Submission on the 2008-09 Policy Address

Business and Professionals Federation of Hong Kong

September, 2008

Review of the 2007-08 Policy Address

1 In looking ahead to this year's Policy Address, it is worthwhile to start by taking stock of last year's Policy Address. A major focal point of the 2007-08 Policy Address was the Ten Major Infrastructure Projects. Progress of the ten projects has been uneven. In particular, the Central-Wanchai Bypass is facing new obstacles as a judicial review on harbor reclamation produced a ruling against the Government. The setback dealt on the Central-Wanchai Bypass is far reaching, as it not only delays much needed relief of traffic bottlenecks between Central and Wanchai, but it could also impact on the Shatin to Central Link (SCL) and development along the Wanchai waterfront. One would trust that the Government has taken steps to remedy these problems, and the public should be updated on the latest progress.

Governance Issues

2 Now and in the near future, the Government will have to make decisions on policy issues with far reaching consequences for Hong Kong. Of urgency are issues such as healthcare reform and the minimum wage. Other critical issues requiring a series of actions far into the future include political reform, cultural development including the West Kowloon Cultural District, the positioning of our ports and air cargo terminals in the face of shifting competitiveness, maintaining the leadership role of our financial markets and our convention and exhibition industry, a thorough review of our tax and regulatory regime to ensure that it

would continue to serve our competitive edge as the region's business hub, economic integration with Guangdong, etc. All of these are long term issues of critical importance to the territory's development strategy.

3 Yet, there are serious doubts as to whether the process in which long term policies are formulated and executed at present is serving its purpose. First of all, the standards of professionalism in government seem to have slackened, and this has contributed to an increasing occurrence of policy mishaps at the implementation stage. The same problem of slackening professionalism has also compromised the process of policy formulation. In addition, in recent years the formulation of long term policies also seems to have been overly influenced by shifting, "daily special" variety of media opinion that fails to take a comprehensive, long term view of public policy. For these reasons, tough policy decisions sometimes suffer extensive delays, if they are made at all. This trend is alarming, especially in light of the fact that competition between the region's economies is fierce, and some of our direct competitors such as Singapore and the Mainland cities are known to take bold, quick decisions in moving their economies forward.

4 Of course, one should be mindful of media opinion because it is influential. However, no society can afford to have media opinion replacing the government in being the key driver (or obstacle, as the case may be) of important policies. We believe that the Government could win more battles on the public opinion front, but it needs to do three things right. First, it needs to be more proactive in setting the terms of public debate and thus in the shaping of public opinion. Secondly, it needs to get a better gauge of public sentiments and, accordingly, shape policies that better cater to the public's concerns. Thirdly, it needs to minimize mishaps at the policy implementation stage, otherwise even policies with the best intentions could backfire badly and result in the loss of government credibility and

authority, as illustrated by the cases with the appointment of the deputy secretaries and the maid levy.

5 In addition, with the ministerial system now firmly in place, it is even more important for the professionals to be in control of the executive departments as well as to provide input in the policymaking stage at the bureau level. To this end, the Government should consider reverting to the matrix structure of the past where policy bureaus and executive departments operated in parallel with each other, rather than the tree structure of more recent years where policy bureaus have gradually been placed over the executive departments. These steps would not only help ensure that policies would be implemented professionally once they have been set, but they would also help ensure that the formulation of public policy itself would take into account practical issues of feasibility and execution. In addition, the greater emphasis on professionalism in the policy bureau would also help ensure continuity and retention of expertise and knowledge, which is an important consideration especially because policy formulation in many key areas such as healthcare reform and tax reform could easily span years and even decades. On this point specifically, the permanent secretaries in the bureaus and other senior A.O.'s should spend more time in individual fields of specializations, for the purpose of policy continuity as well as the buildup of expertise in an age when policymaking is becoming increasingly complex and specialized.

Healthcare Reform

6 Healthcare reform is an important issue as the current system which is already under stress could become downright unsustainable over time under the combined weight of population aging and the escalating cost of advancing

medical diagnosis and treatment. Healthcare reform is by nature highly controversial as it involves not just the well being of all Hong Kong citizens but also myriad deep seated vested interests, which is why decision on a new policy package has been delayed time and again. In fact, the public reception to the current round of consultation has again been less than supportive, in part because the consultation document has said much on how the public will have to cough up more money for healthcare but little on how it will benefit from better healthcare delivery. Still, the lukewarm public reaction notwithstanding, the reality is that on such a complex and controversial issue we may have to move ahead with reform without waiting for a broad consensus to emerge. Some areas where quick action is due include the following.

6.1 Primary Care: An immediate priority is to reform the structure and management of primary care and prevention, so that every citizen would know whom to turn to when he or she gets sick, and indeed how to avoid getting sick in the first place.

6.2 Planning and development of resources: This process needs to be managed systematically and with foresight and continuity, so as to eliminate shortfalls in both hardware and software – the doctors, nurses, and other professionals and supporting staff, as well as the buildings, equipment, and so forth.

6.3 The building up of a community wide patient database that could be accessed by all registered healthcare practitioners with proper authorization.

6.4 Government, instead of giving funds directly to hospitals or other providers of healthcare services, should gradually adopt the "money follows the patient" concept with payments being made through intermediary mechanisms such as vouchers and medical insurance. This would

broaden the choices for patients and promote efficiency in healthcare delivery and ultimately facilitate the healthcare reform process.

Minimum Wage

7 The 2007-08 Policy Address had pledged that, if the Wage Protection Movement (WPM) which is due for review in October is found to be unsatisfactory, then the Chief Executive would move to introduce a statutory minimum wage for two types of workers, namely cleaning workers and security guards.

8 Overall the BPF is sympathetic to the introduction of a minimum wage. However, we believe that the legislative process must be managed with great care. First of all, we are skeptical that a minimum wage could be legislated for workers in two sectors only, on the grounds of fairness and effectiveness. This is especially because some of the lowest market wages are paid to workers outside the two proposed sectors—fast food workers being a prime example. Furthermore, the legal definitions of jobs such as "cleansing" and "security" could themselves be complicated and contentious. We are therefore concerned that a minimum wage limited to two sectors could create a storm of controversy and backfire on the proposal's good intentions. Overall, the BPF believes that if a minimum wage is to be introduced at all, it would best be done as an economy-wide minimum wage applicable across all sectors.

9 There are two primary justifications for a general minimum wage. One is that the prevailing wages received by the lowest paid workers are so low as to be deemed exploitative. The second justification is that workers should not have to work full time and remain deprived of hope of ever achieving a decent standard of living, which is where many of the workers in the lowest rung of the employment ladder find themselves at present, in jobs with skimpy pay and no future.

10 However, while the minimum wage could play a useful role in tackling the problem of the working poor, it also has its limitations because as a policy tool it is a one-size-fits-all instrument applied to workers with diverse circumstances and needs. For example, the "appropriate" minimum wage for a 23 year old unmarried person still living in his parents' home is very different from that of a worker struggling to raise a family of four on one paycheck. To resolve this policy dilemma, the BPF believes that one should adhere to the notion that the minimum wage should be a *wage floor* for work done by an individual and not as a family support mechanism. Indeed, by itself the minimum wage is neither effective nor appropriate in raising the living standards of poor working families. Instead it could serve its purpose only as part of a wider policy package that also includes targeted use of income supplements and assistance with commuting expenses and daycare (both childcare and elderly care) services, and other measures that would augment the livelihood of the poor while making it practicable for them to get to work. In this regard, too, CSSA payments must be structured in a way so that the incentive for people to work and bring home extra labor income is preserved.

11 The minimum wage is also a double-edged sword and it has its pitfalls. One downside is that the minimum wage intervenes in the free working of the labor market and, importantly in our case, could tarnish our "Brand Hongkong" and our much touted status as one of the world's freest economies. But perhaps the most important argument against the minimum wage is that it could increase unemployment, although this prospective effect depends greatly on the level of the minimum wage itself.

12 In assessing the likely unemployment effect of a minimum wage, it would appear that the most vulnerable employment sector is that of small business—the

mom-and-pop operations that run food and retail shops and provide myriad local services, the kind of low cost businesses that tend to employ no more than a handful of individuals. These businesses too provide valuable services at a cost that low income households could afford, which means any pass-through effect of a minimum wage on consumer prices could have the greatest impact on low income consumers.

13 We urge the Government to conduct a detailed, comprehensive study on the issue of the prospective impact of a general minimum wage on these and other businesses, and specifically the effect on unemployment, and conduct elasticity analysis as to how unemployment effects would vary under different minimum wage levels. Armed with such findings, the Government should then take the lead on the public debate as to what specific level of the minimum wage would serve its purpose most effectively, i.e., to uplift the standard of living of a large swath of the working population without creating significant barriers to employment.

14 To conclude, while there is a downside to the minimum wage, it does not in our view outweigh the benefits. The BPF believes that it is possible to set the minimum wage at a level that would meet with society's sense of fairness and acceptability while keeping any prospective unemployment effects to a minimum. Nonetheless, the public would do well to be informed of the mixed ramifications of the minimum wage, and the Government should be ready to take steps to mitigate some of its negative effects.

A Government Strategic Investment Fund

15 The Government is one of the largest managers of foreign exchange reserves in the world. As the combined portfolio of the Exchange Fund and government

reserves has expanded over time, there has been increasing call for the Government to review the management of these assets to increase prospective investment returns. We believe there are indeed good reasons to review the management of the government portfolio, not just to increase investment returns but also to see whether we could not deploy at least a portion of the portfolio for strategic, direct investments to serve Hong Kong's long term economic development. This could take the form of a Hong Kong Strategic Investment Fund akin to the sovereign wealth funds found in many countries. Of course the primary purpose of the Exchange Fund should remain one of maintaining our currency regime for stability, but under this premise there seems to be ample room to set aside a portion of the portfolio for direct investments, especially for that portion of the portfolio contributed by government reserves.

The Crisis in PRD Manufacturing

16 There is widespread misperception that manufacturing has long ceased to matter in our economy. However, a 2006 study by the TDC shows that the manufacturing and trading sector contributes directly to about a quarter of our GDP and total employment. (TDC Study: Development and Contribution of HK's Manufacturing and Trading Sector, "Trade Watch", November 2006). The simple key to making sense of this apparent paradox is that even though the bulk of our manufacturing takes places across the border, especially in the Pearl River Delta (PRD), it generates an enormous demand for high value added services such as trading, management, shipping and logistics, and financing which take places in Hong Kong. Therefore, the health of our manufacturing and trading sector will continue to exert a great impact on the overall performance of our economy.

17 Unfortunately, at present our manufacturing sector is facing challenges that, in our

collective memory, are rather unprecedented. This is due to a combination of factors such as escalating costs of energy and raw materials, a rising RMB, and unfavorable policies pursued by governments in the PRC concerning labor and outward processing. Alarmed by spreading failure of Hong Kong manufacturers operating in the PRD, the Guangdong government has more recently taken steps to help them by cutting charges and levies, and offering assistance for them to upgrade their operations.

18 The Hong Kong Government should also do more to help manufacturers operating on the Mainland, primarily in the areas of helping these manufacturers to upgrade their technology especially for meeting environmental standards, promote branding, develop domestic sales on the Mainland, and relocate factories to lower cost locales. In any case, a very good place to start would be to move quickly to implement the recommendations long advocated by tax and accounting professionals, and that is to expand the tax deduction for research and development, which would help our manufacturers move up the value chain, and to extend to import processing the same 50:50 apportionment of profits for tax purposes currently applicable to contract processing.

Cooperation with Guangdong

19 In recent months, both Guangdong Party Secretary Wang Yang and Shenzhen Mayor Xu Zongheng have expressed the desire for closer economic cooperation with Hong Kong. Mayor Xu specifically mentioned that Shenzhen and Hong Kong could fruitfully cooperate in the areas of financial services, the innovation zone, high-end services, major cross-border infrastructure, and development of the Hetao area. Likewise, Party Secretary Wang has also expressed the wish to further develop the financial services sector in Guangdong by leveraging on the

financial center status of Hong Kong. We suggest that the Government should produce a substantive response as to what measures Hong Kong will take to bring to fruition these initiatives.

Captive Insurance

20 The BPF has recently completed a detailed study on captive insurance which has been forwarded to the relevant government officials. As large Mainland enterprises continue to expand their international operations at a rapid pace, that gives rise to complex off-shore insurance needs including captive insurance. At the same time, captive insurance is a promising business that would fit perfectly into Hong Kong's positioning as a world financial center, by adding depth to our range of financial services and serving as a catalyst for strengthening our status as a regional reinsurance and risk management hub. However, for this business to take hold and thrive in HK would require an accommodating regulatory and tax regime, as well as active promotion to the Mainland companies and support from Mainland authorities. The BPF believes that the Government should seize the initiative in the development of this business as a win-win proposition with the Mainland.

Convention and Exhibition

21 HK has long been a regional leader in the convention and exhibition business. However, continued success of this industry is far from assured. Emerging competitors such as Macao and Guangzhou have invested heavily to attract business while HK has been seriously lagging in adding the necessary space to meet the demand of ever-expanding mega fairs. The Atrium Link expansion currently under construction at the HK Convention and Exhibition Centre (HKCEC)

will not fundamentally resolve this problem. If nothing is done, in just several more years Hong Kong will no longer have the required capacity to host mega fairs. The obvious and urgent solution is timely construction of the proposed Phase 3 of the HKCEC, but there are fears that this plan may be met with opposition as it involves the building of an exhibition venue on the waterfront displacing an existing sports stadium.

22 While Asia World Expo and the surrounding airport site have been proposed as an alternative to Wanchai, this itself would be a mega-undertaking involving upgraded exhibition facilities and new, supporting facilities such as hotels and dining, shopping, and entertainment outlets as well as transport links. Aside from the commercial viability of such a plan which is far from assured, planning and construction on such a scale could easily take well over a decade but to date there appears to be no concrete proposal to show how this might work.

23 Hong Kong has long been known to be a "can do" city. The quandary in which our convention and exhibition industry finds itself makes one wonder if we have tried hard enough to think outside of the box to explore broader options. One idea is that as the Hong Kong Stadium is left idle most of the time, could it not be converted into a fully enclosed facility and substitute for the Wanchai waterfront stadium? Another idea is that as the government offices next door to the HKCEC in Wanchai are to be moved, is it not possible for the area to be used for HKCEC expansion? In any case, this issue needs urgent attention to avoid jeopardizing the convention and exhibition industry in Hong Kong which has long been a proud symbol of our status as the region's prime trading and investment hub.

- END -

7 This sounds sensible.

GST

We must all be thinking about these options.
For example:

- A compulsory saving scheme similar to the MPF.
- Insurance. Special insurance for catastrophic diseases.
- We can increase taxation, such as a specific health tax or if we had a GST we could use that.

Or a mix of all these.

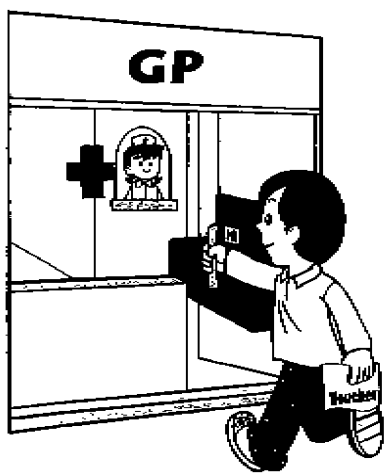
MPF

BALANCE

8 How can we reduce the queue at out-patient clinics?

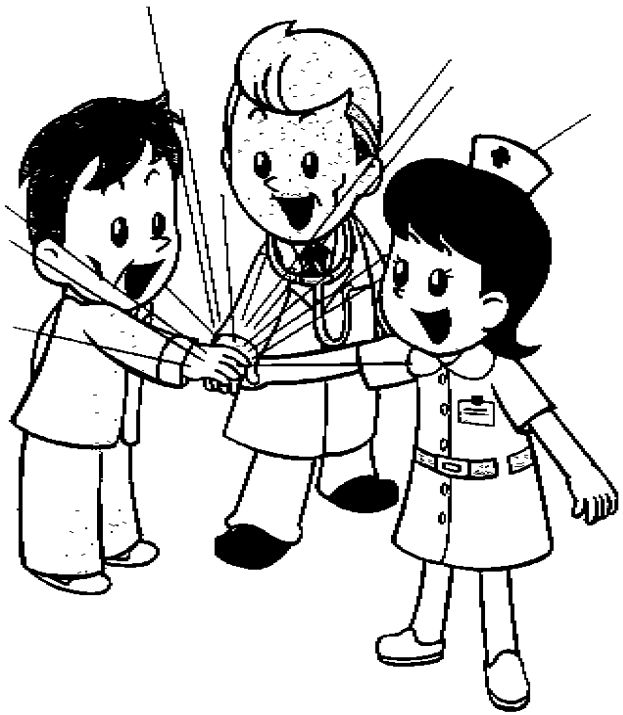
Well, for simple health problems why not give a voucher to those that really can't afford to go to a private doctor and, to make the system more efficient, if people agree, the Hospital Authority to share information with private doctors.

We need to put our heads together and come up with solutions. We must pool hospitals, clinics, health professionals, public and private, so that each bears a share of the load and make use of them all to the best advantage to make our health system better and more efficient.



9 This all sounds a tall order

I know there is so much to think about. But we are all in the same boat, We've done it before. Think of when we had all those squatter fires before you were born well we fixed that! We can fix this!



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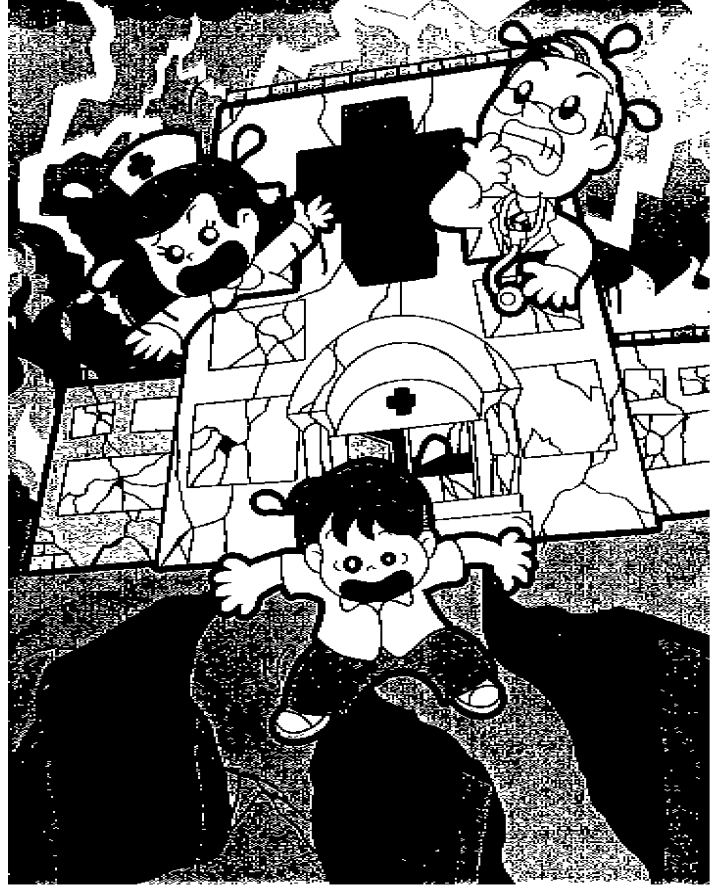
HEALTH CARE IN CRISIS



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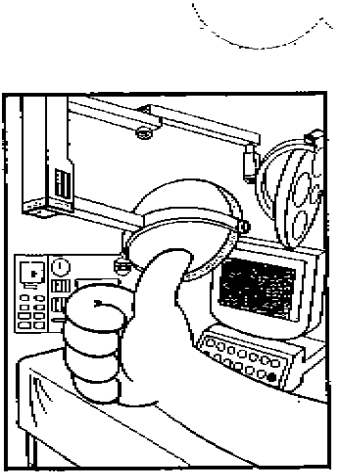
Mainland people spend two days in hospital. They pay, but treatment, everything is so good!

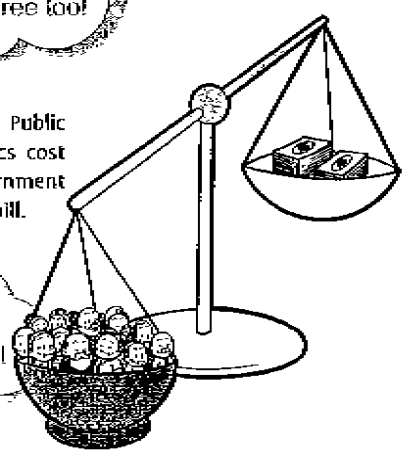


I know! Our hospitals are wonderful. Doctors are well trained and as good as anywhere. Equipment, innovation and technology are all there.

2 And it's cheap, virtually free too!

That's the problem. Public hospitals and clinics cost very little. Government foots nearly all the bill.

I've told people even come from Canada to get their prescription!



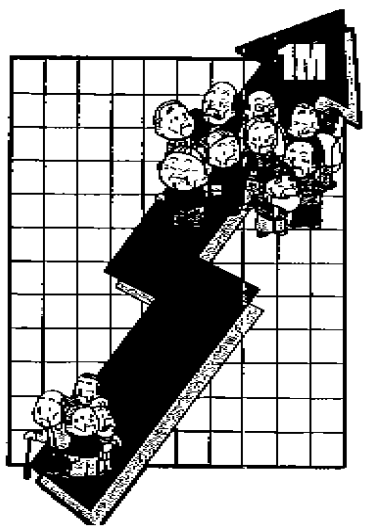
Yes, that happens too. Public hospitals were meant for those who could not afford to go private but now everyone crowds in. Even for simple things. The Hospital Authority is struggling. Waiting time and queues are lengthening. Government coughs up $30 billion a year, but that's not enough. Frankly speaking if it were in the private sector it would be broke! "Jap Lap!"

3 Well, why can't it cut costs?

The HA has been doing this for years! Wage bills are frozen. Specialists are leaving. Dedicated staff are overstretched.

4 Why doesn't the Government pump in more?

Government can't do everything. But you haven't heard the rest of it.



What's that?

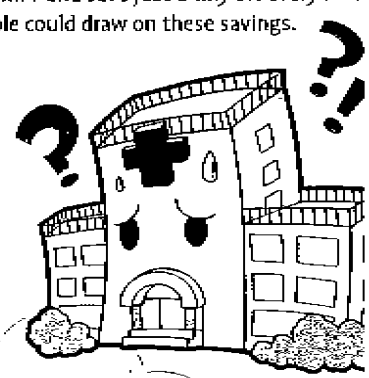
You and I are getting older. In ten year's time there will be a million over the age of 65. You can't blame people for living longer but these are the facts!

Putting two and two together, looking after their health will need at least $3.5 *billion more every year* - and this does not even include the cost of new drugs and new technology.

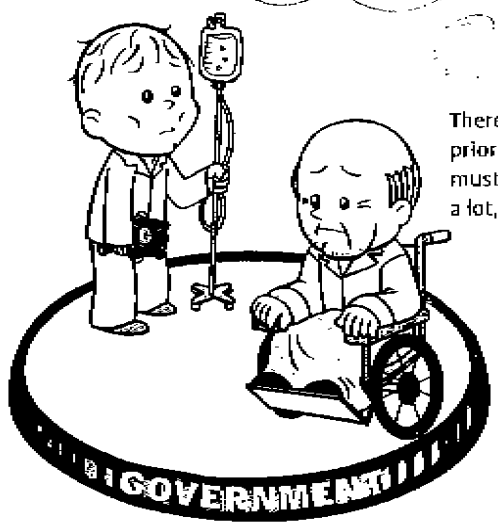
Increasing charges is a must. Just a little for some, but mo from people who can afford more.

This will help but there is a limit and it will not bridge t gap. Everyone in society will need to save for their heal care as a lifestyle habit. We must spread the load and mo services must be moved from the public to the private sect

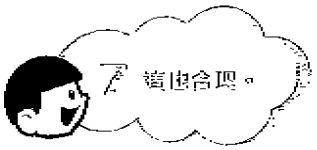
If we could increase MPF and save just a tiny bit every mon for health care, people could draw on these savings.



6 What do you mean? I may probably pay more, but if I had cancer I would not be able to afford the full cost.



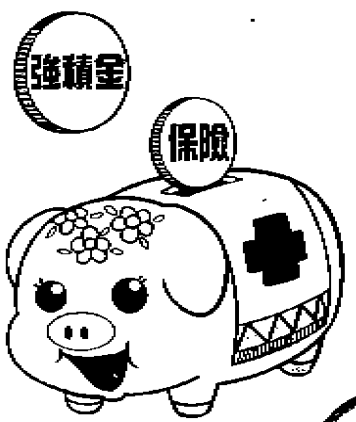
There are solutions. T priority for public fun must be for things costi a lot, like cancer.



銷售稅

強積金

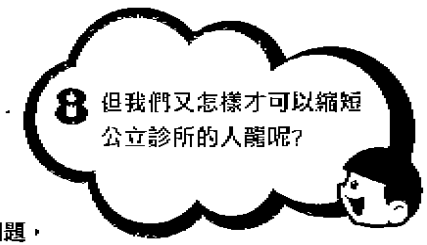
保險



此外，社會上還要考慮不同的方案，增加資源，例如：

- 類似強積金的強制性醫療儲蓄計劃。
- 特定的保險計劃，針對醫療費用龐大的疾病。
- 也可以考慮開徵醫療稅，又或者開徵銷售稅的話，從中撥出某個比例的稅款，用作醫療服務。

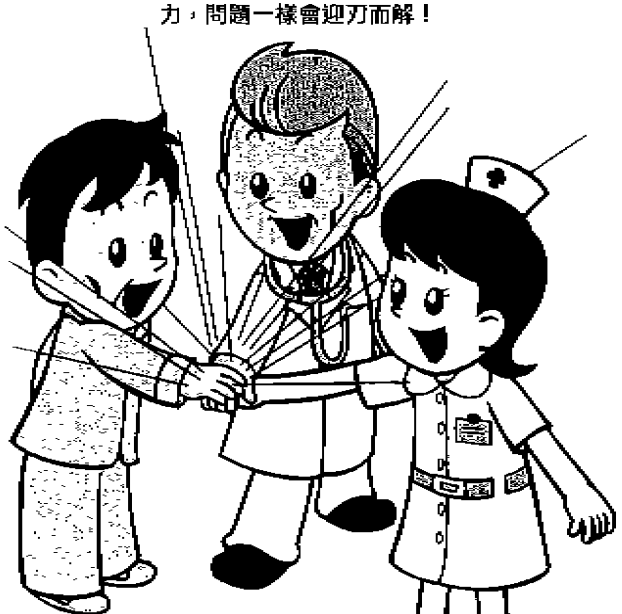
我們要採取的可能不是單一方案，而是雙管、甚至三管齊下。



如果只是一般的健康問題，政府可向那些沒有經濟能力的市民，發放現金代用券，讓他們看私家醫生。還有，在病人同意的情況下，公立醫院可以向私家醫生提供市民病履資料。

要改善情況，整個社會必須一起開動腦筋，想想怎樣解決問題。我們必須集合所有資源：醫院、診所、醫護人員、公立和私家的，使醫療系統結成一個整體。每人都要承擔一份責任，我們的系統才能夠好好地運作。

要解決問題確實不容易。不過，我們同坐香港這一條船，就要同舟共濟。想一想多年前，香港的環境比現在困難得多了，那時候木屋區經常發生大火，最後我們不是把問題解決了嗎？以前的難關都渡過了，今天，只要我們同心協力，問題一樣會迎刃而解！



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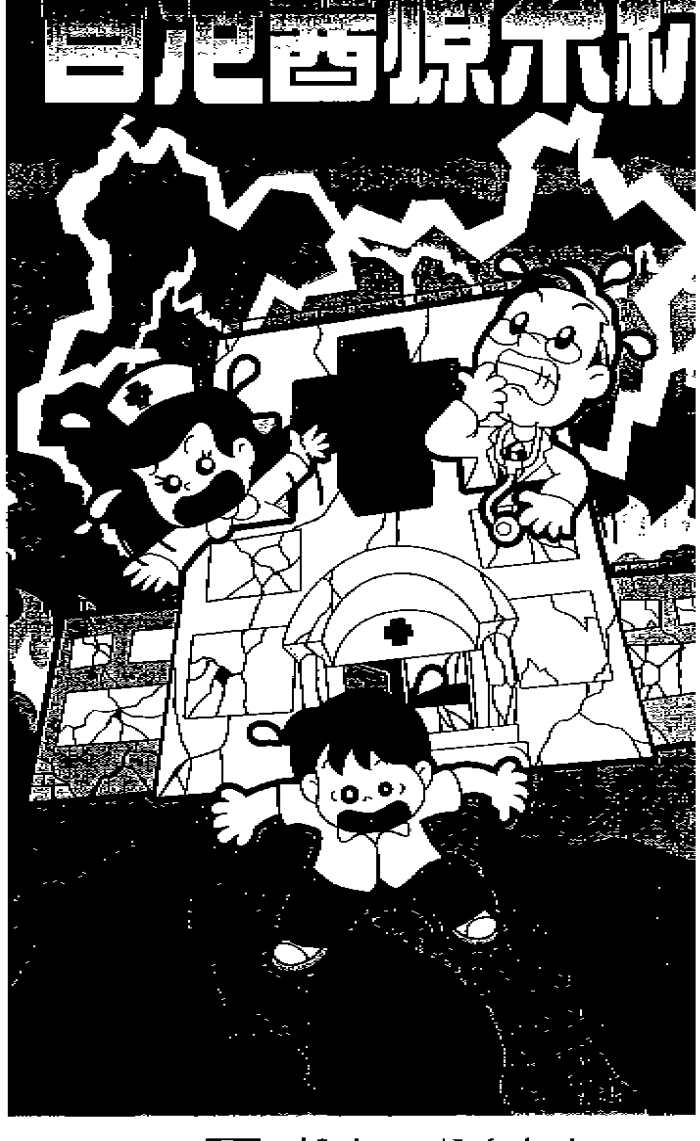
水源大點的自己要保本



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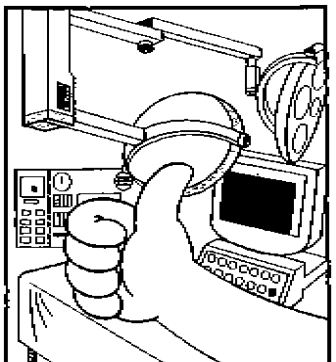
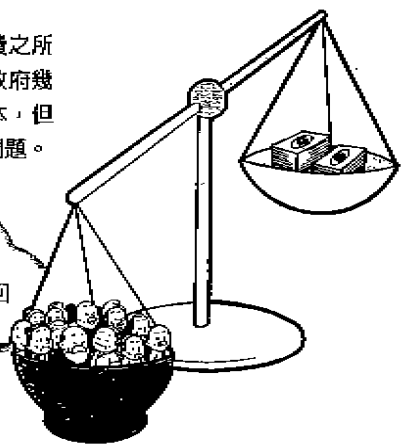


意料中事呀！香港的公立醫院已達到世界一流水平。醫生訓練有素，絕對不比其他地方的醫生差。而且，還有十分先進的設備和技術。

2 收費這十分低廉呢，幾乎免費！

公立醫院及診所收費之所以這樣低，是因為政府幾乎承擔了所有的成本，但也帶來了一連串的問題。

好像有人甚至從加拿大回港配藥呢！



我也聽說過。其實設立公立醫院的原意，是為一些沒有經濟能力的市民提供醫療服務，問題是現在很多人無論大病小病，都跑去公立醫院。結果是排隊的人越來越多，輪候的時間也越來越長，即使政府每年已投放三百億元之多，但仍然不能應付！醫院管理局正陷入財政危機，坦白說，如果這是私人機構，早就「執笠」了！

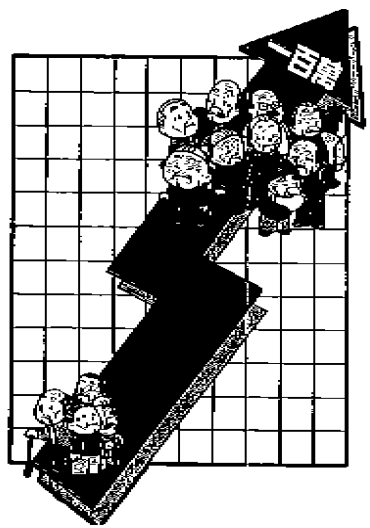
3 錢不夠的話，可以削減開支呀。

事實上醫管局幾年前已經開始這樣做，例如控制薪酬開支，但專科醫生走了一個又一個，員工被工作量壓得喘不過氣來。

4 那麼政府為何不增加撥款呢？

社會上需要政府撥款的不止醫療服務，政府也不可能包攬一切。但這還只是冰山一角！

什麼？還有什麼問題？

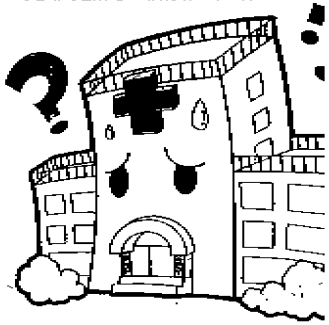


香港人口正急速老化，未來十年65歲以上的市民將增至一百萬人。照顧長者的醫療開支每年最少增加三十五億元——這還未計算通脹和新藥物、新技術的開支呢。

5 [illegible]

加費似是無可避免的了，但部份人只需多付一點點，而有能力的市民會支付多些。

話說回來，加費雖然有點幫助，但作用有限，無法彌補龐大的差額。所以，我們不能再單靠公立醫院來提供大部分的醫療服務，必須充分使用私營醫院和醫生，而每個市民都要養成醫療儲蓄的習慣。其實只要稍微增加強積金的供款百分比，每個月儲蓄一點點，用作個人醫療開支，那麼，整個社會的負擔便可以減輕。



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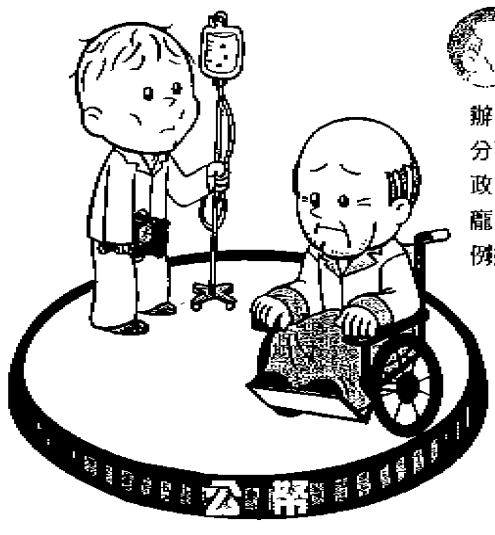
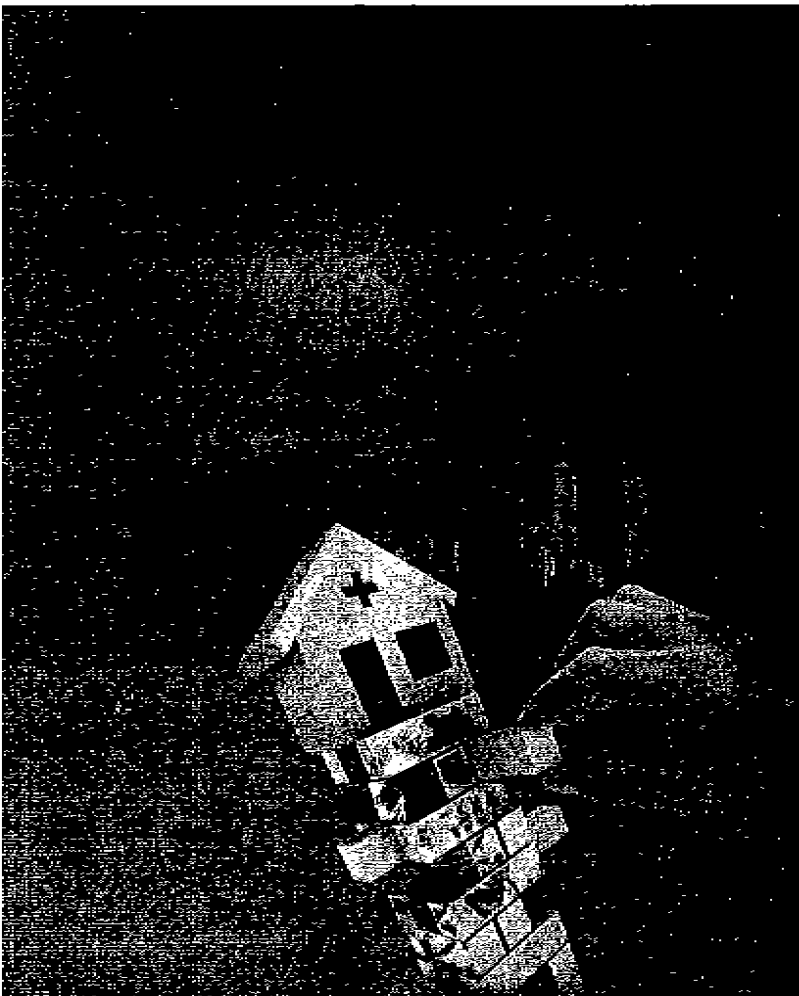


辦法是有的。首先分配公共資源的時政府應優先照顧要龐大醫療費用的市例如癌症病人。



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

工商專聯對醫療改革諮詢文件「掌握健康 掌握人生」的回應

工商專聯對
醫療改革諮詢文件
「掌握健康　掌握人生」的回應

Business and Professionals
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序言

本書以香港工商專業聯會（工商專聯）對政府醫療改革諮詢文件「掌握健康　掌握人生」的回應爲基礎，綜合論述工商專聯對醫療改革的分析和建議。

過去數年，工商專聯一群熱心的專業人士和會員在沈茂輝先生帶領下，致力對本港醫療改革問題進行有系統的研究，並積極與醫護人員、病人組織、政黨、專業人士、社團商會和學術界等各界人士討論交流，了解、吸納他們的意見。因此，我們的建議不但經深思熟慮，還切實可行。

社會對公眾參與的輔助融資方案仍意見紛紜，非一時三刻能達到共識，而隨後的立法工作亦要兩三年才能完成。工商專聯認爲，醫療系統其他重要的改革不應因此受拖延，應馬上開展。至於融資問題及有關的立法工作，可以慢慢一步一步處理。

公立醫院病房有人滿之患、輪候的病人眾多、輪候時間漫長，但其實香港差不多百分之五十的醫療服務是由私家醫生提供的。儘管有種種不便，但因爲公營醫療服務便宜可靠，不少市民仍選擇到公立醫院求診。如能使病人負擔得起私營基層醫療服務的費用，公帑或可更用得其所，病人的輪候時間也會縮短。我們與各界人士討論時，他們都認同這一點。

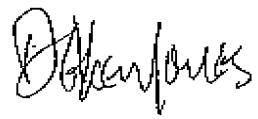
在天水圍推行的試驗計劃，是落實「錢跟病人走」概念的一步，但計劃規模甚小。政府應密切跟進，檢討成效、總結經驗，作出改進，然後全面推行。另一方面，有基層醫療服務人員和診所已回應市民的需要，以團隊形式提供服務。這些轉變值得鼓勵。

基層醫療是整個改革的核心。要加強基層醫療，政府便不能採取放任政策；中期來說應成立臨時委員會，羅致透徹了解基層醫療問題的人士爲委員。最終的目標，則是成立基層醫療管理局。

訓練一名醫生，需時十年，訓練專科醫生的年期則更長。香港目前不但醫生和其他專業醫護人員短缺，還要面對社區醫療設施不足，用以搶救生命的儀器亦並非最新最先進等種種資源問題。要充分利用現有的設施和專業培訓機構，提升市民的健康水平，政府就必須進行跨部門的分析評估，制訂和落實計劃。

若資源短缺的問題未獲解決，改革便難以推動，屆時即使社會就融資方案取得共識也意義不大。向前的第一步是更有效地運用現有資源。

在此，我衷心感謝眾多曾參與工商專聯的討論和給予寶貴意見的人士，特別是沈茂輝先生、他領導的工商專聯醫療委員會，以及他的助手許仲瑩女士。在工商專聯研究醫療改革和回應政府諮詢文件的過程中，他們盡心盡力，貢獻良多。



香港工商專業聯會會長
鍾逸傑爵士
二零零八年八月

香港工商專業聯會（工商專聯）是一策略性智庫，成立於 1990 年，創會會員爲基本法諮詢及起草委員會中提出「八十九人方案」的委員。我們深入研究對香港至關重要的議題，並提出行動建議及進行游說工作，使建議得以落實。

工商專聯並無黨派。我們獨立研究，提出的建議以香港整體發展爲依歸，界別利益並不是我們的出發點。

工商專聯的會員包括企業、社會賢達、學者及工商專業界人士，致力爲香港社會創造美好前景。

本會現任會長爲鍾逸傑爵士;主席爲王英偉先生。

歡迎各界對本文及工商專聯其他工作提出意見，請與秘書處聯絡（電話：2810 6611；傳真：2810 6661；電郵：info@bpf.org.hk）。如需更多本會資料，請瀏覽網站：www.bpf.org.hk。

目錄

香港的願景，是「建立一個能夠提升全體市民健康、提高市民生活質素，同時能爲香港每一位市民提供醫療保障的醫療制度。」

相信沒有人會不支持這崇高的理想。本文以工商專聯對醫療改革諮詢文件「掌握健康　掌握人生」的回應爲藍本，分析改革不同的因素，陳述有關的價值觀和原則，指出要讓市民明白改革的好處，並闡釋各融資方案的優勝之處。

概要

1. 當務之急，是改革基層醫療和預防性護理服務的架構和管理。生病的時候你首先會向誰求助？怎樣才能預防疾病？

2. 在發展基層醫療服務的時候，應採用跨領域團隊合作的模式，盡量涵蓋基層醫療不同的專業。

3. 要進行改革便需要額外的資源。從庫房撥款、開徵新稅項、提高收費以及加強醫療保險的角色等，都是可考慮的途徑。

4. 政府不應直接撥款給醫院和其他醫療服務機構，而應該透過如醫療券或保險等中介機制，落實「錢跟病人走」，從而再把概念推廣至醫院付費或其他醫療服務機構。

5. 就融資方案進行討論，謀求取得共識之時，結構和管理的改革不應受阻。

6. 有系統的資源規劃和發展十分重要。無論是硬件還是軟件，包括專業人員、管理和支援人員、醫療院舍和設備等問題，都需要一一解決。

7. 政府需要向市民闡釋改革的詳情和途徑，並制訂時間表，清楚列明每階段的目標和所需的財政資源。

8. 要取得市民對下一階段公眾諮詢的支持，便需要解釋不同融資措施如何運作，對市民有何影響，以及怎樣帶來改變和使市民獲益。

9. 任何輔助融資方案都要有風險共擔和費用分擔的元素，讓健康的人與患病的人共同作出分擔。

10. 融資方案必須是強制性的，並要爲此立法。

11. 只有強制性保險和稅項可以達到上述所有要求。個人儲蓄只是加強個人責任的工具，可以用來購買強制性保險以外的額外保險計劃，特別是退休後的保險計劃。

12. 就算推行以就業爲基礎的融資方案，它也只能是一個起點。長遠而言要推行全港計劃，不但覆蓋在職人士，還要包括沒有工作和沒有能力供款的人。

13. 改革的最終目的，是建立由政府管治的全港醫護系統，涵蓋基層和第二層醫療服務。

第一章
引言

i) 這次諮詢的焦點是融資方案，但是整個改革的關鍵，是醫療系統的結構改革和規管，尤其是要推行以病人爲本的基層醫療；但擴濶醫療融資的基礎，確保融資來源更穩定，仍然是重要的。

ii) 公眾的討論清楚顯示，大部分市民不甚了解爲甚麼要進行結構改革、改革對社會有甚麼益處，爲甚麼需要額外融資，以及社會需要怎樣的融資方案等。雖然部份人明白注重社區護理和預防性護理的好處，但他們對如何達到目的、市民何時才能獲益，以及輔助融資在改革中所扮演的角色等問題仍然感到非常疑惑。

iii) 在下一階段的公眾諮詢，政府必須解釋改革所帶來的直接和即時的好處、以及達至改革目標的細節與方法，並制訂一個五至十年的時間表，列明每階段的工作和要取得的成績。此外，政府應該計算每階段所需的資本和經常性開支，藉此說明輔助融資方案所扮演的重要角色，以及如何透過其資源收集和使用途徑，帶來重要的轉變。

這份回應主要針對以下三方面：

- 價值觀和原則
- 結構改革
- 對融資方案的意見

第二章
價值觀和原則

價值觀和原則是改革的核心問題，對公共融資方案和醫療系統的架構有決定作用。

最重要的價值觀如下：

2.1 全民享用

i) 已發展國家和地區的醫療系統有一個共同原則：由政府支付或安排的必要醫療服務，所有市民都可以享用，而且服務和質素必須一致，不能因人而異。這包括有助市民保持身體康健以及盡早發現疾病的服務。至於一些特別、對健康不構成影響但對身心有益的服務，則由個人自行選擇及支付。

ii) 若發展由政府管理，但服務水平和選擇卻不統一的醫療服務，甚至爲此立法，那不管是有意還是無意造成的，也會加劇貧富對立的情況，令社會分化。

iii) 然而，可選擇接受公營還是私營服務，是醫療改革的目標之一。由於私營界別的資源和設施有限，服務質素參差，可能無法即時提供私營服務的選擇予所有市民。政府或需要採取分階段的策略，但最終目標必須是提供全民享用的必要醫療服務。

2.2 個人責任

i) 分擔費用是大部份已發展國家或地區醫療系統的一個重要元

素。由病人分擔公營醫療服務的成本，可以鼓勵個人責任感及防止濫用或不當使用服務的情況。工商專聯並不贊成大幅增加收費，令市民不勝負荷，也不認爲分擔費用應該成爲正式融資的主要來源。可是，政府應透過費用分擔，令市民明白醫療服務成本爲多少，並減少濫用服務的意慾。

ii) 目前公營醫療服務獲政府的龐大資助，收費便宜，不少市民因而選擇到公立醫院求診。要鼓勵市民減少使用公營醫療設施，必需提高公營服務的收費，以及促使私營界別降價，從而製造公平的競爭環境。如不能縮小公私營收費的差距，則難以改變大多數病人一有問題便向公營醫療機構求診的習慣。與此同時，爲了減少市民的憂慮，政府應該爲市民的年度個人醫療總開支設上限，確保病人能負擔得起醫療費用。

2.3 風險共擔

不論用甚麼方法來進行公共醫療融資，都必須包含風險共擔的元素，由整個社會一起分擔疾病的成本。否則，政府便沒可能履行爲每一個市民提供劃一、質素有保證的醫療護理的承諾。要由整個社會共擔風險，有兩種獨立但相輔相成的方法：第一是透過稅項、社會保險或全民私人保險等，由社會共同分擔基本醫療的成本，包括有助市民保持身體健康的服務。第二，危疾和長期病患的醫療費用可對病人做成沉重的財政壓力。政府可承擔有關費用，免除個人的負擔。政府將來也可考慮針對危疾另設獨立的經費來源。

2.4 強制性

公眾對強制性融資的抗拒是可以理解的，但是因爲公營醫療系統是爲所有市民而設，所以任何公共融資方案都必須是強制性的；儘管有人反對也改變不了這個事實。堅持不接受強制性供款的人或可以選擇完全不使用公營服務，自行承擔個人的醫療開支，但是有時棄權，有時不棄權，又或者只在某些服務上棄權的情況則不應容許。可是，棄權的做法很可能會引致種種爭議，而當棄權的人因病而用盡所有資源時，將面對困局。

2.5 僱主的參與

i) 僱主和僱員在醫療融資上應分別扮演甚麼角色，是需要探討的問題。無論如何，以就業爲基礎進行融資只能是過渡措施，最終目標是推行全民融資方案。其他地方的經驗顯示，長久以就業作爲融資基礎會令沒有工作和受養人士在醫療上成爲成次等公民。如病人因爲生病而不能工作，那麼他們在最需要保障的時候卻得不到保障。此外，本港及跨境勞動力的流動性越來越強。凡此種種，都使以就業爲基礎的方案不可取。

ii) 強制僱主供款的可取之處不多。這變相是一種有指定用途的就業稅，將打擊僱主自願爲僱員提供更佳福利的動力。

2.6 財富再分配

i) 香港現在的公共醫療融資以稅收爲基礎，已經是一種財富再分配，亦顯示社會認爲必須爲所有人提供醫療安全網。

ii) 不管最終採用何種輔助融資機制，財富再分配歸根究底是政治選擇。較理想的安排，是既強調個人責任，但同時包含風險共擔和爲個人醫療開支設上限的元素；由健康的人與患病的人共同分擔，所有人均分成本。

iii) 毫無疑問，對貨品和服務徵收稅款，並指定把其中一部分用作醫療開支，實際上是財富再分配的一種方法。可惜，開徵銷售稅的建議無法取得足夠的支持。這令政府仍然面對收入因經濟周期而波動的問題，並需要尋找其他更難實施的解決方法。或者我們應重新考慮專爲醫療而設的稅項。

第三章
結構改革

i) 香港醫療改革的核心不單單是錢，更關乎結構和管理改革。新融資機制有助推動結構轉變，兩者相輔相成。即使社會未能就融資取得共識，醫療系統管理的改革都不應受阻礙、進度不能被拖慢。作爲中期措施，政府可從庫房中撥款作爲改革的資金。

ii) 政府已提出若干建議，包括設立「家庭」醫生名冊、成立電子健康記錄互通督導委員會，以及推出長者醫療券等。有的建議已付諸實行。這些措施十分可取，並可成爲催化劑，帶動整個系統的改變。

iii) 結構改革的四大範疇如下：

- 管治／管理
- 基層醫療及預防性護理
- 醫院
- 資源規劃

3.1 管治／管理

i) 現時公共醫療系統的管治／管理重點是公立醫院。雖然衞生署有提供保健和預防護理服務，但政府對基層醫療缺乏管治、管理，亦沒有與服務提供者和病人進行整體協作。這種管治架構根本無法帶來所需的改革。當務之急，是作出改變。**1990** 年 **12** 月發表的《人人健康 展望將來──基層健康服務工作小組報告》提出成立基層醫療管理局。雖然建議一直石沉大海，但這仍然是首要工作。政府可先成立臨時機構或委員會，負責推行措施，爲成立基

層醫療管理局這一法定機構鋪路架橋。

ii) 第二層醫療服務的管理應集中爲公營和私營醫院訂立共同的服務標準及進行監察、改善價格及成本機制、改善資源分配，以及與私營基層醫療界別建立轉介病人和溝通的渠道。

3.2 基層醫療及預防性護理

改革的首要任務，是推廣基層醫療及預防性護理予全港市民，而公營和私營界別均可提供有關服務。下一階段的諮詢應包括下列四個範疇：

3.2.1 推行試驗計劃，引進跨領域團隊合作模式

香港已經有綜合診所，提供不同領域的醫護服務。它們有公營的，也有私營的。要進一步推廣這概念，發展基層醫療綜合診所，可推出一系列試驗計劃，以地區爲單位，邀請私營界別參與，或把同區不同領域的基層醫護人員集中／連結在一起。

3.2.2 醫生名冊

醫生名冊應稱爲基層醫生名冊，而非「家庭醫生」。政府可參照中醫的註冊模式，涵盖所有具備專業資格、正在提供基層醫療服務的醫護人員，並加入長期培訓和再培訓的要求。

3.2.3 預防護理

預防護理必須成爲主流基層醫療的一部分。政府早前便宣佈推出長者醫療券。這意念值得推廣。

3.2.4 藥物

藥物是基層醫療的一個要素，可以藉此預防疾病，減少病人住院的需要。 任何新基層醫療架構是否可行，將取決於有否措施，規管藥物的售價、品質，以及確保藥物安全可靠，包括控制成本和用量。現時在公立醫院以外，有關的監控規管少之又少。這問題必須予以正視。

3.3 醫院

目前，醫管局透過普通科門診提供基層醫療服務。醫管局應該在適當的時候減輕在基層醫療中扮演的角色，把提供服務的責任和管治工作交給新的基層醫療管理局。醫管局的主要任務是確保醫院服務的質素，基層醫療若繼續置於醫管局之下，在政府財政緊絀時會獲得比較少的資源。

3.4 資源規劃

i) 缺乏合適或經專業培訓的醫療護理人員，既影響服務，也不利改革。因此，資源規劃，尤其是人力資源規劃十分關鍵。

ii) 若諮詢文件的推算正確，未來二十五年香港需要的醫護專業人才將倍增，而要培訓足夠的專業人才需時可達十年。這將是艱巨的任務，我們必須馬上開展有關工作。

iii) 在資源緊絀的情況下，鼓勵病人轉用私營醫療服務只會令種種問題迅速浮現。此外，目前個別專業界別保護主義意識強烈，增加解決問題的難度。

iv) 政府需要盡快成立一個跨部門、高層次的工作小組，檢視各醫療服務領域未來需要的人力資源，以及如何藉加強培訓、採取更開放的輸入專業人才政策等方法，解決上述種種問題。

v) 此外，政府對醫院、診所和護理院等的土地供應和價格控制嚴格，對擴建醫護設施造成不必要的限制。政府應檢討有關政策。

第四章
對融資方案的意見

4.1 概論

i) 現時政府稅收和用者自付費用佔香港醫療融資來源逾八成。這幾年的經歷顯示，這種模式使我們的醫療系統受經濟周期波動的支配。政府必須確保將來的融資來源廣闊，免受經濟周期的影響。

ii) 政府最終會選擇其中一個輔助融資方案，但是其他選擇，例如自願性保險和用者自付費用等仍可繼續在整體融資中佔重要的地位。諮詢文件提供的選擇中，除了方案一，即社會保險外，並沒有包括一般或有指定用途的稅項。我們認爲稅項不應該被排除在考慮之外，並相信開徵專爲醫療開支而設的稅項，較其他複雜和局限性大的方案更可取。

4.2 諮詢文件中的六個方案

- 方案 **1:** 社會醫療保障

i) 社會醫療保障在世界各地廣爲採用，一般是由政府管理的強制性計劃。若市民未能就強制性私人保險取得共識，社會醫療保障是值得香港考慮的一個選擇。

ii) 諮詢文件指社會醫療保障通常與收入和就業掛鉤。這的確非常普遍，尤其當它是醫療融資的主要來源時，但卻並非唯一的做法。香港的直接稅收已經以收入爲基礎進行財富分配，是否還需要藉醫療融資再分配財富呢？其實，另一個選擇是推行中央管理的社

會保障系統，統一保障範圍、由整個社會共同分擔風險，並劃一保險費；政府則爲低收入人士提供資助。這與推行強制私人醫療保險相似，只是由政府作爲管理／承保人。跟強制私人保險一樣，爲防止濫用，計劃要有相當程度的分擔費用，並在購買醫療服務方面實行嚴格控制。

- 方案 2: 用者自付費用

用者自付費用是醫療融資的一個重要元素，讓個人可以自己付款購買公營系統以外的服務，而要求病人分擔費用，亦是防止濫用醫療服務的主要方法。儘管現時提高公立醫院收費也不會爲公營融資帶來大量收入，但目前的費用實在太低，必須作出改變。毫無疑問，用者自付雖然不能成爲輔助融資的主要來源，卻有助提高個人責任的意識。

- 方案 3: 醫療儲蓄戶口

i) 目前，推行醫療儲蓄戶口的地方只有新加坡。當地的醫療儲蓄戶口是確保市民能支付全費，享用公立醫院服務的重要元素。

ii) 個人儲蓄有助鼓勵市民爲自己的醫療護理負責，但儲蓄並沒有風險共擔的元素，對年老病人龐大的危疾和長期病患醫療開支幫助有限，更可能令市民錯誤產生安全感。既然醫療費用是長者的主要支出，爲甚麼要在強積金之外另設醫療儲蓄戶口，用來支付年老時的醫療費用呢？如果要考慮個人儲蓄的可行性，政府應對強積金進行全面獨立的評審，並假設供款需要包括醫療儲蓄。要考慮的問題包括應保留多少比例的退休金於戶口內，用以支付醫療和醫療保險費用，但年紀極爲老邁時的開支問題則可分開處理。

iii) 除非醫療儲蓄可用來購買保險，否則醫療儲蓄戶口並非一種直接可靠的醫療融資機制，不能獨自成爲一個公共融資的方案。

- 方案 4: 自願醫療保險

前文指出，任何由政府管理的融資機制都應該是強制所有市民參與，並共同分擔風險的。因此，自願保險不能成爲政府機制的一部份。自願保險，特別是由僱主提供的，已佔全港醫療融資的 12%，並對香港基層醫療服務產生重要的影響。將來，只要作出適當的規管，僱主及保險業界可以繼續扮演重要角色，推廣強制保險以外的額外保障計劃，並在提高醫療服務質素方面發揮影響力，甚至參與提供服務。

- 方案 5: 強制性醫療保險

i) 任何公共輔助融資都必須包含強制性保險（無論由保險業界或由政府提供）或稅收的成分。

ii) 只要保險範圍是由政府批準和劃一的，強制醫療保險便可提供全民風險共擔的元素，而且相對來說是比較簡單的機制。它沒有自願醫療保險的主要缺點，如盡量只接受健康的年青人投保、市場推廣成本高及保障範圍不一。政府可以強制醫療保險作爲平台，透過提供稅務優惠，鼓勵市民自願購買「額外」保障。

iii) 強制性醫療保險應該由私營保險機構而非政府提供。只要有適當的規管，由市場推動的系統更能提供創新意念和抑制成本。

- 方案 6: 個人康保儲備

這方案結合了醫療儲蓄戶口和強制保險，但諮詢文件建議只規定收入超過某水平的在職人士參加計劃。他們要把收入的一定比率存進醫療儲蓄戶口，其中一部分指定用於購買受規管的強制醫療保險，其餘則撥作儲備基金，支付退休後的醫療開支。這方案有可取之處，包括協助個人爲未來的醫療開支作準備、按群體保費率收取保費、減輕下一代的負擔，以及提供可持續的輔助融資來源。可是這方案也有缺點，包括管理和規管工作複雜繁重、服務可能會被濫用，以及保費因人口老化和科技發展而不斷上升等。可是，反對此方案的最大原因，是純粹以就業作基礎將製造優越階級，進一步分化社會。方案要變得可取，必須作出修正，使計劃覆蓋全港市民，並由政府爲收入不足的市民支付保費。

結語

醫療改革的問題錯綜複雜。要解決問題，需要一步一步向前行，首要任務是改革基層醫療服務，接著要確保香港有足夠的醫護人員及設施，繼而再處理醫療融資，可能會令問題更容易解決！

二零零八年八月

工商專聯醫療委員會名單

主席

沈茂輝先生

顧問

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副主席

龐愛蘭女士　　黃自傑醫生

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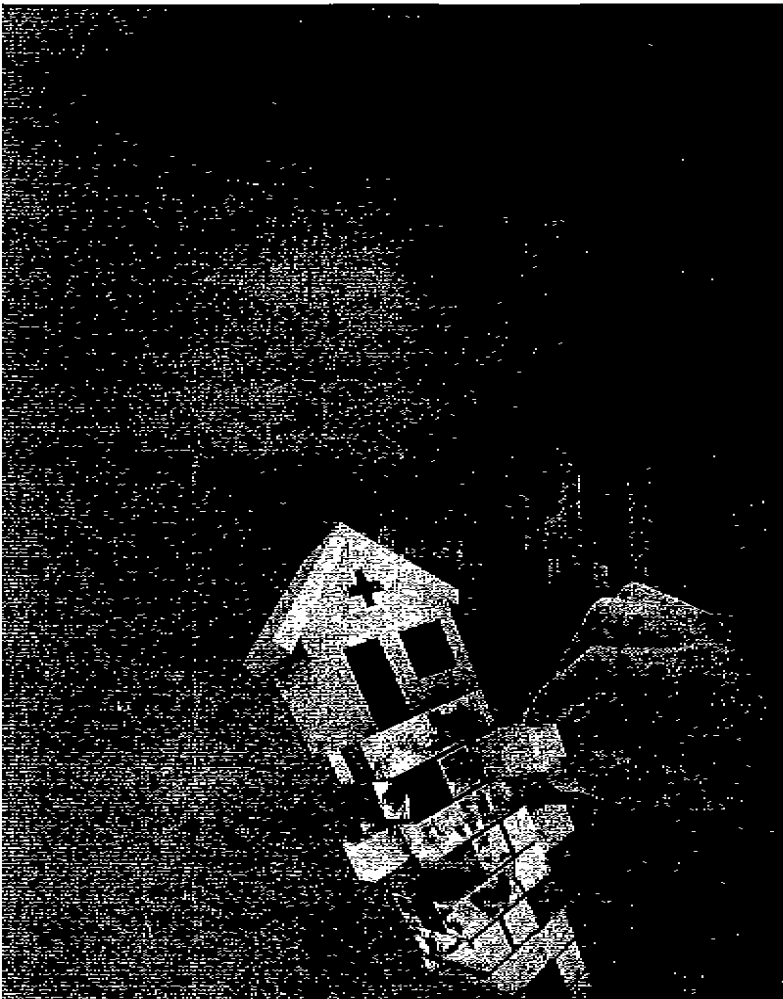
對委員會成員的大力支持和寶貴意見，工商專聯謹此致謝。本書爲工商專聯對政府諮詢文件的回應，並不代表個別成員的意見。



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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"

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

Business and Professionals Federation of Hong Kong
香港工商專業聯會
www.bpr.org.hk

Foreword

This booklet is a distillation of the response the Business and Professionals Federation of Hong Kong (BPF) submitted to the Health Bureau's consultation paper, "Your Health Your Life."

These past few years have seen a dedicated effort by a BPF team of members and professionals under the leadership of Michael Somerville to examine the consultation paper proposals systematically. Hundreds of meetings with workers in the field, political parties, professionals, associations, academics and individuals have been held. Our response is deliberate and practical.

Bearing in mind that any solution involving supplementary funding and publicly financed contributions will take time to decide—and two or three years to legislate—the BPF recommends that many things needing to be done should proceed, while the more protracted work on finance and legislation can take its time.

Despite the overcrowding, queues for attention and a long waiting time at our public hospitals, the fact remains that nearly half of health care is provided by our private doctors. In spite of inconvenience, people turn naturally to the trusted and inexpensive services provided from public funds at our public hospitals. But money could be better used and the waiting time shortened by enabling patients to be able to afford the fees of primary care professionals in the private sector. Everyone we have spoken to is convinced of this.

Some hesitant steps in this concept of "money follows the patient" have already been taken at Tin Shui Wai. The idea needs examining in the light of experience, amending as necessary and pursuing vigorously. In other ways primary care providers in the field are already responding to public demand by establishing group practices. These changes should be encouraged.

At the heart of future reform, primary care should be strengthened and put under an interim supervisory body of independent and knowledgeable members rather than let it drift along among various departments until such time as a fully fledged Primary Care Authority can be set up.

It takes ten years to train a doctor and longer to train a specialist. There is a shortage of doctors and other health care professionals. There is a shortage of facilities in our communities and a need for the employment of up-to-date life saving equipment. Making good the capacity of present facilities, and the ability of professional bodies to take care of the health of our citizens requires comprehensive analysis and implementation. A cross departmental review should be expedited.

Reaching agreement on controversial funding schemes will take time and even when agreement is reached if the system cannot respond for lack of resources it will be meaningless. But as a start, we can use existing resources to better effect.

I should like to thank most sincerely all those too numerous to name who joined in the discussions leading to the BPF response to the Consultation Paper especially Michael Somerville, his Health Care Committee, and hardworking assistant, Connie Hui.

Sir David Akers-Jones
President
Business and Professionals Federation of Hong Kong
August 2008

The **Business and Professionals Federation of Hong Kong (BPF)** is a strategic think tank and lobbying group founded in 1990 as a successor to the Group of 89 members of the Basic Law Consultative and Drafting Committee. It conducts research into and advocates "actions" on issues of critical importance to Hong Kong.

It is non political, non factional and above all strives to promote the overall interests of Hong Kong rather than those of any single sector.

The membership comprises a wide spectrum or corporations, community leaders, academics, business and professional people committed to the betterment of the whole society.

The present President of the BPF is the Hon. Sir David Akers-Jones and Chairman is Mr Wilfred Y W Wong.

We welcome views on this booklet and our other work; please contact the BPF Secretariat (Tel: 2810 6611; Fax: 2810 6661; Email: info@bpf.org.hk). Further information on the BPF could also be found on its website: www.bpf.org.hk.

Table of Contents

The Hong Kong vision 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".

No one could fail to support this high ideal. In this response to the Health Care Reform Consultation Document, "Your Health Your Life", the BPF has analysed the various options and factors involved. Views are expressed on how the values and principles of reform can be achieved, on the need for a better public understanding of the benefits, and on the merits of various funding options.

Executive Summary

1. An immediate priority is **to reform** the structure and management of **primary care and prevention.** To whom do you turn first when you are unwell, and how can you avoid getting sick in the first place?

2. A **broad approach** is necessary and this should preferably cover **all** the disciplines involved in primary care.

3. Reform and improvement will need **additional funds,** that is to say **supplementary funds** whether from existing Government revenues, taxation, cost sharing, medical insurance and so forth.

4. Government, instead of giving funds directly to hospitals or other providers for provision of health services, should adopt the "**money follows the patient**" concept through intermediate mechanisms such as vouchers or medical insurance and then onto payments to hospitals and other providers.

5. While agreement is sought on where to source those extra funds, **other aspects of the reform** of the health structure and management **should not be held up.**

6. The systematic **planning and development of resources** and elimination of shortfalls, both hardware and software – the professionals, administrators and supporting staff, the buildings, equipment and so forth, is needed and must be addressed, without which reform would be meaningless.

7. The detail and means of achieving reform supported by an **implementation programme** should be prepared with clear achievement objectives for each stage of reform and its financial requirements.

8. An **explanation** of how various funding measures and how they will affect and help the individual and will facilitate beneficial change is essential **to gain public support** for the next stage of public consultation.

9. Any supplementary funding must be **risk pooled** and cost sharing whereby the fortunate and misfortunate of our citizens are grouped together.

10. Funding must be **mandatory** and be backed by legislation.

11. A form of mandatory insurance or taxation will meet all the criteria. Personal savings, if incorporated, can only be a vehicle to reinforce responsibility and for purchasing additional insurance more particularly post employment insurance.

12. **Employment based funding** and benefits, if adopted, should be **only a preliminary stage** as part of a community wide scheme in which not only the workforce but those not in employment and those unable to contribute are cared for.

13. A **community wide** publicly sponsored health system embracing both primary and secondary care should be the ultimate objective.

Chapter 1
General Introduction

i) The main focus of the Consultation is on financing options but the structural refocusing and regulation of our health care system, most especially **the delivery of patient centred primary care,** must drive the reform process. That said, the need to broaden the base of health care financing onto a more stable footing is of course important.

ii) It is clear from the public debate that there is a **widespread lack of understanding** on why structural reforms are necessary, how they can benefit the community and why and what additional financial means and resources are needed. Among those who acknowledge the benefits of shifting the emphasis to community-wide 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 financing will have in achieving this.

iii) It will be critical at the next stage of consultation to explain the direct and immediate benefits of reform, 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. There must be both capital and recurrent financial projections at each stage and illustrations of the vital role supplementary financing will play and how new fund flows will be the key levers of change.

This booklet in the following chapters covers three areas:

- Values and Principles
- Structural Issues
- Funding Options

Chapter 2
Values and Principles

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.

Outlined below are the most important of these values.

2.1 Universal Access

i) A principle embodied in developed health care systems across the world is that the **same level and quality of publicly sponsored or financed essential health care must be available to all.** This should include services focused on encouraging wellness and early detection of illness. Special or discretionary services which are not essential to health but may contribute to well being are for the individual to select and to pay for.

ii) To develop, legislate for or bring about **different levels of service and choice** for publicly administered health care (even if this occurs inadvertently) will only serve to **emphasise the division** between rich and poor and create discord.

iii) Since encouraging choice between public or private service providers may be part of the reform objective, the limited resources and facilities and variable quality of services available in the private sector will constrain the extent to which such choice can be widely offered. A staged approach will have to be followed but the ultimate goal must be universal access.

2.2 Individual Responsibility

i) A majority of health systems in the developed world include features of

copayment. That is to say the **sharing of cost between patients and providers** in publicly provided health care to encourage responsibility and to inhibit inappropriate use or overuse. The BPF does not recommend that personal payment should be raised to onerous levels, nor it should be made a major source of formal financing, but such payment arrangements should stimulate better public awareness of the cost of health care services, and discourage profligate use.

ii) To encourage a shift away from public health facilities, there has to be a reduction in the massive subsidies currently biasing the public towards using them. In other words, there has to be an **increase in public sector fees and a reduction in the gap between public and private sector fees.** Failure to reduce this gap will perpetuate the disincentive for patients to change present habits in which the majority took to public health facilities. To address possible public anxiety over affordability, reforms must embody a capping process that will set an upper limit on the total health payment by an individual in any particular year.

2.3 Risk Pooling

No matter what the source of public funding for community health care is, it must incorporate a pooling process, a **sharing by everybody of the** potential cost of ill health. It is impossible for Government to meet its commitment to provide quality health care to all without this sharing concept. This can be achieved by two separate but complementary channels. The first is through pooling of the costs of basic health care, including services that encourage people to remain in good health. This can be based on tax, social insurance, or universal private insurance. The second, the supplementary system, would address the potentially crippling cost of **catastrophic or chronic illness** by shifting this expense from the individual to Government. Some form of separate community fund for catastrophic illness could be an option for future consideration.

2.4 Mandatory Payment

Because a public health care system must by definition be for all, **any public system of financing must be mandated and cannot be voluntary** – in spite of some pockets of opposition to this reality. Individuals who insist on refusing this mandate could be given a choice to "opt-out" of the public health care system in totality and to make their own provision for health care, but selective or partial "opt-out" cannot be an option. However, any form of opting out is likely to lead to disputes and possible distressing unforeseen circumstances for example if resources run out.

2.5 Employer Involvement

i) The respective roles played by employers and employees in the funding of health care need to be considered. **Employment based funding can only be a stage towards the introduction of community wide funding solutions.** An approach confined to the workplace as a permanent funding base contributes to the creation of an underclass of those who are not employed, or of dependents lacking proper cover. This danger is particularly acute, since the onset of illness can be the trigger for loss of employment, leaving individuals without proper cover at exactly the moment they require it. Labour mobility both within Hong Kong and across borders also exacerbates the problem of employment-based solutions.

ii) As for employers, there is little merit in mandating for employer contributions, which would amount to a hypothecated employment tax and would act as a disincentive to the grant of voluntary top-up benefits by employers for their employees.

2.6 Wealth Distribution

i) Our current tax based health care financing re-distributes wealth in the

community and underpins the community's concern to provide a health care safety net for all.

ii) Whether any new Government funding mechanism should be wealth distributive is, in the final analysis, a matter of political choice. The preference is to move towards a **system of funding which emphasises personal responsibility for health care coupled with risk pooling and the capping of potential liabilities.** Those blessed with good health are called upon to share their good fortune with others less fortunate and by averaging out of costs among all contributors.

iii) In this regard there is no doubt that hypothecated revenues from an across the board tax on goods and services could be used for health care financing and would be redistributive. Unfortunately the introduction of a GST in Hong Kong when proposed did not garner support. Without it, the Government needs to search for other more difficult-to-impose solutions. Perhaps the idea of a tax devoted simply to health care need to be re-examined.

Chapter 3
Structural Issues

i) The crux of reform to Hong Kong's health system is not just a matter of money. It is to achieve changes to the structure and management of health care in all its aspects. Structural and financial reforms are linked and new financing mechanisms can help drive change, but delay in reaching consensus on additional permanent methods of funding must not be allowed to impede or slow down the implementation of **management reform**, the financing of which can be, as an interim measure, achieved from current Government revenues.

ii) Measures already proposed or underway in this regard include the "family" doctor registry, the task force to develop electronic health record sharing, and medical vouchers for elderly. All these are welcome and will act as catalysts for change throughout the system.

iii) Structural reform can be divided into the following four areas:
- Governance / Management
- Primary Care and Prevention
- Hospitals
- Resource Planning

3.1 Governance / Management

i) Our current public system of health care management, weighted as it is to the delivery of public hospital-based care and the promotion of health and prevention of sickness by the Health Department, leaves out the providers of primary care and their patients from overall recognition, coordination and oversight. For as long as they are left out, we cannot deliver the reform which is needed. There is a critical need to focus on the better management of our primary care and prevention sectors. A **Primary Care Authority,** proposed but not acted upon many years ago,

remains a priority. Eventually a statutory body will be needed and the December **1990 Report of the Working Party on Primary Health Care entitled Health For All – The Way Ahead** should be revisited and reviewed. Meanwhile measures that take us towards the introduction of a Primary Care Authority should be introduced and these could be undertaken by a provisional body.

ii) The existing management for secondary care should concentrate on establishing and overseeing common delivery standards for hospitals (both public and private sectors), upgrading pricing and costing mechanisms and resource allocation, and building channels of communication and referral with private sector primary care professions.

3.2 Primary Care and Prevention

Since primary care and prevention for the whole community by both public and private providers is the immediate priority for reform, the following aspects of primary care must be included in the next round of consultation.

3.2.1 Introduction of multidisciplinary pilot projects

There are already **multidisciplinary clinics** in both the public and private sectors. The further development of this approach to primary care should be explored involving pilot projects using private sector practitioners and grouping various primary care professionals together.

3.2.2 Register of doctors

The register of doctors to be created should be designated as a **register of primary care doctors**, rather than the loosely descriptive term "family doctor". It should be an **inclusive** register and it should require **long term training and retraining of these providers**, adopting a similar method to that implemented for Traditional Chinese Medicine (TCM) practitioners.

3.2.3 Prevention

Prevention must be drawn into the mainstream of primary care. The introduction of a medical voucher payment scheme for the elderly has been announced and is being tried out. This follows the concept of "money follows the patient" and any inadequacies in the present trial must be ironed out and if necessary be modified and extended into a territory-wide scheme.

3.2.4 Medical Prescriptions

Medical prescriptions are a core element in primary care, particularly as a means of prevention of illness and in the avoidance of hospitalisation. Thus viability of any new structure for primary care will be dependent on measures to **regulate the affordability, reliability and quality of drugs**, including control over costs and levels of usage. Apart from controls at public hospitals, these controls are currently minimal. This issue must be addressed.

3.3 Hospitals

At some stage the **Hospital Authority should reduce its involvement** in the delivery of primary care which it now undertakes through the General Out-Patient Clinics (GOPC) structure and transfer the responsibility and governance to the new Primary Care Authority. Since the Hospital Authority's over-riding responsibility is to ensure the quality of hospital-based services, the danger exists that the primary sector under its responsibility will remain exposed to the danger of lower resource priority in times of financial constraint.

3.4 Resource Planning

i) Lack of adequately or appropriately trained professionals is a major constraint in bringing about change and in the present delivery of

services. **Resource planning and in particular human resource planning are critical issues.**

ii) If the projections in the consultation document are correct, Hong Kong needs to double its professionally trained manpower in the health sector over the next 25 years. Given that the training period for a professional may take 10 years, to break the back of this problem will be extremely challenging. It is essential that we begin to tackle this issue now.

iii) Against this background of **strained resources**, trying to move patients from the public to the private sector will quickly reveal the problems to be faced. In addition to its situation of shortage, the current protective environment of some health care professions imposes constraints on the search for solutions.

iv) These resource issues require the urgent establishment of a **high level, across department task force** to examine 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.**

v) Controls on the **availability and pricing of land for hospitals, clinics and care homes** impose counterproductive constraints on the development of additional buildings for our health system. Specific measures are required to reexamine and address change to the policies which govern this.

Chapter 4
Funding Options

4.1 General Commentary

i) Recent experience has shown that current funding, of which over 80% either is linked to current Government revenue or out-of-pocket expenditure, is at the mercy of the volatility of economic cycles. Our future system must have a stable basic source of funds and not be vulnerable to the winds of business fortune.

ii) Whilst one option will no doubt be chosen as the Government sponsored supplementary financing mechanism, others such as voluntary insurance and out of pocket expenditure can continue to play a role in overall funding. 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, a tax dedicated to health expenditure may be more acceptable than other complicated and confined solutions.

4.2 The Six Options in the Consultation Document

- **Option 1: Social Health Insurance**

  i) This approach, by which is meant mandatory contributory schemes administered by Government, is widely adopted for health care financing elsewhere and is an option for Hong Kong, if consensus cannot be reached on a mandatory private insurance solution.

  ii) 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 except that Government would be acting as manager of the pool and/or as insurer. As with mandatory private insurance, a significant sharing of costs and tight control of purchasing of health care will be essential to combat overuse.

- **Option 2: Out of Pocket Payments**

Out of pocket payments, i.e. user charges, are an important element in health funding both in the purchase of health care beyond the scope of a public system and through copayment, a sharing of the expense, as an **essential tool to inhibit overuse.** Public sector charges are low, and notwithstanding that the revenue generated by any increase will not significantly enhance public funding, there is no doubt that user charges impart a sense of responsibility and contribution. However, they cannot be a main source of supplementary funding.

- **Option 3: Medical Savings Accounts**

i) Individual medical savings are not a feature of any funding system other than in Singapore. Medical savings in Singapore are a major feature in enabling the public to have access to fully priced public secondary care.

ii) **Personal savings** encourage self responsibility for health care, but they are **not risk pooled.** This limits their value as a provision for major catastrophic or chronic illness in old age, whereby they may create a false sense of security against very expensive health care in later years. There is moreover questionable logic in separating health provision through personal savings for old age from the

general MPF provision, given that health care expenses are already a major cost element in old age. If personal savings has to be considered, this should be embodied in a more comprehensive and separate review of the MPF system in which contributions might encompass health care savings. 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.

iii) Except that they are used to purchase insurance, medical savings are not a direct and reliable funding mechanism for health care, and as such cannot on their own represent a public funding scheme option.

- **Option 4: Voluntary Health Insurance**

Voluntary insurance **cannot be part of any publicly sponsored system of 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 a major influence over the structure of primary care in Hong Kong. **Employers and the insurance industry have a major role to play** in promoting wider usage of voluntary additional health insurance and in building a medical insurance industry better able to influence, even to participate directly in providing quality health care.

- **Option 5: Mandatory Health Insurance**

i) **A core element in any supplementary funding must either be mandatory insurance** – whether provided by the insurance industry or by government – **or by taxation.**

ii) Mandatory health insurance provides **a community wide risk pool**

and is relatively simple, if based on a mandatory package of Government approved benefits. It eliminates the major disadvantages in voluntary insurance of exclusive risk pools limited to healthy younger persons, high marketing costs and variable benefits. It also provides a firm platform on which to build tax incentivised voluntary schemes to cover additional risks.

iii) A system of mandatory health insurance scheme should be **provided by private insurers** rather than Government. With proper regulation, a market driven system is more likely to deliver innovation and cost containment.

- **Option 6: Personal Health Care Reserve**

This option combines the features both of the medical savings and mandatory insurance options already discussed above. 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 be set aside in a reserve fund to meet post-retirement medical related expenses. The advantages of this option include facilitation for individuals to make 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 complicated administrative and regulatory burden, potential demand-side abuse, and escalating premiums because of aging and technology driven cost inflation. The main objection to this option in its present form if purely employment based is that it would again create a preferred class, further polarising the haves and have-nots. For this to be an acceptable option, amendments would be needed to develop it into an all-citizen programme with the Government paying the premium for those without adequate income.

A Final Word

The questions raised by health care reform are complex. A step by step approach in logical progression, first tackling primary care provision, then by ensuring the measured availability of professionals and facilities before proceeding to the major question of funding, may make the major question of funding, when we come to it, easier to resolve!

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