Kowloon Hospital Alumni Society
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Our View on the Reform of Healthcare Financing

1. In general, we support the reform
We understand that there is an imminent need to reform. We agreed that there is a substantial increase in demand together with a rising expectation from the public. The present system is not sustainable. In fact, the reform has been discussed for over 20 years, and it is the time for action.

2. We are of a view that the Healthcare Financing reform should serve both ends, how to get the money and how to spend the money.

3. We are of the view that the problems associate with the present health care system is not from money alone, although money is one of the major problems.

4. We are of the view that at present the public is not quite understand the real situation. And there are a lot unrealistic expectation. We can foresee that the public expectation will escalate when further resources are required to keep the system. These unrealistic expectation may often generate a lot of pressure to the healthcare providers. In fact, Hong Kong is running a very efficient system when compared to other part of the world. The public shall be given a full picture.

5 We agree that Medical Insurance may help in the Health Care Financing. But this must be handled with care. The present insurance system has a lot of loopholes and often the most needed population is not covered or overcharged. Similarly, expensive treatment and a lot of areas and subspecialties are not included (e.g. psychiatric service, occupational therapy, etc) When considering insurance, details must be taken good care of, especially on how to provide medical protection to all, to avoid unnecessary usage of the facility and service, and to control of HMOs, especially avoid their manipulation of the professional practices.

6. We are also of concern to the Medical Saving Account (MSA). How it is run, the possibility of high management fee, and the consequence of it to the patient and provider.

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7. In exercising the "Money goes with Patient" policy, care must be taken to ensure that the public service is not being exploited.
   a) There are many reasons why patients choose the public healthcare service and price is not the only one. In the past, there are incidents that the budget is relocated whereas the workload persists. We should also note that when services are to be relocated, extra resources are required.
   b) .Unnecessary competition might be created between the public and private sector and even between private/ private and public/ public sector. There would be overprovision of the "money making " services and under provision of those does not. Also, patients might be graded according to the amount of money made by the disease category.
   (Please refer to the attachment).

8. We should separate the need and demand. In the past, government and the Hospital Authority gave a lot of attention to the demand rather than the actual need of patients. Resources allocation often follows those who are vocal or has a lot of publicity, rather than the real need.

9. We do not agree that the government limits its priority on acute and emergency services, the unprivileged, the expensive diseases and training alone. In fact, in an aging population, geriatric and chronic disease, rehabilitation and psychiatric diseases are worth given more attention.

10. There is an ever-tightening budget towards community work. This is especially important in rehabilitation and psychiatric services. The limited budget is very much against the modern trend of psychiatric practice when mental hospitals are downsizing and patients are given early discharge to be treated in the community. There are frequent complaints from the NGOs that they do not get full support from the government. What they meant is not just money. They need expertise to give them backup, e.g. visiting psychiatrists, OTs, CPs etc. We are of the view that in order to be successful in community health service, all must work as a team, with long-term relationship, with well planned policy and enhancement of communication. The present system of asking NGO to bid projects make them feel like auctioneer rather than partners.

11. We agree that attention should be paid to individual need of patients at the same time; attention should also be paid to group education and community control of diseases.

12. With regard to individual need, it should not be limited to family physicians alone. Specialty care, especially those of rehabilitation and psychiatric services require attention to individual need.

13. Medical treatment is not only "adding years to life", equally important, it should be "adding life to years'. For example, 10 hip replacements may be cheaper than a liver transplant and probably will bring no less benefit, if not more, to patients.

14. Training of staff should be well planned and co-ordinated with the job and human resources requirement. In the past, a lot of allied health worker had been trained but they cannot go back to the career they studied.

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Attachment

1) From the perspective of a citizen

When insurance industries are invited to participate in financing health care and to provide mandatory health insurance, priority may be given to maximize the profits of these companies instead of insuring citizens in the most cost-effective way. We may not see any short-term change in premium/benefits but situation may deteriorate when public attention dwindles some years later. In the US and Singapore, insured citizens are paying higher and higher premium and getting lesser and lesser medical benefits each year. Would there be any mechanisms to oversee the operations of insurance companies?

The Government Report suggested the medical saving account (MSA) is managed similarly to MPF. We did observe exorbitant management fee of MPF. Would similar scenario occur in MSA, and people's medical savings are used to "feed" managers?

2) From the perspective of health-care worker in public sector.

When patients having MSA and health insurance get sick, they are free to choose medical services in different HA hospitals, see doctors of their preference and have shorter-waiting time than those without. As they will pay a higher fee to the department/hospital and are considered as "income providers', health-care workers would be inclined to offer them better medical services in order not to loss these 'customers'. Treatment of these patients would be obviously different from citizens without MSA and insurance. These differential treatments would cause social injustice. Moreover, when department/hospitals are allowed to charge a higher fee to the former group of patients, would their budget be cut? Unhealthy competition among different departments/hospitals for patients with MSA and insurance may also be seen.

When insurance industries are involved in financing health care, would they intrude and interfere with clinical work of health-care professionals? In the US, many investigations and treatment have to get preauthorization from insurance companies. More papers work is also anticipated. The loss of professional autonomy and increased bureaucracy will be detrimental to morale of health-care workers.