

TOWARDS
BETTER
HEALTH

A CONSULTATION
DOCUMENT

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FOREWORD

"Global health has little to do with doctors and hospitals. The basic determinants of health are nutritious food, adequate shelter, clean water, elementary education (especially of women), being a non-smoker, and having access to low-cost, low-tech primary and preventive health services, which include immunization and family planning."

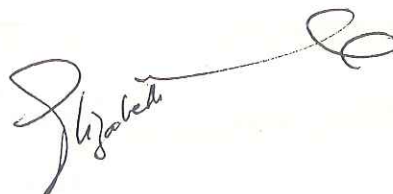
*The State of Health Atlas
Dr Judith Mackay*

Over the last two decades, healthcare in Hong Kong has evolved to be of a high standard and at a low cost to users. This evolution is a continual process : new goals are set and old boundaries redrawn. The 1974 Medical White Paper, the 1985 Scott Report and the 1990 Primary Health Care Report have all contributed to the impetus for change. Recent milestones include the setting up of the Hospital Authority and the Academy of Medicine.

This document takes stock of current services and fashions a possible response to community needs and future challenges building on the sound foundation of today. The medical profession's continuing quest for excellence and the community's rising aspirations have made it necessary to put in place a system capable of meeting these demands and sustaining the jet-speed technological advancement towards the 21st century. The road to reform is anything but smooth. However, we need to adjust to rapidly changing medical demography. Unless this is done, the quality of healthcare services in Hong Kong will deteriorate.

In charting the way forward, our emphasis is on removing remediable flaws; rationalising the financial structure of public health services and facilitating interface between the public and private sectors. We believe them to be the key issues for resolution and long term solution to many of the existing system's shortcomings. We have focussed on options which are practicable in Hong Kong, having regard to our time honoured policy that no one should be denied adequate medical treatment through lack of means. Our objective is to uphold this policy in the ideal of achieving efficiency in service delivery and performance; equity in access to care; income protection and freedom of choice for consumers.

We seek to put you, the consumer, first. This is your healthcare system. We will see your need through your eyes. Do let us have your views.



*Mrs Elizabeth Wong, ISO, JP
Secretary for Health and Welfare*

NEED FOR REFORM

Many of the world's healthcare systems are wrestling with difficulties concerning the accessibility, cost and efficiency of healthcare delivery.

Hong Kong is no exception. Whilst we have been successful in keeping our sizeable population healthy at a low cost, the need for change is, nevertheless, obvious. The pressure is greatest in the tertiary sector:

- . hospitals constitute a major component in Government's public healthcare expenditure
- . access is inequitable and unco-ordinated in both the public and private sectors
- . choice at affordable prices is lacking

The changing environment adds to the pressure for reform :

- . the population as a whole is ageing whilst the working population is decreasing proportionately
- . medical costs are rising at a rate faster than the growth rate of the economy;
- . public expectations about standards of medical care are rising

The meaning of reform and how you could benefit :

- . improved accessibility and better service
- . more choice for consumers at a price they can afford
- . improved environment for patients and providers
- . more cost-effective delivery of services
- . greater emphasis on preventive care
- . better interface between primary and tertiary care

The existing policy that no one should be denied adequate medical treatment through lack of means will remain paramount

KEYPOINTS

CHAPTER 1 The public and private sectors provide a wide range of medical and health services. In the public sector, these services are heavily subsidized, resulting in an ever-enlarging gulf between public and private sector fees.

CHAPTER 2 The healthcare environment is changing. This highlights the need for reform, particularly in the financing of our healthcare system.

CHAPTER 3 We must decide how best to invest in health services so that we can get the best possible health return. Any reform should be measured against the following objectives:

- . increased accessibility
- . more choice
- . better service
- . improved efficiency and cost-effectiveness
- . simpler administration

CHAPTER 4 We have identified five possible options as a way forward :

- . percentage subsidy approach
- . target group approach
- . co-ordinated voluntary insurance approach
- . compulsory comprehensive insurance approach
- . prioritization of treatment approach

In all this, there is a need to develop concurrently a culture of service.

CHAPTER 5 We aim to strike the right balance. Better healthcare for the community may come from a combination of approaches featuring:

- . different ways of charging and waiving
- . greater choice of accommodation
- . a co-ordinated approach to promote voluntary insurance

**The existing policy that no one should be denied
adequate medical treatment through lack of
means will remain paramount**

WHERE ARE WE NOW?

INTRODUCTION

There are reasons for the people of Hong Kong to be proud of its healthcare system. Our sizeable population of 5.75 million is served by a comprehensive range of medical facilities and healthcare services, many of which are of the world's best standards. In the public sector, government subsidy for health and medical services is substantial, thus making them accessible to the public. The health status of Hong Kong residents is good. The community's health statistics compare favourably with those of developed countries.¹ Obviously, much of this has to do with lifestyle and other social or cultural characteristics but the quantity and quality of healthcare services that people receive must also be relevant.

Table 1 : Comparison of health indicators

		<u>Hong Kong</u> (1991)	<u>U.S.A.</u> (1990)	<u>U.K.</u> (1990)	<u>Japan</u> (1989)	<u>Singapore</u> (1990)
Expectation of life at birth (years)	Male	75.1	72.1	72.9	75.9	72.1
	Female	80.6	79.0	78.5	81.8	76.8
		(1991)	(1989)	(1990)	(1989)	(1990)
Infant mortality rate (deaths per 1,000 live births)		6.4	9.7	7.9	4.6	6.7

Sources : Census & Statistics Department
Published statistics of relevant countries

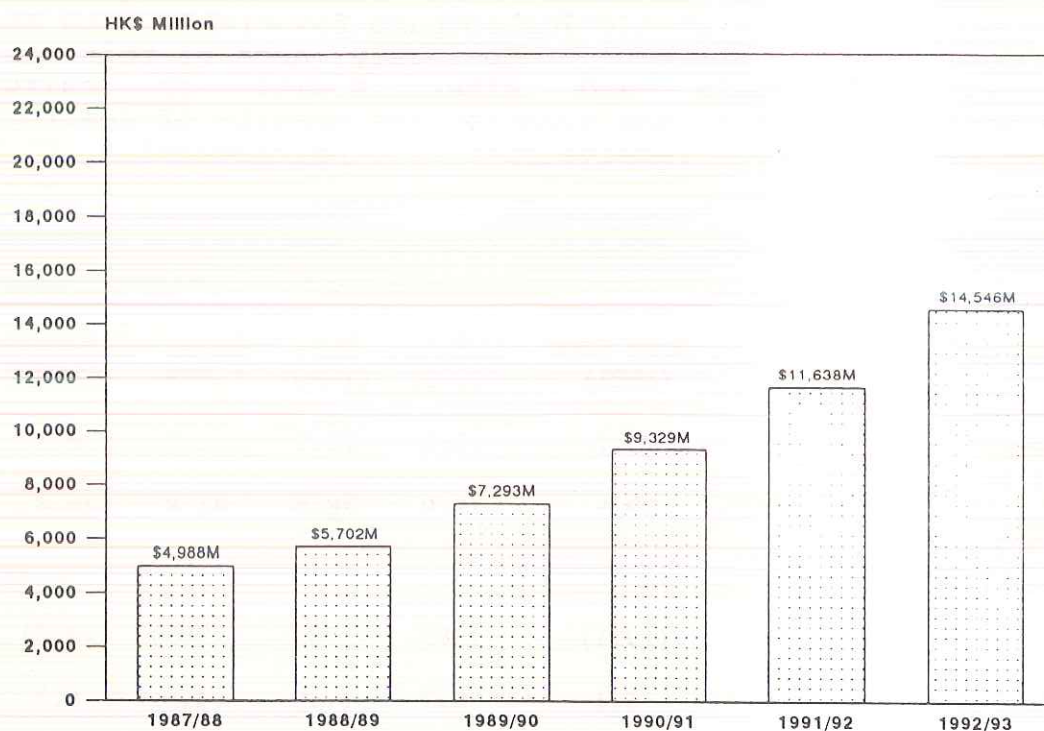
1.2 The Government has taken upon itself to safeguard and promote the general public health of the community as a whole and to ensure the provision of medical and health services to all.² It is committed to a policy enshrined

1 MACKAY, Judith, "The State of Health Atlas", Simon & Schuster Ltd., 1993

2 White Paper on the Further Development of Medical and Health Services in Hong Kong, July 1974

in law that no one should be prevented, through lack of means, from obtaining adequate medical treatment.³ The Government subsidizes heavily various healthcare services in fulfilment of this commitment. Public expenditure on healthcare in 1992/93 has tripled that of 1987/88 (Figure 1), representing an increase per capita from \$883 to \$2529.

Figure 1 : Public expenditure on healthcare
(at current market prices)
from 1987/88 to 1992/93 *



* fiscal year from 1 April to 31 March

Source : Financial Secretary's Budget Speech 1992/93

³ Section 4(d), Hospital Authority Ordinance

1.3 In terms of Gross Domestic Product, the Government and private sector together spend 3-4% of the GDP on healthcare every year.⁴ This excludes spending on infrastructural and supporting services. If these were included, Hong Kong's annual expenditure on healthcare would be about 6% of the GDP.⁵ While direct comparison of GDP expenditures is not always meaningful due to socio-economic differences, this figure approximates the reported figures of Japan and the United Kingdom.

THE PUBLIC SECTOR

Primary Health Care Services

1.4 As the health authority in Hong Kong, the Department of Health operates a wide range of primary health care services. Primary health care is participatory care : bad habits increase cost to the community. Primary health care can be promotive or preventive. It covers areas such as health education, family planning, maternal and child health, immunization and the treatment and control of diseases. These services are delivered through a network of clinics and health centres. Primary medical care is also part of primary health care. It is provided in the form of medical consultation and dispensary services in 68 general out-patient clinics throughout the territory.⁶ Other healthcare services include child assessment, the immunization of school children and occupational health services. A range of new screening programmes for women aged 45 and above and elderly persons aged 65 and above will be introduced in late 1993 and early 1994.

1.5 In 1991/92, there were 3,956,543 consultations at the Department of Health's general out-patient clinics⁷ and 766,623 consultations at the Hospital Authority's general out-patient clinics.⁸ According to a survey

4 Of this, 2.3% was public expenditure and 1.6% was private consumption in 1992/93.

5 HAY, Joel, "Health Care in Hong Kong - An Economic Policy Assessment", Chinese University Press, 1992, p. 11

6 12 of these clinics are run by the Hospital Authority; the rest by the Department of Health.

7 Department of Health statistics

8 Hospital Authority statistics

conducted in 1989, a fairly large proportion of the Department of Health's out-patients was elderly and from the lower-income group (32% over the age of 60; 23.1% having a personal monthly income of less than \$3,000).⁹

Hospital Services

1.6 There used to be a distinction between government and subvented hospitals, both of which were overseen by the Hospital Services Department. Since the establishment of the Hospital Authority in 1991, the dual system of government and subvented hospitals has been integrated into an independently administered system of public hospitals. The Hospital Authority is a statutory body operating outside the civil service. It is responsible for the overall management of public hospitals, whereas funding and overall policy continue to be the responsibility of Government.

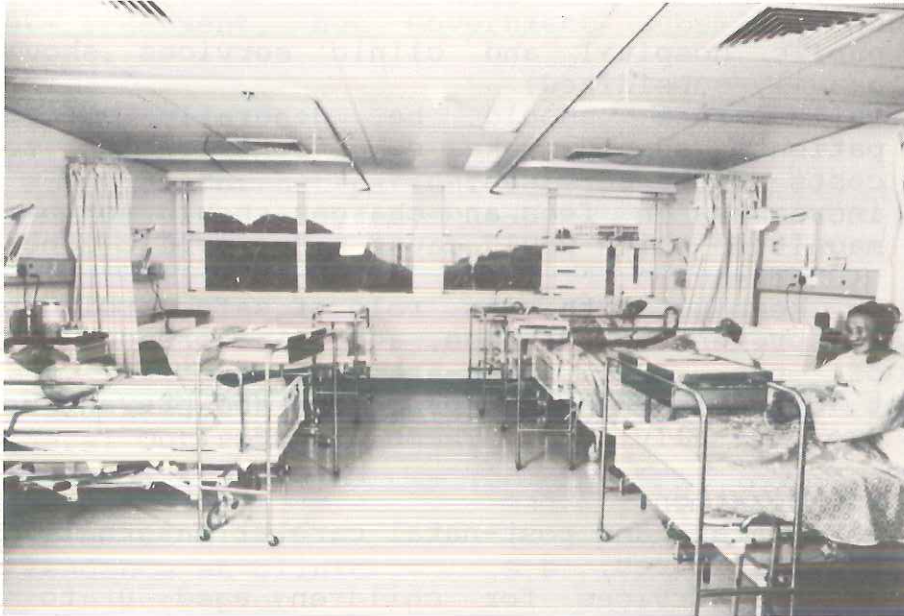
1.7 There are now 39 medical institutions under the management of the Hospital Authority. The network has a total of 21,684 beds, constituting some 84.8% of all hospital beds in Hong Kong.¹⁰ That alone represents a ratio of 3.8 public hospital beds per 1,000 population. In addition, there are about 1,000 hospital beds in Government institutions such as the Correctional Services Department. The types of services delivered through the various hospitals are acute/general, convalescent, rehabilitative, geriatric, general and specialist out-patient, hospice, community nursing and psychiatric. While the world trend is moving towards a decreasing requirement for hospital beds, Hong Kong's requirement is projected to increase. According to a review completed recently by Hospital Authority, there will be a projected requirement of 30,660 public hospital beds in Hong Kong by the year 2000. This compares with a total supply of 29,629 public hospital beds to be made available by projects in the pipeline representing a 4.92 public beds per 1,000 population by the turn of the century.

1.8 To rationalise the supply of beds and to optimize resources in service delivery, the concept of clustering and networking of hospitals and the redesignation of beds is being developed. Hospitals in a given geographical area are progressively networked to ensure cooperation and to avoid gaps and duplications. Surplus general beds are to be converted into infirmary beds and psychiatric beds.

⁹ Survey commissioned by the Working Party on Primary Health Care and conducted by the Department of Community Medicine, Hong Kong University, 1989

¹⁰ End-1991 figures

1.9 In 1991/92, a total of 665,729 in-patients were treated in the public hospitals. About 37% of the bed days were taken up by persons aged 65 and above. In the same year, there were 1,222,991 attendances at 12 accident and emergency departments. The number of attendances at the specialist out-patient clinics was 4,247,805. ¹¹



A New Ward in Queen Elizabeth Hospital

Dental Services

1.10 Government's focus on oral health is in prevention and education. Care and treatment are directed at specific groups in the community such as school children, residents in remote areas and patients with special needs. Emergency treatment is available to members of the public but is limited to relief purposes. For prevention, the Department of Health organizes oral health education activities that are essentially aimed at school children. The Prince Philip Dental Hospital receives cases suitable for teaching purposes or requiring specialist opinion beyond the scope of general practice. Staff and students at the hospital also provide oral health education programmes for schools and community organizations on request. Voluntary agencies provide another source of public sector service, often with the help of the Hong Kong Dental Association.

¹¹ Hong Kong Hospital Authority statistics

Fees and Charges

1.11 In keeping with the policy that no one should be denied adequate medical treatment through lack of means, and Government's commitment to safeguard and promote public health, the fees and charges for public healthcare services for entitled persons ¹² are set at levels which reflect the following considerations:

- (a) public hospital and clinic services should be heavily subsidized;
- (b) while fees should be generally affordable, patients should make some contribution to the costs of the services;
- (c) increases in fees and charges should not be of a magnitude which would cause undue public concern.

1.12 In keeping with its role of safeguarding public health and preventing disease, and in accordance with the spirit of the 1978 Alma-Ata Declaration ¹³, the Department of Health's health promotion and preventive care services are generally free. These include :

- (a) immunization;
- (b) ante-natal and post-natal care at Maternal & Child Health Centres;
- (c) health services for children aged 0 to 5 at Maternal & Child Health Centres;
- (d) preventive and promotive programmes for the control of communicable/non-communicable diseases;
- (e) consultation at Tuberculosis and Chest Clinics, Venereal Disease Clinics and Leprosy Clinics.

12 An entitled person must normally be a holder of a Hong Kong identity card or his or her children under the age of 11. Holders of United Kingdom passports are treated as entitled person by virtue of a reciprocal arrangement with the United Kingdom. By contrast, non-entitled persons are not eligible for subsidized medical treatment and must pay the full cost.

13 The International Conference on Primary Health Care, held at Alma-Ata, Kazakhstan, in September 1978, spelt out the responsibilities for world governments to achieve primary healthcare.

A nominal fee is charged for other preventive services, eg. \$1 for a visit to a Family Planning Clinic; \$10 annual enrolment fee for the School Dental Care Service.

1.13 The operating cost of the above services varies between \$100 and \$400 per attendance/consultation.

1.14 A fee is charged for general or specialist out-patient treatment, but Government subsidy is substantial (Table 2) :

Table 2 : Fees for out-patient services ¹⁴
(1992/93 figures)

	<u>Fee</u>	<u>Average Operating Cost</u>	<u>Subsidy</u>
(a) Attendance at a General Out-Patient Clinic	\$21	\$111	81%
(b) Attendance at a Specialist Clinic	\$33	\$313	89%
(c) Attendance at clinic for injection or dressing	\$ 9	\$ 39	77%

1.15 The fees for in-patient services are also highly subsidized and vary according to the type of hospital and the kind of ward occupied. The current fees per bed-day are as follows (Table 3) :

Table 3 : Daily fees for in-patient services in general ward (1992/93 figures)

	<u>Fee</u>	<u>Average Operating Cost</u>	<u>Subsidy</u>
Acute General Hospital	\$43	\$2,105	98%
Convalescent/Infirmary Hospital	\$43	\$ 910	95%
Psychiatric Hospital	\$43	\$ 429	90%

14 The fees are inclusive of prescriptions, X-rays and laboratory investigations.

While the average cost for a general ward bed in an acute general hospital is \$2,105 per day, some individual treatments can greatly exceed this. For example, the daily operating cost of a bed in an Intensive Care Unit could be many times higher, while a kidney transplant costs about \$200,000 including one year of follow-up care.

1.16 Fees for private wards in public hospitals are considerably higher and vary significantly between hospitals. In addition, private ward patients pay separately for professional services, treatment and procedures. However, public hospitals consist almost entirely of general ward beds. The daily fee of \$43 is inclusive of all medical services but is calculated only on the basis of the cost of catering.

1.17 Treatment at Accident and Emergency Departments is at present free, representing a 100% subsidy on the average operating cost of \$428 per patient.

Waiver

1.18 In order that no Hong Kong resident is denied adequate medical treatment through lack of means, designated officers in the Department of Health, Hospital Authority and Social Welfare Department are authorised in law to waive the medical fees of those who suffer genuine financial hardship.¹⁵ Fees and charges for hospital maintenance, attendance at general out-patient clinics, physiotherapy, occupational therapy, speech therapy, community nursing, community psychiatric nursing and the supply of prosthetic-orthotic appliances are among those that can be waived.

1.19 Applications for waiver are considered in the light of the patients' financial resources and factors relating to their health problems, such as the nature of illness, length of hospitalization and frequency of admissions. Waiver is granted to all public assistance recipients.

1.20 In 1991/92, the Hospital Authority waived 78% and 13% of its in-patient fees in psychiatric and non-psychiatric hospitals, respectively. The total amount waived was \$61,808,966, involving 56,003 individual patients. In the same year, its specialist out-patient clinics waived \$3,284,622 for 44,649 individual patients. For general out-patient clinics, \$117,166 was waived for

15 Section 38(2), Public Finance Ordinance

5,448 individual patients.¹⁶ The number of waivers in the Department of Health's general out-patient clinics in 1991/92 was 79,314, forgoing some \$1,179,502.¹⁷

THE PRIVATE SECTOR

Out-patient Consultation

1.21 About 65-70% of all out-patient consultations in Hong Kong are provided by private medical practitioners. Another 15% are provided by Government general out-patient clinics. The remainder are accounted for by other types of medical practitioners such as company doctors, and by traditional Chinese practitioners.¹⁸ Fees for private consultation vary between doctors, locations of practice and the treatments given. Such fees can be significantly higher than those charged at public clinics. According to the survey conducted by the Hong Kong Medical Association in June 1992, the range of private consultation fees is as follows (Table 4) :

Table 4 : Range of private consultation fees

	<u>Service</u>	<u>Charges</u>
General practitioners	Regular consultation	\$ 80 - \$300
	Extended consultation	\$100 - \$300
	Minor office procedure	\$157 - \$700
Specialists	Regular consultation	\$150 - \$ 517
	Extended consultation	\$200 - \$ 600
	Minor office procedure	\$315 - \$2000

Source : Hong Kong Medical Association, June 1992

16 Hospital Authority statistics

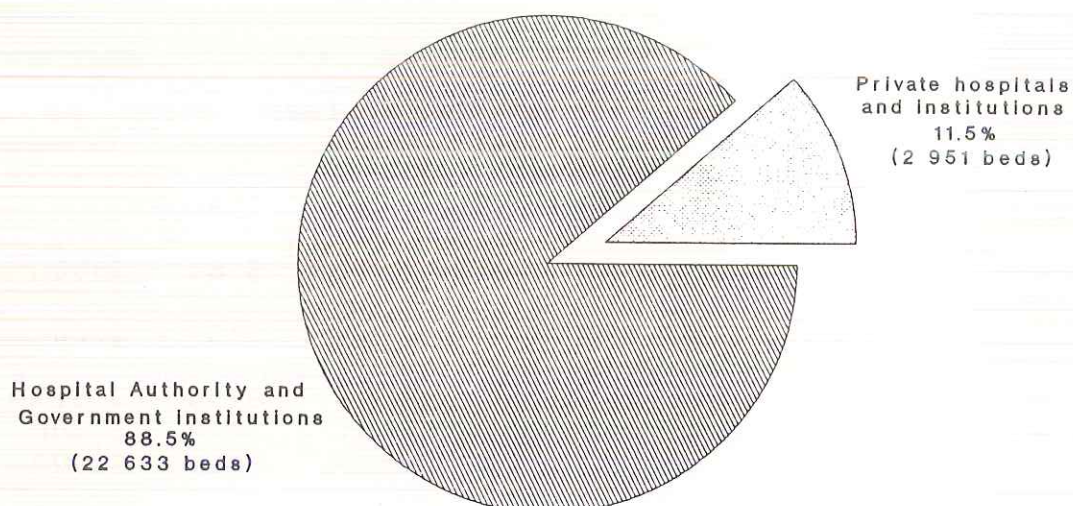
17 Department of Health statistics

18 First Quarter General Household Survey, 1989 by the Census and Statistics Department; survey commissioned by the Working Party on Primary Health Care conducted by the Department of Community Medicine, Hong Kong University, 1989

Private Hospitals

1.22 There are 11 private hospitals in Hong Kong. Together they account for less than 12% of all the hospital beds in the territory (Figure 2). While they operate independently of the Government, the Government has hitherto provided land at designated sites at nil or nominal premium for private hospitals. The range of services provided are generally less comprehensive than those in large public hospitals. However, most private hospitals have either established themselves in acute care or operate as up-market general hospitals with some specialization involving high-technology and expensive equipment.

**Figure 2 : Distribution of hospital beds
(end-1991 figures)**



Source : Hospital Authority and Department of Health statistics

1.23 There has been renewed interest in the operation of private hospitals recently, perhaps due to increased use of medical insurance. Applications are now being processed for two new private hospitals with an ultimate capacity of 1100 beds, a day surgical centre with 66 beds and a 500-bed extension to an existing private hospital. Unlike most existing private hospitals, the two new hospitals and day surgical centre will have their own resident staff instead of just offering hotel facilities for patients.

1.24 Fees in private hospitals vary considerably. The range of daily room and board charges in private hospitals is as follows (Table 5) :

Table 5 : Range of daily charges in private hospitals (room and board only)

\$1,000 - \$3,900	intensive care
\$ 800 - \$2,900	private room/VIP room
\$ 450 - \$1,100	semi-private room
\$ 180 - \$ 475	ward bed

Source : BUPA Limited, January 1993

1.25 The above are basic charges. They do not, for example, cover the costs of X-rays, clinical investigations, laboratory tests, dressings and medication and the use of the operation theatre, which can run to thousands of dollars. Doctors also charge separately for ward rounds and operations. The range of doctors' fees for services performed in private hospitals is indicated as follows (Table 6) :

Table 6 : Range of doctors' fees for services provided in private hospitals

General practitioners	Daily attendance	\$400 - \$1,500
	Bedside procedure	\$500 - \$3,000

Specialists	Daily attendance	\$ 600 - \$ 1,500
	Bedside procedure	\$ 500 - \$ 4,000
	Ultra-major operation	\$20,000 - \$120,000
	Major operation	\$10,000 - \$ 50,000
	Intermediate operation	\$ 6,000 - \$ 25,000
	Minor operation	\$ 2,000 - \$ 10,000

Source : Survey by Hong Kong Medical Association, June 1992

Some examples of surgical fees in private hospitals are given below (Table 7) :

Table 7 : Examples of surgical fees in Hong Kong

	Surgeon's Fee					
	Private Bed		Semi-Private Bed		Ward Bed	
	High	Low	High	Low	High	Low
	(\$)		(\$)		(\$)	
Appendicectomy	12,640	10,320	7,890	6,500	5,570	4,520
Caesarean Section	17,220	14,060	10,740	8,850	7,580	6,160
Simple Hernia	18,090	4,630	11,290	2,910	7,970	2,030
Corneal Grafting	37,060	25,810	23,120	16,240	16,320	11,310
Excision of Brain Tumour :						
supratentorial	43,600	35,600	27,200	22,400	19,200	15,600
infratentorial or posterior fossa	52,320	42,720	32,640	26,880	23,040	18,720

Source : The Medical Insurance Association of Hong Kong,
August 1991

Dental Services

1.26 As in the case of primary medical care, private practitioners provide the bulk of Hong Kong's oral healthcare. The dentist-population ratio varies widely from region to region but the availability of oral health services in the private sector appears to be generally adequate for the majority of the population on a territory-wide basis. However, most private practitioners are engaged in restorative and curative activities with little clinic time spent on preventive care. Private dental fees vary widely, depending on a number of factors. Generally, they are thought to be affordable.¹⁹

¹⁹ Report of the Dental Sub-committee, Medical Development Advisory Committee, 1991

Private Fees

1.27 Private medical fees are either borne out of the patient's personal finances, paid for by the employer as a fringe benefit or covered by insurance (either purchased privately or by the employer). It is believed that many large private companies have contractual arrangements with major medical group practices which, in turn, have links to certain hospitals to provide care for their employees. Despite the annual growth of about 40% in the private medical insurance market, a survey has indicated that only about 14% of the population is covered. Those insured are most likely to be male, better educated, employed and with relatively higher income. ²⁰

20 HAY, Joel, "Health Care in Hong Kong - An Economic Policy Assessment", The Chinese University Press, 1992, p. 25

HOW DOES THE PRESENT SYSTEM AFFECT US?

THE ISSUE

The distinct public and private sectors provide Hong Kong with a dual healthcare system with little interface. The public sector supplies a variety of primary healthcare services for the prevention and control of diseases. This reflects its responsibility for the maintenance of community health. It also gives treatment to out-patients at general and specialist clinics and to in-patients in public hospitals at a highly subsidized rate. This reflects its responsibility for providing a medical safety net for the less affluent. The private sector offers greater choice, less waiting time and more personal attention and comfort, but often charges significantly higher fees. Where both public and private sectors offer a similar service, a patient's choice between the two is often determined by how much he is prepared to pay or by how long he is willing to wait.

2.2 The issue to be addressed is how well the existing healthcare system will be able to meet the future expectations of the community as a whole as well as the needs of the individuals within it. This issue is particularly relevant given the changes in the environment in which healthcare is provided in Hong Kong. These changes are partly demographic, partly economic and partly social. They also bring into focus some of the problems already affecting the healthcare system.

THE CHANGING ENVIRONMENT

Ageing Population

2.3 One of the factors affecting the provision of healthcare is the age of the population. According to the 1991 Population Census, the median age of people of Hong Kong is now 32. This is expected to increase to 37 in 2001 and to 41 in 2011. At the upper end, the group who are aged 65 and above is also increasing. It is expected to rise from 8.8% of the total population (0.5 million) in 1991 to 11.6% (0.71 million) in 2001 and 12.3% (0.79 million) in 2011. (Table 8) The size of this population group is increasing at an average rate of 2.3% per annum. The rate of increase is even faster among those who are aged 70 and above. Their number is likely to double over the next 20 years, at which point they will have increased from 5.4% to 9% of the total population.

Table 8 : Elderly Population in Hong Kong

<u>Year</u>	<u>Total Population</u>	<u>Population 60 and over</u>	<u>% of Total</u>	<u>Population 65 and over</u>	<u>% of Total</u>	<u>Population 70 and over</u>	<u>% of Total</u>
1981	5,183,400	530,700	10.2	343,400	6.6	199,900	3.9
1991	5,686,600	741,100	13.0	500,000	8.8	309,000	5.4
2001	6,080,500	937,800	15.5	705,200	11.6	476,800	7.8
2011	6,479,800	1,172,400	18.1	794,300	12.3	580,900	9.0

Sources : 1. Hong Kong Population Projection, 1992-2011, Government Printer, Hong Kong, 1992
 2. Hong Kong Annual Digest of Statistics 1990 Edition, Census and Statistics Department, Hong Kong, 1990

2.4 Old age is often accompanied by deteriorating health and chronic illnesses. Modern medicine has increased life expectancy, but it does not necessarily improve the health of the elderly. One consequence of this is that elderly people will continue to consume healthcare resources for a longer period of time.

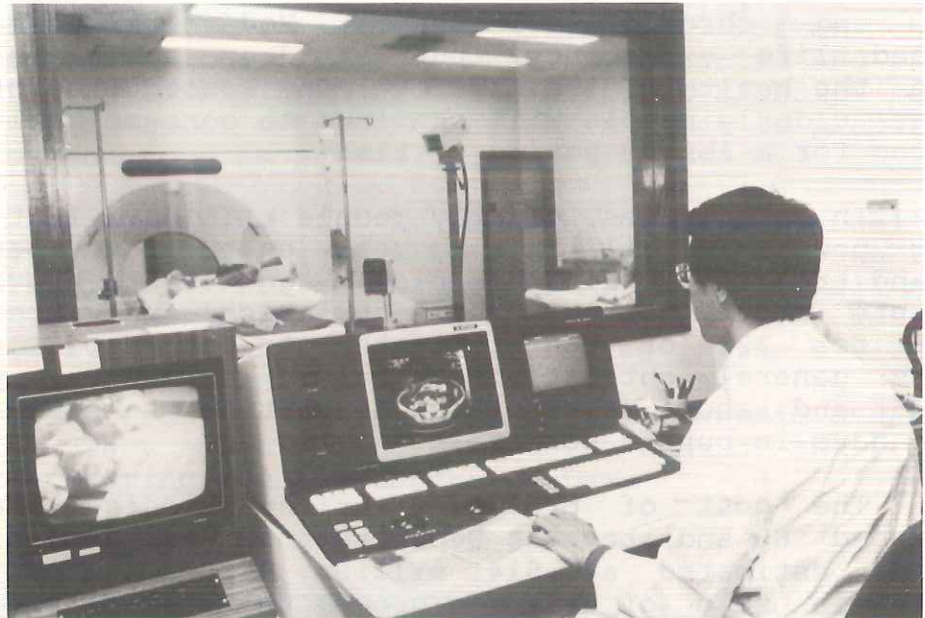
2.5 In most cases, elderly people will have lost their earning power and will have to rely on the Government for care and treatment. Although people aged 60 and above only constitute about 13% of the population, they presently account for 32% of the patients at the Department of Health's general out-patient clinics. Similarly, people aged 65 and above (8.8% of the population) take up 37% of the bed days in public hospitals.²¹

2.6 The cost of providing primary medical care to those aged 60 and above at Department of Health clinics in 1992 was estimated at \$141 million. Given the projected increase in size of this age group, the cost of providing the same service will be \$178 million in 2001 and \$223 million by 2011 at today's prices. This represents an increase in expenditure of 27% and 58%, respectively. Similarly, the cost of providing in-patient treatment to those aged 65 and above will increase from \$2,721 million in 1992 to \$3,838 million in 2001 and \$4,323 million in 2011 at today's prices. This represents a cost increase of 41% and 59%. Ways must be found to meet the needs of elderly people to whom society owes a debt of gratitude.

 21 See paragraphs 1.5 and 1.9 above

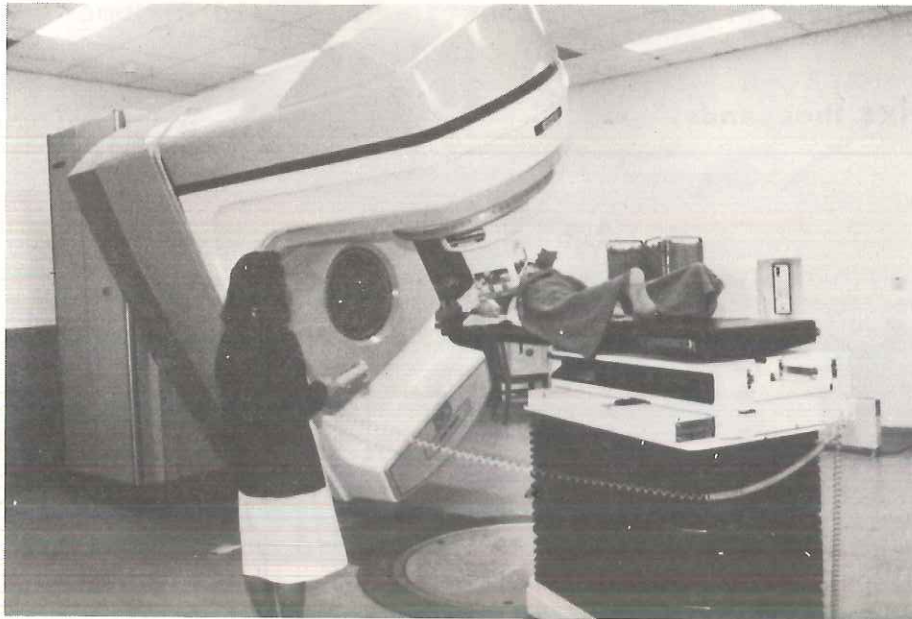
Rising Medical Costs and New Challenges

2.7 The medical field has seen tremendous innovations in the past two decades. New ways are being discovered to address previously untreatable conditions, while the treatment of other illnesses is becoming increasingly sophisticated. Both involve highly expensive drugs, procedures and equipment. Despite the considerable costs involved, the tendency is to use more of new technology as it develops. A typical example is organ transplantation, which is expensive to perform and requires the administration of expensive anti-rejection drugs for a long period after the operation. Even when new procedures are cheaper than those they replace, overall spending often rises because they are more widely used. The consequence is that the overall cost of providing medical care to the community as a whole will continue to spiral.



CAT Scanner
(Capital Cost : \$11.5M each;
Recurrent Cost : \$1M per annum)

2.8 The advancement of medical technology is a race against new challenges. With the discovery of diseases such as AIDS, new drugs and special treatments have to be developed. Where a disease imposes particularly hazardous health risks, extensive measures need to be taken to promote awareness and prevention among the public. There is a corresponding need to enhance understanding of and compassion for those who suffer the disease, and to ensure that they are not unfairly treated. All this requires substantial resources, from both Government and community as a whole.



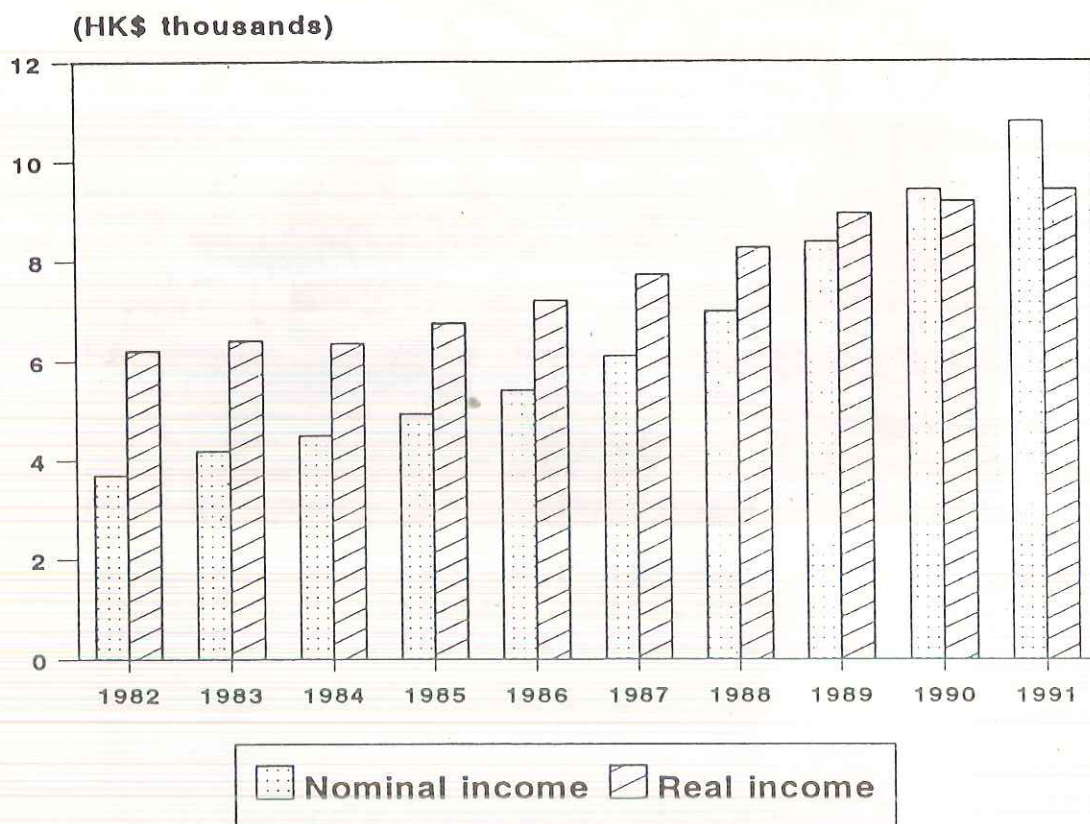
Linear Accelerator
(Capital Cost : \$8.15M each;
Recurrent Cost : \$733,000 per annum)

Rising Community Expectations

2.9 As real income rises, community expectations of goods and services rise. Consumers are willing to pay more for better quality and greater choice. This is partly due to better communication and awareness which have rendered it possible to make comparisons. The rise in expectation applies not only to conventional consumer products but also to things such as education, housing and healthcare. Indeed, there are indications that the people of Hong Kong are no longer content with some of the existing facilities and environment often associated with public hospitals and clinics.²²

22 In an independent survey commissioned by Radio Television Hong Kong in 1989, 45% of the respondents agreed that charges should be increased in order to improve the quality of Government medical services. Of those who agreed, 65% thought that in-patient charges should be increased while 55% agreed that there should be a fee for attendances at accident and emergency departments. Since 1989, fees and charges for Government medical services have not increased more than to cover inflation.

Figure 3 : Median monthly domestic household income



Source : Census and Statistics Department

EXISTING PROBLEMS

Overloading

2.10 Demographic changes, rising costs, new medical challenges and enhanced consumer expectations have all brought new pressures on the healthcare system. Until recently, hospitals were often lined with camp beds. Long queues still clog the clinics. That is a constant source of dissatisfaction to, and a point of complaint from, the public. Some of these problems are capable of solution by better management, and are being put right by the Hospital Authority. The Department of Health is also taking steps to make it more convenient and pleasant to visit its clinics, such as by shortening waiting time and improving the environment in waiting areas. Paradoxically, these improvements may exacerbate old problems by causing a new influx of patients from the private sector.



Camp Beds in Hospitals

2.11 A less apparent symptom of overloading is the appalling waiting time at specialist out-patient clinics. This is the number of days that a person has to wait for first attendance upon referral. It may be the result of inadequate manpower and resources but other possible causes include unnecessary referrals, lack of screening for urgent cases, poor organization of clinic time, low throughput of cases and one way referral from the private sector. The same reasons may explain the long waiting time for hospital admission or surgery.



Queuing Patients

Manpower Constraints

2.12 The problem of overloading has dampened the morale of healthcare staff who have to work long hours in a stressful environment. It has added to the problems of staff recruitment and retention. In response, a range of improvements has already been made to the pay and service conditions of doctors, nurses and supplementary medical professionals. Significant milestones have also been set in establishing the Hospital Authority and Hong Kong Academy of Medicine - for better management of hospitals and enhanced post-graduate training of doctors. Despite these efforts, it remains difficult to recruit and retain nurses. Detraction from tasks that nurses are trained for and engagement in non-professional and menial work have made nursing work relatively frustrating and unattractive. The manning ratios in hospitals are outdated and unsuitable for present-day application. Clearly, there is a need to re-orient and re-align duties, and to improve career prospects and training opportunities. Measures such as the introduction of Ward Stewards and Clinic Assistants to take up non-professional duties, and the development of a professional stream of Nurse Specialists, are only the first steps forward. More needs to be done as rapid advancement in medical technology requires greater professional skills and specialization. The Hospital Authority is currently finalising its manpower review. A comprehensive strategy and plan of action will be formulated upon completion of that review.

Inequitable Fee Structure

2.13 All public health services are heavily subsidized by Government. The level of subsidy reaches 80% or more of the costs in most cases. The rest is covered by an all-inclusive fee at a flat rate. The rationale is that the public sector acts as a safety net for those who are less fortunate and that no one would be denied adequate treatment through lack of means. In practice, even those who can afford to pay more than the token fee use the highly subsidized services, particularly hospital services. Moreover, the fact that public health services are cheap to the patient may not be conducive to public awareness of the high cost of maintaining community health.

Lack of Choice

2.14 Private hospitals offer a choice of accommodation but their generally high fees ²³ have forced many into

23 See Tables 5, 6 and 7

public hospitals, which consist almost entirely of general ward beds. However, many of these patients are able and willing to pay more than \$43 a day for better accommodation and greater privacy. As it is, they have no choice but to stay in a general ward, at a highly subsidized rate.

Lack of Interface

2.15 The dual healthcare system sharply separates the public from private sector and inhibits interface between them. An example is that some advanced equipment may be under-utilized in one hospital while similar facilities are being stretched to their limit elsewhere. A better and more efficient system of referral needs to be instituted.

THE PRIVATE SECTOR

2.16 Most of problems discussed above concern the public sector. But the private sector also has its problems. Specialists charge high fees because the demand for their services exceeds the supply of expertise available. There is need for more specialists to be trained. This will be addressed by the new Hong Kong Academy of Medicine. At the same time, the lack of a fee schedule and the perceived excessive charging tend to be the focus of criticism by the public. The absence of a fee schedule has also made it difficult for the medical insurance industry to devise a standard premium schedule or to offer the public unlimited cover. Generally, it is believed that the high cost of private medicine has limited patients' choice and accessibility to private hospital care. While it may not be appropriate for Government to set fees for the private sector, there appears to be a case in the interest of consumer protection for the profession to publish a fee schedule.

WHERE DO WE GO FROM HERE?

NEED FOR REFORM

Government consistently spends around 9% of its annual budget on healthcare. For public institutions, the apparent solution to the problems described in chapter 2 is to increase resources. Indeed, having regard to overall growth of the Hong Kong economy and the financial needs of other equally important policy areas such as education, housing, transport and security, it is Government's plan to raise the recurrent spending on healthcare by 22% in real terms over the next five years.²⁴

3.2 However, medical costs have in the past increased faster than the overall growth rate of the economy. This trend is likely to continue. It is therefore clear that the above increase in Government spending alone will not be enough to solve the problems of our healthcare system or to achieve the kind of improvements that the community expects. We need not only to spend more, but also to spend more efficiently and cost-effectively.

3.3 At present, our existing healthcare system has too narrow a financial base and there is not enough interface between public and private sector providers. Unless there is a restructuring of the way that public healthcare services are financed and a new mechanism to enable the private sector to provide more services that are affordable by the public, the quality of healthcare services in Hong Kong is likely to deteriorate.

3.4 The need for change is particularly evident in the public hospital sector which constitutes the system's major component. Many of the issues affecting that sector are attributable to how services are priced, paid and delivered. The ratio and distribution of public and private sector services are also relevant. These problems defy simple solutions such as raising the recurrent expenditure on health. In the long run, reform of a more extensive nature is necessary in order that there may be real improvement in healthcare services.

24 "Our Next Five Years - The Agenda For Hong Kong", address by the Governor at the opening of the 1992/93 session of the Legislative Council on 7 October 1992, Government Printer

3.5 Hong Kong is not alone in having to reform its healthcare system. It is a major preoccupation in 18 out of 24 OECD²⁵ countries and, indeed, a priority issue for the new U.S. administration. Other countries such as the U.K. and New Zealand have also found it necessary to review their own system. Some of the forces for change are common the world over. Among them are the ageing of the population and escalation of medical costs. Other reasons for reform differ from country to country. In general, the trend is towards a convergence between government financed and operated systems and multi-player, free-market systems. Primarily public sector systems are incorporating private sector elements while privately based systems are experimenting with greater public regulation. Detailed proposals for change vary according to the perceived imperfections of a country's system.

3.6 In Hong Kong, the setting up of the Hospital Authority marked the beginning of long-term reform. It is envisaged that by separating the funder and provider of medical care, and by integrating public hospital services under one independent authority, the delivery of public sector services will become more efficient. The time has come to address the deeper, structural problems affecting the healthcare system. It is in order that steps be taken to widen the range of services, improve their standard and make them more readily available to the public. This is in keeping with the aspirations of the community and healthcare professionals.

OBJECTIVES

3.7 The problems described in Chapter 2 concern the mechanical side of healthcare. Reform needs to be holistic. It should aim to deliver quality in both environmental and human terms. An ideal healthcare system should offer the following features :

- * increased accessibility
- * more choice
- * better service
- * improved efficiency and cost-effectiveness
- * simpler administration

25 Organization for Economic and Cultural Development

Each of these features is explained below, with a brief assessment of the existing healthcare system. Some of these features conflict with each other. The best system will be the one which strikes the right balance to meet the needs of the community, individual users and service providers. The ultimate aim must be to reduce waiting time to enable individuals with urgent healthcare needs to be treated early and also to ensure equity in financing to the effect that those who have greater ability to pay will be subsidized less. Examination of the available options is the subject of the next chapter.

Increased Accessibility

3.8 Healthcare should be accessible. This is a restatement of the policy that no one should be prevented from obtaining adequate medical treatment through lack of means.

3.9 At present, general opinion is that accessibility to public hospital services needs to be improved. Despite low fees, long waiting time has always been a problem for patients. Yet, in the absence of widespread use of medical insurance, private hospitals are expensive and may be inaccessible to many. The existing system therefore does not provide patients with adequate access to hospital services.

3.10 In contrast, primary medical care, provided largely by the private sector, is generally affordable. The essence of primary healthcare is participatory care and involves interface for delivering care in the community.

3.11 The aim of reform should be to improve accessibility to both the public and private sectors while continuing to provide a safety net for those patients with lack of means.

More Choice

3.12 Real choice implies options that are affordable. In the present context, the emphasis is not so much on the kind and quality of medical treatment, which is often advanced by international standards, but the manner and environment in which treatment is given. As Hong Kong becomes more affluent, it is considered desirable that the system moves from providing basic but medically sufficient services to a greater emphasis on convenience, privacy and comfort to meet community aspiration.

3.13 In the private sector, where fees are generally higher, patients have a choice of doctors and the levels of hospital accommodation. Within the public sector, patients may choose which general out-patient clinic to attend but

have no choice of doctor. Public hospitals offer little choice of accommodation to cater for patients with different demands and abilities to pay.

3.14 The aim of reform should be to give patients more freedom of choice particularly with regard to hospital accommodation and environment.

Better Service

3.15 Patients are consumers and have the right to expect good service from healthcare providers. The existing healthcare system has been accused of being impersonal with insufficient human touch. Provider-patient relationships need to be improved.

3.16 The aim of reform should be to instill a patient-oriented culture of service, with greater community participation so that providers are more in touch with what users need. Measures are continually being taken by the Hospital Authority and Department of Health to achieve this.

Improved Efficiency and Cost-effectiveness

3.17 This means the effective and economical delivery of healthcare services and giving the community and individual users good value for money. It also means containing costs to a level which the community can afford. It implies a greater degree of competition among providers.

3.18 Hitherto, the public sector has contained costs by putting a cap on annual expenditure. When faced with rising demand, this approach causes the quality of service to suffer unless this cap is lifted. This is a particular problem in the hospital sector, where costs are greater and are more affected by new and expensive technology.

3.19 The aim of reform should be to facilitate greater efficiency in use of resources and thus cost containment. The question of costs is not simply about how much each institution spends. Cost shifts and community spending as a whole must be closely scrutinized so that it can be kept at a manageable level. Regard should be had to the financial implications for service providers, consumers and third party financiers (eg. insurance companies) collectively when charting the course of reform.

3.20 Interface within the public sector needs to be improved. For example, patients whose condition has been stabilised in specialist out-patient clinics should be referred back to general out-patient clinics for follow-up,

where operating costs are lower. Better information management systems and patients' records can help to achieve this. At the same time, there should be greater sharing of facilities between public and private sectors, so as to maximise usage.

Simpler Administration

3.21 Simplicity in administration has many advantages such as low costs, high responsiveness and increased efficiency in the delivery of service. Complex administration leads to red-tape, bureaucratic attitudes and increased costs.

3.22 Public sector facilities are constrained by the need to adhere to bureaucratic procedures, although Hospital Authority can now enjoy greater flexibility than before. Compared with a system for reimbursement, the predominance of payment by patients at the point of use helps to reduce overheads and simplify administration in both public and private sectors. A move towards a "paper-less" system relying heavily on computerisation will further reduce paperwork. Computerisation in the public sector will also facilitate better patient records and drug labelling without adding to administrative complexity.

3.23 The aim of reform should be to make improvements to the healthcare system without adding to administrative complexity which would undermine cost savings, efficiency and user-friendliness.

HOW DO WE GET THERE?

OPTIONS

As mentioned in paragraph 3.3, in order for it to be effective, any reform of Hong Kong's healthcare system must be directed at restructuring the way that public healthcare services are financed as well as improving access to (and interface with) private sector services.

4.2 In charting the course of reform, Government has had the benefit of advice from two working parties: the Medical Insurance Study Group and the Health and Welfare Services Review Committee on Fees and Waiver. Members of the working parties came from different walks of life bringing much expertise and insight from the fields of medicine, insurance, business management, law, accountancy, tertiary education and consumer protection. Their recommendations, which have been separately publicised, form the basis of some of the options that are now offered for consultation. Apart from local experience, Government has drawn reference from the agenda for change in overseas countries including the UK, USA, Canada, New Zealand, Australia and Singapore.

4.3 Government has identified five possible options (plus variations) to reform the existing dual system. For convenience, these are referred to as :

- (a) the percentage subsidy approach
- (b) the target group approach
- (c) the co-ordinated voluntary insurance approach
- (d) the compulsory comprehensive insurance approach
- (e) the prioritization of treatment approach

(a) and (b) are ways of fee charging and waiver; (c) and (d) are ways of funding health services for the community; (e) is a way of allocating resources. The approaches are not mutually exclusive. Different combinations of charging, funding and allocation approaches form possible options.

4.4 Given the inadequacies facing the existing public hospital system, maintaining the status quo in public hospitals is not a viable option for the future. This has therefore not been included among the approaches to be discussed in this chapter. In contrast, the public primary health care system is generally working well. It attracts about 15% of those in need of primary medical care, a fairly large section of whom are elderly or from the lower income groups. ²⁶

²⁶ See paragraphs 1.5 and 1.21

OPTION A :

PERCENTAGE SUBSIDY APPROACH

4.5 At present, the fee for a general ward bed in a public hospital is \$43 per day, inclusive of accommodation, food and all medical attendance and treatment (such as drugs, laboratory tests and surgery). The fee reflects only the cost of catering and bears little relationship to the actual cost of providing the service. The real cost ranges from \$429 per day in a psychiatric hospital to \$2,105 per day in an acute general hospital. The amount of Government subsidy thus varies from 90.0% to to 98.0%. Most patients are unaware of the real cost or the level of subsidy given. All patients in public hospitals are given the same level of subsidy irrespective of their financial needs.

4.6 Under the percentage subsidy approach, the operating cost of each type of hospital would be subsidized to the same percentage. To increase patient awareness, the operating cost and subsidy would be printed on each patient's bill. Depending on the percentage of subsidy, the corresponding daily fees charged would be as illustrated below (Table 9) :

Table 9 : Comparison of daily fees for general ward under different subsidy scenarios (1992/93 figures)

Type of Hospital	Operating Cost	General Ward Fees assuming			
		95% Subsidy	90% Subsidy	85% Subsidy	80% Subsidy
Acute general	\$2,105	\$105	\$210	\$316	\$421
Convalescent/ infirmary	\$ 910	\$ 46	\$ 91	\$137	\$182
Psychiatric	\$ 429	\$ 21	\$ 43	\$ 64	\$ 86

The above approach was advocated in the Scott Report ²⁷, which recommended that the percentage of overall cost

²⁷ The commissioned report on the delivery of medical services in hospitals by W. D. Scott Pty. Co., submitted to Government in December 1985.

recovery could progressively increase to 15-20%. At 15% cost recovery, the fee would only represent less than 2.8% of the median annual household income.²⁸ A waiver system would be retained for the benefit of those who could not afford to pay.

Pros

4.7 The percentage subsidy approach can be argued as an equitable way of financing the public hospital system. It subsidizes less those who are better able to pay while fees would be waived for those who cannot afford to pay. It is also a rational way of charging. Instead of paying for just the cost of catering, as is the present system, users of public hospital services would be contributing to the cost of treatment. Moreover, long-stay patients in psychiatric and convalescent/infirmity hospitals would be paying less than short-stay patients in acute general hospitals. This approach has the additional advantage of making both patients and healthcare professionals more conscious of costs, which is conducive to overall cost containment. Finally, retaining a flat fee per day, as opposed to charging on the basis of individual treatment, keeps the administrative system simple.

Cons

4.8 Healthcare is an important Government responsibility. The raising of fees in acute general hospitals, even if offset by reduction in other types of hospital and despite the existence of a waiver system, might be seen by some as a weakening of Government's commitment to ensure the provision of health services to all. Furthermore, an increase in revenue from higher fees might be accompanied by an increase in the number of waiver applications. More importantly, the fixed subsidy approach does not go far enough on its own to rid the system of some of its existing problems. In particular, there is no extra choice of services and the way which public healthcare is financed from general tax revenue remains narrowly based.

28 The figure of 2.8% was based on the median length of stay in a public hospital of 4.4 nights, 1989 level of fees and a median domestic household income of \$100,000 per annum. These were the findings of a survey commissioned by the Provisional Hospital Authority in 1989. Given that hospital fees have only been increased in line with inflation since then, the figure should be about the same now.

OPTION B :

TARGET GROUP APPROACH

4.9 The target group approach consists of two major elements, plus an option for waiver :

- (a) semi-private rooms in public hospitals
- (b) itemised charging
- (c) target waiver groups

Among other things, it is aimed at providing patients with greater choice in public hospitals while achieving greater equity in financing in the public sector generally. In other words, government subsidy is targetted more accurately to those in need.

4.10 Semi-private rooms constitute a standard of accommodation between unsubsidized private wards and heavily-subsidized general wards. They aim to combine greater privacy, convenience and comfort with affordability. Semi-private rooms could accommodate six to eight patients each. They could be equipped with a television, telephone and en-suite bathroom. There could be a choice of meals and flexible visiting arrangements. Permission could also be given for employment of private nurses and helpers. However, there would be no preferential treatment over general ward patients either in terms of choice of doctors or priority for elective surgery. Access to, and quality of, medical services would be the same for all patients.

4.11 In return, a flat rate fee would be charged. This could be set at, say, 40% or 60% of the operating cost per bed day and the rest would be subsidized by Government. Depending on the percentage of subsidy, the corresponding daily fees charged would be as illustrated below (Table 10) :

Table 10 : Comparison of daily fees for semi-private rooms under different subsidy scenarios (1992/93 figures)

<u>Type of Hospital</u>	<u>Operating Cost</u>	<u>Semi-private Room Fees assuming</u>	
		<u>60% Subsidy</u>	<u>40% Subsidy</u>
Acute/General	\$2,105	\$842	\$1,263
Convalescent/ Infirmary	\$ 910	\$364	\$ 546
Psychiatric	\$ 429	\$172	\$ 257

Given the typical length of stay in a public hospital of 4.4 nights ²⁹, the average cost of hospitalization in a semi-private room in an acute/general hospital would be about \$3,705 at 60% subsidy and \$5,557 at 40% subsidy. These figures can be measured for affordability against statistics on household income for a sample of in-patients (Table 11).

Table 11 : In-patients by monthly household income

Monthly household income (\$)	Type of hospitals			
	Public		Private	
	No. of patients ('000)	%	No. of patients ('000)	%
Less than 4,000	4.9	5.6	0.6	1.6
4,000 - 5,999	10.7	12.2	1.6	4.5
6,000 - 7,999	16.5	18.8	2.0	5.8
8,000 - 9,999	9.4	10.7	3.4	9.9
10,000 - 13,999	18.1	20.6	6.1	17.7
14,000 - 17,999	9.8	11.1	5.6	16.0
18,000 - 29,999	13.9	15.8	9.1	26.4
30,000 and over	4.5	5.1	6.3	18.1
Total	87.9	100.0	34.6	100.0
Median (\$)	10,552		16,615	

Source : Census and Statistics Department, 1991

4.12 It should be emphasised that choosing a semi-private room would rest entirely with the patient. No one would be forced to occupy a semi-private room. If a

²⁹ Provisional Hospital Authority survey, 1989; see footnote 28.

patient demanded a general ward bed and none was available, the patient would be given a semi-private room at the general ward fee until such a bed became available.

4.13 It is estimated that some 2,000 beds could initially be made available for semi-private rooms. Actual provision would be assessed against prevailing demand.

4.14 Itemised charging entails imposing a fee on certain procedures that are now included in the flat fee charged. The purpose is to reflect more accurately the extra cost in providing specific services and to contain the overall cost to the general tax-payer :

(a) *admission charge in hospitals*

According to a study by the Hospital Authority in 1992, the cost for the first day of an in-patient's hospitalization is 2.3 times more expensive than for the rest of his stay. This is because of the disproportionate number of procedures that have to be performed on the first day. Moreover, 31% of all the stays are less than two days. Hospitalization is unnecessary in most of these cases. An admission charge, say, of \$100, may go some way to meet the marginal cost.

(b) *first referral to specialist clinic*

A first-time registration fee of, say, \$50 could be charged to offset part of the additional cost associated with extra tests and procedures required for first attendance.

(c) *drug charge at specialist clinics*

At present, there is a considerable wastage of expensive drugs at specialist clinics as patients often do not comply with the prescription. A per prescription or per item charge to be worked out is likely to instil greater cost-awareness among patients.

(d) *use of accident and emergency service*

At present, the service is free. Since the treatment provided and associated costs are similar to those in specialist clinics, the same level of fee might be appropriate. The principle of charging for accident and emergency services exists in other countries, eg. Canada and Singapore.

In all the above cases, the level of the extra charges would be carefully considered with regard to patients' affordability. Waiver would also be available to those with genuine financial hardship.

4.15 Target waiver groups involves identifying groups of patients according to income profile. Groups which generally have less ability to pay are granted automatic waiver without having to apply for it on each occasion. Possible target groups are :

- (a) Public Assistance recipients - full waiver (as is the current practice)
- (b) Disability Allowance recipients - partial waiver
- (c) Persons aged 70 years and above in receipt of Old Age Allowance - partial waiver
- (d) Unemployed chronically ill patients - partial waiver

Actual target groups and percentages of waiver would need to be determined by careful survey. Discretionary waiver on application would be retained for other categories of patients.

Pros

4.16 The target group approach is conducive to greater equity in public healthcare financing. It achieves this by diverting public subsidy from those who are willing and able to pay more for greater personal comfort to those in financial need. By introducing semi-private rooms, a real choice is made available to those who demand something better than general ward accommodation but for whom top range hospital care may be too expensive. Semi-private rooms also facilitate healthy competition with private hospitals and encourage subscription to private medical insurance. It is possible that the level of fees charged for semi-private rooms would serve as a benchmark for the private sector. These developments may, in the long run, attract patients away from the public system, thus lessening the burden on the public sector. For those who cannot afford or are unwilling to pay for semi-private rooms, the general wards will continue to ensure that public hospitals remain accessible. Finally, the target group approach builds on the existing system. It is administratively simple to implement and effective in containing costs. The target waiver groups option reduces the administrative cost of having to process waiver applications on an individual basis.

Cons

4.17 There are two major criticisms of the target group approach. Both of them concern semi-private rooms. First, it is said that semi-private rooms may create a reverse flow of patients into public hospitals, thereby straining the system further. Second, semi-private rooms may be created at the expense of the number of general ward beds. Neither of these concerns is valid since the market mechanism will indicate the appropriate level of fees and number of beds to be made available. Moreover, no one will be compelled to opt for a semi-private room.

OPTION C :

CO-ORDINATED VOLUNTARY INSURANCE APPROACH

4.18 Insurance is a science of spreading risks. The idea of insurance is that if a large number of people pays money into a pool, the money can be drawn from the pool to ease the hardship of the people who might suffer losses. The co-ordinated voluntary insurance approach involves relatively little Government intervention. It consists of a framework whereby private insurance companies could compete with each other in greater openness and transparency to users. They would do so by submitting medical insurance plans for approval by a designated body which could be statutory. Approval would only be given if a plan met certain criteria for adequacy of coverage and appropriateness of premium. Approval would serve as a kind of quality assurance for consumers. No one, however, would be forced to take out insurance. Where someone took out insurance, the premium could be paid by him or by his employer as a fringe benefit.

4.19 Not all medical insurance plans would be subject to approval. Plans involving only private sector facilities would be exempt; they would however be considered by the approving body upon request. Where a plan involves public facilities, whether or not in conjunction with private sector facilities, it would have to have the designated body's approval before being marketed. This body would comprise the insurance industry, the medical profession and consumer interests. It is not intended to duplicate the existing functions of the Office of the Commissioner of Insurance. Other operational details will have to be worked out by the statutory body to be set up.

Pros

4.20 For subscribers, the greatest advantage of this approach is the assurance that the coverage and corresponding premium of an approved plan have received independent endorsement. In addition, competition between the insurance companies would enhance choice and keep base premiums competitive. For those who could not or did not wish to take out insurance, heavily subsidized public services would still be available. More generally, this approach is simple to administer. It has the potential for directing a significant portion of patients away from the public sector, thus providing easier access for those who need heavily subsidized services. The burden of financing healthcare would be more evenly distributed between Government and those who are better able to look after

themselves. This approach may facilitate interface between the public and private sectors, particularly in the use of expensive equipment, and reduce the segregation that the present dual system causes.

Cons

4.21 All commercially run insurance plans are risk-rated, which means that the level of premiums reflects the relative likelihood of the insured person to claim for benefits, and those who are likely to be heavy users of the service may encounter difficulty in obtaining cover. As a result, most high-risk groups would fall back on the public system for treatment. Containment measures notwithstanding, the introduction of any insurance scheme would unavoidably lead to an increase in healthcare expenditure, both in the public and private sectors. A lot would go to the costs of administration. Moreover, the number of subscriptions is likely to fluctuate according to the economic situation. These factors must be carefully considered to ensure that the costs do not outweigh the benefits.

OPTION D :

COMPULSORY COMPREHENSIVE INSURANCE APPROACH

4.22 This approach involves compelling all households in Hong Kong to participate in a medical insurance scheme. The scheme is centrally administered with Government or a statutory body set up specifically for that purpose as the central insurer. This is to avoid risk-rating, denial of coverage and other problems common to the insurance industry. Having a central insurer should also provide economy of scale to reduce premiums. The insurance would cover primary and hospital care, in both public and private sectors, up to a certain standard. Under this approach, public sector providers would pursue a more vigorous cost recovery strategy. Participants in the scheme would be free to purchase supplementary insurance from private medical insurance companies to upgrade the level of benefit.

4.23 A number of variations to the above approach are possible, turning on who pays the premium, the scope of coverage and the framework of the scheme. The insurance premium could be set at the same rate for everybody or vary according to age and risk. Or premium could be fixed at a percentage of income. It could be paid by Government and/or participants and/or employers. Those unable to afford the premium could be subsidized by Government or by other premium payers. The central insurer could also assume the role of sole provider of services, thus eliminating the private sector and creating a public sector monopoly or "nationalised" health service. Alternatively, the central insurer could be concerned only with finances. Public sector facilities could be "privatised" and Government could contract out services to independent providers. Instead of being required to join a central scheme, all participants could be required to purchase private insurance providing a specified level of cover. Or participants might be required to join a "health maintenance organization" or "sickness fund association" which will be responsible for providing direct or contracted-out treatment for their members.

Pros

4.24 The compulsory comprehensive insurance approach provides basic coverage for everyone. Where the level of premium is income-related, it is a comparatively equitable way of financing healthcare as it is based on cost sharing. The means by which public sector services are financed will be broadened if employers are required to contribute to their workers' premium.

Cons

4.25 The major problems of compulsory and/or centralised insurance are both structural and practical. If employers were required to insure all their workers, it would encourage bunching of individual policies with uneven spread of premiums. It represents an open-ended commitment to employers which could fracture the market. Any additional requirement to cover the workers' families and children would further add to cost. Moreover, companies with older and less healthy workers would have to pay higher insurance premiums which would make them less competitive. These workers might become targets of discrimination and dismissal. Unemployed workers, together with the sick and elderly, would have to have their premiums paid by the Government.

4.26 Medical insurance is seldom portable. The lack of portability frustrates mobility of workers. Conversely, the current high mobility of Hong Kong workers would make a compulsory employer contributory scheme difficult and costly to administer.

4.27 A compulsory comprehensive insurance approach would overturn the existing dual system and could prove very disruptive. The start-up cost of a public insurance scheme involving some 5.75 million people is enormous. Once the scheme is established, particularly where the Government pays part of the premium, public expenditure on healthcare will escalate; that is, unless the percentage of cost recovery for services is increased drastically, in which case there will be an upward surge in overall spending by the community as a whole without attendant better health. Experience elsewhere has also shown that universal and comprehensive coverage will lead to over-utilization (particularly on curative services in primary healthcare) and therefore cost escalations. A ceiling on reimbursement may be set but given the high cost of modern medical technology, its practical effect is questionable. The cost of a single procedure may exceed the ceiling so it is those who require expensive treatment who will suffer. Over-utilization will also affect the system's accessibility by prolonging waiting times and lowering standards. Where there is a public sector monopoly, choice of services is likely to be limited and patients are likely to be subject to "rationing" through waiting lists. Finally, the compulsory insurance approach is based very much on the idea of "collectivism" which some developed countries have tried and sought to abandon.

OPTION E :

THE PRIORITIZATION OF TREATMENT APPROACH

4.28 Government's policy that no one should be denied adequate medical treatment means that nobody is ever turned away from a public facility -- they just join the queue and wait for their turn. This has resulted in overloading and long waiting times. One way to overcome this problem would be for Hospital Authority and the Department of Health to list medical conditions and treatments in order of priority and fund them according to available resources. Treatment would not be given to low-priority conditions. Resources would be concentrated on treating patients with higher priority conditions. ³⁰

Pros

4.29 This approach means that patients with the same medical condition would, as a group, either be eligible or not eligible to receive treatment. It also gives higher priority to patients with greater "need". The approach contains costs by capping them and providing only those services can be afforded within the budget allocated. Furthermore, this approach reflects community value judgment on healthcare priorities.

Cons

4.30 The major objection to this approach is that it redefines what is "adequate medical treatment" and departs from the existing policy by deliberately turning away patients with low-priority conditions. It may be medically and ethically controversial to determine priorities. Need is based on contentious "Quality of Life" measurements. A balance has to be struck between value to society and value to the individual. For example, given the limited pool of resources and if the total cost is the same, whether it is more worthwhile to improve the health of many people through inexpensive treatment or to save the life of one person through expensive treatment. Extensive public consultation will be required on a periodic basis to determine the community's priorities.

³⁰ This approach has been experimented with in the American state of Oregon as the "Medicaid Demonstration Project", commonly called "The Oregon Plan".

CULTURE OF SERVICE

4.31 This is a feature which underpins an attempt to improve the healthcare system. It reinforces material effectiveness by creating an atmosphere that is friendly, caring and sensitive to the feelings of patients. This can only be achieved through an attitude change among healthcare professionals.

4.32 The Hospital Authority and Department of Health are committed to a range of improvements to make the public sector more user-friendly. They will declare and make progressive improvements on maximum waiting time for treatment. Qualified staff will be available to provide helpful and courteous service to patients. Drugs will be labelled and records kept to provide a continuum of care for better patient management. Patients' rights to confidentiality and to know their medical condition and treatment will be assured. Standards will be made explicit, so that users will know what to reasonably expect and can complain if the declared standards are not met. Deficiencies can then be more readily identified and corrected.

4.33 The medical profession has also been responsive to the call to be more patient-oriented. It has published a list of "patients rights and responsibilities" in conjunction with the Consumer Council. This is a significant step forward in safeguarding consumer interests in the use of healthcare services.

4.34 Through various performance pledges, service targets and professional initiatives, a deeper sense of trust, cooperation and general well-being can be forged between users and providers of healthcare.

4.35 To enhance transparency and partnership, community leaders and members of the public are involved in the governing bodies at all levels of the Hospital Authority. The Authority is further developing its public complaints machinery and patient feedback system for greater responsiveness of service to patient needs. It is also establishing links with community groups and volunteers to enlist greater public participation in providing support to patients during the course of their treatment.

COMMUNITY PARTICIPATION

4.36 Primary health care is participatory care. Government will intensify its health education programme to promote self-care and individual participation in maintaining

a healthy lifestyle. The District Health System has already been introduced on a pilot basis in Kwun Tong to facilitate interface among service providers and to encourage community participation in health promotion. Among the 100 or so private practitioners in the district, 30 have responded positively to the initiative. Some of them are taking part in a disease surveillance survey and health promotion activities in the area. This system will be further developed and extended. Meanwhile, the Department of Health is exploring ways to foster closer collaboration with private healthcare professionals through a system of shared care and partnership in clinic services. The development of polyclinics in public housing estates by providing basic clinic premises to private practitioners at market rent has been identified as one option. By imposing conditions such as operating hours and the range and standard of services, local quality care can be guaranteed. Moreover, such arrangements should aim at facilitating group practice which has the advantages of reducing costs, providing peer review and enabling doctors to take leave for further training. Finally, family medicine has been recognised as a specialty in the Department of Health. The Education and Training Centre for Family Medicine at Ngau Tau Kok now provides vocational training and continuing education to government doctors but has the potential to develop into a training centre for practitioners in both the public and private sectors.

HOW CAN WE HELP ONE ANOTHER?

It is a truism that the cost of medical care is ultimately borne by the public no matter what system of financial structure is adopted. The cost falls either on the community or on individuals.

5.2 In the foregoing chapters, we have reviewed Hong Kong's healthcare system and identified its problems. We have set the criteria for possible reform and measured the existing system against them. We have found the provision of primary health and primary medical care generally adequate. This can be explained by the low cost of preventive and minor curative treatment, and the extensive use of private sector facilities for that purpose. The same cannot be said of hospital treatment. It is often expensive which means that most people can and do obtain it through public institutions at a substantial rate of subsidy. Within the existing dual system, the public sector remains the major provider of hospital services. The ensuing problems have made it necessary to concentrate reform in this area.

5.3 The proposed approaches to reform are the result of collective wisdom and take into account a wide variety of community interests including consumers' interest. Our main concern is to facilitate universal accessibility and cost-effectiveness. Of the five approaches offered for consultation, the Government prefers a combination of the target group approach and the percentage subsidy approach. Without repeating the full arguments, this has the advantage of continuity in maintaining heavily-subsidized public hospital services for general ward patients while providing greater choice through the introduction of semi-private rooms. Meanwhile, the fee system would be rationalised and the waiver system improved for those who need it. At least half the extra income generated through increases in fees will be retained by the Hospital Authority according to existing administrative arrangements. We also favour the introduction of a co-ordinated voluntary insurance scheme as a framework within which the target group approach and percentage subsidy approach can operate more effectively. Coupled with Government's plan to raise recurrent spending on healthcare by 22% in real terms over the next five years, these will put public sector services on a sound financial basis for the future.

5.4 The preceding paragraphs only serve to explain Government's present thinking with the help of experts. Your views are equally important. We consider the reform of Hong Kong's healthcare system very much a partnership programme. Your participation in this consultation exercise is essential. It is only with a system which best serves your needs that the challenges of healthcare in the 21st Century can be met.

Our Mission is to Serve

YOU

Please write with your comments to the following address
before 30 September 1993 :

Secretary for Health And Welfare
P.O. Box 8 1 3 8
General Post Office
H O N G K O N G

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