The Politics of Health Care Financing Reforms in Hong Kong: Lessons of the Tung and Tsang Administration

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Abstract

The purpose of this study is to examine the politics of health care financing reforms in the Hong Kong Special Administrative Region (HKSAR). It argues that health care financing reforms in the HKSAR are shaped by the dynamic interaction of three forces — political institutions, policy-makers' strategies, and stakeholder engagement. This study shows that health care financing reform is a political process revealing an intricate interplay of power relationships and diverse interests. It yields some useful lessons for reformers in other countries.

Keywords: political institutions, policy feedback, policy ideas, dynamic interaction

Introduction

Health care financing reform is one of the policy domains central to the welfare states and a major international concern. Governments and policy-makers worldwide are facing a major challenge in balancing sustainable and equitable funding for health care with available resources (Figueras *et al*., 1998, p. 7). Driven by the need to contain costs, governments desire to find alternative options for generating financial resources for health care (Lee and Goodman, 2002, p. 97). Governments in Western welfare states strive to use their financial resources effectively and contain health care costs by introducing elements of market and competition to their health care systems, albeit to varying degrees and by different methods. Like their western counterparts, governments in Asia are under great pressure to reform their health care systems because of limited funding and rapid health care cost escalation caused by ageing populations, increasing health care demand, and technological advancement (Gauld, 2005, pp. 4-5). They have embarked upon a sustained process of health care financing reforms. But these reforms vary considerably in terms of the pace and scope due to cross-national differences in health care systems, institutional arrangements, history, and values. In Hong Kong, implementing health care financing reforms is a slow and winding process. From the early 1990s onwards, the government in Hong Kong has proposed different options to reform the health care financing system. After failing repeatedly, the Hong Kong Special Administrative Region (HKSAR) government in 2010 proposed the implementation of a government-regulated voluntary private health insurance scheme

called Health Protection Scheme (HPS), with the purpose of encouraging those who are able and willing to pay to use private health care services. Without facing stiff political and public opposition this time, the government plans to draft and introduce HPS legislation as appropriate and implement HPS in 2015 the earliest (Legislative Council Secretariat, 2012, p. 2).

The Hong Kong government is not alone in having difficulty reforming its health care financing system. International experience shows that implementing health care financing reform is an ongoing effort. Health care financing reform is "more than the technicalities of raising and allocating financial resources" (Blank and Burau, 2007, p. 63). Instead, it is a political process revealing an intricate interplay of power relationships and diverse interests. The purpose of this study is to examine the politics of health care financing reforms in the HKSAR. It will examine how the dynamic interaction of three forces — political institutions, policy-makers' strategies, and stakeholder engagement —shapes the development trajectory of health care financing reforms in the HKSAR and draw useful lessons for reformers in other countries.

Analytical Foundations: Institutions, Policy-makers' Strategies, and Stakeholder Engagement

The 1990s was "a decade of major health system reform" (Saltman, 1994, p. 287). The wave of health care reform that was sweeping across the globe had attracted substantial scholarly attention. Historical institutionalism was one of the common approaches to examine the issue (Immergut, 1992; Wilsford, 1994; Hacker, 1998). The traditional theory of historical institutionalism assumes that political institutions and policy legacies matter in structuring the strategic behavior and interactions of political actors and organized interests during the policy-making process and generating distinctive outcomes (Skocpol, 1992; Hall and Taylor, 1996; Immergut, 1998; Peters, 1999; Thelen, 1999; Lecours, 2000; Béland, 2005a; Béland, 2005b; Steinmo, 2008). It emphasizes that institutions play a determinant role in distributing power among political actors in a given polity that influence the ways political actors interpret and pursue their self-interests, define their goals, policy preferences and strategies based on their institutional position, institutional responsibilities and relationships with others (Thelen and Steinmo, 1992; Koelble, 1995; Hall and Taylor, 1996; Immergut, 1998). It "sees different institutional structures as setting different political rules of the game" (Shih *et al*., 2012, p. 307) and establishing different sets of opportunities and constraints that privilege some interests at the expense of others, leading to some political actors win while others lose (Thelen and Steinmo, 1992; Hall and Taylor, 1996; Immergut, 1998; Thelen, 2010). Besides, it centers on the concept of path dependence (Thelen, 2003), which refers to the dynamics of positive feedback processes with the potential for a lock-in of a specific trajectory, developmental pathway or distinct track in a political system (Pierson, 2000a; Pierson, 2000b; Pierson and Skocpol, 2002; Pierson, 2004). The idea of lock-in is that past policy decisions which are also known as policy legacies "bring about the policy-induced emergence of elaborate social and economic networks that greatly increase the cost of adopting once-possible alternatives" (Pierson, 1994, p. 42).

Institutions "constrain action but they do not eliminate agency" (Thelen, 2010, p. 56). Policy actors articulate ideas and translate them into "language and slogans appropriate for political decision-making" (Thelen and Steinmo, 1992, p. 24). Ideas are "notions which link norms and values to practical action" (Alaszewski and Brown, 2012, p. 208). They help policy actors make sense of their world, their interests and their position within it (Béland and Waddan, 2012, p.8) by performing three vital roles: enabling legitimacy, bounding rationality, and framing policies (Alaszewski and Brown, 2012, p. 208). Firstly, ideas help policy actors "legitimize or oppose policy change" (Béland and Waddan, 2012, p. 10), win or dispel support by associating their policy decisions, choices, and actions with commonly held assumptions, norms, and values (Alaszewski and Brown, 2012, pp. 188-208). Secondly, ideas bound the rationality of decision-making and narrow the policy focus by prioritizing certain concerns of policy actors over others (Alaszewski and Brown, 2012, pp. 192-208). Thirdly, ideas help policy actors strategically craft frames to make policies politically plausible and acceptable (Campbell, 1998, pp. 380-1; Campbell, 2002, pp. 26-7).

Stakeholder engagement is important during the decision-making process. It can develop "an open and inclusive environment where information, comment, opinion and criticism is valued and utilized" (NSW Health, 2013, p. 1). Differences "in reform proposals generate differences in the particular interests of stakeholders and their positioning on reform proposals" (Gilson *et al*., 2012, p. i64). Stakeholders' "perception of policy problems and options are seen as an important input for evidence-based policy making" (Gilson *et al*., 2012, p. i65) and viability. A decision is considered legitimate "if a large number of stakeholders are included and given adequate opportunities to contribute to the decision-making process" (Veronesi and Keasey, 2009, p. 3). Besides, "the inclusion of a wide range of stakeholders and multiple perspectives is likely to increase the successful design and effective implementation of policies" (Veronesi and Keasey, 2009, p. 3). In sum, this study will demonstrate the dynamic interactions among political institutions, policy-makers' strategies and stakeholder engagement in shaping the developmental trajectory of health care financing reforms in the HKSAR while emphasizing the distinct role of institutions in affecting policy continuity and change.

The Health Care System in Hong Kong

In the early 1960s, Hong Kong established a national health care system heavily subsidized by taxation. The bulk of specialist and inpatient care is delivered through the public sector (Yuen, 2012, p. 11). The Hospital Authority (HA), which is "a statutory autonomous public corporate body, owns and manages over 40 public health care institutions" (Yuen, 2012, p. 11), capturing over 90 percent of inpatient admissions (Gauld, 1998; Gould, 2006). All Hong Kong residents enjoy full access to public health care. They are eligible to receive medical treatment at public hospitals and clinics by paying a nominal charge. Hong Kong has "one of the least expensive universal health care systems in the world" (Ramesh, 2012, p. 455). Its total health expenditure accounted for 5 percent of Gross Domestic Product (GDP) or some HK$75 billion (Food and Health Bureau, 2010, p. 86) in 2006/07, which was considerably lower than

the average of 9 percent in OECD countries (Organization for Economic Co-operation and Development, 2009, p. 162). Public funding financed 95 percent of the cost involved in delivering public health care services in 2006/07 while user fees only financed 5 percent of the cost (Food and Health Bureau, 2010, p. 87). The public health care system delivers equal and high quality services for the public. "Hong Kong's health indicators such as life expectancy and infant mortality rank among the best in the world" (Food and Health Bureau, 2008, p. 3). In 2012, the expectancy of life at birth was 81 years for men and 86 years for women (Census and Statistics Department, 2012). Since 2000, infant mortality rate "has been below 3.0 per 1000 registered live birth" (Census and Statistics Department, 2013, p. FB2), "which compares favorably with other developed countries, such as Japan, Singapore and Sweden" (Census and Statistics Department, 2013, p. FB2).

From the mid-1960s to the mid-1980s, a booming economy in Hong Kong enabled the colonial government to "pursue a vigorous public hospital and clinic construction programme" (Gould, 2006, p. 21). The colonial government consistently spent about 9 percent of its annual budget on health care (Hong Kong Government, 1993, p. 22). However, medical cost had "increased faster than the overall growth rate of the economy" (Hong Kong Government, 1993, p. 22). In view of rising medical costs and the rapid growth of ageing population, the colonial government wanted to increase the sustainability of health care finance in the long run and "spend more efficiently and cost-effectively" (Hong Kong Government, 1993, p. 22). In July 1993, the colonial government made its first formal attempt to reform health care financing by publishing a consultation document entitled *Towards Better Health* (commonly known as *The Rainbow Report* because of the design of the cover). *The Rainbow Report* listed five reform options: (1) cost recovery of 5 to 15 percent of operating cost; (2) introducing semi-private rooms and itemized charging in public hospitals; (3) coordinated voluntary private health insurance; (4) compulsory public health insurance; and (5) resources being concentrated on treating patients with higher priority conditions (Hong Kong Government, 1993, pp. 27-38). The government favored the introduction of the coordinated voluntary insurance scheme (Hong Kong Government, 1993, p. 41). However, the reform was shelved due to "public opposition and [the government's] fear of public misunderstanding" (Hong Kong Legislative Council, 1994, p. 3235).

Health Care Financing Reforms in the HKSAR

After returning to the Chinese rule on July 1, 1997, Hong Kong became a Special Administrative Region (SAR) under the concept of 'one country, two systems' (Lee, 2009, p. 162). The Basic Law, which was the constitutional instrument for the HKSAR, laid down the general framework of governance that was similar to that of the colonial governance: a high degree of autonomy, executive-led government, a capitalist way of life, a balanced budget, a low tax policy, and the protection of individual rights and freedoms. Over the past 17 years, the HKSAR government has made four formal attempts to reform health care financing. The first two reform attempts made by Tung Chee-hwa, the first Chief Executive of the HKSAR, ended in failure. On the other hand,

a two-stage public consultation on health care financing reform carried out by Donald Tsang, the second Chief Executive of the HKSAR, had eventually gained public support that the "implementation of HPS will take place in 2015 the earliest" (Legislative Council Secretariat, 2012, p. 2).

The Tung Chee-hwa Administration (1997 - 2005)

The Harvard Report: In November 1997, the government commissioned a team of economists, public health specialists, physicians and epidemiologists from Harvard University to conduct a study on the health care system of Hong Kong. In 1999, the Harvard Team completed the study with the release of a public consultation report entitled *Improving Hong Kong's Health Care System: Why and For Whom?* (Known as *the Harvard Report*) (Health and Welfare Bureau, 2000, p. 2). *The Harvard Report* concluded that the current health care system had three inter-related weaknesses: the compartmentalized health care system, the variable quality of health care, and the questionable long-term financial sustainability (The Harvard Team, 1999, pp. 2-82). For these reasons, *The Harvard Report* proposed implementing Health Security Plan (HSP) and Saving Accounts for Long Term Care (MEDISAGE), a two-tier mandatory health insurance scheme which required both employers and employees to jointly contribute about 1.5 to 2 percent of employees' wages to HSP for paying inpatient and outpatient medical expenses, and 1 percent of employees' wages to MEDISAGE for purchasing long-term care insurance at age of 65. It proposed introducing the concept of 'money follows the patient' by establishing the Health Security Fund, Inc. to pay a standard payment rate to public or private health care provider chosen by a patient (The Harvard Team, 1999, p. 13). Public health sector providers would not automatically receive funding from the government (The Harvard Team, 1999, p. 13). Besides, public hospitals would be reorganized into 12 to 18 regional groups, "contracting with private practitioners and competing with other private hospital groups to provide services at pre-defined fees" (Cheng, 2009, p. 781). However, *The Harvard Report* was shelved due to public resentment.

The Life Long Investment Document: In December 2000, the government produced its own version of health care financing reform in a public consultation document entitled *Life Long Investment in Health*. The document rejected HSP proposed by *The Harvard Report* because "a compulsory insurance scheme would increase labour costs, promote overuse and be prone to deficits" (Ramesh, 2012, p. 460). It instead proposed introducing a mandatory medical savings scheme called Health Protection Accounts (HPA). HPA required every individual aged 40 to 64 to contribute 1 to 2 percent of his/her earnings to a personal account which covered the future medical and dental expenses of both the individual and his/her spouse when the individual reached the age of 65 (Health and Welfare Bureau, 2000, p. 57). An individual would only be reimbursed at the public sector rates if he/she sought medical treatment at the private sector and needed to meet the price difference either from his/her own means or "from the entitlement of private insurance" (Health and Welfare Bureau, 2000, p. 57). However, this reform attempt was also shelved due to public resentment.

Reasons for Failure

During the Tung administration, two formal attempts were made by the government to reform health care financing. However, both the two-tier mandatory health insurance scheme proposed by *The Harvard Report* in 1999 and the mandatory medical savings scheme proposed by *Life Long Investment in Health* in 2000 were shelved due to widespread criticisms from different stakeholders and strong resistance from the public. There are three main reasons why these two reforms ended in failure.

A Disjointed Political System: Firstly, a disjointed political system acts as an impediment for the HKSAR government to gather political support, reach a consensus on policy decisions and implement health care financing reforms. Before 1985, the colonial government under an elite consensual polity could easily secure support from the Executive Council (Exco) and Legislative Council (Legco) because the appointed business elites in the Councils were proponents of the government's recommended policies. However, the democratization reform implemented since 1985 had turned the polity into a consultative democracy, which weakened the government's capacity to secure majority support. The introduction of the indirect election of legislators based on functional constituencies, which represented business and professional interests in 1985, and the introduction of the direct election of legislators for the first time in 1991 substantially reduced the number of appointed officials in the Legco and simultaneously accelerated the formation and growth of political parties (Choy, 1999). The political system was further democratized when the new and last Governor Chris Patten in 1992 prohibited members from simultaneously serving on the Exco and Legco to avoid conflict of roles and in 1995 abolished the appointment system in the Legco (Ma and Choy, 2003; Ma, 2007). Appointed members who resigned from the Exco to keep their seats in the Legco were not obliged to support the colonial government thereafter, while the appointed Legco members who wanted to gain a seat in future direct elections would not blindly support the government position in debates (Ma and Choy, 2003, p. 290; Ma, 2007, p. 105). The separation of the Exco membership from the Legco membership led to a disjunction between the works of the two Councils (Scott, 2000, p. 40).

After the 1997 handover, the Tung administration suffered from a legitimacy deficit because both the Chief Executive and the Exco lacked an electoral mandate. Being a shipping tycoon, Tung was a political newcomer and an outsider of the civil service. He failed to have "a preexisting network of political allies to assist him" (Lau, 2002, p. 10) and support him in policy making. He had poor working relationship with the civil service because of his paternalistic attitude towards senior civil servants. On the other hand, the Legco had electoral mandate because legislators were elected by voters. It had become a more representative political institution for legislators to gather, channel and reflect public opinion. On the issue of health care financing, even the pro-government and pro-Beijing political party, the Democratic Alliance for the Betterment of Hong Kong (DAB), and the government-friendly and pro-business political party, the Liberal Party, failed to give reliable support to the HKSAR government in the Legco. The DAB actually shared a pro-grassroots position with the Democratic Party (Ma, 2007, p. 106),

while the Liberal Party represented employers' voices. The tense Exco ─ Legco relationship after the 1997 handover further limited the capacity of the HKSAR government to secure majority support from legislators for implementing health care financing reforms. With the delinking of the Exco and Legco, the Legco had the right to challenge the Exco. Government officials and the heads of policy bureaux were left to present a lengthy defence of their reform proposals and became targets of anger and criticism in the Legco.

The Adoption of Radical Reform Strategies: Secondly, the reform strategies adopted by policy makers were too radical to be accepted by the public at large. Tung's decision to commission the Harvard Team to recommend reform options was due to the fact that he lacked his own team of policy advisors on health care. Besides, he believed that the fame and the reputation of the Harvard Team could easily win public acceptance. Unfortunately, the Harvard Team's proposed mandatory health insurance scheme could hardly fit into the context of Hong Kong where the idea of free health care was deeply embedded in the public health care system. There was widespread public belief that health care was a fundamental right and legal entitlement for all. Since 1960, the government's official statement that 'no one should be denied adequate health care through lack of means' had become the government's fundamental philosophy. The government was committed to providing heavily subsidized medical services irrespective of age, sex, income or health status. The establishment of the HA in 1990 further accentuated the government's role in financing and providing health care services (Gauld, 1997, p. 29). It had strengthened the image of the public hospital system as a strong welfare safety net. The enactment of Hospital Authority Ordinance, which stated that the HA should uphold the policy that 'no one should be denied adequate medical treatment through lack of means', had institutionalized the ideas of free health care, universal access to health care and equality. The institutionalization of these time-honoured ideas sharply reduced the government's capacity to persuade legislators and the community to accept and support the mandatory health insurance scheme. The public, who were used to paying nominal fees for public health care services, were not willing to pay more for it (Gould, 2006). However, the Harvard Team and the government did not seem to realize in advance that the public would react negatively to the mandatory health insurance scheme or they underestimated the public's negative emotions because of their lack of touch with ordinary people. Besides, Tung's rush decision to propose a mandatory savings scheme in 2000 showed his lack of political wisdom without learning lessons from the 1999 health care financing reform that mandatory options were unpopular options in the eyes of the public and legislators. In fact, the public's bad impression of the government's earlier decision to implement the Mandatory Provident Fund (MPF) scheme made both the mandatory health insurance and medical savings schemes proposed afterwards even more unpopular. The MPF scheme was unpopular because of its mandatory nature, the perceived financial burden it brought and its insufficient retirement protection. Therefore, legislators, political parties and the public felt annoyed when the government subsequently proposed

mandatory health insurance scheme in 1999 and medical savings scheme in 2000. Also, both the mandatory reform options were proposed in the wrong time when Hong Kong had suffered a severe economic downturn after the Asian financial crisis of 1997 (Wong and Luk, 2007). Both the middle and lower classes suffered "unemployment, wage decline and asset deflation" (Lee, 2005, p. 7). The Legco and the community complained that it was inappropriate for the government to propose these two mandatory schemes at a time of economic hardship.

The Problem of Stakeholder Resistance: Thirdly, stakeholder resistance made the implementation of health care financing reform extremely difficult. The public health care system generates positive-feedback effects that a strong and wide base of support was created for free health care and the existing arrangement of the HA. The public resisted both mandatory health insurance and saving schemes because both the mandatory schemes deprived them of their freedom to choose and violated the spirit of freedom embraced by the community for a long time. They thought that they were forced by the government to pay or save for their medical expenses. Besides, both the HA and doctors resisted the mandatory health insurance scheme proposed by *The Harvard Report* because, following the principle of 'money follows the patient', the HA would no longer automatically receive funding from the government and had to compete with private hospitals in the market. Also, political parties were opposed to the mandatory reform options. The Democratic Party, the DAB and the Liberal Party "were skeptical of the proposed health insurance and savings schemes, which they regarded as adding new hardships to the people" (Cheung and Gu, 2004, p. 34). The Liberal Party called for a voluntary medical contribution scheme and suggested that the government should let citizens choose the kinds of medical services "according to their ability and wishes" (The Legislative Council, 2001, p. 4054). Meanwhile, the DAB criticized the ideas of co-responsibility and user pay respectively emphasized by mandatory health insurance and medical savings schemes for conflicting with the idea of equity embedded in the current health care system and the idea that medical service was a social welfare (The DAB, 1999; The Legislative Council, 2001, p. 4078). The DAB also criticized the idea of mandatory contribution for conflicting with the idea of social justice because it personalized the issue of health care in the name of individual responsibility and aggravated social disparity, which increased the financial burden of the low-income groups and the poor.

In fact, the public, legislators, medical associations, and the Patients' Rights Group found the idea of implementing the mandatory medical savings scheme especially irritating because they doubted the effectiveness of the scheme in providing financial security for citizens and were discontented with the government's insufficient disclosure of information about the scheme. They criticized the HKSAR government for refusing to give figures and evidence to support its proposed mandatory medical savings scheme despite their repeated requests because the government contended that the figures and evidence confused the picture (Benitez, 2001a January 26; Benitez, 2001b January 27; Benitez, 2001c March 13). Hence, they criticized that *The Life Long Investment document* was 'a blank cheque' (Benitez, 2001a January 26), 'a skeleton proposal' (Benitez, 2000 December 13), and 'an empty proposal' (Benitez, 2001c March 13) used

by the government to force the public to pay for their medical expenses. In sum, a disjointed political system, radical reform strategies adopted by policy makers at the wrong time, and stakeholder resistance were obstacles to implementing health care financing reforms.

The Donald Tsang Administration (2005 - 2012)

Your Health, Your Life Document: In March 2008, the government published a health care reform consultation document entitled *Your Health, Your Life* as the first of a two-stage public consultation. Instead of recommending a particular option, the document simply laid out six supplementary health care financing options, "with a view to putting forward concrete recommendations in the second stage consultation" (Food and Health Bureau, 2008a, p. 47). The six supplementary health care financing options included: (1) social health insurance; (2) cost recovery of 5 to 10 percent of operating cost; (3) mandatory savings accounts; (4) voluntary private health insurance; (5) mandatory private health insurance; and (6) personal health care reserve. The document stated that the six supplementary health care financing options proposed would not affect current tax-based public funding as the major source for financing health care (Food and Health Bureau, 2008a, p. 2). The public health care system would "continue to provide an available and accessible safety net for the community" (Food and Health Bureau, 2008a, p. xv). In December 2008, the government released the consultation report on the outcome of the first-stage public consultation. The consultation result showed that "no single proposal commanded majority support" (Food and Health Bureau 2008b, p. vii). Nevertheless, the consultation result showed that the community embraced five societal values — individual need, voluntary participation, equity, freedom to choose and employer's responsibility. It provided a useful reference for the government to develop a detailed proposal for the supplementary health care financing option in the second-stage public consultation.

My Health, My Choice Document: In October 2010, the government published the second-stage consultation document, entitled *My Health, My Choice*, which proposed a Health Protection Scheme (HPS) that standardized and regulated voluntary private health insurance (Food and Health Bureau, 2010, p. ii). The consultation document stated that HPS offered three advantages over existing private health insurance schemes in the market: first, it must accept high-risk individuals and those with pre-existing medical conditions; second, it had transparent age-banded premium schedule, guaranteed renewal for life and was fully portable; and third, it promoted transparent packaged charging based on diagnosis-related groups (DRGs) and established High-Risk Pools to buffer the risks of high-risk subscribers, with financial injection from the government when necessary (Food and Health Bureau, 2010, pp. 29-30). The government would use HK$50 billion fiscal reserve earmarked to provide incentives and subsidies to HPS subscribers (Food and Health Bureau, 2010, p. v). The consultation result showed that more than 60 percent of respondents supported the introduction of the proposed HPS (Food and Health Bureau, 2011, p. vi). The government plans to proceed to draft and introduce HPS legislation and implement HPS in 2015 at the earliest (Legislative Council Secretariat, 2012, p. 2).

Reasons for Getting Support

Compared with the Tung Administration, the Tsang Administration did not face vociferous and adamant opposition when proposing health care financing reforms. This can be explained by three main reasons: (1) internal cohesiveness, (2) the adoption of mild reform strategies, and (3) the strategy of public engagement.

Internal Cohesiveness: Firstly, Donald Tsang was formerly Chief Secretary for Administration and a long-time civil servant (Cheung, 2007, p. 51; Cheung, 2010, pp. 38-9). Tsang, due to his bureaucratic background, "returned to the age-old colonial wisdom of government by administrators" (Cheung, 2010, p. 39). He mainly depended on "the civil service as the backbone of his administration" (Cheung, 2010, p. 48). The senior civil servants once again provided the government with the unifying and sustaining force that brought "policy and administrative organizations together within more coherent structures and processes" (Cheung, 2010, p. 48). The internal cohesiveness was conducive to carrying out study and analysis of different health care financing options.

The Adoption of Mild Reform Strategies: Secondly, the government adopted mild reform strategies to gain public support. Reform ideas proposed in the health care consultation document were more acceptable. It is notable that health care financing options proposed in the two-stage public consultation were just "a supplementary financing source for health care" (Food and Health Bureau, 2008a, p. xii) or "health care financing supplementary to public funding" (Food and Health Bureau, 2010, p. v). The idea of "supplementary" has sent a message to the public and key stakeholders that the government had no intention to use these proposed financing options to replace the existing financing model, i.e. taxation, as the main source of health care funding. Besides, it has sent a message to the public that the government had no intention to back out of its commitment to health care. Another notable feature is that achieving financially sustainable health care in the long run was not mentioned as an objective in the second stage public consultation although this was the main reason why the reform was implemented in the first place. Instead, the proposed HPS was meant to provide citizens with "more choices and better protection in private health care" (Food and Health Bureau 2010, p. ii). The ideas of "voluntary" and "more choices" have sent a message to the public that citizens had the freedom to choose whether they bought this health insurance. When proposing the voluntary HPS, the government strived to soften its image by depicting itself as citizens' lifelong health partner in *My Health, My Choice* document, investing together with citizens in their long-term health protection (Food and Health Bureau, 2010, p. ii). Compared with the Tung administration, the Tsang administration took a less aggressive role in implementing health care financing reform and its reform agenda was less ambitious. The old ideas of universal access and equality embedded in the public health care system were preserved while the reform ideas of ″voluntary" and "more choices" did not encounter public resistance. Therefore, the proposed HPS was able to gain public support.

The Strategy of Public Engagement: Thirdly, the government used the strategy of public engagement to gain support and reach consensus required for the implementation

of health care financing reform. Health care financing reforms touched upon vested interests embedded in the health care system. Knowing that the government had weak structural legitimacy, Tsang was prudent enough not to take any hasty steps to introduce health care financing reforms in order to avoid provoking any public outcry. In early February 2007, Tsang pledged in his election platform that "the proposed medical financing system would have more flexibility, engaging the government, the Hospital Authority, the private sector and individuals" (Yung, 2007). He secured the support of the Election Committee members from the Hong Kong Medical Association in the Chief Executive Election (Lee, 2007 February 16) after he told Election Committee members from the medical sector that "his top priority would be constitutional reform, followed by medical reform" (Lee and Wong, 2007 February 11).

After winning the election, Tsang fulfilled his health care election promise through a step-by-step approach. Unlike previous health care consultations carried out in the Tung era, health care consultation during the Tsang administration was carried out in two stages. *Your Health, Your Life* document published in the first stage public consultation simply laid out different financial options without recommending a particular option. The aim of the first stage public consultation was mainly soliciting initial views from the public and key stakeholders on "the pros and cons of possible supplementary financing options" (Food and Health Bureau, 2008a, p. iii) and their key concerns related to health care financing reforms. These views received during the first stage consultation served as ready inputs for the government to formulate detailed proposal for the second stage public consultation. "[W]ritten submissions from over 4 900 organizations and individuals" (Food and Health Bureau, 2008b, p. ii) were received in the first stage public consultation. The result showed that "the public generally favoured voluntary proposals like voluntary health insurance" (Food and Health Bureau, 2008b, p. viii) over mandatory proposals such as mandatory medical insurance and mandatory medical savings. That is why a regulated voluntary private health insurance HPS was proposed in the second stage public consultation. A two-stage public consultation was a lengthy process. But it created enough room for the public and key stakeholders to discuss the issue and helped reduce public resistance and widespread criticism from legislators.

Discussion

This study shows that health care financing reforms in the HKSAR was shaped by the dynamic interaction of three forces — political institutions, policy-makers' strategies, and stakeholder engagement. Firstly, political institutions affect the ability of policy actors to place reform strategies on the decision-making agenda and implement reform strategies (Cortell and Peterson, 1999, pp. 189-190). They play a determinant role in constraining the government's capacity to secure majority support for implementing health care financing reforms. Under a political system with weak structural legitimacy, the government was less capable of securing majority support to implement health care financing reform. As Rathwell (1998) argues, the "lack of broad public support for reform [acts as] a major barrier to change" (p. 396). Without political support and public trust, the HKSAR government could face high political costs of

reforming the health care financing system. The "government would have no alternative but to back down" (Cheung, 2010, p. 54). This explains why the first two reform attempts made by the government during the Tung era ended in failure.

Secondly, reform strategies adopted by policy makers matter. The adoption of mild reform strategies can gain public acceptance and support more easily than the adoption of radical reform strategies which provoked public outrage. The public health care system was a powerful institutional legacy. It had a wide base of public support and institutionalized the old ideas of free health care, universal access to health care, equality and health care as a welfare benefit. These ideas became societal beliefs that were widely accepted and endorsed by the public. Hence, the public became strong defenders of free health care when the government proposed mandatory health insurance and medical savings schemes that asked them to bear greater responsibilities for their medical expenses. They found the mandatory options infuriating and unacceptable. Timing also matters. The government's earlier decision to implement the mandatory pension made the mandatory health insurance and medical savings schemes proposed afterwards unattractive. Besides, the difficult economic circumstances failed to open any window of opportunity for the government to secure majority support for the mandatory reform options. Meanwhile, the voluntary HPS proposed by the government was a more moderate alternative that was less politically controversial but more politically feasible. The public was more acceptable to the voluntary HPS because it was just a supplementary financing option to support public funding and would not affect the public health care system as a safety net for the whole population. The government strategically framed the HPS as a way of increasing individual freedom to choose while reaffirming its commitment to funding health care. It simultaneously promoted the ideas of choice and universalism in order to make the HPS more acceptable to the public. However, the implementation of the voluntary HPS in future will only bring incremental change to the heavily subsidized health care through taxation because the problem of long-term sustainability of health care financing remains unresolved. As Ramesh (2012) argued, the government could not afford policy solutions that addressed the financial unsustainability of the health care system "because that would require political resources that it lacks" (p. 467).

Thirdly, stakeholder engagement is fundamental to the effective planning, development, and implementation of health care financing reforms. It is a more interactive form of policy making that provides an opportunity for different stakeholders to voice out and exchange their opinions without restriction, accommodate differences, and foster a sense of trust and respect. Reaching out to stakeholders that are interested in or are affected by health care financing reforms can increase the awareness of stakeholders about the reforms, establish inclusive relationship with stakeholders, and enable better-planned policies. It can facilitate more transparent lines of communication and the likelihood of health care financing reforms "capable of meeting people's needs and are more adaptable to the local context" (Veronesi and Keasey, 2009, p. 3).

Conclusion

To conclude, this study shows that health care financing reform is a political process revealing an intricate interplay of power relationships and diverse interests. Health scholars must begin with an analysis of the structuring impact of political institutions and pay greater attention to the ways in which policy makers and stakeholders interact with political institutions if they are to fully understand the politics of health care financing reform. In recent years, the topic of health care financing reform has continued to attract considerable attention. The problems of an ageing population and rising health care expenditure call for a critical look at how the health care financing system can be reformed to make it sustainable. The evidence summarized in this study presents some useful lessons for reformers in other countries. Firstly, health care financing reform is a political controversy. It is shaped by the dynamic interaction of forces, with special emphasis placed on the role of political institutions and policy legacies. Secondly, a disjointed political system does not mean that reform is impossible. But it requires the government to make more efforts to present its reform options skillfully and in a more acceptable way. In order to secure more support, the government under a disjointed political system needs to avoid confrontation. The government can set a less ambitious reform target and promote a milder reform option that is more politically feasible and strategically draw upon existing ideological repertoires to frame reform alternatives in order to make the alternatives more acceptable to the public. Thirdly, the government should understand that implementing health care financing reform is an ongoing effort. The government should review the health care system regularly and implement reform initiatives that can respond to the changing circumstances. Sweeping changes in the structure of a health care system are rare. A mild reform agenda can create room for discussion, reaching a consensus and paving the way for further reform in future.

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