Symposium on Healthcare Reform
Points Discussed

Organisers: The Professional Commons
Contemporary China Research Project, City University of Hong Kong
Date: 27th November 2010
Venue: LT-16, City University of Hong Kong
Time: 10:15am to 4:00pm

On 27th November 2010, The Professional Commons and Contemporary China Research Project of City University of Hong Kong co-organized a symposium on healthcare reform. There was a marathon but inspiring discussion of 6 hours in a midst of over 80 participants. Speakers include representatives of both public and private medical sectors, trade representatives of insurance industry, government officials, scholars and other stakeholders (details refer to Annex I). As far as the scope of discussion is concerned, speakers and participants expressed and exchanged their views over the voluntary private insurance scheme proposed by the Government, in which subsequent issues including packaged charging in private practices, insurance arrangements, healthcare finances as well as how to spend the $50 billion appropriation earmarked to the scheme were under heated debate.

I. Concerns on Packaged Charging in Private Practices

The Government representative was of the view that an extreme in risk allocation of medical resources between public and private practices has been an issue of great concern. Simply put, the Government has been taking care of all the risks in the public sector, while those in private sector are being shouldered by patients. This is far from satisfactory, as far as the Government is concerned. By introducing packaged charging into private practices, the proposed private insurance scheme aims to facilitate a fairer burden of risks amongst practitioners in private sector, doctors and insurance companies. More people in the private-insurance net suggests more usage of private medical services, then more spare public resources is expected to go towards the needy.

On the whole, both private hospitals and doctors tended to have reservations over the implementation of packaged charging in private practices, suggesting that it is obtrusive of the Government to impose something upon them without considering an avalanche of unsettled doubts which would result in difficulties in implementation. Despite so, there were also stakeholders who appreciated a trial go-ahead.

1. Extra risk that is obtrusive toward private practices

Private hospital representatives were of the view that it is not reasonable that private hospitals have to burden extra risks derived from packaged charging, given that they take care of their gain or loss without any assistance from the Government. As a medical service provider that is financially independent, private hospitals have to run with adequate reserves from contribution of profits. In this connection, proper risk management would be of utmost importance in order to ensure no operations under deficit. In Hong Kong, 12 out of 13 private hospitals are being run by non profit-making organizations. They are on their own to gather funds, to deal with inflation, as well as to deal with gain/loss-related risks from economic cycle of alternate booms and doldrums, in which no single cent from the Government is required. In the light of this, private hospitals are in an inferior position to manage any extra risks on their own.

Besides, as far as private practices are concerned, packaged charging is not capable of dealing with the uncertainty in medical industry, which has been vividly illustrated as the difficulty in price setting. In fact, condition of patients is so varying that it would

not be easy to have a prognosis of the root course of cases of illness concerned. It is highly likely that private hospitals undergo a deficit if price does not accurately reflect the cost.

More importantly, private practices were of the view that risk management was out of their professional terrain, insurance companies were supposed to shoulder some of them as part of the premiums they collected. In the light of this, it is not reasonable that private practices are obliged to have all these risks shouldered.

2. Divisive views concerning how packaged charging to be implemented

It had been revealed from the symposium that different stakeholders had different interpretations about how packaged charging mechanism was to be operated. As far as the charge is concerned, there was a general understanding from private practices that it will be by prognosis, where initial treatment and charge in total are determined in accordance with the priced items involved in the proposed treatment, which in turn resonates with the average cost of each designated types of illness. Once the sum has been determined, no extra charge is allowed regardless of the state of illness that comes afterward, which is what incurs a strong resistance from private practices. Given that scale of local private hospitals are relatively small that only a small pool of clinical cases is possible, it is difficult for private hospital, by virtue of these limited medical cases, to ensure an effective risk tradeoff. As a result, a few extreme cases would be powerful enough to drain all fiscal reserves of the hospitals for necessary operations.

Instead, government officials had their alternative interpretation, suggesting that charge was to be set according to diagnosis-related groups (hereafter "DRG"). Such arrangement does not require definite quotation before treatment is given but that in accordance with the disease after cured. Simply put, the payment is determined according to patients' cured illness rather than the medical procedures involved in the cure. The mechanism is to be used for insurance claims concerned, therefore no prognosis will be involved, and private doctors do not require a crystal ball to have exact prediction of patients' conditions. Furthermore, as far as government representative was concerned, price setting of DRG was nothing with the adverse effect on quality of healthcare services. The price yardstick is to be set at median in a midst of similar clinical histories that suggests the equal chance of getting profits and deficits, therefore breakeven in overall sense. Besides, it was suggested that price

mechanism by DRG was proved successful in numerous OECD countries for over 40 years, whose experiences were of utmost significance for its successful implementation in Hong Kong.

As predicted by some participants, in order to manage risk in an effective manner, private practices are expected to screen people who seek medical services in accordance with their conditions, before decisions of acceptance are to be made. As a result, private hospitals would be keen on accepting patients whose condition is easier to be determined, therefore requiring a much simpler treatment. They might even transfer those with complicated condition to public hospitals in order to lower the risk by adopting packaged charging scheme. In fact, even private hospitals in the scheme are only ready to cover certain types of illnesses, while screening is expected upon incoming patients. Even hospitals willing to consider the option are afraid of burdening risk as a small private hospital, therefore only in readiness for acceptance of a coverage of certain illnesses. Albeit so, specific measures have to be in place to ensure an effective implementation, including ensuring (1) cooperation between private hospitals and doctors concerning proper risk management; (2) accurate quotations, as well as detailed explanation regarding the advantages and disadvantages of concerned operations, to the patients before they are accepted, so that patients are capable of making informed decision.

3. Rights to patients: improvement or damage?

Quality of services varies across hospitals, so does the price level. In the wake of introducing packaged charging mechanism, diagnoses and treatments on a single patient are supposed to be given by doctors assigned by the hospital concerned. This suggests that patients concerned are not entitled to choose doctor(s) of their favor, therefore jeopardizing patients' right of choice.

As with whether packaged charging will incur issues like making quality of services worse with pressing budget, views expressed were also of considerable division. Some considered that it was genuinely a malpractice but believed that local practitioners in general abided by the best interest of their patients and gave them the most suitable treatment and diagnosis. Those holding opposite views contended that treatments given according to patients' insurable budget is an objective fact. Hence, it should be beyond reproach for those doctors who follow the packaged charging

scheme. In this connection, packaged charging should not be the culprit that incurs the worsening of quality of healthcare services.

Another view considered that specifically, risk was balanced through transferring to those who were less likely to get ill. As a result, more premiums are expected from these people to compensate those who get greater chance of illness, which is not fair to healthier policy holders.

4. Not conducive to problem solving

Representative of private practices were of the view that packaged charging was not very helpful in improving the transparency of pricing mechanism in private hospitals, which was a non-issue as far as private practices are concerned. By contrast, items are all clearly priced so that the patients and their family are able to have a check whenever necessary. The price list is as detailed as showing relevant sub-items of all the medical services provided, involving lump sum as big as the amount of usage for operation theatres, to that as small as even a piece of cotton. Moreover, fees from diagnosis from doctors and services provided by the hospitals have been treated separately so that patients, as a consumer, would have considerable room to make their choice.

Individual private doctors even contended that the underlying objective of the proposed packaged charging mechanism was to force a price competition by private hospitals and doctors, therefore interfering professional autonomy concerning private healthcare services and their provisions.

5. Conducive in sparing valuable public resources?

Concerning the issue whether the proposed packaged charging scheme is capable of sparing valuable public resources upon implementation, views of participants were also divisive. As one of their main concerns, medical professionals normally believed that it was difficult to expand the private practices in view of the existing limited supply capacity of 3,000 beds. It was therefore unrealistic to expect that expansion of private sector could channel mounting pressure of public hospitals. They also highlighted that no spare capacity was expected as private hospitals had been busy enough to entertain surging demand from Mainland users. Therefore, their lukewarm attitude to entertain the idea to broaden the local sources via introducing packaged

charging mechanism is expected. Despite so, this pricing mechanism has been adopted by some private hospitals, some of those have expressed interest to expand its scope of services. Simply put, its success hinges on the number of private hospitals in willingness to introduce packaged charging, as well as eventual scope of coverage accordingly.

By contrast, it is more optimistic of the Government to believe that private practices have been fulfilling their task to alleviate pressure on public healthcare system via providing medical services for Hong Kong people.

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II. Concerns toward the proposed voluntary private insurance scheme

The proposed insurance scheme covers the insured of all ages and of pre-existing medical conditions, therefore enhancing their protection. Given the attractiveness of the scheme in regard to its broad coverage and reasonable premiums at the existing level, why are there still substantial voices doubting the effectiveness of the proposed scheme? Sustainability is one of the issues of great concern that can be summarized into a question: Will the money in the long run be adequate to deal with the future enormous claims in the wake of ageing of population?

1. Healthcare reform: enhancing services on a sustainable basis?

The insurance industry in general welcomes the government's proposal on healthcare reform, but sustainability is still their major concern in the anticipation of risk augmentation. As far as the representative was concerned, the whole insurance mechanism, if not dealt carefully, would be bogged into a complete collapse, and their clients would be the one who suffered all the misfortune. The proposed scheme accepts the insured over 65 of age, who are considered high-risk in insurance companies' point of views. As a rule of thumb, more these people join, more risk is expected. In the light of this, healthier and younger policyholders are required to ensure an effective balancing of risk, but their contributions are not necessarily on the rise at all times. It is also anticipated that the subsequent revenues as all sorts of premiums including the basic and age-ascending one as well as re-insurance compensations are inadequate to cover the expected expenditures unless a continued fund injection from the Government. But the Government has no further commitment to inject more funds on top of the $50 billion it has promised, concerns on the sustainability of this scheme without adequate supporting funds is therefore of critical significance.

Strengthening of supervision is one of the main points that the consultation document has suggested. In this regard, opposite views were so clear for us to see. Insurance representatives were of the view that the proposed supervision body was indeed superfluous as they it would overlap the existing one that had been considered adequate. Also, insurance premium of all kinds had been clearly regulated by the Office of the Commissioner of Insurance. Regarding transparency, information including premiums, administration and brokerage charges had all been uploaded on a regular basis, therefore unnecessary to have another supervisory body established.

Rather, government representative reiterated that the way to regulate under the existing mechanism would be different from the proposed one specific to private medical insurances. He considered that the Office of the Commissioner of Insurance emphasized on the regulation of insurance companies *per se* including their financial risk, whereas the proposed supervisory body put a rein on insurance claims, arbitration, policy transparency and issues in relation to the formulation and implementation of medical loss ratio. Furthermore, it was highlighted by the Government that there exist plenty of room for improvement concerning the on-the-street insurance plans available. The fact is 40% of all existing insurance plans do not cover hospitalization, whereas more than 50% cover outpatient of over 30 times a year. More importantly, it was maintained that the proposed scheme would not cover things that happened without an uncertainty and items that could be afforded by consumers, so as to prevent premiums from pushing up, therefore resulting in a mismatch of resources.

Given the severe abuse concerning existing private insurance schemes and the incompetent self-discipline regulation, it has been generally acceptable, as suggested by government representative, to step up scrutiny via establishment of a new supervisory body to boost public confidence.

2. Healthcare reform: fairness

Fairness is another pivot of heated debate upon implementation of the proposed healthcare reform, in which, first and foremost, queue-jumping in public hospitals would be the issue that attracts much attention. There were views that there would be no difference from jumping queue if those diagnosed with serious illness by private doctors were able to be given treatment in public hospitals at once, a much longer waiting time was therefore expected for those who are out of the coverage of the proposed private insurance. As a result, there would be two separate queues in public hospitals struggling for healthcare services, therefore not fair to those out of the proposed scheme. Rather, the Government was of the view that public hospitals accepted those who sought further diagnosis regardless their source. Also, the policy was not supposed to change in the future.

Second, as far as private practices were concerned, a double taxation was expected once joining the proposed insurance scheme, in which one was entitled to public

medical services but meanwhile sought private medical services out of one's pocket. Instead, government representative was of the view that since members of the public were using private medical services covered by their insurance policy, they were meanwhile abandoning their title to public medical services. By following this line of thought, these people are also paying a "double tax". As an objective, the proposed insurance scheme, without any coercive implications, aims to embody the right of choice by the people, suggesting that they are in a willingness of paying extra to request medical services of higher quality.

3. The truth behind inadequate capacity of medical services

Some participants were dubious of the reputed predicament of healthcare financing. It was highlighted that, as shown by the previous consultation, the base GDP upon which medical cost of the next 30 years was projected was problematic. As a base year of reference, 2004 was the year during which all economic figures were at the rock-bottom. Further, figures from the latest consultation document were up to 2007, latest figures since 2008 had not been given. Therefore, people are unable to make informed decisions based on adequate supply of information.

As another area that attracts doubting remarks, issues in relation to ageing population is not supposed to impact as much as what the Government considers. Statistics showed that number of births once declined until a recent upturn to 80,000 per year. Despite beyond any doubts concerning the seriousness of ageing problem, relevant projection undertaken by the Government only focused on the change of domestic population, without realizing the fact that 4 out of 10 newborn babies whose parents were Mainlanders. They are all HK ID card holders and are entitled to residence. As regards impacts on population structure, demand on medical services and the anticipated risk-balancing effect when these people engage into local labour market, the Government has not undertaken any projections then explained its ideas.

A few participants preferred conspiracy theory. They were of the view that the Government, in order to abdicate its responsibility, forced healthier people to burden medical cost from high-risk groups. Further, they were concerned of the possible curtailing of manpower and resource that had happened before. Besides, such covert move was treated as a red herring to shift public attention from its wrongdoings of underestimating demand on manpower in public hospitals, which is totally not responsible.

4. Issues concerning healthcare financing

Another point that attracts considerable attention is that the proposed scheme may not be able to alleviate the existing ever-severe financing problems. Assuming that there are 3 million of participants who are interested in the scheme with annual premium to be set between three and four thousand dollars, the amount to be injected into the scheme will be between ten and twelve billion dollars, the same as the amount contributed to existing insurance plans. It can be seen that the proposed scheme will not necessarily bring about apparent capital growth for the operation of the private medical system.

Rather, government representatives held a different view, maintaining that the government was obliged to take away "bottlenecks" to ensure that insurance plans available was indeed value for money. As an example, through strengthening of regulations, the Government ensures that premium of reasonable proportion will be used to settle medical expenditures, and it is stipulated in the US that any insurance options must ensure a medical loss ratio of at least 85%.

Some participants indicated that, despite their fast development, the existing medical insurance plans were not very effective in terms of the money spent. Money has always been spent on services that do not involve considerable risks like routine body checkups and non-specialist out-patient services. At present, there have been 2 million of people under the coverage of various private insurance plans, but 80% of which treat services provided by public sector as the last resort when they suffer serious illness. More importantly, insurance companies are in fact under government's subsidy to pay medical claims, given that they bear the same medical cost as ordinary citizens do. Under these circumstances, private insurance as a business can guarantee no deficits. In the face of such issue that might have profound impact, no forceful measures has been suggested by the consultation document to rectify the situation, in which more intention by people covered by insurance to use public medical services suggests less possibility that the public healthcare system cuts its surging cost of operation, provided that there is no change concerning the existing fee charging policy for the public healthcare system. If this is the case, not only does the proposed healthcare reform fail to solve the problems concerning healthcare financing, but medical cost that contributes to profits of insurance companies is doomed to push up, as considerable proportion is attributed towards administrative and brokerage charges

that are nothing with the provision of medical services.

They were of the view that if capping the concerned administrative and brokerage charges, less insurance companies would be interested in joining the proposed scheme, therefore badly affecting its effectiveness.

III. How is the $50 billion to be spent

1. Not on the proposed voluntary insurance plan

The Government was of the view that the $50 billion would be able to improve the situation of those who bought private insurance but with no suitable coverage, in particular benefiting those aged 65 or above and those chronically ill. Furthermore, the Government would be the sole dealer engaging into the re-insurance, thereby responsible for all the claims accordingly.

It was generally accepted that the earmarked fund should not be the incentive for subsidizing citizens to join the proposed insurance scheme, therefore encouragement to use private healthcare services. The reasons were suggested as follows:

- Expenditure on private medical services by Hong Kong people has been rising up to the amount that is the same as the public funds being injected into the public healthcare system in GDP ratio, suggesting 50% of the overall healthcare expenditure. Despite so, there is no apparent growth in the patient number in private hospitals, therefore not effective in mitigation of the mounting pressure of the public healthcare system;
- Since citizens are under no government's coercive force and assistances to devote more money to purchase private healthcare services, arguments on spending the $50 billion as an incentive to encourage the extensive use of private healthcare services are not tenable;
- Given the fact that the growth is nothing with government incentive, rather than a pusher, the strengthening of regulation of the existing healthcare insurance market will be adequate, as far as the role of the Government is concerned;
- It is in violation of the principle of justice while sponsoring financially-able people to buy insurance. Embodying their right to choose, as suggested by the proposed scheme, is apparently not applicable to the underprivileged;
- As far as the current inclined use of public resource on hospitalization is concerned, 90% of the appropriation to HKHA is in fact not in line with the preferred development of preventive and primary healthcare services as a recent global trend. Further injection of the $50 billion into hospitalization services is expected to worsen, and even reinforce this wrong trend, therefore exacerbating the current mismatch of resources.

2. Proposed uses

It had been a consensus that the amount of $50 billion was huge enough to make a difference concerning the improvement of quality of healthcare services in Hong Kong. Proposals were suggested by some participants as follows:

- Interest generated by the $50 billion should be injected into the public healthcare system to improve preventive and primary healthcare services. Given interest rate at 5% p.a, extra fund of 2.5 billion is expected to be generated on a yearly basis. Rather than being put in insurance market and private healthcare system, effects concerned would be more apparent;
- Personal account for each eligible Hong Kong citizens specific to healthcare saving is to be set up by the Government with fixed amount of fund injected. Account holders are allowed to spend the money within to settle their medical expenditure. Since this is the fixed amount of money given by the Government to each of the citizens as their one-off lifetime subsidy, no replenishment is expected. Such arrangement is conducive to ensure prudent spending amongst people, therefore as an indirect means to encourage early savings.
- Saving plans should be initiated by the Government by using the $50 billion as a seed. Grasping the moment of the next few years that ageing problem is yet to be serious, injection of part of the fiscal reserves is expected during economic boom times, so that interest can be accrued to prepare for the hard times with adequate medical reserves when cycle of ageing population starts.

IV. Concluding remarks

After a heated discussion of 6 hours, participants reached consensus on the following aspects:

- The existing "public-based, private-supplemented" model is considered necessary to entertain the medical needs of Hong Kong until foreseeable future;
- Issues concerning healthcare financing are not as serious as anticipated by the Government. Notwithstanding the case, medical expenditures will have been at most 5% of GDP in 2033, still far behind the standards of the OECD countries;
- Healthcare reform should not be accomplished in one move. As a strategy, the proposed reform is not expected to eradicate deep-rooted healthcare finance problems, despite success to boost private hospitals under scrutiny;
- Despite general agreement on establishment of a regulatory mechanism over implementation of healthcare reform as a policy goal, participants disagreed to spend the $50 billion on attracting people to buy private insurance;
- Forceful measures should be in place to prevent the huge public money of $50 billion from abuse of any kinds. As a socially justifiable principle, the amount should be instead spent on those who need the most;
- It should be admitted that members of all walks of life should contribute more to the overhaul of the existing private healthcare system and insurance industry. To this end, it is indispensable of the Government to facilitate concessions amongst different stakeholders by putting aside some of their interests.

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Annex 1

Symposium on Healthcare Reform
Co-organised by
The Professional Commons
Contemporary China Research Project, City University of Hong Kong

Date: 27th Nov 2010 (Saturday)
Venue: LT-16, City University of Hong Kong

Time	Programme
09:30 – 10:15	Registration
10:15 – 10:20	**Opening Remarks** Mr. Charles MOK Vice-president, The Professional Commons Professor Joseph CHENG Y. S Contemporary China Research Project, City University
10:20 – 10:30	**Background of Healthcare Reform** Dr. Stephen NG Kam-cheung Adjunct Associate Professor, Dept. of Community and Family Medicine, Chinese University of Hong Kong.
Session 1 10:30 – 11:15	**Reforming Private Healthcare Service Delivery: Challenges of Packaged Charging in Private Practices** Dr. Gabriel CHOI Kin President, Hong Kong Medical Association Dr. Alan LAU Kwok-lam Chairman, Hong Kong Private Hospitals Association Dr. Ares LEUNG Kwok-ling Deputy Medical Director, Union Hospital Prof. Gabriel LEUNG Cheuk-wai Undersecretary for Food and Health, HKSAR Government
11:15 – 11:35	**Open Discussion**
11:35 – 11:50	**Break**
Session 2 11:50 – 12:20	**Reforming Private Health Insurance: More Protection with Less Premium?** Ms Elaine CHAN S.H Member, Task Force on Health Care Reform, Hong Kong

	Federation of Insurers Dr. Gabriel CHOI Kin President, Hong Kong Medical Association Prof. Gabriel LEUNG Cheuk-wai Undersecretary for Food and Health, HKSAR Government Mr. Frankie YAN Man-sing Treasurer, Vascular & Interventional Radiology Foundation
12:20 – 12:40	**Open Discussion**
12:40 – 14:15	**Break**
Session 3 14:15 – 15:15	**Other Options in Healthcare Financing** Prof. HO Lok-sang Director, Centre for Public Policy Studies, Lingnan University Dr. LAU Yuk-kong Consultant & Head, Cardiology Department, Ruttonjee & Tang Shiu Kin Hospitals Prof. Peter YUEN Pok-man Dean, College of Professional and Continuing Education, The Hong Kong Polytechnic University
15:15 - 15:45	**Open Discussion**
15:45 - 16:00	**Closing Remarks** Dr. Stephen NG Kam-cheung Adjunct Associate Professor, Dept. of Community and Family Medicine, Chinese University of Hong Kong.