Academic Review of the
Feasibility Study on the Key Features of the
Health Protection Scheme

Background

1. The Chief Executive announced in his Policy Address 2009-10 the Government's plan to work out a supplementary healthcare financing scheme based on voluntary participation, comprising insurance and savings components, and standardized and regulated by the Government. In working out this scheme, the Government will consider how to make use of the HK$50 billion earmarked to support healthcare financing reform.

2. To take this forward, the Food and Health Bureau ("FHB") has commissioned a series of consultancy studies to support formulation of feasible proposals for a Voluntary Supplementary Financing Scheme for the second stage public consultation on healthcare reform in 2010 viz. the Health Protection Scheme ("the Scheme") unveiled for three-month public consultation on 6 October 2010. Amongst these studies, FHB has appointed the Milliman Limited to conduct the "Feasibility Study on the Key Features of the Health Protection Scheme", which is aimed to design actuarially sound insurance product templates and develop policy options for provision of incentives where necessary to enable the Scheme to operate effectively.

3. In view of the importance and sophistication of this feasibility study, FHB has set up an academic review panel with diverse expertise to review the study findings, with particular attention to its merits and limitations, and applicability to local context. Some 30 experts from local and overseas academia (Appendix A) have accepted the invitation by FHB to be the Panel Members. Their participation and contributions are highly appreciated by FHB.

4. The Executive Summary is prepared by Professor Wai-Sum Chan[1] who has been appointed by FHB to be her independent advisor in the deliberation of the Scheme. Professor Chan has contributed significantly to the works of this academic review panel.

5. The Executive Summary is based on Professor Chan's best understanding of the comments from the Panel Members. A majority of Panel Members have given their consent to publicize their comments in original forms, which are set out in the Addendum.

6. Since a few Panel Members have yet to provide their comments due to the tight schedule that FHB regrets about, the Executive Summary and the Addendum will be revised to incorporate their comments in due course.

7. The views expressed in all parts of this report should not be taken to represent FHB's position.

Food and Health Bureau
4 November 2010

[1] Professor of Finance, The Chinese University of Hong Kong.

Executive Summary

General

1. A number of Panel Members commend the Scheme design concepts and principles that the Study Report recommends, and appreciate the efforts that the Study has made in addressing many essential concerns, such as long-term affordability and accessibility of insured persons to private health care.

2. Some Panel Members have not indicated clear support or objection to the Scheme in overall terms, while focusing their evaluation on the specific scheme features proposed in the Study Report. One Member states that he requires more scheme details before making the overall assessment. This is probably also the overall stance held by some other Members.

3. Some Panel Members express reservation or objection to the Scheme in overall terms. They largely opine that the Study failed to convince that the Scheme can provide the right medicine in the financing context, and that it can enhance equity and efficiency of Hong Kong's healthcare system.

4. Notwithstanding their diverse attitudes towards the Scheme in overall terms, the Panel Members have provided many insightful comments on the feasibility and desirability of specific Scheme features in the light of the stated scheme objectives and possible downside risks.

Scheme Objectives

5. There are considerable concerns on whether the incentives are sufficient to induce a critical mass of participants necessary to achieve the two stated scheme objectives, particularly the first objective of enhancing access to private healthcare and relieving the burden on the public system.

6. Some Panel Members stress that the Scheme should attract not only the currently insured but also newly insured in order to bring about material impacts. In particular, there is an opinion arguing for the need to target at the elderly and low-income people who have more difficulties in

accessing PHI protection.

7. Views are divided on the linkage between the two objectives. There is an opinion that the two objectives are complementary to each other, and that the second objective is instrumental to achieving the first. Yet some views indicate that they may be realized separately if needed. Some Panel Members opine that unlike the first objective, the second objective of increasing market transparency and competition does not necessarily require a large sum of government subsidy.

Protection Scheme

Coverage and Exclusions

8. The Panel Members generally welcome or at least do not object to the proposed packaged benefit structure of insurance protection to encourage packaged pricing of private healthcare services. This is notwithstanding some worries that packaged pricing may not be readily acceptable to the private healthcare providers.

9. Some Panel Members express concerns on the fundamental design of the Protection Scheme which excludes primary care and pays little attention to disease prevention and promotion of healthy lifestyle. They consider this undesirable since primary and preventive cares have proved to be cost effective in improving health outcome. It is also proposed that more innovative provider payment methods other than fee-for-service be tested with a view to rewarding good performance of providers and increasing effectiveness of the Scheme.

10. A few Panel Members disagree on the exclusion of specialist outpatient care, general outpatient care, maternity care, and dental care, etc. They opine that cost concern should not justify these exclusions as such cares are necessities to basic health.

11. Two Panel Members suggest that the grace period for accepting enrolment by those aged 65 (maximum entry age) be extended, as the elderly are commonly less familiar with insurance products and need more time to make up their mind.

12. There are different opinions on the length of waiting period for pre-existing conditions. One view is that the proposed three year period to qualify for full coverage is too long and undermines the protection of the sick. On the other hand, there are some worries that too short a waiting period and a spurt in claims after the waiting period is served would induce anti-selection and mean excessively high premium that can only be supported by a large population of healthy lives for the risk pool to function.

Cost sharing

13. A Panel Member subscribes to the idea of introducing co-insurance arrangement and optional deductible into the scheme products. He considers that a moderate level of co-insurance is suitable to combat over-prescription of healthcare as this risk is established. On the other hand, a Panel Member opines that increasing co-payment cannot lead to more efficient or more appropriate care as patients cannot distinguish low-value from high-value care.

14. Several Panel Members worry that the co-insurance component featured into the scheme products would encourage the insured persons to fall back to public hospital services and defeat the purpose of the Scheme. Some of them opine that more details should be provided in the Study Report to explain how this downside risk can be overcome.

Premium setting

15. There are not many concerns on the calculation of the standard premiums under the proposed base plan, by which the standard premiums rise with age.

16. Yet affordability of premium especially in the long run draws quite extensive attention. Some Panel Members propose different measures to bring premium rise under control. Suggested control measures include direct fixing of insurance premium by the government, cost control and profit control on the insurers. The concern on this issue is also manifested by extensive discussions on how the cost of operating the Scheme can be managed, how moral hazard-induced healthcare utilization can be controlled, and how investigations on these fronts can be pursued further.

17. Some Panel Members consider the proposed ceiling on premium loading for high-risk insured at 200% too high to attract the high risk individuals to join the Scheme. There is a view that the high risk individuals joining the Scheme should receive more subsidy as diversion of their demand provides greater relief to the public system.

18. A Panel Member notices that the ceiling on premium loading is meant to keep the High Risk Pool viable and contain the scale of cross-subsidy from the healthy to the unhealthy. However, he considers it more appropriate to find a way of subsidizing high healthcare costs from general government revenue. Another Panel Member proposes setting up some kind of "equalization fund" amongst insurers to overcome this problem.

19. The idea of introducing No Claim Discount (NCD) off the standard premium does not receive extensive support. Some Panel Members cast doubt on the usefulness of this pricing method to attract healthy lives into the risk pool, and worry that the tendency to preserve NCD may induce more insured patients to fall back to public healthcare services at the end. There are also some queries that NCD cannot provide any co-insurance incentive to avoid moral hazards, and that NCD can in effect penalize the ill who seek care for better health.

Savings Scheme

20. The opinions on the proposed savings scheme are diverse. Some Panel Members strongly support in principle inclusion of savings component into the Scheme recommended by the Study. They agreed on the assessment in the Study Report that savings component can help alleviate the premium burden of Scheme Members when they turn old and sustain the insurance take-out. However, a few Panel Members consider the discussion on technical details in the Study Report rather insufficient.

21. On the other hand, some Panel Members do not consider savings the right medicine to tackle low insurance penetration at old age. One Panel Member specifically points out that the obvious way of insuring against high old-age premiums is to have an insurance policy with a premium

that is the same at all ages.

22. Amongst the three savings options by degree of freedom proposed in the Study Report, preferences are rather divided among the Panel Members. Some Panel Members go for stricter rules on contribution and withdrawals to ensure adequate savings for future use and increase overall savings rate. Some other Panel Members support less stringent arrangements and query why the Study Report proposes the use of savings under the Scheme to be restricted to health insurance premium payment. Besides, a Panel Member opines that the option of direct premium rebate to elderly people should work better as the problem is essentially related to low income rather than low savings.

23. There are noticeable concerns on the administration charges and investment return of the savings under the Scheme. In order to ensure adequacy of the savings for future use, a Panel Member suggests that the government should provide guarantee on investment return of the savings balance, and should regulate the administration charges.

<u>Supervisory Structure</u>

24. The Review Panel generally welcomes the proposed supervisory structure involving three entities: prudential regulation on insurers about fund sustainability, quality assurance on health care providers, and scheme administration.

25. Some Panel Members particularly highlight the importance of supervisory structure to increase market transparency, strengthen disclosure of information, and safeguard consumer interests.

26. Yet there are concerns that the cost of supervision on the part of the Government and the cost of complying with the supervisory requirements on the part of insurers and providers may be prohibitive. Since the Scheme involves three different entities, some Panel Members opine that effective co-ordination among the supervisory entities is necessary to lighten the cost burden and provide a more enabling environment for the Scheme to operate.

Capacity

27. A number of Panel Members highlight the capacity pressure exerted by the Scheme to the healthcare system. A notable case in point is the resultant public-private shift in demand, and the corresponding drain in manpower resources, which would generate pressure for both the public and private sectors to maintain service capacity and quality. Besides, it is pointed out by some Panel Members that because of moral hazard-induced healthcare utilization in the private sector, and increased number of chronic disease patients in the public sector as the Scheme shortens their waiting time and better maintain their lives, the Scheme tends to increase overall demand and hence overall capacity requirement.

28. There is a noticeable worry that if the private healthcare market is already facing a tight supply condition at present, the Scheme would accentuate the demand-supply imbalance in the market and heighten the private hospital charges. Because of this, sufficient accommodative expansion in private healthcare capacity is considered necessary for the Scheme to succeed.

Government Incentives

29. To varying extent, a number of Panel Members support the incentives proposed by the Study to induce Scheme participation. Generally, they consider provision of incentives necessary to attract a high participation rate which is imperative for the success of the Scheme, though some of them are cautious about whether the proposed incentives can adequately attract the low risk lives to enroll.

30. On the modes of incentives, the Panel Members are generally concerned about the implications for scheme take-up and social equity. As far as scheme take-up is concerned, some Panel Members agree on the Study's recommendation that the incentives should be tied to savings in order to enable the participants to stay insured in the long term. But there are considerable concerns on whether the proposed incentives can adequately attract people especially the healthy lives to enroll.

31. There are diverse opinions regarding tax deductibility of the Scheme premium that the report argues against. The divergence largely rests with different evaluation of its effectiveness to increase enrolment and induce newly insured.

32. As regards equity concern, some Panel Members suggest that the incentives be more targeted at helping the lower income groups, the disabled and chronically ill; and rewarding healthy lifestyles of Scheme participants.

33. There are queries on why the proposed incentives are not means-tested and regressive to income. Besides, a Panel Member questions the need to assist the Scheme participants who are supposedly relatively well off in the society.

34. A few Panel Members consider that the information available in the Study Report is not sufficient for them to judge on the validity and adequacy of the proposed incentive measures.

Risk and Control Knobs

35. There are considerable worries that the healthy lives are under represented and unhealthy lives over represented in the risk pool of the Scheme due to anti-selection, thereby making the Scheme too expensive to run. A lot of proposals by Panel Members in different dimensions are geared towards attracting the young and healthy lives to join the Scheme in order to achieve effective risk pooling.

36. Whilst considering the co-insurance feature helpful to tackle moral hazard, some Panel Members worry that Scheme Members may fall back to the public healthcare system if the co-insurance payment is burdensome. Their tendency to do so may also be motivated by the motive to preserve NCD.

37. A number of Panel Members share the concern raised in the report that old-age lapsation of Scheme Members is a key risk for the Scheme to sustain in the long term. They generally agree on the direction of providing some forms of government incentive tied to savings to mitigate the risk.

38. Some Panel Members consider supply-side moral hazard the pertinent risk and challenge to the Scheme. A Panel Member in particular worries that the Study is over-optimistic about the effectiveness of packaged pricing to improve transparency and predictability of medical charges. He explains that the patients may not be well placed to make informed and timely choice of care under certain circumstances, such as emergency situation.

39. Some Panel Members point out that the proposed Protection Scheme may create excessive new demand for private services within a relatively short period, and hence induce sharp price hikes to the detriment of the Scheme viability. Expansion in the healthcare capacity (hospital beds, doctors, specialists, nurses, etc.) is called upon to offset the pressure.

40. Some Panel Members cast doubt on the high degree of competition in the health insurance market that the Study Report indicates. Consistent with this, there is quite extensive support for the government to regulate the market and enhance market transparency that can encourage competition and reduce the threat of collusion.

41. The Study Report mentions that there may be "stiff resistance" to the control knobs set up to combat supply-side moral hazard, such as medical necessity arbitration panel and clinical protocols. Some Panel Members worry that these administrative controls can be very costly.

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Appendix A

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Addendum

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Comments by

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The Milliman Report has made many good policy suggestions for the Government to attract more people to use private health insurance. Nevertheless, the promotion of private insurance is not the only objective for the introduction of the voluntary Health Protection Scheme (HPS). It also purports to alleviate the financial burden of the public healthcare system so that the system can be more equitable by targeting resources to healthcare services for the poor, and patients with acute, severe, or high-cost illnesses. However, this fundamental policy objective is not included in the study (p. 17), and so there is a concern as to whether such an objective can be met by the HPS for the following reasons:

First, there is the risk that the deductible and coinsurance of the Basic Plan may create incentives for patients to fall back to HA even for mild and relatively low-cost illnesses. Some of these patients may be young or relatively healthy.

Second, the No Claims Discount (NCD) may create a similar risk arising from the incentive to obtain discounts on premiums.

Third, based on the overview of the Savings Scheme in the report, it is difficult to judge whether the post-retirement savings supplemented with government contribution or premium rebates is adequate to afford the relatively high premium at the older ages. There are the risks of falling back to HA and old-age lapsation.

Fourth, if patients fall back to HA anyway, the incentive for joining or staying on the HPS will not be strong and the risk pooling effect of the scheme will then be weakened. As a result, the Scheme may not effectively serve the objective of alleviating the financial burden of the public healthcare system, nor can the Scheme effectively maintain its sustainability.

Fifth, the report admits that the risk pool mechanism of the High Risk Pool (HRP) may not be able to provide adequate protection for unhealthy lives. They may have to fall back to HA or rely on the Government to inject money into HRP. The major financial burden of the public healthcare system indeed stems from the healthcare need of high risk groups. The HRP may therefore have limited effect on alleviating such a burden.

Sixth, the report estimates that the above risks are low, but data and projections are not provided to substantiate this estimation. It will be risky to launch the HPS without strong evidence that these risks are low.

Mental illnesses and AIDS are not in the general exclusions of the proposed Basic Plan. However specialist outpatient and general outpatient visits (i.e. primary care) are in general excluded. Specialist outpatient visits are not low cost events, and many psychiatric patients, e.g., those who suffer from depression, and HIV-infected persons can

and should be treated and monitored with outpatient care without hospitalization. So there is a *de facto* discrimination against these patients in the Basic Plan.

Similarly the exclusion of maternity can be regarded as a discrimination against women. Maternity is indeed covered by many existing insurance plans offered by employers as benefits. Since the HPS aims to strengthen the risk pooling effect by attracting more people to use private insurance, it should be able to absorb the extra cost stemming from maternity, given the fact that many existing plans can do so.

The general exclusion of primary care services will significantly weaken the protection offered by the HPS. Primary care serves not only the purpose of treating minor diseases, such as flu. It also serves the purposes of prevention, early detection of major illnesses, and providing continuous treatment for chronic illnesses. The cost of such services is not low and people may not have a strong incentive to use them for financial reasons.

Nevertheless, primary care plays an indispensable role in healthcare cost containment by gatekeeping. Without adequate primary care, patients will have more early and frequent, and longer hospitalization. This will have a significant impact on the sustainability of the HPS and the public healthcare system in the long run. Of course, as the report stresses, there is the risk of abuse and anti-selection if primary care is included, but it does not follow that primary care services should then be indiscriminately excluded except for those related to hospital inpatient and covered ambulatory procedures. This risk can be managed by introducing some control knobs to cap the number of outpatient visits, limit the coverage to selective primary care services, and so on.

Finally it is too stringent to exclude dental care and dental surgery unless necessitated by the injury in an accident. Such services can be medically necessary for other reasons.

In sum, the public healthcare system should not be regarded as a back-up for 'protecting' the HPS. The cart should not be placed before the horse. On the contrary, the Scheme should play the role of alleviating the financial burden of the public healthcare system so that the system can be more equitable by targeting resources at providing services for the most needy. The HPS should also provide adequate protection for various patient groups without discrimination, and reduce their reliance on hospital inpatient care by providing coverage to relevant primary care. The HPS should not 'protect' itself by offloading such protection to individuals or the public healthcare system.

Comments by

Mr Sung Ming CHOW
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It seems that the HPS is caught in a dilemma for on the one hand, enforcing better regulation and protection for PHI, and on the other, achieving a high enrollment rate. It seems that the Feasibility Study on the Key Features of the Health Protection Scheme has predominantly inclined towards the latter. This may not only create a public image of bias towards the interests of insurance industry and private providers, thus inviting severe oppositions during the consultation; but also, through the employment of incentives, create an illusion of high acceptance, distorted demand and supply, economic bubble with the long term sustainability however jeopardized.

If the HPS is able to enforce better regulation and protection for PHI, it will naturally result with high enrollment rates. There is no need to manipulate the enrollment rate artificially.

Capacity of private providers

1. Limited scheme membership especially during start may be considered as a political failure but this will not fundamentally defeat the financial viability. On the contrary, limited membership will induce more moderate changes and less market shock, especially for the relatively low capacity of private providers.

2. Although the study correctly stated that the patient to manpower ratio remains unchanged, it is highly doubtful if medical personnel shift from HA to private sector will be cost neutral. The excess new demand for private services within a relatively short period may induce sharp price hikes, which will be hazardous to financial viability of the scheme.

3. The study falsely assumed that the HPS should rely on private hospitals as key service providers and should prevent patients fall back to HA. It was not clarified whether 13.2e in consultation paper 2008 still holds, "The participants may also choose healthcare services in the public sector, in which case the insurance will be charged the full cost for the public services used… in the same way as the insurance would be charged for private sector services used by the insured". This already ensure no extra burden will be induced on HA even if patients fall back.

4. It was also not clarified whether 13.2e in consultation paper 2008 still holds, "If (members) choose general class public services, they will only need to pay out-of-pocket the standard fees of public hospital services. Since the participants have been insured up to a certain level that enables them to afford private sector service, in the case of choosing public sector service they may still prefer private services in public hospitals to general class services."

Government incentives

1. In order to avoid artificial enrollment rate, **no subsidy should be directly provided on premiums.** If the government insists on the 30% one off premium rebate as the scheme starts, the rebate should be input as notional government contribution to the saving scheme for deferred spending.

2. The 30% one off premium rebate as the scheme starts should be provided for a longer period, or through gradual reduction over time, so that no excess demand will be created all of a sudden.

3. In order to encourage enrollment and sustained contribution, the HPS should be tied up with the saving scheme. HPS members can only enjoy post-retirement premium rebate after a required period of contribution.

4. It was not clarified whether 13.2g in consultation paper 2008 still holds, "**Second safety net**: consideration may also be given to introducing a second safety net for participants in the scheme, by allowing an individual participant who has used healthcare services beyond his/her insurance benefit limit to access private services in the public sector at a lower rate." **This will by far be the best government incentive, through an indirect subsidy by kind, which will be able to attract people especially feel uncertain about the benefits of current PHI. The piecemeal premium rebate is not their main concern.**

Transparency of insurance companies

1. There is general mistrust about the administrative costs and profit margins of insurance companies. They may be considered as drain of public and private resources instead of better coverage and protection, especially resulted from the dissatisfying experiences of MPF. The principles and mechanisms of cost containment as well as the accountability and transparency of fund management should also be explicitly addressed.

2. A ceiling should be set for administrative costs and profit margins of insurance companies and excess income should totally be rebated to members or deposited into a reserve, or

3. The rates of low claim/no claim bonus should be objectively and transparently determined, thus indirectly placed control on the administrative fees and profits of insurance companies.

4. The PHS balance sheet of insurance companies should be enforced to publish.

5. In viewing of the general public mistrust in insurance company regulation, "public option" should still be included as a possible alternative in the provision of HPS, reinsurance and residual insurance products.

Note: The original comments include words bolded by the author to draw readers' attention.

Comments by

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Before the release of the Milliman report, the government has already leaked out the proposed plan to the public, and I read the report with no surprises. Anyhow, the Milliman report has done a good job in trying its best in designing a voluntary but protective health insurance scheme. If we treat it as an independent health financing scheme, the proposal is acceptable. The Milliman report tried its best to work on the economics and financial sustainability of the scheme, and adopts a complementary PHI (service + user charges) so that policy coverage is extended while government subsidies are contained. Yet, most of the questions raised by the public on private health insurance are in relation to the public sector, and people do not treat it in isolation because we already have an NHS model that existed for 20 years. Without bearing this in mind, it is hard to comment on the proposal because it is related with the principles of choices and equity.

The first question

One of the major objectives, though covert, of this supplementary scheme is about the **"public-private flow"**, i.e. the flow of patients from the public sector to the private sector so as to lessen the burden on public service and expenditure. Can improvements in the private medical insurance market help to shorten the waiting time in the public sector? However, many national and international studies showed that only minor changes occurred, because there are class differences in entering into voluntary insurance schemes. In the Melbourne Institute Report, it was depressing to note that "(i) there is little evidence that the recent PHI policy changes have alleviated the burden of public hospitals. In fact, ….there is an increase in the overall utilization of health resources due to the moral hazard problem, and (ii) there is strong evidence that the recent PHI policy changes have adverse distributive consequences, particularly if one considers the likelihood of households in various income and socio-economic groups taking up PHI". The Institute Report concluded, "if the principal aim of the reforms was to take pressure off the public hospital system, we would recommend redirecting the public funding that has been used to encourage increase take up of PHI, to other purposes…[1]"

How effective is the scheme to solve the problem of long queues in the public sector? Are there any estimated outflows from the public sector, say, in the first 3 years of implementation?

The second question

The whole idea of the scheme is to provide a "private-insurance-safety-net" to ensure

[1] Melbourne Institute Report, #3: Peter Dawkins et al, Recent Private Health Insurance Policies in Australia: Health Resource Utilization, Distributive Implications and Policy Options. Melbourne Institute of Applied Economic and Social Research.

basic protection in the private medical market. However, we know that it is extremely difficult because the insurer and medical professionals do not live on safety nets. Medical inflation will surely rise as more people join the health insurance market, and this in turn will affect medical expenditure in the public sector.

Cost containment is the primary function as governments intervene into the private health insurance market. However, as the report proposed, the supervisory body will only consist of 3 entities: prudential regulation on insurers about fund sustainability, quality assurance on health care providers, and scheme administration. It seems that the government has left out an important stakeholder – the insured – from the supervisory structure, and cost-containment is mainly decided by the two parties - the government and the providers. In some countries, there were codetermination negotiating mechanisms among the government, providers/insurers and the public, will the SAR government invite the insured to take part in the setting of medical costs? What would the future supervisory body look like?

<u>The third question</u>

This question is about **equity**. Under an encroaching M-society in which the middle class is splitting – lower middle class are falling while upper middle class is getting richer – and it leads to greater income disparity and also social antagonism. The Scheme helps the insured to have wider policy coverage, a good way of protecting the affordable middle class, yet how about those people of the lower middle class that are less affordable to pay, those in need of urgent treatment but have to wait long queues in the public services? What are the policy priorities of the government in health care financing? $50 billion are allocated to help people already affordable for health insurance. Is this fair?

The Milliman Report may not be able to provide an answer, yet the government has to make clear to the public about its policy priority. In such a political climate, this question is the most taxing one requiring definitive answers.

<u>A short concluding note</u>

The objective of the Scheme aims to provide a safety-net protection when people are insured. However, the Milliman Report is narrowly confined on the financial sustainability of the scheme, while there are lots of important issues remained untouched, thus it is very hard to judge its impact and effectiveness.

Questions on **public-private flow, cost-containment and equity** will appear in the consultation period. It is pertinent for the government to address these issues. If without good reasons, concrete measures and firm policy promises from the government, the proposed Scheme may stir up social antagonism that leads social discussions to nowhere. All in all, the most important issue of the Milliman proposal is about policy priority. This is a question that the government has the duty to answer.

Note: The original comments include words bolded by the author to draw readers' attention.

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We have read it with interest and it has much to recommend it. However, we have a major concern and that is that the fundamental design of the Scheme specifically excludes primary care and pays little attention to prevention. We believe this would put Hong Kong's healthcare reform on a track opposite to the direction set forth earlier by the government. Page 31 of the study states "The use of primary care is discretionary." This may reflect the current situation in Hong Kong, but is exactly one of the major areas that require reform. Indeed, the 2008 Healthcare reform consultation document *Your Health Your Life* put enhancing primary care (including emphasis on preventive care and reducing the need for hospital care) as the first and foremost area of reform. International comparisons also suggest that those countries with health systems that are more primary care orientated are more likely to have <u>better health outcomes as well as lower costs and greater satisfaction</u> [Starfield]. As people in Hong Kong live longer and prevalence of non-communicable disease increases, an insurance scheme that focuses on inpatient care, particularly elective inpatient care, will not be able to meet the population's health needs. Primary care is the best route to universal access, the best way to ensure sustainable improvements in health outcomes, and the best guarantee that access to care will be fair. By excluding primary care from the scheme, it not only discourages use of primary care and leaves a huge hole in terms of providing comprehensive coverage for all, but also creates challenges to continuity and coordination of care (the lack of which would increase financial burden on both government and individuals). In particular, as our research shows, to many individuals with lower income, primary care services from the private sector still represent a significant but unpredictable financial burden, because of lack of transparency, regulation and standard pricing in the private market. Therefore, many rely on the public sector, which leads to long waiting time in GOPCs and SOPCs. We strongly recommend another serious look at this exclusion. It will be a great opportunity missed if primary care—both its financing (i.e. including it in the covered insurance benefits) and provision (i.e. more regulation on private sector)—is excluded from the Scheme.

Another concern of ours is whether the incentives as currently designed in the scheme would be effective and efficient to encourage *additional* take-up of medical insurance and savings plans much beyond the current level (especially among those who are older, sicker, and/or have lower income) and eventually improve health care. If the first objective cannot be successfully met with the current scheme and subsidy design, then perhaps another approach should be considered to better utilize the HK$50 billion government resource and realize the second objective (i.e. improve transparency in the PHI and healthcare markets) by itself. More specific comments on incentives and other

scheme designs are provided below.

1. Although one of the main objectives of the Protection Scheme is to encourage take-up of medical insurance, we have a hard time finding the *appropriate* financial incentives (other than improved transparency) in the study to encourage *additional new* take-up among those who currently don't have private insurance. Data from the Thematic Household Survey (THS) suggest that, as it currently stands, younger, healthier, higher-income people are more likely to take up private insurance; while elder, less healthy, low-income individuals are more likely to rely solely on public system without private insurance. Past experience suggests it's very difficult to change the latter group's care-seeking behavior. We have also found this in the study on vouchers and willingness to pay that we have undertaken for FHB. It's unclear that the 30%NCD (max.) level premium rebates would be enough to change the existing pattern. The appropriate incentives should be encouraging people who are not currently insured to buy into the Scheme, instead of subsidizing people already insured (who would have insurance without subsidies anyway and would simply migrate to the Scheme). We believe we need to better understand the elasticity of demand among different subgroups of population.

2. It's unclear how other commercial products offered by the insurers would compete with the Scheme products in the open market. Because more regulation is posed on the scheme products (e.g. guaranteed issue, coverage of pre-existing conditions), it's possible that the scheme products may attract unfavorable risks. The study suggests the creation of a high risk pool. However, the likelihood of someone with high risk to pay a high premium amount to get private insurance is very low, given the alternative of falling back to the public system. Furthermore, insurers themselves could design or market other products to attract more favorable risks thus achieve higher profit margins, leaving the scheme products unsustainable. Without similar regulations on insurers' practice outside of the scheme (e.g. minimum medical loss ratio) and a leveling playing field, it's hard to avoid such cherry-picking behavior.

3. The study also provides little specification on what and how much may be the "meaningful" incentives the government could provide to encourage the population, especially, the elder population to save under the Savings Scheme: will it be sliding-scale based on income? Will it kick in at the first dollar of savings or only after individuals meet certain floor of savings amount? Without more specification, not only it's hard to predict whether the incentives could work, but also it may raise a serious equity concern (i.e. people who are more affluent would save more and get more government contributions).

4. How will the Savings Scheme attract those *currently* age say, 50 and above, who are close to retirement age, and won't have a long period of time to save?

5. Other than that the savings could be withdrawn to pay for the post-retirement Protection scheme premium, the relationship between the Protection Scheme and the Savings Scheme is not well defined: Are they two independent components that could be undertaken separately? Or is the financing or operation of the two schemes inter-related? If so, how? Will the implementation of one affect the other? Why can't the savings be used for medical services other than the Scheme premiums (including

deductibles, copays, or services not included in the Scheme)?

6. To deal with provider moral hazard, there should be a certain level of risk-sharing (without jeopardizing patients' access to care) among the providers. More innovative provider payment methods other than fee-for-service should be tested. For example, episode-based payments, global payments, pay-for-performance (for example, based on patient-reported outcome measures, i.e. PROMs), etc.

7. Regarding competition among insurers, where is the specific evidence of "the profit margins are generally very thin" (page 53)? What is the average and range of medical loss ratio among insurers? Many of the PHI products currently sold are not comprehensive health insurance policies. Experience there may not be representative of the scheme to be implemented.

8. Regarding private provider capacity, where is the specific evidence of "the supply appears to be lagging demand" (page 58)? If the Scheme is unlikely to attract many additional newly-insured individuals who are more likely to use private provider, there shouldn't be too much extra burden on the private sector. If the private providers are already stretched as of now, then what is the point of encouraging more people to use the private sector? Or is this an issue of overall shortage of healthcare workforce/capacity in HK? We need to better understand the supply and demand of services provided by the private sector.

Note: The original comments include words underlined and in italics by the authors to draw readers' attention.

Comments by

Prof Lok Sang HO
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Lingnan University

The Milliman proposal has made a number of good points, but is short in some key aspects:

- It fails to assess the financial risks by various groups living under the regime; in some cases the financial burden could be very high for an unfortunate person caught in a difficult situation;

- It fails to deal with key moral hazard problems, notwithstanding the proposal for various control knobs;

- It is not very effective in incentivizing people to adopt a healthy lifestyle when they are young;

- There is a danger that private insurers work with private doctors to refer patients to HA hospitals on grounds of complexity, which can be ambiguous at times.

- A crucial weakness is that the role of HA hospitals is not entirely clear. If the protection scheme offers basic care no better than HA, people will ask why subscribe to the protection scheme; if the HA does not even offer basic care comparable to that under the protection scheme, then people will complain that access to basic health care in Hong Kong for the poor is inferior to those who can afford it and is limited. There is a danger that poorer people who subscribe only to the basic plan are denied care because they do not have the top up plans, and that they cannot wait for treatment in the HA hospitals.

<u>Strong points</u>: I commend the consultants for:

- proposing standardized packages to be priced in a transparent manner;

- noting the importance of quality assurance in the private healthcare sector;

- noting the need for close monitoring of the behaviour and readiness of insurers to insure;

- noting the need for benchmarking;

- noting the supply side bottlenecks for the private sector that need to be dealt with should the scheme be implemented.

- noting the preference for choice among Hong Kong people when it comes to savings and care plans.

Detailed comments:

1. An elderly person subject to three times the standard basic premium could be paying $45,000 a year plus copayment at 20% of chemotherapy (which costs $200,000) or $40,000 "plus any amounts exceeding the budget". (p.4 in the Executive Summary and p.31)

2. For an unfortunate person caught in complicated medical situation, "the benefit limits would likely not be sufficient"(p.4) While the HA hospitals provide a safety net, there is the possibility that patients cannot wait for treatment. Unless care in HA hospitals are available in a timely fashion, unfortunate people may be caught in the cold.

3. For the savings scheme, there is a reference to incentives through "notional government contribution to savings", "combination of notional government contributions and post-retirement rebates," and "post retirement rebates." It is important that the incentives are fairly applied, regardless of the choice of the individual over degrees of freedom. (p.7)

4. P. 9 notes that there may be "stiff resistance" to the control knobs set up to combat supply side moral hazard. But the proposal does not really address this problem. The control knobs based on administrative controls ("medical necessity arbitration panel and clinical protocols) are expected to be very costly. (p.46) I have recommended that the government sets the standard pricing for "standard but acceptable" services which private hospitals need to comply with unless the patient opts for better-than-standard care. Only when the prices of services are set at levels that are not excessively remunerative, can supply side moral hazard be controlled effectively.

5. The control knobs proposed in p. 11 to contain adverse selection are unfair to unfortunate people who are denied benefits during the waiting period, who are subject to increased premiums. Again, it may be said that HA is available as a safety net. Again the question is the timely availability of care and treatment.

6. p.12 refers to coinsurance payments. This is truly necessary. But if coinsurance payments are much higher in private hospitals than in HA hospitals there will still be a problem of opting for HA hospitals. Charges need to be raised in HA hospitals to levels that can contain demand side moral hazard. In addition, as I have argued in my proposal to the Food and Health Bureau before, there should be a cap to the amounts of co-payments paid in a year, as under the National Health Insurance system in Taiwan or in Sweden. Otherwise even "insured people" do not know how much they will have to spend on medical care.

7. p.14 says "there is a risk that if queues at HA reduce in the future, perhaps as a result of the Scheme, then there is a risk individuals will withdraw from the Scheme and return to HA." The Milliman Proposal does not tell us how the consultants propose to deal with the problem. The question of paying more but not necessarily getting more is at the heart of the Proposal. Under my alternative proposal, standard care packages are priced the same in private as in public hospitals. All patients have their

annual eligible care payments capped, and everybody is automatically enrolled in the standard care plan, funded by taxes. Top up plans are optional and provided in the market place.

8. Under the Milliman proposal, standard premiums for standard care rise with age. High risk patients may be subject to higher, up-to-three times, the standard premium. The first provision does not really promote prevention because older people pay higher premiums any way. Healthy lifestyle may help them avoid the higher premiums, but at three times the standard elderly premium, the total premium becomes very onerous and it does not even cover copayments and beyond-budget care. This exposes some people to very high financial risks and causes anxiety in the general public who may worry that if they should fall sick they may have to face unbearably high healthcare cost. Under my plan, elderly people are subject to higher annual deductibles. But their expenses are capped at relatively modest levels (say $15,000). Healthier elderly people do not have to pay higher premiums and if they do not use the services do not even have to pay the copayments. The rising age-dependent annual deductibles promote healthy lifestyle when people are young.

9. I commend the consultants for making a strong case for sound supervisory structure to ensure quality and preparedness of health caregivers and insurers. (p.14) But presently incidents in private hospitals are reported only to the HA and not necessarily disclosed to the public. I recommend mandating equal accountability and disclosure of medical incidents in private as in public hospitals.

10. I fully endorse the consultants' proposal to encourage packaged charging rather than itemized charging (p.25). This helps reduce uncertainty for patients and encourage efficiency by suppliers. But I would recommend price setting for standard packages to be determined by publicly appointed professionals at a level that does not promote supply side moral hazard and yet does cover costs adequately on average. I would only allow private sector pricing for top-up services over the standard service level. Copayments on top-up services should not count toward the annual spending cap on eligible medical expenses.

11. I am appalled by the statement that "the benefit limits are not sufficient to cover high cost, complex diagnoses, particularly those requiring inter-disciplinary care." While HA hospitals remain as a safety net in these scenarios, it is imperative that services are available in a timely fashion to those who need it. Otherwise, accessibility to healthcare is grossly inadequate to those who need it the most! If, on the other hand, HA hospitals are there to take referrals from private doctors too easily on grounds of complexity, there could be a moral hazard problem especially if the doctors align with insurers. The latter may then shirk their responsibility to the HA.

12. I do not see why coverage should not be extended to specialist outpatient, general practitioner, and maternal care, or emergency repatriation costs. If patients need the services genuinely the services should be covered. They can be charged a sufficient copayment fee to deter misuse and the cost sharing can reduce the pain of those already caught in a very difficult and helpless situation. I have proposed covering all these areas while capping the annual payments for each individual (or his family). The level of the cap is a policy parameter that balances public cost and protection for

the public. It can be raised somewhat to allow inclusion of various contingent situations.

13. I shall elaborate here. Specialist outpatient care must not be denied patients simply on grounds of cost if they genuinely need the services. Otherwise what is the use of the insurance? Repatriation is costly but if it is needed there is no question about moral hazard. If needed services are not covered, what is the point of the insurance? For maternal care, I thought the government is encouraging people to have more children. (p.31) Giving birth to a baby is not sinful and to be discouraged. The Milliman proposal goes counter to the government policy. As for patients who keep seeing doctors for minor problems, a big enough copayment will do the trick. Denying coverage for GP visits could delay care that may be needed in a timely fashion and may even engender higher costs.

14. p.29: maximum age at entry. I find this unacceptable. How about a person who migrates to Hong Kong one year after the plan and who is older than 65? The "grace period" is gone and the poor person is left without coverage.

15. p.31: drug addiction, alcoholism, and drunk driving are not covered. While these apparently are the results of voluntary behaviour, their treatment is in the public interest, because other people will benefit.

16. p.31: I have already expressed disagreement for excluding specialist outpatient and general outpatient care. I also would decry exclusion of dental care or dental surgery for these are also health related problems that need treatment. Similarly it is unreasonable to exclude allied health services such as occupational and physical therapy. Cost is not a justification for excluding these things, because they are basic to basic health.

17. p.33: I believe insurers should be free to set prices for top up products, but basic insurance premium rates should be fixed by the government. Diverse premium rates for presumably identical standard care does not really make sense.

18. p.33: potential 3 times the standard published premium rate can be quite onerous.

19. p.34: waiting periods (bottom of the page) leave needy people helpless.

20. The proposed savings schemes mandate that only protection scheme members are entitled to subsidized savings. (p.38) This apparently is intended to push people to become members. Perhaps it will. But this may be unfair, especially given that it is the poorer people who are most likely not to subscribe to the protection scheme. Another group that may not subscribe to the protection scheme are those who do not trust the private healthcare sector as much as the public healthcare sector. It is unfair to penalize them.

21. Rates of return on investments (p. 38-39): If the savings are so crucial, there is a need to guarantee rates of returns on savings. I would guarantee real rates of return at 2%, and let the government absorb the risks.

22. P.41: Why restrict the spending of the savings on insurance? If the individual wants to spend it on healthcare that falls outside the standard category, such as experimental or frontier care, he should have the option. There is the worry that mandating that the savings have to be spent on private insurance is intended for creating business for the insurance industry. It is a tricky business convincing people that they cannot spend their own money any way they want. Suppose the individual wants to withdraw their own money to buy a house, or to pay tuition fees for his child. Where is the justification not to allow this?

23. P. 41: not clear what is meant by "surrender benefits" under withdrawal benefits.

24. P.48: The reference to "waiting period" as a way to fight the "anti-selection" problem is totally unacceptable. Needy patients with existing problems cannot wait. They need timely, and quality care. The proposal is seen as a way to ensure profitability without regard to the real needs of patients.

25. P.48-51: Who will pay three times the standard premium to get standard or basic care? They will simply opt out and go to the HA. Will the HA provide them with the timely and needed care?

26. P.50: "there is a risk that insurers would try to find convenient ways and means to avoid enrolling high risk individuals". This is not a risk. This is a fact. "The Scheme supervisory body would need to monitor this." This is a pain.

27. P.48: The funding of the high risk pool (HRP) is problematic. As alluded to earlier, no one is likely to pay the 3 times standard premium, if all the protection is just "standard" and extra payments are still necessary. The burden is huge, and the security to be gained is small. People would simply opt for care under HA, especially if HA care is readily available. If HA care is not available, then the scheme will be seen as unjust.

28. Persistency at old ages is a big problem that cannot be tackled (p.50-51). The cost benefit ratio for remaining in the scheme simply turns patients off.

29. "Product Exchange" (p.53-54) This idea is borrowed from the Obama healthcare reform. It appears to make sense. But if you are talking about a genuinely standardized protection plan, with the product being homogeneous, prices will converge. Under open competition, inefficient insurers will not survive, the marginal insurer makes a normal profit and just manages to survive. The worry is that instead of open competition, the insurers collude and raise prices. It is far better for the government to appoint professionals to work out the standard premium for the standard protection. Given the need for economies of scale, the chances for open competition are very slim indeed.

30. P.54-55 really begs the role of the HA and the level of its services to be supplied. If it is "the government's strategic direction" for the HA to cover "complex admissions, particularly those requiring inter-disciplinary care", then the message to the public is "HA care is superior and cheaper." Getting HA care had better be early than late. P.54 does point out the dilemma, but provides no convincing way to tackle the

dilemma.

31. "Our recommendation is ….that each person would receive the same dollar amount of incentive regardless of socio-economic standing."(p.72) Why are the poor not given more assistance? If the poor get HA care, is that comparable, better, or inferior care? If it is comparable or better care, there is no reason why the non-poor should buy the protection plan. If it is inferior care, then there is unequal access to care.

32. P.65: quality assurance: as explained earlier, it is important for the public to know that HA and private hospitals are subject to the same rules of quality assurance and information disclosure. It is not enough if reports of incidents or other issues of public concern are only made to the Department of Health.

33. P.67: savings scheme: unless the contributions of the government are actual and not "notional", it is difficult to make the case for mandating that savings must be spent on insurance premiums. After all the money belongs 100% to the savers themselves.

34. P.71: savings contribution and premium rebates will certainly enhance enrollment, but if serious cases all go back to HA while the small problems go to the private caregivers, potentially involving moral hazard and fraud, can the consultants be sure that this is a wise use of taxpayers' money?

<u>An Alternative Simple Scheme for the Government and for Public Consideration:</u>

(1) The SAR Government will guarantee quality basic care to all HK people;

(2) Basic services are subject to identical charges to be announced by the SAR Government or its agents (HA or Department of Health), whether they are provided by HA or private hospitals; the charges should be at levels that can contain demand side moral hazard but not remunerative enough to cause supply side moral hazard; the Government may offer limited and pre-specified subsidies to private hospitals for the services.

(3) Every HK citizen and permanent resident will at most spend $X per calendar year on all eligible standard healthcare services; the Government will pay the rest.

(4) HK people have the option of going to HA or private hospitals to get basic services(to be defined, but should cover basic dental care, repatriation during emergency, etc.; should exclude experimental or frontier services); complex diagnoses, including those requiring inter-disciplinary care, will be covered unless the cost is considered to be unacceptable, in which case the patient has recourse to the Life-time Healthcare Supplement proposal to be outlined in (8) below;

(5) The ceiling $X rises with the age of the person. An elderly person will spend at most 3 times the maximum spending for prime age person. If they are healthy they will have no need to spend. If they are sick, chronic or otherwise, the most they need to spend is $X per year.

(6) Top-up protection is available in the market place through private insurers. Private insurers may also underwrite co-payments if they choose to.

(7) Prices of top-up services should be transparent; pricing of healthcare packages are to be encouraged as in the Milliman proposal.

(8) Every citizen is to be given a contingent "notional" amount, say $300,000, by the SAR Government to be spent on any healthcare services as long as:

   i. He/she will match the withdrawal with his own funds;
   ii. Total withdrawal is limited to the $300,000 ceiling over his lifetime.

   The contingent fund is called "Life-time Healthcare Supplement", and will help fund costly frontier or other services through a "cost sharing" mechanism. The cost sharing as well as the life-time cap contains demand side moral hazard.

(9) HK citizens are encouraged to save money in a Medisave Account with incentives given by the SAR government along lines as proposed by the Milliman Report, but citizens will have the option of a guaranteed return savings plan at say 2% in real terms.

(10) Charges for the poor under basic care as well as the yearly spending limit are halved based on a means test. The matching ratio for (8) may also be revised downward for them.

Note: The original comments include words highlighted by the author to draw readers' attention.

Comments by

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I presume the goal of this study is to design financing schemes to

(1) Improve resource mobilization for health care services in HK

(2) Improve the access to private health care services, especially inpatient services, and provide relief for some services currently provided by the HA

By offering more private health insurance schemes and medical savings schemes, the proposed HPS schemes could help to achieve the above-stated goals. However, success depends on the following conditions:

(1) The affordability of HA services (fee schedule) for HA citizens

(2) The accessibility and quality of HA services

(3) The affordability of private health services

(4) The accessibility and quality of private health services

(5) The incentives for consumers to join the private health insurance and medical savings account.

The proposed HPS schemes provide some interesting incentives:

(1) Premium discount schemes for joining the private health insurance (for claim-free individuals) and an extra premium for those with pre-existing conditions, and

(2) Government contribution and post-retirement premium rebates for medical savings account.

It is good that the report has acknowledged numerous limitations and challenges to implementing the two proposed schemes. However, before the HK government launches a full-fledged proposal for the public to consider, an empirical feasibility analysis and actuarial simulations are needed to provide the following information.

(1) Who are those 2.1-2.3 million current private health insurance holders? How many are employer insured, and how many are individually insured? What are some of the economic and demographic characteristics of PHI holders?

(2) Simulation of premium discount for different claim-free populations.

(3) Simulation of result of deficient amounts of government contributions to potential medical savings account participants.

(4) Simulation of different HA fee schedules, subsidization rate as a factor for consumers to join these two schemes.

Overall, there is merit to implementing both the "protection scheme" and the "savings scheme" and using the "savings scheme" to supplement the "protection scheme", especially during the period of old age. I remember a few years ago FHB commissioned a very comprehensive "medical savings study." Some of the implementation issues still remain. It seems the administrative cost for the government to implement the "savings scheme" (especially the government contribution portion) would be a challenge. The PHI scheme would be relatively easier for the government to initiate first.

Comments by

Prof Pun Lee LAM
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The Hong Kong Polytechnic University

In general, the document is well-written and covers many issues that might arise from a voluntary health insurance scheme. In the final report, I hope that your bureau would pay more attention to the following issues:

1. To encourage more people to join the scheme, there should be a moderate (and reasonable) increase in medical fees in the public sector, subject to a cap on expenditure. The government cannot avoid this sensitive political issue. The increase can also help the public sector to keep good medical practitioners.

2. There should be measures to tackle the supply constraints (hospital beds, doctors, nurses, etc.) to prevent a rapid increase in medical fees in the private sector. Import of doctors (specialists) and nurses, or export of patients (and paid by insurance companies) should be considered, if it is more cost-effective to do so.

With the government funding support of ($50 billion), it is a good opportunity to deal with the above issues. My suggestions are for the long-term interest of the community.

Comments by

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Sir Robert Kotewall Professor in Public Health,
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General Comments

This report focuses on one method, the Health Protection Scheme. The Scheme does not seem to be very attractive. For existing PHI policyholders, it is important to highlight that they have zero subsidy from government now, and what they will get when they migrate to the scheme. To attract new members to join the Scheme, 30% NCD is not attractive, especially there are many uncertainties of future increase in premium, and when they get into high risk pool. It seems that no matter how much one has paid/how long one has joined, when one can't pay, he/she will lose everything and shall have to move back to HA. This is likely for many, as the additional premium at HRP is likely to be unaffordable by many, except the very rich.

Specific Comments

1. P.10 third para: also need to consider intake of medical students for medical schools.

2. P.11, "migration process will entail little to no inconvenience": anything to support this? Any estimate for % of migration and % of new members? What about those who are covered by the usual existing PHI policyholders or other medical benefits (such as employee medical benefits of government or some universities)?

3. P.11, second para: It is important to estimate how much the Scheme can increase or decrease (with existing PHI migrating to the scheme) overall PHI penetration in the community, unless the sentence means zero increase (or decrease).

4. P.12, High risk pool: How to decide on the funding of the costs if this is to be equitable? It seems that government has to provide more for this.

5. P.14, What is the evidence for expecting "<u>most</u> insurers will try …… and <u>many</u> members will purchase a top up product…"? If "most" means more than half, the "Basic product" is really something for a minority, and will be seen as somewhat misleading.

6. P.14, "if the queues at HA reduce", and if the queues at private hospitals lengthen, the risk of withdrawal from the Scheme and return to HA is really high. Any estimation of such risk? The incentives to retain members to stay in the Scheme are important and need to be adjusted according to the risk or actual withdrawal rates.

7. P.14, Supervisory structure: what would be the cost implications? What are the indicators to "monitor scheme achievements"?

8. P.16 The discussion on tax reductions is too brief, and the recommendation, if any, is

unclear. It is not clear how many (%) already have PHI coverage, what is the coverage (basic or more), incentives to stay on till old age, etc.

9. P.29 "Premium loading for those aged 65 and above would not be capped …": Does this mean no upper limit, and if so, how should the premium be determined, and if too high, few would be able to afford.

10. P.32 "30% NCD level": Is this enough to encourage people to join the scheme? Why is this recommended as the incentive, and not other options? Is this the only incentive? What will be the minimum and maximum incentive for different categories of people (eg. younger or older people).

11. P.35 "last payer relative to other insurance policies": Does this also mean last payer relative to other non-insurance cover, such as those provided by employers.

12. P.41 Withdrawal benefits: "If the member chooses to leave the Scheme or dies, his/her estate … would …, but not the government's portion of the contributions. What about government's contributions in terms of premium rebates already paid for example for High DOF? I presume such contributions cannot be retrieved back by government? Does this means there is no "fund balance" for the government contributions for High DOF? [This point has become clearer on P.67]

13. P.48 Which insurers can charge up to 3 times the standard premium and if not sufficient, funding from HRP is needed? Would insurers be tempted to charge more than 3X? I think 3X is politically intolerable, not to mention 4X.

14. Should the use of private beds of HA be included for Scheme members?

Note: The original comments include words underlined by the author to draw readers' attention.

Comments by

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I have basically only two major comments.

- The study has adequately covered most of the related issues in a private health insurance scheme and has made relevant suggestions, i.e. control knobs. However, many of the discussions are too tentative, and perhaps speculative, and it would be much better, if the consultant has already tested out the issues with the relevant stakeholders even though it may be hypothetical as this stage. Examples of these issues are:
  - The issue of whether private hospital services will have sufficient incentive to offer packaged pricing is a bit speculative.
  - The issue of provider moral hazard: "However, there may be stiff resistance to this from the medical fraternity". So what is the assessment of the Consultant? Are the medical professional ready to do so?

- Private provider capacity – the conclusion that the "the patient to manpower ratio across Hong Kong would remain unchanged" is dubious. It is highly likely if the number of people covered under private insurance is increased, the total demand for in-patient health care services can be increased. If the queue at HA is shortened because of the implementation of the Scheme, and if earlier medical care can indeed save and maintain lives, and yet not 100% curing the disease, the number of chronic patients will increase over time, and the supply of doctors, and nurses and other key medical personnel would probably be a problem for the whole health sector, though not necessarily in the private sector. If there is any policy holder moral hazard effect, the above issue would be even bigger.

Comments by

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The proposed Health Protection Scheme and Savings Scheme appear to be initiatives that aimed more at luring people away from using public inpatient services and at seeking relief to public health care financing rather than at mobilizing individual resources to enhance access to affordable private hospital care and to better managed individual health and financial risks. It is not readily discernable how these two Schemes may help to slow or arrest undesirable increases in health care costs and total expenditure on health or contribute to shifting from being disease-focused to health-focused.

Nevertheless, the Health Protection Scheme has merit as an effort to stimulate changes in Hong Kong's private health insurance market. But the extensive control knobs proposed to address the risks, problems and undesirable consequences associated with voluntary private individual indemnity health insurance are largely conventional and may not totally befit Hong Kong's unique sociocultural-economic traditions and aspirations. The no claim discounts, for example, may be interpreted to deviate from the real intent of health insurance and do not make sense to those who genuinely fall sick: who can really predict and welcome the misfortune of the arrival of illness, especially one that requires hospitalization?

How to incentivize and reward healthcare providers for performance, apart from perhaps leaving it to market forces which, as seen elsewhere, tend to fail, are noticeably missing. They should be made explicit and integral components of the Scheme. Furthermore, it should be made clear if there are annual ceilings and lifetime ceilings in the Scheme's basic plan.

The Savings Scheme should be given more emphasis. As many already know, it can be a productive vertical risk (resource) pooling mechanism to enhance choice and access to care, especially during old age. It can also be an effective vehicle to promote prevention, early detection of diseases, reward healthy behavior and self-responsibility. Beyond the proposed three approaches based on "Degrees of Freedom", a more assertive strategy involving more innovative approaches to get buy-ins of the Scheme should be considered.

It would be advisable to recast the Scheme's risk pooling strategy to be community rated, simplify consumer moral hazard control knobs, and detail provider payment methods that provide incentives for good performance. It should also clarify who is to gain and if anyone will lose from the aforementioned initiatives.

Comments by

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Since the executive summary is essentially extracts from the main part of the study, my comments begin with Section 1, p.17.

p.17. I am not sure where these "parameters" come from. Are they recommendations by the writers, or constraints imposed by the terms of reference. If the former, I would have expected more supporting argument than is provided later in the study. In particular, the possibility of setting up a not-for-profit insurance entity to create the desired insurance policies should have been considered. And the constraint on premium rebates assumes that the scheme or schemes provided should not have age-independent premiums. It is a serious omission not to have considered them.

Benefits
p.24 and following.

The benefit structure has coinsurance, no-claim-discounts, and optional deductibles. I do not find the arguments given for the form of coinsurance and for no-claim-discounts convincing. The study correctly argues that there should be coinsurance to provide patients and, indirectly, physicians with incentives to avoid unnecessary diagnostics and procedures. I do not see how that justifies making patients pay $40,000 for a course of chemotherapy. There should be coinsurance for those procedures where there is an established risk of overprescribing. The Study argues that would be too complicated for patients to appreciate. It need not be, for example if a fixed patient fee applied per diagnostic test. In any case, that is a small point when set beside the unreasonable charge for expensive procedures.

The problem is accentuated by introducing no-claim-discounts (for individuals scheme members). These are used for motor insurance as an imperfect alternative to damage coinsurance. In the form proposed, it means that a normally healthy person, no doubt most people in their middle years, when she has a treatment, has to pay an extra amount (over and above explicit coinsurance) of (usually) half the annual premium – 30%+20%+10% over the following three years. It is not paid to the hospital, but it is paid. Extra procedures create no extra payment, so that the NCD does not even provide valuable coinsurance incentives. The no-claim-bonus system is simply a way of making the less healthy pay more of the costs of their care. The Study says that consumers want to have the system. That is because they do not really understand how it works. An insurance system should be devised to compensate for ill fortune, not make people pay more when they are unlucky enough to need treatment, except when there ought to be incentives to reduce that need. In the medical case, such incentives are best provided by moderate coinsurance for specific procedures.

One advantage claimed by the Study for the NCD is that young people will be attracted into the scheme by the lowered initial premium (guaranteed till thirty). The standard

premium for under-thirties can be set at that discounted level even if the scheme does not provide NCDs.

It is a good idea to allow optional deductibles in the scheme, since that can reduced administration and transaction costs. But I would have thought it better to have a per-annum deductible rather than a per-treatment deductible. It is a minor point.

p.28 Pre-existing conditions are to be covered according to a sliding scale over the first three years of scheme membership. The numbers seem rather arbitrary. I would have expected some rationale for the proposal. Three years seems quite a long period before full coverage. Bearing in mind that HA costs would be reduced when people join the insurance scheme, is there not a case for public subsidy of these costs, perhaps to the full extent?

p.30. Exclusions do not mention medication, I assume deliberately. Costs of maternity complications should surely not be excluded. The case for excluding primary care and (normal) maternity is well made, and the authors are right to note that there can be separate independent insurance for them. If alcoholism is excluded, tobacco-caused conditions and sporting injuries might be excluded too, but surely not. These decisions have to be rather arbitrary. What would it cost to include alcoholism treatment? Perhaps it is ineffective. Perhaps 50% coinsurance would be appropriate.

Premiums

p.32. I believe the illustrative premium rates are intended to cover benefit pay-out on average. I was surprised that they increase as rapidly in the 20-60 range as in the table, and wondered whether the income level was allowed to have any influence on the figure (because of wanting to encourage people to join the scheme early).

"Insurers would be free to set premium rates" (p.33) It must be the intention of the scheme that, once people have joined, insurers would not be able to raise the premiums for particular individuals because they appear to have become worse risks – otherwise the rule against termination could be nugatory. Any loading should be fixed once a person had joined the scheme. That should be explicit. It might be best achieved by prescribing the ratios between premiums at different ages. Quite simple ratios could be used.

The limit on premium loading, that the premium is capped at three times the standard rate, seems a high cap. The aim is to keep the High Risk Pool, which will attract a cross-subsidy from insurees in general, small. I would have thought it right to find a way of subsidizing high healthcare costs from general government revenue. As always, there is the consideration that people who are discouraged from insuring by high loading will then, as patients, be a charge on HA. There will be some saving if they are encouraged to join the insurance scheme, and that at least would justify some substantial subsidy. That would be a subsidy of higher healthcare costs, say 50% of the excess over $15000 per year. As a consequence insurers would require smaller loading. And the loading cap could be set smaller, perhaps at 50%.

Saving for old-age premiums

Saving is an imperfect way of dealing with the serious problem of premiums rising with age. Saving, if sufficient, means that funds remain at the end. It is therefore more expensive to provide for high old-age premiums by saving rather than some kind of insurance. The obvious way of insuring against high premiums is to have an insurance policy with a premium that is the same at all ages. The premium will have to rise with time as general medical costs increase. Usually, the consumer will have no incentive to leave the policy as time goes on. The insurer must be required to maintain cover. Furthermore, people must be able to leave the scheme temporarily, because of temporary income loss (unemployment) or living for a period abroad, and should have a right to re-enter on return. The premium would differ according to the age of first entry into the scheme. The government subsidy that, in the scheme, would apply to old-age premiums would be applied to all premiums. It might be good to have a lower premium at earlier ages (0-30) to make joining the scheme easier.

I do not have time to lay out and justify such a scheme in detail. It seems to me that such a scheme should have been worked out. It might be offered as an alternative to the scheme. There is no need to compel people to save. But a scheme with contributions that do not significantly increase, like a pension scheme with working-lifetime contributions better fits the earning/needs pattern of most of the population than the unsatisfactory health-insurance schemes that the free market has so far provided.

Comments by

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Scope of comments

The study identifies two main goals of the Health Protection Scheme (p.17), which I re-phrase as follows:

i) Shift the (future) burden of financing health care from public to private budgets, and make greater use of private health care providers;

ii) Increase competition and consumer confidence in private health insurance and provider markets.

To an extent, the second objective is instrumental to achieving the first. The fiscal pressures propelling the first objective are understood. I will not comment on the general reform strategy of increasing the role of private financing, in particular private health insurance (PHI), relative to others that have been considered in the past, such as social insurance and increased public sector user fees. I restrict my comments to possible consequences of increasing private financing and the effectiveness of the measures recommended for achieving this.

On the whole, the study identifies a clear, and quite possibly effective, strategy for increasing the role of private financing of health care in Hong Kong. It does so recognizing the constraints on the available policy instruments and it considers carefully the risks that could jeopardize the strategy. I do not have comments on the specifics of the policy levers proposed. The two comments that follow are rather more general.

As an aside, **more empirical support could have been provided for some of the assumptions made**. For example, 65% of the 85+ population maintaining a 3-year No Claims Discount (p.32) seems optimistic. I would have liked to see the empirical basis for this, and other, assumptions.

Consequences for the Hospital Authority (HA)

The general strategy proposed to relieve the burden of health care on the public purse is to encourage households to opt for private sector alternatives to public health care, while maintaining universal access to the latter. The encouragement will be both pecuniary, through subsidization of insurance and saving products, and non-pecuniary, through a more transparent private sector. One wonders whether these instruments that seek to pull households to the private sector will be sufficient, or whether a push from the public sector, due to falling quality, will also be necessary to achieve a substantial shift from public to private care.

The PHI policies proposed have substantial deductibles and coinsurance rates. This is perfectly understandable as a protection against moral hazard. Given these out-of-pocket (OOP) costs, patients will only have an incentive to opt out of the public care to which they will continue to be entitled if either the quality of care is sufficiently greater in the private sector, or if user fees are raised substantially in the public sector. Changes in the quality, scope or charging of HA services is not discussed in the report**. If no such changes are envisaged, then the study should make a more convincing argument that instruments that pull households toward the private sector will be sufficient to generate a substantial shift in the balance of public-private financing, while maintaining a universally accessible HA.**

Even if there are no intended changes in the public sector, one wonders whether this would be sustainable over time. Under current arrangements, there is a broad range of middle income households whose benefits from public health care are roughly equivalent to their contribution to the financing of it. The proposed reforms aim at encouraging these households to move from the public to the private sector. Provided the budget remains constant, such movement would release resources that could be better concentrated on poorer, and sicker, patients. But it is perhaps unlikely that the HA budget would indeed remain constant. Many middle income households would become net contributors to public health care and their support for maintaining its quality may be eroded. **The study could consider whether undermining of support for the public sector as a consequences of the reforms is a likely scenario within the Hong Kong context.**

Protection Scheme versus Savings Scheme

The study argues that increasing savings with the aim of financing private health care (insurance) costs in old age is crucial to the success of the reforms. Subsidization of PHI alone is unlikely to be sufficient to motivate older households to pay substantial premiums without having money put aside for this purpose and the existing penetration of PHI at younger ages limits scope for further development of the market within this population. Despite the acknowledged importance of the Savings Scheme, the study says very little about how it would operate, beyond sketching three models differing in degrees of flexibility. The analysis concentrates on the Protection Scheme encouragement of PHI. **The study could provide a more detailed analysis of the scope for further increasing the saving of Hong Kong households, of how exactly savings would be encouraged and of the extent to which these savings would encourage purchase of PHI at old ages given very high premiums and differential consequences of savings and PHI for leaving inheritances.**

Note: The original comments include words bolded by the author to draw readers' attention.

Comments by

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Since I have not seen the actual terms of reference provided to the study authors, I divide my comments into two parts. The first part deals with the extent to which the study report meets the goal as described by the authors themselves (p.17): "*The aim of the Feasibility Study on the Key Features of the Health Protection Scheme is to design actuarially sound insurance product templates and develop policy options for provision of incentives where necessary to enable the Scheme to operate effectively*", and the comprehensiveness of their proposal in terms of meeting the Scheme objectives as defined in the subsequent paragraph, i.e., encouraging take up of medical insurance and savings plans and so inducing greater use of private alternatives to public services, and improving transparency within the PHI and healthcare markets. The second part of my comments deal with the implications for the underlying government objectives, which may or may not have been in the terms of reference given to the study authors.

The extent to which the Feasibility Study on the Key Features of the Health Protection Scheme makes a proposal that is realistic, actuarially sound, improves market transparency, and provides feasible policy options for provision of incentives

- The report is over-optimistic about the extent to which providing package pricing can improve transparency and predictability to the patient. A critical problem that is not adequately discussed or explored is that much medical care is not elective, and so does not provide the patient with substantial opportunity to make price comparisons during selection of care. For example, p.25 refers to the difficulty that hospitals may have in predicting the costs of care for stroke or acute brain injury, but does not discuss the more serious issue that families needing to find care for member suffering from an acute stroke or brain injury are usually not well placed to make informed and deliberate judgments in choosing treatment options in such emergency situations. Such realities need to be taken into consideration when presenting the idea of cost packages.

- The report does not adequately discuss the implications of the division of the PHI market in Hong Kong into group and individual insurance schemes, or even provide any statistics on the current market structure. I assume that the bulk of the insurance market in Hong Kong comprises the group insurance market. This market suffers less from the problems of adverse selection and the affordability of insurance. To the extent that the market can be expanded, most growth must come from the individual market.

- Control of premium rate increases (p.30): The proposal does not adequately deal with how premium rate increases will be moderated, since it only deals with the issue of ensuring that insurers fees are linked to underlying medical inflation. This is not adequate from a policy perspective since it ignores the more fundamental problem that may arise with underlying medical inflation, i.e., the prices presented by

providers. In order for the scheme to be financially and socially sustainable, both elements need to be moderated, but this requires some discussion of how or whether this is feasible in this kind of scheme. Experience from the US market would suggest that insurers in fact have great difficulty in controlling the underlying cost structure that providers present, which is a principle driver behind the high medical cost inflation in the US insured market.

- I sympathize with the justification given for the exclusion of outpatient and primary care, on the grounds that these are not inherently insurable, but this implies a market failure that would presumably require other government intervention or incentives to address, which the report should discuss. For example, it would be reasonable to argue that under-use of some types of primary care will lead to later increased inpatient costs (e.g., secondary prevention of heart disease, management of early-stage diabetes, etc.). This sub-optimal use of care is a market failure, which the government would have to address through other financing, which should be discussed in the report as measures to support the effectiveness of the proposed scheme.

- Premium rates (p.32): The rates presented as illustration in Exhibit 2.2 explicitly exclude the costs of commissions and acquisition costs. This is not an adequate presentation, since the government will need to consider the overall premium levels faced by Hong Kong residents in reviewing the feasibility of the proposal, and the costs of commissions can be sizeable. The study authors should have used their global experience to at least provide an indication of the additional mark-up to these rates that commission and acquisition costs will add, with some idea of the range in such costs in other countries.

- Approaches to saving schemes (p.37): This discussion does not address the critical issue of how effective any of the proposed schemes would be in increasing overall savings and the fiscal cost-effectiveness of government incentives. If the proposed schemes do not increase savings rates, then all they will do is to ear-mark a portion of future savings balances for use in paying for health insurance premiums. This would happen if households put some of their savings into the proposed scheme, but then reduce their investment in other savings assets by an equal amount – which would be fairly consistent with standard economic models. The discussion takes the view that Hong Kong people are averse to restrictions or mandates on what they do, so it is not clear how restricting the future use of savings that would have been accumulated anyway is consistent with that view of Hong Kong people's preferences. On the other hand, if the objective is to increase overall savings rates, then the report is amiss in not discussing how effective the proposed schemes would be, nor in discussing what the fiscal cost would be of government incentives to do so. This is not an academic issue, since the global experience is that it is extremely difficult to increase overall savings rates in the context of a market economy like Hong Kong's, if the primary mechanism is voluntary savings schemes as proposed. In fact, OECD studies generally have found that only compulsory savings schemes are effective in increasing savings rates, and even then only in lower-income households where savings rates are low to start with.

- Financial parameters of saving schemes (p.37 onwards): The discussion of potential savings options is deficient without some discussion of the required savings rates. The critical problem being addressed is lapsing of policies at ages 65 and above. However, the annual cost of premiums at above this age can be three to four times or more than the annual cost for those aged 30-50 years. Given that average life expectancy at age 65 in Hong Kong is likely to trend over 20 years, it would have been useful to provide some estimate of the annual savings required from say age 40, if an individual wishes to pre-fund say a given percentage of his premiums above age 65. A very rough estimate would suggest that an individual wanting to pre-fund say 50% of later premiums during the period from her 40th birthday to her 65th birthday might need to set aside annual savings equivalent to the current cost of her current year premiums. This is not an insignificant sum, and the authors should have at least provided some guidance to the likely numbers given their actuarial expertise and reasonable assumptions about future inflation and investment returns in Hong Kong.

- Policyholder moral hazard (p.45): There is no economic evidence that the stated problem implied ("buffet mentality") of over and excessive use of medical care owing to lower prices exists. The economic literature and empirical studies do not support the view that increasing charges/copayments leads to more efficient or more appropriate care. Studies such as the landmark RAND health insurance study in USA show that the impact of prices is to reduce both needed and unneeded care equally, since people cannot distinguish low value from high value care. This section of the report is quite erroneous and misleading in its characterization of the impact of prices on patient demand.

- Provider moral hazard (p.45): This section of the report is incomplete, as it only discusses one component of provider moral hazard, namely the prescribing of increased volumes or intensity of care. However, the other part of provider moral hazard is also significant which is the increased prices charged by providers when faced by insured patients. The implications of this problem needs to be discussed and what solutions might exist and their likely effectiveness if any.

- Use of medical audit and protocols to improve appropriateness of care (p.46): The changing of physician behavior although desirable is not easy, and the discussion is remiss in not discussing the difficulty and cost of changing such behaviors. The imposition of greater scrutiny of medical behavior would be extremely costly, and the costs should be factored into the estimation of the scheme costs – it could certainly substantially increase the reporting burden on providers as well as the administrative costs of the insurers. Further, it is not clear that simply increasing the availability of protocols will be effective, since much global evidence indicates that these are ineffective without the use of high powered financial incentives and supporting investments in information systems. Simply arguing as the report does that Hong Kong can build on existing protocols is not enough, since the real costs are in the implementation and monitoring of protocols, and in the linking of payments to adherence to protocols.

- High risk pools (p.48): The impact of the rate loading required to implement the HRP on the demand for HPS schemes when most other schemes do not have this loading is not discussed. This is likely to lead to adverse selection pressures which will reduce

the expansion of HPS coverage. The alternative of course would be to provide a government subsidy as indicated, but then the report should provide some estimates of the likely costs of such subsidies.

The extent to which the Feasibility Study on the Key Features of the Health Protection Scheme makes a proposal that addresses underlying government objectives

I infer from the report that the underlying objectives of the Hong Kong government are to reduce its fiscal burden arising from public financing of healthcare, and to make the PHI market more transparent to consumers. I suspect that the first objective is indifferent as to whether the care is provided by the public or private sector.

From that perspective, the report raises a number of questions about how effective the HPS will be in reducing the government's fiscal costs. This issue is not assessed at all in the report.

The report makes clear that if the HPS is to be successful in significantly expanding PHI coverage it will require significant government fiscal subsidies, both initially and on a recurring basis:

(i) The main reason why older persons do not buy PHI is the cost relative to their income. Although the HPS proposal would reduce the intra-person variability in premiums, it would not significantly reduce the average price of PHI premiums for older persons, unless government subsidies are provided. Older persons in Hong Kong face the double burden of both higher premiums and also less likelihood of being employed and thus able to benefit from membership in a group scheme that partly pools risks with younger persons.

(ii) Savings schemes to build up savings to allow older persons to afford PHI premiums are unlikely to be effective in increasing savings rates without significant government subsidies.

(iii) Subsidies are also indicated as being necessary in several areas, such as a high-risk pool, initial no claim discount, etc.

(iv) Subsidies may be required to implement interventions to change clinician behavior to make it more appropriate and consistent with clinical best practice.

These fiscal costs are mostly not quantified and no estimates are given in the report how much they might conceivably be.

If the subsidies are to reduce the fiscal burden of the government, then they must meet one requirement. The marginal cost savings achieved by reducing government expenditures on Hospital Authority services when a person who would have used HA care does not but switches to use private sector services funded through the HPS must be greater than the fiscal costs incurred by government in the form of increased budgetary spending and also foregone tax revenues in incentivizing the marginal increase in PHI coverage. Given that private hospital services are substantially greater than public sector

services in Hong Kong according to my limited knowledge, even a partial subsidy for private use may be fiscally inefficient.

Furthermore, the report indicates that the HSP might be effective in attracting large numbers of covered persons, but that the bulk of these might simply be switching from non-HSP PHI schemes to HSP schemes. I find it credible the report's caution that it may not be easy to substantially increase PHI penetration. I note also that in Australia, where many of the incentives discussed have been implemented with short-term increases in coverage, these same incentives have not been effective in preventing a long-term decline in PHI coverage. If this was the case, then the bulk of the fiscal costs incurred by government in incentivizing the HSP will have achieved no benefits in terms of reduced use of public sector services.

This suggests that the current report, which does not attempt to discuss these overall fiscal cost trade-offs, possibly because the authors were not required to do so, is not be adequate a basis to assess the fiscal benefits or costs to the government or to households of this policy reform. The report does not provide a basis to argue that the proposed HSP would reduce the net fiscal burden of government, and so I hope that the government has commissioned such an analysis in its other commissioned or planned reports.

Note: The original comments include words in bold and italics by the author to draw readers' attention.

Comments by

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General Comments on the Health Protection Scheme

1. The Health Protection Scheme is a good initiative to tackle the problems of increasing health care cost resulting from increasing sophistication and capability of the medical system, as well in deteriorating health of the population. However, it would be more effective and desirable if the HKSAR Government can clearly spell out the rationale of mounting such a scheme, without new thinking about health financing, our health care system will not be able to meet the demand from our future population, to say that Hong Kong people are not adverse to saving for the post-retirement living expenses, including medical expenses is far from reflecting the reality, *to the contrary, majority of Hong Kong people are NOT prepared to be responsible for their own health expenditure*.

2. The Hospital Authority (HA) is the major provider of hospital service and related out-patient service in Hong Kong, the types of service that the Health Protection Scheme is seeking to provide. To move some of their patients out from her patient load will have effect on the HA, directly in terms of cutting short their queues (this may have consequential change in terms of budget HA is going to receive from the Government), indirectly through the flow of doctors and other health professionals into the private sector (leaving HA service), and remotely when the HA is required to provide new private hospital service to meet the demand arising from the Health Protection Scheme (when the private sector cannot meet the need). All these need to be considered and "managed", any of these may contribute substantially towards failure of the Health Protection Scheme.

3. When the queue is shortened at the HA, this may attract some of those patients who are protected under the Health Protection Scheme will return to seek treatment at the HA, in order to avoid the co-payment and deductibles, or to preserve "no claim discount". The implication of this would be the HKSAR Government subsidizing the insurances firms, for the premium was computed based on patients making claims for reimbursement: the greater the proportion of patients who are returning to seek treatment in the HA, the less these insurance companies will be paying out. The Health Protection Scheme should consider capping the "allowed percentage profit" by these insurance companies, with excess put into a reserve account, alternatively, these patients going to the HA for treatment should be charged a slightly reduced sum than that normally be charged in the private sector (even if they have treatment in the general ward by the general team of specialists in the HA).

4. The report had made an assumption that the total number of health professionals can take good care of patients, whether they are in the public or private sector. This assumption is quite wrong, the demand for service in the HA had been suppressed to various extent, and the criticism that medical service in the private sector has been

artificially inflated is also quite right, for example the hospital stay is usually longer than really necessary. Thus, despite the provision of co-payment to discourage unnecessary usage, the demand for facilities (such as hospital beds) and health care professionals would be out of proportion to the percentage of patients shifted from the HA to the private sector.

5. Whilst the Government has good control over the supply of doctors in Hong Kong (through the University Grants Council in changing the number of places in the 2 medical schools), the control over the number of specialists trained is more complicated, the Academy Colleges and the HA both had strong influence on the training positions available. Better coordination should be put in place.

6. In the unlikely scenario of inadequate provision of service in the private sector, and the HA being forced to provide more private beds, it should be mandatory for the HA to create a separate arm to provide such private service, in terms of staff, accounting and accountability, so that the service for the public class patients will not be adversely affected, and the efficiency (and real cost) of such service can be open to public scrutiny (to avoid the even worse scenario of public money being used in subsiding all parties taking part in Health Protection Scheme), to the detriment of public class patients.

7. Concerning the saving component of the Health Protection Scheme, whilst the Mandatory Provident Fund was recently heavily criticized for overly expensive management fees and poor return from investment, severe criticism on the saving component will be expected when this Health Protection Scheme is out for consultation. In fact, the management fees of such saving component is consists of 2 components, the administration in terms of handing paper works (joining and switching, etc) and the professional fees for investment, with the latter being, at least in theory, the more expensive part. Unfortunately, these 2 parts normally are not separable, perhaps deliberately bundled by these investment firms in order to disguise the heavy professional fees for investment. Given the good track record of the Exchange Fund managed by the Hong Kong Monetary Authority, it can be an attractive approach to give an option for the investment to handled by the Hong Kong Monetary Authority (to come under the Exchange Fund investment portfolio), whilst the administration still remains under an administrative arm of the insurance company or other organizations.

Specific Comments

8. When some of the patients of the HA are shifted to the private sector, it is expected that the high-cost services will remain with the HA. This would mean that the HA should be prepared for sizing down, able to re-distribute her resources and re-structure her service. The HA is not well known for such changes, mechanisms to facilitate such re-structuring must be put in place.

9. Coverage for pre-existing medical conditions: the present proposal to reduce coverage in the first 2 years can easily be surmounted by staying with the HA for service in the first 2 years, and claiming benefit starting from the 3rd year. Thus, the insurance company must assume 100% coverage starting from the 3rd year, under such

circumstance the premium will be exceedingly high unless a large population of the healthy individuals is joining the Scheme.

10. Competition amongst providers: it is assumed that there will be means to benchmark performance of services in the public and private sector, this is going to be a very difficult task.

11. Limited scheme membership: there was an assumption that the migration of the present PHI policyholders to the Scheme will be an easy decision. This assumption will only be true if the future premium is comparable with the current policies.

12. Anti-selection: as discussed in paragraph 3 above, even the provision of 200% premium will not discourage the unhealthy lives to be over-represented in the Scheme unless the scheme is also very popular amongst the health population.

Note: The original comments include words in italics by the author to draw readers' attention.

Comments by

Prof Raymond Wai Man SO
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The Proposed Scheme is a long await one and medical insurance is one of the right way to formulate a good health care system for Hong Kong. However, I would like to make two observations to the Proposed Scheme.

First, I do not see any big economic incentives for joining this scheme. For people who voluntarily elect to purchase medical insurance, they already lock in some forms of "Scheme" already. The proposed Scheme though is aware of this, the Scheme provides no real incentives for people. It has been suggested by many to include tax incentives for medical insurance. I would like to echo this point. If tax incentives are provided, it is a better alternative than asking the Government to subsidy the insurance premiums. We all know that once the Government will subsidy a particular product, the industry will design a product that aims to maximize the subsides that can be absorbed by industries. The industry will not decide a product to cater for the need of the people. In my opinion, tax incentive is a must in order to make this Scheme workable.

Second, the issue of equity is still largely unresolved. Many of the HA users are the less privileged groups and the society should help them. However, there are quite a bit of people who adopt unhealthy living styles when they are young and when they are old or become ill, their medical bills are paid by taxpayers. In the current HA practices, we do not discriminate against them and it is acceptable given the role and responsibility of the Government to provide public medical care. In the proposed Scheme, I do not figure out how to address this inequitable issue. Many people who buy medical insurance (and not rejected by insurance companies) are risk-averse and maintain a healthy life style. The risk of making a claim in their younger days are lower. In this aspect, the pooling of risk is indeed letting the good to subsidize the bad. For normal insurance products, the insurance companies can reject the applicant, so the pooling of risk is among people of more or less similar risk profiles. The issue of equity is then not a major concern. But for the proposed Scheme, it seems to me that higher cost will be inequitably borned by the less risky group.

Comments by

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The main rationale for the proposed Health Protection Scheme can be summarized by three policy objectives: (1) to divert some of the health care demands from the public sector to the private sector, thus relieving the Hospital Authority of its caseload burden and improving the quality of its service (e.g., shorter waiting times); (2) to provide a platform for affordable access to private hospital services, thus increasing their scope of choice; and (3) to widen the customer base of private hospitals in Hong Kong, thus giving an opportunity for the development of the economy as a regional health care center.

Objectives (1) and (2) are contained in the report. Objective (3) is not explicitly stated but is probably implicit. I do not include the point raised on page 17 ("improve transparency about service standards and price levels in the PHI and healthcare markets, with a view to encouraging standardized product development and offerings, promoting market competition, and enhancing consumer protection and confidence") as part of the policy objectives. While laudable and perhaps even feasible, that policy goal cannot possibly justify spending an estimated $50 billion to achieve.

If we accept these three policy objectives, it should be borne in mind that methods of financing are in some sense a secondary issue. The more fundamental instrument to achieve these objectives has to be an increase in supply. Shifting demand within a fixed supply of hospital services may marginally achieve a better match between patients and the type of services they desire, but an improvement in overall quality has to rely on an expansion of supply. The report mentions the provision of extra plots of land for private hospitals. Are there plans to increase the supply of manpower too? To be sure, these issues are not within the scope of the present report and I will not discuss them further, but they have to be a key component of any overall policy package.

The report discusses both an insurance scheme and a savings scheme. The key features of the insurance scheme are summarized in exhibit 2.3 (page 36). The big advantage is the establishment of a common platform with guaranteed issue, guaranteed renewal, and portability between individual insurance covers. The report also spends quite a bit of space to dwell on offering coverage based on "package charges." The practice, if adopted by more private hospitals, seems to offer more certainty and transparency to consumers. These features appears to be well thought out, and there is no denying that they may bring some genuine, if marginal, gains to the operation of the private hospital insurance market.

The success of the insurance scheme, however, has to be measured against the reduction in uninsured population in the territory. The report assesses the probability of "limited scheme membership" to be "moderately low." The assessment is based on the fact that there are currently 2.3 to 2.4 million existing lives with private hospital insurance in Hong Kong, and encouraging these people to migrate to the new scheme should not be

too difficult, especially in view of the incentives offered. However, the migration of people from one scheme to another does not contribute to relieving the demand burden on public hospitals, not does it contribute to improving the quality of health care they receive. Most of the existing private hospital insurance holders obtain their coverage as an employment benefit, and are therefore enjoying an implicit tax subsidy. The remaining insurance holders are probably relatively well off, and the grounds for subsidizing them are weak. If a large membership in the proposed Scheme comes primarily from the pool of existing policy holders, I do not see how this can be a legitimate ground for the introduction of the Scheme when the estimated costs are so high.

The report is a lot more pessimistic when it comes to increasing the overall private hospital insurance penetration—which is the only outcome that would possibly justify the use of public subsidy. The report states, "However, increasing the overall size of the PHI population, i.e. getting the uninsured to join the Scheme will be more difficult because the cost of assessing HK is so cheap and those who have not already purchased PHI may be set on staying with HA. At the end of the day, the Scheme may be able to achieve its objective of improving the transparency, market conduct, and competitiveness of private insurance and private providers, but it may not be able to increase the overall PHI penetration rate significantly" (page 59).

Turning to the savings scheme, the report proposes three alternatives with different "degrees of freedom." The report points out that "Hong Kong people are not averse to saving for the post-retirement living expenses, including medical expenses. However, they do not like to be told how to save." The purpose of the savings scheme is to encourage elderly people to obtain insurance coverage (or hold on to their coverage). Inadequate coverage among the elderly population comes from the problem of low income, not the problem of low savings. Compulsory saving (the low and medium "degrees of freedom" alternatives) is therefore the wrong medicine to the malaise. A more direct and effective approach would be to provide premium rebates to elderly people in the insurance Scheme (the high "degrees of freedom" option). Whether such rebates should be tied to the length of insurance Scheme membership should be subject to more careful scrutiny. On one hand, such a link would encourage younger people to join the insurance Scheme early. On the other hand, elderly people without prior membership in the Scheme would be discouraged from joining.

Clarifications sought:

- Does "guaranteed renewal for life" means renewal without the risk of being loaded with a higher premium?

- Would no claim discounts be portable across insurers within the Scheme?

- The reports states that the High Risk Pool will be funded in part by "reinsurance premiums paid by insurers, which would be a percentage of all individual Scheme premium income" (page 48). Does this mean that people paying the standard premium are cross-subsidizing people in the high risk pool?

Comments by

Prof Tak Jun WONG
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I. Provide a clearer objective or objectives of the entire scheme upfront

Is "improving the transparency, market conduct, and competitiveness of private insurance and private providers" (page 11) the primary objective of the scheme? What is the objective of increasing the overall PHI penetration rate? Is it also a primary objective or a secondary objective?

These objectives should be presented earlier in the document.

Some discussion on how the "choice and access to private hospital care in a better-regulated environment with more certainty" (page 14) should be presented more thoroughly as a key objective of the scheme.

II. More detailed comments on the scheme

I am concerned about the possible abuse in the system. If this scheme is expanded to more users (other than the current PHI users), the risk of abuse by doctors and patients may increase. I would like to see more discussion on how to control for such kind of moral hazard issues. Some may even argue that government is not necessarily as effective as the market in handling this type of moral hazard issue.

I agree that we need to provide better coverage for the public, especially those with pre-existing conditions. It is not clear how this would not create an adverse selection problem – attracting only the high-risk cases into the government scheme and making the scheme too expensive to run. A more thorough deliberation is needed.

III. Real contribution of the scheme

As mentioned in Section I, it is not clear to me if expanding PHI to the aging population and/or to the lower income groups that currently do not receive PHI is the primary objective of the scheme. To me, if this is not the primary objective, I really do not see the value of running this new scheme just to take care of the current PHI users. Is it worth using taxpayers' money to run a scheme that is currently covered by PHI.
If the scheme's primary goal is to provide insurance to the aging population and the lower income groups, then I will have the following concerns:

1. I will need to understand more about the savings scheme. How attractive is it for a current PHI user to put his/her money on a savings scheme so they could save up more money for future health insurance cost than otherwise. If the HA option is always available, the problem of deferring future costs (vs. saving and free riding will still be there. The Singapore scheme of mandatory savings would work better in this case.

2. It is not clear to me how we could offer this new scheme to lower income groups that do not currently enjoy PHI. Can they afford the premium and why they would want to leave HA and join a private insurance scheme? The current draft fails to elaborate on this.

IV. Financing

I hope that future draft will talk more about the financing. Those that currently have PHI are probably the ones that pay most of the income taxes. If only this tax money is used for financing the incentive schemes for joining the insurance and saving schemes, I don’t see how this will create more savings for the government. If we want to attract more people to join the new scheme (elderly and lower income groups), where do we get the financial support?

Comments by

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Korea

In general, I am in favor of the Savings Scheme (SS), but not the portion on Insurance Product Scheme (PS) (i.e. without any savings component).

My comments are more or less on the PS as a system, but not on the specific features of PS elements. That is, I am raising a more fundamental, but at the same time profoundly practical, issue in relation to HK's PS. Please forgive me if my following comments are stemming from my ignorance of details of HK's Healthcare (HC) System.

Through this PS, HK sort of plans to privatize HC, especially the inpatient and high cost outpatient portions. There must be reasons why this kind of change at the system level needs to be introduced, which I hardly know. They may be political, social, economic or changing social norm. However, whether it is HK or elsewhere, privatization of health care generates unintended or often unexpected negative side effects from the public's perspective, particularly in the long run.

Private is private. Their primary goal is not to serve the public, but to make profits. More profits, the better. They try to achieve their primary goal thru means of innovative ways, clever ways, and often political ways. When you come to the stage of political involvement, HK health care system would never be safe from distortions stemming from private insurers/private providers in making greater profits. Unless the gov't perfectly controls such distortions, which is often nearly impossible, distortions for the interests of the private insurers/providers could be unavoidable. This is so mainly because of the nature of health care service as a commodity, that is, market failure due to information asymmetry. When this market failure is combined with political involvement, distortions will be existent and jeopardize the HC System.

As we are well aware of, the concept of private sector matches well with the market mechanism. When we come to market failure, private sector hardly works well, both in terms of equity and efficiency. We got to realize that there will be loss of efficiency, not alone equity, thru privatization of health care provision. For example, excessive provision of services, drugs, provision of unnecessary care, provision of high cost care where low cost care would suffice, and false claims. Even under the DRG structure, all the above problems are likely to persist, especially when there are benefit limits and beyond the limits are the responsibilities of individuals to bear. DRG creeping will appear, and is very hard to monitor/manage, and cost shifting to outpatient care (and so, toward HA) could be another concern to the system organizer, HK government.

Ultimately, facing financial pressure, PSs will first monitor the private providers' behaviors and then will attempt to raise contributions of beneficiaries to cover the rising costs. Once (undesirable) politics is involved (inevitably, it will happen as private market becomes a key functioning basis), it will be difficult to stop this kind of inflationary spiral.

That is, cost increase will be followed by contribution rate increase, which will be backed up by directly/indirectly involved politicians. These distortions are all linked to efficiency loss at the system level, and are likely to take place as they are connected to increased profits for private providers and insurers.

In your section of ‘Risks and Control Knobs’, under the heading ‘Provider moral hazard’, you correctly mentioned this potential aspect as one of the risks.[1] By the space it takes within the whole Report, it looks a small risk. But no! It would be a major risk attached with the privatized PS. We can hardly discount the size of risk of provider moral hazard. The success of the whole HK HC System will depend on to what extent this kind of risk will be existent. I am sure it will be big enough to be scared, and because of that, the HC System of HK won’t be sustainable in the long run.

There are ways to manage this sort of distortions. HK govt may heavily regulate private providers/insurers not to practice such distortions. But in practice, this sort of regulation is nearly impossible to happen. International experiences over time tell us that regulation of private providers to guarantee the efficient operation of the health care market never works. That is why Professor Alan Enthoven calls health care an ‘art’. Can we properly regulate the contents of the arts?

What are we trying to achieve thru No Claim Discounts (NCDs), for example? Economic incentive not to use necessary health care or unnecessary health care? Did we see many people to get unnecessary surgery because they have insurance coverage? There may be a few, but definitely not many. Then why do we need this? Isn’t it the case that this NCD clause somehow penalizes those who are ill and seek care for better health? May I ask this is the kind of health care philosophy that HK govt/society has toward the sick people?

As stated in the report, manpower drainage, particularly the good ones, from HA to private sector is expected to happen. The end result seemingly to happen is the possible dichotomy of the HC System of HK; high quality private sector and low quality of service from HA providers. Once such a recognition becomes widespread among the people, it will be very difficult to turn around the situation, if not impossible. Some un-ignorable social costs will be involved in the long run when such recognition that gov’t is a less reliable source of health care provision prevails.

So my comment here is, no matter how pretty/perfect your design of the PS is, it is not gonna work as you expect or as you intend to achieve thru the PS.

If PS to work with the private providers, why not to make it a govt Scheme? If run by HK govt, there will certainly be efficiency loss due to bureaucracy. But that loss will be far less than such a loss from privatization of HC in HK.

In conclusion, I believe PS-HK will not work for health equity and resource efficiency in the long run. Quality of care will not be guaranteed either when private providers provide unnecessary and excessive care. Is MRI a good quality of care when X-ray suffices as a diagnosis tool? If you try to contain costs thru private PS, it will never happen, especially

[1] The Report mentions over-prescription and over-servicing only. But as we can imagine, other types of distortions are highly likely as well.

in the long run.

Equity, efficiency, quality of care, and income protection are four pillars that HK try to achive thru HK's HC System. PS will function much better when managed by the gov't and services are provided by public providers.

In relation to the above comments, here is my question to the HK Government.

Q: Why is HK govt trying to introduce this private-natured PS in the first place?
- Is the government reluctant to collect high tax to support increasing medical costs by HK residents?
- By introducing private DRG under private insurance, is the HKG intending to shift costs from govt to individuals OOP (insurance payment + coinsurance payment at use of service)?
- But doesn't that mean loss in equity in health financing? That is, as private insurance payment (regressive) and OOP (regressive) is substituted for tax payment (progressive/proportional), the HK health financing will become more regressive.
- As seen in my comments above, PS would mean loss in efficiency as well.
- So my question is once again, why do you intend to change your system in this way?

Q: If high cost services with complex case mix still remain with HA, why not the packages in the PS? What is wrong with a system where the HA takes care of all?
- Is it a political thing?
- Is it a change in social norm?
- Or is it a recent change in philosophy of health care in HK?

Comments by

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There is a dilemma of accessibility versus affordability in the current healthcare market in Hong Kong. On one hand, the waiting line in the public hospitals make public healthcare not friendly accessible; on the other hand, the high costs in the private hospitals make private healthcare not feasibly affordable. We need a structural reform to balance the public and private medical services by making public healthcare friendlier accessible and private healthcare more economically affordable.

The voluntary health protection scheme has the potential to serve as a catalyst to enhance both accessibility and affordability. To achieve the goals, we need to create enough incentives to attract people to join the scheme, thereby inducing higher utilization of private medical services and shortening the waiting line in the public hospitals.

Given the fact that the Scheme is run and operated by insurers in the private sector, the Scheme shares some common features of commercial insurance: voluntary participation, emphasis of individual equity, inevitable individual (or group) underwriting, etc. One fundamental characteristic of commercial insurance is to place emphasis on individual equity, which requires policyholders to shoulder insurance costs according to their level of risks. Private insurers charge high-risks higher premiums to reflect the greater uncertainty of their expected losses. Although this satisfies the actuarial fairness principle, it may cause huge financial burdens to some policyholders.

According to the current proposal, the cap on the premium and the limited application of pre-existing conditions may make the Scheme welcome by the high risks (HR), but less attractive to the low risks (LR). However, in order to make the Scheme sustainable, we need a critical pool of heterogeneous risks in the scheme. We have to recognize the fact that HR and LR have very different priority in their respective financial planning decision-making. The LR tend to neglect the importance of a sound medical insurance protection, as they are already overwhelmed by many financial obligations including mortgage, kids' tuition and other children-care expenses, parents support costs, etc. Only the HR will put medical insurance a higher priority as they are personally aware of needs.

Because the Scheme is on a voluntary basis, the odds are in favor of higher participation rate of HR. If the majority of LR chooses not to join the scheme, the Scheme will gradually bear the infamous image of a HR pool. Therefore, the key element to make the Scheme successful is to attract and retain the LR in the Scheme. I think the well-structured proposal needs to consider incentive mechanisms seriously. We need to provide incentives of tax deductibility, loss-control encouragements, family packages, among others.

For tax deductibility, the premium payment into the Scheme should be able to claim as expenses in tax reporting, just like the tax deductibility of education, mortgage, etc.

For loss-control encouragements, the Scheme should offer several kinds of discount to encourage healthy lifestyle, such as non-smoking discounts, adequate body mass index (BMI) discounts, etc.

For family package incentives, the Scheme should provide discounts for multiple family member participants including parents and working kids and provide government subsidies to the retired grandparents and non-working kids under 20-years-old. This is to recognize the heavy financial burdens of sandwich families and to create a sense of insurance unity/security among family members.

To provide a more positive and better public image of the Scheme, the SAR Government should focus more on how the Scheme enhances accessibility and affordability, instead of talking too much on government financial burden, who-pays-for-what, and so on. The rhetoric in the PR campaign is also crucial to assure a complete understanding of the Scheme from the general public. In this regard, I attach three newspaper articles (in Chinese)* which elaborate more on the issue for your reference.

<u>*Reference</u>

1. "醫療保險「歧視」長期病患者?" Hong Kong Economic Journal 2005-08-19
2. "香港醫療體系資源嚴重錯配" The Sun 2005-08-22
3. "認清強制醫保的真義" Hong Kong Commercial Daily 2008-06-04

Comments by

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In general, I think the proposed scheme is a reasonable compromise between the policy objectives and political reality. The actual effect of the scheme in alleviating demand on public health service maybe moderate and there is limited redistributive implication. However, introduction of this scheme may provide a framework for further reform and a direction for prospective institutional diversification, and it is thus highly commendable.

Specifically, I have the following comments:

1. As high participation rate is imperative for the success of this Scheme, I fully support the various incentives for policy subscription proposed in the document. And I also agree that tax deductibility of premium should not be considered as substantial number of Scheme participants may have already enjoyed the one-off subsidy of 50 billions. Nevertheless, more thoughts should be given on how to facilitate group migration to the Scheme. A massive migration wave would have a significant demonstration effect and may help snowball the general enthusiasm in local community. A low level of basic coverage is now utilized as the major leverage for enticing employers to join the new scheme, but incentive like covering of administrative cost for migration, or even limited rebate on premium for the first year should not be excluded.

2. Length of the grace period for participation of those aged 65 should be extended. We have to take the complexity and unprecedented nature of the scheme, and the relative inaccessibility to information of the age group into account. The community in general will need time to digest and reason with the Scheme and it probably warrants even more patience for the elderly who may have never subscribed insurance policy in their life to make the decision to join the scheme. And if most of these elderly are deprived of the chance of participation due to the short grace period, it may in fact defeat the purpose of the scheme as this group is more likely than others in soliciting regular medical assistance.

3. Concerning the Saving Scheme, I am skeptical with the option of withdrawal. While I understand such allowance may diffuse resistance to the Scheme, it may come with the price of making the Scheme vulnerable to political pressure particularly during economic downturn. Depletion of the saving component would simply encourage falling back to the public sector. Voices demanding similar MPF arrangement raised in recent months are illustrative of the possible danger. In addition, the possibility of merging the saving component with the MPF account should be explored. The arrangement would reduce administrative charge and thus make the scheme more attractive for individuals.

4. Public confidence in the scheme also depends on the existence of an effective monitoring mechanism over its implementation. I welcome the suggestion of

setting up an independent statutory body as the Scheme supervisor. The supervising body should however enjoy the power to regulate over key issues like premium level, administrative charge, and scope of coverage. In addition, appointment of representatives of patient and consumer groups to this body should be mandatory. And in order to enhance public confidence in the scheme, the supervisory body should consider publishing indicators for measuring the performance of the Scheme and produce a review report every 3 or 5 years. The indicators should include: (a) participation rate (b) age distribution of participants (c) product availability (d) complaint against policy providers.

5. Despite the good intention and merits of the Scheme, the public may find it difficult to comprehend the significance of the proposed change. It is very likely that public debate will be focused on narrow issues like premium level or financial burden of individuals. For presentation purpose, I would urge the government to focus on three features of the Scheme: (a) renewal for life (b) policy for those with pre-existing medical conditions (c) right to use HA would not be diminished and in fact quality of service could be improved with the reduction of pressure. These messages are simple and direct and enable individual citizen to draw easy relevance to their own concern.

6. Lastly, it is very likely that the media would inquire on the exact breakdown of the 50 billion non-recurring subsidy. The document does not contain such information. In fact, many questions remain unanswered. For example, how much will be spent on premium rebate? What is the estimate on age distribution of participants at the initial stage of implementation? What is the estimated portion of participants confined to Basic Plan, and how many will choose the top-up plan? These details are crucial for making a strong case for the proposed Scheme.

Comments by

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Overall Comments

The aim to encourage more Hong Kong persons to take up private health insurance that provide adequate protection with a high degree of transparency is laudable.

However, I have grave reservations on spending the $50 billion, earmarked for healthcare financing reform, on this Scheme. The reasons are as follows:

1. This Scheme intends to finance mostly acute inpatient services. Currently around 90 percent of Hong Kong's public health care funding is already channeled to acute inpatient care. Health planners throughout the world are trying to find ways to divert resources away from the expensive acute inpatient sector to the more cost-effective and users-friendly primary care, community based care, and long-term care sectors. It seems that the FHB is trying to do the opposite here.

2. This Scheme targets the working-age population – relatively young, healthy, and with income – and does little for the elderly, the chronically ill, and other persons without income. This group is not the group that faces the most hardship.

3. No evidence is presented to demonstrate the extent to which this Scheme can contribute to mitigate the problems of health care financing as a result of aging population and new technology. The Protection Scheme is basically a pay-as-you-go scheme, which cannot effectively address the problems associated with the changing societal age structure. The document does not provide much detail on the Savings Scheme -- such as the amount of contribution, the cumulative balance upon retirement etc. – which is essential for assessing the effectiveness of the Scheme in addressing the aging population problem.

4. Many of the features proposed can be implemented without any major injection of funds.

Specific Comments

5. The Plan does not intend to cover preventive and early detection services, allied health services, or Disease Management Programmes, many of which have been demonstrated to be highly cost-effective.

6. The suggested encouragement for young people to join the Scheme is not attractive. In Australia, for example, a person joining the scheme at say aged 30 will continue to pay the premium rate for the aged 30 group year after year.

7. The plan is not attractive to high risk individuals. There will be a fairly high co-insurance payment. Expenses exceeding benefit limit will have to be borne by the

individual. Insurers would be allowed to charge the high risk individual up to three times his/her standard premium. To overcome this, some kind of "equalization fund" can be set up for all participating schemes to mitigate the expenses of high risk individuals, instead of having these individuals bearing a large part of the expenses.

8. It would be desirable to have an on-line platform (known as "exchange" under the Obama plan) in which all participating schemes must disclose all essential information to facilitate consumers to make decisions regarding which scheme to choose.

In general, I support having this Health Protection Scheme. However, I feel that the $50 billion should be spent on those currently facing the most hardship – the elderly with chronic conditions; the disabled elderly; and the demented elderly. Alternatively, the money can be used to set up some long term care funds (such as the Eldershield and Eldercare funds in Singapore) to cater to the needs of the elderly in the future.