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Options for Financing Health Care Service

Annex - Public responses to the Harvard Report

Chapter 1 – Background

Over the years, we have developed in Hong Kong an enviable health care system, which provides an accessible, quality, equitable and affordable health care service. Highly subsidised, the public health care sector offers protection to individuals from significant financial risks that may arise from catastrophic or prolonged illnesses. While more expensive to the consumers, the private sector offers patients greater choice and convenience. The two sectors serve different but complementary roles, and together, they provide comprehensive health care of a high standard to the Hong Kong community.

2. Our health indices are among the best in the world. In1999, the life expectancy at birth was 77 years for men and 82 years for women. The infant mortality rate was 3.2 per 1 ,000 live births, while the maternal mortality rate for 100,000 total births was2.0. The illness and disease patterns in our community resemble those of developed countries, with cancer and chronic illnesses emerging as our leading causes of mortality and morbidity. Communicable diseases have been effectively placed under control.

3. While our existing health care system has served us well for many years and is still delivering quality services, like other health care systems, it has to evolve and develop to meet changing societal needs. The need for the system to change is reflected in a few widely recognised problems. The most frequently discussed is the work pressure encountered by staff and financial constraints experienced by service providers in the public sector. Public health care services are delivered mainly through the Department of Health and the Hospital Authority. Between them,

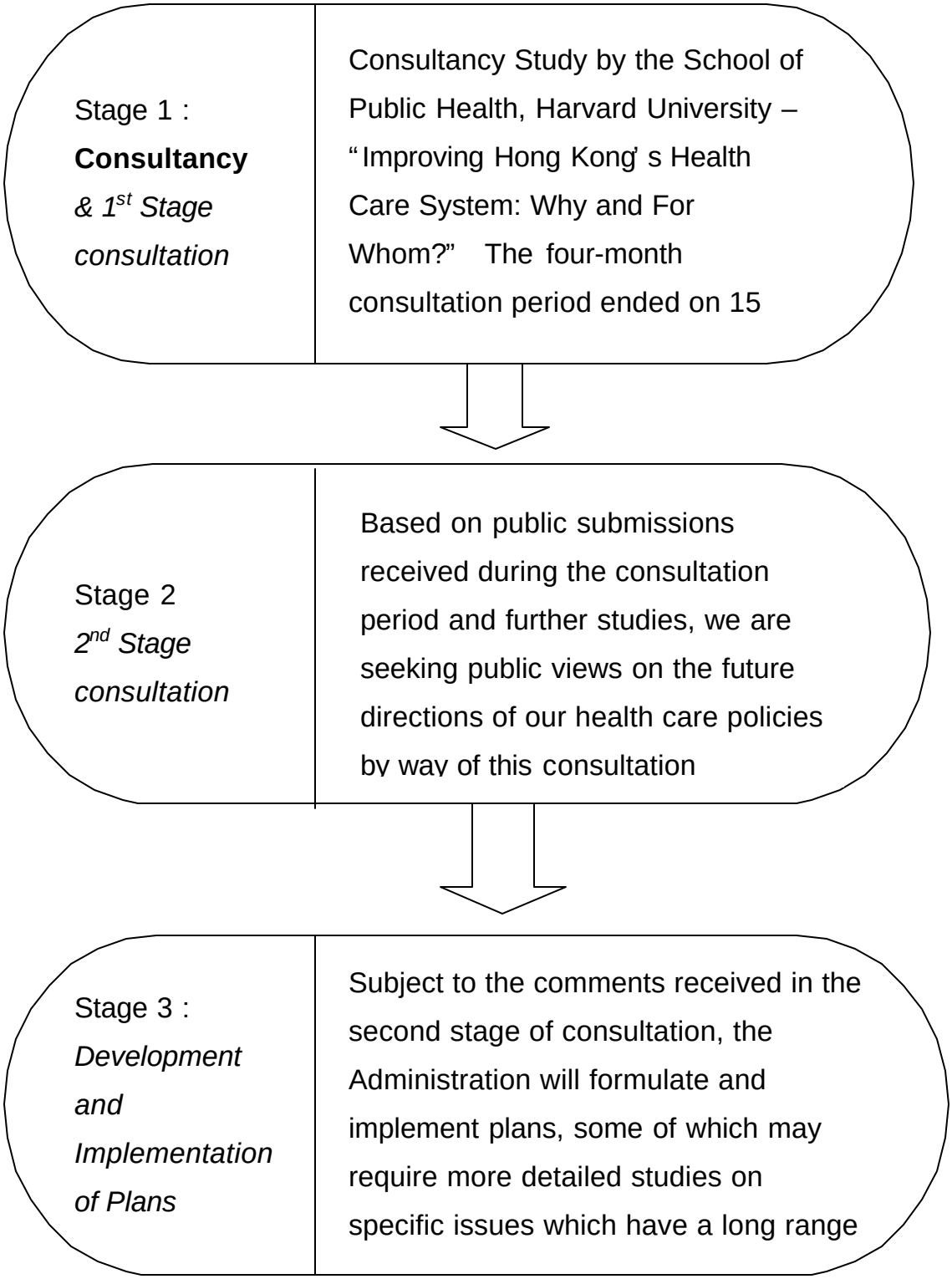
they provide a full range of preventive, curative, and rehabilitative services. Because of the highly subsidised fees charged for services and improving standards, the public sector faces an increasing number of patients, mounting work pressure and threat of financial sustainability.

4. In November 1997, we commissioned the School of Public Health of Harvard University to conduct a study on the existing health care system and to recommend necessary changes. The study was completed in April 1999 with the release of a Report entitled "Improving Hong Kong's Health Care System - Why and for Whom?" for public consultation. According to the Harvard report, our present system suffers from three key weaknesses - compartmentalisation in the delivery of service, variable quality of care, particularly in the private sector, and questionable financial and organisational sustainability. These findings by the Harvard consultants point to the need to seriously re-think and re-structure the existing health care delivery and financing system to one which is able to meet the future needs and aspirations of the population of Hong Kong.

5. Since the release of the Harvard report, there have been intense media interest and public debates on the subject. We have received over 2,200 written submissions from different sectors of the community. Although views are diverse and varied on the reform proposals recommended by the Harvard consultants, they have been constructive and helpful to our policy deliberation process. The most important observation from these submissions is that the public is generally supportive of the need for reforms. A summary of the feedback we have obtained is at Annex.

6. On the basis of the comments received, we have further reviewed the three main pillars of our health care system - the organisation and provision of health services (service delivery system), mechanisms to assure the quality of health care provided (system of quality assurance) and the funding and financing for health care services (health financing system) - and formulated strategic directions for reforms to ensure that the system would be able to meet the needs and aspirations of our future generations. This consultation paper sets out our proposals. Chapter 2 will bring you through our vision, policy objectives, guiding principles and values for the evolution of our health care system. In Chapters 3 to 5, you will be presented with the proposals on re-organisation of our service delivery system, measures to enhance our system of quality assurance, and options for financing the health care system. We look forward to your support and comments on our proposed directions.

Review of the Health Care System



Chapter 2 – Vision and Policy Objectives

7. Health is not merely the absence of disease and infirmity. Using the time-honoured definition of health by the World Health Organisation, health is "a state of complete physical, mental and social well-being". Health is a resource which enables individuals to fulfil human potentials and maximise capabilities, achieve successes at work, enable social participation, and enjoy a good quality of life. For the community, investment in health can bring the invaluable returns of a productive, vibrant and successful society.

8. The key determinants of the health of a population include not only the quality and effectiveness of the health care system, but also socio-economic and environmental factors, and individual health and illness behaviours, lifestyles and genetic differences. Health is integral to life and well-being; and the pursuit of health is of necessity a continuous lifelong process. The time, efforts, human capital and financial resources we invest in health need to be lifelong and multi-generational.

9. The pursuit of health requires investing in an effective and sustainable health care system which provides comprehensive and holistic lifelong care. The health care system protects and promotes health, prevents and cures illnesses, and minimises and eliminates disabilities. However, the promise of good health cannot be achieved without the individual's personal actions and contributions through early planning for the individual's long term health care needs and the adoption of health-promoting behaviours and lifestyles which enable healthy aging. Health is also an individual responsibility.

Our Vision

10. Our vision is to re-create a health care system which promotes health, provides lifelong holistic care, enhances quality of life and enables human development.

Objectives

11. Based on the values we believe that should guide the transformation, the objectives of our health care system should be:-

(a) To protect the health of the population, prevent diseases and disabilities, promote lifelong wellness, and support continuous health sector development.

(b) To provide comprehensive and lifelong holistic health care which is humane, where care and comfort to the individual is as valued as medicine and technology-based interventions.

(c) To provide accessible, equitable and quality services to members of the community on the basis of health needs.

(d) To remain cost-effective, sustainable and affordable both to the individual and the community.

(e) To reinforce the notion that the pursuit for better health is a shared responsibility among the individual, the community and Government.

Principles

12. We believe that the following set of principles are fundamental to meeting the objectives of the health care system envisioned, and they should guide the formulation of our reform proposals :-

(a) We believe that good health stems from health-sensitive, health-protecting and health-promoting public policies and infrastructure and an environment conducive for people to make health-enabling personal choices.

(b) We believe that the best health care system is community-focused, patient-centred and knowledge-based, comprising an appropriate balance of promotive, preventive, curative and rehabilitative services, delivered in a seamless, humane manner in a collaborative network, over an individual's lifetime.

(c) We believe that health is also a personal responsibility, and individuals should be enabled to take more responsibility for their own health, through better information and understanding and more active involvement in decisions about their health.

(d) We believe that patients have the right to information and freedom to choose their providers if they so wish. The existing dual public and private systems, serving complementary roles, should be maintained, with better collaboration between them.

(e) We believe that the community is entitled to consistent delivery of a high standard of health care services, ensured by a dual system of accountability, comprising regulatory, accreditation and monitoring mechanisms by Government and quality assurance by health care providers.

(f) We believe that everyone should have equitable access to quality health care for comparable needs. Any reform measures should maintain our existing strengths of accessibility, equity and affordability, and enhance quality. There must be a safety net for the financially vulnerable.

(g) We believe that the community is entitled to expect that public resources are used efficiently, and that public subsidies are targeted at areas of greatest needs. Those who have the means should bear an affordable share of the medical expenses they have incurred.

(h) We believe that a commitment to long term financial sustainability of the health care system is crucial, which can best be achieved through risk-pooling and pre-funding. Care should be taken not to pass on an unnecessary burden to our future generations.

(i) We believe that changes to the system should be evolutionary to allow time for acceptance and adoption by different stakeholders, but positive steps should be taken early to demonstrate our commitment to changes.

Chapter 3 – Reforms to the Health Care Delivery System

The Challenge

13. The current life expectancy at birth is 77 years for men and 82 years for women. At present, about 11% of Hong Kong's population of 6.7 million are at 65 or above. It is projected this percentage will increase to 15% by 2019. To promote health and minimise disability among older persons, many preventive health programmes, medical interventions and rehabilitative services are required.

14. Hong Kong has experienced its epidemiological transition from communicable to chronic diseases. Chronic illnesses rank high in our burden of diseases and disabilities. These illnesses require long term management, which is labour and technology intensive and generally expensive, and the illness may significantly affect patients' quality of life.

15. Into the new millennium, one of the main challenges to our health care system is to develop a framework for providing health care services which can minimise and best manage the prevalence of chronic diseases and burden of disability, and promote health and wellness. Against this background, this chapter looks into the issues in the existing delivery system and proposes some directions for change.

Objective

16. The fundamental role of a health care system is to enhance the health of the population and improve the community's quality of life. To ensure that our health care delivery system can fulfil this role, we need to protect the health of the population, prevent disease and disability, promote lifelong wellness and provide treatment, care and rehabilitation to the sick, injured and disabled. We seek to improve the health outcome and cost efficiency of the system through the development of a community-focused, patient-centred and knowledge-based health care system, comprising an appropriate balance of preventive, ambulatory, in-patient and community outreach services,

delivered in a humane way over an individual's lifetime, supported by sustained collaboration among health care providers, and between the latter and the community.

Strategic Directions

17. To achieve our objective, we propose to pursue the following strategic directions :-

(a) Strengthen preventive care;
(b) Re-organise primary medical care;
(c) Develop a community-focused, patient-centred and knowledge-based integrated health care service;
(d) Improve public/private interface;
(e) Facilitate dental care; and
(f) Promote Chinese medicine

Strengthen Preventive Care

18. Preventive care is the science and art of preventing disease, promoting and protecting health and improving the quality of life through organised community efforts. Effective preventive care has a significant impact on the health care needs of the community. It reduces the incidence of disease, both communicable and non-communicable, enhances the health status of the population and lowers the overall burden of disease and disability of the community.

19. Maintaining good health is a personal responsibility and any effort to prevent diseases needs to involve the individual. Taking ownership of one's own health, an individual should make appropriate plans on how to avoid illness and disability and remain healthy. Many infections, illnesses, diseases and disabilities are preventable, or at least, their effects ameliorated through self-care efforts.

20. In preventive care, one key role of Government is to provide the necessary information, encouragement and infrastructure to enable people to control and improve their health. This infrastructure includes not only the structure and processes for health and patient education but also the wider knowledge and understanding of the health impact of socio-economic decisions . A key responsibility of Government is to oversee the development of preventive care, identify and assess the impact of social and environmental variables to health, protect health through legislation and regulations, provide services ranging from disease

surveillance and prevention, health education and promotion, to immunisation and health screening.

Proposal

21. In spite of the good work already performed, there are still ways to strengthen the effectiveness of preventive care to achieve greater health gains. We propose that the Department of Health should adopt the role of an advocate for health, working in concert with the Health and Welfare Bureau, seeking political commitment, policy and systems support and social acceptance for different health goals and programmes. The Government will address the full range of potentially modifiable determinants of health – not only those related to individuals, such as health behaviours and lifestyles, but also factors external to the traditional health domain. Significant health gains may be achieved by managing the health impact of the wider social, physical and economic environments of the community.

22. We propose that Government should build up an intersectoral infrastructure, covering all related sectors, including health care, education, environment and others, to focus and collaborate on preventive health issues. Together with Government, the parties concerned would identify and set priorities for health, formulate health targets, plan and develop strategies and monitor their implementation. It will be easier to gain influence over the determinants of health through such joint efforts.

23. We propose that the Department of Health must seek to continuously enhance community involvement in health education and promotion activities. These efforts will strengthen, at the personal level, the capability and commitment to prevent diseases, the knowledge and understanding to improve health and the ability to make decisions on treatment processes; and at the community level, the influence to create living conditions conducive to health. A high level of continuous public participation sustains health promotion efforts, provides social support to health issues and helps address related conflicts within the community.

Implementation

24. The Department of Health will, commencing from 2001-02, prepare for and phase in various new initiatives devised in accordance with the directions described above. The efforts will be supported by appropriate staff training, outside consultancy help and development of performance indicators. We expect the Department to develop, by end- 2002, a long term plan for strengthening preventive care as proposed.

25. As a start, based on its monitoring of the health trends in Hong Kong, the Department aims to commence preparing, in two years' time, regular reports on the health status of the community. In parallel, the Department will carry out health impact assessment of socio-economic variables and different environmental problems. These efforts will form the basis to

support the formulation of health priorities, targets and strategies.

26. The Department of Health will review its health promotion strategies and capacity, provide training to enhance skill in health promotion, expand intersectoral collaboration, build up an alliance for health and actively solicit community participation and support. The Department will develop evaluation tools to measure the effectiveness of health education and promotion efforts.

Re-organise Primary Medical Care

27. People will still get sick in spite of preventive care, and when that happens, normally their first point of contact is with primary medical care practitioners. Primary care practitioners are engaged in preventive care and provide continuing care and medical treatment to patients and refer them to specialised care where necessary. Effectively carried out, the functions of the primary care practitioners can help reduce significantly the pressure on secondary and tertiary care and the overall health care expenditure of the community.

28. We believe that the effectiveness of primary medical care can be gradually enhanced by the promotion and adoption of family medicine practice and the development of other primary care practitioners, including other physicians, nurses and allied health professionals. Family medicine is a specialised discipline

of medicine that provides primary, continuing and comprehensive care to an individual and the family in their own environment. The care is holistic, incorporating the interaction and inter-relatedness of psycho-social and physical elements of health. In Hong Kong, the development of this specialty is still at an early stage. There are currently only about 120 qualified family medicine specialists, and the benefit of family medicine is still not widely known and appreciated. The role of other physicians as primary care practitioners also needs to be examined. The development of the role of nurses and other allied health professionals, such as pharmacists, as primary care providers is also not well recognised and deserves greater emphasis.

29. At present, primary medical care is predominantly provided by general practitioners in the private sector. Patients prefer to consult private practitioners because :-

(a) the private sector allows choice of doctors and offers more flexible consultation hours. The service is more easily accessible than that in the public sector; and

(b) the fees charged by the general practitioners, in the order of $150 per consultation, are generally affordable by the public and regarded as good value.

30. The Department of Health currently operates 65 general out-patient clinics, charging a low fee of $37 per attendance. About 35% of the patients are elders at 65 or above. At unit cost of $219 per attendance, the general out-patient service is highly subsidised. This marked price difference between the public

and the private sectors has generated huge demand for the Department of Health's clinic services. The huge workload has made it difficult for the quality of service to be upgraded.

Proposal

31. To improve primary medical care, we propose that the public sector should take the lead in promoting family medicine practice by doctors, nurses and allied health professionals and provide the relevant training opportunities. The Hospital Authority has started its family medicine training programme since 1997-98, and set up family medicine-based clinics to assist the specialist out-patient clinics by attending to patients in stabilised conditions. These clinics also serve as training ground for health care professionals. The Hospital Authority plans to provide training to a total of 316 family medicine trainees in 2001-02, and in the longer term, about half of the doctors recruited to the public sector will be trained in family medicine and primary care. The Hospital Authority has also been developing the role of nurses as primary care practitioners for long term care in the community.

32. We propose that the Department of Health's general out-patient service should be transferred to the Hospital Authority to facilitate integration of the primary and secondary levels of care in the public sector. At present, there is regular liaison between the two organisations on the referrals to and from the Hospital Authority's specialist out-patient clinics, and shared care programmes, such as those for diabetic patients, have been implemented, but because of the different environments in which

the staff have to work, there remains interfacing problems that need to be addressed.

33. We propose that upon transfer, the general out-patient service should be redesigned into clinics attending to, primarily, the financially vulnerable and those chronically ill, who are exposed to high financial risk because of the long term treatment required. These clinics can also serve as the training ground for family medicine and other models of primary medical care, such as general medical practice, and for other primary care professionals.

34. We propose that the public sector should explore ways to improve collaboration with the private sector, to assist family medicine trainees to complete their training, and to improve on the quality and continuity of care. This objective can be achieved, for example, by contracting out some of the general out-patient services to private practitioners for the purpose of training in family medicine and establishing a network between public and private sectors to support exchange of information and knowledge in primary medical care.

35. We propose that all health care professionals, in the public as well private sectors, should be required to undertake continuing professional education and development which helps maintain and upgrade their standard of service. This proposal will be discussed further in Chapter 4.

Implementation

36. We shall work out, by the end of 2001 –

(a) an implementation plan for transferring general out-patient service from the Department of Health to the Hospital Authority;

(b) the improvement plans for the general out-patient service, including gradual adoption of family medicine practice and training of health care professionals in primary care; and

(c) some initial proposals for collaborating with the private sector in the provision of primary medical care.

Subject to finalisation of these plans and proposals, and consultation with the staff and other relevant parties, we shall seek to implement these initiatives, incrementally, from 2002 onwards.

Develop a Community-focused, Patient-centred and Knowledge-based Integrated Health Care Service

37. With the establishment of the Hospital Authority in 1990, followed by the implementation of the hospital management reforms, public hospital services have significantly improved over the years in terms of quality, cost-effectiveness and efficiency. Supported by its modern day management, development of clinical protocols, pursuit of clinical audits, experience in risk

management and comprehensive information systems, services in the Hospital Authority have become a possible source of benchmarking for the overall health sector.

38. Because of the long term care needs of the chronically ill, and a better understanding of the inter-relatedness of the psycho-social and physical elements of health and illness, international trend has been to focus on the development of ambulatory and community care programmes and to replace, where appropriate, in-patient treatment by ambulatory and out-patient services. This has been made possible following advances in medical technology and changing perspectives of policy makers, providers and users, supported by appropriate training of staff and patients. For example, some of the on-going medical care required by patients with chronic renal disease, including the process of haemodialysis, which is usually offered in hospitals, can now be carried out in clinics on self-service basis with minimum assistance from the health care professionals. For better off patients who can afford the equipment, they can carry out the process of haemodialysis even at home. Locally, we have also proceeded along this route and the Hospital Authority has in recent years stepped up its developments on day surgery, day care, community nursing, outreach programmes, home care and others.

39. Initiatives have been made by the Hospital Authority to develop a patient-centred health service, which recognises the vital role of the individual both as recipient and participant of health care, with better understanding of the psycho-social elements of health and illness and increasing appreciation of the

need for continuity of health care over an individual's lifetime. New models of delivering health care need to be created and new skills to be learnt by health professionals to further develop this attribute.

40. Health care services are evolving both in breadth and in depth, with better appreciation of socio-economic and environmental factors and psycho-social variables which influence health. The knowledge needed for delivering health services has incorporated environmental, social and behavioural sciences. The organisation and provision of health care has become increasingly complex, and skills in managing and organising also need to be learnt and developed in order to provide effective care. Medical science technology is advancing rapidly, with knowledge and understanding evolving so rapidly that systems for knowledge management and application are vital. These systems include continuing education of health professionals, development of research-based clinical practices (evidence-based medicine) and adoption of tools such as clinical practice guidelines which incorporate research evidence. Substantial efforts have been made in developing the systems for knowledge management and application in the Hospital Authority.

Proposal

41. We support this new trend to emphasise less on in-patient services and to develop, in addition to and in partnership with the hospital system, a network of community-based integrated health care services. Care delivered in or around people's home, or in

homely settings in the community, helps maximise the patient's quality of life. The target is to shorten, as much as appropriate, the length of stay in hospitals but to continue the treatment and care in the community. Hospitals are expensive to construct, and complex and costly to maintain and operate. Well designed ambulatory and community care programmes also have the added benefits of achieving greater cost-effectiveness.

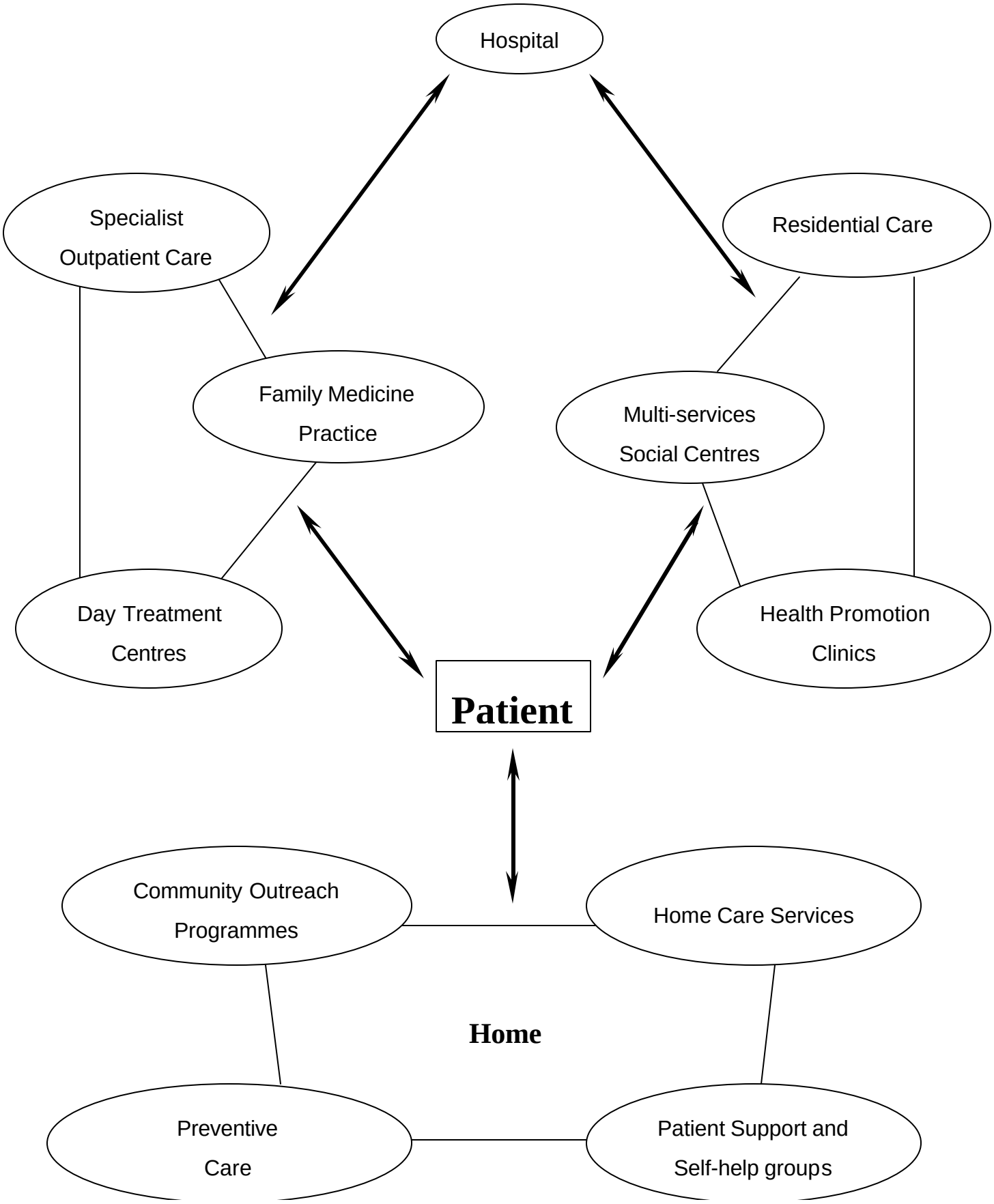
42. We propose that this community-based model should adopt a multi-disciplinary (i.e. joining the efforts of different health care experts and professionals) and multi-sectoral (i.e. joining the efforts of providers in the public and private sectors as well as providers outside the health care sector, particularly the welfare sector and community groups) approach in order to provide a comprehensive and integrated health care service to the patients. A multi-disciplinary approach links up various parts of the delivery system, ensuring that patients obtain the best care from the most appropriate professional staff. A multi-sectoral approach extends the link to outside the health care sectors, ensuring continuity of care for patients and avoiding unnecessary duplication of services.

43. To facilitate the development of community-based services, we are taking steps to revamp the funding mechanism for public health care provision. The allocation of public funding should move away from being input- or facility-based. Instead, it should be based on population needs and specific programmes aiming to enhance health outcomes and the quality of life of people or patients while living in the community. We would encourage the mobilisation of resources from institutions to

community settings with enhancements to the training and provision of community-based teams and workers to support the provision of community-based health care delivery. In the long run, we hope to reduce the over-emphasis on institutional care.

44. Physicians in family medicine and in primary care, in partnership with nurses and allied health professionals, play a leading role in a community-based health care model. They are partners to hospitals by providing treatment and care to patients in the community and helping them with prevention and self-care efforts. The welfare sector is an important ally by extending the care process to cover long term care and social needs. Upon discharge from hospitals, some patients, while in stabilised conditions, but because of their infirmities, require residential care, or from time to time, respite service. Patients staying at home in better health conditions who require assistance with activities of daily living would benefit from services provided in day care centres and by home care teams. With the combined support from the medical and welfare sectors and the community, patients and families, including frail elders and the chronically ill, can continue to enjoy a good quality of life despite their medical conditions. We will facilitate the development of collaborative programmes among various health care and welfare service providers to provide mutual support and shared care. The development of an electronic Health Information Infrastructure (see paragraph 53 below) will help link up all relevant providers in a community network to facilitate their communication and provision of care in continuity. A diagrammatic illustration of this community-based integrated health care service is set out at below.

Community-Based Integrated Health Care Model



45. We propose that continuing professional training and development be required for all health care professionals to enable them to meet the requirements of knowledge-based and patient-centred health services. This proposal will be further discussed in Chapter 4. The Hospital Authority will also work with other health care providers and professional bodies to develop knowledge-management tools such as evidence-based clinical practices.

Implementation

46. We would finalise, for the 2001-02 estimates, a new funding formula for the Hospital Authority based on population and demographic profiles rather than on the number of hospital beds as at present. This will remove one major barrier to the development of community-based service. Providers will no longer be deterred from developing care programmes not directly linked to beds or facilities.

47. The Hospital Authority would formulate, by end-2001, an outline plan for the development of this community-based integrated health care service. The plan would include proposals on different community care programmes, targets to be achieved and evaluation tools to measure the effectiveness of these programmes. The process will be a dynamic one, and the model will take time to evolve.

48. The Hospital Authority would also work out, by end-2001, a plan for the future development of knowledge-based health services.

Improve Public/Private Interface

49. The lack of effective interface and collaboration among health care providers, in particular between the public and the private sectors, has been a main concern. It causes discontinuity of care, unnecessary duplication of services and abortive expenses. It restricts the choice of providers by patients. Some patients find themselves entrapped within a particular sector, if not within a particular institution or provider. This lack of an effective interface has led to the present rather uneven distribution of workload between the public and the private sectors. Both the medical professionals and patients would like to see improvements in this area.

50. There are several barriers giving rise to the lack of effective interface between the public and private sectors. Firstly, there are the barriers relating to professionals practising in different sectors. Doctors in different sectors have their own preference for clinical practices and dissimilar perspectives on outcome evaluation. Secondly, there are the information gaps. There is no effective mechanism for doctors to exchange health and patient information between the public and private sectors. Thirdly, there are the price barriers. The significant price differences between the public and the private sectors have been regarded by many practitioners as another reason for the compartmentalisation between the two sectors.

51. We fully appreciate that the private health care sector has a valuable role to play in Hong Kong. At present, about half of our registered medical practitioners practise in the private sector,

providing a wide range of primary and specialist out-patient as well as in-patient services. Unlike the public sector, the private sector offers patients the choice of doctors, and many of them are generally more flexible in responding to the patient's requests. More importantly, many private doctors have built up continuing long term relationships with their patients and the patients' families and are well respected and trusted by them. To many patients, this sense of confidence and comfort is much treasured. In short, a considerable number of patients are relying primarily on the private sector for their medical treatment, although many also seek care from the public sector at the same time. Better interface, communication and collaboration between the public and the private sectors, and among different health care providers, will be of great help to these patients by providing better continuity of care, and ensuring consistency in care practices and in assessment of health outcomes.

Proposal

52. To overcome the professional barriers, we propose that the public sector should work with the private sector in formulating common clinical protocols and mechanisms for outcome evaluation, for use, initially, in the public sector and for patients who use both the public and private sectors. The adoption of common protocols will facilitate the transfer of patients at different stages of treatment and ensure continuity of care. These efforts can be further supplemented by some shared staff training and development programmes between the two sectors. These common clinical protocols may also be used by private practitioners for their own practices.

53. With the rapid advances in information technology, it is now possible to overcome the information barriers that exist between various health care providers. In the public sector, the Hospital Authority has developed comprehensive information systems to assist in clinical management, and is planning to introduce lifelong electronic patient records for public hospital patients. We propose to develop a computer-based Health Information Infrastructure, beginning from the public health sector, extending to allow access to all health care providers, including those in the private sector, and eventually to the welfare sector. This network can provide a platform for sharing medical knowledge, information and clinical protocols, for quality assurance and patient care audit, and subject to the individual patient's wishes, for sharing of the patient records. The Health Information Infrastructure would facilitate the development of a lifelong health record for each individual.

54. The price differences between the public and the private sectors can be overcome by product differentiation. There will always be price differences between the public and the private sectors, but when patients choose a provider, they normally have regard to the entire service package. The fee level is an important factor to consider, but so are other factors, such as freedom to choose doctors, convenience and confidence. We encourage the private sector to consider further the value of product differentiation.

55. We propose that the public and private sectors should jointly explore how the two sectors can collaborate and develop

new health care products in which both sectors can participate and contribute to the benefits of the patients. Such integrated plans involving both sectors and some of their respective strengths will allow the patients another choice in seeking treatment. We encourage the medical insurance industry to develop new health care insurance policies to support such new products.

Implementation

56. The Hospital Authority will commence in 2001 promoting the development and use of common clinical protocols and sharing of staff training and development with the private sector. Each major hospital will proceed to set up a liaison network with local private practitioners, streamlining patient transfer arrangements, and reducing the need for duplication of investigations and tests upon patient transfer. The Hospital Authority will also seek the assistance of the Hong Kong Academy of Medicine and the Academy Colleges in minimising the present professional barriers.

57. The Hospital Authority will conduct a project definition study in 2001-02 on the establishment of a Health Information Infrastructure, which will support the communication and co-operation between the public and the private sectors and assist in the clinical management of individual patients. We shall pay careful and particular attention to the protection of patient records from unauthorised access.

58. We shall set up, in 2001, a task force with private sector participation to explore how public and private sectors can jointly develop some new health care products involving both sectors. For example, some better-off patients in Hospital Authority's specialist out-patient service may be attracted to return to the private sector for follow up sessions after an operation in the public sector, by the more flexible consultation hours, shorter queues and more personalised services provided in the private sector.

Facilitate Dental Care

59. On oral health and dental care, our policy has been to focus on educational and preventive efforts. Prevention assumes a special position in oral health because there is in practice no complete cure once the teeth have decayed. On the other hand, decay of teeth is preventable by good self-care efforts. Given the constraint on public revenue, public funds should be used in where the funds can help achieve the best health outcome. In the case of oral health, we consider that the public funds available should be primarily channeled to educational and preventive efforts, which will bring the best benefits to the population.

60. The Department of Health is at present offering virtually free preventive and curative care to primary students, and is providing subsidised curative service to emergency cases and persons with special needs, such as patients with haemophilia, HIV infection, severe physical or mental handicap. The role of the Department in dental care will continue in these areas but the focus in the provision of these services should be reviewed. We

recommend that curative care, in general, should be provided by private dental practitioners and non-governmental organisations.

Proposal

61. We propose that the Department of Health should review the focus of the present educational and preventive efforts and the special curative services provided. The Department should collaborate with the dental profession, the College of Dental Surgeons of Hong Kong and the Prince Philip Dental Hospital (the teaching hospital for dentists) in formulating standards, setting oral health goals, conducting surveillance programmes, promoting the importance of oral health to the community and assuring quality throughout the profession. The data obtained from the surveillance programmes will enable the Department to identify where standards and goals have not been met and to formulate strategies to deal with the problems.

62. In view of the importance of prevention in oral health, we propose that the Department of Health should explore with the dental profession how to introduce an oral health scheme for secondary students, as an extension to the school dental scheme for primary students provided by the Department. While this oral health scheme for secondary students will not be government-subsidised, the Department of Health will assist as the coordinator and facilitator and liaise with the parties concerned.

63. To assist the lower income groups to obtain quality dental care services, we propose that Government should take active

steps to encourage more non-governmental organisations to provide affordable dental care services to the public on a self-financing basis. With good preventive care starting from a young age and good oral health habits, people can generally enjoy good oral health for a long time.

Implementation

64. The Department of Health will consult all concerned parties, including the dental profession and the Prince Philip Dental Hospital, in 2001 to work out various collaboration plans, with a view to announcing the surveillance and monitoring mechanism , oral health targets and other initiatives on quality assurance and oral health promotion in 2002. Meantime, the Department of Health will intensify its educational and promotional efforts in collaboration with the dental profession.

65. The Department of Health would commence discussion with the dental profession immediately to propose the introduction of an oral health scheme for secondary students, with a view to launching the scheme in 2002.

Promote Chinese Medicine

66. Chinese medicine has been widely used in Hong Kong for many years, both as an alternative and a complement to western medicine. Its application to prevention of diseases and maintenance of health, and to treatment particularly of chronic illnesses and intractable disease is widely recognised and

acknowledged. At present, there are about 7,000 Chinese medicine practitioners practising locally, engaged in the provision of general practice, bone-setting and acupuncture services. About 22% of the medical consultations in Hong Kong are currently provided by Chinese medicine practitioners. Chinese medicine, which has benefited many millions of patients over thousands of years, has much room for growth and to contribute to Hong Kong's health care system.

67. In his 1997 as well as 1998 Policy Address, the Chief Executive affirmed his belief that Hong Kong has the potential to develop into an international centre for Chinese medicines and Chinese medicine practice. Significant developments towards achieving this goal have taken place in the past few years :-

(a) The Chinese Medicine Ordinance was enacted in July 1999, providing a statutory framework for the regulation of Chinese medicine in Hong Kong. Through a system of registration and discipline, the Ordinance recognises the professional status of Chinese medicine practitioners. The establishment of a sound regulatory system will enhance the standard of Chinese medicine and public confidence in the practice;

(b) formal education at tertiary level on Chinese medicine has been introduced in Hong Kong since 1998. Three local universities are now operating a full-time degree course on Chinese medicine; and

(c) work is in hand to set up an Institute of Chinese Medicine to carry out and co-ordinate research, help in the development of standards and assist in the improvement of the overall quality and efficacy of Chinese medicine. There has been a lot of expressed interest from the private sector in carrying out Chinese medicine research and developing the Chinese medicine industry in Hong Kong.

Proposal

68. We shall take further the above developments. Chinese medicine has been demonstrated to be very effective in the prevention of diseases and maintenance of health, and in the treatment of illnesses. The effects on the treatment of illnesses such as common cold and eczema by herbal medicine formulation and the treatment of some painful conditions and management of stroke rehabilitation by acupuncture are particularly well known. In some cases, Chinese medicine is also less costly than western medicine. The development of Chinese medicine will complement western medicine and allow patients another choice, and Chinese medicine's capability to help individual maintain health also contributes to preventive care.

69. We shall proceed expeditiously with the establishment of the regulatory system. Registration of Chinese medicine practitioners has commenced. The existing practitioners can apply to register under the transitional arrangement stipulated in the Chinese Medicine Ordinance. Under this arrangement, the more experienced practitioners may register without the need for passing an assessment or examination. The less experienced will

be given a period of time to enable them to satisfy the registration requirements. The regulation of Chinese medicines, including the registration of proprietary Chinese medicines and licensing of manufacturers and traders in Chinese medicine, will be implemented by phases, commencing in 2001. Given the large number of proprietary Chinese medicines being sold in Hong Kong, it will take several years to complete the first round of assessment of their safety, quality and efficacy.

70. We propose that the Department of Health should support the Chinese Medicine Council of Hong Kong, which was established under the Chinese Medicine Ordinance in September 1999 to regulate Chinese medicine, to liaise and co-operate with the Chinese medicine profession and trade in regard to the setting of standards, conduct of basic and clinical research, education and training of practitioners and related personnel, compilation of data and information and the promotion of safety, quality and efficacy of Chinese medicine in general. The Department should liaise with overseas regulatory authorities to keep the trade updated of the international requirements.

71. The Department of Health has set up close liaison with Chinese medicine institutions in the Mainland. The Department will not only keep up with this liaison, but will actively explore ways and means to facilitate exchange of ideas, knowledge, expertise and experience in Chinese medicine between the two places so as to support the continuous development of Chinese medicine in Hong Kong.

72. We propose to introduce the provision of Chinese medicine in the public health care system, and will, as the first step, examine how best out-patient Chinese medicine services may be provided in the public sector. Primary care is one of the strengths of Chinese medicine. This proposal will enable this strength to be maximised for the benefit of the patients.

73. We propose to pilot the practice of Chinese medicine in selected public hospitals, supporting clinical research, and facilitating the development of standards and models of interface between western and Chinese medicines. We expect that in the long term, Chinese medicine will be integrated into the public health care system, providing treatment to patients in collaboration with western medicine. Appropriate referral guidelines will be formulated based on experience to support the collaboration.

74. We encourage the Chinese Medicine Council of Hong Kong to initiate contacts with the Medical Council of Hong Kong (which regulates western medicine practitioners) and other health care profession regulatory bodies to discuss interface issues and to explore areas for collaboration for the benefit of the patients.

Implementation

75. The process to register Chinese medicine practitioners has commenced since August 2000, starting first with the registration of the existing practitioners who are exempted from the assessment and examination requirements. Following from that, the first round of assessment and examination will be held in

2001 to enable those who are not qualified for the exemption to register as soon as possible.

76. The controls over the trading and manufacture of Chinese medicines will commence by phases from 2001. The licensing and registration regulations are now being formulated by the Chinese Medicine Council of Hong Kong. The Department of Health, as the Council's executive arm, will consult the profession and trade prior to the finalisation of the regulations.

77. We shall examine options on modes of provision of out-patient Chinese medicine services in the public sector. We aim to pilot these new clinics in 2001-02.

78. We will make plans to introduce Chinese medicine practice in selected public hospitals. We expect some pilot schemes to start in 2002, which will seek to develop a framework of collaboration between Chinese and western medicines.

Chapter 4 – Improvements to the System of Quality Assurance

The Challenge

79. The Hong Kong population is entitled to a health care system that can consistently maintain and provide a high standard of service. As leaders in the health care system, all health care professionals - medical practitioners, nurses and allied health professionals - have the responsibility to ensure that such high standards are always achieved. Any doubts that this is not happening may create mistrust in the providers and harm the relationship between patients and providers. Systems for quality assurance are well established mechanisms to ensure the standard of care and practice.

80. An effective complaint mechanism is a powerful tool for driving improvement. The complaint may have arisen from an unintended mistake or a mere misunderstanding, but there is always something to learn. A complaint mechanism that is unbiased, transparent and credible helps improve the trust of the community in the health professionals and providers, which is conducive to effective operations and improved quality .

81. A number of observations made by certain quarters of the community have cast some doubts on whether the standards of service in the health care system are as high as they should be. This chapter proposes some measures to help remove these doubts.

Objective

82. To protect patient rights and safety, there should be a framework of quality assurance in the health care system to ensure that a high standard of service is provided to patients consistently. We aim to achieve this through a combination of education and training, systems support and regulatory measures. Complementary to the system of quality assurance should be a redress system which is credible, transparent and unbiased.

Strategic Directions

83. To achieve our objective, we propose to pursue the following strategic directions :-

(a) Enhance quality assurance through continuing education, systems support, such as clinical audit, and regulatory efforts; and

(b) improve the patient complaint mechanism to enhance public confidence in health care services.

Enhance Quality Assurance

84. We have in Hong Kong some of the finest medical practitioners and health care professionals, and some of the most modern facilities and technologies, and our standards of medical care have been highly regarded both locally and overseas. However, we cannot be complacent. In line with rapid changes in medical knowledge and technology, efforts to maintain high

standards have to be continuous and lifelong. To ensure consistency, these efforts need to be supported by systems such as clinical audit, appropriate supervision, monitoring and evaluation, and where necessary, government regulations.

Education and Training

85. Education is a lifelong investment. We propose that all health care professionals, including doctors, dentists, nurses and allied health providers, should be required to undertake continuing professional education and development to ensure that their knowledge, practice and skills are updated. This requirement is not new to the health care professions. Specialists who want to remain in the Specialist Register maintained by the Medical Council of Hong Kong are required to undertake continuing medical education (CME). Under the Chinese Medicine Ordinance, Chinese medicine practitioners will be required to satisfy CME requirements before their practising certificate may be renewed. We are glad to note that the medical, dental and nursing professions have been receptive to this proposal and are pursuing the issue within their respective professions. We encourage the other health care professions to do the same. The public sector will take the lead in providing training opportunities for its employees. We also propose that the professional regulatory bodies should maintain close liaison with the tertiary institutions to ensure that the teaching curricula match with patients' current needs and aspirations.

86. We believe that a holistic approach offers the best care to our patients, and we advocate a co-ordinated multi-disciplinary

team approach, which can offer our patients comprehensive and seamless care. This requires new knowledge and skills for all health care professionals based on social and behaviourial sciences, enabling them to better understand the inter-relatedness of the psycho-social and physical elements of care. Skills and knowledge in management and communication sciences will enhance capabilities to interact with patients and other colleagues and to work in complex organisational settings where health care is provided. To take this approach forward, we will persuade professional bodies to incorporate these new competencies in the professional development programmes and encourage them to step up their liaison and examine how their respective work may interface, complement or relieve each other so as to improve the overall quality of service. In the long term, we look for a more multi-skilled health care workforce, with a broad knowledge base, which will be conducive to a more efficient and effective health care service.

Systems Support

87. We propose that the professions should put in place various systems support mechanisms to facilitate continuous quality improvement. These include the use of clinical protocols, a system of clinical supervision, regular peer review and clinical audit, and risk management. The public sector has accumulated experience in these areas and will work together with the private sector to take these efforts further.

88. We recognise the potential benefits that may derive from separating drug prescription from drug dispensing, which allows

for segregation of professional work. It is already being practised in the public sector. For the private sector, the priority is to ensure that there are good dispensing procedures and standards to ensure patient safety. Patients should also be allowed the freedom to choose between obtaining the drug from a doctor or a pharmacist. In this connection, to protect the right of the patient to choose, we propose that medical practitioners should make it clear to their patients that they have this freedom to choose and are not bound to purchase the drug from the clinics. We will be in discussion with the Medical Council of Hong Kong to formulate appropriate guidelines for the practitioners to follow.

89. In a free market like Hong Kong, we do not consider it appropriate for the Administration to interfere in the pricing in the private health care sector, but we would encourage the private sector to take proactive steps to make the pricing transparent so that consumers can exercise their right to choose before receiving the services. We are pleased to note that the Medical Council of Hong Kong is taking steps to prohibit excessive charging by medical practitioners. The public sector will regularly conduct costing of its services and make the information available as a reference for the community to take into account.

90. Quality service originates from quality policy, which should be based on a combination of evidence, resources and values. We acknowledge that in spite of the efforts of many local health care researchers and providers, we lack in Hong Kong a health sector-wide, co-ordinated programme of data collection and research activities to support policy formulation work. We propose to set up a Research Office to support the Administration

in collecting data, identifying problems, assessing priorities, formulating solutions and evaluating results. The Office will be located in the Health and Welfare Bureau and the research work may be conducted in-house or contracted out.

Regulatory Measures

91. We shall complete in the near future a review of the licensing requirements for private hospitals and of the existing controls over the sale of drugs. Subject to the findings of the review, we would propose amendments to the relevant Ordinances with a view to exercising appropriate control and facilitating enforcement. In this connection, we are pleased to note that the private hospitals are examining the setting up and use of an accreditation system to improve hospital services. The licensing requirements ensure that only hospitals meeting certain stipulated requirements may operate. An accreditation system provides a tool which may help further improve standards.

92. We propose to carry out a comprehensive review of the present statutory regulations in relation to the operation of clinics, use of medical facilities/equipment, and provision of medical services in general. The review will also examine the impact of managed care schemes in Hong Kong and how these schemes affect our patients. Our aim is to ensure that patients will receive quality service in all circumstances. Another perspective in the review is to ensure that patients and clients have sufficient and appropriate information to make choices. We believe that the best way to achieve all these is through co-operation with and self-regulation by the professions; but subject to the findings of

the review, we may need to propose some legislative changes to strengthen our regulatory framework and facilitate continuous quality improvement.

Implementation

93. The Director of Health will take up the role as the coordinator or regulator to ensure quality in the health care sector. In 2001, we will seek to involve the professions, providers and patient groups to examine the various proposals put forward in this chapter to enhance quality assurance.

94. The Health and Welfare Bureau will proceed immediately with the setting up of the Research Office. We expect the Office to become operational in 2001-02.

Improve Patient Complaint Mechanisms

95. We regulate the professional practice and conduct of health care professionals in Hong Kong through a system of statutory registration and discipline, enforced by the regulatory bodies of respective professions. The Medical Council of Hong Kong, for example, is responsible for regulating the western medicine practitioners practising in Hong Kong. Each regulatory body has its own code of practice/ethics for its members to follow, and a discipline mechanism to handle and investigate complaints lodged by the public. In the event that a professional is found guilty of certain misdemeanour, the respective regulatory body can institute punishment, ranging from warning to de-registration.

The present system is based on the principle of professional self-regulation.

96. The Department of Health and the Hospital Authority have additional channels to handle complaints lodged against their staff. The Department of Health carries out investigations and takes appropriate disciplinary action in accordance with the Civil Service Regulations. The Hospital Authority operates a two-tier complaint system. Aggrieved public can complain directly to the hospital concerned or to the Hospital Authority Head Office. If the complainants are not satisfied with the responses, they can appeal to the Authority's Public Complaints Committee. The latter is chaired by a Member of the Board of the Hospital Authority, who is not an executive of the Authority, and comprises other members drawn from the community and the Board. The Hospital Authority is currently reviewing how to further improve the operation and credibility of the Public Complaints Committee.

97. In recent years, some patient groups started to question the credibility of the present patient complaint mechanisms. In particular, they are concerned about the handling of the complaints against medical practitioners. It has been alleged that while complaint channels are available, the complaint process is not user-friendly and non-transparent, and since it is difficult to find a doctor to testify against another doctor, the findings tend to be biased in favour of the practitioners, as illustrated by the very small number of successful complaint cases in the past. There are indications in the community that the confidence in the existing patient complaint mechanisms is declining.

Proposal

98. Given the imbalance of knowledge and information in favour of the professionals, it is essential that there should be a credible complaint mechanism to protect the patients. Both the patients and the professionals must have confidence in the objectivity of the mechanism so that the former will be prepared to allow the professionals to take major decisions in relation to their health and the latter be prepared to offer their best advice and service without the need to resort to the practice of defensive medicine. A health care system in which there is reducing trust between patients and providers will not be efficient or effective.

99. In devising improvement measures, we propose to take into account the following two underlying principles :-

(a) The mechanism must be user-friendly, transparent and unbiased. Both the complainants and the professionals must be satisfied that they will be fairly treated.

(b) As with other professionals in Hong Kong with a specialised body of knowledge, medical and health professionals are in an appropriate position to appraise and pass judgement on the practice and conduct of their peers.

100. There are already a number of channels for complaints to be addressed to, including the Office of The Ombudsman, the regulatory Councils, the Complaints Division of the Legislative Council and the complaint mechanisms of individual providers.

We need to examine how the present arrangements are functioning to protect patient interest and if additional channels are necessary.

101. In response to public sentiment, the Medical Council of Hong Kong has proposed some improvement measures to its existing complaint mechanism, including the setting up of a committee to address standards, increasing the number of lay members to enhance transparency and publication of guidelines to assist complainants in lodging complaints. We support these initiatives. The handbook on complaint procedure has been published and made available to the public, and we note that the Council is actively pursuing the implementation of the other two proposals.

102. We believe that the above measures proposed by the Medical Council of Hong Kong would not be able to satisfy the concerns of patients, who would like to see greater objectivity. We propose to set up a Complaint Office in the Department of Health to assist the patients in lodging complaints. Taking on the role of an advocate for health and a regulator to ensure quality, and giving up eventually its direct health care services, the Department is well-placed to take on this task. The Office, handling only cases related to patient care, will conduct investigations into the complaints, assist complainants to obtain expert advice, and brief complainants as much as possible of the facts of the case as known. The Office will try to mediate between the complainant and the complained; and if that fails, the Office will, at the request of the complainant, forward its findings to the relevant regulatory body. Since substantial amount of work has

already been gone into the case, the regulatory body should be able to make a quick decision on whether or not to institute disciplinary proceedings. The power to deliver a verdict and to award discipline, if justified, will remain with the regulatory body. In parallel, there is a need for these regulatory bodies to review their complaint handling procedures. Complainants are not compelled to use the service of the Office and can choose to go directly to various existing complaint channels to lodge their complaints. Cases related to offences against statutory or licensing requirements may have to be first dealt with by the enforcement agencies.

103. This proposed approach has several advantages. Firstly, with the Complaint Office taking on the role of an independent third party, the transparency and credibility of the investigations are enhanced. Secondly, complainants will now have the full benefit of the expertise and advice of the Complaint Office and be in a better position to appreciate the facts of the case. Thirdly, with the final decision and discipline resting with the regulatory body, the principle of professional self-regulation is preserved and the professions would find it more acceptable that their practice and conduct are not to be judged only by a layman who does not possess the relevant professional knowledge.

Implementation

104. We will consult the professions and patient groups about the proposed Complaint Office and set up a committee in 2001 to formulate the detailed implementation plan, with a view to setting up the Office in 2002. The operation of the Office will be reviewed

two years after its establishment. In parallel, we will discuss with the regulatory bodies, starting with the Medical Council of Hong Kong, how to enhance their complaint handling procedures.

Chapter 5 – Options for Financing Health Care Service

The Challenge

105. At present, about 94% of the hospital services rendered to the local population are provided by the public sector. It is important for the benefit of the whole community that we must have a financially sustainable public hospital system. At a charge of $68 per bed per day in a general ward and $44 per specialist out-patient attendance, the public health care services are currently heavily subsidised by general revenue. Fee income accounts for only about 2.5% of the Hospital Authority's recurrent operating expenses. In 2000-01, the public sector health care recurrent allocation amounts to $30.8 billion, taking up 14.7% of the total recurrent public expenditure.

106. We expect the health cost to continue to grow, and this pressure is not only confined to Hong Kong but is common to many other health care systems. First, the population is aging. At present, 11% of our population are at 65 or above. We expect this figure to increase to 15% in 2019 and to 20% in 2029. Older individuals have a greater cumulative risk of chronic illness and disability, requiring more intensive medical and rehabilitative services. About 46% of the bed days in public hospitals are now taken up by persons at 65 or above. Technological advances enable health systems to treat illnesses and disabilities hitherto to which no curative option was available; and community aspirations add further pressure to cost. New technologies are generally labour intensive and tend to be financially expensive and need to be managed to ensure they are appropriately applied,

effectively used and financially accessible. With a robust mechanism for technology management, we anticipate that new technologies in the coming years can be maintained at a cost-increase of approximately 1% per annum, but this is probably a conservative estimate. People always tend to ask for more and better health care services as society gets more affluent. Some overseas studies have shown that when per capita GDP increases by 1%, health care expenditure per capita increases by 1.67%.

107. The Harvard consultants have pointed out that the long term financial sustainability of our current health care system is highly questionable. They predict that public health care recurrent expenditure, as a percentage of the total recurrent public expenditure, would increase from the current 14.7% in 2000 to as much as 28.4% by 2016, based on an annual 3% real GDP growth rate. While the situation may not turn out to be as predicted, especially as the Hospital Authority has already implemented many programmes to enhance productivity and reduce cost, the growth trend is however unmistakable. To expect such a major increase in the allocation of public revenue to health care will not be realistic as it will mean corresponding major reductions in other equally deserving public programmes, such as education, welfare and infrastructure. On the other hand, inadequate funding to the public health care sector will hurt the lower income groups, who have to depend on public sector health care services. Generally, as the population ages and the percentage of younger (and working) people declines, a financing model based on inter-generational subsidisation, that is, with the younger people paying taxes and contributing to the health care of their elders, has fundamental difficulties regarding long term viability.

108. This chapter looks at how to identify and obtain supplementary funding to finance the public health care system.

Objective

109. One fundamental role of the public health care system in Hong Kong is to protect the citizens from potentially huge financial risks arising from catastrophic or prolonged illness. To fulfil this role, the public health care system must remain accessible to all, affordable by individuals, and of a high standard. We shall continue to invest in the public health care service and ensure that it provides protection for the citizens from potentially huge financial risks, but in the light of the rapidly rising cost, we need to identify supplementary funding sources to ensure the system's financial sustainability in the long term.

Strategic Directions

110. To achieve our objective, we propose to pursue the following strategic directions :-

(a) Reduce costs and enhance productivity;
(b) Revamp public fees structure; and
(c) Establish Health Protection Accounts.

Reduce Costs

111. We always believe that the first place to look for new resources is from within the organisation. Reducing costs and enhancing productivity can yield significant savings for re-

deployment, and this effort must be a continuous one. The reforms to the delivery system described in Chapter 3 will help slow down the increase in total health care costs in the long term. In the interim, the public sector has different cost containment mechanisms that will help produce savings and keep the total costs down. These mechanisms include :-

(a) rationalisation of service delivery network to minimise duplication – The Hospital Authority at present organises its public hospital services by eight hospital clusters, with hospitals and facilities within each cluster complementing each other. The Authority is taking active steps to enhance and enforce this cluster concept, and to take this a step further by developing an integrated community-based health system, incorporating primary medical care and strategies of partnerships with private health care providers, welfare services and community organisations;

(b) improvement of productivity and operational efficiency through service re-design and process re-engineering – The Hospital Authority has pursued a programme of productivity gain initiatives since its establishment, and has so far achieved an accumulated savings of 9% of its recurrent operating cost. These efforts will continue;

(c) structured management of health care technology to ensure cost effectiveness – The Hospital Authority will strengthen its established mechanisms to consider the desirability, appropriateness and effectiveness in the

introduction and diffusion of new technologies in the service;

(d) development of guidelines and protocols to guide appropriate application and ultilisation of investigations and services – The Hospital Authority will expedite efforts in this respect, which will also help improving the overall quality of service; and

(e) appropriate pricing of public services to influence both provider and patient behaviour - pricing has always been an effective tool in influencing health-seeking and health-giving decisions. Cost could be better managed as a result of more appropriate use. This will be discussed further in subsequent paragraphs.

Revamp Fees Structure

112. The financial pressure on the public health care system is further aggravated by the fact that funds available are not sufficiently well targeted in terms of service provision or population groups. These problems have arisen because of our current fees structure. Recipients of comprehensive social security assistance can apply to have their medical fees waived, but apart from this, our existing fees structure does not distinguish the rich from the poor. The huge subsidy invested in the system, plus the improving standards, have attracted to the public sector a substantial number of patients who can afford to pay more. In short, as a result of the present fees structure, we have not been able to prioritise our resources to areas of greatest needs.

Proposal

113. We propose to carry out a full-scale review of our fees structure. We have no intention of reducing Government commitment to the financing of the public health care system, and indeed, we would expect the allocation from General Revenue to continue to increase in future, having regard to community needs and economic growth. The aim of the review is to examine how to target our subsidy to various services in the most appropriate manner. We believe that public funds should be channeled to assist lower income groups and to services of major financial risks to patients. The review should also examine how the relative priorities of services provided may be reflected in the subsidy level and how inappropriate use and misuse of services can be minimised. Following the review and the consequent revision of the fees structure, charges will continue to be affordable but could be effective in influencing patient behaviour to minimise inappropriate use and misuse. The revised fees structure will also influence the distribution of workload between the public and private sectors.

114. We propose that whatever the revisions, the fees must be set at a level generally affordable by individual patients. We are aware that there are always patients who cannot afford even a highly subsidised fee. We propose that we must continue to uphold our long-held policy of ensuring that no one is denied adequate medical care because of insufficient means. In addition to the first safety net provided by Government, namely, the allocation from General Revenue to provide heavy subsidies to the public health care sector, we should build up a second safety net,

similar to the existing Samaritan Fund, to assist those who have insufficient earnings or who have difficulty to pay for even the heavily subsidised services because of serious or chronic illnesses. Patients eligible can apply for full or partial subsidy.

Implementation

115. We shall immediately proceed to conduct a detailed study of the fees structure and how it can be restructured to reflect the objective of targeting the public subsidies at areas of greatest needs. The study will include an evaluation of the impact of the restructured fees and charges on utilisation and on the financially vulnerable. We estimate that the study will take about 18 months to complete.

Establish Health Protection Accounts

116. For the longer term, the Harvard consultants recommended to establish a Health Security Plan with mandatory contribution of 1.5% to 2% of the salaries from the working population to pay for large medical expenses. This proposal is based on the risk-pooling concept, spreading the financial risks arising from serious illnesses among the entire population and relying on substantial copayments and deductibles as demand management tools to maintain its financial viability. This proposed Health Security Plan have not been well received by the local community. It has also been pointed out that while the concept of risk-pooling is appealing, it involves inter-generation subsidisation; and given the aging population and the declining percentage of young people in Hong Kong, such an approach will put undue funding pressure on future generations. The adequacy of the levels of contribution has not been studied, and

with a smaller proportion of the population in actual employment as the population ages, premium will inevitably rise. In view of the public sentiment, and a probable scenario in the future of having to raise the premiums and/or increase copayments (user fees) substantially to maintain the financial viability of the system, we do not recommend to pursue further this proposal of Health Security Plan.

117. We have also considered the pros and cons of promoting a scheme of voluntary insurance as the main source of supplementary funding to the health care system. At present, the low levels of public sector fees have been regarded as the main disincentive to the expansion of voluntary insurance. To induce the public to purchase private insurance will require substantial increases in public sector fees. Furthermore, as long as purchase is voluntary, there will be population groups who will not have insurance protection either because of their own choice or because they are rejected by the insurance companies. These population groups could suffer substantial financial risks arising from illness under such a scheme.

118. The above said, we would like to emphasise that we recognise the potential contribution of voluntary insurance as one of the sources of supplementary funding of the health care system and that it could provide greater choice. While we shall recommend to establish a savings scheme, as described below, as the principal supplementary source of funding for the longer term, we encourage the medical insurance sector to create new health products and devise attractive packages for the public to consider. We are confident that there would be a market for these products and packages in certain sectors of the population.

Proposal

119. To reduce the burden on our next generations and to strengthen the long term financial sustainability of the public health care system, we propose to introduce medical savings through a scheme of Health Protection Accounts as the principal supplementary funding source for health care services in the longer term. We propose that this scheme should comprise the following features :-

(a) This will be a mandatory contributory scheme, with every individual putting approximately 1 to 2% of the earnings to a personal account, from the age of 40 to 64, to cover the future medical needs of both the individual and the spouse. The savings will attract investment returns.

(b) The savings cannot normally be withdrawn until the person reaches the age of 65 (or earlier in case of disability). Upon withdrawal, the savings can be used either to pay for medical and dental expenses at public sector rates, or to purchase medical and dental insurance plans from private insurers.

(c) If the person chooses services in the private sector, the person will still be reimbursed only at the public sector rates from the accumulated savings. The price difference will have to be met either from the person's own means outside the savings account or from the entitlement of private insurance.

(d) In the case of the death of an individual, any unspent savings left in the account will be passed on to the surviving family.

120. This Health Protection Account is designed to assist individuals to continue to pay for heavily subsidised medical services after retirement, and not to shift the burden to the next generations. In order to keep the savings rate to an affordable minimum, we have therefore proposed to limit the withdrawal by the individual to until age 65 and above and to reimburse the individual only at public sector rates. For those patients who prefer private sector services, the savings will help meeting the medical bills. We estimate that for a family at median income level, the couple will be able to pay for, based on the territory's average utilisation rate, their medical expenditure at public sector rates up to the average life expectancy age. For those patients who have managed to save very little or who have already exhausted their savings because of frequent sickness, they will have the assistance of the second safety net provided by Government.

121. While the above proposed Health Protection Accounts will assist individuals to pay for their medical needs, a small group of our population will require, in addition to medical treatment, long term nursing care. This group of people, while medically in stable conditions, suffer from various degree of disability and require multi-services, from health care professionals to personal care helpers, to assist them either to live in the community or in nursing homes. Prolonged long term care is expensive, and will become a heavy burden on the recipients and their families. The Harvard consultants recommended to establish a separate personal savings account, called MEDISAGE, with contributions

from the individual at the rate of 1% of the salary, to purchase long term care insurance upon retirement. Both the contribution and the purchsae of insurance would be compulsory.

122. This proposed MEDISAGE scheme has been well received by the community. The two principles underlying the scheme are self-responsibility (savings) and risk-pooling (insurance), which we support. However, as long term care insurance is not well developed in Hong Kong, we would require to conduct more in-depth studies of the different options for long term care and the detailed features of such a scheme, including the rate of contributions, the services to be included in the scheme, and whether or not the purchase of insurance should be mandatory or voluntary. We propose to proceed with a study immediately and we may suggest modifications to the MEDISAGE proposal, subject to the findings of the study.

Implementation

123. Subject to the community's views on our proposals, we shall commission in 2001-02 a study on Health Protection Accounts, which will examine in detail the merits of such a scheme and its feasibility for application in Hong Kong. We expect that the study will take about 18 months to complete, and we shall consult the public on the study findings and recommendations. In parallel, we shall carry out a detailed study on the long term care needs of our population and how best to finance and provide these services. We expect to have a report of the study in 2003, and we shall consult the public on the recommended way forward.

Chapter 6 – Summing Up

124. We have set out in preceding chapters our proposed directions for reforming the health care delivery system, enhancing quality assurance and improving the financing of our health care services. Upon implementation, these proposals, collectively, will make some fundamental and long-lasting changes to Hong Kong's health care system. For example :-

(a) The focus of our delivery system will shift from provision of cure to improving the quality of life. The shift will be driven by new knowledge and our efforts to strengthen preventive care and to develop community care programmes centred on patients. The development of Chinese medicine will complement western medicine and will offer a greater choice of providers to the population.

(b) The role of the Department of Health will change significantly. It will gradually phase out its direct services, and while quality assurance remains a responsibility of the professions, the Department will oversee the process to ensure that quality care is consistently maintained and delivered.

(c) While a substantial and major part of the public health care system will continue to be financed by Government, financing of the public health care system will be supplemented by affordable individual contributions and medical savings in order to sustain continuing

improvements in quality and introduction of new technologies.

125. We said in Chapter 2 that the Hong Kong health care system should promote lifelong wellness and provide lifelong holistic care to individuals. These will be pursued through the strengthening of preventive and primary medical care and the development of a community-based health care service. We said that the health care system must be able to provide a high standard of service and support continuous medical development. The proposed continuous quality improvements through education, systems support and regulatory measures will help ensure that this aim is achieved. We said that we want the health care system to be an equitable one, accessible to all persons requiring treatment and affordable by the individuals. The two-tier safety net described in paragraph 114 will ensure that medical care is accessible to all, including those who have inadequate or no means. By prioritising public subsidies to areas of greatest needs, we ensure that services will continue to be affordable by individuals. We said that we want the system to be cost-effective in delivery of health services and financially sustainable in the long term. The many reform proposals to the health care delivery system and the cost containment mechanisms being implemented in the public sector will slow down the increase in cost. The proposal to save for our future medical and long term care needs will help make the system financially sustainable in the long term.

126. We have set out in the preceding chapters how to take these proposals further, and we expect to initiate some of the

implementation plans in the next two years, while others will be phased in over the coming decade. We look forward to your support and comments, which will assist us in developing various programme plans. We are confident that upon implementation of these proposals, we shall achieve in Hong Kong a world-class health care system, which can effectively support the individual's pursuit for good health and a good quality of life, and add value to the community's development.

Chapter 7 – Executive Summary

Background

127. Over the years, we have developed in Hong Kong an enviable health care system, which provides an accessible, quality, equitable and affordable health care service. Highly subsidised, the public health care sector offers protection to individuals from significant financial risks that may arise from catastrophic or prolonged illnesses. While more expensive to the consumers, the private sector offers patients greater choice and convenience. The two sectors serve different but complementary roles, and together, provide comprehensive health care of a high standard to the Hong Kong community. Our health indices are among the best in the world. In 1999, life expectancy at birth was 77 years for men and 82 years for women. The infant mortality rate was 3.2 per 1,000 live births, while the maternal mortality rate for 100,000 total births was 2.0. While our existing health care system has served us well for years, like other health care systems, it has to evolve and develop to meet changing societal needs. Because of the highly subsidised fees charged for services and improving standards, the public sector faces an increasing number of patients, mounting work pressure and threat of financial sustainability.

128. We commissioned the School of Public Health of Harvard University to conduct a study on the existing health care system. The study was completed in April 1999 with the release of a Report for public consultation. After intense media interest and public debates on the subject, we received over 2,200 written submissions from different sectors of the community generally supportive of the need for reforms. On the basis of the

comments received, we have further reviewed the three main pillars of our health care system - the organisation and provision of health services (service delivery system), mechanisms to assure the quality of health care provided (system of quality assurance) and the funding and financing for health care services (health financing system) - and formulated strategic directions for reforms to ensure that the system would be able to meet the needs and aspirations of our future generations.

129. Health is "a state of complete physical, mental and social well-being". Health is a resource which enables individuals fulfil human potentials and maximise capabilities, achieve successes at work, reduce financial losses caused by illnesses, and enjoy a good quality of life. The pursuit of health requires investing in an effective and sustainable health care system which provides comprehensive and holistic lifelong care. The health care system protects and promotes health, prevents and cures illnesses, and minimises and eliminates disabilities. However, the promise of good health cannot be achieved without the individual's personal actions and contributions through early planning for the individual's long term health care needs and the adoption of health-promoting behaviours and lifestyles. Health is also an individual responsibility.

Vision and Objectives

130. Our vision is to re-create a health care system which promotes health, provides lifelong holistic care, enhances quality of life and enables human development.

131. Based on the values we believe that should guide the transformation, the objectives of our health care system should be:-

(a) To protect the health of the population, prevent diseases and disabilities, promote lifelong wellness, and support continuous health sector development.

(b) To provide comprehensive and lifelong holistic health care which is humane, where care and comfort to the individual is as valued as medicine and technology-based interventions.

(c) To provide accessible, equitable, and quality services to members of the community on the basis of health needs.

(d) To remain cost-effective, sustainable and affordable both to the individual and the community.

(e) To reinforce the notion that the pursuit for better health is a shared responsibility among the individual, the community and Government.

Reforms to the Health Care Delivery System

132. The fundamental role of a health care system is to enhance the health of the population and improve the community's quality of life. To ensure that our delivery system can fulfil this role, we need to protect the health of the population, prevent disease and disability, promote lifelong wellness and provide treatment, care and rehabilitation to the sick, injured and

disabled. We seek to improve the health outcome and cost efficiency of the system through the development of a community-focused, patient-centred and knowledge-based health care system, comprising an appropriate balance of preventive, ambulatory, in-patient and outreach services, delivered in a humane way over an individual's lifetime, supported by sustained collaboration among health care providers, and between the latter and the community. To achieve our objective, we propose to pursue the following strategic directions.

Strengthen Preventive Care

133. We propose that the Department of Health should adopt the role of an advocate for health, working in concert with the Health and Welfare Bureau, seeking political commitment, policy and systems support and social acceptance for different health goals and programmes. The Government will address the full range of potentially modifiable determinants of health – not only those related to individuals, such as health behaviours and lifestyles, but also factors external to the traditional health domain. The Government will build up an intersectoral infrastructure, covering all related sectors, including health care, education, environment and others, to focus and collaborate on preventive health issues. The Department of Health will seek to continuously enhance community involvement in health education and promotion activities. These efforts will strengthen, at the personal level, the capability and commitment to prevent diseases, the knowledge and understanding to improve health and the ability to make decisions on treatment processes; and at

the community level, the influence to create living conditions conducive to health.

Re-organise Primary Medical Care

134. The effectiveness of primary medical care can be gradually enhanced by the promotion and adoption of family medicine practice and the development of other primary care practitioners including other physicians, nurses and allied health professionals. Family medicine is a specialised discipline of medicine that provides primary, continuing and comprehensive care to an individual and the family in their own environment. The care is holistic, incorporating the interaction and inter-relatedness of psycho-social and physical elements of health. To improve primary medical care, we propose that the public sector should provide training opportunities for family medicine practice to doctors, nurses and allied health professionals.

135. We propose that the Department of Health's general out-patient service should be transferred to the Hospital Authority to facilitate integration of the primary and secondary levels of care in the public sector. Upon transfer, the general out-patient service should be redesigned into clinics attending to, primarily, the financially vulnerable and those chronically ill who are exposed to high financial risk because of the long term treatment required. These clinics can serve as training ground for family medicine and other models of primary medical care and for other primary care professionals.

136. The public sector should explore ways to improve collaboration with the private sector, to assist family medicine trainees to complete their training, and to improve on the quality and continuity of care. This objective can be achieved, for example, by contracting out some of the general out-patient services to private practitioners for the purpose of training in family medicine and establishing a network between public and private sectors to support exchange of information and knowledge in primary medical care.

Develop a Community-focused, Patient-centred and Knowledge-based Integrated Health Care Service

137. International trend has been to focus on the development of ambulatory and community care programmes and to replace, where appropriate, in-patient treatment by out-patient services. This has been made possible following advances in medical technology and changing perspectives of policy makers, providers and users, supported by appropriate training of the staff and patients. Health care services are evolving both in breadth and in depth, with better appreciation of the socio-economic and environmental factors and psycho-social variables which influence health. The knowledge needed for delivering health services has incorporated environmental, social and behavioural sciences. The organisation and provision of health care has become increasingly complex, and skills in managing and organising need to be learnt and developed in order to provide effective care. Medical science technology is advancing rapidly, with knowledge and understanding evolving so rapidly that systems for knowledge management and application are vital. These systems include continuing education of health

professionals, development of research-based clinical practices (evidenced-based medicine) and adoption of relevant tools such as clinical practice guidelines which incorporate research evidence.

138. We support this new trend to emphasise less on in-patient services and to develop, in addition to and in partnership with the hospital system, a network of community-based integrated health care services. Care delivered in or around people's home, or in homely settings in the community, helps maximise the patient's quality of life. Well-designed ambulatory and community care programmes also have the added benefits of achieving greater cost-effectiveness. This community-based model should adopt a multi-disciplinary (i.e. joining the efforts of different health care experts and professionals) and multi-sectoral (i.e. joining the efforts of providers in the public and private sectors as well as providers outside the health care sector, particularly the welfare sector and the community) approach in order to provide a comprehensive and integrated health care service to patients. The development of an electronic Health Information Infrastructure will help link up all relevant providers in a community network to facilitate their communication and the provision of care in continuity.

139. We propose that continuing professional training and development be required for all health care professionals to enable them to meet the requirements of knowledge-based and patient-centred health services.

Improve Public/Private Interface

140. To facilitate the choice of providers by patients and minimise discontinuity of care, we propose to take measures to overcome the existing professional, information and price barriers that have given rise to the present lack of collaboration between the public and private sectors. We propose to overcome the professional barriers by adopting common clinical protocols and sharing some staff training and development programmes. The information gaps can be overcome by the development of a computer-based Health Information Infrastructure, to which both the public and private sectors can access. This network will provide a platform for sharing medical knowledge and information, for quality assurance and patient care audits and for sharing patient records. The price differences between the public and private sectors can be overcome by product differentiation and we encourage the private sector to pursue this further. We propose that the public and private sectors can jointly explore how the two sectors can collaborate and develop new health care products in which both sectors can participate. We encourage the medical insurance industry to develop new health care insurance policies to support these new products.

Facilitate Dental Care

141. On oral health, since public funds should be used in where the funds can help achieve the best outcome, we propose that the Department of Health should continue with the present educational and preventive efforts and the special curative services, and at the same time review the focus of the services. The Department of Health should collaborate with the dental

profession to formulate standards, set oral health goals, conduct surveillance programmes, assure quality and promote the importance of oral health to the community. We propose that the Department should assist the dental profession to launch an oral health scheme for secondary students, as an extension to the school dental scheme for primary students now provided by the Department. To assist the lower income groups to obtain quality dental service, we propose that Government should take active steps to encourage more non-governmental organisations to provide affordable dental care on self-financing basis.

Promote Chinese Medicine

142. Chinese medicine has been widely used in Hong Kong for many years and its application to prevention of disease and maintenance of health and to treatment of illnesses is widely recognised and acknowledged. We support the promotion of the use and development of Chinese medicine in Hong Kong. As the first step, we shall proceed expeditiously with the establishment of a regulatory system for Chinese medicine in Hong Kong in accordance with the Chinese Medicine Ordinance. The Department of Health will co-operate with the Chinese medicine profession and trade in regard to the setting of standards, conduct of basic and clinical research, education and training of practitioners and related personnel, compilation of data and information and the promotion of the quality and efficacy of Chinese medicine in general. We propose to introduce the provision of Chinese medicine in the public health care system. At the first step, we will examine options on modes of provision of out-patient Chinese medicine service in the public sector. We will make plans to pilot the practice of Chinese medicine in

selected public hospitals to support clinical research and the development of standards and mode of interface between western and Chinese medicines.

Improvements to the System of Quality Assurance

143. We believe that the Hong Kong population is entitled to a high standard of service and it is the responsibility of the health care professionals, the medical practitioners in particular, to ensure that quality health care services are always maintained and delivered. We propose to enhance our quality assurance mechanisms through a combination of education and training, systems support and regulatory measures.

Enhance Quality Assurance

144. We propose that all health care professionals, including medical practitioners, dentists, nurses and allied health providers, should be required to undergo continuing professional education and development to ensure that their knowledge, practice and skills are updated. We believe that a holistic approach offers the best care to our patients, and we advocate a co-ordinated multi-disciplinary team approach which can offer our patients comprehensive and seamless care. This requires new knowledge and skills for all health care professionals based on social and behaviourial sciences, enabling them to better understand the inter-relatedness of the psycho-social and physical elements of care. Skills and knowledge in management and communication sciences will also enhance capabilities to interact with patients and other colleagues and to work in complex organisational settings where health care is provided. To take this approach

forward, we will persuade professional bodies to incorporate these new competencies in the professional development programmes.

145. We propose to put in place, both in the public and the private sectors, a system of peer review, common clinical protocols, clinical supervision, clinical audit, and risk management to help the professionals identify problems and maintain quality. We recognise the potential benefits that may arise by separating drug prescription from drug dispensing, and it is being practised in the public sector. For the private sector, the priority is to ensure good dispensing practice and patient safety. To protect the right of the patients to choose, we propose that the medical practitioners should make it clear to patients that they have the right to obtain the drug not from their clinics. We do not propose to interfere in the pricing in the private sector, but we encourage the latter to make the pricing transparent to allow consumers the opportunity to choose before receiving the services.

146. To support our policy formulation efforts, we propose to set up a Research Office to support the Administration in collecting data, identifying problems, assessing priorities, formulating strategies and evaluating results. The Office will be located in the Health and Welfare Bureau and the research work may be conducted in-house or contracted out.

147. On regulatory measures, we shall continue with our review of the licensing requirements for private hospitals and of the existing controls over the sale of drugs. We propose to commence a review of the present statutory regulations in relation to the operation of clinics, use of medical facilities/equipment, and provision of medical services in general. The review will also

examine how managed care schemes affect our patients in Hong Kong. We want to ensure that patients will always receive quality treatment and care.

Improve Patient Complaint Mechanisms

148. We are aware of the increasing pressure from the community to improve our patient complaint mechanisms. Given the imbalance of knowledge and information in favour of the professionals, it is essential that there should be a credible complaint mechanism to protect the patients. A health care system in which there is reducing trust between patients and providers will not be efficient or effective. Therefore, the mechanism must be unbiased, transparent and user-friendly so that both the complainants and the professionals are satisfied that they will be treated fairly under the mechanism.

149. In response to public sentiment, the Medical Council of Hong Kong has proposed some improvement measures to its existing complaint mechanism, including the setting up of a committee to address standards, increasing the number of lay members to enhance transparency and publication of guidelines to assist complainants. The latter has been issued and made available to the public. While we support these initiatives, we also propose to set up a Complaint Office in the Department of Health. The Office, which will handle only cases related to patient care, will conduct investigations into the complaints, assist the complainants to obtain expert advice, brief the complainants of the facts of the case as known, and attempt to mediate between the complainant and the complained. At the request of the complainants, the Office will forward its findings to

the relevant regulatory body to decide whether or not to take disciplinary proceedings. The power to deliver a verdict and to award discipline, where appropriate, will remain with the regulatory bodies. In parallel, there is a need for these regulatory bodies to review their complaint handling procedures to enhance the credibility of their final decisions. We shall commence discussion with these bodies.

150. This proposal of setting up a Complaint Office has several advantages. Firstly, the transparency and credibility of the investigations will be enhanced by the involvement of the Complaint Office as an independent third party. Secondly, the complainants will now be assured of the full benefit of the expertise and advice of the Complaint Office. Thirdly, with the final decision and discipline resting with the professional bodies, the professions would find the arrangement more acceptable as their practice and conduct will still be judged by their colleagues who possess the relevant professional knowledge.

Options for Financing Health Care Service

151. Of the many problems now facing the health care system, financial pressure is the one most talked about. One fundamental role of the public health care system in Hong Kong is to protect the community from huge financial risks that may arise from serious or prolonged illnesses. Given that about 94% of our hospital services rendered to the local population are provided by the public sector, it is important that we must have a financially sustainable public hospital system. At present, our public health care services are heavily subsidised by general revenue. The recurrent public health care expenditure takes up about

14.7% of the Government's total recurrent public expenditure. As health care cost continues to grow against a background of aging population, advances in medical technology and rising community aspirations, we shall have to decide whether or not to allow major increases in the allocation of public revenue to health care. Such option is, however, not acceptable as it would mean corresponding major reductions in other equally deserving public programmes. On the other hand, inadequate funding will hurt the lower income groups most, who have to depend on public sector health care services.

Reduce Costs

152. We are fully aware that the first place to look for new resources is from within the organisation. To this end, the public sector has already implemented many programmes to enhance productivity and reduce cost, and these efforts will continue. These cost containment mechanisms include : the cluster concept by the Hospital Authority to minimise unnecessary service duplication; improvement of the productivity and operational efficiency through service re-design and process re-engineering; structured management of health care technology to ensure cost effectiveness; development of clinical guidelines and protocols to minimise inappropriate investigations and services; and appropriate pricing of the public services to influence provider and patient behaviour. We are confident that these cost containment measures will help produce savings. In the longer term, the reforms to the delivery system, such as strengthening of preventive care, practice of family medicine, development of

community care and collaboration between the public and private sectors ,will help slow down the increase in total health costs.

Revamp Fees Structure

153. The financial pressure on the public health care system is further aggravated by the fact that the public funds made available are not sufficiently well targeted in terms of service provision or population groups. In short, we have not been able to prioritise our resources to areas of greatest needs.

154. We propose to carry out a full-scale review of our fees structure. We do not intend to reduce Government commitment to the financing of the public health care system, but we would like to examine how to target our subsidy to various services in the most appropriate manner. We believe that public funds should be channeled to assist the lower income groups and to services of major financial risks to patients. The review should also examine how the relative priorities of services provided may be reflected in the subsidy level and how inappropriate use and misuse of service can be minimised.

155. We shall ensure that public fees would be set at a level that is affordable by individual patients, and will evaluate the impact of restructured fees on utilisation and on the financially vulnerable. We shall also ensure that there will be a safety net to support those unfortunate persons who cannot afford even a highly subsidised fee. In short, we shall continue to uphold our long-held policy of ensuring that no one is denied adequate medical care because of insufficient means.

Establish Health Protection Accounts

156. For the longer term, we propose to establish Health Protection Accounts to assist individuals to meet their medical needs upon retirement. The Harvard consultants recommended to establish a Health Security Plan, which has not been well received by the local community. This Plan, funded by mandatory contributions from the working population, is based on the concept of risk-pooling, involving inter-generation subsidisation and requiring substantial copayments and deductibles, which would have to be borne by users. We do not propose to take this Plan further as we are concerned that given the declining percentage of young people in Hong Kong in the future, such an approach will put undue pressure on the future generations. We have also considered carefully the pros and cons of promoting voluntary private insurance. While we do not consider voluntary insurance to be a viable long term solution to our problems, we do recognise the potential contributions from voluntary insurance, and we encourage the medical insurance sector to devise attractive packages for the public to consider. We are confident that there are population groups who would like to purchase some additional protection.

157. We propose to establish Health Protection Accounts which will contain the following principal features :-

(a) This will be a mandatory contributory scheme, with every individual putting approximately 1-2% of the earnings to a personal account, from the age of 40 to 64, to cover the

future medical needs of both the individual and the spouse. The savings will attract investment returns.

(b) The savings cannot normally be withdrawn until the person reaches the age of 65 (or earlier in case of disability). Upon withdrawal, the savings can only be used to pay for medical and dental expenses at public sector rates, or to purchase medical and dental insurance plans from private insurers.

(c) If the person chooses services in the private sector, the person will still be reimbursed only at the public sector rates. The price difference will have to be met from the person's own means outside the savings account or from the entitlement of private insurance.

(d) In the case of the death of an individual, any unspent savings left in the account will be passed on to the surviving family.

158. Our future public health care system shall continue to be supported primarily by allocation from general revenue. To ensure long term financial sustainability, we propose to target public subsidies at areas of greatest needs, supplemented by affordable contributions and (medical) savings plans by individuals in their working lives to meet their health needs after retirement. We will also establish a safety net to ensure that those who are unable to pay the highly subsidised fees will still be able to receive the needed health care. Under this arrangement, the needs of the lower income groups are protected as they will

continue to have good access to an equitable and affordable health care system.

159. In addition to medical treatment, long term nursing care may also be required by a small group of our population. This group of persons, while medically in stable conditions, suffer from various degree of disability and require multi-services to assist them to live in the community. Prolonged long term care is expensive; and to relieve the burden, the Harvard consultants recommended to establish a personal savings account called MEDISAGE to purchase long term care insurance upon retirement. We support this proposal, but as long term care insurance is not well developed in Hong Kong, we need to conduct further study of the subject before we can recommend how to bring the matter further. We may suggest modifications to the MEDISAGE proposal, subject to the findings of the study.

Summing Up

160. We seek your support for and comments on these proposals, which will make some fundamental and long-lasting changes to our health care system. Subject to the views received, we shall proceed immediately to set up working committees and appoint studies to formulate detailed plans and implementation timetable. We expect to initiate some of the implementation plans in two years, while others will be phased in over the coming decade. We shall consult the public again on some of the more long term plans, such as the setting up of the Health Protection Accounts, when more details are drawn up. We are confident that upon implementation of these proposals in due course, we shall achieve in Hong Kong a world-class health care system,

which can effectively support the individual's pursuit for good health and a good quality of life, and add value to the community's development.

Public Responses to the Harvard Report

Summary

Upon its release in April 1999, the Harvard report generated much in-depth and constructive discussion in the community on Hong Kong's health care system. We attended over 50 seminars and meetings to explain the content and recommendations of the Report and listened to the views of the participants. We received over 2,200 written submissions from different sectors of the community offering advice and suggestions on how to improve our health care system. A summary of the feedback is set out in the following paragraphs.

Overview

2. While opinions on reform options vary, there appears to be a general consensus among the public that there is a need to reform our current health care delivery and financing systems. There is a concern that unless some reform measures are carried out, our health care system may not be able to continue to offer to the community the same quality of service in the future.

Health Care Delivery System

3. There is strong support for the Administration to introduce measures to strengthen primary health care through the development of family medicine practice and improvement to the general out-patient services. It is considered that apart from offering better medical care to their patients, family medicine

practitioners can help contain overall health care cost through their gatekeeping functions.

4. There is a lot of concern about the heavy workload in the public sector and respondents urge for the implementation of measures to ease the burden of our frontline health care staff. It is suggested by some that closer collaboration between the public and private sectors is the key to achieve re-distribution of the present rather uneven workload between the two sectors. In the long term, closer collaboration can help reduce the financial pressure on the public sector.

5. Many respondents are disappointed that the Harvard Report has not discussed how to improve dental care, nor paid sufficient attention to the role and contributions of nurses and supplementary health care professionals to the health care system. We are also reminded that in devising reform measures, the contributions of Chinese medicine must not be overlooked. It is believed that Chinese medicine has a major role to play in our future health care system.

6. There seems to be general agreement among the respondents that our service delivery is at present fragmented and needs improvement. There is however little support to Harvard's proposal of reorganising the Hospital Authority into 12 to 18 regional health care integrated systems. People appear to be generally satisfied with the present services provided by the Authority.

Quality Assurance

7. The main focus of discussion is on continuing medical education (CME) and patient complaint mechanisms. There seems to be general agreement that health care professionals should undertake CME in order to update their knowledge and practice. The point of discussion is whether or not the CME should be made mandatory and linked to the renewal of practising certificate.

8. On patient complaint mechanism, opinions are divided. The community in general, the patient groups in particular, support the proposal of setting up an independent Medical Ombudsman. Some respondents are concerned that the existing complaint mechanism against medical practitioners appears to be biased in favour of the latter, as doctors tend to protect one another. Others point out that the existing mechanism is not user-friendly nor transparent.

9. Medical practitioners do not support the setting up of the proposed Medical Ombudsman. In their view, it would not be possible, nor fair to the profession, to rely on a non-professional who has no or little knowledge about the profession to appraise professional practice and conduct. At the same time, the Medical Council of Hong Kong has proposed to introduce a number of measures to improve the transparency and user-friendliness of the existing complaint mechanism.

10. We received a number of submissions for the separation of the prescribing and dispensing practice as a measure to protect

patient safety and consumers' freedom to choose. This separation is being practised in the public sector; and some respondents point out that in the private sector, patients do have the freedom to choose obtaining drugs from a doctor or a pharmacist, and this freedom to choose should be maintained.

11. There is a good measure of support from the respondents for the establishment of an Institute for Health Policy and Economics to be responsible for collecting data and conducting researches on health care matters.

Financing Options

12. While opinions are divided on what should be the solutions to the financing problems, there appears to be some general consensus among the respondents that we need to look for additional funding sources to the public health care system, otherwise its long term financial sustainability will be in question. Many respondents remind us that the first step should be to look for savings from within the public sector organisations and to enhance productivity. A significant number of respondents appear to accept that some upward revisions of the public sector fees are acceptable, as a way to increase funding and to persuade the better-off patients to use the private sector. There is however little discussion on the level of revisions.

13. There is little support for the proposed Health Security Plan, which spreads the financial risks arising from serious illnesses among the entire community by requiring mandatory contribution of 1.5% to 2% of the salaries from the working

population. This proposal is not popular because many respondents see the contribution as a tax in disguise, increasing further the burden of the middle class. Other arguments have also been put forward against the proposal. It is pointed out that under the proposed plan, people would tend to overuse the medical services and that would drive up the entire health care cost of the community. Such misuse may be restrained by imposing a high co-payment fee for service received, but that is regarded as unfair to the middle class seeking treatment.

14. Some respondents support the idea of a personal savings account to pay for medical services, but there is no detailed discussion on how such a scheme should operate. There is also a suggestion that the promotion of voluntary insurance may be a way to overcome the financing problem. It is proposed that the public sector fees can be raised substantially so as to persuade the community to purchase voluntary insurance. To induce the lower income groups to join in, the Administration can subsidise these groups to pay for the insurance premium through the enhanced fee income.

15. Respondents in general support Harvard's proposed "MEDISAGE" scheme, which is a personal savings arrangement to pay for long term care upon retirement. Again, there is no discussion on the details. Some respondents do question how a rather low savings rate of 1% of the wages would be sufficient to finance the expensive long term care services.

歡迎你提出意見

本諮詢文件可於各區民政事務處諮詢服務中心，醫院管理局大樓的健康資訊天地，各公立醫院的病人資源中心和衞生署轄下的普通科門診診療所索取。本文件亦已存放在各大公共圖書館及載於衞生福利局網頁：http://www.info.gov.hk/hwb/

請將你的意見於二零零一年三月十五日前寄往：-

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Your Comments are Welcome

The Consultation Document is available from the Public Enquiry Service Centres of District Offices, the Health InfoWorld in the Hospital Authority Building, the Patient Resource Centres in public hospitals, and the General Out-patient Clinics of the Department of Health. It is also available for public inspection in major public libraries, and can be accessed via the Health and Welfare Bureau website: http://www.info.gov.hk/hwb/

Please send your comments on this Consultation Document **before 15 March 2001** to:-

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