香港醫學會

The Hong Kong Medical Association

FOUNDED IN 1920·INCORPORATED IN 1960 AS A COMPANY LIMITED BY GUARANTEE
MEMBER OF WORLD MEDICAL ASSOCIATION AND CONFEDERATION OF MEDICAL ASSOCIATIONS IN ASIA & OCEANIA

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2007 - 2008

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13 June 2008

Dr. York YN CHOW, SBS, JP
Secretary for Food and Health
Food and Health Bureau
19/F Murray Building
Garden Road, Central
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E-mail: beStrong@fhb.gov.hk

Dear Dr. CHOW,

The Hong Kong Medical Association welcomes the long awaited Government initiative in health care reform but regrets that the medical profession was not consulted before its publication in March 2008. Subsequently we collected views from the profession on the consultation paper through various discussion platforms and arranged an open forum with direct dialogue between you and our members. An opinion survey of all registered medical practitioners of Hong Kong was conducted in May 2008.

The attached submission was compiled taking into consideration members' views and taking reference to the result of the said survey.

Yours sincerely,

Dr. CHOI Kin
President
The Hong Kong Medical Association

c.c. Chief Executive, HKSAR
c.c. Members of the Executive Council
c.c. Members of the Legislative Council
c.c. Medical Colleges and Societies
c.c. Professional Bodies
Encl.

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The Hong Kong Medical Association
Submission to the Food and Health Bureau
In response to the
Healthcare Reform Consultation Document
"Your Health Your Life"

Introduction

The latest healthcare reform consultation document from the Food and Health Bureau titled 'Your Health, Your Life' warns us again that because of *our rapidly ageing population*, because of *rising medical costs due to advancement of technology and consumer expectation,* there will be a *declining level and quality of public healthcare services* unless we do something about it. It predicts that the occupancy in public in-patient wards for major specialties could *reach congestion within the next three years,* the waiting time of new cases for specialist out-patient services triple by 2012, and the waiting time for non-urgent surgery like cataract extraction increase from 3 years to 6 in 2015. The document proposes to enhance primary care by developing basic models for primary care services, establishing a family doctor register, subsidizing patients for preventive care, improving public primary care and strengthening public health functions. The document goes on to threaten that our system is not sustainable and supplementary financing has to be implemented. Despite denials, it is obvious that medical saving account, mandatory private health insurance and personal health care reserve are the choices of the government to lessen its contribution to public health care.

Like many other consultative documents on health care, this latest one was created behind close doors without the input from the majority of healthcare providers. Like the other consultative documents, the majority of the healthcare providers are not in agreement with the government's choices suggested in the document.

Primary Care

Putting emphasis on primary care has to be good, and the results of NHS (UK), OHIP (Canada) and the Australian Health System serve to demonstrate that this may be the way forward. All 3 countries, however, invest tremendous amount of revenues in primary care. In UK, the NHS allows the general practitioners to be fund managers to bargain for the appropriate hospital and specialist fees. In Canada, the general practitioners are reimbursed fee-for-service by the Canadian government, as is the case in Australia. "Your Health Your Life" suggests that Hong Kong Government pay barely nothing and hopes that citizens get good primary care through their own financing (short of the experimental coupons). The Mandatory Private Health

Insurance is only for hospital fees and specialist consultations, and how this is seen as promoting primary care is beyond us.

The Hong Kong Medical Association likes to remind the government that good medicine, or family medicine at that, does not come cheap. Paragraph 2.2 in the document, which states *'stronger primary health care results in better health of the population at lower cost'* may be wishful thinking. The 3 major countries with strong primary care system within its infrastructure, including Canada, UK and Australia, have injected more and more money into their healthcare system throughout the years without seeing much shortening of the waiting time and evidence of better health indices than Hong Kong.

In Canada, for example, where the new undersecretary obtained his medical training, there is no mandatory insurance. Healthcare is provided through general taxation. All citizens have equal access to their general practitioners free of charge and government is billed fee-for-service. Prescription medications are paid for by citizens unless they have extra insurance or when the medicines are being given in hospital. Half of the doctor population are general practitioners whose basic qualification CCFP is gained after two years' training post-graduation (without internship). The pass rate for CCFP is almost 100%. The manpower supply of the whole country is closely monitored and each graduate is linked to a training position in the country.

In Hong Kong, young doctors train seven years after graduation (including one year internship) to gain an Academy Fellowship title in Family Medicine. Not too many doctors joined the family medicine program (25 in 2004 and 43 in 2006). Of the 90 doctors who enrolled in 2000, only 9 were conferred with Academy Fellowship in 2006, a meager 10%. Professor Richard YU postulated to the media the reasons for the low output as: dissatisfaction in trainees towards the content and process of training, suboptimal trainer quality, high failure rates in the examinations, drop-outs of trainees along the training pathway. *(5.2 submission of Hong Kong Civic Association Healthcare Committee)*

Hong Kong College of Family Physicians submitted the "Manpower Projection for the Specialty of Family Medicine" to the Hong Kong Academy of Medicine in April 2005, and calculated that about 2,700 full time primary care doctors would be needed to serve the whole population. With the existing 154 specialist family doctors (as at 2005) and assuming an annual output of 100 new comers (which is not materializing), it should require about 26 years to reaching the target. *(4.2 Submission of the Hong Kong Civic Association Healthcare Committee)*

Worse still, without instilling the most needed finance into primary care, the document starts to lay out plan to control the private sector. A family doctor register is no big deal and the HKMA created a similar register 2 years ago for public information. It was deemed not acceptable by the Medical Council because somehow, freedom of speech does not apply and we could not use the word 'register'. Now it is obvious that this word 'register' is only restricted for use by government. To control general practitioners, only those with the *appropriate training requirements and qualification milestones* can *remain on the register in the future.* With the Canadians, this is no problem. 50% of their graduates underwent a two year government funded training program to sit for the CCFP with an almost 100% pass rate. However, in Canada, general internists and general pediatricians can opt to practice as primary care doctors as well

and be rebated as such. With the requirements suggested, these specialists doctors practicing currently as primary care doctors in Hong Kong may not be allowed on the register. In Hong Kong, with the figures we just provided, when and how can we create a team of qualified family doctor in the register as the paper suggested? With only over 150 specialist in Family Medicine currently, the current enrolment of trainees in the program, and the pass rate, what should general practitioners without the required *qualification* to get into the register do in future with their basic primary degree? Beg rice? Is this not an attempt to control general practice?

For the last century, general practitioners has provided between 70-90% of primary health care to the community. To establish the family doctor register, the consultation paper proposes a working group involving the public and private sector, which will be formed to look at it. When the public sector contributes so little to primary health care in the past, what is its role in the working group? Is this not an attempt to control general practice?

The document looks at accessibility and back-up arrangements. Like the NHS, the document wants doctors to form groups to *provide mutual support in service provision. Doctors who register as solo practitioners should be required to make back-up arrangements in the event they take absence from practice.* So in future, general practitioners have to register and inform how they will provide 24-hour service. Most general practitioners choose the job for the life-style and do not have in mind a 24-hour on-call vision. In NHS, government funded primary care dictates that only GP groups can survive and in 2004, there were only 6.1% solo general practitioners. However, even in UK, studies found little relationship between practice size and quality. Small practices are considered by patients to be more accessible and achieve higher level of satisfaction than larger practices. Nearly half of the general practitioners in USA are solo practitioners. If Hong Kong wants the general practitioners here to act like their counterparts in UK, then government should take the tab and pay them like their counterparts in UK.

The document suggests that the Department of Health *should focus on devising appropriate standards and protocols for various primary care services and to promote and monitor the application of such standards.* We are concerned that in future, the size, structure, furniture of a general practice clinic will be fixed and audited. But how does government deal with the LINK, which controls the rental and size and shape of the public housing estate clinics? Has government, in fact, Mr. TSANG, not shrink away from touching LINK under the pretext of free trade? If LINK controls the rental of the estate clinics, how can government dictate what should be the size and structure of a clinic? Government has not helped with the management of general practice clinics in the past; now without funding general practitioners, it wants to audit general practice clinics of the future. Is this not an attempt to control general practice without the proper financial support?

Healthcare Manpower Planning

Paragraph 14.3 suggested that *'following the reform and financing proposals, the Government will need to examine the issue of healthcare manpower planning, with a view to ensuring that there is sufficient manpower supply of different healthcare professions to support the sustainable development of the healthcare system in the long run, both in the private and public sectors'.*

However, even before this document is properly considered and adopted, the University Grants Committee has allowed medical student intake to increase from 125 to 160 per year; increasing the annual output to 320, according to media reports on 10 June, 2008. It is proposed that the final increase in intake is to 400. 80% of the expenditure of Hospital Authority goes to salary, and increasing the number of medical students will translate into increasing the number of doctors. Nursing and paramedical staff will necessarily be increased in the same ratio. This is in gross contrary to paragraph 3.2, which talks about saving and cost-effectiveness and public hospitals focusing *'on its priority services such as acute cases and the treatment of complex illnesses requiring costly treatment'*. This is a gross violation of the principle of a small government and limiting services of the Hospital Authority to 4 pillars only. The extra manpower is obviously employed to deal with the anticipated increase in patient load in the public hospital in the future. Without the supplementary funding, the salary of this extra manpower cannot be met.

The Medical Association met with Mrs. Laura CHA, Chairperson of UGC on June 5, 2008. Unfortunately, she explained that the UGC has no authority over formulating policies and the adjustment of the number of medical students. As to her role in the Executive Council, she concurred that the EC only had the Bureau's paper to look at and members could not do any consultative work. She agreed that her work in the EC amounted to rubber-stamping any Bureau's proposal.

We wish to remind the Bureau that only a few years ago, doctors could not get training positions in the Hospital Authority after internship and were thrown to the wolves. Some of them ended up in slimming parlors and were found guilty of professional misconduct for improperly keeping dangerous drug register. Professors had at that time either made it crystal clear that the University was not responsible for finding interns a training job or suggested that they could work as research assistant in the University at $10,000/month. The same professor has always clamored for young graduates to return to the motherland and work there when the Ministry of Health has never requested for young trainees nor agreed to create positions for them.

We emphasize that there is no lack of doctors in Hong Kong. If there are vacancies in the Hospital Authority, it is because public doctors are unhappy with the administration and voted to resign and migrate into the private sector. To increase the number of young doctors is to rob them of the chance of training when there are inadequate trainers and inadequate patients for the trainee to learn from. The only reason for increasing the number of interns is to obtain cheap labor without concern for their subsequent career. The increase in number is not equated to increase in quality and citizens will not be getting a better deal. Hospital Authority will of course be able to better control the salary of young doctors and prevent another strike. We regret the Universities for being parties to this venture.

Paragraph 3.3 of the paper agreed that *'healthcare human resources are costly and medical and healthcare professionals take time to train'*. It takes millions of dollars of tax payers' money to train a medical student. To see the students end up as a slimming pill dispensing doctor in a beauty parlor or slimming shop cannot be what citizens want.

Public-Private Partnership

Chapter 3 of the document is about promotion of public-private partnership. Although this has been chanted for over 20 years, it has been a big flop over the last 2 decades because no financial incentives have been forwarded to patients and doctors alike. Subsidizing cataract surgeries to reduce waiting time is a first step forward. Co-location of public and private hospital facilities in a new hospital in North Lantau is doomed to fail because few private doctors and their fee-paying patients will go to Lantau for health service.

The Chief Executive suggested that government would collaborate with private doctors to provide service to residents to Tin Shui Wai. The mindset of public officials on this matter is worrying. In a Legislative Council Health Panel meeting, it was reported that Dr. WL CHEUNG of Hospital Authority suggested that paying $105+45/visit to the general practitioners of Tin Shui Wai for service is more than fair because Hospital Authority will be supplying the medicine to be stocked in the doctors' offices and the money is 'net profit'. The same sentiment was agreed by Dr. York CHOW when he attended the Health Care Reform Forum in our Association premise in May 2008. In fact, Dr. CHOW was of the impression that night that young doctors going into general practice would be making a million dollars a year. How he came to that conclusion is beyond us. It is unfortunate that health care officials seem to know absolutely nothing about family medicine. The essence of family medicine is in the consultation, the contact with the patient, the understanding of his physical, psychological and social well being. The offer of preventive care, continuity of care, comprehensive and whole person care, family care and appropriate advice is more important than drugs. If even the Secretary of the Bureau thought that drugs are the mainstay of the consultation and the general practitioners are reaping a fortune from the $105+45 each visit for doing nothing, then there is no hope in using family medicine as the cornerstone for our future health care system. When the Secretary thought that medicine is so important, how can patients not demand more medicine from doctors and how can doctors fight the urge to provide unnecessary medications to patients? Poly-pharmacy, prescribing more than what is necessary for patients, must have its origin from Hospital Authority.

Hospital Authority uses 80% of its budget in salary and the cost of each GOPD Consultation is averaged at $240/visit. 80% of $240 is $192, which is about the amount HKMA suggested that the government pays the general practitioners in Tin Shui Wai for the consultation. To talk about partnership but refuse to listen to reason when fees are discussed cannot be claimed as good partnership.

Preventive Care

Paragraph 2.16 talks about subsidizing patients for preventive care. While preventive care is part of good family medicine, government should know what is necessary, what is cost-effective, and what is evidence-based. Many laboratories and even private hospitals offer check-up packages, which are not evidence-based and may cause harm to patients through false positive and false negative results. One of our senior members in the USA wrote to remind the government that unnecessary CT scans may pose radiation hazards and the risk of breast and lung cancer after 12

years may be as high as 1 in 400.

The need for change?

Chapter 1 of the document praised the healthcare system for *'delivering high quality services to the public'* and attributed *'advancement of medical technology'*, *'higher public and consumer expectation'* and *'medical inflation'* as the reasons for *'rising medical costs'*.

A medical reporter praised the public health care system not too long ago for successfully performing coronary angioplasty on a 99 year old man. She does not realize that the operation is not curative and the gentleman may relapse in 6 months; he may also die at this age from a stroke or pneumonia or a fall any time given that the average life span of a man in Hong Kong is about 79. The *'public expectation'* will of course be raised when government does not think it necessary to give citizens more information. Doctors should not be ageist and be forced to decide who to treat or who not to. Policies based on public decision have to be clear for doctors to follow. This is obviously not the case, resulting in the *'delivery of high quality service'* to one and all alike and hence the *'medical inflation'*.

Throughout the consultation period, the Secretary has made derogatory remarks about the private sector, which is not substantiated. There were remarks on the transparency of fees in the private sector. While private hospitals can define the cost of each treatment down to a piece of gauze, Dr. CHOW admitted to the HKMA Council Members in a meeting on 26 March 2008 that the fee structures of each procedure in the Hospital Authority are not very detailed because the Government had to take care of some essential services, like training and safety net, irrespective of the costs. There were remarks to the media that the citizens do not trust private doctors without explaining why private hospital beds are full when there is so much mistrust and why the public hospitals are bombarded by the media everyday over medical mishaps and loss of patient data via memory sticks.

Although Dr. York CHOW reiterated during the meeting that the public services had been positioned to the four essential services and patients had been given choices as to whether to line up for the public services or to pay for the private services, subsequent actions like the increase in number of medical students do not seem to agree with his initial suggestion.

Status Quo

Citizens do not necessarily agree with the need for change. Mr. SZE Wing Ching of Centraline Property Agency Ltd. talked about Health Care Reform in a speech during the Annual Dinner Meeting of Public Doctors Association in front of Dr. York CHOW and Dr. CH LEONG. He proposed that like housing policy, government should supply the basic necessities in health care. If more luxuries are required, citizens will have to work hard and earn it themselves, just like private flats and houses. This will ensure that citizens work hard for their future and not to be over-dependent on government.

On the same theme, Professor HO Lok sang of Lingnan University provided an argument for the public healthcare sector to cover 'basic care', to implement marginal cost pricing for such services, and for the government to negotiate standard pricing for basic drugs with pharmaceutical companies, while leaving premium services and premium drugs entirely to the market.

Professor HO informed us that Medisave in Singapore in 1984 gave birth to Medishield in 1990, Medifund in 1993 and then Eldershield in 2002. If we believe 5% will work, we will be witnessing the birth of more or more health plans as in Singapore. Similarly the National Health Insurance plan in Taiwan raised concern about sustainability and moral hazard problems, while co-payment requirements also raised concern about fairness.

We reminded the Secretary in that meeting that though Taiwan began 3 years ago at a premium of 4.5% for mandatory insurance, it was almost bankrupt and so government had to inject further revenue to rescue it and the premium soared to 7%. The premium in Germany was 14%. The proposal of 3-5% would not be viable and citizens would be dragged down the drain to pay more and more. The countries mentioned required employers to contribute at least half the premium, but the role of employer is not mentioned in the document.

Our health care spending in 2004 of $37.8 billion represented 2.9% of GDP, and even if we increase this by five times, to HK$189 billion by 2033, it will only be about 5.5% of GDP, which is way behind the Organization for Economic Cooperation and Development countries' average of 8.1%. Professor HO Lok Sang commented that *'while sustainability is a legitimate concern, a rise in the share of healthcare spending in GDP does not necessarily signal any problem, and may simply reflect the changing needs of society'.*

Supplementary Financial Options

The majority of organizations we met and listen to are against Mandatory Private Health Insurance and Medical Savings Account. This is in agreement with the survey result from our own profession. It is not fair to the middle class to shoulder the burden when they have been taking care of themselves in the form of voluntary private health insurance. Their effort and contribution in caring for themselves have never been acknowledged and over the last twenty years, despite appeals to recognize the effort of these citizens who lessened the burden of public health care, government has refused to provide tax incentives for these conscientious citizens. Mandatory Private Health Insurance will further penalize the middle class and an ordinary citizen paying a few hundred dollars in tax each year will end up paying $5,000 more in health tax.

Medical Savings Account would be appreciated if well managed. However, the management fee, wastage and return of the Mandatory Provident Fund had been alarming. Citizens are worried about how well their savings will be managed. Furthermore, if the savings are only for the purchase of healthcare insurance, elderly citizens may be left without a burial ground or coffin when they need the money for it. Some doctor expressed in the media that the fortune amassed from Medical Saving Account will only be used to feed retired government officials, fund

managers and ended up in a Mandatory Health Care Fund with a mean management which will further restrict patients' choice and use of service. Citizens will be sharing the bill but not given more choices.

Our Council has met and discussed with the Bureau. We were told that 30-40% of patients of the Hospital Authority were underprivileged and on CSSA and would not need to contribute anyway. The target would be on those 60% of currently paying patients in HA. By contributing to Mandatory Insurance, they will be paying the full fee to HA to sustain HA. We are not convinced that the Mandatory Insurance will allow more patients' choice to see private doctors or go to private hospitals, the payment is grossly inadequate. Ultimately, more patients who have contributed will be forced back to Hospital Authority because they have no extra money left after contributing to the mandatory insurance. Alternatively, citizens will be paying more than the 5% initially suggested. Unless government is committed to control the contribution of citizens to less than 5%, which it refuses to do so, the final contribution from individual citizens may be jacked up to 15% before it is enough.

One Standard, one protocol

The Bureau and in fact some doctors believe that private doctors may be providing services that are of marginal benefits and the money may best be used following one standardized protocol set up by the Hospital Authority.

This is exactly what the Medical Association is objecting to. Patients in the Hospital Authority are not given choices. If they have cancer or leukemia, they are given a standardized treatment if they are financially embarrassed. Drugs providing better prognosis are not given unless the patient can afford it financially. Biologics for rheumatoid arthritis, colon and lung cancers, Glivec for chronic myeloid leukemia, Herceptin for metastatic breast cancer are only for those who can afford it. Age related Macular degeneration is common in the elderly. Anti-vascular endothelium growth factor and photodynamic therapy are of more than marginal benefits but not available to HA patients unless they can afford $8,000/dose of anti-VEGF or $10,000/dose of photodynamic therapy. Patients on CSSA are left without a chance to marginal improvement and allowed to go blind because they do not have the financial resources for these types of expensive therapy. While patients were going blind, our doctors in HA noticed that the hospital's funding, once allocated for a purpose, could not be used for any other purpose other than buying more un-needed computer monitors. Mandatory Insurance will only aggravate the two tiers of patients in the Hospital Authority.

The Special Drug Formulary is the curse of many widows and orphans whose dear ones cannot live just because they are not on CSSA but still incapable of purchasing the needed drugs by themselves.

We suggest that government considers the Voluntary Private Health Insurance proposal. Although the Australian model is smeared with numerous disadvantages in paragraph 11.18, paragraph 11.13 demonstrated what a government should do and can do to promote voluntary private health insurance scheme.

Hong Kong Government has never been courageous enough to regulate private health insurance policies despite persistent complaints and numerous flaws in the system. When the Australian government can implement 'Lifetime Health Cover', which requires Health funds to apply the same base premiums, calculated at age 30, so long as individuals take out insurance cover before 30 and remain insured thereafter, Hong Kong government should and can do the same for its citizens. Allowing bad insurance companies and unfair policies to ruin the health of citizens of Hong Kong should not be the role of a good government.

The Australian government provides a 30% rebate of the premium and even higher for the elderly if the citizens take up voluntary private insurance scheme. With the 50 billion dollars at hand, Hong Kong government should be able to top this to a 50% rebate for our citizens who purchase voluntary private insurance scheme. With government's contribution, government has every right to inspect and negotiate with the insurance companies for more ethical and appropriate policies.

It should be noted that the majority of our Association members support voluntary private health insurance as supplementary financing option.

We are particularly concerned about paragraph 6.22 of the consultation paper which proposed that *'the public sector to increase moderately the capacity of its private services operating on a full cost-recovery basis……the provision of such private services should help bring in additional financing into the public health care system and relieve its financial burden'*. As suggested by the academics, government should provide the basic needs and leave premium facilities to the free market. It is unethical for Hospital Authority to be provider of basic care and competitor in the premium market when it has all the edges. We hope this is not the main reason for this document.

Summary

The HKMA supports extra funding to upgrade primary care doctors to provide holistic primary care.

The HKMA supports Public-Private Partnership in Healthcare provided public healthcare officials have the right mindset about family medicine and allows proper and respectful negotiations in the partnership.

The HKMA supports Electronic Health Record sharing to better manage our patients. We also support a Family Doctor register for information purpose, which must not be exclusive and subjected to the agreement of the majority of the profession.

The HKMA does not think government should waive wine tax and decrease profit tax of the very rich and big corporations. Alcohol only creates health problem for the community and result in extra health problems.

The HKMA does not agree to Mandatory Private Health Insurance and Personal Healthcare Reserve. We consider that citizens have the right to use their Medical Savings Account when they reach the appropriate age and for the appropriate purpose. The money in the account must not be restricted to purchasing Health Insurance.

HKMA suggests government to explore Voluntary Private Health Insurance as supplementary financing and use the reserves as incentives and provide tax rebates for those who purchase these insurance.

HKMA insists government to regulate the Insurance industry to prevent citizens being cheated out of their savings by fraudulent policies.

Dr. CHOI Kin
President
The Hong Kong Medical Association

13 June 2008

Appendix

The Hong Kong Medical Association

Health Care Reform Survey

The Hong Kong Medical Association had conducted an opinion survey on Health Care Reform among the medical profession in May this year. We have sent out altogether 11,811 questionnaires. Up to 5 June 2008, 1,852 returned, 45 were from medical students or absent members. The overall response rate was 15.68%.

Result

1. Do you agree that the Hospital Authority should define its scope of service?
   95% agreed, 4% disagreed and 1% abstained.

2. Do you agree that supplementary healthcare financing is necessary?
   74% agreed, 24% disagreed and 2% abstained.

3. Do you agree to increase the number of private beds or to provide private medical services by Hospital Authority?
   59% disagreed while 40% agreed and 1% abstained.

4. Do you agree to the principle of "money follows the patient"?
   79% agreed, 17% disagreed and 4% abstained.

5. Do you agree to increase the number of medical students to 400 per year?
   84% disagreed, 14% agreed and 2% abstained.

6. Do you agree that the government should fix the price of private healthcare charges?
   82% disagreed, 17% agreed and 1% abstained.

7. Do you agree that a modest increase in tax e.g. profit tax, stamp duty, wine tax, tobacco tax etc. to provide extra funding for public healthcare services is acceptable?
   63% agreed, 36% disagreed and 1% abstained.

8. Do you agree that a modest increase in user fees for HA services?
   92% agreed, 7% disagreed and 1% abstained.

9. Do you agree that individuals should save money to meet future medical needs?
   92% agreed, 7% disagreed and 1% abstained.

10. Do you agree that the government should have policies to provide incentives for individuals to save money for future medical needs?
    91% agreed, 8% disagreed and 1% abstained.

11. Do you agree to mandatory savings for medical needs?
    59% disagreed, 40%agreed and 1% abstained.

12. Do you agree that the government should have policies to encourage more individuals to take out private health insurance in the market voluntarily?
    88% agreed, 11% disagreed and 1% abstained.

13. Do you agree that mandatory health insurance is the only way the government can exercise control over private healthcare insurance companies?
    83% disagreed, 15% agreed and 2% abstained.

14. Do you agree to mandatory health insurance?
    66% disagreed, 32% agreed and 2% abstained.

15. Do you agree that private doctors can practice/teach in public hospitals/clinics?
    71% agreed, 28% disagreed and 1% abstained.

16. Do you agree that public doctors can practice/teach in private hospitals/clinics?
    54% agreed, 44% disagreed and 2% abstained.

Conclusion

The Hospital Authority:

1. 95% of the respondents agreed that the HA should define its scope of service.
2. 59% of the respondents objected to increase the number of private beds or services in the Hospital Authority.
3. 92% supported that HA could increase the user fees
4. 71% supported the idea of private doctors to practice/teach in public hospitals/clinics
5. However, only a slight majority (54%) supported the idea of public doctors practice/teach in private hospitals/clinics.
6. 84% were against the increase of medical students.

Supplementary Health Care Financing:

1. 74% considered that supplementary health care financing is necessary.
2. 79% agreed to the principle of "money follows the patient".
3. 82% of the respondents were against the government to fix the price for private healthcare.
4. 63% could accept a modest increase in tax to provide extra funding for public healthcare services.
5. 92% agreed that individuals should save money to for their own future medical needs. And a similar percentage (91%) would support the government to have policies to provide incentive for such savings while 59% were against mandatory savings schemes.

As to health insurance, 66% were against mandatory health insurance. 83% do not believe mandatory health insurance is the only way the government could exercise control over health insurance companies. And 88% were of the opinion that the government should have policies to encourage individuals to take out private health insurance.

香　港　醫　學　會
The Hong Kong Medical Association

FOUNDED IN 1920•INCORPORATED IN 1960 AS A COMPANY LIMITED BY GUARANTEE
MEMBER OF WORLD MEDICAL ASSOCIATION AND CONFEDERATION OF MEDICAL ASSOCIATIONS IN ASIA & OCEANIA

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香港醫學會
提交食物衛生局
回應醫療改革諮詢文件《掌握健康 掌握人生》的意見書

序言

食物及衞生局發出的醫療改革諮詢文件《掌握健康　掌握人生》再次提醒我們：由於*人口不斷老化、科技急速發展令醫療成本上漲及醫療需求不斷增加*，若不進行改革，醫療服務的水平和質素極可能會下降。按其推算，公營病房的使用率*在未來三年可能達至飽和*；到了二零一二年，專科門診新症的輪候時間會比現時增加三倍；到了二零一五年，非緊急手術如白內障手術的輪候時間會大幅延長至六年。文件提出要加強基層醫療服務，並建議透過制訂基層醫療服務的基本模式、設立家庭醫生名冊、資助市民接受預防性護理、改善公營基層醫療服務及加強公共衞生職能來實現目標。文件亦同時指出，現行的醫療制度不能支持長期持續發展，有需要推行輔助醫療融資。無可否認，「強制私人醫療保險」及「個人健康保險儲備」方案明顯是政府減輕公共醫療開支的選擇。

像過往許多的醫療諮詢文件，這份文件亦是閉門造車，沒有吸收醫療服務供應者的主流意見。一如以往，其他諮詢文件的反應，多數的醫療服務供應者對政府在文件中的選擇不表認同。

基層醫療

著重基層醫療是好事，試看英國的國民醫療保健系統、加拿大安大略省的健康保險計劃及澳洲的醫療系統，便知道這是正確方向。但是，這三個國家都投放了大量資源在基層醫療。英國的國民醫療保健系統容許全科醫生擔任基金經理，以便洽商合適醫院及專科收費；加拿大與澳洲的全科醫生則獲政府支付服務費。《掌握健康　掌握人生》揭示了政府不願付出（除了象徵式的試驗性醫療券），但卻希望市民自費去獲得良好基層醫療。強醫保只是爲了應付住院費及專科收費，至於它如何推廣基層醫療，是超乎我們的想像。

香港醫學會欲提醒政府，良好醫療或家庭醫學並不便宜。諮詢文件的第 2.2 節曰：「*基層健康服務越健全，越能以較低成本爲民眾帶來更佳的健康效益*」；這或許只是一廂願的想法。加拿大、英國及澳洲三國均建立了健全的基層醫療體制，並每年增加注入經費，惟沒有證據證明病人輪候服務的時間因而縮短，又或是國民健康指數比香港好。

以加拿大（我們副局長學醫的地方）爲例，她是沒有強醫保的。醫療福利是由政府的稅收支出，全部國民同等地享有免費的全科醫生診治服務，醫生費由政府繳付而藥費則由市民自己承擔，除非他們購買了額外保險或是從醫院取藥。當地半數的醫生爲全科醫生，他們的基本資格爲畢業後接受兩年（不需實習）訓練以考取合格率達百份百的加拿大家庭醫學文憑試。加國的醫生人手受到緊密監控及每位醫科畢業生均獲安排銜接的有受訓的工作崗位。

香港的年輕醫生畢業後要受訓七年（包括一年實習），方可取得香港家庭醫學學院院士資格。而報讀家庭醫學的醫生人數不多：二零零四年有二十五名，二零零六年有四十三名。二零零零年入讀家庭醫學的醫生人數爲九十，但只有九人於二零零六年獲授院士，僅是課程報讀人數的十份一。余宇康教授曾向傳媒發表意見，指家庭醫學訓練課程成效欠佳，是因爲：*很多學員學得不開心、不滿意、師資不濟、考試殺得太兇、學員中途放棄*。(香港公民協會醫療委員會文件 5.2)

香港家庭醫學學院於二零零五年四月給香港醫學專科學院呈交了《家庭醫學專科人力統籌》，並計算出服務全港人口需要約二千七百 位基層醫生。現時家庭醫學專科醫生人數爲一百五十四名(截至二零零五年)，而每年新增人數估計爲一百（未實現），那麼，需要約二十六年時間才可到達到目標。(香港公民協會醫療委員會文件 4.2)

更糟糕的是，除了缺乏對基層醫療給予最需要的財政注資外，諮詢文件還部署控制私營體系。兩年前，我們以爲編訂一本家庭醫生名冊是不會遇到什麼難題，故此，本會輯錄了一本《家庭醫生名冊》，以爲公眾提供資訊。惟這名冊不獲醫委會接受，「言論自由」於此事件並不適用，我們不獲准使用「名冊」一詞。現在終於悟出真相，原來「名冊」二字只有政府才有權使用。*將來，全科醫生會被控制接受指定訓練及完成指定課程，他們才可獲登記在名冊上*。加拿大是不會存在這問題，因爲百份之五十的醫科畢業生都會接受爲期兩年的政府資助課程，然後報考加拿大家庭醫學文憑試，而該試合格率接近百份之一百。根據上述我們所列舉的數據，香港如何及何時才可設立文件所提出的名冊？現時香港僅有超過一百名家庭專科醫生。將來，那些因未能符合《家庭醫生名冊》所規定的資歷，而不獲登記在名冊上的全科醫生，單憑持有基本學位，將有什麼作爲呢？乞米乎？這不是試圖控制全科醫生嗎？

剛過去的一個世紀，全科醫生爲社區提供了百份之七十至九十的基層醫療服務。爲設立《家庭醫生名冊》，一個由公、私營醫療界組成的工作小組將會成立。既然公營醫療界過往對基層醫療服務的貢獻甚微，那麼他們在工作小組的角色是什麼呢？那不是試圖控制全科醫生嗎？

文件亦著眼於醫療服務的便捷度及替代安排。像英國國民醫療保健系統，政府希望醫生自設組合，互相提供支援，並要求登記爲單獨執業的醫生在缺席工作崗位時，須安排同業替代應診。所以，未來閣下將要登記，並交待如何提供 24 小時服務。很多全科醫生選擇私人執業是因爲生活及工作方式可以較平衡及穩定，他們沒打算提供 24 小時電召服務。全力作出財政支持基層醫療的英國政府，其國民醫療保健系統規定全科醫生組合運作，因此，當地於 2004 年只有 6.1%的單獨執業醫生。話雖如此，英國的研究卻發現，執業規模

與服務質素並無關係。病人覺得小規模形式的執業較大規模更便捷及滿意。在美國，約有一半的全科醫生是單獨執業。若政府希望香港的全科醫生像英國那樣，那麼我們的政府就不要吝嗇付出，要與英國政府的做法看齊。

文件建議衞生處應聚焦爲各類基層醫療服務設定準則及常規，並推廣這些準則及進行監察。我們關注未來普通科診所的大小、結構及設置將受到規範及審核。但面對控制着公共屋邨診所租賃、面積及間隔的領滙，政府又可以怎樣呢？曾特首不是以自由貿易爲擋箭牌，在處理領滙問題時閃閃縮縮嗎？若領滙控制了公共屋邨診所的租賃，政府又怎能規範這些診所的大小及結構呢？政府過往並沒有在普通科診所的管理方面提供幫助；如今，還想在不提供財政援助下，審核將來的普通科診所。那不是試圖控制全科醫生嗎？

醫療服務人力規劃

文件的第 14.3 段裏建議「*在醫療改革和融資建議推出後，政府需要研究醫療服務人力規劃的問題，以確保各類醫護專業人員都有足夠人手，支援醫療體制（包括公私營醫療界別）的長遠持續發展。*」

根據二零零八年六月十日的傳媒報導，在文件公開諮詢及認受之前，大學教育資助委員會已容許醫科的收生額由每年一百二十五人增至一百六十人，而每年的畢業名額則增至三百二十人，且建議最終的收生額將遞增至四百人爲止。醫院管理局的開支，其中八成用於支付員工薪酬，增加的醫科生最終會歸入醫管局轄下，相關的護士及醫療輔助員職位亦需同時按比例增加，這與文件第3.2段所提及的節約開支、提高成本效益和公立醫院「*專注提供本身的優先服務，例如急症個案及需昂貴醫療費用的疾病（例如危疾或慢性疾病）*」相違背，此舉更公然違反了小政府和限制醫管局提供四大支柱服務的原則。多出來的人力顯然就是用來應付公立醫院預期將會增加的病人。沒有政府的額外經費，這些人員的薪津將無從發放。

二零零八年六月五日本會與大學教育資助委員會主席查史美倫女士會面，很不幸地得知大學教育資助委員會並沒有權限去左右政府擬定的政策和增減醫科生名額；而以行政會議非官方成員身份，查太表示他們只可閱讀局方的文件，但不能做任何諮詢的工作，並同意她在行會內的工作等同爲當局的所有提案提供一個橡皮圖章的角色。

我們要提醒當局，僅在數年前，就曾發生醫科畢業生未能在醫管局內找到職位而被迫投身私人機構事件，有些最終加入纖體行列，更甚者有因管理危險藥品不善而被定專業失當的罪名。當時，教授們斬釘截鐵地說明大學沒有責任爲醫科畢業生找工作，更建議畢業生可在大學內做月薪一萬的研究助理工作。雖然衞生部並不需要新的醫生亦沒有爲他們開設新職位的打算，但這教授當時依然叫畢業生回歸大陸尋找就業機會。

我們重申香港並不欠缺醫生。醫管局若有空缺，也只因醫生在公立醫院的管治環境下工作得不愉快，情願離職選擇私人執業。當沒有足夠的培訓員和病人可供實習時，貿然增加醫

科生人數是褫奪他們的培訓機會，增加實習生名額唯一原因是提供廉價勞動力，而且完全漠視他們日後的職業前景。增加名額並不等同質量好了。市民亦不會有好的醫生提供服務，新畢業生薪酬的釐定對醫管局來說當然是較易操控，而且可預防另一次罷工浪潮的出現。香港醫學會對大學參與這次冒進感到十分遺憾。

文件的第 3.3段同意*「醫療人力資源非常昂貴，而醫護人員需長時間培訓。」*培訓一個醫科生成材需耗掉納稅人數以百萬計的金錢，最後卻淪落美容院或纖形院，成爲替人開方減肥的醫生，這結果絕非市民樂見。

公私營醫療協作

文件的第三章推動公私營醫療協作。雖然已高調地談論了廿多年，卻因爲沒有向病人和醫生提供的經濟誘因，至使廿多年過去依舊只是空談。資助白內障手術以縮減病人的輪候時間是我們認同的第一步；在北大嶼山建立一間新的公私營設施共融的醫院則注定失敗，因爲只有少數的私家醫生和他們的付費病人會遠赴大嶼山治病。

行政長官提議政府與私家醫生合作爲天水圍居民提供服務一事上，官員的心態令人擔憂。在立法會衛生事務委員會會議上，醫管局張偉麟醫生提議：醫管局每次支付$105＋45 的診金予天水圍診症的醫生是公平的，因爲醫管局會預先存放藥物在私家醫生的診所內，而這些診金是『淨賺』的。當食物及衛生局局長周一嶽出席本會於二零零八年五月舉辦的醫療改革論壇時亦同意這看法。事實上，當晚周局長認爲年青醫生投身私家市場即有百萬年薪，真不明白他如何得到這印象，很不幸我們的醫療衛生官員原來對家庭醫學全無認識。家庭醫學的精髓是透過診斷，與病人的接觸，對病人身、心和社交各方面的了解，提供預防性護理，持續看顧，綜合及全人的照顧，全家庭的照顧，及恰當的提點比藥物來得重要。如果連局長都認爲藥物才是治病的主幹，而普通科醫生沒作任何付出就能從中獲取每次 $105+45 的利潤，那還談什麼以家庭醫學爲未來醫療體制基柱？連局長都認爲藥物是這麼重要時，病人又怎會不向醫生多要藥物？醫生又如何能拒絕病人索取不必要藥物的要求？複方用藥，開出比病人需要的更多的藥物，其來有自，醫管局也！

醫管局的財政預算中 80%用來支付員工薪金。每一個公立門診病人的平均成本爲$240，$240 的八成是$192 ，金額與本會向政府建議支付予爲天水圍居民服務的私家普通醫生診金相若。只高談協作，而論到收費就拒絕聆聽及商議，絕對稱不上爲一個好的協作對象。

預防性護理

文件的第 2.16 段裏講到資助病人接受預防性護理。預防性護理是家庭醫學裏重要的一環，政府必須知道什麼是重要的，什麼是有成本效益的和什麼是證據爲基礎的。許多化驗所甚或私家醫院都有提供體檢的套餐服務，很多都是沒證據基礎的，那些假陽性或假陰性報告甚至會對病人做成傷害。我們一位身在美國的資深會員致函我們，提醒非必要的電腦掃瞄會造成輻射遺害，十二年後乳癌及肺癌的風險會高達 1:400。

需要變革

諮詢文件第一章裡面讚賞香港的醫療制度*「爲市民提供優質醫療服務」*，並將醫療成本上漲歸咎於*「醫療科技進步」*，*「市民和消費者期望提高」*及*「醫療通脹」*。

一名醫療版記者在不久前稱讚香港的公共醫療制度成功爲一名九十九歲的老翁進行『通波仔』手術。她有所不知，該項手術並不能治本，有可能在六個月內舊病復發；以香港的男士平均壽命爲七十九歲計算，他這個年紀亦隨時會因中風、肺炎或是跌倒而身亡。政府認爲沒有需要給予市民更多資料，引致「市民和消費者期望提高」。醫生不應該年齡歧視，或被迫作出醫誰不醫誰的決定。政府應該制定政策，讓醫生有所依從。現實卻非如此，導致向全民「提供優質醫療服務」，及至「醫療通脹」。

在諮詢期期間，局長對私營醫療作出了一些有損害性而且沒有根據的評論，包括有指私營醫療收費欠缺透明度。但當私家醫院能仔細列出每項治療，甚至每片紗布的收費，周一嶽局長卻於二零零八年三月廿六日的一次會面中向香港醫學會承認，醫管局內各項程序的收費模式並不太清晰，因爲政府需要照顧到一些必要的服務，如培訓及社會安全網等，不計成本。他亦向傳媒表示，市民不信任私家醫生，但卻沒有解釋到爲何在不信任的情況下私家醫院床位仍然長期爆滿，亦沒有解釋到爲何公立醫院每一天都因醫療事故或遺失病人記錄而受到傳媒的追訪。

雖然，周局長在會議中重申，公營醫療定位於四項主要服務，而病人可以花時間去輪候公營服務或私下選擇私家服務，但從他隨後的行動，例如增加醫科學生數目，卻顯得前言不對後語。

現狀

市民沒必要認同有改變的需要。中原地產的施永青先生在香港公共醫療醫生協會週年晚宴的演辭中提及醫療改革，當時周一嶽局長及梁智鴻醫生亦有在場。施先生建議政府應參考房屋政策，只提供基本必需的醫療服務。若市民要求更高質素的服務，則要努力工作賺取所需，情況如私人房屋和樓宇。此舉可以確保市民爲更好的生活而工作，不會過份依賴政府。

在同一個議題下，嶺南大學的何濼生教授建議香港的公營醫療只提供『基本照顧』，並以邊際成本價格提供服務，由政府與各藥廠協商以統一價錢購買基本藥物。而優等之服務及藥物則由自由市場去提供。

何教授表示，一九八四年新加坡推行的 Medisave 計劃，衍生出一九九零年的 Medishield， 一九九三年的 Medifund，以至二零零二年的 Eldershield。如果我們相信百分之五的供款能解決問題，那我們只會步新加坡的後塵。同樣地，台灣的中央健康保障計劃令人關注到持續性和道德危機的問題，而自付費用要求亦引起公平的問題。

在同一個場合，我們提醒局長有關台灣的例子。台灣在三年前實施強制性保險，供款額爲百分之四，系統近乎破產，而政府需額外注資挽救，最後保費急升至百分之七。德國的供款額爲百分之十四。建議中的百分之三至百分之五並不可行，市民會被迫越墮越深，供款額不斷提升。上述國家都要求僱主負責最少一半的供款，但本諮詢文件中並沒有提及僱主的角色。

以二零零四年的數字爲例，香港的醫療開支爲港幣三百七十八億，佔全民生產總值的百分之二點九，若到了二零三三年，開支升至一千八百九十億，亦只是全民生產總值的百分之五點五，相比其他經濟合作與發展組織國家的平均百分之八點一還有相當距離。何濼生教授評論『醫療系統的持續可行是一個應該關注的問題，醫療開支在全民生產總值的比例有所提升，並不一定表示有存在問題，可能只是反映出社會需求的轉變』。

輔助融資方案

大部份我們曾經接觸及聽取意見的機構都表示反對強制私人醫保，這與業界的問卷調查結果吻合。中產人士一直以來都以自願性醫保來保障自己，要他們承擔這重擔並不公平。他們照顧自己健康的努力和承擔一直得不到嘉許。過去二十年，政府漠視社會的訴求，沒有去認定這些肯付出去減輕公共醫療負擔的市民，拒絕爲他們提供稅務優惠。強制私人醫保對中產人士是另一項懲罰，令一個原本只需繳交幾百元稅款的普通市民，額外繳付五千多元的醫療稅。

醫療儲蓄戶口若管理適宜，應可接受。但強積金的管理費用，浪費及回報卻令人擔憂。市民十心憂慮他們的積蓄是否管理完善。另外，如果供款只用作購買醫療保險，那長者未必有錢處理身後事，亦無權去運用戶口內的存款。一些醫生在媒體上表示，醫療儲蓄戶口所滾存的巨額款項，只會用作支付退休官員和基金經理的薪酬，最終由強制性醫療基金接手，採取吝嗇的管理模式，進一步限制病人的選擇和可使用的服務。市民將要分擔醫療開支，但卻沒有更多的選擇。

會董會曾與局方開會討論。有關人士告訴我們，醫管局內三至四成的病人屬弱勢社群及領取綜援，他們不需要任何付出。所以對象是其餘六成付款接受醫管局服務的人士。向強制醫保供款等同於支付全數醫療費用去維持醫管局。我們不相信強制醫保提供病人選擇使用私營醫療的機會，因供款額遠遠不足。最終，只會有更多參加強制醫保的病人被迫回流至醫管局，因他們供款以後再沒有多餘的金錢。又或是市民需要支付多於預期中的百分之五。除非政府承諾控制個人供款於百分之五以下，但她已斷然拒絕，否則市民需要供款達百分之十五才能足夠。

同一個標準，同一個方案

局方及某些醫生相信，私家醫生或會提供療效不高的治療方案，最好是依照醫管局所制定

的標準模式。

這正是香港醫學會所反對的。醫管局並沒有向病人提供選擇。當病人患上癌症或白血病，若經濟上不許可，他們只會得到標準治療。療效較好之藥物需要病人自費購買。治療類風濕性關節炎、腸癌及肺癌使用的 Biologics，慢性脊椎性白血病使用的 Glivec，乳癌使用的 Herceptin，只有能負擔的才能享用。年長人士中經常有眼底退化的情況。Anti-vascular endothelium growth factor 及 photodynamic therapy 是有顯著療效的藥物，但醫管局不會提供，除非病人能負擔每劑分別為八千元和一萬元的費用。領取綜援人士根本沒機會接受較佳的治療而導致失明，因他們沒法承擔昂貴的治療。當月更多病人因病導致失明之際，醫管局內的醫生都知道，醫院的撥款是不能夠由原先的用途轉移至其他有需要地方，縱然原先的計劃只是購買一些沒必要的電腦屏幕。強制醫保只會進一步惡化醫管局內病人的階級情況。

藥物名冊是對很多孤兒寡婦的詛咒，他們的摯親離世，只因他們不是領綜援人士，而又沒有能力負擔所需的治療藥物。

我們建議政府考慮自願性私人醫保計劃。雖然澳洲的模式在 11.18 段中被抹黑，盡數不足，但 11.13 段內卻有提及政府能做及應該做些什麼去推行自願性私人醫保計劃。

縱然私人醫保計劃經常收到投訴及缺憾處處，但香港政府從來沒有勇氣去監管。澳洲政府推行'Lifetime Health Cover'計劃，要求醫療基金收取相同的保費（以三十歲計），只要市民於三十歲前投保及其後繼續供款。香港政府應該及能夠效法。一個好的政府不應該容許不道德的保險公司及不公平的保險計劃去危害市民的健康。

澳洲政府向有買自願性私人醫保的長者提供相等於百分之三十保費的回贈。香港政府有五百億元資本在手，應該可以向有買自願性私人醫保的市民提供百分之五十的保費回贈。有了政府的供款，政府有權去審查及與保障公司協商一些更為道德及恰當的保險計劃。

這裏必須指出我們大部分會員都是支持自願私人醫療保險作為輔助融資的選擇。

我們特別關注諮詢文件的第 6.22 段建議*「公營界別適度提高其轄下私家服務的容量，並按收回十足成本的基礎收取費用。……提供這類私家服務，應有助公共醫療系統引進更多的資金，減輕其財政負擔。」*。如學者建議，政府需提供基本需要和讓自由市場去釐訂保費。醫管局作為基本醫療提供者，又同時參與私人市場服務，會予人不道德的感覺。我們希望這不是造就這諮詢文件的主要原因。

總結

香港醫學會支持額外撥款，以提升基層醫療服務的醫生提供全面的基層護理。

香港醫學會支持公私營醫療協作。前提是政府的衛生官員要對家庭醫學有正確的認識，能

在協商過程中容許適當的、互相尊重的談判。

香港醫學會支持共用電子醫療紀錄，使更有效地醫治我們的病人。同時，我們也支持以提供資訊爲目的的家庭醫生登記，但必須先得到大部分同業的支持，而且不能有人被拒於登記之門外。

香港醫學會不認同政府放棄酒稅和降低有鉅額利潤的大企業的利得稅。酒精會引發健康問題，最後造成更多額外的醫療問題。

香港醫學會不同意強制私人醫療保險和個人健康保險儲備。我們認爲當市民達到適當的年齡和有適當的需求時，應有絕對的權利決定如何使用他們的醫療儲蓄帳戶。戶口內的儲備金不應局限於購買醫療保險。

香港醫學會建議政府深入研究自願私人醫療保險作爲輔助融資，並動用儲備作起點，和提供退稅給予購買這些保險的人士以作獎勵。

香港醫學會堅持由政府監管保險業，以防止市民的儲備被那些欺詐的保單騙去。

香港醫學會會長
蔡堅醫生
二零零八年六月十三日

附件

香港醫學會
醫療改革意見調查

香港醫學會於本年五月向醫學界進行了一次關於醫療改革的意見調查，總共發出了 11,811 份問卷，截至六月五日爲止，共收回 1,852 份，其中 45 份爲醫學生或缺席會員，總體回覆率達 15.68%

結果:

1. 你是否同意醫管局的服務需要定位?
   百份之 95 同意，百份之 4 不同意及百份之一棄權。

2. 你是否同意需要作醫療融資?
   百份之 74 同意，百份之 24 不同意及百份之 2 棄權。

3. 你是否同意醫管局增加私家病床數目?
   百份之 59 不同意，百份之 40 同意及百份之一棄權。

4. 你是否同意”錢跟病人走”的原則?
   百份之 79 同意，百份之 17 不同意及百份之 4 棄權。

5. 你是否同意每年增加 400 個醫科生名額?
   百份之 84 不同意，百份之 14 同意及百份之 2 棄權。

6. 你是否同意政府應爲私營醫療市場定價?
   百份之 82 不同意，百份之 17 同意及百份之一棄權。

7. 你是否同意酌量增加稅收，如利得稅、印花稅、紅酒稅或煙草稅等可爲公營醫療提供額外融資?
   百份之 63 同意，百份之 36 不同意及百份之一棄權。

8. 你是否同意酌量增加醫管局的收費?
   百份之 92 同意，百份之 7 不同意及百份之一棄權。

9. 你是否同意個人需要爲未來醫療開支作儲蓄準備?
   百份之 92 同意，百份之 7 不同意及百份之一棄權。

10. 你是否同意政府應提供誘因令市民爲未來醫療開支作儲蓄準備?
    百份之 91 同意，百份之 8 不同意及百份之一棄權。

11. 你是否同意強制醫療儲蓄?
    百份之 59 不同意，百份之 40 同意及百份之一棄權。

12. 你是否同意政府應有政策鼓勵更多市民自願購買醫療保險?
    百份之 88 同意，百份之 11 不同意及百份之一棄權。

13. 你是否同意強制醫療保險是政府唯一可以控制保險公司的方法?
    百份之 83 不同意，百份之 15 同意及百份之 2 棄權。

14. 你是否同意強制醫療保險?
    百份之 66 不同意，百份之 32 同意及百份之 2 棄權。

15. 你是否同意私人執業醫生可在公營醫院/診所行醫或執教?
    百份之 71 同意，百份之 28 不同意及百份之一棄權。

16. 你是否同意公營醫生可在私家醫院/診所行醫或執教?
    百份之 54 同意，百份之 44 不同意及百份之二棄權。

<u>結論:</u>

關於醫管局的服務：

1. 百份之 95 的回覆者認爲醫管局應爲其服務定位。
2. 百份之 59 的回覆者反對醫管局增加其私家病床數目或提供更多私家服務。
3. 百份之 92 支持醫管局增加收費。
4. 百份之 71 支持容許私人執業醫生於公營醫院或診所行醫或執教。
5. 但祇有僅過半數的回覆者(百份之 54)支持容許公營醫生於私家醫院或診所行醫或執教。
6. 百份之 84 反對增加醫學生名額。

輔助醫療融資：
1. 百份之 74 認爲有需要進行輔助醫療融資。
2. 百份之 79 同意”錢跟病人走”的原則。
3. 百份之 82 的回覆者反對政府干預私營醫療市場收費。
4. 百份之 63 可以接受酌量增加稅收爲醫療服務提供額外資源。
5. 百份之 92 同意個人應爲自己將來之醫療開支作儲蓄，而約相同百份比(91%)之回覆者支持政府推出政策爲儲蓄者提供誘因，但百份之 59 卻反對強制醫療儲蓄。
6. 對於醫療保險，百份之 66 反對強制醫療保險，百份之 83 不認同強制醫療保險是唯一讓政府可以監管醫療保險公司的方法，而百份之 88 則認爲政府應推出政策鼓勵個人購買醫療保險。