Response to Healthcare Reform Consultation Document

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submitted to
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This submission is made in response to the Food and Health Bureau's Healthcare Reform Consultation Document ("consultation document") published in March 2008[1].

Having reviewed very carefully the proposals put forward in the consultation documents, I respectfully suggest some new and modified options to be explored or adopted in combination. The difficulties that need to be resolved involve quality and financing issues, alongside capacity constraints and ethical problems. The issues must be tackled on multiple fronts. My suggestions are detailed in the different sections, and I draw some concluding remarks in the final section.

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[1] This submission is made via e-mail to the Food and Health Bureau at beStrong@fhb.gov.hk.

The need for change

1. This consultation document operates from the premise that it is a desirable goal to furnish public healthcare at a low price. While the objectives are laudable, there is no easy route to achieve quality healthcare with limited resources. An optimal remedy does not exist. Rather, a combination of remedies must be adopted.

2. The public healthcare sector undoubtedly has done a good job, especially since the establishment of the Hospital Authority ("HA"). It is mentioned in paragraph B.18 at Appendix B that improvement in public hospital services since the establishment of the HA has prompted patients requiring hospitalisation to turn to public hospitals, in anticipation of highly subsidised and quality service. There is some truth in this assertion, and the HA would definitely not wish to revert to the past where private hospital treatment was the choice of those affordable. There is always room for improvement in delivering quality healthcare.

Quality healthcare and education

3. While the high healthcare standards in Hong Kong are praise-worthy, indicators such as life expectancy and infant mortality (para 1.1) by themselves do not tell the quality of life. The healthcare focus in Hong Kong is curative care and disease-based. In fact, quality healthcare should be patient-based with an emphasis on multi-disciplinary care. The lack of communication and co-ordination among healthcare providers (general practitioners, specialists, Chinese medicine practitioners, pharmacists, physiotherapists, psychologists and nutritionists etc) is one major deficiency in Hong Kong's healthcare system.

4. The lack of healthcare education and the uncoordinated effort in the dissemination and delivery of information is another area that needs improvement. The public do not know proper safeguarding measures (or simply overreact by taking unnecessary vaccination or even treatment from improper channels) when there are suspected variation in disease strains or emergence of new breeds of viruses. The culture of polypharmacy, repeated visits to doctors, or even worse, self-administration of antiviral therapy are all counter-effective and detrimental to health. The outcomes are manifested in emerging antiviral resistance and adverse side effects.

Financing and capacity constraints

5. While supplementary financing options are intended to shift some demand to private in-patient care and reduce the public sector caseload, financing alone will not improve service quality. The ultimate goal of a quality healthcare system should be reduced demand for hospital care, through improvement in the overall health status of the community and elimination of unnecessary invasive treatment[2]. Quality issues must be addressed alongside financing issues. Otherwise supplementary financing will drive up

[2] The private sector is prone to recommend more costly and invasive treatment than the public sector. Some studies indicate that caesarean section is performed proportionately more in private than public hospitals. Another example is in investigative diagnosis. To investigate whether a parotid gland tumour is benign or malignant, a fine needle aspiration biopsy on the tumour is the standard procedure performed in a public hospital. In contrast, private practitioners may recommend a patient to undergo a minor surgery for taking out a sample of the tumour cells for diagnosis.

demand through defensive medicine, duplication of healthcare procedures and even worse, unnecessary invasive treatment.

6. Alongside the healthcare reform, some emphasis should be put on expanding the capacity of public healthcare services to cater for demand, even if the level of subsidisation has to be reduced. Whatever mode of financing, capacity is a real constraint that causes the public sector to provide the majority of in-patient care, given that the ratio of hospital beds between the public and private sectors is 9:1 (para B.13 at Appendix B)[3]. It is mentioned further in paragraph B.19 that the capacity of public hospitals is over-stretched[4]. This needs to be resolved by increasing capacity, both in public and private sectors. The capacity problem is however not addressed in the consultation, dwarfed by the major objective to appeal for supplementary financing.

Enhancing primary care

7. The recommendation for developing basic models and clinical protocols for primary care services (paras 2.11 to 2.13) should be applauded. An important criterion for success is co-ordination between the medical profession and other healthcare professions in the initiative.

Family doctor

8. Establishing a family doctor register (paras 2.14 to 2.15) may be a logical move, but it requires very clear mandate as to how family doctors should add value.

9. It is observed that "doctor shopping" is a common phenomenon where patients look for quick cure (para B.7 at Appendix B). In fact the problem is deeper than that. It is a lack of confidence that drives patients to shop around for doctors. In the supply side, deficiency in quality or inadequacy in clinical communication[5] can contribute to such phenomenon. In the demand side, the patient may be simply too nervous. As such, the development of a family doctor registry only tackles the problem from the surface, and will not solve the root of the problem. If all doctors are eligible to register as family doctors, without pre-requisite of specific training in family medicine and clinical communication, problem will resurface sooner or later when patients lose confidence again in the family doctor, whatever the designation. Some credible criteria must be developed to admit doctors to the family doctor registry. The public is entitled to expect that family doctors are competent in technical skills as well as in clinical communication.

10. As family doctors can come from diverse backgrounds, it is difficult to envisage that they will automatically adopt a patient-centred mindset as opposed to a disease-based approach in treatment, especially if no additional training is required for initial registration as family doctor. "[I]t is imperative that registered family doctors should undergo continued professional training and medical education, especially in the field of

[3] According to para B.13 at Appendix B, there were 39 public hospitals with a total of 27,755 hospital beds as compared to 3,124 beds provided by 12 private hospitals as at end 2006.

[4] It is likely that the capacity of private hospitals is also over-stretched, the more so when private hospitals have strong financial incentives to cater for the demand for obstetric services of mainland women giving birth in Hong Kong.

[5] Clinical communication has been a neglected area in the past. Medical training has been focused on clinical techniques, professional standards and medical ethics. Over the recent years, much improvement is shown in clinical communication, especially in the public sector.

family medicine" (para 2.14(b)). Some assessment criteria need to be imposed on continued professional training. If continued professional requirements are met simply by attendance at medical seminars or conferences, it may not add much substance to the practitioners' training.

Preventive care

11. To subsidise patients for preventive care, the recommendation on "primary care voucher" (paras 2.16 to 2.17) is well intended. However, restrictions governing the issue and use of the voucher, as well as the monitoring mechanism, will render the administration costly and burdensome. It may not be feasible when the cost-benefit ratio is taken into account. If the electronic health record ("eHR") infrastructure can be developed to accommodate e-vouchers, it may bring down the administrative and monitoring costs to make it feasible. E-vouchers instead of physical vouchers may be explored in due course.

12. It is concurred that "preventive care services should be incorporated alongside existing curative care services in GOPCs" (para 2.19(b)). In fact, it may even be less administratively burdensome to provide preventive care services through GOPCs at cost, subject to the restrictions in paragraphs 2.16 (a)-(b) and (e)-(g), and eliminate the primary care voucher scheme altogether. If the said preventive care services are provided at cost, the charge may even be lower than co-payment with subsidy through primary care voucher. Judicious use is also encouraged as out-of-pocket payment for the cost is required, and restrictions in paragraphs 2.16 (a)-(b) and (e)-(g) still apply. Without the need to obtain preventive care (say initial health assessment and screening) through a private family doctor[6], it also dispenses with the requisite consultation fee. For those who cannot afford the cost of the said preventive care services, fee waiver or financial assistance mechanism will apply. To be feasible, it requires GOPCs to expand capacity to accommodate preventive care services and the eHR infrastructure to bring down the administrative and monitoring costs.

13. In terms of enhancing public health education (para 2.20(a)) and public health promotion (para 2.20(b)), the Department of Health should play a more proactive role. More emphasis should be put on preventive care (para 2.4). Even if preventive care (coupled with healthcare education) does not dramatically reduce the need for curative care, it is at least a less expensive measure to retard the escalation of curative care contributed by the adverse outcomes of polypharmacy and improper treatment.

Staying healthy

14. A holistic view of preventive care includes not only healthcare education, regular health checks, but also means of assisting the public to take care of their own health. Quality healthcare is not only confined to curing of illnesses, but also psychological support to help patients summon up the strength and willpower to combat illnesses, with courage and dignity.

15. In promoting a healthy lifestyle, for example, it is not effective for an anti-smoking campaign simply to educate the public about the harm of smoking. More needs to be done, such as to provide therapy and psychological support to assist smokers to quit

[6] The test results from GOPCs will then be available to the private family doctor through the eHR infrastructure.

smoking. The prevalence of slimming programmes indicates that some people value a slimming body very highly, even at the expense of health. More needs to be done to counter the influence of advertising, celebrities and commercial interests. A very problematic social issue is increasing instances of juveniles abusing drugs[7]. Such problem is too complex to be effectively handled by the Health Department alone. A co-ordinated effort and multi-disciplinary approach needs to be adopted.

16. People seldom rely on the Government for health education, contrary to what is suggested in paragraph 2.5. In fact, the Government has little success in co-ordinating the efforts in health education. A number of seminars sponsored by pharmaceutical companies are hosted by private medical practitioners to give talks to target groups or interested parties. The underlying commercial interests aside, these seminars are often well received and serve to inform and alert the public of certain catastrophic illnesses. However, it is difficult to assess whether these seminars bring ultimate benefits to the public.

17. According to the Population Health Survey conducted by Department of Health in 2003-04, only 23% of persons aged 15 and above have regular physical check-ups. This piece of summary finding provided in paragraph 2.5 is not very helpful, as regular physical check-ups for age groups 15 to 35 may be unnecessary[8]. If preventive care leads to unnecessary health checks and anxiety, it is simply a failure. Health awareness is good, but too much anxiety is counter-productive. Moreover, the practice of defensive medicine is not necessarily helpful (and can even be harmful). It is unwise to have more medical examinations than necessary – health checks are not only expensive, sometimes with ambiguous results[9], but also can cause discomfort[10], and even be invasive[11].

Public-private partnership

18. The consultation document is confusing when it attributes the promotion of competition (para 3.4)[12] to public-private partnership ("PPP"). It is unclear how competition is created by the public sector procuring primary care and even certain hospital services from the private sector, or subsidising individuals to undertake preventive care in the private sector (para 3.5).

19. Given the great disparity in fees, the public and private healthcare sectors in Hong Kong never compete for patronage. Even if the public sector assumes also the role of purchaser through the PPP initiative, it may not have sufficient bargaining power to demand high quality at a relatively low negotiated fee[13]. As such, the private sector will continue to provide the majority of profitable out-patient care and certain profitable in-patient

[7] Abuse of drugs sets off a journey of self-destruction. Ketamine and Ecstasy, the most popular party drugs used by juveniles, cause psychological and physical dependence, inflict severe bodily malfunctions, and can give rise to death.

[8] It will be more informative if the percentage of persons having regular physical check-ups is further divided into different age groups.

[9] For example, tumour markers, with non-negligible occurrences of false positive or false negative.

[10] For example, mammogram.

[11] For example, gastroscopy and colonoscopy.

[12] In para 3.4, it is suggested that "a more balanced spread of caseload of certain types of hospital services between public and private hospitals would create competition between the two sectors for service quality and standards."

[13] Private insurers also have negotiated contracts with medical practitioners (especially group practices), and they control expenses by restricting the number of repeat consultations and the type of prescriptions.

services, and the public sector continue to offer unprofitable yet essential services such as emergency, catastrophic cases and chronic conditions, complex and high-risk surgery and intensive critical care. It is supply-side economic interests and demand-side price disparity that drives the public-private imbalance.

20. The PPP initiative in fact presupposes and entrenches the demarcation of services provided by the two sectors, and will not drive competition in the provision of health services. If the disparity in fees is narrowed, competition will be induced by potential service substitution[14] between the public and private sectors. Competition can be driven by introducing a third class ward[15] at a small subsidy of say 20% (with marginally better amenities than public wards but without the choice of physicians) in public hospitals and by moderately increasing the level of private consultation services. The introduction of third class ward and the increased private consultation in public hospitals will bring downward pressure to bear on private care fees, and drive competition at the private sector for cost-effectiveness. Those who can afford better amenities will elect private treatment, especially for the choice of physicians.

21. It is recognised that there is room for engaging more private sector doctors to serve in public hospitals, to address the shortage of human resources in some specialties (para 3.9). To tackle the core issue of staff shortage, some focus must be placed on how to nurture, attract and retain talents. Improving work conditions and corresponding pay levels, or even providing flexible arrangements will satisfy only lower-order hierarchical factors in Maslow's theory of human needs, but are not real motivators for practice in public hospitals. A healthcare professional will value very highly training opportunities and structured path for achieving proficiency in a chosen specialty[16]. A staff with passion will go the extra mile to deliver quality, even if labouring for long hours without corresponding recognition in pay. Tremendous volume of cases, complex or not, will provide unparalleled learning opportunities[17] in a public hospital, if the work culture is stimulating, facilitating and supportive.

[14] Kessler and Geppert (2005) investigate how competition in hospital markets, as measured by a Hirschman-Herfindahl index, affects the healthcare utilisation and outcomes of essentially all non-rural elderly individuals enrolled in traditional fee-for-service Medicare who suffered a new heart attack, Acute Myocardial Infarction, between 1985 and 1996. They estimate the effect of concentration on the mortality, cardiac complications, and medical expenditures of low- and high-valuation patients, and for patients overall. They find that low-valuation patients in competitive markets receive less intensive treatment than in uncompetitive markets, but have statistically similar health outcomes. In contrast, high-valuation patients in competitive markets receive more intensive treatment than in uncompetitive markets, and have significantly better health outcomes. Their findings suggest that the competition-induced increase in variation in expenditures is, on net, expenditure-decreasing and outcome-beneficial, and hence welfare-enhancing. (See Kessler, Daniel P and Jeffrey J Geppert, 2005. "The Effects of Competition on Variation in the Quality and Cost of Medical Care", *Journal of Economics & Management Strategy*, 14(3): 575-589.)

[15] The queue for third class ward is likely to be much shorter than that for public ward, because the subsidy is small and without the choice of physicians. This class will however cater for the needs (such as elective surgery) of those who cannot afford private treatment but are otherwise deterred by the long queue at public wards.

[16] There are of course some healthcare professionals who are driven by economic interests to abandon the mainstream healthcare profession to work in beauty and slimming centres instead.

[17] Delivery of healthcare is a lifelong learning process. Rotation between different specialties will be conducive to learning if it is well-structured, and not on uncoordinated relief basis.

Developing electronic health record sharing

22. One objective of electronic health record sharing is to enhance continuity and integration of care (para 4.3), but it is unclear how this high-level objective can be achieved. The difficulty in bilateral sharing is not simply infrastructural, but rather how to facilitate a sharing culture. The eHR infrastructure seems a unilateral initiative to facilitate record sharing for a patient originally from public hospital to subsequently seek treatment from the private sector. Even if the private practitioner is able to access the patient's health record, it is difficult to ensure that he will not ask the patient to repeat certain diagnostic tests. If a patient originally taking private care subsequently seeks treatment from public hospital, there seems no mechanism in place to compel the private practitioner to make available the patient's diagnostic report to the public hospital.

23. Another concern is on privacy issues. As patients' data are mostly sensitive personal data, the public is entitled to expect them to be handled with utmost care and respect. Unfortunately the incidents of loss of patients' data from the public sector, as revealed in late April and early May 2008, have undermined the public's confidence in the adequacies of security measures taken. USB flash drive is a small and handy device to store and transfer data, which should at least be encrypted to prevent data leakage in the event of loss of the physical device. The incidents have shocked the public as to why the patients' data have not been encrypted on some occasions and whether there is a genuine need for the data transfer in the first place.

24. Stepped-up safeguarding measures may have now been adopted by the public sector, but the development of the eHR infrastructure implies that accessibility is available to healthcare professionals in both public and private sectors. The more the data are accessible, the higher are the risks of data loss or leakage. While access to patients' data through the eHR infrastructure must be subject to authorisation by the patients, onward storage and transfer of the data need to be highly restricted.

Strengthening public healthcare safety net

25. If there are freed-up resources, it may be possible to inject funding into the Samaritan Fund, as suggested in paragraph 5.4(d). But resources, if freed-up by raising fees, or by the introduction of a third class ward, or by increasing the capacity of private consultation services, may need to be utilised for expanding the capacity of the public healthcare. As regards the Samaritan Fund, it is possible to encourage private donations by providing matching grants similar to that applicable to tertiary institutions.

26. The Government has launched the Matching Grant Scheme (MGS) since 2003 to match (subject to certain criteria and capped at $1 billion for each round) private donations secured by the tertiary institutions[18]. The MGS is an effective tool to promote a philanthropic culture in the community, and will broaden the financing sources[19]. If

[18] The first three rounds of MGS from 2003 to 2007 awarded grants to the eight institutions funded by the University Grants Committee (UGC), and the fourth round commencing January 2008 has expanded its scope to cover also two private tertiary institutions.

[19] For the first three rounds, the eight institutions have together secured close to $4.8 billion of private donations and about $2.9 billion of matching grants. For the fourth round up to the end of April 2008, the ten institutions have together raised more than $1,660 million of private donations and have been allocated $865 million of matching grants. (See Reply to Legco Question on "Matching Grant Scheme" raised on 4 June 2008).

matching grants for donations are similarly introduced to the Samaritan Fund, the communities and also pharmaceutical companies may have better incentives to donate for a good cause.

27. If successful, similar matching grants may also be introduced to public hospitals, this will encourage patients appreciative of a public hospital's services to donate voluntarily. If a ceiling is to be set on each rounds of matching funds, this should be set on a per hospital or per cluster basis. Donations provide one of the best means for patients to show their support and recognition of services rendered in a particular hospital, and will encourage and motivate the healthcare team to work even better.

28. While it is expected that public healthcare services will remain highly-subsidised overall and provide a safety net for those struck by catastrophic or chronic illnesses (para 5.6), it does not necessarily mean that the level of subsidisation should remain as high as 95% overall. If capacity is over-stretched for lack of funds partly because of high subsidisation, timely access to healthcare services will be compromised. Equitable access through queuing is an illusion. Substantially below-cost services will give rise to the situation (possibly termed as "inverse care law") where only those who can wait (say for elective surgery) will obtain treatment, but those having rapidly deteriorating conditions will be turned away by the long queue. Raising fees for SOPCs and in-patient healthcare, introducing third class wards at low subsidy and increasing private consultation services moderately are viable means to reduce expenses and increase revenues without jeopardising the safety net.

Reforming healthcare financing arrangements

29. One consensus that can possibly be reached in this consultation exercise is "the need for change". The reform necessitates two elements, service delivery and financing arrangements of the healthcare system (para 1.8) The level of quality and how it is achieved will have implications on the financing options.

30. In addressing the provision of quality healthcare, Chapters 2 to 5 of the consultation document take up only 21 pages in total. The information provided is only superficial, without an in-depth analysis on how the quality of care can be improved by the proposed initiatives. In comparison, Chapters 6 to 13 take up the bulk of the consultation, 64 pages in total.

31. It gives the impression that it is not quality healthcare per se which the policymakers are concerned about, but the financial dependency on the public purse which it entails. The reform appears to have budget control as its main agenda. At its core, the financing reform consultation appeals to the working population for funds (para 6.8). Subtle package aside, the exercise ultimately asks the tax-paying income earners to make provisions for future healthcare needs, so as to relieve the pressure on public healthcare.

<u>Financing pledges</u>

32. Compared to the long-term alternative financing options that the working population is proposed to shoulder, a one-off injection of $50 billion[20] to be drawn from the fiscal

[20] The magnitude of $50 billion in the healthcare context can be viewed against the total health expenditure of Hong Kong in 2004-05, which is $67.8 billion (as provided in Table C.1 at Appendix C).

reserves to kick off the reform (para 6.16) is not enough to show the Government's commitment to long-term financing. Rather, the Government should match every dollar that the working population pays into supplementary financing (if mandatory).

Improvement in cost-efficiency

33. Besides supplementary financing, there should be room for further improvement in cost-efficiency in healthcare delivery. The efficiency gain of around 1% sustained by the public healthcare system over the years (para 6.2) is small when viewed in light of the factors contributing to the "efficiency". The examples on the contributing factors are not impressive either. First, the reduction in the average in-patient length of stay in public hospitals, from 10.0 bed-days in 2000-01 to 8.9 bed-days in 2006-07, is not necessarily an efficiency gain in itself. This must be viewed against why the average in-patient bed-days can be reduced. It offers some comfort only if it takes shorter duration than previously for convalescents to be discharged for home care[21]. Second, the productivity and efficiency programmes, however described, involve the reduction of staff salaries and allowances on new recruits. It is difficult to accept that disparity in remuneration package is efficiency in a real sense.

34. Table B.1 at Appendix B provides the fee structure and subsidy level of public hospitals and clinics in 2006-07. It appears from the costs that there should be room for improvement in terms of efficiency. For example, the costs of each general and specialist out-patient consultation are $260 and $740 respectively. In comparison, the fee levels in the private sector (at profit) are $100 to $250 for a general consultation (para B.33 at Appendix B), and $450 upwards for a specialist consultation. Apparently the public sector is inefficient in terms of cost structure, which should be examined carefully. An improvement in cost-efficiency implies a reduction in subsidy level, and in turn decreases the exigency for supplementary financing.

Increasing public health expenditure

35. The health expenditure may be growing much faster than the growth rate of GDP in Hong Kong, but whether it is consistently faster by a magnitude of more than 50% (para 1.2(c)(i)) needs very careful evaluation. Public healthcare undoubtedly encounters financing problem that will only escalate in the future, but there is no consensus on the magnitude of the problem, which is subject to many variations anyway.

36. The growth in GDP can change substantially from year to year, but the health expenditure may progress moderately upwards (without major fluctuations). It is also noteworthy that universal insurance coverage will contribute to escalation in health expenditure, because of supply-side price inflation[22] and demand-side increase in utilisation. The reliability of the financial projection on Hong Kong's total healthcare expenditure from 2004 to 2033 (Table 1.2, Chapter 1) is also very much subject to the working assumptions. Even if all the assumptions are robust, the public health expenditure as a share of GDP is not really high by international comparison, even with an increase from 2.9% in 2004 to 5.5% in

[21] Some studies show that it is better for convalescents to be cared for at home than in a hospital.

[22] While the ethical standard upheld by the medical profession as a whole in Hong Kong is very high, some private practitioners (especially those in solo practice) and diagnostic laboratories do charge higher fees on patients with insurance cover than on those without.

2033 (Table 1.2, Chapter 1). In other words, substantial increase of public health expenditure as a share of GDP is an option worth exploring.

Raising tax

37. It is unconvincing why the low-tax regime cannot be departed from, as suggested in paragraph 7.10(a). The healthcare needs of the population should not be compromised for the sake of maintaining economic competitiveness. In fact the raise in tax needs not be substantial, when adopted in conjunction with other financing measures (such as raising fees for SOPCs and in-patient healthcare, introducing third class wards at low subsidy and increasing private consultation services moderately). The adverse impacts of moderately raised tax bills on Hong Kong's economic competitiveness are small, if any[23].

38. If potentially quality public healthcare would otherwise become under-financed because of insufficient taxation, then raising tax across the board[24] (profits tax as well as salaries tax) is a more logical route than supplementary financing options. Between raising tax across the board and imposing the financing burden solely on the working population, the former is a more preferable means of wealth re-distribution.

39. Profits tax is charged on net profit at a flat rate, so the extra tax, say by raising 0.5%, borne by corporations is proportionally uniform across all enterprises, big or small, as long as they make profits. In terms of salaries tax, a standard rate is charged on net income for high-income groups and a progressive rate on net chargeable income for low- and middle-income groups. If high-income groups need to share a bigger slice of the increments, this is exactly behind the logic of wealth re-distribution, as long as it does not impose an excessive burden on a particular income group. How best to take into account the financial implications on different income groups is a matter of design. A possible balance may be struck by, say raising the salaries tax by 0.5% on the standard rate and by 2% on the third tier of the progressive rate[25].

40. As an instrument for general wealth re-distribution, taxation is not specific to any social cause. If raising tax is one of the options adopted for healthcare financing reform, the difficulty is how to ensure that the additional tax raised will not be diverted to other purposes. This is one of the reasons why the general public is averse to raising tax when under-financing on a particular worthwhile cause is identified. To ensure that the tax raised is earmarked for healthcare purposes, the Government should set up a healthcare

[23] Public resources are always scarce. It is questionable whether policymakers are setting priorities correctly by abolishing the duty on wine, beer and other alcoholic beverages when there are so many pressing social issues competing for funds. It is unconvincing why the economic interests of developing Hong Kong into a wine trading and distribution hub, which may or may not be contingent upon the abolition of the duty, should take a high priority.

[24] Raising tax across the board is much better than placing the burden on the income earners alone. In an advanced economy enterprises should pay more attention to corporate social responsibility, which pays dividends (intangible benefits) in the long run.

[25] In 2007-08, the standard rate is 16%, and a 0.5% increment is unlikely to be an excessive burden on this high-income group. For the progressive rate, the first tier is 2% on net chargeable income below $35,000, and the second tier is 7% on net chargeable income of $35,000 to $70,000. To exempt the low-income group from additional tax burden, these two tiers should remain unchanged. To take into account the overall financial implications, a 2% increment should be imposed only on the third tier (raising it from 12% to 14%), while leaving unchanged the final tier of 17% on net chargeable income above $105,000. On this basis, income groups having net chargeable income more than $70,000 will each pay an extra tax up to $700, which is unlikely to be an excessive burden on these income groups.

fund (without undermining its financing pledges on increasing healthcare expenditure), designated for specific purposes. The healthcare fund can be employed for multi-purposes such as annual capacity expansion for in-patient curative care, investment in medical facilities, or preventive care and public health education.

Reallocation of public funding

41. Reduced funding for other public services (para 7.4) should not be viewed negatively. When under-financing of public healthcare is exposed, it simply poses the sensible question whether the current allocation of public expenditure is justified.

42. Public health expenditure benefits the whole community, in theory at least. Yet its share of total public expenditure is only 14.7% in 2004. The Government's commitment to increase recurrent government expenditure for health and medical services from 15% to 17% of overall recurrent government expenditure by 2011-12 (para 6.1) is certainly very modest and inadequate. In comparison, funding for education[26] benefits only the youth[27] (or more precisely their parents) but accounts for some 23.8% of recurrent Government expenditure in 2008-09[28] (para 7.4). Moreover, no explanation is given as to why the total public expenditure should be kept below 20% of GDP, as suggested in paragraph 7.3. There can be some room to expand the total pie, especially in years of prosperity when tax revenues are high.

Implications on future generations

43. The increasing burden on future generations (para 7.10(b)) comes from demographic changes with a shrinking workforce in an ageing population. The financial burdens on future generations are high, whatever mode of financing on healthcare. Taxation is actually a more flexible instrument in the allocation of resources than supplementary financing designated for particular purposes. In comparison, the supplementary financing options, especially those involving the insurance sector, have long-term implications and little flexibility. It is unwise to commit the future generations to long-term financial burdens, based on present projection of the future scenarios. It may not be optimal to trade in present utilities for future utilities, given that projections and statistical analysis are all sensitive to underlying assumptions.

Social health insurance

44. Social health insurance, as a form of mandatory contributory schemes (para 8.1), is a new hypothecated tax in effect (para 8.9(a)). Compared to the simpler option of raising tax, social health insurance incurs additional administrative costs and provides the community with little choice of services beyond a prescribed level (para 8.9(g)). As such, it does not add much value to the general community, is especially redundant to those already

[26] It is outside the scope of this discussion to explore whether funding for education is cost-effective or contributes to the development of an ancillary market (tutorial institutions) and divergence in quality.

[27] The working population benefits very little (if any) from the public purse when pursuing education alongside employment, as advanced part-time courses are self-financed and without subsidisation in most circumstances.

[28] Starting from the 2008-09 school year, Hong Kong's free primary and secondary education will be extended to 12 years (including 3 years' free senior secondary education provided through public sector schools). The reform to 3-3-4 education structure (comprising a 3-year junior secondary, a 3-year senior secondary and a 4-year undergraduate programme) may be a move with good reasons, but also with huge financial implications.

covered by more comprehensive health insurance, individually purchased or employer-provided.

45. Overseas experience as regards social health insurance is not at all impressive, but has encountered significant challenges to its sustainability (para 8.5) and pressures for increasing contribution rates (para 8.6). Another uncertainty is whether social health insurance is to be shouldered by the working population alone, or the burden is shared with employers. If employers also share the contribution, it is more reasonable than imposing the burden on employees alone. In fact, the Government should also contribute in a separate role apart from that of an employer. If tri-partite contribution is made, the scheme may be more sustainable and viable. But there is not a single indication that the Government will also share the contribution[29]. If employers are not required to contribute either, just to keep down labour costs, this may not have positive impact on economic performance. The reduction in employees' take-home pay decreases their consumption power and ultimately affects the economy adversely.

Out-of-pocket payments

Increasing user fees

46. The option of out-of-pocket payments (increasing user fees) is viable, when taken in conjunction with other financing arrangements. User fees of course need to be subsidised in the public sector, but only to the extent that the subsidised fees would be affordable to the general public (presumably cheaper than private care). When the user fees are raised (subsidy reduced), this does not necessarily impose disproportionate burden on low-income and under-privileged groups, as these groups are likely to fall within the fee waiver or financial assistance mechanism anyway.

47. It is suggested in para B.16 that many stabilised cases of patients requiring long-term medication have remained within the public SOPCs system where the drugs are highly subsidised, resulting in long waiting lists. If the specialists do not exercise the discretion to discharge the stabilised cases back to the primary care doctors, it must be because the medication requires specialist's prescription. As such, a triage system to prioritise new referrals is the logical route. Notwithstanding that, raising fees at public SOPCs[30] is still an option worth pursuing, say to $150 for the first consultation and $100 for subsequent consultations. This will encourage judicious use of scarce resources and also reduce the financial pressure to a certain extent. The freed-up resources can be employed to expand capacity.

[29] To show how the Government shares the responsibility for new financing initiatives, the case with MPF contribution is illustrative. When launching the MPF scheme, the Government claims that it also participates in the MPF scheme as an employer. The reality is that its employer's contribution is very minor, if not minimal. First, the Government is exempted from contributing to the MPF scheme for its civil servants who are entitled to the pension system or Civil Service Provident Fund Scheme. Second, its contribution for non-civil service contract staff will eventually be deducted from end-of-contract gratuity offered to the staff. In other words, it is the contract staff who pays every cent into the MPF scheme (both the employer's and the employee's contribution). The Government's contribution is confined only to those small portions of non-civil service staff without gratuity payments.

[30] If the fee levels of the SOPCs are increased to say $150 for the first consultation and $100 for subsequent consultations, they will not impose excessive hardships on most patients, given that the least affordable will fall within the fee waiver or financial assistance mechanism.

Introducing third class ward

48. It is pointed out in para B.27 that there is no differentiation of ward classes (except the $100 public beds and $2,600 or $3,900 private beds, with nothing in between). It is further recognised that there is no choice for patients who prefer to patronise public hospitals but who can afford and are willing to pay a bit more for better amenities. In reality, the long queue for public beds will turn these patients away.

49. To cater for these patients, it is worth exploring the differentiation of ward classes. The flat rate for public beds at 97% subsidy (Table B.1 at Appendix B) is not conducive to rationing demand. As a suggestion, it is possible to introduce a third class ward[31] to be charged at a cost-minus basis (say with a subsidy of 20%). To make the cost structure simple and fees predictable, surgical operations on third class wards should be charged (but still with some subsidy) at three levels of complexity, say minor, semi-major and major. With a much reduced degree of subsidy and without the choice for in-patient doctors and surgeons, the third class ward is likely to have a much shorter queue than the public ward, but can cater for those who would otherwise be turned away by the long queue.

50. Such third class ward not only reduces the financial pressure on public resources (as the level of subsidy is small), but also brings downward pressure to bear on private care fees, which will in turn become affordable to the middle-income family struck by catastrophic illnesses. The two services are still not in direct competition, as patients have a choice for private practitioners only in the private sector, but not on the third class ward in the public sector. Yet the competitive pressure can promote healthy competition in the private sector, and bring down the level of fees, which is the most opaque and can be astronomical.

51. Rather than relying on insurance coverage to effect a shift of demand from the public to the private sector, the accessibility of third class wards (at small subsidy) in public hospitals will absorb some demand from public wards. In fact, the level of user fees at public wards[32] can also be adjusted upwards to say $500 per day for the first ten days of hospitalisation and $200 per day thereafter. This is unlikely to jeopardise the welfare of the least affordable, who would fall within the fee waiver or financial assistance mechanism anyway. Even if increase in user fees for public services does not lead to a proportional recovery of revenues (para 9.6), raising fees is still a logical option to take in conjunction with other alternatives (such as raising tax), which are not mutually exclusive.

[31] The third class wards should provide only marginally better amenities than public wards in terms of fewer patients sharing a ward, but without the choice of physicians.

[32] The current fee of $100 per day is too low almost by any standard. It is even lower than the accommodation rate for elderly residential care homes. At such level, it is unlikely to promote judicious use of resources on the demand side, and can only be regulated on the supply side, which may not be effective. A lower degree of subsidisation will better promote judicious use on the demand side, say by increasing the public ward fee to $500 per day for the first ten days of hospitalisation and $200 per day thereafter. Such level of subsidisation is unlikely to impose excessive financial burden on patients requiring long hospitalisation, and will not compromise the healthcare demand of the least affordable as they will be covered by the fee waiver or financial assistance mechanism. In fact, judicious use of resources will shorten the queue to a certain extent and better serve the demand of those in need.

Expanding private consultation services

52. Private beds in public hospitals are scarce and costly resources[33]. However, over 60% of the private bed days are occupied by serving or retired civil servants or HA staff, who generally pay only a nominal fee for the services. While no form of supplementary financing can reduce their demand, there are scopes for expanding private services in the public sector to cater for the need of some affluent public. There is indeed some specialised expertise in the public sector not readily available in the private sector, and there is certainly demand for access to such specialised services. The honorarium regime[34] should be reviewed to moderately increase the level of private consultation services[35].

Medical savings accounts

53. Medical savings accounts as a mode of financing healthcare is unlikely to be effective, as significant mismatch between utilisation and resources tend to arise. Individuals have very diverse healthcare utilisation patterns (para 10.8) and very different financial means. Those having the fortune of staying healthy and those with the benefits of employer-provided health insurance will have sizeable savings locked up as idle funds.

54. The actuarial simulation, while sensitive to the underlying assumptions, does not provide individuals with meaningful information as to how much they need to save for their future utilisation. Tables 10.1 and 10.2 are not actually helpful, where the sufficiency levels predicted are on the basis of meeting only 20% of public healthcare cost. In fact, many of the lowest 30% of income earners (because of their small income) cannot easily meet their healthcare needs even if they put aside 5% of their income starting at age 20-29, for the entire working life until retirement at 65. However, putting aside 5% in savings is already a huge financial burden, in addition to the MPF requirement. For the highest 20% of income earners, many of them have sufficient financial means without relying on any medical savings accounts anyway.

55. There is no logical reason why the working population should be mandated to save, and be mandated how to spend their savings and what to invest (with restrictions). The MPF scheme has already reduced the take-home pay of the working population, and medical savings accounts will further decrease their disposable income and can cause substantial hardships to low-income families. Even if the lowest income band is exempted from the scheme, the next income band may also find the scheme very burdensome, especially if they have other large financial obligations. Besides, the fees and scheme costs can be high, and deplete a large portion of savings.

[33] It is provided in para B.25 at Appendix B that less than 400 private beds are made available in public hospitals. The private fees are $3,900 per day for a bed in a first class ward and $2,600 per day for second class beds, inclusive of accommodation and food, drugs, and certain diagnostic tests. In-patient doctor consultation fees and surgical operations are charged separately, ranging from $3,900 for minor operation to $300,000 for ultra-major operations.

[34] While the honorarium regime helps to retain talent in public hospitals, appropriate checks and balances must be implemented to ensure the proper allocation and use of the revenues generated from private consultation services and to avoid discrimination against general patients.

[35] In 2006-07, private specialist out-patient attendance accounts for 2.9% of the total, and private bed-days utilisation accounts for 3.2% of the total at the two teaching hospitals. (See Reply to Legco Question on "Private consultation services by Faculties of Medicine staff" raised on 9 May 2007).

Voluntary private health insurance

56. Rather than promoting voluntary private health insurance for individuals, the better route is to encourage enterprises (possibly with incentives and sanctions as appropriate) to provide group insurance for their staff. The merits of group insurance over individual insurance are that the former often comes with fewer exclusions, so that even the less-healthy staff members can obtain coverage. Also, enterprises have better bargaining power than individuals to negotiate coverage and insurance premiums with insurers, and in turn can procure coverage for their staff in a cost-effective manner, not to mention the availability of tax deduction.

57. The "carrot and stick" measures adopted in Australia (para 11.13) can be modified and applied to Hong Kong enterprises to encourage voluntary group insurance, while allowing some flexibility. As a suggestion, incentives should be available to small and medium enterprises ("SMEs")[36] with a headcount of say below 30 employees[37], and sanctions only applied to enterprises with a headcount of say over 50 employees, regardless of the business or industry sectors. Enterprises employing between 30 to 50 employees will have flexibility towards the procurement or otherwise of group insurance for staff members.

58. The logic behind offering incentives is that enterprises with a small headcount are less motivated (perhaps also less able to afford) to procure group insurance for their staff members. As incentives, a rebate of say 30% of the group premiums will be helpful. SMEs not making profits in some financial years will still benefit from the rebate (unlike tax incentives). The logic behind imposing sanctions is that large enterprises making profits should share the fruits of success with staff members, such as insuring their health (possibly among other fringe benefits). As sanctions, it can take the form of levying a surcharge of say 0.5% on the taxable income of enterprises (answering the headcount criterion) that have failed to take out group insurance for staff members. As such, only large enterprises making profits will be penalised. The revenues from this surcharge should contribute towards making rebates to SMEs, or be channelled back to the public health system.

Mandatory private health insurance

59. Mandatory is by definition coercive, not participatory. There is no logical reason why the tax-paying working population should be mandated to subscribe health insurance plans out of their own pockets. If mandatory, plans should be non-contributory, or substantially financed from the public purse. In reality, it is illusive to anticipate that insurance will resolve financing issues. If the crucial problem is inadequacy of funds, engaging the insurance sector will not cover the financing deficiency. Instead, problems tend to exacerbate.

[36] SMEs are usually defined in terms of assets or number of employees, without a uniform definition across different economies. According to the Trade and Industry Department in Hong Kong, SMEs are defined as follows: manufacturing firms employing fewer than 100 persons in Hong Kong, or non-manufacturing firms employing fewer than 50 persons in Hong Kong.

[37] In the context of applying carrot or stick to the procurement of group insurance, it does not necessarily need to follow the definition adopted by the Trade and Industry Department. But headcount is still a good criterion. The underlying consideration is that enterprises with a large headcount are attractive clients to potential insurers, and will have the bargaining power to negotiate coverage for staff members at favourable terms (likely to be much better than staff members taking out individual insurance).

60. In case of mandatory plans, the regulatory requirements of "continuity" and "no exclusion" (para 12.12(b)) will substantially drive up the community-rated premium (para 12.1) to a prohibitive level, and/or reduce the coverage (with co-payment, deductible and ceiling on claims) to an inadequate level. The estimated levels of premium (para 12.7) do not appear to offer value for money. If the scheme is designed to include the whole elderly population, the community-rated premium is actually high. If the elderly population is excluded, it defeats the very purpose of meeting future healthcare needs.

61. The insurance sector comprises lucrative (not charitable) undertakings. The distributive concept of risk allocations does not always work, and very often does not benefit the high-risk community. Loading will be imposed on and exclusions applied to high-risk individuals. On the other hand, demand for curative care tends to be induced on low-risk individuals, thus escalating the overall healthcare expenses in the community. The insurers tend to minimise their liabilities by putting a higher-than-average risk premium on the insured. Universal coverage does not guarantee a low premium[38], nor optimal allocation of risks. Contrary to paragraph 12.12(a), the scenario of effective pooling may be just idealistic. Insurers contain their financial exposure by both exclusions and additional premiums[39], statistically justifiable or otherwise.

62. Contrary to paragraph 12.12(d), insurers do not have real motivation to promote competition among medical practitioners to achieve cost-effectiveness. Insurers have two instruments at their disposal – compromising quality through restrictive negotiated contracts with medical practitioners (notably group practices) and raising insurance premiums to pass on the escalated expenses to the insured. If mandatory private health insurance is regulated to such an extent as to adopt a uniform rate and to disallow exclusions, the coverage will be minimal. In fact, mandatory plans are likely to be too inferior to pay for a tiny portion of severe illnesses. On the other hand, it is not rare for some enterprises, especially international corporations, to provide very comprehensive medical coverage for their staff members.

63. If the mandatory private health coverage does not lessen the employer's motivation to maintain the existing comprehensive coverage, the staff still gets nothing extra from paying for a mandatory plan (which is superfluous and inferior at the same time)[40]. If the employer reduces the benefits originally provided for its staff, who will even be in a worse position than before (being penalised in effect). For those without the benefits of employer-provided insurance, a minimal coverage may only afford them the expenses for curative care in a public hospital anyway. Therefore, it is doubtful if mandatory private health insurance accrues any benefit to the working population.

64. Even in the case of universal insurance, it is illogical for the Government in a free market to regulate the profit margins of insurers. On the one hand, the Government does not actually have the ammunition at its disposal to regulate. Central planner is a role that it is ill-equipped to perform. Regulatory measures can be cumbersome, and the costs of

[38] Premiums for healthcare can escalate substantially as new breeds of viruses emerge.

[39] An example is illustrative in the context of accident insurance. In the aftermath of the 911 event, some policies raise premiums and exclude terrorism from coverage without assuming risks for such unforeseen eventualities. They employ both instruments at their disposal to increase profits and decrease liabilities.

[40] It does not make sense for those amply covered by corporate medical benefits to pay extra premiums for mandatory insurance, which is simply redundant (or benefit the insurers solely).

regulation (in terms of administration, monitoring and enforcement) can be high, and will also come from the public purse. On the other hand, if insurers make only slim profits on the basic plan of universal insurance, they will be driven to market top-up plans to the insured. As such, mandatory private health insurance simply becomes a vehicle[41] for insurers to market top-up plans[42] to the working population.

Personal healthcare reserve

65. Personal healthcare reserve ("PHR") has the drawbacks described in both mandatory private health insurance and medical savings accounts. By locking up large portion of an individual's disposable income, it will cause undue hardships to individuals with limited means. It lacks the flexibility to cater for an individual's short-term financial requirements. Besides, the investment option on savings will introduce new elements of uncertainty as regards financial returns.

66. A comparison of the actuarial study in para 13.5(c) against the estimate in para 13.5(b) will reveal how premium payments easily deplete the hard-earned savings and returns. If the investment return turns out to be inferior than the predicted level, i.e. persistently 3% net of inflation (para 13.5(b)), the accrued savings will even be exhausted before retirement. In other words, savings for the entire working life (40 years, from age 25 to 65) are not sufficient to finance the healthcare needs post-retirement (20 years, assuming a life expectancy of 85).

67. The average number of public hospital bed days utilised by age in the year 2006 is depicted in Figure 1.2 (Chapter 1). The utilisation of public hospital bed days by the working population is small (less than 1 bed day for those under 55, approximately 1 bed day for those between 55 and 59, and less than 2 bed days for those between 60 and 64). Given such utilisation pattern, either the working population has very small need for hospitalisation (if private hospital utilisation shows similar bed days) or they are already using private care for hospitalisation (which is more likely, as the public sector caters much more for the chronically ill and the elderly). Under both scenarios, whether their needs are minimal or they are already using private care (out of pocket or from insurance already taken out), it is questionable why they should make premium payments on the PHR. This can exhaust rather than preserve their accrued savings, leaving behind inadequate provisions for their hospitalisation needs post-retirement.

68. Of course, using the utilisation pattern depicted in Figure 1.2 and the actuarial estimates in para 13.5(c) to project future healthcare needs and accrued savings may be unreliable. As the demographics are changing, the affluence is also changing. Whether the elderly of tomorrow (including the affluent working population of today) depend heavily on public healthcare is just speculation, and policy choice based on speculation is likely to be misguided.

[41] By analogy, the MPF scheme has created awareness among the working population that they cannot rely on MPF savings alone to provide for their financial needs post-retirement. The insufficiency in funds becomes a selling point for insurers (and also banks) to market insurance products (especially investment-linked products) to the public, taking high profits.

[42] When the community-rate premium is not driver for profits, profit shifting will cause insurers to increase profit margins on top-up plans. Competition among insurers does not necessarily reduce the profit margins, because insurers are apt to adopt product differentiation that makes comparison of benefits against premiums very difficult. In addition, distribution costs for top-up plans are high and will be passed on to the insured.

Conclusion

69. To build a healthy tomorrow, many of the Government's high-level objectives are laudable. There is no easy route to achieve quality healthcare with limited resources. An optimal remedy does not exist. Rather, a combination of remedies must be adopted.

70. While primary care can be improved through better co-ordination of resources and communication among healthcare providers, financing options (possibly without consensus on any one option) must be carefully evaluated on their cost-effectiveness against regulatory burdens and other possible adverse outcomes. It is accepted that the reform necessitates some institutional changes (para 14.2), but a complex structural reform will make it difficult to achieve the objectives.

71. Simple options such as raising tax, increasing fees for SOPCs and in-patient healthcare, introducing third class wards at low subsidy and increasing private consultation services moderately are all viable means to reduce expenses and increase revenues without jeopardising the safety net. It is illusive to anticipate that insurance will resolve financing issues. If the crucial problem is inadequacy of funds, engaging the insurance sector will not cover the financing deficiency, but exacerbates the difficulty by imposing long-term financial burdens on the working population.

72. If insurance is to be adopted as one of the financing options, voluntary group insurance has some merits over individual insurance. The former comes with fewer exclusions so that even the less-healthy can obtain coverage. The preferred route is to encourage voluntary group insurance among enterprises, using headcount as the criterion for applying "carrot and stick" measures as appropriate. Enterprises are in a better bargaining position than individuals to procure coverage at favourable terms.

73. Universal insurance can lead to unexpected outcomes. Financing shifted to insurance will in fact inflate medical expenses (doctors charge more) and induce moral hazard (the insured consumes more) and drive up insurance premiums. Co-payments and deductibles are devices that can reduce, but not eliminate, excessive utilisation from the demand side, but have no bearings on the escalation of medical expenses from the supply side. Universal insurance may also give rise to defensive medicine, prescribing more diagnostic tests than necessary, which is not necessarily helpful (and can even be harmful).

74. Mandatory insurance with community-rated premiums will not achieve cost-effectiveness. While there is no clear and convincing basis for regulatory intervention on the private insurance sector, the Government is ill-equipped to regulate the profit margins of insurers. In addition, unprofitable mandatory plans will drive insurers to market top-up plans with high profit margins. Insurers do not have real motivation to promote competition among medical practitioners to achieve cost-effectiveness, given the instruments at their disposal – compromising quality through restrictive negotiated contracts with medical practitioners (notably group practices) and raising insurance premiums to pass on the escalated expenses to the insured.

75. Universal mandatory insurance, if implemented, should not be underwritten by private insurers. Instead, it should be a form of social insurance underwritten by the Government on a non-profit making basis.

76. Finally, to promote a philanthropic culture and to broaden the financing sources, private donations can be encouraged by matching grants provided by the Government. Matching grants can be introduced to the Samaritan Fund, and if successful, be expanded to the public hospitals.