Business and Professionals Federation of Hong Kong
香港工商專業聯會

BPF Response to
Health Care Reform Consultation Document –
"Your Health Your Life"

Executive Summary

The vision of Government is to achieve a health care system that improves the state of health and quality of life of our people and provides health care protection for every member of the community.

BPF fully supports the Government in realising this vision. In our response to the Health Care Reform Consultation Document, "Your Health Your Life", we submit our views on how this can be achieved, on the need for a better public understanding of the benefits, on the values and principles to be applied, and on funding options.

We emphasise in particular:-

1. The structure and governance of ***primary and preventative care*** for the whole community by both public and private providers are the immediate priority and key to reform.

2. A ***multi disciplinary team approach*** to primary care and prevention is the best way forward.

3. Implementation of structural reform should not be impeded by delay in agreeing the form of or in introducing supplementary financing.

4. ***Resource planning*** is a major challenge.

5. A clear understanding of the details and means of achieving reform supported by a bench marked ***implementation programme***, and financial projections with an explanation of how supplementary funding will facilitate change will be essential to gain public support at the next stage of consultation.

6. It is essential that any supplementary funding be ***risk pooled***.

7. Any publicly sponsored funding must be ***mandatory***.

8. Only some form of mandatory insurance or taxation meet these criteria. Any savings element, if incorporated can only be a vehicle for enforcing self responsibility and purchasing insurance particularly post retirement.

9. A ***community wide publicly sponsored health system*** embracing both primary and secondary care should be the goal.

10. Employment based funding and benefits, if adopted, should be only as a first stage towards a community wide scheme in which those not in employment and unable to contribute should be subsidised.

11. This can be achieved by ***re-routing existing producer based government funding*** through purchaser funding.

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1. Introduction

The BPF is glad to have an opportunity to respond to the Healthcare Reform Consultation document, "Your Health Your Life". Our response is consistent with previous submissions made by us on health care reform. These submissions are attached as appendices.

Whilst the main focus of the consultation is on financing options we emphasise that the essential structural refocusing and regulation of our health care system, most especially the ***delivery and nature of patient centred primary care, must drive the reform process***. The need to broaden the base of health care financing on a more stable footing is important, but the options now under discussion should be seen as a tool to facilitate reform rather than an end in themselves.

It has been apparent from the community debate during the consultation period that there remains a widespread lack of understanding on why the structural reforms are necessary, how they can benefit the community and why supplementary financing is needed. Among those who acknowledge the benefits of shifting emphasis to community based care and prevention, there remain strong doubts as to how this will be achieved, when the benefits can be expected to emerge, and what role supplementary financing will have in achieving this.

It will be critical at the next stage of consultation to address both the details and means of achieving reform and to support this with a benchmarked implementation programme over the next 5 to 10 years together with both capital and recurrent financial projections, illustrating the vital role of supplementary financing and how new fund flows will be the key levers of change.

Our response addresses three areas

- Key Structural Issues
- Values and Principles
- Commentary on Funding Options

2. Key Structural Issues

We have highlighted that the crux of reform to Hong Kong's health system is structural reform. We continue to favour the linkage of structural and financial reforms, recognizing that new financing mechanisms can be used to drive structural changes. We urge however that any ***delay in reaching consensus on supplementary funding should not be allowed to impede or slow down the implementation of structural reform***, the financing of which can, as an interim measure, be achieved from current surplus.

BPF gives its full support to all the structural initiatives outlined in the consultation paper, not the least the idea of a family doctor registry, the task force to develop electronic health record sharing, and the earlier announced medical vouchers for elderly.

In this response we wish to focus on four aspects of structural reform

- Governance
- Primary Care and Prevention
- Hospitals
- Resources planning

2.1 Governance

From the outset we have emphasised that our current system of governance, weighted as it is to the delivery of public hospital based secondary care and the promotion of prevention by Government, which excludes stakeholders from overall coordination and oversight of the primary sector cannot deliver the reform which is needed. In our earlier submissions we have proposed a Health Commission to oversee the operation of a single health system for Hong Kong. Increasingly however we have come to the view that the short to medium term challenge is the need to focus on ***better governance of our primary care and prevention sectors***. In our last submission to Government we identified the need for a ***Primary Care Authority*** and we remain convinced that this is the immediate priority. Leadership will be critical and, as it will necessarily be a statutory body, it can only be established after due process. Meanwhile the emphasis should be on introducing ***measures which act as levers for change*** and we repeat our earlier recommendation that these be undertaken by a provisional body or task force.

Integrating our public and private sector health care in both secondary and primary care under one governance umbrella should be the ultimate objective.

For the next five to ten years, however, setting priorities for quality control, cost control and resource planning are the priorities for the primary and prevention sectors. For this ***a new structure involving stakeholders is essential***. The existing structure of governance for public secondary care should be refocussed on improving its own delivery, establishing and overseeing common delivery standards for hospitals in both the public and private sectors, upgrading its pricing and costing mechanisms, preparing a higher proportion of purchaser based funding and building communication channels with the primary care sector.

We are continuing our studies on an appropriate governance structure, both for the immediate future and in the longer term and will be making a separate submission to Government on this vitally important issue.

2.2 Primary Care and Prevention

Primary care and prevention for the whole community by both public and private providers are the immediate priority for reform.

We have already expressed our support for the initiatives outlined in this consultation paper and at this stage only wish to highlight four areas which we feel have not been adequately addressed. We also strongly recommend that the ***December 1990 Report of the Working Party on Primary Health Care entitled Health For All – The Way Ahead*** be revisited and reviewed.

2.2.1 Introduction of multidisciplinary team approach by pilot projects

In our earlier submission we recommended to you the importance of a multidisciplinary team approach to the delivery of primary care and proposed that the best approach to the introduction of a network such multidisciplinary clinics on a district basis throughout Hong Kong would be through ***a series of pilot projects commissioned by Government using private sector resources***. This approach is not covered in the consultation document. The centres of excellence, which are mentioned, will operate at a quite different level. We therefore urge that greater emphasis be placed on this team patient centred approach.

2.2.2 Register of doctors

We recommend that the registry of doctors which you propose be designated as a ***register of primary care doctors***, rather than the more restrictive term “family

doctor". It should be an ***inclusive*** register and incorporate ***grandfathering*** and ***long term training requirements*** adopting a similar pattern to that implemented by TCM practitioners. The team approach we are recommending will greatly facilitate the scheduling of training and back up arrangements, which are seen as a major problem for those in sole practice.

2.2.3 Prevention

The second area which concerns us is how prevention can be drawn into the mainstream of primary care delivery. Whilst the Government has already announced earlier the introduction of medical vouchers for the elderly, the consultation paper is largely silent on this issue.

2.2.4 Drugs

The consultation paper makes no reference to issues relating to drugs. The appropriate use of drugs, particularly as a means of prevention of illness and in the avoidance of hospitalisation, is a core element in primary care.

We have previously made a specific recommendation on the need to address this issue of ***the availability and cost of drugs as an essential part of the strategy to deter inappropriate use of public hospital outpatient facilities***.

Other issues relating to drugs which should be addressed are the need for a ***community wide formulary***, the ***regulation of pharmacies***, which is currently inadequate and, in the longer term, the separation of prescription and dispensing of medicines.

The viability of any new structure for primary care will be dependant on measures to regulate the affordability, reliability and quality of drugs, while maintaining control over costs and appropriate levels of usage. These controls are currently minimal outside the public hospital area.

We hope that these four important aspects of primary care will be fleshed out in the next round of consultation. We stress again the need then to present the public a more detailed time table of achievement objectives, how they will be implemented, what are the financial implications and what will be the beneficial outcomes to patients.

2.3 Hospitals

We wish to reiterate that we do not see the need at this stage to make any substantial change to the structure of governance of public hospitals. We have already indicated where we believe some of these priorities should be and repeat the need for common standards of quality and delivery between public and private hospitals.

Logic dictates that at some stage the ***Hospital Authority should reduce its involvement in the delivery of primary care*** through the GOPC structure and transfer the responsibility and governance to a new Primary Care Authority. Leaving them under Hospital Authority control would expose them to lower resource priority in times of financial constraint and fuel a two tier approach to the delivery of primary care.

2.4 Resource Planning

Since lack of adequately or appropriately trained professionals threatens to be the biggest constraint in introducing structural change ***resource planning and in particular human resource planning are a critical governance issue***.

The scale of the challenge is enormous and cannot, we submit, be addressed within existing structures either of professional training or land policy.

If the projections in the consultation document prove to be valid, they will necessitate a doubling of the professionally trained manpower in the health sector over the next 25 years. Given that the training period for a professional is up to 10 years, this is a formidable undertaking that requires long term planning and must commence urgently. In addition to the urgent need to augment skills in health care administration, of which Hong Kong currently suffers a serious shortage, there will be growing needs in primary care, nursing and care of the aged both at tertiary and vocational levels, including voluntary carers. Moving patients from the public to the private sector will very quickly highlight the inadequacy of resources in the private sector, and the training bottleneck that results from in our current professionally protective training environment. We therefore urge Government as a matter of extreme urgency to establish ***a high level across department task force*** to examine future human resource requirements in all areas of health care delivery and how these can be met both by accelerated training and by ***a more open approach to the importation of skilled personnel***. Likewise existing controls on the availability and release of affordable land for hospitals, clinics and care homes will impose a major constraint on the restructuring of our health system unless specific measures are adopted to address this issue.

3. Values and Principles

We agree that the core values and principles are at the heart of reform. They should govern both the method of public and government mandated financing and the structure of the system.

We outline below our views on the most important of these values.

3.1 Universal Access

It is a universal feature of health care systems in the developed world that the same level and quality of publicly sponsored and financed essential health care is available to the whole community, whether these services are delivered by public or private providers. Other services of environmental (e.g. private wards), cosmetic or non-essential nature are for the individual to choose and pay for.

We are particularly concerned that Hong Kong should not exchange its current two tier system, in which public funding and governance is concentrated in public hospital care leaving primary care to the market place, with ***another two tier system***, which perpetuates different levels of services and choice for publicly mandated health care to different sectors of the community. This ***could only serve in the long run to exacerbate the division between rich and poor and undermine harmony in society***. Nor do we believe it is either morally or practically tenable to legislate for these differentiations.

However, to the extent that choice of service provider, whether public or private, may be part of the reform objective, we recognise that the limited resources and facilities available in the private sector will constrain the extent to which such choice can be widely offered at the initial stages. ***A staged approach to universal access*** may be the answer but we strongly urge that the ultimate goal must be universal access.

3.2 Self Responsibility

A large majority of health systems in the developed world include ***copayment*** features in publicly provided health care to encourage self responsibility and to inhibit overuse of the system. Whilst we do not consider copayment as a single, major source of formal supplementary financing, we believe that copayment should be part of any new supplementary financing system. With the introduction of choice and to encourage a shift to private sector services, there must be an ***increase in public sector fees and a reduction in private sector fees*** those who can afford to pay to create a more level

playing field. Failure to address this will perpetuate a positive disincentive for patients to change existing usage of the public system. In future much greater emphasis should be placed on a ***capping of total fees*** over a specific time period to ensure continued affordability of public health care.

3.3 Risk Pooling

No matter what is the source of public funding for community health care, it must incorporate a pooling of the health risk ***across the whole spectrum of the community***. It is impossible for Government to meet its commitment to provide the same level and quality of health care to all without this pooling concept. This can only be achieved in two ways. The first method is through risk pooling at the level of funding, whether this be tax, social insurance, or universal private insurance. The second which removes risk from the individual is for Government to take responsibility for major "one off" or cumulative exposure through capping or a catastrophe safety net. Some form of separately funded catastrophe pool could be an option for future consideration but is not suggested at this stage of financing reform. These two methods should not be regarded as mutually exclusive.

3.4 Mandatory

While the public resistance to mandatory financing is understandable, ***any publicly sponsored system of financing must by definition be mandatory***. The only exception to this could be through opt out, whereby individuals are given a choice to opt out of the public system in totality and make their own provision for health care. Selective or partial opt out cannot be an option. The BPF does not support the concept of opt out.

3.5 Employer Involvement

This must be considered at two levels: employment as the base for funding and employer responsibility to contribute to health care cost. BPF is on record as regarding ***employment based funding only as a stage towards the introduction of community wide funding solutions***. Experience elsewhere has shown this privileged approach as a permanent funding base fuels the creation of an underclass in health care. Labour mobility both within Hong Kong and across borders exacerbates this problem. ***We also do not see the merit of mandatory employer contributions***. We regard this as a hypothecated employment tax which would act as a disincentive to voluntary top up benefits for employees. Neither is it conducive to self responsibility. We do however support the use of corporate record systems (especially those created

for MPF purposes) as a mechanism for channeling individual contributions.

Whatever supplementary funding system is introduced, the provision of suitable health care benefits (whether total or top up) for employees and their families, in conjunction with voluntary insurance should be encouraged, through incentives for employers and employees.

3.6 Wealth Distribution

Whilst the desirability of seeking a community solution points to clear answers on the above principles this is not the case with wealth distribution.

Wealth distribution is already inherent in our current tax based financing and a major factor in Hong Kong's ability to provide a health care safety net which is of world class standard for the poor and disadvantaged.

Whether any new government sponsored supplementary funding mechanism should be wealth distributive is, in the final analysis, a matter of political choice. On balance the ***BPF preference is for a system of supplementary funding which emphasises personal responsibility for health care protected by risk pooling*** over one in which the rich take greater responsibility for the poor. We have however in the past recommended and would still support hypothecating a portion of any future GST to health care financing. This would of course be wealth distributive in effect.

4. Commentary on Funding Options

Before commenting on the six funding options, we emphasise the importance of Hong Kong ***moving to a stable financing platform for health care***. As recent experience has shown, current funding, of which over 80% either is linked to current government revenue or out of pocket expenditure, is too heavily at the mercy of the volatility of economic cycles.

Therefore whilst one option will probably be selected as the government sponsored supplementary financing mechanism, others such as voluntary insurance and out of pocket expenditure will continue to play a major role in overall funding. We illustrate this with a possible future funding mix in the Appendix. Taxation, whether general or hypothecated, has not featured in the six options other than social insurance in Option 1. We do not think this should be excluded from consideration. As already indicated we continue to support GST as a potential future option.

4.1 Social Health Insurance

This approach is widely adopted for health care financing and is an option for Hong Kong, if consensus cannot be reached on a mandatory private insurance solution.

The consultation paper indicates that social health insurance is earnings or employment linked. This is common, particularly where social health insurance is the main source of health care funding, but it is not the only option for social insurance, particularly for Hong Kong when our current tax system already provides earnings based redistribution. As a preferred alternative, a centrally administered social insurance system ***can be based on a standard insurance benefit with a standard community risk pooled rate and subsidies for low income groups***. This is similar to mandatory private insurance with government acting either as manager of the pool and/or as insurer. As with mandatory private insurance, ***significant copayment and tight control of purchasing of health care are essential*** to combat over usage. The experience of Taiwan which operates such a scheme highlights the fundamental importance of managing demand.

4.2 Out of Pocket

Out of pocket expenses are an important element in health funding both in the purchase of elective health care beyond the scope of a public system and through copayment as an ***essential tool to inhibit over usage***. We have already commented that public sector fees are too low in this context, notwithstanding that the revenue generated will not significantly enhance public funding. There is no doubt that out of pocket important expenditure though it is, cannot be a main source of supplementary funding.

4.3 Medical Savings

We have mixed feelings about the value of medical savings. They are not a feature of any funding system other than Singapore which does not have a similar low cost public safety net to Hong Kong, making them a major feature there in ensuring public access to fully priced public secondary care.

We recognise their merit in encouraging self responsibility for health care, but the fact that they are personal savings ***not risk pooled*** limits their value as a provision for major illness in old age creating a potentially false sense of security. We also question the logic of separating health provision for old age from general provision for old age through ***MPF***, given that health care expenses are already a major cost element in old

age. Our preference would be for a more comprehensive and separate review of the MPF system and contributions. This would include consideration of the extent to which a proportion of retirement benefits should be retained to meet medical expenses and health insurance, possibly isolating the costs of extreme old age for separate treatment.

Except to the extent that they may be used to purchase insurance, medical savings are not a funding mechanism for health care per se, and as such cannot on their own represent a public funding option.

4.4 Voluntary Health Insurance

We have already made the point that voluntary insurance ***cannot be part of any publicly sponsored system of supplementary financing***, which by definition must be mandatory and community risk pooled. Voluntary insurance, particularly that purchased through employers, already contributes 12% of health care financing and has exerted major influence over the structure of primary care in Hong Kong. Going forward employers and the insurance industry, suitably regulated, have a big role to play in promoting wider usage of voluntary 'top up' health insurance and in building a medical insurance industry better able to influence, even to participate in providing quality health care.

4.5 Mandatory Health Insurance

We have recommended this in the past and believe that a ***core element in any supplementary funding must either be mandatory insurance – whether provided by the insurance industry or by government – or taxation***.

The merits of mandatory health insurance are that it provides ***a community risk pool*** and, if based on a mandatory package of government approval benefits, is ***relatively simple***. It eliminates the major disadvantages in voluntary insurance of exclusive risk pools limited to the healthy younger persons, high marketing costs and variable benefits. It also provides a natural platform for tax incentivised voluntary top ups.

We prefer a system of mandatory health insurance provided by private insurers rather than a government administered pool, believing that, with proper regulation, a market driven system is more likely to deliver innovation and cost containment.

The incorporation of copayment features would be an important element in inhibiting overusage.

4.6 Personal Health Care Reserve

This option combines the features of the medical savings and mandatory insurance options discussed above and, as presented, it would only apply to people with income above a certain level. Part of the stipulated percentage deduction from income would be used to purchase regulated mandatory medical insurance and the rest of the fund set aside in a reserve fund to meet post-retirement medical related expenses. The advantages of this option include facilitation of individuals making provision for future medical spending, community rated insurance plans, alleviation of the next generation's burden and a more sustainable supplementary funding source. The disadvantages include a very high and complicated administrative and regulatory burden, potential demand-side abuse and escalating premiums with ageing and technology driven cost inflation. Our main objection to this option in its present form if purely employment based is that it would create a preferred class, further polarising the haves and have-nots. For it to be an acceptable option ***amendments are needed*** **to develop this into *an all-citizen programme with the Government paying the premium for those without adequate income***, combined with other structural reforms such as provider/purchaser split, money following patients, copayment with annual capping and raising public sector charges coupled with capping and waivers etc.

5. Conclusion

It has been a matter of great frustration to BPF that a matter of such basic importance to our society has been left on the back burner for so many years. The need to put a new structure in place before we are overwhelmed by the demographic challenges of our aging population is incontrovertible.

We are much encouraged by your obvious determination to press ahead with reform and continue to offer our full support in achieving this.

13 June, 2008

Illustration of a Possible Future Funding Mix