"SIU Shing-Chung" <>

08/06/2008 16:37

Please respond to "SIU Shing-Chung" <>

To "beStrong@fhb.gov.hk" <bestrong@fhb.gov.hk>

cc

bcc

Subject comments to Healthcare Reform Consultation Document

☐ Urgent ☐ Return receipt ☐ Sign ☐ Encrypt

Dear Sir,

Here are my views as attached in the file.

S C Siu

Comments on Healthcare Reform HK.doc

1. **A chapter - "Enhance People's Health", is missing**
    a. Chronic diseases, mainly non-communicable diseases like heart diseases, stroke, diabetes and kidney diseases and so on, are the major burden of our future health care system.
    b. Provided people are given the opportunity to understand the situation and the chance to improve their lifestyle, these chronic diseases can largely be prevented.
    c. A proportion of 10% the health care budget should be allocated to carry out the ***'Enhance people's health programme'*** through territory wide education programmes, healthy eating projects and very low-cost exercise promotion programmes.
    d. Currently, there is little formal surveillance on chronic diseases in Hong Kong.
    e. The Hong Kong SAR Government (the Government) should allocate resources to carry out ***research*** and set up ***statistical surveillances*** on non-communicable diseases to facilitate rational planning of medical services targeting against chronic diseases.
    f. Prevention of chronic diseases is not cheap, but the effect will be fruitful. You either spend your money on disease prevention thus remaining healthy, or you spend a similar or even more amount to treat your ailing and poorly functioning body.
2. **Other missing points**
    a. The Healthcare Reform Consultation Document (the Document), though titled "Health Care Reform" with clear and good visions, obviously concentrates most of its efforts on financial arrangements, while neglecting the important issue of ***upstream prevention*** of diseases by health promotion and diseases prevention. It has also left out the call for ***efficient and quality disease management*** through restructuring the existing health care systems. Both are important if we are to control the growing healthcare demand.
3. **Projected health care expenditure - not high at all**
    a. The Document gives the public a frightening impression that public health expenditure in the future will be very high and unmanageable.
    b. However, one should not be too worried with the Document's projection. According to the Document, even if we do nothing in 30 years, public health expenditure in 2033 is still 5.5% of the GDP, which is quite within our capabilities.
    c. And most likely, the figure 5.5% is exaggerated. One can see that there is practically no increase in that figure from 1998/9 to 2004/5, maintaining at around 2.8%.
    d. Even if the projected figure 5.5% of the GDP is true, it is not something called very high. It is in fact a very reasonable figure in a developed, civilized and prosperous city like Hong Kong. The figure is actually even lower than the current corresponding figures (5.7-7.7%) in most Western countries.

e. People here, living in the affluent city of Hong Kong and life being precious, like their counterparts in Western countries, are naturally willing to provide a greater proportion of their GDP to maintain their health.

4. **Health care cost can be controlled.**
    a. With more emphasis on "Enhance People's Health" mentioned above, the whole Hong Kong population may become healthier and there may be less people with chronic diseases. In addition, if we do pay a little bit more attention on improving the efficiency and quality of our current health care system, the amount of money spent on public health care in the future will be very likely be less than projected by the Document.
    b. This has happened recently. On reviewing the recently released economic data, it is found that, to the contrary of the Document's projection, public health expenditure as a proportion of the GDP actually decreases from 2.8% in 2004/5 to 2.4% in 2007/8.
5. **Change mindset to save medical cost**
    a. To further save medical cost in the long run, we may need to change our mindset. Instead of allowing early diseases to become more serious as is the case today by triaging them to the long waiting list, people with diseases in the earliest stage should be given the best care to tackle the disease and retard its progression. Fast track access to medical care that are both intensive and of high quality should be installed.
    b. Good management of diseases at their early stage saves the huge medical cost in caring for late stage diseases.
    c. The reformed health care should pay attention to both prevention of diseases from occurring (primary prevention) and prevention of progression of established diseases (secondary prevention).
6. **Manoeuvring financial arrangements cannot lessen burden to future generations**
    a. The Document suggests that if we maintain the present financial arrangements, the burden on future generations will increase.
    b. The statement is false. Health care burden depends, among others, heavily on disease load and overall health of the population rather than financial arrangements. Our present financial arrangement is quite efficient. There is an inherent risk that, at its worst, manoeuvring around with financial arrangements may aggravate the burden if it happens that the financial arrangement so changed is less efficient than the present one.
7. **Over-reliance on the public health care system? No!**
    a. The Document is highly critical of the over-reliance of the public on public health care system. But to be fair, at least the current *public in-hospital system*, to the envy of other countries, is working very effectively and efficiently. By using only 1.6% of our GDP ($21.2 billion in 2004/5), it forms the backbone of health care system in Hong Kong and provides the safety net for all of us, including the very rich, when we are real sick. It is entirely proper and right for citizens in Hong Kong to rely on this public in-hospital system, which one would say, is both the pearl and pillar of Hong Kong's stability.

b. As for the present public out-patient service, due to the very poor coordination, little cooperation and great price difference between the private primary care sector and the public hospital services (both in-patient and out-patient services), there is great difficulty in discharging stable patients to private primary care. Furthermore, the standard of care provided to people with established diseases by primary care sector still has a big room for improvement. Unless these problems are resolved by reform, it is quite reasonable for a normal person with chronic disease to stick to the public outpatient system.

8. Public health care deserves a bigger share of the GDP

a. The document warns of the presence of significant public-private imbalance as though it is something very bad and that public health care is spending too much.

b. Let us take a closer look on public health expenditure. In 1989/90, the public health expenditure accounted for 1.4% of GDP, a meager and shameful figure. The public health care services were quite unsatisfactory at that time.

c. That is the reason why the Hospital Authority (HA) was established in 1991. The move was to rectify the situation. Money was injected into the public health care system to make the process possible. We all witness the subsequent great improvement in public health care, benefiting all people especially the lower and middle social class.

d. Therefore, it is not astonished at all to see that in 2004/5, the proportion of public health care rises to 2.8% of the GDP, which though still low in international standard, is a much more respectable figure. The double increase in proportion from 1.4 % to 2.8% should be seen as a reversal of the wrong.

e. It may be true that there is an imbalance, but it is the public health care sector that is having the deficit all along.

f. Hong Kong is by all means a rich city. Our 2007 GDP ranks 37th among 180 districts, and our 2007 GDP per capita, reaching US$ 29900, ranks 27th among 180 districts, just a bit under New Zealand's US$ 30256. Yet, New Zealand is spending 6.5% of her GDP on public health care in 2004 as compared with our figure of 2.8%. With our economic capabilities, people of Hong Kong are entitled to have better public health care and a fair share of the wealth. Our current public health spending is too little, not too much.

g. Regarding the private health care spending as a proportion of GDP, there is a small rise from 2.1 % to 2.3% from 1989/9 to 2004/5. For 6 years from 1998/9 to 2004/5, the ratios of GDP consumed in the public verses private health care remain stable: 2.8%/2.3% vs 2.8%/2.3%. In 2004/5, the expenditure on public health is $37 billion whereas that of the private sector comes up to $31 billion, which is not a small amount at all. One can hardly describe the situation as imbalance.

9. There shall be no status quo

a. The Document warns that public health care system would not be sustainable if we do nothing.
b. But we shall do something. With restructuring of the primary and secondary health care system, with addition of modest resources and investment on prevention of chronic diseases, the public health care system is entirely sustainable.

10. Restructure the hospital out-patient system

a. Take 2004/5 spending on out-patient care as an example. The public hospital out-patient, the public primary out-patient and the private out-patient spend roughly $7.9 billion, $4.6 billion and $12.6 billion respectively, making up a total of about $25 billion, accounting for 37 % of the total health care expenditure. This is a large sum if we are reminded that the public in-patient hospital system only uses $21.2 billion, $4 billion less than total out-patient services.
b. One always says that the public specialist out-patient service (SOPD) is of fair quality and has a very long queue. There is no secret that at least 50-70% of patients attending the SOPD have stable medical conditions and they continue to come back to SOPD to take medications. This culture creates a large workload to the clinics. As a result, patients with unsolved medical problems may have difficulty in getting prompt, intensive and comprehensive medical care.
c. Waiting list to attend the SOPD for the first time is too long for people with diseases. These people as a consequence end up with more severe and advanced diseases, requiring more hospital admissions in the long run. The vicious cycle spirals on. Yet there is little willingness to reverse the condition as the working performance of the SOPD is judged more by its number of attendances rather than its quality of care.
d. We should transfer stable patients of SOPD to primary care. Hospital medical teams made up of specialists should then concentrate their efforts to provide the best possible care to the remaining patients with unstable diseases. With time, most of them will become stable and be able to leave the SOPD to spare resources for others who are needy.
e. In doing so, public hospitals will have the capacity to reduce the waiting time of the SOPD so that patients with whatever diseases will be seen earlier and cared for better. Overall, the health status of the patients will be improved and hospital admissions will be reduced at probably very little additional resources. In short, an efficient and quality SOPD is one of the best gate-keepers of hospital admissions.

11. Private primary care should play a bigger role

a. All the recommendations in the Document concerning private primary care enhancement, including the setting up of the family doctors register, primary care voucher and purchase of private primary care services, are piecemeal and vague.

b. The private primary care sector, consisting of 6000 mostly very experienced and dedicated GPs, has been doing excellently in the past and has contributed greatly to health care of Hong Kong. The large numbers of GPs constitutes an extremely huge and precious human resources and should be channeled to shoulder a greater task. The private care sector should have the courage to take up new challenges.
c. To play a bigger role in primary health care, private doctors (GPs) in the era to come have to get themselves ready to collaborate with hospitals to receive substantial numbers of patients with chronic diseases. A formidable task. More often than not, a patient suffers from not just one disease but multiple diseases. Care of these people with multiple chronic diseases demands a lot from GPs.
d. At present, most GPs work single handed with their clinics receiving practically no support from the Government. Assistance to their day in day out work from medical associations is also pretty petty. If you consider the situation of the public health sector, both the in-hospital and specialist out-patient medical services are strongly supported by thousands of very talented and committed administrative and clerical staff. No wonder they thrive so well. And it becomes obvious that it is quite unfair to ask for too much from GPs.
e. Yet, one must be reminded again that the amount spent on private primary out-patient care is quite substantial, amounting to $12.6 billion in 2004/5 whereas the corresponding figures for the public primary care outpatient and public specialist out-patient sector are 4.6 and 7.9 billions dollars respectively. And the public sectors are performing fairly well.
f. To make the case worse for the average GPs, the administration of the public primary care outpatient clinics (GOPCs) is taken over by HA. As a result, the standard of care provided by the GOPCs, known to be at most fair in the past, is improving progressively, to the delight of the public, but to detriment of the private sector, as patients may be further attracted to the GOPCs.
g. Many people are willing to attend their GPs if they are well assured that they will be well taken care of and the money spent is worth the value. The Government should prime the community about the new health care logistics - that patients must leave the public specialist outpatient clinics once their conditions are stable. At the same time, private care sector needs to enhance her service capabilities and be able to compete with the public primary care services.

12. Set up the Primary Care Authority (PCA)

a. A proportion of 1-2 % per year of the private primary care budget, a sum of about $150 million, should be allocated to set up the Primary Care Authority (PCA), which should preferably be funded and managed by private sector.

b. The duty of the PCA is to establish the long overdue family doctor system in Hong Kong as well as be responsible to oversee the planning and coordination of private primary care services. It will also set service standards and be responsible for maintaining the standards and training of GPs through the keeping of the GPs register. With PCA, liaison and cooperation with the public health sector will become much more efficient.
c. As a result, the overall standard of private primary care will improve markedly and will be able to attract patients and compete with public health care system.

13. Rationalize public fee structure

a. In 2004/5, user fees accounted for 4.6% (3%, 10%, 17% of the hospital inpatient, SOPD and GOPC respectively) of the total public health expenditure of $37 billion. The proportion should be increased.
b. The proportion of user fees for outpatient services should be increased to ***25% and 30%*** for SOPD and GOPC respectively. This will discourage the unnecessary stay of stable patients in public service. Furthermore, the transfer of care of them to the private primary care doctors will be easier as the price difference between public and private primary care will be smaller.
c. User fees for public hospital should increase to ***5%*** of the public hospital expenditure and should remain low to accomplish our goal that no citizens with severe illnesses will be denied of care due to lack of means.
d. One should note that upon the increase in user fees proportion, there will be little increase in public revenue as it will be offset by the drop in public out-patient attendances. But the move will help greatly to harness the unnecessary growth of public out-patient services.
e. As a result, private doctors will take a larger role in taking care of patients with chronic diseases. And at the same time, public outpatient departments will have resources to see new patients earlier (i.e. cutting the waiting time) and manage all patients better.

14. Public health expenditure should be linked to GDP

a. The statement that Government will increase its commitment on health care by spending more on public health, from 15% to 17% of *overall recurrent government expenditure* in 2011/2 is flaw.
b. The Government has been trying to limit the growth of its total recurrent expenditure for the past years and the years to come. For the past 7 years from 2000/1 to 2006/7, government operating recurrent expenditure rises only from $186.7 billion to $ 194.0 billion, a mere 0.5% per year. Public health care, even with a little growth, will naturally assume an exaggerated proportion in the total government recurrent expenditure. An increase stated by the Government does not therefore truly reflect any commitment on the part of the Government on health care at all.

c. In a fair and just society, citizens are entitled to enjoy a fair share of the community wealth. This will ensure Hong Kong's stability. GDP, the result of the efforts of all, reflects how rich a country is. In Hong Kong, since 2004, GDP has grown significantly at a rate of about 7 % per year, meaning that Hong Kong is richer than before.
d. A committed Government should lead the public to decide how much in terms of the proportion of the GDP the Government is prepared to invest on public health care. The exact amount is determined by GDP rather than by recurrent government expenditure.
e. When our society gets more prosperous, as evidenced by a growing GDP, the average citizens living in this civilized city would reasonably expect more to improve their health.
f. In 2004/5, the Government is spending 2.8% (2004/5) of the GDP and taking back 0.1% as user fees. Other western countries are obviously spending much more now (5.7% to 7.7%).
g. In 2007/8, even if we keep the 2004/5 figure 2.8 % of the GDP without any increase as the benchmark, public health expenditure based on domestic health account should be about $45.2 billion. Yet, the actual public health expenditure similarly based on domestic health account is only $38.4 billion, a difference of $6.8 billion. Imagine how much the public health care system will improve if the sum of $6.8 billion were injected into the system immediately. (2004/5 GDP $1287 billion, 2007/8 GDP $1616 billion)
h. We need to decide the target proportion and then live within our means. A ceiling figure of **5.5%** would be reasonable taking reference from other countries and taking consideration of Hong Kong's local situation. In summary, how much the Government spends on public health care depends on how rich the community is. From then on, we shall decide where the money will come from.

15. Private secondary health care sector

a. The private secondary health care should be free to grow and compete with public health care to provide more choices for people who can afford it. Yet the basic principle regarding the public health expenditure in relation to GDP to safeguard the rights of the citizen mentioned above must be guaranteed first.
b. The private secondary health care sector, with its special merits, is very capable providing excellent quality services, attracting people from other countries to come for services.
c. The growth and development of the sector has already occurred in recent years, and will surely contribute to the prosperity of the community and the growth of GDP.

16. Health care financing – incorrect statements in the document

a. The Document's statement that public health expenditure is increasing at a much faster pace than the economy is at least not true for the past 9 years. From 1998/9 to 2007/8, a period of 9 years, GDP grows 26.7 % (from $1274 billion to $1616 billion), which is much faster than the 7% growth of public health expenditure (from $35.9 billion to $38.4 billion) in the same period.

b. If one looks closer into the past 4 years, from 2004/5 to 2007/8, GDP is rising rapidly at a rate of about 7 % per year, yet the public health care expenditure basing on domestic health accounts has increased only about 0.8% per year. Economy is growing, but not public expenditure.

c. The incorrect statement in the Document is due to the inclusion of data from 1989 to 1997. During the period, HA was established, much money was injected to upgrade the whole public health care system, with subvention to HA rises sharply from $3.8 billion in 1991/2 to $24.1 billion in 1997/8. There after, subvention to HA reaches a plateau at around $30 billion despite the growth of the economy.

17. Public health expenditure is much less than projected

a. The Document, basing on the studies of HKU Department of Community Medicine and School of Public Health, projects, from 2004/5 onwards, an annual growth of 5.4% of total health expenditure, which is 1.9 % points over the growth of GDP.

b. But what has really happened from 2004/5 to 2008/9? Public health expenditure rises only slightly from $37.2 billion to $39.7 billion (estimate), an annual growth of 1.5%, much lower than the projected 5.4% by the Document, and is grossly behind the annual growth of GDP of around 7%.

c. Furthermore, the projected increase in public health expenditure per GDP not only does not occur, in contrary, it decreases progressively from 2.8% in 2004/5 to 2.4% in 2007/8, and may be to an even lower value of 2.3 % in 2008/9.

18. Projection on public health expenditure should be revised

a. The revised version should take into account of two factors; the effect of public health enhancement (Point 1) leading to health promotion and disease prevention; the restructuring of existing health care system (Point 10-12) improving the efficiency and quality of health care system.

b. The revised projection on public health expenditure will be smaller and nearer to the real world scenario.

19. Is there a need of supplementary finance?

a. Given the recent 7 % growth of the economy and the very efficient public health care system, averaging 0.7% growth per year for the past 9 years, there is little urgent need of getting extra financial resources for public health care in the short run.

b. In the long run, supplementary finances, collected basing on the principle of fair sharing of community wealth and with the least disturbance to the public, should be obtained by a combination of options to support public health care up to a ***ceiling spending of 5.5% of GDP***.
c. The acquisition of supplementary resources needs to stick to the following principles: simple, efficient, discouraging abuse and encouraging lower health care cost.

20. Supplementary finances– a combination of 4 options

a. **Salary tax and profit tax**
    i. Increase both by **0.5%,** to 15.5% and 17% respectively. Considering that the Government has just cut both by 1% this year (2008), the proposed increase is minimal.
    ii. It is fair, as only people earning more will have to pay more; simple, as there will be no additional administrative cost.
    iii. This will nevertheless provides an additional $2.7 billion per year to supplement health finances ($0.5 billion and $2.2 billion from salary tax and profit tax respectively), contributing a substantial proportion of 6.8 % of the public health expenditure ($39.7 billion in 2008/9).
b. **Social health insurance**
    i. Applies to those with monthly income of **$12000** instead of the proposed $5000. Increase the cap from proposed $20000 per month to **$60000** per month. Monthly contribution keeps at **2.0%**.
    ii. This will alleviate the burden of people with monthly income of less than $12000.
    iii. Again, collection of this tax can be done with little additional administrative cost.
c. **Out of pocket payments** – as stated in Point 12 (Rationalize public fee structure).
d. **Voluntary insurance**
    i. We are living in a free world; people are always at their liberty to purchase medical insurance to seek for better service. This is well demonstrated by the fact that private insurance is getting more common. From 1989/9 to 2004/5, its contribution to total health care expenditure and private health expenditure both rises 5 fold from 1% to 5% and 2% to 11% respectively.
    ii. The Government, however, has her obligations to supervise the process and to devise systems at the cost of the insurers to make sure that there is no abuse by patients and insurance companies to the detriment of public.

iii. For example, patients cared in the public health system should not be allowed to have financial gains. Otherwise, patients with insurance cover will tend to stay longer in public hospitals or public out- patient clinics for more trivial problems at the expense of the public. Without any checking mechanisms, the more public health service they consume, the more money they gain. At the end, the general public suffers.

e. Implementing this combination of 4 options will ensure sufficient fund for public health in the future. In the process, the Government will act as the biggest health insurer, providing peace of mind for the average citizens in case they are seriously ill. Money collected will mainly be used in health care and little will be spent on administration.

21. Why not mandatory insurance or medical saving options?

a. **Medical saving is unnecessary**

i. For most citizens with average income, the amount saved will be negligible and certainly not enough to pay for health care should they suffer from chronic diseases or fall seriously ill.

ii. Besides, it incurs a moderately high administrative cost and does not have risk sharing effect. The Government as the insurer should be good enough.

b. **Mandatory insurance must not be an option**

i. Among the many disadvantages, the most serious drawback is the fact that it will greatly increase the overall health care cost by encouraging health care use, thus starting a terrible vicious cycle. We must not fall into the failing path of the United States – the country depends heavily on insurance somewhat like mandatory insurance as recommended in the current Document, their proportion of GDP spent on health care is 3 times ours (15.3% vs 5.2%) and yet, many of their poor suffer as they have difficulty in getting proper care.

ii. Another major problem is the very high administrative cost. A substantial portion of the total health expenditure is actually used up in the very tedious process of reimbursement. Both the patients and the staff of the medical teams are very often exhausted. Energy of the doctors is spent unnecessarily in filling the reimbursement forms rather than on patient care.

iii. Furthermore, it may create a lot of arguments and disputes in the process. It is a very inefficient system and money is not well spent. At the end, the insurance companies gain most, patients and the medical team loose.

22. **Monitor the success of health care reform**
    a. **Health care status and performance** - Data should be presented to the public on a regular basis for appraisal. For example :
        i. Perform regular surveillance on major chronic diseases.
        ii. Monitor age-specific hospital admission rates and age-specific total hospital stay and present the findings to the public for appraisal
        iii. Present to public regularly the quality of primary care and the obstacles encountered in its coordination with hospital care.
    b. **Major health care financial status** - data should be presented to public on a regular basis.