Views of Lee Yat Sau on
Healthcare Reform Consultation Document

Overall View

1. I believe Hong Kong has one of the best public healthcare systems in the world, and I believe this is a main reason for the phenomenon that Hong Kong people had the longest life span in the world. Care must be taken not to change the quality of the healthcare services in any reform except for the better.

2. Nevertheless, such a high-quality and high-protection healthcare system comes at a high cost. However, the biggest problem is not the cost itself, if it is unavoidable, but how to derive the funds, use the money and distribute the benefits in the fairest and most cost effective and efficient manner possible.

3. The greatest problem with our existing public healthcare system is that low-cost public healthcare is provided to everybody equally regardless of their income and financial capability. In this sense, I think the current system is NOT equitable as claimed in Table 3. The unfair results include: wealthy people competing for low-cost public healthcare with low-income people thus lengthening waiting time for all, and low- and middle-income people subsidizing the healthcare costs of middle- and high-income people. **To ensure fair and wise use of public money on healthcare, the reform must feature the provision of different levels of subsidy/sponsorship of healthcare services according to individuals' income or wealth.**

4. The second problem is how to make the public healthcare system more cost effective. The Hospital Authority (HA) is NOT operating in a cost-effective manner. For example, many senior doctors and specialists are spending too much of their time on hospital administration instead of providing medical care to patients, such as IT development, general administration, business development, purchasing, etc. Such matters can be performed by generalist or other professional administrators at a lower cost, at the same time freeing medical professional resources to provide medical services. There are also too much bureaucracy in hospitals that waste both doctors' time and patients' time. **The internal operations of HA and public hospitals must be revamped as part of the reform to enhance cost effectiveness and efficiency.** The government and HA should not ask the public to contribute to subsidize HA's inefficiencies and doctors to carry out non-medical duties. The public should not be asked to make more contribution to fund the public healthcare system medical financing system unless the government demonstrates value for money to us.

5. The paper emphasizes the need and strategy for enhancing primary healthcare, but there is no elaboration on or solid examples of what "primary healthcare" services may be (e.g. could it possibly mean subsidizing Hep B carriers to go for half-yearly blood tests and ultra-sound screening, and other high risk factor persons to go for regular monitoring of those risk factors). The paper is vague over the scope, type and level of primary healthcare services to be

provided/developed, and there is no information on what portion of the future overall public expenses or amount of government subsidy on primary healthcare would be. This is unacceptable, because the population of primary health recipients could be many times that of the current patient population receiving public healthcare services and the time span they receive primary healthcare services could be lifelong, and hence the cost could be astronomical. While I support the initiative in principle, I find it difficult to support it without more information on what primary healthcare services you are proposing and what the cost implication (in respect of the public purse) is. Given that waiting time for essential secondary healthcare services is already unreasonably long, enhancing primary healthcare seems to be a myth.

6. There will also be an equity issue in respect of subsidizing primary healthcare. It may be acceptable for the general public to sponsor primary healthcare services for people who suffer from health risks which they have no control of, but it would not be fair to require people who consciously maintain a healthy life to sponsor those who are irresponsible for their own health, e.g. smokers and heavy drinkers – e.g., why should the public subsidize smokers to undergo regular screening for diseases caused by smoking when they continue to smoke?

7. In my view, the key features of the reformed healthcare system should include:

   (a) Highly subsidized healthcare (like current public healthcare services) should only be provided to the low-income, either by providing public healthcare services to them directly in public hospitals or through heavily subsidizing mandatory medical insurance. People with high income should not be entitled to highly subsidized healthcare unless exceeding a certain limit (i.e. there should be an ultimate safety net for all).

   (b) Middle and high income people should be required to rely mainly on personal medical insurance for their healthcare needs. However, they can be financially assisted in some ways: (i) a certain level of direct government subsidy for the premiums, (ii) a mandatory insurance regime may help bring down the premiums, and/or (iii) a safety net to cover exceptional expensive healthcare services.

   (c) Low-income people can either be directly provided with heavily-subsidized public healthcare services or also be required to subscribe to the mandatory medical insurance scheme but with more government subsidy.

   (d) The medical insurance system should be regulated to ensure fair and adequate protection, at the same time giving people enough freedom in choosing the insurance packages and level of insurance at their own cost, provided they meet a minimum requirement. For example, my family is currently enjoying reasonably satisfactory and affordable medical insurance taken out by my own. I expect any mandatory medical insurance schemes to be able to provide no less favourable packages for my choice.

(e) To enhance equity, the medical insurance system should be designed to require those who voluntarily put themselves at higher health risks (e.g. smokers, heavy drinkers) to contribute higher premiums (loading). This is because those who lead a healthy life should not be required to subsidize those who put their health at risk with unhealthy habits.

(f) Consideration should be given to require employers to contribute to employees' medical insurance.

(g) If heavily-subsidized public healthcare services are restricted to the low-income, then it should be largely be funded by the existing tax system (government should make more detailed assessment). Middle- and higher income people should not be further required to subsidize the low-income's medical expenses. They should only be required to pay more for their own medical expenses (i.e. receive less government subsidy).

(h) Revamp the administrative systems, operations and work distribution in HA and public hospitals to achieve the highest cost-effectiveness possible, so as to ensure greatest value for money for the tax payers.

(i) There should be an ultimate safety net even for middle- and high-income people where the mandatory insurance they take out is unable to provide protection. The safety net can also be designed as a form of subsidy of their premiums.

(j) Primary healthcare should be encouraged and enhanced but the use of public money on such services must be prudent. The above equity principles should also apply to primary healthcare services: i.e. the level of subsidy should depend on income level and those receiving subsidy must cease any habits hazardous to health.

Detailed Responses

8. I also have specific comments on specific issues in the Executive Summary:

Para.	Comments
5 (a)	See my comments in paras. 5-6 above.
5 (b)	See my comments in para. 4 above. In particular, too many doctors in HA engage themselves in administrative work. There's a culture/practice in HA that doctors senior in rank would retreat from front-line medical care work and assume management roles and administrative duties in comfortable offices. This culture and practice should change to enhance cost effectiveness in public hospitals. There are also too many bureaucracies and administrative inefficiencies

Para.	Comments
	in public hospitals. I have once accompanied my father to see a doctor in QE. In the 15-minute consultation session, the doctor spent 2/3 of the time operating his desktop computer to work on with data, documents, internal reference letter, etc. Also, the doctor had to write and print a referral letter to refer my father to another unit in the same hospital, and my father had to bring along the letter to make an appointment booking by visiting the other unit's booking counter in person, despite so much had been spent on computerization in QE. These kinds of administrative arrangements are not designed to facilitate efficient services to patients, and also make HA hospitals cost ineffective.
9(a) to (d)	The high occupancy rate and long waiting time arises from the problems I raised in paras. 3 and 4 above.
10	It is no use to "continue to take measures to enhance …" because no piecemeal improvements can make the change. The public sector healthcare services need an overhaul. Moreover, the problem is not merely long waiting time, but a matter of live or die. I knew of a civil servant who decided to queue for removal of a colon tumor in a public hospital, but unfortunately the tumor started to spread before it was his turn.
13	The statement that we may not have much choice other than unsubsidized and "more costly private hospital and specialist services" is misleading. Ever since 1995, I have found it unreliable to rely on public healthcare services. My whole family is now covered by comprehensive medical insurance at a cost reasonable to all middle-income families. The most important issue is the insurance provides much better **value for money**.
14	The header is also misleading. I do not agree that the present safety net is not wide enough. It is wide enough to cover basically all Hong Kong permanent residents.
17(c)	Development of electronic health record sharing has been an existing initiative for a long time. Why include this in the current reform proposal? It should be done with or without the reform.
17(a) and 19	See comments on primary healthcare above.
21	The private medical industry should contribute to the system, instead of only public funding.

Para.	**Comments**
22(a)	It is important to be specific and quantity the reduction in waiting time that could be achieved. Reduction of waiting from 2 yrs to 1 yr 8 mths means nothing. Also, would increase in demand for public healthcare services offset any intended reduction of waiting time? The government or HA should be specific as to what measures/funding would result in what reduction of waiting time, instead of simply issuing blank cheques that won't pay at all.
25(a)	Disagree. Not equitable.
25(b)	There cannot be the same level of user fees for all. The fee level for middle- or high-income people should be equivalent to that of private hospitals.
25(c)	Disagree. People should be able to receive the benefits from their own contributions as and when needed. I do not accept a medical funding scheme which locks up my current contributions only for future use.
25(d)	Disagree. Not sure how you can encourage, if people not taking out medical insurance are allowed to enjoy highly subsidized public healthcare services.
25(e)	Agree. Currently, such specified "group of population" may be entitled to receive subsidized public healthcare services. Part of this could be diverted to subsidize their taking out of medical insurance. The mandatory medical insurance system should be regulated to ensure fair and adequate protection, but people should be given enough freedom in choosing the insurance packages and enhanced level of insurance at their own cost, provided they meet a minimum requirement.
25(f)	Disagree. This may not allow flexibility in people's use of their own contributions. The linking with investment makes the scheme too complicated.
26	I do not agree to wealth re-distribution in the financial arrangement for the reformed healthcare system. The tax system already provides wealth re-distribution and is already giving enough burdens to the middle-class. Introducing further wealth re-distribution in the healthcare financing system will add considerably heavier burdens to the middle-class and is unfair. A financial arrangement whereby heavily subsidized public healthcare is provided only to the low-income and middle- and high-income people have to take out medical insurance with fewer subsidies is a much fairer arrangement.

Para.	Comments
Table 1	I do not see why under mandatory private health insurance must result in high-income and low-income paying the same. I support a mandatory health insurance scheme where low-income people are subsidized more by the government. I don't see how this cannot be done. I don't think the comparison table provides a fair and full picture.