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Health Care Reform in Hong Kong

A Discussion of the Harvard Report

香港亞太研究所

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Introduction

After the release of the report entitled "Improving Hong Kong's Health Care System: Why and for Whom?" (hereafter the Harvard Report) on the evaluation of the Hong Kong health care system, responses from the public, health care practitioners and politicians were mixed. The step towards a mandatory health insurance, for the moment neglecting the government's determination, faces resistance from the general public. Do we need health care reform in Hong Kong? Or, does the Harvard Report really provide no other option to Hong Kong people except the *status quo*? Who are the winners and who are the losers if the reform is implemented? This paper will address these questions.

The paper is organized as follows. Section 2 summarizes each chapter of the Harvard Report. Section 3 discusses the present system from an industrial organizational point of view. Section 4 discusses the option of reform put forward by the report. Attention will be given to the notion of the Competitive Integrated System Option, reviewing its virtues. Section 5 concludes that the success of its implementation is more than an issue of economics but, indeed, a matter of education, courage and politics.

The Harvard Report

In November 1997, a team of academics including economists, physicians, epidemiologists and public health specialists was commissioned from Harvard University by the Hong Kong government to conduct a comprehensive study and evaluation and to

provide policy recommendations on the Hong Kong health care industry. The end report is commonly known as the Harvard Report. Let me go through each chapter roughly describing the contents. Chapter 1 of the report contains an executive summary. Chapter 2 is a comprehensive description of the Hong Kong health care industry in a short and concise section. The chapter contains an overview of the historical and present-day situation of the health care system in Hong Kong. Section 3 discusses the present situation.

Chapter 3 outlines the objective of the investigation and the methodology the team adopted, for example, an evidence-base investigative approach and a micro-stimulation model for projecting the financial burden. Information was gathered through a telephone household survey and, in consultation with the members of the team's Steering Committee, more than 200 persons were sought for their views, including government officials, the leaders of major political parties, business and labour leaders, patients' rights organizations, the Consumer Council, major employers, insurers and organized medical groups. By flipping through the pages, one can find data from the Hospital Authority and, sometimes, data from homepages at different web-sites.

Chapter 4 is the most important chapter; it describes the pros and cons of the current Hong Kong health care industry. Three advantages are given in the report. First, the Hong Kong system is equitable. Everyone from different income levels has equal assess to health care services provided by the public and private sector. Secondly, there has been an apparent improvement in the quality of the provision of care in the public sector, measured by the physical environment in hospitals, the attitude of medical staff towards patients and technical quality, that is the *perception* of service quality. Thirdly, using health care expenditure and gross domestic product (GDP) figures, Hong Kong's health care system is also cost effective, compared to countries like Singapore and Taiwan; in fact, it is much better than in the United States and Canada.

The rest of Chapter 4 describes the findings that attracted the most attention. First, the team simply puts the quality of care provided in Hong Kong to question, based on the drug prescribing pattern, the long waiting time and the short patient encounter with the physician. These include the antibiotic prescribing pattern in the private sector, but not in the public sector, the long waiting time in the public sector and the short consultation time in both the private and public sector. Since there is no clear evidence for substitution of doctor time for nursing time, this makes a strong argument for quality health care being very difficult to sustain.

Secondly, the team projects an increasing demand for care due to the aging population, technology adoption, increased specialization in medicine and rising public expectation of health care quality, all contributing to increasing spending on care. The team projects that, by year 2016, health care expenditure as a percentage of GDP will be around 6%, compared to the present level of 4.6%. If the real GDP growth rate is 4%, then health expenditure as the percentage of GDP will be about 7%. But, if real GDP growth is only 1%, then health expenditure as the percentage of GDP will be about 11%, in which 60% will come from the public sector and 40% from the private sector. The situation, the report claims, may be even worst since resource allocation is without a well-chosen target. In particular, it argues that resources are allocated to curative and inpatient care. Instead, the report claims, more attention should be given to preventive care, primary and outpatient care as well as nursing care. Public funds for health care are also not targeted to the most needy.

Thirdly, the report claims that health care in Hong Kong lacks integration. Public and private hospitals are compartmentalized. Chinese medicine is not in the mainstream. Therefore, there is a lack of communication, causing unnecessary repetition of treatments and diagnoses, incurring unnecessary cost. The team claims that an integrated system is important to face the future challenge arising from the expected increase in chronic illness due to the aging population. Incentives should be given to providers to con-

sider the entire disease process, from prevention through cure to rehabilitation and follow-up.

Chapter 5 reports the conclusion. The major recommendations are, first, a mandatory health insurance scheme and the imposition of a savings account system, MEDISAGE. The second set suggests a Competitive Integrated System Option to be implemented in the long term. It should be clear by now, from the summary, that a Competitive Integrated System Option, as an option, stems partly from the compartmentalization of the health care market and partly from the target of an efficient and effective health care delivery.

The report has troubled the public because of the notion of a compulsory health insurance and a forced saving scheme; the idea of a competitive integrated system appears revolutionary. It means a divestment of the Hospital Authority in the long term. The recommendation on the reimbursement scheme to doctors in the Harvard Report virtually kills doctors' freedom to set price charges (for example, price caps would be imposed on doctors' fees). For some people, it is discretionary and a form of governmental market intervention. Before returning to proposals in the Harvard Report, let us consider the present situation from an industrial organizational view.

Status Quo: What Is the Present System?

The present system consists of mainly two sectors: a public sector and a private sector. According to survey results in the Harvard Report, patients who prefer visiting a public hospital do so because of the provision of effective treatment, trustworthiness and competent doctors. However, cost consideration is abstracted deliberately from the survey. To restore the importance of price incentives, we begin by considering a situation in which all patients would have visited the private-sector physicians and hospitals from the beginning. Then we develop a theory of consumer

choice over public and private hospitals and clinics, using simple economic tools.

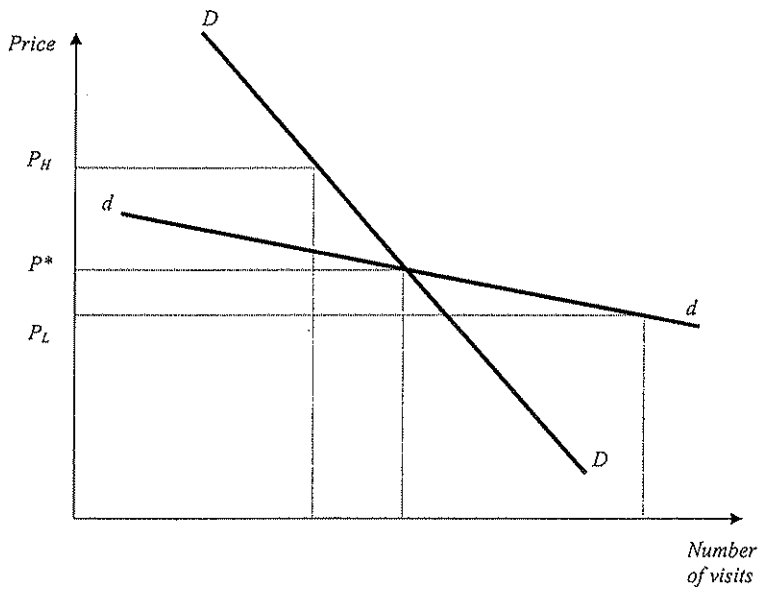
Private-sector physicians are profit makers who respond to the market situation. Their ability to charge depends largely on their skills and specialties as well as the ability and willingness of patients to pay. Furthermore, it is a well-accepted idea among health economists that the doctor market is in fact monopolistic competitive.

A monopolistic competitive market is a market that consists of economic commodities that are different, yet they are all the same and there are many. For an example, consider hair shampoo: all brands perform the same function, yet they all have different images and qualities. If we further segregate the market by grouping the shampoos with equal quality together, they might still be different as regards image and packaging, causing a minor difference in price. When there are many of them in the market, they all charge the same price, and economic profit goes to zero with free entry.

A physician market is similar. All doctors are different, yet they are the same. Say, we group doctors into specialty groups, then further in terms of years of experience; doctors are still competing with one another on competence, experience and the price they charge, or said differently, the consumers' willingness to pay for doctor services varies across doctors. Since the number of doctors practicing in the market, that is, the stock of doctors in the market, is influenced by the medical profession's dual role of assuring quality and rent seeking, it is hard to imagine economic profit converging to zero in an absence of free entry condition. Instead, we shall expect variation in profit earned by these physicians.

Consider Figure 1 that illustrates the monopolistic competitive situation. There are two demand curves, DD and dd. In a standard Chamberlin's monopolistic competitive model, dd is the industrial demand whereas DD is the firm's demand curve. By construction, DD is price inelastic relative to dd. We could use the same diagram to describe various situations. First, the diagram

Figure 1 Monopolistic Situation in the Physician Market



differentiates between specialties. General practitioners (GP) face elastic demand, dd, and specialists face demand curve, DD. Specialists are able to charge a higher price, but GPs cannot because the common cold is sometime left to self-recovery without medication or is easily curable in many ways. Secondly, consider a single group of physicians with similar training, experience and specialization. Which curve describes the market demand? Answer: It depends. Demand dd is more elastic because patients have market substitutes. When does it happen? It happens probably in the beginning of the consultation period. However, when patients finish the diagnosis process and consent to a particular treatment delivery, substitutability decreases dramatically; therefore, physicians gain market power over their patients. (This is

particularly so when consultation records are not transferred effectively.) Then, DD becomes the relevant demand curve faced by physicians. In this case, price will be substantially above the marginal cost of production of treatment, resulting in a handsome economic profit. Thirdly, this diagram also suggests that physicians with better credibility and reputation, as perceived by patients, have an advantage over the market, decreasing his or her substitutability and allowing the doctor to charge a higher price right in the beginning.

Monopolistic competition in the physician market is extensively studied by Satterthwaite (1979). Economic commodities that are being transacted in the health care market are called credence or experience goods. Once a doctor-patient relationship is stabilized, the market power of the doctor becomes larger, the demand curve becomes steeper, enabling the doctor to charge a higher price. This is not unique to the doctor market; however, it is apparently more so as a doctor accumulates specific knowledge regarding one's patient's condition due to repeated consultations, increasing the patient's willingness to pay a high price. Formally, it can be modelled as an increase in search cost by the patient. Pauly and Satterthwaite (1981) showed the peculiar result that an increasing number of doctors in the market would not lower price charged by doctors. Instead, it would increase prices due to the increase in search cost, altering the price elasticity of demand. The result is controversial since it conflicts with conventional wisdom; however, it illustrates some peculiar features of the health care market.[1] The Harvard Report suggests that the physicians' market is indeed monopolistic competitive by providing evidence of monopolistic pricing behaviour in the health care market in Hong Kong.

The above paragraph illustrates why the doctor market is monopolistic competitive since doctors accumulate market power over patients, although they perform the same function. A monopolistic market also arises when there is asymmetric information, formally modelled by Wolinsky (1986). Asymmetric information is the most important market failure that exists in the

health care market. Arrow (1963) first pointed out the importance of asymmetric information and the principal-agency problem in the health care market. Modern health economists have abandoned for some time the idea of doctors as being perfect agents of patients. Both financial and non-monetary costs for providing treatment affect doctors' behaviour. Therefore, assuming that doctors are charging a price that maximizes their profit is not a poor proxy, most economists would agree the assumption is approximately correct, even though it only reflects an extreme behaviour of doctors. Although professional ethic may constraint a doctor from misbehaving, the incentives for fraudulent act, or supplier-induced demand (SID) under fee-for-service, are ways too strong to support the argument that doctors are perfect agents for patients.

Consider Figure 1 again. Suppose specialists for a certain illness in the private market maximize profit by charging a price, P_H. (Some physicians can practice almost perfect price discrimination, for example, for surgery.) Then, for those who are willing to pay such price will buy the services from private specialists. The rest of patients will search for other options, for example, from the public sector. Therefore, the private market in this case is a Stackelberg leader, so to speak, that determines the market size for the public sector. The demand curve faced by public hospitals is thus a residual demand from the private sector. The higher the monopolistic power is in the private market, not only creating a deadweight loss in the market, the higher is the demand for public health.[2]

The situation should be less severe in the GPs' market; it is because GPs in general do not have monopoly power as the specialists do. GP services are easily substitutable among general practitioners, and pricing power is lower. However still, the residual demand for health care will also end up being a demand for public care. Due to capacity constraint in the public sector, and low price charged by public specialist out-patient department (SOPD) and general out-patient department (GOPD), this results

in excess demand, creating long waiting time and short consultation time by doctors.

The incentive faced by public doctors is completely different from the incentive in the private sector. Public facility doctors are paid on a salary base. Therefore, the only consideration is the personal, possibly non-monetary, cost of treating patients. Once we formally analyze a doctor's decision on exerting effort, one would find few reasons for a doctor who is paid on salary to exert effort. There must be some mechanisms that penalize a doctor for exerting zero time and effort, such as, for example, complaints from patients, or supervision from a higher authority, like the Hospital Authority administration, which accompany a creditable regulatory system. This point is raised in the Harvard Report that there is an absence of an effective third-party body to assure quality in general practice in Hong Kong's health care system. For instance, currently, the Medical Council accepts complaints from patients; however, its role in seeking responsibility is being questioned in the Harvard Report. Furthermore, the Harvard team notes that complaints from doctors about other doctors are not acceptable by the Medical Council, making complaints solely from patients to end up unsubstantiated. The discussion of the issue in the Harvard Report concludes with a question: "If medical professionals cannot report misconduct, how can they protect the public against it?" This problem of under-exertion is relatively less serious in the private sector, since supplying effort and care are ways of creating demand for individual doctors when competition is effective. But, when market power is established the same problem also occurs.[3]

Excess demand raises the cost of seeing public doctors. Waiting time is part of the cost for patients who visit public doctors, as suggested by Hay (1992). The marginal patient who visits a private doctor would be the one who is indifferent to paying the high price of the private doctor or paying the low price of the public doctor, adding the opportunity cost of long waiting time. Therefore, the patients who have the lowest opportunity cost of time are the ones who visit public hospitals for care, for example, the

elderly, people with lower earning ability and patients with less *urgent* illnesses.

In the above paragraphs, I have sketched a model that describes the present health care industry in Hong Kong. The interaction between the public and the private sector generates a general equilibrium in the health care market. The recent policies adopted by the Hong Kong Hospital Authority have improved the quality of care provision, for example, the investment in hospital physical environment and the improvement of staff attitudes towards patients; these have increased the substitutability of the public sector care for private care. As a result, such improvement has lowered the economic profit earned by private doctors; in particular, private GPs have been affected most. Specialists who fail to establish market power are also victims. Excess demand for care by the public sector will become more serious. Consequently, there will be an even longer waiting time for patients and shorter consultation time to be spent on them.

What would the future direction be if we keep the *status quo*? For those private physicians who cannot survive the competition, thus suffering economic loss, they will eventually leave the market according to the standard theory of competition until economic profit converges to zero. However, in the health care market, insurance companies which organize health services, may enter the scene by negotiation with providers for a lower charging price in exchange for more patients. For example, some health management organizations (HMO) pay a fixed salary to doctors, and patients who join the health plan can freely visit the enrolling doctors with unlimited time for certain treatment by paying an insurance premium. Sometimes, these organizations require doctors to share some cost of prescribing certain medicines and require patients to pay a copayment or a deductible.

This has been happening in Hong Kong. According to newspaper reports, a joint venture by the American International Group (AIG) and United Healthcare has been established to provide managed care in Hong Kong (*South China Morning Post*, 13 December 1997). The HMO has contracted hospitals, specialists

and doctors to treat patients on a pre-paid basis. The managed care movement has faced much resistance from the health profession. Some practitioners question the ultimate quality of care to be provided by such organization. I think the problem is not the marriage of insurance and medicine that creates problems. Insurance companies can effectively contain cost and provide relevant information to patients that are, at least theoretically, welfare enhancing. The real problem is the market power that exists among the insurance companies that is causing much concern among economists, notwithstanding the complexity of a health care market that includes asymmetric information, possibly SID, demand-side moral hazard, selection via pre-existing health conditions and exclusion, etc. Encinosa and Sappington (1997) consider that the competition among HMOs in the United States makes this point clear. Even with perfect competition among insurers in the absence of market imperfection, consumer welfare may still be socially sub-optimal, as analyzed in Leung (1999). Uncertainty about the direction of the health care market is no doubt a concern, as the process of development of managed care is in its early stage in Hong Kong.

So where are we heading? I guess the following holds true. Increasing quality in the public sector attracts an increasing number of patients from the private sector, lowering the latter's profitability. To alleviate the heavier burden in the public sector, its user fee has to be adjusted upward.[4] Some private doctors will find it hard to compete with well-established incumbents who join health organizations. As a result, a range of service outlets will be provided in the health care industry as choices for consumers. A variety of choices are normally favourable. Feldstein (1995) in his discussion of the economics of health care, for example, agrees that heterogeneity in health care provision is central, offering a range of choices to consumers to cope with their preference and attitude towards risk. However, does the evolving direction about which I speculate solve the problems which worried the Harvard team? Answer: Probably not. Without further explanation, I think it is so by definition. What exists now will exist in the future, but

with more complication, namely, the development of managed care.[5] In contrast, the Harvard Report provides a series of reasons explaining why the *status quo* will not work well, based on financial and organizational sustainability in meeting the future needs of Hong Kong.

Reform Options

As pointed out in the Harvard Report, a suitable health care system for a particular society should satisfy the needs of its citizens, but the way it is designed depends on people's values. It is not easy to decide on the direction a health care policy should pursue. Fuchs (1996) conducted a survey of views on normative health policy among top health economists. There was strong divergence of opinions. Fuchs then used this divergence of opinions to argue why health economists were not influential in President Clinton's health care reform project. Later, Newhouse (1998) performed a similar exercise but included health economists in the United Kingdom, ending with similar results. Similarly, there was divergence of opinions in the committee when forming the Harvard proposals for Hong Kong; however, a general agreement emerged on the following guiding principle:

> Every resident should have access to reasonable quality and affordable health care. The government assures this access through a system of shared responsibility between the government and the residents, whereby those who can afford to pay for health care should pay.

This leads the Harvard Report to the following proposals. There are two major reform recommendations suggested by the report: first, to set up an individual long-term savings account, MEDISAGE, to purchase (private) health insurance covering a combination of nursing-home days, visiting-nurse services and home-aid visits. The second major recommendation is to set up a health security plan (HSP) that provides a benefit package for some particular illnesses, for instance, cancer, diabetes, stroke, etc.

Under HSP, patients have the freedom to choose their physician in the private or public sector who have signed up with the plan. The reimbursement rate for each illness episode is then negotiated between providers and the HSP. The two recommendations together pave the way for the third recommendation, namely, the competitive integrated health care system, which is claimed to be suitable in the long run.

Obviously, the first two recommendations are raised to suggest how to handle the long-term financing problem of Hong Kong's health care sector. MEDISAGE is designed as a compulsory savings account that is remarkably similar to a recent proposal in the United States called the Prefunding Medicare. Medicare is a United States government-run insurance programme that covers old-age health care. The cost of running Medicare has been increasing rapidly in recent years, due to the extended life span and aging of the "baby-boomers" (people born in the 1940s and 1950s). Feldstein (1999) suggests that compulsory saving accounts for individuals during their working years for their old-age health care expenditure would solve the problem. The Hong Kong government shows a strong determination to implement this policy option; there is less resistance against MEDISAGE from the public than against the second recommendation, namely HSP.

The second recommendation of HSP is like a compulsory insurance plan, that covers some basic needs of the consumers. A compulsory plan avoids many potential problems, such as the selection of the candidates for insurance by insurers by means of exclusion because of pre-existing health conditions.[6] It also maintains the system's accessibility to the public and the system's equity. Similarly, Fuchs (1996), in his presidential address at the 108th meeting of the American Economic Association on health care reform, mentioned that he wished to see all Americans to be entitled to some basic health care plan. He claimed that there were only two ways to achieve universal coverage: a broadly based general tax with implicit subsidies for the poor and the sick or a system of mandates with explicit subsidies based on income. He

preferred the former, for he thought the latter to be expansive administratively and to distort incentives.

HSP and MEDISAGE have many implications. They provide effective control knobs to manage the public health care budget, to target the public subsidies applied to health care, to improve the efficacy, efficiency and quality of health care and to respond to the changing needs of Hong Kong's residents. The two recommendations also satisfy the objective of the Hong Kong government in terms of sharing the risk and financial burden with the public of the future health care expenditures.

It is worth pointing out that there are economic implications, under these policies, which are related to the method of publicly financing health care. A compulsory health insurance premium to be shared by employee and employer has in fact labour market implications; namely, there will be a deadweight loss in the labour market that, in principle, is distortionary in nature. Fuchs' (1996) discussion of health care reform prefers a financing through a value-added tax (VAT) because such tax is more efficient than a payroll tax for it does not tax labour, whereas a payroll tax ignores capital.[7] He continues by arguing a VAT is better than an income tax because it encourages savings and discourages consumption, based on his own value judgement. The VAT is more difficult to escape and is clearly progressive. Although VAT does not exist in Hong Kong, the implication for the labour supply and demand in Hong Kong via a compulsory health insurance scheme should draw our attention.[8]

The competitive integrated system is the next step after the implementation of HSP and MEDISAGE. It features prepaid integrated healthcare, including preventive, primary, outpatient, hospital and rehabilitative care. The Hospital Authority is reorganized into 12 to 18 regional Health Integrated Systems that can contract with private GPs and specialists (or physician groups) to provide a defined benefit package. Health professionals are responsible for assuring and monitoring the quality of care. There is no insurance company overseeing and second-guessing

providers on each treatment decision. The system also expands the coverage of the HSP+MEDISAGE option.

The integrated health care delivery system (IDS) is not a new proposal, uniquely suitable for Hong Kong. It is an important development of the health care industry in the United States. IDS is a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population, willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served, according to Shortell, Gillies, Anderson, Mitchell and Morgan (1993). IDS has a very different philosophy of health care that contrasts with the stand-alone hospital operation. For example, instead of providing discrete episodes of inpatient care in a stand-alone hospital, an IDS provides a continuum of care to patients. IDS promotes an overall view of health instead of treating illness; it cares about the health status of the population instead of caring for individual patients; it covers the life span of a defined population, instead of individual admissions. IDS is like an enterprise, managing a market, instead of an organization, managing a department. It requires mutual understanding of values and cooperation. To achieve its goals, IDS asks physicians, caregivers, nurses, administrators and hospitals to share information, medical resources and facilities. It is commonly agreed in the health care profession that IDS is the dominating trend of the future (see Tonges (1998) for a discussion). Fuchs agrees and advocates an integrated system in the United States as a future direction. Let me quote directly from Fuchs:

> Second recommendation: "provision of care through integrated health system that include hospitals, physician services, and prescription drugs. These systems would be led by physicians, would be reimbursed by capitation plus modest co-payment from patients at the time of use, and would be required to offer a wide variety of point-of-services options to be paid for by patients with after-tax dollars." (Fuchs, 1996:16)

In his wording, Fuchs claims that "both theory and experience show that integrated health care systems are usually the best way to deliver cost-effective care. The primary reason is the physician's central role in medical decision-making.... Only in an integrated system, however, do physicians have the incentive, the information, and the infrastructure needed to make [cost-effective decisions].... At a minimum, health care professionals should have a prominent place in governance of the systems." He goes on to discuss how competition cannot control cost, due to the insufficient population size, making competition ineffective. Fuchs suggests there is room for a revitalization of professional norms as an instrument of control.

Fuchs then goes to his third recommendation for the American Health Care Reform that involves supply-side tactics. He suggests the formation of a large private centre for technology assessment to disseminate systematic knowledge about the cost effectiveness of medical technology. In contrast, the Harvard Report, specific to the situation in Hong Kong, recommends the establishment of an Institute of Health Policy and Economics to conduct ground level work, for instance, data mining, for further health care research for policy formation in the future.

How do well integrated systems work? The integrated systems are characterized by competition among doctors or physician groups and the free mobility of patients, plus a third-party uninformed payer, by definition a social planner. In Hong Kong, it is the HSP which acts on behalf of the consumer. Patients are compulsorily insured. Doctors who are willing to accept the terms offered by the HSP through negotiation join the plan. Then, they are reimbursed on the perspective base. The problem of HSP is to seek an optimal design for the health insurance contract that contains cost and, yet, maximizes consumer welfare through its choice of supply- and demand-cost sharing for different illness categories. The economics of perspective payment, deductibles, supply- and demand-side cost sharing have been widely investigated. For example, Rand Health Insurance Studies in the United States in the 1970s contribute an excellent reference. Recent theoretical and empirical work has been done by Ellis and McGuire (1986, 1990, 1993), Arrow (1973), Keeler, Newhouse and Phelps (1977), Keeler, Carter and Newhouse (1998) and Newhouse (1996), among numerous others. Cost sharing is widely used in many different countries, for example, Australia, Austria, Denmark, Finland, Norway and, for course, the United States, according to OECD reports (OECD, 1994). A recent paper by Ma and McGuire (1997) analyzes such a system approximately. In their model, they emphasize the asymmetric information among the payer and the providers, but not among the providers and the patients. Patients and providers can misrepresent information to the payer together in order to extract an economic benefit. The authors show that, under such condition, a health insurance contract that maximizes consumer welfare will only be a second best solution, putting restrictions on the payment scheme. However, when the truth-telling constraint binds, a second best solution is not attainable. Then, they consider professional ethic as a constraint on doctor behaviour; a third best outcome is obtained. The authors also consider the effect of competition and show that there will be an improvement in the outcome only if efforts and treatment are substitutes in the production of health status. Although the paper is theoretical, it represents a most recent contribution that may reflect some analytical characteristics of the Competitive Integrated System Option.

Conclusion

Health care reform is a forthcoming reality in Hong Kong, given the determination of the government. Although we are missing many years of experience elsewhere accumulated in the health care industry, as in the United States, we need a leap of faith to a new system, to face the challenges, such as an influx of mainlanders. Probably, the new system may answer the dream of health economists across the Pacific after so many years. Who will win? I guess that, if the Hong Kong people are more educated about the

economics of health care and insurance, they will not find the compulsory health insurance scheme that awkward to accept. An economist can show us the reason why risk-averse people and the ones with an opportunity cost for the out-of-pocket medical expenditure would prefer to purchase insurance. Consumers are no doubt winners at the end of the game. Then, who loses? Physicians who are currently earning supro-normal economic profit due to their monopoly power over their patients will lose at the end. But, how certain is the Hong Kong government of winning the battle over the resistance of a group of physicians? We miss in Hong Kong the battles that were fought and the crucial contractual development between insurance companies and physicians that took place in the United States. This makes the competitive integrated system option unnatural and awkwardly fitting into our local development of the health care industry in Hong Kong. The proliferation of IDS in the United States, as pointed out by Phelps (1997), is a natural development to follow up on managed care since IDS achieves the economies of scope. It is pointed out by Phelps that an IDS organization can serve up to 0.5 million or more people, so a handful number of IDS organizations can serve the entire metropolitan area of most cities. It translates into 12 to 18 regional Health Integrated Systems in Hong Kong, as suggested by the Harvard team, which would be enough to serve the entire population, taking population growth into account. Undoubtedly, the theory of IDS is sound and well accepted by the health profession across the Pacific. However, do we want to import from the United States their ideas directly into Hong Kong? Considering that our stage of development in the health care industry is, I would say, pretty far behind the United States' development, the answer should be left to the judgement of the readers.

Notes

1. See Phelps (1997) for a discussion about the counter argument relating to the Pauly-Satterthwaite model.

2. Residual patients can also seek care across the border on the mainland.
3. A similar issue on the quality of doctors is the one regarding the abuse of antibiotics, that I choose to omit in this discussion.
4. Whereas the Harvard Report considers an increase in user fee would be mainly due to the financing of the health care system.
5. The Harvard Report provides an alternative reason managed care may proliferate: it is due to the increase of demand in the private sector as a result of an increase in user fees or a cap on health care expenditure in the public sector, based on the financial non-sustainability of the public system. The Harvard Report also rejects managed care as a health care option for Hong Kong since it intrudes in the doctor-patient relationship and reduces the equity of the Hong Kong system.
6. The issue of cream-skimming is considered by Lewis and Sappington (1995); they argue that the contract that avoids adverse selection involves the exclusion of some income groups in the society.
7. A value-added tax is a tax that is imposed at each stage of production on the difference between the sales by a firm and what it purchases from other firms; that is, on the value added by the firm (see Stiglitz, 1988).
8. For reference, Gruber (1998) provides a discussion on the issue of health care insurance and the labour market in the United States.

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Health Care Reform in Hong Kong

A Discussion of the Harvard Report

Abstract

This paper reviews the recently released Harvard Report on the evaluation of the health care system in Hong Kong. It investigates the *status quo* from an industrial organizational point of view in contrast to the approach of the Harvard Report, projecting a possible future direction for the health care industry. This paper and the Harvard Report, with different reasoning, both reach the conclusion that the proliferation of managed care is unwelcome by the health care profession. Finally, the paper discusses the virtues of the Competitive Integrated System Option in the Harvard Report, providing arguments about how it may be the optimal candidate in any health care system in the long run, although it may only be a second-best solution.

香港醫療改革

梁志明

（中文摘要）

本文探討哈佛醫療報告（《香港醫護改革：爲何要改？爲誰而改？》）對香港醫護制度之評估，並從市場結合的角度分析保留現有制度所帶來的市場形勢。本文採用了異於哈佛報告的理據，但得出相若的結論 — 如讓現況繼續發展，將引入更多醫業界所不歡迎的醫療保健機構。本文進而分析哈佛報告提出的互聯保健競爭制度的優劣，以及在長遠而言，此制度爲一可取方案之可能性，雖然此方案在醫生和病人中詢訊不等下還只是次優的方案。