

ON THE PROPOSED VOLUNTARY HEALTH INSURANCE SCHEME

The Institute for Health Policy and Systems Research



SUBMISSION ON
THE CONSULTATION DOCUMENT ON
VOLUNTARY HEALTH INSURANCE SCHEME
(VHIS)

15 May 2015

The INSTITUTE FOR HEALTH POLICY AND SYSTEMS RESEARCH

(IHPSR), a voluntary non-profit independent organization devoted to making a difference in healthcare by informing decisions, imparting new knowledge and injecting advances and breakthroughs, submits the following comments and suggestions on or related to the *Consultation Document on Voluntary Health Insurance Scheme* (VHIS):

1. **IHPSR supports** strongly the current Administration's commitment to building for Hong Kong a more *integrated and balanced* healthcare system for the benefit of all in the community and to maintaining and strengthening the *dual-track* healthcare system by which the public and private healthcare sectors complement each other and through *sustainable development* of the public system as the *safety net* for all. In addition to addressing immediate problems and needs, Hong Kong indeed must be much better prepared to face future healthcare challenges and to take full advantage of future opportunities. It should greatly benefit Hong Kong to have total and transformative strategies formulated and enacted to achieve the desired objectives.
 - 1.1 Yet, these are overarching, long-term and complex issues that deserve innovative and forward thinking as well as having the community mobilized to come up with locally befitting solutions. The mostly top-down and technocratic approach that has prevailed over the past 25 years has not worked well and should be discontinued. Hong Kong should depart from the way things were done and adopt instead a more inclusive and balanced approach to developing new thinking and formulating effective future healthcare policies and strategies.
 - 1.2 We urge the Government to undertake an *open and facilitative approach*, making full use of meaningful research and inclusive-participatory platforms, to work proactively in partnership with key stakeholders to develop *new paradigms and models* of health and healthcare, including more clearly defined roles of the public and private sectors, to advance and protect people's health with better value and better care.
 - 1.3 In parallel, we urge the Government to *actively engage and mobilize providers* in the private, voluntary and public sectors, particularly the

latter, to release their full potentials, discharge their social responsibilities, make full use of obtainable resources and execute forward looking initiatives to shaping a new direction and contribute proactively to the system's development.

2. We applaud the current Administration's intent to address the shortcomings of the existing private health insurance market so as to enhance the accessibility, quality and transparency of its products and services. We see merits in making health insurance products, coverage and fees and charges more transparent so as to facilitate choice and provide better insurance protection. But, we have also, as set out below, a number of observations and improvement recommendations regarding the minimum requirements, benefits coverage, payment method, premium structure and regulatory strategy that we hope the Government will take into account in taking forward the proposed VHIS.

2.1 **Minimum Requirements** – We support the concept of *Minimum Requirements* as it pertains to right what have been omitted or ignored. We have concerns, however, on two of the 12 *Minimum Requirements* as set out in the proposed VHIS: the **no cost sharing** (that is, no deductible, no co-payment) and **no lifetime benefit limit** provisions.

2.1.1 We understand that high-deductible health insurance policies can hurt patient health. But international experience indicates that the elimination of cost sharing requirements can swing the doors open for **moral hazard** behaviors that will in turn lead to resource over-use and abuse. This will fuel medical inflation, particularly in the case of individual fee-for-service payment systems like the proposed VHIS. And, to the extent that private insurance products should need to be also market responsive, imposing these requirements on all new products in the future may limit consumer choice and stifle product innovation.

2.1.2 Accordingly, we propose that, for new products in future, cost-sharing and life-time limit provisions be allowed and be set by the **market and competition**.

2.2 **Benefits Coverage** – The proposed VHIS offers benefits coverage that is limited to inpatient curative care and certain designated costly ambulatory procedures. Clearly not included are maternity and newborn

care, outpatient care, chronic disease management and long-term care, which are Hong Kong's critical healthcare needs and systems development issues. The proposed scheme's narrow scope or focus is unusual. Many health systems worldwide, most notably the United States in the rollout of its current health reform act (see HealthCare.gov), are mandating insurers to offer minimum or essential health benefits coverage that is more inclusive and comprehensive. Furthermore, the proposed VHIS appears regressive as its benefits coverage focuses on *sick care* while many others have already progressed to encompass the contemporary concept of *health promoting care*.

2.2.1 In a *focus group* conducted by IHPSR in February 2015, the twenty (20) participants in attendance indicated that the undesirable aspects of the proposed VHIS include the missing offerings of preventive care, primary care, ambulatory care and chronic disease management. These benefits are important. Health promotion and health promoting care are not only effective ways to advance individual and population health but also to relieve the pressures on inpatient care and to make better use of the healthcare dollars.

2.2.2 Based on the most recently available data, we find that only 36 percent of all Hong Kong's private personal healthcare services expenditure was spent on inpatient care whereas 62 percent was on outpatient care (HKDHA, 2011/12). From another perspective, only 17 percent of total private household out-of-pocket expenditure of the year was spent on private inpatient care whereas 37 percent was on private primary care or outpatient services. So, it is puzzling why the proposed VHIS has chosen to focus almost entirely on inpatient curative care and exclude the outpatient segment where users are spending substantially more money.

2.3 **Payment Method** – The proposed VHIS, an indemnity hospital insurance product (IHIP), adopts a fee-for-service payment system that many healthcare systems in the world are shunting or have dropped in favor of other payment methods (Lieu, 2010). International evidence has indicated that fee-for-service is prone to adverse selection and moral hazard. It and can also fuel medical inflation because it tends to reward quantity of service. As newer and more effective cost containment and incentive payment models are available, the *pros and cons of fee-for-*

service should have been assessed more thoroughly and the results made explicit for people to make informed decisions. Moreover, in light of the current lack of meaningful cost and outcome data, *package pricing* and informed financial consent must be coupled with effective performance and value based payment systems in order to achieve desired outcomes.

2.3.1 We urge the Government to engage both the healthcare and insurance communities to take on the challenge of: (a) *upgrading* the design of the proposed VHIS to offer richer and more comprehensive benefits that should include, for example, health promoting products, primary care, ambulatory care and Chinese Medicine; and (b) *incorporating* effective performance and value based incentive payment mechanisms to maximize the scheme's potential as an effective *control knob* to addressing the shortcomings of Hong Kong's healthcare system.

2.4 **Premium Structure** – Based on a review of the *indicative annual standard premiums* for standard plan, we find that the elderly (age 70 and above) have lower premium loadings, relative to corresponding age-specific healthcare expenditures, than those of adults aged between 25 and 69 (see APPENDIX I). These findings suggest that the premium loadings should be standardized and measures to prevent inequitable loadings instituted.

2.4.1 There is ample evidence that the elderly consumes more health care and incur more expenditures than the young. Data from the Hospital Authority indicated that patients age 65 and older accounted for 50 percent of all patient days and tended to have a 4 times higher relative risk of being hospitalized than the young (Hospital Authority, 2012a). In addition, the average cost of treatment for an elderly patient in the Hospital Authority is 57 percent higher than that for a non-elderly patient (Hospital Authority, 2012b). In the U.S., it was found that persons age 65 and older would expend 60 percent of their lifetime healthcare costs in the remaining years (Alemayehu and Warner, 2004). In Australia, the elderly (age 65 and above), as they get older, spends 3.30 to 6.34 times more on healthcare than those between 25 and 29 years of age (de la Maisonneuve and Martins, 2013). Accordingly, the setting of the elderly's annual premiums should reflect their risks of higher healthcare spending.

2.4.2 We compared the ratios of age-relative per capita public spending on health and long-term care to the reference age group (age 25 to 29) of 20 OECD countries and Australia (for closer comparison) with those of age-relative indicative annual standard premiums of the proposed VHIS (see APPENDIX I). The findings suggest that the indicative VHIS premiums are noticeably **under-rated** for the elderly groups of age 70 and above but **over-rated** for adults between age 25 and 69. This suggests that adults between 25 and 69 years of age will be paying higher premiums, thus shouldering more than their share of healthcare expenditure, as compared to the other age groups. If this in fact happens, the premium structure of the proposed VHIS is inequitable as it is unfair for young adults to cross subsidize the old in a private voluntary insurance scheme.

2.4.3 The premium structure of the standard plan puts a heavier burden on adults of working and early retirement age. It is only fair, in a private age-adjusted community rating plan, that each age group bears a level of annual premium that is commensurate with its own risks of healthcare spending. Hence, premium loading standardization and preventive measures to ensure **intergenerational equity** of the proposed scheme should be instituted.

2.5 **Regulatory Strategy** – While existing shortcomings in Hong Kong’s current private health insurance market must be addressed, it may be unnecessary at an early stage of the VHIS implementation to intervene through legislative and government bureaucratic mechanisms. In particular, we have reservations on instituting a new regulatory agency within the government bureaucracy to monitor and regulate compliance.

2.5.1 The Consultation Document makes it very clear what people want and what the Government intends to do about the shortcomings. Insurers seem to have responded: new products have incorporated some or most of the minimal requirements. Hence, the industry should be given time to do its job, show their responsibility and protect people’s interests. In fact, in line with Hong Kong’s long held **“big market, small government”** policy of minimum intervention, the Government should first exercise **soft power to influence the market to address market problems** and

avoid the potential inefficiencies of direct controls.

2.5.2 We urge the Government to actively engage leaders in the insurance and related sectors to come up with *sustainable and meaningful fixes*, including information transparency, voluntary compliance and self-regulation. Regulatory mechanisms should be enacted only when provider and insurer behaviors deviate from best practices, violate consumer rights or defy public interests. That is, intervene when market forces fail. This should also avoid spending tax dollars unwisely and prematurely.

3. We investigated the likely extent to which the proposed VHIS may be able to attract public sector users to move and stay in the private sector and thus lower the pressure on the public healthcare system, i.e., relieving public queues, and thereby improve the access to public hospital care. Our findings and analyses below suggest that it is unlikely that those in the public sector will migrate to the private sector. They will need or choose to rely on the public sector for care. Hong Kong shall continue to need a *strong, vibrant and responsive public healthcare sector*, a sustaining society foundation, to doing its best to serve people.

3.1 We calculated, using data for males as a more conservative estimate, the likely lifetime premium contributions at varying annual premium levels at selective ages of taking up the proposed scheme (see APPENDIX II) in an attempt to evaluate if the lifetime premium contributions may be a deterring factor for people signing up with the proposed scheme. The total lifetime premium contribution of an individual taking up VHIS at age 25 could accrue to HK\$1.5 to 2 million. Not considering the inevitable additional *out-of-pocket payments*, these premium expenses can constitute a hefty lifetime spending. This suggests that it is unlikely that young self-paying healthy adults will want to take up the scheme. And, it is highly questionable if employers will choose to offer the proposed VHIS to their employees when the premium structure carries a heavier loading on the young than on the old.

3.2 From the *focus group* conducted in February 2015, we found also that:

- those who indicated a strong likelihood (equal to or more than 70% chance) to enroll in the proposed VHIS tend to already have some form of private hospital insurance cover or plan to use private sector hospital care in any case if needed;

- those who indicated a low likelihood (equal to or less than 40% chance) to sign up for the proposed VHIS are public sector users, do not see any gain in real benefits in switching or cannot afford the private health insurance premiums; and
- those who indicated uncertainty (50 or 60 percent chance) in joining tend to have already some form of private hospital insurance cover and want to wait and see in detail how the scheme works and if it will work to their benefit before deciding.

The findings above suggest that it is unlikely that public sector users will take up the proposed VHIS and shift to the private sector. Those who will more likely sign up are already private sector users or have always intended to use private hospital services when needed. They tend to also have some form of insurance cover that is either self-purchased or employer provided. It seems unlikely that there will be an exodus of a sizeable number of public sector users switching to the private sector.

3.3 At the same *focus group*, we asked pre- and post-session questions of participants' understanding, support level and likelihood of signing up with the proposed VHIS. The results indicate that:

- their *understanding of the proposed VHIS* went up from 49 percent to 78 percent, or a 59 percent better understanding, before and after attending the focus group;
- their *level of support*, however, dropped from 5.53 points to 5.22 points on a 10 point scale (with 10 being most supportive and 1 not supportive) or a 5.5 percent decrease;
- their *likelihood of enrolling* in the scheme dropped from 5.28 points to 4.82 points on a 10 point scale (with 10 being most supportive and 1 not supportive) or 8.6 percent lower.

Subject to focus group and generalizability limitations, the results nevertheless indicate that those who are better informed of the scheme details tend to be less supportive and less willing to sign up for the scheme than those who are not or as well informed. This suggests that it is important to manage people expectations with what they think they may be able to benefit from the proposed VHIS.

- 3.4 If the proposed VHIS is to attract public sector users who are financially able to switch to the private sector, it seems that enhanced benefits, better value for money services and ready access to hospital care need to be made available to facilitate the changeover. But it has been observed that private hospitals and practitioners have already reached their maximum capacities such that inpatient admissions and surgical procedures are often delayed and waiting times in some private doctor offices are excessively long. If public sector users were to switch to the private sector in large numbers, these issues may be exacerbated and the attraction and sustainability of the proposed scheme threatened. On the other hand, to the extent that more people were to take up the proposed scheme, there should also be an exodus of public sector doctors, nurses and other personnel to the private sector. This could cause greater pressure on the already overloaded and understaffed public sector: queues will continue to be long and access not improved.
- 3.5 The shortage in manpower supply and the overloaded service delivery capacities are already apparent and inhibiting the advancement and development of Hong Kong's healthcare. Unless there is a quick rise in the availability and supply of medical, nursing and other healthcare professionals as well as expansions in service delivery capacities or modalities, it is difficult to see how the proposed VHIS can be successful and how it can help to alleviate the pressures of the public system.
- 3.5.1 We urge the Government, working with related statutory bodies if applicable, act to boost the supply of *qualified practitioners and providers of the international medical and healthcare community* as well as to expand Hong Kong's service delivery capacities and modalities. Acting strategically and accordingly will enhance user access and choice, help harness emerging opportunities and sustain Hong Kong's health systems development and growth in addition to the duty of improving and protecting people's health.
- 3.6 Although the intensifying pressure on the public system has been frequently attributed to staff shortages, the problem may not be purely a manpower issue. It may also be a volume management issue that relates to governance and management, including if innovative delivery modalities, proper resource allocation and effective performance rewards and incentives are encouraged and instituted.

3.6.1 Even if there were a sizable number of users taking up VHIS were to switch to the private sector, it is unlikely that the public sector pressure will diminish because of the existing service gaps, backlogs and emerging demands. Hong Kong shall need new initiatives to build *a more vibrant and responsive public healthcare system*. Accordingly, we urge the Government to also incentivize leaders and executives in the public system to act proactively to formulate and introduce promising options and transformative solutions without delay.

4. Based on the above, it is doubtful that the proposed VHIS will be an effective *control knob* to recalibrate the *public-private balance*, build a more *integrated and balanced system* and ensure a *sustainable and balanced development* of the *dual-track system*. The proposed scheme's pros and cons and potential adverse impacts are not fully discussed in the Consultation Document, although it is clear that the target is to attract those with the financial means to switch or stay with the private sector. In this regard, the proposed scheme may accelerate the dual-track system to evolve quickly into a two-tier system that is pro-rich and less equitable as a whole.

4.1 We conducted a *high-level cost comparison* of inpatient curative care between Hong Kong's public and private sectors (see APPENDIX III) and found that the cost per inpatient discharge (including deaths) in the private sector is *2.42 times higher* than that in the public sector. This means only those with adequate financial means are the likely ones who can afford the costly private hospital care. Shifting patients to the private sector, in a macro sense, is not cost efficient, can accelerate escalating medical costs and add to higher total healthcare spending.

4.2 In addition, the Consultation Document makes no specific mention how private hospitals, doctors and other providers will be incentivized to provide cost effective care and to keep medical inflation in check. This is essential for developing and upholding a sustainable system. The private sector's highly priced services will predominantly benefit and make services more accessible to the rich. When this happens, it may "*exacerbate the status quo pro-rich horizontal inequities*" in Hong Kong's healthcare system (Leung et al, 2008) and thereby adversely affecting Hong Kong's competitiveness as a whole.

4.3 At the *focus group* mentioned above, we asked the participants at the

end of the session what kind and how much they feel the proposed VHIS will impact Hong Kong's future *public* healthcare system. The results were: positive impact – 34 percent, negative impact – 56 percent. That is, participants feel that the impact will be much more negative than positive on the public system. This sentiment should be a noteworthy caveat: if the Government forges ahead with implementation of the scheme as proposed, a weak or *pro-poor public system* with a *pro-rich private system* may emerge. Is this what people want and will it be good for Hong Kong?

- 4.4 With the wealth and economic wellbeing rapidly improving in the Region and the resultant accelerating demands for better healthcare services, there should be sharply rising opportunities for Hong Kong to develop healthcare as an industry to better serve people and to act as a *powerful engine for economic growth*. Hong Kong needs and should benefit socially and economically from having in place *a strong, efficient and vibrant dual-track healthcare system* offering high quality care in the public sector and high value care and services in the private sector. But, effective strategic solutions must be deployed, expeditiously and with determination to address existing problems and to take full advantage of emerging opportunities.

5. **In sum**, it is likely that the proposed VHIS will have only *limited impact* as a control knob to addressing the healthcare system's shortcomings. It is very unlikely that it will be a meaningful policy move to help build the needed foundation to tackle future challenges or to exploit emerging opportunities. There ought to be re-prioritization. The most pressing healthcare issue is not about regulating and improving the quality of hospital health insurance, although the Government has the fiduciary responsibility to ensure access to high quality high value care and helping people to spend healthcare dollars wisely.

The most pressing issue is to have formulated, with strong community support, an *overarching inclusive healthcare development plan with holistic strategies* to building the necessary capacity to innovate and improve the services delivery capacities and modalities and to reforming the financing and incentive payment systems to make the dual-track system more efficient, effective and better integrated. This should be where focused attention and concerted efforts should have been or are to be directed.

We urge the Government to therefore act to:

- work expeditiously to **increase manpower supply and build expanded capacities**, including recruiting well qualified medical practitioners and talents as well as renowned provider institutions internationally to contribute to meeting new and rising demands as well as to help advance Hong Kong's healthcare system and growth;
- engage relevant stakeholders, building on the momentum already gained over the years with planning of the proposed VHIS, to design an **upgraded version of the proposed VHIS** to include comprehensive and meaningful **benefits coverage** such as primary care, ambulatory services, long-term care and prescription drugs coupled with innovative **value based provider payment and incentive systems** that promote health and drive high quality, high value care;
- dialogue and develop, through participatory and inclusive platforms, an **inclusive healthcare development plan and reform agenda** to advance an **equitable and vibrant dual-track system** with carefully designed roles and relationships between public and private sector services and finance as well as **innovative, people-oriented and patient-centered delivery modalities** that promote and protect people's health; and
- partner with the private sector to build strong **research capabilities** and broad-based coalitions to better understand and define **the nature and business of healthcare**, including health economics, financing, service innovation, performance improvements and health services management; to identify opportunities for enhanced and sustained **future healthcare development**; and to also build healthcare as a powerful **engine for socioeconomic growth**.

Hong Kong has a healthcare system that has served its people well. But a **new and clear way forward** is needed to enhance and protect people's health. We need to build healthcare to be a powerful engine also for Hong Kong's socioeconomic growth. IHPSR stands ready to assist the Government and partner with others to actively contribute to rebuilding Hong Kong's healthcare system and making things happen. □

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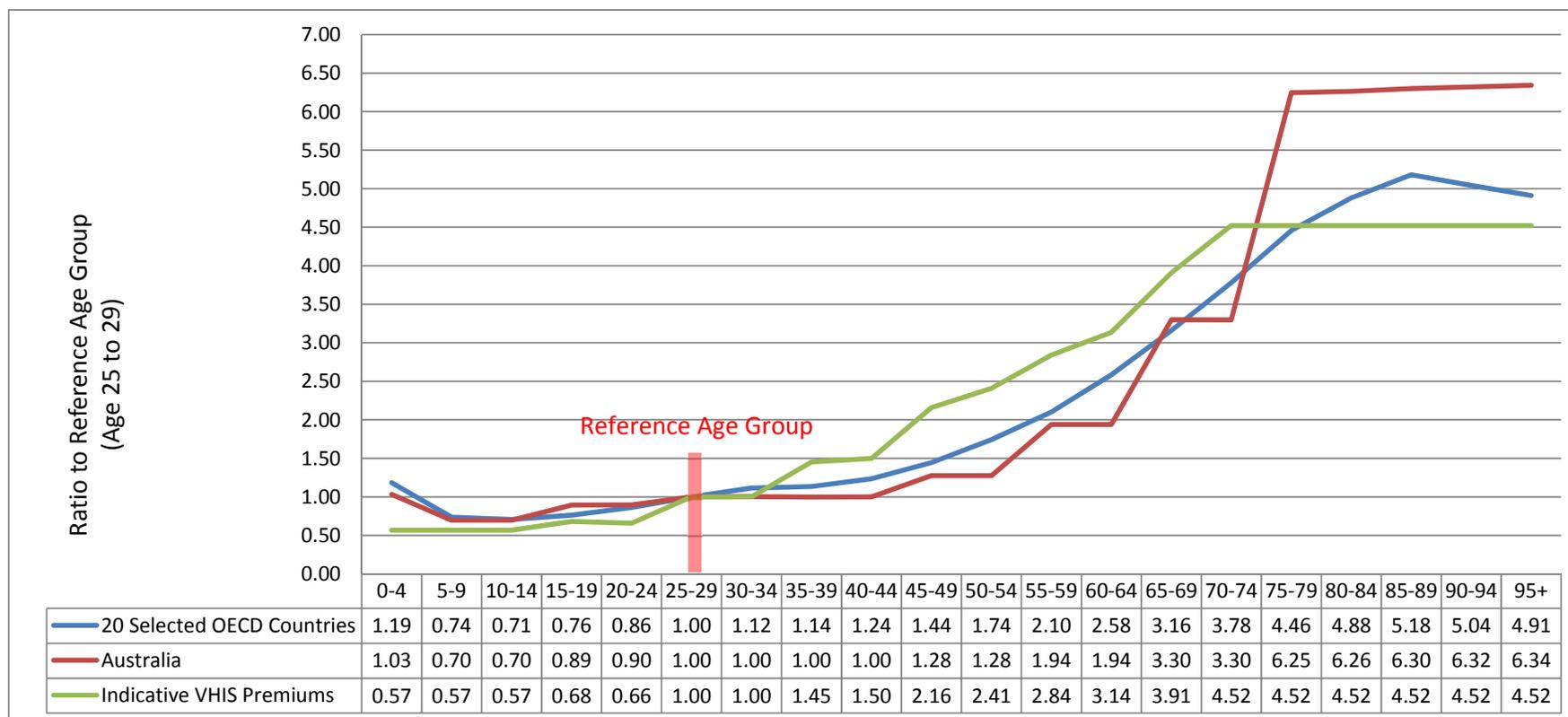
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APPENDIX 1

COMPARISON OF RATIOS OF AGE-RELATIVE PER CAPITA PUBLIC SPENDING ON HEALTH AND LONG-TERM CARE IN 20 SELECTED OECD COUNTRIES & AUSTRALIA¹ AND RATIOS OF AGE-RELATIVE INDICATIVE ANNUAL STANDARD PREMIUMS OF THE PROPOSED VOLUNTARY HEALTH INSURANCE SCHEME² TO REFERENCE AGE GROUP (AGE 25 – 29)



¹ Ratios derived from data in Figure 4. Public health care expenditure by age groups (percent of GDP per capita) in de la Maisonneuve C and Martins JO. 2013. *Public spending on health and long-term care: a new set of projections*. OPECD Economic Policy Papers No. 6. OECD Publishing. Available: <http://www.oecd.org/eco/growth/Health%20FINAL.pdf> Australia was singled out as an additional and comparable source for comparison.

² Ratios derived from data in Table 3.3 Indicative Annual Standard Premiums of Standard Plan in Food and Health Bureau. 2014. *Consultation Document Voluntary Health Insurance Scheme*. Available: http://www.vhis.gov.hk/doc/en/full_consultation_document/consultation_full_eng.pdf

ESTIMATED LIFETIME CONTRIBUTIONS OF MALES AT SELECTED AGES UNDER THE STANDARD PLAN AT INDICATIVE STANDARD AND VARYING ANNUAL PREMIUMS UNDER THE VOLUNTARY HEALTH INSURANCE SCHEME (VHIS)

(Hong Kong dollars, in 2012 constant prices)

Years of age to commence premium contribution (a)	25	35	45	55	65	75	85
Expectation additional years of life at designated age ¹ (b)	62.49	57.54	47.75	38.18	28.96	24.59	12.90
Expected years of age at end of life (c) = (a) + (b)	87.49	87.54	87.75	88.18	88.96	89.59	92.90
Indicative annual standard premium for standard plan ²	\$ 2,200	\$ 2,200	\$ 3,300	\$ 5,300	\$ 6,900	\$ 8,600	\$ 9,950
Indicative standard premium at commencement (assuming +10% increase)	\$ 2,420	\$ 3,520	\$ 5,225	\$ 6,875	\$ 9,460	\$ 10,945	\$ 10,945
Life time contribution³ for standard plan at standard premiums : from age (a) to (c)	\$ 1,532,441	\$ 1,119,847	\$ 807,742	\$ 579,004	\$ 391,163	\$ 238,181	\$ 125,472
Adjusted standard premium at commencement ⁴ (varying from -8% to +45%)	\$ 1,936	\$ 2,816	\$ 6,009	\$ 7,906	\$ 13,717	\$ 15,870	\$ 15,870
Life time contribution³ for standard plan at varying premiums : from age (a) to (c)	\$ 2,073,182	\$ 1,526,370	\$ 1,111,338	\$ 814,591	\$ 567,186	\$ 345,362	\$ 181,935

¹ Data from Hong Kong Life Tables for Males, 2014 (provisional figures), *Hong Kong Life Tables, 1971-2014*. Available: <http://www.censtatd.gov.hk/hkstat/sub/sp190.jsp?productCode=D5320184>. We use male data to keep the estimates conservative as males usually show shorter life expectancies and consume less healthcare resources than females.

² Based on data provided in Table 3.3 Indicative Annual Standard Premiums of Standard Plan (Year 2012, in 2012 constant prices), *Consultation Document Voluntary Health Insurance Scheme*, p. 72. Available: http://www.vhis.gov.hk/doc/en/full_consultation_document/consultation_full_eng.pdf

³ We assume an annual premium increase of 3 % per year throughout the lifetime of the enrollees and that all persons join at commencement of the scheme.

⁴ For illustration and comparison, the indicative premiums at commencement are reduced by 8% for ages 25 and 35, increased by 20% for ages 45 and 55 and by 45% for ages 65, 75 and 85 respectively. These adjustments are made in line with the Consultation Document's indication that the Indicative Annual Standard Premiums are subject to a potential range of variation between -8% and +45%.

APPENDIX III

COMPARISON OF COSTS OF INPATIENT ACUTE CARE BETWEEN THE PUBLIC AND PRIVATE SECTORS: HONG KONG - 2009/10

	PUBLIC SECTOR	PRIVATE SECTOR	TOTAL
Total health expenditure: ¹			
Inpatient Curative Care ²	\$ 14,716	\$ 9,465	\$ 24,181
<i>Percent of Total</i>	<i>61%</i>	<i>39%</i>	<i>100%</i>
Number of Inpatient Discharges and Deaths ³	1,385,987	368,815	1,754,802
<i>Percent of Total</i>	<i>79%</i>	<i>21%</i>	<i>100%</i>
Cost per Inpatient Discharge and Death	\$ 10,618	\$ 25,663	
RATIO	1	2.42	

¹ Hong Kong dollars, in millions.

² Data from *Hong Kong's Domestic Health Accounts (DHA) Estimates of Health Expenditure 1989/90 - 2010/11*. Available: http://www.fhb.gov.hk/statistics/download/dha/en/a_estimate_1011.pdf

³ Data from *Hospital Authority Statistical Report 2010 -2011*. Available: http://www.ha.org.hk/upload/publication_15/411.pdf