

RESEARCH REPORT
PREPARED FOR
FOOD AND HEALTH BUREAU

**Survey on Healthcare Service
Reform 2008**



Prepared by
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Chapter One Introduction

The Social Sciences Research Centre of the University of Hong Kong (SSRC) was commissioned by the Food and Health Bureau in June 2008 to conduct a survey to canvass the general public's views on healthcare service reform. In particular, whether they are supportive of, or have any concerns over each of the following reform proposals:

- Enhance primary care to put greater emphasis on preventive care, reduce the need for hospital care, and improve the health of the community in the long run.
- Promote public-private partnership in healthcare to provide more choice of quality, efficient and cost-effective services and enhance health competition and collaboration between the public and private sectors in providing healthcare services.
- Develop electronic health record sharing to allow individuals' health records to follow them wherever they go for healthcare in improve the quality of healthcare for the public and provide the necessary infrastructure to support the healthcare reform.
- Strengthen public healthcare safety net to retain and improve the currently public healthcare safety net for the low-income families and underprivileged groups, while strengthening the safety net for patients stuck by illness requiring expensive healthcare.
- Reform the current healthcare financing arrangements to introduce supplementary financing apart from government funding, in order to sustain the level and quality of healthcare services and to sustain the above reforms on a long-term basis.

Chapter Two Survey Methodology

2.1 Survey Design

Survey data were collected through telephone interviews from 3rd to 14th July 2008. A structured questionnaire was used to collect information from the target respondents. All telephone interviews were conducted using the CATI (Computer Assisted Telephone Interview) system. Interviews were conducted in Cantonese, English or Putonghua.

A random sample was drawn from 30,000 residential telephone numbers. These numbers were generated from the latest English residential telephone directory by dropping the last digit, removing duplicates, adding all 10 possible final digits, randomizing order, and selecting as needed. The Chinese residential telephone directory was not used because the total number of listed telephone numbers was less than that in the English residential telephone directory. This method provided an equal probability sample that covers unlisted and new numbers. In addition, it would have a lower response rate than pure directory sampling, but unlike pure directory sampling, it would cover ex-directory and new numbers.

Where more than one eligible person resided in a household and more than one was present at the time of the telephone contact, the 'Next Birthday' rule was applied to each successful contacted residential unit, i.e., the household member who had his/her birthday the earliest was selected. This reduced the over-representation of housewives in the sample.

2.2 Target Respondents

The target respondents for the telephone interviews were all adults of age 18 or above and able to speak Cantonese, Putonghua or English. Foreign domestic helpers were not included.

2.3 Questionnaire

A bilingual questionnaire was designed by the SSRC and approved by the Bureau. Most of the questions were closed-ended and anticipated responses could be coded numerically.

2.4 Pilot Survey

Two weeks before the actual survey, a pilot survey of randomly selected households was conducted to test the questionnaire and to identify any problems prior to the survey proper. Results from the pilot survey were not included in subsequent compilation and analysis of the main study.

2.5 Enumeration Result

A total of 14 547 telephone numbers were attempted. However, 3 075 households were not available at that time, 525 households refused and 193 answered only part of the questionnaire. An unanswered telephone number was tried at least 5 times before classifying as non-contact case, including one contact attempt in day time to eliminate the business telephone numbers in non-contact cases.

Ultimately, a total of 1 118 respondents were successfully interviewed by using the CATI in the survey. The contact rate was 40.4%¹ and the overall response rate was 60.9%². Table 2.1 shows the detailed breakdown of telephone contact status.

Table 2.1 Final status of residential numbers attempted

Type	Final status of contacts ³	Number of cases
1	Success	1 118
2	Drop-out	193
3	Refusal	525
4	Language problems	72
5	Not eligible aged under 18	27
6	Business lines	861
7	Not available	3 075
8	Busy tone	280
9	No answer	3 117
10	Fax/data lines	544
11	Answering machine	3
12	Invalid number	4 732
TOTAL		14 547

¹ Contact rate = the number of answered telephone calls divided by the total number of calls attempted, i.e. from Table 2.1, Sum of (types 1 to 7) / Total = (1 118+193+525+72+27+861+3075)/(14 547) = 40.4%.

² Response rate = the number of successful interviews divided by the sum of the numbers of successful interviews, drop-out cases and refusal cases, i.e. from Table 2.1, (type 1) / (type 1 + type 2 + type 3) = 1 118/(1 118+193+525)=60.9% (type 7 “Not available” cases are not included because eligibility has not been confirmed).

³ ‘Drop-out’: eligible respondents who initially accepted the interview but failed to complete the interview due to some reasons. ‘Refusal’: eligible respondents who refused the interview. ‘Language problems’: eligible respondents who were not able to speak clearly in any of our 3 languages. ‘Not available’: potentially eligible respondents were busy at the time of telephone contact. ‘Invalid number’: not a valid telephone line (because we used a random method to generate telephone numbers, see section 2.1).

2.6 Overall Sampling Error

The survey findings are subject to sampling error. For instance, for the total sample of 1,118 respondents, the maximum sampling error is $\pm 2.9\%$ ⁴ at the 95% level of confidence (ignoring clustering effects). Therefore, we have 95% confidence that the population proportion falls within the sample proportion plus or minus 2.9%, based on the assumption that non-respondents are similar to respondents.

The table below serves as a guide in understanding the range of sampling error allowed for a variety of sample sizes before percentage differences in data results are statistically significant.

**95% Confidence Level
Maximum Sampling Error by Range of Percentage Response**

	Percentage response				
Sample size:	10%/90%	20%/80%	30%/70%	40%/60%	50%/50%
N = 1,118	$\pm 1.8\%$	$\pm 2.3\%$	$\pm 2.7\%$	$\pm 2.9\%$	$\pm 2.9\%$

As the table indicates, the maximum margin of error for all aggregate response of residential line users is between 1.8% and 2.9% for the sample of respondents. This means that for a given question answered by all respondents, one can be 95 percent confident that the difference between the sample proportion and that of the population is not greater than 2.9%.

Possible non-sampling errors are further discussed in Chapter Seven of this report.

2.7 Quality control

All SSRC interviewers were well trained in a standardized approach prior to the commencement of the survey. All interviews were conducted by experienced interviewers fluent in Cantonese, Putonghua and English.

The SSRC engaged in quality checks for each stage of the survey to ensure satisfactory standards of performance. At least 15% of the questionnaires completed by each interviewer were checked by the SSRC independently. About five objective questions

⁴ As the population proportion is unknown, 0.5 is put into the formula of the sampling error to produce the most conservative estimation of the sampling error. The confidence interval width at 95% confidence level is:

$$\pm 1.96 \times \sqrt{\frac{0.5 * 0.5}{1118}} \times 100\% = 2.9\%$$

were used to verify the data accuracy and reliability⁵. A problem case meant that the answers provided by the respondents for the objective questions were wrong. While there were more than 20% of the interviews done by the interviewer were found to have errors, all of the contact cases of that interviewer would be recalled for checking. If at least one third (about 30%) of the total recalled cases were found to be problematic cases, all of the cases done by the problem interviewer would be discarded. Otherwise, just the problematic cases would be dropped.

2.8 Data Processing and Statistical Analysis

This survey revealed some differences in gender and age proportions when compared with the estimates for Hong Kong's land-based non-institutional population compiled by the Census and Statistics Department (hereafter called C&SD) in 2008 2nd Quarter. The proportion of respondents among age groups 18-29, 40-49, 50-59 and 60-64 are higher than the population while the proportion of respondents aged 30-39 and 70 or above are lower. The sample also contained a higher percentage of females in comparison with the population. Table 2.2 shows the differences in terms of age and gender.

Table 2.2 Distribution differences of age and gender between this survey and the Hong Kong population estimates compiled by the C&SD for 2008 2nd Quarter

Age Group	This survey			Land-based non-institutional population aged 18+ (excl. FDH)		
	Male	Female	Total	Male	Female	Total
18-29	8.7%	11.7%	20.4%	9.6%	9.8%	19.3%
30-39	6.9%	11.1%	18.0%	8.6%	10.1%	18.6%
40-49	7.1%	16.7%	23.8%	10.9%	11.9%	22.8%
50-59	9.4%	11.6%	21.0%	9.4%	9.3%	18.7%
60-64	3.5%	4.0%	7.5%	2.8%	2.6%	5.4%
65-69	1.6%	2.3%	3.9%	2.1%	1.9%	4.1%
70 or above	3.8%	1.4%	5.2%	5.0%	6.0%	11.0%
Age data missing		0.2%	0.2%	-	-	-
Total	40.9%	59.1%	100.0%	48.3%	51.7%	100.0%

Notes : Figures may not add up to the totals owing to rounding.

Source : General Household Survey, Census & Statistics Department

⁵ The demographic questions such as age and gender were used to identify the same respondents in the households. The questions of the highest educational attainment, whether currently engaged in a job, whether they were working in the health or insurance related industries, job status and whether they were suffering a chronic disease were used to verify the data accuracy and reliability

In view of the demographic differences between this sample and the population, weighting was applied to gender and age group in order to make the results more representative of the general population. The weights are the ratio of the age and gender distribution (in %) of the population to that of this sample (Table 2.3).

In order to calculate the sample weight for the corresponding gender and age, we need to calculate the population ratio⁶ and sample ratio⁷ for the corresponding gender and age. After we calculate the population ratio and sample ratio, the calculation for the sample weight is as follows:

$$\text{Sample weight for the corresponding gender and age} = \frac{\text{Population ratio}}{\text{Sample ratio}}$$

If respondents refused to provide their age information, the sample weight is set as 1.

Table 2.3 Weights by age and gender applied in the analyses (sample weights)

Age Group	Male	Female
18-29	1.100828351	0.832341240
30-39	1.240505401	0.905065482
40-49	1.541544861	0.711788560
50-59	0.997983383	0.802154367
60-64	0.793814881	0.654545455
65-69	1.315640881	0.831863788
70 or above	1.328063241	4.186194241
Age data missing	-	1.000000000

⁶ **Population ratio:**

$$= \frac{\text{Population size for the corresponding gender and age}}{\text{Total land-based non-institutional population aged 18 and above (excluding foreign domestic helpers)}}$$

⁷ **Sample ratio:**

$$= \frac{\text{Sample size for the corresponding gender and age}}{\text{Total sample size}}$$

For the grossing up to the population, weighting was applied by gender and age group in order to make the results more representative of the general population. The weights are the ratio of the population by age and gender to the corresponding sample size by age group and gender of this sample (Table 2.4).

For the calculation of population weight for the corresponding gender and age for non-missing cases (the age information is provided), the calculation is as follows:

$$= \frac{\text{Population size for corresponding gender and age}}{\text{Sample size for corresponding gender and age}} \times \frac{\text{Total sample size for non-missing cases for corresponding gender}}{\text{Total sample size for corresponding gender}}$$

If respondents refused to provide their age information, the calculation for the population weight by gender as follows:

$$= \frac{\text{Population size for aged 18 and above by corresponding gender}}{\text{Sample size for corresponding gender}}$$

Table 2.4: Weights by age group and gender applied in the analyses for grossing up to the population)

Age Group	Male	Female
18-29	5415	4082
30-39	6103	4439
40-49	7584	3491
50-59	4910	3934
60-64	3905	3210
65-69	6472	4080
70 or above	6533	20531
Age data missing		4292

Statistical tests using sample weighting were applied to study the significant differences between sub-groups. Associations between selected demographic information and responses of selected questions were examined and tested by Pearson Chi-square Test. Significance testing was conducted at the 5% level (2-tailed). The statistical software, SPSS for Windows version 12.0, was used to perform all statistical analyses.

All results are presented in percentage form unless otherwise stated. For tables presented in this report, figures may not add up to totals due to rounding. Comparison of data was performed using cross tabulations and one-way frequency tables.

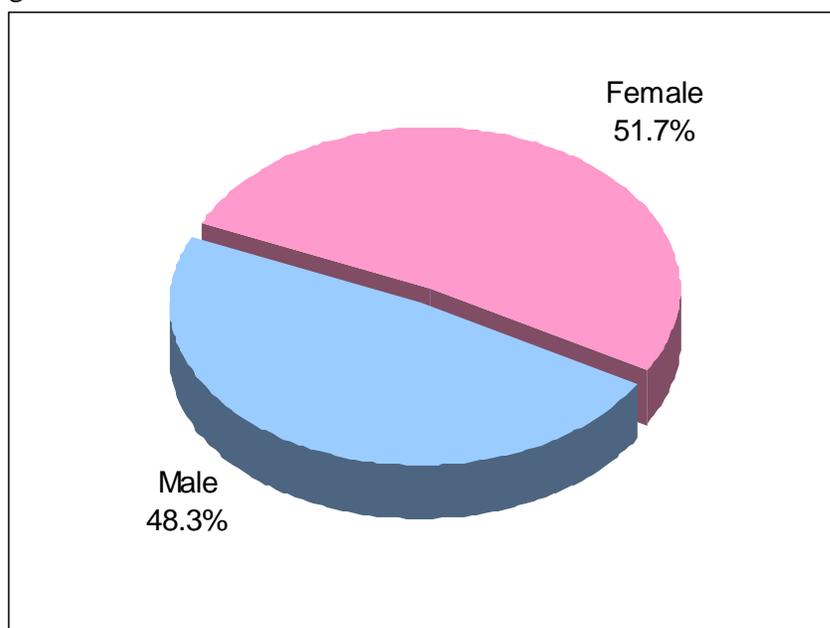
Chapter Three Profile of All Respondents

Respondents provided information such as gender, age, education level, household size, monthly household income, employment status and health status.

3.1 Gender

Figure 3.1 indicates that 51.7% of the respondents were female and the remaining 48.3% were male.

Figure 3.1: Gender



(Base: All respondents)

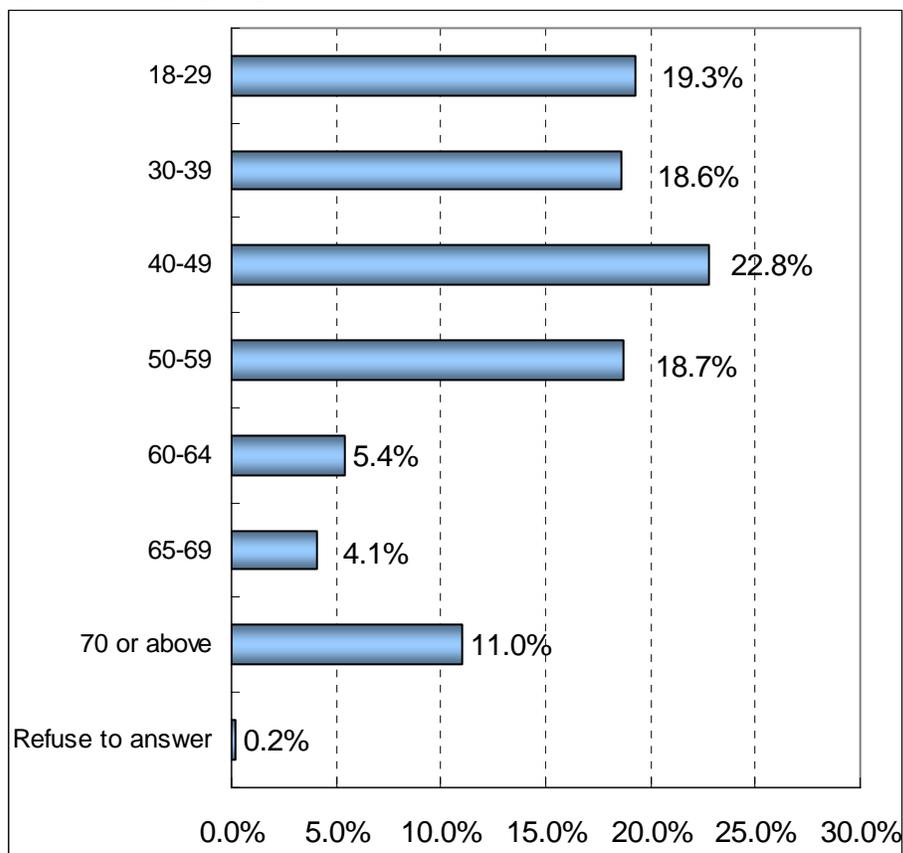
Table 3.1 Gender

Gender	Percent	Cumulative Percent
Male	48.3	48.3
Female	51.7	100.0
Total	100.0	

3.2 Age group

Figure 3.2 shows that almost 80% of respondents (79.4%) were aged 18 – 59, while slightly over 10% of them (11.0%) were aged 70 or above.

Figure 3.2: Age group



(Base: All respondents)

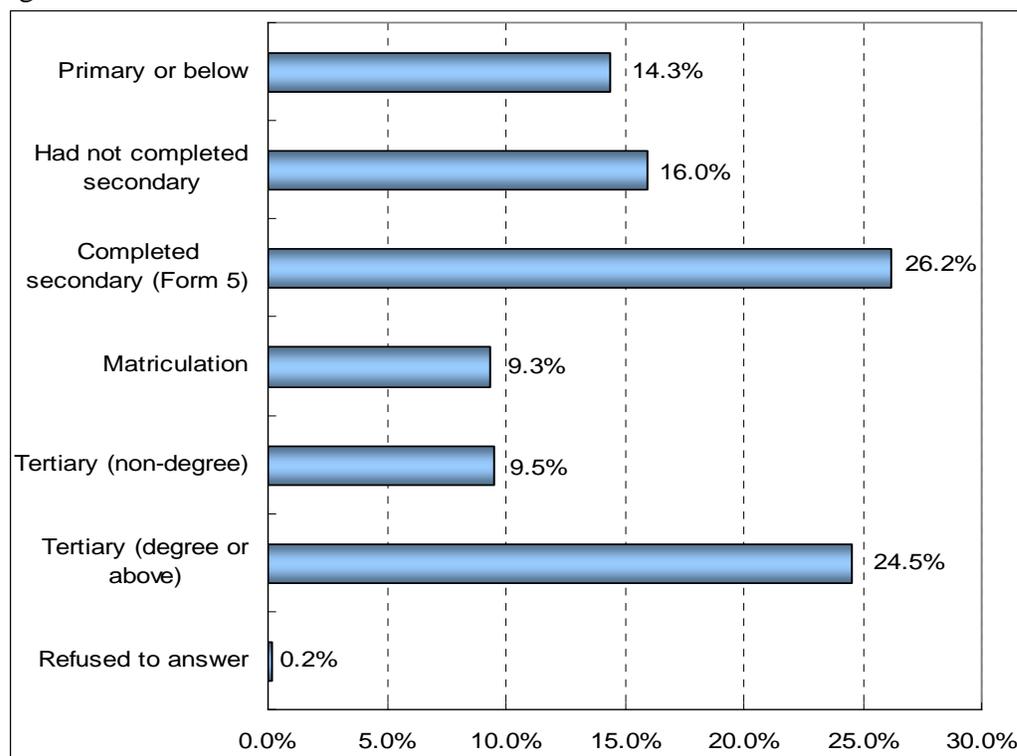
Table 3.2 Age group

Age group	Percent	Cumulative Percent
18-29	19.3	19.3
30-39	18.6	37.9
40-49	22.8	60.7
50-59	18.7	79.4
60-64	5.4	84.8
65-69	4.1	88.9
70 or above	11.0	99.8
Refuse to answer	0.2	100.0
Total	100.0	

3.3 Education level

Figure 3.3 shows that over two thirds of respondents (69.5%) had an education level of secondary (completed Form 5) or above. Slightly over one third of them (34.0%) had tertiary education while 30% of them (30.3%) had not completed education level of secondary or below.

Figure 3.3: Education level



(Base: All respondents)

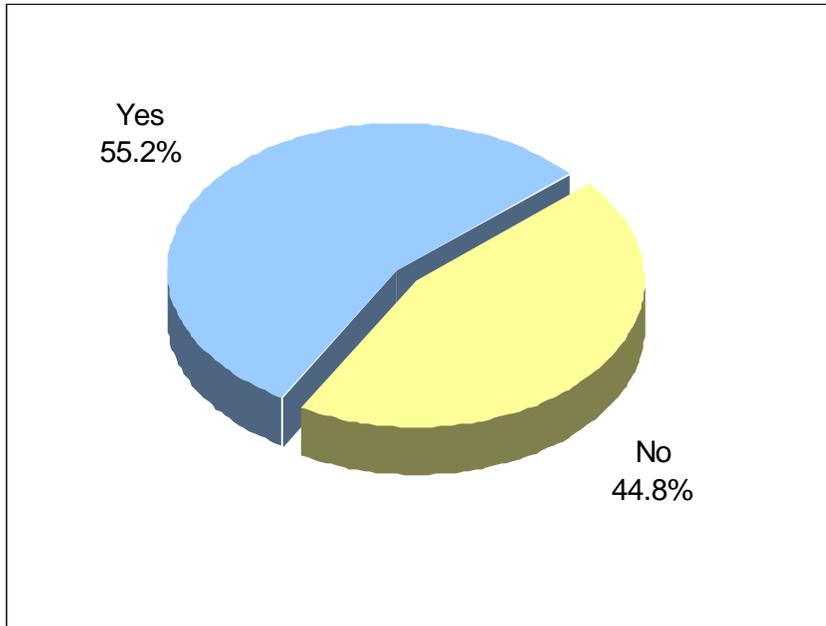
Table 3.3 Education level

Education level	Percent	Cumulative Percent
Primary or below	14.3	14.3
Had not completed secondary	16.0	30.3
Completed secondary (Form 5)	26.2	56.5
Matriculation	9.3	65.8
Tertiary (non-degree)	9.5	75.3
Tertiary (degree or above)	24.5	99.8
Refused to answer	0.2	100.0
Total	100.0	

3.4 Currently engaged in a job

Figure 3.4 shows that slightly over half of the respondents (55.2%) were currently engaged in a job while the remaining (44.8%) were not.

Figure 3.4: Currently engaged in a job



(Base: All respondents)

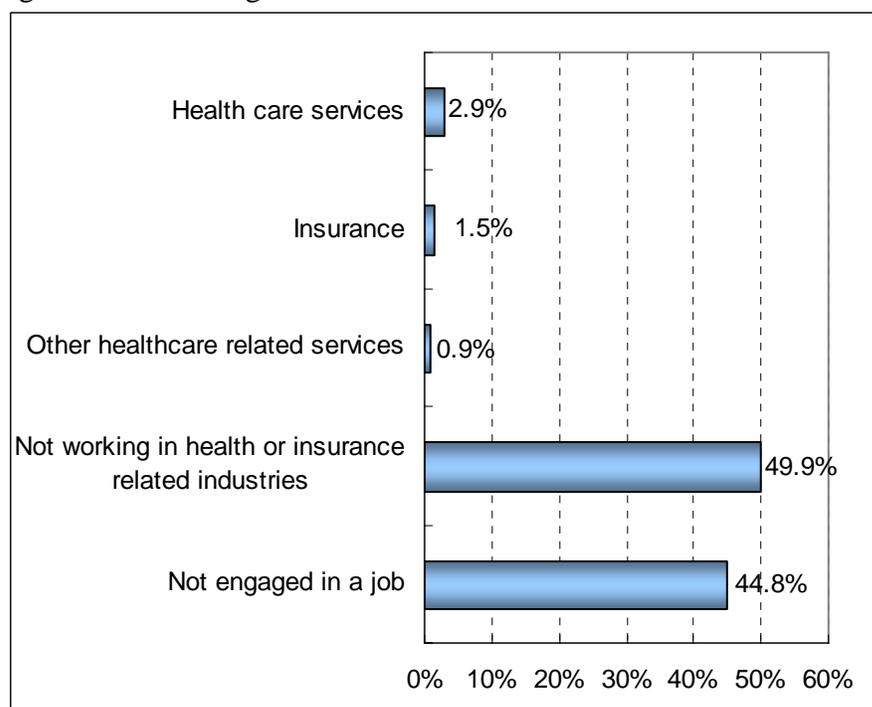
Table 3.4 Currently engaged in a job

Currently engaged in a job	Percent	Cumulative Percent
Yes	55.2	55.2
No	44.8	100.0
Total	100.0	

3.5 Working in the health or insurance related industries

Figure 3.5 shows that only about 5% of all respondents (5.3%) were working in the health or insurance related industries including health services (2.9%), insurance (1.5%) and other healthcare related services (0.9%).

Figure 3.5: Working in the health or insurance related industries



(Base: All respondents)

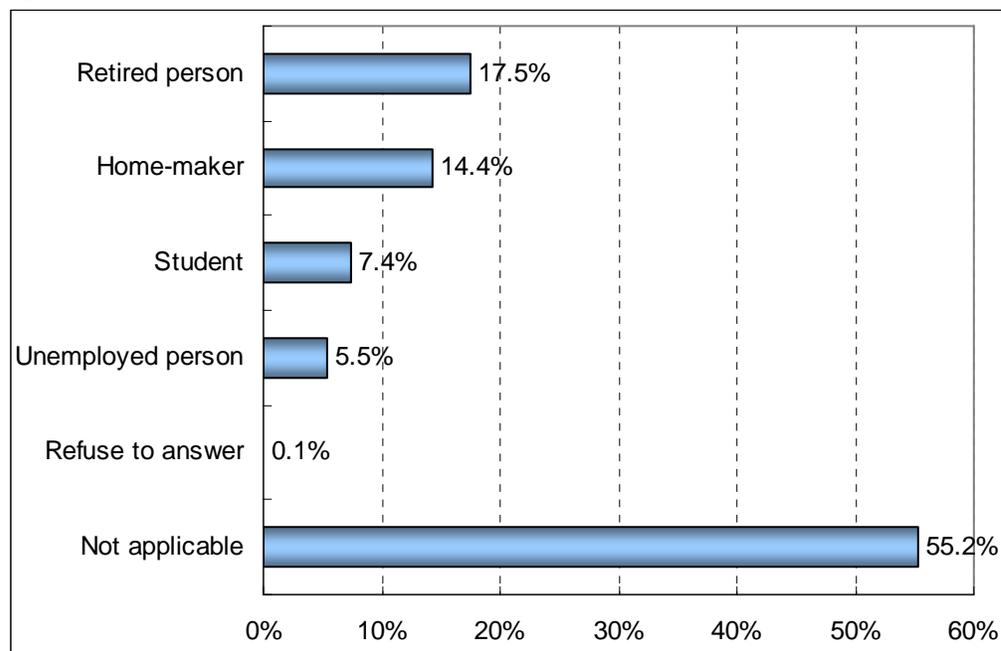
Table 3.5 Working in the health or insurance related industries

Working in health or insurance related industries	Percent	Cumulative Percent
Insurance	1.5	46.3
Health care services	2.9	49.2
Other healthcare related services	0.9	50.1
Not working in health or insurance related industries	49.9	100.0
Not engaged in a job	44.8	44.8
Total	100.0	

3.6 Job status

Figure 3.6 shows that about one-sixth of all respondents (17.5%) were retired and about one-seventh of them (14.4%) were home-makers.

Figure 3.6: Job status



(Base: All respondents)

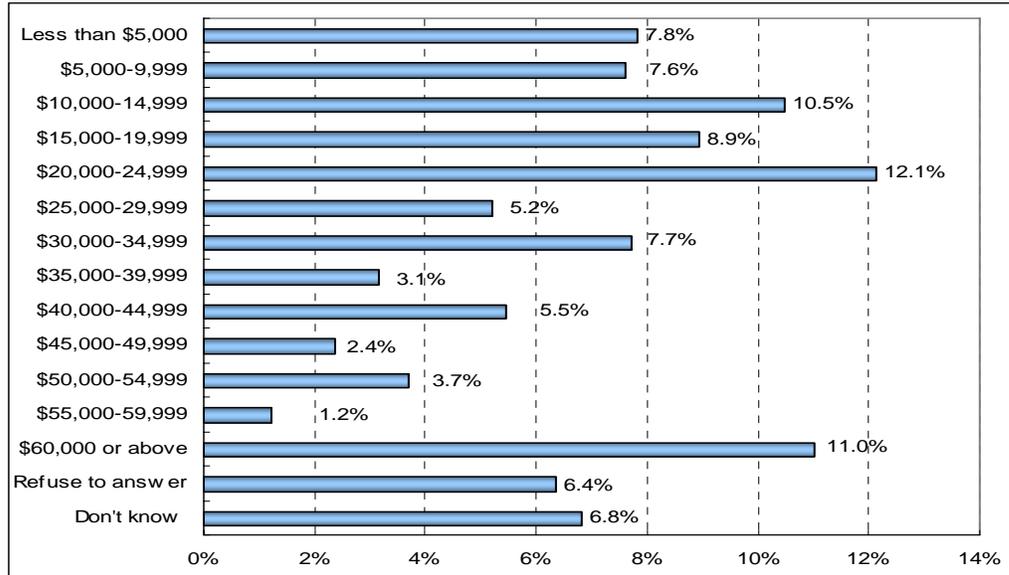
Table 3.6 Job status

Job status	Percent	Cumulative Percent
Student	7.4	62.7
Home-maker	14.4	77.0
Unemployed person	5.5	82.5
Retired person	17.5	99.9
Refuse to answer	0.1	100.0
Not applicable	55.2	55.2
Total	100.0	

3.7 Monthly household income

Figure 3.7 shows that slightly over one third of all respondents (34.6%) had a monthly household income of \$30,000 or above while another one third of them (36.7%) had a monthly household income between \$10,000 and \$29,999. About 15% of them (15.4%) had a monthly household income below \$10,000.

Figure 3.7: Monthly household income



(Base: All respondents)

Table 3.7 Monthly household income

Monthly household income	Percent	Cumulative Percent
Less than \$5,000	7.8	7.8
\$5,000-9,999	7.6	15.5
\$10,000-14,999	10.5	25.9
\$15,000-19,999	8.9	34.9
\$20,000-24,999	12.1	47.0
\$25,000-29,999	5.2	52.2
\$30,000-34,999	7.7	59.9
\$35,000-39,999	3.1	63.0
\$40,000-44,999	5.5	68.5
\$45,000-49,999	2.4	70.9
\$50,000-54,999	3.7	74.6
\$55,000-59,999	1.2	75.8
\$60,000 or above	11.0	86.8
Refuse to answer	6.4	93.2
Don't know	6.8	100.0
Total	100.0	

When compared with the corresponding statistics on Hong Kong's land-based non-institutional population compiled by the C&SD for the second quarter of 2008, figures in Table 3.7 show that there are fewer respondents belonging to the household income groups \$5,000 to less than \$20,000 in the sample of the survey. More specifically, the proportion of respondents among monthly household income groups less than \$5,000, \$40,000-\$44,999, \$50,000-\$54,999 and \$60,000 or above are higher than the population while the proportion of respondents with monthly household income \$5,000-\$9,999, \$10,000-\$14,999, \$15,000-\$19,999, \$25,000-\$29,999 and \$35,000-\$39,999 are lower.

Table 3.8 Difference in distribution of population by monthly household income group between this survey and that of the Hong Kong land-based non-institutional population compiled by the C&SD for the second quarter of 2008

Monthly household income (HK\$)	This survey	Land-based non-institutional population aged 18+ (excl. FDH)
	%	%
Less than 5,000	7.8%	6.4%
5,000 - 9,999	7.6%	12.7%
10,000 - 14,999	10.5%	14.3%
15,000 - 19,999	8.9%	13.6%
20,000 - 24,999	12.1%	11.6%
25,000 - 29,999	5.2%	9.2%
30,000 - 34,999	7.7%	7.5%
35,000 - 39,999	3.1%	5.0%
40,000 - 44,999	5.5%	3.7%
45,000 - 49,999	2.4%	2.9%
50,000 - 54,999	3.7%	2.4%
55,000 - 59,999	1.2%	1.6%
60,000 or above	11.0%	9.2%
Refuse to answer or don't know	13.2%	-
Total	100.0%	100.0%

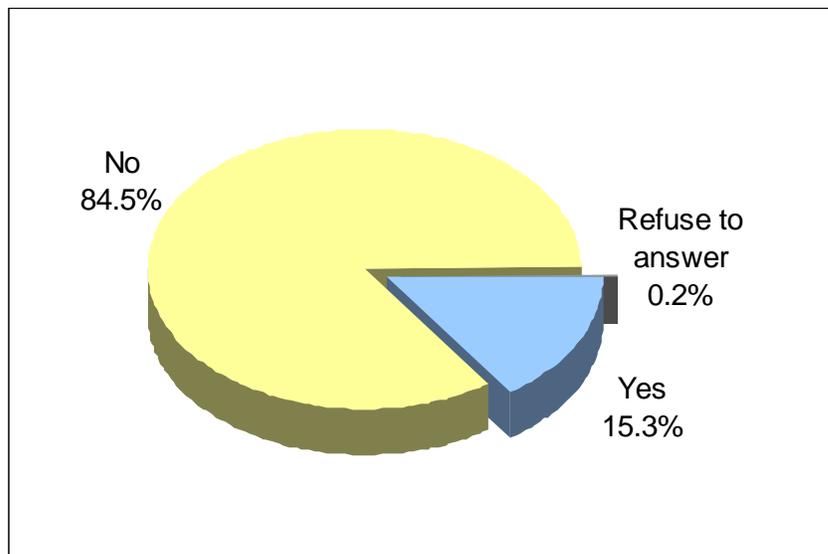
Notes : Figures can only be compiled for domestic households, i.e. excluding collective households and households with only Mobile Residents.

Source : General Household Survey, Census & Statistics Department

3.8 Admission to a hospital within the last 12 months for any reason

Figure 3.8 shows that about 15% of all respondents (15.3%) had been admitted to a hospital within the last 12 months for any reason.

Figure 3.8: Admission to a hospital within the last 12 months



(Base: All respondents)

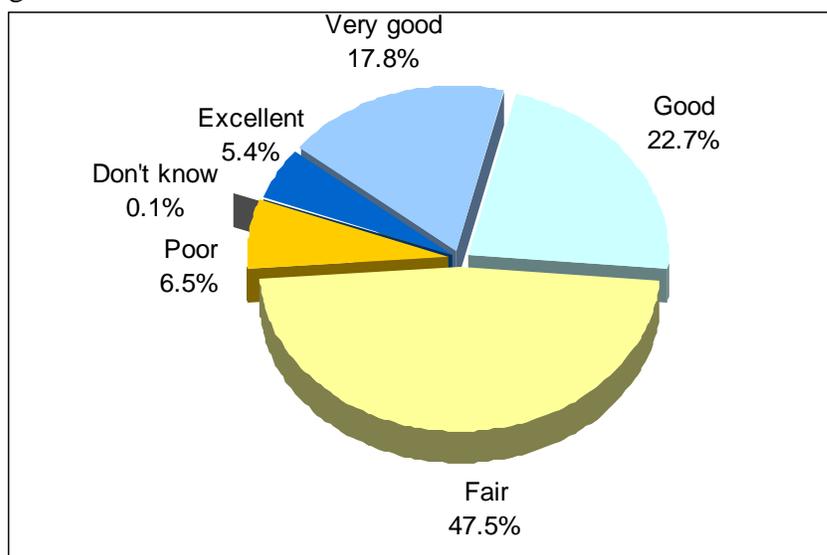
Table 3.9 Admission to a hospital within the last 12 months

Admitted to a hospital within the last 12 months	Percent	Cumulative Percent
Yes	15.3	15.3
No	84.5	99.8
Refuse to answer	0.2	100.0
Total	100.0	

3.9 Health status

Figure 3.5 shows that less than a quarter of all respondents (23.2%) claimed that their health status in general was excellent or very good while similar proportion of them (22.7%) said that their health status was good. Only about 6% of them (6.5%) claimed that their health status was poor.

Figure 3.9: Health status



(Base: All respondents)

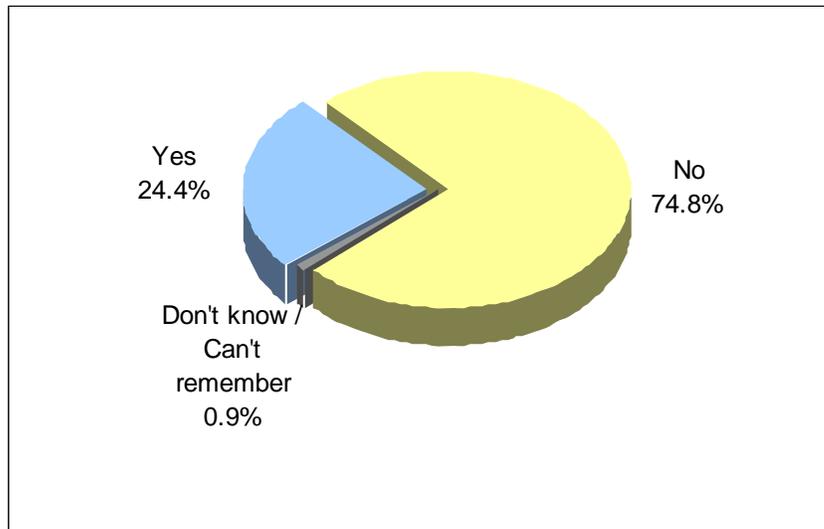
Table 3.10 Health status

Health status	Percent	Cumulative Percent
Excellent	5.4	5.4
Very good	17.8	23.2
Good	22.7	45.9
Fair	47.5	93.4
Poor	6.5	99.9
Don't know	0.1	100.0
Total	100.0	

3.10 Suffer from a chronic disease

Figure 3.10 shows that about a quarter of all respondents (24.4%) had been told by a western medicine practitioner that they suffer from a chronic disease.

Figure 3.10: Suffer from a chronic disease



(Base: All respondents)

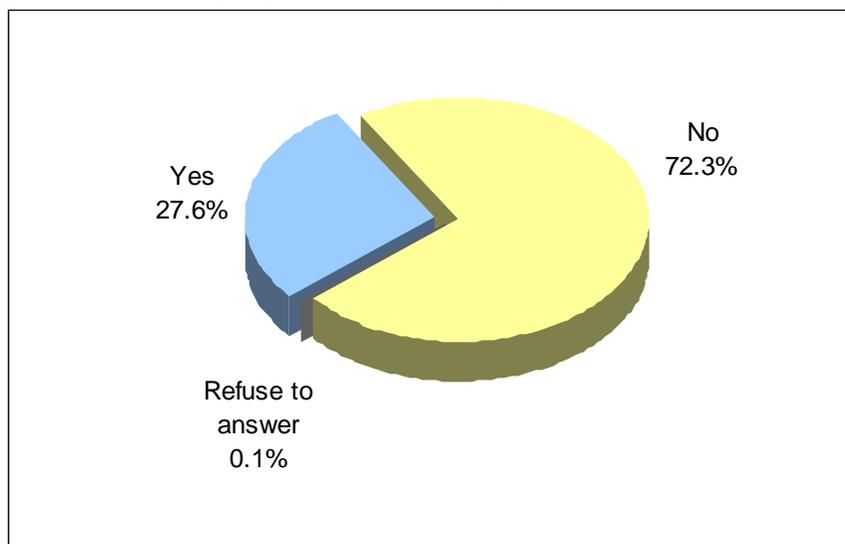
Table 3.11 Suffer from a chronic disease

Suffer from a chronic disease	Percent	Cumulative Percent
Yes	24.4	24.4
No	74.8	99.1
Don't know / Can't remember	0.9	100.0
Total	100.0	

3.11 Taking regular medications prescribed by a doctor during the past 6 months

Figure 3.11 shows that over a quarter of all respondents (27.6%) reported that they have been taking regular medications prescribed by doctor during the past 6 months.

Figure 3.11: Taking regular medications prescribed by a doctor



(Base: All respondents)

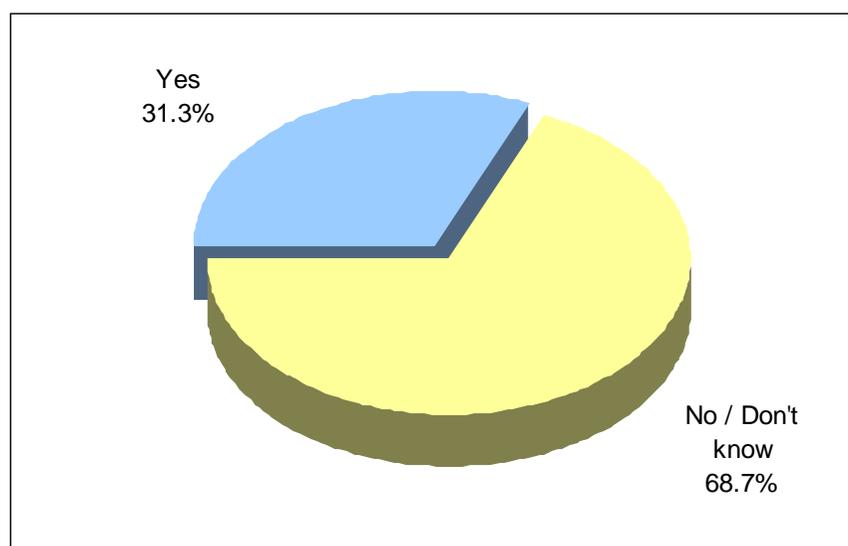
Table 3.12 Taking regular medications prescribed by a doctor

Taking regular medications prescribed	Percent	Cumulative Percent
Yes	27.6	27.6
No	72.3	99.9
Refuse to answer	0.1	100.0
Total	100.0	

3.12 Respondents who reported having a chronic disease or taking regular medication

Further to the respective results of respondents having been told by a western medicine practitioner that they suffered from a chronic disease and taking regular medications prescribed by doctor during the past 6 months, Figure 3.12 shows that less than one third of all respondents (31.3%) reported having a chronic condition or being on regular medication.

Figure 3.12: Respondents who reported having a chronic condition or being on regular medication



(Base: All respondents)

Table 3.13 Respondents who reported having a chronic condition or being on regular medication

Either have a chronic disease or taking regular medication	Percent	Cumulative Percent
Yes	31.3	31.3
No/Don't know/Refuse to answer	68.7	100.0
Total	100.0	

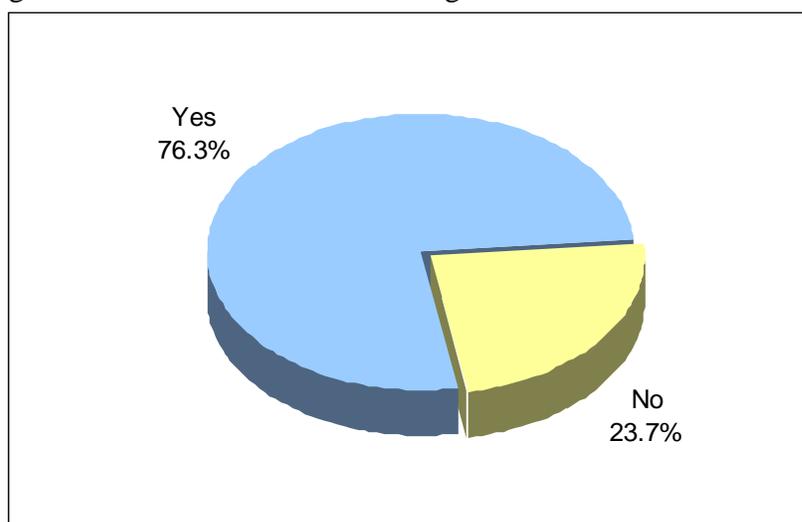
Chapter Four Findings of the survey

In this chapter, respondents were asked about their awareness of the recent government consultation on healthcare reform and their opinion on the reform.

4.1 Awareness of the consultation on healthcare reform

When respondents were asked for their awareness of the recent government consultation on healthcare reform, over three quarters (76.3%) were aware of the consultation while the remaining (23.7%) did not know about it.

Figure 4.1: Awareness of the recent government consultation on healthcare reform



(Base: All respondents)

Table 4.1 Awareness of the recent government consultation on healthcare reform

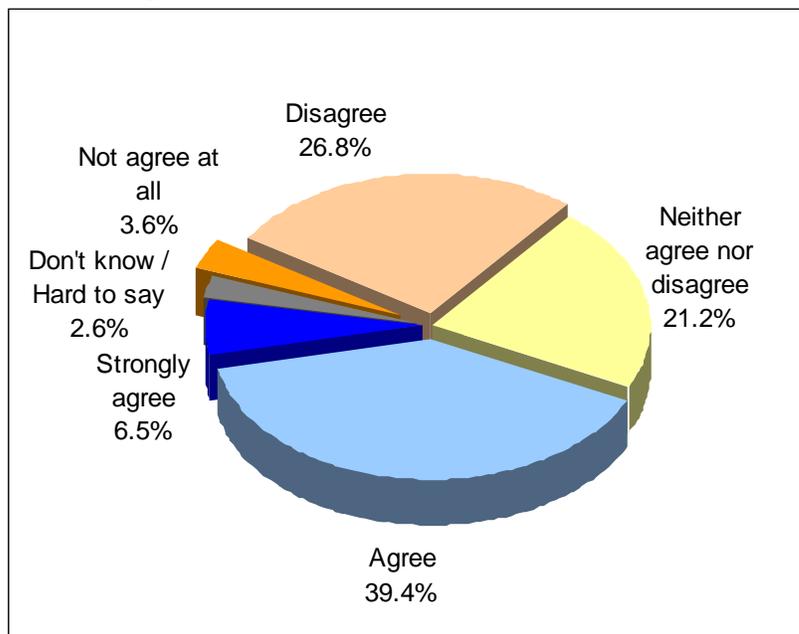
Awareness	Percent	Cumulative Percent
Yes	76.3	76.3
No	23.7	100.0
Total	100.0	

4.2 Primary care

Respondents were asked to rate their level of agreement with there being currently insufficient emphasis by both patients and healthcare providers on comprehensive primary care, which includes preventive care and wellness promotion. The respondents were given a five-point scale (strongly agree, agree, neither agree nor disagree, disagree and strongly disagree) and an option of “Don’t know/Hard to say”.

Figure 4.2 indicates that a few percent of all respondents (6.5%) strongly agreed and another about two-fifths of them (39.4%) agreed that there was insufficient emphasis while about 30% of them (30.4%) disagreed/not agree at all. Over one-fifth of them (21.2%) neither agreed nor disagreed.

Figure 4.2 Agreement with there being currently insufficient emphasis by both patients and healthcare providers on comprehensive primary care which includes preventive care and wellness promotion



(Base: All respondents)

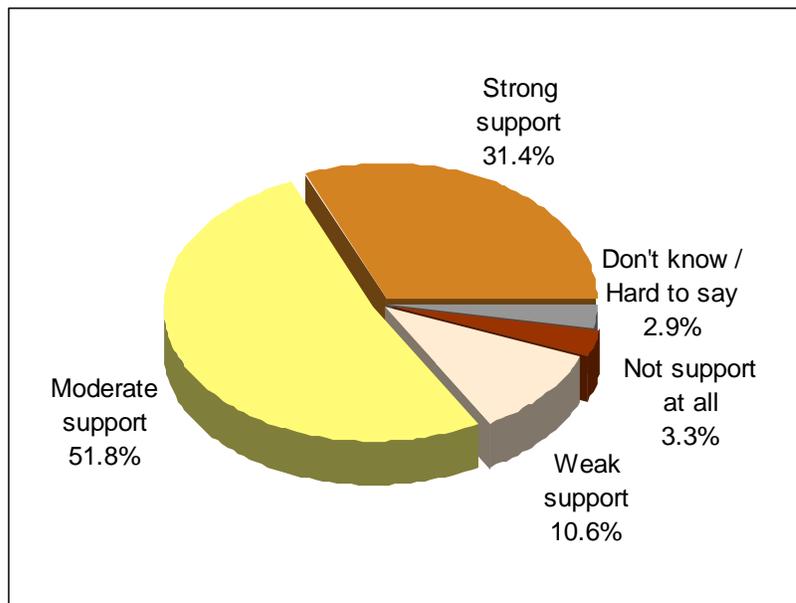
Table 4.2 Agreement with there being currently insufficient emphasis by both patients and healthcare providers on comprehensive primary care which includes preventive care and wellness promotion

Level of agreement	Percent	Cumulative Percent
Not agree at all	3.6	3.6
Disagree	26.8	30.4
Neither agree nor disagree	21.2	51.6
Agree	39.4	91.0
Strongly agree	6.5	97.4
Don't know / Hard to say	2.6	100.0
Total	100.0	

Respondents were asked to rate their level of support for the development of basic models for comprehensive primary and preventive care services for reference by both healthcare professionals and individuals. The respondents were given a four-point scale (strong support, moderate support, weak support and not support at all) and an option of “Don’t know/Hard to say”.

Figure 4.3 indicates that about one third of all respondents (31.4%) expressed strong support and another half of them (51.8%) had moderate support for the development of the basic models while about 14% of them (13.9%) had weak support / not support at all.

Figure 4.3 Level of support for the development of basic models for comprehensive primary and preventive care services for reference by both healthcare professionals and individuals



(Base: All respondents)

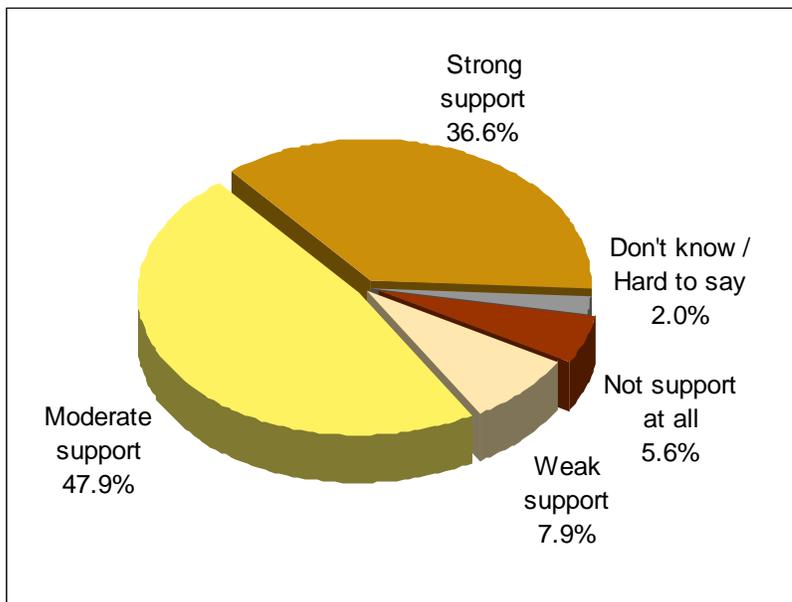
Table 4.3 Level of support for the development of basic models for comprehensive primary and preventive care services for reference by both healthcare professionals and individuals.

Level of support	Percent	Cumulative Percent
Not support at all	3.3	3.3
Weak support	10.6	13.9
Moderate support	51.8	65.7
Strong support	31.4	97.1
Don't know / Hard to say	2.9	100.0
Total	100.0	

Respondents were asked to rate their level of support for establishing a family doctor register for reference by individuals who wish to receive comprehensive primary and preventive care.

Figure 4.4 indicates that over one third of all respondents (36.6%) expressed strong support and another about half of them (47.9%) had moderate support for establishing a family doctor register for reference by individuals while about 14% of them (13.5%) had weak support / not support at all.

Figure 4.4 Level of support for establishing a family doctor register for reference by individuals who wish to receive comprehensive primary and preventive care



(Base: All respondents)

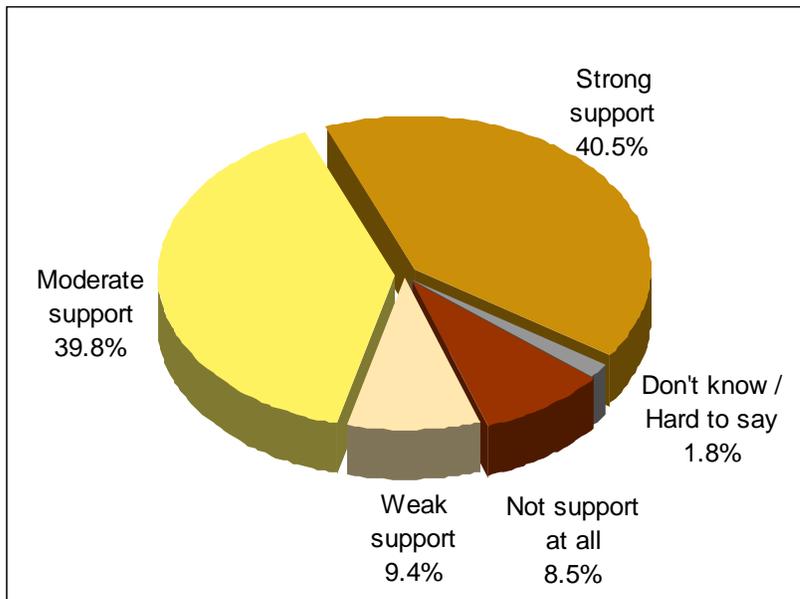
Table 4.4 Level of support for establishing a family doctor register for reference by individuals who wish to receive comprehensive primary and preventive care.

Level of support	Percent	Cumulative Percent
Not support at all	5.6	5.6
Weak support	7.9	13.5
Moderate support	47.9	61.4
Strong support	36.6	98.0
Don't know / Hard to say	2.0	100.0
Total	100.	

Respondents were asked to rate their level of support for subsidizing individuals to undertake preventive care through private family doctors.

Figure 4.5 indicates that two-fifths of all respondents (40.5%) expressed strong support and another about two-fifths of them (39.8%) had moderate support for subsidizing individuals while about 18% of them (17.9%) had weak support / not support at all.

Figure 4.5 Level of support for subsidizing individuals to undertake preventive care through private family doctors



(Base: All respondents)

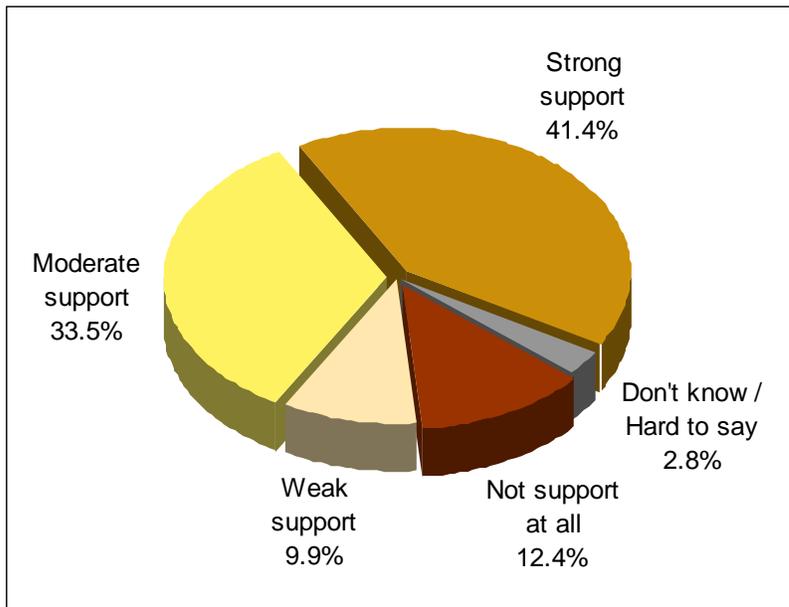
Table 4.5 Level of support for subsidizing individuals to undertake preventive care through private family doctors

Level of support	Percent	Cumulative Percent
Not support at all	8.5	8.5
Weak support	9.4	17.9
Moderate support	39.8	57.7
Strong support	40.5	98.2
Don't know / Hard to say	1.8	100.0
Total	100.0	

Respondents were asked to rate their level of support for the Government purchasing primary care services from the private sector for low-income families and under-privileged groups.

Figure 4.6 indicates that over two-fifths of all respondents (41.4%) expressed strong support and another one third of them (33.5%) had moderate support for the Government purchasing primary care services from the private sector while over one-fifth of them (22.3%) had weak support / not support at all.

Figure 4.6 Level of support for developing basic models for comprehensive primary and preventive care services for Government purchasing primary care services from the private sector for low-income families and under-privileged groups.



(Base: All respondents)

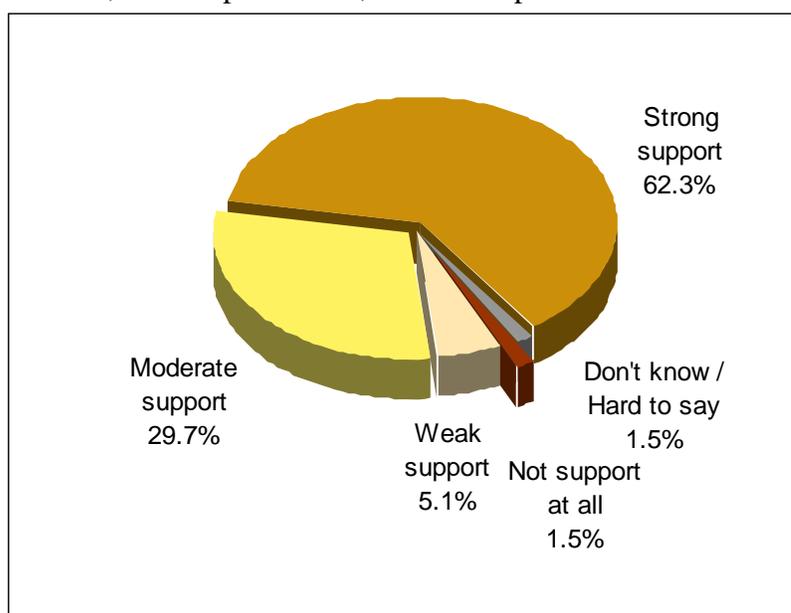
Table 4.6 Level of support for developing basic models for comprehensive primary and preventive care services for Government purchasing primary care services from the private sector for low-income families and under-privileged groups

Level of support	Percent	Cumulative Percent
Not support at all	12.4	12.4
Weak support	9.9	22.3
Moderate support	33.5	55.8
Strong support	41.4	97.2
Don't know / Hard to say	2.8	100.0
Total	100.0	

Respondents were asked to rate their level of support for strengthening public health education, healthy lifestyle promotion, disease prevention, and develop and set the standards for primary care services.

Figure 4.7 indicates that nearly two thirds of all respondents (62.3%) expressed strong support and about 30% of them (29.7%) had moderate support for strengthening the health education and developing the standards for primary care services while only about 7% of them (6.6%) had weak support / not support at all.

Figure 4.7 Level of support for strengthening public health education, healthy lifestyle promotion, disease prevention, and develop and set the standards for primary care services.



(Base: All respondents)

Table 4.7 Level of support for strengthening public health education, healthy lifestyle promotion, disease prevention, and develop and set the standards for primary care services.

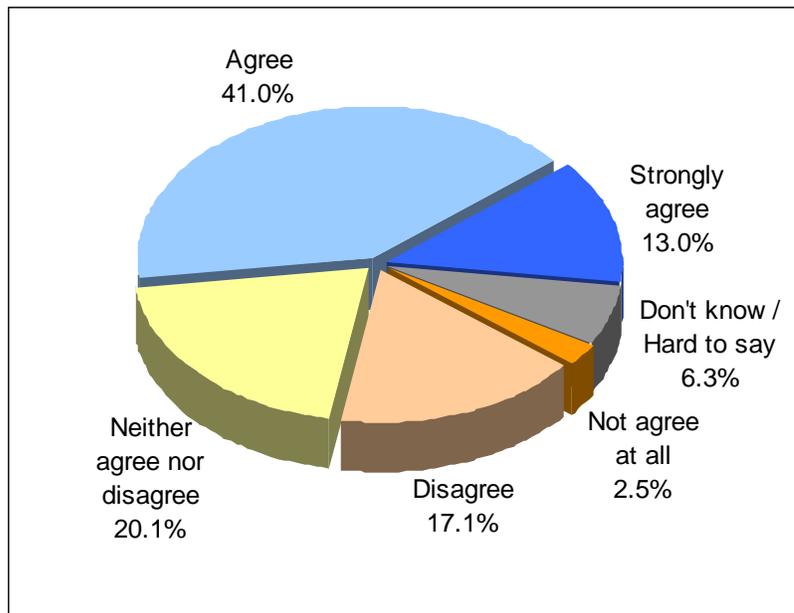
Level of support	Percent	Cumulative Percent
Not support at all	1.5	1.5
Weak support	5.1	6.6
Moderate support	29.7	36.2
Strong support	62.3	98.5
Don't know / Hard to say	1.5	100.0
Total	100.0	

4.3 Public-private partnership

Respondents were asked to rate their level of agreement that the significant public-private imbalance in the healthcare system has led to limited choice for them as well as inadequate competition and collaboration among healthcare providers in both the public and private sectors.

Figure 4.8 indicates that over one-tenth of them (13.0%) strongly agreed and another two-fifths of them (41.0%) agreed that the imbalance has led to limited choice for them and inadequate competition and collaboration among healthcare providers in both the public and private sectors while about one-fifth of them (19.6%) disagreed/not agree at all. One-fifth of them (20.1%) neither agreed nor disagreed.

Figure 4.8 Agreement that significant public-private imbalance in the healthcare system has led to limited choice for them as well as inadequate competition and collaboration among healthcare providers in both the public and private sectors



(Base: All respondents)

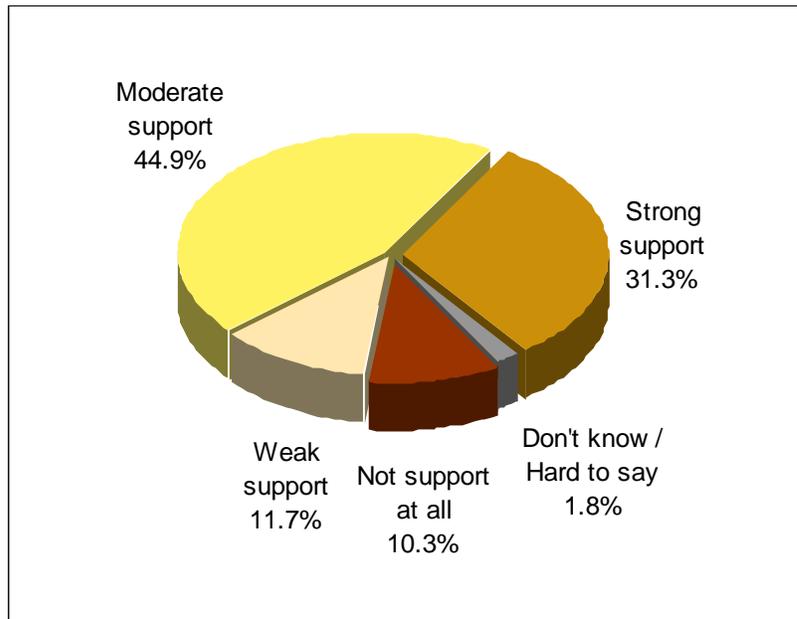
Table 4.8 Agreement that significant public-private imbalance in the healthcare system has led to limited choice for them as well as inadequate competition and collaboration among healthcare providers in both the public and private sectors

Level of agreement	Percent	Cumulative Percent
Not agree at all	2.5	2.5
Disagree	17.1	19.6
Neither agree nor disagree	20.1	39.7
Agree	41.0	80.7
Strongly agree	13.0	93.7
Don't know / Hard to say	6.3	100.0
Total	100.0	

Respondents were asked to rate their level of support for the government purchasing hospital services from the private sector, especially for non-urgent and/or elective procedures.

Figure 4.9 indicates that about one third of all respondents (31.3%) expressed strong support and another over two-fifths of them (44.9%) had moderate support for the government purchasing hospital service from the private sector while over one-fifth of them (22.0%) had weak support / not support at all.

Figure 4.9 Level of support for the government purchasing hospital services from the private sector, especially for non - urgent and/or elective procedures



(Base: All respondents)

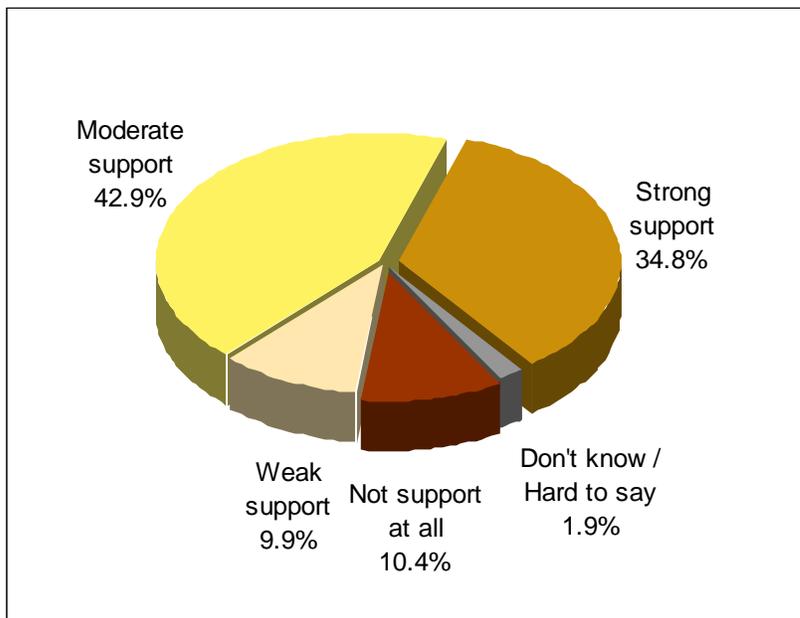
Table 4.9 Level of support for the government purchasing hospital services from the private sector, especially for non - urgent and/or elective procedures

Level of support	Percent	Cumulative Percent
Not support at all	10.3	10.3
Weak support	11.7	22.1
Moderate support	44.9	66.9
Strong support	31.3	98.2
Don't know / Hard to say	1.8	100.0
Total	100.0	

Respondents were asked to rate their level of support for co-locating public and private hospital facilities to enable coordinated planning and shared use of facilities.

Figure 4.10 indicates that slightly over one third of all respondents (34.8%) expressed strong support and another over two-fifths of them (42.9%) had moderate support for co-locating public and private hospital facilities while one-fifth of them (20.3%) had weak support / not support at all.

Figure 4.10 Level of support for co-locating public and private hospital facilities to enable coordinated planning and shared use of facilities



(Base: All respondents)

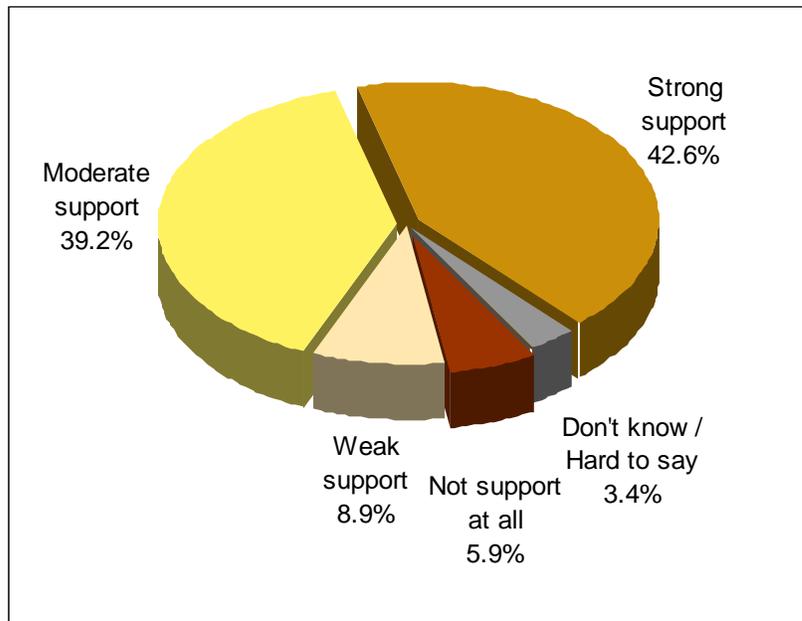
Table 4.10 Level of support for co-locating public and private hospital facilities to enable coordinated planning and shared use of facilities

Level of support	Percent	Cumulative Percent
Not support at all	10.4	10.4
Weak support	9.9	20.3
Moderate support	42.9	63.3
Strong support	34.8	98.1
Don't know / Hard to say	1.9	100.0
Total	100.0	

Respondents were asked to rate their level of support for setting up medical centres of excellence to draw together top expertise of the relevant specialties locally and overseas, with participation of experts from both the public and private sectors.

Figure 4.11 indicates that over two-fifths of all respondents (42.6%) expressed strong support and another about two-fifths of them (39.2%) had moderate support for setting up the medical centres while about 15% of them (14.8%) had weak support / not support at all.

Figure 4.11 Level of support for setting up medical centres of excellence to draw together top expertise of the relevant specialties locally and overseas, with participation of experts from both the public and private sectors



(Base: All respondents)

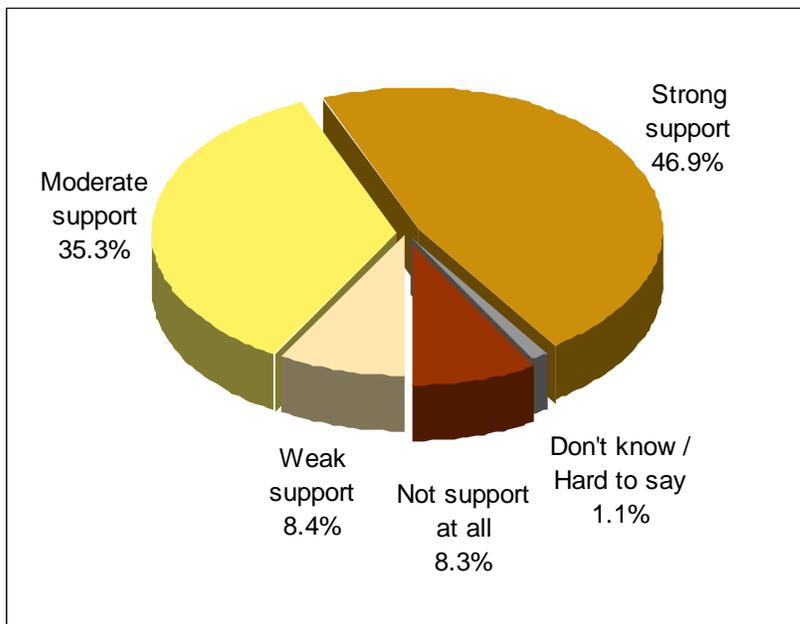
Table 4.11 Level of support for setting up medical centres of excellence to draw together top expertise of the relevant specialties locally and overseas, with participation of experts from both the public and private sectors

Level of support	Percent	Cumulative Percent
Not support at all	5.9	5.9
Weak support	8.9	14.8
Moderate support	39.2	54.0
Strong support	42.6	96.6
Don't know / Hard to say	3.4	100.0
Total	100.0	

Respondents were asked to rate their level of support for engaging private sector doctors in public hospitals, on a part-time basis, to help cross-fertilization of expertise and experience.

Figure 4.12 indicates that nearly half of all respondents (46.9%) expressed strong support and another over one third of them (35.3%) had moderate support for engaging private sector doctors in public hospitals on a part-time basis while about one-sixth of them (16.7%) had weak support / not support at all.

Figure 4.12 Level of support for engaging private sector doctors in public hospitals, on a part-time basis, to help cross-fertilization of expertise and experience



(Base: All respondents)

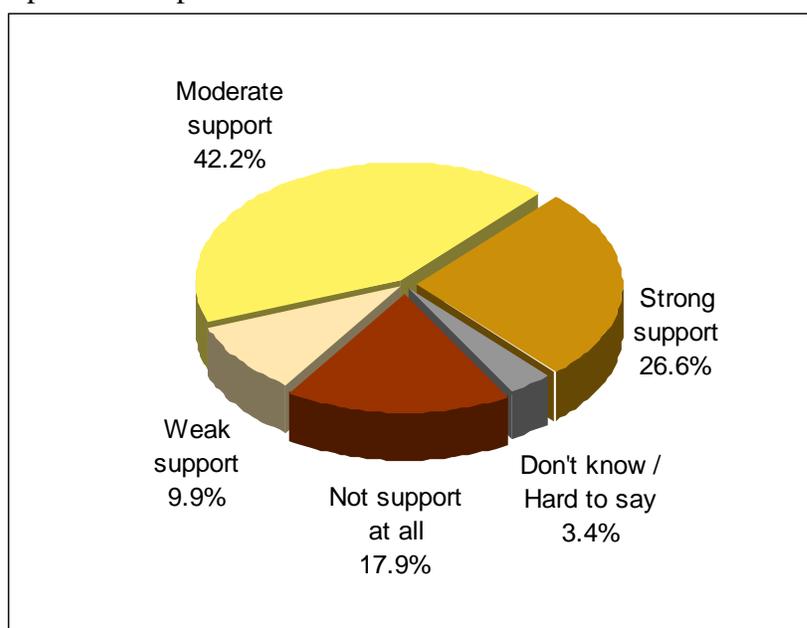
Table 4.12 Level of support for engaging private sector doctors in public hospitals, on a part-time basis, to help cross-fertilization of expertise and experience

Level of support	Percent	Cumulative Percent
Not support at all	8.3	8.3
Weak support	8.4	16.7
Moderate support	35.3	52.0
Strong support	46.9	98.9
Don't know / Hard to say	1.1	100.0
Total	100.0	

Respondents were asked to rate their level of support for facilitating the expansion of capacity in private hospitals through leasing out of vacant public premises or making sites available for private hospital development.

Figure 4.13 indicates that over a quarter of all respondents (26.6%) expressed strong support and another over two-fifths of them (42.2%) had moderate support for facilitating the expansion of capacity in private hospitals while over a quarter of them (27.8%) had weak support / not support at all.

Figure 4.13 Level of support for facilitating the expansion of capacity in private hospitals through leasing out of vacant public premises or making sites available for private hospital development



(Base: All respondents)

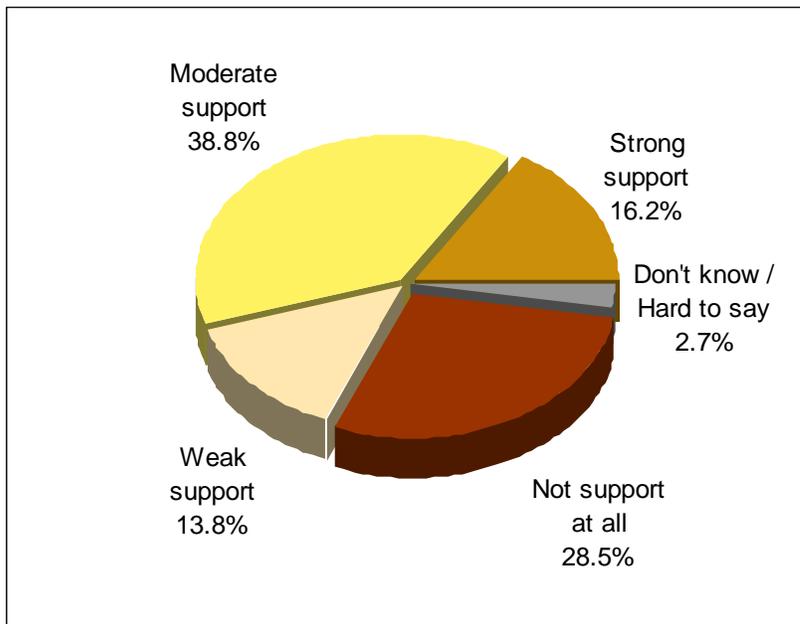
Table 4.13 Level of support for facilitating the expansion of capacity in private hospitals through leasing out of vacant public premises or making sites available for private hospital development

Level of support	Percent	Cumulative Percent
Not support at all	17.9	17.9
Weak support	9.9	27.8
Moderate support	42.2	70.0
Strong support	26.6	96.6
Don't know / Hard to say	3.4	100.0
Total	100.0	

Respondents were asked to rate their level of support for facilitating a moderate increase in capacity in public hospitals for private services operating on a full cost-recovery basis.

Figure 4.14 indicates that less than one-fifth of all respondents (16.2%) expressed strong support and another about two-fifths of them (38.8%) had moderate support for facilitating a moderate increase in capacity in public hospitals for private services while over two-fifths of them (42.3%) had weak support / not support at all.

Figure 4.14 Level of support for facilitating a moderate increase in capacity in public hospitals for private services operating on a full cost-recovery basis



(Base: All respondents)

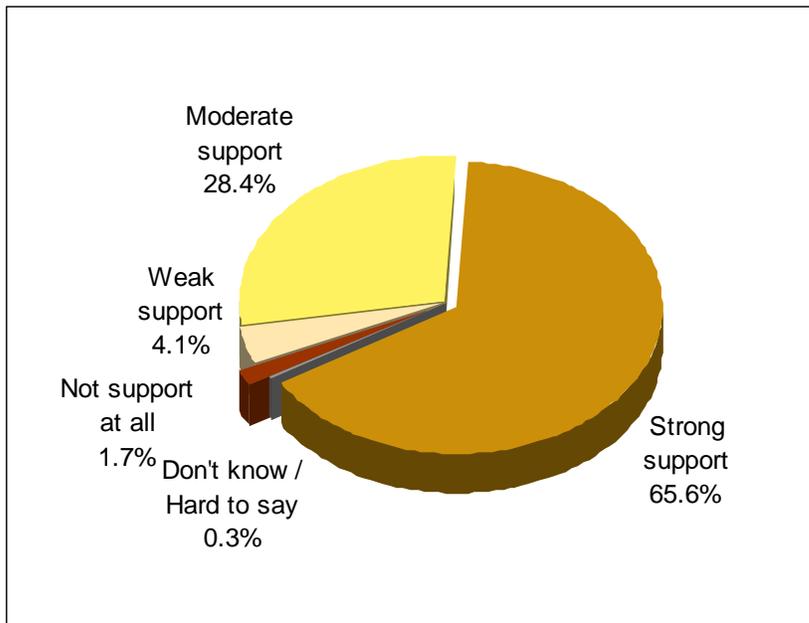
Table 4.14 Level of support for facilitating a moderate increase in capacity in public hospitals for private services operating on a full cost-recovery basis

Level of support	Percent	Cumulative Percent
Not support at all	28.5	28.5
Weak support	13.8	42.3
Moderate support	38.8	81.1
Strong support	16.2	97.3
Don't know / Hard to say	2.7	100.0
Total	100.0	

Respondents were asked to rate their level of support for examining the forecast of manpower requirements to ensure that there is education and training capacity for an adequate supply of various healthcare professionals.

Figure 4.15 indicates that about two thirds of all respondents (65.6%) expressed strong support and another over a quarter of them (28.4%) had moderate support for examining the forecast of manpower requirements while about 6% of them (5.8%) had weak support / not support at all.

Figure 4.15 Level of support for examining the forecast of manpower requirements to ensure that there is education and training capacity for an adequate supply of various healthcare professionals



(Base: All respondents)

Table 4.15 Level of support for examining the forecast of manpower requirements to ensure that there is education and training capacity for an adequate supply of various healthcare professionals

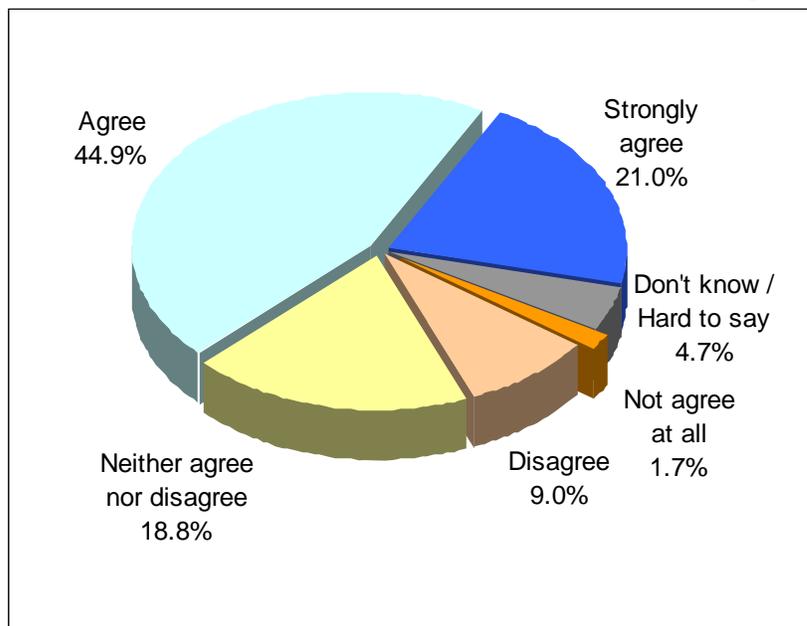
Level of support	Percent	Cumulative Percent
Not support at all	1.7	1.7
Weak support	4.1	5.8
Moderate support	28.4	34.2
Strong support	65.6	99.7
Don't know / Hard to say	0.3	100.0
Total	100.0	

4.4 Electronic health record sharing

Respondents were asked to rate their level of agreement that currently not enough attention is being given to the development of continuity of care and an effective interface between different healthcare providers at different levels of care, which are essential for providing better quality of care.

Figure 4.16 indicates that over one-fifth of all respondents (21.0%) strongly agreed and another over two-fifths of them (44.9%) agreed that not enough attention is being given to the development of continuity of care and an effective interface while about one-tenth of them (10.7%) disagreed/not agree at all. About one-fifth of them (18.8%) neither agreed nor disagreed.

Figure 4.16 Agreement that currently not enough attention is being given to the development of continuity of care and an effective interface between different healthcare providers at different levels of care, which are essential for providing better quality of care



(Base: All respondents)

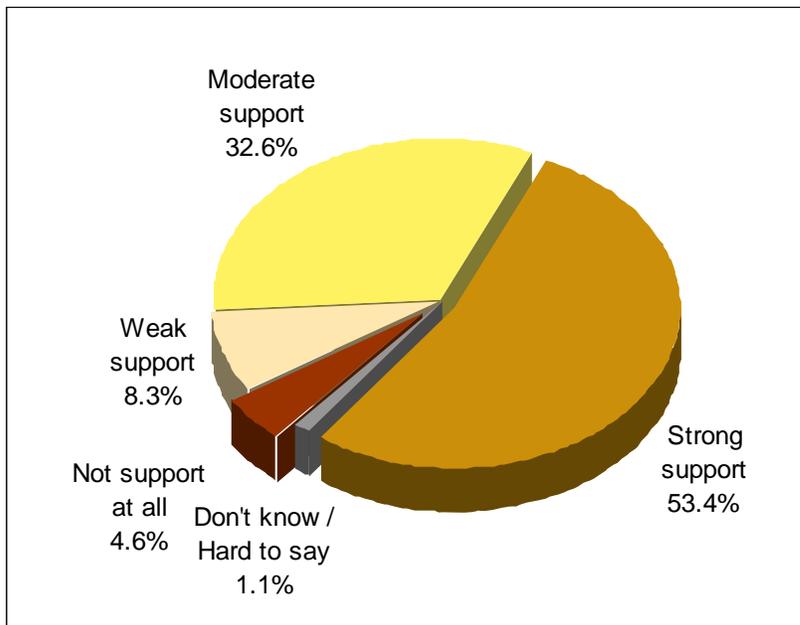
Table 4.16 Agreement that currently not enough attention is being given to the development of continuity of care and an effective interface between different healthcare providers at different levels of care, which are essential for providing better quality of care

Level of agreement	Percent	Cumulative Percent
Not agree at all	1.7	1.7
Disagree	9.0	10.7
Neither agree nor disagree	18.8	29.4
Agree	44.9	74.3
Strongly agree	21.0	95.3
Don't know / Hard to say	4.7	100.0
Total	100.0	

Respondents were asked to rate their level of support for the development of an electronic health record sharing system for sharing medical records between private and public healthcare providers.

Figure 4.17 indicates that over half of all respondents (53.4%) expressed strong support and another about one third of them (32.6%) had moderate support for the development of an electronic health record sharing system while almost 13% of them (12.9%) had weak support / not support at all.

Figure 4.17 Level of support for the development of an electronic health record sharing system for sharing medical records between private and public healthcare providers



(Base: All respondents)

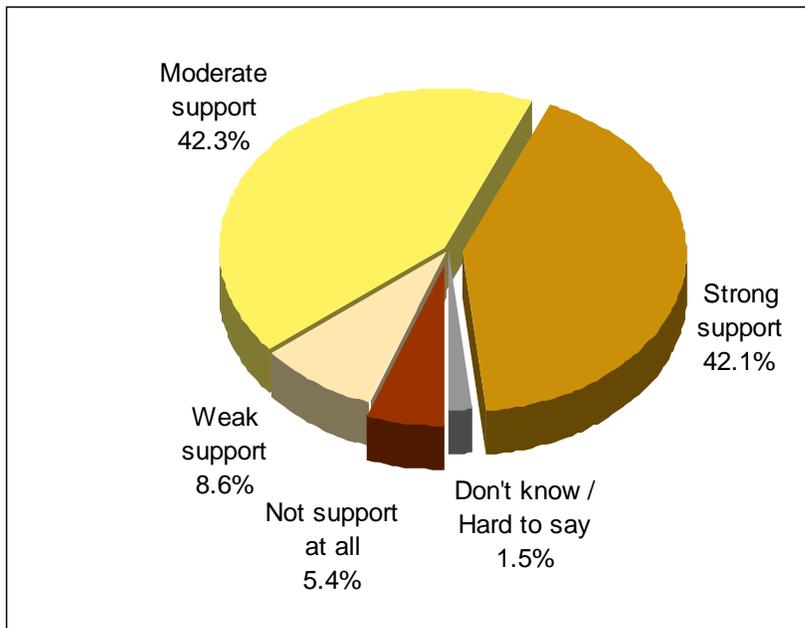
Table 4.17 Level of support for the development of an electronic health record sharing system for sharing medical records between private and public healthcare providers

Level of support	Percent	Cumulative Percent
Not support at all	4.6	4.6
Weak support	8.3	12.9
Moderate support	32.6	45.5
Strong support	53.4	98.9
Don't know / Hard to say	1.1	100.0
Total	100.0	

Respondents were asked to rate their level of support for the government funding the capital cost for the necessary infrastructure for sharing electronic health records.

Figure 4.18 indicates that about two-fifths of all respondents expressed strong support (42.1%) and another similar proportion (42.3%) had moderate support for the government funding the capital cost while 14% of them had weak support / not support at all.

Figure 4.18 Level of support for the government funding the capital cost for the necessary infrastructure for sharing electronic health records



(Base: All respondents)

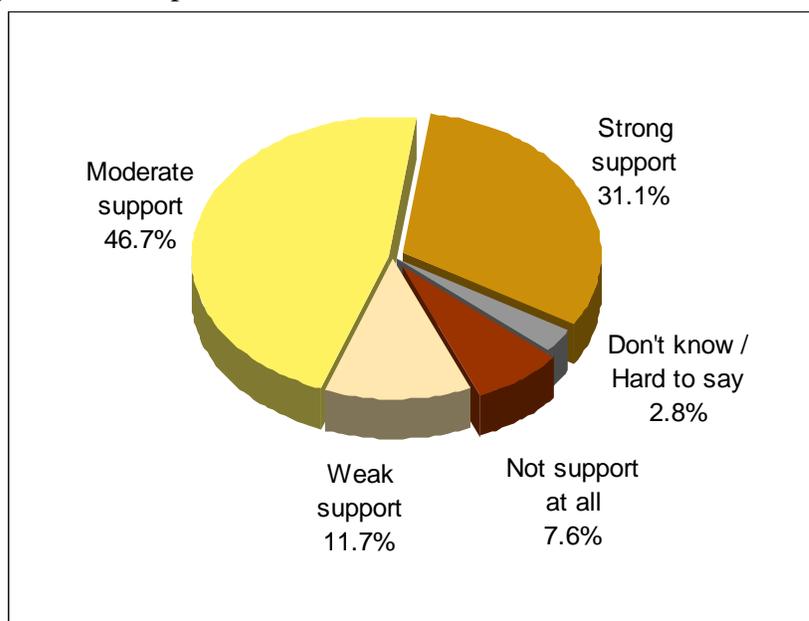
Table 4.18 Level of support for the government funding the capital cost for the necessary infrastructure for sharing electronic health records

Level of support	Percent	Cumulative Percent
Not support at all	5.4	5.4
Weak support	8.6	14.0
Moderate support	42.3	56.3
Strong support	42.1	98.5
Don't know / Hard to say	1.5	100.0
Total	100.0	

Respondents were asked to rate their level of support for making available public sector software and know - how for further development and deployment of the electronic health record sharing systems in the private sector.

Figure 4.19 indicates that less than one third of all respondents (31.1%) expressed strong support and another over two-fifths of them (46.7%) had moderate support for making available public sector software of these systems in the private sector while about one-fifth of them (19.3%) had weak support / not support at all.

Figure 4.19 Level of support for making available public sector software and know - how for further development and deployment of the electronic health record sharing systems in the private sector



(Base: All respondents)

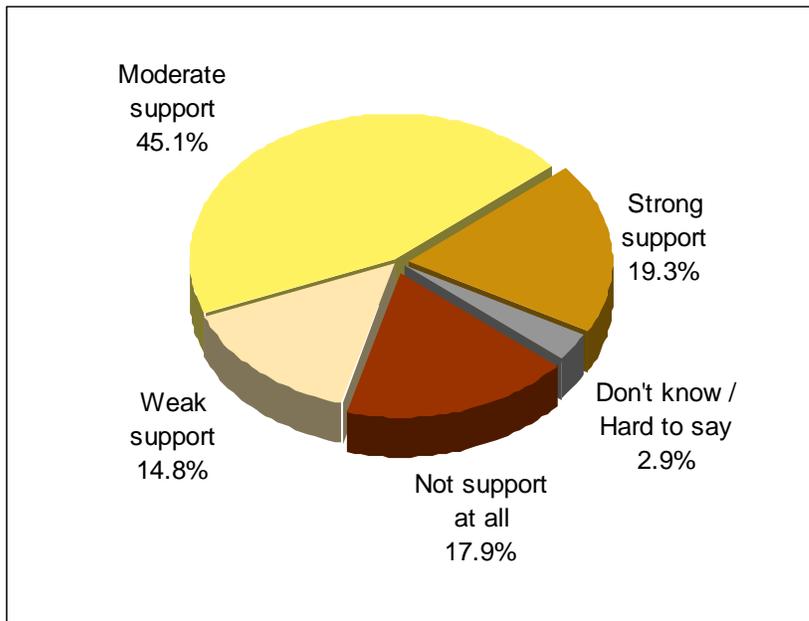
Table 4.19 Level of support for making available public sector software and know - how for further development and deployment of the electronic health record sharing systems in the private sector

Level of support	Percent	Cumulative Percent
Not support at all	7.6	7.6
Weak support	11.7	19.4
Moderate support	46.7	66.0
Strong support	31.1	97.2
Don't know / Hard to say	2.8	100.0
Total	100.0	

Respondents were asked to rate their level of support for providing other financial assistance to facilitate the development and deployment of the electronic health record sharing systems in the private sector.

Figure 4.20 indicates that the about one-fifth of all respondents (19.3%) expressed strong support while over two-fifths of them (45.1%) had moderate support for providing other financial assistance of these systems in private sector. However, about one third of them (32.7%) had weak support / not support at all for providing other financial assistance.

Figure 4.20 Level of support for providing other financial assistance to facilitate the development and deployment of the electronic health record sharing systems in the private sector



(Base: All respondents)

Table 4.20 Level of support for providing other financial assistance to facilitate the development and deployment of the electronic health record sharing systems in the private sector

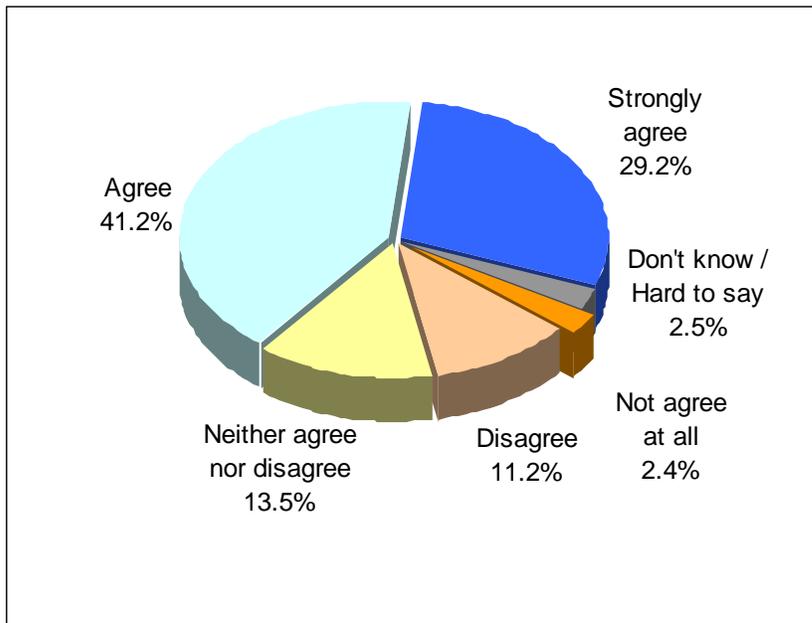
Level of support	Percent	Cumulative Percent
Not support at all	17.9	17.9
Weak support	14.8	32.7
Moderate support	45.1	77.8
Strong support	19.3	97.1
Don't know / Hard to say	2.9	100.0
Total	100.0	

4.5 Public healthcare safety net

Respondents were asked to rate their level of agreement that the present public healthcare safety net does not sufficiently protect patients with illnesses that require costly treatment.

Figure 4.21 indicates that less than one third of them (29.2%) strongly agreed and another slightly over two-fifths of all respondents (41.2%) agreed that the present public healthcare safety net does not sufficiently protect patients while the same proportion of them disagreed/not agree at all (13.6%) and neither agreed nor disagreed (13.5%).

Figure 4.21 Agreement that the present public healthcare safety net does not sufficiently protect patients with illnesses that require costly treatment



(Base: All respondents)

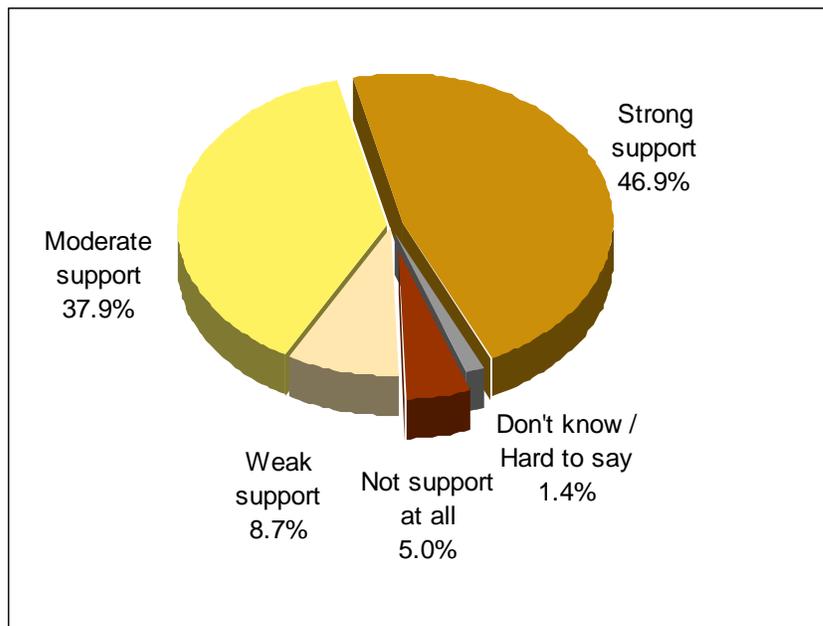
Table 4.21 Agreement that the present public healthcare safety net does not sufficiently protect patients with illnesses that require costly treatment

Level of agreement	Percent	Cumulative Percent
Not agree at all	2.4	2.4
Disagree	11.2	13.6
Neither agree nor disagree	13.5	27.1
Agree	41.2	68.3
Strongly agree	29.2	97.5
Don't know / Hard to say	2.5	100.0
Total	100.0	

Respondents were asked to rate their level of support for reducing the waiting time of public hospital services through strengthening existing service provision or purchasing services from the private sector.

Figure 4.22 indicates that over two-fifths of all respondents (46.9%) expressed strong support and another over one third of them (37.9%) had moderate support for reducing the waiting time of public hospital services through strengthening existing service provision or purchasing services from the private sector while about 14% of them (13.7%) had weak support / not support at all.

Figure 4.22 Level of support for reducing the waiting time of public hospital services through strengthening existing service provision or purchasing services from the private sector



(Base: All respondents)

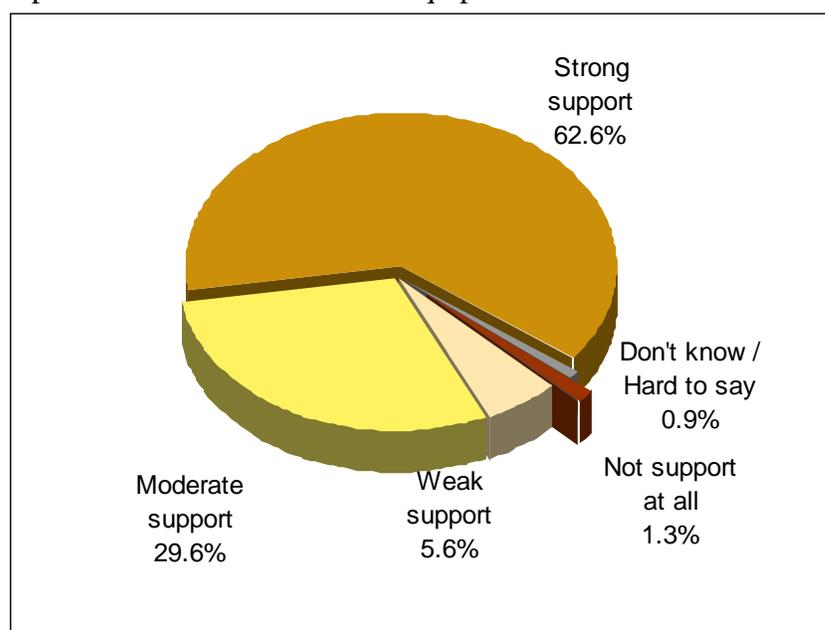
Table 4.22 Level of support for reducing the waiting time of public hospital services through strengthening existing service provision or purchasing services from the private sector

Level of support	Percent	Cumulative Percent
Not support at all	5.0	5.0
Weak support	8.7	13.7
Moderate support	37.9	51.6
Strong support	46.9	98.6
Don't know / Hard to say	1.4	100.0
Total	100.0	

Respondents were asked to rate their level of support for improving the coverage of standard public services especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment.

Figure 4.23 indicates that the about two thirds of all respondents (62.6%) expressed strong support and another about one third of them (29.6%) had moderate support for improving the coverage of standard public services while about 7% of them (6.9%) had weak support / not support at all.

Figure 4.23 Level of support for improving the coverage of standard public services especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment



(Base: All respondents)

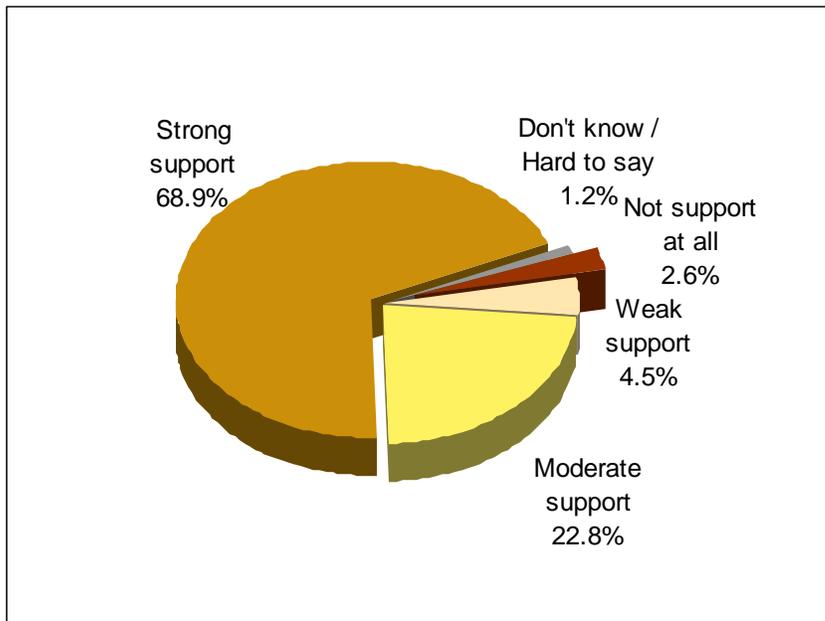
Table 4.23 Level of support for improving the coverage of standard public services especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment.

Level of support	Percent	Cumulative Percent
Not support at all	1.3	1.3
Weak support	5.6	6.9
Moderate support	29.6	36.5
Strong support	62.6	99.1
Don't know / Hard to say	0.9	100.0
Total	100.0	

Respondents were asked to rate their level of support for a “personal limit on medical expenses” beyond which financial assistance would be provided to protect individual patients against financial ruin due to illnesses requiring costly treatment.

Figure 4.24 indicates that over two thirds of all respondents (68.9%) expressed strong support and another over one-fifth of them (22.8%) had moderate support for a “personal limit on medical expenses” beyond which financial assistance would be provided to protect individual patients while about 7% of them (7.1%) had weak support / not support at all.

Figure 4.24 Level of support for a “personal limit on medical expenses” beyond which financial assistance would be provided to protect individual patients against financial ruin due to illnesses requiring costly treatment



(Base: All respondents)

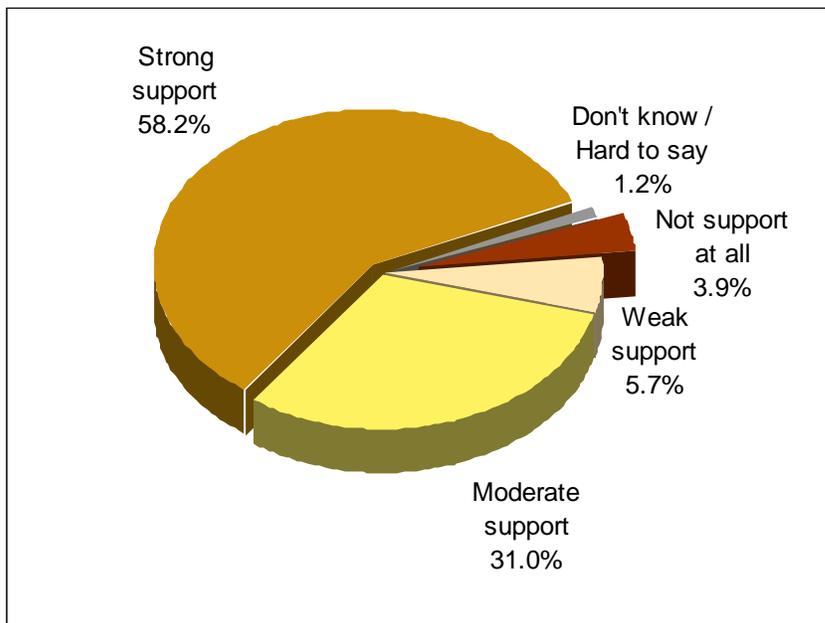
Table 4.24 Level of support for a “personal limit on medical expenses” beyond which financial assistance would be provided to protect individual patients against financial ruin due to illnesses requiring costly treatment

Level of support	Percent	Cumulative Percent
Not support at all	2.6	2.6
Weak support	4.5	7.0
Moderate support	22.8	29.9
Strong support	68.9	98.8
Don't know / Hard to say	1.2	100.0
Total	100.0	

Respondents were asked to rate their level of support for providing extra funding to finance those who are in need, but lack the means to obtain certain expensive medical treatment outside the standard public services.

Figure 4.25 indicates that about three-fifths of all respondents (58.2%) expressed strong support and another, nearly one third of them (31.0%) had moderate support for providing extra funding while about 10% of them (9.6%) had weak support / not support at all.

Figure 4.25 Level of support for providing extra funding to finance those who are in need, but lack the means to obtain certain expensive medical treatment outside the standard public services



(Base: All respondents)

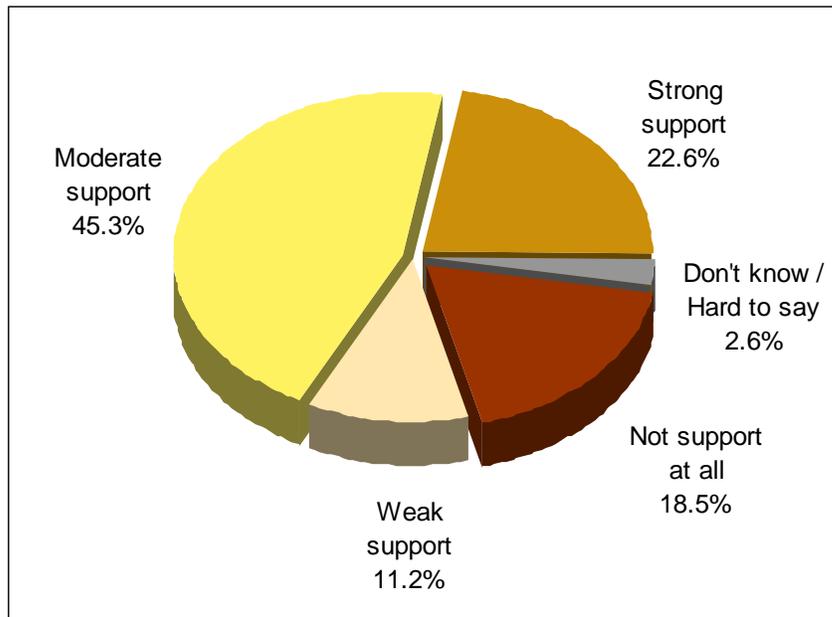
Table 4.25 Level of support for providing extra funding to finance those who are in need, but lack the means to obtain certain expensive medical treatment outside the standard public services

Level of support	Percent	Cumulative Percent
Not support at all	3.9	3.9
Weak support	5.7	9.6
Moderate support	31.0	40.6
Strong support	58.2	98.8
Don't know / Hard to say	1.2	100.0
Total	100.0	

Respondents were asked to rate their level of support for reviewing the public fee structure and adjust upward fees for certain services, subject to ensuring that the safety net adequately protects low income and underprivileged groups.

Figure 4.26 indicates that over one-fifth of all respondents (22.6%) expressed strong support and another over two-fifths of them (45.3%) had moderate support for reviewing the public fee structure and adjust upward fees for certain services. However, about 30% of them (29.7%) had weak support / not support at all.

Figure 4.26 Level of support for reviewing the public fee structure and adjust upward fees for certain services, subject to ensuring that the safety net adequately protects low income and underprivileged groups



(Base: All respondents)

Table 4.26 Level of support for reviewing the public fee structure and adjust upward fees for certain services, subject to ensuring that the safety net adequately protects low income and underprivileged groups

Level of support	Percent	Cumulative Percent
Not support at all	18.5	18.5
Weak support	11.2	29.6
Moderate support	45.3	74.9
Strong support	22.6	97.4
Don't know / Hard to say	2.6	100.0
Total	100.0	

4.6 Summary of support for all the above mentioned government proposals

Figure 4.27 shows a summary of support for all the above mentioned government proposals for reform of the public healthcare system.

Figure 4.27 Summary of support for all the above mentioned government plans

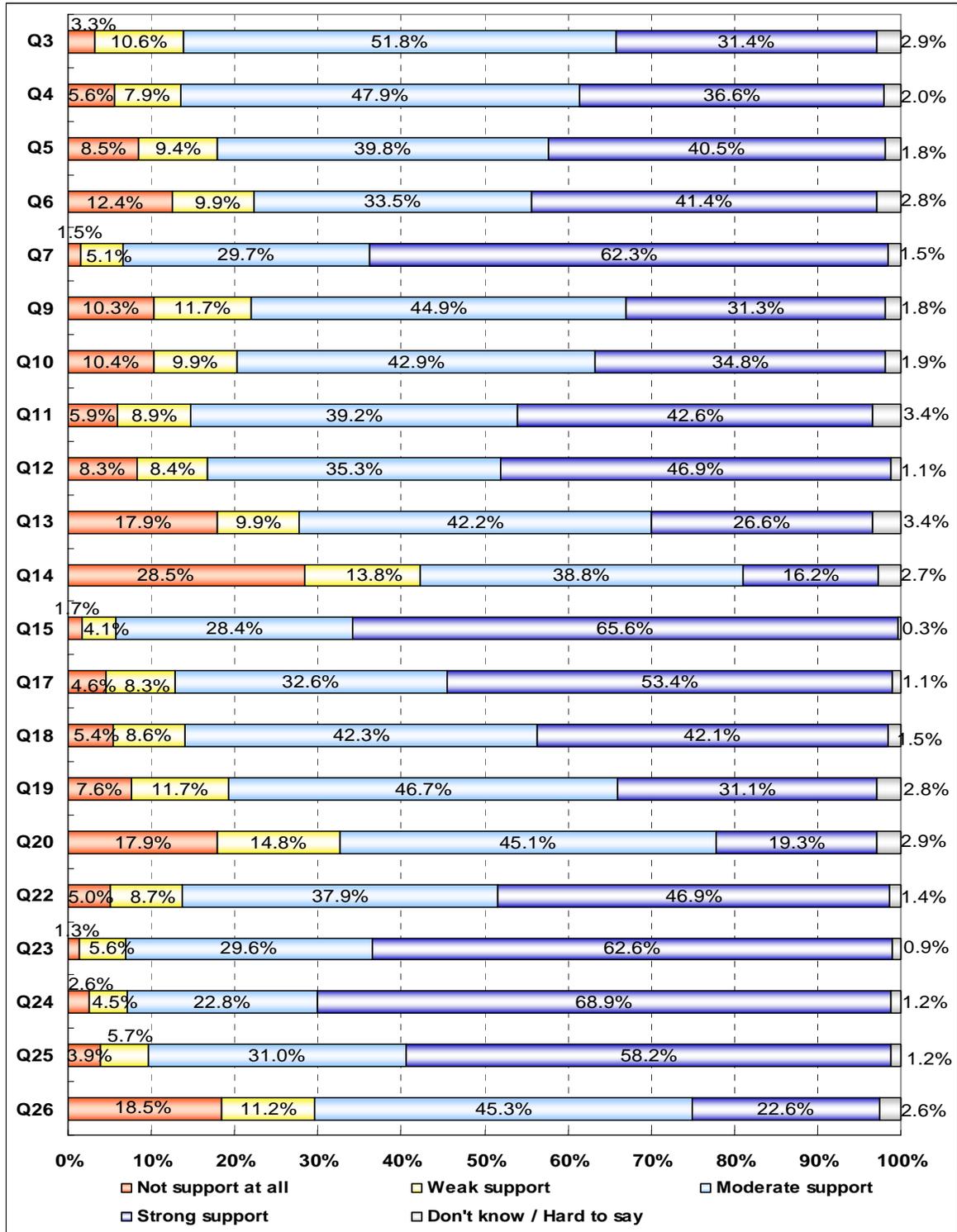


Table 4.27 Question list for all the above mentioned government proposals

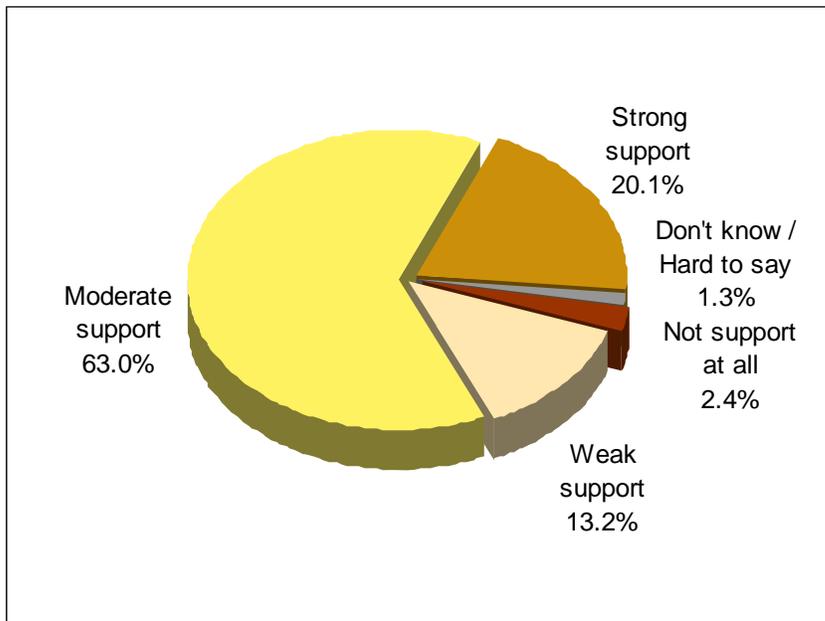
Q3	Developing basic models for comprehensive primary and preventive care services for reference by both healthcare professionals and individuals.
Q4	Establishing a family doctor register for reference by individuals who wish to receive comprehensive primary and preventive care.
Q5	Subsidizing individuals to undertake preventive care through private family doctors.
Q6	Government purchasing primary care services from the private sector for low - income families and under -privileged groups.
Q7	Strengthening public health education, healthy lifestyle promotion, disease prevention, and develop and set the standards for primary care services.
Q9	Government purchasing hospital services from the private sector, especially for non - urgent and/or elective procedures.
Q10	Co -locating public and private hospital facilities to enable coordinated planning and shared use of facilities.
Q11	Setting up medical centres of excellence to draw together top expertise of the relevant specialties locally and overseas, with participation of experts from both the public and private sectors.
Q12	Engaging private sector doctors in public hospitals, on a part - time basis, to help cross - fertilization of expertise and experience.
Q13	Facilitate expansion of capacity in private hospitals through leasing out of vacant public premises or making sites available for private hospital development.
Q14	Facilitate moderate increase in capacity in public hospitals for private services operating on a full cost - recovery basis.
Q15	Examine the forecast of manpower requirements to ensure that there is education and training capacity for an adequate supply of various healthcare professionals.
Q17	The development of an electronic health record sharing system for sharing medical records between private and public healthcare providers.
Q18	Government funding the capital cost for the necessary infrastructure for sharing electronic health records.
Q19	Making available public sector software and know - how for further development and deployment of these systems in the private sector.
Q20	Providing other financial assistance to facilitate the development and deployment of these systems in the private sector.
Q22	Reducing the waiting time of public hospital services through strengthening existing service provision or purchasing services from the private sector.
Q23	Improving the coverage of standard public services especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment.
Q24	A "personal limit on medical expenses" beyond which financial assistance would be provided to protect individual patients against financial ruin due to illnesses requiring costly treatment.
Q25	Providing extra funding to finance those who are in need, but lack the means to obtain certain expensive medical treatment outside the standard public services.
Q26	Reviewing the public fee structure and adjust upward fees for certain services, subject to ensuring that the safety net adequately protects low income and underprivileged groups.

4.7 Overall support for all the above mentioned government proposals

Respondents were asked to rate their level of overall support for all the above mentioned government proposals⁸ for reform of the public healthcare system.

Figure 4.28 indicates that one-fifth of all respondents (20.1%) expressed strong support and another about two thirds of them (63.0%) had moderate support for all the above mentioned government proposals for the healthcare reform while about 16% of them (15.6%) had weak support / not support at all.

Figure 4.28 Level of overall support for all the above mentioned government proposals for reform of the public healthcare system



(Base: All respondents)

Table 4.28 Level of overall support for all the above mentioned government proposals for reform of the public healthcare system

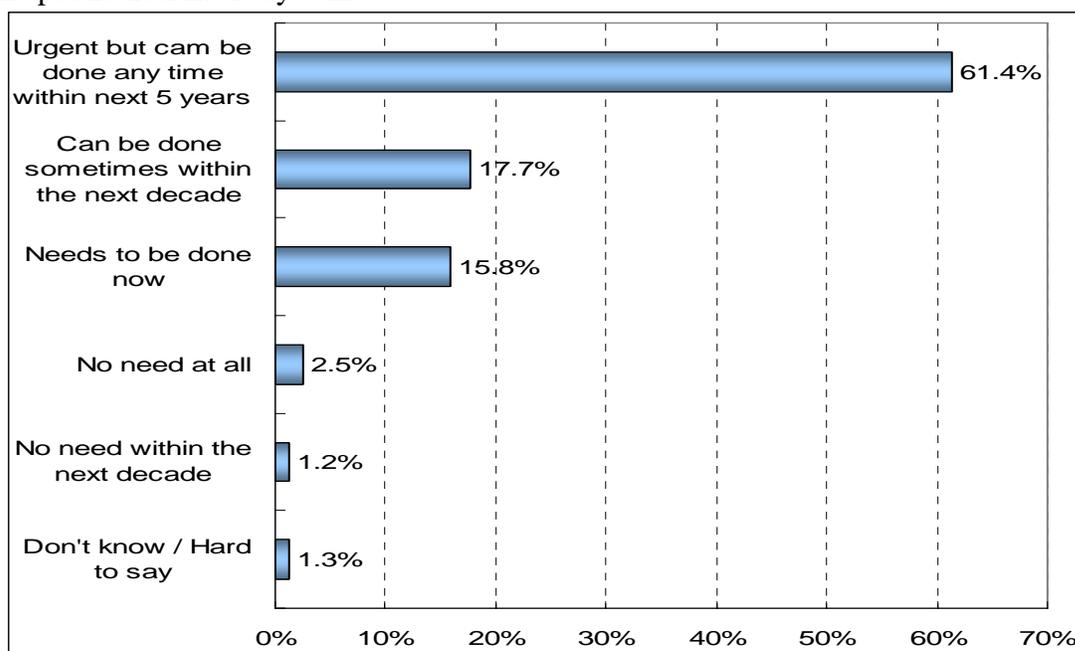
Level of support	Percent	Cumulative Percent
Not support at all	2.4	2.4
Weak support	13.2	15.6
Moderate support	63.0	78.6
Strong support	20.1	98.7
Don't know / Hard to say	1.3	100.0
Total	100.0	

⁸ Use the term “plans” in the questionnaire

Respondents were asked the urgency of all the above mentioned government proposals for reform of the public healthcare system.

Figure 4.29 indicates that over three-fifths of them (61.4%) thought that the above mentioned government proposals for the healthcare reform are urgent but can be done any time within next 5 years. The proportion of respondents who thought that it can be done sometime within the next decade (17.7%) and needs to be done now (15.8%) were similar. A very small minority of them thought that there is no need at all (2.5%) and no need within the next decade (1.2%).

Figure 4.29 The urgency of all the above mentioned government proposals for reform of the public healthcare system



(Base: All respondents)

Table 4.29 The urgency of all the above mentioned government proposals for reform of the public healthcare system

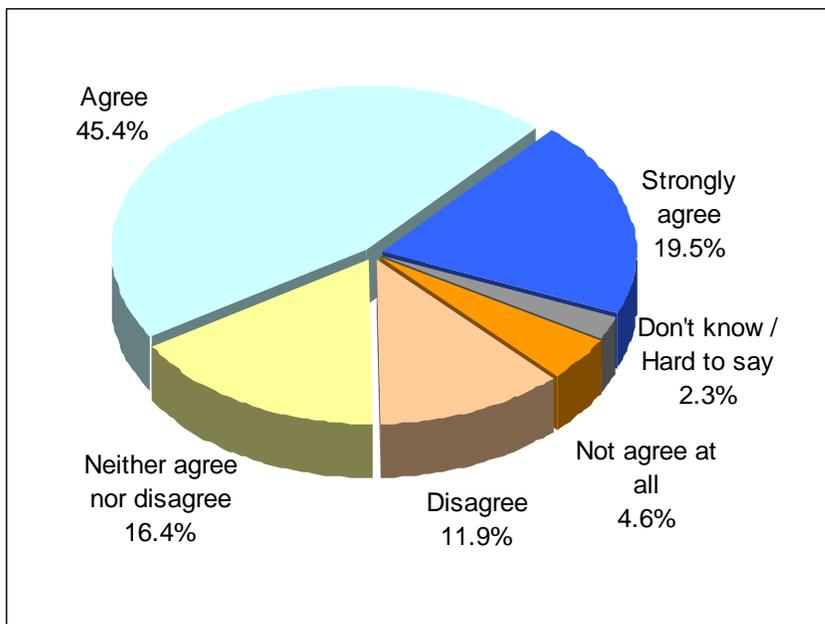
The urgency	Percent	Cumulative Percent
Needs to be done now	15.8	15.8
Urgent but can be done any time within next 5 years	61.4	77.2
Can be done sometime within the next decade	17.7	95.0
No need within the next decade	1.2	96.2
No need at all	2.5	98.7
Don't know / Hard to say	1.3	100.0
Total	100.0	

4.8 Financing reform

Respondents were asked to rate their level of agreement that government funding alone is not sufficient for implementing the above mentioned reform suggestions, together with the need to meet increasing healthcare demand due to population ageing.

Figure 4.30 indicates that about one-fifth of them (19.5%) strongly agreed and nearly half of them (45.4%) agreed that government funding alone is not sufficient while about one-sixth of them (16.5%) disagreed/not agreed at all. Another one-sixth of them (16.4%) neither agreed nor disagreed.

Figure 4.30 Agreement that the government funding alone is not sufficient for implementing the above mentioned reform suggestions, together with the need to meet increasing healthcare demand due to population ageing



(Base: All respondents)

Table 4.30 Agreement that the government funding alone is not sufficient for implementing the above mentioned reform suggestions, together with the need to meet increasing healthcare demand due to population ageing

Level of agreement	Percent	Cumulative Percent
Not agree at all	4.6	4.6
Disagree	11.9	16.4
Neither agree nor disagree	16.4	32.8
Agree	45.4	78.2
Strongly agree	19.5	97.7
Don't know / Hard to say	2.3	100.0
Total	100.0	

Chapter Five Sub-group analysis by demographic information and related questions

In this chapter, sub-group analyses are shown based on the breakdown of respondents' demographic information including gender, age group, education level, employment status, economic activity status, and monthly household income to see if there are any significant associations between these demographic factors and the areas being investigated. Besides, other related factors were also considered for special areas of interest. This includes hospitalisation within the last 12 months, health status, and self-reported to having a chronic condition or being on regular medication.

The demographic variable of age has been re-grouped into smaller number of categories in order to make the sub-group analyses more robust and representative. The response of 'don't know/can't remember', 'don't know/hard to say', 'not applicable' and 'refuse to answer' have been excluded from all the sub-group analyses in this chapter.

The statistical test⁹ used for sub-group analysis in this report is the Pearson chi-square test with weighting and all percentages are reported after weighting for gender and age.

Only statistically significant results at the 5% level are presented in this chapter. For the Pearson chi-square test, those tables with more than 20% of cells had expected values less than 5 were not reported, as in this case the underlying assumption of chi-square test was violated. Thus, only those tables where no more than 20% of the cells had expected values less than 5 are included.

Table 5.1 Re-grouping the responses of demographic information

Demographic variable	Original level	Re-grouped level	Sample size (weighted)
Age group	18-29	18-29	216
	30-39	30-39	208
	40-49	40-49	255
	50-59	50-64	269
	60-64		
	65-69	65 or above	168
	70 or above		

⁹ The statistical software package SPSS was used to perform these statistical tests. Formulae for the three tests are included for reference.

Pearson chi-square statistics:

$$\chi^2 = \sum_i \sum_j \frac{(O_{ij} - e_{ij})^2}{e_{ij}}$$

where O_{ij} is the observed value corresponding to the i th column and the j th row, e_{ij} is the expected value corresponding to the i th column and the j th row. The calculation of e_{ij} is as follows: expected value = (ith column total x jth row total) / Overall total

5.1 Awareness of the consultation on healthcare reform

Younger respondents (aged 18-29), those with lower education attainment (primary or below), students and those with lower monthly household income were less likely to be aware of the reform.

Table 5.2 Awareness of the consultation on healthcare reform (Q1)

Variable	Level	Yes	No	P-value
				Chi-square test
Age group	18-29	62.6%	37.4%	<0.001
	30-39	85.2%	14.8%	
	40-49	83.3%	16.7%	
	50-64	74.3%	25.7%	
	65 or above	75.1%	24.9%	
Education level	Primary or below	58.4%	41.6%	<0.001
	Had not completed secondary	70.9%	29.1%	
	Completed secondary (Form 5)	77.1%	22.9%	
	Matriculation	74.1%	25.9%	
	Tertiary (non-degree)	82.4%	17.6%	
	Tertiary (degree or above)	88.0%	12.0%	
Engaged in a job	Yes	80.1%	19.9%	0.001
	No	71.6%	28.4%	
Not working status	Student	46.7%	53.3%	<0.001
	Home-maker	75.2%	24.8%	
	Unemployed person	72.7%	27.3%	
	Retired person	79.1%	20.9%	
Monthly household income	Less than \$10,000	65.5%	34.5%	<0.001
	\$10,000-19,999	78.0%	22.0%	
	\$20,000-29,999	78.2%	21.8%	
	\$30,000-49,999	80.0%	20.0%	
	\$50,000 or above	87.0%	13.0%	

5.2 Primary care

Older respondents (aged 65 or above), those not working respondents, those who have been admitted in a hospital within the last 12 months for any reason and those who reported to having a chronic condition or being on regular medication during the past 6 months were more likely to not agree at all that there is currently insufficient emphasis by both patients and healthcare providers on comprehensive primary care.

Table 5.3 Agreement that currently insufficient emphasis by both patients and healthcare providers on comprehensive primary care which includes preventive care and wellness promotion (Q2)

Variable	Level	Not agree at all	Disagree	Neither agree nor disagree	Agree	Strongly agree	p-value
							Chi-square test
Gender	Male	3.9%	30.1%	15.9%	43.4%	6.7%	<0.001
	Female	3.6%	25.0%	27.1%	37.8%	6.5%	
Age group	18-29	1.7%	20.8%	31.5%	41.2%	4.8%	<0.001
	30-39	2.1%	29.3%	20.6%	40.0%	8.0%	
	40-49	2.7%	28.8%	21.2%	39.0%	8.3%	
	50-64	3.3%	32.2%	15.9%	41.4%	7.2%	
	65 or above	10.3%	24.4%	20.3%	41.2%	3.8%	
Engaged in a job	Yes	2.0%	28.4%	20.2%	41.1%	8.2%	0.002
	No	5.8%	26.3%	23.5%	39.8%	4.7%	
Admitted to a hospital	Yes	9.5%	27.7%	16.8%	40.7%	5.3%	<0.001
	No	2.7%	27.3%	22.5%	40.6%	6.9%	
Having a chronic condition or being on regular medication	Yes	7.8%	27.9%	19.6%	38.2%	6.5%	<0.001
	No / don't know	1.8%	27.2%	22.7%	41.6%	6.7%	

Males, older respondents (aged 65 or above) and those with lower education attainment (had not completed secondary or below) were more likely to express weak or no support for the development of basic models for comprehensive primary and preventive care services for reference. Retired persons and those with poor health status were more likely to not support at all.

Those with higher monthly household income, those working respondents and those who reported better health status tended to have strong support for the development.

Table 5.4 Level of support for developing basic models for comprehensive primary and preventive care services for reference by both healthcare professionals and individual (Q3)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	4.8%	12.9%	51.6%	30.7%	0.012
	Female	2.0%	9.2%	55.0%	33.8%	
Age group	18-29	0.4%	12.0%	63.8%	23.8%	<0.001
	30-39	2.1%	10.5%	47.7%	39.7%	
	40-49	2.7%	10.8%	48.2%	38.3%	
	50-64	5.4%	8.4%	48.8%	37.4%	
	65 or above	7.0%	14.7%	62.4%	15.9%	
Education level	Primary or below	3.1%	18.6%	55.7%	22.7%	0.002
	Had not completed secondary	7.4%	10.0%	53.7%	29.0%	
	Completed secondary (Form 5)	2.4%	13.2%	49.2%	35.1%	
	Matriculation	1.0%	5.9%	56.8%	36.4%	
	Tertiary (non-degree)	2.9%	4.4%	55.7%	37.0%	
	Tertiary (degree or above)	3.1%	9.7%	54.0%	33.2%	
Engaged in a job	Yes	2.7%	10.4%	50.3%	36.5%	0.007
	No	4.2%	11.6%	57.2%	26.9%	
Not working status	Student	1.0%	10.0%	68.8%	20.3%	0.008
	Home-maker	0.9%	14.0%	51.2%	33.8%	
	Unemployed person	4.7%	12.1%	54.0%	29.3%	
	Retired person	8.3%	10.3%	58.0%	23.4%	
Monthly household income	Less than \$10,000	5.6%	11.3%	56.7%	26.4%	0.044
	\$10,000-19,999	1.2%	12.1%	59.1%	27.6%	
	\$20,000-29,999	4.3%	10.9%	49.0%	35.7%	
	\$30,000-49,999	3.4%	11.3%	47.9%	37.4%	
	\$50,000 or above	2.6%	5.6%	53.5%	38.2%	

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Health status	Excellent	1.8%	6.9%	44.5%	46.8%	0.010
	Very good	3.2%	8.1%	52.7%	36.0%	
	Good	2.8%	8.6%	53.2%	35.5%	
	Fair	3.0%	13.3%	55.6%	28.1%	
	Poor	9.9%	14.1%	47.7%	28.3%	

Females, home-makers and those with higher monthly household income were more likely to have strong support for establishing a family doctor register for reference. In contrast, older respondents and those with monthly household income less than \$10,000 and those with poor health status were more likely to have no support at all.

Table 5.5 Level of support for establishing a family doctor register for reference by individuals who wish to receive comprehensive primary and preventive care (Q4)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	6.1%	8.8%	52.5%	32.5%	0.019
	Female	5.4%	7.4%	45.5%	41.8%	
Age group	18-29	3.4%	12.9%	52.4%	31.4%	<0.001
	30-39	2.7%	7.0%	44.4%	45.9%	
	40-49	7.5%	4.8%	50.2%	37.6%	
	50-64	6.0%	5.1%	49.2%	39.6%	
	65 or above	9.9%	12.8%	47.2%	30.1%	
Not working status	Student	3.4%	19.1%	59.4%	18.1%	0.001
	Home-maker	6.0%	6.1%	43.0%	44.9%	
	Unemployed person	5.8%	5.6%	61.5%	27.2%	
	Retired person	7.1%	11.3%	46.5%	35.1%	
Monthly household income	Less than \$10,000	10.6%	7.5%	53.4%	28.5%	0.013
	\$10,000-19,999	3.8%	7.9%	54.5%	33.8%	
	\$20,000-29,999	7.0%	7.7%	46.0%	39.3%	
	\$30,000-49,999	7.0%	6.1%	41.2%	45.7%	
	\$50,000 or above	2.9%	6.4%	48.3%	42.4%	
Health status	Excellent	4.8%	5.8%	42.9%	46.5%	<0.001
	Very good	3.8%	5.8%	46.0%	44.4%	
	Good	2.3%	9.4%	48.2%	40.0%	
	Fair	5.7%	9.3%	52.4%	32.6%	
	Poor	24.1%	2.9%	38.8%	34.3%	

More females, those with completed education level of secondary, aged 30-39, those working respondents and those who did not report suffering from a chronic disease or taking regular medication during the past 6 months were more likely to have strong support for subsidizing individuals to undertake preventive care through private family doctor. Furthermore, respondents aged 50 or above tended to not support at all.

Table 5.6 Level of support for subsidizing individuals to undertake preventive care through private family doctors (Q5)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	11.3%	11.7%	39.2%	37.9%	0.001
	Female	6.2%	7.7%	41.9%	44.3%	
Age group	18-29	4.2%	12.7%	44.6%	38.5%	<0.001
	30-39	7.0%	9.6%	30.7%	52.7%	
	40-49	6.8%	7.5%	44.4%	41.3%	
	50-64	13.1%	8.2%	36.8%	41.9%	
	65 or above	12.3%	11.0%	47.7%	29.0%	
Education level	Primary or below	10.1%	16.8%	40.6%	32.5%	0.042
	Had not completed secondary	12.9%	5.9%	41.0%	40.1%	
	Completed secondary (Form 5)	6.5%	7.4%	39.2%	46.9%	
	Matriculation	5.1%	8.9%	40.9%	45.0%	
	Tertiary (non-degree)	7.5%	9.7%	42.4%	40.4%	
	Tertiary (degree or above)	9.2%	10.5%	41.0%	39.4%	
Engaged in a job	Yes	7.1%	8.8%	39.4%	44.7%	0.023
	No	10.6%	10.6%	42.1%	36.7%	
Having a chronic condition or being on regular medication	Yes	11.4%	8.2%	46.2%	34.2%	0.002
	No / don't know	7.4%	10.3%	38.0%	44.3%	

More females, those aged 40-49, those working respondents and those who claimed that their health status was excellent/very good were more likely to strongly support for the government purchasing primary care services from the private sector for low income families and under privileged groups. On the contrary, a higher proportion of unemployed persons did not support at all.

Table 5.7 Level of support for the government purchasing primary care services from the private sector for low income families and under privileged groups (Q6)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	15.6%	10.3%	35.1%	39.0%	0.020
	Female	10.0%	10.0%	33.9%	46.1%	
Age group	18-29	7.5%	11.9%	38.8%	41.8%	<0.001
	30-39	13.2%	8.2%	35.7%	42.8%	
	40-49	13.0%	6.9%	34.0%	46.2%	
	50-64	16.1%	6.9%	33.7%	43.3%	
	65 or above	13.5%	20.9%	28.8%	36.7%	
Engaged in a job	Yes	13.8%	7.3%	35.7%	43.3%	0.004
	No	11.4%	13.8%	33.0%	41.8%	
Not working status	Student	1.0%	12.9%	42.0%	44.0%	0.010
	Home-maker	11.1%	14.0%	33.9%	40.9%	
	Unemployed person	22.7%	10.4%	19.3%	47.6%	
	Retired person	12.8%	15.2%	32.1%	39.9%	
Health status	Excellent	13.9%	6.4%	24.3%	55.4%	<0.001
	Very good	3.6%	9.1%	38.8%	48.4%	
	Good	12.4%	8.8%	38.1%	40.7%	
	Fair	16.4%	10.1%	33.9%	39.6%	
	Poor	12.2%	21.9%	22.4%	43.5%	

Working respondents were more likely to express strong support for the strengthening public health education, healthy lifestyle promotion, disease prevention, and develop and set the standards for primary care services.

Table 5.8 Level of support for strengthening public health education, healthy lifestyle promotion, disease prevention, and develop and set the standards for primary care services. (Q7)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Engaged in a job	Yes	1.6%	3.9%	27.7%	66.7%	0.029
	No	1.4%	6.7%	32.9%	59.0%	

5.3 Public-private partnership

Older respondents (aged 65 or above), those with primary education level or below and students and respondents with lower household income were less likely to strongly agree that the significant public private imbalance in our healthcare system has led to limited choice for you as well as inadequate competition and collaboration among healthcare providers in both the public and private sectors.

Table 5.9 Agreement level with the significant public private imbalance in our healthcare system has led to limited choice for you as well as inadequate competition and collaboration among healthcare providers in both the public and private sectors (Q8)

Variable	Level	Not agree at all	Disagree	Neither agree nor disagree	Agree	Strongly agree	p-value
							Chi-square test
Age group	18-29	0.8%	16.1%	29.3%	41.7%	12.1%	<0.001
	30-39	3.9%	12.8%	23.4%	40.1%	19.8%	
	40-49	2.5%	19.1%	21.3%	39.3%	17.8%	
	50-64	3.2%	17.6%	20.2%	48.0%	11.0%	
	65 or above	3.1%	27.7%	10.8%	51.6%	6.8%	
Education level	Primary or below	4.3%	23.9%	17.0%	49.3%	5.5%	0.035
	Had not completed secondary	2.8%	18.5%	23.7%	43.7%	11.3%	
	Completed secondary (Form 5)	2.2%	17.8%	25.1%	41.2%	13.7%	
	Matriculation	2.1%	18.8%	21.2%	45.1%	12.9%	
	Tertiary (non-degree)	1.2%	17.8%	28.7%	37.0%	15.3%	
	Tertiary (degree or above)	3.0%	15.6%	16.2%	45.3%	19.9%	
Engaged in a job	Yes	2.4%	17.1%	23.2%	40.1%	17.2%	0.001
	No	3.0%	19.7%	19.3%	48.4%	9.5%	
Not working status	Student		19.1%	29.6%	46.6%	4.7%	0.009
	Home-maker	1.7%	18.2%	18.6%	47.3%	14.3%	
	Unemployed person	6.5%	11.2%	25.1%	43.8%	13.4%	
	Retired person	4.4%	23.7%	13.8%	51.5%	6.7%	
Monthly household income	Less than \$10,000	3.2%	17.9%	18.7%	53.5%	6.7%	<0.001
	\$10,000-19,999	3.1%	18.3%	30.9%	39.5%	8.1%	
	\$20,000-29,999	2.4%	16.9%	19.1%	45.2%	16.4%	
	\$30,000-49,999	.9%	17.3%	19.4%	46.9%	15.5%	
	\$50,000 or above	3.3%	14.4%	15.8%	40.2%	26.4%	

A higher proportion of working respondents, home-makers, retired persons and those aged 30-49 expressed strong support for the government purchasing hospital services from the private sector, especially for non urgent and/or elective procedures. Those who did not report suffering from a chronic disease or taking regular medication during the past 6 months had moderate support.

Table 5.10 Level of support for the government purchasing hospital services from the private sector, especially for non urgent and/or elective procedures. (Q9)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Age group	18-29	4.6%	18.9%	56.8%	19.8%	<0.001
	30-39	9.7%	9.3%	42.6%	38.4%	
	40-49	12.7%	10.0%	39.3%	37.9%	
	50-64	13.0%	9.4%	44.4%	33.1%	
	65 or above	11.5%	13.4%	46.9%	28.3%	
Engaged in a job	Yes	11.5%	9.4%	45.4%	33.6%	0.018
	No	9.1%	15.1%	46.0%	29.8%	
Not working status	Student	1.0%	26.1%	57.6%	15.3%	<0.001
	Home-maker	10.1%	12.1%	43.4%	34.4%	
	Unemployed person	14.1%	19.7%	44.3%	21.9%	
	Retired person	10.2%	11.6%	43.4%	34.8%	
Having a chronic condition or being on regular medication	Yes	14.1%	11.9%	38.6%	35.4%	0.003
	No / don't know	8.8%	12.0%	48.9%	30.3%	

A higher proportion of those who claimed that their health status was poor or excellent had strong support for co-locating public and private hospital facilities to enable coordinated planning and shared use of facilities. Furthermore, a smaller proportion of those aged 18-29, with primary or tertiary degree education and students had strong support.

Those with higher education attainment, not working, especially students and unemployed persons, and those with excellent health were more likely to express no support at all.

Table 5.11 Level of support for co-locating public and private hospital facilities to enable coordinated planning and shared use of facilities. (Q10)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Age group	18-29	11.6%	16.9%	47.2%	24.3%	<0.001
	30-39	10.2%	10.9%	40.6%	38.2%	
	40-49	12.0%	5.4%	41.8%	40.8%	
	50-64	11.1%	4.2%	46.2%	38.5%	
	65 or above	7.0%	17.0%	42.7%	33.3%	
Education level	Primary or below	5.7%	18.0%	48.8%	27.5%	<0.001
	Had not completed secondary	6.2%	7.5%	46.2%	40.0%	
	Completed secondary (Form 5)	8.5%	8.6%	39.9%	43.1%	
	Matriculation	13.9%	10.2%	41.7%	34.2%	
	Tertiary (non-degree)	12.8%	8.0%	41.4%	37.8%	
	Tertiary (degree or above)	16.6%	9.8%	45.2%	28.4%	
Engaged in a job	Yes	9.7%	8.8%	42.8%	38.7%	0.050
	No	11.7%	11.8%	45.1%	31.4%	
Not working status	Student	15.9%	16.6%	51.7%	15.8%	0.032
	Home-maker	7.9%	10.9%	47.7%	33.5%	
	Unemployed person	17.1%	14.6%	38.0%	30.4%	
	Retired person	11.4%	9.5%	42.1%	36.9%	
Health status	Excellent	15.3%	14.0%	26.3%	44.4%	0.010
	Very good	9.5%	8.4%	44.5%	37.6%	
	Good	11.8%	7.6%	44.4%	36.2%	
	Fair	10.8%	11.0%	47.1%	31.1%	
	Poor	4.3%	14.6%	31.0%	50.2%	

Those aged 65 or above, with primary or below education level, retired persons, with monthly household income less than \$10,000 and those who claimed that their health status was fair were less likely to express strong support for setting up medical centres of excellence to draw together top expertise of the relevant specialties locally and overseas, with participation of experts from both the public and private sectors.

Table 5.12 Level of support for setting up medical centres of excellence to draw together top expertise of the relevant specialties locally and overseas, with participation of experts from both the public and private sectors. (Q11)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Age group	18-29	3.6%	14.6%	39.2%	42.6%	<0.001
	30-39	5.0%	7.7%	39.0%	48.3%	
	40-49	7.8%	5.0%	36.8%	50.5%	
	50-64	6.6%	8.1%	40.2%	45.0%	
	65 or above	7.8%	12.3%	51.8%	28.1%	
Education level	Primary or below	10.6%	12.1%	50.1%	27.2%	0.001
	Had not completed secondary	5.9%	7.4%	46.8%	39.9%	
	Completed secondary (Form 5)	5.1%	8.8%	35.1%	51.0%	
	Matriculation	4.9%	9.6%	31.9%	53.6%	
	Tertiary (non-degree)	2.6%	5.2%	41.3%	51.0%	
	Tertiary (degree or above)	6.9%	10.7%	40.2%	42.2%	
Not working status	Student	2.7%	12.2%	35.6%	49.5%	0.025
	Home-maker	3.0%	12.7%	38.5%	45.8%	
	Unemployed person	9.5%	5.6%	44.2%	40.7%	
	Retired person	10.1%	11.7%	46.3%	32.0%	
Health status	Excellent	4.0%	3.9%	46.0%	46.1%	0.021
	Very good	2.6%	11.1%	36.0%	50.4%	
	Good	6.2%	8.9%	35.0%	49.9%	
	Fair	7.5%	9.6%	45.0%	37.9%	
	Poor	7.6%	6.1%	36.8%	49.5%	

Those aged 50-64, those who had been admitted to a hospital within the last 12 months and those who claimed that their health status was poor were more likely to express strong support for engaging private sector doctors in public hospitals, on a part-time basis, to help cross fertilization of expertise and experience.

Table 5.13 Level of support for engaging private sector doctors in public hospitals, on a part-time basis, to help cross fertilization of expertise and experience. (Q12)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Age group	18-29	6.9%	11.4%	40.7%	41.1%	0.025
	30-39	8.7%	10.7%	32.6%	48.0%	
	40-49	10.3%	7.1%	36.6%	46.0%	
	50-64	8.9%	3.4%	34.7%	53.0%	
	65 or above	6.5%	12.2%	32.7%	48.6%	
Admitted to a hospital	Yes	5.3%	15.4%	28.1%	51.2%	0.001
	No	9.0%	7.2%	36.9%	46.8%	
Health status	Excellent	8.1%	9.3%	27.5%	55.2%	0.020
	Very good	6.0%	9.8%	35.1%	49.1%	
	Good	7.6%	5.1%	34.1%	53.3%	
	Fair	9.7%	10.0%	38.9%	41.4%	
	Poor	8.9%	5.1%	24.2%	61.7%	

Males, retired persons and those who reported having a chronic condition or being on regular medication were more likely to express strong support for facilitating expansion of capacity in private hospitals through leasing out of vacant public premises or making sites available for private hospital development. On the contrary, those aged 18-29 were less likely to express strong support.

Table 5.14 Level of support for facilitating expansion of capacity in private hospitals through leasing out of vacant public premises or making sites available for private hospital development. (Q13)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	17.6%	10.2%	39.3%	32.8%	0.003
	Female	19.2%	10.4%	47.6%	22.8%	
Age group	18-29	20.2%	20.4%	44.3%	15.1%	<0.001
	30-39	16.2%	11.6%	43.3%	28.8%	
	40-49	24.0%	4.8%	43.0%	28.1%	
	50-64	19.8%	6.0%	39.9%	34.2%	
	65 or above	8.5%	10.3%	50.1%	31.0%	
Not working status	Student	15.6%	28.0%	40.5%	15.8%	<0.001
	Home-maker	19.8%	14.0%	42.3%	23.9%	
	Unemployed person	30.9%	7.0%	36.7%	25.5%	
	Retired person	12.9%	5.6%	50.9%	30.6%	
Having a chronic condition or being on regular medication	Yes	16.0%	6.3%	45.4%	32.3%	0.004
	No / don't know	19.6%	12.1%	42.9%	25.4%	

Older respondents, males, those with low educational attainment at primary level or below and unemployed persons were more likely to not support at all facilitating a moderate increase in capacity in public hospitals for private services operating on a full cost recovery basis. On the contrary, students were less likely to not support at all.

Those with primary or below education level, those with monthly household income \$10,000 - \$19,999 and those who claimed their health status was fair were less likely to express strong support, while working respondents were more likely to have strong support.

Table 5.15 Level of support for facilitating a moderate increase in capacity in public hospitals for private services operating on a full cost recovery basis (Q14)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	33.7%	14.2%	37.1%	15.0%	0.014
	Female	25.1%	14.3%	42.4%	18.2%	
Age group	18-29	16.5%	24.5%	47.9%	11.1%	<0.001
	30-39	27.0%	10.8%	42.0%	20.2%	
	40-49	33.3%	8.3%	40.0%	18.5%	
	50-64	35.7%	9.2%	36.7%	18.4%	
	65 or above	32.8%	21.9%	31.5%	13.9%	
Education level	Primary or below	37.5%	18.2%	34.0%	10.3%	0.028
	Had not completed secondary	30.8%	15.4%	37.1%	16.7%	
	Completed secondary (Form 5)	27.9%	10.1%	41.4%	20.6%	
	Matriculation	20.3%	21.6%	45.7%	12.4%	
	Tertiary (non-degree)	28.4%	15.9%	39.7%	15.9%	
	Tertiary (degree or above)	29.1%	12.3%	41.2%	17.5%	
Engaged in a job	Yes	29.2%	10.9%	41.2%	18.7%	0.002
	No	29.4%	18.4%	38.1%	14.1%	
Not working status	Student	15.8%	32.9%	43.8%	7.5%	0.002
	Home-maker	31.3%	18.2%	36.6%	13.9%	
	Unemployed person	37.7%	11.7%	41.2%	9.5%	
	Retired person	31.3%	14.3%	36.0%	18.4%	

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Monthly household income	Less than \$10,000	24.9%	15.4%	43.2%	16.5%	0.044
	\$10,000-19,999	34.7%	16.8%	39.5%	9.0%	
	\$20,000-29,999	27.5%	13.4%	40.4%	18.7%	
	\$30,000-49,999	29.9%	10.3%	42.2%	17.7%	
	\$50,000 or above	23.7%	13.2%	40.1%	23.0%	
Health status	Excellent	27.3%	17.3%	29.8%	25.5%	0.008
	Very good	25.1%	15.8%	41.9%	17.2%	
	Good	22.6%	13.3%	44.7%	19.4%	
	Fair	33.2%	14.8%	38.9%	13.2%	
	Poor	37.4%	6.5%	32.6%	23.5%	

A higher proportion of females and working respondents expressed strong support for examining the forecast of manpower requirements to ensure that there is education and training capacity for an adequate supply of various healthcare professionals.

Table 5.16 Level of support for examining the forecast of manpower requirements to ensure that there is education and training capacity for an adequate supply of various healthcare professionals (Q15)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	1.2%	5.1%	31.4%	62.3%	0.022
	Female	2.2%	3.1%	25.6%	69.1%	
Engaged in a job	Yes	1.2%	2.4%	27.8%	68.6%	0.003
	No	2.3%	6.2%	29.1%	62.3%	

5.4 Electronic health record sharing

Those with tertiary education attainment and those who claimed that their health was poor were more likely to strongly agree that currently not enough attention is being given to the development of continuity of care and effective interface between different healthcare providers at different levels of care, which are essential for providing better quality of care. Those who did not report suffering from a chronic disease or taking regular medication during the past 6 months were more likely to agree.

Table 5.17 Agreement level that currently not enough attention is being given to the development of continuity of care and effective interface between different healthcare providers at different levels of care, which are essential for providing better quality of care (Q16)

Variable	Level	Not agree at all	Disagree	Neither agree nor disagree	Agree	Strongly agree	p-value
							Chi-square test
Education level	Primary or below	1.9%	9.3%	14.1%	60.0%	14.7%	0.029
	Had not completed secondary	3.0%	11.4%	20.4%	43.3%	21.9%	
	Completed secondary (Form 5)	2.0%	11.1%	22.1%	43.5%	21.4%	
	Matriculation	0.7%	11.1%	27.5%	46.7%	13.9%	
	Tertiary (non-degree)	0.9%	5.9%	16.4%	48.4%	28.4%	
	Tertiary (degree or above)	1.4%	7.2%	18.3%	45.5%	27.6%	
Admitted to a hospital	Yes	2.1%	11.7%	10.3%	54.5%	21.4%	0.017
	No	1.7%	9.1%	21.5%	45.7%	22.0%	
Health status	Excellent	3.0%	12.5%	17.3%	47.9%	19.2%	0.023
	Very good	1.3%	6.3%	21.6%	47.7%	23.1%	
	Good	0.6%	8.1%	21.3%	47.3%	22.6%	
	Fair	1.8%	9.9%	20.1%	48.1%	20.0%	
	Poor	5.8%	16.7%	7.2%	37.5%	32.8%	
Having a chronic condition or being on regular medication	Yes	2.8%	12.8%	20.0%	42.4%	22.1%	0.039
	No / don't know	1.3%	8.0%	19.6%	49.2%	21.9%	

Those aged 40-49, working respondents, higher household income and retired persons were more likely to express strong support for the development of an electronic health record sharing system for sharing medical records between private and public healthcare providers.

Table 5.18 Level of support for the development of an electronic health record sharing system for sharing medical records between private and public healthcare providers. (Q17)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Age group	18-29	5.2%	15.6%	34.9%	44.2%	<0.001
	30-39	4.0%	4.7%	34.0%	57.2%	
	40-49	4.9%	4.7%	28.7%	61.6%	
	50-64	5.6%	6.3%	30.5%	57.5%	
	65 or above	2.6%	12.2%	39.3%	45.9%	
Engaged in a job	Yes	4.4%	6.3%	29.2%	60.1%	<0.001
	No	4.9%	10.9%	37.6%	46.6%	
Not working status	Student	6.0%	20.6%	41.5%	31.9%	0.001
	Home-maker	4.5%	13.0%	34.5%	47.9%	
	Unemployed person	11.5%	3.4%	43.5%	41.5%	
	Retired person	2.6%	7.4%	36.3%	53.7%	
Monthly household income	Less than \$10,000	6.5%	14.8%	37.7%	41.0%	<0.001
	\$10,000-19,999	4.6%	7.8%	39.5%	48.0%	
	\$20,000-29,999	3.9%	8.1%	32.9%	55.1%	
	\$30,000-49,999	5.9%	6.5%	27.8%	59.7%	
	\$50,000 or above	3.1%	4.7%	24.7%	67.4%	

Males, those aged 50-64, those working respondents, retired persons and those with higher household income and those who claimed that their health status was excellent were more likely to express strong support for the government funding the capital cost for the necessary infrastructure for sharing electronic health records.

Table 5.19 Level of support for the government funding the capital cost for the necessary infrastructure for sharing electronic health records. (Q18)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	6.0%	7.4%	38.9%	47.7%	0.006
	Female	5.1%	10.0%	46.8%	38.1%	
Age group	18-29	4.5%	14.7%	48.0%	32.8%	<0.001
	30-39	4.8%	5.7%	42.5%	47.0%	
	40-49	9.4%	6.5%	37.5%	46.6%	
	50-64	5.7%	6.2%	37.5%	50.7%	
	65 or above	1.5%	12.5%	54.7%	31.3%	
Engaged in a job	Yes	5.4%	5.8%	39.5%	49.3%	<0.001
	No	5.7%	12.5%	47.4%	34.5%	
Not working status	Student	7.0%	26.4%	42.3%	24.3%	<0.001
	Home-maker	6.8%	16.7%	41.3%	35.3%	
	Unemployed person	15.2%	6.1%	48.9%	29.9%	
	Retired person	1.3%	5.0%	54.3%	39.4%	
Monthly household income	Less than \$10,000	2.7%	14.8%	47.8%	34.6%	0.002
	\$10,000-19,999	8.0%	8.1%	46.6%	37.2%	
	\$20,000-29,999	5.6%	7.8%	37.7%	48.9%	
	\$30,000-49,999	5.1%	5.1%	41.6%	48.2%	
	\$50,000 or above	6.5%	5.4%	37.7%	50.5%	
Health status	Excellent	8.9%	10.0%	25.6%	55.5%	0.037
	Very good	4.2%	9.7%	40.3%	45.7%	
	Good	4.8%	8.6%	37.7%	49.0%	
	Fair	5.7%	8.5%	48.8%	37.0%	
	Poor	7.5%	8.0%	42.4%	42.1%	

Males, those who completed secondary and tertiary (degree or above), those with monthly household income over \$20,000, those working respondents and those who claimed that their health status was excellent were more likely to express strong support for making available public sector software and know how for further development and deployment of these systems in the private sector. However, respondents aged 65 or above were less likely to express strong support.

Table 5.20 Level of support for making available public sector software and know how for further development and deployment of these systems in the private sector. (Q19)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	7.4%	11.3%	45.2%	36.1%	0.038
	Female	8.3%	12.8%	50.9%	27.9%	
Age group	18-29	5.2%	20.0%	49.3%	25.5%	<0.001
	30-39	6.2%	8.2%	51.6%	33.9%	
	40-49	8.5%	9.1%	46.3%	36.1%	
	50-64	9.1%	8.7%	43.6%	38.6%	
	65 or above	10.6%	16.9%	52.3%	20.2%	
Education level	Primary or below	9.9%	18.0%	50.0%	22.1%	0.023
	Had not completed secondary	9.2%	12.1%	49.6%	29.1%	
	Completed secondary (Form 5)	8.7%	11.5%	43.0%	36.8%	
	Matriculation	5.2%	10.3%	54.7%	29.7%	
	Tertiary (non-degree)	6.7%	6.8%	59.9%	26.6%	
	Tertiary (degree or above)	6.4%	12.2%	44.1%	37.3%	
Engaged in a job	Yes	6.1%	9.8%	46.5%	37.6%	<0.001
	No	10.0%	15.0%	50.2%	24.8%	
Monthly household income	Less than \$10,000	10.3%	17.0%	47.1%	25.6%	<0.001
	\$10,000-19,999	11.7%	16.1%	51.8%	20.4%	
	\$20,000-29,999	6.0%	10.6%	46.9%	36.6%	
	\$30,000-49,999	5.2%	8.7%	48.0%	38.1%	
	\$50,000 or above	4.5%	7.5%	46.5%	41.4%	

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Health status	Excellent	7.9%	8.1%	38.9%	45.1%	0.001
	Very good	7.1%	11.5%	43.5%	37.9%	
	Good	5.3%	10.1%	48.2%	36.4%	
	Fair	8.3%	14.9%	51.1%	25.7%	
	Poor	15.8%	3.7%	47.5%	33.0%	

Those aged 18-29, students and those who did not report suffering from a chronic disease or taking regular medication during the past 6 months were less likely to express no support at all for providing other financial assistance to facilitate the development and deployment of these systems in the private sector. Furthermore, males, those with excellent health status, aged 50-64 were more likely to have strong support for it.

Table 5.21 Level of support for providing other financial assistance to facilitate the development and deployment of these systems in the private sector (Q20)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	20.3%	14.4%	42.2%	23.2%	0.006
	Female	16.8%	16.1%	50.5%	16.5%	
Age group	18-29	8.3%	30.6%	44.8%	16.3%	<0.001
	30-39	27.6%	10.9%	42.7%	18.8%	
	40-49	19.9%	11.3%	47.3%	21.5%	
	50-64	20.7%	9.5%	45.8%	24.0%	
	65 or above	14.2%	16.4%	53.3%	16.2%	
Not working status	Student	7.1%	33.5%	43.6%	15.8%	0.001
	Home-maker	23.5%	18.4%	41.5%	16.6%	
	Unemployed person	16.4%	15.3%	51.0%	17.4%	
	Retired person	17.8%	10.6%	52.3%	19.3%	
Health status	Excellent	13.9%	14.8%	41.0%	30.3%	0.016
	Very good	18.9%	19.1%	40.8%	21.2%	
	Good	16.7%	15.6%	45.0%	22.8%	
	Fair	18.1%	14.9%	50.9%	16.1%	
	Poor	30.5%	7.1%	39.8%	22.5%	
Having a chronic condition or being on regular medication	Yes	21.2%	8.9%	50.5%	19.4%	0.001
	No / don't know	17.3%	18.0%	44.7%	20.0%	

5.5 Public healthcare safety net

Those aged 30-39, those with non-degree tertiary education level, home-makers and retired persons were more likely to strongly agree that the present public healthcare safety net does not sufficiently protect patients with illnesses that require costly treatment. Furthermore, those who reported having a chronic condition or being on regular medication were more likely to disagree.

Table 5.22 Agreement with the present public healthcare safety net does not sufficiently protect patients with illnesses that require costly treatment (Q21)

Variable	Level	Not agree at all	Disagree	Neither agree nor disagree	Agree	Strongly agree	p-value
							Chi-square test
Age group	18-29	0.4%	7.1%	19.0%	45.9%	27.6%	0.006
	30-39	2.4%	12.6%	14.2%	33.4%	37.4%	
	40-49	2.4%	9.7%	13.5%	42.5%	31.9%	
	50-64	2.8%	13.1%	11.6%	43.6%	28.9%	
	65 or above	4.3%	16.3%	10.9%	46.8%	21.7%	
Education level	Primary or below	2.8%	25.1%	13.0%	41.5%	17.7%	<0.001
	Had not completed secondary	1.7%	11.6%	14.3%	42.2%	30.2%	
	Completed secondary (Form 5)	1.4%	7.4%	14.5%	45.3%	31.5%	
	Matriculation	2.0%	9.5%	15.2%	43.7%	29.7%	
	Tertiary (non-degree)	1.4%	6.7%	9.6%	39.4%	42.9%	
	Tertiary (degree or above)	4.1%	10.7%	14.7%	40.6%	29.8%	
Having a chronic condition or being on regular medication	Yes	3.3%	15.0%	11.3%	38.4%	31.9%	0.018
	No / don't know	2.0%	9.9%	15.1%	44.2%	28.9%	

Those aged 50-64, those with secondary education, those who reported having a chronic condition or being on regular medication and those who claimed that their health was poor were more likely to express strong support for reducing the waiting time of public hospital services through strengthening existing service provision or purchasing services from the private sector. In contrast, students were less likely to have strong support.

Table 5.23 Level of support for reducing the waiting time of public hospital services through strengthening existing service provision or purchasing services from the private sector. (Q22)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Age group	18-29	3.7%	16.0%	49.0%	31.2%	<0.001
	30-39	4.2%	7.7%	36.3%	51.9%	
	40-49	6.2%	7.3%	38.1%	48.4%	
	50-64	5.9%	4.7%	32.4%	57.0%	
	65 or above	5.1%	9.5%	37.5%	48.0%	
Education level	Primary or below	7.6%	13.2%	37.1%	42.1%	0.001
	Had not completed secondary	3.6%	7.9%	32.2%	56.4%	
	Completed secondary (Form 5)	4.0%	6.4%	32.6%	57.0%	
	Matriculation	7.1%	10.8%	44.2%	37.9%	
	Tertiary (non-degree)	1.7%	5.7%	44.0%	48.6%	
	Tertiary (degree or above)	6.3%	9.8%	44.9%	39.0%	
Not working status	Student	1.3%	12.9%	56.8%	28.9%	0.003
	Home-maker	7.4%	10.5%	35.7%	46.4%	
	Unemployed person	9.1%	9.4%	33.8%	47.7%	
	Retired person	3.7%	7.9%	33.8%	54.6%	
Health status	Excellent	2.6%	7.6%	35.1%	54.7%	0.010
	Very good	2.2%	8.6%	40.5%	48.8%	
	Good	4.4%	7.9%	35.9%	51.7%	
	Fair	5.9%	10.0%	41.5%	42.6%	
	Poor	11.1%	4.7%	23.0%	61.1%	

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Have chronic condition or on regular medication	Yes	5.9%	5.2%	38.1%	50.8%	0.029
	No / don't know	4.7%	10.4%	38.6%	46.3%	

Working respondents were more likely to express strong support for improving the coverage of standard public services especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment. Those who reported having a chronic condition or being on regular medication were more likely to express support.

Table 5.24 Level of support for improving the coverage of standard public services especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment. (Q23)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Engaged in a job	Yes	1.0%	4.2%	28.0%	66.7%	0.018
	No	1.6%	7.5%	32.2%	58.7%	
Having a chronic condition or being on regular medication	Yes	0.7%	3.1%	33.4%	62.8%	0.025
	No / don't know	1.6%	6.9%	28.3%	63.3%	

Older respondents (aged 65 or above) and those with monthly household income less than \$10,000 were less likely to express strong support for a 'personal limit on medical expenses' beyond which financial assistance would be provided to protect individual patients against financial ruin due to illnesses requiring costly treatment.

Table 5.25 Level of support for a 'personal limit on medical expenses' beyond which financial assistance would be provided to protect individual patients against financial ruin due to illnesses requiring costly treatment. (Q24)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi- square test
Age group	18-29	2.2%	5.2%	27.4%	65.2%	0.018
	30-39	3.1%	4.8%	19.7%	72.4%	
	40-49	3.9%	3.9%	20.5%	71.7%	
	50-64	1.5%	2.9%	19.1%	76.5%	
	65 or above	2.4%	6.8%	32.4%	58.4%	
Monthly household income	Less than \$10,000	1.6%	8.8%	28.6%	61.0%	0.008
	\$10,000-19,999	1.8%	5.1%	20.4%	72.7%	
	\$20,000-29,999	1.9%	1.3%	20.4%	76.4%	
	\$30,000-49,999	3.3%	4.1%	18.3%	74.4%	
	\$50,000 or above	5.5%	5.1%	22.3%	67.1%	

Older respondents (aged 65 or above) and those who reported having a chronic condition or being on regular medication during the past 6 months were more likely to express no support at all and less likely to have strong support for providing extra funding to finance those who are in need, but lack the means to obtain certain expensive medical treatment outside the standard public services. Those with primary or below education and those not working respondents were less likely to express strong support. Furthermore, those with monthly household income between \$10,000 and \$49,999 were more likely to have strong support.

Table 5.26 Level of support for providing extra funding to finance those who are in need, but lack the means to obtain certain expensive medical treatment outside the standard public services. (Q25)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Age group	18-29	1.4%	9.0%	33.7%	55.9%	<0.001
	30-39	2.7%	4.6%	31.1%	61.7%	
	40-49	3.8%	4.4%	30.8%	60.9%	
	50-64	3.0%	2.2%	29.1%	65.8%	
	65 or above	10.8%	10.9%	33.0%	45.2%	
Education level	Primary or below	7.8%	12.3%	29.6%	50.3%	<0.001
	Had not completed secondary	6.2%	3.0%	35.9%	54.9%	
	Completed secondary (Form 5)	2.3%	4.0%	25.7%	68.0%	
	Matriculation	2.6%	3.1%	29.3%	64.9%	
	Tertiary (non-degree)	0.9%	5.9%	31.3%	62.0%	
	Tertiary (degree or above)	3.9%	6.6%	36.3%	53.2%	
Engaged in a job	Yes	3.1%	4.1%	31.0%	61.8%	0.011
	No	5.1%	7.8%	31.8%	55.3%	
Monthly household income	Less than \$10,000	7.3%	5.5%	35.1%	52.1%	0.018
	\$10,000-19,999	3.3%	5.7%	28.5%	62.5%	
	\$20,000-29,999	1.4%	2.1%	31.8%	64.7%	
	\$30,000-49,999	2.9%	5.1%	24.8%	67.2%	
	\$50,000 or above	3.5%	6.7%	35.3%	54.5%	
Having a chronic condition or being on regular medication	Yes	7.6%	3.2%	30.5%	58.6%	<0.001
	No / don't know	2.3%	6.9%	31.7%	59.1%	

Older respondents (aged 65 or above), those who reported having a chronic condition or being on regular medication during the past 6 months were more likely to express no support at all and less likely to have strong support for reviewing the public fee structure and adjust upward fees for certain services, subject to ensuring that the safety net adequately protects low income and underprivileged groups. Those with lower education attainment (had not completed secondary or below) and those with monthly household income less than \$10,000 were more likely to have no support at all. Those working respondents, students, those with higher monthly household income and those who claimed that their health status was excellent were more likely to have strong support.

Table 5.27 Level of support for reviewing the public fee structure and adjust upward fees for certain services, subject to ensuring that the safety net adequately protects low income and underprivileged groups (Q26)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Age group	18-29	12.5%	16.0%	53.0%	18.5%	<0.001
	30-39	16.9%	6.8%	50.5%	25.8%	
	40-49	16.8%	6.2%	48.3%	28.8%	
	50-64	19.8%	12.0%	42.2%	26.1%	
	65 or above	32.7%	19.3%	36.3%	11.7%	
Education level	Primary or below	28.8%	18.2%	37.6%	15.5%	<0.001
	Had not completed secondary	25.3%	10.9%	38.2%	25.6%	
	Completed secondary (Form 5)	15.9%	11.0%	49.5%	23.7%	
	Matriculation	20.2%	7.1%	47.0%	25.7%	
	Tertiary (non-degree)	12.3%	9.4%	57.7%	20.7%	
	Tertiary (degree or above)	14.7%	11.3%	48.9%	25.1%	
Engaged in a job	Yes	16.2%	8.6%	48.7%	26.6%	<0.001
	No	22.5%	15.2%	43.6%	18.7%	
Not working status	Student	12.9%	13.9%	48.8%	24.4%	0.010
	Home-maker	19.0%	18.5%	44.2%	18.3%	
	Unemployed person	14.8%	18.5%	53.6%	13.0%	
	Retired person	31.9%	11.9%	37.7%	18.5%	
Monthly household income	Less than \$10,000	31.4%	13.2%	37.3%	18.1%	<0.001
	\$10,000-19,999	17.3%	15.5%	50.6%	16.6%	
	\$20,000-29,999	13.2%	8.0%	53.3%	25.5%	
	\$30,000-49,999	14.5%	9.3%	47.3%	28.9%	
	\$50,000 or above	15.5%	8.3%	46.6%	29.6%	

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Health status	Excellent	23.9%	7.5%	35.0%	33.7%	<0.001
	Very good	15.1%	10.1%	45.2%	29.6%	
	Good	12.1%	10.6%	53.4%	23.9%	
	Fair	21.2%	13.2%	47.1%	18.5%	
	Poor	32.5%	9.4%	30.7%	27.4%	
Having a chronic condition or being on regular medication	Yes	26.3%	9.9%	47.3%	16.5%	<0.001
	No / don't know	15.7%	12.2%	46.1%	26.1%	

5.6 Overall support for all the above mentioned government proposals

Females, those aged 50-64, those with completed secondary and non-degree tertiary education, those claimed that their health status was excellent and poor were more likely to express strong support for all the above mentioned government proposals for reform of the public healthcare system.

Table 5.28 Level of support for all the above mentioned government proposals for reform of the public healthcare system (Q27)

Variable	Level	Not support at all	Weak support	Moderate support	Strong support	p-value
						Chi-square test
Gender	Male	3.6%	16.2%	60.6%	19.6%	0.002
	Female	1.3%	10.7%	66.8%	21.2%	
Age group	18-29	1.5%	13.6%	70.1%	14.8%	0.033
	30-39	3.3%	12.3%	61.8%	22.6%	
	40-49	2.7%	12.8%	62.9%	21.7%	
	50-64	1.6%	9.9%	63.7%	24.7%	
	65 or above	3.3%	21.2%	59.5%	16.0%	
Health status	Excellent	3.6%	9.1%	52.7%	34.7%	0.036
	Very good	2.5%	12.0%	62.0%	23.6%	
	Good	2.1%	11.4%	66.5%	19.9%	
	Fair	2.5%	15.9%	65.2%	16.4%	
	Poor	1.7%	10.0%	57.9%	30.3%	

Compared with males, females were more likely to think that it is urgent but can be done any time within next 5 years rather than within the next decade. Those not working respondents and those who reported having a chronic condition or being on regular medication during the past 6 months were more likely to think that all the above mentioned abovementioned government proposals for reform of the public healthcare system needed to be done now.

Table 5.29 Urgency of all the abovementioned government proposals for reform of the public healthcare system (Q28)

Variable	Level	Needs to be done now	Urgent but can be done any time within next 5 years	Can be done sometime within the next decade	No need within the next decade	No need at all	p-value
							Chi-square test
Gender	Male	16.9%	57.4%	21.0%	1.3%	3.4%	0.014
	Female	15.2%	66.6%	15.3%	1.2%	1.7%	
Engaged in a job	Yes	12.7%	63.8%	20.0%	1.8%	1.7%	0.001
	No	20.2%	60.1%	15.6%	0.6%	3.5%	
Having a chronic condition or being on regular medication	Yes	20.4%	60.5%	14.9%	0.2%	4.0%	0.002
	No / don't know	14.1%	62.9%	19.4%	1.7%	1.9%	

5.7 Financing reform

Females, working respondents, those with higher monthly household income and those who had not been admitted in a hospital within the last 12 months were more likely to strongly agree that the government funding alone is not sufficient for implementing the abovementioned reform suggestions, together with the need to meet increasing healthcare demand due to population ageing. In contrast, older respondents (aged 65 or above) and those with primary or below education were less likely to strongly agree.

Table 5.30 Agreement with the government funding alone is not sufficient for implementing the abovementioned reform suggestions, together with the need to meet increasing healthcare demand due to population ageing (Q29)

Variable	Level	Not agree at all	Disagree	Neither agree nor disagree	Agree	Strongly agree	p-value
							Chi-square test
Gender	Male	6.8%	15.6%	14.0%	46.3%	17.3%	<0.001
	Female	2.7%	8.7%	19.4%	46.6%	22.5%	
Age group	18-29	2.9%	9.6%	17.9%	48.3%	21.3%	0.030
	30-39	4.9%	9.6%	16.4%	42.5%	26.7%	
	40-49	4.7%	15.2%	14.8%	50.0%	15.2%	
	50-64	5.5%	14.3%	14.7%	42.7%	22.9%	
	65 or above	5.5%	10.2%	22.3%	49.7%	12.3%	
Education level	Primary or below	7.3%	16.7%	22.6%	41.7%	11.7%	0.027
	Had not completed secondary	3.2%	13.9%	18.8%	47.9%	16.2%	
	Completed secondary (Form 5)	3.9%	10.1%	18.0%	45.7%	22.2%	
	Matriculation	5.1%	8.5%	16.5%	50.6%	19.3%	
	Tertiary (non-degree)	4.3%	9.0%	7.3%	57.9%	21.5%	
	Tertiary (degree or above)	5.1%	13.1%	14.9%	42.8%	24.1%	
Engaged in a job	Yes	5.5%	13.9%	14.3%	44.5%	21.8%	0.007
	No	3.6%	9.9%	19.9%	49.0%	17.7%	
Monthly household income	Less than \$10,000	3.8%	11.9%	20.2%	50.8%	13.3%	0.016
	\$10,000-19,999	3.9%	16.5%	21.9%	42.6%	15.1%	
	\$20,000-29,999	3.9%	12.2%	14.2%	49.0%	20.8%	
	\$30,000-49,999	4.4%	9.9%	14.6%	47.1%	24.0%	
	\$50,000 or above	7.5%	12.5%	12.2%	41.1%	26.7%	
Admitted to a hospital	Yes	3.9%	12.8%	12.3%	57.0%	14.1%	0.033
	No	4.7%	12.0%	17.6%	44.6%	21.0%	

Chapter Six Conclusions

This survey has collected opinions from 1,118 respondents about the government proposals for reform of the public healthcare system. They were asked for their level of support about the government proposals including “primary care”, “public-private partnership”, “electronic health record sharing”, “public healthcare safety net” and “financing reform”

6.1 Awareness of consultation on healthcare reform

It is reassuring that more than three quarters (76.3%) of respondents (i.e. adults) were aware of the consultation, although a few specific target groups had less than two-thirds being aware: monthly household income of under \$10,000 (65.5%), aged 18-29 (62.6%), primary education or below (58.4%) and lowest of all, students (46.7%).

This suggests that additional efforts should be made to target young adults and the poorly educated in future healthcare consultations.

6.2 Support for government position and proposals in different areas

6.2.1 Primary care (Q2-Q7)

Nearly half (45.9%) of respondents agreed or strongly agreed that there is currently insufficient emphasis by both patients and healthcare providers on comprehensive primary care, while nearly one third (30.4%) disagreed or did not agree at all, with those aged 65 or above most likely to disagree (34.7%).

The primary care initiative with the highest proportion giving strong support was strengthening public education and setting primary care standards (62.3% of respondents), with only around one third of respondents strongly supporting the other initiatives (41.4% for models of government purchasing primary care from the private sector for the poor, 40.5% for subsidizing preventative care from the private sector, 36.6% for establishing a family doctor register and 31.4% for developing primary care service models for reference).

Generally, males, those aged 65 or above and those with primary education or below were less supportive of the proposed primary care initiatives, while those with better health status were more supportive.

6.2.2 Public-private partnership (Q8-Q15)

Slightly more than half (54.0%) of respondents agreed or strongly agreed that significant public-private imbalance in the healthcare system has led to problems, while around a fifth (19.6%) disagreed or did not agree at all. The elderly (30.8%), those with low education (28.2%), and retirees (28.1%) were more likely to disagree, while those with high incomes were more likely to agree (66.6%).

The public-private initiative with the highest proportion giving strong support was ensuring adequate supply of healthcare professionals (65.6% of respondents) while nearly half of respondents expressed strong support for engaging private doctors in public hospitals (46.9%) and setting up medical centres of excellence (42.6%). Around one third gave strong support for co-locating private and public hospitals (34.8%) and purchasing hospital services from the private sector (31.3%), while around a quarter gave strong support for facilitating expansion of private hospitals (26.6%). The smallest proportion of strong support was for facilitating private services in public hospitals (16.2%), for which 42.3% expressed weak support or no support at all.

Retirees and the middle aged were more likely to support these initiatives, while those with poor health status were generally more likely to have no support. However, for co-location, many highly educated and excellent health status individuals showed little or no support.

6.2.3 Electronic health record sharing (Q16-Q20)

Around two-thirds (65.9%) of respondents agreed or strongly agreed that not enough attention is being given to continuity of care, while only a few (10.7%) disagreed or did not agree at all.

More than a half of respondents (53.4%) expressed strong support for electronic sharing of healthcare records between private and public providers, while around two fifths (42.1%) expressed strong support for government funding the infrastructure costs and nearly one third (31.1%) expressed strong support for sharing public sector software and know-how with the private sector. Less than a fifth (19.3%) expressed strong support for other financial assistance to facilitate health record sharing, while one third (32.7%) gave weak or no support for this initiative.

The strongest support generally for these initiatives came from those with higher education, higher household income and the middle aged, with the exception of other financial assistance, for which those with high education had weaker support.

6.2.4 Public healthcare safety net (Q21-Q26)

More than two-thirds (70.4%) of respondents agreed or strongly agreed that the present safety net is inadequate, while only a small proportion (13.6%) disagreed or did not agree at all, although the proportion of those with low education who disagreed was higher (27.9%).

Around two thirds of respondents gave strong support for a personal limit on medical expenses (68.9%) and improving the coverage of standard public services (62.6%), while around half gave strong support for extra funding for those who need expensive non-standard treatment (58.2%) and reducing public hospital waiting times (46.9%). Around a quarter of respondents (22.6%) gave strong support for reviewing public fees structure, while slightly more (29.7%) gave weak or no support at all.

Generally the middle aged, middle educated, middle income groups were more supportive of these initiatives, although for reviewing public fees, those with higher income or better health status were more supportive.

6.2.5 Summary of support for all the above mentioned government proposals

Over half of the respondents expressed strong support for the following six proposals:

- A “personal limit on medical expenses” beyond which financial assistance would be provided to protect individual patients against financial ruin due to illnesses requiring costly treatment (68.9%)
- Examine the forecast of manpower requirements to ensure that there is education and training capacity for an adequate supply of various healthcare professionals. (65.6%)
- Improving the coverage of standard public services especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment. (62.4%)
- Strengthening public health education, healthy lifestyle promotion, disease prevention, and develop and set the standards for primary care services (62.3%)
- Providing extra funding to finance those who are in need, but lack the means to obtain certain expensive medical treatment outside the standard public services (58.2%)
- The development of an electronic health record sharing system for sharing medical records between private and public healthcare providers (53.2%).

Conversely, over a quarter of the respondents expressed weak support or no support at all for the following four proposals:

- Facilitate moderate increase in capacity in public hospitals for private services operating on a full cost-recovery basis (42.0%). Those aged 18-29 and students were more likely to express weak support or no support at all.
- Providing other financial assistance to facilitate the development and deployment of the electronic health record systems in the private sector (32.8%). The elderly and those with low education level were more likely to express weak support or no support at all.
- Reviewing the public fee structure and adjust upward fees for certain services, subject to ensuring that the safety net adequately protects low income and underprivileged groups (29.6%). Those with low income or poor health status were more likely to express weak support or no support at all.
- Facilitate expansion of capacity in private hospitals through leasing out of vacant public premises or making sites available for private hospital development (27.9%). Homemakers were more likely to express weak support or no support at all.

6.2.6 Overall support (Q27-Q28)

Around a fifth of respondents (20.1%) gave strong support overall to the initiatives above, with the majority (63.0%) giving moderate support and a small minority (15.6%) giving weak or no support. The middle aged, middle educated and best and worst health status groups were more supportive, while males, the elderly and poorly educated were least supportive overall.

The overwhelming majority of respondents agreed that the proposals are urgent (77.2%), although only a small minority (15.8%) stated that the proposals need to be implemented now, while the majority (61.4%) stated that there is five years to implement. Only a tiny proportion (3.7%) believed that there is no need to do anything in the next decade. These views are very consistent across the demographics, except that females are more likely to think the proposals need to be implemented in the next five years rather than the next decade and those not working are more likely to think that the proposals need to be implemented now (2.4% vs 14.1% for those not working).

6.2.7 Financing reform (Q29)

Around two-thirds (64.9%) of respondents agreed or strongly agreed that government funding alone is not sufficient for implementation. The major demographic differences are the distinction between agree and strongly agree, with female, younger, better educated, who had not been admitted in a hospital within the last 12 months and higher income respondents more likely to strongly agree.

Chapter Seven Non-sampling errors

1. The use of the ‘Next Birthday’ rule to select a respondent when there was more than one eligible respondent residing in a household at the time of the telephone contact could not cover people who were always not at home in the evening and weekends.
2. Household telephone survey excludes households without fixed line telephones and excludes institutionalized people, which might result in selection bias due to under-representation of certain segments of the population. However, the possibility of people not being interviewed for the first reason should be small as domestic fixed-line telephone coverage in Hong Kong is about 85.0%.

Appendix: Bilingual Questionnaire**Survey Questionnaire on Health Care Reform (20080627)****Section I Introduction**
第一部份 引言

你好，我姓 x，係香港大學社會科學研究中心嘅訪問員。我哋受食物及衛生局委託進行一項有關醫療改革嘅調查，只需您大約十分鐘嘅時間。你所提供嘅資料係會絕對保密同埋只會作統計分析用途。如果你有任何嘅疑問，請於辦公時間早上 9 點至下午 6 點，致電 3921 2600 到香港大學社會科學研究中心查詢。如閣下想知道更多有關研究參與者嘅權益，請致電 2241 5267，聯絡香港大學非臨床研究操守委員會。

Hello! My name is _____, an interviewer from the Social Sciences Research Centre of the University of Hong Kong (SSRC). We are commissioned by the Food and Health Bureau to conduct a public survey on health care reform. It will only take you around ten minutes and all the information provided by you will be kept strictly confidential and for collective analysis only. If you have any queries on this survey, you can call the SSRC at phone number: 3921 2600 during office hours between 9 am and 6 pm. If you have any questions about your rights as a research participant, please contact the Human Research Ethics Committee for Non-Clinical Faculties of the University at 2241 5267.

Section II Selection of Respondent
第二部份 揀選被訪者

How many household members excluding domestic helpers are there at home right now aged at least 18 years?

請問你依家有幾多位 18 歲或者以上一齊居住嘅家庭成員係屋企？出左街嘅同家庭傭工並唔計算在內。

_____ Persons 位

Who is the one who will next have a birthday? (Interviewer: explain the “Next Birthday” rule if respondent questions)

呢幾位依家係屋企嘅家庭成員當中，邊一位係下一個生日？麻煩請他 / 她接聽電話。（訪問員：如被訪者有疑問，請解釋：依個用生日日期嚟揀選被訪者嘅方法）

(受訪者不是第一位接電話的家庭成員：你好，我姓 x，係香港大學社會科學研究中心嘅訪問員。我哋受食物及衛生局委託進行一項有關醫療改革嘅調查，首先多謝你接受訪問。你所提供嘅資料係會絕對保密同埋只會作統計分析用途。)

Section III Main Questions

第三部份 主要問題

Awareness of Consultation

諮詢嘅認識

- Q1 Are you aware of the recent government consultation on health care reform?
你知唔知道政府最近進行醫療改革嘅諮詢呢?
- | | |
|-----------|-----|
| 1. Yes | 知道 |
| 2. No | 唔知道 |

Primary care

基層醫療

I would like to know how much you agree with the government characterization of the current situation for primary care* in Hong Kong.
我想知道你對於政府就依家香港嘅基層醫療服務*嘅描述有幾同意。

- Q2 Do you agree that there is currently insufficient emphasis by both patients and healthcare providers on comprehensive primary care* which includes preventive care and wellness promotion?
你同唔同意依家病人同醫護人員，都唔夠重視包括疾病預防同促進健康嘅全面基層醫療*服務呢? [訪問員：請追問程度]
- | | |
|----------------------------------|------------|
| 1. Not agree at all | 完全唔同意 |
| 2. Disagree | 唔同意 |
| 3. Neither agree nor disagree | 唔係同意亦唔係唔同意 |
| 4. Agree | 同意 |
| 5. Strongly agree | 非常同意 |
| 6. Don't know/Hard to say | 唔知道/好難講 |

[If participants ask about primary care] Primary medical care is the first level of healthcare which includes preventive, curative and rehabilitative services provided by medical doctors (in particular general practitioners), nurses and other health professionals.

[如果受訪者詢問有關基層醫療服務] 基層醫療服務指市民第一層接觸的醫療服務，包括醫生（特別是普通科醫生）、護士和其他醫護人員提供的疾病預防、治療和康復服務。

The government has some proposals to improve primary health care and I would like to know your level of support for the following:
政府有以下幾個建議去改善基層醫療服務，我哋想知道你對呢啲建議嘅支持程度：

- Q3 Developing basic models* for comprehensive primary and preventive care services* for reference by both healthcare professionals and individuals. (Interviewer: please read out the answers one by one from 1 - 4)

制訂全面基層醫療同預防護理服務*嘅基本模式*，俾醫護專業人員同市民參考。[訪問員：請讀出個別答案由 1 至 4]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

[If participants ask about preventive care services] Healthcare services that aims at preventing diseases or injury. For example, vaccination, health checks, screening for hypertension, cervical cancer, etc.

[如果受訪者詢問有關預防護理服務] 以預防疾病或傷患為目標的醫療服務範疇。例如：進行疫苗注射、身體檢查、高血壓及子宮頸癌普查等。

[If participants ask about basic model] A set of primary and preventive care services with associated clinical protocols that are considered basic and essential for comprehensive primary care for individual.

[如果受訪者詢問有關基本模式] 一套基層醫療及預防護理服務，連同臨床指引，作為個人基本及必需的全面基層醫療護理。

Q4 Establishing a family doctor register for reference by individuals who wish to receive comprehensive primary and preventive care.

設立家庭醫生名冊，俾希望接受全面基層醫療服務同預防護理服務嘅市民作為參考。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Q5 Subsidizing individuals to undertake preventive care through private family doctors. 資助市民接受私家家庭醫生提供嘅預防護理。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Q6 Government purchasing primary care services from the private sector for low-income families* and under-privileged groups.

政府為低收入家庭*同弱勢社群向私營醫療界別購買基層醫療服務。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

[If participants ask about low-income families] This is a general description and there is no specific definition, but includes families receiving CSSA.

[如果受訪者詢問有關低收入家庭] 這是一個概括性的描述，並沒有具體的定義，但包括綜緩家庭。

Q7 Strengthening public health education, healthy lifestyle promotion, disease prevention, and develop and set the standards for primary care services.
加強公共衛生教育、推廣健康生活方式和疾病預防措施，以及發展及制訂基層醫療服務嘅標準。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Public-private partnership

公私營協作

I would like to know how much you agree with the government characterization of the current situation for the public-private partnership in healthcare in Hong Kong.

我想知道你對於政府就依家香港嘅公私營醫療機構協作嘅描述有幾認同。

Q8 Do you agree that the significant public-private imbalance* in our healthcare system has led to limited choice for you as well as inadequate competition and collaboration among healthcare providers in both the public and private sectors?
你同唔同意嘅我哋嘅醫療系統裡面，公私營醫療服務嚴重失衡*，局限咗你嘅選擇，同埋令公私營醫療界別之間缺乏競爭同合作呢？

[訪問員：請追問程度]

- | | |
|-------------------------------|------------|
| 1. Not agree at all | 完全唔同意 |
| 2. Disagree | 唔同意 |
| 3. Neither agree nor disagree | 唔係同意亦唔係唔同意 |
| 4. Agree | 同意 |
| 5. Strongly agree | 非常同意 |
| 6. Don't know/Hard to say | 唔知道/好難講 |

[If participants ask about significant public-private imbalance] For example, over 90% of the in-patient services are provided by the highly subsidized public hospitals while the remaining is provided by the unsubsidized private hospitals.

[如果受訪者詢問有關公私營醫療服務嚴重失衡] 舉例說明：公立醫院提供超過 90% 高度資助的住院服務，其餘的則由沒有資助的私家醫院提供。

The government also has proposals for promoting the public-private partnership, so I would like to know your level of support for the following:

政府亦都有計劃去推動公私營醫療協作，我哋想知道你對以下建議嘅支持程度：

- Q9 Government purchasing hospital services from the private sector, especially for non-urgent and/or elective procedures. (Interviewer: please read out the answers one by one from 1 - 4)
政府向私家醫院購買醫院服務，特別係非緊急療程。[訪問員：請逐一讀出答案由 1 至 4]
- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |
- Q10 Co-locating public and private hospital facilities to enable coordinated planning and shared use of facilities.
喺同一個地點同時設立公營及私營嘅醫院設施，方便協調規劃及共同使用呢啲設施。[訪問員：請追問程度]
- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |
- Q11 Setting up medical centres of excellence to draw together top expertise of the relevant specialties locally and overseas, with participation of experts from both the public and private sectors.
設立多方合作嘅卓越醫療中心，匯聚本地及外地相關專科嘅頂尖專家，以及嚟自公營同私營機構嘅專材。[訪問員：請追問程度]
- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

- Q12 Engaging private sector doctors in public hospitals, on a part-time basis, to help cross-fertilization of expertise and experience.
委聘私營機構嘅醫生喺公立醫院以兼職形式執業，以鼓勵專業知識同經驗嘅交流。[訪問員：請追問程度]
- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |
- Q13 Facilitate expansion of capacity in private hospitals through leasing out of vacant public premises or making sites available for private hospital development.
出租空置嘅公共樓宇或者批出用地以發展私家醫院，從而促進私家醫院嘅擴展。[訪問員：請追問程度]
- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |
- Q14 Facilitate moderate increase in capacity in public hospitals for private services operating on a full cost-recovery basis.
按照收回十足成本嘅原則，推動公營醫院適量提高私家症服務量。
[訪問員：請追問程度]
- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |
- Q15 Examine the forecast of manpower requirements to ensure that there is education and training capacity for an adequate supply of various healthcare professionals.
詳細研究人力資源嘅需求，確保有充足嘅教育同培訓能力，去提供各類醫護專業人員。[訪問員：請追問程度]
- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Electronic health record sharing 電子病歷互通

I would like to know how much you agree with the government characterization of the current situation for the electronic health record sharing* in Hong Kong

我想知道你對於政府就依家香港電子病歷互通*嘅描述有幾同意。

[If participants ask about electronic health record sharing] For example, doctors in the private sector can access patient's health record generated in public sector, if authorized by the patient.

[如果受訪者詢問有關電子病歷互通] 例如私家醫生可以係病人同意嘅情況下，檢視病人係公營醫療機構嘅病歷。

Q16 Do you agree that currently, not enough attention is being given to the development of continuity of care* and effective interface between different healthcare providers at different levels of care, which are essential for providing better quality of care?

你同唔同意喺目前制度下，醫療護理服務缺乏連貫性*，不同護理層面嘅服務提供者之間嘅配合亦未盡完善，而呢啲都係為市民提供質素更佳嘅醫療服務所必需的。[訪問員：請追問程度]

- | | |
|-------------------------------|------------|
| 1. Not agree at all | 完全唔同意 |
| 2. Disagree | 唔同意 |
| 3. Neither agree nor disagree | 唔係同意亦唔係唔同意 |
| 4. Agree | 認同意 |
| 5. Strongly agree | 非常同意 |
| 6. Don't know/Hard to say | 唔知道/好難講 |

[If participants ask about continuity of care] If different healthcare service providers are involved in the care of a patient, they communicate with each other to coordinate healthcare, so that the care provided to the patient is continuous and not being disrupted by any changes in service providers or places of care.

[如果受訪者詢問有關醫療護理的連貫性] 假如一個病人的治療涉及不同的醫護服務提供者，彼此之間亦會溝通協調所提供的醫護服務，使該病人即使服務提供者或服務地點有變，都能護得連貫的服務。

The government also has proposals for an electronic health record sharing system and I would like to know your support for:

政府亦都有建議電子病歷互通系統，我哋想知道你對以下建議嘅支持程度：

Q17 The development of an electronic health record sharing system for sharing medical records between private and public healthcare providers. (Interviewer: please read out the answers one by one from 1 - 4)

發展電子病歷互通系統，以便病人嘅病歷喺私營同公營醫療服務提供者之間可以互通。[訪問員：請讀出個別答案由 1 至 4]

- | | |
|----------------------|-------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |

- | | |
|---------------------------|---------|
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Q18 Government funding the capital cost for the necessary infrastructure for sharing electronic health records.

政府提供資金開發互通電子病歷所需嘅基建系統。

。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Q19 Making available public sector software and know - how for further development and deployment of these systems in the private sector.

讓私營界別取得公營界別電子病歷軟件同埋相關技術，以推動呢個系統嘅私營界別進一步發展同應用。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Q20 Providing other financial assistance to facilitate the development and deployment of these systems in the private sector.

向私營醫療界別提供其他財務支援以發展同應用呢個系統。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Public healthcare safety net

公共醫療安全網

I would like to know how much you agree with the government characterization of the current situation for the public healthcare safety net* in Hong Kong.

我想知道你對於政府就依家香港公共醫療安全網*嘅描述有幾同意。

[If participants ask about public healthcare safety net] The role of the public healthcare system is to offer healthcare protection for the whole population, and ensures that necessary

medical care remains accessible to those in economic hardship or suffer heavy financial burden due to serious illnesses.

[如果受訪者詢問有關公營醫療安全網] 指公營醫療系統為全體市民提供醫療保障，以及確保經濟有困難同因重病而承受重大經濟負擔的市民，都可以獲得必須嘅醫療照顧。

Q21 Do you agree that the present public healthcare safety net does not sufficiently protect patients with illnesses that require costly treatment?

你同唔同意目前所提供嘅公共醫療安全網，未能足夠保障患上一些需要高昂費用醫治嘅病症嘅病人呢？[訪問員：請追問程度]

- | | |
|-------------------------------|------------|
| 1. Not agree at all | 完全唔同意 |
| 2. Disagree | 唔同意 |
| 3. Neither agree nor disagree | 唔係同意亦唔係唔同意 |
| 4. Agree | 同意 |
| 5. Strongly agree | 非常同意 |
| 6. Don't know | 唔知道 |

The government also has proposals to strengthen the Public Healthcare Safety Net and I would like to know your support for:

政府亦都有建議加強公共醫療安全網，我哋想知道你對以下建議嘅支持程度：

Q22 Reducing the waiting time of public hospital services through strengthening existing service provision or purchasing services from the private sector. (Interviewer: please read out the answers one by one from 1 - 4)

透過加強目前嘅服務或者向私營機構購買服務，以縮短公共醫院服務嘅輪候時間。[訪問員：請讀出個別答案由 1 至 4]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Q23 Improving the coverage of standard public services especially the inclusion of new drugs and treatments in the public healthcare safety net and the procurement of new medical equipment.

改善標準公共醫療服務嘅涵蓋範圍，特別係喺公共醫療安全網內，加入新藥物同新療法，以及採購新醫療儀器。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Q24 A “personal limit on medical expenses” beyond which financial assistance would be provided to protect individual patients against financial ruin* due to illnesses requiring costly treatment.

設立「個人醫療費用上限」，個別病人超出此上限就可以獲得經濟援助，保障佢地唔會因為高昂嘅醫療費用而陷入經濟困境*。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

[If participants ask about financial ruin] For example, one has to sell his/her own property in order to pay for the costly treatment.

[如果受訪者詢問有關經濟困境] 例如，賣屋賣樓以支付昂貴的治療。

Q25 Providing extra funding to finance those who are in need, but lack the means to obtain certain expensive medical treatment outside the standard public services.

提供額外資金，資助有需要但同時有經濟困難嘅人，等佢地可以接受某啲唔包括係標準服務內嘅昂貴治療。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Q26 Reviewing the public fee structure and adjust upward fees for certain services, subject to ensuring that the safety net adequately protects low income and underprivileged groups.

在確保安全網能夠為低收入同弱勢社群提供足夠保障的前提下，檢討公共醫療服務收費結構，並調高個別服務收費。[訪問員：請追問程度]

- | | |
|---------------------------|---------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |
| 5. Don't know/Hard to say | 唔知道/好難講 |

Q27 Overall, what is your level of support for all the abovementioned government plans for reform of the public healthcare system?

整體嚟講，你對政府以上所有嘅改革方案有幾支持呢？[訪問員：請追問程度]

- | | |
|----------------------|-------|
| 1. No support at all | 完全唔支持 |
| 2. Weak support | 少少支持 |
| 3. Moderate support | 一般支持 |
| 4. Strong support | 非常支持 |

5. Don't know/Hard to say 唔知道/好難講

Q28 How urgent do you think all the abovementioned government plans for reform of the public healthcare system is (Interview: please read out the answers one by one)?
整體嚟講，你認為以上嘅改革方案有幾迫切呢？[訪問員：請讀出個別答案]

1. Needs to be done now 需要即時完成
2. Urgent but can be done any time within next 5 years 迫切但可以係未來五年內完成
3. Can be done sometime within next decade 可以係未來十年內完成
4. No need within the next decade 十年內都唔需要
5. No need at all 完全唔需要

Financing reform

融資改革

I would like to know how much you agree with the government characterization of the future situation for health care financing in Hong Kong

我想知道你對於政府就將來香港醫療系統資源嘅描述有幾同意。

Q29 Do you agree that Government funding alone is not sufficient for implementing the abovementioned reform suggestions, together with the need to meet increasing healthcare demand due to population ageing?

你認唔認同單靠政府撥款並唔足夠推行以上所有嘅改革建議，同埋要應付因人口老化而增加嘅醫療需求？[訪問員：請追問程度]

1. Not agree at all 完全唔同意
2. Disagree 唔同意
3. Neither agree nor disagree 唔係同意亦唔係唔同意
4. Agree 同意
5. Strongly agree 非常同意
6. Don't know/Hard to say 唔知道/好難講

Personal Information**個人資料**

Please tell us more about yourself in the order to facilitate our analysis. All information collected would be treated in strictest confidence.

我會問你幾條有關您嘅個人資料作為研究用途，你所提供嘅所有資料係會絕對保密。

Q30 Record the gender

記錄性別

- | | |
|-----------|---|
| 1. Male | 男 |
| 2. Female | 女 |

Q31 What is your age? _____

請問你幾多歲? _____

- | | |
|---------------------|---------|
| 1. 18-29 | |
| 2. 30-39 | |
| 3. 40-49 | |
| 4. 50-59 | |
| 5. 60-64 | |
| 6. 65-69 | |
| 7. 70 or above | 70 歲或以上 |
| 8. Refuse to answer | 拒絕回答 |

Q32 What is your highest educational attainment? (Interview: please read out the answers one by one)

請問你最高嘅教育程度是？ [訪問員：請讀出個別答案]

- | | |
|---------------------------------|-------------|
| 1. Primary or below | 小學或以下 |
| 2. Had not completed secondary | 未完成中學 |
| 3. Completed secondary (Form 5) | 完成中五 |
| 4. Matriculation | 預科 |
| 5. Tertiary (non-degree) | 專上教育(非學位) |
| 6. Tertiary (degree or above) | 專上教育(學位或以上) |
| 999 Refuse to answer | 拒絕回答 |

Q33 Are you currently engaged in a job?

你現時有工作嗎？

- | | |
|---------------------|--------------|
| 1. Yes | 有 |
| 2. No (skip to Q35) | 沒有 (跳答至 Q35) |

Q34 Are you working in the following health or insurance related industries?

你現時係唔係喺以下有關健康或保險行業工作呢?

- | | |
|--------------------------------------|--------------|
| 1. Insurance | 保險業 |
| 2. Health care services | 醫療護理服務 |
| 3. Pharmaceuticals | 製藥 |
| 4. Other healthcare related services | 其他同醫護服務有關嘅行業 |
| 5. None of the above | 以上行業都唔係 |

Q35 Are you a? (Interviewer: read out the answers one by one)

你係 ? [訪問員: 請讀出個別答案]

- | | |
|----------------------------------|---------|
| 1. Student | 學生 |
| 2. Home-maker | 家庭主婦 |
| 3. Unemployed person | 失業/待業 |
| 4. Retired person | 退休人士 |
| 5. Others (Please specify _____) | 其它(請說明) |
| 999 Refuse to answer | 拒絕回答 |

Q36 How much is your monthly household income including all the income?

你嘅每月家庭總收入係

- | | |
|-----------------------|---------------|
| 1. Less than \$5,000 | \$5,000 以下 |
| 2. \$5,000-9,999 | |
| 3. \$10,000-14,999 | |
| 4. \$15,000-19,999 | |
| 5. \$20,000-24,999 | |
| 6. \$25,000-29,999 | |
| 7. \$30,000-34,999 | |
| 8. \$35,000-39,999 | |
| 9. \$40,000-44,999 | |
| 10. \$45,000-49,999 | |
| 11. \$50,000-54,999 | |
| 12. \$55,000-59,999 | |
| 13. \$60,000 or above | \$ 60,000 或以上 |
| 14. Refuse to answer | 拒絕回答 |

Q37 Have you been admitted to a hospital within the last 12 months for any reason?
喺過去 12 個月內，你有冇因為任何原因而入住醫院呢？

- | | |
|--------|---|
| 1. Yes | 有 |
| 2. No | 冇 |

Q38 In general, would you say your health is: (Interviewer: Read out the answers)
一般來說，你認為你嘅健康狀況係：(訪問員：請讀出個別答案)

- | | |
|--------------|----|
| 1. Excellent | 極好 |
| 2. Very good | 很好 |
| 3. Good | 好 |
| 4. Fair | 一般 |
| 5. Poor | 差 |

Q39 Have you ever been told by a western medicine practitioner that you suffer from a chronic disease? e.g. high blood pressure, diabetes, heart disease, lung disease etc.?
有冇西醫曾經話你患有長期病呢？例如高血壓、糖尿病、心臟病、肺病等等。

- | | |
|--------------------------------|--------|
| 1. Yes | 有 |
| 2. No | 冇 |
| 3. Don't know / Can't remember | 唔知/唔記得 |

Q40 Have you been taking regular medications prescribed by a doctor during the past 6 months?
在過去 6 個月，你有冇定期食醫生處方的藥呢？

- | | |
|--------|---|
| 1. Yes | 有 |
| 2. No | 冇 |

This is the end of the survey. Thank you very much for your cooperation and time!
問卷已經完成。好多謝你抽時間幫我哋完成呢份問卷。