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Health Care Policy 醫療政策

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OPINION PAPERS 評論文章

香港醫療政策的現狀和將來

馮康

香港政府有個既定的醫療政策：任何人，無論貧富，都可以得到他所需的醫療服務。這政策以公平為本。透過公立醫療系統，市民可以極其低廉的價錢，享用到全面的醫療服務，從基層保健，到最先進的檢查治療。另方面，醫療的開支約佔全民生產總值的百分之四，公私體系各佔一半。市民對醫療服務普遍感到滿意，其對醫療的關注，遠不如房屋、教育、社會福利、交通等更迫切的問題。

香港的公立醫療系統分三方面。公共衛生和普通科門診服務，由政府直屬的衛生署負責；醫院和有關的專科服務，則由醫院管理局負責。衛生署的普通科門診服務，佔全港門診服務的百分之十五，求診者多屬年老和經濟條件稍差的病人。醫院管理局的服務，包括急症、住院、康復、專科門診、社區護理等，佔全港住院服務的百分之九十，也是公共醫療開支的主要成份。私營醫療系統則包括私人執業醫生和私家醫院，主要提供基層與第二層的醫療服務。

政府既然政策明確，按道理應該很容易釐訂自己在提供服務上的角色。然而，過去幾年，隨着社會經濟的發展，人口及其結構的轉變、政治系統的更動、醫療架構的改革，政府跟公立醫療的角色，日見模糊。至主要的原因，是因成立醫院管理局而帶來的公立醫院服務的大規模改革。一九九零年底，政府成立醫院管理局，原意是引進現代化管理，以改善久為市民詬病的公立醫院服務，與及資源分配的效率。數年下來，公立醫院服務素質大為提高，服務範疇亦不斷擴闊。市民的反應譽多於譏，對公立醫院服務的關心和需求，都增加了不少。私營醫療服務尤其是私家醫院的經營，反陷困境。跟著的問題是：醫院管理局的持續發展改進，到最後會否扼殺原來生氣勃勃的私營市場？會否尾大不掉，帶來自身解決不了的許多問題，如再度擠迫的環境、輪候時間過長等，有意見認為，香港的醫療政策，必須再次面對改革了。

改革的其中一個議題，是醫療政策應否放棄過去以公平為重的原則，倡導能者自付，讓有經濟能力的市民多承擔一點醫療責任和開支，以減輕政府的負擔，亦以平衡公立和私營醫療服務間的競爭條件。改革的另一個議題，是香港政府應否限制公立醫院所提供的服務範疇和素質水平；參照外國經驗，清楚界定廉價醫療可換取的基本醫療項目。然而，醫院管理改革的成效，已經大大提高了市民對服務的期望。現有的服務水平，像潑了出去的水，不能收回。市民既認同執行已久的公平為重的醫療政策，醫療就不能分等級。再昂貴的醫療服務，如器官移植，也只能按醫療需要而分配。到目前為止，在公平和有效地分配資源之間，市民似乎還沒有感到需要取捨的壓力。改革的倡議，大抵反映了許多醫療政策關注者的更長遠的憂慮而已。

或許香港政府以企業改革的模式，透過醫院管理局間接地進行醫療改革，其實有點意料之外的好處。醫院管理局以企業式的統一機構文化和價值取向，針對市民的醫療需要，強調連貫醫療系統，推動以成效為本的醫療，協調各項服務的發展，從而在資源運用上，得到較佳的成本效益。這種以文化價值為主導的改革，軟的一面，是以病人為中心，加強溝通聯繫，增加市民對服務系統的信任和信心；硬的一面，是透過科學辯証，平衡社會的價值取向，滿足各類服類服務的發展需要。機構盡量開放，市民能參與，能監察，反而少了許多價值取捨的爭議。

香港醫療政策的發展似乎還沒到必須改革的十字路口。香港經濟的持續發展，人口的不斷增長，給整個醫療系統帶來繼續發展的資源和壯大的契機。資源分配的最大爭議，始終是公立醫療和私營服務之間的角色平衡。而決定平衡的因素，將不會是空泛的公平原則，而是兩者相對的服務素質。公立醫療服務的輪候時間過長，市民就會往私營服務去尋找替代；私營服務的收費過昂，市民便往公立醫療處鑽。資源分配的過程中，也不需要太多的價值爭論。只要保持開放透明，素質成效就是最好的標準。

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醫療融資的抉擇

黃岐

香港政府在醫療政策的承諾，一言以蔽之是：「沒有人會因經濟困難而得不到適當的醫療照顧。」事實上，香港人的確不怕「有病沒錢醫」，公立醫院這張安全網基本上是可靠的。香港不是福利社會，但市民大眾早已認定基本的醫療服務是一種權利，是政府的責任。

問題是政府的承擔是否能長期維持。政府在醫療融資上面的負擔是與年俱增的，因為它要支持近九成的昂貴的住院服務作為最後的安全網。一九八五年時，政府在醫療方面的開支約佔社會總體醫療支出的35%，十年後它佔的比例已增至45%。看情形，政府的負擔只有愈來愈重。這包袱甚麼時候會壓折腰？

醫療費用支出愈趨龐大，國力強大如歐美諸國亦吃不消。克林頓總統第一任期內，由第一夫人親自抓改革還是焦頭爛額，可見醫療融資問題確不易解決。

從幾方面看，下一世紀本港的醫療融資處境會日漸緊迫。一是人口增長，總消費增加。二是社會發達，期望也愈高。同一毛病，在科技發達的國家，檢查項目比較貧窮地區的檢查繁多，這一來，人均服務使高速增長。三是人口老化。有研究顯示，六十五歲以上的老人，人均醫療費用比青壯年人多四倍。香港下一世紀人口老化迅速，醫療融資壓力肯定大增。第四，服務價格騰貴。醫療服務通脹率比平均通脹高，是世界性的現象。醫療愈專科化，分工愈細，人手密集亦令每一病床的成本劇增。

從以上各點看，下一世紀的醫療融資問題必須早為之計。

醫療融資的財源，不外稅收，保險金和市民自負。香港的公立醫療基本上是以稅收支付。經濟增長一旦放緩，稅收會減少，但醫療支出反而會增加，因為市民口袋褪沒錢，會更依賴價廉的公立醫療。香港政府一貫堅持維持低稅率，在增加稅收方面制肘頗大。

私人醫療保險，近年雖然有長足增長，但仍非主流。有了政府這張安全網，市民投保的意欲自然不高。很多發達國家，如加拿大、澳洲等，都有一套公營的醫療保險計劃，為醫療支出融資。前不久，台灣亦實施了全民健保。公營醫療保險，有規模的優勢，加上政府的財政支持，自有其優點。未來特區政府，大可考慮。目前政府想推出的用者自負策略，民間阻力甚大，就算通過亦只能是杯水車薪，無助於士局。

融資的方法，可變化多端，但萬變不離其宗，一定要解決以下的一些價值觀念的問題：

1. 市民有權得到的「基本」醫療照顧，應怎樣定義？
2. 政府對市民的津貼，應用怎樣的準則？市民自付的部分應怎樣釐定？在醫療服務方面，是否可以有「富戶政策」？
3. 醫療服務的設計，在公平、擇醫自由、價格控制和素質方面，如何取得平衡？價廉物美，人人平等並可有選擇的醫療服務，基本上是不可能的。

這些問題，都沒有標準答案。每一社會，都要經不斷的討論和調整，來達到共識，香港社會是否已準備好這場辯論呢？

(黃岐醫生是香港公立醫院醫生及專欄作家)

ETHICAL AND POLICY ISSUES IN THE PREVENTION OF HIV/AIDS IN CHINA

Ren-Zong Qiu

The first case of HIV infection was reported in China in 1985 and now reported cases of HIV infection amount to 2,428 including AIDS 77 from among 500 millions tests over 10 years. The HIV rate is still low considering China's population of 1.2 billion. It has been estimated that, by now, the actual number of cases should be between 100-200,000

Now the issue is: Does this low HIV prevalence show that our policy is adequate for preventing or controlling the HIV epidemic in China? The figure may only be the tip of the iceberg. Of course, many health professionals and social workers have done much work preventing and treating HIV/AIDS, but it does not mean that our experience is sufficient, or our policy is effective in deterring HIV epidemic, as inferred by Mr. Yuan Mu at the AIDS Congress at Berlin in 1993 when he stated "The relatively low HIV infection rate is associated with the preventive work and treatment in China."

A related issue is: Will China possibly become a high HIV-prevalence country like India or Thailand? At present, there are insufficient grounds for us to say that China will definitely become a country with a high HIV infection rate in the future. However, we have much less sufficient grounds for saying that China will never reach the stage. It is very probable for China to become a country with high HIV infection rate if we leave the current policy unchanged.

The reasons include: economic reforms associated with unprecedentedly large scale population movements, with 80-100 millions now travelling around the country with goods, services, information and diseases; proliferation of high risk behaviour such as intravenous drug use, prostitution and homosexuality which all foster HIV spread; presence of other STDs which facilitate the spread of HIV, the risk of iatrogenic spread through untested blood transfusion; the "sex revolution" with changes in patterns of sex behaviour and increased pre-and extra-marital sex, casual sex, multiple sex partners among the younger generation; population ignorance of the transmission mode of and protection against HIV; and the lack of appropriate ethical and legal atmosphere for effectively preventing the HIV epidemic.

The third issue is: Is our conventional public health approach sufficient to prevent or control an HIV epidemic? Since the Republic's founding in 1949, a number of communicable diseases, such as smallpox, diphtheria, typhus, cholera and plague have been successfully controlled. When the cases of HIV infection were detected in China, health professionals and programmers believed that they could take a conventional public health approach on a case-by-case basis to cope with HIV epidemic. But HIV infection is an epidemic so special that conventional public health measures such as testing, reporting, contact tracing, isolation may will be inadequate or ineffective to control the epidemic. HIV is often spread among those groups who are usually marginalized or stigmatized by society through behaviours both confidential or private. When physicians in the STDs clinics were required to ask the outpatients to fill a card with name and address, the number of patients coming to the clinics was dramatically reduced, and many of them went to quacks to ask help or treated the illness by themselves. Some of them had to return to the clinics with pseudo-name and pseudo-address.

The fourth issue is: Can effective policy of preventing HIV ignore ethical issues? Unfortunately many of health professionals and programmers bypassed ethical issues emerged in the prevention of the HIV epidemic. Even some health educators, sexologists and officials believe that "AIDS is the punishment for promiscuity". Such moral conception of disease has already proved wrong and harmful to the treatment and prevention of any disease, especially to HIV. When their positive serological status was disclosed, HIV patients faced the risk of being expelled from school or fired from working unit, even rejected for admission into hospital, and their rights to confidentiality and privacy were often infringed upon. If all these ethical issues cannot be properly treated, how can those persons at risk get access to information, services, education, counselling and techniques necessary to prevent HIV infection? One Chinese adage says: "You cannot have fish and also the bear's palm". In the prevention of HIV epidemic we have to balance the protection of public health and the safeguarding of individual rights.

Indeed, if we cannot safeguard individual rights, there will be no guarantee to protect public health.

Last but not least: For controlling HIV epidemic, do we need a penalising law or a supportive law? Some programmers argue that we need a supportive law to protect AIDS patients, HIV positive or members of high risk groups as patients, but we need a penalising law to deter their wrong behavious. The problem is how these two qualities (penalising and supportive) can be compatible? A small proportion of prostitutes (perhaps only one fifth or even one tenth) are arrested and put into Institute of Women Education, how about the remaining majority of them? They are driven underground and cannot get access to information, services, education, counselling and techniques necessary for the prevention of HIV infection. However, the law on prohibiting prostitution cannot be overturned for various reasons. The only solution at present is to appeal to NGOs to do more work on HIV prevention and education to the high risk groups and other individuals.

(Prof. Qiu is Professor of Chinese Academy of Social Sciences, China)

Advanced Medical Care in Japan: Ethical Debate Missing

Jiro Nudeshima（檜島次郎）

The state of advanced medical care in Japan is riddled with some unsettling contradictions. Because brain death, for example, is not recognized as the point at which death occurs, heart and liver transplants cannot be performed using organs taken from the brain-dead. Yet partial liver transplants from living donor relatives are much more common than in the West, with close to 400 such transplants performed in the seven-year period since 1989.

Another inconsistency can be seen in infertility treatment. Neither surrogate pregnancy nor donation of eggs is practiced. Sperm donation is performed only in a limited number of facilities. Yet the number of cases of in vitro fertilization is growing steadily; more than 18,000 procedures were performed in 1994, with close to 3,500 children born as a result. The microinjection of sperm, which is still in the experimental stage, has also increased dramatically; through the use of this technique, 670 children (from 4,000 attempts) were born in 1994.

In gene therapy, just two of the four applications submitted to the authorities for permission to perform gene therapy as of the end of 1996 have been approved. Of these two, only one patient is currently undergoing treatment. These figures stand in stark contrast to the 150 protocols performed in the United States, the clear leader in gene therapy. The UK and France, also active in this field, are currently performing at least ten protocols.

The applications of advanced medical practices reflect choices by Japanese doctors and the medical establishment at large. But the criteria for these choices have never been clarified. There is no expressed ethical reasoning for not allowing organ transplantation from the brain-dead, nor for the rejection of surrogate motherhood and egg donation. The only reason thus far offered is that "a social consensus has not yet been reached." As a result, no legal regulations for fertility treatment, genetic diagnosis, and gene therapy exist. The single encouraging development is that, according to the staffs of several Diet members, a bill will be passed by June of this year that will allow organ transplants from brain-dead donors. The bill has been in deadlock for years because of the appalling indifference and lack of precedent in these areas among lawmakers.

Sometimes, decisions to prepare advanced medical care procedures are based more on whether the subject in question has attracted the attention of the mass media than on any medical considerations. The clearest example of this can be seen in the prohibition of organ transplants from the brain-dead. Another example is the trial preimplantation diagnosis of an embryo at Kagoshima University. As soon as questions were raised in the press regarding whether life and death decisions based on genetic characteristics constituted an act of discrimination, the university and the Obstetrics Society have temporarily halted the procedure. In contrast, the microinjection of sperm–which has not attracted much media attention –has moved forward unhindered. If this approach continues unchecked, standards will never be hammered out. Unfortunately, Japan has contributed little or no original thought to the matter of bioethics.

TWO FUNDAMENTAL PROBLEMS

Two basic elements are required to ensure the appropriate supervision of advanced medical care practices. The first is a self-regulating system of the medical societies. Second, a supervisory and regulatory system for clinical trails must be in place because advanced medical care techniques are being used in clinical settings when still in the experimental stage. Unfortunately, both these elements are currently lacking in Japan, and their absence is a fundamental cause for the inconsistencies that have cropped up in the implementation and scope of Japan's advanced medical care.

Physicians in most countries in Europe are required to join professional societies. These bodies, including the Arztekammer in Germany, l'ordre des médecins in France, and the General Medical Council in Britain, are self-governing and officially recognized under the law. They have procedures for disciplining members, they set self-imposed limits on the scope of their practices, and they can warn, shut down, and expel members who violate the rules. Members who are dropped from the rolls of these organizations can no longer practice medicine. No similar self-governing body of physicians is in place in Japan. The Japan Medical Association is no more than a voluntary, self-interest organization that works for the benefit of its members. This trade union type of body also exists in western Europe, but it operates separately from the self-policing organizations.

Japan lacks a systemic foundation on which medical societies can be entrusted with their own self-government. Guidelines issued by medical societies in Japan do not carry sufficient weight and enforcement power. The Japan Society of Obstetrics and Gynecology, for example, has issued guidelines regulating areas like in vitro fertilization and microinjection of sperm, but not all physicians observe them. Even if someone is found in clear violation of these guidelines, no effective sanctions are levied against the violator.

The impetus to establish the principles of modern medical ethics can be traced to the desire to ensure the appropriate execution of medical testing involving human subjects, and it probably began with the Nuremberg Trial of Nazi physicians (1947) and the Helsinki Declaration (1964) issued by the World Medical Association. Yet no legal system has been established to govern clinical trials in Japan. The policies issued by the Ministry of Health and Welfare in 1989 covered only the protection of subjects in development trials for new drugs, and it has only been since June 1996 that adherence to good clinical practice in drug trials is required by law. Improvements have recently been implemented in the supervisory system for drug testing, but only in response to a series of incidents related to adverse drug testing, but only in response to a series of incidents related to adverse drug reactions and to external pressure to fall in line with international rules.

Advanced medical care, however, is not regulated within the framework of clinical trials; it is performed from the beginning under the category of "therapy." This practice raises a plethora of ethical questions. Rules governing the protection of subjects should be codified in an officially sanctioned committee system and evaluation standards to be used in the review not just of new drugs but also of clinical trials of all new medical technology. If this foundation is present, advanced medical care in all forms can be properly implemented. Awareness of this issue, however, by the general public and even in the medical community in Japan has been sorely lacking.

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This article is adapted from his paper "Biomedical Ethics in Japan: An Imperative" published in NIRA Review, Spring 1997.

MESSAGES 消息

1997年5月16日，"醫學的目的再討論"研討會在北京中國中醫研究院理論研究所報告廳舉行。邀請參加的單位有北京醫科大學、中國醫學科學院、中國預防科學院、中國中醫研究院、中國社會科學院哲學研究所、全國政協科教文衛體委員會、衛生部政策與管理專家委員會、國家中醫藥管理局政策法規司、中華醫學會、健康報社等。

呂維柏教授首先對 醫學的目的(Goals of Medicine)"的討論背景、主要問題及國際研究計劃作了情況簡介，美國哈斯廷斯中心發起的 醫學的目的"國際研究計劃，共有14個國家代表參加，我國是其中之一。中國中醫研究院教授呂維柏、北京醫科大學教授彭瑞聰、中國社會科學院哲學所研究員邱仁宗、中國協和醫科大學教授金大劼、中國中醫研究院教授陸廣華、孟慶雲都是GOM計劃中國組的成員。我國自參加GOM計劃活動以來，已經舉行了十幾次中國組討論會，在一些重要問題上與國際組織達成了共識。中醫以其投入少、效果好以及對健康與疾病、生與死、人與自然、宿主與病原體之間的關係認識上的獨到見解，引起國際組織的關注。

在專題發言中，金大劼教授認為，以往對付醫療危機的辦法都僅從經濟或政策的角度來探討，忽視了對醫學目的的探討，這是不夠的。金大劼教授還就現代醫學存在的主要問題和困難；現代醫學存在的問題與醫學目的的關係等問題進行了論述。

彭瑞聰教授認為，在醫學目的的討論中應注意 把醫學與公共衛生結合起來；將治療與照料放在同等地位；以及正確對待死亡"這三個重要問題。

邱仁宗研究員在報告中對醫學的目的與衛生方針政策的關係，對健康的積極定義、消極定義、功能定義及狀態定義以及對醫學把很大的費用花費在避免死亡等問題上闡述了自己的觀點。

北京市醫院管理研究所的黃慧英以 北京公療大額死亡病例的資源消耗"為題就臨終醫療問題進行了個案分析報告。她提出一條意見：1、急重症病人的治救應着重於生命質量；2、對有缺陷的公療的全方位改革，除了引進個人承擔部分費用外，還應加強預防和家庭保健，引人科學的預後預測。3、對公療高投入的搶救應有適應症。還有幾位北京的臨床醫師通過對神經管畸形病例的分析、對哮喘及銀屑病的治療管理問題的個案分析來說明醫學的目的。

陸廣華、孟慶雲以 醫學目的的討論與中醫學"為題做了發言。巴德年、陳春明、顧瑗以 醫學目的與科研、醫療保健服務"為題做了發言。

(中國社會科學院翟曉梅供稿)

《徵求會員》

香港生命倫理學會在九六年底成立，目的是推廣本地及華人社區對生命倫理的關注。學會現公開招收會員，誠邀對生命倫理有興趣的朋友加入。有興趣者，請與學會秘書余錦波聯絡。

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EDITORIAL NOTE 編者的話

本期的主題是「醫療政策」。醫療政策與生命倫理有甚麼關係？有論者曾指出，醫療管理範圍內，有所謂「矛盾之管理」(management of paradox)，這與醫療倫理學者處理的「兩難的紓解」(resolution of dilemmas) 恰恰可以接頭。[1] 這一期的主要文章處處反映了這些paradox與dilemmas。香港的馮康醫生與黃岐醫生分別探討了「公平」、「醫療權利」與「融資有限」之間的矛盾；分析了改善公營醫療危及私營服務的兩難。邱仁宗教授提出HIV及愛滋病的公共衛生控制與病人權利的衝突。Jiro Nudeshima報道了日本在應用新醫療與實驗性治療時政策上的矛盾現象。各篇文章共通的是對醫療與生命倫理課題深入討論的寄望。醫療政策是公共政策。公眾怎樣才能參與其中的倫理討論？

[1] Marinker M (ed.) (1994) Controversies in Health Care policies, P.23, BMJ.

預告…

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