Presentation to the Legislative Council of the Hong Kong Special Administrative Region, The People's Republic of China, Monday 28 June 1999 at 8:30 a.m. in Conference Room A of the Legislative Council Building.

"Discussion on Hong Kong's health care system and the direction of future reform."

By Professor Joseph C.K. Lee

I would like to thank you for allowing me to voice my views on this complex issue. The following are my personal opinions. They do not represent those of the Faculty of Medicine, The Chinese University of Hong Kong. The Faculty will submit its official response in due course.

I am a pathologist. I am neither a health care economist nor a health care policy maker.

I understand that in the session on 28 June 1999 the discussion is on "Coordination between different health care structures". However, in order to make my presentation a coherent whole, I would like to begin on the "three-legged-stool" concept of health care in a community.

The three-legged-stool analogy is that in order to have a comfortable stool on which a patient sits each of the three "legs" -- FINANCE, STRUCTURE and QUALITY, should be in a healthy state supporting the weight of the patient. Weakness in one or more may result in a precariously balanced situation; the stool may be crippled or may even topple over. In any health care system the three elements are intimately and intricately linked. Therefore, in any review of our health care system, all three should be considered.

Before looking forward, I would like to point out where we are today. In 1987 in a public lecture (The Fifteenth Digby Memorial Lecture on "Medical and Health Systems with Special Reference to Hong Kong"), Dr. K.L. Thong, the retiring Director of Medical and Health Services of the Hong Kong Government, pointed out the problem in our health care system:

"This Colonial Medical System therefore possesses all the classical characteristics of a public assistance system. Whatever medical care is available in the system is provided for the majority of the population through Government hospitals and health centres financed from the public purse by narrow-based taxation. The system is relatively under-financed, understaffed and certainly overcrowded which is typical of a Colonial Medical System. There were various reasons for this state of affairs and not the least of which is the fact that the Government, being not elected by popular franchise, has always been looked upon as a "father image", who in his benevolence, is expected to provide social services, especially medical services, for all and sundry without charge in order to maintain its popularity and credibility. Hence, relative to the declared objective, the Colonial Medical Service is always under-financed, understaffed and overcrowded, simply it is not possible to provide medical services on such a universal scale without proper allocation of resources". (Underlining is mine.)

We are two years after the end of our colonial links. Have we emerged from being "under-financed", "understaffed" and "overcrowded"? I submit we have not. The Hong Kong SAR is in the process of transiting to a yet unknown (to me) system. This is the opportunity to put it right. The question is do we have the data to help us to make a rational choice?

"Under-financing": The bean counters have been telling us that we are only spending 2.5% of our GDP (in 1996) on health care in the public sector, three-or four-fold less than that of the OECD countries. And yet we have been told that Hong Kong's health care is comparable to the best in the world. With relatively high salary and cost of modern equipment and reagents similar to those in the OECD countries (since we import most of them), I must conclude that our overworked and talented health care teams have been exceptional in efficiently and effectively achieving "good value for money".

In 1986 in a response submitted to the then Hong Kong Government on "The Delivery of Medical Services in Hospitals" (The Scott Report), the Faculty of Medicine of The Chinese University of Hong Kong warned:

"In this connection, it is to be noted that the cost estimates quoted in the Report are not considered realistic and that it is illogical to suggest that improved facilities will not entail quite material additional costs unless these are to be recovered from the patient." (Underlining is mine.)

I have no doubt with all the reasons that have been given: aging population, new technology, rising expectations, health care cost would inevitably rise. I have no data on how fast this increase will be. Our Chief Secretary for Administration, Mrs. Anson Chan, has told us that it is increasing at 7% per year. Taking the experience from overseas countries

and knowing the inherent needs of health care, I firmly believe that no government can sustain the insatiable demand on health care and hence the cost. Rationing will have to come at some time. (Of course, this will be a topic for another day.) Any success in reform in our systems, I believe, will be of a limited duration even if our citizens are contributing to part of this cost. Again in the words of Dr. K.L. Thong in the same lecture in 1987:

"The aspirations and demands from the public for more hospital services both in quality and in quantity directly or through their representatives in the government are ever increasing. It will be difficult, if not impossible, to meet such demands if the public assistance system is not modified in such a way as to attract proper financing and improved efficiency in administration and to provide for political participation in its management."

In 1991 Dr. Joel W. Hay in *Health Care in Hong Kong: An Economic Policy Assessment,* after analyzing our health care system in detail proposed that a ChoiceCare option be given to all Hong Kong residence - a form of voluntary enrollment into private medical insurance plans qualified by the Government.

The Harvard Team (1999), in *Improving Hong Kong's Health Care System: Why and For Whom?,* offered a compulsory enrollment in a Health Security Plan (HSP) and an individual savings account for retirement or disability (NIDISAGE) as one of the options.

I believe that we have no choice but to ask the users to pay for part of the cost with a built-in mechanism to prevent abuse.

We have to look seriously at the options and make a choice, in the process modifying it to suit the needs of Hong Kong.

"<u>Overcrowding</u>": Under this heading I would like to discuss STRUCTURE. The ideal health care structure is one in which a patient's illness can receive continuity of care from the moment symptoms or signs appear (or in the future data from molecular genetic screening). The present preferred arrangement is for the patient to go to a family doctor or to the accident and emergency department of a hospital. If necessary, the next step is referral to a specialist or admission to a hospital. And upon discharge the patient goes back to the community under the care of the family doctor and community health centres. This truly "seamless" health care is based on good cooperation of the hospitals, clinics, all types of health care workers and a perfect patient record system (probably in the electronic form), both in the public and private sectors. We should

improve cooperation in all sectors. As a first step, since Hong Kong is a small place, we should invest in a database of total patient information system with proper security safeguards.

Again, referring to the 1986 submission of the Faculty of Medicine on the "Scott Report":

"Members of the Faculty also view with some concern and misgiving the fact that the Report excludes outpatient services and primary care services. They realize that the Consultants were only asked to review the operation of hospital services, but doubt that this can be done in isolation. In any community, primary care services are a pre-requisite to a comprehensive health service and it is at least arguable that any improvement in these areas will have a significant effect on the hospital services. It is therefore the unanimous view that measures to limit the demand on hospital resources and to discourage wastage should be considered concurrently and that adequate resources must be allocated for improving primary care services, for preventative medicine, for health education, and any other appropriate methods designed to keep patients out of expensive hospital beds." (Underlining is mine.)

"Understaffing": Under this heading I would like to bring in the discussion on maintenance of quality. Staff is the most costly and important component in an organization; they are also the main "maintainers" of quality. I believe, as do many of my colleagues, that quality is an attitude. The statutory requirement of continuing medical education (CUE) in the recently established Hong Kong Academy of Medicine goes to some extent towards maintenance of professional quality. The medical audits in hospitals of the Hospital Authority are good beginnings. The primary medical care certificate assessment proposed by the Hong Kong College of Family Physicians for general practitioners should be pursued. The Hong Kong Dental Council, the Hong Kong Medical Council and many professional boards are keeping an eye on quality. There are various quality assurance programmes. Accreditation is coming into being. I think that the next step should be accreditation of hospitals, both private and public.

Of the three "leg" - finance, structure and quality, I believe that maintenance of quality, being less tangible, is the most difficult. A strong partnership among the stakeholders should be struck. The partners are the patient, the doctor and the Government. Each has a role to play. In the process we should be mindful of the "consumer-provider" relationship.

Conclusion You would be disappointed if I do not say a few words on the role of the medical school in this endeavour.

It is the business of a medical school, in which there are world-class experts, to provide quality education, caring practice and advancement of knowledge. Our role can be to:

1. Collect and objectively analyse data;
2. Formulate proposals on policy issues;
3. Research into cost-effectiveness of processes;
4. Maintain standards of practice; and
5. Provide educational opportunities and experience.

This is the opportune time for us to work together for the health and wealth of Hong Kong.

26.6.1999