10th June, 2008

To the Hon. Dr. York Y.N. Chow,
Secretary for Food and Health,
Government of the Hong Kong SAR.

Response to the Consultative Document 'Your Health Your Life'

Writing this response at the last week of the consultative exercise has the advantage of gathering the opinions of other people. Up to 6th June, I had the opportunity to attend 6 seminars on healthcare reform, listening to you and your staff as well as various peoples' views. The last one of which, I shared the platform with Mr. Thomas Chan, the Deputy Secretary on Health Projects right inside the premise of the Hong Kong Professional Teachers' Union. Hence this response will contain elements of public opinions as heard by me.

After witnessing the ups and downs of the past consultations on healthcare reform in the last ten years, I must congratulate you and your staff for asking the right questions as well as for completing a thorough and sincere consultative process.

A. Difficulties with 'Mandatory Saving for Health'

Of the six options for supplementary financing of health care, the document gives the impression that you favour the sixth option – namely 'Personal Healthcare Reserve'. But I am sorry to tell you, the sum of public opinions and experience form other countries projects for a low possibility of this particular way of financing being accepted by the public. It is my opinion that even if it is accepted, its implementation will be difficult. It will result in a two-tier provision of medical care for Hong Kong.

There is considerably agreement among front-line social and medical workers as well as the working population that the idea of 'Mandatory Saving for Health' is not appealing to them because of two main reasons: (a) it will cause hardship for them in carving off 3 to 5 % of their present meager incomes in a society that has failed to protect them against chronically low income in the face of increasing prosperity and inflation. (b) Personal healthcare reserve for the lower income groups and lower middle class is no guarantee that their hard-earned savings might not be sufficient for them or their family members. when faced with a single catastrophic illness.

Technically, I need to point out that while mandatory private insurance accounts are most appealing to the higher income and professional classes because it ensure their personal control and freedom to choose for spending in any illness, it will be implemented with considerable difficulties for the majority of the population. This is because Hong Kong people, teachers including, have very low level of knowledge about Western medicine. Significant proportion of my patients does not know the purpose of their past operations, many of the chronically ill patients cannot even name a single drug they have been taking for umpteen years. Quite often, new patients come to me revealing poorly planned strategies for major operations because Hong Kong populace choose their specialist

doctors by way of word-of-month reputations and literally the number of clients waiting in doctors' office. In such a climate of wide-spread ignorance, implementing 'money follows the patient' philosophy will result in providers sophisticated in capturing cartel-type of business or practicing lowly priced service that is inferior in technical quality and efficacy capturing the medical market.

While Switzerland and Netherlands have implemented mandatory private saving accounts, these are scarcely examples we can copy because they are much more advanced in their history of Bismarckian model of universal healthcare provision. Holland had, since the end of Second World War, adopted social health insurance for financing. The reform laid out in the Dekker Report twenty years ago was meant to standardize prices and allow for personal choices. Even for her maturity and experience in social health insurance, it took eighteen years for Netherlands to move into "managed competition". I really doubt Hong Kong, with our comparative weaknesses mentioned, can skip twenty years and do it over the next few years.

Yet another difficulty is our health insurance companies, Netherlands started in 1941 with hundreds of non-profit health insurance called Sickness Funds which were highly regulated. Going the market way means merging newly formed private insurance with existing non-profit ones. In contrast Hong Kong has never had a single non-profit insurance company. To ask our for profit-orientated companies to offer non-profit insurance schemes is calling for quite radical transformation. This is akin to asking the wolves who are used to feast themselves et lib by killing sheep to self-transform themselves to obedient sheep dogs who will only be fed from the master's hands. As a participant in a medical company's operation, I can sum up their main mode of operation is by way of 'cartel' business and market domination by 'relationship' (*guanxi*). With Mandatory Private Health Insurance, you will need them to learn to operate by cost-effectiveness and quality in an open and regulated way. This need time and training, We need to import academics and health managers, eg. from UK, and start training for some years before implementation.

I have scanned Hong Kong's health companies' past reports whose overall administration cost (profit + middlemens' share) run yearly at 35% of paid up premium. Involving them to help run personal saving schemes will incur cost of at least 20%. Will this be acceptable?.

B. Need for Instituting Community Consultations

Whatever the financing system, the painstaking and attentive thoroughness with which you and your staff have set out to collect public opinions would have pointed out to you the usefulness of such an exercise. Not only does consultative sessions allow ample opportunities for you to voice your preferences, it build trust with your audiences and give you a chance to allay hidden fears. It is also extremely useful for you to plan your next move from the responses gathered.

During the planning and implementation stage of the reform, needs of such consultations will not be any more less and recurring in nature. I suggest a *Community Health Council* be set up to give overall advice and policy feedbacks to the Central Health Insurance Authority. The concept of 'community health councils' have been recommended by the WHO whenever a territory employs mixed public and private provision of health care. It is a good way to demolish the compartmentalization between public and private sectors, primary and secondary care providers, as well as to breach the gap of understanding between professionals and the public.

Regional needs and demands of medical service will vary because of the regions' differing backbone populations, proximity to the mainland and value systems. People in the northern districts of the New Territories would find it wise to save resources by sending their old folks up further north in Shenzhen's old folks' homes, opting to spend on traditional Chinese medicine and primary medical care. Residents Hong Kong Island might wish to keep their old folks nearby but spend less on primary care, preferring to use their personal pockets to maintain rapport with their preferred family doctors.

These call for the division of health services into 5 to 7 Regions, with their respective *Regional Health Authorities*. Five to Seven Regional Community Councils should be set up to gather opinions from all stake-holders as well as district boards. A representation of the local GPs are essential because of their understanding of both consumers' needs and the hospital service' strengths and weaknesses (please see diagram). If such consultative instruments were to be in operation during the SARS epidemic in 2003, the public misunderstanding over difficulties with disaster medicine and acceptable risks necessary when using innovative therapies (eg. high dose steroids) could have been avoided. Some senior doctors would have no necessity to resign.

C Supplementary Financing most appropriate to Hong Kong

For an advanced city like Hong Kong who pride itself of being a financial hub of the world, the most appropriate supplementary health financing method is the social health insurance. This allows the caring community to practice the basic tenets of insurance: the healthy will pool their resources to help in the restoration of sick to wellness. It enables the community to garner the largest amount of supplementary funding and allows a Central Health Fund Authority to wield a powerful instrument for reform . The high Gini co-efficient of 0.533 calls for the pooling of the health resources of the rich with the poor. This is not only necessary but just.

Put in the feature of instituting community health councils, the financing method becomes an excellent way to implement structural reforms and channel doctors' behavior in the right direction. The controversial questions of how much of TCM or dental care should be included can be simply solved by allocation 10 to 20% of the global allocation for Regional Community Councils to decide.

The Document mentioned that social health insurance only offer limited choice, but I will counter that if the Australian example of offering inducement for purchasing additional

private insurance to those who earn more than $25,000 per month will attract over 20% of the working population to use more of private hospitals.

My suggestion is to require subscription to social insurance only from those earning more than $10,000 per month. The premiums to set at two per cent each from employer and employee. Employees who earn between $6,000 and $9,900 will either be subsidized fully or partially in their premiums by a special Fund. This Fund can be derived from surplus from monetary funds and revenues of each year, and if insufficient, an additional profit tax of half per cent or sales tax of luxury items such as expensive cars, super-luxurious houses and yachts.

While the absolute limit of premium payment is set at salaries/income of $30,000 per month. The inducement for purchasing private health insurance is in allowing anyone earning over $25,000 to either continue premium deduction from income accrued from $25,000 to $30,000 or purchase a private health insurance requiring an annual premium of at least $7,000. This will practically force 20% of the working population into the arms of private insurance and private hospitals (learning from the Australian measure of requiring people earning over A$100,000 to pay a surcharge of A$1,000 if they do not have a private insurance policy). .

D. Speed of Reform Implementation & Institutional Reform

Past Secretaries of Health had been rather fearful of 'drastic changes', preferring to wallow in the path of 'incremental reform;, thus skidded retrogressively with every so little steps taken (eg. Start charging the nominal fee of $100 in the A. and E patients.) You have demonstrated remarkable decisiveness as exemplified by the rapid delineation of government responsibility in medical care within weeks of taking office. If the implementation of a 2% premium rate on wage-owners' income seems "drastic" in suddenness, it should and could be implemented by stages. Thus we can begin by taking only ½ to ¾ per cent of monthly income, over three stages and 4 years increase the subscription rate to 2.0% in the final stage. Take to heart that the incrementally sector targeted reforms in Mexico has been a subject of much criticism. If novel institutions are needed in due course say 7 years from now, it is better to publicize it at the onset and allow discussions of their merits and disadvantages later on. Reform has to be comprehensive and imaginatively planned out for the next 10 years.

Institutions that needed consideration include, other than community councils, (a) an institution for collating costs of health plans and sectoral expenditures as well as evaluating outcomes. Cost-effectiveness figure might eventually be generated by such a institution. Developing trade-wide instruments of health cost estimation and accounting such as Disease Related Groupings were started by the HA but abandoned later. DRG facilitates negotiations of contracting services from hospitals and bypass the present system of paying cases-by-case which encourages inefficiency and longer hospital stays. US, Australia and lately United Kingdom have adopted their versions of DRG. Should Hong Kong develop its own set?

Setting up a regulation-sanctioned independent expert drug committee will screen out expensive and redundant late comers to existing efficacious drugs and offer a less controversial approach in standardizing the HA Drug List. A parallel Committee on Evaluation of New Technology should have the power to recommend licensing and to regulate the number of new technologies and expensive medical machines introduced into the SAR. These measures will reduce the medical inflation rates of Hong Kong.

E. Legal Barriers

The present Hong Kong laws forbid doctors from undertaking health insurance as well as insurance companies from handling medical care. We should learn from the US example, where group practices should be able to bear limited risks in undertaking the capitated health insurance of a population. They called it Risk-bearing Provider Groups. The logic of it is that the main expenditure of medical service lie in the fees demanded by doctors, they can guarantee that easily by promising to work overtime etc and clear up their contracture commitments. I have already submitted a paper to LEGCO's Committee Hearing on HMOs in 2007 on this matter.

Yours sincerely,

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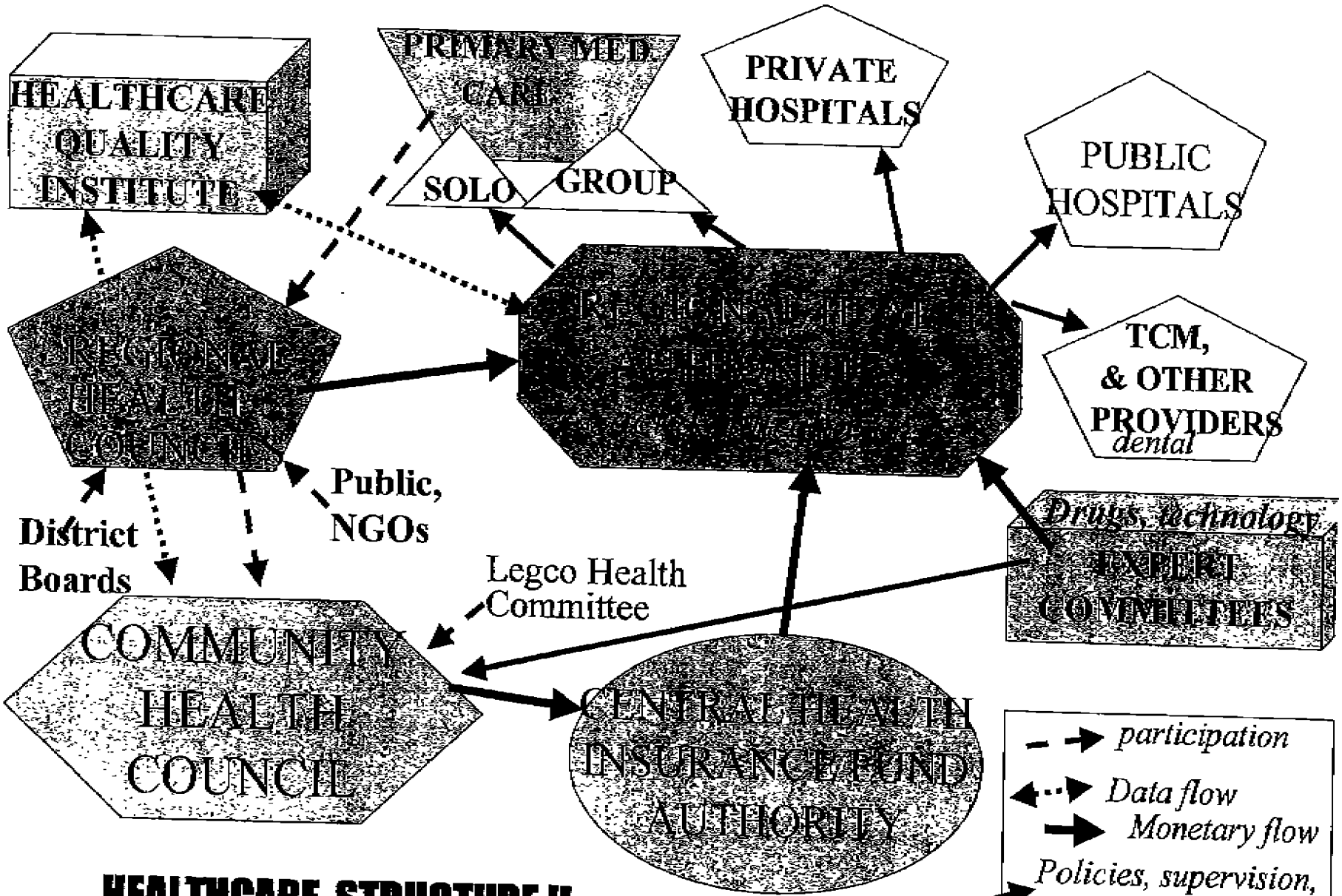

HEALTHCARE STRUCTURE II
UNDER CENTRAL HEALTH INSURANCE

TOTAL P.06