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Health Care System 醫療保健制度

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FEATURE ARTICLES 專題文章

❤ Canada's Universal Health Care

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Historical Background

To understand Canada's health care system, one should understand the Canada Health Act 1984, and events that led to its establishment. The BNA (British North American) Act of 1867 and the Constitution Act of 1982 defined the responsibilities for the federal and provincial governments in regard to health care in Canada. National health concerning quarantine, marine hospitals, and health services for natives and the armed forces belonged to the federal government. Local health matters relating to hospitals, asylums and charities are provincial responsibilities.

Universal health insurance was first proposed in 1919. Instead of establishing a full health insurance plan, the federal government funded the provinces in building hospitals through the Hospital Construction Grants Program (HCGP). As a result of this program, there was a rapid expansion of hospitals over the next 12 years. The number of hospital beds increased at double the rate of the expansion in population resulting in a surplus of beds. By 1950, provinces like Saskatchewan, British Columbia and Alberta all enacted universal hospital insurance plans. Other provinces then followed. In 1957, the Hospital Insurance and Diagnostic Services Act (HIDS) was passed.

Prior to 1957, Canada had a hybrid prepayment system consisting of both private and public plans: provincial medical and hospital coverage for low income individuals, universal hospital insurance provided by a number of provinces, private medical and hospital insurance on a non-profit basis.

The downside of the HIDS was that funds were granted only to hospital-related expenses. There was no incentive to use less costly sites (e.g. home care). There was no accountability of the funds required, which created disincentive for efficiency. The result: the number of in-patient beds increased by a further 34% from 1960 to 1970, while the Canadian population increased by only 19 percent.

The Medical Care Act of 1966 (implemented in 1968) provided federal-provincial cost-sharing for services provided by physicians only. To qualify for funding, a province's program had to be: universal – it had to cover all residents of a province; portable – it had to cover residents of one province requiring medical services in another province; comprehensive – it had to cover all medically necessary services; and publicly administered – a non-profit program. By 1971, all provinces and territories participated.

Hospital costs continued to escalate because the provinces had no incentive to control costs and the federal government had no control over total provincial expenditures.

The Canada Health Act

In 1984, the Canada Health Act (CHA) was passed, which captured the bulk of requirement of the earlier 1966 Medical Care Act. Federal payments to the provinces would be reduced by the amount of user charges by hospitals and extra billing by physicians. The five federal guidelines for grant: universality, accessibility, portability, comprehensive and publicly administered, were enshrined as principles in the Act. Provinces that fail to conform to these conditions would risk cash withholding from the federal government as penalty.

Universality requires that 100 percent of the residents of a province be entitled to insured services. Accessibility means that all residents are entitled to equal access regardless of sickness, age, gender and income. Portability means that it has to cover residents of one province requiring medical services in another province. Comprehensive means that it has to cover all the medical necessary services. The plan has to be publicly administered by a non-profit administration.

Medicare in Canada is actually made up of 12 interlocking provincial and territorial plans. In 1991, Canada spent 66.8 billion on health care – 2474 per person. One out of ten dollars in the Canadian economy pays for health care costs. One third of provincial budgets and an increasing share of employer expenses are on health care. Over 70 percent of health care in Canada is financed through public expenditures. The remaining 30% come from private sources. This ration of public-to-private health expenditure is similar to that of other industrial countries. (*Canada Year Book* 1997)

Widely regarded as quintessentially Canadian, the Health Care system is passionately supported by Canadians from all walks of life. It is a system based on health needs, not a competitive system to serve the health market. The system is based on a single-payer system. For the most part, the government is not the provider of care. It pays for the services provided by nonprofit organizations or by doctors working on a fee-for-service basis. The single-payer system reduces administrative costs, and hence makes health care cheaper, and also provides a coherent management of services. The United States covers only the elderly, the very poor, the military and some of the disabled. At any three months within a year, there are tens of million of Americans uninsured, while all Canadians are medically covered all time of the year. The single-payer

system also enables equal access regardless of wealth through a one-tier system. It is not possible for the rich to purchase quick access or preferred services. (Armstrong and Armstrong 1998)

There has been a steady decline of federal financial support for health care since the late 1970's. In 1995, the federal government announced that it would cut federal transfers to the provinces further. As federal funding decreases, these funding arrangements become less and less binding. The provinces find themselves with more freedom to reform their health care system.

In 1994, the Canadian government formed a National Forum on Health to examine the current state and future possibilities of the health system. The Forum published its report : *Canada Health Action: Building on the Legacy* (Vol. I & II, 1997), which contains recommendations for reform.

Canada Health Care in the OECD context

How does the Canadian system perform compared with other OECD nations? There are several observations, especially offered by those who advocate more privatization of the health care system:

(1) The percentage of gross domestic product spent by OECD countries on health varies considerably. As of 1992, Denmark spends 6.7 percent of its GDP on health care while the U.S. spends 14.1 percent, yet life expectancies of the two countries are quite the same. Japan spends 7.3 percent, yet its population enjoys the longest life expectancy: female at 82.2 and male for 76.1. Canada spends 10.2 percent, life expectancy for female is 81.2 years and for male is 74.9 years. These data may help to support the claim that higher health expenditure does not necessarily create a healthier population.

(2) Publicly funded and controlled health care system is not necessarily the most efficient and effective way to ensure quality health care. Japan, New Zealand, and the U.K, all have good health care systems, spend less than 8 percent of their GDP on health care, while Canada and the U.S. spend more than 10 percent of their GDP. Canada public expenditure on health care (more than 7 percent of GDP) exceeds those of the U.K., Australia, and New Zealand in 1993.

(3) Increase the proportion of private health providers does not necessarily harm the patients. In Canada, hospital accounts for about 38 percent of health care expenditures, and 75 to 80 percent of their costs are staffing costs. Japan has staff-to-bed ratio of 0.8, the U.S. has ratio of 3.6 and Canada has 2.8 staff per bed. In terms of acute bed per 1000 people, Canada has 3.9 beds per 1,000, which is slightly more than half of those of Germany, and New Zealand. (1991 figures)

Canada, along with a few OECD countries, has less than 5 percent of the private hospital beds. In most countries, private hospitals play a key role in care provision: Belgium 61.8 percent, Germany 47.8 percent, France 36 percent, U.S. 81.6 percent, Australia 39.1 percent, and New Zealand 35.5 percent (1993 OECD data). Private hospitals are run like a business that aims at efficiency and profit, they are only accessible by those under private insurance plan.

Criticisms of the Health Care System

Critics charge that the government as a result of ill-defined problems based on half-truths, has proposed ill-conceived solutions to the reform of health care in Canada. These include cutting health care expenditure, closing hospitals, cutting the number of hospital beds, restricting hospital billing numbers and prohibiting private clinics etc. Pro-market critics advocate the increase of privatization of health care.

Critics allege that the major weakness of the Canadian Health Care system is its lack of competitiveness. The result of the bureaucratic, central planning and over-protective nature of the present system creates expensive, unresponsive and wasteful health care system. They urge that the centrally controlled and regulated system should be properly reformed to make it more competitive and responsive. (McArthur et al 1996, pp. 163-164) That the system needs competition is beyond question, the problem is how to introduce it without compromising the quality of care to its citizens.

Furthermore, another main focus of recent debate about health care is on the CHA: whether adhering to its principles makes Canadian healthier, or give more flexibility of the health care system to adapt to new circumstances. Many regard the CHA as the core of Canadian health care system, while others see it as impediment to provincial changes that needed to respond to new needs. Some argue that there should be an increased role of private clinics and health providers. Others advocate abandoning the Act for more relevant alternatives.

References

Armstrong, Pat and Hugh Armstrong 1996, *Wasting Away: the Undermining of the Canadian Health Care*, Don Mills, Ontario: Oxford University Press.

Armstrong, Pat and Hugh Armstrong , with Claudia Fegan, 1998, *Universal Health Care: What The United States Can Learn From the Canadian Experience*, New York: The New Press.

Evans, Robert G., 1993, "Health Care in the Canadian Community," in *Looking North for Health: What we can learn from Canada's Health Care System*, eds. Arnold Bennett and Orvill Adams, San Francisco: Jossey-Bass Publishers, pp. 1-27.

McArthur, William, Cynthia Ramsay, Michael Walker eds., 1996, *Healthy Incentives: Canadian Health Reform in an International Context*, Vancouver, B.C.: The Fraser Institute.

Health Canada Web page.

❤ 香港醫療制度的融資問題

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香港醫療制度的融資安排與改革

很多人相信，由於深受唯古典資本主義的影響，香港政府一直奉行對市場經濟不作干預的政策。這個看法其實並不準確。雖然政府在社會保障的開支不算高，對資本流動、商品流通和勞務市場等運作甚少作出干預，但是，政府在住房、教育和醫療方面擔當一個積極的角色，並作不少的投資 (Wilding *et al.*, 1997)。

香港政府於 1974 年 7 月發表的《香港醫療衛生的進一步發展白皮書》已確立不應有人因經濟原因而得不到適當的醫療服務的政策。現時，公立醫院的每日住院費用為港幣 68 元，只佔平均成本 2-3%。按1996 年人口中期普查，一般家庭 (以 3.3 人計算) 的中位月收入為 17,500 元。這樣低的住院收費對絕大部份家庭不會構成嚴重負擔，而政府亦豁免有經濟困難人士 (如領取公共援助人士) 的住院費用。所以，本港公共醫療服務的財政能及度 (financial accessibility) 是極之高的。

目前，香港 92% 的住院服務是由政府醫院提供 (何濼生，1997，p.28; Tse, 1998)。但是，醫療整體支出只佔本地生產總值 4.81%，許多發達國家在這方面的支出比例約為 7-10% (美國約為 15%) (Langan, 1998, p. 39)。公共醫療支出僅佔本地生產總值 2.16%，比私營醫療支出所佔的 2.65% 還要少 (何濼生，1997，p. 4)，許多發達國家的公共醫療支出佔本地生產總值 5-7% (Langan. 1998, p. 39)。雖然香港醫療支出這麼低，但是，不少指標顯示香港醫療服務質素不斷提升，並且已達到相當高的水平，例如，香港人的平均壽命比美國人高，而嬰兒夭折率亦比美國低 (Tse, 1998)。

香港政府一直有效地控制公共醫療支出開支的增長。雖然政府的一貫理財原則是容許公共開支有實質增長，但是，這個增長要基本上與本地生產總值的增長同步。另一方面，政府亦把公共醫療開支在公共開支所佔的比例盡量維持在一個固定水平。公共醫療開支一直有持續的實質增長，過去十年的平均實質增長速度為每年 7.8% (Tse, 1998)。這個增長主要是由香港經濟發展所帶動，速度與本地生產總值的增長速度差不多。公共醫療的開支仍然一直維持在本地生產總值約 2% 的低水平，而公共醫療支出在公共開支中所佔的比例亦十分穩定。經常性公共醫療支出在整體經常性開支中所佔的比例，只是從 1990/91 的 13.1% 增加至 1996/97 的 14.5%，而公共醫療的總體開支 (包括經常性開支) 亦能維持在政府整體開支 11-12% 水平 (Tse, 1998)。

然而，財政能及度、醫療服務質素與財政負荷能力三者關係往往是不一致的。極高之財政能及度和不斷提升的醫療服務質素，自然會令到本港公共醫療系統負荷過重。香港政府一直希望透過提高效率和減低浪費以紓緩公共醫療服務的需求壓力，但是，香港的醫療開支比例遠低於其他發達社會，90% 以上的醫院服務要由只佔本地生產總值約 2% 的公共醫療開支承擔，公營醫療部門的負荷十分重大，所以，這種紓緩壓力的方法是有一定的極限。隨著人口逐漸老化，醫療科技所帶來的成本上漲，和公眾對醫療服務水準的期望越來越高 (香港政府，1993)，公營醫療部門的財政負荷只會不斷增加。據估計，至 2010 年，公共醫療的開支佔政府整體開支的比例將會增加 50%，至 2016 年，這個比例將會是現時的比例的兩倍 (SCMP，8/12/98)。由於財政能力有限，政府認為這個增長速度會阻礙其他公共服務的發展。

為了解決公共醫療體系財政負荷問題，便要改革醫療制度的融資安排 (financial arrangement)，改革方向離不開採取以下幾個方案：

(1) 增加稅收；
(2) 增加醫療服務收費；
(3) 強制式醫療儲蓄計劃；
(4) 自願或強制式醫療保險計劃；
(5) 醫療保健組織 (HMO) 制度。

簡單地說，以上方案均會直接或簡接地令市民把更多的資源投入醫療服務，因而增加公營醫療部門的投資/收入，或者將有較強支付能力的病人分流到私營部門去，所以，以上任何一個方案均會對社會整體醫療服務的分配有深遠影響。因此，醫療融資改革要以社會公義原則作為指導，改革的目標不應純粹為了減輕公共醫療系統的財政負荷。如果這個是改革的目標，政府為何不向醫療服務的使用者收取相等於服務成本的費用呢？這個做法不是可以令公共醫療系統的財政負荷減至零嗎？我們不贊成這個做法，是由於有不少人會因為不能支付昂貴的醫療費用而得不到足夠的醫療服務，而這是有違社會公義的。不論在 1974 年發表的白皮書還是在 1993 年發表的諮詢文件，政府一再強調醫療政策的首要原則是不應有人因經濟原因而得不到適當的醫療服務。哈佛顧問團提交了研究報告後，政府還一再肯定這個合乎公義的原則 (SCMP，8/12/98；文匯報，8/12/98；明報，8/12/98)。所以，任何醫療融資改革方案均不應與這個原則相違背，反而要令公共醫療系統更有效地履行這個原則。

醫療融資改革可帶來的道德危險

為著紓緩香港公營醫療部門的財政壓力，政府無可避免要向市民的口袋打主意。加稅未必受歡迎，因為病人得到的服務並不與他們所繳付的稅項掛鉤，所以，有不少人主張採納 (3) - (5) 的供款計劃，以增加病人的支付能力，從而減輕公營醫療部門的財政壓力。但是，他們似乎沒有留這些計劃所帶來的道德危險問題 (moral hazard problem)。

強制式醫療儲蓄計劃：這個未雨綢繆的計劃可以增加個人支付醫療費用的能力，如果強制僱主一同供款，更能進一步強化病人的支付能力。如果社會以強制式醫療儲蓄計劃來承擔醫療成本，醫療費用便由個人負責，我們會更加注意個人的身體健康，採納健康的生活方式，和不會濫用醫療服務。但是，這個計劃有不少缺點。第一、有些人在未儲蓄足夠金錢時，便要付出一大筆醫療費用。第二、儲蓄計劃只是要求個人負責自己的醫療費用，沒有分擔風險 (risk pooling) 的效應。亦即是：當一個人健康的時候，他的供款不會被調撥來協助支付其他病人的費用；反過來說，當他自己生病的時候，他亦只可以依靠自己的儲蓄。所以，低入息人士的儲蓄能力自然偏低，他們面對的醫療風險便十分高。第三、新加坡的經驗顯示，由於缺乏分擔風險效應，很多人還是依賴自願醫療保險或政府資助的服務，所以，只有低於 10% 的醫療開支是由儲蓄計劃支付。

自願或強制式醫療保險計劃：由於投保人透過繳付保金分擔醫療風險，他們患病時便可以獲得所需要的昂貴服務。當然，進一步發展香港的醫療保險市場，有助更多比較富裕人士轉向採用私營醫療部門提供的服務，自然有助減輕公營部門的負荷。但是，我們不應該以醫療保險計劃作為支付社會整體醫療成本的主要機制，美國醫療制度出現的種種問題，顯示這個融資安排有不少缺點。首先、由於保險公司以第三者身份向醫療服務提供者支付病人 (投保人) 的費用，服務提供者與病人均沒有強烈動機防止濫用醫療服務和濫收醫療費用，醫療開支便會急速上升，這個現象稱為「第三者償還」(third party reimbursement)。其次、投保人總是希望承保的範圍和保額愈大，但是，保險公司又常常沒法區分高風險與低風險的客戶，而願意買保險的人往往會經常使用醫療服務，所以，保險費用自然會被提高，這個現象稱為「逆性選擇」(adverse selection)。另一方面，有一些人 (如長期病患者) 卻很容易被保險公司分辨出為高風險人士而被拒諸門外。最後，透過集體保險計劃，例如，由僱主為僱員安排集體購買保險，甚至立例強制要求所有僱主承擔這個責任，有助解決逆性選擇問題。

因為，集體投保的客戶中有不少是低風險人士，保險費用自然可以減低。但是，集体保險計劃仍不容易為在小型企業的僱員、自僱、沒有固定工作，或從事危險工作人士、老年人，和長期病患者等提供足夠的照顧。保費高的人士亦可能受到歧視，難以找工作或成為解僱對象。

醫療保健組織 (HMO) 制度：簡單地說，醫療保健組織既是承保人又是服務提供者，所以，這個制度有助解決第三者償還問題。由於保健組織對所提供的服務範圍有嚴格限制，逆性選擇令到保險費用上升的壓力可以得到紓緩。但是，HMO 制度並未能解決醫療保險制度所帶來的其他問題，還會產生一個「合法性問題」(legitimacy problem)。市場競爭令到保健組織要壓抑醫療成本的增長，它們因而會拒絕為病人提供某些服務，所以，保健組織實際上成為一個醫療服務配給機制。由於資源限制，公營部門無可避免要把服務配給病人，但這個過程是受到政府與公眾監管；保健組織的配給決定卻是商業性，難以監管，而追逐最大利潤的目標亦大大限制醫護人員的專業自主性，難以全面照顧到病人的基本需要和社會整體利益。

香港醫療制度的融資改革不宜操之過急

香港政府最近似乎誇大了醫療融資問題的嚴重性。香港公共醫療支出只佔本地本地生產總值 2.16%，而許多發達國家的公共醫療支出佔的比例為 5-7%。但是，香港 90% 以上的醫院服務是由公共醫療部門承擔，這不是奇蹟嗎？除了這個數據外，正如前文所述，還有不少其他指標顯示這個系統的效率是相當高。亦有數據顯示新移民的不斷增加抵消了人口老化的影響。再者，醫療器材與藥物佔經常性開支的一個很低的比例 (9.3%)，醫療科技不會是令到成本上漲的主要因素。所以，不少人似乎誇大了公共醫療系統財政負荷問題的嚴重性 (Yuen, 1998)。美國推行 HMO 制度是他們醫療體制差不多受保險制度拖跨，亦有種種因素令其公營醫療部門不可以成為醫療制度的骨幹，但是，香港有其特殊歷史文化背景，所以不可以把別人的制度照搬過來。特首董建華不是常常說他保守穩健，而英國保守黨過去亦不是沒法剷掉國家醫療系統 (NHS) 嗎？所以他不應操之過急，鬧醫療「革命」。

或許政府透過內部資源調撥，重整公營醫療部門各項開支的比例以增加效率，訂定基本服務範圍，避免資源浪費在不必要項目上，和改革現時收費制度，甚至稍微增加稅收，已可以紓緩公營部門的財政壓力。

(本文曾發表於《思》第 61 期 (1999 年 5 月，香港基督徒學會)，此次發表曾作若干修改。)

參考書目

何濼生 (1997)，《醫療改革的經濟分析》，香港：商務印書館。

香港政府 (1974)，《香港醫療衛生的進一步發展白皮書》，香港：香港政府印務局。

香港政府 (1993)，《促進健康諮詢文件》，香港：香港政府印務局。

明報 (8/12/98)，〈醫療融資倡設基金觸礁〉。

文匯報 (8/12/98)，〈醫療十年後佔公共開支兩成〉。

(SCMP) South China Morning Post (8/12/98), "Patients Will Have to Pay in Overhaul -Health Chief".

Tse, Nancy(1998), "Counting the Cost of Health", *Hong Kong Standard*, 30 March 1998.

Yuen, Peter P. (1998), "To Change or Not to Change: A Review of Health Care Financing in Hong Kong", *Asian Hospital, Third Quarter in Review, 1998*, pp. 26-28.

REPORTS 報告

❤ The 120th Xiang Shan Science Conference on " Problems and Challenges of Bioethics in the 21st Century" - China's Bold Step Forward

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When some of China's finest scientists and philosophers came together to meet in Kunming in August this summer to discuss what would be the *criteria for right action in science and in bioethics in the next millennium*, it came close to what Aristotle had described as "an activity of excellence in the exercise of reason" to search for what is the good for human beings.

The meeting was a 3 day conference from 16th to 20th August 1999. It was initiated, organized and sponsored by the Chinese Academy of Sciences with support from the State Commission on Science and Technology. It marked the one hundred and twentieth meeting of the highly regarded national Xiang Shan Science Conferences in mainland China. The idea of the Xiang Shan Science Conferences was first conceived by the State Commission in 1992 and was subsequently launched as a collaborative project in conjunction with the Chinese Academy of Sciences in 1993. Since its first inaugural meeting held at Xiang Shan in Beijing, Xiang Shan Science Conferences have met for one hundred and nineteen times already and have become a symbol and a major forum for open exchange of ideas and free debate of issues in science and technology to promote human development.

The special significance of the Xiang Shan Science Conference held in Kunming in August this year was that it was an invitation initiated and extended by scientists to philosophers and social scientists to establish a dialogue for cross discipline exchange to search for understanding and response to problems and challenges in the field of bioethics in the 21st century. It was a conference with a futuristic outlook and a broad vision. The 3 day conference focused on 3 highly significant themes:

(1) The Human Genome Project and its Challenge to Ethical Issues in Genetics in the 21st century
(2) Third Party Assisted Reproduction and its Implications for Moral and Legal Considerations
(3) Cloning and Ethical Problems of Cloning

The conference has invited approximately 40 participants from all over China, two of whom were from Hong Kong. They are academics, researchers, practitioners, administrators and professionals from a diversity of backgrounds including medical colleges, universities, human reproductive engineering laboratories, national research institutes for family planning, national centres of genetic medicine, philosophy institutes, centres for bioethics, medical ethics societies and professional associations.

The most senior participant at the conference is a woman director of the National Research Institute for Family Planning in Beijing who is also a Fellow of the Chinese Academy of Sciences. She received her medical training at St. John's University in Shanghai in the 1920s and is now 76 years old. Her modest outlook and humble manners were reminiscent of those of an ordinary village peasant woman in rural China. But every time when she spoke, she was immediately transformed into someone who is a 26 year old blooming intellectual, her voice rich and sonorous, her mind sharp and agile. She spoke on many issues with critical self-awareness and she urged for undogmatic solutions based upon sound

ethical reasoning. She also advocated a bottom-up approach to initiate policy developments and to set up self-regulatory mechanisms in China at the grassroot level, calling for a more proactive and leadership role by professionals and intellectuals in the policy change process. Her presence exemplifies the true spirit of the scientific tradition, the spirit of unassuming inquisitiveness and undogmatic frame of mind.

The choice of Kunming for holding the conference is itself a thoughtful decision since one of China's two Institutes for Zoology where cloning research is being conducted is located in Kunming, the other one being in Beijing. The directors of the two Institutes of Zoology were both key paper presenters at the conference. They represent two generations of scientists in China, one well-established and bordering on retirement age, the other young and upcoming. Notwithstanding the generation gap, they share a common respect for science and for human rationality which is almost contagious. In their papers, they both underscored the point that as our power expands and increases, the more urgent it becomes for us to guide our decisions and interventions in the course of human evolution by deep and continuous reflections on questions about: What is human nature? What is the nature of being human? What is the boundary between human and non-human? The poignancy and the cogency of both of their presentations reflect how breakthroughs in biomedical sciences and unprecedented bioethical problems have gripped the Chinese consciousness today.

The 3 day conference covered many grounds and interests. On one level, the conference explored foundational questions such as: How to characterize the relationship between science and morality? How to understand the nature of philosophical inquiry and scientific inquiry? How to define rationality? On another level, it debated fundamental issues such as: What should be the limits of freedom and responsibility? How and when is state intervention justifiable? Is human dignity a defensible notion? The openness of the debates and the liberal mindedness of the participants reassure faith that the tradition of free spirit of inquiry is very much alive in today's China.

The success of the Kunming conference is due no less also to the dedication and foresight of a group of highly committed philosophers who have been devoting themselves to promote research, discussion and awareness of bioethical issues at different levels in China over the past decade. Their philosophical enterprise represents an important force of critical self-reflection in the Chinese society, foundational to the continuous self-renewal of its immensely rich culture. Their philosophical inquiry upholds the pursuit of reason as a human activity in two directions: the direction of theoretical reason aimed at determining truth; and the other direction of practical reason aimed at determining what is good. Their philosophical deliberation contributes to awareness of the value-laden nature of human decisions, and hence the importance of subjecting our decisions to critical questioning at all times. They demand us to aspire to sound arguments and to persuade always with reason.

Notwithstanding the success of the Kunming conference, it is however important to bear in mind that the nature of philosophical ethics is practical. In other words, the aim of philosophical ethics is always philosophical inquiry "to make practical difference". Philosophical ethics must always have an eye to a practical end. The practical end is the good for human beings. As Aristotle has reminded us that in the realm of ethics, "We are inquiring not in order to know what virtue is, but in order to become good, since otherwise our inquiry would have been of no use."

Good men and good women that they were, those who gathered in Kunming to deliberate about what is the good for human beings. But they must also bear in mind that the end of philosophical deliberation is not knowledge but action. Philosophical ethics must have an eye to a practical end which will "make a difference". The good men and good women in the mainland will no doubt still have a long way to go to achieve the practical end to attain the good to make a difference to the way we live our lives. But they have already taken one big bold step forward in the direction of the good.

When will the good men and good women in Hong Kong take their stand with their counterparts in the mainland ? When can we expect them to take a similar bold step forward to join together to bring to bear on the many bioethical issues that challenge us, the full strength and wisdom of their divergent backgrounds, as well as to appreciate with full awareness the increasing urgency of these challenging issues as we step into the 21st century? Do we have to wait long? How long?

❤ Second Sino-German Interdisciplinary Symposium on Medical Ethics in China

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The second Sino-German Interdisciplinary Medical Ethics Symposium was held in Shanghai Second Medical University, Shanghai from 19-23October, 1999. The theme of the symposium was Medical Ethics in Clinical Medicine, Medical Theory and Research and in Medical Education. Sponsored by the Dr. Helmut Storz Foundation and the Heinrich-Boell Foundation, and co-organized by Institute of Asian Affairs in Hamburg, Germany, the Chinese National Human Genome Research Centre at Shanghai, and the Shanghai Second Medical University, this symposium is the sequel to a symposium held in Hamburg in 1998. Some forty scholars from Germany, the US, Canada, New Zealand, Taiwan, Hong Kong, Beijing, Dalian as well as local universities and institutes participated.

Some forty papers were presented under various sub-themes: major ethical issues in medicine, ethical aspects of guiding clinical medicine, ethical issues of medical theory and research, cultural and educational issues in medical ethics, issues of medical ethics in life, death and society, the role played by World Health Organization in the development of medical ethics. One day was devoted to case discussion with 10 cases relating to the ethics of human reproduction, genetic counselling and artificial abortion, well-bear and well-rear in family planning; ethics of geriatric medicine and psychiatric medicine, terminal care and euthanasia; collection, research and protection of genetic resources. The conference was concluded with a key-note speech by the veteran bioethicist Qiu Renzong, who spoke on the role medical ethics could play in transforming Chinese society.

Conference participants were offered the opportunity to visit the newly established National Human Genome Center at Shanghai. In addition to this center, there is another Human Genome Center in Beijing. Together, these two centers are responsible for sequencing and mapping of 1% of the Human Genome Project, which is projected to be completed in 2002, 3 years ahead of the original schedule.

MESSAGES 消息

Forthcoming International Bioethics Conferences

World Conference on Bioethics
Organizer: International Society of Bioethics
Date: 20-24 June, 2000
Place: Gijón, Spain
Website: http://www.bioetica.sibi.org/index2.html

Second World Congress of Philosophy of Medicine
Organizers: European Society for Philosophy of Medicine and Health Care; Central and East European Association for Bioethics; Department of Philosophy and Bioethics, Jagiellonian University, Cracow, Poland
Date: 23-26 August, 2000
Place: Cracow, Poland
Theme: Human Heathcare: Sciences, Technologies, Values
Website: http://www.uj.edu.pl/confer/philmed00

Fifth World Congress of Bioethics
Organizer: The International Association of Bioethics
Date: 21-24 September, 2000
Place: Imperial College, London
Theme: Ethics, Law and Policy
Website: http://www.uclan.ac.uk/facs/ethics/fifthcon.htm

Eighth International Congress on Ethics in Medicine
Organizers: Ben Gurion University of the Negev, Israel; Beth Israel Medical Center, New York (The Albert Einstein College of Medicine); Center for Jewish Medical Heritage, Tel Aviv, Israel; British Institute of Medical Ethics, London; and Karolinska Institute, Stockholm
Date: 5-9 November, 2000
Place: Beer-Sheva, Israel
Theme: Ethics Across Cultures, Eras and Borders
Website: http://www.teumcong.co.il/ethics/index.htm

《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，或從本會網址下載入會表格。

http://logic.csc.cuhk.edu.hk/~B086712/bioethics.htm

預告…

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