Financing Health Care and Long-term Care in a Rapidly Ageing Context: Assessing Hong Kong's Readiness

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Abstract

This article assesses Hong Kong's readiness to tackle the problems associated with the financing of health care and long-term care brought about by rapid population ageing. The article examines the speed of the ageing process in Hong Kong, the pattern of care delivery, the organizational structure in the Hong Kong Special Administrative Region Government responsible for the provision of health care and long-term care, the financing arrangements, and Government's responses to this impending phenomenon. The article concludes that Hong Kong is poorly prepared for the rapidly ageing process that it will face in the next twenty odd years, and recommends immediate public consultation on the establishment of a government medical savings fund and long-term care insurance.

Keywords: health care financing, long-term care financing, ageing, Hong Kong

Introduction

Hong Kong people are often proud of the fact that Hong Kong has the highest life-expectancy at birth in the world (Food and Health Bureau, 2013). While longevity is a cause for celebration, the problems associated with ageing, if not managed properly, can almost certainly be a cause for concern. This article examines the issue of financing health care and long-term care in Hong Kong in the context of population ageing and relevant public policies. It first describes the change in the population age structure in the next twenty odd years, and the associated decline in the size of the labour force and the taxpaying population. It then reviews the increase in demand in health care and long-term care as a result of ageing and the financing implications. The existing financing and delivery mechanisms for medical care and long-term care as well as Government's health care financing and other relevant proposals are then examined.

The Speed and Magnitude of Population Ageing in the Next Twenty Years

While many industrialized countries are experiencing or have experienced population ageing, the latest population projections show that Hong Kong's population will age much more rapidly than many industrialized countries and much faster than previously expected (Chung *et al*., 2009). The number of persons aged 65 or above will increase to 2.16 million by 2031 — more than double the 2012 elderly population of 980,000 (Secretariat of the Steering Committee on Population Policy, 2014). This phenomenon is the consequence of longer life expectancy — 86 for women and 80 for men in 2011, being one of the highest in the world (Food and Health Bureau, 2013) and very low birth rate of 1.3 in 2012, being one of the lowest in the world (Secretariat of the Steering Committee on Population Policy, 2014). This speed and magnitude of population ageing will have important repercussions on the financing and delivery systems of health and long-term care. Hong Kong data suggest that a person aged 65 or above uses on average six times more in-patient care than a person aged below 65 (Food and Health Bureau, 2008), and US data indicate that approximately 24 percent of the persons over the age of 65 will require some long-term care services (Feldstein, 1993).

Cost-Ineffective Care Delivery Structure and Patterns

Health care, in this article, refers mainly to diagnosis and treatment services including primary care, secondary care, tertiary care, and rehabilitation services, provided either on an out-patient basis or in a hospital setting. Long-term care refers to a continuum of services to assist an impaired person to function in activities of daily living. It covers both community services and residential services. Community services include services delivered to the home of the individual (such as home-helpers' services, visiting nursing services), and services provided at day care centres. Residential services include a range of residential facilities depending on the severity of disability (such as self-care homes, care and attention homes, nursing homes and infirmaries).

Health care delivery: In Hong Kong, the bulk of specialist and inpatient care is financed and delivered through the public sector. The Hospital Authority, a statutory autonomous public corporate body, owns and manages over 40 public health care institutions, providing over 90 percent of all hospital beds in Hong Kong. Institutions under the Hospital Authority provide a comprehensive range of services at a heavily subsidized rate. The Hospital Authority receives over 90 percent of its income from the government's general revenue. All Hong Kong residents are eligible to receive care from public hospitals and clinics at a heavily subsidized rate. Patients in public hospitals pay a fixed per diem fee of HK$100, which covers less than 4 percent of the actual average cost of a patient day in an acute public hospital. The per diem fee is all-inclusive with the exception of a short list of the "Privately Purchased Medical Items (PPMI)" which the patients have to pay the full cost separately (Yuen and Gould 2006). Private hospital services are financed privately in the form of direct payment or through private health insurance. Currently, private hospitals deliver less than 10% of total inpatient care. The bulk of outpatient care, is however, delivered and financed privately. Over 60 percent of all outpatient visits are provided by private practitioners in either solo practice or group settings (Food and Health Bureau 2014a).

Despite clear evidence that stronger primary health care results in better health of

the population at lower cost and greater user satisfaction (Atun, 2004), the Hong Kong Government's expenditure primary care service is only a fraction of what it spends on hospital care, leaving the bulk of general outpatient care in the hands of private practitioners with practically no government subsidy. This funding pattern creates incentives for the public, especially the elderly, to over-rely on public hospitals for care, as the care provided by public hospitals are heavily subsidized, while those provided by private practitioners in the community are not.

Long-term care delivery: As for long-term care, community long-term care is provided predominantly by Non-governmental organizations (NGO's) receiving funding mostly from Government, supplemented by donations and users fees. As for residential care services, they are delivered by a mix of NGO's and private providers. Some NGO's receive heavy subsidies from Government, covering almost full operating expenses, capital costs and the provision of premises. Many NGO's and private providers operate on a self-financing basis. Government also has a programme to subsidize residents to stay in privately run facilities, known as the "enhanced bought place scheme". In general, the quality of care is higher in government-subsidized homes than the self-financing homes. However, over 70 percent of the homes are privately operated, and waiting time for a place in a subsidized home is long (Chui, 2009; Legislative Council 2013).

There is also imbalance between residential long-term care and community based long-term care in terms of volume and government financing (24,746 subsidized residential places vs. 7,089 community based places; $2,549M vs. $381M) (Sau Po Center on Ageing, 2011), despite the long standing government policy of "ageing in place", the significant difference in the cost of residential care vs. community care (Chappell *et al*., 2004), and the clear preference amongst the elderly to remain living in their own home instead of in an institution (Chiu *et al*., 2009). This has resulted in a undesirably high institutionalization rate of 6.8% of population aged 60 and above, which is more than double that of Japan, and more than three times that of Singapore and Taiwan, even though the health status and "activities daily living" abilities of Hong Kong's elderly are similar if not better than those in these countries (Chiu *et al*., 2009).

Compartmentalization: The absence of a single government body to oversee both health care and long-term care contributes to further inefficiencies. With the funding of health care services under the Food and Health Bureau and the funding for long-term care services under the Labour and Welfare Bureau, it is difficult to divert resources from the relatively well funded acute health care sector to the long-term care sector to help with the early discharge of elderly patients who stay at acute hospitals inappropriately. This compartmentalized arrangement has also led to frequent loss of nursing and allied health staff in long-term care facilities to acute care facilities because of the lack of promotion prospect in long-term care agencies for these professional staff. The lack of medical staff in long-term care facilities has also resulted in frequent visits to high cost hospitals' Accident and Emergency Departments and/or hospital admissions

of residents in long-term care institutions.

Existing Delivery Systems Already Stretched

Even today, with a relatively modest percentage of elderly population, Hong Kong's health care and long-term care systems are showing strains.

Long waiting time in public hospitals: In public hospitals, waiting times and waiting queues, especially for non-urgent conditions, elective procedures and specialist outpatient services, are unacceptably long (Oriental Daily, 2012, 2013). There are frequent allegations of unreasonably long wait: for example, queuing time at Accident and Emergency Departments were found to have often exceeded the pledged time (Apple Daily, 2013, Ming Pao, 2013a); waiting time for non-urgent radiographic services is more than five years (Ming Pao, 2013c); waiting time for non-urgent orthopedic cases is over two years (Ming Pao, 2014); and waiting time for a first appointment at psychiatry clinics is over ninety-four weeks (The Sun, 2014). Government itself predicts that by 2015, waiting time for cataract surgery will increase from currently three years to six years, and for benign prostatic hyperplasia surgery from currently 2-3 years to 4-5 years (Food and Health Bureau, 2008).

Long waiting time in long-term care facilities: As for long-term care facilities, in August 2009, there were 25,000 applicants in the Central Waiting List of the Government Social Welfare Department for placement to subsidized residential institutions. Waiting time for a place in subsidized care and attention homes was around 22 months, and for nursing homes 40 months (Chiu, 2009). It has been alleged that around 5,000 elderly persons die every year while waiting for a place in a subsidized nursing home (South China Morning Post, 2014).

Giving that Hong Kong's elderly population will more than double by the 2030's, it is unimaginable how the system, with its current arrangements, will be able to cope.

Highly Tax-dependent Financing Systems Unsustainable

Hong Kong's total health care expenditure is expected to grow from currently around 5.3 percent to 9.2 percent in the 2030's, and public sector health expenditure is expected to grow from the current level of 2.9 percent to 5.5 percent by then (Food and Health Bureau, 2008).

Hong Kong long-term care expenditure is projected to increase from the current level of roughly 1.4 percent of GDP to a range of 2.2 percent to as high as 4.9 percent of GDP (with a central case scenario of 3 percent) by 2036 (Chung 2009), which would be amongst the highest within industrialized countries (OECD, 2011).

The increase is particularly alarming in light of Hong Kong's acute care and long-term care services are mostly funded by tax money. The increase in elderly population will be coupled with a decline in the labour force participation rate, which is estimated

to decline from the current 58.8% to 49.5% by 2041 (Secretariat of the Steering Committee on Population Policy 2014). Revenue from direct taxation will certainly decline as a result. The amount of tax dollars available to fund these services will be proportionally less and not more. The present financing model is obviously not sustainable.

Many countries have implemented supplementary financing schemes to deal with the situation. Japan, South Korea, and Singapore, for example, have all implemented long care insurance schemes (Ichien, 2000, Kwon, 2009, Phua, 2001). Singapore, back in the 1980s had implemented compulsory individual medical savings accounts for all to pay for acute care services (Phua, 2001). For these countries with compulsory social health insurance, there are built-in "control knobs" allowing government to increase premium and/ or copayment of consumers, as well as adjusting the fee schedule of providers (Lu and Chiang, 2011). For countries that have primarily tax funded health care systems, their tax rate are normally much higher than that of Hong Kong, and they all have high sales tax (Food and Health Bureau, 2014b), which tend to be less susceptible to decrease as a result of population ageing as compared with direct taxation. New Zealand has also established a government future fund to help pay for the extra needed services for the impending population ageing (Savings Working Group, 2011).

Inadequate Government Responses

A number of official policy documents published recently have emphasized the seriousness of the ageing process and the associated impact on health care (Food and Health Bureau, 2008, 2010, 2011), on the elderly (Social Welfare Department, 2013; Secretariat of the Steering Committee on Population Policy, 2014), and on public finances (Tsang, 2014). Proposed strategies to deal with the problems can be described as weak at best.

Health Care Financing: Regarding health care financing reform, the government is proposing a government regulated voluntary private health insurance scheme, known as the Health Protection Scheme (HPS) to divert some middle class patients from public hospitals to private hospitals (Food and Health Bureau, 2011). Elsewhere, the author has analyzed the scheme in detail (Yuen, 2012). The ability of the HPS to draw and retain a significant number of elderly persons is highly questionable. As with all voluntary private health insurance, HPS will have to adopt 'experience-rating', (i.e. premium will vary depending on the age and health status of the subscriber). According to the "Indicative Premium Schedule" of the HPS (Food & Health Bureau, 2010), the premium that a healthy elderly person has to pay will be more than 3.8 times that of a young person. Moreover, many elderly persons will have conditions, which will render them to be classified as high-risk individuals, who will be subjected to even higher premium. Many will also have pre-existing conditions, which will further increase their out-of-pocket payment in the event of hospitalization. While HPS caps the premium for high-risk individuals at three times that of the premium for the normal age group, a

high-risk elderly person will still be paying more than 11 times the premium of a young person. Persons over the age of 65 are often retired individuals with no regular income. Many will find such premium level unaffordable. Furthermore, HPS requires deductible and co-payment for every hospitalization episode in amount of tens of thousands of dollars. Many retirees, especially high-risk individuals that require frequent hospitalization, are likely to find such out-of-pocket payment unaffordable or undesirable when public hospital services are still available at an all-inclusive fee of HK$100 a day. Those elderly persons who find HPS premium and out-of-pocket payments acceptable are likely to be financially well-off, in small numbers, and have the means to purchase existing private health insurance products in the market or to pay the expenses out their own savings even without HPS. The scheme is, therefore, not likely to be attractive or affordable enough to attract large number of subscribers to make a significant difference in alleviating pressure on public hospitals (Yuen, 2012).

Long-Term Care Financing: As for long-term care, there are still no proposals or official consultation on how to find supplementary sources of funds to better finance these services (Social Welfare Department, 2013). The recent consultation on population policy only proposes measures to expand the workforce, without addressing the inadequacies of the current long-term care financing model (Secretariat of the Steering Committee on Population Policy, 2014).

The last proposal on long-term care financing considered by Government was the Harvard Team's proposal of a savings-insurance scheme known as MEDISAGE back in 1999 (Harvard Team, 1999). The Harvard Team proposed the establishment of individual mandatory savings accounts, as part of the mandatory provident fund, to be used to purchase long-term care insurance upon retirement or disability. Contributions to this savings account were estimated to be around 1% of salary, to be made jointly by employees and employers. For the low-income and unemployed, the contributions would be made by the government. Upon retirement, the balance in the savings account will be used to purchase a single premium long-term care insurance policy, offered by private insurance companies. The insurance would pay for the cost of long-term care, including nursing home stay, visiting nurse services and home helper services, if and when required. The MEDISAGE scheme could provide additional funds for the development of long-term care services, which currently are very much underdeveloped. As many elderly persons do not have the resources to purchase long-term care for themselves, the burden often falls on their children, many of whom are unable and/or unwilling to pay for the services needed by their parents. Such type of scheme, providing extra funding in addition to tax funding, is necessary if the long-term care needs of the elderly are to be met in a satisfactory manner. The administrative costs of these savings accounts could be relatively low, as these accounts could be established as a part of the existing Mandatory Provident Fund scheme. Unlike the mandatory health insurance proposed by the Harvard Team, the MEDISAGE scheme received general support from major stakeholders and the public (Food & Health Bureau, 1999). Fifteen years have elapsed, and the proposal has still not been followed up.

Public Budget: The latest Government budget commits more government expenditure to fund initiatives such as a world class children's hospital, health care voucher for the elderly, subsidies for colonoscopy, and more long-term care places (Tsang, 2014). Some of these initiatives are nice to have and others are badly needed in light of the current inadequacies. However, without any effective plans to generate supplementary funding for health and long- term care in the future, these moves will only contribute to an earlier onset of government budget deficit and financial non-sustainability of these services.

The only suggestion in the whole budget speech that makes sense regarding population ageing is that the Financial Secretary would "consider setting up a savings scheme to prepare for the future" (Tsang, 2014). Elsewhere, the author has advocated the establishment of a public medical savings fund, with an annual injection of HK$11billion to the fund (which is equivalent to roughly three percent of salary of wage-earners using existing MPF rules). A larger injection should be made during the year when Government experiences large budget surplus. In the event of public budget deficit, this public medical savings fund can be used to supplement the income of public hospitals, in a targeted manner, on the top of the regular recurrent subvention from Government, to meet the additional requirements as a result of the ageing population (Yuen, 2012). Part of the Financial Secretary's proposed savings scheme can be earmarked for this purpose, and should be set up without delay.

Conclusions

The above analyses show that Hong Kong will face an unprecedented ageing process, of speed and magnitude that few countries in the world have ever experienced. The system at the present day is already stretched. The bureaucratic structure and the funding model for health and long-term care services have inherent problems resulting in cost-ineffective delivery patterns.

Hong Kong has no savings schemes for either health care or long-term care. It has no effective "control knobs" to effectively mitigate the rise in public expenditures in health and long-term care when face with surges in demand. It has one of the lowest income tax rates in the world. It has a very narrow tax base. The highly tax dependent financing model for health and long-term care is likely to be non-sustainable with the declining labour force and the growing number of elder persons.

In short, Hong Kong is ill prepared to meet these serious challenges as the population continues to age. It is certain that Hong Kong will not be able to avoid paying more for care. Without an adequate and coherent plan to deal with the situation, it is, therefore, certain that quality of care will decline. It is also certain that equity will be compromised, with the lower socio-economic groups suffering most.

Credible strategies to deal with this serious problem have yet to be developed. Public consultations on the Government savings scheme and long-term care insurance (such as the MEDISAGE scheme) should be conducted without delay.

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