Public Policy Forum on Hong Kong Healthcare Reform

5 June 2008

Summary Notes of Discussion

Ms Susan Chan

Manager, Business and Professionals Federation of Hong Kong

1. Health Care in Hong Kong
   - Hong Kong is proud of its low mortality rate and longevity of its people. A good health care system, however, should also place emphasis on the quality of life.

   - There has been no vision for health care in Hong Kong. We need to examine what the existing situation is and envisage what we want Hong Kong to be over a certain period of time. Health care goals should be set accordingly.

2. Health Care Reform & Financing
   - Why it is necessary to mix the two together? Can't we just proceed with structural reform?

   - It seems that the Consultation Document is all about asking for more money from the public. It does not explain:
     - why more money is needed?
     - how the money raised will be used?
     - how Government will ensure that the reform will succeed?

3. Primary Care
   - The team approach proposed by speakers is the right way forward but the public needs to be educated about its importance.
   - How can the underprivileged afford the costs of primary care, such as regular body check-ups?
   - Is there any evidence showing that better primary care can reduce total health care costs? A local study is needed.

4. Financing
   - A question has to be asked: does more money guarantees better results?
   - While self-responsibility should be promoted, Government commitment is equally important.
   - Those who can afford to pay more should pay more.
   - The idea of increasing public sector fees while imposing a cap can be considered.

However, a second safety net should be established for the underprivileged.

- When we talk about increasing tax, people usually think of salaries tax which means extra burden for the middle class. However, Government can look for other options, such as increasing stamp duty and using the revenue raised to set up a health care reserve fund.
- The U.S. experience shows that voluntary insurance is not an option.
- If insurance becomes a supplementary funding option, those with insurance may become a preferred class and receive better treatment.
- Though the concept “money follows patients” is worth looking into, it does not help shorten the existing queue in the public sector.

5. <u>Other issues</u>

- Transparency

  The public has no say on how the money allocated to the HA is used now. How can government ensure greater transparency?

- Manpower

  It is obvious that there is a shortage of health care professionals, including doctors and nurses. Can Government consider importing talents from other places? For example, nurses from the Mainland can be allowed to perform more basic procedures so as to alleviate the workload of local nurses.

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公共政策圓桌系列-香港公共醫療改革(2008 年 6 月 5 日)

香港城市大學公共及社會行政學系副教授陳浩文博士
主持之小組討論內容撮要

討論小組各組員並沒有清楚共識，下列各項爲個別人士的意見:

1) 反對強制儲蓄計劃。這方案對低收入人士成效不大，況且醫療開支可以很大和難以預計，即使退休後有一點積蓄，大病一場便可以用光。
2) 反對爲改革公共醫療而增加稅收。原因是對政府缺乏信任。 政府因財政盈餘而在本財政年度推行減稅措施(例如"還富於富"的減低紅酒稅) ， 但假如以醫療改革爲由而加稅，只會令人無所適從， 更突顯政府政策前後不一致。
3) 贊成保險方式集資，但不應強迫市民供款。澳洲現行模式可作爲參考對象。
4) 同意以香港醫療制度要以公共醫療系统作爲主導，對嚴重及緊急疾病和弱勢社群有所承擔，但同時市民亦要重視個人責任，應對自己的身體健康負責，有較多財富的人應爲社會整體付出及承擔更多。
5) 不應只集中討論融資，要改革醫療制度，加強預防及基層醫護服務的發展，把投資在更有效的項目，例如提倡健康生活方式、家庭醫療，從而達致提升醫療素質而又減低醫療成本。
6) 有人對以上觀點有保留。在 05 年的<創設健康未來-探討日後醫療服務模式討論文件>，政府建議改革醫療服務模式，很多人問政府爲何不討論融資改革，是次醫療改革諮詢文件的重點是融資方式，卻又有人問爲何不先政革現時的服務模式才再處理融資問題。這樣來回往返地討論，結果只會是沿地踏步，裹足不前，不會有任何實質結果。
7) 有人亦認爲，改革醫療服務模式和加強預防及基層醫護服務的發展對解決融資問題的幫助有限。很多疾病是不能預防，醫療成本上升的其中一個重要原因是人均壽命越來越長，很多社會資源要用在照顧長期病患者身上，所以社會正視融資問題，不要轉移話題。

Public Policy Forum, 5 June, 2007

Summary Report of Group Discussion

Ms Connie Hui
Secretary General, Business and Professionals Federation of Hong Kong

1. The Government asks money from the public but offers no vision or promises in services in the Consultation Document.

2. The group however agreed with the need for reform. Although the Hospital Authority has done well, problems are obvious: the price of drugs, queues, time a patient able to spend with a doctor, etc.

3. The reform should not limit to the public sector but must include the private sector.

4. The Group agreed that primary care should be the thrust of reform and act as a platform for public-private cooperation. It also agreed with:
   - multi-disciplinary clinics
   - Primary Care Authority
   - that the Report of the Working Party on Primary Care in 1990 should be revisited.

5. On financing, the Group:
   - did not support any of the six options in the Consultation Document;
   - opposed to placing the entire burden of health care on salaried workers. It should be everyone's responsibility and funded by the complete spectrum of Government revenue (e.g. including land premium) and not only by direct taxes;
   - agreed that the better off should contribute more;
   - supported the $50 billion concept, that in good years, instead of tax refunds ("派糖好無聊"), Government should put aside money and save for everyone for health care.
   - felt that sin tax, e.g. wine tax, tobacco tax, should be implemented.

6. The Group strongly supported "evidence based assessment" which should be adopted not only in treatment but also management and how money is spent.

7. Worries were expressed on resources, the shortage of doctors and nurses. Small hospitals could be considered.

13 June 2007

公共政策圓桌系列-香港公共醫療改革(2008 年 6 月 5 日)

九龍醫院行政總監區結成醫生
主持之小組討論內容撮要

本人主持的小組共有八名組員，當中以外籍人士爲主，而一位華籍醫生亦以英語交談，因此是次討論以英語進行。我並無深究各組員的背景，但似乎其中兩人是醫生，一人任職美國領事館，而另一人在討論過程中表現對醫療護理個案管理相當熟悉，其職業可能與保險業相關。至於其餘各人都是關心香港醫療的專業人士。

綜觀整個討論，我認爲組員相當熟悉何謂良好的醫療，亦具有清晰的理念，不必多加講解即可明瞭討論的焦點，因此組員迅即集中討論醫療改革的兩大方面:一是融資，另一方面是制度與服務內容，即所謂實質部分(Substantive Part)的改革。

組員先討論制度與服務內容的改革。他們花了相當多的時間討論如何改善基層醫療。主導討論的組員是一位醫生，他認爲香港目前的基層醫療，如同報告書所言，是需要改革的。他建議不應將基層醫療定義收窄至以家庭醫學爲本，而是應盡快實行改革，盡量讓醫生參與，由政府監管。相信實行幾年後，服務將漸上軌道，而素質亦得到改善。

其他組員則比較關心兩方面。首先，他們認爲即使改善了基層醫療，但基層醫生如何融合第二、第三層的專科醫生、醫管局與私家醫院的服務? 他們覺得電子病歷或會促進融合，但有問題尚待解決。例如醫院目標是減少住院病人，則需基層醫生配合以達成目標。結果基層醫生不但需要細心照料病人，更可能要扮演看門人(Gatekeepers)的角色，這種融合如何實行呢? 又例如基層醫生與專科醫生如何分工合作以達致更高的服務水平? 故此，組員都反對成立 “基層醫療管理局”。因爲將基層與其他醫療分割，不僅有礙融合，更可能導致各自爲政的情況。對於如何實行這種 “垂直融合” (Vertical integration)，組員都未有具體建議。

另一方面，有幾位組員都不約而同地指出目前醫療融資報告書似乎將融資與基層醫療分開討論，並無顯示兩者任何相互、關聯或促進的作用。假如融資是政府動用一筆款項爲市民購買保險，而市民則可享用醫療服務，但這並不表示人們會更正確使用醫療服務或促進基層醫療發展。兩者並無必然關係。有組員亦指出如果不優先考慮制度與服務內容(即實質部分)的改革，可能會出現爲花費資本而推出措施。因此組員都同意融資方式與服務和制度應同時考慮，尤其涉及雙方介面的項目，例如疾病類別管理的設計: 糖尿病、心臟病等疾病可以因病情而由分別基層、第二層或醫院負責護理，但整體策略上如何提供護理? 因此組員認爲需要考慮改革如何促進疾病類別管理。另一方面，有關收費問題，組員認爲如果未能合

理地改革公立醫院收費，即使市民得到融資，亦未必會使用私人服務。從外國經驗可見，有保險制度不一定使人離開公立醫院，因爲公立醫院與私家醫院價格差距實在太大。而收費改革亦影響實質部分的服務模式，如目前廉價的收費住院服務與較昂貴的社康服務相比之下，醫療模式始終傾側向住院服務。因此各人都認爲改革是雙方面的，即實質與融資的改革，但必須盡早理解兩者之間的關鍵。

關於價值觀與融資的關係，小組內各成員的觀點相近，同樣重視全人使用(Universal access): 不論任何社會階層都可以公平地使用公共醫療服務。其中一位組員分享個人經驗，因其父患病三個月，期間多次進出公立及私家醫院，所費甚鉅。在私家醫院中，他更目睹其他病人已耗費十多萬至一百多萬元，結果花光金錢，被迫回到公立醫院繼續治療。雖然在座的組員都屬較高收入的中產階級，但都認同在本港現有制度下，即使購買保險，一旦患上嚴重或複雜的疾病，始終會到公立醫院求醫。故此，他們認爲如何保持公共醫療作爲“公眾安全網”(Public Safety net)的素質和可以供全人使用，並不是只有基層市民關心，而是全部人都需要關注。

其次，組員贊成以自負責任(Self-responsibility)，即每人應負責自己的健康；生病時，有能力負擔的人應該自己付出能承擔的部分。當然，亦應爲嚴重病患設有風險共擔(Risk pooling)及上述的全人使用。

在綜合上述討論，組員都考慮可取的制度須具備若干的特色。首先，因爲需要鼓勵自負責任，因此共同承擔(Co-payment)是必須的。第二，應該是全人的，並非小部分人可以使用。第三，是具備合理的價格制定。當考慮諮詢文件提供的方案時，組員以第六個方案(即個人健康保險)爲起點，但他們都不接受此方案只要求170 萬在職人士擁有保險，結果並非全人享有；而沒有保險的人則不能得到較佳的服務，是不公平的。

結果，組員的建議是全民擁有輔助(Supplementary)的保險，有能力者應該供款，而不能供款的人，則由政府補貼。這個模式近似社會保險，但爲了鼓勵自負責任，應設立個人戶口。政府亦可爲市民醫療費用加設上限(Capping)，即定出每人每年自費最大金額，如超出上限，則由政府代爲支付。由於政府須補貼不能供款人士，組員都理解或有加稅壓力，但無論如何，各人都堅持醫療制度須爲全人使用。

最後，此建議是一個混合方案: 第一是價格改革；第二是類似全人享用的社會保險，形式類似第六個方案(即個人健康保險)，即保險加儲蓄或政府注資的個人戶口，但應讓全民而非只有在職人士受保。在職人士自供保費；無收入/低收入人士可用政府津貼保費。

Public Policy Forum on HK Health Care Reform (June 5, 2008)

A summary of Group Discussion moderated by Dr. Amy Po-Ying HO
(Senior Lecturer, the Hong Kong Polytechnic University)

This group represented citizens from a wide range of backgrounds

3 NGO representatives who work with patients with chronic illness and HIV/AIDs,
2 doctorial students from CUHK (Mainland students)
1 elderly advocacy group member,
1 pharmacist,
1 Hospital Authority administrative staff,
1 Insurance agent

Discussion on the core values of health care reform

After a heated debate, the participants came to the following consensus:

- All participants regard health care as social goods which have great impact on people's quality of life. The government should strike a balance between humanistic concerns with economic principles in formulating health care policies.

- Equity and wealth distribution were the two core values of our existing health care system and should, therefore, be upheld in any future reform. In other words, universal access to public health services for all citizens should be guaranteed (i.e. equity of access). The health financing methods should be affordable to the citizens (i.e. equity of financing). Furthermore, the participants believe that wealth distribution through taxation is important in Hong Kong to narrow the income gap between the rich and the poor.

- Some NGO representatives spoke on behalf of patients with chronic illness (HIV/AIDS, DM and mental illness). They expressed their concern on the possibility of developing a two-tier system in public health sector – one for those who have insurance and one for those don't. In other words, patients who rely on public health services do not wish to see any differentiation in service quality; waiting time and choices of care should the supplementary financing options be implemented.

- Some participants pointed out that the term "middle-class" represents citizens with a wide range of monthly incomes ranging from 20K to over 100K. The so-called middle could easily become "citizens in need" if they or their family members encountered catastrophic illness. Thus, universal access to health care is a common concern for low income and middle class citizens alike.

Discussion on <u>how</u> to reform our health care system

- It was a consensus among the participants that the overhaul of the existing health care system and policy directions should be the core business of health care reform.

- Refocusing policy directions – the SAR government must formulate health policies which truly reflect the importance of primary and preventive care. This implies a reallocation of public resources between the Hospital Authority and Department of Health.

- Restructuring of health care system – some participants strongly advocated for the setting up of a Health Authority which oversee and coordinate health care at all levels (primary, secondary and tertiary). Only through this structural change could a patient-centered, integrated care for patients be made possible.

- A majority of the participants were surprised by the small proportion of health care budget spent on drugs in the public health care sector. They urged the government to look into this problem and increase the budget on drugs appropriately. NGO representatives, in particular, pointed out that many patients suffered physically and financially since the new drugs that they need were not subsidized by the Hospital Authority.

- NGOs and patients' self-help groups are playing an important role in promoting health among the elderly and vulnerable groups by virtue of their extensive community networks. So the government should enlist these organizations as partners in primary care and health education.

- Two participants in this group advocated for the separation of medical consultation and drug dispensary in public hospitals. They argued that this is an effective way to control costs in the public health sector.

Discussion on health care financing options

- Compared with what had been discussed so far, health care financing is not a core issue of concern for this group. There was no consensus on any financing option among the participants either.

Prepared by Dr. Amy Ho
June 8, 2008