Response to
Voluntary Health Insurance Scheme Consultation Document

submitted to
Food and Health Bureau

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The views expressed in this submission are the personal views of the author, and do not represent those of the organisation to which the author is affiliated. All errors and omissions are the author’s own.
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I. Introduction

1. Having submitted my views in response to the first stage Healthcare Reform Consultation Document “Your Health Your Life”\(^1\) and the second stage consultation “My Health My Choice”\(^2\), I appreciate the opportunity to respond to this final stage consultation, in the hope that my views will be taken into consideration.

2. In this submission, I reiterate my previous proposals for tackling the financing issues on multiple fronts. Alongside my discussion on the deficiencies surrounding the proposed Voluntary Health Insurance Scheme (VHIS), I recommend other alternatives. Some of my recommendations are drawn from my previous submissions.

3. This paper is structured as follows. In Section II, I draw a distinction between healthcare and health insurance, followed by a focus on primary prevention to combat lifestyle-related diseases and some chronic illnesses. I discuss in Section III why it is a misguided policy to rely on regulated insurance to adjust the public-private imbalance, ration demand and redistribute resources. I discuss in Section IV the potential drawbacks of the proposed VHIS and the related question of sustainability. On the proposition that insurance is to be employed as a supplementary financing arrangement, I argue in Section V that the better route is to adopt “carrot and stick” measures to encourage voluntary group insurance, rather than regulating voluntary individual insurance. In Section VI, I applaud the development of Hong Kong’s first not-for-profit and self-financed teaching hospital. I recommend in Section VII simple measures to increase revenues: raising tax, increasing fees for inpatient hospitalisation and introducing third class wards. Section VIII concludes.

II. Healthcare and health insurance

Distinctive concepts

4. First of all, I would like to draw a distinction between healthcare and health insurance. Healthcare is the management of health conditions and the treatment of illnesses to restore individuals to normal health. Health insurance is a protection against the financial risks associated with meeting healthcare expenses. Without health insurance, healthcare expenses need to be met out of pocket. If private healthcare services turn out to be cost-prohibitive, one has to rely on the heavily subsidised public healthcare services.

5. In theory, the availability of health insurance will shift healthcare demand from the public sector to the private sector. Insurance works by pooling risks. It is financially sustainable only if it consists of a mixture of risks, where the healthy policyholders draw fewer benefits than their cumulative premiums payment. In other words, there must be both healthy and unhealthy policyholders in the same insurance pool such that the healthy subsidise the unhealthy. It is a privilege to be healthy to subsidise the unhealthy in premiums, provided that the premiums are fairly priced and affordable.

6. It is important to note that health insurance does not reduce healthcare costs, whether incurred in the private or public sector. If public healthcare services are difficult to

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\(^1\) My submission is available www.fhb.gov.hk/beStrong/files/individuals/I1070.pdf.

sustain because of escalation in healthcare costs, the escalating healthcare costs will also drive up insurance premiums to a cost-prohibitive level for some policyholders and shift them back to public healthcare services. It is illusive to anticipate that health insurance will be part of a solution for resolving financing issues.

**Cost driver analysis and policy response**

7. As described in paragraph 1.4 of the VHIS consultation, a combination of factors contributes to the rising demand for healthcare services and the escalating medical costs: an ageing population, more common lifestyle-related diseases and advances in medical technology. However, analysis is lacking as to the significance of each of these cost drivers, which have different policy implications.

**Ageing population**

8. For an ageing population, the majority of healthcare expenditure is not spent on the elderly suffering from arthritis or dementia. These conditions are treated with or alleviated by drugs and medications, very often without the need for hospitalisation. As such, the regulation of hospitalisation insurance may not be a targeted response.

**Common lifestyle-related diseases**

9. Common lifestyle-related diseases such as colon cancer, lung cancer, diabetes and congestive heart failure, stroke, hypertension etc are caused by obesity, smoking and other poor lifestyle choices. Many of the cancer-related illnesses require inpatient care and follow-up treatments. They are significant drains on resources. As such, the VHIS may be a corresponding response.

10. Many lifestyle-related diseases require diligent follow up and patient compliance. Outcomes are doomed when patients fail to adhere to medication regimen, fail to alter their lifestyles and fail to return for follow-up. They cause multiple health problems and heavy demand on medical resources. A more effective and outcome-oriented approach is primary healthcare. Primary healthcare can reduce the risk factors and prevent occurrence of the illnesses through lifestyle changes as simple as healthy diets and regular exercise. Indeed, lifestyle-related diseases and also a large portion of chronic illnesses are preventable through the reduction of major behavioural risk factors, such as tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity.

11. Healthcare includes different interventions - some resource intensive while others inexpensive. There is more to healthcare than therapeutic care. Economic benefits are derived from clean air, improved sanitation, improved nutrition and food safety, and immunisation against preventable diseases. An important impetus for lifestyle changes is through promoting healthcare literacy. I find it disturbing that healthcare seminars are seldom hosted by the Government, but mostly by the pharmaceutical sector that has vested interests. Pharmaceutical companies’ publicity initiatives (or in a more subtle way, through healthcare presentations etc) drive demand for new prescription drugs and treatment, which are very expensive.
Advances in medical technology

12. Advances in medical technology do bring about accuracy in diagnosis and effectiveness of treatment. But if the improvement in diagnosis and treatment is only marginal with costs substantially driven up, it is not cost-efficient.

13. It is hard to resist the temptation to exploit technology to the full. A delicate issue is quality of life versus quantity of life. Technology has made the choice ethically difficult. While prolonging life by a few months for a terminal cancer patient is statistically significant from the perspective of healthcare providers, this does not by itself speak about the quality of life for the patient. When life is extended beyond the natural limits set by physiology, this is often done with medications, equipment and procedures. Costs aside, this is only about survival but not quality.

Child obesity and drug abuse

14. A cost driver analysis is incomplete without mentioning child obesity and adolescents abusing drugs. Healthcare expenditure can be substantially saved tomorrow if the issues of child obesity and drug abuse are markedly reduced today. The challenge is how to encourage healthy eating habits, exercising and staying away from drugs, and to mobilise abusers of drugs to commence and adhere to drug therapy programs.

III. Regulation of individual indemnity hospital insurance

Objectives of VHIS Proposal

15. The Food and Health Bureau (FHB) clearly states in paragraph 8.1 that the VHIS “aims to facilitate choice of private healthcare services by providing better insurance protection to those who are willing and can afford private healthcare services … thereby better enabling the public sector to focus on serving its target areas and enhancing its services”. Implicit in these objectives is the rationing of demand, which also aligns with the Government’s role in redistribution of resources across income groups. If insurance is a means to achieve such purposes, it is public but not private insurance that should accomplish this social goal of redistribution. The private insurance sector comprises lucrative but not charitable undertakings.

The better-off paying twice for their healthcare

16. In fact, the simplest means to achieve distribution is through taxation, or earmarked “tax” payment in the context of healthcare, as I suggest in my previous submissions. Raising tax may introduce inefficiency, but taxation is a flexible instrument that does not oblige the public to long-term commitments. While the VHIS is targeted at the middle-income group with better financial means, it is worth noting that those with better financial means are paying twice for their healthcare. They pay once in the form of tax to finance the public system, and pay twice when their healthcare needs are practically met by private healthcare and health insurance.

17. According to the Thematic Household Survey Report (THSR) No. 50 published in January 2013 (covering survey period between October 2011 and January 2012), 3.12 million people have medical benefits and/or health insurance coverage, representing 46.3% of the total population. These comprise of employer-provided medical benefits
(1.29 million, or 41.2%), individually purchased insurance (1.07 million, or 34.2%) or both (0.77 million, or 24.6%). It appears that the majority of those who can afford their own healthcare already have insurance coverage, without relying on public healthcare services. Besides, there is also handsome growth in the uptake of insurance in recent years with neither incentives nor sanctions.

**Over-stretched healthcare services**

18. Hong Kong’s dual-track healthcare system seems not very balanced. According to the Hong Kong’s Domestic Health Accounts 2010/11, Hong Kong’s total health expenditure amounts to some $93.4 billion. The public and private health expenditure share $45.5 billion (48.7%) and $47.9 billion (51.3%) respectively. As such, the share of the public is roughly the same as that of the private in terms of financing. But in terms of the number of bed days in inpatient service, the public sector shoulders 90% of hospitalisation. The FHB indicates that the public health sector is so over-stretched that warrants shifting some demand to the private sector.

19. I find this unconvincing. In terms of hospital beds available in end-2013, the numbers are 27,400 (87.6%) and 3,882 (12.4%) in public and private hospitals respectively. As hospital beds cannot be expanded in a short period, the private sector is hardly able to accommodate demand shift from the public sector. In fact, the figures seem to suggest that the public health sector is much more productive. As such, its services should be expanded to respond to increasing demand. The public health expenditure is currently less than the private. There is no reason why the Government should not shoulder a bit more financial responsibility, but pass the buck on.

**Adjustment of public-private imbalance**

20. THSR No. 50 estimates that some 483,300 persons have been hospitalised during the 12 months before enumeration of the survey. Of these 483,300 persons, some 42.2% have employer-provided medical benefits and/or individually purchased health insurance. Their total number of hospital admissions during the said 12 months is 649,000. Analysed by type of hospitals admitted, some 501,300 (77.2%) admissions pertain to public hospitals. The FHB considers that better health insurance coverage will shift some policyholders to private inpatient services. It therefore puts forward 12 Minimum Requirements in the VHIS.

21. On a closer look at the figures, 58.6% of the 483,300 inpatients have chronic health conditions that necessitate much higher hospitalisation rate (15.0%) than the remaining 41.4% inpatients without chronic conditions (4.1% hospitalisation rate). As such, the Minimum Requirements may not be able to have the effect of shifting demand if they are not catered to the needs of policyholders with chronic health conditions.

22. As regards health insurance provisions, some policies provide hospital cash allowance in the form of fixed cash benefit paid for each day of hospitalisation in public hospitals, in addition to recovery on indemnity basis. Such additional hospital cash allowance, while not prohibited under the VHIS, may incentivize policyholders to elect public inpatient services. I would suggest such hospital cash allowance be prohibited under indemnity hospital insurance.
Insurance sector as intermediary

23. It must be borne in mind that increased insurance coverage will contribute to escalation in healthcare expenditure, because of supply-side price inflation and demand-side increase in utilisation. On the supply side, some private practitioners (especially those in solo practice) and diagnostic laboratories do charge higher fees on patients with insurance coverage than on those without. Even if the ethical standard upheld by the medical profession as a whole in Hong Kong is quite high, the practice of some physicians making a quote on the basis of insurance coverage, or allocating the fee categories in such a way as to maximise a policyholder’s claim and hence its own charges, is bordering on the unethical. On the demand side, the policyholders are inclined to opt for more expensive treatment, investigative procedures and medications on the misconception that more expensive treatment leads to better outcome.

24. Without regulating the healthcare sector, it is a misguided policy to regulate the insurance sector alone. A complex regulatory scheme involving the insurance sector as intermediary has long-term implications and little flexibility. Regulatory measures can be cumbersome, and the costs of regulation (in terms of administration, monitoring and enforcement) can be high, and will also come from the public purse.

IV. The proposed VHIS

Minimum Requirements at a cost

25. In proposing the VHIS with 12 Minimum Requirements, the FHB has in fact set a threshold below which enrolment is denied. Indeed, all the features that are considered superfluous by discretionary policyholders are not without cost, but offered at the expense of an otherwise higher surgical limit or lower premium.

High risk pool

26. To support the feature of guaranteed acceptance, policies of high-risk individuals with assessed premium exceeding three times of the relevant age-banded premium would be transferred to the high risk pool (HRP). Therefore, the HRP comprises of policies with inadequate premium income, and is inherently not self-sustaining. The HRP would be financed by premium income and the Government’s injection of funds.

27. It is indicated in the consultation paper that the Government will inject $4.3 billion into the HRP, which according to its estimate, will be sufficient for running the HRP for 25 years. The reliability of this estimate is very much subject to sensitivity analysis, which is not provided for in the VHIS consultation. I wonder if the Government has contingency plans ready or extra funding available in case the $4.3 billion injection is fast depleting.

Guaranteed renewal without re-underwriting

28. Guaranteed renewal without re-underwriting seems a very attractive feature. This especially benefits those whose health conditions deteriorate substantially a few years after joining the VHIS. But it has the effect of underwriting some policyholders at a level that they do not deserve, as their health deteriorates by ageing or poor lifestyle etc. The premiums will in turn escalate across the board at a faster rate than will otherwise.
High premiums will turn away the young and healthy. How can the Government ensure that the inferior risk will not drive away the good risk to the extent of threatening the sustainability of the VHIS?

29. The longstanding healthy VHIS policyholders face a dilemma. They are paying an escalating premium for a clean record of claims, which is not worthwhile. The financial burden is especially heavy for those without ample financial means. But if they do not renew the VHIS policy, they will later be subject to re-underwriting when their health subsequently deteriorates. The guaranteed renewal appears very attractive, but put some policyholders at a dilemma.

Cost-sharing restriction

30. The VHIS prohibits cost-sharing arrangements (deductible or co-insurance) in Standard Plan, except for a list of prescribed advanced diagnostic imaging tests necessitated by assessed medical conditions, which are subject to a prescribed rate of 30% of co-insurance with an annual cap of $30,000.

31. The cost-sharing restriction appears attractive to some policyholders. But it handicaps the insurers’ ability to use the tools of deductible and co-insurance to combat moral hazard. It is unconvincing why the cost-sharing restriction is dictated to the market, without variations among competing insurers.

32. It is also doubtful whether “no cost-sharing” caters to the need of individuals who wish to pay a low upfront premium in return for making a deductible and co-payment when requiring hospitalisation in future. Price conscious individuals with a healthy lifestyle will favour deductible or co-insurance, in return for a higher surgical limit in case of surgery.

Surgical limit on Standard Plan

33. The surgical limit of $58,000 (including surgeon, anaesthetist, operating theatre) in the illustrative outline of benefit schedule of Standard Plan is modest at best. How can such surgical limit attract and retain the young and healthy? After having paid insurance premiums for decades, such a policyholder if suffering from a condition that necessitates hospitalisation, will find his coverage inadequate, to be heavily subsidised by out-of-pocket payment.

34. For example, a policyholder takes out a policy at age 20, and continues renewal of the policy without interruption, and maintains healthy lifestyle and requires surgery once at age 50. His cumulative premium over 30 years (from age 20 to 49) is already $85,500, but his maximum surgical claim is only $58,000. Is this value for money? Even if he requires surgery 10 years earlier, at age 40 instead of 50, his cumulative premium over 20 years (from age 20 to 39) is $45,250. Does a claim of $58,000 sound attractive?

35. An individual’s optimal level of insurance coverage depends on his risk aversion and expected utility, constrained by financial means. In making a rational choice on whether to take out hospitalisation insurance, an individual will discount the value of

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Cost-sharing arrangements have no bearing of major surgeries where the total charge far exceeds the surgical limit.
coverage by putting an expectation value on his need for hospitalisation. Assuming zero inflation, a surgical limit of $58,000 is worth only $11,600 to an individual who considers himself as having a 20% probability of ever requiring surgery. If inflation is added to the calculation, there is much less incentive for hospitalisation insurance as medical inflation is invariably higher than the inflation in consumer prices.

Portability

36. Portability will possibly induce uniformity in price and service level in the insurance sector, in an efficient market with low search cost for information. But market friction in an imperfect market renders this not very likely.

37. An insurer with a large portfolio of network physicians may have many policies ported to it. This insurer is obliged by its predecessors’ assessment of underwriting class, even if being financially prejudiced. The costs borne by an acquiring insurer to accommodate policyholders arbitrating between insurers will be disproportionately shared by the acquiring insurer’s longstanding policyholders. It will eventually result in higher premiums for all policyholders.

38. As a suggestion for reducing a policyholder’s motivation for arbitrage, a discount should be applied to the policyholder’s served waiting period for pre-existing conditions. That is, the served waiting period is ported along at a discount. For example, 3.75 years of served waiting period is counted as 3 years at a 20% discount; and 4 years of served waiting period is counted as 3 years at a 25% discount.

Packaged prices

39. When private hospitals offer certain services at packaged prices, a patient seems to have choices among packages offered by different hospitals. However, when the benefit limits are regulated in the VHIS Standard Plan but the healthcare market not regulated by the Government, it is too idealistic to expect value-for-money healthcare packages on offer. Indeed, the wide price dispersion of private healthcare services is indicative of non-competitive healthcare market.

40. Common procedures and surgeries such as endoscopy and cataract surgery may be good candidates for packaged prices. Indeed, cataract surgery is mostly offered as a package by the private sector under the public-private-partnership (PPP) programme. Endoscopy is also a good candidate for PPP initiative with packaged pricing. However, the variations and complexity of most other treatments may render packaged pricing difficult.

41. Besides, renowned or experienced physicians seldom or rarely offer packaged prices at the premium-priced hospitals with which they maintain practising privileges. These physicians are also keen to limit their services to very few hospitals, so as not to dilute their well-established relationships. By limiting the number of servicing hospitals, they also save much precious time in terms of commuting between their specialist clinic and the hospitals. As such, price-conscious policyholders relying on packaged prices may find very limited choices on offer.
V. “Carrot and stick” on group insurance

42. If insurance (despite the deficiencies) is to be employed as one of the financing options, the better route is to encourage enterprises (coupled with incentives and sanctions depending on headcount\(^4\)) to provide group insurance for their staff, rather than promoting VHIS for individuals. The logic behind incentives is that enterprises with a small headcount may be less motivated (perhaps also less able to afford) to procure group insurance for their staff. The consideration underlying sanctions is that enterprises with a large headcount are attractive clients to potential insurers, and will have the bargaining power to negotiate coverage for their staff at favourable terms.

43. The “carrot and stick” measures adopted in Australia can be modified and applied to Hong Kong enterprises to encourage voluntary group health insurance. As a suggestion, incentives should be available to small and medium enterprises (SMEs)\(^5\) with a headcount of say below 30 employees, and sanctions be applied to enterprises with a headcount of say over 50 employees, regardless of the business or industry sectors. Enterprises employing between 30 and 50 employees are at liberty, with neither incentives nor sanctions, in the procurement or otherwise of group insurance for staff members.

44. As incentives, I suggest a rebate of say 20% of the group insurance premiums. SMEs not making profits in some financial years will still benefit from the rebate. As sanctions, it can take the form of levying a surcharge of say 0.5% on the taxable income\(^6\) of enterprises (answering the headcount criterion) that have failed to take out group insurance for staff members. The revenues from this surcharge can contribute towards making rebates to SMEs, or be channelled back to the public healthcare system.

VI. Self-financed teaching hospital

45. In my previous submissions, I have suggested introducing self-financed public hospitals to bring downward pressure to bear on private healthcare fees and drive cost-efficiency. I am glad to learn that the Chinese University of Hong Kong (CUHK) has received a donation to develop Hong Kong’s first not-for-profit and self-financed teaching hospital. I anticipate its charges to set a benchmark for the healthcare sector.

46. It must however be cautioned that “not-for-profit” is a misnomer. Any economic entity must make profits in the long run, otherwise it will fail. The expression “not-for-profit” means only that its shareholders are prohibited from sharing the profits, but to invest them into the undertaking. As such, a “not-for-profit” teaching hospital may have every incentive to make handsome profits to finance its teaching and research activities. If the Government provides loans to the CUHK Teaching Hospital to partially finance its development, I suggest that the loans be offered subject to a scrutiny on its profit margins.

\(^4\) In the context of applying sanctions or incentives to the procurement of group insurance, headcount is a logical basis for demarcation because an enterprise with a large headcount possesses the bargaining power to negotiate value-for-money coverage for its staff.

\(^5\) SMEs are usually defined in terms of assets or number of employees, without a uniform definition across different economies.

\(^6\) Enterprises with a large headcount but not making profits will not be penalised.
47. A benefit that can accrue from teaching and research activities is the provision of training for healthcare professionals. A new hospital, without the legacy of entrenched bureaucracy, can develop its own work culture which is stimulating, facilitating and supportive. It is hoped that the CUHK Teaching Hospital will groom young talents and offer them wide training opportunities and well-structured paths for achieving proficiency in selected specialties.

VII. Tackling financing issues on multiple fronts

Raising tax

48. The healthcare needs of the population should not be compromised for the sake of maintaining a low-tax regime. Between raising tax across the board and imposing the financing burden solely on the working population, the former is a more preferable means of wealth re-distribution.

49. Profits tax is charged on net profit at a flat rate, so the extra tax increase of say 0.5% borne by corporations is uniform across all enterprises, big or small, as long as they make profits. Alternatively, a progressive rate (say in two tiers for simplicity) can be introduced to the profits tax, where the profits of an enterprise exceeding a certain threshold will be taxed at 1% higher than the current rate. This is a simple way for enterprises making big profits to share the fruits of their success with the community, while SMEs making profits below the threshold are unaffected in tax payment.

50. In terms of salaries tax, a standard rate is charged on net income for high-income groups and a progressive rate on net chargeable income for low- and middle-income groups. If high-income groups need to share a bigger slice of the increments, this is exactly behind the logic of wealth re-distribution, as long as it does not impose an excessive burden on a particular income group. How best to take into account the financial implications on different income groups is a matter of design. A possible balance may be struck by, say raising the salaries tax by 0.5% on the standard rate and by 2% on the third tier of the progressive rate.

51. For the Provisional Salaries Tax rates in 2014-15, the standard rate is 15%, and a 0.5% increment is unlikely to be an excessive burden on this high-income group. For the progressive rate, the first tier is 2% on net chargeable income below $40,000, and the second tier is 7% on net chargeable income of $40,000 to $80,000. To exempt the low-income group from additional tax burden, these two tiers should remain unchanged. Taking into account the overall financial implications, a 2% increment should be imposed only on the third tier (raising it from 12% to 14%), while leaving unchanged the final tier of 17% on net chargeable income above $120,000. On this basis, income groups having net chargeable income more than $80,000 will each pay an extra tax up to $800, which is unlikely to be an excessive burden on these income groups.

52. Taxation is actually a flexible instrument in the allocation of resources, without unnecessarily imposing long-term financial burdens on the future generations, as tax rates are reviewed annually. An instrument for general wealth re-distribution, taxation is however not specific to any social cause. If raising tax is one of the options adopted for healthcare financing reform, the difficulty is how to ensure that the additional tax
raised will not be diverted to other purposes. This is one of the reasons why the general public is averse to raising tax when under-financing on a particular worthwhile cause is identified. To ensure that the proposed tax raised is earmarked for healthcare purposes, the Government should set up a healthcare fund (without undermining its financing pledges on increasing healthcare expenditure), designated for specific purposes. The healthcare fund can be employed for multi-purposes such as annual capacity expansion for preventive care and health literacy, inpatient curative care and investment in medical facilities.

**Increasing fees**

53. When resources are over-stretched, access to healthcare services will be compromised. Equitable access through queuing is an illusion when the queue is exceedingly long. The long waiting list deters those who can afford private care (willing to pay out-of-pocket or being insured) from access to public healthcare services. This has the effect of according priority only to those with limited financial means, and is hardly equitable in the real sense. A counter-effect of the VHIS is that a VHIS policyholder may be prejudiced by the triage for public healthcare services, given that he is arguably in a better position than another individual with similar financial means but without any insurance coverage.

54. While it is anticipated that public healthcare services will remain highly-subsidised overall and provide a safety net for those struck by catastrophic or chronic illnesses, it does not necessarily follow that the level of subsidisation should remain as high as 95% overall and 97% for public beds. If the sustainability problem is partly attributable to high subsidisation, it is logical to raise fees slightly to alleviate the difficulty.

55. For public wards, at the current fee level of $100 per day, the fee is too low almost by any standard. It is even lower than the accommodation rate for elderly residential care homes. At such level, it is unlikely to promote judicious use of resources. Indeed, some insurers even offer cash allowance for policyholders in addition to eliminating the co-payment if they elect services from public hospitals. By raising fees for public wards, it will increase the insurers’ costs in such inducement.

56. I suggest increasing the all-inclusive public ward fee to $500 per day for the first ten days of hospitalisation and $200 per day thereafter. This increase is unlikely to impose excessive financial burden on patients requiring long hospitalisation, nor compromise public healthcare.

**Introducing third class wards**

57. For hospitals managed under the Hospital Authority, there is very little differentiation of ward classes (except the $100 public beds and $2,600 or $3,900 private beds, without any other tiers in between). The middle-income group who can afford and are willing to pay a bit more for better amenities will be denied access to the public health sector. They are turned away by the long queue for public beds but are unable to afford private beds.

58. To cater for these patients, it is worth exploring the differentiation of ward classes. The flat rate for public beds at 97% subsidy is not conducive to rationing demand. I suggest
introducing a third class ward to be charged at a cost-minus basis (say with a subsidy of 20%). The third class wards should provide only marginally better amenities than public wards in terms of fewer patients sharing a ward, but without the choice of physicians. To make the cost structure simple and fees predictable, surgical operations on third class wards should be charged (but still with some subsidy) at three levels of complexity, say minor, semi-major and major.

59. With a much reduced level of subsidy and without the choice for in-patient doctors and surgeons, the third class ward is likely to have a much shorter queue than the public ward, but can cater for those who would otherwise be turned away by the long queue. Such third class ward not only reduces the financial pressure on public resources (as the level of subsidy is small), but also brings downward pressure to bear on private healthcare fees.

VIII. Conclusion

60. There is more to healthcare than therapeutic care, and healthcare is distinct from health insurance. Some attention should be drawn to role of primary prevention, such as healthy eating habits, exercising and staying away from alcohol and drugs, to combat lifestyle-related diseases and some chronic illnesses. In terms of achieving financial sustainability for healthcare, there is no easy route, but simple measures such as raising tax, increasing fees for inpatient healthcare and introducing third class wards are viable means to increase revenues without jeopardising the safety net. The initiative taken by CUHK to develop a not-for-profit and self-financed teaching hospital is laudable. Its professional fees and service quality can set a benchmark for the healthcare sector.

61. The proposed VHIS is a timely opportunity to stimulate discussion on the regulation of the health insurance sector. But it is illusive to anticipate that insurance will resolve healthcare financing. As an instrument for financial risk allocation, health insurance will impose long-term financial burdens on the policyholders. In regulating health insurance without scrutinising the healthcare cost escalation, the proposed VHIS is inherently deficient. This warrants particular caution because it can distort the market to the extent of no return. The Government is well advised to have contingency plans ready, in case the VHIS is not sustainable, with healthcare expenses escalating, healthcare insurers exiting and individuals falling back on the public health system.