To	:	Food & Health Bureau
Re	:	Response to the Healthcare Reform Consultation Document
From	:	Dr. SHAE Wan-chaw
Date	:	10th June 2008

The captioned document has missed the most troublesome issue in the finance of HK's healthcare system. The rising healthcare costs is not so much caused by service-users (such as patients' indiscreet use of public health services, aging population etc.) as caused by service-providers. It is therefore tragic that the government's Healthcare Reform Consultation Document has failed to address this issue head-on.

In the financial year of 1988/89 (before the establishment of the Hospital Authority), public health expenditure was HK$5.673 billion, or 8.7% of total government expenditure. In 2007/08, public health expenditure rose to HK$38 billion, or 15% of total government expenditure. Clearly, these increases cannot be accounted for by the combination of advances in medical technology, an aging population, and improved services. The Harvard Report (1999:46) has already pointed out that consultants and management took a lion's share of the Hospital Authority's increased budget. Of the 4,935 doctors employed by the HA in 2006/07, 1,512 of them are associate consultants or above, costing the HA more than HK$4 billion per year. The salaries of the top 5 highest paid executives alone consumed more than HK$18 million. With almost 83% of the recurrent public health expenditure going to HA personnel, it is of course unlikely that any reform that leaves their salaries and packages intact would have any significant impact on the level of public expenditure.

Nor do the economic laws of supply and demand apply to the private sector of healthcare. Physician earnings in the private sector are high both in comparison with physicians overseas and other professionals in HK. According to the Harvard Report, fees for procedures in HK's private sector were substantially higher than those in US, even after adjustments for cost of living differences. Although the numbers of doctors in HK increased from 1.45 per 1000 people in 1997 to 1.63 in 2002, the Hong Kong Medical Association's *Doctors' Fee Survey 2002* found that the median consultation fee did not drop accordingly. Instead, it rose by 14% from 1999 to 2002, much higher than the inflation rate during the same period (HKMA 2003). This shows that the market for medical & health services is not a 'free' one. Already there are voices that doctors in our public hospitals are underpaid, hence 'the great exodus' of them into the private sector where they can earn 'real money'. But this is precisely my point, any further increase in healthcare expenditure, public or private, that does not involve a radical restructuring of the HA, a holistic healthcare manpower policy, and regulation of the health service pricing system would easily end up in the drain.

In an attempt to gain more popular support for a mandatory medical insurance scheme, Secretary for Food and Health York Chow has recently announced that a mechanism to monitor and standardize private medical fees will be set up if such a scheme is adopted in a financing revamp. While this is a laudable move in itself, it is not clear why the government has done nothing for so many years, and why it has to be tied to the adoption of a mandatory medical insurance scheme. Moreover, it is unlikely that such a mechanism in itself would succeed in lowering private medical fees in the long run without at the same time reforming the 'fee-for-service' payment method and increasing the supply of healthcare professionals. If the government is unable to

control the costs of our healthcare services, is it fair to shift this burden to the public by coercive means such as mandatory health insurance and medical savings?

Not is the problem one of an imbalance between the private and public sectors. There is no doubt that the compartmentalization of service delivery both within and between the private and public sectors have led to a duplication of service, repeated tests, and discontinuity of care (and therefore better regulation and coordination is clearly necessary); but the so-called 'private-public imbalance' has to be put in its proper perspective. In Hong Kong, the public/private ratio of total healthcare spending is 5.5:4.5; whereas that of OECD average is only 7:3. This means that the market share of our private sector is already by no means small. It has already been noted by many experts that any shift from public to private financing will transfer costs from rich to poor, and from the healthy to the ill. For it is in the nature of private health providers to selectively discourage healthcare utilization by those with lower incomes and improve access to care for those with higher incomes. Moreover, single pipeline funding enables more effective control than countries where funding is fragmented. For example, both US and Switzerland have a substantially larger private sector, and they spent 15.3% and 11.6% of GDP on their healthcare systems, compared to the OECD average of 8.9%, but without any apparent health benefit (OECD 2006). Indeed, a dual-system may well create a vicious cycle of cost escalation as identified by the Harvard Report:

> [T]he rivalry between the two sectors may very well drive up health care costs and may threaten financial sustainability of the entire system…. When public hospitals improve their quality of services, it leads to a shift in demand towards public hospitals that strain available resources. Thus the government faces greater demand for funds. If budget limits are imposed on public hospitals to let quality and availability of services to decline, both physicians and patients will move to the private sector. To retain high quality and technically competent physicians, the public sector will have to increase salaries to be competitive with the private sector. Since the bulk of the large HA budget already is allocated to salaries, this competition for human resources will put increasing strain on the public budget. (*Harvard Report*, 1999:78-79)

Unless these issues are dealt with properly, any talk about healthcare finance reform would be preposterous. Kong Kong's current healthcare system is one of the most cost effective in the world: it has the lowest infant mortality rate among all modernised societies; its people's life expectancy at birth is second only to Japan. All these have been achieved by a relatively low level of health expenditure. There is therefore absolutely no reason why the system should be changed drastically. An alternative way of interpreting these figures is that the health condition of a population is the result of numerous factors, where both the quality and quantity of healthcare services may only be of secondary importance. There is a certain level of healthcare services beyond which further investments would yield little improvements in terms of health benefits. This interpretation does not lend support to the Document's recommendations either. There is ample international experience to support the prognosis that a mandatory health insurance would result in an uncontrollable escalation of healthcare costs, often without concomitant health benefits; and simple arithmetic calculations would demonstrate that mandatory medical savings would be of little help to those in need. Whereas financing our healthcare service out of government general revenue at least has the additional advantages of being both flexible and politically accountable. Tax rates and government expenditure levels may rise and fall, subject to the government's policy priorities and legislative monitoring, which ideally reflects changing social conditions and public need rather than just political bargaining and lobbying; whereas the setting up of a statutory body to look after the mandatory scheme

would create yet another runaway monster which major preoccupation will be the ceaseless pursuance of its own interests, just like the HA and other similar bodies.

Even if the government is flooded with surplus, as it certainly is, it still does not automatically justify an increase in public health expenditure. Whether it should do so depends on 2 considerations – whether it can bring real benefits commensurate with the increased budget, and whether the public wants to, after balancing the pros and cons of an expanded budget for public health vis-a-vis that of other public services. And the public can only make such a decision 'rationally' if they are provided with sufficient information. Despite its being voluminous, it is not immediately apparent that the Document has been successful in doing this. Nothing in the above analysis suggests that health is unimportant, that there is no room of improvement for our healthcare services, or that we should not invest more on them. But the impression that the government is figuring out our level of affordability so that it can tap as much of our incomes as possible into such services without at the same time doing its best at controlling healthcare costs is appalling. Not only does it undermine the government's self-professed ruling ideology of 'small government, big market', it also goes against the very idea of holistic health itself. Surely the former should mean the respect of individual initiatives rather than the adoption of draconian measures by the government to create a 'big market' for healthcare and insurance industries. Likewise, the holistic conception of health does not mean that the government should force its people to spend as much as they can on their health. Rather, it highlights first and foremost the importance of our ability to negotiate physical and social realities both cognitively and emotionally, to make informed choices and to act upon them over sustained periods of time. But for most people all the 6 options (except the government funding model) are more likely to be debilitating than empowering. Ultimately, the Document is beset with a paternalist-managerialist mentality that not only runs against this ideal, it is also self-contradicting - it wants to maximise people's access to healthcare but does not want to increase public expenditure or streamline its bureaucracy; it wants people to receive the best available medical treatment but does not want to better coordinate its services or regulate healthcare costs. It can only lead to its (il)logical conclusion: coercing people into buying insurance and/or saving money 'for their own good' without attempting to control the price or cost of medical and health services. It may also lead to public resistance.

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