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The Politics of Health Care Reform in Hong Kong

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The Politics of Health Care Reform in Hong Kong

M. RAMESH

Abstract

The government of Hong Kong has been trying to reform the territory's health care financing system since the early 1990s and is finally on the verge of succeeding. The objective of the paper is to assess the reform efforts and explain the causes of repeated failures and eventual success. It will argue that the government's fortunes changed only after it abandoned the core reform goal and decided to pursue peripheral objectives. It will explain the abandonment with reference to the peculiar political system in Hong Kong which makes it difficult for the government to adopt substantial policy reforms in the face of even moderate opposition. The reason for the government's policy incapacity is the existence of Liberalism in a non-democratic setting which allows the government to neither suppress opposition nor mobilize popular support. This has been illustratively evident in its health care reforms when its proposals to improve the system's fiscal sustainability invariably met early death because they imposed costs on employers or the population or both. The current proposal has fared better not only because it addresses a simpler peripheral problem but also because it offends almost no one and pleases many among the powerful.

Introduction

Despite having one of the least expensive universal health care systems in the world (Wagstaff, 2005), the Government of Hong Kong has fretted over its financial viability since the early 1990s. To deal with what it sees as a serious impending problem, it has over the years launched five major reform initiatives. After failing repeatedly, the government finally has success in sight with its fifth attempt at reform. The purpose of this paper is to examine the Hong Kong government's efforts to reform the health care system and, more importantly, explore the reasons that account for their fate.

The paper will begin by describing the salient features of the health care system in Hong Kong and the government's attempts to reform it. The discussion will show that the government has persistently failed to convince the population that, first, there is a looming health care policy problem and, second, that they must accept a larger share of the burden for financing it. After failing repeatedly on both counts, the government has abandoned the goal of securing the long-term financial sustainability of the health care system and chosen to pursue a more achievable goal of expanding choice of providers. The paper will argue that the move away from the primary to a peripheral objective is the result of Hong Kong government's incapacity to adopt difficult policy reforms. The underlying reason for the incapacity, it will argue, is the peculiarly liberal but non-democratic political system that is un conducive to making difficult policy choices. The links between liberalism, democracy and social policy have been the subject of philosophical reflection and empirical analysis for decades without generating firm generalizable conclusions. It is not the purpose of the paper to contribute to the vast extant literature on the subject, but rather to further our understanding of the institutional contexts that shape policy reforms in Hong Kong. It will show that the entrenched liberalism in the territory makes it difficult to adopt solutions that challenge the current interests of powerful segments of the society. The constrain is aggravated by the absence of democracy which denies the government mechanisms for mobilizing the population against resistance to reforms. In the case of health care reform, the constraints manifest in the government's inability to adopt reforms involving any form of additional compulsory payment by employers and/or users. Eventually, the government turned to voluntary subsidized insurance because it is not compulsory and it is subsidized and, hence, acceptable to powerful groups even though it does not address the problem the problem of financial unsustainability.

Difficulties in adopting health care reforms are, of course, not unique to Hong Kong as governments everywhere find it difficult to adopt measures that increase taxes or charges or reduce benefits. Some do succeed in adopting such reforms, by persuading and cajoling reluctant population and out-manoeuvring powerful opposition groups to accept necessary changes. Deep health care reforms in South Korea and Taiwan during the early 1990s (Ramesh, 2004; Wong, 2004), in China and Vietnam throughout the 1990s (Bloom, 1998), and in Thailand in 2003 (Ramesh and Wu, 2009) offer telling contrasts to Hong Kong government's stilted and listless attempts over two decades. However, the challenge for the Hong Kong government is comparatively more difficult because it is in effect trying to reduce public benefits while its neighbours were expanding benefits (for effects of democracy on social policy reforms in Asia, see Wong, 2004; Haggard and Kaufman, 2008). Raising the health care costs borne by the population is an enormous challenge for any government which

has to face election. The absence of elections in Hong Kong would suggest easy adoption of difficult health care reforms but that is not the case and, hence, the question is why. The answer, the paper will argue, lies in the territory's liberalism and, curiously, the very lack of democracy that apparently makes adoption of difficult measures easy. Elections not only encumber governments but also enable them by affording mechanisms for mobilizing the population to adopt needed reforms. The Hong Kong government is thus handicapped by having liberalism without the enabling benefits of democracy.

The Health care system in Hong Kong: Design and Performance

The most salient feature of Hong Kong's health care system is that hospital care is largely public and outpatient care is largely private. Some 90 percent of all hospital admissions are in the public sector and this share has remained largely unchanged since the 1980s. In contrast, approximately 70 percent of outpatient care is provided in private facilities (GovHK, 2010). The payment system for public providers consists largely of capped annual budgets provided by the government whereas the private providers are paid largely from private sources on a Fee-for-service (FSS) basis. This particular combination of provision and financing has delivered some of the best outcomes in the world. The territory's average lifespan of 80 years for male and 86 years for female is the longest in the world whereas the infant mortality rate of 1.8 per 1,000 live births is one of the lowest (CSD, 2010). Similarly, its average Healthy Life Expectancy (HALE) at birth of 70 years for men and 76 years for women is the third and second highest respectively in the world (Law and Yip, 2003).

Remarkably, Hong Kong's fine health care status has been achieved at rather modest expenses, as its Total Expenditures on Health (TEH) forms some 5 percent of GDP which is considerably lower than the OECD average of 9 percent

(http://www.fhb.gov.hk/statistics/en/statistics/health_expenditure.htm#table1. Visited 16 April 2011). Hong Kong's TEH is estimated to be 18 percent below the rate 'predicted' by its income level (Wagstaff, 2005). No less remarkably, the population enjoys a highly equal access to health care which is reflected in the low incidence of catastrophic health care expenditures. In Hong Kong, the fraction of households with annualized per capita catastrophic payments exceeding 15 percent of the total annual per capita household spending amounts to only 5 percent of the population (Wagstaff, 2005).

Why reform the health care system which delivers such fine outcomes at modest cost? One reason is the rising TEH, which between 1980 and 2006 grew at an average annual rate of 8.2 percent compared to average economic

growth rate of 5.4 percent (Hong Kong, 2010B). A more significant reason worrying policymakers is the large government's share (approximately 50 percent) of TEH. What particularly vexes them is that nearly all of public financing is from government budget, as there is no social insurance in Hong Kong. The public budget spending is especially large for inpatient care – 73 percent of total inpatient spending - which is the most expensive and fastest growing component of health care (Hong Kong, 2010A Hong Kong, 2010C). The government fears that its large and growing expenditures on inpatient care is fiscally unsustainable in the long run. Health care already forms 15 percent of the total government expenditures and is projected to rise to 20 percent in 2020 and 27 percent in 2033. Correspondingly, the government's health spending is projected to rise to 4.1 of GDP in 2020 and 5.5 percent in 2033. While these shares are small by international comparisons, the government claims that it is large for the territory's low-tax environment (Food and Health Bureau, 2008). It is also the case that the government is uncomfortable with the commitment to financing such a large share of health care services due to its belief in “big market, small government” and would like to reduce it (Tsang, 2006).

Hong Kong population too is not as satisfied with the health care system as one might think looking at the headline expenditure and outcome indicators. Its greatest reason for dissatisfaction is the long waiting times at public hospitals, which on average is, for example, 3 hours for emergency, 3 months for CT scan for liver tumour, 5 months for liver cancer treatment, 31 months for cataract surgery, and 31 weeks for new cases for specialist outpatient services (*Sing Tao Daily*, 22nd April, 2009; *The Sun*, 8th March, 2008; *Hong Kong Daily News*, 15th June, 2010; Food and Health Bureau, 2008). While no one is denied immediate treatment in life-threatening situations, people would prefer greater access to medical services according to their own perceived need rather than as determined by the public provider. They do not appreciate that a main reason for Hong Kong's low TEH is its reliance on capped payment to public providers which necessarily involves some degree of rationing for non-urgent services. Provision of health care services on demand, as is the case in FFS system, would in all likelihood expand supply and reduce waiting time but will also increase expenditures (McPherson, et al. 1981; Wu and Ramesh, 2009).

History of Healthcare Financing Reforms in Hong Kong

Throughout the 1970s and 1980s, the main thrust of the Hong Kong government's health care policy was to expand the supply of hospital care and make it universally available. The objective was accomplished by making large investment in public hospitals and making the services available almost free of

charge to the entire population. While total health expenditures were small – forming about 3.9 percent of GDP in 1990 (Hay, 1992) – the government’s health expenditure was large and rising, from 1.4 percent of GDP in 1985 to 1.5 percent in 1990 (Dodsworth & Mihaljek, 1997) which the government considered ominous for fiscal sustainability.

The debate on reforming health care financing was launched in 1989 with the publication of a report by the Provisional Hospital Authority (the predecessor of Hospital Authority, which commenced operation in 1990). The report proposed recovery of 15 to 20 percent of the costs of services from patients, instead of the less than 3 percent that was the case at the time. The proposal made little headway in the context of a booming economy, which yielded increasing government revenues, and public apathy towards what was not yet a problem.

The first formal attempt to reform health care financing began with the publication of the consultation paper *Towards Better Health* in 1993 (Health and Welfare Bureau, 1993). The paper listed five options for reducing the government’s health care financing burden: 1) cost recovery of 5-15 percent of operating cost; 2) semi-private rooms in public hospitals for extra charges and itemized billing; 3) government coordinated voluntary and private health insurance; 4) compulsory public insurance; and 5) the Oregon approach giving the community a say in how public health care resources are allocated. The discussion paper drew more than 500 submissions, most of which supported option 2 (establishing semiprivate rooms) or option 3 (voluntary private insurance). In late 1993, the government expressed support for Option 2 and 3 favoured by the submissions (Bennett et al, 1996). However, it did not follow up with the necessary legislative or regulatory changes on the grounds that none of the options enjoyed sufficient community support (Legislative Council, 2005). There were speculations at the time that the government backed off in an effort to not aggravate the rocky ongoing negotiations with China over the future of Hong Kong (Woo, 2006).

The 1999 publication of a government-commissioned report entitled *Improving Hong Kong’s Health Care System: Why and For Whom?* (known as the Harvard Report, after the team from Harvard University that prepared it) generated much debate and laid the foundations for future discussions on the subject. The report concluded that while the existing system was equitable as well as efficient, it needed to be put on sounder fiscal footing because otherwise health care would be taking up 20-23 percent of the total government budget by 2016. The centrepiece of its reform proposal was the establishment of two new financing schemes: Hospital Security Plan (HSP) and Medisage. The former was a low-cost insurance scheme for specified chronic illnesses while the latter was a compulsory individual medical savings account plan

which could be drawn upon only during old age. Furthermore, it proposed cost recovery of up to 30 percent of the costs of services at public hospitals through user charges. The government did not express views on the proposals and the general public did not understand all the data and technical arguments presented in the report. Of those who did get involved in the discussion, the majority vociferously opposed the proposals for higher user charges and compulsory contributions to HSP and Medisage. Remarkably, doctors launched an unprecedented campaign against the proposal for centralized purchase of outpatient services by HA.

The Harvard Report formed the basis for the government's second consultation paper, called *Lifelong Investment in Health* published in 2000. The paper rejected the Harvard Report's proposed HSP on the grounds that a compulsory insurance scheme would increase labour costs, promote overuse, and be prone to deficits. It instead proposed higher user charges for non-essential services and a compulsory medical savings account scheme called Health Protection Account (HPA) to which everyone would contribute 1-2 percent of their income during the ages of 40 to 60 years and draw on it after the age of 65 years. The proposal was met with widespread opposition from the general population which disliked the idea of compulsory contribution to individual medical savings or paying higher user charges. Business groups opposed the proposal on the grounds that compulsory employer contribution would raise labour costs and thus reduce their international competitiveness. The proposal gradually disappeared from the agenda in the face of widespread opposition to its core features.

The third reform proposal came in the form of a consultation document entitled *Building a Healthy Tomorrow* published in 2005. The document concentrated more on provision rather than financing of health care. It recommended that public hospitals should concentrate on: 1) acute and emergency care; 2) services for low-income and under-privileged groups; and 3) illnesses that entail high cost, advances technology and multi-disciplinary team work that would either not be provided by the private sector or would be provided at unaffordable price. In effect, the document was recommending the transfer of all non-emergency and non-acute cases to general practitioners, who are largely in the private sector. Similarly, all simple or inexpensive inpatient and specialist outpatient care were to be shifted to private providers. The government did not do much to promote the report's recommendations and the public hardly got involved in the debate it was meant to generate. The report died a slow and unremarkable death by neglect.

The fourth effort at reform started with the publication of the consultation document *Healthcare Service and Financing Reform* in 2008. The document merely laid out different financing options without making a

recommendation, though the accompanying commentary indicated preference for compulsory medical savings account. The ensuing public consultation showed severe public opposition to any scheme requiring mandatory contributions, individual savings account or insurance. Correspondingly, the population indicated strong preference for voluntary schemes subsidized by the government.

Public consultations over the 2008 document was followed by the publication of another consultation paper called *My Health, My Choice* in 2010. The document is based on the feedback received on the 2008 paper and a government-commissioned consultancy report (Milliman, 2010). The cornerstone of the document is the proposal for a private voluntary health insurance scheme called Health Protection Scheme (HPS). The stated objectives of the HPS are :

- “A) *To encourage taking-out of health insurance and savings in order to:*
 - i) provide choice to those who are able and willing to pay for private healthcare...; and*
 - ii) in so doing, facilitate the greater use of private services as an alternative to public services.*
- B) *To improve transparency about service standards and price levels in the private health insurance and healthcare markets...” (Hong Kong, 2010B)*

It is notable that enhancing the financial sustainability of the health care system program is not mentioned as an objective, despite the fact that this was the reason why the reform was launched in the first place. HPS is rather meant to promote private health insurance and private health care in order to give users more choice, stated in the document’s title “My Health, My Choice”. It seeks to achieve the objective through measures to make private insurance attractive to the young (who tend to find insurance less attractive) and the aged (who may find insurance premium too high if set to the real cost of insuring them) by subsidizing them and to the rest of the population by guaranteeing portability. Subsequent announcements by the government indicated that it would provide up to HK\$ 50 billion in subsidies towards insurance for the young and the aged (Food and Health Bureau, 2010b). Notably, nowhere in the document or in the subsequent discussions did the government mention that a successful HPS would reduce the government’s expenditure on health care, avowedly a vital reform objective.

If and when HPS is adopted and implemented, the share of the insured population in Hong Kong will expand by approximately 300,000 households,

estimates the Government (Commercial Radio Hong Kong, 6th October, 2010). The insured will have more choice of providers than is currently the case, as they will be able to seek private services in addition to the continued right to use public services. Correspondingly, an expansion of the use of private medical services can be expected as patients use their insurance to avoid the unavoidable queues at public hospitals. However, utilization rates at public hospitals may not decline because of the various caps and deductibles under private insurance that will deter acute patients from using private hospitals.

The most optimistic estimates show that HPS will reduce waiting time at public hospitals rather than reduce demand for their services, thus making no or little impact on their expenditures (Milliman, 2010B). Even the waiting time may not decline if the private sector succeeds in attracting medical personnel with offer of higher income and thus causing supply shortage in the public sector. Furthermore, the erosion of the size of the public sector may weaken the government's bargaining power in negotiating prices and quantum of care with the providers which will weaken its ability to hold down expenditures (Milliman, 2010B). The Milliman consultancy (2010D) concludes "Overall, although the [HPS] Scheme is projected to provide some marginal relief to public health expenditure, it would result in almost negligible change in total government expenditure as the reduction in public health expenditure (due to reduction in utilisation of public health care services) is readily offset by provision of government incentives. In other words, the government turns out to spend more or less the same."

There is thus little chance that HPS would contain rising health care expenditures, avowedly the main goal of the government's health care reform efforts. There are two and only two ways to improve any public service program's financial viability: reduce expenditures or increase revenues. The HPS contains provisions for neither. It contains no recommendation for reducing expenditures and, in fact, the government has stated that it will maintain current levels of expenditures. If anything, HPS will increase expenditures to the extent of the subsidy that will be offered to HPS subscribers to make insurance attractive. Securing additional revenues is the only long-term option for reducing public expenditures and it is for this reason that all previous health care reform proposals have concentrated on it. By avoiding the entire issue of raising revenues and instead promoting choice for consumers, the current reform efforts do not even aspire to do what the government set out to do. So the question is, why did government turn away from securing the health care system's financial future, which according to its own admission is the greatest challenge, and is instead promoting choice for consumers which it has never presented as being a problem? The answer lies in Hong Kong's peculiar political system and the way it plays out in the health

care arena.

The Political Context of Health Care Reforms in Hong Kong

The government-dominated health care (along with education and housing) in Hong Kong developed without much deliberation or planning in the context of dire health care needs amidst economic boom in the 1970s and 1980s (Ramesh, 2004; Tang, 1998). Its development was a historical anomaly for the territory as it sat uneasily with the avowed *laissez faire* predilections and policies of the government, but the public coffers were overflowing and the contradictions were easy to overlook. The circumstances changed when public expenditures on health care rose exponentially and policymakers became aware of the fiscal effects of ageing population. The privatization wave that was sweeping the world in the 1990s also affected Hong Kong, tilting the government towards further reducing its already small role in the economy and society (Mok and Lau, 2002). In the health care arena, the shift manifested in efforts to make households and/or employers shoulder greater share of health care financing, despite solid evidence that the public system was already one of the world's most inexpensive and equitable (Harvard Team, 1999).

Once the government had decided to reduce its role in health care financing, it had only two sets of choices: reducing expenditure and/or increasing revenue. The room for former was limited, as it was already low compared to other high income countries. With expanding revenue as the only alternative, the government had to choose among a limited number of policy tools: higher user charges at public facilities, compulsory public insurance, and compulsory individual medical savings. All were painful options, as they required households and/or employers to make additional payments for what had been almost free. Looking back, the consultation documents proposing revenue-raising measures appear naïve but not surprising, given that the territory was ruled largely by civil servants lacking experience in the political craft necessary for driving difficult policy reforms.

Difficulties in adopting health care reforms are not unique for the Hong Kong government as it has had similar difficulties with other reforms, on issues as diverse as broadening the tax base, building waste incinerator, and developing cultural facilities (Cheung, 2004). In theory, the government can ram through any reform, because it does not have to face the wrath of voters. But the existence of liberalism and the diverse channels for free expression that are available make ignoring public opinion difficult. The limitation is compounded rather than offset by the absence of democracy in the territory, as we will see below. John Stuart Mill (1913) warned of the threats democracy posed for Liberalism. What the case of Hong Kong shows is that the lack of democracy poses just as much a problem because it weakens governments'

capacity to govern.

Hong Kong is one of the most liberal and open societies in the world (Alan, 1998). Right from the beginning of its establishment as a British colony, it has been a free port with a strong emphasis on ‘due process’ and ‘rule of law’ (Kuan, 1997; Loh, 2004). The Bill of Rights was adopted in 1991 guaranteeing the complete range of civil liberties typically found in Western democracies. The return of Hong Kong to China in 1997 left the liberal institutions intact and indeed enshrined in Chapter 3 of the Basic Law, which serves as the territory’s interim constitution (Davis, 2006). The territory continues to top Heritage Foundation’s (2011) Index of Economic Freedom (<http://www.heritage.org/index/>) and Fraser Institute’s Economic Freedom of the World Annual Report (<http://www.freetheworld.com/release.html>) more than a decade after re-integration with China. Public protests against the government and media criticism of public officials and policies are as robust as anywhere in the world.

The practical implication of entrenched Liberalism for policy-making is that it severely limits the Hong Kong government’s capacity to coerce the population to accept unpopular decisions as is often the case in illiberal systems such as mainland China. The rapid proliferation of civic groups and the spread of political activism since the mid-1990s has made the task of making unpopular decisions yet more problematic as civic groups and media outlets constantly scrutinize the government and freely express their opposition to proposed government measures (CIVICUS, 2006, Ma, 2008; Ortmann, 2009). Similar to popular media in other countries, local newspapers amplify and often exaggerate opposition to government’s policy proposals which undermines its capacity to adopt them.

More significant for policy purposes is the lack of democracy in Hong Kong. Unlike its ranking in the Freedom index, Hong Kong ranks lowly on the Democracy index: in the Economist Democracy Index, it is ranked 80 out of 164 countries and territories surveyed (*The Economist*, 2010). While not an authoritarian or even a semi-authoritarian system – thanks to the strong liberal institutions in place – Hong Kong is one of the few remaining places in the world where the government is not elected directly by the population. Neither the Executive nor the legislature is elected by popular vote which, remarkably, weakens rather than strengthens their capacity to govern in a liberal political context.

The executive arm of the government in Hong Kong is almost entirely undemocratic. The Chief Executive does not owe his office to popular mandate but to the support of his backers in the Central government and the local business and professional communities that appoint him (Steinhardt, 2007).

The members of the Executive Council (Execo), in turn, are appointed by the Chief Executive and tend to be drawn largely from the civil service or the corporate sector. As in Presidential systems, the executive branch is separate from the legislature and has to work with it on a case-by-case basis to secure passage of legislations (Lam, 2004). That neither the Chief Executive nor his Executive Councillors are members of a political party or indeed have political experience make their task of mobilizing legislative support difficult.

The Legislative Council (LegCo) is only slightly more democratic than the Execo. While it was established in 1843, it was not until 1991 that it had a directly elected member. Even today, only thirty of the sixty members are directly elected by the population: the remaining 30 are elected by “functional constituencies” consisting mostly of various business and professional interests. No single political party commands majority in the legislature which makes the passage of legislations difficult. Indeed the lack of a stable majority promotes posturing among parties jostling to solidify their voter base. In the absence of majority for any party, the business members are the most coherent group who often band together to stall policy proposals not to their liking. The absence of majority for any party also means that the Chief Executive must negotiate with different groups of legislators and offer compromises in order to secure their support.

In the absence of direct elections for the executive and the legislature and no mechanism to promote majority support for legislations, all major policy reforms face serious hurdles in Hong Kong. The Chief Executive cannot even turn to the population to rally against the legislature or call an election with the proposed policy as the main campaign issue because he himself is not popularly elected. Furthermore, the marginal position of voters in the political process promotes apathy and cynicism on their part and undermines the government’s capacity to seek their support for tough decisions (Loh, 2004). The absence of meaningful elections thus robs the governments of the legitimacy and popular support needed for adopting difficult reforms. As Gandhi (2008) has shown, elections perform vital legitimizing functions in non-democratic political system.

The Hong Kong government’s dependence on local elites and the Central government, and its lack of ability to turn to the population for support due to lack of democratic elections, vitally shape its policy orientation and capacity. The Chief Executive and his ministers cannot understandably take measures opposed by those who appoint them, evident in its reluctance to stand up to employers’ opposition to contributory health financing programs. Nor is it possible for the government to suppress opposition due to the liberal context which allows groups to assert their interests and protests to flourish. It is also difficult for government leaders to mobilize public support for their policies

because of their lack of experience in political campaigns, something that politicians elsewhere need to do routinely. With low capacity to resist and persuade, the government backs off easily in the face of opposition from business and/or business.

Lacking democratic legitimacy as well as political opportunities and skills in mobilizing support, and unable to ignore the opinion of the general public or powerful groups, the government typically panders to elites, negotiates with different factions in the legislature, and appeals to the public with giveaways (Cheung, 2010). To win their support, it often offers grants or subsidies or offers to relax proposed regulations. What is lost in these political transactions is the search for policy solutions that address the substance of the problem being addressed.

The particular political context in Hong Kong has grave consequences for controversial or deep policy reforms. In the case of health care financing, any meaningful reform must necessarily involve reducing expenditures or increasing revenues, not an easy choice for any government. Since reducing health care expenditure is not practical in the face of growing need for it, increasing revenues is the only option. But each time the Hong Kong government proposed revenue-raising options, the population and/or business predictably launched campaigns against the proposal and the government had to back off. Realizing that it does not have the capacity to make the population and/or the business to contribute more towards health care, in 2009 it finally gave up trying to adopt meaningful reform. It instead turned to voluntary insurance because of the political convenience it offers.

While people are not willing to pay insurance premium or make compulsory contributions to medical savings account, much less pay higher taxes or user charges, they are understandably all too happy to receive higher subsidies proposed under HPS. The offer of subsidized private insurance does not arouse significant opposition from the vast majority of the population who currently rely on the public system and expect to continue to rely on it. The mass public has accepted the government's assurance that budget support for public hospitals will be preserved (Chow, 2010, <http://www.myhealthmychoice.gov.hk/en/index.html>). The lack of mass opposition is fortuitously complemented by varying levels of support the HPS proposal enjoys from those expecting to benefit from it.

HPS is attractive to the middle class – the “sandwich class” – who feel that the government looks after only the rich and the poor (who receive public assistance and nearly free housing) and neglects them (Cautherley, 2009). They prefer the level of personalized health care that the rich receive and are frustrated by the often long waiting times at public hospitals. They support

HPS because subsidized private health insurance would give them more choice of providers without making them bear its full cost. The middle class' support for HPS is a key reason why it has not suffered the fate of the previous proposals that required additional contributions.

Voluntary private insurance also appeals to the business community because it imposes no additional cost on them, unlike social insurance or individual medical savings account arrangements. Moreover, promotion of a health insurance market that HPS promises is consistent with Hong Kong's ambition to be a global financial centre, a goal strongly supported by the business community. After the hollowing out of the territory's manufacturing base in the 1980s and 1990s, the government and business have placed great emphasis on promoting financial services industries, including health insurance (CSD, 2011; Hong Kong, 2003). In this regard, HPS has close parallels with the decision to launch the Mandatory Provident Fund (MPF) scheme in 1995 which was as much about developing the fund management industry in Hong Kong as providing income maintenance to the aged (Chan, 1996; Chan, 2001; Yu, 2006). It is hoped that a stronger health insurance and private hospital care industries would do for the local economy what the adoption of MPF has done since 2000.

Private hospitals are a strong supporter of HPS because they will be the largest beneficiary from its launch. They will see their business expand as those currently unable to afford private services would be able to do so after they have purchased subsidised HPS insurance plan. This is especially significant considering that there is significant under-utilization in private hospitals: the average occupancy rate for private hospitals is 69 percent, which is significantly lower than the 82 percent in public hospitals. (gia.info.gov.hk/general/200806/11/P200806110147_0147_40832.doc. Visited 12 April 2011). In fact, HPS is expected to be so successful in generating new business that there are concerns about the private hospitals' capacity to meet the additional demand (Food and Health Bureau, 2010a).

The private health insurance industry is also supportive of HPS, because of the new business it promises to bring. However, their enthusiasm is somewhat curbed by the slim profit margins it offers due to the various controls on what they can charge in premium and what they must provide to the insured as a condition for being certified as an HPS scheme (RTHK, 29 September 2010). Notwithstanding perfunctory reservations, the health insurance is solidly behind the HPS proposal.

The HPS proposal has come at opportune time, as the current Chief Executive nears the end of his term. Donald Tsang Yam Kuen, came to office with stellar policy credentials, widespread support and tremendous optimism

(<http://jmsc.hku.hk/hkstories/content/view/136/69/>), but his administration's record for adopting major policy reforms is thin. His government will be remembered for handing out ad hoc grants and subsidies – amounting to as much as US\$8 billion in 2011-12 alone (Leung, 2011) - to appease the population. HPS will continue his administration's record of giving away money in the name of addressing a public problem. The government can afford to offer subsidies for private health insurance because of the large budget surplus (equivalent to 4.1 percent of GDP in 2011/12 (Financial Secretary Office, 2011) it enjoys. What it cannot afford is policy solutions that address problems in a substantial manner because that would require political resources it lacks.

Conclusion

Hong Kong has an admirable health care system in terms of maintaining universal access at modest cost. The success is built on a publicly provided and financed hospital care system in which providers are paid on a capped basis whereas outpatient care is provided by the private sector paid from private sources. Yet the government has been concerned about the long-term financial viability of the current system as the population ages, expensive medical technology and pharmaceuticals proliferate, and the population's expectations of care rise. Some sections of the population too have been dissatisfied with the public hospital system because of the long waiting-time for non-emergency services.

After repeatedly failing to reform the health care financing system for two decades, in 2010 the Hong Kong government changed tack. Realizing that it was beyond its political capacity to adopt reforms involving user charges, compulsory insurance or individual medical savings accounts, it turned to promoting voluntary private health insurance and private hospitals for those who prefer private care. The unexpected turn in the government's reform efforts, whereby the focus shifted from securing long-term fiscal viability to expanding choice of private providers, reflects the peculiar political system that exists in Hong Kong. The existence of a liberal legal, economic and political system in a non-democratic context means that the government can neither stifle opposition nor build popular support for difficult policy measures. As a result, it can only adopt reforms that face no significant opposition from the population, local business elites, or Central government.

The proposed HPS arouses strong support from business and influential segments of the population and determined opposition from none. The vast majority of the population is agnostic towards it because it expects to remain untouched by it. On the other hand, the proposal is enthusiastically supported by the middle class that expects to benefit from subsidy for private insurance.

Similarly, private hospitals and private insurers are supporting it because they expect expanded business from the newly insured people. As a result, the government seems set to adopt private health insurance in some form, even though it is fully aware that the measure will do almost nothing to strengthen the health care financing system. Given the current political system in Hong Kong, expecting more meaningful health care reforms would be unrealistic.

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