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Special Issue on Health Policies

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Special Issue on Health Policies

Editor: Professor Peter P. Yuen

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Introduction to the Special Issue

This Journal was re-launched in Spring 2012 with the support of the new co-publisher, the School of Professional Education and Executive Development (SPEED) of The Hong Kong Polytechnic University (PolyU). So far, we have published four issues, Spring & Fall 2012 and Spring & Fall 2013. Articles in these four issues are on various aspects of public administration and policy. We hope they have provided insightful and critical information and analyses on topics that will have bearing impacts in the region and beyond.

As pointed out in the first issue in Spring 2012, we plan to publish special issues on different themes and subjects such as health care, housing, and higher education. We are delighted to present this first Special Issue on "Health Policies", and have Professor Peter Yuen of PolyU, a specialist in health services management, as our Guest Editor. We would like to thank Professor Yuen, all the paper contributors and reviewers of this special issue. I hope you find the articles interesting and useful for your understanding on health policies.

We appreciate our readers' support and input so that the Journal will continue to provide a useful source of information and a forum for intellectual exchange in the years to come.

Peter K.W. Fong, PhD
President, Hong Kong Public Administration Association

Preface to the Special Issue on Health Policies

Health care reform is high on the agenda of most governments. Ageing population, health care cost escalation, sluggish economic growth, rising expectations of patients, demanding better value for money and greater accountability by legislators are a few common problems that compel governments to re-examine their health care policies and push for reforms. *Public Administration and Policy* has therefore decided to publish a special issue on this important policy area.

This special edition contains five articles analyzing current issues in the area of health policies and administration. The topics covered include problems caused by population ageing and measures to deal with it, how New Public Management approaches are implemented in health care reforms, the determinants of successful health care reform implementation, and how to transform the health care sector into a revenue generating industry.

I hope that readers will find the diverse background of the contributors and the different perspectives they bring to the analyses useful and interesting.

Peter P. Yuen, PhD
Special Issue Editor

The Challenges of an Ageing Society from a Health Care Perspective

Richard M.F. Yuen
Permanent Secretary for Health, The Hong Kong SAR Government

Countries around the world, especially the developed economies, are grappling with the challenges of an ageing society and Hong Kong is no exception. This may come as a surprise that just only two centuries ago, the British economist Thomas Malthus predicted in his famous treatise "An Essay on the Principles of Population" that a point would come when human population would reach the limit up to which food sources could support it and any further increase would lead to population crash caused by natural phenomena like famine or disease. Malthus' famous prediction is based on the premise that man is a complacent animal and would continue to procreate when his basic needs are fulfilled and his family is well fed. It implies that population growth is only constrained by adequate food supply and natural or man-made catastrophes.

It therefore perplexes us that the first countries, which will experience a real reduction in population, like Japan, Germany and Italy, are among the most advanced economies in the world with the highest quality of life and an abundant supply of food! How this has come about would be a subject for other studies and research. The human society is facing a new challenge — an ageing community coupled with possibly a shrinking population. This is the complete opposite to the traditional concept of driving social and economic improvement through continued population growth. The message is clear that we can no longer rely on traditional concepts and experiences to help us tackle the challenge of an ageing society. We need new thinking.

What is the challenge of an ageing society? Ageing population is a multi-facet problem and different countries and societies will have different experiences due to different stages of social and economic development and the social policies adopted by them. We will focus on Hong Kong and look at the challenge from the health care perspective.

The left side of Figure 1 shows that Hong Kong will continue to experience a "healthy" population growth in terms of numbers. However, a closer look at the components of the projected population growth, as shown on the right side of the table, gives a very different picture — the growth of the population below aged 65 shows a marked decline after peaking in the next decade. Persistent low birth rate will lead to an actual contraction of the population below aged 65 in some 20 years' time. In short, population growth in the coming years will be mainly driven by the extension of longevity of the people of Hong Kong, the same in many other developed economies in the world.

Figure 1

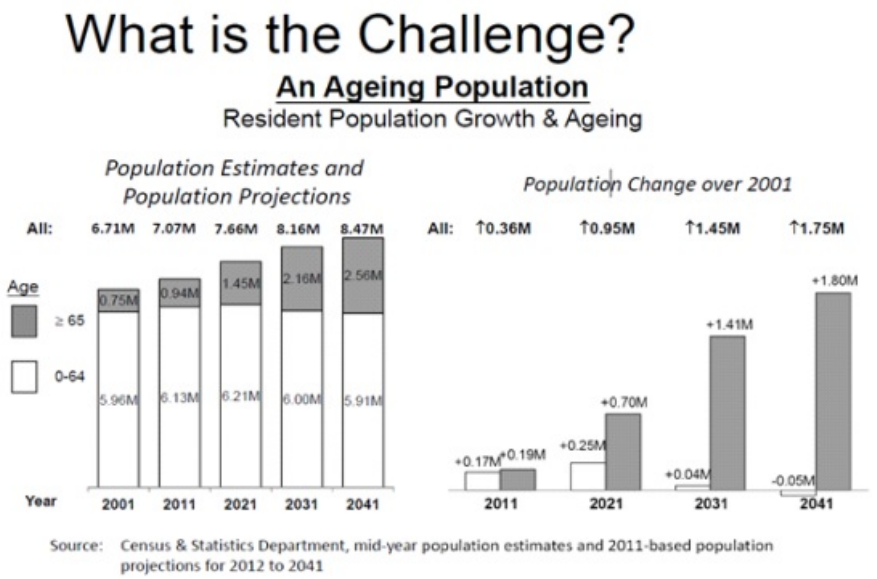
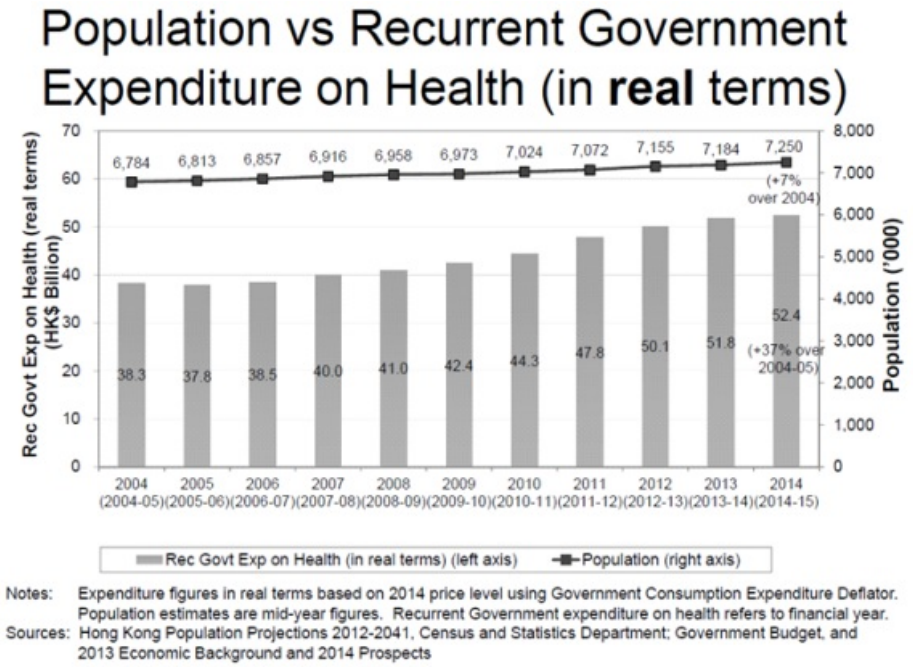


Figure 2



The implication of the ageing phenomenon is already being felt — without much of our notice. Figure 2 compares the real growth of Government spending on health care with population growth in the past decade. It shows that Government investment

on improving health care services (37%) has outpaced population growth (7%) by a wide margin of more than five times during the same period. However, the quality of public hospital service in terms of waiting time at the Specialist Outpatient Clinics (SOPC) (Figure 3) shows no corresponding improvement notwithstanding the rapid increase in Government funding. The true story is the growth of those aged 65 who are more prone to sickness and being hospitalized has been increasing at a much faster rate (30%) than that of the overall population (7%) (Figure 4).

Figure 3

Figure 4

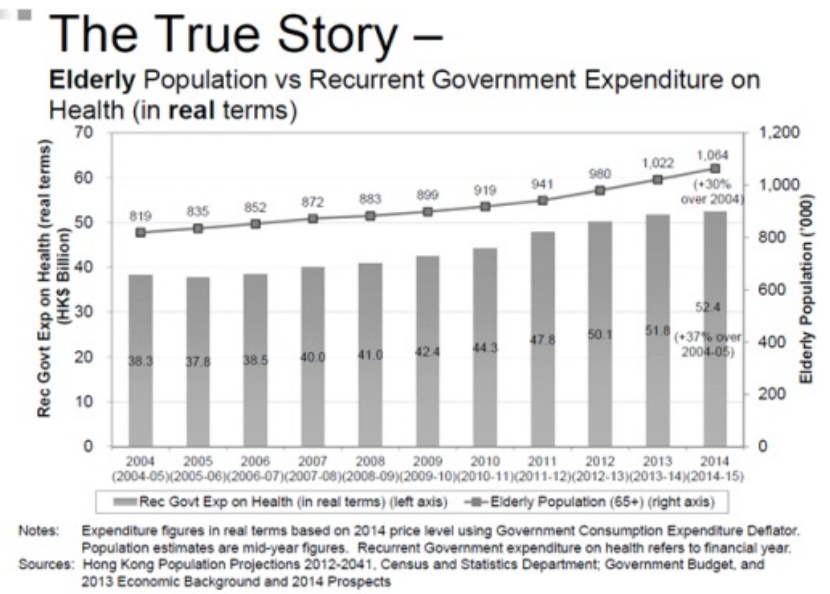
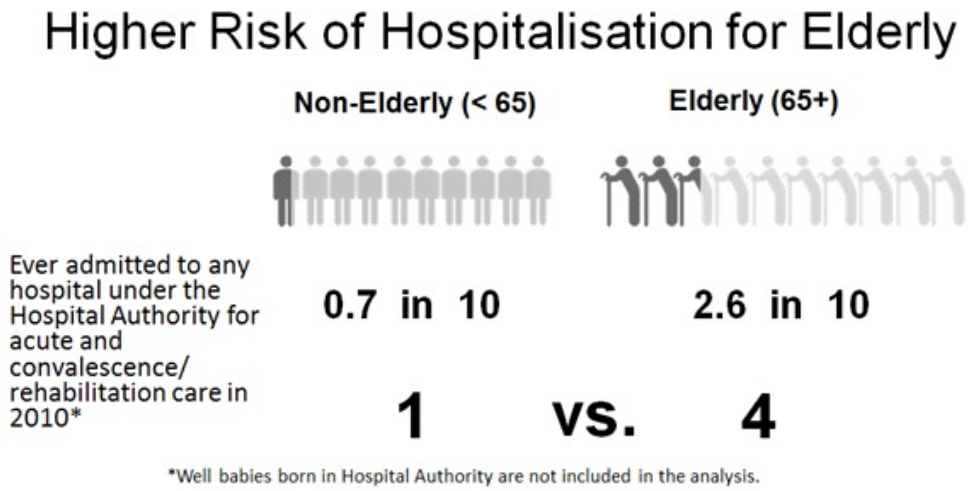


Figure 5



The demand for medical treatment is compounded by the fact that, according to the Hospital Authority's figures, the hospitalization rate of a person who is aged 65 or above is four times that of someone who is aged below 65 (Figure 5) and it grows exponentially as the age advances (Figure 6).

To quantify the challenge of ageing in terms of the demand for and provision of public health services, the Hospital Authority has estimated that Hong Kong will need to provide an additional 8 800 hospital beds in the public sector alone in the next 20 years to meet forecast growth in demand (Figure 7).

Figure 6

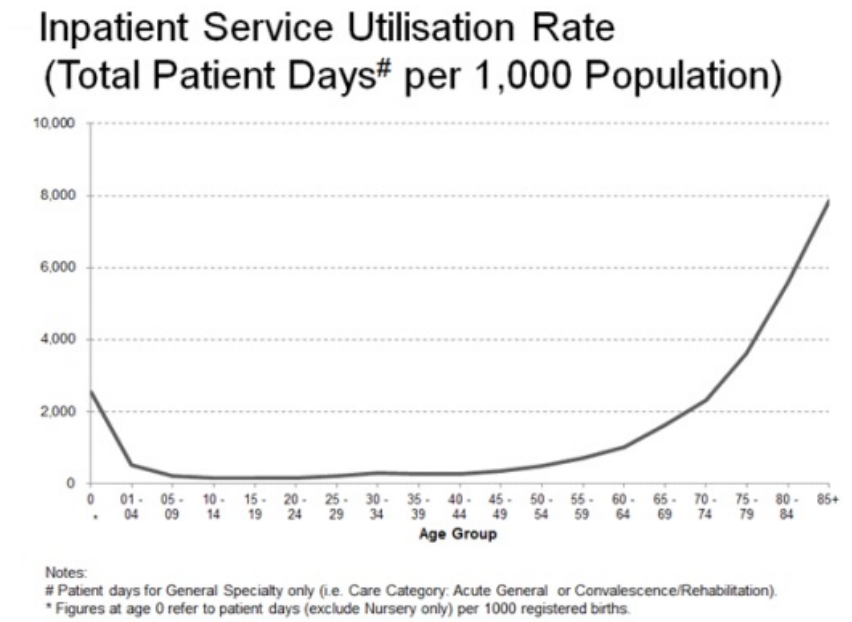


Figure 7

To help visualize the impact, what this means is that Hong Kong will need to build six comprehensive hospitals, each of the size of Queen Mary Hospital, in the next 20 years. The capital cost of each such hospital is in the region of $15 billion in current day prices. Each will need a land footprint of some 10 hectares and a team of some 5000 health care professionals and supporting staff and an annual budget of $ 3 billion to manage and operate it.

While we tend to focus on the public finance implications of the challenge of an ageing population, the challenge to the public health (and private) system actually has three different dimensions — cost, manpower, and facilities — and we cannot just look at reforming the health care financing system alone to solve the challenges of an ageing population in public health and other public services provision.

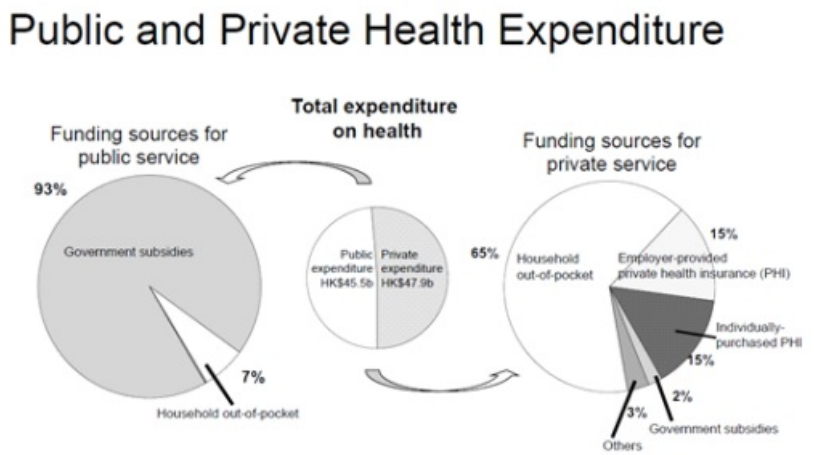
Cost

In the last two decades, similar to many other economies, the Hong Kong Government has made several attempts to reform the health care financing system to ensure its long-term sustainability (Figure 8).

Figure 8

They were all subsequently shelved due to the lack of public support in the subsequent public consultation process. Many blame it on the lack of political will. But is it true that the reason for the public to resist health care reform is their unwillingness to take more responsibility of their share of the health care costs? A closer look at the health care expenditure in Hong Kong (Figure 9) shows that the people of Hong Kong are already paying half of the health care costs out-of-pocket.

Figure 9



Source: Hong Kong's Domestic Health Accounts: 2010-11

This is because in Hong Kong, primary care, mostly episodic treatments, is mainly provided through the private medical sector, and the Government — through the statutory Hospital Authority — focuses mainly on the provision of secondary and tertiary (i.e. hospital) and emergency and other specialized services. Compared with other public health systems in the world (which are either wholly public funded or primarily relying on the private market to meet the health care needs of the citizens), the Hong Kong model is already based on shared responsibility and it gives people a choice and encourages them to take charge of their health through primary care. It also enables the private medical sector (including private hospitals which currently account for around 10% of hospital admissions) to have room to develop, gives doctors a career choice and mobility, and promotes synergy and complementarity between the public and private systems. Had primary care been provided through the public system like some other countries and economies, the challenge of ageing population would have been doubled.

It is, therefore, easy to understand that, conceptually, the Health Protection Scheme (HPS) being proposed is fundamentally different from the previous three health care reform initiatives in one major aspect — it neither copies from any overseas model nor is it intended to be a total solution. It is developed having regard to, and building upon, the strengths of the unique health care system in Hong Kong — the co-existence

of a vibrant, successful and well trusted public and private health care market. We have no intention and no one would agree that we should fundamentally change this well tested and well trusted dual markets system in Hong Kong and any mandatory contributory scheme is unlikely to be able to carry the day.

The objective of HPS is to leverage on the growing affluence of the community, as the baby-boomers are also growing old, and the successful and vibrant private health insurance market in Hong Kong, to encourage and facilitate those who can afford it and willing to do so to have a choice to use private hospital service through the support of a value-for-money private health insurance policy. To do so, we need to enhance consumer protection by addressing its current perceived weaknesses including insufficient protection, no guaranteed renewal which tends to discourage claims and the policyholders from seeking early treatment, complicated and confusing product structure, and opaque hospital charges. It is not just affordability, but also the adequacy of protection and the trust in the product, that influences a consumer's decision to take out a private health insurance.

The key word of HPS is "voluntary" and the main objective is "empowerment". It should be emphasized that those who have taken out a private health insurance policy will continue to be able to use the service of the Hospital Authority just like anybody in Hong Kong. But he will have an additional choice. It will be up to the individual (and not the Government) to decide whether he wants to seek treatment in the public hospital setting or a private hospital when he needs to do so. With the support of a quality private health insurance policy, an individual may prefer to seek treatment in the private sector for the common diseases where he can have a choice of doctor, better time management and a more convenient setting. And in more complicated cases, he may like to be treated in the public hospital setting with its strong medical team, which has the expertise and capability of handling such procedures. With private health insurance, he will have the choice and HPS is designed to enable more Hong Kong people to have and to be able to afford such choices. We will not force anyone to make the choice. With a trusted HPS, more people will be able to afford the choice and for every individual who opts to use the private hospital, the place thus released from the public hospital could be provided to someone who is more in need of the service, which will help reduce the waiting time of public hospitals and allow the individual who has HPS and the one who cannot afford private health insurance both to receive treatment earlier. The HPS will serve as a tool to facilitate the rebalancing between public and private hospital service through the willingness of the patients concerned and, by giving more people a choice, it helps promote synergy between the two sectors and better and more efficient use of public and private hospital facilities and capacities.

Manpower

The rapid increase in demand for medical services as the population ages does not only create a huge burden on public finance, it has also created other non-financial implications. Money is only the means; ultimately we need people to provide the service. Indeed, as demonstrated in Figure 2, there is no shortage of Government commitment in investing in the public health system to enhance the capacity of public

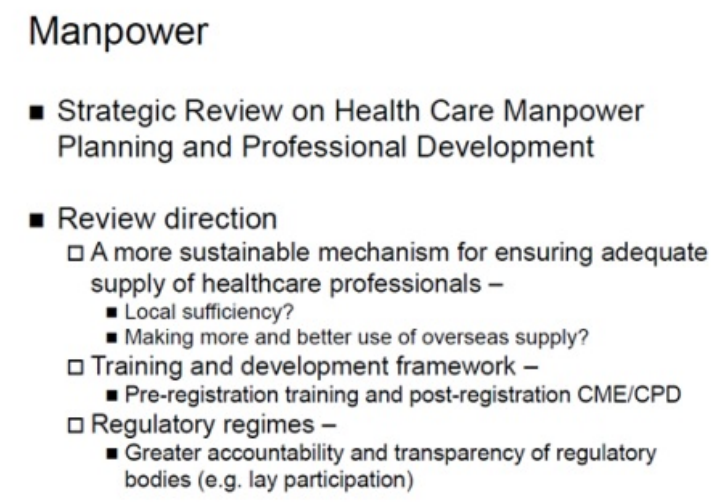
hospitals to meet demand in recent years. The bottleneck is in the supply of health care workers. Shortage of health care workers has become a universal problem and everywhere is scrambling to train and attract more health care workers to join the profession.

The two medical schools in Hong Kong, which provide the main pool of young doctors, have increased their combined annual intake of medical students from 250 to 320 in 2009/10, and further to 420 in 2012/13. It takes six years to train a young doctor and 13 years to train a specialist. The public sector alone is currently short of some 300 doctors. The shortage is not due to the lack of public funding. It is primarily a result of the reduction in the number of annual intake of medical students from 320 to 280 in 2003/04 and further to 250 in 2005/06 due to the economic downturn and fiscal constraint of the Government in the early 2000s.

Given the long turnaround time for training a medical doctor, we cannot afford to make such a planning mistake again in the future, especially with the challenge of an ageing population. Short-term measures are being made to attract overseas trained doctors to return to serve Hong Kong, including increasing the number of annual licensing examinations from once a year to twice a year and exploring with the Medical Council the possibility of reducing the period of internship training requirement so as to attract more overseas practicing doctors (especially those with family roots in Hong Kong) to come back.

To provide a longer-term solution, the Government has committed the University of Hong Kong to establish a computer-aided dynamic forecasting model to project the long-term manpower needs of the main health care professions. The objective is to formulate a long-term health care manpower training and professional development strategy, which will help ensure a stable supply of health care workers in both the public and private sectors (to cater for the unique dual-market health care system in Hong Kong) and the long-term sustainability of our health care system, and avoid long-term training of health care professionals being affected too much by the vicissitudes of the economic cycle (Figure 10).

Figure 10



Facilities

A unique problem facing Hong Kong in tackling the health care challenge of an ageing population is the scarcity of land. Even with funding and adequate supply of manpower, the identification of suitable land to meet the hospital redevelopment and building programme would be a major difficulty. Given the land constraint, we must continue to plan ahead and in the meantime to optimize the land use and capacity of existing hospitals. Instead of the traditional way of meeting forecast demand by planning hospital projects on an individual basis, the Hospital Authority is taking a new approach of developing cluster-based clinical service plans starting with the Hong Kong West Cluster (Figure 11).

Figure 11

This would help define clearly the role of different hospitals inside the cluster, promote synergy and collaboration between hospitals and focus the health care team on the needs of the cluster as a whole and not just their own clientele. This new approach will raise the efficiency of the public hospital system and capacity utilization in the hospitals and the cluster as a whole, helping ensure the sustainability of our public health system under the challenge of an ageing population.

We need New Thinking

To deal with the long-term financial challenge of an ageing population, the rational approach is to promote self-reliance and a medical saving scheme, which is also a common model in many countries and economies in the world. This has to be implemented before, and preferably long before, the trend of ageing has set in when the community collectively and the population individually are more able to afford it and take up the responsibility. The projected demographic change of the Hong Kong population in Figure 12 and the rising trend of dependence ratio in Figure 13 show that the shifting of the traditional population "pyramid" from a rhombus to a reversed pyramid means that the burden of taking care of the old and young will increasingly fall on the shrinking stratum of the economically active population in the community. Any

mandatory contributory scheme or saving scheme is not going to be palatable to the community, especially taken into account the fact that in Hong Kong, the community has already contributed to half of the health care costs through out-of-pocket or private insurance in the primary care market and, at the same time, they are enjoying a highly subsidized but efficient and well trusted public hospital system. In public administration, a balance has always to be struck between the theoretical rationality and political reality.

Figure 12

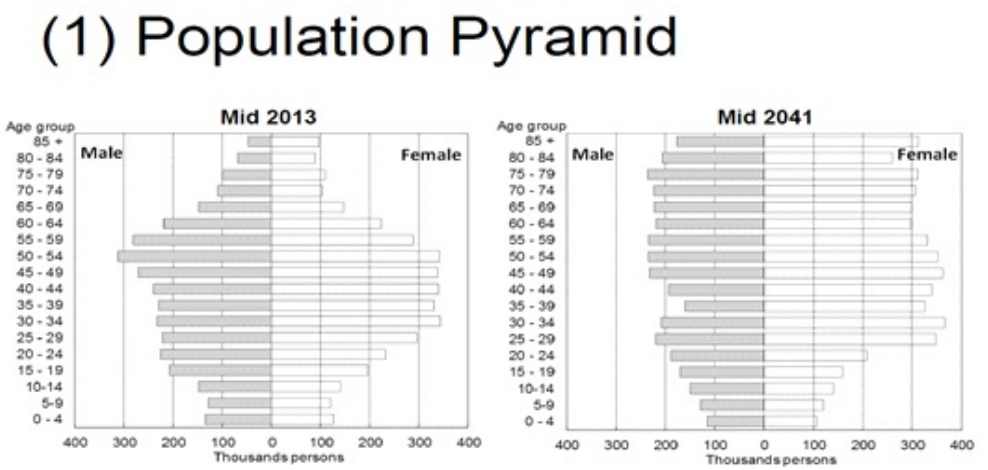


Figure 13

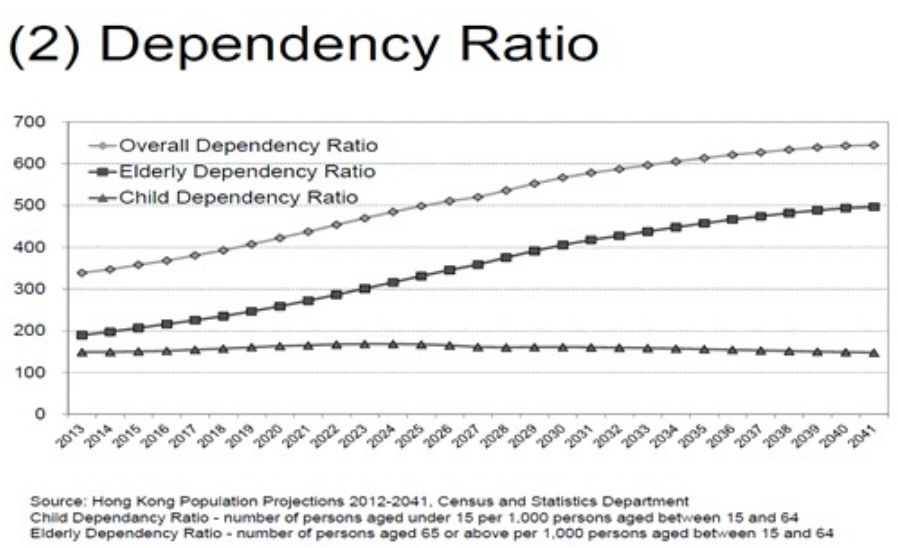
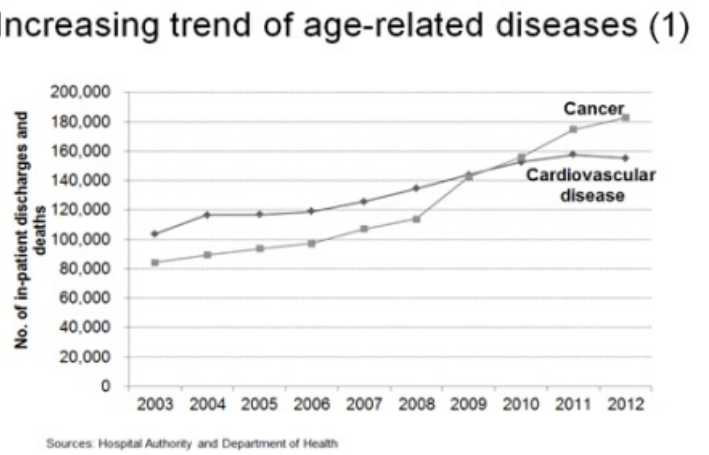


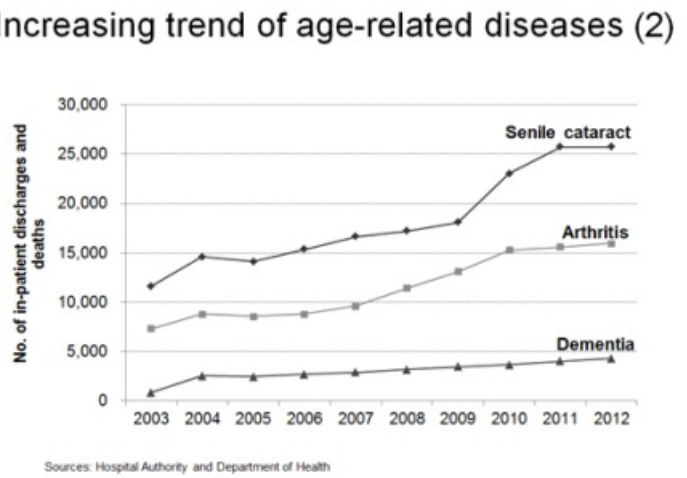
Figure 14



Simply put, to tackle the challenge of an ageing society, we cannot simply look for or rely on a fiscal solution. With a shrinking population — and at least a shrinking economically active stratum of the population — in the horizon, we have to look for solutions that would optimize the use of existing and any additional resources. After all, we are facing an unconventional challenge that has not been seen by humankind in its history and we need innovative thinking.

The main challenges to the public health system in the coming years are the age-related diseases (Figure 14 and 15). The inexorable rise of demand for treatment and surgical procedures means that even with the best will in the world and unlimited amount of financial resources, it would be impossible to meet the demand given the natural limitation of physical land and manpower constraints (land to build new hospital facilities and training of health care professionals). Money alone cannot solve the problem. We must look for other solutions in parallel, especially advancement in medical technology and new service delivery models.

Figure 15



Procedural re-engineering, such as concentrating cataract operations in a few dedicated cataract centers, has produced a multiple increase in capacity and a reduction of waiting time from years to months. This demonstrates that we have to move away from the conventional linear approach to capacity expansion, where in order to double the capacity we need to double the amount of resources financial, physical and manpower resources alike. Such an approach will be unsustainable in dealing with the exponential growth of demand for health care service in an ageing society. We have to look for solutions that have a significant multiplying effect so that, with the same amount of resources or same amount of additional resources, it can produce a multiple increase in efficiency and service capacity. We need to take a proactive approach and identify the most prevalent age-related diseases such as joint replacement orthopedic surgery, prostrate-related diseases, cancers, and dementia, etc. and start looking for such solutions.

Another top priority area that we have to look at is integrated elderly care service. The medical wards are the main pressure points in public hospital services (see Figure 16 and 17).

Figure 16

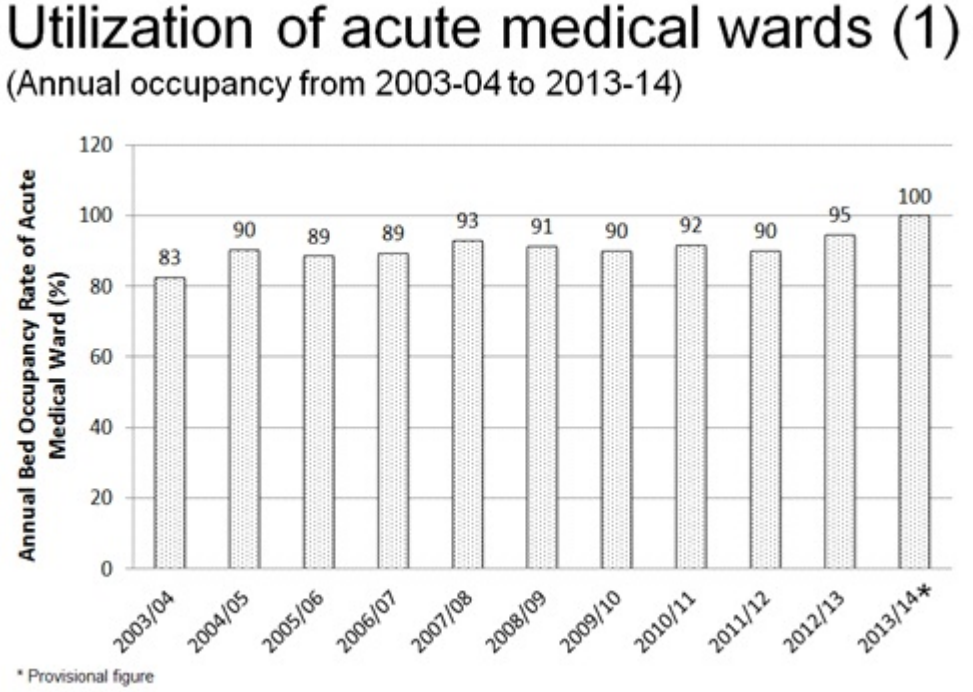
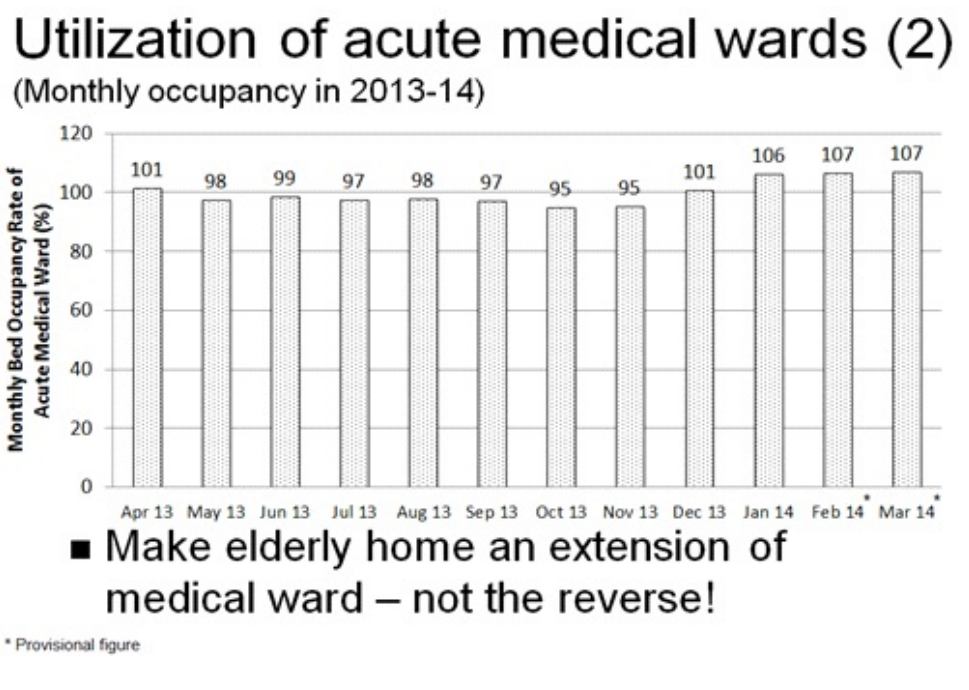


Figure 17



They are operating at nearly full capacity during most of time of the year and are being utilized at over 100% capacity during influenza peaks each year. The beds are mostly taken up by elderly people, many of whom stay in elderly home and are suffering from chronic illness and are more prone to influenza infection and weather change. We need to make better use of elderly home facilities and promote cooperation and collaboration between hospitals and elderly homes, so that through better facilities, resources and medical support, we can reduce the number of elderly admission to hospital. It will not only help relieve congestion in public hospitals, it will also avoid shuffling elderly between hospitals and elderly homes with all the associated public health concerns and risks and discomfort and psychological shock to the elderly. To tackle the challenge of an ageing population, we need to mobilize community support and resources, especially in handling those diseases where care is more effective than treatment such as dementia, so that we can sustain an affordable health care system in the face of the challenge of an ageing society.

The community as a whole has to consider the concept of home-based care, neighbourhood support and community care, and reviving the tradition of itinerant doctors (where the doctor goes to visit a patient instead of moving the elderly between home, elderly home and hospital) and end-of-life care. We should not only focus on extending life (where hospitals are good at) but also maintaining the quality of life of elderly (home-based care).

Conclusion

Ageing presents society with a multitude of challenges. The exponential growth of the elderly population means that the conventional linear model of proportional increase in resources to meet increase in demand is unsustainable and unaffordable to the economy. Around the world, countries and economies are looking for new solutions. With the diverse social, economic, and political situation; no single solution can work for all. Indeed, given the multiple challenges of ageing to a society, there is no "silver bullet" that can solve all problems. We need a multi-pronged approach, taking into account our unique social, historical and cultural environment. The HPS is not meant to be the "single" solution to solve the health care financing problem. Its objective is to build on the distinct feature of the Hong Kong health care system where we have the co-existence of vibrant, successful, and well-trust public and private medical sectors. The objective of the voluntary HPS, through better regulation of the private health insurance market and more transparency of private hospital charges, is to provide incentive and to encourage and facilitate more people who are willing and can afford it to take up private health insurance, and those who have already bought health insurance to make better and full use of their policies, so as to rebalance the public and private medical sector and optimize the utilization of resources of both sectors. Through better use of the slack capacity in the private health care sector, it will be a more cost effective solution to address the general and acute shortage of health care professional resources, which we are all facing around the world. We have to continue to look for solutions to address the long-term health care financing problem. Money alone cannot solve the problem, especially given the rising dependency ratio associated with an ageing community. We need to have new thinking and look for solutions, other than fiscal solutions, to tackle the challenges. The way going forward has to be reviving the traditional Chinese virtue of family, community and neighbourhood support, and promoting the concept of ageing at home and home-based care. We should not be clouded by the financial challenge of an ageing population and focus only on maintaining and extending life, we need to focus equally, if not more, on maintaining the quality of life of ageing.

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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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An Assessment of Medical Tourism Development Potential in Mainland China

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Abstract

Medical tourism is an emerging form of tourism, which has been developing, rapidly in the past decade. Medical tourism has gradually become an important sector that generates revenues for many countries and regions around the world (e.g., India, Thailand and Singapore). China has the potential to develop medical tourism. Traditional Chinese medicines and therapies (e.g., acupuncture, cupping) have a long history and have become a popular form of alternative medicine/treatment in many countries (e.g., U.S.). Nevertheless, China has not yet fully leveraged its resources and lacks behind its Southeast Asian counterparts in terms of medical tourism development. The current paper aims to evaluate the resource that China possesses for medical tourism, analyze its strengths and weaknesses, and offer policy implications for all stakeholders concerned.

Keywords: medical tourism, China, traditional Chinese medicine, strength, weakness

Medical Tourism

Medical tourism has gained increasing popularity in recent years. It is a term to describe the phenomenon that people travel across international borders to obtain health care (Ye *et al*., 2011). Medical tourism has been developing rapidly in many countries and regions such as India, Thailand, Singapore, and Taiwan. For example, there are approximately 500,000 medical tourists visiting Thailand in 2011, growing by 16% annually (Eden, 2012). India has attracted 850,000 medical tourists in 2011, and the number of its foreign patients is expected to reach 3,200,000 by 2015 (Hassan, 2013). In 2008, the number of medical tourists in Singapore has reached 370,000, together with 230,000 accompanied friend or relatives, which generated around 1.5 billion U.S. dollar (Singapore Tourism Board, 2009). In 2008, India, Thailand and Singapore occupied approximately 90% of the Asian medical tourism market (NaRanong and NaRanong, 2011). Accordingly to KPMG (Klynveld Peat Marwick Goerdeler), which is one of the largest professional services companies in the world, the global medical tourism market experienced an annual growth rate of 20%-30% in recent years and the market is expected to reach 100 billion US dollar by 2012. As compared with the fast growth in many east-Asian medical tourism destinations, China is lacking behind in its

development. According to a recent nation-wide in-bound tourist research on travel motivation, sight-seeing (41.1%) and enjoying leisure holidays (23.3%) are the major motivation for their visit to China, while other motivations such as for medical reason remain occupy trivial proportion (Xu and Liu, 2011).

China has the potential to become the regional medical tourism destination. First, traditional Chinese medicines and therapies (e.g., acupuncture, cupping) have a long history and have become a popular form of alternative medicine/treatment in China and many other countries (e.g., U.S.). Second, China also has abundant natural and cultural resources for tourism which can enrich tourist experiences during their journey (Kucukusta and Heung, 2012). Third, the medical tourism expenditure in China is rather low as compared with developed countries. Despite of the aforementioned advantages, China has not yet fully leveraged its resources and its medical tourism development is in infant stage.

By far, there have been some cities (e.g., Sanya, Shanghai) that launched medical tourism by offering particular medical service (e.g., traditional Chinese medicine) to overseas patients and some provinces and cities (e.g. Hainan province) have implemented strategic plans to develop themselves into medical tourism hub. For example, Hainan province plans to establish "Boao Lecheng" medical tourism centre, covering services such as elderly care, cosmetic and plastic surgery, traditional Chinese medicine, chronic diseases rehabilitation and sub-health sanatorium. The State Council of China has implemented a series of favourable policies for the centre. These policies, specifically designed for such a special zone, cover tax reduction for imported medical facilities and medicines, approval of foreign capital investment in hospitals, speeding up procedures for importing medical facilities and medicines, extended foreign medical professionals' working period in the zone to 3 years, and approval of state-of-the-art research on stem cell technology and so on (People.com, 2013). Guangdong province, under the "Mainland and Hong Kong Closer Economic Partnership Arrangement (CEPA)", allows Hong Kong service suppliers to set up on the Mainland, wholly-owned medical institutions or medical institutions in the form of equity joint venture or contractual joint venture with Mainland medical institutions, companies, enterprises and other economic organizations (CEPA Supplement IX). Such policies encourage foreign capitals and professionals to enter into Mainland market and boost medical tourism development. In fact, the first wholly owned hospital of Hong Kong opened in Shenzhen, Guangdong in 2013, receiving both mainlander patients and medical tourists from Hong Kong. By far, there have been 22 medical institutions in Hong Kong established outpatient departments in Guangdong province according to Guangdong health care administration. It is expected that the scope of the policy will expand to other provinces and capital cities in China.

Although China has initiated some strategic plans and formulated favourable policies at the provincial level in recent years, medical tourism development of China is still lacking behind as compared with its Southeast Asian counterparts. The current paper aims to evaluate the resources that China possesses for medical tourism, analyze

strengths and weaknesses, and offer policy implications for parties concerned.

Assessment of China's Medical Tourism: its Strengths and Weaknesses

Strength 1: Uniqueness of traditional Chinese medicines and therapies

Chinese people have been using Traditional Chinese Medicines (TCM) and therapies for more than two thousand years (Li, 2009). TCM encompasses herbal medicines and a variety of practices, ranging from acupuncture, cupping to massage ("tui na"), tai chi, qi gong. TCM is a unique system to diagnose and cure illness. Although it is generally criticized that TCM lacks scientific proof and clinical validation, the effectiveness of TCM in curing some diseases was noticeable and there has been a growing number of scientific research revealing its active components (Chan, 1995; Efferth *et al*., 2002; Efferth *et al*., 2007; Konkimalla and Efferth, 2008; Yuan and Lin, 2000). As compared to western medicines, TCM applies a holistic approach, viewing the mind and body as a whole system, and aims to restore a harmonious equilibrium (Chan *et al*., 2002). For example, cited by the World Health Organization (WHO) to treat more than 40 conditions and recognized as Intangible Cultural Heritage, acupuncture has gained its popularity as an alternative form of treatment in many countries (e.g., U.S.), with a number of training centres established (Accreditation Commission for Acupuncture and Oriental Medicine, 2013). Many foreigners even visit China to learn it and the principles about TCM. According to the latest research by the World Federation of Acupuncture-Moxibustion Societies, acupuncture and moxibustion of traditional Chinese medicine has been widely applied in 183 countries, including all the countries in Asia and South America (Liu, 2013). It has been reported that foreign patients who could not cure their diseases with conventional western medicines or treatments will turn to TCM for alternative treatment (Sina, 2010). In addition, TCM places much emphasis on disease prevention. With its uniqueness of TCM, China may differentiate from other competitors, gaining much room for growth.

Strength 2: Low medical care cost and availability of certain procedures

Like many other east-Asian counterparts, China has relatively low medical care cost. For example, heart surgeries cost around one tenth of the price in US and hip or knee replacements in Shanghai are less than 30% that of the US prices (Songwanich, 2013). For meson knife in the treatment of tumor, the price in Shanghai is around one sixth of the US prices (Sina.com, 2010). The price difference of various procedures was denoted in Table 1. As can be seen, the prices of many procedures in Shanghai, China were even lower than its east-Asian competitors. Hence, China gains competitive advantage in terms of medical care cost. Most importantly, medical tourists can undertake some procedures that are illegal or prohibited in their home countries (e.g., stem cells technology) and some procedures that are no longer available in their home countries (e.g., industrial pneumoconiosis). It has been reported that many medical tourists in China sought medical procedures that not available in their countries (Sina.com, 2010).

Table 1: Price Comparison of Different Medical Procedures in Some Countries

Surgery	USA	India	Thailand	Singapore	China
Heart Bypass	$130,000	$10,000	$11,000	$18,500	$10,500
Heart Valve Replacement	$140,000	$9,500	$25,000	$22,000	$10,000
Angioplasty	$57,000	$11,000	$13,000	$13,000	$11,500
Hip Replacement	$43,000	$9,000	$12,000	$12,000	$10,000
Knee Replacement	$40,000	$8,500	$10,000	$13,000	$10,400
Spinal Fusion	$62,000	$5,500	$7,000	$9,000	$6,500
Dental Implant	$2,200	$600	$2,150	$2,500	$1,500
Breast Implants	$10,000	$2,600	$2,700	$8,000	$3,500
Rhinoplasty	$8,000	$2,000	$5,300	$2,000	$2,500
Face Lift	$15,000	$4,800	$5,000	$7,500	$5,000
Hysterectomy	$20,000	$3,000	$4,500	$6,000	$4,000
Gastric Bypass	$28,000	$11,000	$15,000	$15,000	$12,000
Prostate Surgery	$16,000	$3,600	$4,400	$5,300	$3,000

Note: These costs are an average and may not be the actual cost to be incurred. The price of medical procedures in China was represented by the prices in Shanghai.

Sources: Shanghai Medical Tourism Products & Promotion Platform http://www.shmtppp.com/cost

Strength 3: Abundant cultural and natural resources

One important facilitator for medical tourism development is the tourism resource of destinations. Although it is not advisable to travel after the medical procedures for some treatments, many medical tourists can enjoy their trips before the treatments by participating into a variety of tourism activities (e.g., sightseeing, shopping etc.). China possesses various landscapes ranging from coastlines, lakes, and rivers to mountains and valleys. China is also rich in its diversified ethnic cultures (i.e., 56 ethnic groups) and more than 4000 years' history. At present, China has 31 world cultural heritages and 10 world natural heritages, ranked number two in the world. Accordingly to the forecast of the world tourism organization, China will become the first tourist country by 2020, with 130 million arrivals (UNWTO: Tourism 2020 Vision). The rich cultural and natural resources of China serve as great attractions to medical tourists. In fact, Hainan province, which features its comfortable weather and world-class scenic resorts along the coastlines, has already positioned itself as the best place for medical tourism. A large project named "Boao Lecheng" was in progress, with an aim to develop into a globally renowned medical tourism destination (Ho *et al*., 2011).

Weakness 1: Language and cultural barriers

Unlike many other Asian medical practitioners who receive education in English and are more proficient in English (e.g., India, Thailand, Singapore), many Chinese medical practitioners lack English proficiency. It was revealed that differences in languages create communication barriers during medical service, which in turn, affects the service quality (Ye *et al*., 2012). Trust with the medical practitioners has been found

to influence medical tourists' intention to engage in medical tourism (Han, 2013). If medical tourists and medical practitioners cannot communicate in an efficient manner, the former will perceive greater risk and have less trust with medical providers. In addition, it would be difficult for Chinese medical practitioners to communicate with medical tourists, particularly westerners, the mechanism of TCM which has its roots in Chinese cultural (e.g., Taoism). Hence, it takes time and effort to convince medical tourists about the mechanism and efficacy of TCM.

Weakness 2: Lack of international accreditation

Quality and safety are major concerns for medical tourists. One of the crucial ways to ensure quality and safety, and establish a positive image of medical tourism is to gain international accreditation of medical service. Joint Commission International (JCI) accreditation, whose checklist includes over 350 standards ranging from surgical hygiene to credential medical staff and nurses, was an important and popular channel where hospitals gain international prominence. After several rounds of accreditation surveys (e.g., interviews with staff and patients, on-site observations), hospitals that demonstrate acceptable compliance with all standards will be granted accreditation. Although China has been developing very rapidly since the economic reform in the late 1970s, the overall health care service image of China is not comparable with those of the economically developed countries. The numbers of hospitals in China, which obtain international accreditation such as JCI, are scant. At present, there are only 23 hospitals in China are JCI Accredited Organizations (Taiwan 10, Singapore 14, Thailand 27, India 19). It would be a major barrier for medical tourism to go international if there were not enough accredited medical service providers.

Weakness 3: Inadequate policy support

Medical tourism development requires support from the government to coordinate efforts from different stakeholders such as hospitals, travel agents, medical service agents, and tourism board and health authority. Many countries have established offices and formulated policies that facilitate medical tourism development. For example, Thailand formulated a goal to become a Health Care Tourism Hub in Asia. Singapore aims to develop into medical hub in Asia. Singapore has implemented a policy called "Medical Hub in Asia", which includes seven policy recommendations as the policy framework. These policies range from brand establishment (i.e., SingaporeMedicine), simplified the immigration procedures, supported clinical research in health care institutions, to encouraging greater transparency on pricing and clinical practice norms. India has established association of medical tourism of India and formulated a series of regulations, policies and plans that facilitate medical tourism development. While the east-Asian counterparts received substantial government support in terms of policy formulation and establishment of medical tourism office, China does not have adequate support from the central government (Kucukusta and Heung, 2012). At present, only a few provinces or cities have formulated strategic plans and policies that guide medical tourism development (e.g., Hainan province). However, such favourable policies are confined to this special zone and not yet implemented to the provincial level and

country level. Still, there seems to be lack of coordination among medical service providers, tourism service providers and different level of governments.

Inadequate policy support for quality assurance and dispute resolutions system is also a barrier for medical tourism development in China. There have been some malpractices in medical tourism such as non-medical institutions or unlicensed practitioners offering traditional Chinese therapies (People.cn, 2012). In the past decade, the medical disputes in China have also received increasing media exposure, and some of the disputes turned into violence in the hospitals, which we termed "yi nao (medical disturbance)". In 2010, the total number of medical disturbance increased by 5000 to 17243 cases within 5 years (People.cn, 2012). One of the plausible reasons is that the patients did not trust the service providers and allegedly challenge the reliability of the medical verification system. The media coverage of medical disputes has undoubtedly affected the overall image of medical tourism in China.

Weakness 4: Low brand awareness

Unlike cosmetic surgery in Korea, heart surgeries in India, and trans-gender procedures in Thailand, China currently does not have some featured medical treatments that are popular among medical tourists. Hence, the brand awareness of medical tourism in China is rather low. The medical tourism development in China is in its infancy stage, without offering a wide range of products that cater to tourists' need. Although TCM gains its popularity among some western countries, negative publicity and scientific evidences regarding toxic substances contained in TCM (Lv *et al*., 2012) have undoubtedly worsen the image of medical tourism in China. Therefore, visiting China to obtain medical care is still not a preferred option for many medical tourists. This was reflected by the phenomenon that the majority of medical tourists visiting Hainan province are domestic tourists (Ho *et al*., 2011). As aforementioned, Hainan province plans to develop into a medical tourism hub. Without adequate awareness from the international medical tourists, it is difficult to achieve such a strategic goal.

Policy Implications

Based on the above discussion, there seems to be a long way to for the medical tourism development in China. To sharpen its competitive edge and accelerate development, the practitioners and the Chinese government should put much effort on the following areas:

Gaining more international accreditation

To gain brand awareness and build up trust among potential medical tourists, it is a prerequisite for medical service providers gain international accreditation. The Chinese health care department should offer some necessary guidance and support for some hospitals, which aim to attract medical tourists to obtain JCI. Particularly, for some cities or provinces that aim to develop medical tourism (e.g., Shanghai, Beijing, Guangzhou, Hainan), the government should consider offer some financial support or incentives for the hospitals, which possess adequate resources and facilities to pursue

JCI. Particularly, accredited hospitals should be encouraged to exchange their experiences to obtain JCI and other accreditation.

Establishment of medical tourism office and association

The Chinese government should consider establish offices responsible for coordinating different departments such as tourism association and health authority. Particularly, a medical tourism office under China National Tourism Administration (CNTA) and a medical tourism association should be established. The proposed medical tourism office under CNTA mainly deals with policy formulation and strategic planning that guide development. The association should facilitate cooperation between medical service providers and travel agent that jointly promote and offer medical tourism products.

Formulation of regulations

Regulating the medical tourism market is crucial for sustainable development. The government should formulate entry requirements, quality control system, and other policies to regulate the market and build up customer confidence. For example, the government may consider emulate India's practice to establish a star-rating system based on each hospital's service quality.

In addition, the medical dispute system should be reviewed and improved. Safety is a major consideration for medical tourists. Medical tourists hope to have a pleasant and safe medical trip. Whenever there are medical accidents or medical dispute, medical tourists want to have a fair resolution system. Therefore, the central government should consider formulate new policy to ensure a transparent and credible system to ensure any disputes regarding medical tourism be resolved properly.

Enhancement of promotions

Although the number of overseas tourists keeps mounting, little is known about medical tourism in China. Currently, there are only a few official platforms that promote medical tourism in China and publicity of medical tourism by hospitals is even scarcer. Hence, a joint marketing campaign incorporating inputs from both medical and tourism sector should be considered. The promotions may first feature unique characteristics of China such as acupuncture, cupping and tui na with which medical tourists may be more familiar and acceptable, followed by traditional regimen, traditional Chinese medicine and its underling mechanism, so that medical tourists recognize and establish faith with medical tourism in China in a progressive manner. The promotion may also focus on the-state-of-the-art technologies (e.g., meson knife in the treatment of tumor) with a much lower cost in China, while simultaneously enjoying the holidays in beautiful scenic resorts.

Conclusion

Medical tourism in China is at its infancy stage, with only a few medical service providers attempting to enter into the market. With its immense developmental potentials, China could leverage its unique resources and advantages such as low cost to compete in the market. For the Chinese government, it is necessary to establish a medical tourism office that responsible for international promotion, regulating practices, and coordinating efforts from different sectors. It is a tedious task but with a promising future.

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The Application of New Public Management in the Reforms of French and German Health Care Systems: A Comparative Analysis

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Abstract

The purpose of this research is to review the application of New Public Management (NPM) in German and French health care systems. The paper traces the progression of NPM implementation, and advises the reader on NPM's most salient characteristics: delivery mechanisms and the quest for rationality and accountability. While networked-based organizations and regulatory changes signal a strengthening of the government's role in health care, opportunism has remained strong and accountability weak. Despite NPM's high portability, there are national differences in its implementation. Finally, key limitations and significant misfits (e.g. decentralization) between policy announcements and NPM's implementation emerge, which leads us to a critical evaluation of NPM's application in French and German health care.

Keywords: NPM Reform, France, Germany, health care

NPM Adoption in France

While many instruments of New Public Management (e.g. control and evaluation, quality circles, definition of cost targets and quality objectives) were introduced in the mid-1980s under the guise of the Public Services Association (Bezes, 2009), New Public Management (NPM) culminated with the government Juppé (1995-1997) who viewed the State as a 'strategist' and encouraged the delegation of strategy execution when possible (Martinache, 2009). The arrival of the rightist Sarkozy government (2007-2012) at the helm of the country provided a new momentum to NPM at a time when the legitimacy crisis of the French State was greater than in other countries. Moreover, many stakeholders, particularly the media and the public, questioned the State's role in various areas. The 1994-1997 economic crisis lasted longer in France than in neighbouring countries. Despite rising education budgets, French academic outcomes have been falling (PISA, 2009). In agriculture, the government failed to redistribute subsidies to the poorer groups of farmers, such as fruit producers or truck farms. Public programmes, such as housing, have been unable to cope with demand; others such as adult learning programmes have been accused of resource squandering. The government also failed in core roles, i.e. street safety (in 2001, France had a 1% higher crime rate than in US; France ranked 13th then, compared to the US at 15th)

(UNICRI, 2002), and was also indicted on major health scandals (e.g. blood transfusion in the 1980s, asbestosis in the 1990s) while both economic and social inequities were rising. Other factors such as tendencies to over-spend and over-regulate, the pursuit of self-interest amongst both politicians and civil servants, resource misallocation, decisions based on political rather than public benefits (Coignard and Gubert, 2011) led more individuals to express a rising distrust against governmental actions. Succumbing to the pressure of capital markets, a fear of capital outflow, politicians have increasingly been worrying about unstoppable budget deficits and have been more outspoken about ways to combat it. Senior officials were prompted to reform the government under EU directives and to respond to lobbies (for instance, insurance and drug firms lobbies in health care). Public sector monopolies (e.g. the airline sector before the privatization of national carriers and the opening-up of competition to private airlines; telecommunication services) were dismantled with relative ease in the 1990s, opening the way for further reforms, in sectors including health care that were thought to be relatively immune to NPM. These reforms were needed. While demand for commodity goods has flattened, health care expenditures have grown steadily and at a faster pace than the GDP per capita.

NPM Defining Characteristics

NPM focuses on using market forces to serve public purposes; opening up to competition; and instilling competition among public and private service providers. The practice of contracting out government services to networks of non-profit and for-profit organizations has been referred to as the '*hollow state*' (Milward and Provan, 2000). NPM also entails the devolution and decentralization of decisions within public services (Ferlie *et al.*, 1996), incentivization or economic motivations to enhance public sector efficiency and desegregation or splitting of large bureaucracies into smaller more manageable entities (Pollitt, 1993). Other NPM tools include a greater emphasis on explicit standards of performance (e.g. performance targets for managers); benchmarking; managerial autonomy (Dunleavy and Hood, 1994); and new ways of using resources to increase efficiency and effectiveness. NPM also entails a strong implementation component with practical and managerial recipes (Ferlie *et al.*, 1996).

The French and German Health Care Systems: Differences and Similarities

Since 1945, the French National Health Insurance has been combining all health insurance contributions into a common fund (risk-pooling). This is a quasi-monopolistic situation designed to spread risk across a very large population base and to enable the National Health Insurance or 'Assurance Maladie', the country's largest buyer of medical services, to exert its bargaining power during fee negotiations with care providers and physicians. The central government has retained the core function of health policy planning and financing, including hospital funding with decentralization being limited to reform implementation and care delivery. In contrast, Germany developed a health coverage system for its workers (other categories such as self-

employed craftsmen were excluded from the system) well ahead of France, as early as 1883. Today, medical costs in Germany are equally split between employers and employees, with the government paying for medical coverage of the poor. Unlike France, Germany has a dual system that requires employees to purchase a statutory insurance or *Gesetzliche Krankenversicherung (GKV)* from their *sickness funds.* However, civil servants, the self-employed, and those earning more than approximately €50,000 per year can opt out of the GKV and purchase a private health insurance. The statutory insurance covers 90 percent of the population while private insurance covers the remaining 10 percent. Another difference, the German ministry of health plays a monitoring role. Reimbursement decisions and health policies are defined by a federal joint committee that regroups a variety of stakeholders (health providers, insurers, and even patients). This keeps the system dynamic and in the hands of health care stakeholders rather than in the hands of a central government. Both the French and German systems are overstretched due to an ageing population and rising health care expenditures per capita ($4,218 per capita or 11.1% of GDP in Germany; $4,021 per capita in France or 11.6% of the GDP), despite good health outcomes. Germans perceive their general health status to be roughly similar to that of the French and the British: 74% rate their health as good or very good (European Commission, 2007). For a recap of the main characteristics of both health care systems, see Table 1.

Table 1: Main characteristics of German and French health care systems

	France	Germany
Insurance	Single unified and centralized Insurance system (French Assurance Maladie) divided only into three main branches (employees, self-employed professionals and agriculture).	Fragmented with Statutory Health Insurance comprising about 200 competing sickness funds
Coverage	Universal with the adoption of the "universal medical coverage" (CMU—Couverture médicale universelle) in 2000 with identical benefits	Universal; Generalized access, benefits differed depending on affiliation to sickness fund
Role and Extent of Private Insurers	Private insurers provide co-insurance, and pay for services that are poorly-covered by the public system	Private insurers cover 10 % of the population with civil servants and self-employed being the largest groups
Cost-sharing	Up to 30 % via co-insurance, copayments or extra billing	Cannot exceed 2 % of household income
Payment mechanisms	DRG-like prospective payment system and non activity-based grant for public and non-profit hospitals	DRG (1,192 categories)
Hospitals	2/3 of hospital beds are in government-owned or not-for-profit hospitals. The remainders are in private for-profit clinics.	Hospitals are mainly non-profit, both public (about half of the beds) and private (around one third of the beds)
Organizational reform	Merger of public insurance and public administration (e.g. health policies, care management, social services) into regional health agencies; national computerized system of medical records	Decentralized implementation with regions ("*Länder"*), sickness funds, and health ministry; attempt at centralizing financing: with the creation of a central health fund ("Gesundheitsfonds")
Decision making	Political parties have limited involvement; reform proposals drafted by governing elite drafts	Self-governance regime with a mix of health insurance and non-governmental organizations, employers' associations and medical labor unions

Source: Commonwealth Fund (2010); Steffen (2010)

The Move toward a Re-Concentration of Policy Planning and Financing

The fragmentation of health services has always been a longstanding characteristic of the French health care system, as health care has always been person-centred and politically sensitive. In many French cities, the hospital is the largest employer; the city mayor is a member of the hospital board of directors. A compounding factor was the rise of a regional authority of the early 1990s (Montricher, 2000, 1995). Moreover, there have always been a high number of public and non-public regional health organizations with regulatory and monitoring powers. Among these were the Health Authority on Health or '*Haute Autorité de la Santé*' which replaced the National Accreditation and Health Evaluation Agency or '*Agence Nationale pour l'Accréditation et l'Evaluation de la Santé*' in 2004 and the National Safety Agency for Health Care Products or '*Agence Française de Sécurité Sanitaire des Produits de Santé*'. Add to that the local agencies, e.g. the Regional Sickness Funds or '*Caisses Régionales d'Assurance Maladie*'; the Regional Association of Sickness Funds or '*Union Régionale des Caisses d'Assurance Maladie'*, which was subsequently dismantled by the 2009 Hospitals Patients Santé (Health) Territories (HPST) law; the Regional Directorship for Sanitary and Social Affairs or *'Direction Régionale des Affaires Sanitaires et Sociales*' (suppressed by the 2009 HPST law); the Health Regional Observatories or '*Observatoires Régionaux de Santé*'; the Public Health Regional Groups or '*Groupement Régionaux de Santé Publique'* that often supplemented the Regional Hospitalization Agencies or '*Agence Régionales d'Hospitalisation'* instead of complementing them. The fragmentation created uncertainties among the public about the accountability and responsibility of outcomes, for instance, between the ministry of health, the local health agency, and the physicians. As the European Healthcare Fraud and Corruption Network (EHFCN) reports, '*Services are highly decentralized and individualized, making it difficult to standardize and monitor service provision and procurement*' (EHFCN, 2010). Moreover, that fragmentation did not lead to optimal results, unless there was a 'civic-regarding' entrepreneurialism in which citizens play an active role. Unfortunately 'civic regarding' is more difficult in a domain as complex and specialized as health care, as shown by the delay in tackling the PIP breast implants (though the defective product had been on the market since 2001, it was only recalled in 2010) and the Mediator drug scandal in 2010 (the French Agency for Safety of Health Products admitted that 'at least 500 deaths' could be attributed to the drug). The drug should have been recalled as early as 1999 (IGAS, 2010). Due to these limitations and in contrast to the NPM axiom that legitimized the dismantling of large bureaucratic organizations into smaller closer-to-users entities, the French government attempted to re-concentrate all decentralized powers into Regional Health Agencies, the core element of the HPST 2009 law. In 2010, the Regional Health Agencies or *'Agence Régionales de Santé'* replaced the Regional Hospitalization Agencies and became responsible for all health care institutions (not just hospitals), negotiating multi-year contracts with hospital directors according to hospital activity volume. They are also set to implement centrally-defined policies, including cost and quality targets; prevent the widening of regional health care disparities; counter the formation of the local strongholds characterized by crony

management; accelerate hospital mergers and provide the financial expertise that regions typically lack in an effort to contain rising costs. From 2000 till 2010, the debt of regions and departments increased by 124 % and 64% respectively (Capital, 2011). The law also intends to bring coherence to a national health system; allow a better planning and monitoring of hospital activity from the Ministry of health rather than from the regional level; reduce conflicts at the hospital strategic apex (Sarkozy demanded 'a real boss at the hospital') (Sarkozy, 2008) and respond to specific missions (the 2009 HPST law attributed 14 missions to hospitals), as in the NPM corporate model. Under this new framework, public hospitals no longer exist (they were renamed 'health care centers'). Privatization was also part of the government agenda, as was opening-up the public sector's labor market. For instance, public hospitals can now hire managers from the corporate world instead of the government-run National School of Public Health.

Rather than a re-concentration of power within Regional Health agencies, Germany opted for a recentralization of financing of its health system, a major U-turn from earlier policies. Decentralization had been on the German agenda since the 1970s with the federal government seeking to reduce its involvement in hospitals. 'Dual' (federal government and Provinces/Länder) financing of hospitals and planning competence of Länder were introduced as early as 1972. Länder were then entrusted with planning, financing and constructing new hospitals with statutory health insurers paying for their operating costs. By 1984, the federal state had withdrawn from hospital investment and financing. The 2004 reform introduced explicit financial incentives for sickness funds and care providers to negotiate contracts and fee schedules directly with one another, as in a system of Managed Competition. The NPM doctrinal makeshift (Bezes, 2005) views patients as customers. Until 1996, Germans were assigned to statutory sickness funds based on their work affiliation and therefore often ended up being covered by the same sickness fund for their entire life. Moreover, insurance premiums varied extensively from one sickness fund to another, which threatened the solidarity of the system. With the 2004 reforms, individuals were given more freedom to choose between competing *sickness funds*, though they still had to opt in through their employer. Finally, Germany achieved full universal coverage (Cheng and Reinhardt, 2008). Due to the crisis, more people, especially the youth, became self-employed or worked on and off, thus were not mandated to take up insurance. From 1 January 2009, however, every German has been covered under a basic insurance package. That same year the federal government took on responsibility for pooling all social health insurance contributions, via the creation of a central health fund or '*Gesundheitsfonds*', which was subsequently allocated to independent, private, competing sickness funds. The central health fund pays each sickness fund a risk-adjusted capitation rate (which depends on age, gender, and chronic conditions of the insured) for each insured person it covers. So, while the purchasing function remained in the hands of competing insurers, the financing and risk-pooling functions were unified; fiscal responsibilities were shifted away from the sickness funds to the national government level (Saltman, 2008), as in the French model of centralized financing.

The Rise of the Regulatory State

NPM-inspired entrepreneurial culture does not imply deregulation. With the adoption of NPM, there were more, not fewer, state regulations in France. Examples include: monitoring prices for services paid privately; substituting contract-based performance-related reimbursements for input-oriented budgets; preserving the confidentiality of patient records; regulating private insurers; controlling physician fees and allowing horizontal mergers. Growth in entrepreneurial activity was accompanied by a parallel growth in regulations, such as, state-funding mechanisms to calculate hospital budgets. French activity-based payments, via a synthetic activity indicator (*Tarification a l'Activité)* that reflects activity volume and German DRGs (where a dollar value is assigned to each group as the basis of payment for all cases in that group without regard to the actual cost of care or duration of hospitalization of any individual case) (Fritze *et al*., 2002), replaced global budgeting or input-oriented budgets (Reinhold *et al*., 2009). These new payment mechanisms expanded, rather than reduced the size of the regulatory state apparatus (Hassenteufel and Palier, 2007), as in foreign exemplars (Walshe, 2002).

Far from the Bismarck doctrine that originally prohibited the state from intervening in social issues, the German government has become very active in health care, not only via regulations, but also by taking part in the Advisory Council for Concerted Action in Health Care (i.e. a non public regulatory entity comprising insurers, care providers and employer representatives, public authorities and labour unions) and by controlling hospital planning and construction. Although entry barriers in the insurance market were eased, the law still monitors premiums and health services and calls upon officials from federal or state supervisory units to approve insurance contracts (Fischer, 2009). These are testament to the German State's increasing role, not a sign of its withdrawal from health affairs, as many had feared. Accreditation procedures provide a balance between strengthening entrepreneurialism and preserving patient's health benefits, and guarantees stability to the current health system while offering a safety net to the vulnerable (e.g. pensioners, chronic patients).

Mixed Performance of New Organizational Forms of Care Delivery

NPM's attempt to improve performance was conducive to new experiments in health care delivery, such as health networks and gatekeeper physicians. As advocated by NPM, there was a greater coordination between professionals (e.g. physician, welfare officers), for instance via health networks that include health and social workers to cater to certain population sub-groups (e.g. chronic patients, the destitute), via physician quality groups. Health networks often included non-medical organizations (e.g. social welfare organizations) and were widely accepted by both physicians and patients. They increased organizational performance in Germany (Stock, 2010) (Göbel *et al*., 2009) and France (Bagnis, 2008; Laville *et al*., 2007).

Other experiments such as gatekeeping were less successful. Reforms to implement

gatekeeper physicians fare well in the NPM conceptual framework, as they make patients and physicians more responsible for their decisions e.g. should a patient consult a specialist without being referred by a gatekeeper; he/she will bear a higher share of the consultation cost. Moreover, the physician is expected to become more cost-conscious (Mousques and Paris, 2002) under this scheme, as he/she controls access to hospital care. But experiments were short-lived: gatekeeping in France (e.g. '*médecin-référent*') was adopted in 2005 to control access to specialty care, but only 5 % of French citizens signed up for the programme which was dropped 2 years later. A subsequent reform that created a family doctor ('*médecin-traitant*') was successful as 85% of the insured had one in 2008. In Germany, gatekeeping experiments ('*hausarztsystem*') were confined to a small number of voluntary programmes (Greß *et al*., 2004).

Responsibility, Rationality and the Fight against Fraud

Was accountability greater under these reforms? The adoption of the NPM was partly based on the promise that a clear responsibility structure would raise transparency and help deter fraud, a prominent issue in French health care. According to the European Healthcare Fraud & Corruption Network (EHFCN), France has the second highest estimated fraud losses (i.e. Euros 10,576 billions) among 27 EU nations (EHFCN, 2010). Health reforms and decentralization in the 1990s, particularly in France, led to the emergence of multiple public agencies that have their own agenda along with limited obligations to comply with regulations since sanctions are financial rather than criminal (doctors nonetheless have an obligation to meet standard of care). Only in a few cases can the management of a public hospital be withdrawn from the hands of the director and his/her staff be directly monitored by the central government. Unlike the corporate sector where sanctions are a strong deterrent, and constitute a business risk that may lead to company closure, the risk is nil for state-run health care organizations since deficits will eventually be paid for by the tax-payer. As for the political risk, it remains a distant threat. Unlike pension reforms and unemployment, health care is rarely on the French political agenda. In Germany, though health policy was a major theme in the 2005 general elections, it was not among the openly debated issues during the 2009 general elections (Zander *et al*., 2009), probably because the grand coalition had just passed the Health Insurance Reform Act of 2009. Public organizations' inability to act rationally, even after NPM reforms, is compounded by the lack of external insight. Audit committees, supervisory public bodies and private consulting firms that help governments revamp the health care sector are run by too small of a community of policy makers. In Germany, public sickness funds claimed back €1.5 billion in 2009 from hospitals (Eucomed, 2010) due to fraudulent billing (information asymmetries regarding treatment options facilitate fraudulent billing) and fee shifting. According to the EHFCN, the cost of health care fraud in Germany is estimated to vary between €5 to 18 billion per year. Some NPM mechanisms, such as the computerized processing system for medical claims (submission, payment) created opportunities for fraud. Moreover, a competitive system (in contrast to the French

single payer system, German sickness funds compete for patients) is more conducive to fraud (Bade, 2011; Bade, 2012; Kulik *et al*., 2008).

Performance Evaluation and Quality Measurement

New Public Management did not contradict public policy making in France. Some of its elements (performance evaluation) have been part of the French budgeting process from early on. There has always been a long tradition of efficiency-oriented policies and of cost/benefit analysis in public policy making (Damart and Roy, 2009), particularly for major public investment projects. With the introduction of a new policy in 1968, known as the Rationalization of Budgeting Decisions or '*Rationalization des Choix Budgetaires*' designed to streamline budgetary decisions, France adopted a PPBS-modelled scheme (or Planning-Programming-Budgeting Scheme), focusing on outcome-oriented rather than input-based budgets; breaking down programmes into missions that were monitored by performance indicators and subjected to Parliamentary scrutiny. Though cost/benefit analysis was abandoned in health care in the 1980s due to poor implementation (Chicoye *et al.*, 2002), it remained in use in other public sectors, such as infrastructure.

With NPM, France devoted more resources to the evaluation of the quality of care, particularly hospital care, via for instance the National Accreditation and Health Evaluation Agency. Part of that assessment effort was also delegated to the High Authority on Health. However, evidence of their effectiveness is still lacking. In the few evaluation exercises (High Authority of Health, 2010) conducted in France, quality indicators were often perceived by grassroots level stakeholders as a process imposed on them, designed to monitor their activity rather than improve it. Assessment of DRG's impact on measurable health outcomes (e.g. hospital readmission rates, length of stay, quality of care) and other basic indicators (e.g. mortality rates, quality of life), are not routinely available (Zeynep, 2010, 2011). According to the General Accounting Office (2009), there have been limited attempts to improve efficiency. As for the number of medical errors, only estimates (between 270,000 and 400,000 medical errors) exist. In Germany, the creation of an independent Centre for the Quality of Medicine (*"Das Deutsches Zentrum für Qualität in der Medizin"*), comprising representatives of sickness funds, hospitals, doctors and patients to decide on therapeutic standards and tools to evaluate quality of care and drug effectiveness (cost/benefits calculation), was discussed prior to the 2004 reform (GKV-Modernisierungsgesetz). However, the project was rejected and an Institute that provides evidence-based evaluations of health services replaced the Centre for the Quality of Medicine for Quality and Efficiency in Health Care. Quality measurement and monitoring in German hospitals include an array of 194 mandatory indicators that could potentially be used in a nationwide benchmarking exercise (Busse *et al*., 2009).

Differences in NPM Adoption

They were differences in the adoption of NPM: greater competition between

sickness funds was more suitable in Germany than in France; priority was given to health networks and care coordination in France. The French health system was modeled after the Bismarck (hospitals, doctors and supplementary insurance plans are private) and Beveridge doctrines (e.g. Universal Coverage). Though the Bismarck doctrine prohibits the State from intervening in social issues, leaving market regulation to sickness funds, the French government is actively in charge of health affairs. Owing to its long history of centralization, delegation was limited to the now defunct Regional Hospital Agencies (the current Regional Health Agencies will implement centrally-defined policy at the local level) and to the implementation of local health networks (e.g. between GPs and specialists). France never allowed sickness funds to participate in hospital governing boards, nor did it provide insurers with capitated payments, as in the German model (the *Gesundheitsfond has* been providing sickness funds with risk-adjusted capitated funds for their insured since 2009)**.** French labor unions and other key stakeholders (e.g. local politicians) oppose reforms, albeit often unsuccessfully, particularly those that may lead to hospital closure, as each medium-sized city wants its own hospital. In 2010, the closure of low-activity hospitals (e.g. those with fewer than 1,500 surgical operations per year) was postponed on the ground that surgeons operating in low-activity hospitals are equally experienced than those in high-activity hospitals. In addition to this, there was the slow implementation of legislation, political wrangling, weak enforcing capacities, and public demand for certain services (e.g. maternity care) that prevented more hospital closures. In Germany, hospital closure is equally difficult, not for fear of job losses, but because of the number and diversity of stakeholders that need to agree on strategic decisions. German hospitals, including university hospitals, do not belong to the federal government but to Länder, communes (*Kommune*) or private groups, and receive funding from sickness funds.

In both countries, NPM alone could not reduce health care costs and more conventional and drastic cost control measures were needed: frozen wages in the French public health sector; capped numbers of practitioners in Germany (e.g. doctor establishments are regulated); strict quotas for medical students in France, despite a critical lack of physicians in rural areas; a cap on the number of hospital beds (8.7 per 1,000 in France); bed closure; more stringent cuts in drug expenditures (e.g. a switch to non-branded drugs); and more emphasis on prevention than cure (Landrain, 2004).

German vs. French Physicians

French reformers can hardly expect the cooperation of physicians on reforms, though many are active as politicians and local notables. The strong physician culture, built over years of socialization in university hospitals where rite abounds, has led to the development of a strong group ethos. French physicians constitute powerful professional groups that are politically influential and enjoy the support of the population (i.e. there is a long tradition of having a family physician). Their clan culture and high professional independence often clash with public managerialism and remain a powerful deterrent to any attempt at reform. Unlike the UK with the local

commissioning system and Italy with its small medical units ("*Aziende Sanitarie Locali"*), France had difficulty reorganizing the primary care sector. GPs geographic dispersion, a lack of GPs in rural areas, and physician solo practice, which is a major characteristic of the French health system, not to mention its disconnection from any budgetary constraints, have hindered the implementation of health networks. The French government has little room for reform for fear of angering both physicians and citizens, who have always been supportive of the former. Hence, a 'Trust Pact' was established between the Ministry of Health and public hospitals to amend the 2009 HPST law (Couty, 2013): the newly-elected government will adopt a different DRG scale for public and private operators (as public hospitals face a higher burden such as physician training and residency, emergency and transplant services); reintegrate physicians in the hospital boards of directors; and grant 1.6 billion Euros to hospital financing in 2013. German doctors too experienced mounting bureaucracy and the growing power of hospital managers, but these changes were accepted, albeit reluctantly: professional discipline is higher; sickness funds benefit from greater bargaining power when negotiating with doctors; changes are negotiated with (rather than forced upon) physicians and endorsed by physician professional associations. Finally, for the insured, the benefits of competition between private health insurers (PKV) and statutory health insurance funds (GKV) outweigh its disadvantages (Leienbach, 2009).

NPM Limitation

The Washington Consensus that describes a set of policy prescriptions advocating a market-orientation: greater liberalization, privatization of state enterprises, tax reform and fiscal policy, was broken down in the aftermath of the 2008 financial crisis. Its key tenets that also inspired NPM offer no formula to deal with the rising health emergency (Rodrik, 2006). There is little evidence that private institutions perform better than public institutions. In terms of accessibility (Evans 2012; Horwitz and Nichols, 2011), responsiveness, and quality of care (Comondore *et al*., 2009; Beaulieu, 2004), public non-profit hospitals perform better than for-profit hospitals. For-profit facilities, and more generally, systems with managed competition, are only top performers on the criteria of shareholder profitability; compensation of hospital managers, physician and CEOs of insurance companies thanks to higher user fees - not higher productivity **(**Lamarche and Trigub-Clover, 2008**).** Compared with public ownership, private ownership (i.e., private non-profit and private for-profit) is not necessarily associated with higher quality (Mogyorósy, 2004**)**; lower costs (Herr, 2008); higher efficiency (Tiemann *et al*., 2012) or equity (billing disparities have been rising in US health care) (Centers of Medicaid and Medicare Services, 2013).

Not all principles contained in the NPM paradigm prove to be correct. NPM recommends smaller health players. However, in Germany, sickness funds experienced greater concentration (Nuscheler and Knaus, 2005). There were fewer than 500 sickness funds in 1998 with an average of 100,000 members per fund. That number fell to 420

in 2000; 242 in 2007; and in 2010, there were 166 statutory sickness funds. In France, public health authorities encouraged the regrouping of small-scale health units in high-volume hospitals to achieve economies of scale (Garabiol, 2006) and improve patient safety, as medical outcomes are better in larger - rather than smaller - hospitals (Tepas *et al*., 2013; Ross *et al*., 2010). This contradicts the NPM recommendations for smaller closer-to-patient facilities. Finally, rising medical disparities between French regions (surgical rate and per capita health care expenditures vary by 50 %, even between areas with similar demographic characteristics) (Clavreul, 2010) and discrepancies in medical follow-up and physician density (National Physician Council, 2011) raise questions about whether patients can still be served equitably. All these clash with the traditional Weberian theory that emphasizes equality and uniformity in the provision of public services (Weber, 1946).

Conclusion

NPM policies do not take into account institutional differences with some of their tools such as: disaggregation being popular in NPM index cases (mostly Anglo-Saxon countries) but not in Continental Western European countries, which also remained much more statist in terms of the organization and delivery of public services. France and Germany adopted quasi-markets between funders and providers. French public and private care providers compete for funding from Social Security, via DRG payments. German sickness funds can contract with care providers directly. However, this provider-funder dichotomy is expensive, as observed in the UK where quasi-markets increased transaction costs (Hunter, 2011) and created upward pressure on wages (care providers compete for physicians) (Saltman and Busse, *2002*). NPM adoption has reached its limits. Though the increased popularity of NPM ideas among political circles (for instance, the current French president Francois Hollande was a member of the French Public Services Association that endeavored to modernize public services using corporate management instruments, Martinache, 2009) backs private financing and outsourcing, decision makers must follow their citizens' aspirations. The Germans and the French are strongly attached to their universal coverage, which is achieved in different ways: via a single-payer system in France, and via mandatory health insurance and subsidized premiums in Germany. Both systems provide greater equity than the US: the entire population is subjected to the same basic insurance scheme. French citizens are increasingly preoccupied with unemployment (unemployment rate in France reached 10.9% in May 2013) and fear more hospital closings (in some rural areas, the hospital is often the largest employer). Thus, traditional NPM recipes, such as competition or outsourcing, which in the French psyche, all have the potential to create unemployment and social exclusion (privatization is often associated with higher user fees), are harder to trigger in the health care sector compared with other sectors (telecommunication services, air transportation), which were deregulated and privatized early on and with relative ease. The government is now rolling back the 2009 HPST law. We also found in the application of NPM in the French and German health care sectors some of its earlier and traditional critics (Hood, 1991). For instance, it did not solve

long lasting problems such as opportunism, buck-passing and regional disparities in France (Clavreul, 2010) and Germany (Ozegowski and Sundmacher, 2012). It did however; strengthen some of its elements. For instance, there is a greater integration and coordination of general practitioners and hospitals, via health networks.

Health care stakeholders were diversely affected. Reforms affected care providers and insurers more than they affected patients. There is a greater concentration of care providers in Germany (Schmid and Ulrich, 2013), and a greater competition between public or not-for-profit and for-profit providers in France (two-thirds of beds are government-owned or not-for-profit hospital beds) (Commonwealth Fund, 2010). Regarding insurers, rising differences in flat-rate premiums intensified competition in Germany, but the intended surge in quality failed to appear (Gopffarth and Henke, 2013). Though the French supplementary insurance market also experienced greater competition and concentration, it still managed to grow at an annual rate of 7.4% (Mutuelle Sante, 2010). Patients were not unscathed. More were prompted to purchase supplementary insurance. Between 1980 and 2008, the percentage of individuals covered by a supplementary insurance rose from 69 % of the French population to 94 % (Perronnin, Pierre and Rochereau, 2011; Commonwealth Fund, 2010). Moreover, patients are no longer free to consult a specialist without a referral from a general practitioner (if they wish to, they must pay a higher copayment). In contrast, German patients are better off. The 2007 reform achieved full universal coverage (before freelance workers or the self-employed were excluded). French physician specialists lost their discretionary power. They face a higher administrative burden, for instance, for the coding of medical procedures, and must comply with Regional Health Agencies, which have auditing power. In contrast to specialists, general practitioners were spared. Despite rising participation in health networks and pay-per-performance contracts for chronic diseases, they were not constrained by the same rationing efforts that affected hospitalists.

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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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