Hong Kong Women Doctors Association
香港女醫生協會

12 June 2008

Food and Health Bureau
19/F Murray Building
Garden Road
Central, Hong Kong

Dear Sir / Madam,

Consultation Document on Health Care Reform

In response to the Consultation Document on Health Care Reform, we have studied and discussed the various options presented in the Consultation Document at our talk and discussion meeting before deliberating a consolidated response for submission to the Government.

Enclosed is our HKWDA's response paper to this consultation document for your perusal. If you need further information, please feel free to contact me at 2855 6187.

Yours sincerely,

Dr. Cissy YU
President
Hong Kong Women Doctors Association

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HONG KONG WOMEN DOCTORS ASSOCIATION

Response to Healthcare Reform Consultation Document

June 2008

The Hong Kong Women Doctors Association (HKWDA) is formed in October 2006. Our membership includes women doctors working in private practice, public hospitals and clinics, and universities. We are a group of specialists and general practitioners who are providers of healthcare services in Hong Kong. One of HKWDA's mission is to raise the awareness of current affairs of women doctors, participate in the discussion of government policies and give appropriate response to government consultation on areas which are of our concern. Besides being healthcare providers, we also represent the interests of professionals who are users of the healthcare service. As we are working in the Hong Kong healthcare system, we understand the complexity of the issues and challenges we are facing. We know the urgency of the healthcare reform and hope that our comments would contribute to building a better healthcare system and improving the overall health status of the Hong Kong community.

We share the following values which guide our supplementary healthcare financing options:

1. Health is an individual's own responsibility. Maintaining good health is a life-long process.

2. There should be fairness in contribution vs service received. Those who have contributed more to the funding of healthcare should enjoy more choices when they use the service, eg choice of doctors and hospitals, choice of wards and environment, choice of drugs and technologies, choice of Western and Traditional Chinese Medicine.

3. Disease prevention and health promotion should receive the same attention as disease treatment, by the government, the public and the healthcare providers.

4. Care of poor elderly with chronic illnesses is best done in the community, to be shared by the public and the private sectors, with heavy subsidy from the government. No one should be denied adequate healthcare through lack of means.

There are six supplementary healthcare financing options introduced in the consultation paper. These financing models have been implemented in other countries and their pros and cons are well known to the health care professionals. Hong Kong has its own political environment and the development of new healthcare delivery system and funding model has been very slow. While studying various funding models, the government should be careful not to directly import any overseas countries' healthcare financing model into Hong Kong. The government should develop a supplementary funding model which suits the local situation to ensure its success.

Before finding sustainable supplementary financing, we believe there are still rooms for improvement in our existing public healthcare system. We suggest the government should look into the following areas:

1. Modernize the Hospital Authority's management structure and system to improve efficiency and lower cost, to allocate resources on scientific base and to strengthen corporate governance of individual hospitals. At a micro-level, education of the doctors on the cost of medical treatment will reduce wastage of resources.

2. Expand the scope of Centre of Health Protection to include controlling the rise in lifestyle related diseases and chronic diseases such as diabetes, obesity and hypertension, not just focusing on infectious diseases.

Our HKWDA has invited Mrs. Ingrid Yeung, Deputy Secretary of Food and Health Bureau for a detailed discussion on the various healthcare financing models. Many issues were clarified and we have a better understanding of the six options presented in the consultation paper. We are concerned that the public may not have the opportunity to fully understand all the financing models, which in fact are very technical. There so many variables in each of the models, such as which income group will be included in the scheme, how much % of their income will contribute to supplementary healthcare funding, and the age limit of benefit coverage, that it is difficult for the public to feel comfortable in choosing any options.

Based on our values in healthcare, we believe a combination of medical savings accounts and mandatory private health insurance is a better option in supplementary healthcare financing. This financing option can be effective in shifting the huge demand on the public healthcare system to the private sector, therefore giving the private sector a new opportunity to develop itself, to be more transparent and more accountable, and to improve interface with the public healthcare system.

We would like to make further suggestions to safeguard the success of our preferred option of medical savings accounts and mandatory private health insurance, as follows:

1. Create incentives for the insurance consumers to maintain their own health, encourage health-seeking behaviour and penalize health-risking behaviour, eg. subsidize regular health-check, subsidize weight reduction program/smoking cessation program, lower premium for no claims, higher premium for smokers.

2. Create disincentives for moral hazard, e.g. using co-payment to prevent abuse of service.

3. The health insurance scheme should have a built-in mechanism to allow consumers to upgrade their benefits with more comprehensive health care services, e.g. dental service, physiotherapy, clinical psychology consultation etc.

4. Mandatory private health insurance should include retirees with age above 65 years. Their insurance premium must be affordable to the retirees, with possible subsidy from the government.

5. Mandatory private health insurance should not be confined to employees. It should be extended to cover all sectors of the community, e.g. the self-employed, low income group, spouses of the insured who are not working/earning income.

6. Medical savings account can be used for treating catastrophic illness before the account owner reached the normal age limit allowing withdrawal from the account.

7. Public healthcare service fees should be increased to lower the price gap between the public and the private sectors. The fee waiver policy for social welfare recipients should be continued to protect the poor's reliance on public healthcare service.

8. The supplementary healthcare finance must be injected in the right places. The money should be used in developing new models of healthcare delivery to meet the needs of the aging population. Besides establishing prestigious centres of excellence, programs like end-of-life care and many innovative community health care projects require funding. These community-based programs are mainly led and provided by the public sector and they are worth investing because pilot programs have generated strong evidence that they are effective in decreasing hospital utilization and improving quality of life. To ensure that the money invested in community healthcare goes to the right place, the funding must be protected and separated from hospital funding.

9. After surviving nearly ten years of continuous budget cut, the Hospital Authority is lagging behind in infrastructure development and there is a huge backlog of medical equipment requests. Many medical equipments are old and beyond repair. Without modern facilities and new medical equipment, the quality of healthcare in the public sector is hard to sustain.

10. With more choices offered to the healthcare insurance consumers, public hospitals must set up structure and system to allow private doctors to practise in public hospitals. This arrangement not only benefits the consumers, it can also decrease the brain-drain from the public sector to the private sector. Flexible employment offered to healthcare professionals in the public sector can further decrease manpower wastage.

11. Little is known to the public on the real cost of medical treatment. If they know the treatment cost of some major illnesses such as Coronary Artery Bypass Graft (CABG), Percutaneous Coronary Angioplasty (PTCA), drug cost of chemotherapy, molecular-targeted therapy and radiotherapy for common cancers, the public will have a different perspective in healthcare reform and financing.

12. Private healthcare insurance providers will be regulated under the mandatory scheme and the government has the duty to protect the consumers' interest.

13. Administrative cost of medical savings accounts must be controlled and performance of the savings investment must be reviewed.

We support enhancing primary care in the healthcare system, and we have the following suggestions:

1. In developing basic models for primary care services with emphasis on preventive care, the government needs to take into account the implication and the aftercare of the screening-detected early stage diseases, e.g. mass screening of cervical cancer should be supported by a standardized referral system to specialized units for further treatment. Supply of gynaecologists and oncologists have to be considered in the follow-up of cases generated from the cervical screening program.

2. When setting up the primary care doctor registry, the government must have certain requirements to ensure the doctors on the registry meet the standard and competency to provide holistic primary care to patients.

3. In implementing the e-health record which can be shared by the public and private doctors, personal data privacy must be protected and enough training should be offered to senior private doctors who are not familiar with electronic devices and the clinical information system.

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