

Health Care System Reforms in Hong Kong: The Implications of Greater Private Sector Participation

PETER P. YUEN*

The interactions between the public and private sectors constitute a major picture of the Hong Kong health care system. Recent initiatives by the government—the establishment of the Hospital Authority and the formation of a medical health insurance study group – are attempts to contain and reverse the growth of the government's involvement in financing and delivering health services. Such attempts can lead to serious cost escalations in view of the institutional and contextual characteristics of the Hong Kong health care system. The various options of health financing for Hong Kong are presented and a government regulated voluntary insurance scheme as the means to provide additional funding to the system is proposed. Under the scheme, private financing, in the form of private insurance, would play a greater role under stricter government monitoring and regulation. Mechanisms for quality assurance and cost-containment will be introduced as part of the scheme. The paper concludes by pointing out the impact that the system might have on the future health policy of the government.

Introduction

A report on Public Sector Reform was published in February 1989 by the Finance Branch of the Hong Kong Government containing suggestions for institutional reforms within the government. These reforms are along the lines of "contracting out," "corporatization," and "privatization" (Hong Kong Government Finance Branch 1989).

The transfer of the management and control of public hospitals from a government department to a corporate body – the Hospital Authority – was examined elsewhere in an earlier article (Yuen 1991). It argued that the direct financing and delivery of hospital services by the government was mainly responsible for making the community one of the healthiest in the world at less than half the cost spent by equivalent societies elsewhere. It also warned against the dismantling of the bureaucratic control mechanisms of the old system before having effective alternative control mechanisms in place. It predicted health care expenditure would go up after the devolution.

Whether intended or not, this recent devolution has created a situation which will inevitably lead to the expansion of private sector financing of hospital services. Such

*Senior Lecturer, Department of Management, Hong Kong Polytechnic.

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development could have important implications for employers, taxpayers and consumers. This paper has four parts. First is the review of the historical development of the Hong Kong health care systems in terms of the role played by the public and private sectors in both financing and delivery. Second is the examination of the contextual and institutional characteristics of the hospital services delivery system before and after the establishment of the Hospital Authority. Third is the analysis of the various health financing options and the proposal to institute a voluntary regulated health financing scheme for the new devolved public hospital system that could, in general, meet the needs of different sectors of the community without causing excessive escalation of health care expenses. In this connection, the implications of greater private sector financing of health services are also discussed.

Historical Development of the Hong Kong Health Care System

The Early Days

Government medical services was first introduced to Hong Kong in 1843 with the appointment of a "colonial surgeon" whose patients were mainly garrison and European residents in Hong Kong (Choa G.H. 1976). In 1887, a sanitary board (which later evolved into the Urban Council) was set up to deliver public health services (Miners 1986). A number of government hospitals was set up in the 1850s to 1880s providing services to patients with mental disorders and contagious diseases. The patients were predominantly European (Choa G.H. 1976). Most local residents were taken cared of by private practitioners of traditional medicine--herbal medicine, bone-setting and acupuncture. In 1872, some Chinese community leaders raised enough funds to build the first private charity hospital--the Tung Wah Hospital, staffed by both traditional and Western medical practitioners (Tung Wah Group of Hospitals 1970). The building of more private hospitals followed in the late 1800s and early 1900s (Choa G.H. 1976).

1950s and 1960s

In the immediate postwar years, the government mainly prioritized the establishment of preventive health services, particularly communicable disease control (Hong Kong Government 1976). Public social services started in the mid 60s with the publication of a series of white papers on welfare, education and medical services (Chow N. 1985). A White Paper entitled "The Development of Medical Services in Hong Kong," was published in 1964 (Hong Kong Government 1964), establishing minimum ratios for hospital and clinical services. But government medical services started to develop slightly earlier in the 50s and 60s. During this period Queen Mary Hospital, the first teaching hospital, and Queen Elizabeth Hospital, the then largest hospital in the Commonwealth, were commissioned. By 1970, there were a total of 16,471 beds or a ratio of 4 beds per 1,000 population. Of these beds, 41 percent of the beds were in government hospitals; 46 percent were in hospitals ran by voluntary agencies receiving government subsidies (known locally as subvented hospitals); and 13 percent were in private hospitals (Hong Kong Government 1970). Public hospitals are accessible to all Hong Kong residents

regardless of income. They are primarily funded from general taxation (Medical & Health Department 1985).

The 1970s

Medical and other social services underwent further expansion in the 70s under the administration of Murray McLehose (1971-1981). The McKinsey Report published in 1973 criticized the government machinery for the lack of adequate long-term planning (McKinsey & Company 1973). An immediate response to the report was the drafting of the first ten-year plan for medical and health services (Miners 1986). A 1974 White Paper, "The Further Development of Medical and Health Services in Hong Kong," set an objective of 5.5 beds per 1,000 population, and committed the government to meet any shortfall. It states that "...in the absence of further proposals by private or government assisted bodies, it is clear that the government should put action in hand toward meeting the shortfall" (White Paper 1974).

The White Paper also committed the government to train an adequate supply of health care personnel:

...to meet this need and to meet the requirements of the private sector, a minimum additional annual local supply to produce 100 doctors would be required (White Paper 1974).

Massive government hospital building programs were launched in the 70s and 80s, together with major expansion of training facilities for medical, nursing, and paramedical professionals.

Another development in the 70s that led to the growth of the public sector was regionalization. Under this scheme, Hong Kong was divided into four (later five) medical and health services regions (Miners 1986). The adoption of a regional approach to the planning and administration of health services required the government to provide for each region the following: "(a) a regional hospital to patients requiring the highest level of care, (b) one or more district hospitals to deliver the basic hospital services, (c) one or more specialist clinics, and (d) a number of general clinics" (White Paper 1974).

The White Paper of 1974 made no mention of private sector activities. The 1979 Review of the Medical Development Program recommended that "encouragement should be given to the development of more private nonprofit making hospitals" (MDAC 1979), but did not suggest any concrete measures to encourage the development.

There were, nevertheless, modest growth in the private sector during the 70s. The number of private hospital beds increased from 2,150 in 1970 to 2,531 in 1979. The increase was insignificant when compared to the increase of government-funded hospital beds from 13,832 in 1970 to 17,685 in 1979 (Hong Kong Government 1970; 1979).

The 1980s

There has been no signs of reduction in government commitment to the provision of health services as manifested by the building and commissioning of a number of new government hospitals in the 80s. However, the escalation of health care costs and the increase in demand for care as a result of population growth and aging has led to the call for the expansion of the private sector for the provision of in-patient services made by some politicians (Chiu 1985; Ip 1985). In 1985, a report by the consultants Coopers and Lybrand - W.D. Scott recommended a series of measures to the government, which many viewed as aimed at the privatization of a greater degree of health services. The recommendations include: (1) the establishment of a financially independent hospital authority to take over all of the public hospitals, (2) more flexible contracts for hospital consultants, and (3) measures for cost reduction and cost recovery (Coopers & Lybrand - W.D. Scott 1985).

A Provisional Hospital Authority was established in 1988, and the Hospital Authority was formally incorporated in July 1990.

Private hospital beds have not grown in any manner in the 80s. In 1986, there were 2,664 beds in private hospitals or 11 percent of the total number of hospital beds (Hong Kong Government 1987). This is lower than in 1970 where private hospital beds constituted 13 percent. The sluggish growth of the private hospitals has been attributed to three reasons:

(1) low rate of private health insurance subscription.

A study in 1987 indicates less than 5 percent of the population in Hong Kong are covered by private health insurance although the percentage could have increased substantially in recent years (Yuen P. 1988b). Only 21 percent of those who go to private hospitals carry private health insurance (Yuen P. 1988a).

(2) escalation of land and real estate prices in Hong Kong in the late 70s and 80s.

This made private hospitals an unattractive investment to potential developers. Investors opted use the land for residential or commercial complexes, which have a much shorter payback period and a much more certain return (Yuen 1986).

(3) the government's economic policy of laissez-faire.

Referred to as "positive noninterventionism" by some officials (Hong Kong Government 1980), this policy gives no preferential treatment to private enterprises (including private hospitals) in the form of grants or loans. Employers are not required by law to provide any form of medical benefits to their staff. No tax incentives for individuals who choose to purchase private health insurance. No government interference over land prices.

The Current Situation

The enactment of the Hospital Authority Ordinance in July 1990 set in motion the abolition of a health care system that finances the bulk of the hospital services from general taxation. This system delivers the hospital services through a central government department without any formal cooptation of citizens and/or interest groups into the management process. The major strength of such a system is its ability to control health care expenditure. The overall health expenditure of Hong Kong as a percentage of GDP, is extremely low by industrialized nations' standards (Yuen 1991). Government medical and health expenditure as a percentage of government overall expenditure has remained fairly constant and always under 10 percent (Scott 1985). All public hospitals come under a tight civil service system of financial controls over personnel and procurement matters. The doctors in the public hospitals are all salaried employees. The capital expenditure control procedures of the government have also been rather successful in containing the proliferation of expensive hi-tech medical equipment in the public sector (Hay 1990). "Moral hazards" (Feldstein 1988) do not exist under such a system on the part of the health care providers i.e., there are no incentives for public hospital doctors to perform unnecessary procedures. Fees are also kept low under such arrangements, as all revenue received by the department from fees and other sources go directly to the Government Treasury. There is little incentives for the department to increase charges. Consequently, public hospital services are very affordable in Hong Kong, and no one is deprived of medical attention because of inability to pay. For those who are able and willing to pay more, they can opt out of the system entirely and obtain services in more comfortable surroundings from the private sector. Health status indicators for the population of Hong Kong are also among the best in the world, although some have attributed that to factors other than the efficacy of the public hospital system (Fung 1990; Hay 1990).

This system is not without its shortcomings. Overcentralization, inflexibility, the archaic management structure, low staff morale, the lack of courtesy to patients, long waiting lists, overcrowding conditions, poor coordination between government and subvented hospitals, and the lack of public participation in the management of public hospitals are some of the frequently cited problems of the public hospital system (Scott 1985). Some also feel that the amount of resources allocated to the public health care system are inadequate (United Democrats of Hong Kong 1990; Lee 1990). The formation of the Hospital Authority was the strategy chosen by the government to tackle these problems (Wilson 1989; Wong 1990). There are four reasons given by the government as behind the establishment of an independent hospital authority outside the civil service.

First is the greater flexibility in dealing with personnel matters such as salary scales, hiring and firing, the employment of part-timers, and allowing public hospital doctors to undertake private practice.

Second is the better integration of government and subvented hospital services, which would raise the occupancy rate of the latter and reduce the overcrowding condi-

tions of some government regional hospitals. It would also raise the morale of subvented hospital staff by bringing their remuneration package in line with that of their government counterpart.

Third is the greater participation of major stakeholders of the health care system-voluntary organizations, professional bodies, academic institutions, and community groups-through membership in the Hospital Authority and its committees.

Fourth is the granting of incentives to spur better management through devolution and financial independence at the Hospital Authority level and decentralization and financial autonomy at the hospital level (Provisional Hospital Authority 1989).

The government repeatedly reiterated that corporatization is not privatization, and that the government is not shirking its responsibility in the provision of medical services. However, a closer examination of some of the implications of this devolution suggests that a considerable degree of privatization in terms of private financing is certain to follow irrespective of intentions.

Implications of Devolution

While some of the goals of the Hospital Authority are commendable, little evidence is available to show that this new devolved entity will be as effective as the old system in controlling the growth of health expenditure. On the contrary, there are reasons to believe that health care expenditure will increase substantially. Relevant contextual and institutional factors suggests that a significant increase in hospital services expenditure and the resultant increase in private financing of hospital services are almost inevitable.

Institutional Factors

The corporate status of the Hospital Authority gives public hospitals complete autonomy over personnel and financial matters. Civil service regulations on salary structure and procurement procedures will no longer be obligatory for public hospitals. The Provisional Hospital Authority (1989) already recommended that senior doctors in public hospitals will be allowed to undertake limited private practice. The Authority can also create positions with much better remunerations than those in the civil service.

The proliferation of expensive medical equipment is more likely to happen with the Hospital Authority, under which purchasing decisions will no longer be subjected to the usual government controls.

The financial independence of the Authority allows public hospitals to retain whatever income they receive. This provides incentives for public hospitals to raise charges, and/or admit more private patients. Fee increases appear to be only a matter of time and degree. "Class B" beds and other cost recovery measures are also being

planned (Provisional Hospital Authority 1989). The ability to raise funds through higher charges and other means also reduces the necessity for public hospitals to strictly control spending within annual budgetary limits.

While the participation of citizens and special interest groups in the policymaking process of the Hospital Authority might improve the system's responsiveness, it is also likely to result in increase in spending. Corporatization without competition is not likely to result in significant increase in efficiency (Veljanovski 1989). The new institutional arrangements under the Hospital Authority are not at all conducive to cost-containment. The situation is aggravated by certain contextual factors.

Contextual Factors

Many studies have shown that the demand for health services is income elastic (Newhouse 1977). This means that people tend to spend a larger proportion of their income on health services as their income increase. The economic growth experienced by Hong Kong during the past decades has unavoidably increased the demand for health services, not just in terms of volume, but also in terms of quality.

The pressure on the government to spend more on health and other social services will be greater, especially with the pending introduction of direct elections to the legislative council. This can breed a sizeable number of politicians who would have to submit themselves for election and reelection by the general public.

The pressure on the government for more health care spending also comes from the growing number of elderly population in Hong Kong, and the proliferation of expensive hi-tech medical services in industrialized countries.

More Private Financing is the Only Solution

There are only two ways through which a major increase in health care expenses can be met: allocate more tax dollars to public hospitals or inject more private funds into the system. The use of tax dollars to finance more and better public hospital services is highly unlikely because of the following reasons: (1) the tradition of the Hong Kong government in maintaining a relatively low direct tax rate (Miners 1986); (2) indirect taxation on many noncontroversial items (such as cigarettes, liquor, petroleum, and cars) is already very high; and (3) huge amount of public funds needed for the ambitious infrastructure development program (Wilson 1990). The use of more private funds to finance the increase will prove to be the only feasible solution. The new arrangements under the Hospital Authority, such as higher fees, more private patients, and class B beds, support such proposition.

Implications of More Private Financing

There are two ways through which more private money can be injected into the public health care system: more direct payment by users and more payment through private health insurance or through some form of public health insurance. The amount of money that the Hospital Authority can obtain through strict direct payment will likely remain modest because public pressure will make substantial fee increase difficult. An increase in the existing daily hospitalization charge of \$34 by 1,000 percent would still only recover around 20 percent of the actual hospitalization cost. The expansion of health insurance is, therefore, the only realistic alternative. A Medical Health Insurance Study Group was formed in February 1991, chaired by the Secretary of Health & Welfare to explore the feasibility of expanding health insurance in Hong Kong (Ming Pao 1991).

Implications of More Health Insurance

While health insurance can be viewed as a way to finance more health services without increasing the taxpayers' burden, it has proved to be a major contributor to overutilization and cost escalations (Abel-Smith 1990). This is particularly true when schemes are based on fee-for-service reimbursement to providers, and zero cost to patients at the point of consumption. In Hong Kong, abuses are likely to occur because of the inadequacies of peer review systems, poor access of consumers to information regarding prices and quality, and the absence of other effective cost-control mechanisms (Hay 1990). Insurance also contributes to higher health care costs because of the inclusion of the insurance companies' profits and administrative expenses. Administrative expenses are likely to be high for Hong Kong because of the small percentage of people who are currently covered by private health insurance, and the fact that there are more of small and medium size companies in Hong Kong is much larger than in many industrialized countries (Yuen 1988a; Yuen 1988b).

Apart from having an inflationary effect, insurance often creates more financial burden for employers as well as for employees. Lee Iaccoca has complained that Chrysler spent more on health insurance premium for its employees than on steel to make cars (Iaccoca 1984). Hong Kong employers have been extremely fortunate in not having to provide health insurance benefits to their employees if they do not choose to do so. Most of Hong Kong's employees currently receive reasonably inexpensive outpatient care from private general practitioners, and in the event of major illness, practically free services from public hospitals. This relatively low labor cost has contributed not insignificantly to Hong Kong products' competitiveness in international markets.

Many companies require employees to contribute to their health insurance scheme. Most public health insurance plans also require some payroll deductions as a form of employees' share of the premium (Fulcher 1974; Raffle 1984). Such contribution is often viewed by employees as another form of taxation, especially those with compulsory schemes.

Alternative Financing Options

While many proposals have been made by different individuals and groups on how Hong Kong should restructure its health financing system (Hong Kong Medical Association & Hong Kong Society for Medical Executive 1991), they can be broadly categorized as either (1) compulsory public health insurance schemes—including centrally administered compulsory health insurance (modelled after the Singaporean Medisave Scheme), and community based schemes (modelled after the Sickness Fund Associations in Germany and Holland), mandatory for employees in the lower income brackets; or (2) voluntary health insurance schemes—including the issuance of government vouchers to citizens to purchase private health insurance, and the encouragement of the growth of Health Maintenance Organizations (Marcarelli 1976). Below is an outline of a proposal by the author.

The Yuen Scheme

The proposal is a government regulated voluntary insurance system, tentatively termed the Yuen Scheme, that has the potential to provide better and more health services for the people of Hong Kong on one hand without having all of its negative effects on the other. This scheme considers the practical realities of the Hong Kong situation without compromising the objectives of fairness, freedom of choice, competition, quality, efficiency, cost-containment, and access to health care regardless of financial ability. This proposed scheme shares some common characteristics with the "ChoiceCare Plans" outlined by Hay (1990), but differs significantly on the role played by the public sector. Under the Yuen's Scheme, the government will be active in regulation, financing and delivery of services. The role of the government under ChoiceCare is confined mainly to regulation and to a limited extent provision of such as emergency care and certain specialized care.

Organization: Management, Financing and Delivery

Unlike Singapore, Hong Kong does not have a Central Provident Fund. To set up a compulsory central health insurance scheme with universal coverage would involve a huge setup cost of enrolling six million persons. To minimize initial start-up expenses, and to maximize choice for consumers, a voluntary government-directed scheme comprising a mix of public and private plans is proposed, at least for the early phases. The current level of services provided in public hospitals, funded mostly by general taxation, would be maintained for people who might not want to join the scheme. Existing private health insurance companies would be invited to participate in the scheme. To safeguard against private insurance companies from obtaining windfall profits through collusion, the government would also set up its own plans on a nonprofit but self-financing basis to compete with private plans. A regulatory body would be established to register insurance plans that meet the following criteria: coverage comprehensiveness, guidelines on premium and fee schedule, quality assurance based on peer reviews, and cost-

containment mechanisms. Both individual and corporate subscribers of these registered plans would be granted certain tax advantages (e.g., tax deductible premiums; and nontaxable benefits). No employers would be forced to join the scheme if they do not wish to do so. However, in a competitive labor market, many employers will probably find it necessary to join the scheme in order to attract and retain employees. Innovative arrangements such as Health Maintenance Organizations (HMOs) (Marcarelli 1976), Preferred Providers Organizations (PPOs) (Kodner 1982), and plans using prospective payment systems (PPS) (Lichtig 1986) or Relative Value Scales (RVS) (Feldstein 1988) should be encouraged. All registered plans will have to compete with each other for subscribers. Plans that offer choice, flexibility, quality care, and competitive rates will get the most subscribers. If the scheme is successful, with the number of voluntary subscribers exceeding a significant percentage of the population, the government should then consider making such scheme mandatory for employers.

Each plan would have its own arrangement regarding the choice of doctors and hospitals. Both private practitioners and doctors employed by public hospitals would be eligible to deliver health care service under the scheme. Their mode of remuneration would vary from fixed salary, to capitation, to fee-for-service, or a combination of some of these modes. Doctors in public hospitals should be compensated according to the RVS Method (Yuen 1991). Private hospitals and hospitals under the Hospital Authority would all be eligible to participate in the scheme.

Range of Benefits

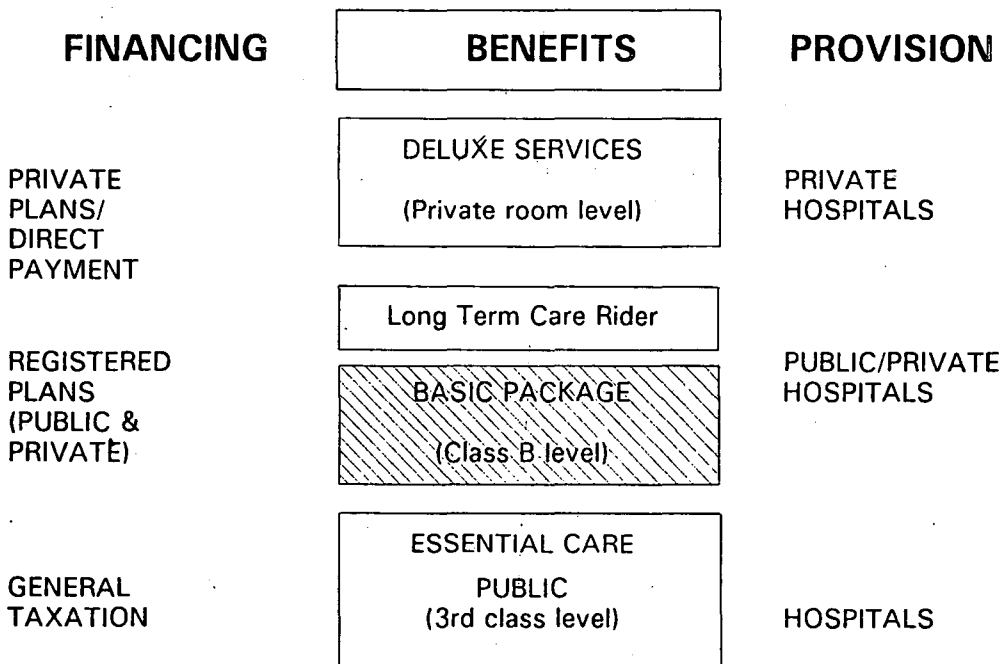
While it is desirable to have plans that provide comprehensive coverage—from primary care, to acute in-patient care, to long-term care—it would be realistic for the scheme to initially focus the effort on acute in-patient services, and eventually on long-term care. Currently, private ambulatory care in Hong Kong is, in most cases, quite affordable (Chiu 1985). The need for insurance for outpatient visits is not evident. All registered plans must provide a basic package comprising a reasonably comprehensive coverage for secondary and acute diagnostic and therapeutic services, as well as nursing and "hotel services" equivalent to those of Class B beds. These services constitute the basic package for registered plans. Tax privileges will be extended only to such basic package. Consumers are free to purchase additional coverage over and above those of the basic package without any tax advantages. Additional coverage for catastrophic/chronic conditions can also be purchased. Subscribers are entitled to choose their own doctors and hospitals. However, a list of "preferred providers" is made available to subscribers. Patients using the "preferred providers" can expect to have their expenses fully reimbursed. The type of benefits, as well as financing and provision mechanisms are illustrated in Figure 1.

Advantages and Disadvantages of the Scheme

The Yuen scheme has advantages and disadvantages. There are six advantages.

First is the freedom of choice. No one is forced to join any plan if he or she does not wish to do so. Existing level of services and charges, i.e., equivalent to those of a third class ward in a public hospital, would still be made available to those who are unable or unwilling to pay more than the existing nominal fees. No one would be denied basic health care because of inability to pay, and no one would be subjected to means-testing. For those who desire more comfortable surroundings when receiving care, a wide variety of plans--from basic to deluxe--are available. Employers are also given the option to join or not to join the scheme.

Figure 1. Types of Benefits, Financing and Provision Mechanisms



Legend:

 TAX CONCESSIONS

Second is the quality assurance. By means of the registration process, the government could require all registered plans to implement quality assurance programs. Under the scheme, all claims by providers are subjected to review on the appropriateness

of hospital admissions, diagnostic and treatment procedures, length of stay, and drug use. Government would also establish its own Peer Review Organization (PRO) to establish quality standards and conduct independent medical audits. Offenders would be banned from participation in the scheme. This would put an end to the situation of a total lack of control that currently exists in the private medical sector.

Third is cost containment. Only plans with built-in cost containment measures would be registered by the government. Many of the key features of the scheme, such as the fee-schedule, peer review, competition among plans, would deter providers against overutilization. Most plans would probably introduce deductibles and copayments to reduce unnecessary utilization on the part of the consumer. Competition among plans would also contribute to lower cost through the reduction of the systems' X-inefficiencies.

Fourth is the low start-up costs. The implementation of the scheme would involve the setting up of an office to register and regulate the plans, and a public corporation to administer a public plan. Compared with the establishment of a Medisave scheme or a compulsory employer contributory scheme, the start-up cost for the proposed scheme would be a great deal lower.

Fifth is the greater resources for health care. With proper management, the additional funds generated from the insurance scheme could increase the quality and the quantity of health services provided to consumers. It would raise the morale of the health care workers in public hospitals. It would even ameliorate the crowding conditions of the third class wards in public hospitals, as some of the patients who would otherwise stay in the third class ward would move to the Class B beds or to private hospitals.

Sixth is a fairer treatment to the middle class. Under the current system, individuals who have paid their fair share of taxes and have decided to opt out of the public health care system by going to private hospitals would not receive any tax concessions. The proposed scheme would rectify this rather unreasonable state of affairs.

The scheme has three disadvantages.

First is adverse selection. When insurance plans are voluntary, the problem of adverse selection (i.e., only those who are likely to heavily use the system would purchase insurance) is inevitable, resulting in premium escalations. The problem could be partially dealt with through the use of age-adjusted premium schedules. The severity of the problem would also be reduced if the number of subscribers, especially corporate subscribers, are substantially large.

Second is its two-tiered system. While a two-tiered system (public vs. private hospitals; first and second class vs. third class rooms in public hospitals) already exists to certain extent, the expansion of the insurance coverage would create a much larger and significant private subsystem within the public hospital system. A stronger social stigma is likely to be attached to the users of third class wards in public hospitals.

Third is the higher health expenditure. Even with all of the cost-containment measures described above, the introduction of the scheme would unavoidably lead to an increase in health care expenditure, both in the public and private sectors. Such increase would have a number of social and economic implications, especially during periods of sluggish economic growth.

Conclusions

This paper proposes to replace the existing predominantly publicly financed and supplied health care system. The alternative system is characterized by greater private sector participation, competition, and quality assurance. At the same time, it also maintains the access of those who are unable or unwilling to pay for the actual cost to basic care. Such system permits various innovative patterns of health care delivery to develop and compete with each other. It also allows progression to schemes of universal coverage, if the people of Hong Kong so chooses in the future.

The Hong Kong Government has often been criticized for not having a clear health policy (Ng 1989). On one hand it claims that no one would be deprived of health services because of inadequate financial means (Wong 1990), but on the other hand, the public health care system does not have adequate resources to properly support the delivery of high quality care to 100 percent of its population. The proposed scheme will rectify this situation. The introduction of a government-regulated voluntary insurance scheme will result to the formation of a more definitive health policy. The Government would be in a position to say that the 8.9 percent of the annual public budget which it consistently allocated for health care purposes from general taxation will continue to provide essential health care for anyone who is unable or unwilling to pay for the more comfortable surroundings when receiving care. Those who demand services over and above the essential care have to pay the difference either through health insurance or at the time of consumption. Such a policy should be more acceptable to the various stakeholders of the health care system than the existing policy which tries to do everything with limited resources.

References

- Abel-Smith, Brian
1989 World Trends in Health Care Financing and Delivery. A paper presented at the International Symposium on Health Care Systems, Taipei.
- Choa, G.H.
1976 A History of Medicine in Hong Kong. *Medical Directory of Hong Kong*, First Edition. The Federation of Hong Kong Medical Societies.
- Chiu Hi Kwong
1985 Speech by Dr. the Hon. Chiu Hin Kwong to Legislative Council on 28 November 1985. UMELCO, Hong Kong.

- Feldstein, Paul J.
1988 *Health Care Economics*. 3rd edition. New York: John Wiley & Sons.
- Fung, Hong
1990 Do We Need Alternative Funding? View from Where We Stand. A paper presented to the seminar on How Should We Pay? Financing Health Care in 1990s. Hong Kong Medical Association, Hong Kong.
- Fulcher, Derick
1974 *Medical Care Systems: Public and Private Health Coverage in Selected Industrialised Countries*. Geneva: International Labour Office.
- Hay, Joel
1990 Is Hong Kong Ready for a Free Market in Health? A paper presented at the seminar How Should We Pay? Financing Health Care in 1990s. Hong Kong Medical Association, Hong Kong.
- Hong Kong Government
1960-1990 *Hong Kong 1960 ... Hong Kong 1990*. Hong Kong Government Printer.
1964 *White Paper: The Development of Medical and Health Services in Hong Kong*. Hong Kong Government Printer.
1974 *White Paper: The Further Development of Medical and Health Services in Hong Kong*. Hong Kong Government Printer.
- Hong Kong Medical Association & Hong Kong Society of Medical Executive
1991 *Financing Health Care in 1990s: How Should We Pay?* Hong Kong. Iacocca, Lee and William Novak
1984 *Iacocca: An Autobiography*. New York: Bantam Books.
- Ip, H.
1985 Speech by Dr. Hon Henrietta Ip to Legislative Council on 28 November. UMELCO.
- Kodner, Karen
1982 Competition: Getting a Fix on PPO's. *Hospitals*. (November).
- Lee Cheuk-Yan
1990 Statement by the Joint Committee on Medical Services. Hong Kong Confederation of Trade Unions, Hong Kong. (4 April).
- Lichtig, Leo K.
1986 *Hospital Information Systems for Case Mix Management*. New York: John Wiley & Sons.
- Marcarelli, J.L.
1976 Health Maintenance Organizations: When Friends or Patients Ask About. *Journal of American Medical Association*. (February).
- MxKinsey & Co.
1973 *The Machinery of Government: A New Framework for Expanding Exercise*. Hong Kong. (May).
- Medical Development Advisory Committee (MDAC)
1979 *The 1979 Review of the Medical Development Programme*. Hong Kong Government Printer.
- Medical and Health Department
1960-1985 *Medical and Health Department Annual Report*. Hong Kong Government Printer.

- Miners, Norman
1986 *The Government and Politics of Hong Kong*. Fourth edition. Hong Kong: Oxford University Press.
- Ming Pao
1991 Establishing Medical Insurance Plan: The Government Appointed Study Group (In Chinese). Hong Kong: (6 January).
- Newhouse, Joseph
1977 Medical Care Expenditure: A Cross-national Survey. *The Journal of Human Resources* 12.
- Ng, Anthony
1989 Medical and Health. In T.L. Tsim and B.H.K. Luk (ed.) *The Other Hong Kong Report*. Hong Kong: Chinese University Press.
- Provisional Hospital Authority
1989 *Report of the Provisional Hospital Authority*. Hong Kong: Hong Kong Government Printer, Hong Kong.
- Raffel, M.W.
1984 *Comparative Health Systems*. The Pennsylvania State University Press, State College.
- Scott, W.D.
1985 *The Delivery of Medical Services in Hospitals: December 1985*. A Report for the Hong Kong Government. Hong Kong: Coopers & Lybrand.
- Tung Wah Group of Hospitals
1970 *One Hundred Years of the Tung Wah Group of Hospitals 1870-1970*. Hong Kong: Tung Wah Group of Hospitals.
- United Democrats of Hong Kong
1990 Provisional Hospital Authority Report Policy Document (Draft). Document No. EC /39/90, Hong Kong.
- Veljanovski, Cento
1989 *Privatization & Competition: A Market Prospectus*. London: Institute of Economic Affairs.
- Wilson, David
1989 *Annual Address by the Governor 1989*. Hong Kong: Hong Kong Government Printer.
- Wong, Elizabeth
1990 *Report of the Provisional Hospital Authority*. Official Report of Proceedings, Hong Kong Legislative Council Report of Proceedings, Hong Kong Legislative Council. Hong Kong: Hong Kong Government Printer. (4 April).
- Yuen, Peter P.
1988a *The Characteristics of Private Hospital Patients in Hong Kong: A Discriminant Analysis Approach*. Proceedings of the 1988 Pan-Pacific Conference V, Singapore. (May).
- 1988b *The Private Medical Insurance Market in Hong Kong: Implications for the Privatization of Health Services*. Proceedings of the 1988 Annual Conference of the Academy of International Business (South East Asia Region). (June). Bangkok. pp. E39-E57.
- 1991 The Implications of the Corporatization of Health Care Delivery in Hong Kong. *Asian Journal of Public Administration*. 13 (1) (June).