Hong Kong College of
Health Service Executives

Newsletter Issue 3 2006/07

Message from the President

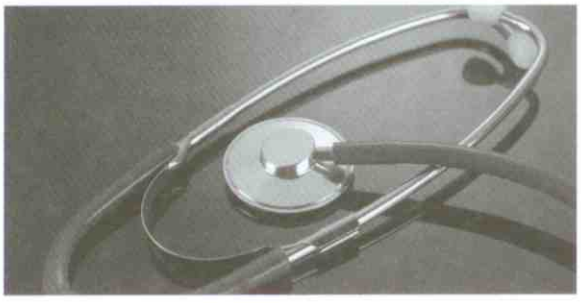
There are some statements or beliefs concerning health care that have been quoted repeatedly without going through careful critique. In view of their far-reaching implications, I think they deserve further elucidation and clarification:

Medical savings account and Healthcare vouchers are effective means of health care financing for Hong Kong

The idea is attractive since we already have the Mandatory Provident Fund and there is already a similar mechanism in Singapore. However, it is recognized that medical savings accounts have their pitfalls. They are payroll-dependent, and do not provide any risk pooling effect for the population against major and/or devastating illnesses. Thus those most at risk of catastrophic illnesses (meaning the elders) will not be provided with adequate protection with this method of health care financing. It has also been shown in Singapore that such savings accounts could not serve as a disincentive to reduce overall health care spending. Whether it can serve as a supplementary public health care financing tool is still debatable, as it is not promoting health care equity across the whole population (just like paying ones health care bills from out-of-pocket money), and would incur significant administrative costs.

The idea of health care vouchers probably follows that of education vouchers, with the potential merit of enhancing competition among health care providers by allowing government subsidies to follow patients' choices. However, we must remember that unlike primary education which is universally applicable to every child, the need for health care differs vastly among people. Many people need very little health care for most of their life span, while some people require a lot of medical care over a long period of time. To give every resident an equal share of public health care resource every year will grossly reduce the amount available to those having huge health care needs, while for the majority of people the voucher may even induce moral hazard and inefficient use of health care resources.

Hong Kong with its renowned expertise in medical care can become the regional hub for medical tourism



A recent visit to Thailand by a delegation of the College provided members some insight into the topic of "medical tourism". Indeed, it may be a misnomer to coin this term in describing the phenomenon of people seeking medical care from abroad, because it contributes relatively little to the tourism industry of the providing country. The Thai health care sector calls it "international medicine", and that sounds more appropriate. We were told by our Thai friends that there were some pre-requisite conditions for a thriving international medicine business.

First, there should be excess capacity of the health care system in relation to the health care demand of the local people. This is well illustrated by the recent saga of pregnant Mainland mothers flocking to Hong Kong for delivery. The already stretched capacity of the Obstetrics service for the whole territory is in no time overwhelmed by the high influx of expectant Mainland mothers. The situation for Thailand was rather unique in that there was encouragement of the private hospitals by the Government to expand their inpatient capacity for the period immediately before the Asian Financial crises of 1997. Following the sharp financial downturn in 1997, most of these hospitals were left with very low occupancy rates. In order to survive, these hospitals started to promote their health care services to local expatriates and then residents of foreign countries with very competitive fee schedules. This was the starting point of the whole matter.

The second prerequisite is to have a reputable health care professional workforce. Many Thai doctors were trained in USA with specialty board certification. That gives strong confidence to the potential foreign clients; many of them are from the developed countries. The third factor is the level of living. The level of living in Thailand is relatively inexpensive, and that makes both the medical fees as well as cost of staying in Thailand very affordable to the clients. Finally there are also cultural factors that must be taken into account. The Thai people are well known to be friendly and receptive of foreigners. They also possess fairly good command of English.

It is the combination of all these factors that make Thailand so successful in attracting international patients. However, even with all its tourist attractions, ubiquitous shopping facilities and refreshing resorts, the increase in tourists related to health care services is not significant at all. If Hong Kong really wants to offer its well acclaimed medical expertise to the international clients, then we need to review whether we have all the features mentioned above. Otherwise we need to explore other models for serving as a regional medical hub. Although some people argue that Hong Kong can attract wealthy patients from the Mainland, so far the number of such patients coming to Hong Kong is small save the pregnant women whose main target is either the right of abode for their babies or the avoidance of sanctions from the Mainland for violating the one child policy, or both.

Workload distribution between public and private sectors

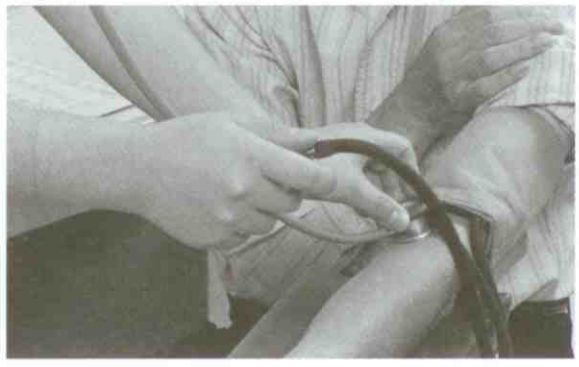
There is a frequently quoted statement that with less than 50% of the registered medical workforce in Hong Kong, the doctors of Hospital Authority

(HA) shoulders 90% of the health care burden. With this statement comes the verdict that there is gross imbalance between public and private health care sector, and the culprit is the expansionistic strategy adopted by HA over the past decade.

As I have pointed out previously, such a statement is far from being accurate. The percentage of so-called health care burden actually refers to the ratio of hospital bed numbers between HA and private hospitals. But we need to make a lot of adjustments because there are several types of inpatient services that could not be taken up by the private hospitals. These include the psychiatric beds (both voluntary and gazetted beds), the beds for long term care of severely mentally retarded children, the infirmary beds that cater for members on the Central Infirmary Waiting List (CIWL) kept by the Social Welfare Department, the isolation beds designated for epidemic outbreaks and the acute beds for serious trauma victims. Of course we should also make provision for the number of private beds in public hospitals for more accurate comparison. Even then we are only talking about inpatient services. If we also take into account the clinic consultations for primary and specialist care, then the workload distribution between the two sectors becomes a very complex matter, especially when we do not have reliable data regarding the throughput of private clinics. So it would be imprudent to draw any conclusion from such oversimplified statement, and the vow to stop the expansion of HA may become a slogan without a sound foundation. However, for the sake of political correctness, such statement has been re-iterated again and again by clinician leaders, politicians, academicians and private sector service providers alike. I hope policy makers can take note of the above caveats when referring to such statement for their decision making process.

Regular comprehensive body checkup is the way to practice preventive medicine

Nowadays the importance of preventive medicine is gaining momentum world-wide. In Hong Kong there is in the lay population a belief that preventive medicine is about having regular comprehensive body checkups involving a batch of different diagnostic tests and examinations. Indeed many private hospitals or medical centres provide such body checkup packages with a spectrum of components and prices to the general public without the requirement of medical referral. Obviously we cannot deny that such tests and examinations do very occasionally detect some abnormalities and allow early intervention for their treatment.



The issue is whether such comprehensive checkup is a cost-effective way to safeguard population health. Since in most cases there is no medical referral, many tests are either not indicated because of very low yield, or difficult to interpret because of existing co-morbidities or some other personal factors. In some cases, false-positive results may even cause unnecessary harm to the individual because more invasive investigations are required to repudiate such results. In many developed countries, there are guidelines developed by professional bodies to advise on the ordering of screening tests with reference to the local epidemiological data and disease pattern. Apparently such guidelines are lacking in Hong Kong. In the last few years, we have invested a lot of public resource in the prevention and management of infectious diseases. This is understandable in view of the immense political pressure following the SARS epidemic. But that should not prevent us from putting emphasis on the prevention of non-communicable diseases that are imposing heavy health care burden to society. With the collaboration of clinical epidemiologists and specialists in clinical diagnostics, we should be able to come up with scientifically sound guidelines for people to take screening tests appropriate to their demographic and health status. Diagnostics service providers should not aim at maximizing their profits by promoting unselective use of such tests to the public, and one way is to encourage people to consult their family physicians before taking such tests.

Dr H C MA

Private Health Insurance: The Swiss and Australian Experience

In anticipation of Government's proposal on health care financing reform, many have advocated expanding private health insurance in Hong Kong as a possible way forward. Some suggested that Government should grant tax incentives for persons with private health insurance. Private insurance is seen as a way to inject more money into the health care sector, especially the private sector, without having to add burden to Government. This article examines the current private insurance market in Hong Kong, and contrasts it with that in Australia and Switzerland.

Health Insurance

Unlike social health insurance, private health insurance is generally purchased on a voluntary basis, either by individuals or by groups (most employers). The premium varies depending on the benefits and the health condition of the insured (known as experience rating). Consequently, the elderly and persons with existing medical conditions are required to pay prohibitively high premium.

Private Health Insurance in Hong Kong

The private health insurance market in Hong Kong is highly unregulated. There are no requirements that employers must provide health insurance for their employees. Insurance companies are free to sell any product they wish. There are no requirements on benefits or premium rate. The result is that most of the plans purchased provide very inadequate protection. The elderly and persons with pre-existing medical conditions are generally excluded because of the extremely high premiums. Many persons with private health insurance also go to public hospitals during major illness, because the benefits provided by their insurance plan would cover only a small fraction of the expenses if care is rendered in private hospitals. While more than 2 million persons (almost one-third of the population) in Hong Kong are covered by some form of private health insurance, 95% of the patient days came from public hospitals. Many plans just provide general outpatient coverage and others a small indemnity payment (often only a few hundred dollars a day) in the event of illness requiring hospital stay.

Private Health Insurance in Switzerland

The private health insurance market in Switzerland was not regulated until 1996. Since 1996, health insurance has been made compulsory (the scheme is similar in many ways to Hong Kong's Mandatory Provident Fund), and insurance companies wanting to sell statutory health insurance must register with the Government and are prohibited from refusing anyone. Registered plans are eligible for government subsidies, and must cover

a basic package of benefits defined by the Government. The basic package includes coverage for outpatient, inpatient and medical rehabilitation services. In addition to the mandatory insurance, policy holders can take out additional insurance to cover semiprivate or private room accommodation. Premiums are community rated – subscribers, regardless of age and health status, pay a fixed percentage of their income. An equalization fund was established for risk adjustment and transfers between companies depending on the risk profile of their customers. Policy holders who agree to limit their choice of doctors and hospitals or to increase their amount of co-payment pay a reduced premium. Low income persons are eligible for reduced premiums.

Private Insurance in Australia

Australia has a compulsory national insurance scheme known as Medicare. A levy of 1.5% to 2.5% of income is applied on taxable income of individuals. Under Medicare, residents are eligible to receive free treatment in public hospitals and subsidized outpatient care and pharmaceuticals.

Private health insurance is voluntary but regulated. Registered plans must practice community rating. The Government provides financial incentives for people to purchase registered private health insurance plans. Private insurance policy holders receive 30% rebate on their Medicare levy. Private insurance provides benefits such as choice of doctors in the private sector, choice of private hospitals and the more flexible scheduling of care for non-urgent conditions. Lifetime Health Cover was introduced in 2000 to encourage more residents to take out private health insurance. Under this scheme, persons joining a registered private health plan before the age of 31 and staying with the plan will pay a lower premium throughout their lives relative to persons who join at an older age. Over 45% of the population have private health insurance.

Lessons from the two countries

It is clear that from the experience of these two countries that the private health insurance market needs to be regulated. Simply granting tax credits to persons with private health insurance without first having a health insurance regulatory system in place is not likely to produce desirable impact. The industry and government should get together and work out a registration system. Registered plans must provide adequate hospitalization coverage, and their premiums must be community rated.

The existing situation in Hong Kong is clearly unsatisfactory. Private health insurance in Hong Kong has not, in any significant manner, diverted demand away from public hospitals. Its impact on creating demand for private hospitals is modest. Policy holders do not always have greater choice of doctors and/or hospitals in the event of major illness. Insurance companies also complain about the low profit margin, as the many of the plans cover general outpatient care, in which the probability of claim to the maximum limit is very high. In short, no one is benefiting from the current state of affairs.

Acknowledgement: An abridged version was published in the South China Morning Post of 3 July 2006.

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