EXECUTIVE SUMMARY

1.1 Introduction

In November 1997, the Health and Welfare Bureau of the Government of Hong Kong SAR commissioned a team of economists, physicians, epidemiologists, and public health specialists from Harvard University to conduct a study on Hong Kong’s health care system. This study was to include a comprehensive assessment of the current system and a proposal for alternative options to improve financing and delivery of health care. In particular, the study aimed to answer the following questions:

- What are the strengths and weaknesses of the Hong Kong system of financing and health care delivery?
- Can the current arrangement for financing health care be sustained?
- What are the causes of the weaknesses in the health care system?
- What are the strategic options for improving the Hong Kong system?
- What institutions need to be put in place if Hong Kong chooses a particular option?

The answers to these questions will differ depending on the perspective from which the assessment is made. This study used a patient-centered approach, basing our findings mainly on the patients’ perspective.

1.2 An Evidenced-Based, Consultative Approach

To assess the system’s strengths and weaknesses and to develop rational and credible options for reform, every effort was made to ensure that the assessment was based on the best evidence available to the Harvard team. Many organizations in Hong Kong generously provided information and data, and new information was gathered to fill in any missing gaps. The findings of this study are based on the analysis of data obtained by:

- developing Domestic Health Accounts to provide a systematic and accurate accounting of total public and private health care expenditures based on international standards, and by documenting what the funds were spent on (for details see Special Report #1: Hong Kong Domestic Health Account (DHA) Report);
• reviewing international experience to determine which features of different health care systems may be constructively adapted to the Hong Kong context (see Special Report #2: International Comparison of Health Systems);

• conducting a household telephone survey (in collaboration with the University of Hong Kong) to determine health care utilization behavior and general satisfaction with the quality of services (see Special Report #3: Hong Kong Household Survey Report);

• conducting a provider survey (in conjunction with the Hong Kong Medical Association) to understand the current practices and challenges facing private doctors (see Special Report #4: Hong Kong Private Practice Survey Report);

• conducting patient studies (in collaboration with the University of Hong Kong and the Chinese University of Hong Kong) to gain a more in-depth understanding of health care utilization behavior and satisfaction with quality of services from a patient’s point of view (see Special Report #5: Hong Kong Patient Studies Summary Report);

• developing financial projection and simulation models to project future health care expenditures under the current situation as well as under alternative options (see Special Report #6: Financial Projection and Simulation Model).

• developing a framework for the assessment of the performance of a health care system (see Appendix A)

In addition, there was extensive consultation with the leaders and major parties in Hong Kong. Our Steering Committee consisted of government officials and leaders in medicine, business and academia, who met every six to eight weeks to provide guidance and advice on issues confronting the current system, the objectives of the health care system, and viable reform options. In addition to Steering Committee members, we consulted over two hundred people, who are business and labor leaders, heads of organized medicine and health professional groups, patients’ rights organizations, the Consumer Council, major employers, insurers, group medical practices, and over forty private practicing doctors. (See Appendix B for a full list of the individuals and groups consulted during the study.)
1.3 Outputs

This project produces four major products which are submitted to the Hong Kong Government: (i) The Main Report; (ii) The methods of compiling the Domestic Health Account (DHA) for Hong Kong and the manual by which the Government can itself compile the DHA annually; (iii) Reports on the detailed findings of the Household Interview Survey and Focus Groups; and (iv) Projections and simulation models developed for Hong Kong’s use.

1.4 Assessment of Hong Kong’s Health Care System

1.4.1 Achievements

- **Hong Kong has a relatively equitable system.** From the patients’ perspective, everyone has access to essential health care regardless of their financial means. Furthermore, the services are readily available in all communities so most residents do not need to travel more than thirty minutes to reach a provider. Our evidence indicates that both rich and poor residents spend a similar portion of their household income for health care, travel similar amount of time to reach a provider, and have similar utilization rates. In other words, almost no-one has to reduce their use of health services due to an inability to pay or because they have to travel long distances to receive care.

  This enviable achievement is largely due to the government’s commitment to assure every resident access to adequate hospital care when needed. In particular, the government allocates a significant portion of its budget to health care.

- **The establishment of the Hospital Authority (HA) in 1990 has brought steady improvement to certain specific aspects of quality and efficiency.** Patients have become more satisfied with the technical quality of care and the attitudes of personnel in health facilities. Efficiency gains have also been apparent in specific areas, such as drug procurement. It is unclear, however, whether there is an overall improvement in operational efficiency since that depends on how the outputs of hospitals are measured. According to international standards, changes in economic efficiency should be measured by cost per episode of illness by disease category, but since the Health Authority has not collected the historical data, this study had to use proxy data on outputs that gave ambiguous results.
These improvements in quality and efficiency have been achieved under the strong and enlightened leadership of the Health Authority, which has introduced modern management techniques. Information systems for management purposes, such as performance standards, cost accounting systems, and uniform clinical record systems, have been gradually put in place. A new corporate structure has been implemented and a patient-oriented culture initiated. In the future, these will serve well to support other major improvements in Hong Kong’s health care system.

- **Hong Kong’s health care system has often been praised for its cost-effectiveness** when compared to European countries and when cost effectiveness is defined as achieving a better health outcome given a specified amount of resources. The conclusion becomes less certain, however, when it is compared to neighboring Asian countries, such as Singapore and Taiwan, that have comparable levels of economic development, and similar cultures, demographic profiles, climate and genetic composition.

1.4.2 Weaknesses/Areas Needing Improvement

Hong Kong has successfully provided essential medical services to all its residents despite the fact that it has had to absorb millions of immigrants while trying to modernize its health care delivery system. Compared to other advanced nations, Hong Kong has had to compress nearly a century of health care development into the last three decades. Under such accelerated change, it is understandable that there are gaps and weaknesses in the present health care system. Several major ones are presented below.

- **The quality of health care is highly variable.** Hong Kong can boast some of the best health care practitioners and facilities in the region. On the other hand, there is considerable evidence of widespread sub-standard medical practice that adversely affects the quality of health care and even the health of Hong Kong’s residents. Overall, Hong Kong does not have effective measures to ensure that patients receive comprehensive, high quality medical care, particularly in the private health care sector. For example, Hong Kong lacks (a) ongoing medical education for GPs, (b) grievance procedures that have the confidence of patients, and (c) independent external monitoring of clinical practices to safeguard patients’ welfare. For this study, we collected extensive information on patients’ experience with health services and their assessments of the quality of care. Studies conducted on drug prescribing behavior, physician/patient communication, queuing and waiting times, and the time physicians spend with patients in such activities as taking their history and assessing
their previous treatments, raise serious concerns about the medical care that Hong Kong residents receive. Equally important is the absence of information on the outcomes of medical services and the performance of providers, either because these are not being collected or are not made available to the public. Consequently, patients do not have appropriate or adequate information on how to make a rational decision in selecting a provider or in choosing from various treatment options that may be open to them.

One explanation for the highly variable quality of medical services in Hong Kong is the privilege enjoyed by the medical profession to self-regulate without interference and inadequate oversight from external organization. International experience shows that physicians possess a natural dominance in medicine because of their superior medical knowledge and professional authority. Physicians in Hong Kong are no exception. Experience in other advanced nations also shows that the self-regulation of a dominant profession does not protect the public interest unless strong check and balance measures are put in place. Hong Kong has few such measures. The leaders of organized medicine in Hong Kong are largely graduates of one medical school and have close professional ties to other commonwealth nations. As a result, their professional education and beliefs tend to be similar, creating close professional loyalties and collective defenses against external criticism. This situation has been further exacerbated by the fact that colonial powers commonly rule through the local elite, who decide on policies and programs; the general public, lacking influence and substantive input, depend on the good intentions of the elite. This legacy continues in Hong Kong where there is little transparency or public input in assuring quality of health care, and raises a fundamental question: are the interests of patients and the public best served by the current system?

- **The long-term financial sustainability of the current health care system is highly questionable.** Public health expenditures have grown significantly as a share of GDP over the past decade, increasing from 1.7% to 2.5% from 1989 to 1996. If we assume that Hong Kong maintains the current level of quality and access to public health services, this past rate of growth in public health care expenditure will have to continue. The reasons are straightforward, given the aging population, increasing specialization in medicine, and rising public expectations for quality health services. The adoption of new (and costly) technology will also put increasing demands on the public health budget. Assuming that real GDP continues to grow at 5% per year, this study projects that public health expenditures will increase from the current 2.5% to between 3.4 and 4.0% of GDP by the year 2016. This means that in the next 18 years, public health care expenditure may take up 20 to 23% of the total
government budget, a significant increase from its current 14%. (Figure 1.1) Given the Basic Law, which states that, over time, the increase in total government expenditure should be kept in line with growth in GDP, funds for other public programs, such as education, housing and infrastructure, will have to be reduced when public health expenditure takes a larger share of the total budget. This financial pressure on the system is further exacerbated by the fact that public funds are not well targeted, either by service (e.g., health promotion and disease prevention vs. inpatient services) or by population group (e.g., those truly needing public support vs. those able to pay on their own).

**Figure 1.1 Actual and projected trends in total public health expenditures as share of total government budget**

![Chart showing actual and projected trends in public health expenditures as share of total government budget from 1989/90 to 2016.]

Note: Public health expenditures for 1989/90 – 1996/97 are based on the Domestic Health Account data.

- **Hong Kong’s health care system is highly compartmentalized, threatening the organizational sustainability, quality and efficiency of the system.** The lack of coordination and cohesion between primary and inpatient care, acute and community medicine, and the private and public sectors often results in:
- duplication of services (e.g., laboratory tests repeated unnecessarily or the same type of service offered by more than one organization when there is no need or patient demand);
- discontinuity of health care (one organization or provider not knowing what another has already done); and
- confused patients.

This lack of integration in the health sector adversely affects patients’ health and health care, and unnecessarily increases the expenditures for health services. Of greater concern is that such a system does not effectively address the needs of a population increasingly suffering from chronic illnesses. This means that it will be difficult for patients to navigate their way through different types of care and to move easily between the public and private sectors to access the care which best serves their needs. The compartmentalization of the health care system is depicted in Figure 1.2.
The organization of Hong Kong’s health care delivery system and its emphasis on medical specialization are outdated. The society faces socio-health problems that are typical of post-industrialized countries, such as mental disorders, alcoholism, sexually transmitted diseases, violence and substance abuse. With a life expectancy of 79 years, Hong Kong residents are increasingly suffering from diabetes, heart disease, stroke and cancer. Japan, Great Britain and the United States have long known that compartmentalized specialty services cannot effectively prevent and treat these socio-health problems and chronic illnesses, and that they are even less suited for the elderly who often have multiple health problems. Fifty years ago, the U.K. recognized the need for Family Physicians to manage the health care needs of people living in a post-industrialized society, and began to develop the GP system. Other advanced nations followed suit, but Hong Kong has lagged far behind. Equally important, advanced nations recognized that to provide effective and efficient health care, a society must integrate prevention, community medicine, outpatient, inpatient, rehabilitation and other health services. Great Britain and the United States have led the way in developing integrated health care systems, yet in Hong Kong a system of compartmentalized health care that was developed decades ago remains firmly in place.

- **Hospitals are the dominant institutions providing health care in Hong Kong.**
  **Priority is given to hospital-based services.** The Hospital Authority is staffed almost completely for specialty services. This means that priorities and resources are drawn away from primary care and community medicine, which will become increasingly important in managing the growing number of chronically ill patients as the elderly population increases. Currently, family and community medicine is underdeveloped and traditional Chinese medicine, which many chronically ill patients find beneficial, is excluded from the organized medical system.

  A policy of benign neglect may be the major cause for this compartmentalized and hospital-dominated system. The approach taken by the government in the past was to step in only when a problem became serious and to seek a solution without dealing with its major interrelated components. This has left *Hong Kong without a coherent overall policy for financing or organizing health care*. At the same time, the Hong Kong government lacks sufficient capacity, competency, and information to set sound health policy and monitor its execution.

  The circumstances under which the Hospital Authority was created is a typical illustration of the lack of a coherent policy. When public hospitals became overcrowded, the government contracted W.D. Scott & Co. to address the management and organizational issues of the public and subvented hospitals. However, there was no policy on the respective roles of public and private hospitals or on how to finance the
newly created Hospital Authority. No thought was given on how to effectively link primary care with hospital services so patients can move easily through the entire health care system. In addition, the role of the Hospital Authority is ambiguous because it is both the buyer and supplier of health services. When the Hospital Authority Head Office (HAHO) decides on which particular services it will make available (i.e., supply) to patients, it negotiates with individual HA hospitals to deliver the services by making the necessary funds available (i.e. buying). At the same time, the HAHO is also responsible for maintaining all HA hospitals, assuring that they are financially sound, and establishing job security for the physicians and staff. This means that HAHO, acting in the role of supplier, looks after the interests of the hospitals, while it simultaneously acts on behalf of the public in its role as the buyer of health services. Patients’ needs and interests are determined to a significant extent by HAHO as supplier-cum-buyer, whose direct accountability is not to patients or the public, but to the Hospital Authority. Consequently, the financing and delivery of medical services may not necessarily be focused on the best interest of patients.

The policy of benign neglect can also explain some other problems in Hong Kong. This policy, de-facto, left the private health care sector to market forces with minimum government regulation (i.e. laissez-faire). For a free market to function properly, several conditions are necessary. The patients must have sufficient medical knowledge to make informed choices on physicians, hospitals, treatments and drugs. Moreover, the patients must have the time, and a clear mind to shop for the “best value for his money.” Unfortunately, international experience has long shown that these conditions do not exist sufficiently in the health care market. Under these circumstances, suppliers can obtain high profits by charging monopolistic prices as well as by compromising quality of health services.

1.5 Developing Options

1.5.1 Guiding Principles

Since resources are limited, every society must make trade-offs in its health care system when pursuing multiple goals, such as equity, efficiency, quality, and cost control. The benefits a society is willing to give up in exchange for other advantages will depend on its beliefs and values as well as on the prevailing political possibilities. The Harvard team worked with the Steering Committee to clarify the values underlying Hong Kong’s desired health care system, and the following guiding principle emerged:
Every resident should have access to reasonable quality and affordable health care. The government assures this access through a system of shared responsibility between the government and residents where those who can afford to pay for health care should pay.

The Basic Law specifies a principle for government budget. The expenditure and the revenue should be balanced. Budget deficit is to be avoided whenever possible. Over time, the budget should grow in commensurate with the growth rate of Hong Kong’s GDP. For the Harvard team to develop an analysis and strategic options for health system reform, the Finance Bureau has indicated that they would accept a working assumption that government spending on health care would grow in line with the overall growth in government spending. In other words, its share of health care financing would be kept at a constant share of GDP.

1.5.2 Objectives of Reform

Our recommendations are based on the premise that Hong Kong should further enhance its achievements and address the weaknesses of the current system, while upholding the above guiding principle. These factors were distilled into five specific objectives of reform:

- Maintaining and improving equity;
- Improving quality and efficiency;
- Improving financial sustainability by managing the government budget on health and by better targeting of government subsidies;
- Meeting the future needs of the population; and
- Managing overall health expenditure inflation.

1.5.3 Five Options

Hong Kong has a number of strategic options to improve its current health care system that vary by their capability to achieve different objectives. It would be very expensive and time consuming to have each option developed in detail. The cost-effective approach would involve two phases. First, the basic concepts and key operational aspects of various options should be developed in sufficient detail for public consideration. The Government of Hong Kong, civic leaders, residents and health professionals can then reach a broad consensus on which option or set of options is more desirable and politically viable. The second phase involves developing a detailed operational plan, benefit packages, and implementation requirements for these selected options. This study covered the first phase and developed five options for the government
and the public to consider. These options differ by their capability to achieve various objectives, but they are not necessarily mutually exclusive; some of them can be used as incremental steps to build the foundation for another option. This study presents basic concepts and sufficient operational details to allow the public to fully understand each strategic option.

In developing options, we significantly relied on international experience (see Special Report #2: International Comparison of Health Systems). No nation has a perfect health care system. More importantly, every society has its own history, culture, social values, health needs, politics, institutional base and management capability. We do not believe it is wise for any society to copy another society’s system. Instead, we tried to incorporate the best features of various systems which we think are viable and workable for Hong Kong. At the same time, we tried to learn from the failures of other nations so Hong Kong does not have to repeat them. For examples, Option D argues for mandated individual savings to fund long term care, an idea that comes from the experience of Singapore and Japan. The strategy to improve efficiency and quality by separating the HA’s dual role as the supplier-cum-buyer comes from the experience of the UK, Sweden, and New Zealand. Option E argues for developing competitive integrated health care systems, drawing upon the experience of the UK, USA, Germany and Australia.

A. Status Quo

One option for Hong Kong is to maintain the status quo. However, while the current system has many strengths, it also suffers from several serious weaknesses. The evidence gathered by this study indicates that avoiding change today will only postpone necessary change and exacerbate existing weaknesses. The status quo is neither financially nor organizationally sustainable in light of projected demographic, epidemiological and other changes. Attempting to maintain the status quo will not meet the objectives of managing the government budget for health care or better targeting government subsidies. Doing nothing will also forfeit the opportunity to overcome compartmentalization, improve quality and efficiency, meet the future needs of Hong Kong’s population, and manage overall health expenditure inflation.

B. Cap the Government Budget on Health

Capping the government budget may seem to be a straightforward way to meet the objective of managing the government health budget. That appearance is deceiving. Capping the government budget will lead almost inevitably to lower quality care and less access to public health services. The experience of Great Britain is instructive here. Capping the health budget in the U.K. led to exceptionally long queuing times for non-
emergency surgeries, explicit rationing rules, and under-investment in the renovation of facilities and certain medical technologies. In Hong Kong, capping would also be likely to compromise equity. Healthier and more affluent people will find the services provided in the private sector more and more attractive, and will purchase private health insurance to cover the private medical services. The public sector will then be left with the less healthy, the poor and the elderly. As the experience in the United States shows, the middle and upper classes will be reluctant to support public health services with adequate tax dollars, since they will not directly benefit from these services, and the public health sector will deteriorate. This option will also not address the objectives of improving quality and efficiency, and meeting the future needs of the population. Health services will continue to be compartmentalized.
C. Raise User Fees

Public hospitals and clinics can require patients to pay higher fees when they seek services. User fees can be raised across all services or only on selected services. In essence, this option shifts the burden of increasing health care costs from the government budget onto patients. According to our projections, the current fees will have to be raised considerably to keep the government portion of health care financing at a constant share of GDP. Such a large increase in user fees would require developing means testing mechanisms to identify those patients who should be exempt from paying user fees. When poor and low income people are exempted, the level of user fees would need to be even higher for those who can afford to pay in order for the government not to spend a larger share of its budget for health care. Currently, user fees paid by patients finance 3% of total public health expenditures. According to our estimates, 35% of public health expenditures will have to be financed by user fees by 2016 if the Government maintains its health expenditures at 2.5% of GDP. Given that the poor and low income population will be exempt, the burden to pay for 35% of public health expenditures will fall on the non-exempt population. This means that fees would have to be set so that they can recover 50-70% of costs.

Heavy reliance on user fees also ignores the efficiency and equity benefits of risk pooling. This is because with user fees, the sick pay more. In contrast, if the risks are pooled, the burden for paying for an episode of hospital care is distributed throughout the population. In addition, raising user fees by itself does little to address the objectives of improving quality and efficiency, meeting the future needs of the population, and managing overall health expenditure inflation. Moreover, the health care system will continue to be compartmentalized.

D. Health Security Plan (HSP) and Savings Accounts for Long Term Care (MEDISAGE)

This option consists of two separate components: individual savings accounts to be used to purchase long-term care insurance upon retirement or disability (MEDISAGE); and compulsory enrollment in an insurance (HSP) that protects people against unexpected large medical expenses, such as hospitalization and specialist outpatient services for certain serious chronic diseases during and after their working lifetime.

Under this reform option, Hong Kong residents will be required to contribute to an individual savings account, called a “MEDISAGE” account. Contributions to this account will be invested. Funds from MEDISAGE can only be used to purchase an
individual long-term care insurance policy upon retirement or disability. International experience indicates that contributions over the working life of an individual at the rate of 1% of wages may suffice to pay for a single-premium insurance policy for long-term care at age 65. If a worker dies before he reaches retirement age, the accumulated fund in his MEDISAGE account becomes part of his estate.

The benefit package for the HSP includes inpatient hospital services and specialist outpatient services for certain chronic diseases, such as cancer, diabetes, and stroke. Some provisions for patient cost-sharing are incorporated. It is designed to initially cost approximately 1.5 to 2.0% of workers’ wages, and employers and employees will pay jointly for the premium. Under the HSP, patients will be free to choose between public and private providers. The Health Security Fund, Inc. will be established to pool risks and serve as the informed purchaser of health services for the insured. It will be a quasi-governmental body that is supervised and managed by a Board with representatives from the government, employers, employees, and patient representatives. The Health Security Fund will pay a standard payment rate to any provider, public or private, that a patient chooses (that is, money follows the patient.) The “money follows the patient” concept means that regardless of whether patients seek public or private sector, outpatient or hospital services, their care will be paid for; it also means that patients will not have to use providers who do not satisfy their needs. Public health sector providers will not automatically receive funding from the government, as is currently the case. Under this option, the buyer/supplier functions are separated so that the Health Security Fund is directly accountable to patients and the public. Under this option, payment rates will be established through negotiations between the Health Security Fund and the representatives of providers.

When this option is fully implemented, most of the recurrent budget for inpatient services of the HA will be re-channeled to subsidize those who cannot afford to pay, and to fund more primary outpatient services and community medicine for poor and low-income people.

The HSP incorporates numerous features that work in combination to fulfill the six objectives for reform of Hong Kong’s health care system:

*Maintaining and improving equity:* HSP promotes risk pooling and provides equal insurance coverage to every resident. Everyone is assured of health care when needed, paying in when healthy and receiving care when ill. For those who cannot afford to pay, the government provides full or partial subsidies; for those who can afford to pay, everyone pays an equal percentage of their income for HSP. With “money following the patients”, effective choice is assured.
Improving quality and efficiency: “Money following patients” provides a level economic playing field between public and private providers. Neither the public nor the private sector is given financial advantage, thus promoting fair competition between the two sectors. It also reduces the compartmentalization of health service delivery. The Health Security Fund will provide accountability to patients and public, and serve as a balance to the professional dominance of the providers. The likelihood that patients’ interests are protected is increased by separating the purchasing and provision functions in the health system.

Improving financial sustainability:

- Managing the government budget on health: Various built-in “control knobs”, such as negotiated payment rates and demand side cost sharing, help to manage the government budget. The separation of purchasing from provision with “money following the patient” also lays the foundation for fair competition between public and private sector providers and improves accountability and efficiency.

- Better targeting of government subsidies: Government resources are targeted to fund more preventive, rehabilitative, and ambulatory services for the poor and low-income population. The government also pays the full HSP premium for those who cannot afford to pay, subsidizes premiums for elderly and lower income residents, and pays the cost-sharing requirement for poor and low-income households. Separating the financing and provision roles of the Hospital Authority makes it possible for government to target public resources to those who cannot afford to pay by subsidizing their premiums. In this way, public health services, which are currently heavily subsidized and benefit both the rich and the poor, will be targeted to benefit only those who cannot afford to pay.

Meeting the future needs of the population: The MEDISAGE component of this option will enable the frail elderly to live at home with home care services paid by long-term care insurance benefits. MEDISAGE enables individuals to plan for their financial needs in their old age, and helps to meet the changing needs of Hong Kong’s aging population, while simultaneously limiting the government’s liability. Government resources can continue to target those least able to pay for themselves.

Managing overall health expenditure inflation: This option incorporates the following features to manage overall health expenditure inflation: a) the separation of purchasing and provision to improve efficiency and accountability; b) negotiation on payment rates to control cost inflation; c) “money follows patients” to promote efficiency through fair
competition between public and private providers; d) deductibles and co-payments to moderate consumer demand.

E. Competitive Integrated Health Care

This option features prepaid integrated health care, including preventive, primary, outpatient, hospital and rehabilitative care. The financing arrangements and many other features of the HSP+MEDISAGE option will remain. For example, the Health Security Fund, Inc. will continue to operate; money will follow the patient; payment rates will be established through negotiations between the Fund and providers; the government subsidy of the Hospital Authority will be shifted to pay premiums for the poor and to subsidize premiums for low income residents; employers and employees will pay their own premiums.

The main difference from HSP+MEDISAGE is that under the integrated health care option, the HA will be reorganized into 12 to 18 regional Health Integrated Systems (HISs) that can contract with private GPs and specialists (or physician groups) to provide a defined benefit package that will include preventive, primary, outpatient and hospital care. Similarly, private hospitals and physician groups can also form integrated systems to provide the defined benefit package. Under the Competitive Integrated Health Care option, either hospital- or GP-based integrated care systems, providers are responsible for monitoring quality of services. Unlike managed care, there are no intermediaries overseeing and second-guessing providers’ treatment decisions; instead, providers themselves will balance costs and quality in delivering services to meet patient needs. In addition, with regulations and “money following the patients”, there will be some external check and balance.

The Competitive Integrated Health Care option shares all the HSP+MEDISAGE features in achieving the objectives of Hong Kong’s health care system with one additional advantage. By providing integrated care, this option removes the compartmentalization of health services and offers high quality health care and greater efficiency in treating chronic diseases, thereby meeting the future needs of a population with an increasing prevalence of chronic illnesses.

In Table 1.1 below, we summarize the key features of options D & E and their contributions to meeting the reform objectives. In Table 1.2, we compare each option with the status quo and gave a brief qualitative assessment.
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<th>Mandate compulsory insurance</th>
<th>Include deductible and coinsurance</th>
<th>Include payment rates negotiation between providers and the HSP Fund, Inc.</th>
<th>Reallocate government budget to primary care, for the poor, unemployed</th>
<th>Mandate compulsory individual savings accounts for long-term care</th>
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<tr>
<td>- Managing government budget for health</td>
<td></td>
<td>Poor</td>
<td>Slightly improved</td>
<td>Slightly improved</td>
<td>Significantly improved</td>
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<td>- Better targeting government subsidies</td>
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<td>• Meeting future needs of the population</td>
<td></td>
<td>Poor</td>
<td>Unchanged</td>
<td>Unchanged</td>
<td>Moderately improved</td>
<td>Significantly improved</td>
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<tr>
<td>• Managing overall cost inflation</td>
<td></td>
<td>Fair</td>
<td>Unchanged</td>
<td>Slightly improved</td>
<td>Moderately improved</td>
<td>Moderately improved</td>
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1.6 Recommendations

Our recommendations are based on the guiding principle to assure each resident access to “reasonable quality and affordable” care. We have also carefully considered the evolving needs of the population, and the institutional preconditions and political feasibility of alternative options. Given these guidelines, we recommend that Hong Kong adopt the Long Term Care Savings Accounts (MEDISAGE) and Health Security Plan (HSP) option in the interim. This option provides the base and flexibility to develop a system that will coordinate the strengths of the public and private sectors and pave the way for the Competitive Integrated Health Care option. In the long run, the Competitive Integrated Health Care option would be the most appropriate for Hong Kong. However, establishing such a system requires major changes in infrastructure, organization, and capacity building in information management, and should be implemented gradually over an extended period of time.

1.7 Steps Forward

For illustration purposes, we outline steps that the government could consider to move towards a better health care system for Hong Kong in the immediate future.

- Consult with the public on its priorities and how it sees the roles of government, the Hospital Authority, the private sector, primary care and Chinese medicine with the public;

- Establish an Institute for Health Policy and Economics to conduct objective and rational analyses and to monitor the system’s performance;

- Strengthen the Department of Health to conduct patient assessment and to promote quality assurance and patient education;

- Improve the accountability of medical practices by conducting external quality audits; establish a Committee on Quality Assurance with participation from the medical school faculty; set up an Ombudsman Office; and conduct inter-hospital outcome comparisons.

- Raise user fees for “new” public health care products, such as “green lines” with shorter waiting times, better amenities, and choice of doctors;

- Implement long term care savings accounts (MEDISAGE);
• Expand primary outpatient services to poor and low income residents, and promote the development of Family Medicine;

• Conduct pilot projects to promote integration between primary and tertiary care and the public and private sectors by contracting out certain service such as Maternal and Child Health (MCH) Services in a particular region, or specific services which currently have long waiting lines at Hospital Authority facilities.

• Experiment with tax incentives to encourage employers to purchase integrated health care for employees and dependents; and allowing the Civil Service Bureau to purchase integrated health care for civil servants;

• Phase in the Health Security Plan (HSP) through a gradual expansion of benefits, on the one hand, and a gradual expansion of the population groups covered by HSP, on the other.

1.8 Institutional Requirements

As noted above, we recommend that

• the government create and fund an Institute for Health Policy and Economics linked to the major universities;

• the Health and Welfare Bureau needs to expand its professional staff who have mastered the complexities of financing and organization of health care in order to fulfill its policy role and to monitor the execution of government by using the analysis and information produced by the Institute.

• the Department of Health establish a separate Office of Quality Assurance to develop practice guidelines, conduct regular independent patient surveys, disseminate useful information to the public, etc.

• the government select and contract with health providers for maternal and child health services and for selected surgical procedures. To carry out this purchasing function, a separate office within the government has to be established, or this function has to be contracted out to private organizations;

• the government should appoint a top-level Commission charged with guiding and monitoring the progress in transforming the health care system in Hong Kong if option D (HSP and MEDISAGE) or E (Competitive Integrated Health Care) is adopted. In addition, the Health Security Plan, Inc. has to be established to
manage the insurance funds and serve as the informed purchaser of health care for the insured under the Health Security Plan.

In conclusion, Hong Kong can take pride in its system of health care where every resident has reasonably equal access to essential health care, and in the cost-effectiveness of the health care system that is equal to its neighboring Asian nations and better than many European countries. The current arrangement of financing and delivery of health care has served Hong Kong quite well. On the other hand, the present organizational structure, the role of the government and use of resources are outdated. Rapid changes in epidemiological conditions, advancements in health practice and organization over the past decades have contributed to the need for change. This study found that the public interest and patients’ health will not be best served by the current system in the future; the structure of the system has to be reformed. As the experience of putting the Hospital Authority into effective operation, or reforming the National Health Services of the UK. has shown, it will take more than a decade to effectively implement major structural changes. The longer those reforms are postponed, the higher the costs.