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Hong Kong's Health Care Reform: Nursing an Ailing Health Care System Back to Health

Gwen Taylor

Hong Kong's health care system needs reform. With a public sector facing overwhelming workloads and financial unsustainability and a private sector hit hard by Asia's economic slump, government officials and citizens alike fear an impending health care crisis. The public health care sector is highly subsidized by the government, which is in turn supported by one of the lowest tax regimes in the world. (Granitsas, p. 1) A number of health care reforms have been proposed in the past ten years; and four years after the transition to China, it seems that Hong Kong can finally concentrate on revamping its health care system. This will be a slow and painful process, however, as the government and the public debate over everything from insurance schemes and medical fees to complaints offices and doctors' guidelines.

Three key reform proposals have been presented since 1999. First, a government-commissioned Harvard report entitled *Improving Hong Kong's Health Care System – Why and for Whom?* was released in April 1999. (Health and Welfare Bureau, p. 2) Although the report accurately identified many of the most pressing issues facing the health care system, the proposals made by Harvard's School of Public Health were loudly criticized and largely rejected by Hong Kong citizens. A second proposal surfaced in December 2000 when the Health and Welfare Bureau released the consultation document *Lifelong Investment in Health*. While some of the Bureau's proposals were viewed as acceptable, others evoked protests. The Hospital Authority (HA), which manages all of the public hospitals of Hong Kong, offered a third proposal when it responded to the Bureau with its Annual Plan for 2001-02. Doctors, professors, and ordinary citizens all seem to have their own opinions of what should, could, or definitely will

not work. As the debates continue, it becomes clear that there is no easy fix. It also becomes clear when investigating the various attributes and problems of the current system, however, that *something* needs to be done if Hong Kong is to continue providing up-to-date, effective health care for its citizens.

In this article, I investigate Hong Kong's movement toward health care reform. I first outline the structure, strong points, and shortcomings of the current system. I then compare the various reform proposals, how they will address problems of the health care system, and the public reactions to them. Finally, I conclude that reform is necessary and that citizens, although currently unwilling, will eventually have to pay more for health care services.

Current Health Care System

Hong Kong's health care system consists of both a public and a private sector. Public health care services are provided by the Department of Health and the Hospital Authority. (Health and Welfare Bureau, p. 1) The Department of Health provides primary care (preventive and outpatient services) while the Hospital Authority handles the public hospitals. (Lee, "Making an Incision...", p. 1) Established in December 1990, the Hospital Authority is a statutory body independent of, but accountable to, the Hong Kong Special Administrative Region Government. It manages over 40 public hospitals as well as 50 specialist outpatient clinics and 10 general outpatient clinics. The public hospitals are grouped into eight regional "hospital clusters" throughout Hong Kong. (Hospital Authority (HA), *An Introduction...*, pp. 1,4)

The mission of the public health care sector (hereafter referred to as the public sector) is to provide adequate medical and health services to every citizen of Hong Kong, regardless of income. (HA, *Endeavouring...*, p. 73) This translates into large government subsidies. In 1999, patient fees financed only three percent of the total health care expenditure, leaving the

government to supply 97 percent of the financial support for public health care services. (Harvard Team, p. 12) Patients pay HK\$37 (about US\$5) for general outpatient clinic consultations while the unit cost per consultation is actually HK\$219. (Health and Welfare Bureau, p. 15) Patients can stay in the general ward of a hospital for HK\$68 (roughly US\$9) per bed per day, a price that includes doctor's fees, nursing costs, surgery, and medications. (Health and Welfare Bureau, p. 48; Granitsas, p. 2) Visits to the Accident and Emergency ward are free but cost the government HK\$588. (Pritchard, p. 2; HA, *Endeavouring...*, p. 80) Because the public sector promises "accessible, quality, equitable, and affordable health care service," citizens rely on public hospitals for 92 percent of their secondary and tertiary care and 100 percent of their extended and long-term care. (Health and Welfare Bureau, p. 1; HA, *An Introduction...*, p. 7)

The private health care sector (hereafter referred to as the private sector), on the other hand, provides the majority (70 percent) of primary care services. (HA, *An Introduction...*, p. 7) Private sector consultation hours are more flexible, the service is more accessible, and patients are able to choose their doctors. The fee, although higher than the public sector, is generally affordable at HK\$150 per consultation. (Health and Welfare Bureau, p. 15)

While there are advantages to both the public sector (affordable, quality service) and the private sector (flexible, readily accessible service), each is also afflicted with shortcomings.

Problems with the Current Health Care System

Financial Sustainability

Perhaps the most pressing concern for the Hong Kong government is the financial sustainability of its highly subsidized, highly utilized public health care system. Public spending on health care increased from 1.7 percent of GDP in 1989 to 2.5 percent in 1996. These

percentages seem low compared to those of other countries, such as the United States and the United Kingdom, which spent 5.8 percent and 5.9 percent of their GDPs on health care in 1998. (United Nations..., p. 195) The discrepancy may result, however, from inaccurate records of actual health care expenditures in Hong Kong. According to Dr. Joel Hay, an expert in health economics and health policy, pensions and cash and housing allowances for government health care personnel are not included in the budget, and the rental value of land used for facilities, which is the second largest cost for the government health care system, is “either treated as free, or is otherwise totally ignored in the government health care accounting system.” (Hay, p. 11) As Dr. Hay states in his book, *Health Care in Hong Kong: An Economic Policy Assessment*, “No one knows how much the government really spends on health care.” He estimates the actual spending to be at least twice the reported value, which would place Hong Kong’s public spending on health care in the same range as that of the U.S. and the U.K. (Hay, p. 10) Moreover, according to the projections of the Harvard Report, Hong Kong’s public health spending “will rise to between 3.4 percent and 4.0 percent of GDP by 2016.” (Harvard Team, p. 5) The public health care expenditure for the 2000-01 fiscal year was HK\$30.8 billion, which constituted 14.7 percent of the total government budget. If the Harvard projections are correct, however, this percentage may rise to 28.4 percent by 2016. (Health and Welfare Bureau, p. 48) Increasing health care expenditures would result in cutbacks for other government-subsidized programs, such as education. (Wong, p. 2) The system must be revised to avoid these predicted funding problems while still having adequate means to provide patients with up-to-date, quality health care services. Although setting up the Hospital Authority led to improvements in health care services, it was a costly project, and the government is simply unable to continue pouring such large amounts of money into health care. The public sector will have to compensate for a funding reduction through increased efficiency and possibly increased fees.

Quality of service

Quality of health care services is also a matter of concern. While public health care services are attractive due to low prices, there are problems with long waiting times. The Hospital Authority has recently reduced the average waiting time for a first specialist outpatient appointment from the 1999 average of 9.6 weeks to five weeks in 2000-01. (HA, *Endeavouring...*, p. 81) Accident and Emergency ward patients can be seen “idling in enormous queues” for free health care service and low-cost drugs. (Pritchard, p. 2) Public providers face an overwhelming workload as the number of patients seeking inexpensive health care service grows. Of the approximately 2,377,660 emergency patients in 2000-01, as many as three quarters were non-urgent cases that could have been treated by a primary care physician but chose the public hospital because of its free service. (HA, *Endeavouring...*, p. 7; Granitsas, p. 2) The Hospital Authority is also facing a 5 percent decrease in government funding over a three-year period beginning in the 2000-01 fiscal year. Two percent (totaling HK\$571 million) will be deducted in 2001-02. (HA, *Endeavouring...*, p. 21) This cut, combined with the citizens’ increased dependency on the public sector as a result of the economic slump, threatens the ability of the public sector to provide high quality services. Again, increased efficiency within the public sector and new means of funding will be necessary to sustain Hong Kong’s public health care system.

The issue of quality of service applies to the private sector as well, particularly the variable quality of service. In Hong Kong’s laissez-faire system, there is little, if any, regulation of private health care. The Department of Health is responsible for inspecting and licensing of private hospitals, but, according to the chief of one of these hospitals, “The department has no involvement in helping...to maintain quality.” (Lee, “Surgery Needed...,” p. 4) Moreover, approximately 4,000 private clinics are not subject to any supervision or monitoring by health

authorities, and no licensing system sets standards for clinical equipment, drugs, hygiene, or management of medical records. (Lee, “Private Doctors...,” p. 1) Private doctors largely regulate their own standards. (Fidel, p. 3) Pricing varies tremendously among private doctors, and surgeons have been accused of “price-gouging” by charging radically different prices for the same procedure. Private hospitals apparently use a patient’s accommodation selection (a private room or the hospital ward) as a measure of ability to pay and then charge accordingly – those staying in private rooms may be charged twice as much as patients staying in the hospital’s ward. (Granitsas, p. 3) Variability of pricing and lack of regulation in the private sector are issues that need to be addressed in the health care reform.

Compartmentalization

The lack of communication between the public and private health care sectors presents another problem. There is virtually no exchange of information between these two sectors; and, although the Hospital Authority makes patient records available to its doctors via an information infrastructure system between its major hospitals, these records are not readily available to private doctors. As the associate vice-president of the Hong Kong Medical Association, Dr. Chu Kin-wah, said in an interview with the *South China Morning Post*, “You are on your own after being discharged.” (Benitez, “Proposal to Share...,” p. 1) The public and private sectors are largely independent, and this compartmentalization leads to fragmented, inefficient service. (Wong, p. 3) Continuity of care deteriorates as a patient moves from public to private sector and back again, and duplication of services often occurs due to incomplete knowledge of medical histories. One reform aim, then, should be improved communication between the public and private sectors, which would lead to greater efficiency and quality of care.

Shortage of Doctors

A shortage of doctors in the public sector also threatens efficiency and quality of care. The Hospital Authority has only 60 doctors per 100,000 citizens, making it difficult to serve the multitudes of patients who come teeming into public hospitals. (HA, *Endeavouring...*, p. 78) Combining both the public and the private sectors, the city still only provides 142 doctors per 100,000 people, totaling about 9,500 doctors in all. By contrast, in 1998 the United States, United Kingdom, and China had 288, 176, and 160 doctors per 100,000 people, respectively. (“Manpower Statistics...”) The scarcity of doctors forces the Hospital Authority to offer high salaries to discourage their doctors from seeking private practitioner salaries. Consequently, Hong Kong’s public doctors are among the highest paid government doctors worldwide, earning between \$124,000 and \$190,000 a year as recent graduates and up to \$330,000 as senior doctors. The doctor shortage, then, stretches health care budgets. Unfortunately, no reprieve appears to be in sight. In December 2000, the government requested that Hong Kong’s two medical schools reduce enrollments by 15 percent over the next three years because there is no room in public hospitals for the students’ post-graduate training. (Granitsas, pp. 1-4; Leung, p. 2; Yeung, p. 2) If health care reform can increase the number of doctors, the public sector workload would be less overwhelming and the quality of service better. An increased supply of doctors might also allow the public sector to cut costs by lowering salaries.

Aging Population

The changing demographics of Hong Kong’s population also necessitate reform. As lower birthrates and increased life expectancies produce an aging population, health care needs will change. (HA, *Endeavouring...*, p. 78; Wong, p. 2) At an average of 79.4 years, Hong Kong has one of the highest life expectancies in the world, overshadowed only by Sweden (79.6 years) and Japan (80.8 years). (United Nations..., p. 141) More Hong Kong women are marrying and

having children later in life or simply remaining single; and, as of 1999, Hong Kong had a fertility rate of only 0.975 children per woman, the lowest in the world. (Moy, p. 1) While the number of youngsters decreases, the population over 65 continues to grow. At present, 11 percent of Hong Kong's population of 6.7 million is over 65 years old, but this is expected to rise to 15 percent by 2019. (Health and Welfare Bureau, p. 9) In the two-year span from mid-1999 to mid-2001, the number of people over 65 increased by 40, 500. (HA, *Endeavouring...*, p. 81)

As the aging population grows, health care problems will shift from those caused by infectious diseases (such as tuberculosis and pneumonia) to those caused by chronic diseases (such as heart disease, stroke, diabetes, and cancer). (Wong, p. 2) The mortality rate due to infectious and parasitic diseases decreased from 96.1 to 11.3 per 100,000 population between 1961 and 1999 while the mortality rate due to cancer more than doubled, growing from 73.0 to 165.5 per 100,000 population. For people over 65, the mortality rate due to cancer was 1,008.6 per 100,000 people in 1999. ("Age-specific Mortality Rates...") In fact, according to the Hospital Authority's 1998-99 Statistical Report, the leading cause of death in Hong Kong was malignant neoplasms (cancer) at 32.7 percent, followed by heart disease at 15.5 percent. (HA, *Statistical Report 1998-99*) Chronic diseases require labor-intensive, expensive, long-term care. (Health and Welfare Bureau, p. 9) To minimize the incidence of chronic diseases in the elderly (and therefore keep them out of the public hospitals), emphasis will need to be placed on *prevention* by implementing programs to detect disease early and educate patients. (Wong, p. 3)

Current services for the elderly are inadequate. While Hong Kong does have both private and publicly funded nursing homes, there are not enough. It is estimated that 29,000 elderly individuals are on waiting lists for government-funded nursing home beds, and many die during the average 21-month waiting period. (Chan, p. 1) The 450 private nursing homes, with their often low quality care, are not a desirable alternative for most. ("Heard in HK...", p. 2) The

Hospital Authority and the Department of Health currently provide services for the elderly such as day hospitals, community nurses, elderly health centers, and visiting health teams. The services, however, are poorly coordinated, inefficient, and generally unable to meet the growing demand. For example, there were only 71.3 geriatric day places per 100,000 people 65 and older in 1999-2000. In the Community Nursing Service, there are only 4.8 nurses for every 100,000 citizens. (Chan, pp. 2-3; HA, *Endeavouring...*, p. 79) The reform needs to address Hong Kong's changing demographics to provide more quality services for the chronically ill, adequate housing for the elderly, and preventive health care. Unfortunately, these programs all come with costs.

It is evident from this breakdown of Hong Kong's health care problems that reform is in order. Several proposals have surfaced over the past few years, all of which have stirred continuing debates among Hong Kong's citizens. In the following section, I outline the key aspects of the various reform proposals, how they attempt to address the problems discussed above, and the reactions they evoke from the citizens of Hong Kong who seem to be in denial about the costs of health care services.

Health Care Reform Proposals

Harvard Report and Proposal

In November 1997, the Health and Welfare Bureau commissioned Harvard's School of Public Health to conduct a study of Hong Kong's existing health care system and suggest improvements. The subsequent April 1999 report suggested two main options for reform. (Health and Welfare Bureau, p. 2) The first option, a compulsory insurance scheme to which the government and the patient would jointly contribute, includes two elements: the Health Security Plan (HSP) and Savings Accounts for Long Term Care (called MEDISAGE). The HSP would

pool risks to cover major unexpected medical costs through a mandatory contribution of 1.5 percent to 2 percent of salaries. (Harvard Team, pp. 12-13; Health and Welfare Bureau, p. 84) MEDISAGE is a personal savings program meant to help pay for long-term health care when an individual reaches old age and would require a contribution of 1 percent of each individual's salary. (Harvard Team, pp. 12-13; Health and Welfare Bureau, p. 85) The Harvard Proposal also recommended a Health Security Fund (HSF) to run the HSPs. (Harvard Team, p. 13) These proposed insurance schemes would theoretically help alleviate the public financial strain and provide a means for citizens to put money aside for future health care expenses. The second option called for a reorganization of the Hospital Authority into 12-18 regional Health Integrated Systems (HISs) in order to reduce the compartmentalization of the public and private sectors by allowing regional hospitals to contract with private physicians. Benefit packages including preventive, primary, outpatient and hospital care could then be provided to patients, decreasing the variable quality of service and ensuring continuity of care. (Harvard Team, p. 16; Wong, p. 9)

While the Secretary of Health and Welfare, Dr. Yeoh Eng-kiong, felt that "the Harvard report made a correct diagnosis of the health care scene," the proposals were largely rejected by both the government and the public. (Benitez, "Health Care Plan...", pp. 1-2) Strong criticism came from medical professionals who claimed that "the Harvard team knew nothing about conditions in Hong Kong" and that the proposed mandatory insurance schemes were "impractical." (Lee, "Surgery Needed...", p. 3) Lower and middle-income citizens viewed the proposed Health Security Plan as a "tax in disguise" and an unfair financial burden. (Health and Welfare Bureau, pp. 84-85; "Smoking Big Issue...", p. 2) In a survey of 547 people between the ages of 18 and 34, 80 percent of those who had heard of the Harvard report opposed mandatory insurance. (Wan, p. 1) For many citizens, free health care service is worth the long waiting times

and variable quality of service. (Pritchard, p. 3) Citizens must realize, however, that this free system cannot continue to function effectively and that they will have to contribute to the costs of their health care service. It seems that at least some people are aware of this need. Based on 2,200 written submissions to the Health and Welfare Bureau concerning the report, the public generally supported the MEDISAGE scheme, indicating that citizens were willing to contribute to personal savings accounts to offset health care costs during old age. (Health and Welfare Bureau, p. 85) Concerns have been raised, however, that such a scheme would not provide sufficient funds to cover the long period of treatment often necessary for chronic illnesses. (Benitez, “Health-care Plan...,” p. 1) There was very little support for the proposal to reorganize the Hospital Authority into Health Integrated Systems. While the public seems to agree that health care services are fragmented, people are generally satisfied with the structure and services of the Hospital Authority. (Health and Welfare Bureau, p. 82)

Lifelong Investment in Health – The Health and Welfare Bureau Proposal

A second reform document, *Lifelong Investment in Health*, was released by the Health and Welfare Bureau on December 12, 2000. (Lee, “Surgery Needed...,” p. 1) It outlines the Bureau’s proposals for reforming the health care delivery system, improving quality assurance, and financing health care services.

Four primary goals for the delivery system reform include:

- 1) Prevention: Efforts to increase services such as disease surveillance and prevention, health education and promotion, and immunizations and health screenings will decrease the number of people (particularly the elderly) requiring secondary and tertiary care, easing the workload of the public sector and reducing the financial burden placed on the government. (Health and Welfare Bureau, p. 12)

- 2) Supply increases: Increasing the availability of primary care services will also reduce the overwhelming pressure on the public hospitals to provide health care services. The Hospital Authority started a family medicine training program in 1997-98 and plans to enroll 316 family medicine trainees in 2001-02. The long-term goal is to have half of the doctors recruited to the public sector trained in family medicine and primary care.

Increasing the number of primary care physicians will alleviate pressure on the secondary and tertiary health care systems by steering the non-urgent patients out of the overcrowded Accident and Emergency wards. Long wait times will be reduced, quality of service will increase, and unnecessary emergency ward fees will dwindle.

- 3) Reorganization: The Bureau also suggested transferring 65 general outpatient clinics run by the Department of Health to the Hospital Authority. This would integrate primary and secondary care and, therefore, reduce compartmentalization of services.

Compartmentalization would also decline by asking private doctors to help in family medicine training for public practitioners. (Health and Welfare Bureau, pp. 14-18)

- 4) Information sharing: To further improve the interface between the public and private sector, the Bureau proposed a Health Information Infrastructure to share medical information as well as to access lifelong electronic patient records. Such a system would provide a feasible solution to the discontinuity of care and duplication of services that currently plague the system. (Health and Welfare Bureau, pp. 25-29)

Moving to the issue of increasing service quality, one of the Bureau's proposals would require continuous education and training for all health care professionals so that their knowledge, skills, and practices are up-to-date. The Bureau also suggested that health care professionals implement support mechanisms such as clinical protocols and audits, regular peer reviews, and a system of clinical supervision. The Bureau also intends to establish a Research

Office to collect data and identify problems. In addition, to ensure credible, unbiased treatment of patients' complaints, the Bureau proposed an independent third party Complaints Office in the Department of Health. (Health and Welfare Bureau, pp. 38-47)

The final section of the Bureau's document addresses financing. The Health and Welfare Bureau recognizes the financial threat to the current system but also endeavors to continue providing accessible, affordable, high quality health care services to all citizens. The Bureau has presented three proposals in this regard. The first focuses on reducing public sector costs by minimizing service duplication. Guidelines and protocols for application and utilization of services should be developed, and partnerships with private health care professionals pursued. These measures would not only reduce costs from service duplication, but also increase quality of care and assist in breaking down compartmentalization.

The second proposal calls for revamping the fee structure, which currently does not distinguish patients who can pay from those who cannot. The highly subsidized public services attract both, giving no priority to those with greater financial need. Therefore, the Bureau recommends fees for public services with the hope that the charges will deter inappropriate use of these services. The Bureau also suggests a "second safety net" for those who cannot afford the fees.

The third financing proposal takes the form of mandatory contributions similar to the Harvard report's MEDISAGE plan, which gained general support from the public. People ages 40 to 64 would put 1 percent to 2 percent of their earnings into personal savings accounts, called Health Protection Accounts, which would be used for future medical expenses and/or private insurance. Money could not be withdrawn from the account until the person turned 65. The person could use the savings to obtain private health care services, but he/she would only be reimbursed at the public sector rate. Such a scheme would help alleviate the dependence of the

elderly on government-subsidized services and would allow them greater choice. The Bureau plans to study the public's reaction to the proposed Health Protection Accounts in 2001-02.

(Health and Welfare Bureau, pp. 48-59)

Many of the proposals outlined in the Bureau's consultation document are based on suggestions from the 2,200 written submissions they received from the public. Citizens strongly supported the introduction of a stronger primary care system to ease the overworked public health care sector and open the lines of communication between the two health care sectors. The respondents generally supported the establishment of a government office to conduct research and agreed that health care professionals should pursue continuing medical education. Patients also felt that the current complaints mechanism was biased toward practitioners and requested a restructuring of the system. (Health and Welfare Bureau, pp. 81-85)

Not all of the proposals made by the Bureau, however, were welcomed with open arms. Complaints include claims that the document "fails to set out a clear policy" and that the proposed reform "only goes halfway." (Lee, "Surgery Needed...", p. 2; Granitsas, p. 1) A joint group representing 14 medical associations claimed that the document was full of "empty proposals" and that there was "no objective evidence that the reform would work" because there was no "clear definition of how the government was to offer 'high-quality, affordable health for all'." (Benitez, "Medical Group...", p. 1) A survey conducted by the Government Doctors Association and the Hong Kong Medical Association showed that doctors working in the 65 general outpatient clinics run by the Department of Health are generally dissatisfied with their proposed transfer to the Hospital Authority. Of the 107 doctors surveyed, 57 percent said they would want to remain in the Department of Health if the transfer occurred, while 40 percent said they would prefer early retirement to being forced to transfer to the Hospital Authority. ("Doctors Hope...", p. 1) So too, the proposed Complaints Office raised protests from

practitioners who feel that only professionals are qualified to judge professional practice and conduct. The community, however, continues to demand an independent complaints office.

(Health and Welfare Bureau, p. 83)

The proposed financing options have also met with mixed reactions. While some people support the change in the fee structure, others are concerned that increased fees will harm people who most need health care services. The president of the Public Doctors' Association stated that he "fully supported the government's plan to charge accident and emergency ward patients" and that "both public and private hospitals should implement changes to their fee-charging procedures." (Ho, p. 1) In its 2001-02 Annual Plan, the Hospital Authority also stated its support and promised to study the current fee structure and the public impact of increased fees. (HA, *Endeavouring...*, p. 24) Others have suggested that increasing public fees may prevent economically disadvantaged citizens from obtaining appropriate medical care, thereby violating the government's promise to provide adequate health care services to all citizens, regardless of means. There is also concern that high fees may discourage sick people from seeking care until they are so ill that they would require more costly secondary or tertiary care. To alleviate fears of immediate fee changes, the government has frozen public fees for the current fiscal year. (Leung, pp. 1-2) This temporary freeze buys some time, but eventually the need for increased financial contributions from citizens will have to be acknowledged.

Health Protection Accounts have also met both support and opposition. While some believe that a salary contribution of 1 percent to 2 percent would be "inadequate to cut costs," the Secretary for Health and Welfare, Dr. Yeoh Eng-kiong, expresses confidence that the scheme would be "viable." (Benitez, "Health Plan..." p. 1; Benitez, "Harvard Projection..." p. 1) Yet, during a Legislative Council session in March 2001, many legislators expressed skepticism. (Kang-chung, p. 1) There seems to be a general consensus that the timing for a new mandatory

savings scheme is wrong. Hong Kong is still recovering from the recent recession and citizens are reluctant to part with money. (Pritchard, p. 1) In addition, individuals are already contributing 5 percent of their monthly paychecks to the Mandatory Provident Fund, a pension system similar to 401k plans in the United States that was implemented in December 2000. (“Smoking Big Issue...,” p. 3) The government acknowledges that citizens are simply unwilling to pay any more at the moment, but hopes that such a payment scheme can be implemented in the next five to ten years. (Yin, p. 1) As the president of the Medical Association, Dr. Lo Wing-lok, put it, Hong Kong needs “evolution, not revolution.” (“Doctor on a Schedule...,” p. 1)

Endeavouring towards Reform – The Hospital Authority Annual Plan 2001-2002

The Hospital Authority’s Annual Plan for 2001-02, which can be considered the third reform proposal, was largely a response to the Health and Welfare Bureau’s consultation document. The Hospital Authority recognizes the current system’s problems and supports the majority of the Bureau’s proposals. In its Annual Plan, it outlines several positive steps.

To improve service capacity and access, the Hospital Authority will open 610 new inpatient beds and day places including 139 acute general beds and 392 rehabilitation/infirmarary beds next year. (HA, *Endeavouring...*, p. 18) The staffing for these new beds will be met by re-assigning existing personnel. Hospital hours will be extended to provide patients with better access to health care services. To reduce the overwhelming workload, the Authority plans to recruit at least 270 new doctors as well as 150 allied health professionals, 140 degree nurses, and 1,100 graduating trainees as qualified nurses. In April 2001, five general outpatient clinics were transferred from the Department of Health to the Hospital Authority and were converted into family medicine clinics. (Benitez, “Pilot Family Clinics...,” p. 1) The Authority hopes to train at least 106 doctors in primary care (70 percent in family medicine, 20 percent in community-based internal medicine, and 10 percent in pediatrics) in 2001-02. (HA, *Endeavouring...*, p. 26) The

training at these clinics is meant to strengthen Hong Kong's primary care services and reduce pressure on the public hospitals. Compartmentalization of the public and private health care sectors will also be decreased through the Hospital Authority's recruitment of 20 family medicine specialists from the private sector as part-time trainers in the family medicine clinics. The Authority states, however, that private practitioners should be responsible for the bulk of primary care services and that the public sector's role in primary care should focus on "professional training, providing a safety net for those who cannot afford [services], and streamlining the interface with secondary/ tertiary care to improve the overall system efficiency." (HA, *Response...*) It stresses that patients should be encouraged to utilize private services and has even suggested that some services could be contracted out to the private sector. (HA, *Response...*)

To provide better service to the elderly population, the Hospital Authority plans to improve the Community Nursing Service and have this service work with Community Geriatric Assessment Teams to provide community outreach services in all of its hospital clusters. (HA, *Endeavouring...*, p. 28) There are also plans to serve 350 elderly individuals in their own homes. (HA, *Endeavouring...*, p. 29) Providing community services to the elderly may aid in cutting costs by preventing the development of illnesses that would require expensive secondary or tertiary care. It is questionable, however, whether the Hospital Authority's efforts will be enough to meet the needs of the ever-growing population of elders.

The Hospital Authority fully supports the Health and Welfare Bureau's proposal to revise the fee structure and has promised to study the citizens' reactions to such restructuring. It also suggests introducing fees for misused services, such as the Accident and Emergency wards, and reducing government subsidies for general outpatient services so public funds can be directed toward high risk services, such as cancer treatment and trauma care. (HA, *Response...*)

Internally, the Authority intends to cut costs through administrative downsizing, with a goal of reducing the staff in the head office and management by 20 percent between 2000 and 2003.

(HA, *Endeavouring...*, p. 23)

Using the Health and Welfare Bureau's consultation document as a "blueprint for the evolution of Hong Kong's health care system," the Hospital Authority is taking an active role in reform. (HA, *Response...*) It has specific goals to alleviate strains on the public sector, to encourage utilization of private services, to relieve the doctor shortage, and to make health care more accessible for patients. It remains unclear, however, how it will finance all of these improvements with a reduced budget and no hope of immediate relief from a change in the fee structure.

Conclusion

The wheels of reform have started turning, but Hong Kong still has a long road to travel before it will find and implement the solutions that will restore its faltering health care system. Citizens are demanding changes but, for the moment at least, do not seem to be willing to pay for them. The people of Hong Kong are accustomed to high quality, low-cost medical services through the highly subsidized public hospital system. Such a system simply cannot last. As the Hong Kong population ages and, consequently, requires more expensive, long-term care, the financial burden of health care services will increase. Unless tax revenues also rise (which is unlikely), the government will have no means to meet the growing financial demands of the health care system. Both the citizens and the government want to keep the taxes low – the citizens because they are recovering from the Asian financial crisis and are reluctant to part with any money, and the government because low tax rates attract foreign investors. ("Smoking Big Issue...", p. 2) How can the Hong Kong government continue to support a public health care

system that offers up-to-date, high quality services at little or no cost to the patients without a corresponding increase in its own income? The answer: it cannot – reform is necessary.

While the answer seems clear, the solutions to the problem are not. Hong Kong aspires to create a financially sustainable health care system that does not sacrifice quality of care and does not deprive low-income citizens of adequate medical services. It is apparent that Hong Kong's citizens are going to have to start making a greater financial contribution to their health care, but there is much debate as to how this will be accomplished. Judging from their rejection of the Harvard proposal to implement a compulsory Health Security Plan, the people of Hong Kong are not particularly keen on the idea of "risk-pooling." They *do* seem to be willing to contribute to personal savings accounts that can be used to offset medical costs, as was evidenced by the general support seen in the written responses received by the Health and Welfare Bureau. The Health and Welfare Bureau's proposed Health Protection Account, however, may not be the best scheme. The stipulation that funds could only be accessed after an individual turns 65 seems to be an attempt to prevent people from squandering their savings. As the chairwoman of the Hong Kong Federation of Insurers, Sarah Ho Sook-ming, pointed out, however, having access to funds before age 65 would allow people to purchase medical insurance to cover current medical needs in addition to setting aside money for future long-term care. (Benitez, "Medical Insurance...", p. 1) It is also questionable whether the suggested 1 percent to 2 percent of salary contribution would make much of a dent in the high costs of secondary and tertiary care that the savings are meant to cover. For those people whose incomes are low, the savings would most certainly be inadequate to meet costs. An increase in public sector fees may also negatively impact low-income individuals who might be discouraged from seeking medical care because of their inability to pay for services. In its never-ending quest to provide adequate health care services to all citizens, the government has promised to provide a

“second safety net” for those who do not have the means to pay the fees. The government, however, has not yet devised an effective scheme for distinguishing those who can afford to pay from those who cannot. In order to deter the wealthy from taking advantage of government subsidies while at the same time providing the needy with necessary financial assistance, a means-based system of some kind will need to be established.

While the many positive steps that have been taken should not be overlooked, a number of changes are still required. If the citizens of Hong Kong want continued high quality, up-to-date health care services, people who can are eventually going to have to reach a bit deeper into their pockets. Meanwhile, the government is going to have to develop a more concrete budget for the proposed improvements to the health care system. The recent economic slump and the weaknesses of the proposed payment schemes have created stumbling blocks in the reform, and it is obvious that a considerable amount of proposing, discussing, and compromising must occur before an effective solution to Hong Kong’s health care problem is found. The problems, however, are widely recognized by professionals and citizens; and the progress that has been made, although slow, indicates that Hong Kong is ready and willing to pursue a reform. Given time, Hong Kong’s ailing health care system will undoubtedly be nursed back to good health.

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