Health care reform in Hong Kong

Once again at the start of a new decade (as in the early 1990's) Hong Kong is contemplating health care reform. Late in 2000, the Secretary for Health and Welfare finally found an opportunity to launch the new consultation document: Lifelong Investment in Health.[1] Reform of health care delivery in Hong Kong is unquestionably one of the most pressing health and medical care issues facing this Special Administrative Region (SAR), but so far we do not have agreement on the definition of the problems, let alone the solutions. Arguably, there are three principles to guide reform: the system should use scarce resources *efficiently* to deliver care which is *acceptable* to the users and which consistently *reduces inequalities* in health across the community. Whatever we decide to do, we must not lose sight of our equity target.

This seminar series was originally proposed by members of the Medical and Health Research Network of The University of Hong Kong. It was written before the end of the consultation period, so if we make rapid progress in our deliberations during the coming months, some contributions may appear dated in retrospect. Nevertheless, many arguments are based on timeless themes which the government, the public and the health profession must continue to address.

Gould[2] begins with a disapproving analysis of the way in which the policy arm of government has, in previous years, failed to establish a framework for a much needed evolutionary priority-setting process. At one level this includes failure to identify determinants of health and causes of health inequalities, and at another, failure to move towards a primary-care–led system. The government should have a right to reply to these criticisms. Gould's cautionary tale, however, is badly needed currently, because no one who participated in the lengthy and painstaking subcommittee sessions of the 1989 Primary Health Care Working Party will want to experience again the same empty-handed and totally inconsequential outcomes of that era.

The case for a primary-care–led system is strongly advocated by Watt,[3] though even in the UK National Health Service, where it has been 'largely responsible for [its] fairness and efficiency' there is still much to do in order to realise its full potential. How much further behind is Hong Kong, with its disconnected, mixed medical economy, in starting its bid for a primary-care–based and primary-care–led system? As emphasised by McGhee et al,[4] many of the innovations called for in the current government consultation document[1] are dependent on the availability of a good primary care infrastructure.

While we continue to operate a highly demand-led system, Ho[5] presents cost-benefit–based arguments for choosing a Swedish model to fund health care delivery in the future. Ho proposes sharply increasing the fees charged by the Hospital Authority, with the aim of forcing public awareness of the concept of scarce resources, channelling utilisation to the private sector, and raising revenue for improvement of public sector services. Such proclamations will rattle the windows of the Legislative Council, and Gould's[2] paper highlights concerns about such demand-side deterrents. Others will argue that such a model identifies individual responsibility for affordable expenditures, and provides a safety net with spending limits for the majority, calibrated to the median household income. The whole system, however, is underpinned by the burden of insurance rather than by a forced medical savings plan. Ho claims that the usual moral hazards of insurance schemes will be avoided with across-the-board mandatory coverage. This includes countering demand-side moral hazards arising from insatiable health consumerism (which characterises Hong Kong), as well as the supplier-induced form, which serves the needs of health professionals more than it matches health needs to appropriate services.

McGhee et al[4] are also critical of the consultation document to the extent that it is heavily weighted towards demand-side deterrents, some of which, including increased user charges, they argue will inevitably lead to inequity in the present system. It is unclear whether the model proposed by Ho[5] would adequately protect against that event. McGhee et al[4] also identify supply-side inflexibility as a major factor impeding allocative efficiency—an issue inadequately addressed in the consultation document. This is a very sensitive issue, as it concerns many aspects of what the profession regards as clinical freedom. It is, however, highly unlikely that comprehensive reforms will be achieved until a way is found of tackling this problem. A new range of interventions at the interface between primary and secondary care could emerge, given reallocation of resources, including shared-care and integrated clinics. This would make a major contribution to matching of need to level of care but requires a strong

primary care sector which simply does not exist in Hong Kong at present. Integrated clinics have been pioneered by the Hospital Authority. Sound long-term follow-up data, however, is needed to assess the impact of these endeavours.

We have been saying for more than a decade that the public needs help to make informed choices about the use of services. Ho[5] argues that there is no alternative at present to patients being advised of what services they need by service providers, while Lo and Fung[6] attach considerable importance to patient empowerment as a way of adjusting expectations and ultimately improving outcomes. Currently, we pay only 'lip service' to this principle despite the incentives of professional ethical behaviour and increased work satisfaction. There is much to do here in terms of medical education and continuous professional development.

Watt[3] warns against 'stick and carrot' approaches in health care reform, whereas Lo and Fung[6] remind us of Berwick's caveat, that regulation leading to punitive action is totally counter-productive. Lo and Fung[6] suggest the widespread use of 'quality tools' including clinical audit, which would be applied to procedures which are themselves, as far as possible, evidence-based. In addition, they advocate the development of a 'facilitative social environment', while Watt[3] similarly points to the need to 'cultivate' rather than simply manage primary care. These approaches could be applied in the form of a feedback system, where self-motivated professionals respond to information about their performance—whether it is on prescribing patterns, or their patients' perceptions of empathy. Again, it is argued that initiatives must be 'bottom up' and not imposed 'top down'—but is the medical profession in Hong Kong itself ready to initiate such measures?

The consultation document expresses dissatisfaction with the current output of health services research (HSR),[1] although there has not been any formal appraisal of what has been achieved thus far. On the other hand, there is renewed interest in the potential of HSR to guide policy development. Health services research will, of course, assist that process and should begin by examining and questioning the current wealth of information which already exists, once the questions have been framed. Secondly, we should resolve the problem of access to information generated by the majority of health care contacts in the SAR, which largely take place in the private sector and are thus at present, almost totally concealed from independent analysis. These health care contacts ultimately determine most of the costs at higher levels of the health care system.

A major weakness of the Harvard report[7] was the lack of emphasis placed on high quality information systems for information capture and exchange, research and development, and the overall rigorous evaluation of each health care intervention. Contributors to this seminar series recognise this, and call for much greater investment in the development of informatics and HSR, so that such evaluation becomes an indivisible part of all areas of practice. Again, personal commitment and a change of attitudes on the part of many practitioners is needed, before we can expect such a change in our systems.

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