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HONGKONG CIVIC ASSOCIATION

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By Mail

Food and Health Bureau
19/F Murray Building
Garden Road
Central, Hong Kong

20 May 2008

Dear Sirs:

The Hong Kong Civic Association Healthcare Committee wishes to comment on the "Your Health Your Life" Healthcare Reform Consultation Document as follows:

SECRETARY FOR FOOD AND HEALTH MESSAGE

We support the four proposals stated in Para. 4 of the Message, namely:

(1) enhancement to the primary care system, and improvements to the healthcare safety net;
(2) reform the healthcare market structure to promote greater public-private partnership;
(3) develop a territory-wide electronic health record system as the infrastructure for (1) and (2);
(4) and to take forward (1), (2) and (3), to reform the current financing arrangements to provide supplementary financing.

As mentioned in para. 19 of the Executive Summary, Primary Care "also puts emphasis on preventive care that promotes the wellbeing and improves the quality of life in individuals". This represents a sustained community-based health educational commitment, embracing parents, school children, people at work and play, the elderly, the disabled, etc. Making available the right type of preventive care information to the targetted groups, especially at the district level, could be highly productive. The ultimate aim would be to make every individual citizen to be more actively aware of the importance of personal preventive care and how to go about it.

CHAPTER 1 – THE NEED FOR CHANGE

This chapter ends with the following sentence in bold type: "We must therefore act now".

We suggest that the 2nd stage consultation document planned for release next year should include:

(a) not only detailed proposals for reform, including those of supplementary financial arrangements, (Executive Summary, para. 3), but also,
(b) a roadmap and timetable for the reforms to be basically in place, say during a 10-year period.

CHAPTER 2 – ENHANCE PRIMARY CARE

In developing the family doctor concept which emphasizes continuity of care, holistic care and preventive care, it is hoped that after all relevant stakeholders have been consulted, the Family Doctor Register (or Primary Care Doctor Register) can be set up in a practical way adapted to the Hong Kong situation.

In this connection, we <u>attach</u> for your careful consideration a paper "On Manpower for Quality Primary Care" dated 3 April 2008 prepared by Dr. CHAN Amy Kit-Ling, a member of our Healthcare Committee, which includes a number of constructive suggestions on enhancing primary care and expediting the Training Programme in Family Medicine.

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We furthermore attach copy of a Joint Submission from The Hong Kong Society of Professional Optometrists School of Optometry, The Hong Kong Polytechnic University and The Hong Kong Association of Private Practicing Optometrists, dated May 2008, with recommendations on improving eye and vision care, especially at the primary level.

Our Healthcare Committee generally supports the contents and recommendations in the Joint Submission. Good and healthy eyesight is an indispensable requirement of our 7 million population, whether young or old, and we urge government to give priority in setting up suitable mechanism to review and implement the recommendations. This would synergize the relationship and promote closer cooperation between government and the Hospital Authority with the private sector.

In the past few years, there has been springing up in some districts a number of private poly-clinics offering medical care in a range of disciplines. We suggest that government should promote the setting up of poly-clinics that are well equipped and well managed in some of the larger public housing estates. This could alleviate the pressure on the Hospital Authority to open up many more outpatient clinics.

We also take this opportunity to suggest that government should now expand the School Dental Care Service to include not only primary school children, but also Secondary 1 – 3 students as well. In a world-class city as Hong Kong, it is timely for the service to be upgraded to include orthodontic care at minimum fee charge for those students who have such need, so that they can enjoy a better quality of life as they reach adulthood.

CHAPTER 3 – PROMOTE PUBLIC-PRIVATE PARTNERSHIP IN HEALTHCARE

The PPP opportunities for expansion and improvement in quality of healthcare services which are given in this chapter, are both exciting and challenging.

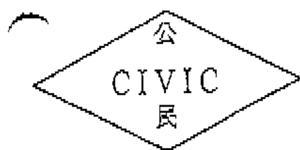
We suggest that in the meantime, apart from actively encouraging the building of more hospital facilities by the private sector, more Hospital Authority beds could be made available to the private sector, where the shortage currently seems to be serious. This would mark the growing cooperation between the Hospital Authority and the private medical sector.

With regard to para. 3.6(c), Hong Kong has quite a number of top quality talents in the health field, and we are in favour of government taking the initiative in the setting up of multi-partite health centres of excellence, which could be beneficial locally, nationally and internationally.

We also support government's effort to actively explore new PPP hospital development projects, such as a Children's Specialist Hospital, which could expand and improve Hong Kong's healthcare system, and also further upgrade Hong Kong's status as a regional medical hub.

CHAPTER 4 – DEVELOP HEALTH RECORD SHARING

We look forward to the Steering Committee on Electronic Health Record Sharing presenting next year its initial recommendations for a work programme, which would include pilot projects paving the way towards a territory-wide sharing infrastructure.



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It goes without saying that the work of this Steering Committee has a vital bearing on overall progress in healthcare reform, requiring the close cooperation of the private medical sector.

CHAPTER 5 – STRENGTHEN PUBLIC HEALTHCARE SAFETY NET

Regarding Para. 5.4(c), we agree that the concept of introducing a limit on medical expenses for individual patients as part of the safety net mechanism to protect families against financial ruin, should be studied in depth.

In this regard, we attach for your careful consideration a copy of "Health Care Financing Reform: A Socio-Economic Perspective" prepared by Prof. Lok Sang Ho, a member of our Healthcare Committee, in which he has made some well thought out suggestions in regard to capping of medical expenses and healthcare insurance.

Regarding Para. 5.4 (d), we would suggest that information on the availability and scope of the Samaritan Fund be expanded and brought to the attention of the private hospitals.

The Samaritian Fund could be a boon to low-income families who are not CSSA recipients, but who may have a member of the family being cared for by a private medical doctor, or specialist and who is in need of Samaritian Fund support by way of subsidized drugs and medical equipment.

As regards Para. 5.5. and 5.6 – Rationalize Public Fee Structure, we would suggest that the fees and charges structure be reviewed once every three years in accordance with the principles stated in Para. 5.5. and 5.6. The government needs to take firm steps in this direction so as to arrive at a rational balance in fees and charges between the public and private sectors.

CHAPTERS 6 – 13

The Personal Healthcare Reserve (PHR) Supplementary Financing Option outlined in Chapter 13 appears in our view, to be the most suitable model under Hong Kong conditions to be explored in depth for the further development of healthcare here.

This is a concept which should combine a mandatory savings account together with a healthcare insurance scheme. The insurance scheme would be provided by the insurance industry private sector, but regularly monitored and coordinated by government through appropriate procedures and regulations.

We are of the view that for PHR to get off the ground, say by 2011, and to be a viable model, there should be 1/3rd equal sharing of the monthly insurance premium for the worker/employee, the employer, and the government, for a minimum initial period of five years. This is the best way forward if we want to maintain a low corporate tax regime in Hong Kong and to ensure our economy remains globally competitive.

Also, the immediate family members should be included in the insurance policy.

PHR should be mandatory, starting off with the working population and their immediate family members, and expanded in coverage by stages to the rest of the population during say a 10-year period.

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CHAPTER 14 – BUILDING A HEALTHY TOMORROW

CHAPTER 15 – WAY FORWARD

Our Committee looks forward to the 2nd stage consultation document expected to be issued in the first half of 2009, which is expected to have a range of firm proposals for public comment.

As a sign of commitment on the part of government, it would be helpful and encouraging if the 2nd stage consultation document could include a roadmap and working timetable on the way forward.

Sincerely,

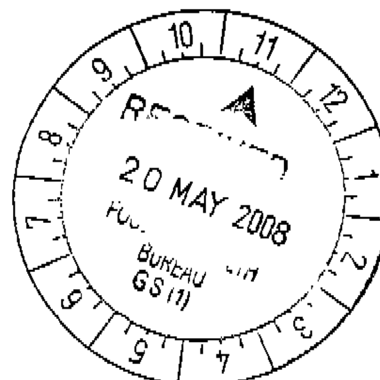
Hilton Cheong-Leen
Co-convenor

Prof. George Woo
Co-convenor

Enclosures: 3

<u>HKCA HEALTHCARE COMMITTEE</u>
Co-Chair: Hilton Cheong-Leen/Prof. George Woo
Frederick Lynn (HKCA Chairman)
Annita Mau, Hon. Secretary
Dr Amy Chan
Prof Lok Sang Ho
Lawrence Ho Wing Him
Prof Edwin Hui
Dr Bernard M H Kong
Angelina Kwan
Prof Aaron Leung
Dr Geoffrey Lieu
Prof Maurice Yap
Dr Robert Yuen

cc: LegCo Panel on Health Services



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Views on Healthcare Reform

Consultation Document

"Your Health Your Life"

(On Manpower for Quality Primary Medical Care)

Dr CHAN Kit Ling Amy
Healthcare Committee
Hong Kong Civic Association
3 April 2008

Summary

1. We agree that the quality of primary care services is central to healthcare reform and the **well-trained generalist** is one of the foundation stones. Most countries have a **policy in primary care workforce** and qualification requirement. We therefore recommend the government to develop such a policy, which includes setting an appropriate **international standard** for the proposed Family Doctor Register.

2. We recommend the government, together with the relevant professional bodies, to **review the Family Medicine Training Program** and to empower the specialty to set their own standard of training and assessment unique to community service.

3. We suggest the government to set up a **Quality Family Doctor Committee** to:

    a) redesign and implement an appropriate model of family medicine training for **new medical graduates**;

    b) design a flexible model of family medicine professional development program for **practicing primary care doctors**;

    c) promote the **Family Doctor Register** as the **official and preferred reference** for citizens to locate a personal doctor for continual whole-person care, along with the new Supplementary Financing Scheme and territory-wide Electronic Health Record system.

1. Introduction

1.1 On the "service reform proposals" (Executive summary), we agree that the quality of primary care services is central to reforming the healthcare system. We firmly believe that the well-trained generalist is essential in a delivery system that emphasizes high quality, cost-effective care. On the contrary, serious efforts to improve quality of care and reduce costs will not be effective unless quality doctors are there to provide that care.

1.2 A generalist, or general practitioner (GP), is a physician who personally provides whole-person health care to individuals and families in their living environment (1) and defines the service in terms of the doctor-patient relationship (2). In the following paragraphs, the term "quality family doctor" is used to stand for a "well-trained community-based medical generalist".

2. Family Doctor Register

2.1 In the proposal of establishing a Family Doctor Register in Chapter 2.14, it is suggested all registered medical practitioners providing family doctor service, or willing to provide such service, may register as family doctors. For obvious reasons, this initial inclusiveness is understandable, yet, ignoring the consideration of quality would defeat the whole purpose of setting up such register.

2.2. Chapter 1.3 states that "currently few private practitioners offer comprehensive primary care ...based on the family-doctor model... The current culture has impeded the development of an effective primary care system". We believe this current culture is the very result of the lack of emphasis in building a workforce of quality family doctors in the past decades.

2.3 As the family doctor is now entrusted to be the key person in the primary care service reform, fit-for-the-purpose training must be provided. A quality family doctor should acquire the knowledge base and skills set as depicted in Appendix 1, but it would be desirable to put more emphasis in training him/her to provide personal continuity of care to citizens or patients regardless of age, sex and disease entities in the community setting.

2.4 It has been proposed that the establishment of a Family Doctor Register be further developed through a working group with the involvement of all stakeholders (Chapter 2.15). We recommend the government to adopt an international standard in setting the training requirements and qualification milestones for registered doctors to remain on the Register, and for newly registered doctors in the future.

3. The international standard of quality family doctors

3.1 As seen in Appendix 2, most industrialized countries have formulated a national policy in primary care workforce since the 1970s. Medical graduates have to undergo vocational training and obtain eligible qualifications to practice in the community as quality family doctors in these countries. The duration of vocational training varies from 2 to 4 years, with the median duration of 3 years.

3.2 In Australia and UK, the qualification milestone for a quality family doctor is the Fellowship or Membership in General Practice, both requiring at least two years of training in the specialty of family medicine. From 2008, new UK trainee GPs are compulsorily required to complete the MRCGP to practice in the National Health Service. In Canada, the qualification milestone is the Certificate in the College of Family Physicians of Canada and the postgraduate training duration for independent practice is at least 2 years. USA medical graduates who wish to be a board-certified family doctor by the American Board of Family Medicine also have to undergo 3 years of postgraduate training.

4. Manpower of Hong Kong primary medical care

4.1 The Hong Kong College of Family Physicians (HKCFP) organizes the Vocational Training Programme in Family Medicine preparing doctors to provide quality care in the community. At the request of the Secretary for Health, Welfare and Food, the Hong Kong Academy of Medicine (HKAM) invited all its colleges to project the manpower need in each medical specialty.

4.2 HKCFP submitted the "Manpower Projection for the Specialty of Family

Medicine" to HKAM in April 2005, and calculated that about 2,700 full time primary care doctors would be needed to serve the whole population. With the existing 154 specialist family doctors (as at 2005) and assuming an annual output of 100 new-comers, it should require about 26 years to reaching the target.

4.4 The 4-year basic training is provided to family medicine trainees employed by the Hospital Authority, while the 2-year higher training is not funded by the government. In the manpower projection, HKCFP recommended additional funding to increase basic training posts and for higher training. We cast serious doubt on the effect of additional funding if insufficiencies (see section 5 below) of the existing training program are not rectified.

5. Insufficiencies of the Family Medicine Training Programme

5.1 As seen in Appendix 3, from 1999 to 2006, the total number of basic trainees was 601, but there were only 42 higher trainees who successfully became specialist family doctors since the commencement of the large scale training in 1999. The number of specialist family doctors remain too low (196 in 2008) to make an impact on the overall healthcare of the community.

5.2 The low output of quality family doctors is of public concern. Prof Richard Yu, council member of HKAM, expressed his views to the media and postulated the reasons for the low output as: dissatisfaction in trainees towards the content and process of training, suboptimal trainer quality, high failure rates in the examinations, drop-outs of trainees along the training pathway (3).

5.3 Research evidence shows that trainers were unsure on what to teach and how to teach (4). The Basic Hospital Trainees perceived low esteem, were uncertain about what they were expected to learn, and engaged more in service than in training. They felt neglected, their role misunderstood, and inadequately supervised (5).

5.4 To tackle the shortage of quality family doctors in the community, private primary care doctors suggested on the media (6) to shorten the vocational training duration because the time cost is considered too high for some graduates, given their

legitimacy to practice in the community without training. Using the 6 years to build one's own clientele in the community is considered time better spent than enrolling in vocational training. The differential financial and non-monetary reward (professional status, availability of hospital posts, further training opportunities, career prospects) between a family medicine trainee and a trainee in other specialties can present dilemmas for those contemplating how best to proceed in their careers.

5.5 The 6 years training requirement began after the establishment of the HKAM in 1993 when the definition of "specialist family doctor" came to be interpreted as "conforming to HKAM", rather than its original meaning of "being trained in the specialty of family medicine". HKAM consists of 15 constituent specialty colleges overseeing the training and continuing medical education of specialists who would mostly be serving in the hospital settings. The unique training and qualification requirement for family doctors who serve in the community is not easily understood or accepted by HKAM.

5.6 The present training requirement can only be exclusively satisfied as family medicine trainees employed by the Hospital Authority. This is pragmatically prohibitory. The training and assessment pathway does not accommodate doctors who return from overseas or have exposed to comparable training. There are no part-time opportunities or back-to-work programs. Though half of medical graduates are now female, issues concerning women doctors are largely neglected (7)

5.7 All doctors who have seven years postgraduate experience including five years in general practice are eligible to sit for Fellowship examinations in family medicine. The so called "intermediate" FRACGP and FHKCFP are international standards for quality family doctors in most countries around the world (Appendix 2). The difference in recognition for Fellows in Family Medicine under the present accreditation system may deter many from pursuing these international qualifications out of their own initiatives and resources. This is counter-contributory to meeting the manpower need for quality primary medical care for the whole population within a reasonable time-frame.

6. Primary Medical Care Manpower Policy Recommendations

In view of the above insufficiencies, our recommendations are as follows:

6.1 We propose the government, together with HKCFP and HKAM, to review the training and professional development program in Family Medicine for future training of both new medical graduates and practicing primary care doctors. We recommend the government to empower the specialty of family medicine to set their own standard of training and assessment specific to the uniqueness of service in the community.

6.2 We suggest the government to set up a Quality Family Doctor Committee to develop and implement manpower planning goals. It should be relatively independent and broadly representative. Membership should include doctors and doctors-in-training from both the public and private sectors, and who are knowledgeable about graduate medical education, but members should not be seen as representatives of particular interest groups.

The Quality Family Doctor Committee is suggested to:

6.3 Review the qualification milestone for a quality family doctor. The President of HKCFP stated his personal opinion of "family doctors should acquire the standard of College Fellow or equivalent" (8)

6.4 Redesign and implement an appropriate model of training for new medical graduates that facilitates relevant and focused learning, and places training doctors in appropriate training environments, especially private primary care clinics, so as to meet workforce requirements.

6.5 With appropriate funding, improve the quality of trainers by actively recruiting potential family medicine trainers, organizing regular "train the trainer" courses and employing an effective feedback mechanism for quality assurance.

6.6 Secure a steady and adequate number of vocational training posts. By adjusting the training duration (from 6 to 4 years) and improving the trainer and training program quality, ensure an annual output of at least 100 quality family

doctors in the next 10 years.

6.7 Design a flexible training and assessment pathway for the 3,000 to 4,000 practicing primary care doctors with a road map that describes a clear direction for all who are yet to reach the appropriate and agreed international standard for quality family doctors. The road map should consist of multiple achievable steps, for example, from certificate courses to diplomas to fellowships for some, or accrediting equivalent qualifications for others. The post-fellowship training and assessment would be open for those who wish to pursue an academic or administrative career path.

6.8 Pool existing training programs organized by various providers and channel to a common training endpoint for practicing primary care doctors. In Hong Kong, academic colleges and universities are statutory bodies to organize a myriad of quotable diploma courses for medical postgraduates. The Department of Health, Hospital Authority, private hospitals and other medical organizations have all invested precious resources in postgraduate training. We recommend the government to take the initiative to collaborate with these training providers, and accredit the training within a centralized framework according to the standard of the specialty of family medicine.

6.9 Generate incentives for practicing primary care doctors to achieve the agreed qualification milestone, for example, subsidies for training programs, qualification requirement to remain in the Family Doctor Register, the Primary Care Coupon system and so on.

6.10 Promote the Family Doctor Register as the official and preferred reference for citizens to locate a personal doctor for comprehensive, coordinated and continual care in the community. Training and qualification requirements for doctors who are eligible to be newly registered, and conditions for registered doctors to remain on the Family Doctor Register, should be explicit and transparent. The public needs to recognize the importance of a well-trained workforce to ensure equitable and affordable access to high quality primary care. We recommend the government to

promote the Family Doctor Register along with the new Supplementary Financing Scheme and territory-wide Electronic Patient Record.

Reference:

1. YT Wun. "What is general/family practice?" Let us define it. Hong Kong Practitioner 2002 Oct; 24: 498-502
2. McWhinney IR. The importance of being different. British Journal of General Practitioner 1996 July; 46: 433-6
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4. Chung JTN, Wun YT, Lam TP. Vocational training in family medicine: a qualitative study of perspectives of trainees in community-based training. HK Pract 2004; 26: 181-186
5. Wun YT, Lam TP, Tsang LCY. What do family medicine trainees say about their training? HK Pract 2003; 25:59-69
6. 〔家庭醫學・何去何從〕信報 2007 年 12 月 21 日
7. Bain J. Editorial: Vocational training: the end or the beginning? British Journal of General Practice 1996 June; 328-330
8. Ip KKA. Message from the President: Family Doctors' List. Family Physicians Link 2008; 49:1

Appendix 1

Competence of a well-trained family doctor as described in "Your Health Your Life" (chapters and sections)

1. Serve as the first contact point and be responsible for the screening and assessment of medical conditions to see if they could be dealt with in the primary care setting or if further intervention is necessary (Chapter 2.6)
2. Serve as the gateway for advising and directing patients for necessary and appropriate healthcare including specialist and in-patient care (Chapter 2.6)
3. Assume the role of managers and long-term providers of holistic care to patients, including preventive care, health risk assessment, follow-up care after medical conditions of patients have stabilized and after discharge from hospitals (Chapter 2.6)
4. Nurture and provide a long-term continuous relationship with patients (Chapter 2.16 part c)
5. Provide patients with out-of-hours access especially in case of urgency (Chapter 2.14 part c)
6. Be able to share their patients records with relevant parties and make use of the future electronic health records (eHR) sharing infrastructure (Chapter 2.14 part d)
7. The professional person through which patients can obtained subsidies for comprehensive and quality primary care, including preventive healthcare services in the form of primary care voucher (Chapter 2.16 part c)
8. Engage in public health education (Chapter 2.20 part a)
9. Involve in public health promotion on healthy life-styles (Chapter 2.20 part b)
10. Contribute in devising appropriate standards and specific protocols for various primary care services (Chapter 2.13)

Appendix 2

International Standard of a trained (quality) family doctor

Country	National primary medical care workforce policy (year of establishment)	Number of years in Postgraduate vocational training	Eligible qualification to practice as a specialist (trained) family doctor	Regulatory / Academic Centres
Australia	Yes (1973)	3	FRACGP (necessary for Medicare rebates	1) Royal Australian College of General Practitioners 2) Australian Medical

			since 1996)	Association 3) General Practice Education and Training Ltd.
United Kingdom	Yes (1979)	4 (since 2005, after 1 year as Foundation House Officer)	nMRCGP (mandatory since 2008)	1) General Medical Council 2) Academy of Medical Royal Colleges
Canada	Yes (1995)	2 3	CCFP CCFP(EM)	College of Family Physicians of Canada
Netherlands	Yes (1973)	3.5	Enrolment in National Vocational Training Program on General Practice	1) Dutch College of General Practitioners 2) Dutch Association of General Practitioners
United States	Yes (1994)	3	Board-certified family physicians (MC- FP)	American Board of Family Medicine
Hong Kong	No	6	FHKAM (FM)	1) Hong Kong College of Family Physicians 2) Hong Kong Academy of Medicine

Key to Abbreviations :
FRACGP – Fellow of Royal Australian College of General Practitioners
MRCGP – Member of Royal College of General Practitioners
CCFP – Certification in the College of Family Physicians of Canada
CCFP (EM) – Certification in the College of Family Physicians of Canada (Emergency Medicine)
MC – FP – Maintenance of Certification Program for Family Physicians
FHKAM (FM) – Fellow of Hong Kong Academy of Medicine (Family Medicine)

Appendix 3

The Flow of Trainees through the Hong Kong College of Family Physicians (HKCFP) Specialist Training Programme

Year	No. of BASIC TRAINEES	Year	Fellow of HKCFP / Fellow of RACGP	Year	No. of HIGHER TRAINEES	Year	Fellow of Hong Kong Academy of Medicine
1988	5	1992	1	-	-	-	-
1989	9	1993	2	-	-	-	-
1990	3	1994	2	1994	15	-	-
1991	1	1995	3	1995	16	1997	8
1992	4	1996	6	1996	11	1998	4
1993	7	1997	2	1997	5	1999	8
1994	11	1998	4	1998	5	2000	10
1995	14	1999	5	1999	5	2001	3
1996	23	2000	9	2000	11	2002	6
1997	21	2001	12	2001	13	2003	12
1998	28	2002	16	2002	11	2004	11
1999	**80**	**2003**	**29**	**2003**	**25**	**2005**	**13**
2000	90	2004	37	2004	34	2006	9
2001	93	2005	35	2005	30	2007	20
2002	97	2006	51	2006	49	2008	-
2003	102	2007	-	2007	-	2009	-
2004	25	2008	-	2008	-	2010	-
2005	71	2009	-	2009	-	2011	-
2006	43	2010	-	2010	-	2012	-

In Response to the Health Care Reform Consultation Document: Your Health Your Life

Joint Submission from
The Hong Kong Society of Professional Optometrists
School of Optometry, The Hong Kong Polytechnic University
And
The Hong Kong Association of Private Practicing Optometrists

May, 2008

CONTENT

Summary of Recommendations

Introduction

Recognition of the Profession

The Existing System – A Costly System

Early Diagnosis Saves Costs, and Life

Better Primary Eye Care, Less Social Costs

An Independent Self-Regulatory Body for Optometrists

SUMMARY OF RECOMMENDATIONS

- promote the need of regular eye check for the public, especially for the high risk group; e.g., diabetics (10% of the HK population has diabetes)
- place optometrist on the first point of contact for eye patient
- utilize the full competency of the optometrist
- have referrals by the optometrist accepted by the Hospital Authority
- provide regular eye examination for the elderly
- provide affordable eye care with visual correction for the elderly
- to provide universal annual eye examination for children once they start schooling
- train teacher to identify children with vision problems
- provide for an independent self-regulatory body for optometrists

INTRODUCTION

We commend the government's vision "to achieve a health care system that improve the states of health and quality of life of its people, and provides healthcare protection for every member of the community".

We also support the government's intention to enhance primary care and its emphasis on preventive care. However, we see that the recommendations in this consultation document fall short of recognizing the role that health care professionals other than medical doctors can play in the delivery of primary health care.

We regret to see that there is little mention of strengthening the role of related primary health professional group that could contribute to minimize duplication of health services and could render much efficient health services.

For the purpose of timely treatment for the patient, and elimination of double health care costs, we propose that functions and duties of health care professions that promote and provide preventive, curative and rehabilitative care should be recognized in accordance to the training and qualification attained in tertiary education. A review on law and policy is much desired for more efficiency in the delivery of primary health care in Hong Kong.

We will speak, in this paper, on what and how the competency of the optometrist could be utilized more fully in primary eye care and serve the community better.

RECOGNITION OF THE PROFESSION

In advanced economies, the status of the optometrist as a primary care practitioner has been recognized more than 20 years ago. The role of optometrist as primary care providers was formally evaluated by the Department of Preventive Medicine and Biostatistics, Faculty of Medicine, University of Toronto in 1980, in a study entitled "Vision Care: A Survey of optometrists in Ontario". This study concluded that optometrists met the criteria for primary care practitioners. The Institute of Medicine of USA defined primary health care and included optometry as a primary health care profession in 1996.

The Hong Kong Polytechnic established Optometry training in 1978. To date this institution has trained over 600 optometrists. Its academic award is recognized world wide. The Hong Kong Polytechnic became The Hong Kong Polytechnic University in 1994. Today, research, education and training at its School of Optometry is considered top notch internationally.

According to the consultation document, optometrists are, *Health professionals trained to provide comprehensive eye and vision care, such as eyesight correction and diagnosis of common conditions related to the eyes or vision. They are not medical doctors but may refer patients to an ophthalmologist for treatment when needed.*

We welcome the recognition by the Bureau that the optometrist is qualified to refer his patient directly to an ophthalmologist. However, we question why the public health care sector run by the Hospital Authority deviates from the Bureau's view and refuses direct referral from an optometrist to its eye departments.

We are obliged to emphasize that the World Council of Optometry has widely publicized that optometry is an independent primary health care profession, which encompasses the prevention and remediation of disorders of eye and visual system through examination, diagnosis and treatment of eye and visual disorders and the recognition and diagnosis of related eye and systemic manifestations of disease.

THE EXISTING SYSTEM – A COSTLY SYSTEM

In the private sector, an optometrist is "a first contact primary health care practitioner". When a patient has blurred vision or discomfort in the eye, he may consult the optometrist directly. The optometrist will give him a comprehensive eye check and identify the problem and decide whether the patient should be treated with vision correction or should be referred to a specialist. The patient does not have to run around. His time and money is saved. And more importantly, he gets timely treatment.

Eye care in the current public system is fragmented among optometrist, general practitioner and ophthalmologist. For the grassroot who cannot afford

private health care for the eye, he goes to the public health care sector. Even though he has the diagnosis rendered by an optometrist, he has to go to GOPC or a private GP to get a referral letter before he could secure an appointment with the HA eye department. This results in double health costs and treatment could be delayed.

We recommend streamlining the process to cut costs and time. Taking UK and Canada as examples, the optometrist is the first point of contact for patients. He will conduct a comprehensive eye examination that includes refraction and evaluation of the visual system. He will then refer the patient to the appropriate specialist should systemic disease be detected, or an ophthalmologist for surgical eye care; meanwhile, he copies the information to the family doctor.

The Hong Kong government allows the streamlined procedure in private sector. An ophthalmologist in private practice would accept referral from an optometrist. We question why the Hospital Authority will not accept referrals from an optometrist. This double standard is a waste of precious public resources and cause unnecessary delay in treatment.

EARLY DIAGNOSIS SAVES COSTS, AND LIFE

Impaired eyesight could be a sign of systemic disease, for instance, diabetes, high blood pressure, or some brain trauma or tumours. According to statistics in Australia, where people go for regular comprehensive eye examinations, 5% of the examined is found to be in need of referral for further investigation. Early diagnosis prevents further damage to vision and calls for timely treatment of systemic disease.

We recommend the following actions:

1. promote the need of regular eye check for the public, especially for the high risk group; e.g., diabetics (10% of the HK population has diabetes)
2. place optometrist on the first point of contact for eye patient;
3. utilize the full competency of the optometrist;
4. have referrals by the optometrist accepted by HA;

BETTER PRIMARY EYE CARE, LESS SOCIAL COSTS

Eye sight is a major sensory faculty for people to communicate with the world. Continuous exclusion is detrimental for physical and mental health.

As elderly people are not as capable in keeping up with the world due to degenerative changes in vision and hearing, they are not aware of hidden dangers in the physical surrounding and consequently, are prone to accidents.

Poor vision turns the elderly off from social and cultural activities which are crucial for the elderly to keep an active life. In face of an ageing population, we should, by all means, help the elderly at the primary care level to maintain good vision to stay in touch with the community. That would save the elderly from distress and consequential physical illness.

We recommend the following:

1. provide regular eye examination for the elderly;
2. provide affordable eye care with visual correction for the elderly;

The lack of proper primary eye care for children goes further than damage on health. It discounts the resources we put into education. Studies suggest that as much as eighty percent of a child's learning process is acquired through their vision. School kid with imperfect eyesight is handicapped from learning. If the teacher is not trained to spot the problem, the child is often mistaken as a lazy student even though he is trying his best. He will lose his self esteem and distance himself from learning.

While vision screenings are undertaken in some primary schools by nurses from the Department of Health, these checks are often confined to the most basic tests. A comprehensive eye examination which includes a series of visual functions such as visual integration, visual skills and eye health, rather than screening is therefore vital for good vision. Early primary eye care for detection of vision related problems is crucial for the academic success of Hong Kong children.

We recommend the following:

1. provide universal annual eye examination for children once they start schooling;
2. train teacher to identify children with vision problems

AN INDEPENDENT SELF-REGULATORY BODY FOR OPTOMETRISTS

The legislation in Hong Kong puts the optometry profession under an umbrella ordinance that regulates five healthcare professions, namely, physiotherapy, radiography, medical laboratory technology, occupational therapy and optometry. Each of these professions is progressing at its own pace and direction. Each deserves recognition of its specialization. The existing ordinance, as it stands, is not flexible enough to deal with changes in each profession with the same provisions. Consequently, advancement of the professions is hindered, and protection for the public delayed.

We need a separate mechanism to regulate the profession with updated rules and regulations catered for the best interest of the public. We urge the Administration to present a bill to provide for an independent self-regulatory body for optometrists.

Health Care Financing Reform: A Socio-Economic Perspective

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August 2007

Health Care Financing Reform: A Socio-Economic Perspective

Abstract

This paper reviews some of the recent literature and experiences in healthcare reform in the light of the peculiarities of human nature. The review suggests that successful healthcare financing reform boils down to working out a cost/risk-sharing formula between the government and citizens that can effectively preserve the incentives for efficient utilization of healthcare resources and for preventive care, while limiting the financial risk of citizens. The paper will also address issues arising from aging and redistributive concerns, as well as political and administrative feasibility.

JEL Classification: I11, I18, I19

Key words: Healthcare financing, human nature, moral hazard, excessive burden insurance, lifetime healthcare supplement, aging, redistribution, public and private interface of healthcare

1. Introduction

A recent paper by Sidorenko and Butler(2007) reviewed the various efforts to provide health insurance among Asian Pacific countries. They cited the WHO Commission on Macroeconomics and Health (2001:21): "good population health is a critical input into poverty reduction, economic growth, and long-term development at the scale of whole societies." But health[1] is also a crucial input in "household production," which is the economist's jargon for the process of turning consumption goods and services purchased in the market place into "consumption attributes," such as nutrition and sensory pleasure, that directly affect people's well being.[2] According to many studies(Veenhoven, 1991, Peiro, 2006), health appears to be an important determinant of happiness[3]. Gruber and Mullainathan(2005) even found cigarette taxes conducive to happiness, and this apparently is because cigarette taxes reinforce the commitment to quit smoking, and ultimately contribute to a healthier and happier life for smokers over the longer run.

Today the healthcare systems in many countries are facing a crisis. The crisis facing Americans is well known and attracted even more debate after Michael Moore's controversial movie Sicko. Even the often-touted Singapore system had to cope with emerging problems with various reforms, which over time have added to the complexity of the system considerably(Taylor *et.al.* 2003). Thus, on top of the better known Medisave, which was launched in 1984, a catastrophic insurance scheme called Medishield was introduced in 1990 to serve as a risk management tool, protecting the insured from excessive burden in the event a major illness struck. To ensure the sustainability of Medishield, Singapore requires of patients payment in the form of deductibles and co-payments, and sets limits over claims per treatment, per policy year, and over one's life

[1] Here health should refer to "functional health." This is the flow of functionally healthy time that an individual enjoys within a specific time period. Duffy and MacDonnald(1990) investigated into the determinants of functional health for the elderly.

[2] One of the pioneers of the household production concept is Becker. See Becker(1965).

[3] Causality is however notoriously difficult to establish. For example, one authoritative result shows that happiness is inversely related to hypertension (Blanchflower and Oswald, 2007). One may ask if it is hypertension that make people less happy, or whether unhappy people develop hypertension.

time. Singapore introduced the Medifund to assist the poor in 1993, and stipulated that only the interest from the endowment fund was to be used to help the eligible poor. Singapore further introduced the Eldershield in 2002 to provide protection against the risk of severe disabilities when one gets old. In Hong Kong, alarm had been raised time and again that the government-funded healthcare system is unsustainable(Hsiao *et.al.* 1999) On the Chinese Mainland, where government funding for healthcare is minimal and hospitals are asked to procure its own finances through fees and charges, considerable anxiety pervades the population over unpredictable and often large medical expenditures(Liu and Mills, 2002; French, 2006), putting great pressure to reform the system. Across the Taiwan Strait, the introduction of a National Health Insurance plan in Taiwan was welcomed by the population, but had raised concern about sustainability and moral hazard problems[4], while the co-payment requirements also had raised concern about fairness(Cheng, 2003)[5].

Generally, there is a dilemma that faces most universal health insurance schemes or national health systems. It is human nature that people are worried about great financial risks. But if patients are protected from the bulk of the cost when health services are required, it is also human nature that they will lose some motive for preventive care and will tend to over-utilize the system ("demand side moral hazard"). Furthermore, when caregivers are asked to bill the insurance fund for the care they give to patients they may give more "care" than necessary ("supply side moral hazard") and they may even bill it for care not given[6]. In an aging society, it is particularly important that people should be motivated to take care of themselves and to save for their healthcare needs[7] at an early age by arousing their cost consciousness. The kind of universal

[4] Moral hazard is a term used in the insurance literature to describe how people respond to insurance by taking less preventive care(demand side moral hazard) or by providing more services than is appropriate(supply side moral hazard).

[5] Critics argue that the sick are already disadvantaged and often poor and should not be burdened with copayments.

[6] "Care" in quotation marks to highlight the fact that it may not be in the patient's interest at all. While living in Canada in the 70s the author read of multiple news reports about such fraudulent claims.

[7] We will argue that they should save for *part* of their healthcare needs when they get old. This is the "affordable share" of their healthcare cost. See below.

health insurance as we know to date[8] however blunts that cost consciousness, raising the possibility of a cost explosion in the future when people grow old. The tendency for diabetes and obesity cases to develop among the younger population as observed in many countries is particularly worrying.[9]

Section 2 will explore the reasons why healthcare reform has been so difficult and why many efforts at reforming healthcare have failed. Section 3 will discuss the key elements of a successful healthcare policy. Section 4 provides an argument for the public healthcare sector to cover only "basic care," to implement marginal cost pricing for such services, and for the government to negotiate standard pricing for basic drugs with pharmaceutical companies, while leaving premium services and premium drugs entirely to the market. Section 5 discusses a modified version of Ho's Excessive Burden Insurance(Ho, 1997) designed specifically to address the aging issue. Section 6 will discuss the concept of Lifetime Healthcare Supplement, which can go hand in hand with Excessive Burden Insurance to increase the choices available to citizens without exposing the government itself to excessive financial risk. Section 7 looks into the subject of political and administrative feasibility, which inevitably will include distributive justice concerns. Section 8 concludes the paper by observing that the key to successful healthcare reform lies in defining the roles of private and public caregivers in a way that reflects their comparative advantages and in combining the best features of a market-oriented system and those of a public healthcare system.

2. Health Policy as a Socio-Economic and a Political Problem

These problems have to do with public policy failing to recognize the peculiarities of human nature, particularly natural incentives and extreme risk aversion, and policy makers failing to build in features in the policy that directly address the incentive problem and the human need for peace of mind.(Ho, 1998, 2001b, 2006).

A sustainable and high quality healthcare system requires providing the right incentives among all key stakeholders and the cooperation of all parties concerned. Unfortunately, typically this is rendered very difficult because of political reasons. Political parties may be wary of introducing

[8] Typically these are in the form of "Fee Reducing" insurance. See Appendix for a comparison with Excessive Burden Insurance.
[9] See Daviglus *et. al.*(2004) & http://www.diabetes.org/diabetes-research/summaries/daviglus-bmi.jsp

cost-based user charges that may turn their voters away. Politicians figure that voters will take the short view rather than the long view. Their own time horizon, too, seldom extends beyond one or two terms of office. Then there are insurers, pharmaceutical companies, private doctors, lawyers, and others who are eager to defend or further their interests, all rendering a fair, longer term solution to the health policy problem "academic."[10]

Although public policy affects different stakeholders differently, it is possible to have a workable definition of "the public interest." Following Rawls(1971) and Ho(2001) we propose that the public interest is the *ex ante* interest of the "representative individual" as he confronts different possibilities: the representative individual being a hypothetical individual who faces equal probability of being anyone within the society. We may perform a thought experiment as suggested by Rawls(1971). Imagine that we could be a doctor; a healthy person or a patient; the shareholder of a pharmaceutical company; the shareholder of an insurance company; or someone not holding any stake in these companies; a rich person or a person of poor means; a fortunate one, or an unfortunate one. We would ask, as we ponder over each policy proposal: if we were "behind a veil of ignorance" about our identity(Rawls, 1971), what policy would we prefer? Thus public interest is the interest of society when all vested interests are forgotten: there is no specific person or party to defend for or to please, but there is a need to defend and to care for anyone in society in a probabilistic sense.

Various surveys on the two sides of the Atlantic and elsewhere show that people are all deeply concerned about healthcare (Blendon, *et.al.*, 1990; Mossialos, 1997, Blendon and Benson, 2001, Peiro, 2006) and unpredictable healthcare costs. Various polls in China indicate that healthcare and healthcare cost are the key concern of the population. Providing reliable needed care at an affordable cost is clearly conducive to happiness and deserves high priority in the social agenda in most countries.

[10] "The pharmaceutical and health products industry has spent more than $800 million in (US) federal lobbying and campaign donations at the federal and state levels in the past seven years." See "Drug Lobby Second to None How the pharmaceutical industry gets its way in Washington", The Centre for Public Integrity. posted July 7, 2005. http://www.publicintegrity.org/rx/report.aspx?aid=723 accessed August 10, 2007.

Yet many governments are worried about the rising burden of healthcare on the public purse. However, while sustainability is a legitimate concern, a rise in the share of healthcare spending in GDP does not necessarily signal any problem, and may simply reflect the changing needs of society. To deal with the sustainability issue, many governments look upon the Singapore healthcare system as a model, as it demonstrably has succeeded in containing public expenditures on healthcare. But with so many rules and impositions all of which limit choice and potentially welfare, the Singapore model may not be the best option.

The task facing a government concerned with maximizing the public interest is the daunting task of seeking the best deal for the representative individual while facing the fight for self interest from patient and consumer groups to doctors and HMOs to insurance companies and lawyers to pharmaceutical companies and their shareholders. This paper argues that the government needs to define its role narrowly as providing just "basic care" at affordable cost while maintaining standards and accountability in the private market. Defining what is covered under "basic care" limits the cost exposure of the government and gives private players the maximum room to play without fear of unfair competition from the public sector. Politically, by allowing pharmaceutical companies to charge market prices for "premium care" drugs, there is a better chance for the government to negotiate affordable drug prices on the "basic care" list.

The essence of healthcare financing reform, from this perspective, boils down to defining the role of the government appropriately and to working out a cost/risk-sharing formula between the government and the citizen that can effectively preserve the incentives for efficient utilization of healthcare resources and for preventive care, and thus to ensure sustainability.

3. Key Elements of Reform

Economists know well that correct prices hold the key to economic efficiency.[11] Common folks know well that the dilemma of having to pay beyond one's means or facing the serious consequences of substandard or inadequate care is the source of much agony both for the patient and for his immediate family members. Recent analysis by Ho(2001, 2006) further suggests that

[11] Economic efficiency means simply making the most out of what is available. It requires producing at the least cost, allocating resources according to people's choices, and consumption efficiency.

the prospect of having to face such a dilemma has an immediate negative effect on happiness.[12] Thus any viable healthcare financing package should include:

(1) a pricing policy that ensures fees and charges reflect marginal or direct costs of services;

(2) an insurance policy that ensures that patients never have to face the dilemma of either going broke or going without proper healthcare at a time when such care is crucial to preserving health or even survival.

Apart from these basic considerations, unless excessive or even bewildering information is involved (Schwartz, 2004), providing more choice is superior to providing less choice. Thus there is:

(3) an imperative to increase choices as long as the benefit of increasing choices exceeds the cost. Finally,

(4) resources should be allocated into healthcare as long as the additional benefit exceeds the cost. This is true for the government as well as for the individual. An appropriate amount of public revenue should be allocated for the prevention of illnesses and accidents, for the treatment of patients, for the training of healthcare professionals, and for research and development. Cost benefit analysis needs to be performed to assess how much of each is optimal. At the individual level, as long as prices are appropriate, we can leave the individual to make his own choice, unless a particular kind of behavior has significant external effects on others, in which case government regulation will be necessary.

While most countries continue to see an increase in the share of resources being devoted to healthcare there is evidence of wastefulness and inadequate resources being allocated to healthcare at the same time for many countries. In China, doctors supplement their meager incomes by overcharging patients through drug sales or unnecessary services and procedures so as to obtain bonuses. The practice is encouraged by hospitals which are under-funded by the government and need extra income to make ends meet (Blumenthal,2005). Because lucrative fees can be charged on high-end services, Chinese hospitals over-invest in costly medical equipment, such as Computerized Tomography machines—the 30.6% ownership rate is even higher than that in major European cities and the US(IBM, 2006).

[12] This is called "prospective happiness."

4. Marginal Cost Pricing for Basic Care for Efficiency

It is important to distinguish between basic care and premium care.[13] For basic care, which is defined as the most cost-effective care to maintain normal health given the constraint of sustainability and universal accessibility, fees and charges need to be regulated and fixed at the marginal cost (the direct cost arising from a service) of the care. This is necessary to minimize both demand side and supply side moral hazard. In general, charging below marginal cost may lead to waste and demand beyond what is optimal. This is well documented by the famous Rand Health Insurance Experiment study(Newhouse, 1993). Charging above marginal cost makes providing a service profitable and may lead to supply-side moral hazard.

Ho(1995) has documented how lucrative fees and charges had caused inappropriate care and waste in China. A more recent study(IBM, 2006) also drew the same conclusion. If patients already have access to basic care, premium care is by definition just an extra choice. Prices therefore should be left entirely to the market. In short, basic care is for basic protection; premium care is on the other hand a kind of "opted care." The former should logically be non-profit and provided by government in the first place. The latter should be profitable and is the exclusive purview of the market. It will be unfair for the government, which has the authority to tax, to compete with private caregivers for profitable business.

If consumers need to pay a price for healthcare services consumed and if this price reflects marginal costs, they will buy the service only when their perceived benefits exceed costs. With fixed costs paid for by the government, there will be no need for any fees or charges to exceed marginal costs. There will then be no cause for supply-side moral hazard. Successful control of supply-side moral hazard is one reason why both the National Health Service of the UK and the Hong Kong Hospital Authority system are generally considered good value for money. In both healthcare systems doctors as well as other healthcare professionals are paid a salary that allows a

[13] This is crucially related to the question of public versus private provision, as pointed out by Lim (2005). As well it is crucially related to the question of affordability: "the thought of denying a fellow human being access to the same level of health care because of his or her inability to pay, stirs deep emotions." (p.461)

reasonable return for their human capital investment. Salaried doctors would not like patients to revisit unless there is a professionally perceived need for it.

On the other hand, if the prices and charges of basic care services are not regulated, and caregivers are allowed to charge whatever they like, then serious abuses are likely. Given the importance of health and the need for timely care those patients and their families would try their best to comply with any excessive charges imposed by caregivers or to purchase unnecessary services. Because of information asymmetry and an absence of alternative choices, patients may not know if the services they are getting are the best for them. With little alternative choices and under duress patients in China or their families would offer doctors "red packets" to maximize the chances of good care.

If basic care services are all priced fairly and at marginal cost, caregivers will not stand to gain anything by giving services or lose anything by withholding services. If basic care at fair prices is available, then there will be no need to regulate the prices of premium services, which patients would opt for only when they perceive good value. In other words those who opt for premium services do so not because they are forced to do so but because they want to.

While public hospitals and clinics should not compete directly with them for profitable business if some private healthcare providers want to provide basic care, they should be allowed and even encouraged to do so. But if their services are truly "basic" they should follow the government's pricing scheme. For such caregivers, since they are helping the government and are alleviating the public burden to fund healthcare infrastructure it may be argued that the government should provide some lump sum grants to defray part of their overhead costs.

Following the marginal cost pricing principle, for efficiency standard basic care drugs should be priced at marginal cost and it will be up to the public health care system to negotiate prices with suppliers and to ensure that these prices will be charged through all authorized dispensaries. For "premium care", on the other hand, to encourage innovation and without undermining basic care, prices should be left to the free market. Allowing pharmaceutical companies to earn a bigger profit for premium care drugs is an inducement for them to charge lower prices on standard drugs.

5. Excessive Burden Insurance for Protection:

If the public is worried about healthcare being excessively burdensome, then the universal Excessive Burden Insurance (Ho, 1997, 2001a) appears to be a logical policy response. The idea of public healthcare based on an annual deductible has been implemented in Sweden, where a patient who has paid a total of SEK 900 in patient fees from the date of the first consultation is entitled to free medical care for the rest of a twelve-month period (Fact Sheets on Sweden, 2003, Swedish Institute). But there the fees as well as the annual deductible appear too low to serve the purpose of healthcare financing or moral hazard control. Excessive Burden Insurance is an insurance scheme in the sense that each citizen is protected or "insured" against having to spend *beyond his means* in some sense. Under Excessive Burden Insurance the insured person pays the direct cost for services consumed up to a pre-set annual limit which is considered a fair and bearable contribution by the patient. Beyond this "annual deductible" the government will offer complete protection for basic care. Of course, the coverage of basic care needs to be carefully defined. Under an EBI insurance, premiums may either be collected from the public individually or entirely paid for by the government. Excessive Burden Insurance distinguishes itself from most national health insurance schemes in that, before the pre-set annual limit has been reached, citizens are expected to pay the direct cost of healthcare services. A problem with many national health insurance plans is that they mitigate the incentive of citizens to take preventive care and that the effective under-pricing of health services often leads to waste and abuse. Under Excessive Burden Insurance waste and abuse are minimized while any revenue collected through user charges is recycled back into basic healthcare. Although beyond the pre-set limit all cost is absorbed by the government it is argued that those citizens who utilize health services so intensively are likely to have a good reason.

Table 1 and Table 2 in the Appendix provide a numerical illustration to show that in order for a "fee reducing" insurance program to significantly reduce the risk exposure to patients, as Excessive Burden Insurance does, the discount off the actual cost of medical care is likely to be as high as 90%. This kind of discount significantly distorts the perception of costs and will cause serious moral hazard.

Finally, it is a well known fact that older people generally use healthcare services much more than

younger people, although there can be a great variation from country to country (Hagist and Kotlikoff, 2005[14]). To be fair to everybody and to encourage saving and a healthy life style at a young age, the annual pre-set limit(the annual "deductible") should be raised for those beyond the age of 50 by some specific amount each year up to some socially agreeable amount. Such arrangement would enable the government to collect more revenue that can be recycled back to the public healthcare system to provide timely quality healthcare for the aged.

6. Lifetime Healthcare Supplement(LHS) for Greater Choice:

The split between basic care and premium care is not an easy one. The easiest way is to include all services currently provided under the HA or the Health Department clinics as basic care. But with charges raised to a more reasonable level, it is possible to consider bringing back some of the earlier included but recently excluded drugs back to the basic care list. There will, of course, always be some drugs that cannot be included under basic care. Patients can however draw funds from the Lifetime Healthcare Supplement and pay for such costly drugs partly with such funds and partly with their own funds as described under Lifetime Healthcare Supplement.

Because medical knowledge and technology are evolving rapidly, modern and particularly frontier healthcare can be very expensive but may not necessarily be effective. Such healthcare is often beyond the means of the ordinary citizen and the government. However, some kind of cost sharing may be welfare-enhancing because it increases citizens' choice. One such cost sharing scheme would have the government offer each citizen an amount of standby backup funding. In order to minimize abuse and to maximize potential benefit, withdrawals can be for any health-related service, but the citizen must match any withdrawal with his own money. The fact that the standby amount is fixed for the lifetime also has a built in mechanism against abuse, because any withdrawal would reduce its availability later on in life. The lifetime fixed amount limits the cost to the government and helps preserve the incentive to use the resources wisely. The matching requirement is like a co-payment in insurance to reduce moral hazard problems.

7. Political and Administrative Feasibility

[14] Their Table 2 is reproduced as Table 3 in the Appendix.

The suggestion that basic health care fees should be based on direct costing and that the annual deductible should rise from age 50 raises worry that it may not be politically feasible. This is on top of the worry that it might undermine access to care or might cause costly delays in getting care. These are valid concerns and need to be addressed.

To mitigate the affordability problem,[15] discounts on fees and reduced annual deductibles may be given those found to be poor. Moreover, for those who are receiving welfare payments, an increase in their monthly stipends may go hand in hand with charging them a reduced fee. The increase in the welfare stipend can in principle reduce the net increase in burden to as small as is desired.

With the affordability issue taken care off, and with the promise of better, more timely and more reliable services in the offing, and on top of that the offer of the Lifetime Healthcare Supplement there is a good chance that political feasibility will not be a problem.

Administratively the proposal is easy to implement especially in light of today's information technology. Indeed Sweden has been implementing some kind of excessive burden protection for over a decade. The proposed system will require setting up a separate central file for each eligible citizen. Under this file will be recorded his medical history, blood type, what he is allergic to, as well as his "basic care" medical spending within the year. The system will be automatically alerted when he has paid up his annual deductible. From that time on till the end of the year the government will be responsible for all his basic care medical expenditures.

Private clinics and private hospitals are part of the healthcare system and should work together to serve patients. The public healthcare system will provide basic healthcare only and will announce official basic care charges from time to time. Private caregivers who opt to provide basic care will have to charge the same rates, but they have the option to provide better than basic care and to charge more, as well as premium care not covered by the basic plan. In the case where caregivers provide better than basic care, only the official basic care charges will be recorded. With

[15] Bundorf and Pauly(2006) found evidence that in the US one quarter to 3/4 of the uninsured can actually "afford" but did not choose to get coverage. Perceived value for money, which may be affected by the insured person's own perceived health, will affect enrollment. Without mandating health insurance, it is quite likely that some people will stay uninsured even when it is subsidized.

authorization by the patient private caregivers will have access to the central file and will record his "basic care" expenses and treatment history as well. The patient's central file will therefore provide the basis of "seamless care" and will serve multiple purposes, including epidemiological studies that can prove crucial to public health.

8. Conclusions:

Healthcare reform is on the agenda of almost every government. Social scientists are in a unique position to inform policy makers in the reform process. It is important that policy makers take full account of human nature when they go about designing the reform package: the human propensity to follow the natural course of incentives and the aversion to extreme risks. If healthcare reform can reduce the worries of citizens it will immediately contribute to the happiness of the society. Reference to human nature will usually reveal why some healthcare reform fails. Moral hazard is a case in point. The challenge is to combine market-oriented options, which will make people more cost-conscious, with public provision, which can reduce risk and information cost and can better ensure quality, innovatively so that healthcare reform works with rather than against human nature.

While many policy makers are right to be worried about containing costs, a rising percentage of the GDP being spent on healthcare is not necessarily a problem. It may simply reflect society's new priorities, changing demographics, and the latest advances in technology. On the other hand, sustainability is a valid concern. One key reason why national health insurance systems may not be sustainable is the demand-side moral hazard problem caused by the under-pricing of key services and possible supply-side moral hazard problem caused by the profitability of rendering services by caregivers. Containing the moral hazard problem is therefore fundamental to achieving sustainability. Pricing "basic care" at marginal cost (direct cost) is therefore important. For premium care, to the extent that it is consumed voluntarily and that it is provided by the free market without subsidy, pricing should not be regulated.

Given the citizens' concern for excessive burden, some form of excessive burden protection is logical. To an extent this is already in place in many countries. The Medishield in Singapore for

catastrophic insurance is a case in point. Excessive burden insurance as discussed in this paper, however, is more flexible in that it covers not only specified illnesses but all basic care expenses up to the yearly pre-set limit.

The idea of a high deductible health insurance plan is also already quite well known, particularly in the United States, where High Deductible Health insurance Plans (HDHPs) are often paired with a Health Savings Account[16]. The purported advantages of such plans by way of reducing the cost of insurance premiums and of reducing waste are also well known. However, HDHPs have been criticized as undermining access to care and as failing to cause a dent in the trend for rising health insurance premiums(Davis, Doty, and Ho, 2005). Regarding access, a problem with the American situation is that there is no regulation of basic care charges and there is typically a co-payment of 20 per cent even after the deductible amount. Because HDHPs account for only about 8% of all private insurance plans it is not surprising that they do not have any noticeable effect on overall costs. The observation that HDHP has effectively reduced access suggests that it is effectively reducing utilization of health services, even though that the fear is that it may be reducing warranted care.

To alleviate excessive burden for the poor and in order not to undermine access, a means test may allow eligible persons to enjoy lower fees and lower annual deductibles. The appropriate discount has to be determined through consultation and consensus, and may be supplemented by a greater stipend for those who currently receive welfare payments. Efficiency considerations dictate that no one should be totally exempt from healthcare charges. Thus redistribution and resource allocation are two different and equally worthy objectives and will require two different policy instruments to achieve them.

[16] Unlike the mandatory health savings accounts in Singapore, US Health Savings Accounts are voluntary with contributions encouraged by tax advantages.

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Appendix

Population of 100,000 is assumed. Social cost of healthcare for the unfortunate = $100,000. That for the fortunate is $10,000 (10 being the "Misfortune Multiple"). Individuals pay full direct costs of care up to the cap. Risk ratio is defined as Maximum Cost to Individual divided by Minimum Cost to Individual. Expected cost = Sum of Minimum Cost and Maximum Cost weighted by probabilities. "Premiums" are the amounts needed to fund the insurance program, ignoring administrative costs. Table 1 shows that the risk ratio is less than 2 for annual deductibles of $20,000. Table 2 shows that if the risk ratio is to be reduced to less than 2 under fee-reducing insurance, the fee reduction will have to involve a 90% discount. Moreover, at 100% discount (i.e., no charges at all), stakes under FRI would be identical with stakes under EBI with an annual cap at $10,000. Given human nature as it is, this is likely to cause serious moral hazard problems.

Table 1: Excessive Burden Insurance when misfortune multiple = 10 and probability of misfortune = 1%

Amount of Annual Deductible D (The "Cap") (a)	Charges paid by fortunate (b)	Charges paid by unfortunate (c)	Premium Required (d)	Minimum Individual Pays (e)	Maximum Individual Pays (f)	Individual's Expected Cost (g)	Risk Ratio (h)=(f)/(e)
10000	*10000*	*10000*	*900*	*10900*	*10900*	*10900*	*1.00*
20000	10000	20000	800	10800	20800	10900	1.93
30000	10000	30000	700	10700	30700	10900	2.87
40000	10000	40000	600	10600	40600	10900	3.83
50000	10000	50000	500	10500	50500	10900	4.81
70000	10000	70000	400	10400	60400	10900	5.81
60000	10000	60000	300	10300	70300	10900	6.83
80000	10000	80000	200	10200	80200	10900	7.86
90000	10000	90000	100	10100	90100	10900	8.92
100000	10000	100000	0	10000	100000	10900	10.00

Note: "Premium Required" is calculated as total healthcare costs minus fees collected divided by the population. Premiums are assumed to be collected in these examples but in practice may be funded from the general revenue.

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Table 2: Fee Reducing Insurance when Misfortune Multiple = 10 and Probability of Misfortune = 1%, assuming behavior is neutral, i.e., not affected by the high premiums.

Discount Factor d (a)	Charges Paid by Fortunate (b)	Charges Paid by Unfortunate (c)	Premium Required (d)	Minimum Individual Pays (e)	Maximum Individual Pays (f)	Individual's Expected cost (g)	Risk Ratio (h)=(f)/(e)
10%	9000	90000	1090	10090	91090	10900	9.03
20%	8000	80000	2180	10180	82180	10900	8.07
30%	7000	70000	3270	10270	73270	10900	7.13
40%	6000	60000	4360	10360	64360	10900	6.21
50%	5000	50000	5450	10450	55450	10900	5.31
60%	4000	40000	6540	10540	46540	10900	4.42
70%	3000	30000	7630	10630	37630	10900	3.54
80%	2000	20000	8720	10720	28720	10900	2.68
90%	1000	10000	9810	10810	19810	10900	1.83
100%	*0*	*0*	*10900*	*10900*	*10900*	*10900*	*1.00*

Note: "Premium Required" is calculated as total healthcare costs minus fees collected divided by the population.

Table 3: Healthcare Benefit-Age Profiles for 10 OECD Countries

	0 – 14	15-19	20 – 49	50 – 64	65 – 69	70 – 74	75 – 79	80 –
Australia	0.60	0.57	0.64	1.00	1.51	2.16	3.90	4.25
Austria	0.25	0.28	0.46	1.00	1.42	1.75	1.98	2.07
Canada	0.45	0.61	0.65	1.00	2.45	3.44	4.97	7.54
Germany	0.48	0.43	0.58	1.00	1.52	1.53	2.11	2.46
Japan	0.44	0.22	0.43	1.00	1.70	2.20	2.76	3.55
Norway	0.57	0.54	0.52	1.00	1.70	2.21	2.69	3.41
Spain	0.57	0.59	0.46	1.00	1.46	1.75	1.97	2.11
Sweden	0.45	0.43	0.63	1.00	1.50	1.53	1.56	1.59
United Kingdom	1.05	0.69	0.74	1.00	2.07	2.07	3.67	4.65
United States	0.58	0.82	0.77	1.00	3.01	3.02	6.32	11.53

Source: Hagist and Kotlikoff (2005), Table 2.

TOTAL P.44