

***(h) Risk-Equalisation / High-Risk Pool Reinsurance Mechanism***

4.55 We propose to set up an HRP under the scheme as a reinsurance mechanism operated by the insurance industry and overseen by the Government. The HRP is aimed to enable insurance companies to share out risks and hence be able to accept subscribers with pre-existing conditions. Under the mechanism, the policies of high-risk individuals with premium assessed by an insurance company to exceed three times its published premium (before NCD) of the relevant age groups would be transferred into the HRP. After that, the premium income, claim liabilities and profit/loss of these policies would be accrued to the HRP instead of the insurance company concerned.

4.56 The HRP would apply to individual policyholders only because group plans mostly do not face anti-selection risks. Existing individual policyholders migrating to the HPS may choose to be re-underwritten in order to enjoy the premium cap if they are now paying more than three times of the published premium.

4.57 The HRP would apply fully to individual policyholders of Standard Plans under the HPS. As regards individual policyholders of other HPS Plans, HRP would only apply to the “Standard-plan” component, but not the top-up components in order to control cost and avoid abuse.

4.58 The HRP would be financed by two main sources. The first source is the premium income of the policies/portion of the policies transferred to the pool, after deducting a fair part for the insurance companies to cover administrative expenses. The second source is the reinsurance premium paid by the insurance companies, which would be equivalent to a percentage of the premium income from Standard Plans, or the “Standard-plan” component of other HPS Plans. The Government would consider injecting fund into the HRP if it cannot be self-sustaining due to higher than normal proportion of high-risk individuals joining the HPS.

4.59 The administrative framework of the HRP would have to be carefully designed to ensure smooth operation and avoid abuses. We are aware of a potential risk that insurance companies may pass on unfavourable risks to the HRP by over-charging the premium loading. Nevertheless, we believe that the risk can be contained through proper check-and-balance measures introduced into the administrative framework.

***(i) Guaranteed Renewal***

Existing health insurance

4.60 Some but not all existing private health insurance products provide lifelong

renewal guarantee. We are aware of the complaints by some insured under existing health insurance products that they face difficulties in renewing their policies when they suffer from catastrophic illnesses after purchasing health insurance, either because of outright refusal by insurers to renew their policies or sharp premium hikes at renewal.

#### Proposals under the HPS

4.61 To address these shortcomings, we propose that under the HPS, participating insurers should be required to provide guaranteed renewal for life for HPS Plans, in order to provide life-long protection to consumers and strengthen the risk-pooling function of private health insurance. This, coupled with the requirements on premium adjustment, should protect people against sharp premium hike due to their illnesses.

#### *(j) Portability*

##### Existing health insurance

4.62 Most current private health insurance plans are not portable between different insurers, or when a person leaves employment with employer-provided health insurance coverage. Limited portability of insurance plans restricts consumers' choices over health insurance products. It also impedes people from investing in health insurance coverage that continues into their older age.

#### Proposals under the HPS

4.63 To address these shortcomings, we propose that under the HPS, participating insurers should be required to provide –

- (a) Full portability of health insurance coverage between insurers, in order to enhance consumer choices and promote healthy competition. HPS subscribers should be allowed to switch from one insurer to another carrying over their coverage for pre-existing medical conditions and any NCD.
- (b) Full portability of health insurance coverage on retirement, in order to encourage continued coverage after retirement. An insured covered by an existing employer-provided HPS Plan should be allowed to switch to an individual HPS Plan carrying over, for example, the coverage for pre-existing medical conditions and any NCD.

#### *(k) Standardization of Policy Terms and Conditions*

##### Existing health insurance

4.64 Under existing health insurance markets, different insurance companies apply different policy terms and conditions to their products and may adopt different interpretations of the same or similar policy term and condition with respect to their fine details. This situation has led to disputes over claims and application of claims.

## Proposals under the HPS

4.65 We propose to require insurers participating in the HPS to adopt a standardized set of policy terms and conditions as well as associated definitions, with a view to enabling consumers to better comprehend the terms upfront and minimizing disputes over interpretations afterwards. To ensure that consumers are adequately protected, the policy terms and conditions of HPS Plans will be subject to approval by the Government. This will create a more level playing field between consumers and insurers to enhance consumer protection and confidence in HPS Plans. To ensure effective claim processing and smooth portability of insurance plans under HPS, insurers are required to adopt industry-wide and standardized diagnosis and procedure coding for claims handling and processing.

### *(l) Government Regulation and Transparency Requirements*

4.66 The HPS will be regulated by the Government to safeguard public interests. HPS Plans will be subject to approval and regulation by the Government.

4.67 We propose to require participating insurers under the HPS to have transparency in insurance costs including claims, administrative expenses and commission.

### **Migration of Existing Health Insurance**

4.68 The HPS is **voluntary** for individuals and employers with existing medical insurance, who may choose on their own accord whether to migrate to HPS Plans. The HPS is designed to be **modular**, i.e. insurers are all required to offer Standard Plans, and are free to design appropriate top-up benefits on additional components to suit consumers' needs, e.g. higher benefit levels to cover better services on rooms and boards, or coverage of services not included in Standard Plans such as out-patient services. Individuals and employers who choose to migrate to HPS Plans may freely choose an appropriate one offered by insurers that suit their own needs.

4.69 Based on discussions with the insurance industry, insurers participating in the HPS should be in a position to facilitate seamless migration of policy-holders from their existing health insurance policies to HPS Plans. To this end, we propose that participating insurers should be required under the HPS to facilitate migration of existing policy-holders as follows –

- (a) **For existing individual policy-holders:** participating insurers will be required to offer them an option to renew their existing health insurance policies to an appropriate HPS Plan which must meet or exceed the requirements for Standard Plans with no less coverage and benefits and without undergoing re-underwriting, and to enjoy advantages offered by the HPS including NCD, portability, coverage of pre-existing conditions subject to waiting period, etc.
- (b) **For existing group policy-holders (mainly employers):** participating insurers



will be required to offer them upon renewal an option to switch to an appropriate tailor-made HPS Plan which must meet or exceed the requirements for Standard Plans, providing no less coverage and benefits and meeting the core requirements and specifications under the HPS. The insurers may offer additional components to suit individual employers' needs.

## **Key Issues on Scheme Design**

4.70 In designing the proposed features of the HPS for public consultation as set out above, we have identified the following key issues on the design of the HPS, which mainly concern how higher-risk groups should be provided access to HPS Plans, and how HPS subscribers could be incentivised to stay insured into their older age –

- (a) **How pre-existing medical conditions should be covered:** as stated above, covering pre-existing medical conditions is an improvement as most existing health insurance products exclude such. A one-year waiting period with partial reimbursement in the second and third years for pre-existing medical conditions is proposed to minimize anti-selection and ensure scheme viability. This, coupled with the requirement for insurance coverage to be portable, will free the insured from worrying about exclusions or coverage of their pre-existing medical conditions and enable them to have truly continuous protection for their medical conditions. With the proposed HRP reinsurance mechanism with government injection to absorb excessive risks as necessary, the coverage of pre-existing medical conditions should not pose a significant burden on the premium charged for all insured including healthy individuals under HPS Plans. However, if we adopt a shorter waiting period or higher reimbursement ratio, we need to balance against introducing excessive risks to the HPS and causing premium escalation for all due to anti-selection.
- (b) **How high-risk individuals may join health insurance:** accepting high-risk individuals subject to a cap on premium is an improvement as existing health insurance products do not accept high-risk individuals or deter them with prohibitively high premium. The proposed requirement that insurers must accept high-risk individuals and charge high-risk loading of not more than 200% published premium for Standard Plans (i.e. maximum premium that can be charged is three times the published premium) is proposed to ensure that high-risk individuals may still get health insurance coverage by paying a reasonable premium loading. This, coupled with the proposed HRP with government injection to absorb excessive risks as necessary, would enable high-risk individuals to get health insurance under the HPS, without posing additional burden on the premium charged for all insured including healthy individuals under HPS Plans. However, we need to balance against introducing excessive risks to the HPS and causing premium escalation for all if we adopt a lower premium cap for high-risk individuals resulting in higher claims ratio.

- (c) **How individuals already at older age may also get health insurance:** current health insurance products usually limit entry to below a certain age. The current proposal to allow those aged 65 or above to join the HPS within the first year after its introduction (but with no cap on high-risk premium) allows older individuals to get health insurance coverage. The entry age limit and time-limited window for joining by those above the age limit are necessary to manage the risk profile and ensure the viability of HPS Plans. An age limit would also encourage people to consider health insurance coverage at an earlier stage. We need to balance against introducing excessive risks to the HPS and causing premium escalation for all if we accept individuals at older age at any time into HPS Plans.
- (d) **How individuals should save for future premium at older age:** a key objective of the scheme is to ensure that HPS subscribers would still be able to afford health insurance at an older age when they need it most. We will put forward a range of options to induce savings for paying future premiums so that more HPS subscribers can stay insured at an older age with government incentives (see “*Savings for Future Premium*” below). The purpose is to reduce the risk of a larger proportion of the insured dropping out of the HPS when they get old.

### Scheme Incentives

4.71 The success of the HPS in achieving its stated objectives and the viability of HPS Plans depend on achieving a sufficiently large insured pool size and a reasonable mix of healthy and unhealthy risks. In designing the HPS, we have considered the provision of incentives where they are –

- (a) essential for ensuring viability or achieving the objectives of the HPS;
- (b) desirable for sustaining healthcare financing; and
- (c) financially sustainable having regard to long-term costs and benefits.

4.72 Having regard to these principles, and subject to finalization of the HPS design for implementation, we propose to consider providing incentives in the following directions under the HPS, making use of the \$50 billion earmarked in the fiscal reserve to support healthcare financing reform –

- (a) **Protection for high-risk individuals:** to allow high-risk individuals to join HPS plans without requiring other healthy insured to pay excessive premium, we propose to consider government injection into the HRP, an industry-operated reinsurance mechanism for taking on high-risk individuals and sharing out their risks, to buffer the excessive risks arising from the participation of high-risk individuals.
- (b) **Premium discount for new joiners:** to attract individuals especially the young to

join HPS plans, we propose to consider government incentives for all new HPS subscribers to enjoy maximum NCD, i.e. 30% discount on the premium for the relevant Standard Plan, immediately on joining. We propose that this discount should be made available at all times for those aged below 30.

- (c) **Savings for future premium:** to enable the insured to continue to afford health protection under the HPS at older age, we propose to consider government incentives to encourage savings by individuals for paying future premium at older age (say from 65). We propose that the government incentives should be proportional to the length of the individual continuously staying insured under the HPS, up to a certain percentage of the premium for the relevant Standard Plan.

### *Tax Incentive Not Recommended*

4.73 As regards the suggestion to offer tax incentive for private health insurance premiums and private healthcare expenditure, we consider it less recommendable compared with the proposed incentives above from the perspectives of the tax system, healthcare system and HPS objectives –

- (a) For the **tax system**, since the proposed HPS will be based on voluntary participation by those who are able and willing to afford, providing tax deduction to health insurance premiums under the HPS but not premiums for other health insurance products would violate the neutral and fair principle of our tax regime. Meanwhile, providing tax deduction to all policy-holders of other private health insurance schemes or to all private healthcare expenses would further narrow our tax base.
- (b) For the **healthcare system**, tax incentive is by nature regressive and relevant only to a relatively small proportion of the higher-income population where penetration of private health insurance is already high, and providing tax incentive for private health insurance premiums and private healthcare expenses without imposing necessary regulatory control would further aggravate the existing shortcomings of the private health insurance and private healthcare markets, especially moral hazards and inefficiency.
- (c) For the **HPS objectives**, tax deduction for health insurance premiums in general or HPS premium in particular provides financial incentive for the working population only during their working age, but does not incentivize premium payment after their retirement when they may no longer have an income while their premium is much higher. It does not serve the purpose of incentivizing savings as private resources to finance future healthcare.

4.74 Upon receiving views in the public consultation over the proposed directions for considering financial incentives, we will formulate the details of the proposals for government incentives under the HPS, and work out the use of the \$50 billion fiscal

reserve earmarked to support healthcare reform.

## **Savings for Future Premium**

### *Why Savings?*

4.75 A key objective of the HPS is to enable sustained access to affordable and value-for-money private healthcare services for those who so choose among the population. We thus aim to design features of the HPS to facilitate and encourage people to stay insured continuously and into their older age when they need healthcare protection the most. We also aim to facilitate the building up of resources by the insured for funding their future healthcare protection so that they can continue to have the choice for private health insurance and private healthcare services as they age.

4.76 However, age-banded premium for voluntary health insurance is bound to increase sharply with age of the insured as their health risk and healthcare utilization increase. As the present penetration pattern of health insurance among different age groups shows, people currently insured have a higher probability of lapsing on their insurance coverage (be it lapsing on individually-purchased health insurance or ceasing coverage by employer-provided health insurance on leaving employment) as they get old. We thus need to consider ways to minimize lapsation from insurance protection so that more people can stay insured at older age, and also to secure supplementary financing to support funding for future healthcare needs.

### *How to Save?*

4.77 One possible way that may help ensure that individuals can still afford continuous health protection under the HPS at older age when they need it the most is to build in a savings component where the savings would be used for paying future premiums. There are a number of factors to be considered with a view to identifying the most appropriate arrangements to encourage the insured to stay on with their plans and secure funding for paying future premiums. The factors including -

- (a) **level of savings and freedom of its use:** how much savings should be required and how freely could the savings be used? and
- (b) **design of the savings arrangement:** how should the contribution pattern, the withdrawal rule, the investment arrangement be designed?

4.78 Specifically, we need to balance the need to encourage the insured to stay on and secure a pool of funding to cover future healthcare protection especially at an older age on the one hand, and the need to minimize the adverse impact of any built-in mandatory requirement to lock in savings to pay for future premiums on the attractiveness of HPS Plans on the other. Having regard to the above considerations, we propose three possible savings options with different degree of freedom on the savings arrangements

and use of savings (a comparison of the three options are set out in *Table 4.2*) –

- (a) **Required in-policy savings:** HPS Plans will be required to incorporate a savings component, where the insured would pay higher premium at a younger age to offset the premium increase at older age. Insurers would be required to accrue the savings and underwrite the investment risks (but not medical inflation) for paying future premiums under the HPS. Incentives via government contribution to the savings component of HPS Plans would be considered.
- (b) **Optional savings accounts:** HPS subscribers would have an option to save to a separate savings account with a range of investment options. The accrued savings and investment returns can be freely used at an older age including paying premiums for HPS Plans.
- (c) **Premium rebate for long-stay:** HPS subscribers are not required to save, but may choose to save on their own means. Incentives via a premium rebate proportional to their length of staying insured under the HPS would be provided at an older age if they continue to stay insured under the HPS.

**Table 4.2** Options on Savings for Future Premium under the HPS

	Degree of Freedom in Use of Savings		
	Low	Medium	High
Option	Required in-policy savings	Optional savings accounts	Premium rebate for long-stay
Funding Target	Higher funding target (say 100% of expected HPS premiums from 65)	Lower funding target (say 50% of expected HPS premiums from 65)	No specific funding target
Contribution Pattern	Stipulated contribution pattern through higher premium at a younger age, but adjusted periodically if necessary so that long-term funding target is met	No restriction on contribution pattern as long as specified minimum fund balance is maintained in the savings account	No restriction on contribution pattern
Funding Vehicle	Insurance company	Savings account	No restriction
Investment Restrictions	Insurers to accrue the savings and underwrite the investment risk of the savings pool	A range of investment options for individuals to choose	No restriction
Qualifying Criteria	Contribution requirement met by HPS subscribers	Contribution requirement met by HPS subscribers	Level of incentive dependent on length of staying insured under the HPS
Possible Incentives	Government contribution to the saving component of the insurance policy	Government contribution to the savings account (withdrawal of incentive subject to the savings being used to pay premium at older age)	Post-retirement premium rebate (for Standard Plans and equivalent in other HPS Plans)

### Healthcare Capacity

5.1 The introduction of the HPS aims to enable individuals who are willing and able to pay to use affordable and quality private healthcare services. As such, there is a need to ensure adequate supply of quality private healthcare services to meet the increase in demand arising from the HPS. As part of the healthcare reform initiatives, the Government has been actively strengthening the infrastructure support to increase the overall capacity of the healthcare system and to facilitate the development of private healthcare services, with a view to addressing the existing imbalance between the public and private healthcare system especially on private in-patient services.

5.2 We project that the implementation of the HPS may require an increase of around 9%-30% in capacity for private healthcare services over the next 10 years (in terms of total number of hospital admissions and ambulatory procedures), and possibly up to 50% by 2036. We estimate that the known redevelopment projects of existing private hospitals and the development of new private hospitals under planning, including those at four pieces of land earmarked for private hospital development, should be able to meet the projected demand for private hospital services arising from the HPS.

### Healthcare Manpower

5.3 The implementation of the HPS and expansion of private healthcare capacity will require additional healthcare manpower. In the first stage public consultation, some respondents advocated the formulation of long-term manpower planning for doctors and other healthcare professionals with a view to meeting the future needs of the community. There were suggestions from the community that increasing the number of healthcare professionals could help shorten waiting time for public healthcare services and enhance healthy competition in private healthcare market in long run.

5.4 We conduct manpower planning exercises from time to time for the various healthcare professions for the purpose of assessing the education and training needs for healthcare professionals. The exercises will take into account the potential demands for manpower increase, including expansion of the healthcare system to cater for demographic changes and implementation of the healthcare reform initiatives. The potential increase in demand for private healthcare services, including those arising from the known and planned private hospital developments, and from the implementation of the HPS, will be taken into consideration. Subject to the outcome of the exercises, we will explore ways to increase the availability of doctors and other healthcare professionals in Hong Kong.

## **Service Provision Based on Packaged Charging**

5.5 For the implementation of the HPS, there is a need for private healthcare providers to provide services that meet the requirements under the HPS, especially the provision of healthcare services based on packaged charging. The use of packaged charging would enhance cost certainty and transparency to consumers and raise their confidence in using private healthcare services, in turn enhancing the development of the private healthcare sector in providing value-for-money in-patient services or ambulatory procedures to the public. We have noted that there are already private hospitals that are providing healthcare services based on packaged charging and there is a trend in the private healthcare sector to move towards service provision based on packaged charging.

5.6 We envisage that the HPS can serve as a catalyst to promote the wider adoption of diagnosis- or procedure-based packaged charging for providing in-patient services or ambulatory procedures in the private healthcare sector, with a view to addressing consumers' concerns over cost uncertainty even with health insurance coverage. To ensure there is adequate supply of private healthcare services based on DRG packaged charging, we will take the following measures –

- (a) For new private hospital developments at the four pieces of land earmarked for such (namely in Wong Chuk Hang, Tseung Kwan O, Tung Chung and Tai Po), we shall design the development requirements (including the land disposal conditions and any other requirements in relation to the developments) taking into account the need to support the HPS, including service scope, price transparency, and the requirement to provide services at packaged charging based on the DRG structure, with a view to ensuring supply of such services.
- (b) For existing private hospitals and other private healthcare providers, we will facilitate discussions between them and health insurers with a view to adopting packaged charging based on the DRG structure. In particular, we will encourage them to offer healthcare services based on packaged charging by providing any necessary infrastructural support and technology know-how on using packaged charging, including the development and maintenance of the DRG structure as well as the information infrastructure required for its administration.

## **Other Potential Options for Service Provision**

5.7 We shall continue to monitor the demand for private healthcare services and further consider ways to increase the capacity for private healthcare services as necessary after the HPS is implemented. In particular, there is a need to ensure a sufficient supply of affordable and quality private healthcare services, so as to meet the demand from those who have subscribed to private health insurance. There is also a need to ensure healthy competition in the provision of private healthcare services in terms of both quality and pricing, with adequate measures to protect consumer interests and build consumer

confidence.

5.8 At this juncture, we believe that with the provision of necessary infrastructure, the private sector should be able to adjust in a free market to meet the demand for private healthcare services. In particular, strong interests were expressed in response to the four pieces of land earmarked for private hospital development and for which we have conducted an Expression of Interests exercise in 2010. In response to the implementation of the HPS and expansion of the private health insurance market, there may also be some private operators who may consider providing private healthcare services integrating with private health insurance meeting the requirements of the HPS.

5.9 Where necessary, however, we may have to consider other means to support the implementation of the HPS and to provide benchmarks for private healthcare services, especially if the private sector is unable to provide sufficient private healthcare services at competitive quality and pricing. We would not rule out at this juncture any possible options including, for example, the feasibility of making use of private services already being provided by HA subject to its provision of public healthcare services not being adversely affected, setting up a public entity for benchmarking and purchasing private healthcare services on behalf of consumers who are insured, or the Government providing healthcare services at packaged charging with service choice and quality assurance so as to provide a competitive benchmark for private healthcare services. We may also make reference to the experience of various PPP pilot projects for provision of healthcare services in devising appropriate models to ensure the supply of private healthcare services that best suit public needs.

### **Provision of Health Insurance**

5.10 Implementation of the HPS requires participation of private health insurers. To this end, the proposals for the HPS are designed with a view to safeguarding consumer interests in private health insurance and private healthcare services, while ensuring that it should be practically feasible and financially viable to offer health insurance plans and provide private healthcare services under the HPS.

5.11 To ensure competition and choice under the HPS, there is a need for more interested private health insurers to participate and offer sufficient and attractive choices of health insurance plans under the HPS. The HPS is formulated taking into account the views of various stakeholders including the insurance industry, and we do not envisage any major obstacle for private health insurers to participate in the HPS. In particular, the HPS would provide a more sustainable platform for the development of the private health insurance industry that would help reinforce consumer protection and in turn consumer confidence.

5.12 However, we are mindful that insurers might be hesitant initially, noting that the HPS introduces many new features and practices not commonly practised in Hong Kong at present (though commonly practised in other overseas health insurance markets).



Should there be a general lack of interests from the industry in offering health insurance plans under the HPS, the Government would consider setting up its own mechanism to provide the public with more choices of health insurance plans. In particular, we would not rule out the option of setting up a public entity to offer health insurance plans under the HPS, with a view to putting the viability of the HPS to test and setting the benchmarks for health insurance plans under the HPS.

### **Health Insurance Claims Arbitration Mechanism**

5.13 To safeguard consumer interests, a proposed requirement under the HPS is for private health insurers participating in the HPS and private healthcare providers providing services to the insured under the HPS (including private hospitals and their engaged or associated doctors) to participate in a health insurance claims arbitration mechanism to handle disputes over health insurance claims and arbitrate disagreements between patients, private health insurers and/or private healthcare providers over such claims. The arbitration mechanism will be regulated by the Government with a view to maintaining impartiality and ensuring protection of the consumers in the private health insurance and private healthcare services markets.

5.14 The claims arbitration mechanism is a new feature proposed in response to the public views expressed during the first stage public consultation on healthcare reform about disputes over health insurance claims in general. There were suggestions from both the public and relevant stakeholders for the Government to establish an effective and efficient dispute resolution mechanism specifically for health insurance with a view to protecting consumer interests as well as curbing moral hazards. In particular, the specificity of health insurance vis-à-vis other insurance in general is noted, in that the insurance involves tripartite arrangements between the insured or customer purchasing the health insurance and consuming the healthcare services, the insurer providing the risk-pooling and financing the healthcare services, and the provider providing the healthcare services to the customer and receiving payments from the insurer.

5.15 The claims arbitration mechanism is thus proposed as an impartial mechanism with a view to resolving potential disputes between parties concerned. The detailed operation of the claims arbitration mechanism will be further developed in the light of views received during the second stage public consultation, including any necessary legislative backing required for its effective and efficient operation. At this stage, we propose that the following general principles may be considered for the mechanism –

- (a) The claims arbitration mechanism will be a government-regulated mechanism to be administered by the dedicated agency responsible for the supervision of the operation of the HPS, designed with effectiveness and efficiency in mind.
- (b) The mechanism will deal with claims made under HPS Plans with standardized policy terms and conditions, including the Standard Plans and other HPS Plans with top-up components.

- (c) Complaints may be made by any of the three parties – customers, insurers or providers – and handled by a process designed to protect consumer interests and be impartial between insurers and providers.
- (d) An advisory panel comprising independent experts in relevant fields can be formed to advise on the arbitration mechanism and independent advice will be sought from relevant professions as necessary for arbitration.
- (e) On the advice of the advisory panel, the dedicated agency may issue guidelines or codes of practice for insurers offering health insurance plans and private providers providing healthcare services under the HPS.
- (f) The advisory panel may also make recommendations on adjustment to the requirements and specifications under the HPS, including the standardized health insurance policy terms and conditions.

### **Other Scheme Requirements**

5.16 To safeguard consumer interests and ensure that the objectives of the HPS can be met, we will be designing other necessary requirements under the HPS that private health insurers will be required to meet as a pre-requisite for participating in the HPS should they choose to do so and offer health insurance plans under the HPS. There may also be a need to consider specifications and requirements that apply to private healthcare providers who provide healthcare services to consumers who are insured and receive payments from health insurers. Such requirements may apply by way of scheme rules that participants are required to comply with or by legislative backing. Details will be developed after consultation on the proposals for the HPS.

### **Supervisory Structure**

5.17 To supervise effectively the implementation and operation of the HPS and to monitor the achievement of the objectives of the HPS in the private health insurance and private healthcare services sectors in Hong Kong, we need to establish a supervisory structure for the HPS with a view to –

- (a) ensuring governance in implementation of the HPS;
- (b) providing supervision in operation of the HPS; and
- (c) monitoring the achievement of the objectives of the HPS.

5.18 In exploring the necessary institutional arrangements for the HPS, a number of broad principles are suggested to guide the development of the institutional arrangements –

- (a) clear delineation of the supervisory, regulatory and administrative roles and

relationship between different components in the entire institutional framework;

- (b) avoidance of duplications with and changes to existing supervisory and regulatory infrastructures unless it is found essential for the benefit of the HPS; and
- (c) minimization of adverse regulatory impacts of the HPS including regulatory, compliance and administrative costs.

5.19 There are in general three main functions to be considered for the implementation and supervision of the HPS. In line with the objectives and principles of the HPS, we propose a supervisory structure with separate agencies to perform the following essential supervisory functions for the HPS –

- (a) **Prudential regulation:** a prudential regulator to serve the functions of prudential regulation to supervise, inter alia, the financial soundness of insurers participating in the HPS and to ensure the financial capability of insurers to discharge obligations to the insured, and to oversee any complaint handling mechanisms applicable to insurance in general. At present, this role is being taken up by the Office of the Commissioner of Insurance and we expect the Office, including its future independent authority proposed to be established, to continue to serve these functions.
- (b) **Quality assurance:** a regulatory authority to serve the functions of quality assurance, including to enforce the regulatory requirements and licensing conditions for private healthcare service providers specifically private hospitals, to supervise the quality and standards of private healthcare services provided, to oversee hospital accreditation and clinical audits, to collect service statistics and benchmarking information, and to administer other quality assurance measures. DH is currently the regulatory and licensing authority for private hospitals, and its role will need to be strengthened in order to take up these functions of quality assurance for private healthcare services. The professional regulation of healthcare professionals will continue to rest with the relevant statutory boards and councils.
- (c) **Scheme supervision:** a new dedicated agency would need to be set up to supervise the implementation and operation of the HPS, including registering health insurance plans, administering the HPS core requirements and specifications, collecting information and statistics about private health insurance plans, compiling benchmarking information and statistics of private healthcare services, compiling necessary pricing and costing information of private healthcare under the HPS, and administering mechanisms for consumer protection specific to the HPS including claims arbitration, complaint handling and case review. It may also assume the role to co-ordinate between the relevant supervisory and regulatory agencies in respect of matters concerning health insurance plans under the HPS.

5.20 To ensure the supervisory and regulatory functions are properly delivered to safeguard public interests, we expect that legislation will be required to support the implementation of the above supervisory structure and functions. We will examine the legislative requirements when finalizing the HPS proposal for implementation after consultation.

### **Impact on Healthcare System Sustainability**

5.21 The healthcare reform introduced in 2008 aims to address the challenges to long-term sustainability of the healthcare system through taking forward reform proposals that aim to achieve the following objectives -

- (a) **Shift costly hospital and specialized care downstream to cost-effective primary and preventive care upstream:** containing the long-term growth of the overall health expenditure requires major structural changes in the healthcare system, and this is the essence of the primary care reform. In broader public health perspective, changing the behaviour of both the public and providers to focus more on health-improving and disease-preventing health and healthcare measures should have tremendous impact in reducing the eventual disease burden such as chronic diseases and other non-communicable diseases plaguing advanced economies in general.
- (b) **Enhance efficiency and cost-effectiveness of the healthcare system as a whole in both the public and private sectors:** the public healthcare system has a good track record of containing its costs (and measures such as case-mix resource allocation are being taken to improve it). However, there is currently little or no check on the efficiency and cost-effectiveness of the private healthcare market which is largely unregulated for quality assurance and consumer protection and is rather opaque in its pricing and charging. Although the private market is currently funded solely by private financing, it does have a significant impact on the public system and overall healthcare system efficiency when it draws healthcare resources and financing away from more efficient uses.
- (c) **Mobilize private resources to provide supplementary financing for healthcare that eases pressure on the public sector:** while the public has expressed reservations on all mandatory supplementary financing options, it remains our aim to design a voluntary supplementary financing option that can channel additional private resources into healthcare and in turn ease the demand pressure for public healthcare services over the long-term. As reflected in the first stage public consultation, the public in general expressed a preference that any voluntary supplementary financing should go towards enriching their individual choices for healthcare.

5.22 The HPS is proposed primarily as a regulatory intervention by the Government in the current private health insurance and private healthcare service markets, with the

aim to ensure and enhance consumer protection, price transparency, and market competition, thereby enhancing the efficiency and sustainability of voluntary private health insurance as supplementary financing for private healthcare. This is in line with the direction of healthcare reform to rationalize the current market structure of the healthcare system by promoting PPP and encouraging development of the private healthcare sector to supplement the public healthcare system. It is not the intention for the Government or the public sector to take over the provision of private healthcare services.

5.23 The HPS will provide a platform that channels private funding for healthcare through regulated health insurance into private healthcare services. In view of the dynamic inter-relationship between the public and private healthcare system, by enhancing the cost-effectiveness and efficiency of the private healthcare system on a sustained basis, the HPS should help enhance the long-term sustainability of the entire healthcare system as a whole through better rationalization of resources as follows –

- (a) **Safeguard consumer interests while strengthening the role of private sector alongside public system:** by continuously inducing greater transparency and competition as well as protecting consumer interests in the private health insurance and private healthcare markets, the HPS should facilitate the public's sustained access to value-for-money private healthcare services and enhance their ability to get health insurance protection through private health insurance on a long-term basis. It should also better ensure that private health funding is channelled to meet healthcare needs of the population effectively and efficiently, which in turn should serve as a catalyst to further mobilize private financing for healthcare in the future. Without such measures assuring consumers, it is doubtful if private funding for private health insurance and private healthcare services can sustain on a long-term basis.
- (b) **Relieve pressure on public healthcare system through facilitating choice of value-for-money private services:** by making private health insurance and private healthcare services a more attractive option to the public, and by maintaining its attraction and affordability into the future as the population ages and as the insured get older, the HPS should help divert to the private healthcare sector some of the healthcare needs that would otherwise have to be met by the public healthcare system. Providing subsidies for those who choose private services and who would otherwise fall back on highly-subsidized public services would be akin to the concept of "money-follows-patient" and enable more rational allocation of public resources for the population's healthcare. With more people choosing value-for-money private services through the HPS, the HPS can help ease the pressure of the public system, thereby strengthening the role of public healthcare to focus resource on targeted services areas and population groups.

5.24 As pointed out in Chapter 3 above, from the perspective of the entire healthcare

system, if the current private health insurance and healthcare markets are left as they are, it is unlikely that there will be a self-adjustment force to correct the existing market deficiencies. Without taking measures to assure consumers, it is doubtful if private funding for private health insurance and private healthcare services can sustain on a long-term basis, and the following situations are likely to occur –

- (a) Continued moral hazards and lack of price transparency will make private health insurance and private healthcare less attractive and affordable.
- (b) More of the insured are likely to lapse on their insurance coverage as they get older due to premium increase and moral hazards.
- (c) Individuals are likely to be hesitant in making any long-term commitment to finance their own future healthcare.
- (d) The existing deficiencies are likely to continue to skew and impair the development of both the private health insurance and private healthcare services, resulting eventually in the population's healthcare burden increasingly falling back on the public sector as the ultimate healthcare safety net for the ageing population.

5.25 In view of the above, the HPS should serve as a positive step in rationalizing the long-term resource allocation within the whole healthcare system in both the public and private healthcare sectors, and contribute towards enhancing the long-term sustainability of the healthcare system.

### **Impact on Long-Term Healthcare Financing**

5.26 The challenge to long-term healthcare financing is two-fold: (i) total health expenditure is bound to outpace economic growth due to rapid demographic changes (both ageing population and population growth) and rising medical costs (medical inflation due to advances in medical technology and rising expectations); and (ii) public health expenditure is bound to grow at a faster rate than private health expenditure as the healthcare burden of the elderly population falls predominantly on public hospitals.

5.27 Considering the voluntary nature of the HPS, it is difficult to predict with a sufficient degree of certainty the financial implications arising from the implementation of the HPS. The financial implications arising from the HPS would depend on a number of inter-related factors including (i) the penetration rate and popularity of the HPS in the population especially at older age which could only be more accurately assessed after the implementation of the HPS; (ii) the design of incentive and supervisory framework for the HPS which could only be finalized after the public consultation; and (iii) the actual utilization of healthcare services in both the public and private sectors by the insured and uninsured population.

5.28 Given its voluntary nature, we expect that the impact of the HPS on long-term

health expenditure will unlikely be substantial. Having modelled a number of possible scenarios, we can draw the following observations regarding the likely impact of the HPS on long-term healthcare financing –

- (a) **Public health expenditure will unlikely be reduced:** Impact of the HPS on public health expenditure taking into account any possible financial incentives will likely be marginal. We do not expect that the HPS will lead to any substantial reduction in long-term public health expenditure. This is especially the case as the Government will uphold the public healthcare system as the equitable safety net for the population. That said, by providing a sustainable platform for private healthcare financing, the HPS should help avoid the worst scenario of the population currently insured falling back en masse onto the public healthcare system thereby further worsening the healthcare financing problem.
- (b) **Private funding for healthcare will increase:** by making private health insurance a more sustainable and attractive choice for health protection and facilitating sustained access to private healthcare services, the HPS should help expand the size of private funding for healthcare especially through insurance, thereby increasing the overall financing available for the healthcare system. By providing a regulated platform for channelling private funding into private healthcare services, the HPS should also help ensure the cost-effectiveness and efficiency of private health expenditure, especially in avoiding moral hazards and ensuring such expenditure goes to meeting the healthcare needs of the population alongside the public system.
- (c) **Long-term sustainability of healthcare financing will be enhanced but not resolved:** the impact of the HPS should be considered in the context alongside the objectives and potential benefits of rationalizing the existing private health insurance and healthcare markets. The HPS aims to better enable people with health insurance to stay insured for health protection to meet their healthcare needs at their older age, as well as enhance healthy competition and value-for-money services in private health insurance and healthcare markets. All these are positive to improve sustainability of long-term healthcare financing. In other words, the HPS on its own could not completely resolve the long-term financing problem for the healthcare system as a whole, but is a positive step in that direction.

5.29 With reference to the proposed framework of the HPS, including the proposed Government incentives under the HPS (see “Scheme Incentives” at Chapter 4 above), the \$50 billion earmarked in the fiscal reserve could be considered to provide incentives in line with the objectives of the HPS for the coming 20 to 25 years after the inception of the HPS. Based on the outcome of the public consultation, we will come up with the detailed proposed arrangements on using the \$50 billion fiscal reserve to provide Government incentives under the HPS.

## Potential Risks of the Scheme

5.30 We assess that the HPS may suffer from the following potential risks that need to be carefully monitored and mitigated through fine-tuning of the HPS –

- (a) **Low subscription:** if the HPS is unable to attract a substantial number of people (both currently insured and uninsured) to join, it may lack the critical mass to be financially viable and to bring about material impact on market developments. The higher the penetration rate of the HPS, the more likely it can mobilize additional funding, in turn larger market impacts, on enhancing efficiency of the private health insurance and healthcare markets.
- (b) **Imbalanced risk pool:** if the HPS attracts mainly the elderly and less healthy people without appealing to the young and healthy population equally, there may be a disproportionate number of unhealthy subscribers in the HPS that lead to ineffective risk pooling and even cause the HPS to fail.
- (c) **Prevalence of demand-side and supply-side moral hazards:** if the HPS design to combat moral hazard behaviours of insured people and private healthcare providers cannot sufficiently check against incidents of moral hazard-induced utilization in the private healthcare market, the higher cost of claims thus resulted may lead to rising premium to the extent that impairs long-term sustainability of the HPS.
- (d) **High administration costs:** if compliance with the HPS requirements involves substantial administrative works for insurance companies, they may have to uplift the premium to compensate for the higher administrative cost or else may refrain from participating in the HPS if such overhead cost is prohibitive. The risk of insufficient participation by consumers and insurers will increase as a result.
- (e) **Regulatory capacity and costs:** the current regulatory regime for insurance focuses on solvency of insurers and does not extend to product or premium regulation. The current private hospital services regulatory regimes will have to be revamped to cater for the requirements of the HPS on service quality and prudent use of healthcare resources. The HPS will require much stronger regulatory involvement on the part of the Government and in turn commensurate regulatory capacity, infrastructure and expertise.
- (f) **Cost-benefits of using public money as subsidies:** use of public money to incentivize enrolment in the HPS should be justified on the ground of cost-benefits. This hinges on whether the design of the HPS can be well received by the market without compromising the need to achieve its desired objectives and whether the control measures featured into the HPS can mitigate the inevitable system risks involved.



5.31 To ensure that the potential risks of the HPS are properly monitored and appropriately mitigated, the HPS has to be monitored by a dedicated agency (*see "Supervisory Structure" above*). The agency will conduct review on the HPS performance vis-à-vis the intended objectives on a regular basis. The review should focus on (i) monitoring the likelihood and scale of the risk; (ii) examining to what extent the HPS objectives are achieved; and (iii) assessing the change of the cost-benefit case due to the risk factors above especially the penetration rate and the high-risk profile in the HPS. Arising from the review, recommendations would be made as to fine-tune or reform the HPS to ensure the objectives to be met.

**We Need Your Views**

6.1 Thank you for your support in the first stage public consultation. To take forward the healthcare financing reform, we need your support and constructive views to take the proposal forward. We welcome your views on the proposed features of the HPS and the proposed design of the Standard Plans (the core requirements and specifications). We would like to seek your views in particular on the following issues –

*General Views*

- (a) Do you support introducing the voluntary HPS providing health insurance standardized and regulated by the Government?
- (b) Do you support regulating health insurance plans under the HPS to provide protection and better choices to consumers?
- (c) Do you support increasing private healthcare sector capacity and strengthening quality assurance measures in support of the HPS?

*HPS Design*

- (d) Do you agree with the proposals for allowing higher risk groups to access health insurance?
  - (i) HPS Plans should cover pre-existing medical conditions after 1-year and provide 25%/50% partial reimbursement in 2<sup>nd</sup>/3<sup>rd</sup> year, and full reimbursement after 3 years.
  - (ii) HPS Plans should accept high-risk individuals with premium plus high-risk premium loading not exceeding 300% of the published premium rate applicable.
  - (iii) HPS Plans should accept those aged 65 or above during the first year of introduction, but without being subject to cap on high-risk premium loading.
- (e) Which option to save for future premium do you prefer?
  - (i) required to save as part of the health insurance policy to pay future premium;
  - (ii) given an option to save to a medical savings account that can be used for any purpose; or
  - (iii) allowed to save on their own, with incentives provided for payment of

premium from age 65.

- (f) Do you agree with the proposals to introduce packaged charging for private healthcare services, to require insurers to facilitate migration of existing health insurance, and to establish a government-regulated claims arbitration mechanism?

### *Financial Incentives for HPS*

- (g) Do you support government injection into the High-Risk Pool where necessary to protect high-risk individuals and avoid premium increases for the healthy under the HPS?
- (h) Do you support that there should be a no-claim premium discount up to 30% of premium for all new subscribers for a limited period after the introduction of the HPS?
- (i) Do you support that there should be rebate up to a certain percentage of savings used to pay Standard Plan premiums under the HPS on or after age 65?

6.2 Based on views received during the second stage public consultation, we will consolidate and analyse them and map out the way forward for our reform. Please send us your views on this consultation document **on or before 7 January 2011** through the contact below. Please indicate if you do not want your views to be published or if you wish to remain anonymous when your views are published. Unless otherwise specified, all responses will be treated as public information and may be publicized in the future.

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## **APPENDIX A HEALTH PROTECTION SCHEME AND ILLUSTRATIVE STANDARD HEALTH INSURANCE PLAN**

### **Introduction**

A.1 This document outlines the voluntary Health Protection Scheme (HPS) that the Government proposes to introduce, and an illustrative standardized health insurance plan to demonstrate possible health insurance plans that may be offered under the HPS.

### **Scheme Objectives**

A.2 The objectives of HPS are –

- (a) To encourage taking-out of health insurance and savings in order to:
  - (i) provide choice to those who are able and willing to pay for private healthcare and improve their sustained access to value-for-money and affordable private healthcare services; and
  - (ii) in so doing, facilitate the greater use of private services as an alternative to public services.
- (b) To improve transparency about service standards and price levels in the private health insurance and healthcare markets, in order to:
  - (i) encourage the development and offering of quality-assured, all-inclusive, condition-specific packaged services and pricing for most medical conditions;
  - (ii) promote healthy market competition and enhance consumer protection and confidence.

### **Scheme Concept**

A.3 The HPS is proposed as a standardized and regulated framework for health insurance under its aegis. Health insurance plans to be offered under the HPS (HPS Plans) will be required to meet core requirements and specifications for health insurance standardized under the HPS. Participating insurers will be required to comply with scheme rules and any other requirements specified under the HPS. These aim at ensuring market competition, price transparency, quality assurance and consumer protection.

A.4 Insurers participating in the HPS will be required to offer standardized health insurance plans (the Standard Plans) that are fully in accordance with the core requirements and specifications without any top-up benefits or add-on components. The Standard Plans are designed to provide the insured individuals with benefit coverage and reimbursement levels that would enable them to access general ward class of private healthcare services when needed.

A.5 The HPS is designed to be modular. Insurers are free to design their own health insurance plans offering top-up benefits or integrating add-on components over and above the

Standard Plans, e.g. better services and rooms and boards, or coverage of services not included in the Standard Plans such as out-patient services. They may also choose to continue to offer insurance plans outside the HPS.

A.6 Individuals may choose to subscribe to HPS Plans on a voluntary basis, and enjoy the provisions under the HPS for consumer protection and other advantages offered by HPS Plans. Employers may also choose to make use of such HPS Plans through their insurers when providing medical benefits to their employees.

## Scheme Features

A.7 The key features of the HPS are summarised in the following table -

Feature	Description
<b>Benefit Coverage</b>	<ul style="list-style-type: none"> <li>◇ Standard Plans:               <ul style="list-style-type: none"> <li>■ Hospital admissions or ambulatory procedures</li> <li>■ Associated specialist services investigation and advanced diagnostic imaging</li> <li>■ Chemotherapy or radiotherapy for cancer</li> </ul> </li> <li>◇ Other HPS Plans may offer top-up benefits or integrate additional components, such as higher benefit limits or broader service coverage, including primary and dental care, better hospital amenities, other specialist services in general, other advance diagnostic imaging in general, other investigative/diagnostic procedures in general, or maternity coverage.</li> </ul>
<b>Benefit Limits</b>	<ul style="list-style-type: none"> <li>◇ Based on packaged charging for common procedures according to standardized diagnosis-related groups. Lump-sum benefit limits for common procedures with packaged charging to reduce charges uncertainty for patients.</li> <li>◇ Itemized benefit schedule available for traditional billing format where packaged charging not available in the market.</li> <li>◇ Basic benefit levels standardized and adjusted to provide sufficient coverage for general ward at average-priced private hospitals.</li> </ul>
<b>Co-payment</b>	<ul style="list-style-type: none"> <li>◇ Standardized co-insurance arrangement for in-patient and ambulatory procedures under Standard Plans of HPS (20% for first \$10,000, 10% for next \$90,000, 0% beyond \$100,000).</li> <li>◇ Insurers may set different (lower) co-insurance levels for other HPS Plans offering top-up benefits.</li> <li>◇ Insurers may set different levels of deductible for HPS Plans.</li> </ul>

Feature	Description
<b>Premium and No-Claim Discount</b>	<ul style="list-style-type: none"> <li>✧ Transparent “age-banded” premium structure with specified lifetime premium for each individual plan.</li> <li>✧ Separate premium schedules for Standard Plans and other HPS Plans for transparency.</li> <li>✧ Transparent guidelines for adjustment of premium rates based on claims and costs over time in order to ensure transparency, facilitate consumer choice and safeguard consumer interest.</li> <li>✧ Insurers to offer no-claim discount under HPS Plans up to a certain percentage of published premium (up to 30%).</li> </ul>
<b>Entry Age</b>	<ul style="list-style-type: none"> <li>✧ No restriction on entry age for those below 65. Persons aged 65 or above can join within the first year after introduction of the HPS.</li> </ul>
<b>Underwriting – Exclusions and Premium Loading and Renewal</b>	<ul style="list-style-type: none"> <li>✧ Those without existing private health insurance joining the HPS will be subjected to medical underwriting according to standardized guideline and underwriting rules for premium assessment applicable to all insurers.</li> <li>✧ Insurers<sup>1</sup> must accept enrolees with pre-existing conditions subject to a one-year waiting period, with partial reimbursement for pre-existing conditions in the second and third years of subscription (25% for second year and 50% for third year) and full coverage after three years, and premium (including premium loadings) according to standardized guideline and underwriting rules subject to not exceeding a cap set at a certain multiple (3 times) of the published premium rate.</li> </ul>
<b>Excess Risk Equalization</b>	<ul style="list-style-type: none"> <li>✧ A High-Risk Pool reinsurance funded and operated by industry and regulated by the Government would be established to enable high-risk individuals to get health insurance without exclusions and with a cap on premium loading, without requiring healthy individuals to pay excessive premium.</li> </ul>
<b>Re-underwriting</b>	<ul style="list-style-type: none"> <li>✧ HPS subscribers may opt for re-underwriting for re-assessment of premium with reasonable limit on frequency.</li> <li>✧ Insurers may not subject any existing individual subscriber to re-underwriting for Standard Plans unless so requested.</li> </ul>

<sup>1</sup> “Insurer” in this context refers to an insurer who chooses to participate under the HPS and offers insurance products in accordance with its requirements.

Feature	Description
<b>Guaranteed Renewal and Portability</b>	<ul style="list-style-type: none"> <li>✧ Lifetime guaranteed renewal.</li> <li>✧ Full portability of Standard Plans at consumers' choice without re-underwriting barrier subject to reasonable limit on frequency (e.g. not more than once a year) and the length of break temporarily without insurance coverage (e.g. upon switch in jobs or on leaving employment).</li> <li>✧ Portability includes carrying-over of pre-existing condition coverage and no-claim discount, which will not be affected upon switching across insurers.</li> </ul>
<b>Migration from Existing Plans</b>	<ul style="list-style-type: none"> <li>✧ Insurance industry will be required to facilitate migration of existing holders of non-HPS policies to HPS Plans.</li> <li>✧ Participating insurers will be required to offer their existing health insurance policy holders an option to transfer to HPS without subject to re-underwriting within a period (one year) after introduction of HPS.</li> </ul>
<b>Unbundling</b>	<ul style="list-style-type: none"> <li>✧ Insurers are required to offer Standard Plans without any top-up benefits or additional components. Insurers are required to publish premium schedule for Standard Plans and accept applicants who choose to subscribe to the Standard Plans only. Insurers may offer other HPS Plans with top-up benefits or additional components, but are required to publish premium schedule for such plans separate from the Standard Plans.</li> </ul>
<b>Coordination of Benefits</b>	<ul style="list-style-type: none"> <li>✧ If the insured are covered by non-HPS products as well, HPS Plans should be the last payer compared to other insurance covers (inc. travel, employee compensation, etc).</li> </ul>
<b>Transparency of Insurance Costs and Standardized Terms</b>	<ul style="list-style-type: none"> <li>✧ Insurers required to be transparent in insurance costs including claims, commissions and expenses including administrative costs.</li> <li>✧ Standardized policy terms and conditions adopted under the HPS to enhance transparency.</li> </ul>
<b>Government Regulation</b>	<ul style="list-style-type: none"> <li>✧ The HPS and Standard Plans standardized and regulated by the Government to protect consumer interests.</li> <li>✧ Health insurance claims arbitration mechanism to handle dispute over claims under the HPS.</li> </ul>
<b>Savings for Future Healthcare</b>	<ul style="list-style-type: none"> <li>✧ Savings to ensure individuals can afford continuous health protection under HPS at older age when they need it most. Three savings options are put forward for consultation - <ul style="list-style-type: none"> <li>■ Required in-policy savings: save via higher premium upfront to offset premium increase at older ages.</li> <li>■ Optional savings accounts: voluntary savings to designated account to be freely used from 65.</li> <li>■ "Long-stay" savings to cover part of the older-age premium.</li> </ul> </li> </ul>

A.8 To support the implementation of the HPS, measures will be taken to –

- (a) **Enhance transparency in medical fees charged by private healthcare providers:** in order to enhance certainty and transparency of costs upfront, we will take steps to facilitate the offer of private healthcare services with packaged charging, including requiring new private hospitals to reserve a certain proportion of their capacity for such services, and providing existing private hospitals with infrastructural support to facilitate the offer of packaged services and charging.
- (b) **Strengthen quality assurance of private healthcare services:** in order to protect consumer interests under the HPS, and as part of the regulatory and licensing framework for private hospitals, private healthcare providers will be required to adopt quality assurance measures, including hospital accreditation, clinical auditing and service benchmarking. Private healthcare providers will also be required to participate in the health insurance claims arbitration mechanism.

### Migration of Existing Health Insurance

A.9 The HPS is voluntary for individuals and employers with existing health insurance, who may choose whether to migrate to health insurance plans under the HPS. Based on discussion with the insurance industry, we propose to require insurers participating in the HPS to facilitate seamless migration of policy-holders from their existing health insurance policies to HPS Plans as follows –

- (a) **For existing individual policy-holders:** participating insurers will be required to offer them an option to renew their existing health insurance policies to an appropriate HPS Plan with no less coverage and benefits and without undergoing re-underwriting, and to enjoy advantages offered by the HPS including pre-existing conditions coverage subject to waiting period, portability, no-claim discount, etc.
- (b) **For existing group policy-holders (mainly employers):** participating insurers will be required to offer them upon renewal an option to switch to an appropriate tailor-made health insurance plan that provides no less coverage and benefits and meets the core requirements and specifications under the HPS. The insurers may offer additional components to suit individual employers' needs.

### Illustrative Plans under HPS

A.10 Based on the HPS objectives stated above, we have drawn up an illustrative plan designed to offer the HPS features with indicative benefit structure to demonstrate the likely shape of possible Standard Plans to be offered under the HPS. The indicative premium for the healthcare protection component of the plan is estimated based on actuarial modelling.

A.11 The illustrative plan is intended to provide an example of possible Standard Plans that are considered actuarially viable. The actual plans that may eventually be offered by insurers in the private market under the HPS may vary, depending on the final design of the core requirements and specifications for Standard Plans under the HPS.



## An Illustrative Standard Health Insurance Plan under HPS and Indicative Premium Schedule

### Coverage

- Hospital admissions and ambulatory procedures
- Specialist out-patient consultations and investigations, and advance diagnostic imaging tests required for the hospital admission or ambulatory procedure
- Chemotherapy or radiotherapy for diagnosed cancer

### Key Features

- Guaranteed renewal for life
- Transparent age-banded premium
- High-risk loading not more than 200% of published premiums (through regulated high-risk pool)
- Cover pre-existing medical conditions (subject to a one year waiting period with partial reimbursement in years two and three)
- Fully portable (e.g. switch jobs, switch insurers, retirement)

### Benefit Levels

- Benefit limits for packaged charging based on diagnosis-related groups (DRG)<sup>2</sup> where offered by private hospitals/doctors. Illustrative examples:

	Benefit Limits
<b>Packages</b>	
Examples of hospital inpatient packages <sup>1</sup>	
<i>Hernia Procedures</i>	\$22,000
<i>Haemorrhoid Procedures</i>	\$30,000
<i>Appendicectomy</i>	\$35,000
<i>Laparoscopic Cholecystectomy</i>	\$40,000
<i>Percutaneous Transluminal Coronary Angioplasty</i> <i>(Stents are covered separately under Surgical Implant benefit.</i> <i>An illustrative benefit limit for stents is \$22,000 per stent.)<sup>2</sup></i>	\$90,000
<i>Laparoscopic Anterior Resection of Rectum with Colostomy</i>	\$112,000
Examples of ambulatory procedure packages	
<i>Haemorrhoid Procedures</i>	\$7,000
<i>Endoscopic Retrograde Cholangiopancreatography (ERCP)</i>	\$10,000
<i>Cataract Procedures</i>	\$13,000
<i>Hernia Procedures</i>	\$13,000
<i>Extracorporeal Shockwave Lithotripsy (ESWL)</i>	\$15,000

<sup>2</sup> Diagnosis-related groups (DRG) is a classification of services and procedures provided by private hospitals and doctors which can be standardized and adopted for the purpose of payment for private healthcare services.

	<b>Benefit Limits</b>
<b>Benefit limits where packaged charging is not available</b>	
Room & Board limit (daily), maximum 180 days	\$550
Doctor's visit (daily)	\$650
ICU R&B limit (daily)	\$2,000
Surgical limit (Surgeon, anaesthetist, op theatre) per procedure <sup>3</sup>	\$50,000
Specialist fee per admission	\$2,000
Miscellaneous hospital expenses per admission	\$8,000
Surgical Implant (subject to approved list of implants)	Per implant schedule
Coinsurance (first \$10K/next \$90K/subsequent) per admission / amb. proc.	20%/10%/0%
<b>Outpatient services related to or in-patient or covered ambulatory procedure</b>	
Specialist consultation, per consultation Maximum 3 consultations per admission / amb. proc.	\$600
Specialist outpatient investigations <sup>4</sup> , per admission/ amb. proc.	\$5,000
Advanced diagnostic imaging tests <sup>5</sup> , per admission/ amb. proc.	\$5,000
Coinsurance	20%
<b>High cost outpatient services</b>	
Chemotherapy or radiotherapy, per disability <sup>6</sup>	\$200,000
Coinsurance	20%

**Notes:**

1. The benefit limits illustrated are for uncomplicated cases. The benefit limit would be increased for cases with complications and comorbidities.
2. An additional payment for stents would be paid under the Surgical Implant benefit. The payment would be subject to a schedule with different limits for different types of implants.
3. Subject to surgical schedule.
4. Examples: endoscopy, colonoscopy, gastroscopy.
5. Examples: MRI, PET scan, CT scan
6. Subject to formulary set by HPS supervisory body.

## Illustration of Benefits Paid

- In general, benefit payment is determined as follows:
  1. Determine Approved Amount. The hospital bill is checked against the scope of coverage and the benefit limits or “budget.” Some of the services provided may not be covered if not medically necessary. Some items may have charges exceeding the benefit limit, and the excess charges will not be covered. After deducting such charges, we get the Approved Amount.
  2. The deductible is applied to the Approved Amount.
  3. The coinsurance is applied to the Approved Amount. The coinsurance is 20% of the first \$10,000 and 10% of the next \$90,000. However, the coinsurance is not applicable to the portion of the bill where a deductible applies. For example, if the Approved amount is \$25,000 and there is a \$10,000 deductible, the 20% coinsurance does not apply to the first \$10,000 (since the member is paying 100% of this) but 10% coinsurance applies to the remaining \$15,000.
  
- How the standard plan benefit limits are applied is illustrated in the following cases:

### Case 1: Hernia

- 1a: Actual charges fall within the benefit limit.
- 1b: Same case where the member has purchased a policy with a \$10,000 deductible.

		Case 1a	Case 1b
Charges vs. Benefit Limit	Actual Charge	\$ 20,000	\$ 20,000
	Benefit Limit	\$ 22,000	\$ 22,000
Approved Amount <sup>1</sup>		\$ 20,000	\$ 20,000
Paid by member	Deductible	N/A	\$ 10,000
	Coinsurance	\$ 3,000 <sup>2</sup>	\$ 1,000 <sup>3</sup>
	Charge Exceeding Benefit Limit	N/A	N/A
	Total	\$ 3,000	\$ 11,000
Paid by Insurer		\$ 17,000	\$ 9,000

#### Notes:

1. Approved amount is the lower of actual charge and benefit limit.
2. Coinsurance:  $10,000 \times 20\% + (20,000 - 10,000) \times 10\% = 3,000$
3. Coinsurance:  $(20,000 - 10,000) \times 10\% = 1,000$

**Indicative Premium Schedule of Standard Plans Based on Actuarial Evaluation  
(Net of Commission and Acquisition Costs)**

**Table 1: Premium with \$0 deductible**

<b>Age</b>	<b>Before NCD Deductible \$0</b>	<b>After 30% NCD Deductible \$0</b>
00-01	2,070	1,450
02-04	1,570	1,100
05-09	1,000	700
10-14	790	550
15-19	1,140	800
20-24	1,570	1,100
25-29	1,710	1,200
30-34	2,000	1,400
35-39	2,360	1,650
40-44	2,930	2,050
45-49	3,500	2,450
50-54	3,930	2,750
55-59	4,570	3,200
60-64	5,570	3,900
65-69	6,710	4,700
70-74	7,710	5,400
75-79	9,500	6,650
80-84	12,570	8,800
85+	15,000	10,500

**Table 2: Premium for higher deductible**

<b>Age</b>	<b>Before NCD Deductible</b>			<b>After 30% NCD Deductible</b>		
	<b>\$5K</b>	<b>\$10K</b>	<b>\$15K</b>	<b>\$5K</b>	<b>\$10K</b>	<b>\$15K</b>
00-01	1,360	1,000	710	950	700	500
02-04	1,070	790	640	750	550	450
05-09	710	570	500	500	400	350
10-14	640	500	430	450	350	300
15-19	860	710	570	600	500	400
20-24	1,210	930	790	850	650	550
25-29	1,360	1,070	860	950	750	600
30-34	1,570	1,290	1,070	1,100	900	750
35-39	1,860	1,570	1,290	1,300	1,100	900
40-44	2,360	2,000	1,640	1,650	1,400	1,150
45-49	2,860	2,360	2,000	2,000	1,650	1,400
50-54	3,140	2,710	2,290	2,200	1,900	1,600
55-59	3,790	3,290	2,790	2,650	2,300	1,950
60-64	4,640	4,070	3,570	3,250	2,850	2,500
65-69	5,640	5,000	4,290	3,950	3,500	3,000
70-74	6,500	5,710	4,930	4,550	4,000	3,450
75-79	7,930	7,000	6,070	5,550	4,900	4,250
80-84	10,430	9,140	7,860	7,300	6,400	5,500
85+	12,430	10,790	9,140	8,700	7,550	6,400

## Pricing Methodology

1. The premium rates are calculated based on the following formula and reflect 2010 utilisation and cost experience:

$$\text{Premium rate} = \frac{\text{Existing expected medical claim costs} + \text{Administrative expenses} + \text{Loading for pre-existing conditions}}{(1 - \text{profit margin} - \text{HRP reinsurance rate}) \times (1 - \text{NCD loading})}$$

### Existing Expected Medical Claim Costs

2. Existing expected medical claim costs are generally calculated using Milliman's Hong Kong Health Cost Guidelines ("HK HCG"), which reflects the claims experience of the existing insured population. This includes the utilisation of public and private health care service providers.

3. There are limited medical insurance data on the elderly in Hong Kong. The HK HCG is augmented by extrapolating the relative changes of local health care utilisation by age at the older ages based on Milliman's UK HCG, as the rate of increase in hospitalisation costs with age appears to be broadly similar over the working ages between the insured populations in Hong Kong and UK.

### Administrative Expenses

4. The administrative expenses are assumed to be broadly comparable to the current market average. Commissions and related acquisition costs, however, are not taken into account. It also does not explicitly take into account any one-off development costs that the insurers may incur such as upgrading IT systems. The administrative expense levels are derived with reference to the US experience by type of function and broad Hong Kong expense benchmarks or rule-of-thumb.

### Pre-existing Conditions and HRP

5. Increases are assumed for medical costs to allow for the cost of covering pre-existing conditions under the HPS, which are generally excluded in the current private health insurance products. This assumption is highly judgmental, and takes into consideration US's experience and how this may differ in Hong Kong, namely:

- Under the HPS, insurers will be allowed to apply premium loadings for new members, if necessary.
- Under the HPS, 100% of the cost of pre-existing conditions will be covered only after three years. Insurers will have time to monitor the pre-existing condition claims in the earlier years and adjust the loading as necessary.
- We believe, because of several factors, existing insurers are already inadvertently paying for some claims involving pre-existing conditions.
- Those with pre-existing conditions are already receiving care from HA and some may choose to continue with their treatment at HA.

6. As for the HRP, the proposed reinsurance premium is based on actuarial assumptions. The actual reinsurance rate will depend on the size of the HRP relative to the size of HPS, the competitiveness of HPS products vs. market products, and the amount of HRP funding support from the Government.

### NCD Loading

7. This is loading so that the net monies collected from members after No Claim Discounts are sufficient to cover the claims and other expenses in a mature portfolio.

### Profit Margin

8. This is assumed to be broadly comparable to the current market situation, but will ultimately depend on market forces.

## APPENDIX B HONG KONG'S CURRENT PRIVATE HEALTH INSURANCE MARKET

### Introduction

B.1 Hong Kong's private health insurance (PHI) market has a relatively short history. It started off in the 80s primarily as employers outsourced their medical benefits scheme provided for their employees to insurers. The PHI market had grown steadily but slowly over the years, more or less on par with the overall insurance market until recent years when PHI grew at a rate faster than the overall insurance market.

B.2 Individually purchased PHI is a relatively new phenomenon: it was almost unheard of in the 80s and remained a small proportion of medical insurance throughout the 90s. Employer-provided medical insurance remained the predominant portion of medical insurance, but its growth has turned more modest in the past decade. By contrast, individual PHI has seen rapid growth since 2004 with double-digit annual growth rate.

B.3 This note summarizes our analyses of the current PHI market and its recent trends.

### Population Coverage

B.4 According to the Thematic Household Survey (THS)<sup>1</sup> conducted by the Census and Statistics Department (C&SD) in February to May 2008, there were around 2.42 million people covered by PHI<sup>2</sup>, equivalent to 34% of Hong Kong's resident population. Of this total, about 1.09 million were covered by individually-purchased PHI only, about 0.86 million by employer-provided PHI only<sup>3</sup>, and about 0.48 million by both. These figures exclude some 0.34 million people who received only Civil Service and Hospital Authority (HA) staff medical benefits. (Figure B.1)

B.5 Compared with 2005, the population coverage of PHI rose by 8.7% to 2.42 million in 2008. The individual segment provided the major growth impetus, with the number of people covered by individual PHI (including those also with group cover) rising by 16.3% to 1.57 million. However, the number of people covered by group PHI (including those also with individual cover) did not show much change, hovering at around 1.35 million. (Figure B.1)

B.6 By comparison, the statistics compiled by the Hong Kong Federation of Insurers (HKFI) show that there were around 2.0 million memberships under individual insurance policies and 1.5 million memberships under group insurance policies in force in 2009. (Figure B.2) However, HKFI's statistics cannot differentiate the overlap in membership between the two types of policies and the memberships under group policies include coverage of the dependents of employees. Hence the total of 3.5 million PHI memberships according to HKFI was larger than the THS results.

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<sup>1</sup> THS covered land-based non-institutional population and excluded foreign domestic helpers.

<sup>2</sup> There is no standard definition of PHI. See paragraphs B.23-26 for the definition of PHI in THS and other definitions of PHI pertaining to other sources of data and information in this Appendix.

<sup>3</sup> Due to data constraints, the figures here also cover employer-provided medical benefits not in the form of PHI provided by employers, except the Civil Service and Hospital Authority staff medical benefits. Yet no significant impact to the overall analysis is envisaged due to this limitation. Unless otherwise stated, the employer-provided PHI is defined by such coverage throughout this Appendix.

B.7 The PHI market has expanded fast in recent years. According to the HKFI statistics, the memberships of group PHI plans went up from about 1.1 million in 2004 to 1.5 million in 2009<sup>4</sup>. The corresponding figure for individual PHI plans rose even faster, from about 1.3 million to 2.0 million. The market expansion was attributable to combined influence of factors, including economic upturn from 2003 to 2008, heightened awareness of healthcare protection within the population, crowdedness of public hospitals, and development of private hospitals in specific niche services to attract patients.

## **Profile of Insured Population**

B.8 The analyses on the profile of population with PHI cover in this section are based on the results of THS in 2008 and figures exclude those who are covered only by Civil Service/HA staff medical benefits.

B.9 Analysed by gender, the proportions of males and females who were covered by PHI (group and/or individual plans) are roughly the same, at 37% and 36% respectively.

B.10 Analysed by health status, the population coverage of PHI was relatively higher for people without chronic disease, at 39%. For people with chronic disease, the proportion was much lower at 28%. Common exclusion of pre-existing conditions in PHI contracts was a major factor that discouraged people with chronic disease to enroll.

B.11 Analysed by age, the population coverage of PHI was highest for people aged 25-54, at 44-56%. (Figure B.3) To some extent, this reflected the fact that a higher proportion of these people were employed and enjoyed PHI protection provided by their employers. Yet for the older age groups, the PHI coverage was markedly lower partly because of refusal by insurers to accept their enrolments and partly because of much more expensive age-tied premium.

B.12 Analysed by household income, the population coverage of PHI increased with level of income. The insured proportion went up progressively from the lowest 6% for households with monthly household income of less than \$5,000 to 61% for households with monthly household income of \$50,000 and above. (Figure B.4)

B.13 For employed persons with employer-provided PHI in particular, they constituted a higher proportion of people working in larger firms compared with those working in smaller firms. In other words, employer-provided PHI was relatively less prevalent for smaller firms. The proportion of employed persons with employer-provided PHI averaged at 25% for the firms hiring 10-19 persons and 14% for those hiring less than 10 persons. (Figure B.5)

## **Premium Revenue**

B.14 According to the statistics compiled by OCI, total gross premium for PHI (including medical insurance of general business and medical riders to long-term business) reported by insurers rose markedly from \$5.4 billion in 2004 to \$9.9 billion in 2009, giving an average annual

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<sup>4</sup> Due to methodological difference, the growth trend for group insurance in recent years as revealed by HKFI figures differs somewhat from that as revealed by THS figures in paragraph B.5. Yet both set of figures likewise point to the phenomenon that the individual segment provides the major growth stimulus to the PHI market in recent years.

increase of 12.9% during the period. The statistics compiled by HKFI through member surveys reveal a similar uptrend, with total premium for PHI rising by 13.5% per annum from \$5.3 billion in 2004 to \$10 billion in 2009. The HKFI statistics also show that in terms of premium revenue, the market share of group plans (predominantly employer-provided plans) was marginally smaller than that of individual plans in 2009. (Figure B.6)

B.15 The HKFI statistics show that the average gross premium per member of PHI policy rose by an average of 6% per annum from \$2,182 in 2004 to \$2,883 in 2009. Although the average premium change is also affected by the composition of products in the market, the upward adjustment in standard premium due to medical inflation and increases in claim incidents in recent years is commonly viewed as the major underlying factor.

B.16 The average gross premium per individual and group PHI policy member amounted to \$2,669 and \$3,168 respectively in 2009, according to the HKFI statistics. Yet strictly speaking, the two figures are not entirely comparable. PHI plans taken out by individuals more often encompass inpatient care only, while PHI plans taken out by groups typically include both outpatient and inpatient covers. Besides, employers especially the larger ones usually enjoy substantial group discount on premium that do not exist in the individual market segment.

## **Competition and Profitability**

B.17 As of December 2009, about 25 life insurance companies and 40 general insurance companies sold some forms of PHI, with the former providing service through medical riders to long-term insurance plans and the latter issuing annual medical insurance policies. Concurrently, there were 59 insurers authorized to carry on long term direct insurance business and 71 insurers authorized to carry on general direct medical insurance. It is crudely estimated that over 80% of PHI premium in the industry are written by ten insurance groups, some of which own both life and general insurance subsidiaries.

B.18 Competition among insurers in the PHI market is intense especially for the group plans. Because of keener competition, the reported underwriting profit margin for group plans is relatively narrow, which is particularly the case for bigger employers which have better bargaining power to seek lower group premium. Despite slim profit margin, some insurers are still eager in the group PHI business as they see it as the opportunity to cross-sell other insurance products, add value to their services, and enhance relationship with group clients. For the group clients, it is quite common for them to commission insurance brokers to select, negotiate and arrange insurance policies with the insurers.

B.19 As regards individual PHI plans, the profit margin is relatively more decent than group plans. Apart from difference in competition environment, lower claim ratio is the underlying factor. According to the HKFI statistics, the claim ratio (amount of claims to amount of premium) for individual PHI plans averaged at 57%<sup>5</sup> during 2005-09, markedly lower than that of 81% for

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<sup>5</sup> HKFI's claim ratio for individual PHI plans covers both reimbursement products and hospital cash products, while most group PHI plans are reimbursement products. Inclusion of hospital cash products has the effect of lowering the claim ratio of individual PHI plans because the claim experience is usually better. Yet this does not alter the broad picture that the claim ratio of individual PHI plans is much lower than that of group PHI plans, in view of limited market share of hospital cash products in the individual PHI market.



group PHI plans. (Figure B.7) Yet unlike group plans, there are substantial commission expenses in selling individual PHI products as they are mainly distributed by the insurance agents acting on behalf of the insurers.

B.20 According to the OCI statistics, the underwriting margin, i.e. proportion of underwriting profit (after net commission, net claims incurred, and operating costs) to net earned premium (after reinsurance), for PHI plans provided by general insurers (including group and individual plans) stood at 4% in 2009. Owing to deteriorating claims experience, an underwriting margin of minus 5% was recorded in 2005. With premium rate increase thereafter, the underwriting performance gradually improved and turned to profit-making again from 2007. On the cost side, net claims incurred, management expenses (including administration and marketing) and net commission payable respectively accounted for 76%, 10% and 10% of net earned premium in 2009. (Figure B.8)

## **Regulation**

B.21 The Commissioner of Insurance, appointed by the Chief Executive as the Insurance Authority (IA), has the principal function under the Insurance Companies Ordinance (ICO) to regulate and supervise the insurance industry to promote its general stability and protect existing and potential policy holders. Insurers offering health insurance are subject to the same general regulation as with other insurers. There is no other statutory or administrative regulation over insurers offering health insurance.

B.22 Under the current regulatory regime, the IA is primarily responsible for the prudential supervision of insurers so that their obligations and policy holders' expectations can be met. The IA does not have the power to intervene into matters relating to premium setting and policy wording. Health insurance is not subject to any specific regulation on premium setting and policy wording under the present regulatory regime.

## **Definitions**

B.23 There is no standard definition of PHI product, and the definitions adopted in different context may slightly differ. Yet it is commonly agreed that a PHI product should be one which is primarily designed to indemnify the cost of medical treatment under the principle of indemnity. While some insurance products such as travel and accident insurance may reimburse health-related expenses under specified circumstances, they are not normally classified as PHI because the product feature does not pertain to general health protection. Also, insurance products offering cash compensation that may exceed the cost of medical treatment, such as catastrophic cash products, are generally not regarded as PHI because they do not follow the principle of indemnity.

B.24 According to the classification of insurance business under the ICO, "sickness" insurance pertains to "effecting and carrying out contracts of insurance providing fixed pecuniary benefits or benefits in the nature of indemnity (or a combination of the two) against risks of loss to the persons insured attributable to sickness or infirmity".

B.25 For the purpose of conducting survey to compile medical insurance business statistics, HKFI defines PHI products as those that reimburse the insured for expenses incurred as a result of

medical treatment of illness (i.e. reimbursement products). It excludes products that do not follow the principle of indemnity.

B.26 In THS, PHI covered both individually purchased PHI and employer-provided PHI. The former referred to “any package of medical insurance policies purchased by individuals covering any combinations of medical benefits, including those packaged in combination with other types of insurance.” However, insurance coverage which “only limits to the defined illnesses on the insurance policy” or “only limits to hospitalization or outpatient claims arising from accidents” are excluded. For the latter, it referred to medical benefits provided to employees, irrespective of whether they were currently employed or retired, and their eligible dependants by their employers / companies in the private sector in whatever form (i.e. not necessarily in form of group medical insurance). However, Civil Service and HA staff medical benefits provided by the Government were not included.

## **Common PHI Products**

### ***Reimbursement Product***

B.27 Reimbursement product is the most common type of PHI product in the market. It indemnifies the insured persons against actual medical expenditure incurred, so that the amount claimable should not exceed the expenditure. For in-patient cover, the indemnity is commonly based on pre-set benefit schedule which encompasses itemized benefit limits by spending type such as room and board, doctor consultation and surgical cost. There may be overall benefit limits per hospital admission, per annum and even lifetime.

B.28 For out-patient cover, insurers usually limit the number of consultations claimable per year. The benefit (with or without ceiling) is typically payable per consultation, and the insured persons are usually required to bear a certain amount of deductible.

B.29 To suit the need and affordability of different customers, insurers normally offer three to four grades of products with diverse benefit limits and correspondingly higher or lower premium levels.

B.30 Premium for reimbursement products is generally age bracketed, with lower premium for younger age groups, and vice versa. This reflects the escalation of average health risks alongside age increase. Besides, an insurer may impose loading on insurance premium for one who is regarded to have health risk higher than average in the same age group, with a view to compensating for higher likelihood of claims. For the sake of containing risk, an insurer may also impose exclusion clauses in the insurance contract to exclude coverage of pre-existing illnesses prior to commencement of contract.

### ***Supplementary Major Medical Cover***

B.31 It is increasingly popular for insurers to offer Supplementary Major Medical (SMM) cover. SMM products are usually sold as optional riders to reimbursement products. SMM cover indemnifies the insured, up to the SMM benefit limits, against actual medical expenses incurred in excess of the benefit limits of the underlying reimbursement product. SMM is also commonly considered as a reimbursement product.

### ***Hospital Cash Product***

B.32 Hospital cash product offers fixed amount of benefits per day, normally from a few hundred to a few thousand dollars, to an insured person during the period of hospitalisation. It is often sold as a medical rider to life insurance policies, but in some cases it is also sold as a standalone product. Because the benefit amount is not tied to the level of spending on hospital care, the product may also serve as a form of income protection under certain circumstances, most apparently for treatment in the heavily subsidized public hospitals.

### ***Catastrophic Cash Product***

B.33 There are certain insurance products that are health-related but are commonly not considered as PHI products because they do not follow the principle of indemnity and the pay-out of insurance benefit is not conditional upon treatment of illness. Catastrophic cash product is the most common example. It offers a large lump-sum payment upon confirmation of any one catastrophic illness on a pre-defined list, without requiring the insured person to undertake treatment. The majority of catastrophic cash products in the market are sold as riders to life or life-cum-saving policies. In such cases, the benefit payment is usually an acceleration of the benefits that the insurers would have paid on death of the policyholder or maturity of the policy.

### **Role of PHI in Healthcare Financing**

B.34 According to Hong Kong's Domestic Health Accounts (DHA), total health expenditure soared at an average annual rate of 8.2% from \$20 billion in 1989/90 to \$75 billion in 2006/07. This remarkable increase was largely led by expansion in public health expenditure, averaging at 9.7% per annum. Against this backdrop, the supplementary role of PHI in healthcare financing nevertheless held up quite well since health expenditure financed by PHI registered a distinct increase of 8.8% per annum over the same period. The impetus mainly came from the individual PHI segment, which witnessed an average annual surge of 17.7% in health expenditure that it financed. The group PHI segment also expanded, albeit at a less rapid pace, by 6.0% per annum in terms of the health expenditure it financed. (Table B.1) As a result, the overall share of PHI in healthcare financing increased from 11.9% in 1989/90 to 13.0% in 2006/07. Based on latest indications, the supplementary role of PHI in healthcare financing should have further enhanced in more recent years.

B.35 The financing role of PHI varies with the type of healthcare expenditure. On private inpatient care (excluding inpatient and institutional long-term care), PHI was the major financier accounting for 58.3% of expenditure involved in 2006/07. As regards private outpatient care, the financing share of PHI was relatively less at 22.2%. (Table C.1) Since individual PHI policies commonly pertain more to inpatient cover, the contribution of individual PHI segment in financing private inpatient care, at 21.4%, was about 3 times larger than the corresponding share in financing private outpatient care, at 6.3%. As regards employer-provided PHI policies, consistent with the fact that their coverage was generally more comprehensive, their shares in financing private inpatient and outpatient care were less divergent, at 36.9% and 15.9% respectively. (Figure B.9)

## **Healthcare Utilization by the Insured Population**

B.36 According to the estimates provided by the consultant commissioned by the Food and Health Bureau, the admission rate of the insured population is lower than that of the uninsured population, at about 13% vs. 23% respectively. The difference is more profound when considering the elderly population aged 65 and above, with admission rates at 33% for those with PHI cover and 57% for those without PHI cover. (Table B.2) One reason for the difference is difficulty for unhealthy individuals to obtain PHI cover in the current market. It is common for insurers to turn away unhealthy individuals and limit PHI policy issuance to individuals below a certain age, which varies from 60 to 75 years of age depending on the insurer.

B.37 There is a higher tendency for people covered by PHI to use private hospitals for inpatient care. It is roughly estimated that for people covered by PHI, 63% of the hospital admissions pertain to the private sector, and for people without PHI cover, only 10% of the admissions pertain to the private sector. For people with PHI cover, the proportion of admissions pertaining to the private sector does not vary by much between people aged below 65 and people aged 65 and above. However, for people without PHI cover, only 7% of the admissions of people aged 65 and above were private while 13% of the admissions of people aged below 65 were private.

B.38 While there is a higher tendency for people covered by PHI to use private hospitals, over one third of the admissions required by people covered by PHI still pertain to the public sector for various reasons. The notable reasons include emergency cases and cases requiring inter-disciplinary care which are usually treated at public hospitals, avoidance of out-of-pocket payment when the insurance protection is insufficient to cover all the private hospital expenses, and budget uncertainty when the insured cannot ascertain the out-of-pocket payment in advance to receiving medical treatment. This situation helps to partly explain why the share of PHI in financing total health expenditure remained at some 13%, although the population coverage of PHI exceeded one-third.

B.39 Overall, the role of PHI in healthcare financing in Hong Kong is determined by not only its market penetration but also how likely people continue to use public services even with PHI coverage. As the decision to go private is closely related to adequacy of insurance benefit coverage and transparency of private hospital charges, the expansion in role of PHI in healthcare financing will be restrained if the relevant situations still have much room for improvement.

## **Factors Constraining the Financing Role of PHI**

B.40 The financing role of PHI in the healthcare system is closely related to its market penetration. Although the PHI market has been growing remarkably in recent decades, the proportion of population covered by PHI is predicted to taper off in the long term. Population ageing is the main reason, as the buyers of individual PHI plans generally have a greater tendency to lapse on their medical insurance at older age when the premium is poised to go up. Besides, employer-provided PHI normally does not extend to retirement so that some retirees have to re-access PHI protection through individual plans and go through a re-underwriting process with entry age and other health status requirements that they may not fulfil. Even if the enrolment is accepted, there may be exclusion of pre-existing illnesses accumulated over the years and the premium loading may be prohibitively high.

B.41 The long-term prospect of PHI market penetration is also restrained by reluctance of young lives to subscribe medical insurance protection early. Although the premium for the young is relatively low, it is often difficult to promote PHI products to those who are healthy and do not see medical protection a pressing need. Besides, some young people who have been insured may lose the appetite to stay on when they have not made claim over a long period. Although the insurance appetite increases with age and deterioration of health status, under such circumstances there is a higher chance of refusal to insurance enrolment, introduction of exclusion clauses for pre-existing illnesses where they exist, and charging of premium loading for higher-risk enrolees. In consequence, absorption of new lives into the insurance pool would become more difficult.

B.42 Of no less importance is consumer confidence on PHI, which is crucial to sustained development of the PHI market. As different sources of information likewise reveal, there is still much room for strengthening public confidence on PHI products. According to the opinions received from the First Stage Public Consultation on Healthcare Reform, there are a number of negative public perceptions about PHI which can boil down into dissatisfaction about PHI product standard and transparency. The perceived shortcomings are summarized below:

- (a) Dispute over insurance claims
- (b) Exclusion of pre-existing conditions
- (c) Inadequate benefit coverage
- (d) Lack of portability and continuity of policies
- (e) No guaranteed renewal of policies
- (f) No assurance on future premium

B.43 For the disputes over insurance claims in particular, a major cause is that different insurance companies may have different interpretation of similar policy terms and conditions in PHI policies, sometimes even for those commonly adopted. According to the Insurance Claims Complaints Bureau, there were 159 complaints about hospitalization/medical insurance in 2009 (compared with 90 in 2004), of which 42 complaints were about excluded items, 42 about non-disclosure, 33 about amount of indemnity, 28 about application of policy terms, 1 about breach of warranties or policy conditions, and 13 about other natures. According to the Consumer Council, many of the complaints about PHI it received in recent years were related to refusal of claims, inadequate amount of indemnity, premium setting and service quality.

B.44 On the supply side, the PHI market is faced with the challenges posed by rising medical costs and moral-hazard induced utilisation of healthcare services. According to HKFI, the average billed amount and paid amount for claims by group PHI policy members (general ward plans) rose sharply by 11.8% and 10.6% respectively per annum during 2002-08. This situation, if sustains, will aggravate premium hike and curb expansion of the PHI market in the long term. The solution partly hinges on long-term increase in capacity of the private healthcare market in terms of infrastructure and manpower to contain medical inflation. But solving of moral hazards is less straight-forward. One major problem is that moral hazard behaviours are difficult to detect and avoid due to information asymmetry. For example, PHI plans normally do not cover investigations or health checks that are not medically necessary. Yet medical necessity can be

highly judgmental in certain cases and this may provide room for irresponsible consumers and providers to make use of the grey zone to claim for procedures that should not be covered according to the insurance contract. The solution rests with strengthening of clinical benchmarks and audits, which are however complicated and challenging due to the balanced need to safeguard patient interest and professional autonomy.

B.45 Another source of moral hazard comes from lack of transparency in medical fees. This may provide opportunity for excessive pricing by irresponsible medical providers or else arbitrary itemized pricing that such providers agree with the insured persons to maximize the amount that can be claimed from the itemized benefit schedule of PHI. There is also anecdotal evidence that some doctors charge differently for insured patients according to their insurance benefit coverage. The solution rests with strengthening of medical price signals without inappropriately distorting clinical decisions and business viability of healthcare providers, and distorting normal price and service competition in the market.

B.46 Continuous improvement of public healthcare services in recent decades has dynamic impact on the PHI market, and the interactive relationship with the public system and the PHI market will affect the role of the latter in the overall healthcare model. With universal access to the public system, Hong Kong residents covered by PHI actually enjoy “double” healthcare protection. To the extent that the benefit coverage of PHI is insufficient to pay for the expenses on private healthcare, or that the adequacy is uncertain beforehand, the incentive for the uninsured to take out PHI would be more limited. Also, the chance for the insured to fall back to the public system would be higher. Under these circumstances, the relief that the PHI market can bring to the public system and the supplementary role that it can play within the healthcare system would be restricted.

**Table B.1** Total Health Expenditure by Financing Source, 1989/90 – 2006/07 (HK\$ Million)

	1989/90	1992/93	1995/96	1998/99	2001/02	2004/05	2005/06	2006/07	Average Annual Change 1989/90 to 2006/07
Government	7,749	15,844	25,316	35,800	39,152	37,094	36,930	37,417	9.7%
PHI	2,338	3,622	6,015	8,198	8,117	8,434	9,057	9,786	8.8%
Individually purchased PHI	263	419	1,336	2,188	2,721	3,284	3,663	4,213	17.7%
Employer-provided PHI	2,075	3,204	4,680	6,010	5,396	5,150	5,395	5,573	6.0%
Out-of-pocket	9,202	14,332	18,963	21,347	20,847	22,114	23,753	26,451	6.4%
Others	370	375	993	928	571	620	903	1,394	8.1%
Total	19,659	34,173	51,288	66,273	68,687	68,263	70,643	75,048	8.2%

Source: Hong Kong's Domestic Health Accounts 1989/90 – 2006/07

**Table B.2** Hospital Admission Rate and Utilisation by Age Group and Insurance Status

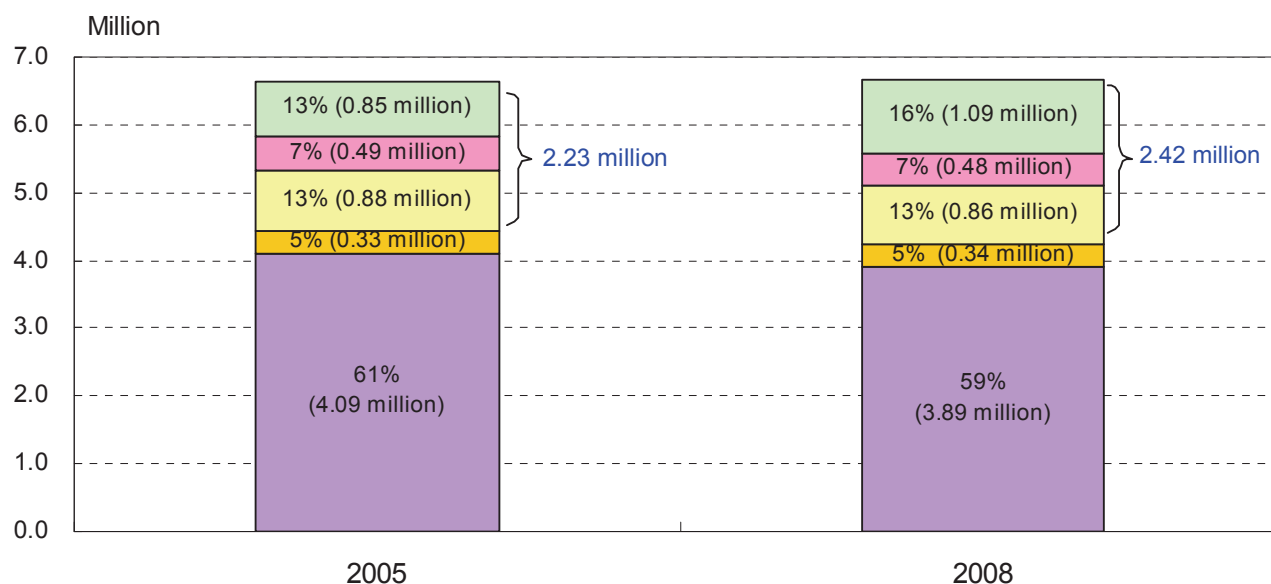
Age Group	Insured with PHI			Uninsured			Overall		
	Overall Admission Rate	Public Share*	Private Share*	Overall Admission Rate	Public Share*	Private Share*	Overall Admission Rate	Public Share*	Private Share*
0-64	12%	37%	63%	15%	87%	13%	14%	70%	30%
65+	33%	38%	62%	57%	93%	7%	56%	92%	8%
Total	13%	37%	63%	23%	90%	10%	19%	78%	22%

Notes: (\*) Share in terms of hospital admissions

Figures are based on the Milliman Hong Kong Health Cost Guidelines, THS 2008, and the number of private and HA admissions

Source: Milliman Limited (Consultant commissioned by the Food and Health Bureau in relation to the design of the Health Protection Scheme)

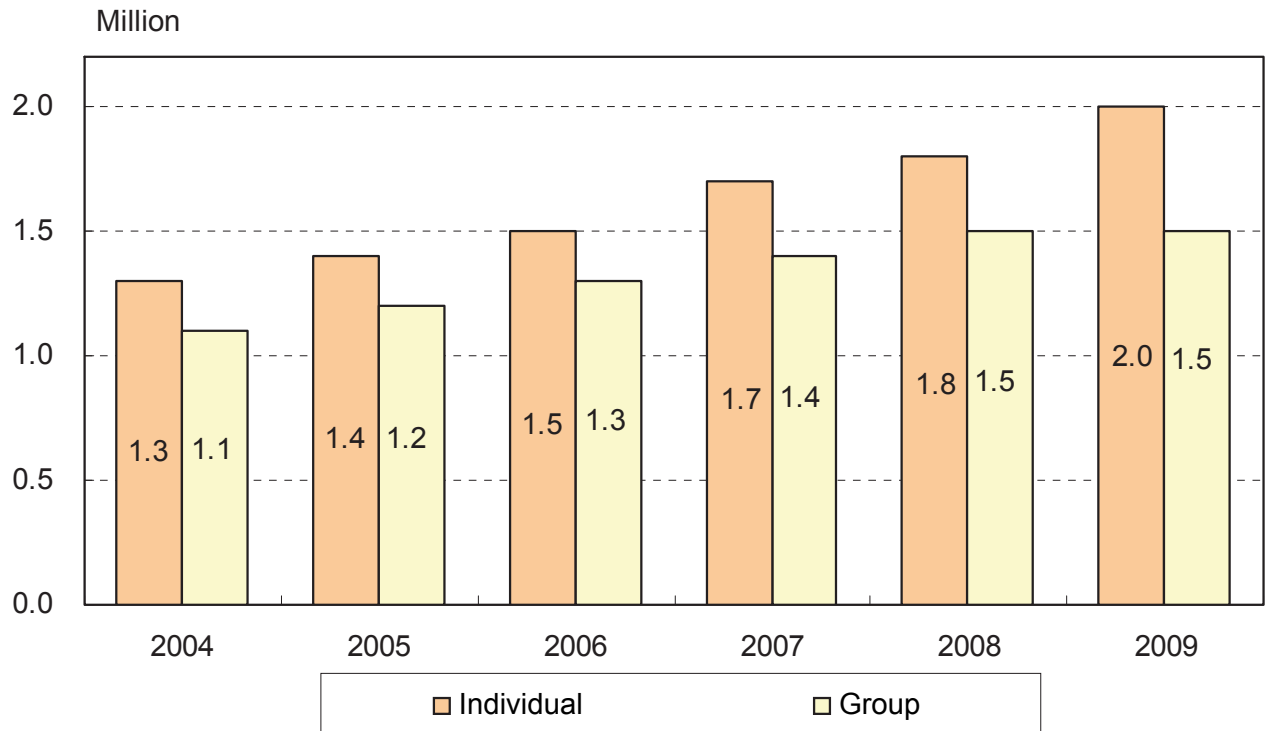
**Figure B.1** Population Coverage of PHI, 2005 and 2008



Individually purchased PHI only
Both individually purchase PHI & employer-provided medical benefits (except Civil Service / HA staff medical benefits)
Employer-provided medical benefits only (except Civil Service / HA staff medical benefits)
Civil Service/HA staff medical benefits only
No coverage

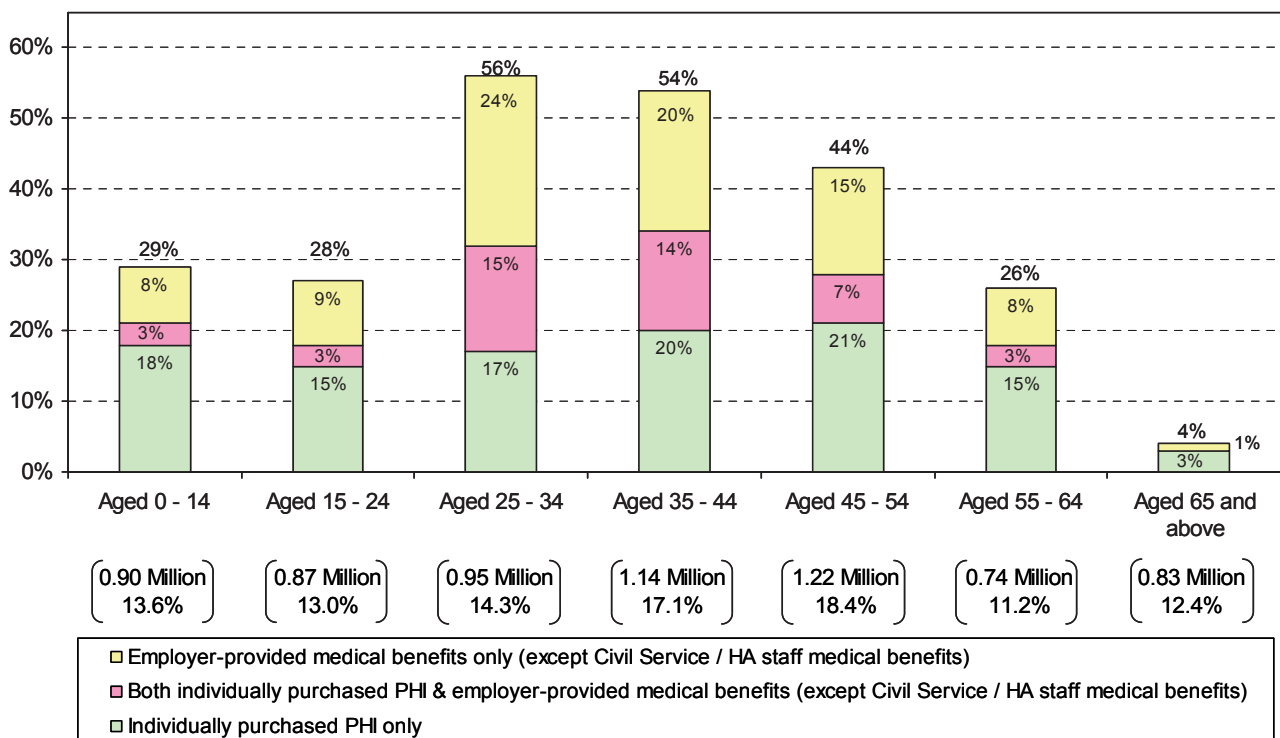
Source: Thematic Household Survey 2005 and 2008

**Figure B.2** Size of PHI Memberships, 2004 – 2009



Source: Hong Kong Federation of Insurers

**Figure B.3** PHI Population Coverage by Age Group, 2008

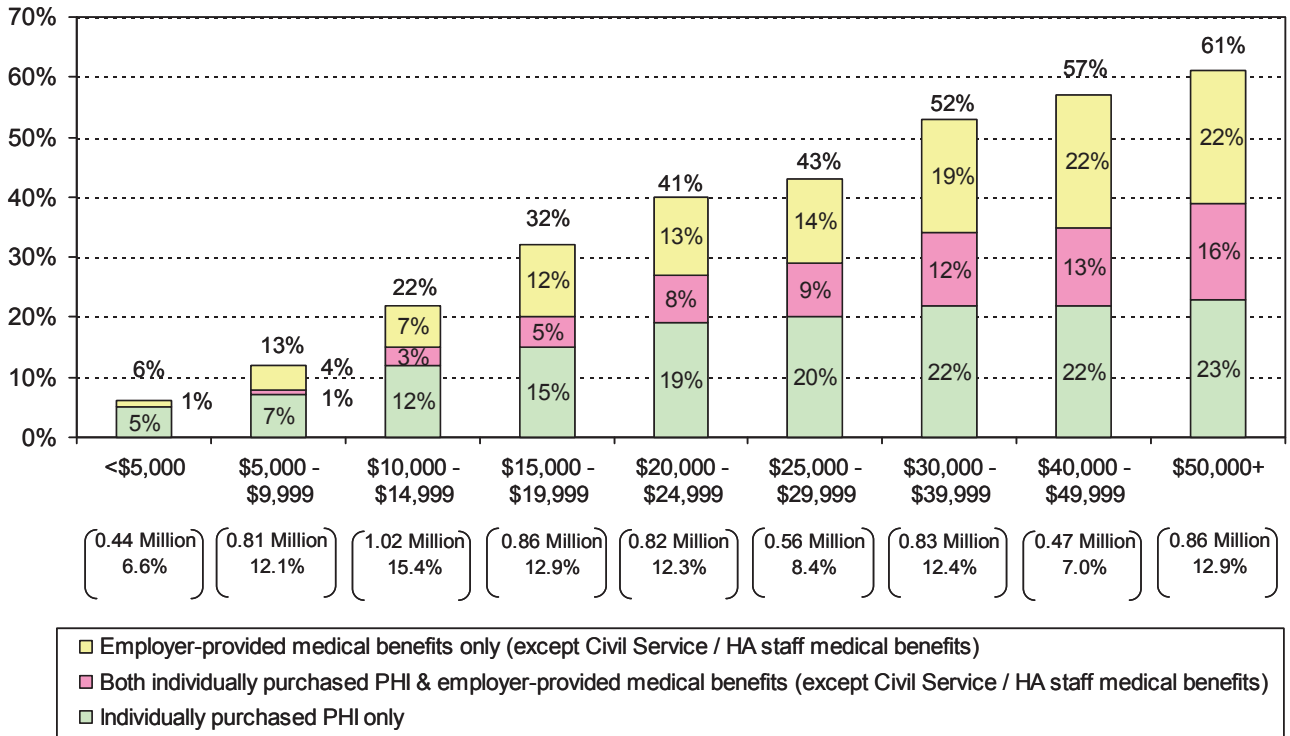


Note: Figures in brackets refer to total number of people in specified age groups, and the corresponding shares in resident population (excluding foreign domestic helpers).

Source: Thematic Household Survey 2008



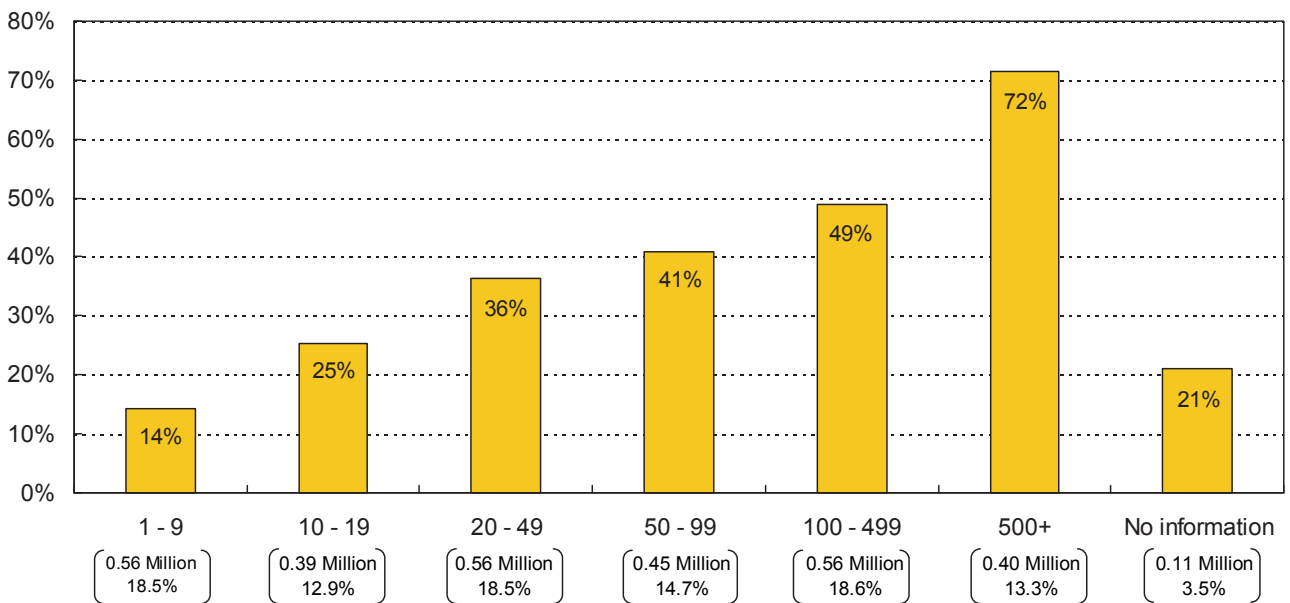
**Figure B.4** PHI Population Coverage by Monthly Household Income, 2008



Note: Figures in brackets refer to total number of people in households with specified monthly household income range, and the corresponding shares in resident population (excluding foreign domestic helpers).

Source: Thematic Household Survey 2008

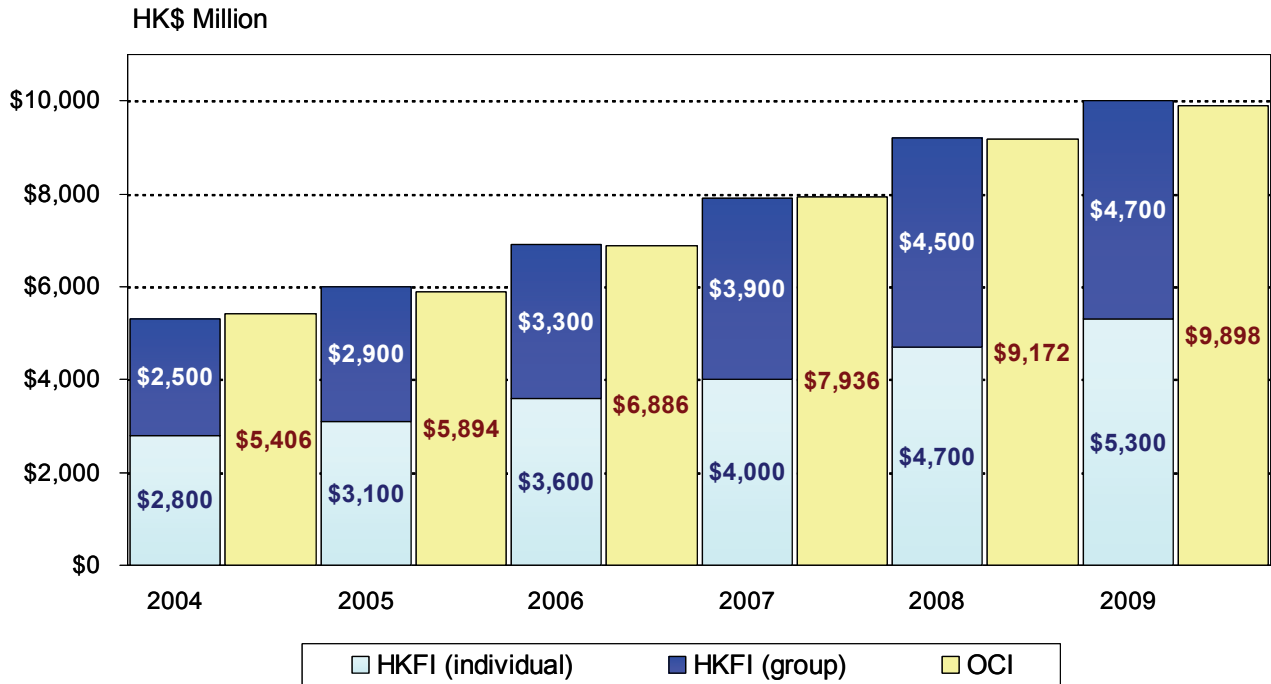
**Figure B.5** PHI Coverage of the Employed Population by Firm Size, 2008



Note: Figures in brackets refer to total number of employed persons in all the firms with specified size of staff establishment, and the corresponding shares in the employed population (excluding foreign domestic helpers).

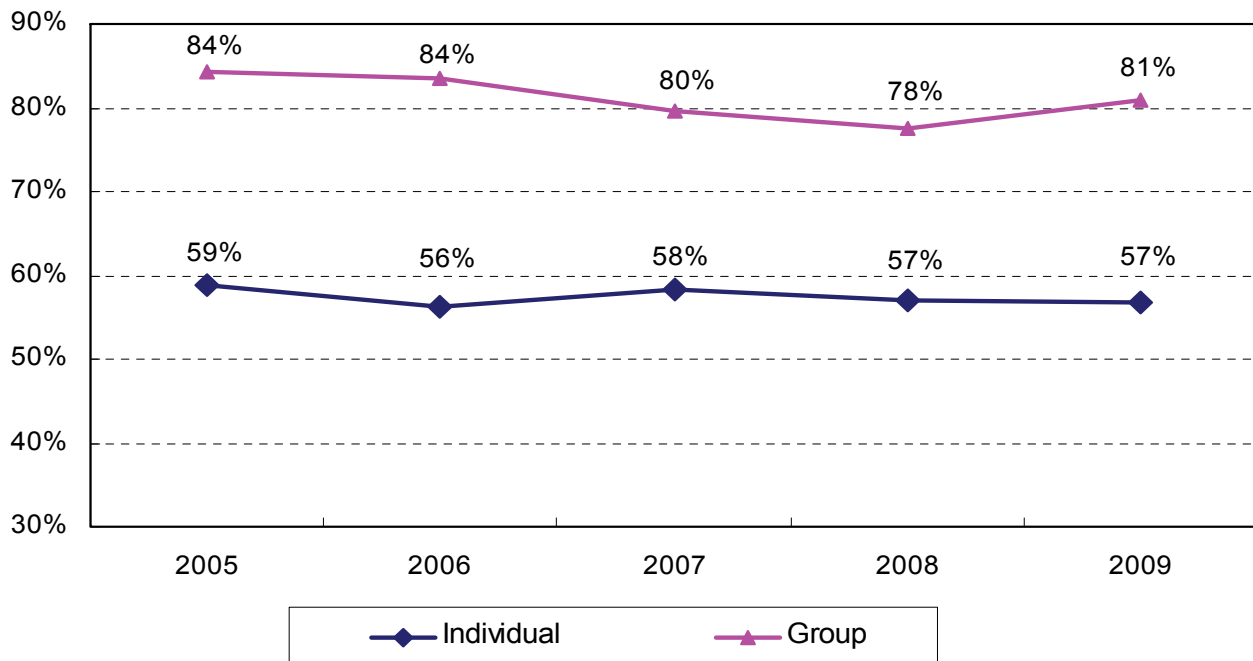
Source: Thematic Household Survey 2008

**Figure B.6** Annual PHI Premium Revenue, 2004 – 2009



Note: Figures in breakdown by group and individual plans are not available for OCI statistics.  
 Source: Office of the Commissioner of Insurance, Hong Kong Federation of Insurers

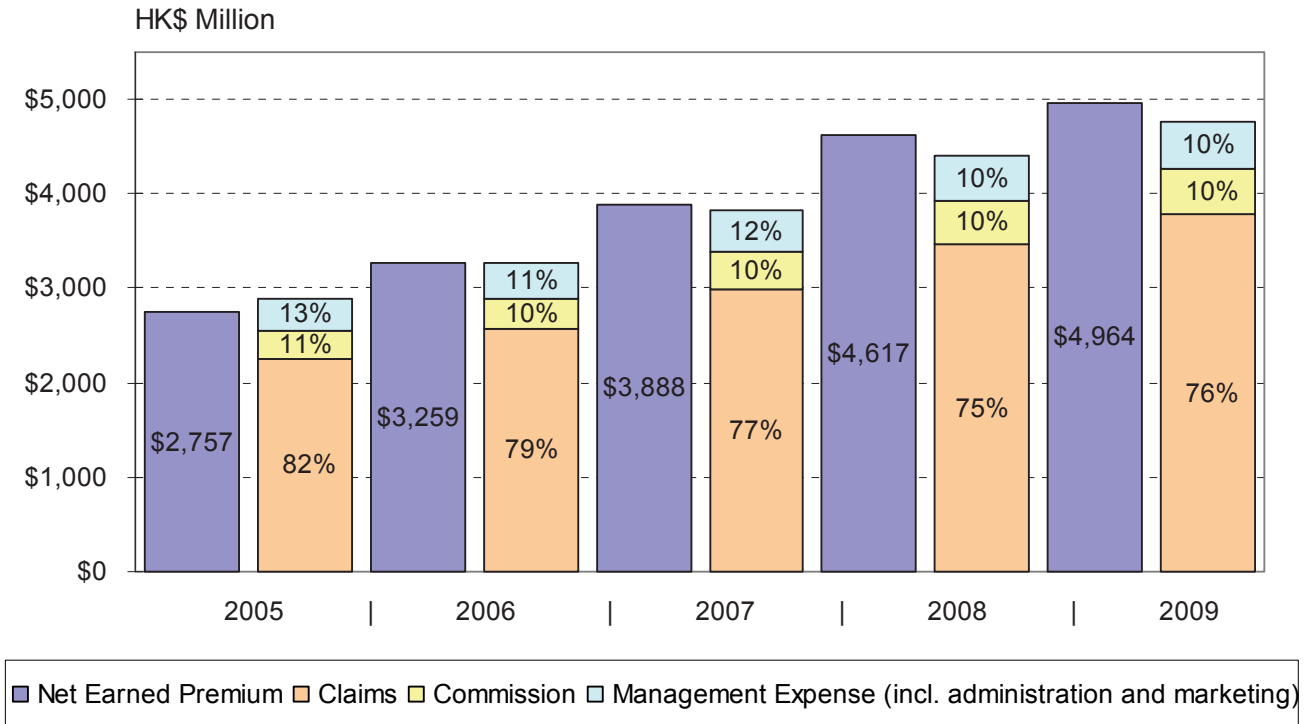
**Figure B.7** PHI Claim Ratios\* for Individual vs. Group Business, 2005 – 2009



Notes: (\*) As % of gross earned premium  
 The claim ratio for individual PHI plans here covers both reimbursement products and hospital cash products, while most group PHI plans are reimbursement products. Inclusion of hospital cash products has the effect of lowering the claim ratio of individual PHI plans because the claim experience is usually better. Yet this does not alter the broad picture that the claim ratio of individual PHI plans remains much lower than that of group PHI plans, in view of limited market share of hospital cash products in the individual PHI market.

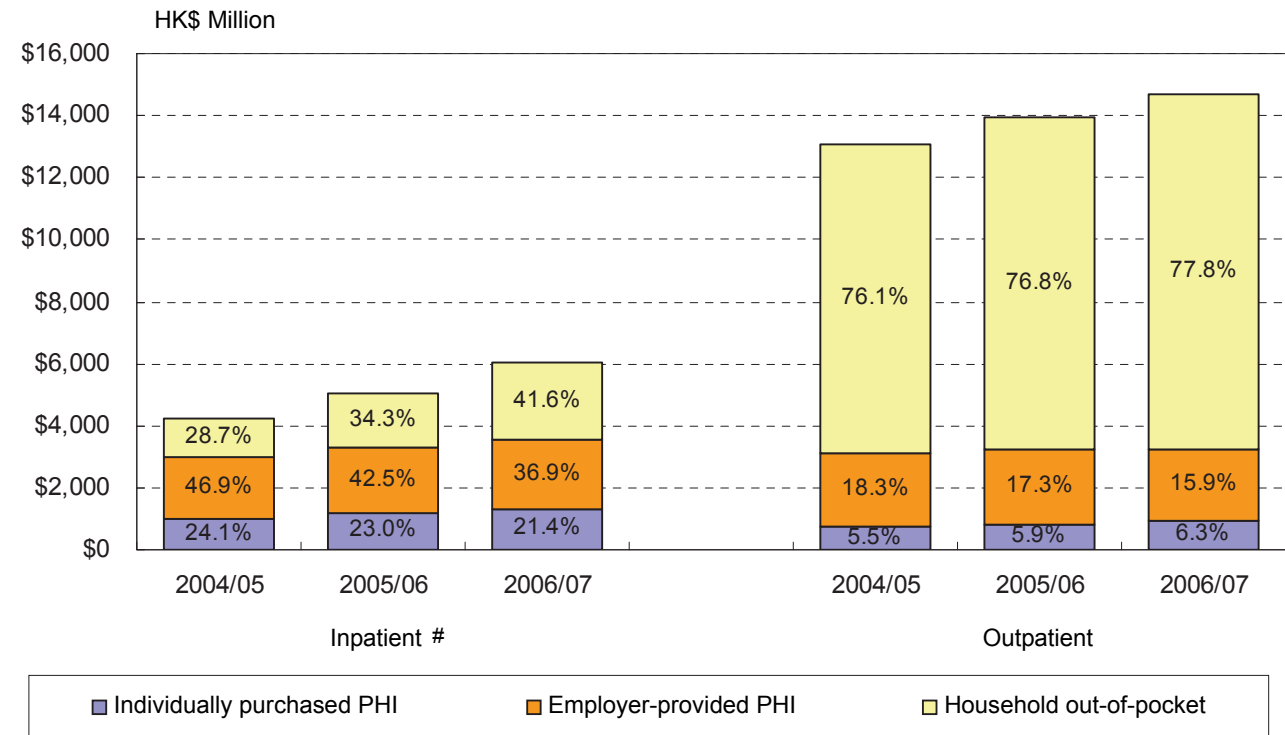
Source: Hong Kong Federation of Insurers

**Figure B.8** PHI Operating Ratios\* for General Insurers' Medical Plans, 2005 – 2009



Note: (\*) As % of net earned premium  
 Source: Office of the Commissioner of Insurance

**Figure B.9** Expenditure on Private Inpatient and Private Outpatient Care by financing source, 2004/05 – 2006/07



Note: (#) Excluding inpatient and institutional long-term care. A negligible proportion of financing came from miscellaneous sources for private inpatient care, such as non-profit institutions.  
 Source: Hong Kong's Domestic Health Accounts 2006/07.

### An Overview of Hong Kong's Healthcare System

C.1 Hong Kong's healthcare delivery system is characterized by its dual public and private healthcare sectors. Both sectors cover the various level of care from primary to the more specialized secondary and tertiary care. Both sectors and all levels of care have their unique roles which are equally important in promoting and protecting the health of the population. This note focuses more on the private healthcare sector and secondary and tertiary care for the purpose of providing background relevant to the discussion of health insurance.

#### *Public and Private Healthcare Sectors*

C.2 In the public healthcare sector, the Department of Health (DH) assumes public health functions including health promotion and disease prevention, while the Hospital Authority (HA) provides public hospital and clinic services through its 41 hospitals/institutions, 48 Specialist Out-patient Clinics (SOPCs), 74 General Out-patient Clinics (GOPCs) and 14 Public Chinese Medicine Clinics. HA concentrates mostly on specialized secondary and tertiary care provided through public hospitals and specialist clinics. The public healthcare system provides the Hong Kong population with equitable access to quality healthcare services at very affordable charges highly subsidized by the Government, underpinned by the long-established policy that "no one should be denied adequate healthcare through lack of means".

C.3 The private healthcare sector is the main provider of primary care<sup>1</sup> and complements the public sector by providing a range of specialist and hospital services. There are 13 private hospitals and more than 3700 Western medical practitioners' offices and clinics in the private sector. They provide the public with various choices of healthcare, including individual aspects of care such as choice of doctors and preference of amenities. Apart from doctors of Western medicine, other healthcare professionals including Chinese medicine practitioners, dentists, nurses, chiropractors, physiotherapists, occupational therapists, pharmacists, optometrists, etc. also provide healthcare in the private sector. Private healthcare services are not subsidized (except for certain institutional or day-time long-term medical and nursing care) and patients have to bear the full-cost for using them.

#### *Public and Private Health Expenditure*

C.4 According to the Domestic Health Accounts for 2006/07 (DHA 2006/07), Hong Kong's total health expenditure amounted to 5.0% of GDP or some HK\$75 billion (Table C.1). Analysed by financing source, the share of the public source was roughly the same as that of the private source (Figure C.1). In 2006/07, public and private health expenditure reached HK\$37.4 billion and HK\$37.6 billion respectively. Public health expenditure, which was financed exclusively by public funding from government budget, was used mostly for funding the highly-subsidized public healthcare system. Private health expenditure, which mainly came from out-of-pocket household payment and insurance pay-out, was mostly spent on healthcare services and medical goods supplied by the private sector, including private out-patient care, private in-patient care and

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<sup>1</sup> Primary care is the first point of contact for individuals and families in a continuing healthcare process.

medical goods at retail outlets.

C.5 Because the public healthcare system is highly subsidized, 95% of the cost involved in delivering the public healthcare services in 2006/07 was financed by public funding while only 5% came from user fees. As regards services delivered in the private sector, they were mostly funded by out-of-pocket household expenditure, accounting for 67% of the expenditure involved in 2006/07, which were mainly destined for private primary care/out-patient services and medical goods at retail outlets. By comparison, employer-provided private health insurance and individually-purchased private health insurance together provided about 27% financing for private healthcare (at 15% and 12% respectively) in 2006/07. The use of insurance funding was broadly equally shared by private primary care/out-patient and private in-patient care. The predominant form of private health insurance (PHI) is reimbursement product which indemnifies the healthcare expenses on a fee-for-service basis with caps on the maximum reimbursement amount. Some of such coverage comes in the form of riders to other types of insurance schemes, most commonly life insurance policies.

### ***Healthcare Manpower***

C.6 Of the 12 424 medical doctors registered in Hong Kong as at end of 2009 (1.77 medical doctor per 1 000 population), around 40% worked in the public sector while 60% were in private practice. Out of these 12 424 doctors, there were some 5 700 specialist doctors (Table C.2) and their distribution in the public and private sector were more or less even. Other healthcare professionals who are mostly working in the private sector include Chinese medical practitioners, dentists, chiropractors, pharmacists and optometrists. On the other hand, most nurses, occupational therapists and physiotherapists are working in the public sector. (Also see paragraph C.15 for related details.)

### **Private Ambulatory Care Services**

C.7 The majority of Hong Kong people seek out-patient services in the private sector in which most doctors are providing primary care. About 26 million out-patients visit were made to western medicine clinics in the private sector each year, representing about 70% of all western medicine out-patient consultations, including both consultations of primary curative care and specialist out-patient services. According to DHA 2006/07, such services were paid for predominantly by out-of-pocket payment (78%), followed by employer-provided PHI (16%), and individually purchased PHI (6%) (Figure C.2). Of total private health expenditure, 39% were spent on acquiring private ambulatory care services.

C.8 It has been difficult to differentiate between primary care and secondary/tertiary care attendance in the private out-patient setting, as many private doctors provide specialist care in conjunction with or alongside primary care. Of note, primary care doctor's referral is not required for private specialist consultation in Hong Kong. According to patients' self-reported nature of consultations in the THS 2008, 86% of private western out-patient consultations were for primary care and 14% for specialist care.

C.9 Fees charged by private doctors for out-patient consultations vary greatly as indicated in The Hong Kong Medical Association's Survey on Doctors' Fee 2010: from some \$150 for consultations by private doctors in general practice to \$1000 or more for specialist consultations.

The Medical Claims Statistics compiled by The Hong Kong Federation of Insurers (HKFI) show that the average bill for private out-patient care posted significant rise in the past few years (Table C.3). Private doctors commonly provide both consultation and drug dispensary services within the same clinic. In many cases, especially the primary care practitioners, the consultation fees include the charges of medicine, but separated charges for medicine are also common for specialists. Patients also have to pay extra or separately for investigations (e.g. X-ray, Ultrasound, laboratory tests) and treatment procedures.

### **Private In-patient Care Services**

C.10 There are currently 13 private hospitals in Hong Kong. In addition to in-patient services, these private hospitals also provide specialist out-patient services, general out-patient services, health screening services, diagnostic services and allied health services. As of December 2009, they provide 3,818 hospital beds (about 12% of total hospital beds) and serve about 360,000 in-patient admissions in the year. General class beds accounted for about 77% of all hospital beds in private hospital, while 15.6% are second class beds and 7.8% are first class beds.

C.11 According to DHA 2006/07, 42% of the expenditure on providing private in-patient care services were financed by out-of-pocket payments, followed by employer-provided PHI (37%) and individually-purchased PHI (21%) (Figure C.3). Compared with private out-patient care, the funding proportion of PHI especially individually purchased PHI was apparently higher for private in-patient care. This situation is related to the fact that PHI plans taken out by individuals more often encompass inpatient care only, while PHI plans taken out by employers typically include both outpatient and inpatient covers. Of total private health expenditure in 2006/07, 16% were spent on private hospital in-patient services.

C.12 While private in-patient services allow choice of doctors and amenities, and often have shorter waiting time, service charges are much more costly than the highly subsidized HA services. Patients are often charged on an item-by-item basis according to the range of services provided during hospitalization, such as fees for surgeons, anaesthetists, laboratory tests, medications, meals, etc. However, the level of charges and the definition and classification of items may be very diverse across different private hospitals. Besides, it is quite common for the price scale to escalate with the level of accommodation. According to the HKFI's Medical Claims Statistics 2008, the average bill for hospital stay increased with the level of accommodation, from about \$23 000 in general ward to \$65 000 in private room. It is also worth of note that the average billed amount has soared across different levels of accommodation in recent years (Table C.4).

C.13 Private hospitals sometimes also offer certain services at packaged pricing (i.e. a fixed charge for a package of services that differ from conventional itemized pricing) and, for example, a private hospital offers over 50 packages. Packages usually refer to a procedure and its related care, or the care for a health condition which comprise more than one service element. Examples include maternity packages, surgical operation packages, health check packages, etc. These packages may target at different user groups and life stages (e.g. employees, students, premarital). Package prices are generally established in advance to enhance price transparency and provide greater certainty for the patients or consumers in their budgeting.

C.14 Although the public hospitals take up a majority of patient loads across all age groups, the private hospitals play a relatively more active role in serving the younger patients than the older patients. This can be manifested by the narrower differential in bed day utilization per

1 000 population between the public and private hospitals for people aged below 40 (around 3.5:1) as against the corresponding figure for those aged 65 and above (around 22:1) (Figure C.4). Compared with the elderly, the younger population are more commonly covered by private health insurance and hence have a higher chance to go private when they require inpatient care (see paragraph B.11 and Figure B.3). On the other hand, hospitalization of the elderly more often involves complex and multi-disciplinary treatments that are expensive and more readily available in the public hospitals. Hence, they have a higher tendency to use the public hospital services under such circumstances.

## **Health Regulatory Activities**

### ***Healthcare Professionals***

C.15 Under existing legislations, 12 categories of healthcare professionals need to be registered with their respective boards or councils to be allowed to practise in Hong Kong. At December 31, 2009, they numbered 12 424 doctors, 2 143 dentists, 6 119 registered Chinese medicine practitioners, 38 641 nurses (including registered and enrolled nurses), 4 525 midwives, 1 878 pharmacists, 118 chiropractors, 2 202 physiotherapists, 1 354 occupational therapists, 2 766 medical laboratory technologists, 2 004 optometrists and 1 700 radiographers.

C.16 The respective councils and boards are empowered to maintain a register of eligible healthcare practitioners, administer their respective licensing examinations and exercise regulatory and disciplinary powers for the professions. Under the principle of professional autonomy, the Administration respects the decisions that are made within the autonomy of the professions.

### ***Private Hospitals***

C.17 All 13 private hospitals are registered with the Department of Health (DH) as required by the *Hospitals, Nursing Homes and Maternity Homes Registration Ordinance* (Cap.165) (the Ordinance). Private hospitals are registered subject to their conditions relating to accommodation, staffing and equipment are considered to be fit by the Director of Health.

C.18 The *Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes* (COP) was developed and promulgated among private hospitals to set out the standards of good practice with a view to enhancing patient safety and quality of service. These standards include the need for a private hospital to ensure that services provided are of quality and appropriate to the needs of patients, requirements on the management of medical incidents and the setting up of a system to deal with complaints, requirements on the management of staff, premises and services, protection of the rights of patients, and requirements to maintain transparency in fees and charges. The COP also includes requirements on specific types of clinical and support services. Compliance with the requirements under the COP is an important consideration for the registration and re-registration of healthcare institutions.

C.19 DH regulates private hospitals through conducting inspections, investigating sentinel events and handling complaints lodged against private hospitals.

C.20 Doctors who provide medical service for patients in private hospitals can be resident

doctors who are employees of the hospital, or doctors with admission or practicing privileges. According to the COP, private hospitals that cater for acute inpatient services are required to have resident doctors available on immediate call within the hospital at all times to provide urgent patient care. Where the private hospital allows the practice of doctors who are not its employees, an advisory body has to be in place to make recommendations on eligibility criteria for practicing privileges of the doctors; and review, renewal, restriction or withdrawal of practicing privileges.

### ***Hospital Accreditation***

C.21 Hospital accreditation is widely adopted internationally as a useful measure to sustain and improve the quality of healthcare services. While there has been no hospital accreditation system implemented in Hong Kong, public and private hospitals have participated in accreditation programmes available overseas. To-date, among the 13 private hospitals in Hong Kong, except for one newly opened hospital, 12 of them have completed five 2-year cycles of accreditation by Trent Accreditation Scheme (TAS) of the United Kingdom.

C.22 In August 2008, a Steering Committee on Hospital Accreditation chaired by the Deputy Director of Health and with representation from the Food and Health Bureau (FHB), DH, HA and the Private Hospitals Association (PHA), was set up to steer the collaboration, implementation and evaluation of the Pilot Scheme of Hospital Accreditation (Pilot Scheme). The Pilot Scheme was launched in 2009. HA has engaged an Australian consultant in the project. One of the key objectives of the Pilot Scheme is to develop a set of common hospital accreditation standards for measuring the performance of both public and private hospitals in various aspects in the long run. Five public hospitals and three private hospitals have participated in the pilot scheme. Two private hospitals have been awarded the accreditation status so far.

## **Healthcare Manpower Training and Development**

### ***Doctors***

C.23 The University of Hong Kong and the Chinese University of Hong Kong provide basic training of doctors. In 2009, 264 bachelor degree medical students graduated from the two universities and 15 medical graduates with professional qualifications obtained outside Hong Kong passed the licensing examination conducted by the Medical Council of Hong Kong.

C.24 The Hong Kong Academy of Medicine is an independent statutory body with the authority to approve, assess and accredit specialist training within the medical and dental professions. Its 15 colleges conduct training and examinations to award specialist qualifications to qualifying candidates. In early January 2010, the number of specialist under the Academy was 5 695, with breakdown by colleges as shown in Table C.2.

C.25 Each year, the majority of medical graduates of the two local universities are offered appointment to HA to receive specialist training while working in HA. In 2009, some 200 doctors completed training at HA and obtained specialist qualification.

### ***Nurses***

C.26 The University of Hong Kong, the Chinese University of Hong Kong, the Hong Kong



Polytechnic University and the Open University of Hong Kong provide basic registered nurse training. The four universities recruited 895 nursing students into their four-year general nursing degree programmes in 2009, while the Hong Kong Polytechnic University and the Chinese University of Hong Kong enrolled another 105 nursing students into their three-year Master Degree of Nursing Programme. In addition, the Hong Kong Polytechnic University enrolled 160 students into its three-year higher diploma nursing programme.

C.27 The Hong Kong Sanatorium and Hospital, St Teresa's Hospital and the Hong Kong Baptist Hospital Nursing School also provide basic enrolled nurse training. Between them they recruited 135 nursing pupils into their two-year Diploma in General Nursing (Enrolled Nurse) programmes. During the year, 43 nurses with professional nursing qualifications obtained outside Hong Kong passed the licensing examinations for registered nurses or enrolled nurses conducted by the Nursing Council of Hong Kong and were awarded practising certificates.

C.28 The Hospital Authority provides basic registered nurse training through its three-year higher diploma programme. A total of 300 registered nurse students were recruited by the Hospital Authority in 2009. The Hospital Authority also runs a two-year enrolled nurse basic training programme and recruited a total of 350 pupil nurses in 2009. During the year, it also recruited 110 trainees into its two-year enrolled nurse basic training programme for the social welfare sector.

C.29 The 2007 Health Manpower Survey conducted by DH indicated that over two third (71.8%) of the active registered nurses enumerated were working in the HA, followed by those working in the private sector (13.5%), the Government (7.5%) and the academic and subvented sectors (6.6%).

### *Allied Health Professionals*

C.30 Hong Kong Polytechnic University offers degree programmes for allied health professionals, in the fields of medical laboratory science, physiotherapy, occupational therapy, optometry and radiography. In 2009, enrolments in these courses numbered 33, 70, 46, 40 and 55 respectively.

C.31 To address the service demand and tie in with the new model of professional development, the Institute of Advanced Allied Health Studies under the Hospital Authority devises structured long-term training plan for allied health staff and runs courses on specialist and multi-disciplinary training and personal development. These include a three-year in-service training course organised for new recruits of 13 allied health grades. A total of 246 new recruits enrolled in the course in 2009.

C.32 Moreover, to tie in with the new career development model, which was first piloted in three of the allied health grades including physiotherapist, occupational therapist and diagnostic radiographer, specialist certificate courses at postgraduate level and a number of overseas scholarships were offered.

### *Private Hospital Development*

C.33 The Government of the Hong Kong Special Administrative Region aims to increase the overall capacity of the healthcare system of Hong Kong and facilitate the development of the

medical sector through the promotion of private hospital development.

C.34 To take this forward, the Government has reserved four sites at Wong Chuk Hang, Tseung Kwan O, Tai Po and Lantau of Hong Kong for private hospital development. Meanwhile, some existing private hospitals and new hospital developer have indicated their plans to expand existing capacity or develop new private hospitals. These hospital development projects are at different stage of planning and would bring additional hospital beds to the community.

**Table C.1** Total health expenditure of Hong Kong in 2006/07 by financing source and function (HK\$ million)

	Gov't Subsidies (note 8)	Household out-of-pocket	Employer-provided PHI (note 9)	Individually purchased PHI	Others (note 10)	Total
Public in-patient (note 1)	20,343	856 (note 4)	-	-	36	21,235
Public specialist out-patient	7,217	864 (note 4)	-	-	*	8,081
Public primary care / general out-patient	4,445	321 (note 4)	-	-	21	4,787
Private in-patient (note 1)	760 (note 3)	2,805 (note 5)	2,240	1,302	7	7,113
Private primary care / out-patient (note 2)	2	11,431	2,341	920	5	14,697
Dental care	483	1,932	76	57	9	2,555
Medical goods outside patient care settings	261	8,065	-	-	113	8,439
Others (including ancillary medical services, investment and administration)	3,906	179	916 (note 6)	1,935 (note 7)	1,204	8,140
<b>Total</b>	<b>37,417</b>	<b>26,451</b>	<b>5,573</b>	<b>4,213</b>	<b>1,394</b>	<b>75,048</b>

Notes: \* Less than 0.5

1. Include in-patient curative care, in-patient rehabilitative care, in-patient and institutional long-term care, and day patient hospital services.
2. Private out-patient included both specialist and general out-patient.
3. Subsidized in-patient and institutional long-term care.
4. Include employer-provided and individually purchased PHI for which there are no separate statistics.
5. Include \$282 million that was spent on in-patient and institutional long-term care.
6. Include expenditures on ancillary services to healthcare (such as laboratory services and diagnostic imaging services) as well as the administration and operation of employer-provided PHI.
7. Include expenditures on ancillary services to healthcare (such as laboratory services and diagnostic imaging services) as well as the administration and operation of individually purchased PHI.
8. Include expenditure on civil servant and Hospital Authority staff medical benefit.
9. Include medical benefit not in the form of medical insurance provided by private companies / organizations, and exclude civil servant and Hospital Authority staff medical benefit.
10. Include non-profit institutions serving households, corporations and non-patient care related revenue.

Source: Hong Kong's Domestic Health Accounts: 2006/07

**Table C.2** Number of fellows (specialist doctors) by colleges under the Hong Kong Academy of Medicine (as at 4 January 2010)

College	Number of fellows
Anaesthesiologists	371
Community Medicine	124
Dental Surgeons	223
Emergency Medicine	266
Family Physicians	247
Obstetricians & Gynaecologists	405
Ophthalmologists	230
Orthopaedic Surgeons	347
Otorhinolaryngologists	132
Paediatricians	524
Pathologists	231
Physicians	1 266
Psychiatrists	254
Radiologists	362
Surgeons	713
<b>Total</b>	<b>5 695</b>

Source: Hong Kong Academy of Medicine

**Table C.3** Average billed amounts (HK\$) for out-patient services by type, 2005 - 2008

Type of out-patient services	2005	2006	2007	2008	Average annual change during 2005-2008 (3 years)
<b>General practitioners</b>	207	210 (1.4%)	216 (2.9%)	226 (4.6%)	3.0%
<b>Specialists</b>	449	467 (4.0%)	485 (3.9%)	511 (5.3%)	4.4%
<b>Chinese medicine practitioners</b>	214	229 (7.0%)	237 (3.5%)	258 (8.9%)	6.4%
<b>Physiotherapists</b>	273	291 (6.6%)	300 (3.1%)	316 (5.3%)	5.0%
<b>Chiropractors</b>	439	496 (13.0%)	505 (1.8%)	543 (7.5%)	7.3%
<b>X-ray/Laboratory</b>	603	612 (1.5%)	623 (1.8%)	632 (1.4%)	1.6%
<b>Dentists</b>	655	622 (-5.0%)	653 (5.0%)	699 (7.0%)	2.2%
<b>All</b>	246	255 (3.7%)	265 (3.9%)	282 (6.4%)	4.7%

Notes: Figure in brackets represents percentage change over previous year.

Figures are extracted from The Hong Kong Federation of Insurers' Medical Claims Statistics for 2005 to 2008, provided by the largest medical underwriters in Hong Kong, which represent around 80% of the total market earned premium. The statistics include only group medical insurance policies and are based on the billed amounts of around 6 000 000 out-patient cases each year in 2005 to 2008.

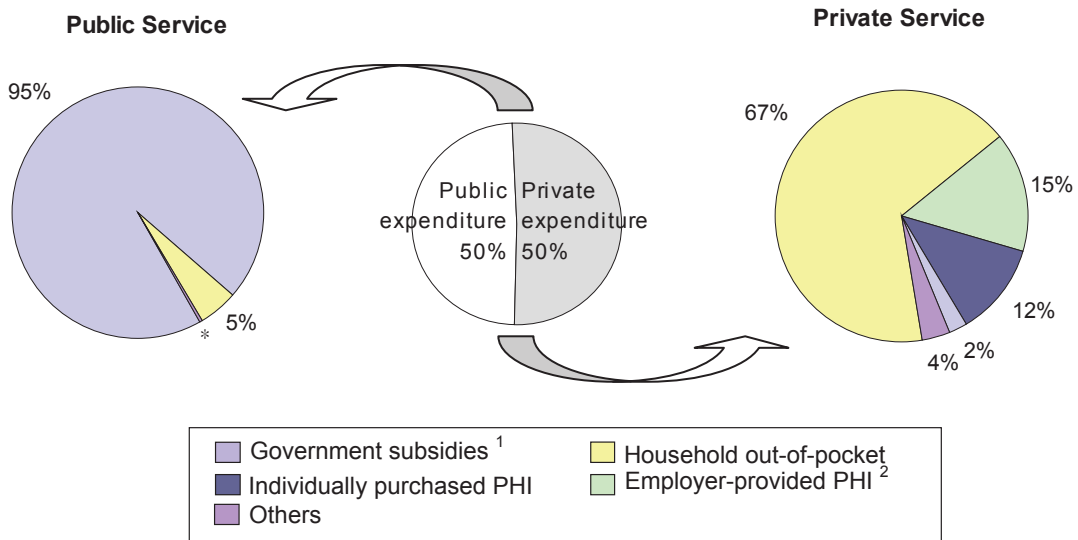
**Table C.4** Average billed amounts (HK\$) for in-patient services by level of accommodation, 2005 - 2008

Level of accommodation	2005	2006	2007	2008	Average annual change during 2005-2008 (3 years)
<b>Private room</b>	57,091	62,151 (8.9%)	64,258 (3.4%)	64,496 (0.4%)	4.1%
<b>Semi-private ward</b>	27,699	32,612 (17.7%)	32,528 (-0.3%)	32,927 (1.2%)	5.9%
<b>General ward</b>	18,588	20,451 (10.0%)	22,529 (10.2%)	22,919 (1.7%)	7.2%
<b>Clinical surgery</b>	3,076	3,177 (3.3%)	3,550 (11.7%)	3,717 (4.7%)	6.5%

Note: Figure in brackets represents percentage change over previous year.

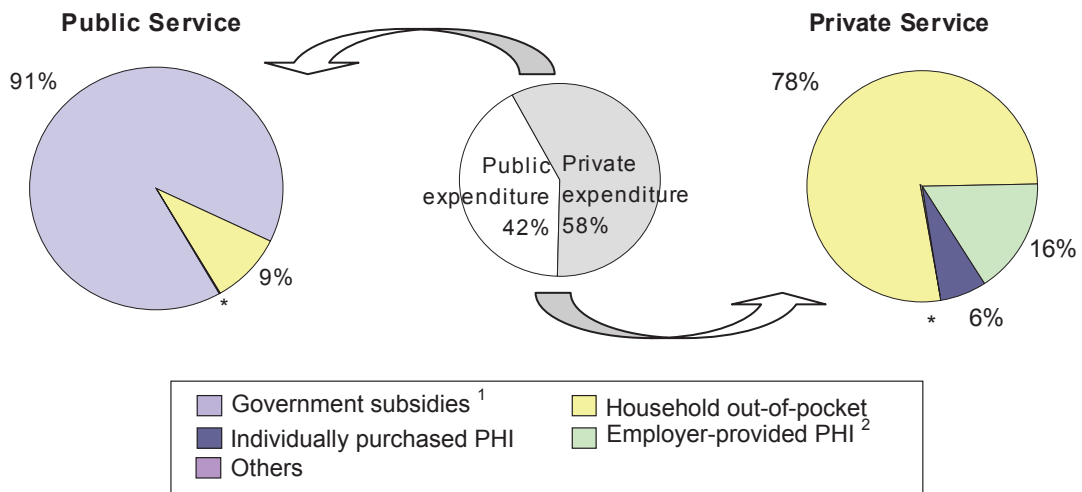
Figures are extracted from The Hong Kong Federation of Insurers' Medical Claims Statistics for 2005 to 2008, provided by the largest medical underwriters in Hong Kong, which represent around 80% of the total market earned premium. The statistics include only group medical insurance policies and are based on the billed amounts of around 100 000 in-patient cases each year in 2005 to 2008.

**Figure C.1** Total health expenditure in 2006/07 by financing source of public and private services



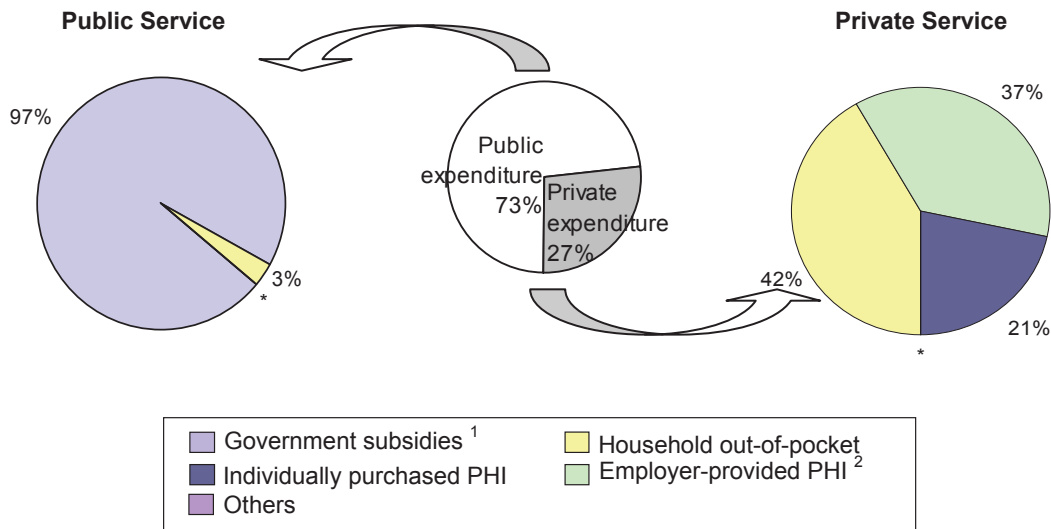
Note: \* figures smaller than 0.1%  
<sup>1</sup> include expenditure on civil servant and Hospital Authority staff medical benefit  
<sup>2</sup> exclude expenditure on civil servant and Hospital Authority staff medical benefit  
 Source: Hong Kong's Domestic Health Accounts: 2006/07

**Figure C.2** Expenditure of out-patient in 2006/07 by financing source of public and private services



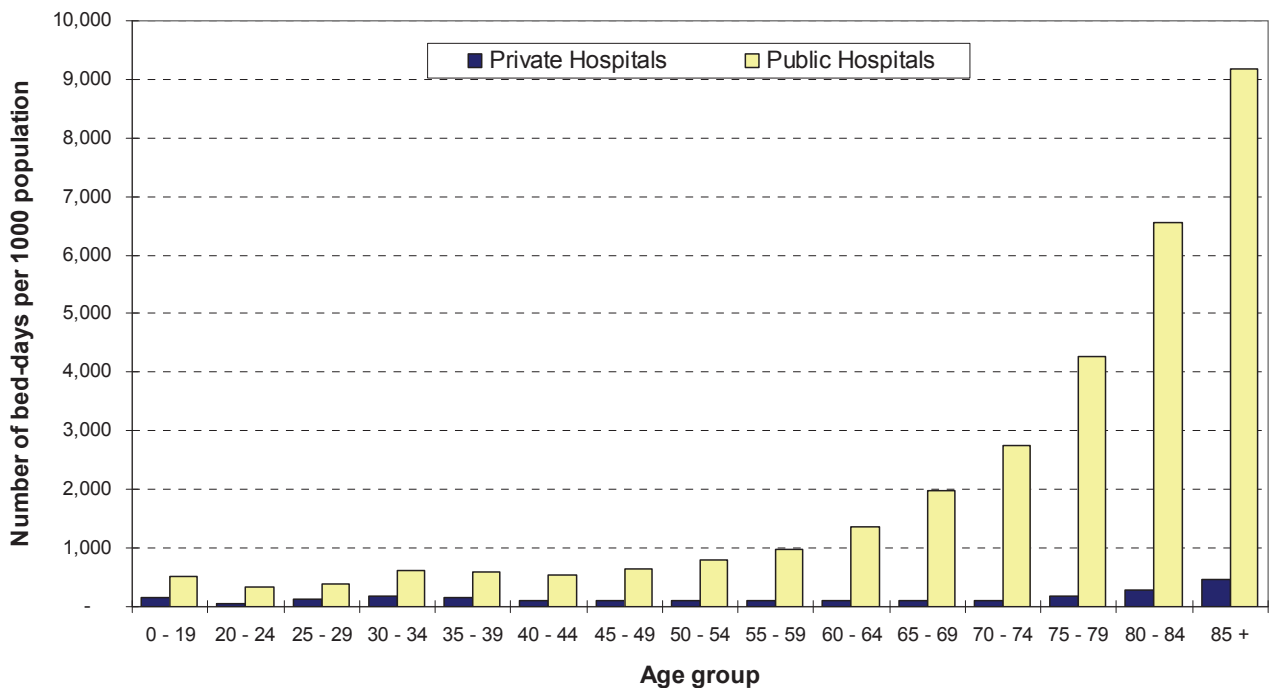
Note: \* figures smaller than 0.1%  
<sup>1</sup> include expenditure on civil servant and Hospital Authority staff medical benefit  
<sup>2</sup> exclude expenditure on civil servant and Hospital Authority staff medical benefit  
 Source: Hong Kong's Domestic Health Accounts: 2006/07

**Figure C.3** Expenditure of hospital in-patient care<sup>#</sup> in 2006/07 by financing source of public and private services



Note: <sup>#</sup> included in-patient curative care, in-patient rehabilitative care, and day patient hospital services.  
<sup>\*</sup> figures smaller than 0.1%  
<sup>1</sup> include expenditure on civil servant and Hospital Authority staff medical benefit  
<sup>2</sup> exclude expenditure on civil servant and Hospital Authority staff medical benefit  
Source: Hong Kong's Domestic Health Accounts: 2006/07

**Figure C.4** Number of bed days per 1 000 population, 2009



Note: The calculation of bed days is based on cases of discharges and deaths for both inpatient and day-patient cares, and the length of stay.  
The length of day-patient care is counted as one day.  
Source: Department of Health and Hospital Authority

## APPENDIX D OVERSEAS EXPERIENCE IN PRIVATE HEALTH INSURANCE

### Introduction

D.1 The healthcare systems in most economies around the world and the roles of private health insurance (PHI) therein are the result of decades of evolution. They reflect the combined influence of unique historical background, social-political values, cultural factors, financial resource constraint, among other factors.

D.2 Depending on the unique situation in different places, the policy attitudes towards the role of PHI in healthcare systems vary. Some governments look to PHI as an important player to increase system capacity and achieve other health policy goals, while some others do not consider it as an important component. The policy attitude determines how a government defines the role of PHI and the efforts it devote in promoting that role.

D.3 Because of the uniqueness underlying the policy towards PHI in different economies, it is impossible to transplant a system that works in one place to another place and expects it to work just as effectively. However, there are certain experiences and lessons that may be useful for design of an incentivized PHI scheme, both in terms of features that may be adapted and incorporated and arrangements that should be avoided. The experiences are mainly drawn from four economies where PHI plays an active role in healthcare financing, including the Netherlands, Switzerland, the United States and Australia.

### General Experience

D.4 It is fundamental to define the role of PHI before deciding how to promote that role. In some places such as the United States and the Netherlands, it is the primary source of health coverage for at least part of the population; in others such as Australia and France, it supplements the public system either by offering a choice of duplicative coverage or filling the gaps not covered by the public system.

D.5 Depending on the defined role of PHI, governments then set the desired objectives of enhancing PHI coverage. In places where PHI is intended to play a prominent role, it may be expected to inject new resources into the system or make the channels of healthcare funding to service delivery more efficient. In places where PHI plays a supplementary role, it may be expected to enhance consumer choice and healthcare protection.

D.6 However, there is a consensus that PHI presents not only opportunities but also risks for the attainment of health system performance goals. According to a study by Organization for Economic Cooperation and Development in the early 2000s (“OECD study”)<sup>1</sup>, a major risk stems from typical information asymmetry problem of insurance market that gives rise to moral hazard-induced excessive utilization and hence adds to total healthcare expenditure. There is also an equity challenge as PHI creates disparity in access to care between those with and those without PHI cover.

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<sup>1</sup> For details on the results of the study, see OECD (2004), “Private Health Insurance in OECD Countries”, Paris.

D.7 The OECD study identifies that a variety of government interventions through regulatory and fiscal instruments can help address the cost control and equity challenges presented by PHI to the healthcare system. Though it refrains from generalizing a set of hard and fast rules, which are probably impossible due to diverse situations in different economies, the study highlights certain areas for government to play an active role, including regulation of the PHI role, access and benefit-related standards for PHI insurers, disclosure requirements, fiscal incentives directed to PHI markets, and broader policies towards private healthcare providers. However, the study is inconclusive regarding how best to strike a balance between the sometimes competing goals of ensuring equity, promoting flexibility, and preserving efficiency incentives within the PHI markets.

### **Scope of Cover**

D.8 The scope of PHI cover is much related to its role in healthcare financing. In the Netherlands and Switzerland where PHI take-up is mandatory and provides the main source of healthcare financing, it covers both inpatient and outpatient care. Yet in Australia and Singapore where the financing role of PHI is supplementary, and where there are no immediate and significant financing concerns with outpatient care, PHI mainly covers inpatient care. Singapore's situation is particularly similar to Hong Kong as outpatient is likewise largely financed out-of-pocket and PHI provided by employers.

D.9 The Dutch Mandatory PHI system allows treatment to be performed abroad with the approval of the insurer, because of shortage of healthcare providers and long waiting lists at hospitals. The idea may be worthwhile to explore in the case of Hong Kong which is also faced with tight supply of private hospital beds and doctors.

### **Cost Sharing**

D.10 The OECD study recommends that some modest cost sharing arrangements for the insured helps to retain their cost awareness and discourage moral hazard-induced utilization. Cost sharing arrangements for PHI usually take the forms of deductibles and co-insurance, which co-exist in the United States and Singapore to tackle moral hazards and avoid abuse. For deductible in particular, it is also a common tool to reduce the premium in Switzerland, Australia, Singapore and the United States.

D.11 It should be noted that in terms of containing moral hazards, coinsurance and deductibles have limited impact of deterring genuine inpatient admissions. Yet they are useful to avoid unnecessary hospital admissions or cases where care can alternatively be provided in an outpatient setting or in a step-down facility, which are relatively less costly.

### **Benefit Limits and Out-of-Pocket Costs**

D.12 Benefit limits are built into PHI product design in some markets to limit the insurers' exposure to the risks of excessive charging by healthcare providers, and as such, patients are required to pay out-of-pocket (OOP) the expenses above the limits. In Singapore, for example, the benefit limits for surgeries are based on the complexity of the surgery and categorized into seven tiers. In the United Kingdom, the number of tiers can be up to 25.

D.13 There are also circumstances under which the private insurers agree with healthcare providers to make payment directly according to negotiated fee schedules, and as such, benefit limits and OOP payments do not exist in principle. In the Netherlands, Switzerland and the United States, there is no benefit limit and hence no OOP costs for the insured except the cost sharing built into the PHI product. The so-called “balance billing” is generally prohibited. This arrangement is beneficial to patients by reducing budget uncertainty for healthcare. However, there are some practical difficulties in disallowing healthcare charges from exceeding the schedule fees, particularly when the supply of healthcare services is tight. In Australia, the insurers have since the year 2000 introduced a Gap Cover Scheme by which healthcare providers can charge in excess of the schedule fees, but are obliged to obtain the patients’ informed financial consent before delivering the treatment.

### **Provider Reimbursement**

D.14 A variety of payment mechanisms to reimburse healthcare charges is observed in some developed economies. For inpatient care in particular, episodic-type payments system based on diagnosis-related grouping (DRG) is common in such economies as the United States, Australia and the Netherlands. In Australia, there are also some hospital admission the reimbursement of which are based on per diems that are differentiated by type of service and level of complexity.

D.15 Overseas experiences reveal that DRG or episodic-type payment system can serve as a form of “packaged pricing” that facilitates market transparency and benchmarking of performance and charges across different hospitals. To the patients, this payment system also provides better certainty in the total amount of insurance benefit for a particular treatment episode, and enables them to predict whether OOP is applicable and the amount more accurately.

D.16 In respect of provider payment mechanism, there are some general lessons from overseas experiences that are worth of note. First, if the provider payment mechanism relies on coding, it is open to abuse as some providers have been known to “upcode” the actual service provide to receive a higher payment. Second, updating of coding rules consistent with changes in environment is critical, since the provider payment mechanism can become outdated quickly with changes in care patterns and introduction of new services, etc. Third, change in provider payment mechanism may provide opportunities for providers to raise charges by taking advantage of changes and lack of continuity and direct comparability between old and new mechanisms. Fourth, to the extent that the payment mechanism leads to lower income to providers from insured patients, the providers may react by providing more services to make up for lower income per services and shifting costs to uninsured patients. There is also a chance that some doctors quit the local market and look for better-paying job opportunities abroad if the payment mechanisms are used as a form of price control.

### **Premium Rating, Underwriting and Anti-Selection**

D.17 Anti-selection is a systemic risk to PHI that is commonly tackled by insurers through medical underwriting and risk-based premium setting. Yet in the mandatory PHI systems of the Netherlands and Switzerland, anti-selection is not an issue as all people have to enrol for PHI cover. Insurers need not do any medical underwriting, and the government can dictate the premium rate structure by having community-rated premium i.e. flat premium of a given insurance plan for all insured regardless of health risk factors such as age and health history. The



strong sense of solidarity in these economies are conceived to make the cross-subsidy implication of community-rated premium acceptable to the society.

D.18 Yet in a voluntary setting, community-rated premium of a government scheme aggravates anti-selection as the young and healthy population who pay more premium than risk-based level may switch to the unregulated market segment or choose to be uninsured. As a result, the Scheme participants would mainly come from older and less healthy population, thereby undermining the risk pooling function and even causing the Scheme to fail. In Australia, community rating of premium is workable because the government heavily regulates the PHI market by prohibiting risk rating of premium for PHI products. Moreover, insurers are not allowed to medically underwrite and must accept all enrollees with or without pre-existing conditions, subject to one-year waiting period to counter potential anti-selection. Yet anti-selection still prevails, resulting in lack of young lives for the insurance pool. In order to encourage the young to enrol, the government has since 2000 introduced the Lifetime Health Cover by which take out PHI after age 30 have to pay an additional 2% of the community rated premium for each year after the age of 30, up to a ceiling of 70%.

D.19 In the United States, the PHI market is fragmented while enrolment is voluntary. Individuals can buy PHI from different states and may even relocate to a different state to seek more affordable PHI. This makes anti-selection difficult to tackle in some states although they strive to restrict risk rating to provide insurance access to higher-risk individuals. The situation in Hong Kong should be somewhat similar as the proposed HPS, if implemented, would not be the sole market segment but would compete with existing PHI products and even products sold in the neighbouring economies. The premium rating and approach to risk classification between the HPS and the existing market would need to be consistent to avoid significant anti-selection and price arbitrage.

### **Risk Selection, Risk Equalization and High Risk Pools**

D.20 In community-rated plans such as those in the Netherlands and Australia, some form of risk adjustment or risk equalization mechanism is adopted to discourage insurers from selecting risk and targeting at the relatively young and healthy members. The mechanisms in these two economies are operated by the government and supported by the insurance industry. The adjustment process involves a pool of fund financed by insurers and redistributing premium across insurers so that those with relatively unhealthy portfolio receive more premium, and vice versa. However, risk adjustment is not perfect and insurers still try to select risk through marketing and different product design for different target market segments.

D.21 Due to imperfection of risk adjustment mechanism, high risk pools or reinsurance pools are adopted in the Netherlands, the United States and Australia to further equalize the risks between insurance companies. This is done by sharing the cost of large claims or the cost of high cost individuals across the different insurers.

### **Cost Containment**

D.22 In the OECD study, review of experiences of the OECD countries reflects an overall limited contribution of PHI to total or public cost-containment efforts. PHI was found not to have shifted significant cost from the public to the private sector. Some cost shifting occurs in

systems with duplicate PHI markets, although this impact is limited because insured persons often continue to utilize the public system for the most expensive services. It also has had less impact in systems with small PHI markets and has been offset by public subsidies to PHI in others. In most countries with PHI playing a prominent role, PHI has resulted in higher public and total health cost as a result of higher medical prices, increased utilization, or both. Yet the study opines that the desirability or acceptability of cost increases depends upon what benefits result from the higher health care expenditure.

D.23 In fact, the inherent nature of the PHI business tends to increase overall healthcare cost if there are inadequate measures, policy measures or market practices, to combat moral hazards and keep the market competitive. In the United States and Switzerland, some insurers have adopted managed care initiatives to control cost and improving quality of care. Yet the effectiveness is mixed. Administration cost is an underlying factor. Initiatives like prior authorization (i.e. requiring the permission of the insurer before hospital admission) had a material impact initially in the United States, but later generated more cost than savings because practice patterns later changed favourably while the cost of administration remained. Some initiatives were also seen to be interfering with the clinical decision-making of the doctors and ultimately resulted in political backlash, thus diminishing the effectiveness of some managed care initiatives. There is an opinion that instead of micro-management, cost containment initiatives can focus on the bigger picture and should be less antagonistic. Creation of more individual responsibility for healthcare costs, and greater transparency and dissemination of information for consumers to make informed choices are more important. Both of these elements have been part of the strategic thinking of Singapore for many years.

### **Transparency, Benchmarking and Competition**

D.24 Transparency and benchmarking of private healthcare providers in terms of performance, price and other information of interest to patients are pursued in several economies like the United States and the Netherlands, with a view to facilitating consumer choice and spurring efforts improve healthcare quality and outcomes.

D.25 The United States has a large repository of medical encounter data that derives benchmarks for insurers to compare different healthcare providers. These benchmarks are now being integrated into “consumer-driven health plan” designs by which an individual takes more financial responsibility for personal healthcare costs, but at the same time is provided with more information on the range of hospitals and doctors available. In the Netherlands, the government has been pushing hard for transparency and benchmarking. To support health organizations in achieving the goal of making healthcare transparent and developing a set of publicly available information on quality of care, the government has set up the programme called “Zichtbare Zorg” (Transparent Healthcare) which develops quality indicators for the whole healthcare market, from general practitioner care to hospital care and pharmaceutical care.

D.26 Regarding performance of private health insurers, Australia and the Netherlands have set up information platforms by which consumers can readily compare PHI products offered by different insurers in the market, with a view to enhancing consumer choice and creating competition pressure for insurers. Such efforts are echoed by the OECD study which recommends fostering readily understood comparative information and product disclosure requirements. The study reveals that disclosure requirements can work together with benefit standards to promote and reinforce consumers’ understanding of their PHI products and coverage

options. It also states that some limits on benefit packages, or their standardization, may be appropriate especially for products targeting the elderly and chronically ill people, although benefit standardization can reduce insurers' ability to innovate and tailor products to individual demands.

## **Appeals Mechanism**

D.27 There are specialized appeals mechanisms in many economies like the United States, Australia, Switzerland and the Netherlands. They are independent organizations charged with dealing with complaints and conflicts among insurers, providers and insured persons. In some cases, their roles extend to determining whether a procedure, medicine, or treatment should be covered by PHI.

## **Regulation**

D.28 The basic scope of regulation related to PHI in different places is mostly similar, usually covering prudential regulation of insurers to ensure that they have sufficient funds to meet their obligations to the insured, product regulation to ensure that the products sold fulfil policy objectives on PHI, and in some cases premium regulation to safeguard consumer interest. Premium regulation is relatively more controversial due to concern over the adverse impact of price control on market efficiency and solvency position of insurers. In Australia, for example, there is considerable controversy in the society over the required approval on annual premium adjustment from the government.

D.29 The regulatory structure differs from one place to another. In the Netherlands and Switzerland, the structure is relatively complicated with multiple bodies involved in different aspects of regulation. Though the Dutch government has streamlined the structure in recent years, there continue to be complaints of excessive bureaucracy and excessive workload on the part of insurers to comply with government regulations. In Australia, most of the PHI regulatory burden falls under one body i.e. the Private Health Insurance Administration Council (PHIAC). PHIAC has devoted concerted efforts in recent years to streamline the regulatory framework and has adopted an "outcome-based" regulatory approach since 2003. The principle is to avoid over-regulating and creating unnecessary paper works, and rather to focus on key performance indicators, such as premium rate increase and management expense efficiency, and require additional reporting if an insurers' performance falls below the requisite standard.

## **Encouraging PHI Ownership**

D.30 In the mandatory PHI systems of the Netherlands and Switzerland, there is no issue of encouraging PHI ownership as PHI coverage is by definition universal. Yet premium subsidy is provided by the government which is meant to relieve the financial burden especially for the poorer people. In some economies without active policy stance towards PHI, like Canada and the United Kingdom, tax credit to offset expenses on PHI premium exists but appears to serve more as an integral part of general fiscal concession to families.

D.31 In Australia, the government has introduced a non-means-tested premium rebate of 30% in December 1998 to boost PHI take-up (with higher rebate up to 40% for elderly since April 2005).

Yet the impact on PHI is insignificant, with population coverage of PHI edging up from 30% in December 1998 to 31% in September 1999. Insufficient response from the young population, as manifested by the PHI coverage of people aged 30-34 at 27% in March 2000, was a major contributory factor. Yet this ratio soared to 46% in September 2000, three months after the Australian government introduced the Lifetime Health Cover (LHC) with premium loading for late enrolment above the age of 30. Overall population coverage of PHI went up to 45% in June 2001. While the combination of incentives and penalties (carrot and stick approach) played a part, it is opined that the final push came from a massive joint marketing campaign by the government and the insurance industry with the theme "Run for Cover", coupled with a time-limited period when those who over the age of 30 could join without the LHC penalty.

D.32 In Singapore, the government uses what may be described as a step-wise approach. The government implemented the Medishield PHI scheme which is a high deductible, low premium PHI package for individuals, in the early 1990s. Central Provident Fund members are automatically enrolled unless they opt out, and only a small proportion of members opted out. After that, top-up covers were introduced on an opt-in basis, and eventually insurance companies were invited to sell Integrated Medishield (comprising basic Medishield cover with wraparound additional cover following regulated specifications) and additional top-up Medishield products (designed by private insurers). In recent years, while continuously propagating the need for individual responsibility for healthcare costs, the Singapore government has not only been expanding the benefit coverage, but also the scope of population covered to include newborns, dependents and self-employed individuals. Currently, Medishield covers over 80% of Singaporean citizens and permanent residents.

## APPENDIX E HEALTH AND MEDICAL DEVELOPMENT ADVISORY COMMITTEE

The Health and Medical Development Advisory Committee (HMDAC) is an advisory body, chaired by the Secretary for Food and Health and comprising 14 non-official members and one ex officio member, tasked to review and develop service models for healthcare in both the public and private sectors, and to propose long-term healthcare financing options. The Working Group on Healthcare Financing under the HMDAC was set up in October 2005 to examine specifically the financing aspect of the healthcare system in the light of the long-term service delivery model.

The HMDAC issued the discussion paper *“Building a Healthy Tomorrow”* in July 2005 for public consultation. It puts forth a host of recommendations for the future service delivery models for our healthcare system, covering primary medical care, hospital services, tertiary and specialized services, elderly, long-term and rehabilitation care, as well as other related issues including private-public sector collaboration and infrastructural support for public discussion, with a view to building a sustainable system that is accessible and affordable by every member of the community.

Building on the HMDAC discussion paper *“Building a Healthy Tomorrow”*, the Government published the Healthcare Reform Consultation Document *“Your Health, Your Life”* in March 2008 to initiate the first stage public consultation on healthcare reform. The healthcare reform proposals therein were developed on the basis of the recommendations of the HMDAC. This consultation document continues the public dialogue by putting forward further proposals for the second stage public consultation on healthcare reform.

## Membership of the Health and Medical Development Advisory Committee (2010)

### Chairman

Dr York CHOW Yat-ngok, GBS, JP  
Secretary for Food and Health

### Non-Official Members

The Hon Ronald Joseph ARCULLI, GBM, GBS, JP  
(Vice-Chairman)

The Hon CHAN Kin-por, JP

Prof Sophia CHAN Siu-chee

Dr Margaret CHUNG Wai-ling

Dr David FANG, SBS, JP

Prof Dennis LAM Shun-chiu, JP

Dr Sigmund LEUNG Sai-man

Dr Jacqueline LUI Chiu-tong

Dr Louis SHIH Tai-cho, JP

Prof Grace TANG Wai-king, SBS, JP

Prof Thomas WONG Kwok-shing, JP

Mr James WONG Ngar-kok, MH

Mr Anthony WU Ting-yuk, GBS, JP

Dr Loretta YAM Yin-chun, BBS

### Ex Officio Member

Ms Sandra LEE Suk-yee, JP  
Permanent Secretary for Food and Health (Health)

## **Membership of the Working Group on Healthcare Financing of HMDAC (2010)**

### Chairman

The Hon Ronald Joseph ARCULLI, GBM, GBS, JP

### Non-Official Members

The Hon CHAN Kin-por, JP

Mrs Diana CHAN TONG Chee-ching, JP

Prof Stephen CHEUNG Yan-leung, BBS, JP

Dr David FANG, SBS, JP

Ms Agnes HO

Mr TIK Chi-yuen, BBS, JP

Dr Philip WU Po-him, BBS, JP

Mr Anthony WU Ting-yuk, GBS, JP

## APPENDIX F CONSULTATIVE GROUP ON VOLUNTARY SUPPLEMENTARY FINANCING SCHEME

The Consultative Group on Voluntary Supplementary Financing Scheme was set up in November 2009 with the aim to provide to the Government views on the proposal to formulate a supplementary healthcare financing scheme based on voluntary participation as announced in the Chief Executive's 2009-10 Policy Address<sup>1</sup> and any other related matters.

The Consultative Group is chaired by the Under Secretary for Food and Health and the Secretariat is provided by the Food and Health Bureau. Its members include representatives from various sectors, including the insurance sector, the medical sector, employers, individual consumers and other stakeholders.

### IN MEMORIAM

The Consultative Group is very saddened that one of its Members, Mr K Y TO, passed away in late-December 2009. Mr TO had participated actively in the meeting of the Consultative Group and had contributed many useful and constructive ideas from the perspective of the insurance sector. The Chairman and all Members of the Consultative Group would like to express their deepest condolences to Mr TO's family.

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<sup>1</sup> **Extract from paragraphs 76-77 of the 2009-10 Policy Address:**

- "...The first-stage consultation on healthcare reform reflects a broad community consensus on the need for the Government to address the issue of healthcare financing. However, the public has reservations about any healthcare financing scheme of a mandatory nature."
- "We are working on a supplementary financing option based on voluntary participation and planning to consult the public on the proposal next year. This option will comprise insurance and savings components, and will be standardized and regulated by the Government. We will also make use of the \$50 billion set aside to support healthcare reform to provide subsidies and incentives to encourage members of the public to join the scheme. This option will enable a wider choice of private healthcare services for those who can afford it, in particular those who are covered by health insurance. The new option will ease the burden on the public healthcare system and make it more sustainable. ..."



## Membership of Consultative Group on Voluntary Supplementary Financing Scheme (2010)

### Chairman

Prof Gabriel M LEUNG, JP  
Under Secretary for Food and Health

### Non-Official Members

Mr David ALEXANDER  
Mr Victor APPS  
Dr George CAUTHERLEY  
Ms Audrey CHAN  
Mr Vincent FAN Chor-wah  
Mr Ronald LAI Chi-shing  
Mr Dominic LAM, MH  
Dr Alan LAU  
Ms Connie LAU  
Mr Joseph M W LAU, BBS, JP  
Mr Stanley LAU, BBS, JP  
Dr LAW Chi-kwong, SBS, JP  
Dr Donald LI  
Prof Raymond LIANG  
Mr Leo MA  
Mr Y K PANG, SBS, JP  
Mr Shane SOLOMON  
Mr Michael SOMERVILLE  
Mr Peter TAM  
Mr TSANG Kin-ping  
Dr TSE Hung-hing  
Mr Raymond YAM  
Dr Ray YEP Kin-man  
Dr Henry YEUNG Chiu-fat

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# Health Protection Scheme