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HEALTH CARE FINANCING AND
DELIVERY IN HONG KONG:
WHAT SHOULD BE DONE

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Health Care Financing and Delivery in Hong Kong: What Should Be Done

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Abstract

In this paper, I would provide a logically consistent taxonomy of alternative health care financing avenues. I then explore the implications of these alternatives, finally establishing the conclusion that a combination of tax-financing and capped voluntary payments, supplemented by the setting of “moral hazard neutral” fees, would serve the purposes of expenditure containment, universal access to health care, and optimal resource allocation.

1. Introduction

Health care reform is a subject of universal interest and constant debate. Despite all the confusion, however, a number of things are clear. It is clear that universal access to health care is very much cherished in every country. It is clear that we need a mechanism to avoid waste and to encourage people to practise preventive medicine. It is clear that expenditures on health care should be made as long as benefits exceed costs. The question is: which way of health care financing will best achieve these goals.

There are no perfect solutions, but some options are obviously better than others, and our task is to look for the best among these. I shall present an option that can be dubbed the Swedish model,¹ and I shall argue that this option is among the best available. I shall

¹ I do not endorse all aspects of the Swedish model. Fees in Sweden tend to be too low and taxes tend to be too high. But the Swedish capping of annual health care expenditures is an eminently sensible idea consistent with the concept of excessive burden insurance.

discuss the details and feasibility of my proposal from both an implementation and a political point of view.

Section 2 will lay out the various financing options that are available. Section 3 will describe the concept of excessive burden insurance, why I strongly recommend this concept, and how it is implemented and received in Sweden. Section 4 will discuss the details of implementation, if it is introduced in Hong Kong. Finally Section 5 will provide a brief summary of the conclusions.

2. A Taxonomy of Financing Options

Health care spending is either forced or voluntary. Forced spending on health care can be in the form of directly forced health spending programmes like mandatory medical savings plans and mandatory medical insurance plans, or indirectly forced spending on health funded out of taxes. Voluntary spending on health care can be in the form of voluntarily subscribed health insurance, or voluntarily paid health care fees and charges.

If information is adequate, all forms of voluntary spending can be considered efficient. Those who spend would consider the benefits and the costs involved and will not spend unless the benefits outweigh the costs. However, information in the health care market is far from adequate. Patients often have to rely on health care service givers to tell them what services they will need. They may also purchase services without knowing that the services will actually bring them benefits, or benefits in sufficient amount. This matter of “information asymmetry” between caregivers and patients has to be considered in any proposal for reform.

In general, forced medical savings plans are inefficient unless the bureaucrats who decide over the medical savings package know better than the individuals who are directly affected as to how much benefits will be derived from such savings. In general, a medical savings plan will not open up new opportunities for the individual; rather, it will reduce his opportunities. So it must be inefficient. On the other hand, a forced medical insurance plan does open up new opportunities. It has potential for improved efficiency. A forced medical insurance plan can pool risks. It will allow small contributions to generate big benefits, in the form of protection for

anyone insured when misfortune strikes. The “forced” element will help combat the problem known as “adverse selection” and “known cost drivers.” Adverse selection refers to the phenomenon of insurance plans attracting bad risks that seek protection while low risk individuals will avoid costly insurance plans. Known cost drivers refers to patients who are known to be costly to service, so voluntary insurers will avoid them. Clearly, there is a case for mandatory health insurance.

However, mandatory health insurance potentially has an important drawback that must be addressed. This is the problem of moral hazard. There is supply-side moral hazard and there is demand-side moral hazard. The former refers to caregivers giving unnecessary services for financial gains. The latter refers to patients consuming services excessively in disregard of the costs involved. Health care reform must address this subject of moral hazard.

Health care spending out of taxes are not voluntarily made by the taxpayers or by patients. Bureaucrats make the decision over how much to spend on health care and on what. While there is an element of compulsion budget allocations on health care out of the general revenue can be efficient if a careful benefit-cost analysis is performed in evaluating whether or not a particular item is worth purchasing. The bureaucrats who make the decisions serve as agents for the taxpayers and for the community to further their interests. While bureaucrats may well pursue their own interests rather than the interests of the community there is no necessary contradiction between the interests of the community and the interests of the bureaucrats, especially when they are responsible to politicians who are in turn responsible to their constituents. In fact, members of the community cannot individually conduct a community-wide benefit-cost study for health care and health related expenditures. They need to engage someone with the authority and training to do the study properly. To the extent that benefits outweigh costs, there is even a case for increasing taxes in order to finance the worthwhile expenditures.

3. Excessive Burden Insurance

It is commonly believed that the government should target its subsidies at the poor. If administrative costs allow, then, there should be means testing for every government subsidy programme ranging from legal aid to health care. This logic appears to be sound, but is really flawed for the simple reason that government subsidies are always financed by those who pay taxes. While no one would question the arrangement that taxpayers subsidize the low income and the welfare recipients when they seek health care, is it therefore wrong for taxpayers to subsidize those who are sick among themselves? In particular, in the case of health care and by the same logic in the case of legal aid, expenditures that may be warranted to save life and to restore justice may stretch the limits of even the well to do. It is certainly unjust and unreasonable for taxpayers to pay for all the costs of health care for others and yet left unprotected at the very times when they need help.

For this reason the case for what I call excessive burden insurance is truly strong. Excessive burden insurance is the concept of requiring the individuals to be responsible for their own expenditures for as long as they can afford it, and providing them to be assisted when they find the burden excessive. In practice, in the case of health care I recommend setting a yearly spending limit for each household. This spending limit would be based on the number of members in the household and in principle should be based on the household income. Because assessing household income is not easy and is administratively costly, I would recommend setting a uniform yearly spending limit per person for the majority of Hong Kong's households, plus one concessionary spending limit for the poor. Based on a survey that I have conducted, I discover that the greater majority of respondents would be prepared to spend up to 6 per cent of their income on health care. On that basis, I propose that the spending limit be set at 6 per cent of the median household income, which in the third quarter of 2000 stood at HK\$17600. Given that there are 3.3 persons per household, this works out to be \$3840 per person. For the poor who are judged to be worthy of further assistance, I would propose that the spending limit be set at half of this, i.e., at \$1920. This means that the

household will be responsible for all qualified health care expenditures up to their respective spending limits but need not worry about any more spending. If they are healthy, of course they do not have to spend this much. If they have health problems, they will not need to worry about not being able to come up with the money.

The advantages of this system are obvious. The most important advantage of course is that household now no longer need to worry about unpredicted health care expenditures that could stretch their limits. The other advantage, also an important one, is that we can now be in the position to price health care services closer to their direct costs, so that individuals will have stronger incentives to use health care services carefully, and they will also have stronger incentives for adopting a healthy lifestyle and to avoid falling sick.

The incentives under this system and the risks for households under this system will be quite unlike what prevail today. Today, charges are unreasonably and extremely low. Patients pay only \$68 for a day of in-patient care regardless of the treatment they receive, unless they need what are stipulated as “privately purchase medical items.” Clearly, such a low rate of charge will not even cover the cost of food provided, not to speak of the professional care that must be provided and the cost of maintaining the hospital bed. For outpatient care the charges are at \$38 or \$42 depending on whether it is general or specialist clinic that is attended. Accident and emergency care, and ambulance services are free. Such low charges must cause excessive use and must draw patients from the private sector unnecessarily and unjustifiably.

It must be noted that because of the huge demand for HA facilities under such pricing, queues at HA hospitals are long. Patients in urgent need of care may have to turn to private hospitals, which can however be prohibitively expensive. Private hospitals are expensive not because the direct costs are necessarily higher than public hospitals, but because there are huge overhead costs that must be paid for. Charging patients only at direct costs will lead to huge financial losses that may not be sustainable. So patients are exposed to the risk of not being able to get the service they need in a timely fashion, and of having to pay possibly highly burdensome costs should they opt for private care. Even in public hospitals, in

case the privately purchased medical items are required, patients may also have difficulty². Presently the list of privately purchased medical items are as follows:

- (1) Percutaneous Transluminal Coronary Angioplasty(PTCA) and other consumables for interventional Cardiology
- (2) Cardiac Pacemakers
- (3) Intraocular Lens
- (4) Myoelectric Prosthesis
- (5) Custom-made Prosthesis
- (6) Implants for purely cosmetic surgery
- (7) Appliances for prosthetic and orthotic services, physiotherapy and occupational therapy services
- (8) Growth hormone and interferon
- (9) Home use equipment, appliances, and consumables.

We are also aware of the fact that because medicines are provided free, a limited budget has prevented the HA from allowing the prescription of certain expensive drugs. So patients are deprived of the opportunity for better care. What is most unacceptable is that patients are not given the option of paying more to get better and faster service.

One objection I heard frequently about excessive burden insurance is that it is complicated. Actually it is not complicated at all. In fact Sweden has practised excessive burden insurance for years. Statistics show that Sweden has kept its health care expenditures at moderate levels. The following is a brief description about excessive burden insurance in Sweden:

Patients' charges for using the health service increased significantly during the 1990s. In 1990 the charge for visiting a doctor stood at SEK 60 either for a visit in the primary health care system or at a hospital. Today a primary health care visit costs an average of SEK 100 and a hospital visit costs twice that.

² It is true that patients in principle can ask for assistance if they can provide evidence of financial difficulty. But financial difficulty may not be so easy to prove sometimes.

However, no-one pays more than SEK 900 a year. Exemption from charges for children and young people was introduced in 1998 and remains in place in most counties.

Charges for prescription medicine have seen the most significant increase. In 1990 patients had to pay the full cost of the medicine up to a maximum of SEK 75 at each purchase. Today we have a system which means that the patient pays the full cost up to SEK 900, and thereafter there is a gradual fall in the proportion of the cost to be paid. However, no-one pays more than SEK 1,800 during a twelve-month period.

(excerpt from: <http://www.sos.se/SOS/PUBL/REFERENG/0003008E.htm>)

Sweden is much more advanced in aging compared to Hong Kong and most other countries, with 17 per cent of its population above the age of 65, as compared to only 10.5 per cent (1997 figures). Yet its health service expenditures as percentage of the GDP was only 8.6 per cent in 1997, a notch lower than that in 1998. The comparable figures for Hong Kong is 4.8 per cent, which is much higher than that in 1998 (3.3 per cent). There is much satisfaction about the Swedish health care system. To wit, a recent article thus described of the achievement of the Swedish health care system:

For the most part, Sweden's health care system is an effective and trusted provider of medical services for the northern European nation of 8.7 million. Swedish life expectancy is long, at 77.6 years, and infant mortality rates are relatively low at 4.5 per 1,000. Sweden spends less than its Scandinavian neighbours on health care—7.6 per cent of its gross domestic product³, compared with 8.2 % in Norway and 8.8% in Finland—yet overall quality of health and health care is comparable throughout the region.

*From: "Swedish Health Care Robust, Despite Regional Disparities,"
Ocular Surgery News, International edition, May 1997*

³ The figure of 7.6 per cent corresponds to the figure for government health care spending as a per cent of GNP cited in <http://www.slackinc.com/eye/osni/199705/sweden.htm>.

4. Details of the Proposal

There are several elements in the proposal:

- pricing of covered health services at standard fees to reflect direct costs;
- setting of an annual spending limit for each person in the household;
- concessionary pricing and lower spending limits for the poor;
- option for private hospitals and medical practitioners to commit to charging standard fees for covered health services in return for a lumpsum grant;
- appropriation from the general tax revenue to fund lumpsum grants, fixed health care expenditures, and the cost of excessive burden insurance;
- a smart card to hold medical records and accumulated health care expenditures.

I propose that we sharply increase the fees now being charged for services rendered in Hospital Authority hospitals and government-funded clinics, to reflect the direct costs of providing these services. This will serve four purposes: to increase the awareness of costs among the public, to better utilize the facilities now available in the private health care sector, to raise revenue, and to improve the quality of services.

There is plenty of evidence that raising fees charged will reduce demand. Provided that the raised charges are within the limits of affordability, we need not worry that this will be at the expense of citizens' health. The higher charges are necessary because we need to promote the cause of sickness and accident prevention and to prevent abusive use of the services. In principle, the charges though higher than those of today should be low enough to be neutral on supply-side behaviour. We do not want suppliers of health care services to oversupply for financial gain or to undersupply to avoid financial loss.

The annual spending limit is the cornerstone of excessive burden insurance. If the annual spending limit is set at a reasonable level, citizens will no longer need to worry about health care

expenses ever stretching their limits. This annual spending limit brings peace of mind and will make higher charges much more palatable for the public.

The concessionary charges and spending limits are politically necessary and socially desirable. We need to charge the poor for their use of health care services, because they also need to be aware of the costs involved. If necessary I would propose that we provide a health care supplement to the current CSSA stipends. If recipients keep their health well they would have an additional income for other uses. This way the incentive to maintain health and to use health services judiciously will be preserved.

I propose that we give private hospitals and medical practitioners the option to join the “basic health care system” by pledging to charge standard, approved fees only for the services covered in the basic health care system. In return for charging lower fees, they would receive an annual lumpsum grant that reflects the range of services that they provide and their capacity. Private hospitals will make their own arrangements with doctors in regard to compensation for professional services rendered under their auspices. The Hospital Authority will not need to step in the contractual arrangements between private hospitals and private doctors.

Once these arrangements are in place, we can expect patients to move out of the public health care system into the private health care system. The public sector then will no longer need to expand as fast as otherwise without the system. We will save a lot of public money that will have to be needed to build more hospitals and to equip them. Quality of services at the HA hospitals will improve as queues get shorter and patient loads decline.

There is no need to charge citizens for excessive burden insurance premium. Under my proposal, the insurance scheme is funded from taxes, which actually means that *those who with higher ability to pay will pay more in support of the system*. This being the case, *there is no longer any need to deprive the richer people of the right to receive subsidies*. An advantage of this arrangement is that the system does not require any payroll tax or direct health care related contributions from our workforce. Excessive burden insurance is also fair in that, by making the sick people pay more when they can afford it, it protects the healthy people from having to

shoulder an unreasonable burden. While the sick will have to pay up to the annual spending limits per year the healthy will not have to pay anything other than regular taxes—in “premiums” or in fees.

The system will generate much needed revenue to improve the quality of health care. Suppose we charge on average five times higher than current charges (I recommend perhaps \$400 per night for in-patient care instead of \$68, and \$100 per visit for out-patient care instead of \$38 to \$44.) Considering the cap, I estimate that we may end up collecting about 3 billion dollars in revenue or perhaps 10 per cent of the total recurrent HA expenditures in 2000/2001. The net increase in revenues would amount to about \$2 billion, which represents some 8 per cent of total revenues from the salaries tax.

While this may not seem to be much, we must consider the fact that the demand for services will be reduced, and there are also savings in terms of less need to build hospitals. Private doctors’ incomes will rise, and so income taxes from private doctors should also rise.

The last element in my proposal is a smart card to carry patients’ medical records and records of fees paid during the year. The smart card is linked to a central data bank which is updated each time a patient pays the eligible fees and receives health care services. As soon as the annual spending limit has been reached, the patient will no longer need to pay any more fees, unless he gets extra services that are not covered in the basic health care plan. The smart card, to be carried around by citizens like an ID card, will provide important medical information in case of emergency and will enable the individual’s medical accounts to be updated automatically. The technology is readily available and will not be very costly. Since no collection of premiums or contributions will be needed, there will also be a saving in administration cost.

In practice, the annual spending limit and the range of health services covered under the basic health care plan must be worked out with community participation. Although I had proposed 6 per cent of median earnings, it is up to the community to decide if this is adequate. Clearly, if the services covered is wider, a higher annual spending limit will be necessary, meaning that each individual will have to be responsible for a large amount of health care expenditures.

5. Conclusions

The proposed excessive burden insurance scheme is, on reflection, not a big departure from the health care system we know today. Like the present system, the excessive burden insurance scheme is tax-funded. There will be no insurance premiums or contributions to collect. Like the present system, costs, particularly overhead costs, will be subsidized heavily. Charges are set at “reasonable levels.” The difference is that the “reasonable levels” under EBI are much higher and in principle reflect the direct costs of providing the services. Both the present system and the proposed EBI place a lot of emphasis on accessibility. Whereas the present system tries to achieve accessibility by making prices very low, the proposed EBI system tries to achieve accessibility by capping health care expenditures borne by the individual. HA hospitals are to be funded in more or less the same manner under the present system as under EBI. There will be no mechanism for “money follows the patient.” However, because charges at public hospitals and subsidized private hospitals are unified, patients will be much more ready to use private hospitals.

While Sweden imposes a uniform annual ceiling on the health care expenditures that must be paid by the patients themselves, the charges on health services vary from county to county. These variations notwithstanding, a basic principle is that quality health care services must be available and easily accessible to all residents in Sweden (Health and Medical Services Act of 1982). This principle can be said to be universal, and is certainly equally applicable in Hong Kong. But Swedish taxes tend to be too high and medical charges tend to be too low. While fees for clinic visits range from SEK 100 to SEK140 in the state sector, the fee charged for a stay in hospital is a mere SEK 80 per day (one Swedish kroner is worth less than HK\$1.) If we want to ensure a high quality of services without excessively burdening the taxpayer, fees charged under excessive burden health insurance should reflect direct costs better. Although estimating direct costs accurately will prove difficult, precise estimates of direct costs is not really necessary. It does not require careful study to learn that current charges in Hong Kong are much too low and will engender wasteful behaviour.

As I argue in my book *Principles of Public Policy Practice*, I support the “professional model” for basic health care(See Chapter 5). The professional model relies on salaried, professional doctors who are largely free of money consideration to provide basic care. The current Hospital Authority follows the professional model and is largely independent of the bureaucracy. Market participation by doctors and insurers will provide useful supplementary services and will enhance choice. Citizens can opt to buy insurance to cover what they have to pay before the yearly spending limit has been reached as well as to have coverage for services not covered under the basic health care plan. The market model will likely leave many people underinsured or uninsured. The bureaucratic model will render it impossible for professional health care givers to operate independently and effectively. In conclusion, I strongly recommend a system of tax-financed excessive burden health insurance for financing and a system of professional-run health care system for delivery of health services.

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