

# The reform of health care funding

## 醫護融資改革

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It is argued that the history of health care in Hong Kong has been characterised by the lack of a coherent government policy concerning who should provide, use, and pay for services. This has led to the present fragmented funding and delivery system. Past reforms have been piecemeal and have failed to address fundamental issues. The Harvard Report offered a comprehensive solution, but its insurance-based approach to funding was politically unacceptable. Since funding determines patterns of service delivery, reform in that area is *the* necessary precondition for any substantive improvement in the quality and quantity of health care. Integrated funding mixes public and private money to overcome compartmentalisation between sectors. Without this, it is doubtful that a primary-led health care system could operate. Whether Government has the political will to implement its current proposals in the face of opposition, and whether these will provide a sufficient foundation for the development of primary-led health care, remains to be seen.

香港的醫療護理，關於由何者提供，使用及支付服務等問題上，歷來被評為缺乏一貫的政策，因此而導致目前融資及服務系統的支離破碎情況。過往的改革只觸及問題的片面，而未能把問題徹底根治。哈佛報告雖然提出了全面的解決方案，但其所提議的保險形式之融資，並未能在政治上取得認同。由於醫療服務的模式取決於融資，因此，如要在實質上改善醫療護理的質與量，這方面的改革是為其先決條件。綜合融資結合了公共和私人資金，從而解決目前架構上之分裂隔離情況。沒有綜合融資，在推行以基層護理為主導的制度上，其可行性便大成疑問。在一片反對聲中，政府是否在政治上仍有決心推行其當前的方案，公眾亦只能拭目以待。

### Introduction

In April 1999, the government published 'The Harvard Report'.<sup>1</sup> In this document, consultants who had been asked to review Hong Kong's health care funding and delivery system concluded:

- (1) That the quality of health care was highly variable; and
- (2) That it was questionable whether the health care system's funding was sustainable in the long term.

These conclusions were largely attributed to the system's compartmentalisation, and the lack of integration among health care sectors.<sup>1</sup> One possible reason for these apparent defects may be the way the health care system developed, without any coordination.

Different sectors of the community have each criticised the Harvard Report's findings. As occurred with a previous patient survey reported in the Hong Kong Medical Journal,<sup>2</sup> doctors and medical organisations

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reacted negatively to the implied shortcomings in their professional standards. Employers and employees also objected to having to pay for compulsory medical insurance. One economist considered that existing sources of finance would remain adequate, with only minor adjustments required.<sup>3,4</sup> A similar view was shared by the Hospital Authority.<sup>5</sup> Although reasons may differ, objectors may all have been seeking to avoid ‘painful’ remedies by denying the existence of any problem. None of the critics appears to have acknowledged the system’s lack of integration as an issue to be resolved.

In response to these objections, the government did not implement the recommendations in the Harvard Report, releasing a different proposal in December 2000.<sup>5</sup> As the Secretary for Health and Welfare acknowledged, this was “mainly a collection of ideas”<sup>6</sup> rather than an integrated reform package. These proposals can be seen to ‘trade-off’ technical solutions for political acceptability. They addressed problems in a piecemeal fashion, without tackling the root cause—the lack of health care system integration. In effect, the government proposals may be said to represent symptomatic treatment, rather than cure.

### The growth of health care services

The mandate of the early colonial government in Hong Kong was to encourage free trade with minimum intervention.<sup>7</sup> The Administration accordingly adopted a *laissez-faire* economic ideology,<sup>8</sup> and later practised ‘positive non-interventionism’ in the market.<sup>9</sup> The government of the day initially did not regard the provision of health care for the general public as its responsibility, and the supply of health care was left largely in the hands of others. Accordingly, private practitioners and private hospitals became established, to meet the demand from wealthy European residents. In contrast, the local population and the less affluent relied on missionary clinics, or traditional Chinese medicine practitioners.<sup>10-12</sup>

The continued existence of such an arrangement in the modern era, presumes that government intervention is unnecessary because health care behaves like any other free-market consumer goods. In other words, medical services in the private sector should be able to satisfy *all* demand, at a fee level which both consumers and providers find acceptable. In reality, health care does not behave in this way. Without government intervention, high medical costs leave the poor without treatment, rather than leading private fees to fall to a level which everyone can afford.

The situation in Hong Kong reached a critical stage in the 1950s and 1960s, with the arrival of many poor refugees from the Mainland. It was estimated at that time that 50% of Hong Kong residents could not afford to consult a private practitioner, whereas 80% could not afford the costs of admission to a private hospital.<sup>13</sup> The government was thus forced to take action. It embarked on a large-scale programme of building public hospitals and clinics, the aim of which was “to provide, directly or indirectly, low cost or free medical and personal health services to that large section of the community which is unable to seek medical attention from other sources”.<sup>14</sup> This implies that the government regarded the provision of public health care as a welfare service for the needy, rather than an entitlement for all citizens.

The 1970s saw an increase in the number of public hospitals and clinics. Despite calls from legislators for a clear policy as to who should be eligible for subsidised care, or what should be provided,<sup>15</sup> the public sector continued to grow throughout the 1980s without any specific plan for how services should evolve and who they should serve.<sup>16</sup>

At the same time, the private sector was largely ignored. This led to “a system with gross imbalances”,<sup>16</sup> and a public sector which was unable to keep up with demand or maintain service standards, despite an ever-expanding budget. The government finally committed to a review, which resulted in the Scott Report, recommending the establishment of a Hospital Authority.<sup>17</sup>

### Organisational reforms, but no financial review

The review commissioned was focused solely on how existing public hospital services could be improved. It did not consider issues such as the respective roles of public versus private health care providers, the interface between primary, secondary and tertiary sectors, eligibility for subsidised care, or how health care services in general should be funded. The government in so doing, continued to act as though market forces alone would separate the rich from the poor, and regulate admission to public hospitals. Its premise appears to have been that only the needy would accept long waiting times and poor service in the public sector, whereas those with the ability to pay would opt for the private sector, with its choice of doctor, immediate service, and more personal care.

Reliance on this means of self-selection was undermined when the Hospital Authority undertook to improve quality in public hospitals, at no extra cost

to patients. As the gap between standards of comfort narrowed, whereas the difference in treatment costs widened compared to private hospitals, patients were increasingly drawn to the public sector. Not all of these patients were unable to afford private treatment. The outcome was that public hospitals were overburdened, whereas private hospitals were left with declining occupancy rates and financial problems.<sup>18</sup>

While it may be argued that the government lacked the capacity to undertake a more broad-based reform at the time it established the Hospital Authority, it also missed an opportunity to negotiate with the community for shared responsibility for health care provision. The government now faces the more difficult task of having to gain public support for reforms, while being unable to offer anything in return. Instead, the Secretary for Health and Welfare used the threat of declining service quality in the public sector, in order to press for acceptance of his current proposals.<sup>19</sup>

Even as the Scott consultants were examining the organisation and management of public hospitals, concern was being expressed by legislators that this was only a partial solution. The problems affecting secondary and tertiary sectors would not be solved, it was argued, unless action was taken to address the overcrowding and poor facilities in government outpatient clinics, as well as to provide a strong and affordable primary health care foundation, as recommended in the Declaration of Alma-Ata.<sup>20</sup>

These issues were addressed in a review of primary health care which took place concurrently with the establishment of the Hospital Authority.<sup>21</sup> None of the 102 recommendations made by the Working Party on Primary Health Care, however, improved system integration and funding. The outcome of the review was not, as some might have hoped, the development of a primary-led health care system.

Contemporaneous with the preceding two reforms, was the establishment of a government Working Party on Chinese Medicine in 1989, whose recommendations led to a Preparatory Committee on Chinese Medicine being appointed in 1995. This committee's deliberations resulted in the government's publication of a final consultation document on the future direction of traditional Chinese medicine (TCM).<sup>22</sup> This document recommended duplication of the framework which currently exists for western medicine, for TCM and its practitioners. The document, however, failed to propose an interface between western and eastern approaches to primary care, even though this

would have been an ideal opportunity to outline such arrangements.

### **Financial review, but no reform**

The government finally acknowledged the need to review health care funding and delivery systems in its 1993 public consultation paper 'Towards Better Health' (also referred to as 'The Rainbow Document' because of its cover design).<sup>23</sup> This review focused primarily on identifying public sector problems, including an inequitable fee structure, lack of patient choice, and lack of a public/private sector interface. To address these issues, in particular, public sector funding concerns, the paper outlined five approaches—two methods of fee charging and fee waiver on the basis of selected patient groups, two ways of funding health care through insurance, and an approach to prioritising and allocating resources.

The consultation paper embraced the Hospital Authority's policy as its own and declared that the government was committed to ensuring 'no one should be denied adequate medical treatment through lack of means'. While this promised that the government would provide for the poor, it did not explicitly state that the government would *not* provide for the rich. The question of whether access to public health care was a welfare or a right was thus not clarified.

One criticism which could be levelled at the proposals, is that while their scope was broad, the ideas were only conceptual and lacking in detail. Solutions were also not offered for systemic problems, such as the lack of interface between sectors.

The consultation document stimulated a great deal of public interest. Whether it generated a better understanding of the issues is questionable. Apart from an inability to grasp funding concepts in the absence of concrete dollar figures, the public seemed unable to comprehend why the government needed to seek additional funding in the future when the economy was then in the midst of an economic boom. The government was also criticised for concentrating on funding, without offering any benefits in return for higher user charges. Regardless, whether the reform could have succeeded is doubtful, as the government had attempted to address funding before determining its health care policy and targets.<sup>24,25</sup> The government's warning that quality would decline unless changes were made went unheeded and the reform approaches were generally rejected by both doctors and the public.

The government's 1993 review was a foretaste of what would happen 6 years later when the Harvard Report was published. During the intervening period, the Hospital Authority further improved services and increased efficiency, only to see conditions deteriorate again under the pressures of rising demand. With fundamental problems untouched, management reforms on their own proved unable to secure permanent results.

### The need for financial integration

The development of health care in Hong Kong has been characterised by each sector moving in its own direction and at its own pace. Reforms have consistently failed to consider 'the big picture'. Instead, initiatives have tended to be piecemeal, focusing on one sector (mainly the public) at a time, with no clear overall strategy. Public health care currently remains dominated by the hospital sector, which consumes the bulk of the government's medical expenditure. Experience elsewhere suggests that this is not an ideal arrangement.

The government has never defined what constitutes a 'public patient'. If this represents a philosophical barrier to reform, then the belief that public money can only be spent in public facilities could be viewed as an ideological 'brick wall'. Current funding arrangements see patients queuing to be treated at overcrowded public outpatient clinics at a current cost to taxpayers of \$219 per consultation, whereas there is spare capacity in the private sector to treat patients at \$150 per consultation. Similarly, patients in public hospitals may occupy temporary, additional beds, while private hospitals have empty wards.

Increasing patient charges for public facilities has been suggested as a solution. This, however, assumes that a lack of tax revenue to fund public hospitals is the whole problem. A previous Secretary for Health and Welfare described such an idea as "very simplistic".<sup>26</sup> It ignores the problem of service fragmentation, and makes no progress towards a patient-oriented system.

If segregated funding causes problems, is integrated funding any better? Experience in developed countries (with the possible exception of the United States) seems to suggest that public money and private money can be mixed in order to purchase services more effectively than private or public money used alone. Where money 'follows the patient', the distinction between public and private sector is blurred and ceases to be a barrier

to obtaining treatment from the most appropriate provider.

Integration of the funding of health care (incorporating any combination of national health, social insurance, private medical insurance, medical savings accounts, or 'out-of-pocket' payment schemes) may also offer a solution for integrated service delivery. The patient thus becomes the subject and not the object of health care provision.

It has also been acknowledged that funding, whether it constitutes a doctor's income, an insurance company's turnover, or a private hospital's profit, is what provides the incentive to providers and hence drives the delivery of health care. The way in which health care is funded in Hong Kong at present, is riddled with perverse incentives which act against the most efficient use of resources. If health care reform introduces an appropriate funding system, it should also facilitate structural changes to ensure new sources of funding enable providers to deliver desired services to the target population. It follows that a health care system cannot be primary-care led unless the primary care physician is part of the integrated funding system, rather than separate from it, as is the status currently.

### Conclusion

The path to a primary-led health care system in Hong Kong is neither a short nor easy one. As a prerequisite, it is recommended that an appropriate funding system be first put in place, providing both the necessary resources, as well as a mechanism for the integration of funding and the delivery of services. The Harvard Report offered such a solution, but this was rejected. The government's current proposals seem unlikely to achieve this end.

The contentious issue in the health care debate is what constitutes an 'appropriate' level and source of funding. Here, economics and politics diverge. The proposed means of generating additional revenue through higher user charges and compulsory personal savings accounts may prove unacceptable to the community. Faced with opposition in the past, the government has always favoured an easy, partial solution over a comprehensive, difficult one. This has led some to question whether the government has the political will and ability to undertake an unpopular reform.<sup>1,27</sup> The current proposals already represent a 'soft option' compared to the recommendations outlined in the Harvard Report.<sup>28</sup> Whether the current proposals will proceed, and if they do, whether they

will provide sufficient foundation for the development of a primary-led health care system, remains to be seen.

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