THE HONG KONG POLYTECHNIC UNIVERSITY
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COLLEGE OF PROFESSIONAL AND CONTINUING EDUCATION
專業及持續教育學院

CPCE Health Conference 2025
PRIMARY HEALTHCARE POLICY DEVELOPMENT IN THE ASIA-PACIFIC REGION

Achieving Sustainable Financing for Primary Healthcare: Balancing the Public and Private Sectors

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Research Question:

Is the Current Hong Kong Primary Healthcare (1) Financing Level and (2) Public-Private Mix Desirable and Sustainable?

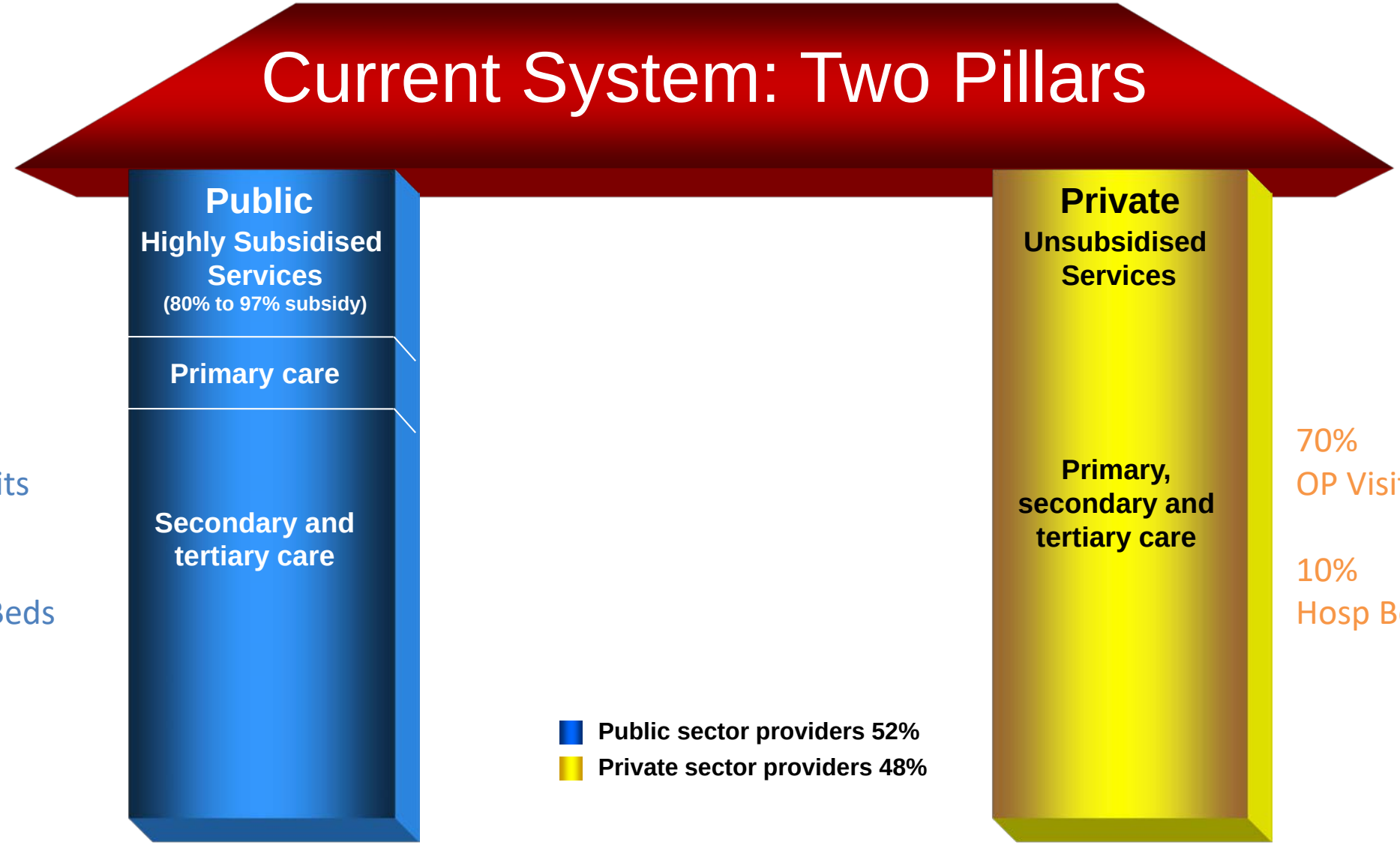
Financing Level

- Should Hong Kong spend more on Primary Healthcare?
  - If yes, where should the money come from?

Financing Mix

- Is the current public-private mix reasonable?
  - If not, how should the mix be adjusted?

Current System: Two Pillars



30%
OP Visits

90%
Hosp Beds

70%
OP Visits

10%
Hosp Beds

Public sector providers 52%
Private sector providers 48%

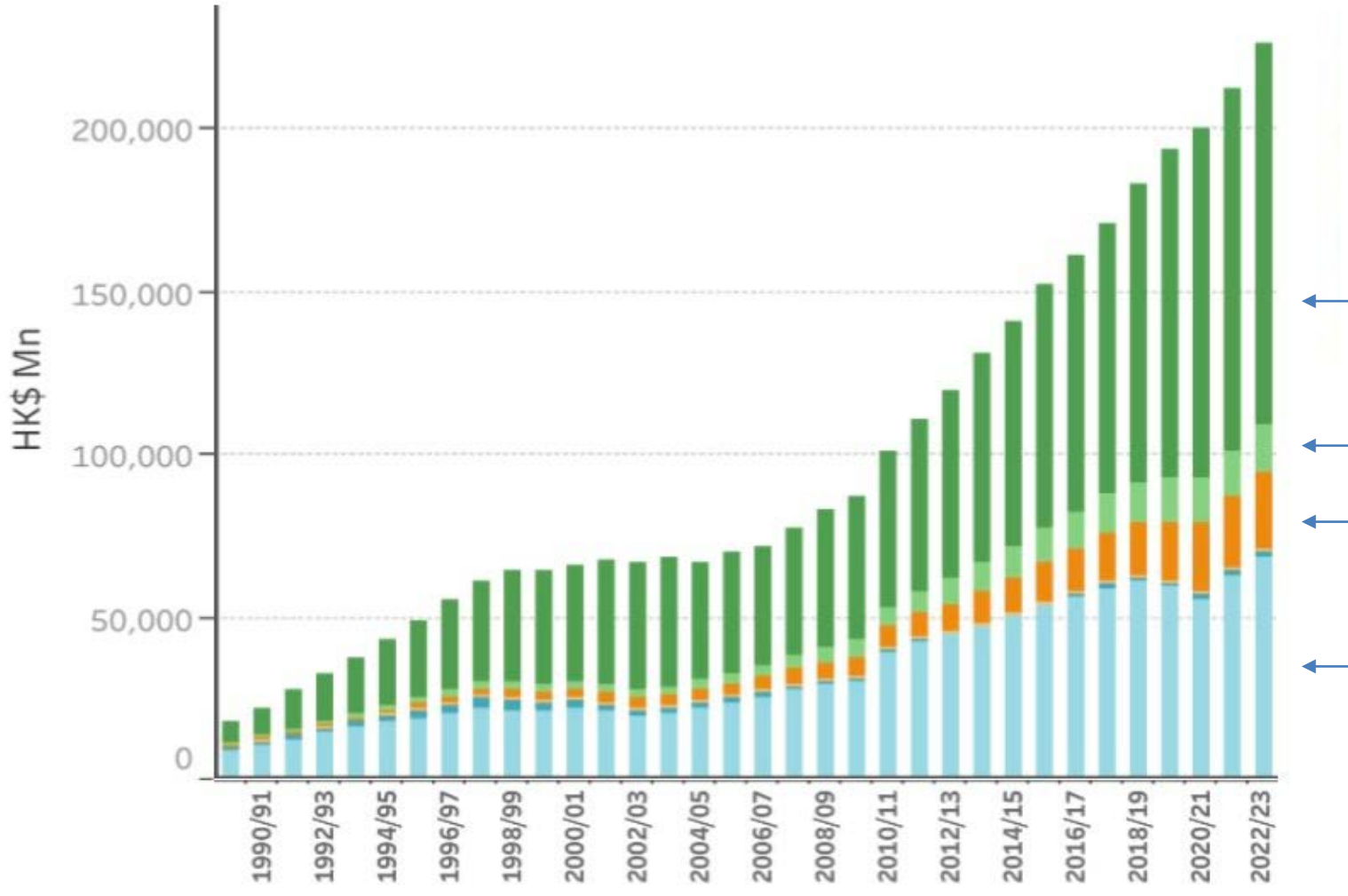
Funding HK$117,745M
Mostly from Taxes

Funding:
HK$108,566M
Mostly Private sources

Source: Domestic Health Accounts 2022/23, Health Bureau, HKSARG

Current Health Expenditure 1990-2023

Source: Domestic Health Accounts 2022-23, Health Bureau, HKSARG



Tax 52%

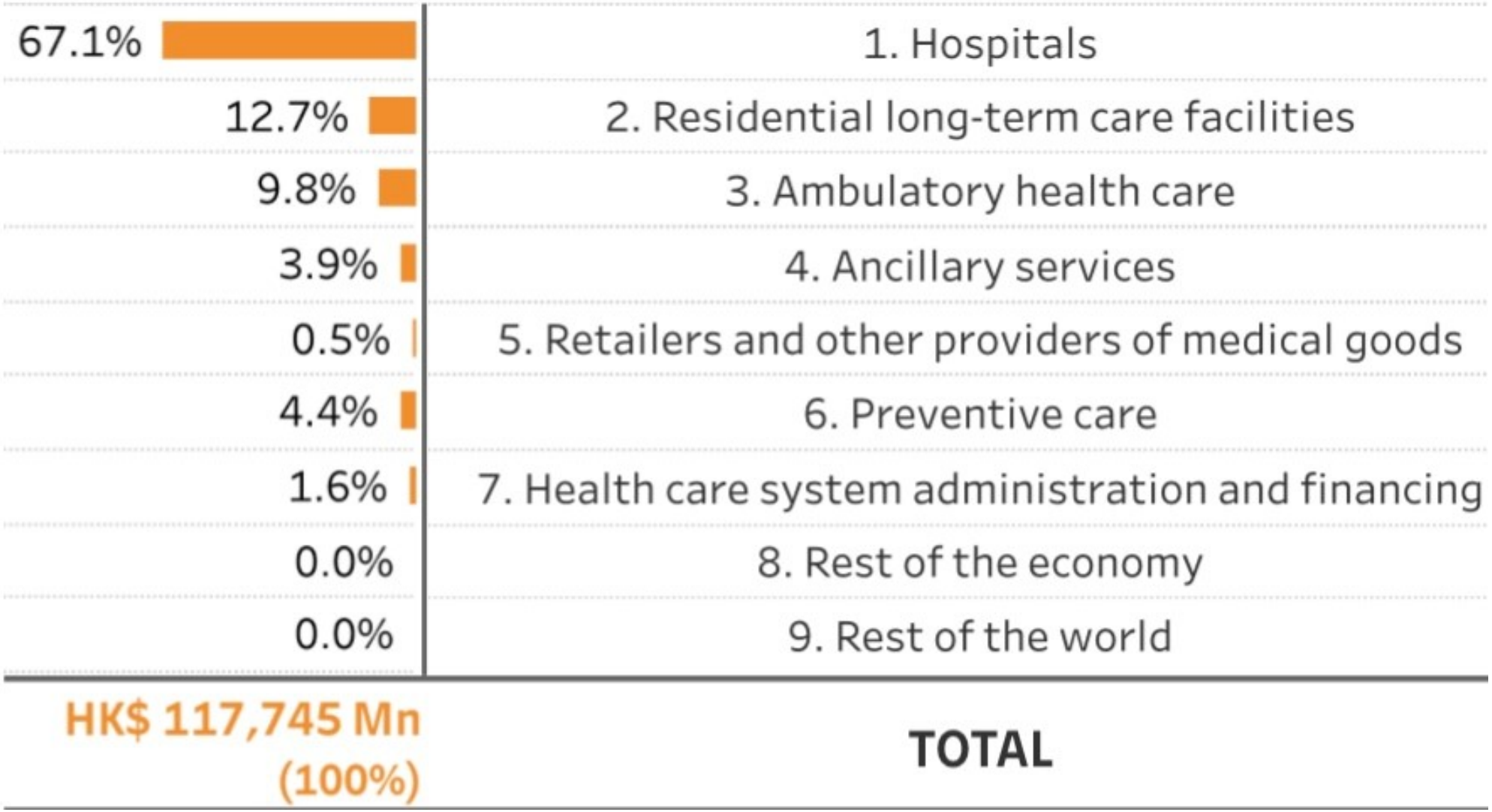
Group Insurance 6.3%

Individual Insurance 10.4%

Insurance Total 16.7%

Out-of-pocket payment 30%

Government Health Spending 2022-23



Source: Domestic Health Accounts 2022/23, Health Bureau, HKSARG

Total Spending on Primary Healthcare and Governments share International Comparison of PHC spending (figures from 2018/2019/2020)

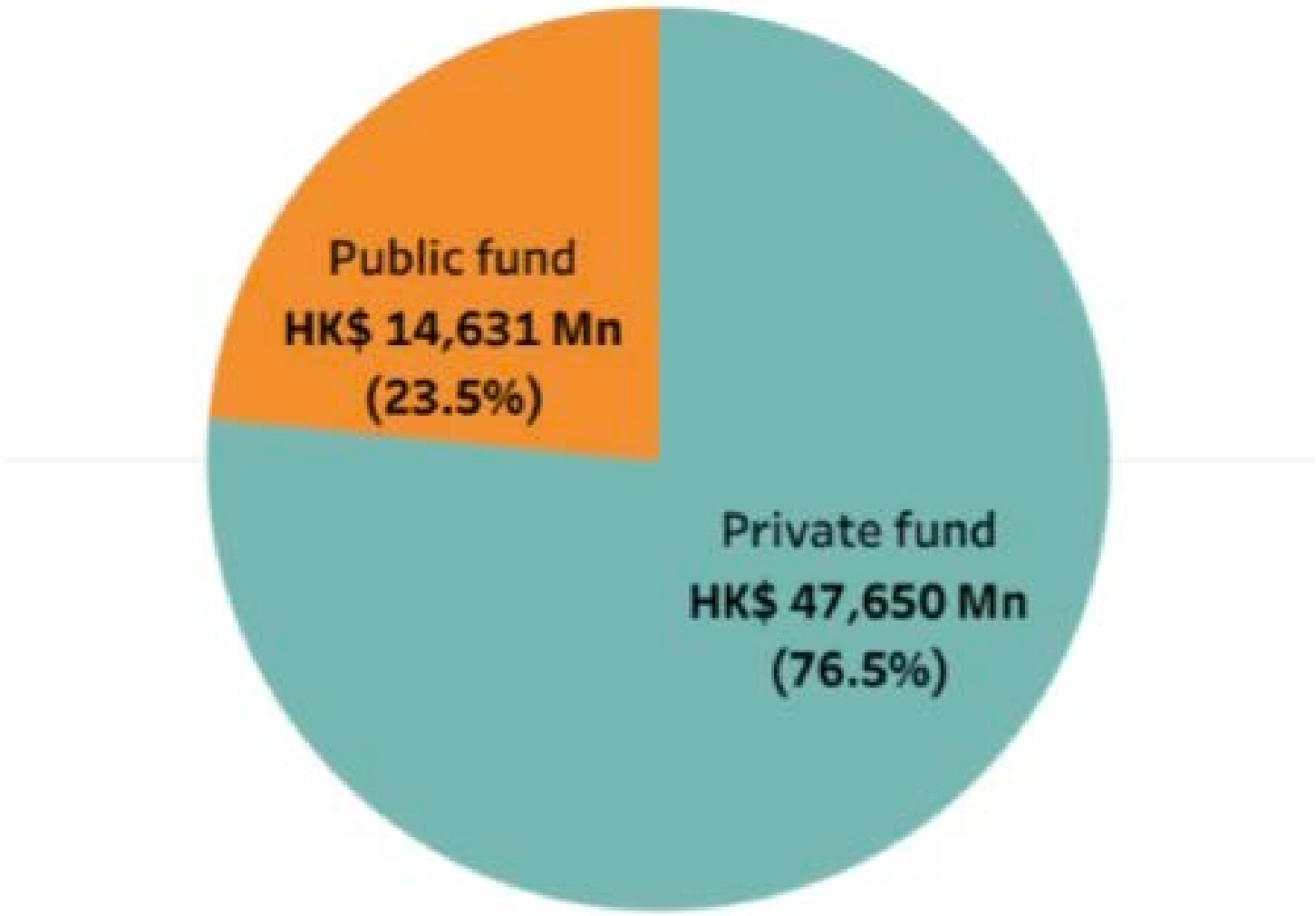
	Spending on Primary Care as a % of Total Current Health Spending	Government spending on Primary care as a % of total Primary Care spending
Low-income group*	59%	13%
Low-middle income group*	52%	29%
Upper-middle income group*	42%	45%
High-income group*	42%	59%
Hong Kong**	27.5%	23.5%

*Hanson et al 2022. The Lancet Global Commission on financing primary health care: putting people at the centre. *Lancet* Vol 10 (figures from 2018 data)
**Domestic Health Accounts 2022/23, Health Bureau, HKSARG

Hong Kong spends about 65% of what high income countries are spending on primary healthcare

Government's share is ~40% of that of high income countries governments'

Primary Healthcare Spending: Public-Private Mix 2022-23



Source: Domestic Health Accounts 2022/23, Health Bureau, HKSARG

Government Spending on Primary Healthcare International Comparison of PHC spending (figures from 2018/2019/2020)

	Government Spending on Primary Care as a % of Total Government Health Spending 政府開支%	Out-of-pocket spending on Primary care as a % of total Primary Care spending 用者自付%
Low-income group*	33%	44%
Low-middle income group*	36%	49%
Upper-middle income group*	34%	39%
High-income group*	36%	28%
Hong Kong** (1)	17%	70%

*Hanson et al 2022. The Lancet Global Commission on financing primary health care: putting people at the centre. *Lancet* Vol 10 (figures from 2018 data)
**Health Bureau (HKSARG) 2023. *Primary Health Care Blueprint Supplement* Ch 2. (figures from 2019-20)

HK Gov't 's spending on primary healthcare is less than half of the high income countries' average

Out-of-pocket spending on primary healthcare in Hong Kong is more than double that of high income countries

In terms of spending on Primary healthcare

- Hong Kong’s overall spending on PHC is too low
- Government’s spending on PHC is way too low
- Out-of-pocket spending on PHC is way too high

Implications

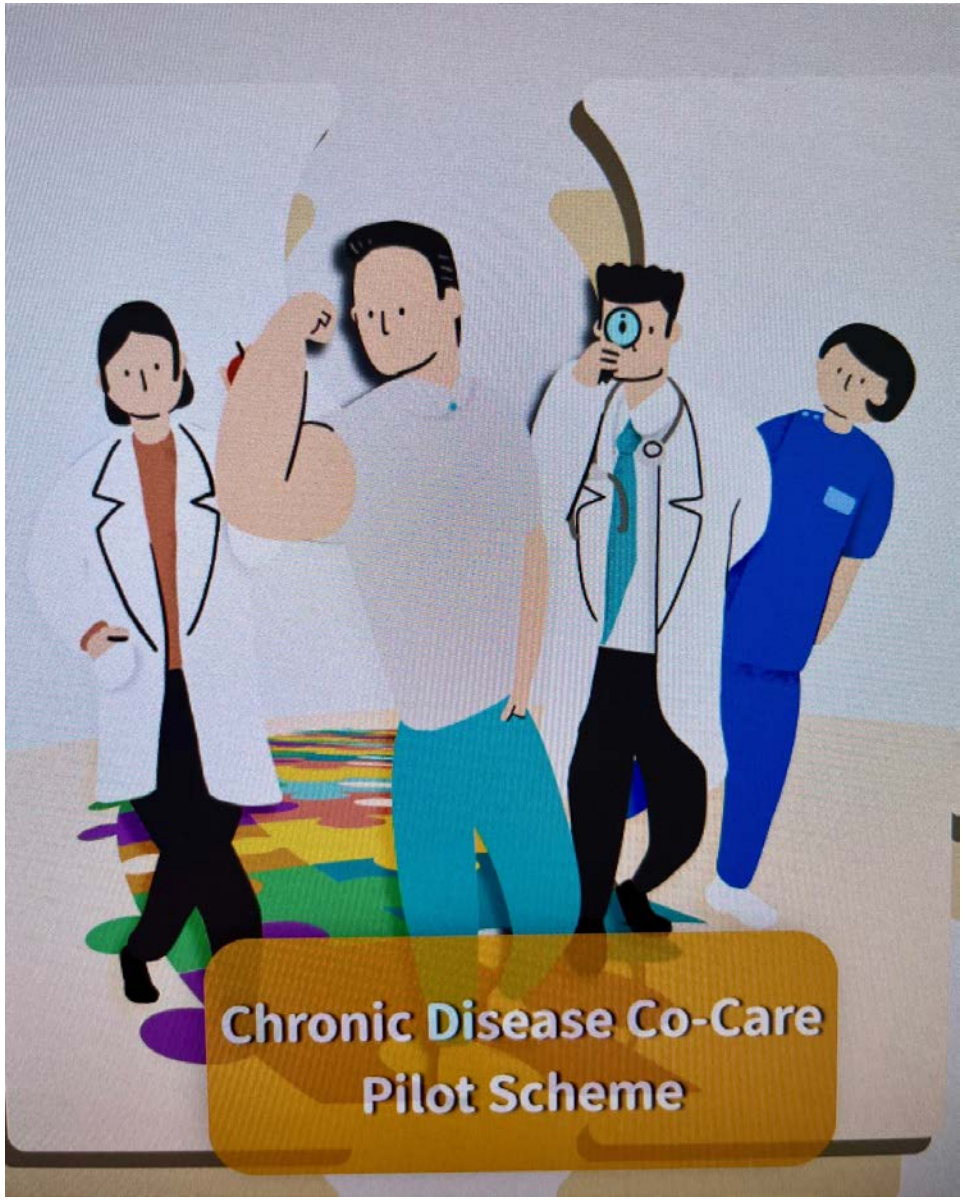
- Low overall spending on PHC suggests that not enough is done for the most cost-effective and high value care – health promotion, disease prevention, early detection, and early intervention.

Government spending is low and Out-of-pocket payment is high – More problematic

- Preventive and Early Detection services are highly price and income elastic, as the patient has no discomfort
- Price elastic: even a small price can deter consumption for many
  - Need to be free, or charge a nominal fee, or even negative price
  - Need to consider time cost and travel cost
- Income elastic: low income persons not likely to consume even if the fee is low
- Therefore, public resources should be the core for PHC funding
- Out-of-pocket payment should be reduced to a level where it is not a barrier
- They need to be delivered in a convenient location with little waiting time

Case Study: Evaluating Chronic Disease Co-care Scheme Nov 2023

- Enroll private family doctors
- Provide convenient screening services for diabetes mellitus and hypertension (and blood lipid added recently) for anyone over 45 without symptoms
- those tested positive will receive treatment by the family doctor at a subsidized rate
- those tested negative can receive healthy living advice from District Health Centres



Micro-economic Considerations in the Development of Primary Healthcare

Chronic Disease Co-Care Scheme (CDCC)

- Are the arrangements of the CDCC appropriate for the attainment of the objectives?

Operational Objectives

- To enroll as many target patients as possible for DM and HT screening
- To enroll as many private family doctors as possible

Key Economic Considerations

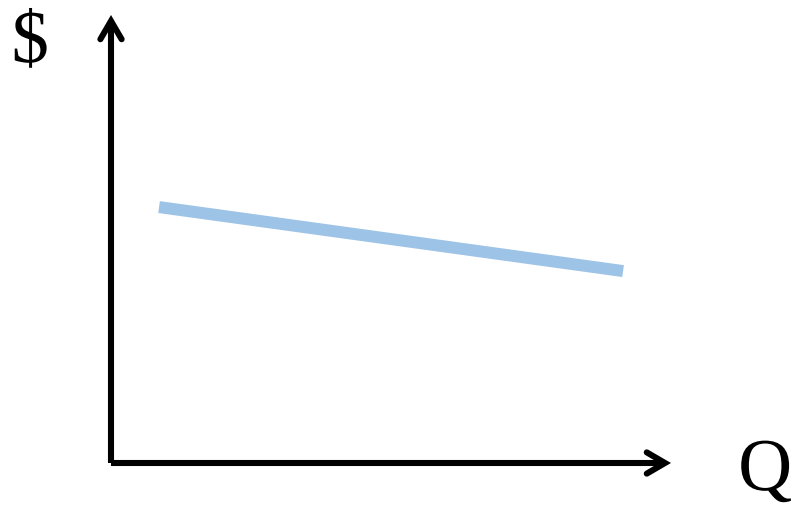
- Fees and charges to consumers for different services
- Other incentives to consumers
- Non-monetary price: convenience
- Subsidies to providers for different services
- Other incentives to providers
- Costs incurred by providers associated with the delivery of the different services

Demand-side Considerations

Can the scheme attract sufficient patients?

Demand for Preventive and Early Detection Services

- Patient experiences no discomfort
- **Highly elastic** : a small increase in price will result in huge drop in demand



PRICE ELASTICITY OF DEMAND

$$\frac{\%\,\Delta\,Q}{\%\,\Delta\,P}$$

Numerator

Denominator

Consumer Behaviour: Monetary Price and Non-monetary price

- First consultation with Family Doctor (FD) + screening: Patient pays $120 (US$15)– that might deter many
- Lab tests are free to patients: Good
- Patients with positive results consulting FD pay $166 (US$20) including standard drugs: OK, as treatment are generally less price elastic, and the charge is much lower than a regular GP consultation
- Patients age 65+ can use voucher + bonus: Good, → lowering of price
- Non-monetary price: location convenience, waiting time: clinic close to home, short-waiting time will attract more patients
- Pay-for performance: for patients – one free consultation ($150) if condition improves to normal level

Willingness-to-pay

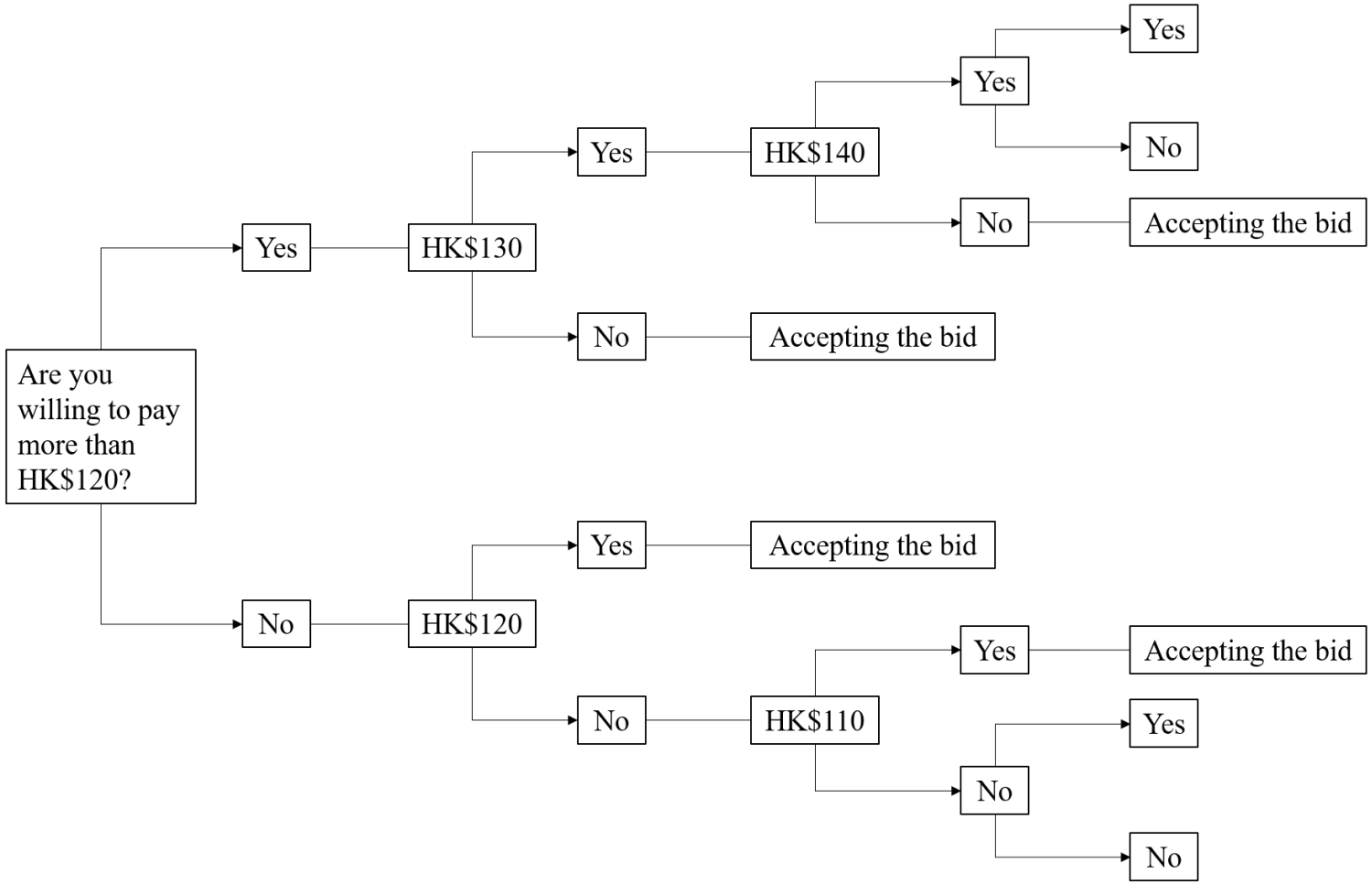
Depends on

- income
- perceived value of the service (often education-related)
- the price of substitutes
- convenience

To assess the willingness to pay (WTP) using the bidding game of contingent valuation method (CVM): An Exploratory Study

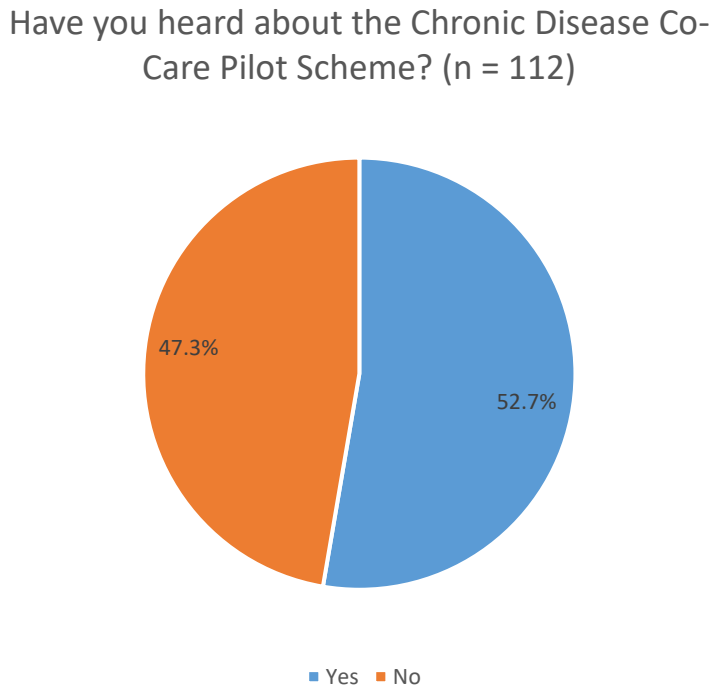
- “Would you willing to pay more than HK$120 of co-payment for screening consultation and related laboratory investigations and examinations (all inclusive)?” will be asked
- If the respondent accepts the amount, the interviewer will increase the bid by HK$10, until the respondent declines the amount.
- If the respondent declines the amount, the interviewer lowers the bid by HK$10, until the respondent accepts the amount. The accepted bid will be recorded as the WTP level.

Assessing WTP using the bidding game of contingent valuation method (CVM)



The Sample : n = 112

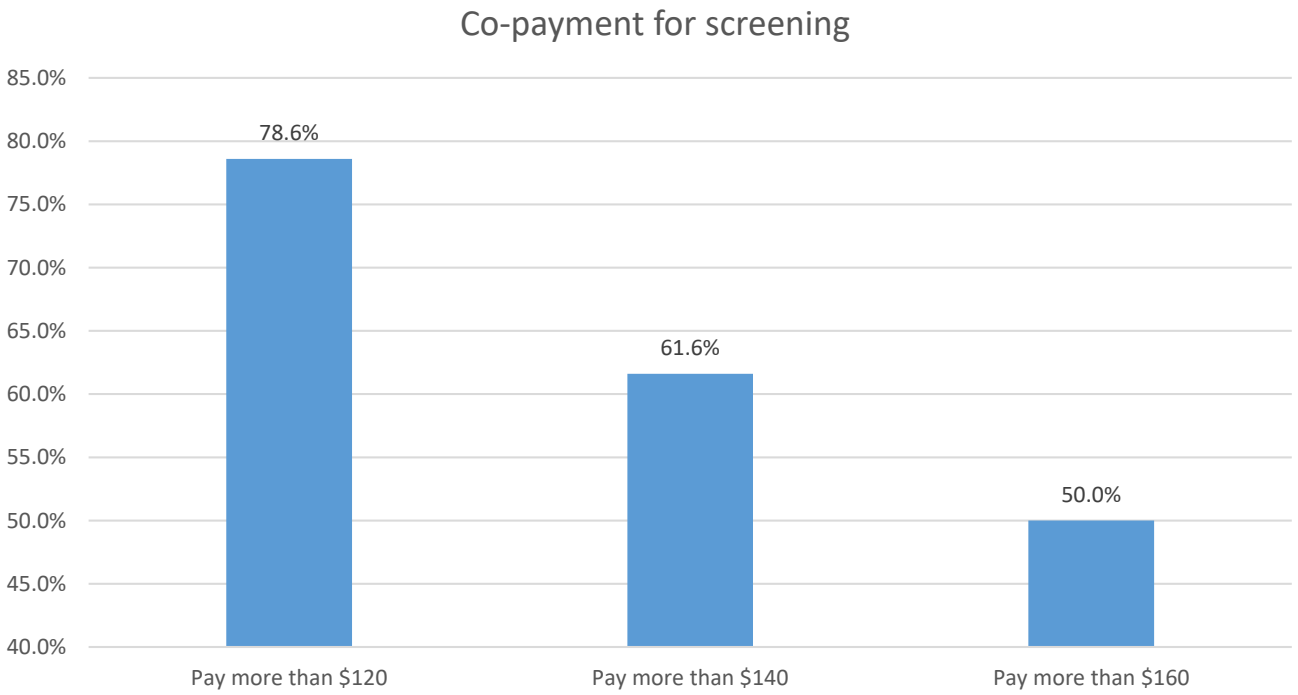
Variables	Number of respondents	Percentage
Gender		
Male	36	32.1%
Female	76	67.9%
Education		
Primary or below	2	1.8%
Secondary	24	21.4%
Post-secondary	23	20.5%
Degree	32	28.6%
Postgraduate or above	31	27.7%



Results

Level of WTP	Co-payment for diabetes mellitus and hypertension screening consultation and related laboratory investigations and examinations	
	n	n of Yes (%)
Pay more than $120	112	88 (78.6)
Pay more than $140	112	69 (61.6)
Pay more than $160	112	56 (50.0)

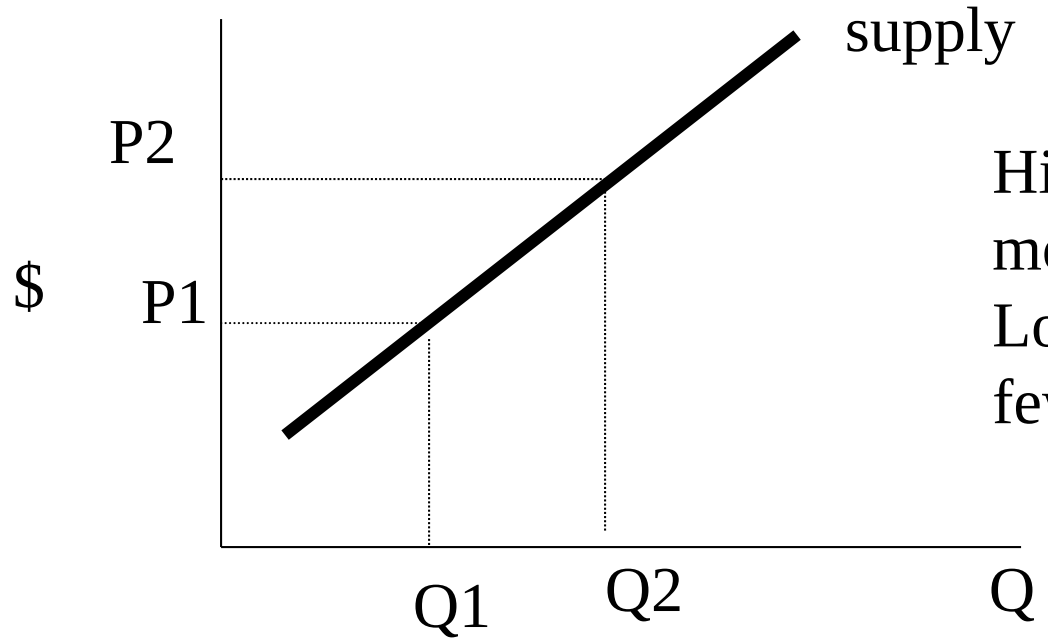
Note: n represents the sample size.



$120 fee appears not to be a problem

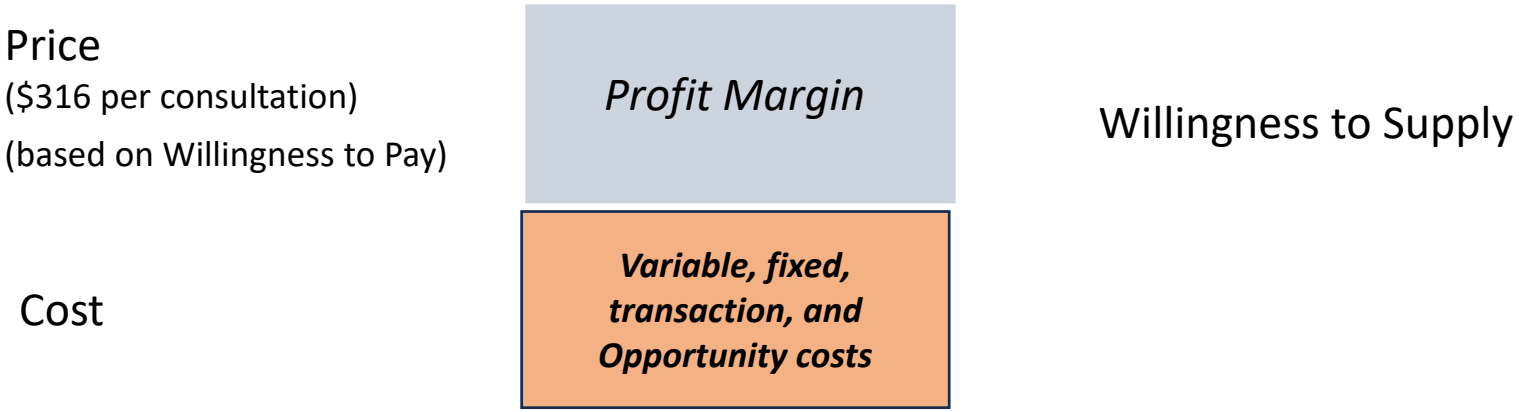
Supply-side Considerations

Supply curve: positively sloped



Higher Price,
more willing to supply
Lower Price,
fewer willing to supply

Factors affecting participation: Willingness to Pay, Price, Costs



Costs

- Costs – fixed costs and variable costs (rent, staff salary, drugs and supplies)
- Transactional costs – whether enrollment, drug procurement, IT system, claim procedures etc will incur additional cost
- Opportunity costs –
  - whether the FD has excess capacity or whether the FD has to turn away other patients;
  - whether the fee for other patients are higher

CDCC's arrangements

Revenue

- FD gets $316 (US$40) per consultation (first and subsequent) (1/3 from patients; 2/3 from government): average fee charged by GPs for simple consultations
- FD gets $105 (US$13) subsidy per patient per quarter for the drugs and can purchase with suppliers at a reduced cost
- Pay-for-performance: FD gets 15% of the patient co-payment fee during the past year, if 70% of their patients improves.
- FD can potentially get more patients as a result of the Scheme

Exploratory study: Providers' Concerns

Content Analysis from the Primary Care Action Group discussions

- *WhatsApp* chat group with 151 members to comment on the CDCC arrangements
- From 23 September 2023 to 10 January 2024
- Employed AI, Chat GPT4-32k, to analysis CDCC relevant discussions:
  - To generate themes
  - Salient points
  - Frequency counts
- Triangulation: manually by Research Assistant (double blind)
- Test for saturation using another W*hatsApp* Chat group: Primary Healthcare Chat Group (with 324 members)

Summarized Comments relevant to willingness to supply

Drugs provision under the Scheme

- Some wish to provide better drugs to patients which will add to their variable costs

Fees and charges allowable by the Scheme

- the fees and charges are not attractive to those
  - in locations with high rental costs
  - who are charging more from their regular patients and
  - are already busy

The IT System

- The IT system for the scheme creates more work, especially problematic for solo practititoners

Results:

after 18 months

Patient enrollment, as of May 2025

- 131,200 persons enrolled in the first 18 months (200,000 is the 2 year target)
- 74,900 screened (~60%)
- 31,100 found to have one or two positive results (very high ratio of 40%, implying that many enrolled might have been known cases going for the subsidies)

- all Hong Kong residents over the age of 45 are eligible : 3.8M persons (target is ~5% of the eligible population)

Source: LegCo questions LCQ22, June 11, 2025

Family doctors enrollment as of May 2025

- 640 family doctors participating in the scheme (LegCo questions LCQ22, June 11, 2025)
- there are 16,180 number of registered doctors, around 8,700 in private practice (LegCo Research Office ISSH32/2024)
- With a population of 7.5 million people, at least 3,750 trained family doctors are needed to maintain a quality primary healthcare system in Hong Kong (Dr Angus CHAN 2018 The Hong Kong College of Family Medicine)
- less than 20% of desirable level of participation

Suggestions for Improvements

- A per capita funding model with pay for performance component, and allowing doctors to set their copayment levels depending on their costs
- More promotion and effective communication with patients about the scheme is crucial.
- "Specified Drugs" list should be reviewed and potentially expanded to cover more common medications
- Special IT support measures for solo practices
- Formal channel for FDs to provide feedback on IT, drug, and compensation issues

Conclusions from Preliminary findings: Encouraging signs, but needs further work

Demand side:

- The CDCC scheme charges appears to be fine
- Need greater promotion effort

Supply side:

- Improvement on the issue of funding (fees and subsidies), drugs, fees, and IT system

Adequate Funding to Make an Impact on Outcomes

- Some of suggestions would require more funding
- If the Scheme is to be successful, many more patients will be recruited and the funding needs to be increased correspondingly
- Possible other new screening programmes -- -- blood lipid, osteoporosis, lung cancer, sarcopenia etc....
- How much more funding?
- Where could the money come from?

How much more?

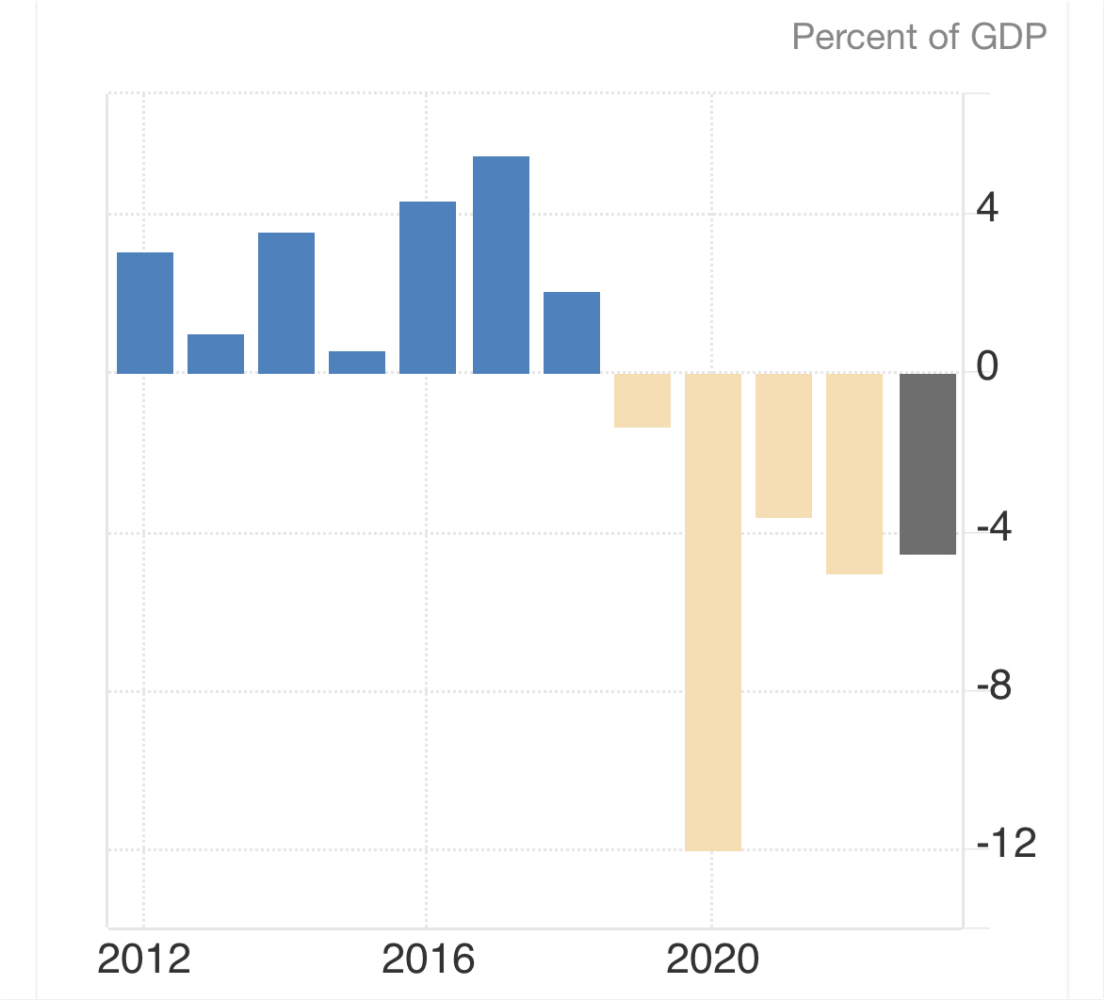
- To be on par with the average of high income countries which spend 42% of their total current health expenditure on PHC, Hong Kong needs to spend another $32,769M on PHC
- To be on par with the average of high income countries which spend 36% of public healthcare spending on PHC, Hong Kong SARG needs to spend another $27,757M on PHC
- Where can we find the money to do?

Hong Kong Government Budget Surpluses/Deficits

The fiscal deficit for 2023-2024 : HK$101.6 Billion

The fiscal deficit for 2024-2025 estimated to be HK$100+ Billion

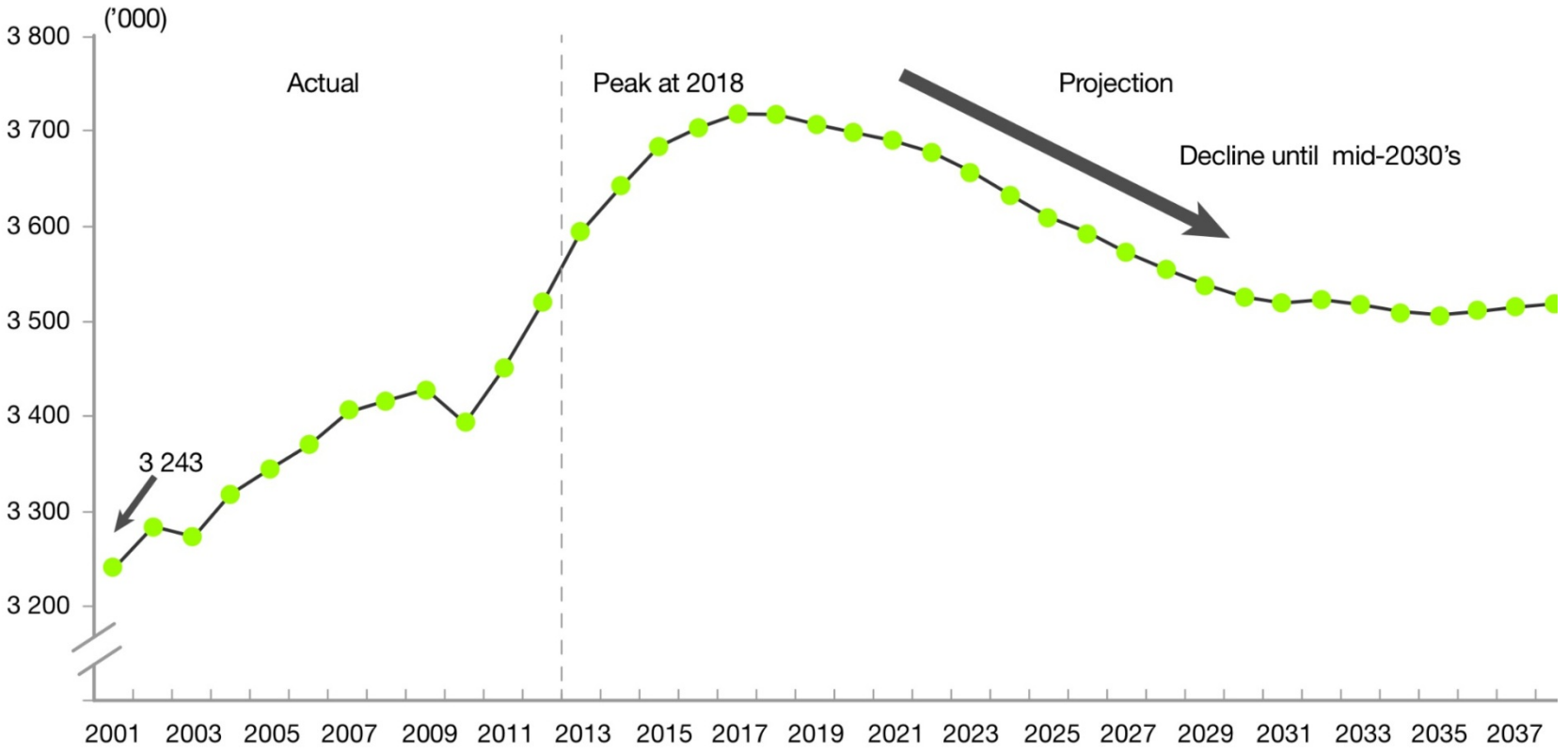
SCMP 2 December 2024



https://tradingeconomics.com/

Tax Revenue Decline is Structural : Decline in Labour Force

Chart 1.2: Projected labour force to 2041



Note: Excluding foreign domestic helpers
Source: General Household Survey Section, Census and Statistics Department

Source: Secretariat of the Steering Committee on Population Policy (2014), *Thoughts for Hong Kong: Public Engagement Exercise on Population Policy*, Chief Secretary for Administration's Office, Hong Kong.
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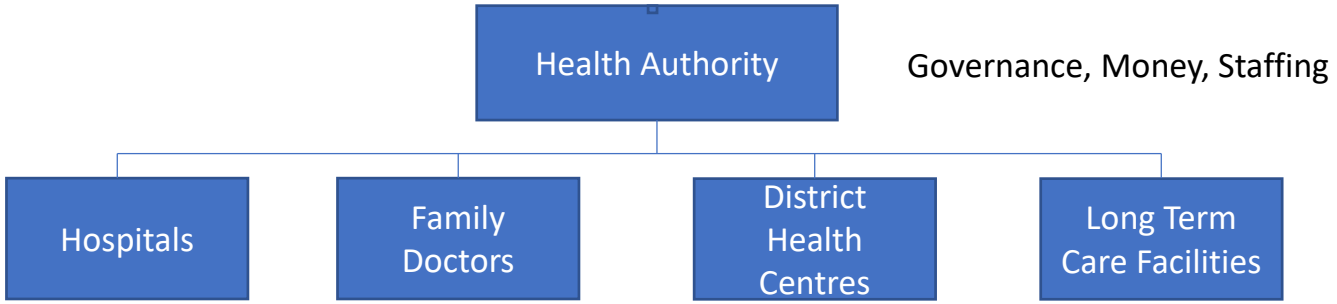
Need to Shift Resources from Lower Value Care Services

- 46.8% of all public hospital admissions were found to be Ambulatory Care Sensitive Conditions (Strategic Purchasing: Enabling Health for All, Our Hong Kong Foundation 2021, p.31)
- Treating these patients who do not need to be hospitalized is not only wasteful but is not maximizing the values of patients
- Treating these patients on an outpatient basis will save money, manpower, and space
- Use the savings to deliver more primary care

How to do it?
Remove the Silos

- Remove the existing compartmentalization: Hospital Authority, Department of Health; Primary Healthcare Commission; LTC under Labour and Welfare Bureau
- Put primary care, hospital services, and LTC under one authority
- This new authority will gradually swift resources from hospitals to primary care and LTC

My Preferred Structure



Questions


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