"Dr. Joyce Tang"

02/06/2008 09:05

To <beStrong@fhb.gov.hk>
cc
bcc
Subject feedback on "Your health your life" from PHC professionals

☐ Urgent ☐ Return receipt ☐ Sign ☐ Encrypt

Dear Dr Chow,

We are a group of 44 primary health care professionals working in the non-profit sector, including doctors, dentists and allied health professionals. Please find attached our feedback on the government health care reform document "Your health, your life".

Thank you.

regards,

Dr Joyce Tang on behalf of 44 primary health care professionals letter to Dr York Chow.tif

Dr York Chow
Secretary for Food and Health
Food and Health Bureau
19/F, Murray Bldg.,
Garden Rd., Central,
Hong Kong.

Dear Dr Chow,

Re: "Your Health, Your Life – Health Care Financing Reform Document"

We are a group of primary health care practitioners, including medical, nursing and allied health disciplines. We are writing to give our views on the above-captioned document. It is timely and we are ready for change. In a developed World city that is Hong Kong, with the already felt need of ageing population and disease burden brought by urbanisation plus our geographical location as the crossroads of both old and new infectious diseases, a long-term vision for health care and health finance is urgently needed. Everyone should be entitled to the same good quality health care.

In giving our views, we have used the primary health care approach with the following priorities in mind:

1. Equity
2. Acceptability
3. Accessibility
4. Affordability
5. Quality
6. Comprehensive, holistic and integrated community-based care

Proposing health care finance is already a good step and whichever model is adopted by the government, it is better than not having a system. Health is so important to the development of the whole society that government should have in place mechanisms to protect health, encourage healthy behaviours and ensure access to affordable health care, and every individual should also bear responsibility to safeguard their own health.

Of the 6 health care financing models proposed, social health insurance is the most equitable and most amenable to control. But as the document has pointed out, people may view it as yet another tax and the middle-class may reject it for this reason. If the government does end up choosing tax based model, the increase in tax rate must not be more than 1% for acceptability and to increase the tax base. Had it been a decade ago, this would have been our first choice. However, taking into account overseas experience, countries that had implemented social insurance, with similar

economic situation and ageing population, they are struggling to cope now. Eg. Austria, Belgium, Japan, Korea, Netherlands. The Netherlands reformed its health care system to Mandatory health insurance and seems to be working.

However, understanding the cultural heritage of Hong Kong people and the word "mandatory" may scare off some people, so the government needs to conduct public education on what it is all about and how it benefits the individual. And how the concept of "risk-pooling" can work only when the coverage is large. Some poor people in the society will face pressure, and in such case, the government should endeavour to help them.

The present state of private health insurance in Hong Kong does not inspire confidence. The priority of the private health insurance industry is business rather than health care, and in its current state, puts those with pre-existing illness at a disadvantage. We see so many patients who have purchased private health insurance but found it next to useless when they became ill. Our elderly patients and those with certain existing chronic diseases are unable to purchase it. And health insurance schemes often explicitly state a long list of non-reimbursable conditions including almost all psychological disorders. Another example of inappropriate conditions of private health insurance is the absolute requirement for inpatient admission to qualify for reimbursement, even if it is for the simplest investigation that could easily be done as an outpatient. (eg CT scan) Such policies are open to abuse and will escalate the costs of health care and undermine the role of the primary health care practitioner and gatekeeper.

So, if the model involves health insurance, then it is imperative that the government strictly regulate the private health insurance industry, otherwise, it may equal to no insurance at all. In case there is regulation of the health insurance industry, mandatory health insurance is our first choice out of your 6 models as the most suitable for the local Hong Kong situation. We would put the personal health care reserve is a reasonable second choice as it would probably find more acceptability among HK people.

As for the Out of pocket model, the purely voluntary medical savings model, and the voluntary health insurance model, we find them unfavourable as they are about the individual alone and do not promote equity, or risk-pooling, and with the ageing population, larger and larger segments of the population will become uninsured. Voluntary health insurance is happening now and is not satisfactory.

Overall, we are glad that the government is proposing health care financing reform. Whatever model you end up choosing is better than not choosing. If you do choose a model with health insurance, please regulate that industry strictly, especially regarding their multiple "exclusion criteria"; and to set a ceiling contribution rate (eg no more than 2% of salary) to be politically acceptable.

Other ways to assist healthcare finance to be explored include raising tobacco taxes, tax on high fat and high sugar processed snack foods (eg. Potato chips, sweets, ice-cream etc) and widening the tax base. These funds could be channelled back into community health promotion programmes, improving public sports facilities etc.

Finally and most important of all, we find it encouraging to hear that the government has plans to develop the primary health care system. In comparison with overseas developed countries, we have observed a huge gap in Hong Kong regarding attitudes towards "primary health care", with a sadly common belief that it must be the poorer relative of the high-tech tertiary hospital care. Evidence from many studies in different countries with different beliefs and cultures all over the world have already demonstrated that a strong primary health care system is related to better population health outcomes and cost-savings.

We are most interested in how the government plans to strengthen the primary health care sector in Hong Kong, seeing that the majority of primary health care is happening in the private sector. We advocate that the government really invest the money in primary health care by developing a system of incentives with the correct checks and balances to promote the practice of integrated and holistic medicine and health care in the community, with rational use of resources. We advocate strongly for government to take the lead and educate the public to adopt primary care ad prevention concepts, rather than chase after often unnecessary specialist consultations for minor complaints and high-tech investigations and treatments!

We need a system that correctly spreads the notion of preventive care and wellness, including health risks assessment, appropriate evidence-based screening, health education and healthy lifestyle promotion. A system that allows the primary health care provider to upgrade practice in the same way that the tertiary care specialist is able to do. The integrated use of IT is something that needs development in HK. The government could support primary care doctors (including GP in private sector) with hardware and software technical support in a way similar to Australia. The new Electronic patient record sharing project of HA is a good start. We recommend that it should include a place for specialist to give specific feedback to GP. In addition, electronic record sharing should be two-ways, rather than one-way. If the specialist could also see the background information from the Family doctor/GP, it could eliminate a lot of wasteful repetitive investigations. A universal healthcare IT system would also be useful in monitoring health services utilisation in private and public sectors.

We note with interest the plan for a primary health care provider registry. This is a good idea but needs precise definition of the criteria to be listed in the registry and how the registry will be used. If any self-proclaimed provider can be listed, then it would defeat the purpose. And on the other extreme, if the criteria were unrealistically strict, you would have so few on the register that it would fail. As it is not certain if this registry is only applicable to medical doctors, we write as though it includes all types of primary health care practitioners including allied health, as multidisciplinary work team is our group's existing working model. The criteria would preferably include those practitioners who have had some formal training in a primary health care discipline. Those who do not yet have such formal training, but who have practised in the field of primary health care in Hong Kong for a certain period, should be included on the condition that they partake such ongoing training in the coming years. The providers of such training need to open up their training programmes to include such people. That is, a declaration that primary health care is their vocation with proof of vocation. As for how the registry will be used, it may be used as a

vocational register, with higher reimbursements to those on the register. Eg. In Australia, those GP's with FRACGP or equivalent are vocationally registered and given a higher financial reimbursement rate than non-VR GP's. In HK, if those with such equivalent qualifications could be reimbursed at specialist rate, it would be a good incentive to raise GP standards, but at the same time, the door to achieving such qualifications must also remain open to those who have motivation to train and improve themselves. It may also be used for the benefit of patient information on choosing a primary health care provider. Apart from medical doctors, the register may include "Registered Dietitians" as distinct from "Nutritionist" as the term "Nutritionist" is currently used by people without real dietetics formal training and who are often found in "slimming companies" offering dubious advice. (These non-qualified "Nutritionists" may take formal education and training to gain proper RD qualifications if motivated) Dentists is another group that was not much mentioned in the consultation document, and basic annual oral check-up and scaling for all children up to age 18 years in the private sector may be considered.

We note that the document refers to the "Family Doctor", rather than "doctor". This is a good sign of the recognition of Family Medicine as a discipline in its own right. But once again, the precise definition of "Family doctor" is needed. Although we are highly supportive of the need for formal Family medicine training, we also appreciate that there are many primary care doctors who have not received formal training, not through lack of want, but because such training was not open for them in the past. We believe that it is preferable to have an inclusive system that fosters continuous learning than one that cuts off a significant proportion of highly experienced and valuable health care resource. Those who have not had a chance in times past should be given opportunities regardless of age and past experiences. In fact, the term "GP" is nothing to be ashamed of, as the GP is the cornerstone of community-based medical and health care. So, keep the door open and give them support and correct incentives.

For the Family doctor/GP concept to work, we would need to have a health care system that acknowledges the role of the family doctor as the key person providing continuous, comprehensive, coordinated and holistic care for the individual and the family. The general public in HK has the perception that the GP's are not as knowledgeable or deserve lower status to "specialists", and most unfortunately, this attitude is also pervasive within our own medical community. A strong government can lead the way to promote the concept of family doctor/GP and how a holistic approach can contribute to the prevention of disease. That the scope of the family doctor/GP includes much more than treating minor illnesses and issuing sick leave or writing referral letter to specialist. That the family doctor/GP should be given incentives to practise medicine that promotes health and prevents, as well as treats disease, and those with higher qualifications and training in family medicine be given same financial reward as other "specialists".

The family doctor/GP needs to be supported by a real gate-keeper mechanism. This should go hand-in-hand with the launch of the primary care registry. Every citizen should choose a primary doctor, and a referral is needed to see the specialist otherwise it will not be reimbursed. Regulation and continuous education within the medical sector itself is just as important as implementing the financial model.

Investment in primary care should focus on giving incentives for the family doctor and allied health providers (including dietitians, nurses, physiotherapists etc.) to provide care that is considered "low-tech and time-consuming" such as health counselling and psychosocial counselling, otherwise these essential elements that make up parts of holistic health care will not be done. These aspects of care are not considered "income-generating" as most patients do not understand why any payment is needed for "just talk", and health insurance schemes do not recognise such service for payment. In fact, most health insurance schemes completely exclude psychological disorders. As these activities take up much of the doctor's time, most primary care doctors just cannot afford to do it as their time could be spent alternatively in simpler tasks such as conducting a number of quick consultations with prescriptions for simple self-limiting illnesses. In forgoing the health education and psychosocial aspects of care, many patients' problems are never addressed, and leads to ongoing frequent consultations for a wide variety of symptoms all incurring extra cost to the individual and the health care system.

The provision of appropriate preventive health services is another gap area needing support through incentives. To conduct a PAP smear takes up significant doctor time, and there is a limit to what the patient is willing to pay for this service, so this becomes another "time-consuming and low reward" activity that is pushed aside, again to favour the quick consultation with prescription. Some private laboratories have been quick to spot this gap and to offer a variety of "health check packages"., However, on closer inspection, many of these are purely a series of lab tests with very limited health promotion value, some lacking explanation of results, and can also lead to a great deal of anxiety in the case of false positive. Preventive health care services should be integrated into a comprehensive health care system rather than stand alone. Most health insurance schemes do not cover preventive health activities. Appropriate incentives and monitoring needed to conduct evidence-based preventive health activities in primary care.

The management of chronic diseases is another area that deserves mention. Common chronic diseases such as hypertension and diabetes mellitus can mostly be managed in primary health care sector using multidisciplinary teams and making drugs more affordable. There are multi-disciplinary providers in the community, but not many are organised in a comprehensive way, and the solo primary health care practitioner is at a disadvantage. This leads to further disintegration of the care system. The inclusion of allied health, eg nurses, dietitians, Physiotherapists etc. as primary health care service providers with services that are reimbursable is recommended. Nurses are able to conduct Pap smears, and a wide range of health education services. Similarly dietitians and physiotherapists have their own defined role in evidence-based primary care.

Take for example the case of Diabetes management in the community. Although a large proportion of diabetes patients are followed up in the HA system, there is definitely large scope for good quality management in the non-government primary care sector. In fact, NGO multidisciplinary clinics have equipment and medical knowledge, training and ability to conduct full range of services from annual diabetes complications screening, to treatment to patient education and allied health support. A modest injection of funding support into these programmes (eg subsidise basic annual

complications screening and some generic drugs) would be sufficient to ensure sustainability and keep the patients well in the community.

Many patients with stable disease attend the Hospital Authority clinics because the cost of long term drugs is heavy for them to bear. Thus, the patients are actually using the GOPC's as a pharmacy. If that is the case, then would the government consider setting up an "essential drugs list" to treat certain very common chronic diseases. Drugs on this list would be proven in effectiveness, inexpensive generics, and available to all primary care providers on the registry at the same low price and on condition that they provide it for the patient at the same standardised rate.

Apart from medical management of disease, the health system should encompass health promotion on a community-wide scale. The health care finance reform should also set aside more money for health promotion as the widespread practice of healthy lifestyle produces a healthier population and reduces disease burden.

The role of the "Family doctor/GP" should be broadened to include the societal and public health context of health. They should work closely with community worker to provide community-based health care service. In Hong Kong, we seldom see doctors integrated with the community such as social service, and it is usually the nurse who does that. We do not mean to undermine the role of the nurse, but to make significant impact about disease prevention and health promotion, more effort should be made from the doctors' perspective. It will be achieved only if the concept of "community-based" Family doctor/GP is recognised and given room to grow.

As there may be many suggestions from the local Chinese community about this proposal, but probably few from the ethnic minorities, we would like to advocate for them as they do make up about 6% of the population. The South Asian minority group are especially marginalised with regards to health, so whichever health care reform the government takes up in the end, it should be acceptable to the minorities as well.

Strengthening of public health functions is one of the areas that should be expanded to the more needy ethnic minority communities. The Department of Health is doing public health education which is an essential complement to enhancing primary health care for the population, but how much is being done for the non-Chinese speaking Hong Kong resident? A survey in 2005 found that the Ethnic minority of Hong Kong had major risk factors for chronic diseases, such as obesity, sedentary lifestyle, low perception of health screening. There is also enough research done in the United Kingdom regarding health need and higher prevalence of chronic diseases among the South Asian community, and several overseas studies identifying higher incidence of cervical cancer in this population group due to lack of knowledge about screening programme.

Despite its World city status and cosmopolitan veneer, many of Hong Kong's South Asian/minority citizens are destitute to ill health because of lack of attention by government. There is a huge language barrier and lack of health professionals from this community. Some government resources should be allocated to overcome these barriers to health. For example, having bilingual teaching more readily available for all levels of health training courses, setting up structured medical interpreter services etc. If these services are not provided for the minority communities, many of them

will fall off the health system safety net no matter what health care reform is conducted.

We have a question about who is going to oversee the "strengthening of the primary health care sector". We highly recommend an independent authority/body to avoid conflict of interest. For credibility and most appropriate input, the majority in this authority must be primary health care providers themselves.

In summary, we support the government's proposal for health care reform and we have indicated our preference for Mandatory health insurance, which should be considered together with checks and balances on the health insurance industry. The Personal health care reserve is also an acceptable possibility. The practical ways to strengthen the primary health care system are also proposed for your consideration.

Contact person for enquiries: Dr Joyce Tang, [redacted]

Yours faithfully,

CAN WAI SUM (HMO)

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Yours faithfully,

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Yours faithfully,

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Yours faithfully,

Signed by:

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