30 May 2008

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

Dear Sir/Madam,

"Your Health, Your Life" – Healthcare Reform Consultation Document

We are writing in response to the above consultation document and are enclosing our submission together with a copy of a public opinion survey on *Selected Healthcare Policy Issues* carried out by the Lingnan University in January 2008 and a paper published in May 2007 by the Healthcare Policy Forum on *"Containing costs, enhancing quality and improving access – A proposal for reforming Hong Kong's healthcare system"*.

We hope you will find the enclosed useful in formulating the healthcare policy.

Yours sincerely,

Alan Lung Ka-lun
Chairman

香港民主促進會
Hong Kong Democratic Foundation
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HONG KONG DEMOCRATIC FOUNDATION RESPONSE TO "YOUR HEALTH YOUR LIFE" HEALTHCARE REFORM CONSULTATION

As the consultation document outlines in Chapter 1, there is a compelling case for the need for reform of the healthcare delivery system in Hong Kong. The Foundation would particularly emphasize the absence of an organized primary care network and related to this, the compartmentalization of service delivery between different levels of care. Other defects the Foundation would also like to highlight are the supplier domination nature of our system and the lack of regulation of the private sector.

Reform Objectives

The key objective of the reform of our healthcare delivery system should be:

1. to contain the long-term growth in the cost of healthcare provision,
2. to enhance the quality of healthcare provided and
3. to ensure efficient access to healthcare on the basis of need and irrespective of means.

Primary Care

In the light of these objectives, the Foundation supports the general thrust of the recommendations in Chapter 2 of the consultation to implement a more structured system of primary care services that will also facilitate a smoother interface between primary care and hospital care and private care and public care.

Furthermore, the Foundation also supports the contention that there is a need to provide funding support to the less well off in our society to enable them to have access to the primary care system, since this will need to be largely provided by the private sector. The Foundation is also in agreement with the objectives of the proposals in Chapter 2 to strengthen public health functions.

Public-Private Partnership and "Money follows Patient"

Also compatible with the objectives of healthcare reform, as set out in our second paragraph above, is the role of public-private partnership in healthcare. However, this should not be on the basis of public funds subsidizing the cost of provision of private healthcare, but on the basis of purchasing/funding patient access to private care at a cost that is compatible with or lower than the cost of provision from the public sector.

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We believe this should be part of a "money follows" patient concept that should also be implemented within the public healthcare system. In regard to this we note that in a public opinion survey carried out by the Lingnan University Public Governance Programme in the latter part of 2007, that 82% of the 1,000 + respondents agreed that patients should be allowed to choose the hospital of their preference.

Electronic Health Record Sharing

The Foundation strongly endorses the proposal in Chapter 4 to develop electronic health record sharing and again we note that in the Lingnan University Public Governance Programme public opinion survey the introduction of this was supported by 82% of the respondents.

Public Healthcare Safety Net

With regard to the issue of strengthening the public healthcare safety net, the Foundation believes that the provision of public healthcare services should not be looked upon as a safety net, but rather viewed in the perspective of the United Nations Research Institute for Social Development's contention that "health systems are set up to serve population health and the provision of all according to need."

Healthcare should be viewed as part of a community's over all social policy, an investment in the well-being and productivity of the community. As such, since healthcare benefits the community as a whole, it should be a key priority for allocation of public money.

Additional Operation Reforms

In addition to the operational reforms proposed in the consultation document, the Foundation would like to endorse two further reforms proposed by the Healthcare Policy Forum in its paper "Containing Costs, Enhancing Quality and Improving Access – A Proposal for Reforming Hong Kong's Healthcare System" published in May 2007.

These proposals were instituting a new healthcare organizational structure and establishing a research institute for clinical excellence. We would strongly urge the Bureau to look at both these initiatives and would hope to see proposals along these lines included in the next consultation document the Bureau issues.

A New Healthcare Organizational Structure

The key, in fact the imperative, to effective implementation of reforms is the strength of the organizational structure within which the reforms are carried out. The Foundation agrees that there is substantive merit in the Healthcare Policy Forum's proposal for a new two-tier organizational structure, with the upper tier responsible for, among other things, macro-level planning, advising the Food and Health Bureau on issues relating to healthcare, allocating public funding to providers, setting and monitoring standards and the lower tier, in effect an extended Hospital Authority, responsible for managing all public health service provision and public health programmes.

Establishing a Research Institute for Clinical Excellence
The Foundation believes such an Institute could have a considerable positive impact, in the longer-term, on the cost effective delivery of healthcare services. This is similar to a proposal made in the 1999 Harvard Report and we envisage such an Institute could reflect functions similar to those of the UK's National Institute for Clinical Excellence.

Healthcare Provision Funding
The consultation document puts forward six options for supplementary funding for Hong Kong's healthcare system in Chapters 8-13. As expressed by many others commenting on the consultation document, the Foundation finds these options are supported with inadequate details. In our view, the information provided is not sufficient to enable an informed choice to be made among the options proposed. Furthermore, from the information provided, it seems quite clear that all of these options, to a greater or lesser extent depending on the individual option, will distribute a disproportionate burden of the supplementary funding onto the middle class, which we believe to be both unjust and possibly socially divisive.

We also believe that it is inappropriate for the Government to come to a unilateral conclusion, in Chapter 7, that the existing financing model is unsustainable. We believe that in the interests of fairness the public view should be sought on this and it should have been included as a seventh option. We would urge the Bureau to seek public opinion on this by including it as an option in its next consultation document.

The Way Forward
The Foundation believes it will be relatively easy for the Government to secure broad public approval for its operational reforms as evidenced. The public opinion survey the Healthcare Policy Forum commissioned to be carried out by Lingnan University Public Governance Programme last September, which covered over 1,000 respondents. This survey showed that 83% of the respondents supported increased government spending on healthcare provision, 82% supported the introduction of a territory-wide system of electronic health records, 82% agreed patients should be allowed to choose to be treated in their hospital of preference and 76% supported the enhanced primary care proposal.

However, the issue of supplementary funding is already proving to be contentious, particularly among the middle class.

In view of this, the Foundation would most strongly urge the Government to proceed with its operational reforms first, both in view of the strong public support for these and particularly in view of the moderating effect the proposed operational reforms will have on the future growth in healthcare costs. The Government should defer the issue of supplementary funding to allow additional time for the community to come to a consensus view on how funding of the healthcare system should be handled for the long-term. With our robust economy and the HK$50 billion set aside by the Financial Secretary for assisting healthcare reform, there are ample financial resources to fund the implementation of the operational reforms without resorting to supplementary funding in the next few years, at least.

Healthcare Policy Forum

Survey on Selected Healthcare Policy Issues

Public Governance Programme
Lingnan University

January 20, 2008

Survey Objectives and Survey Details

- **Objectives：**
  - To collect data on the public's preparation to cope with healthcare expenditures
  - To collect data on the public's healthcare cost burdens and worries
  - To collect data on the public's views on and patterns of healthcare use
  - To collect data on the public's views on public healthcare financing
  - To collect data on the public's views on establishing a territory-wide electronic medical records system
- **Method：Telephone interviews**

Survey Objectives and Survey Details

- **Data collection：August 14 – 21, 2007**
- **Target respondents：Heads of households of Hong Kong permanent residents**
- **No. of successful interviews：1,042**
- **Response rate：42.6 %**
- **Sampling error：±3.1 %**

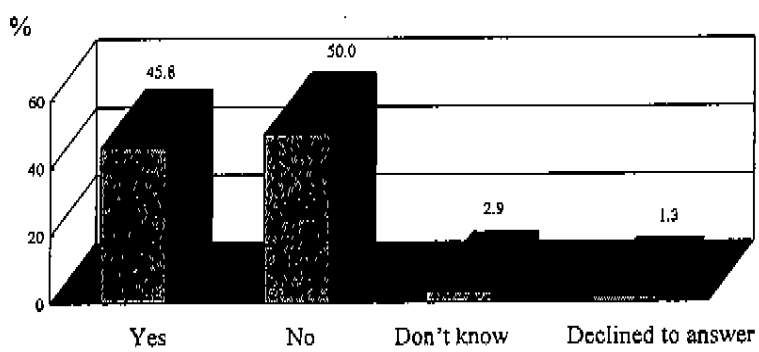
(1) : Preparation to cope with healthcare expenditures

Public Governance Programme, Lingnan University

4

Do you have household savings to cope with contingencies?

N = 1,042

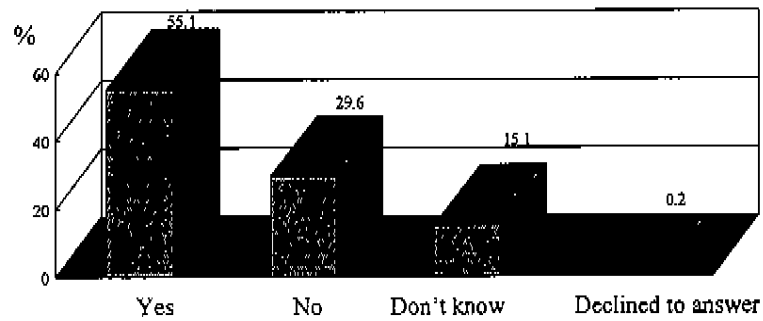


Public Governance Programme, Lingnan University

5

If necessary, do you think you will be able to save more?*

N = 477



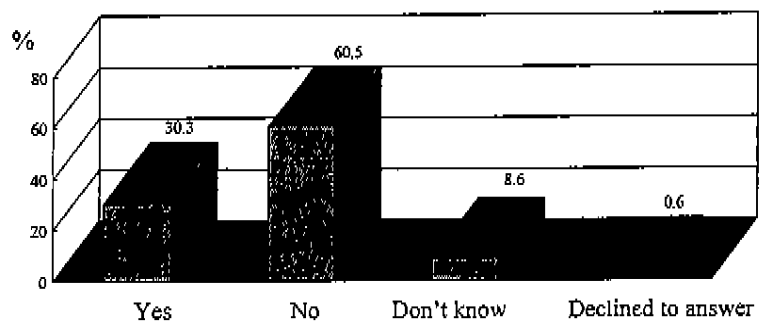
* Only respondents who had household savings to cope with contingencies were required to answer this question.

Public Governance Programme, Lingnan University

6

If necessary, do you think you will be able to save up a portion of your income for contingencies?*

N = 521



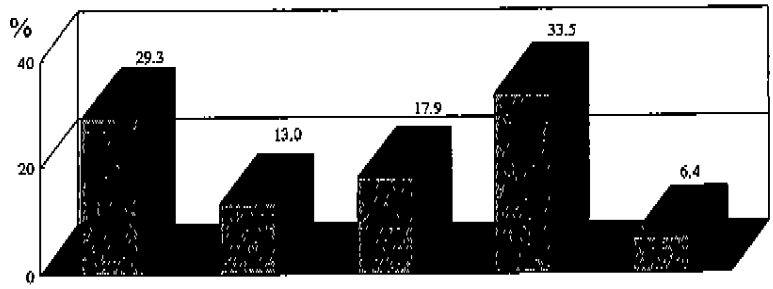
* Only respondents who did not have household savings to cope with contingencies were required to answer this question.

Public Governance Programme, Lingnan University

7

Does any member of your household have any healthcare insurance benefits/coverage?

$N = 1{,}042$



Both employment-related benefits & private healthcare insurance

Employment-related benefits only

Private healthcare insurance only

No healthcare insurance / coverage

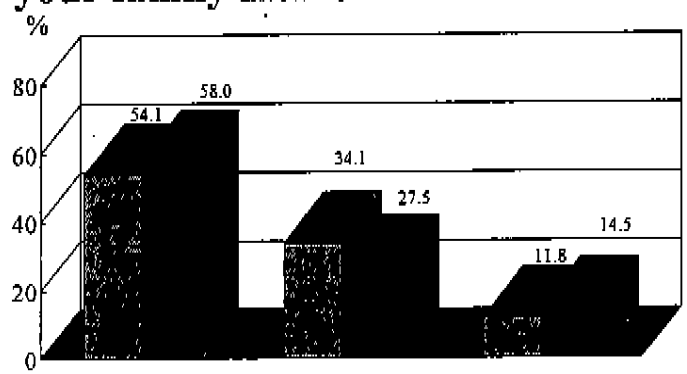
Don't know / declined to answer

Public Governance Programme, Lingnan University

8

Do the employment-related healthcare benefits in general provide sufficient protection to you or your family members?

$N_1 = 305$
$N_2 = 131$



Both employment-related and private healthcare insurance

Employment-related healthcare benefits only

Sufficient / very sufficient

Insufficient / very insufficient

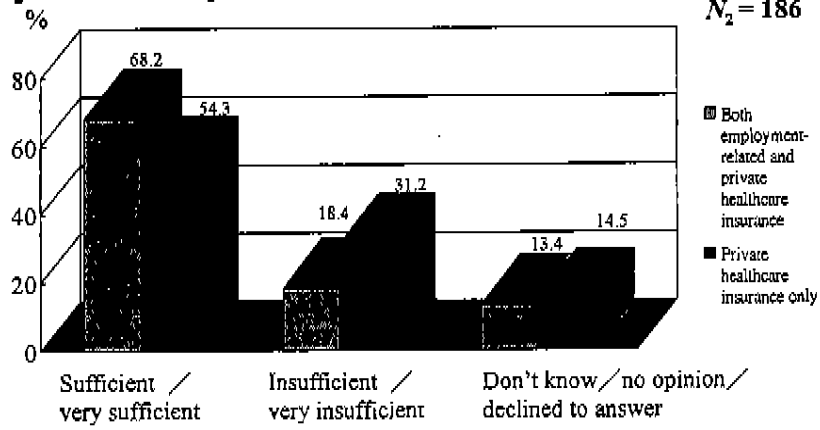
Don't know / no opinion / declined to answer

Public Governance Programme, Lingnan University

9

Does the private healthcare insurance coverage in general provide sufficient protection to you or your family members?

$N_1 = 305$
$N_2 = 186$

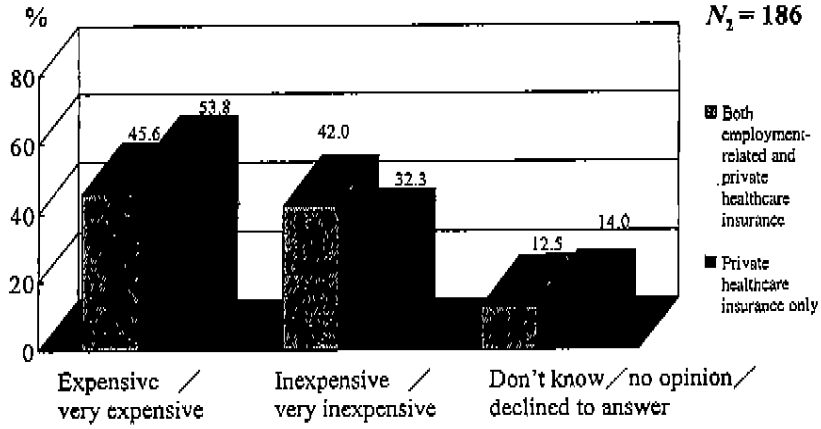


Public Governance Programme, Lingnan University

10

Are the insurance premiums expensive?

$N_1 = 305$
$N_2 = 186$

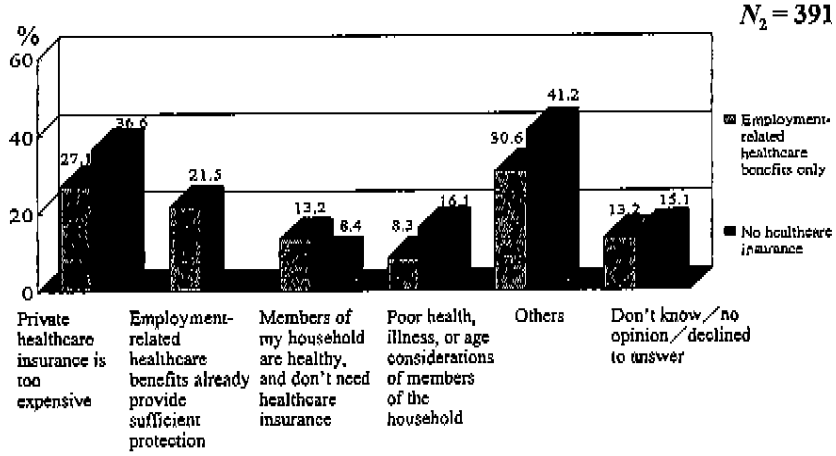


Public Governance Programme, Lingnan University

11

Why do not you or your household members buy private healthcare insurance?*

$N_1 = 144$
$N_2 = 391$



Private healthcare insurance is too expensive

Employment-related healthcare benefits already provide sufficient protection

Members of my household are healthy, and don't need healthcare insurance

Poor health, illness, or age considerations of members of the household

Others

Don't know/no opinion/declined to answer

* Respondents were allowed to give more than one answer, so the sum of percentages exceeds 100%.

Public Governance Programme, Lingnan University

12

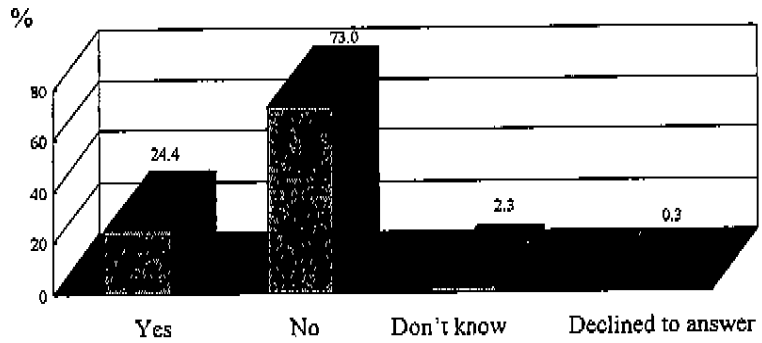
(2) : Healthcare cost burdens and worries

Public Governance Programme, Lingnan University

13

Has it ever happened that, because of medical bills in your household, you have to use up a substantial portion of your household's total savings?

N = 1,042

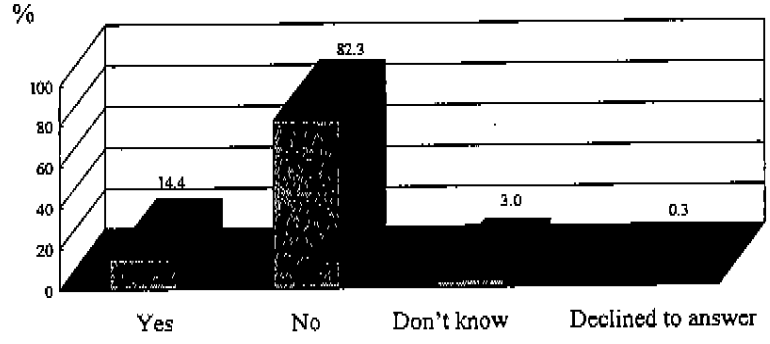


Public Governance Programme, Lingnan University

14

Has it ever happened that, because of medical bills, your household sinks into financial straits?

N = 1,042

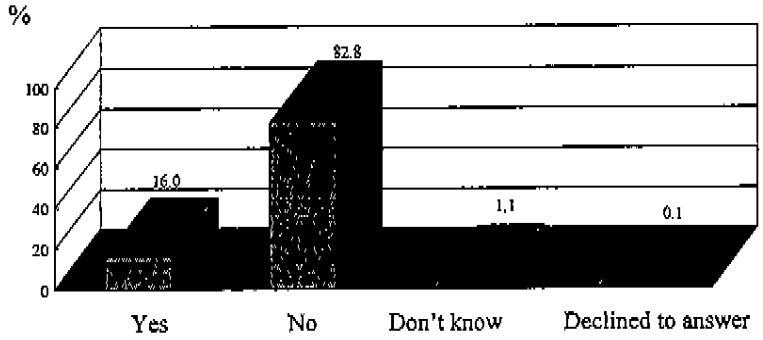


Public Governance Programme, Lingnan University

15

Has it ever happened that, because of the costs of healthcare, you (or other members of your household) have/has to postpone seeking medical help in the event of not feeling well?

N = 1,042

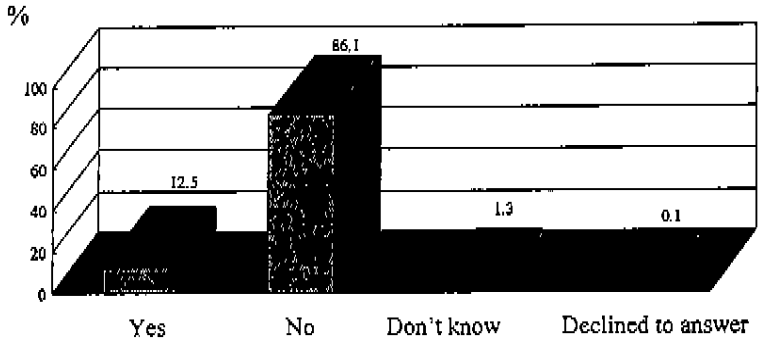


Public Governance Programme, Lingnan University

16

Has it ever happened that, because of the costs of healthcare, you (or other members of your household) have/has to skip seeking medical help altogether in the event of not feeling well?

N = 1,042

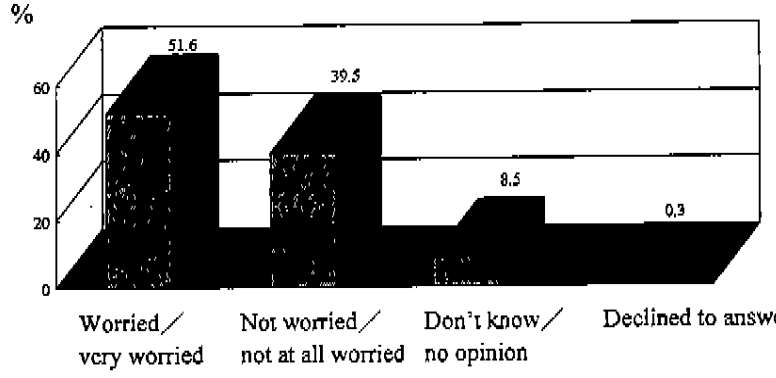


Public Governance Programme, Lingnan University

17

How worried are you that you will not be able to pay for medical costs of your household members in the event of a serious illness or accident?

N = 1,042

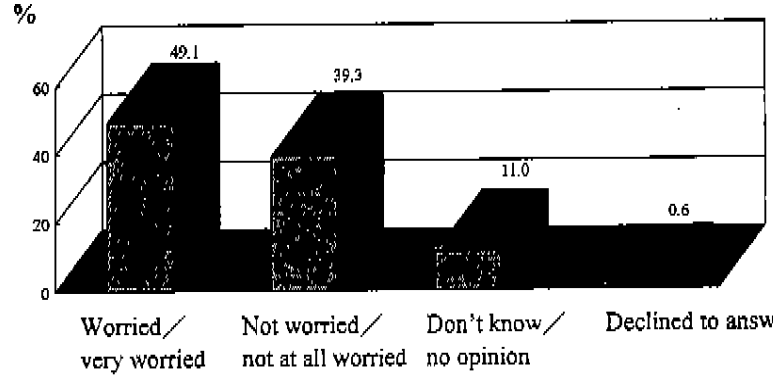


Public Governance Programme, Lingnan University

18

How worried are you that you will not be able to pay for medical costs when you enter old age?

N = 1,042



Public Governance Programme, Lingnan University

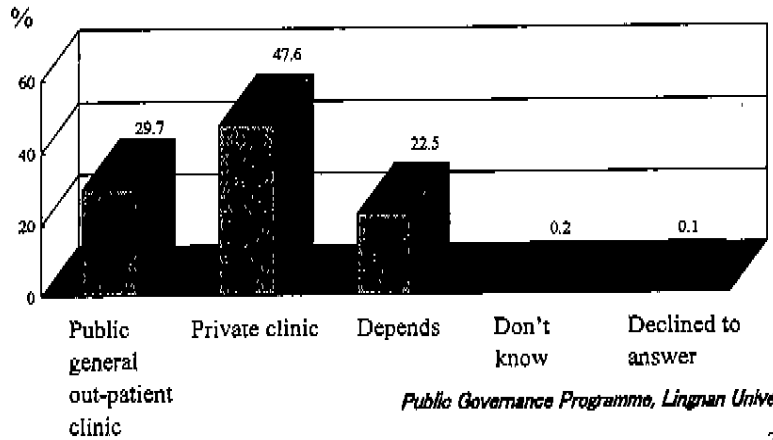
19

(3) : Views on and patterns of healthcare use

Public Governance Programme, Lingnan University

20

If a member of your household does not feel well, do you *normally* seek care at a public general out-patient clinic or at a private clinic? $N = 1{,}042$



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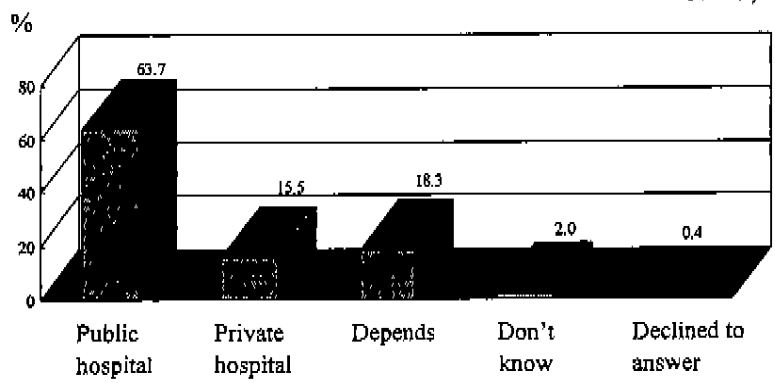
21

If a member of your household needs hospitalization, do you *normally* go to a public hospital or a private hospital?

$N = 1{,}042$

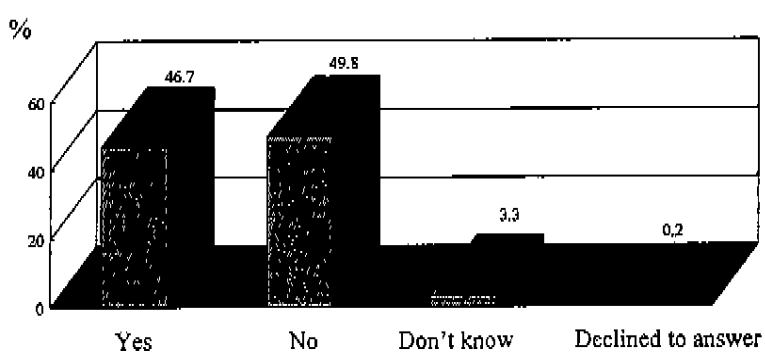


Public Governance Programme, Lingnan University

22

Do members of your household usually consult the same doctor?

$N = 1{,}042$



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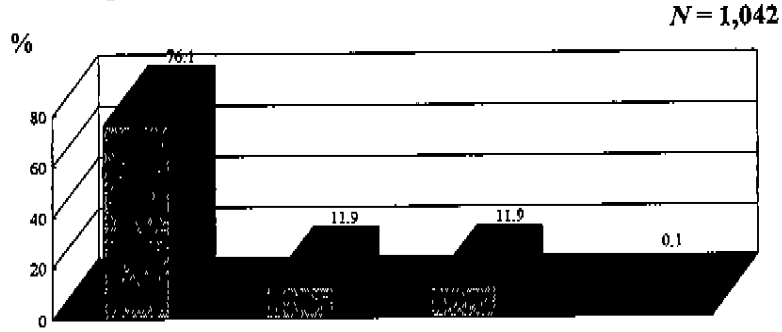
23

Do you agree that each household should have one and possibly two family doctors so household members can be cared for by doctors with knowledge of the household's medical histories?

N = 1,042



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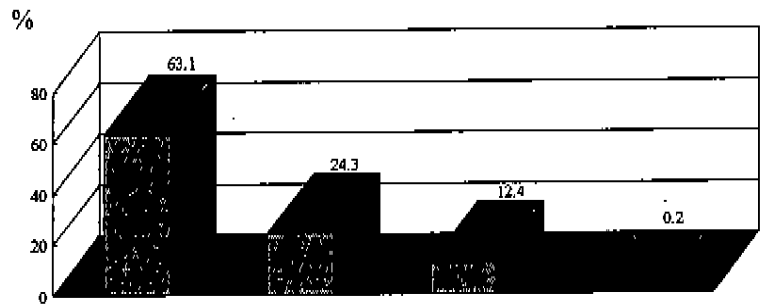
24

Do you agree that generally speaking, it is more logical and practical to consult a GP first in case of ailment before seeking specialist care?

N = 1,042

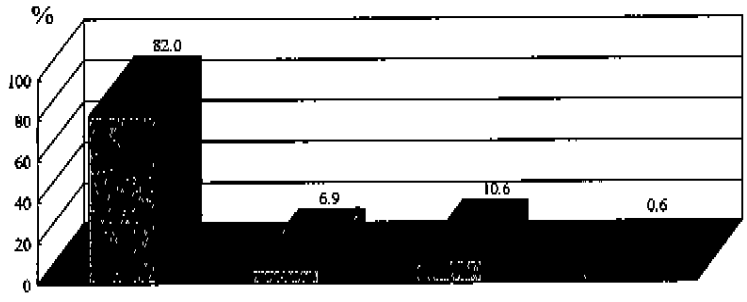


Public Governance Programme, Lingnan University

25

Do you agree that patients should be allowed to choose public hospitals of their preference?

N = 1,042



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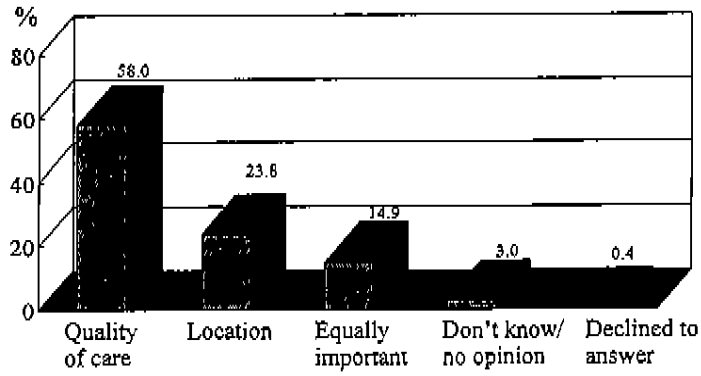
26

If you are allowed to choose public hospitals of your preference, which is more important to you: choice for location, or choice for the quality of care?*

N = 854



* Only those respondents who agreed that patients should be allowed to choose public hospitals of their preference were required to answer this question.

Public Governance Programme, Lingnan University

27

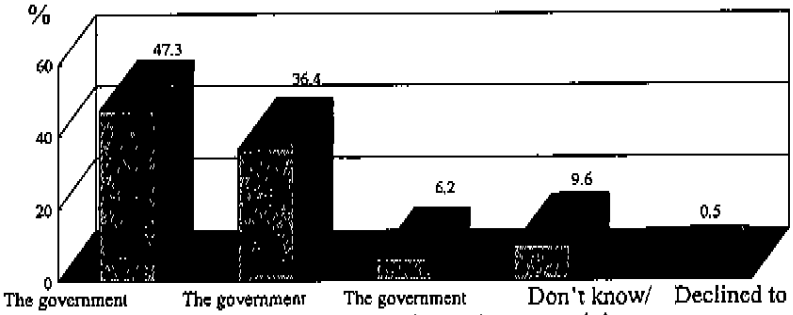
(5) : Views on public healthcare financing

Public Governance Programme, Lingnan University

28

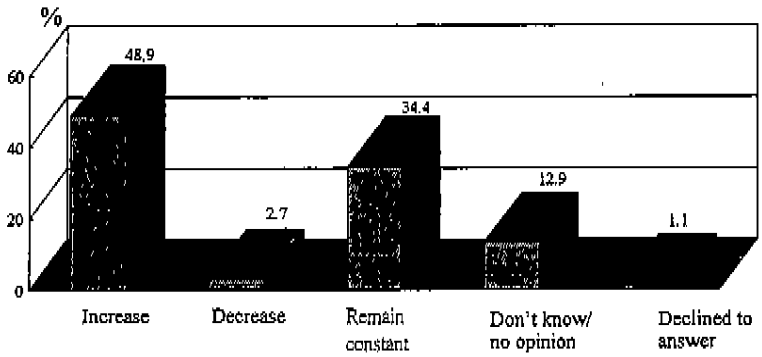
Below are three opinions relating to public healthcare financing in Hong Kong, please indicate which you agree with most.

N = 1,042



29

If contributions are to be in the form of a percentage share of individuals' monthly income, should the percentage share increase, decrease, or remain constant as income increases?* $N = 558$



* Only those respondents who agreed that individuals should bear a greater share of their own healthcare expenses were required to answer this question.

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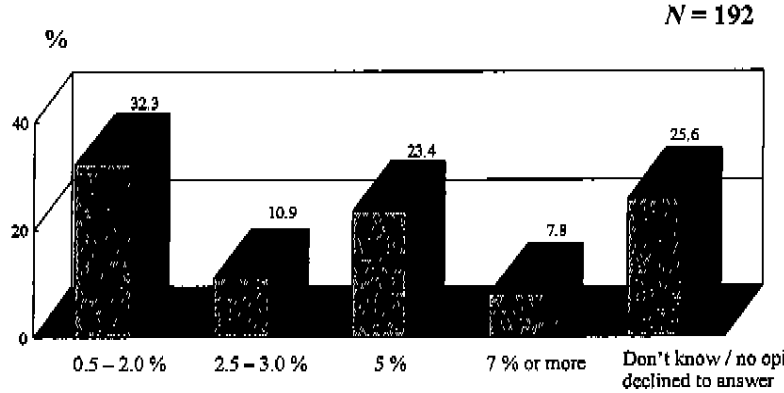
What percentage share of income is reasonable?*

$N = 192$



*Only those respondents in the previous question who favored a flat rate monthly contribution disregarding income levels were required to answer this question.

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31

(5) : Views on establishing a territory-wide electronic medical records system

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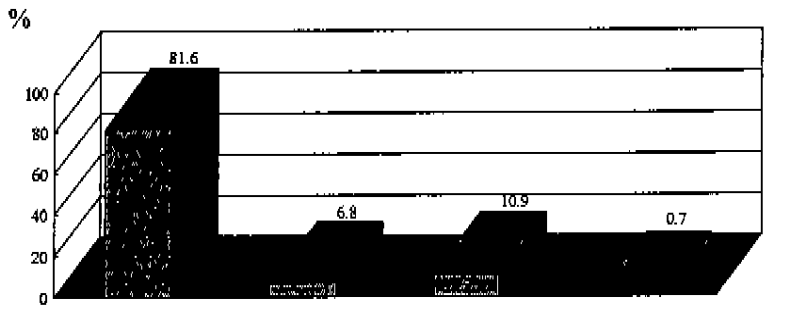
32

Do you support establishing a territory-wide electronic medical records system which, subject to patients' authorization, allows doctors to have instant access to patients' detailed medical records to facilitate diagnosis?

N = 1,042



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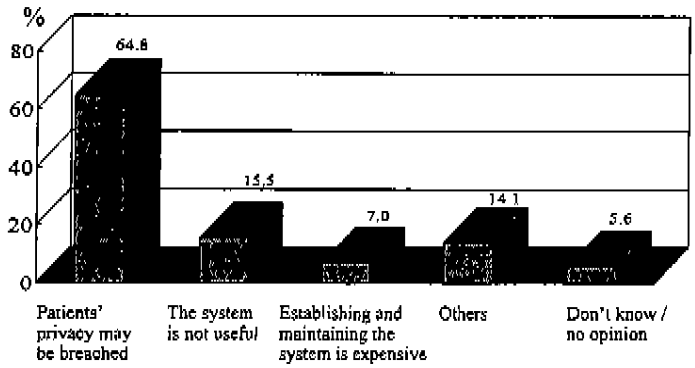
33

Why don't you support establishing a territory-wide electronic medical records system?*

N = 71



* Only those respondents who did not support establishing a territory-wide electronic medical records system were required to answer this question. Respondents were allowed to give more than one answer, so the sum of percentages exceeds 100%.

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34

End

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35

Healthcare Policy Forum
醫療政策論壇

Containing costs, enhancing quality, and improving access
A proposal for reforming Hong Kong's healthcare system by the Healthcare Policy Forum

Defining our agenda

- The purpose of this paper is to explain and substantiate our proposal for reforming Hong Kong's healthcare system.
- The *raison d'être* of a formal healthcare system should be to improve and sustain the health of the community.[i]
- While the ultimate aim of reforming Hong Kong's healthcare system is to maximize health gain for the population of Hong Kong, it is important, at the outset, to recognize the limitation of healthcare on health gain.
  - Healthcare is only one of many determinants of health.
  - It is well established that income inequality has a major if not determining effect on health.[ii]
  - Likewise, clean air, safe foods, and affordable decent housing are all important determinants of health.[iii]
  - In other words, social policies outside the healthcare system are also of critical importance for maintaining and improving the general health of Hong Kong's population.
  - Policies in other social domains may negatively or positively mediate the impacts of healthcare on health. For instance, the absence or presence of environmental laws regulating the quality of air will increase or decrease the demand for and hence total spending on medical care of respiratory diseases.
  - To achieve health effectively and at lower costs, thus, a healthcare policy must be supplemented or complemented by appropriate policies in other social domains.
- For the healthcare system, to maximize health gain for the population of Hong Kong, it must have the capacity to provide care of good quality and to guarantee access to care.
- In addition, given the omnipresence of resource scarcity, the healthcare system must also possess a built-in mechanism for spending control.
- Based on the above understanding of a healthcare system, we set the following reform objectives:
  - containing the costs of care
  - enhancing the quality of care
  - improving access to care
- These three objectives are also goals (or reform goals) of healthcare systems in many countries.[iv]
- Instead of starting with an ideal system, we consider it more productive to adopt a *step-by-step, problem-solving approach* to formulating our reform proposals – that is, we will first identify specific problems in the current system that affect its quality and costs of care and health outcomes, then derive corresponding remedies, and finally propose a time-table for implementing reform initiatives.
- This is because since the "Harvard" paper in 1999 there has been much discussion on reforming our healthcare system but no concrete actions. In our view, we should not maintain this hiatus of inactivity any longer and rather than wait till consensus in the community on the "perfect" system is reached we should adopt a step-by-step approach. The wholesale reform of our healthcare system in a "big bang" approach would put severe stress on the system, if not cause it to breakdown completely. A more prudent strategy would be to move forward by implementing some practical measures to improve our system that can be put in place within a reasonable time-frame, yet still leave the flexibility for further reform developments in the light of experience with these first initiatives.
- In the following, we will
  1. briefly describe the major dimensions of healthcare systems and their bearings on the systems' quality, costs and accessibility; this description will serve as a conceptual tool for designing our reform proposal
  2. diagnose the problems that negatively affect the quality, costs of care and accessibility of Hong Kong's healthcare system
  3. propose our reform initiatives for addressing the problems
  4. provide arguments and evidence to substantiate our reform proposals

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Diagnosing our healthcare system

In terms of its quality, costs and accessibility, we believe that the existing healthcare system in Hong Kong is beset by the following problems:

On the delivery dimension

- *Compartmentalization of service delivery between different levels of care (primary, secondary, and tertiary) and between different sectors (private sector and public sector)*[viii]
  - While the communication and information exchange between different levels of care within the public sector have been improved in recent years, little has been done within the private sector and between the private and public sectors.
  - Compartmentalization results in duplicated/unnecessary care, repeated tests and discontinuity of care. All of these will eventually adversely affect the health of patients and cause an increase in healthcare expenditures.
  - The adverse impacts of compartmentalization between the public and private sectors on health and healthcare costs are particularly pressing because currently the private sector provides about 70% of outpatient care (no. of episodes) while the public sector is responsible for most of the inpatient care (about 90%-95% of bed-days).[ix]

- *Absence of an organized primary care network or a "genuine" referral system*[x]
  - Under the current system, while patients cannot seek specialist care in the public sector without referral, they can do so in the private sector.
  - In the absence of an organized primary care network, patients, after receiving care at the levels of specialist or hospital care, are usually not properly "referred back" to the level of primary care for follow-up treatment.
  - The system thus encourages unnecessary or improper use of specialist/hospital care and the behaviour of "doctor shopping".
  - The absence of an organized primary care network also means that the important role of "family doctors" in providing continuous, comprehensive, and preventive care has been overlooked.
  - Consequently, the system is not as cost-effective as it could be.

- *Supplier-domination and waning professionalism*[xi]
  - Hong Kong's healthcare system is supplier-dominated. Providers usually perform the dual roles of providing healthcare as well as monitoring the quality of care that they provide. Such dual roles raise serious questions about providers' accountability to patients.
  - At present, patients tend to rely on providers' professionalism – i.e. adherence to professional ethics and self-regulation – to ensure quality and appropriate care. This seems to be unavoidable given the nature of medical knowledge and hence the inevitable agency role of healthcare providers.[xii]
  - However, there is evidence of considerable sub-standard treatments and medical negligence. Moreover, the existing patient complaint process remains non-transparent and ineffective.
  - A mechanism supplementing/enhancing professionalism in ensuring quality of care and protecting patients' interests is needed.

- *Under-regulation of the private sector*[xiii]
  - It has been criticized that the government adopts a *laissez-faire* policy towards the private sector.
  - Both consultation fees and quality of care are highly varied.
  - Patients' interests are not duly protected.

On the allocation dimension

- *Perverse incentives in the allocation mechanism of the public sector*
  - At present, in the public sector, funding is allocated to healthcare providers through block grants (i.e. a "patients follow money" allocation mechanism).
  - The positive side of such a mechanism is that it can prevent supply-side moral hazards, i.e. providers have no incentives to perform unnecessary procedures.
  - The negative side is that it does not encourage good performance as good performance will not be rewarded nor bring in more resources.
  - In other words, the system does not possess the right incentive structure to enhance quality and efficiency of care.[xxii]

Proposing our reform initiatives

Given our reform objectives and based on our understanding of the problems impacting Hong Kong's healthcare system, we propose six reform initiatives:

- On the delivery dimension
  1. Introducing a territory-wide electronic medical records system (EMRS)
  2. Instituting a primary care system with primary care practitioners acting as gatekeepers
  3. Instituting a new healthcare organizational structure
  4. Establishing a research institute for clinical excellence

- On the allocation dimension
  5. Adopting the "money follows patient" principle and the prospective payment mechanism for funding hospital and specialist care

- On the financing dimension
  6. Subsidizing low income groups' primary care visits in the private sector

We propose that reform initiatives 1, 2, 5, 6 expounded above should have priority as they can be readily accommodated within the structure of the existing healthcare system. We will explain the reform initiatives in greater details below.

- *Introducing a territory-wide electronic medical records system (EMRS)*
  - At present, the Hospital Authority possesses a very sophisticated inter-operable web-based electronic clinical management and patient record system, which allows real time online remote access through standard internet connection.
  - All 162 HA facilities (43 hospitals, 45 specialist clinics, 74 general clinics) can have real time access to the system.
  - Technically, the HA Clinical Management System is already a territory-wide electronic medical record system.
  - However, the system is not yet accessible to healthcare practitioners in the private sector.
  - We propose to make the HA system truly "territory-wide" by rendering it accessible to healthcare practitioners in the private sector.[xxiii]
  - We also urge the Government to provide the necessary resources for expanding/upgrading the capacity of the HA system and to encourage the private sector to utilize the system.
  - When the system becomes truly "territory-wide", with patents' authorization or other forms of legitimate authorization, all healthcare providers will have access to their patients' medical records at the point where care is provided.
  - The record system will help alleviate the compartmentalization problem and its negative impacts on quality

charging extra payment, so as to prevent differential treatment of patients and discourage providers from providing unnecessary care.

- *Subsidizing low income groups' primary care visits in the private sector*
  - To address the issues of unequal access to primary care and the limited capacity of the general outpatient clinics of the public sector, we propose subsidizing low income groups' primary care visits in the private sector.
  - We propose that the subsidy be $150 per visit and capped at 10 visits per year. These figures are derived from the statistics that:
    - the average no. of GP visits per year per capita is about 6.99[xxiv]
    - median consultation fee per consultation with a private GP is about $150
  - As an initial step, subsidies may be limited to the poorest 20% of the population as they utilize about 37% of public inpatients and specialist/A&E services.
  - If the subsidies succeed in reducing the rates of hospitalization and specialist care/A&E use of the lower income groups (this should be the primary objective of instituting a primary care-oriented system), the potential savings in healthcare costs would be substantial.
  - In other words, the subsidies should also be considered as an initiative to contain healthcare costs in the long run.

- *Instituting a new healthcare organizational structure*
  - In order that the reform will sustain and that better care will be provided in the long run, we believe it is of great importance to put in place a new management structure. As a first step, we propose a new two-level organization structure:
    - the 1st level is responsible for "steering" the whole healthcare system (including the public and private sectors); the agency at this level may be called a Health Commission.
    - the 2nd level is responsible for "rowing", i.e. day-to-day operation of healthcare provision; the agency at this level for providing public healthcare services may be called a Healthcare Services Authority. We intend to put all public healthcare provision facilities under one structure so that better operational coordination can be achieved. The delivery of private healthcare services would also be part of 2nd level structure.
  - Specifically, apart from implementing the proposed reform initiatives, the "steering" functions of the Health Commission may include:
    - macro-level planning and coordination
    - advising the Health, Welfare and Food Bureau on issues relating to healthcare
    - allocating public funding to providers
    - setting and monitoring standards
    - negotiating fee schedules with providers
    - maintaining a registry of primary care practitioners and other healthcare providers
  - To ensure the new organization's legitimacy and accountability, it will be supervised and managed by a broadly representative governing board with budgetary powers, which comprises government officials, representatives of the medical and associated professions and patients' groups, and legislators. From an accountability point of view it would be chaired by either the Secretary for Health, Welfare and Food or the relevant Bureau Permanent Secretary.
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complaint should be set up.

- to continue to deliberate on the financing of the healthcare system since many issues involved either require further examination or remain unexamined. As a step forward, we urge that a more structured, open, and comprehensive review process at the societal level be initiated. (See the first question in the section below for the issues involved)

Substantiating our reform initiatives: arguments and evidence

In the following section we substantiate our proposals through a process of posing and answering hypothetical objections and queries.

Healthcare financing

- *It is commonly believed that reforming the current financing mechanism of Hong Kong's healthcare system should be the top policy priority. Specifically, it is proposed that more private funding should be involved. However, healthcare financing reform is not one of the reform initiatives in the proposal explained above. Is not healthcare financing reform a pressing policy issue in Hong Kong?*
  - We believe healthcare financing reform is an important policy issue, and precisely for its importance, great prudence is in order. This is because many issues involved either require further examination or remain unexamined. Let us review some of these issues.
  - One major argument for financing reform points to cost pressures on the healthcare system resulting from population ageing, technological advancement, raising public expectations and the early occurrence of chronic illnesses. On closer examination, however, it appears that these cost drivers are a lot less pressing or "real" than some argue and are far from being "unmanageable".
    - On ageing, both the reports published by the Organisation for Economic Co-operation and Development (2006) and the European Commission (2001) point out that ageing was not a significant factor for the increase in healthcare spending in the past several decades. Projecting into the future, the two reports estimate that demographic effects will only increase average public healthcare and long term care spending by 0.6% or 0.7% each year.[xxv] Growth rates of similar magnitudes in healthcare spending owing to the ageing effect have also been projected for Australia[xxvi], Canada[xxvii], and the USA[xxviii] by other research studies. The impact of ageing on healthcare spending is thus far from constituting a crisis.[xxix] Moreover, it is noted that many healthcare needs of an ageing population can effectively be met by a primary care system.
    - On technological advancement, one scholar argues that "new technologies may be inherently either cost-enhancing or cost-reducing … but it is the way in which they are taken up and applied that determines their impact on costs."[xxx] In other words, the cost pressure of technology is controllable. The issue is whether we have the will to control it.
    - On rising expectations, it is not really clear what is meant by these and how rising costs can be attributed accordingly. It is also not clear why rising expectations cannot be circumscribed.
    - As for the early occurrence of chronic illnesses, similar to the issue of an ageing population, it is plausible that it can be arrested by an effective primary care-oriented system.
  - The above observations therefore call for a re-examination of the urgency of reforming the current health system's financing mechanism.
  - Another argument for urgent healthcare financing reform by introducing more private funding relates to concerns about substantial increases in public spending on healthcare over the past years. However, it has to be pointed out that such increases should be put into perspective.
    - Firstly, as mentioned before, in Hong Kong, the public sector and the private sector share respectively of total healthcare spending in 2001 were:
      - 57% (public share of total healthcare spending)
      - 43% (private share of total healthcare spending)

insurance and to seek care in the private market, this will not only reduce public spending but also allow focusing public money mainly on the needy. Does voluntary private health insurance not promise a "win-win" situation?

- More needs to be done to demonstrate the attainability of the "win-win" situation.
- Firstly, commercial insurers have strong incentives to limit the amount of claims paid in order to earn profit and stay in business. To ensure profits, one strategy is to enroll only the healthy and avoid or offer limited coverage to the less healthy. The upshot will be a public system burdened with a larger proportion of less healthy and more costly individuals. Therefore, private health insurance may not necessarily help remove cost pressures on the public system.
- Secondly, given the often better pay packages in the private sector, expanding private health insurance may draw doctors and nurses out of the public sector and create a shortage of both therein. To compete with the private sector for human resources, the public sector may have to raise its effective wage levels. Two results are likely, either less public healthcare is provided at a given budget level or more money has to be spent on the public system to maintain the same level of healthcare. In other words, not only is there no guarantee that private insurance will help reduce public spending, but it may in fact induce budget growth in the public system![xxxvi]
- Thirdly, there is a fundamental flaw in the underlying economic logic. To quote a scholar on this: "Why would individuals pay for care if they could receive timely, high quality care 'for free'? As such, privately-financed health care requires that the publicly-funded system be inadequate, or at least, perceived to be inadequate. Rather than strengthening the public system, [mixed funding] models require that it remains weak. Particularly when the same providers offer care [for both publicly-funded and privately-funded patients], they have a strong incentive to ensure that the publicly-funded care remains sufficiently uncomfortable, inconvenient, or inaccessible to maintain a market for their more lucrative privately-funded services."[xxxvii] According to a report published by OECD in 2004, there is evidence that "incentives created by higher payment levels in [private health insurance] markets have [...] encouraged providers to maintain long queues in the public system or refer patients to owned private facilities in order to sustain their private practice".[xxxviii]
- As a general remark, the same report points out that the "ability of [private health insurance] to reduce demand pressures on the public system has nonetheless proved to be constrained."[xxxix]
- Fourthly, the high administration costs incurred by insurers cast a lot of doubts about the efficiency of private insurance as a means of financing healthcare. To do business, insurers have to undertake a host of administrative tasks, including assessing the risk status of the insured, determining premiums, underwriting appropriate policies, billing and claims administration, and marketing. While not contributing to anybody's health, all these activities have to be paid for nonetheless. What is more, private insurance also imposes significant amounts of administrative work on healthcare providers, such as negotiating contracts with insurers and handling fee reimbursement. Similarly, such non-healthcare administrative work has to be paid for. In a tax-financed healthcare system, most of the above administration costs do not exist. The conclusion is that given the same amount of funding, other things being equal, more healthcare will be provided by a public system.[xl]
- Indeed, it has been well documented that healthcare systems financed by private insurance are generally more expensive. According to 2006 OECD data, among OECD countries, the United States and Switzerland, the two countries relying most heavily on private insurance to finance healthcare, had in 2004 the most and second most expensive healthcare systems, absorbing 15.3% and 11.6% respectively of their GDP (the OECD average was 8.9%).
- Another research published in 2003 estimated that in comparison with Canada's tax-financed healthcare, the excess administration costs in the United States were about $209 billion US dollars, equivalent to 17.1% of total American healthcare expenditure. It has been surmised that such money is probably enough to provide full healthcare coverage for all Americans who do not have healthcare coverage.[xli]
- Finally, let us not forget that tax credits are also public money! Offering tax credits to encourage the

- To apply the distinction to the issue of health means that even though we are free to choose a healthy life style, e.g. avoiding tobacco and alcohol, whether such a choice actually results in good health is by no means certain. There are a lot of other factors beyond our control that affect our health. Holding a non-smoking, healthy-living lung cancer patient responsible for his/her ill health thus looks morally objectionable.
- To the extent that the choice of life style may have consequences on health, we can only hold people responsible for those results consequent of their choice and the possible related healthcare costs. This can by achieved by levying health taxes on tobacco and alcohol, for example. But we should not hold people responsible for their actual health status, which may be largely beyond their control.
- Who then should bear the healthcare costs of those who fall ill? Why should the relatively well-off contribute towards the healthcare costs of the less well-off?
- To these questions, we offer the following arguments:
  - society has a responsibility to assure all its members of equality of life opportunity or a level playing-field
  - since:
    1. ill health restricts individuals' range of life opportunities
    2. healthcare contributes to the protection of equality of opportunity
    3. it is arguable that the relatively well-off fully merit the wealth they own and the advantageous social position they enjoy
    4. it is arguable that the relatively less well-off fully deserve the disadvantageous social position they are in
  - therefore, it is not morally unacceptable for the society to require the well-off to contribute towards the healthcare costs of the less well-off.

Finally, we believe that it is in everyone's enlightened self-interest to partake in collective endeavors to improve the general health of a society, enlightened in the ability to see that one's self-interest/personal well-being is embedded in a broader collective interest/well-being and to feel a sense of "shared citizenship" within a society. A comfortable life amidst a world of misfortune and misery is not likely to render much happiness.

Electronic medical records system (EMRS)

- *How exactly does the electronic medical records system achieve the functions of enhancing the quality of care, containing healthcare cost, supporting professionalism, and improving accountability?*

Enhancing quality of care

- An electronic medical system helps to improve the quality of care because it facilitates clinical decisions. With patient records almost instantly accessible at the point of consultation, medical practitioners will be in a much better position to understand the history of a patient's illness and the treatments that have been previously prescribed. This will not only facilitate diagnosis of the patient's current condition but will also alert the doctor to the necessity or otherwise of particular procedures and the appropriateness of particular drugs.
- Studies have shown that physicians usually get to ask only about 30% of the necessary clinical questions while seeing their patients. EMRS makes up for the missing information to enable optimal clinical decisions.
- In another study of in-patients, it was found that computerization of medical prescription records improved safety to the degree of reducing medical errors by more than 80%. Electronic reminders are also useful tools in the effective care of chronic conditions like diabetes.

Containing healthcare cost

- EMRS helps contain healthcare costs in different ways. Firstly, with fuller sets of medical records readily

- A study demonstrated that expenditures for care among the elderly in the US were lower in areas of the country with higher ratios of primary-care physicians to population.
- A nationally representative survey in the US showed that adult respondents who reported a primary care physician rather than a specialist as their regular source of care had lower annual healthcare costs, after controlling for initial differences in health status, demographic characteristics, health insurance status, health perceptions, reported diagnoses, and smoking status.
- In 1998, European countries with gatekeeping systems spent less on healthcare as a percentage of their gross national product than those that allowed direct access to specialists (7.8% *v* 8.6%).

Institute for clinical excellence

- *In what ways does the institute play an important role in enhancing quality and containing cost of healthcare?*
  - Research shows that there is considerable unwarranted variation in clinical practice – variation not explained by illness or patient preference.[xlvii] This means that some practitioners provide more care than others, and that such difference has no impact on health outcomes. In other words, there is considerable "waste" in clinical practice. For example:
    - "After adjustment for age, sex, and race, per capita Medicare spending in 2000 was $10,550 in Manhattan, New York, for example, but only $4,823 in Portland, Oregon. The differences in spending are largely unrelated to differences in illness or price. Rather, they are due to differences in patterns of practice …"[xlviii]
    - In US, patients with similar chronic illnesses who live in high-cost regions do not have better health care outcomes than those living in low-cost regions.[xlix]
    - In US, "among the chronically ill, the frequency of physician visits, diagnostic testing, and hospitalisation and the chances of being admitted to an intensive care unit (ICU) depend largely on where patients live and the health care system they routinely use, independent of the illness they have or its severity."[l]
  - Scholars have also found that many medical interventions are not evidence-based and are of uncertain effectiveness.
    - One study conducted in 2005 reviewing 2404 medical treatments found that
      only 15% were rated as beneficial
      22% were likely to be beneficial
      7% were rated as trade off between benefits and harms
      5% were unlikely to be beneficial
      4% were likely to be ineffective or harmful
      47% were of uncertain effectiveness.[li]
  - The implication of the above research findings is that quality of care can be greatly improved and costs of care greatly reduced if best clinical practice can be encouraged.

"Money follows patient" principle and prospective payment mechanism

- *How do the "money follows patient" principle and the prospective payment mechanism help improve quality of care and contain costs?*
  - Under this funding allocation arrangement, providers' revenues depend on the number of patients treated. In other words, to guarantee income, providers have to compete for patients.
  - To compete for patients, providers may lower price and/or improve quality.
  - Since payment rates are fixed prospectively, providers can only compete on quality, i.e. unless good quality of care can be ensured, providers may lose patients and hence income.
  - In addition to inducing providers to compete on quality alone, the prospective payment mechanism also encourages providers to adopt the most cost effective procedures for treating patients and to avoid clinical

can such perverse incentives be reduced?

- It should be noted that such incentives occur mainly in hospital care and specialist care. Primary care doctors normally do not face this incentive structure as they can always refer relatively ill patients to specialist care or hospital care.
- One way to solve the "dumping patients" problem is to make it impossible. As suggested in our proposed system, providers are not allowed to reject patients.
- To solve the "skimping" problem, we suggest relying on patients' primary care doctors and the electronic medical records system. With real time access to patients' medical records, primary care doctors can help monitor the treatments given by healthcare providers at other levels.

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[iii] For a general discussion on determinants of health, see R. G. Evans and G. L. Stoddart. 1990. Producing health, consuming healthcare. *Social Science and Medicine* 31(12): 1347-1363. and R. G. Evans and G. L. Stoddart. 2003. Consuming research, producing policy? *American Journal of Public Health* 93(3): 371-379.

[iv] R. B. Saltman and J. Figueras. 1997. *European Health Care Reform: Analysis of Current Strategies*. Copenhagen: World Health Organization Regional Office for Europe; T. W. Hu. 2006. *Health Care Financing Options for Hong Kong, Pursuing the Ideal: An Academic View*. Presentation at the Hospital Authority Converntion 2006. Hong Kong Convention & Exhibition Centre, Hong Kong, 8-9 May, 2006; A. Maynard. 2006. *Health Care Reform: Managing the Monster*. Presentation at the International Symposium: Hong Kong's Health System: Reflections, Perspectives and Visions. Faculty of Medicine, University of Hong Kong, 16-17 June. 2006.

[v] R. B. Deber. 2002. *Delivering Health Care Services: Public, Not-for-Profit, or Private?* Discussion Paper No. 17. Saskatoon: Commission on the Future of Health Care in Canada; R. B. Deber. 2003. Health care reform: lessons from Canada. *American Journal of Public Health* 93(1): 20-24.

[vi] These two questions are quoted from R. B. Deber. 2003. *ibid.* p.21.

[vii] The above is paraphrased and quoted from R. B. Deber 2002. *op cit.* p. 2 and R. B. Deber. 2003. *ibid.* p. 21.

[viii] The Harvard Team. 1999. *Improving Hong Kong's Health Care System: Why and for Whom?* Hong Kong: Government Printers; W. Yip and W. Hsiao. 2004. *A Systemic Approach to Reform Hong Kong's Healthcare Financing: The Harvard Report*. Downloadable from www.hsph.harvard.edu/phcf/Papers/HK%20chapter%2010.16.04.pdf [access: 11 Dec 2006]; I. Holliday and W. K. Tam. 2000. Fragmentation in the Hong Kong health care system: myth and reality. *The Asian Journal of Public Administration* 22(2): 161-181.

[ix] These two figures are from G. M. Leung *et al.* 2005. The ecology of health care in Hong Kong. *Social Science and Medicine* 61: 577-590.

[x] The Harvard Team 1999. *op cit.*; G. M. Leung *et al.* 2005. *ibid.*

[xi] The discussion is partly drawn from The Harvard Team 1999. *ibid.* and W. Yip and W. Hsiao. 2004. *op cit.*

[xii] For a general discussion on the agency role of healthcare providers, see A. Maynard and K. Bloor. 2003. Trust and performance management in the medical marketplace. *Journal of Royal Society of Medicine* 96:532–539.

[xiii] The discussion is partly drawn from The Harvard Team 1999.*op cit.* and W. Yip and W. Hsiao. 2004. *op cit.*

[xiv] Hong Kong Domestic Health Accounts. Downloadable from the website of the Health, Welfare and Food Bureau.

[xv] J. R. Lu *et al.* 2006. Horizontal equity in health care utilization evidence from three high-income Asian economies. *Social Science and Medicine* 62: in press; Hong Kong Domestic Health Accounts.

[xvi] G. M. Leung *et al.* 2005. *op cit.*

[xvii] Census and Statistics Department, Hong Kong SAR Government. 2003. *Thematic Household Survey Report No. 12.* Hong Kong: Census and Statistics Department, Hong Kong SAR Government.

[xviii] G. M. Leung *et al.* 2005. *op cit.*

[xix] O. O'Donnell *et al.* 2005. *Who Benefits from Public Spending on Health Care in Asia?* EQUITAP Project Working Paper No. 3. Rotterdam: Erasmus University and Colombo: IPS and Census and Statistics Department, Hong Kong SAR Government. 2003. *op cit.*

[xx] G. M. Leung *et al.* 2005. *op cit.*.

[xxi] G. M. Leung *et al.* 2005. *ibid.*

[xxii] The above is based on an internal workshop on healthcare financing models given by Prof P. Yuen to the Healthcare Policy Forum held in July 2006.

[xxiii] The above description of HA's medical record system is based on N. T. Cheung. 2006. *Realizing the benefits of eHealth in Hong Kong*. PowerPoint Presentation at the First eHealth Forum organized by the eHealth Consortium, Hong Kong Academy of Medicine, September 2006 and W. N. Wong. 2006. *HA Electronic Patient Record: Sharing with Private Sectors*. PowerPoint Presentation at the First eHealth Forum organized by the eHealth Consortium, Hong Kong Academy of Medicine, September 2006.

[xxiv] J. R. Lu *et al.* 2006. *op cit.*

[xxv] European Commission. 2001. *Budgetary Challenges Posed by Ageing Populations*. Brussels: Economic Policy

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[xlviii] E. S. Fisher. 2003. *ibid.*, p. 1666.

[xlix] J. E. Wennberg. 2004. *op cit.*, p. 140.

[l] J. E. Wennberg. 2004. *ibid.*, p. 140.

[li] British Medical Journal Clinical Evidence. http://www.clinicalevidence.com/ceweb/about/knowledge.jsp [accessed 11 December 2006]

[lii] The evidence below is based on a review by C. Propper *et al.* 2005. *Extending Choice in English Health Care: The Implications of the Economic Evidence*. Working Paper No. 05/133. Bristol: Centre for Market and Public Organization, University of Bristol.