# Hospital Authority's Submission on Healthcare Reform Consultation Document "Your Health Your Life"

**(June 2008)**

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## I. EXECUTIVE SUMMARY

1.1 In March 2008, the Government published a Healthcare Reform Consultation Document "Your Health Your Life" ("the Document") as the first of a two-stage public consultation. With a vision "to achieve a healthcare system that improves the state of health and quality of life of our people, and provides healthcare protection for every member of the community", the Document sets out four service reform proposals, namely:-

(a) Enhance primary care
(b) Promote public-private partnership in healthcare
(c) Develop electronic health record sharing
(d) Strengthen public healthcare safety net

and proposals to reform the healthcare financing arrangement as follows:-

(a) The Government will continue to provide the main financing source for healthcare services with commitments to increasing government expenditure on healthcare from 15% to 17% of overall recurrent government expenditure by 2011/12 and drawing $50 billion from the fiscal reserves to assist implementation of the reform; and

(b) Introducing supplementary financing with six options:-
  (i) Social health insurance
  (ii) Out-of-pocket payments (user fees)
  (iii) Medical savings accounts
  (iv) Voluntary private health insurance
  (v) Mandatory private health insurance
  (vi) Personal healthcare reserve

1.2 With the publication of the Document, the Government initiated a three-month consultation period to obtain views from the community for formulation of detailed reform proposals for the second-stage consultation.

1.3 Given the significant implications on the future development of the public healthcare system, the Hospital Authority (HA) established a Working Group with members of the HA Board to study and examine the reform proposals put forward in the Document. With HA being the main public healthcare service provider, the Working Group focused its discussions and analysis of the reform proposals from the following perspectives with a view to assist the Government in developing more detailed reform proposals for the second-stage consultation:-

(a) How will the reform proposals add value to the public healthcare system?

(b) How can HA move forward to support and contribute to the reform in achieving a sustainable healthcare system?

**Financial Sustainability And Stability**

1.4 Being the main public healthcare service provider, HA supports the Government's view that there is a need for healthcare reform as the present system of providing universally accessible health services with quality care through HA is not sustainable in the long run, even with the Government's commitment to increase its spending on healthcare up to 17% of recurrent government expenditure by 2011/12.

1.5 The Document projected the total healthcare costs in Hong Kong will escalate faster than that of economic growth (over and above GDP by 2% to 2.3% by 2033) in light of the growing healthcare needs from ageing population, increasing disease burdens and rapid medical technology advancement. If current market structure and utilization patterns of both public and private healthcare services remain unchanged, it is expected that public health expenditure, as a share of total public expenditure will increase from 14.7% in 2004 to 27.3% in 2033. Such increase will be at the expense of other public services if total public expenditure is to keep below 20% of GDP [Note 1].

1.6 At present, funding of public healthcare services which comes primarily from the Government through taxation is reliant upon the fiscal position of the Hong Kong economy. Following the economic downturn, Government's recurrent subvention to HA reduced from $29.4 billion for 2002/03 to $27.2 billion for 2005/06 notwithstanding the increasing demand and rising cost pressure faced by HA. On the other hand, the current highly subsidized and quality healthcare services offered by the public sector coupled with the limited integration between primary and hospital care have "attracted" and maintained reliance on the public hospital system. This has resulted in over-stretching of the public system with lengthening waiting time for surgical treatment of non-priority conditions, first appointment for specialist out-patient services, and routine radiology examinations. Equipment and some service models are now behind other modern health systems.

1.7 With the Government's pledge to continue to provide highly-subsidized public healthcare services to the population, it is envisaged that the HA, as the key public health service provider, will remain as the ultimate safety net for the community and subvention from Government will continue to serve as the Authority's major source of funding. To this end, it is clear that a stable funding environment in support of the Government's healthcare

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Note 1 Extracted from P10 and P16 of the Healthcare Reform Consultation Document "Your Health Your Life".

policy is of paramount importance not only to the HA but also to achieving the vision of a sustainable healthcare system providing healthcare protection to every member of the community.

**On Public Funding**

1.8 HA welcomes the Government's commitment to increase public expenditure on healthcare. HA is of the view that public funding should be targeted for priority areas of public healthcare services in particular the four target areas as set out in the report on "Building a Healthy Tomorrow" issued by the Health & Medical Development Advisory Committee in 2005. There should be different government subsidy levels for different healthcare services depending on the degree of financial risk to patients and the role of Government responsibility in these services (i.e. the target subsidy approach) rather than a "one size fits all" approach. In general, services with greater needs, stronger evidence of cost-effectiveness, and higher financial risks should remain highly subsidized whereas discretionary services, those purely at patient choices (like better amenities) or where risk of misuse is high, should be subject to lower subsidy levels. HA should offer a universal highly subsidized "core service offering", with additional "choice" service levels receiving lesser Government subsidy.

1.9 In parallel with the alignment of subsidy levels under the "target subsidy approach", the following should also be considered:-

(a) User fees for some currently publicly-subsidized services should accordingly be adjusted. HA believes that user fees in the form of co-payment will serve as price signals in promoting shared responsibility by patients. This will provide patients with the incentives to choose the most appropriate form of care. For public healthcare services aiming to ensure universal accessibility, user fees at point of services will also serve as a demand management tool to encourage judicious and appropriate use of services. These incentives may assist in the balance between use of the public and private sectors for more discretionary services.

(b) However, such price signals should not be such that people are denied access to essential treatment because of lack of means. To ensure this, the existing safety net mechanism should also be enhanced to provide better protection not only for the low income and underprivileged groups but also the middle income families in case of catastrophic medical illnesses. This may include expanding the safety net coverage to provide better protection for those facing excessive financial burden due to costly treatment and high out-of-pocket payment for expensive drugs and medical devices. In this connection, the "spending cap" concept to limit annual personal medical expenditure for public medical services with reference to household income and household size may be considered.

1.10 In addition to the four core areas of reform in the Document, HA believes that two further areas should be considered. First, the growth in future demand will require an increase in the health workforce, with training standards maintained. Second, measures to assure the quality of services across the public and private sectors need to be introduced, particularly if the private sector is to have a larger role in Hong Kong.

**On Supplementary Financing**

1.11 With Government funding continuing to serve as the primary source of financing for the healthcare system, it is expected that the introduction of supplementary financing coupled with various public-private partnership initiatives will help to address the current public/private imbalance and in turn release some pressure from the public system. However, it should be recognized that increased financial accessibility to the private sector is likely to generate extra demand (e.g. diagnostic tests, lesser-priority service interventions), and not only divert demand from the public sector. This follows the established health economics principle of "supply induced demand". Supplementary financing will add value to the healthcare system by facilitating choices of services by patients. Following the adjustments of public subsidy for lesser-priority services, supplementary financing will enable patients with the payment means and incentives for judicious use of healthcare services from both the public and private sectors.

**Supplementary Financing Options**

1.12 HA agrees that choice between the different options of supplementary financing is a matter of the community's societal value. HA is of the view that regardless of the forms of healthcare reform and preference of supplementary financing options, the strengths of the existing public health system (i.e. universal access, low administrative overhead with adequate utilization and cost control) will continue to be the foundation for Hong Kong's hospital system, which is relatively low cost when compared with other universal access systems. A sound and sustainable Funding and Service Agreement will need to be negotiated between the Government and HA in the future to ensure the principle of universal access to needed health services continues to be achieved in Hong Kong. Supplementary financing should both assist in diverting demand to the private sector and providing additional funding for HA's future response to the ageing population and growth in costs of new technologies and modern service techniques.

**Moving Forward – How Can HA Contribute To The Proposed Reform?**

1.13 HA has two key roles in the future of the proposed reforms: as an advisor to Government on community needs, and as a provider of public health services. These are considered below.

HA as an “advisor” to the Government on public healthcare services

1.14 One of the statutory duties of HA under the HA Ordinance is to advise the Government on the needs and resources required for public healthcare services. In this regard, it is envisaged that areas of strategic focus for HA in support of the proposed reforms are:-

(a) Forward planning of healthcare needs and assisting the Government in planning and coordination of future healthcare services delivery, including infrastructure requirements, manpower and training needs for different healthcare professionals to cope with the rising demand.

(b) Working with Government to establish tertiary specialist services and centres of excellence to promote quality care across both public and private sectors.

(c) Ensuring a sustainable and stable funding arrangement is in place for the provision of necessary quality public healthcare services.

(d) Reviewing the subsidy level of various public healthcare services to target public resources to the most needy and adjust user fees to serve as an effective means of encouraging responsibility by both the providers and users for judicious use of valuable healthcare resources.

(e) Enhancing the safety net mechanism (in support of one of the four Government’s service reform proposals) to provide better protection not only for the low income and underprivileged groups but also the middle income families in case of catastrophic medical illnesses.

(f) Continuing to strengthen the “purchasing function” of HA for publicly funded healthcare services, including advising the Government on the effective allocation of public resources for the delivery of different services by different providers (both public and private) as well as monitoring the usage of public funding by providers to ensure best value for money.

HA as a public health service provider

1.15 With the public healthcare system continuing to remain as the ultimate safety net for the community, HA as the key public health service “provider” believes that its roles going forward should focus on:-

(a) Continuing to build on the current strengths in providing universally accessible quality and cost-effective patient care to the Hong Kong community.

(b) Striving to maintain and enhance healthcare quality across Hong Kong by serving as a training platform for healthcare professionals in the public and private sectors, and development of innovative service models and quality systems. An example is the provision of structured and comprehensive training programs by HA in family medicine for the professional development of primary care practitioners in both the public and private sectors in support of the Government's vision of a robust primary care system. HA will also explore the introduction of an internationally recognized accreditation system and continue to invest in information technology to improve quality and safety of the patient care process.

(c) Supporting public-private partnership (PPP) in healthcare by working with private sector to enhance choices and quality through PPP. The development of the Primary and Community Health Centre concept (a new service delivery model that provides holistic primary health services) and the use of HA's clinical information system as a foundation for the development of a territory-wide Electronic Health Record sharing between public and private healthcare providers are examples of PPP initiatives where HA can contribute.

(d) Continuing to respond to the changing needs of patients and market place in the new environment. For instance, in anticipation of greater demand of alternative choices of services following the introduction of supplementary financing, HA (without compromising its role as the healthcare safety net for the community) may consider providing limited additional alternative choices of services (such as better amenities).

(e) Continuing to improve the efficiency of HA's services so the community receives good value for money. Similar to other responsible public organizations, HA will continue its endeavors to improve productivity and efficiency in ensuring best use of public resources for the provision of publicly subsidized healthcare services. These will include for example introduction of more innovative care models and deployment of cost-effective technology (like filmless radiology) to streamline the patient care process.

## II. BACKGROUND

2.1 This section sets out the background for this report and describes the approach taken in its production.

2.2 The Healthcare Reform Consultation Document "Your Health Your Life" ("the Document") published by the Government in March 2008 as the first of a two-stage consultation sets out four service reform proposals namely:-

(a) Enhance primary care;
(b) Promote public-private partnership in healthcare;
(c) Develop electronic health record sharing; and
(d) Strengthen public healthcare safety net

and the following financing reform proposals:-

(a) The Government will continue to be the major financing source for healthcare and is committed to increasing recurrent government expenditure for medical and health services from 15% to 17% of overall recurrent government expenditure by 2011/12; earmarked $50 billion from the fiscal reserves to assist the implementation of healthcare reform; and

(b) Introducing supplementary financing for healthcare with six options:-
    (i) Social health insurance
    (ii) Out-of-pocket payments (user fees)
    (iii) Medical savings accounts
    (iv) Voluntary private health insurance
    (v) Mandatory private health insurance
    (vi) Personal healthcare reserve, a combination of mandatory savings and insurance.

2.3 With the publication of the Document, the Government initiated a three-month consultation period to obtain views from the community to facilitate formulation of more detailed proposals for the reform and the supplementary financing arrangements for the second-stage consultation.

2.4 As the subject matter has major long term implication on the future public healthcare system, the Hospital Authority (HA), being the major public healthcare provider, is contemplating to provide a response from HA's perspective regarding the four service reform proposals and the various financing options as detailed in the Document.

**Process To Formulate HA's Response To The Consultation Document**

2.5 In support of the Food and Health Bureau consultation process, HA had coordinated and arranged briefing forums for the Bureau with different stakeholders including HA staff, patient groups, members of Regional Advisory Committees and Hospital Governing Committees. Public /community had also been engaged through focused group discussions. A number of Board members had also expressed interest in participating in the deliberation process and this submission represents the views of the HA Board, as front-line staff views have been communicated directly through the various forums organized jointly by HA and the Bureau.

**Approach And Strategic Focus**

2.6 Deliberation of healthcare reform is a complex subject. There are different perspectives to consider when discussing the issues. The Consultation Document has described in detail the rationale for the service reform proposals as well as provided in-depth analysis of the pros and cons with comparisons from 8 perspectives for the six supplementary financing options. HA is very supportive of the service reform proposals and looks forward to work with the Government to move ahead. Since the preference for any of the supplementary financing option(s) is a matter of community debate, the choice should rest with our societal value. The community has to determine to what extent the rich will subsidize the poor (wealth re-distribution), the healthy will subsidize the sick (risk-pooling/sharing), the young will subsidize the elderly or how much a person or the family should be responsible for their own health (shared responsibility).

2.7 In view of the complexity of this subject and, in particular, HA as the major public health service provider, the Working Group concentrated on analyzing implications of the reform proposals on the public healthcare system. To this end, HA's response to the Document is focused on:-

(a) How will the reform proposals enhance the value of the publicly funded healthcare system?
(b) How HA can move forward to support and contribute to the reform in order to achieve the desired outcome of a sustainable healthcare system?

2.8 Following this approach, a list of questions and issues requiring consideration for each of the four proposed service reforms and the financing reform options was drawn up to facilitate discussions by members:-

(a) What is best for the HK community?
(b) What is the future role of HA versus our current service position?
(c) How will the reform proposal facilitate HA to contribute to the public healthcare system?
(d) How it may work in practice (including any issues requiring consideration in addition to those mentioned in the Document)?

## III. NEED FOR HEALTHCARE REFORM

3.1 Chapter 1 of the Document highlighted a number of key challenges and structural weaknesses of the current healthcare system in Hong Kong, as summarized below:-

(a) Health expenditure in Hong Kong and especially the share of public health expenditure under the current healthcare market structure are projected to grow much faster than the economy. Rising healthcare needs from ageing population, increasing occurrence of lifestyle-related diseases and rising medical costs in order to keep up with rapid advancement of medical technology are the key contributing factors.

(b) Insufficient emphasis on holistic primary care (especially preventive care and wellness promotion) and limited integration between different levels of care (e.g. between primary and hospital care) are two shortcomings of the existing healthcare system. Coupled with the highly subsidized and quality services offered by the public sector, this has given rise to over-reliance on the public hospital system and in turn significant imbalance between the public and private healthcare markets.

3.2 These structural weaknesses of the current system have hindered HA (as the main public health service provider) from moving forward to support the Government's vision on "achieving a healthcare system that improves the state of health and quality of life of our people, and provides healthcare protection for every member of the community." The present highly subsidized public health services with the lack of effective integration between primary and hospital care have "attracted" and maintained reliance on the public hospital system. This has resulted in over-stretching of the public system. In order to cope with the ever increasing demand, HA has continued to give highest priority to services on four priority areas, namely:-

(a) Acute and emergency care;
(b) Services for the low income and underprivileged groups;
(c) Treatment for illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and
(d) Training of healthcare professionals.

**Financial Sustainability And Stability**

3.3 In the Consultation Document, healthcare cost in Hong Kong is projected to grow much faster than the economic growth (over and above GDP by 2% to 2.3% [Note 2]) and the current healthcare system is considered not sustainable in the long term. It is expected that public health expenditure as a share of total public expenditure will increase from 14.7% in 2004 to 27.3% in 2033, if the current healthcare market structure and utilization pattern of both public and private healthcare services remain unchanged [Note 3]. It is stated in the Budget Speech of 2008/09 Budget that as a general principle, expenditure growth over time should not exceed the growth of the economy and the Government aims to keep public expenditure at or below 20% of GDP. The projected increase in share of public health expenditure will therefore be at the expense of other public services.

3.4 Based on the projection of population growth and demographic changes, current delivery mode of HA's services, excessive demands due to some major disease burdens (such as cancer, mental illnesses, kidney failure) as well as pressure from increasing cost of healthcare, projection of HA's financial requirement in the next 3 to 5 years has shown that the recurrent expenditure of HA needs to grow at 4% to 5% per annum in real terms.

3.5 The current public healthcare funding, which relies heavily on taxation, will be subject to economic fluctuation and conditional upon the fiscal conditions of the Government. For example, following the economic downturn in early 2000s, Government's net recurrent subvention to the HA was reduced from $29.4 billion for 2002/03 to $27.2 billion for 2005/06 (Annex 1). But the demand for public healthcare services did not reduce correspondingly notwithstanding the rising cost pressure faced by the HA during this period. This has resulted in over-stretching of the public system. The waiting time for surgical treatment of non-priority conditions (Annex 2) and first appointment for specialist out-patient services have been lengthening over the years (Annex 3). A stable funding environment is therefore crucial for the delivery of health services in support of the Government's healthcare policy, especially for the public healthcare system which serves as the safety net for the community.

3.6 In addition to stable funding, a sustainable workforce of healthcare professionals with the right skill mix is another critical factor for the delivery of quality healthcare services. At present, supply of the healthcare workforce for the Hong Kong community comes primarily from graduates of local institutions. With due consideration to the rising healthcare needs, it is projected that the demand for well-trained healthcare professionals will "outweigh" the anticipated supply in the foreseeable future. The projected undersupply of doctors and nurses in the medium term are in the region of 120 and 340 per annum respectively.

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Note 2 P10 of the Healthcare Reform Consultation Document "Your Health Your Life".

Note 3 P16 of the Healthcare Reform Consultation Document "Your Health Your Life".

3.7 The HA agrees that status quo is not an option and supports the Government's view that there is a need for healthcare reform. It is clear that the present system of providing universally accessible health services with quality care through the HA is not sustainable in the long run, even with the Government's commitment to increase its spending on healthcare as the primary financing source (up to 17% of recurrent government expenditure). It is also important to note that securing a stable source of funding coupled with a sustainable workforce of well-trained healthcare professionals are equally crucial for the ongoing delivery of high quality healthcare services.

## IV. SERVICES PROVIDED BY HOSPITAL AUTHORITY UNDER THE CURRENT SYSTEM AND FUNDING ARRANGEMENT

4.1 Since the establishment of the HA, the Authority is committed to continuously improving the public hospital system in order to provide adequate, efficient, effective and high quality public hospital services within the resources available, and to meet the different needs of the patients for public hospital services. One of the statutory duties of HA under the HA Ordinance is to advise the Government of the needs of the community and the resources required to meet those needs.

4.2 The major source of recurrent funding to HA comes from the Government (mainly through taxation) in a form of lump sum subvention. Around 8% of HA's recurrent financial requirements are met by fees and charges and other sources of income. For 2008/09, recurrent subvention to HA accounts for about 91% of Government's recurrent expenditure on health and 13.9% of Government's total recurrent operating expenditure. In the HA, about 77% of its expenditure is used to pay for personal emoluments of healthcare professionals and support staff, 12% for drugs expenditure and medical supplies, 11% for maintenance, utilities, minor equipment and other charges.

### Facilities And Throughput

4.3 Currently, the HA is managing 41 public hospitals and institutions with over 27,000 beds, 48 specialist outpatient clinics (SOPCs), 74 general outpatient clinics (GOPCs) and 16 Accident & Emergency Departments (AEDs) providing a comprehensive range of services from primary, community and long term care, secondary care (organized by various specialty departments such as Surgery, Medicine, Orthopaedics, Paediatrics, Obstetrics & Gynaecology, etc), and tertiary and expensive care such as organ transplants and open heart surgeries.

4.4 Being a major healthcare service provider in Hong Kong, the percentages of population [Note 4] using different HA services and the respective level of activities for 2006/07 are summarized below:-

| | % of population using HA services in 2006 | Level of activities in 2006/07 |
|---|---|---|
| Inpatient Services | 8.4% | Over 1.15 million discharges (and deaths) [Note 5] |
| SOPC | 22.0% | Over 7.7 million attendances |
| GOPC | 18.4% | Over 4.8 million attendances |
| AED | 17.0% | Over 2.0 million attendances |

Note 4 Mid-year population from Census & Statistics Department (excl. transient population).

Note 5 Includes discharges (and deaths) for day patients.

**Utilization And Cost Profile Of HA's Services**

4.5 Amongst the $30 billion total HA expenditure for 2006/07, 68.5% was spent on inpatient services and 31.5% on ambulatory and community care (Annex 4). The average cost per inpatient discharge in 2006/07 was $19,170 [Note 6]. The average cost per specialist outpatient clinic (SOPC), general outpatient clinic (GOPC) and Accident & Emergency Department (AED) attendance were $740, $260 and $700 respectively (Annex 5). The current public hospital services are highly subsidized, with subsidy rate ranging from 83% for GOPC to 97% for general inpatient stay.

4.6 The report on "Building a Healthy Tomorrow" issued by the Health & Medical Development Advisory Committee in 2005 suggested that the public hospital services should focus on four priority areas: (a) acute and emergency care; (b) low-income and under-privileged groups; (c) high cost, advanced technology and multi-disciplinary treatment; and (d) training of healthcare professionals. HA attempted to analyze the resources spent on these priority areas and noted that these four areas in fact are describing different dimensions of healthcare with overlapping among them in a matrix manner. Despite the difficulties in clearly defining what these four priority areas mean for technical analysis work, a broad brush approach to quantify and analyze the resources spent in each of these priority areas was performed (Annex 6). The result showed that about 64% of HA's resources were spent on treatment of acute & emergency, high cost and complex illnesses. Around one third of the total resources were used to treat patients who are either Comprehensive Social Security Assistance Scheme (CSSA) recipients or supported by Medical Fee Waiver mechanism. There were also about 20% of HA's resources spent on other core services typically delivered by the public sector (such as mental illness, infirmary and rehabilitation etc). This left around 15% to 20% on non-urgent medical care.

**Efficiency Of HA's Services**

4.7 In terms of public healthcare expenditure, Hong Kong compares favourably with other developed economies having universal access to public hospital care. Annex 7 shows that universally accessible public hospital system is normally associated with public health expenditure as a percentage of GDP of 6% to 7% and tax rates of around 40% to 50% in the dollar. Hong Kong, with HA as the main public healthcare provider providing universally accessible quality and cost-effective patient care to the community, achieves a GDP spending on public health expenditure of 2.8% on a rate of 16% for income tax.

4.8 As noted in Section III, Government's net recurrent subvention to HA showed a reduction from $29.4 billion in 2002/03 to $27.2 billion in 2005/06 following the economic downturn in early 2000s. In order to cope with the challenges of growing demand from ageing population, increasing

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Note 6 For inpatient general services (acute and convalescence).

lethal disease burden (such as cancer, renal and mental health problems) and rising costs to keep up with advancement in medical technology, HA has taken various measures to ensure most cost-effective deployment of resources for the delivery of quality public healthcare services.

4.9 Through different efficiency and productivity improvement initiatives, a total cumulative saving of $3.5 billion (12.4%) was achieved [Note 7] and HA's total expenditure was kept at around $30 billion since 2001/02 to 2006/07 (Annex 8) despite the continued increase in drug costs, medical supplies and minor equipment resulting from rapid advancement of medical technology. To manage the rising drug expenditure, HA has implemented various cost saving measures such as bulk purchasing contracts. Besides, the Head Office administrative costs incurred by HA accounted for less than 2% of the total $30 billion spending, which is at a relatively low level when compared to similar institutions in other developed countries. Coupled with the progressive development and enhancement of outpatient and community care to substitute inpatient treatment, HA was able to treat more inpatient despite a reduction in hospital beds [Note 8].

4.10 HA recognizes the importance of ensuring public resources are used wisely and so will continue its endeavours to improve productivity and efficiency for the delivery of quality public healthcare services regardless of reform.

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Note 7 For the period from 2000/01 to 2005/06.

Note 8 Number of patient treated (discharge & death) per bed showed an increase by 7.5% from 2004/05 to 2007/08, despite the reduction of 621 hospital beds during this period.

## V. ENHANCE PRIMARY CARE

5.1 The majority of primary medical care is currently provided by the private sector at affordable price to most families in Hong Kong. Those who cannot afford to visit a private general practitioner can attend the GOPCs of HA for treatment of incidental minor ailments and pay a very low fee for which the Government has subsidized heavily. In 2006, near to one fifth of the Hong Kong population had used HA's GOPC service. Significantly, 42% of the 850,000 elders in the community are patients of GOPCs. On patients with chronic illness, there are approximately 400,000 of them using HA's GOPCs, which presently also provide free services for civil servants, pensioners and their dependents. Other than providing access to primary care for the low income groups and civil servants, HA's GOPCs and Family Medicine clinics further serve as the training grounds for specialists in Family Medicine.

### Vision – What Is Best For The Hong Kong Community?

5.2 The core value of primary care in a health system has been emphasized by the World Health Organization: *a good primary care system is instrumental to improving population health and in a cost effective manner*. In the reform proposals, the Government has given "enhancing primary care" strategic prominence. This is good for Hong Kong for the following reasons:–

(a) From the public health perspective, it is a paradigm shift of health service from a disease model to a health model that addresses the changing needs of an ageing population with increasing chronic diseases.

(b) From an individual's perspective, patients will receive more appropriate care from family doctors who have better knowledge of their health history and conditions and with whom they could enjoy better doctor-patient relationship. Patients will also be more informed, motivated and empowered to self care and more responsible for their own health and that of their family members, which in turn would lead to better health and less need for costly medical care. Primary care is best able to manage multiple stable chronic health conditions, which will be increasingly the case in the future – primary care integrates the care for the individual.

5.3 In support of Government's vision of a robust primary care system, HA shall play the following roles:–

### Training of family doctors

5.4 HA has enhanced family medicine training over the past years, putting in place a structured and comprehensive training programme in hospitals and in the GOPCs. It is envisaged that the Authority will continue to

be the major training platform for the development of primary care practitioners in both public and private sectors, and work closely with the Hong Kong College of Family Physicians to continuously improve our training in Family Medicine. It is also suggested that HA's trainees should receive exposure in private practice since the bulk of primary medical care rests with the private sector, and to better plan for their career in community-based practice upon completion of training. Therefore some part-time attachment during the higher training period, in the form of regular sessions or discrete module, could be arranged with family medicine specialists in private practice. The Government should also consider setting aside budget to facilitate further enhancement of the family medicine training program.

**Serve as a quality benchmark**

5.5 Through the development of good practice standards, models and protocols, HA could provide reference benchmarks for other primary care providers. In addition, HA can contribute to the accreditation process basing on a set of standards in practice management and quality indicators.

5.6 The new Primary & Community Health Centre (see paragraphs 5.11 and 5.12) would serve as a forum in which a multi-disciplinary team of primary care practitioners work as an effective team to provide patient care. This will in turn facilitate the development of a more robust healthcare system with the capacity and capability to deliver lifelong, holistic and seamless services to the general public.

5.7 This year HA has commissioned the Chinese University of Hong Kong to conduct a comprehensive review of its GOPC service provision and the position of GOPCs in family medicine training. The ultimate aim is to identify cost-effective service models that would be in keeping with the reform direction of the Government in primary care.

**Contribute to the development of a Hong Kong-wide patient electronic health record (eHR) system**

5.8 The effective interface of the eHR with the Clinical Management System of HA will enable a better integration of primary and secondary medical care and provide an environment conducive to the wider practice of family medicine.

**Continue to be the main service provider of primary care for low-income and under-privileged groups**

5.9 The HA GOPCs will continue to target to serve the socially disadvantaged and vulnerable groups.

**How Will The Reform Proposal Add Value To The Public Healthcare System?**

5.10 By emphasizing holistic care and preventive care, the reform proposal promotes more upstream work in clinical care and gives individuals the responsibility, knowledge and support to take care of their personal health. It also emphasizes the need for secondary prevention for people with chronic health conditions – better management of this group will ultimately reduce the cost of healthcare in the future through reduced hospitalization. This reinforces HA's efforts in reducing avoidable hospitalization through our existing programmes of promoting anticipatory care, chronic disease management and patients empowerment.

5.11 The reform proposal has also provided HA with the necessary policy support and enabling environment for the development of Primary and Community Health Centres (PCHCs) – a new service delivery model through a multi-disciplinary approach that integrates preventive, primary and community healthcare services.

**Further Contribution By HA Towards Enhancing Primary Care**

5.12 HA will develop a prototype PCHC to test its effects on providing continuous, comprehensive and holistic healthcare. We will also be piloting a PPP model to primary care service. Through public-private partnership initiatives in primary care and the longer-term PCHCs, these can be eventually shared out and promulgated to the Non-Governmental Organisations (NGOs) and private sector. In time, these will enable the development of a more uniform primary care standard in Hong Kong in both the private and public sectors.

5.13 The proposed PCHCs would be a multi-sectoral collaboration among HA, Department of Health (DH), Social Welfare Department (SWD), NGOs and private sector, with a wide range of services provided under one roof to improve inter-provider communication and interface and to enhance the accessibility of patients who often require services of multiple specialties and professionals:-

(a) HA would focus on its core services, including primary care through GOPC services, as well as existing community-based healthcare services such as community outreaching services and community assessment services.

(b) DH would continue its current public health functions including public health education and promotion such as maternal and child healthcare.

(c) Private health sector and health-oriented NGOs would provide community rehabilitation and health check-ups, as well as Chinese/Integrative Medicine services.

(d) SWD and social service NGOs would focus on community and home-based long-term care services, such as carer support and home care services.

## VI. PROMOTE PUBLIC-PRIVATE PARTNERSHIP (PPP) IN HEALTHCARE

6.1 At present, the public healthcare sector is mainly funded by the Government, acting as a safety net guaranteeing the community affordable and highly subsidized universal access to health services. The private sector mainly operates under commercial principles, developing services primarily suiting market needs and providing diversified choices to users according to affordability.

6.2 The disadvantages of the existing system include:-

(a) Over-reliance of public health services leading to long waits in the less urgent public services while capacity in private sector is not fully utilized.

(b) Lack of effective choices from patient perspectives due to significant price differences of the two sectors.

(c) Compartmentalisation of the two sectors affecting the continuity of patient care when patients flow from one sector to the other.

(d) Lack of an effective common platform to drive for service development and enhancement in scope, efficiency and quality in both the public and private sectors.

(e) Lack of an effective platform to pool up and continually enhance the scarce resources in healthcare in terms of human resources, financial resources, physical resources and information resources.

(f) Significant price differential currently exists between public and private providers (e.g. highly subsidized drug services currently provided by HA's GOPCs and SOPCs) is a major barrier that hinders effective integration between the two sectors.

**Vision – What Is Best For The Hong Kong Community?**

6.3 HA strongly supports the proposed direction of the Government in promoting the integration and partnership development of the public and private sectors. The focus could be on the following areas:-

(a) The present two-sector system should be largely maintained. The existing main roles of the two sectors developed over the years have their merits and are suiting the needs of the Hong Kong community.

(b) Further integration and partnership of the two sectors should be developed to support the refined roles of the two sectors as

described in the previous consultation paper i.e. Building a Healthy Tomorrow Report (listed in the next paragraph "Suggested Roles of the Public and Private Sectors").

(c) Further integration and partnership of the two sectors should be developed to address and enhance the issues identified above.

**How Will The Reform Proposal Add Value To The Public Healthcare System?**

6.4 With successful implementation of public-private partnership, the service utilization between the two sectors will be much balanced. The existing very high service demand on public healthcare system could be relieved, thereby allowing the HA to focus its resources on its priority roles. The foreseeable benefits include:-

(a) Reduction of waiting time for non-urgent cases.
(b) Improvement in individual patient care and individualized care.
(c) Faster introduction of modern technologies.
(d) Better environment in patient care.

**Contribution By HA In Promoting PPP**

**Suggested roles of the public and private sectors**

6.5 HA strongly supports the Government's proposal to re-align the roles of the public and private sectors in developing the future healthcare model. To ensure that the limited resources are being utilised in the most appropriate manner and for those in genuine need of such services, the public healthcare service sector should give highest priority to the following target areas:–

(a) Acute and emergency care;
(b) For low income and under-privileged groups;
(c) Illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and
(d) Training of healthcare professionals.

The private sector will provide choices for the community, and with insurance and/or medical savings accounts, will become more affordable to people of average income level.

6.6 Amongst all major healthcare providers in Hong Kong, HA has the unique characteristic in terms of its major market share, well developed physical, financial and informational infrastructure, broad distribution network, excellent professional expertise and multi-disciplinary team organisation. Based on these, HA can contribute positively in the development of PPP in the following perspectives:-

(a) Purchaser from the private sector on behalf of HA patients
(b) Setting up Electronic Health Record platform
(c) Benchmarking quality of care and services
(d) Allowing private sector to use its facilities in PPP programmes
(e) Develop joint ventures with private sector
(f) Diverting lesser-priority services with long waits to private sector
(g) Supporting the private sector with its community network and multi-disciplinary team structure
(h) Supporting private sector with its developed expertise and training capabilities.

**Possible areas for PPP development**

6.7 HA considers the following areas a priority for developing PPP:-

(a) Non-HA priority service areas and those with high service demand.

(b) Services where the private market has the capacity or capability to take on the provision.

(c) Primary care and preventive care.

(d) Secondary and Tertiary care where the private sector can contribute in terms of human resources, financial resources, physical resources and information resources.

**Pilot projects for development of public-private partnership**

6.8 HA continues to support Government's direction in the development of public-private partnership. PPP is a new development and there is a lack of experience. Therefore, there is a need to set policy, develop strategy and build operation models as well as addressing process-related challenges.

6.9 Given the proposed PPP models of purchasing private medical services, hospital development, setting up multipartite medical centres of excellence and engagement of private sector doctors in the public hospitals, HA has started exploring possible options with these projects:-

(a) Pilot Project in Tin Shui Wai (TSW) GOPC/ Primary Care Services - to explore the feasibility of PPP in primary care service in TSW through purchasing service from private sector for specific patient group. The service mainly targets at the low-income, chronically ill and vulnerable group. Standard protocol will be provided to facilitate the development of Family Medicine Practice.

(b) Cataract Surgeries Programme – to shorten the central waiting list for cataract surgeries through provision of subsidy to eligible

patients to get surgeries done in the private sector. Co-payment by patients will be adopted.

(c) PPP in North Lantau Hospital (NLH) – to explore the feasibility of PPP in phase 2 of NLH. Consideration will be given to co-locate both public and private services at the same site to enable mutual purchase of service and sharing of facilities.

(d) Public-Private Interface – Electronic Patient Records (PPI e-PR) has been piloted which facilitates the continuity of care, free flow of patients and improves clinical decision making across different healthcare providers. This serves as a useful platform for information sharing in the TSW GOPC and cataract surgery project, and acts as a vehicle to facilitate development of territory-wide Electronic Health Record.

6.10 The experience gained in the course of the development of the above projects will provide useful information to Government for reference in formulating health policy. HA can also have the opportunity to refine strategy and operation of the services in future projects.

**Operation principles of the PPP**

6.11 The reform should seek to improve access/service delivery, efficiency, quality, choices, sustainability of healthcare and sharing of experience and expertise between both sectors.

(a) To drive for best and better practices - While partnering with the private sector on the projects /programmes, the opportunity should be taken to help the development of the private sector/practice such as family practice, clinical protocol and clinical guideline development for quality assurance.

(b) To make use of the market dynamics - In the course of planning and designing of PPP projects, market dynamics should be taken into consideration. Care should be taken to avoid undue disturbance to the existing private market practice or draw in untargeted patient population to the public sector.

(c) To make use of the financial dynamics - Deciding on subsidy and co-payment level will be important as it will influence provider and user behaviour. Considerations should include:-

(i) Create incentive towards encouraging appropriate provider and user behaviour.
(ii) Facilitate effective and informed choices.
(iii) Foster individual responsibility towards health.
(iv) Target subsidy based on affordability.

(d) To drive for a better healthcare system and outcome - The design and model should be able to drive for quality, cost-effectiveness, efficiency and appropriate risk sharing. This can be leveraged through utilising appropriate market competition, economies of scale, sharing of resources and appropriate risk allocation.

**Longer-term positioning**

6.12 It is envisaged that HA would have different positions for different service lines in terms of promoting PPP:-

(a) Outpatient services
  (i) GOP services – HA to focus primarily on low income and under-privileged groups.
  (ii) SOP services – Maintenance of stable chronic patients could be channeled to private sector, as an added option for a proportion of patients.
  (iii) Development of Primary & Community Health Centre – HA to work with private sector to set standards and protocols.

(b) Inpatient services
  Three possible options for HA:-
  (i) Make available HA's spare capacities (e.g. vacant wards and off-hours) for private providers to run and/or engage private provider to operate at HA's facilities.
  (ii) In addition to infrastructure, HA also provides supporting services (such as nursing, laboratory test etc) to private providers for operations at HA's inpatient facilities.
  (iii) Allow HA doctors or invite private practitioners to provide private services in HA.

6.13 With the introduction of medical insurance in future, a potential new segment of clientele in HA may arise, in that patients with medical insurance may demand for better services (e.g. choices of doctors, better amenities etc). HA could consider enhancing existing facilities and amenities to cater for the need of this group of patients.

## VII. DEVELOP ELECTRONIC HEALTH RECORD (eHR) SHARING

7.1 In the Document, the Government puts forward electronic health records sharing as a key facilitator to enabling healthcare reform and to achieving the benefits of a better healthcare system. HA has a long history of electronic patient records development and the Clinical Management System (CMS) developed by the Authority is possibly the largest integrated computerized patient records system installation in the world today. HA has already seen many of the improvements mentioned in the Document, such as including improved efficiency and quality of care, improved continuity and integration of care, enhanced disease surveillance, and improved public-private partnership. HA believes that electronic health records would also be equally beneficial to the other healthcare sectors in Hong Kong.

7.2 HA has already leveraged its clinical information systems (the Clinical Management System, CMS and Electronic Patient Record, ePR) to support records sharing with other healthcare sectors in a variety of ways including:-

(a) Printing handheld records for patients to take with them for subsequent care;
(b) Automatic fax transmissions of patient summaries to referring doctors in the private sector; and
(c) Secure electronic sharing of key patient data through the use of the Public Private Interface – Electronic Patient Record (PPI-ePR).

7.3 HA is now redeveloping its CMS and ePR to enable these systems to fully support the standards and technologies necessary for future electronic records sharing, and to even allow these systems to be deployed beyond the walls of the HA if necessary.

### Vision - eHR In The Near Future

7.4 Not only will a territory-wide eHR system facilitate continuity of care, HA also anticipates such a system may be necessary to support other specific initiatives in enhancing primary care, stronger public-private partnership, or any financing reforms. For example, disease management protocols that cross healthcare sector boundaries will be much more effective if such protocols exist in the territory-wide eHR by providing specific information support to carers both in the public and private sectors.

7.5 The creation of a territory-wide eHR system is a very complex task, with social, legal, financial and technical hurdles that will require the collaboration of all healthcare stakeholders in Hong Kong to overcome. HA is already fully engaged with the Government and other healthcare sectors in the development of electronic records sharing in Hong Kong, and HA will

continue to contribute our knowledge and experience in Health Informatics to the furtherance of this objective.

7.6 HA also views the development of Health Informatics capabilities in the wider community as crucial to enabling electronic records sharing in Hong Kong. HA will continue to support efforts to enhance eHealth skills and awareness.

7.7 Many, if not all, of the developed countries in the world are pursuing electronic records sharing as a key strategy to improve the quality and sustainability of their healthcare systems. The HA believes that the CMS gives Hong Kong a significant jumpstart in the creation of the territory-wide eHR.

**From eHR To eHealth**

7.8 From the development of eHR, HA further looks towards the development of personal health records (PHR) in which individual citizens would be able to have their own health records. Information technology should enable individuals to manage their own health and promote self-care. The development of infrastructures and services to support self-care and eHealth could go in parallel with the eHR development.

## VIII. STRENGTHEN PUBLIC HEALTHCARE SAFETY NET

8.1 It is the Government's healthcare policy that "no one should be denied adequate healthcare through lack of means". Under the existing system, if individual patients cannot afford to pay the highly subsidized rate for public healthcare, the patients can be further assisted through a well established medical fee waiver mechanism. Moreover, the Government's Samaritan Fund (administered by the HA) will provide financial assistance to patients who cannot afford certain self-financed drug and privately-purchased medical items.

### Vision - What Is Best For The Hong Kong Community?

8.2. The HA, being the main public healthcare provider funded by the Government, acts as a safety net guaranteeing the community highly affordable universal access to healthcare through provision of services under high subsidy. HA is of the view that the public safety net should be aimed for two major objectives:-

(a) To guarantee all eligible persons the universal access to a reasonable level of medical care.

(b) To provide services at reasonable cost so that treatment of medical illnesses does not significantly affect the standard of living of an individual or family.

### How Will The Reform Proposal Add Value To The Public Healthcare System?

8.3 While the primary financial responsibility of the future safety net should remain with the Government, the safety net could be enhanced through different healthcare financing options. Different funding options could facilitate risk pooling, guarantee certain level of healthcare funding being available or promote individual responsibility on personal health and thereby reducing demand on the safety net but not replacing or substituting it.

### Contribution By HA In Strengthening Safety Net

8.4 HA believes that the existing function of HA as the ultimate safety net should be maintained by providing highly subsidized, affordable and universally accessible public services so as to guarantee the community especially those low income /underprivileged groups and those suffering from catastrophic and chronic illness where the cost of treatment grossly affects the standard of living.

8.5 The existing safety net mechanism can be strengthened in two perspectives:-

(a) Streamline the application process and bring the various financial assistance schemes, i.e. the medical fee waiver system and Samaritan Fund application procedures under one single platform; and

(b) Expand the coverage to middle income families facing with financial catastrophes due to costly treatment and high out-of-pocket payment for expensive drugs and medical devices. For example, some people with chronic health conditions use a high level of HA services and can find themselves paying a relatively unfair percentage of their annual income on HA fees and charges, even though some are small. A sample analysis revealed that the annual spending on HA fees and charges by these high-frequent HA service users can range from $12,500 to $189,800 per year (Annex 9). In this regard, consideration may be given to:-

(i) Explore the “spending cap” concept to provide better protection for those suffering from catastrophic and chronic illnesses, incorporating all HA fees and charges in a full year, and linking this to people’s income; and

(ii) Increase subsidy for services with greater needs and higher financial risks, e.g. incorporating certain Patient Purchased Medical Items like coronary stents and certain expensive cancer drugs that have strong medical evidence of clinical effectiveness.

8.6 The need to strengthen the safety net mechanism is pre-conditional upon (a) there will be a revision of fees and charges to dovetail with the adjustments of subsidy level for priority and non-priority services, (b) patients are still required to pay for the expensive drugs and medical devices not covered by the current basic public medical services, and (c) there is no successful medical insurance or medical savings accounts payment mechanism, or there is no protection for those un-insured or exhausted their medical savings.

8.7 Without revision of fees and charges for public medical services, the existing safety net mechanisms have already been sufficient to cover the basic needs of those low income and underprivileged groups. There is no need to expand the scope of current coverage. With the introduction of mandatory medical insurance schemes in the future, it is likely that medical expenses for public medical services will be reimbursed or financed adequately and thus the safety net will be catered for those un-insured due to lack of means.

8.8 The expansion of safety net to cover those middle income families by introduction of “Spending Cap” on public medical expenditure requires additional public funding on one hand. On the other hand, with the

Government's three other service reform proposals and the six supplementary financing options, it is envisaged that the demand pressure on the public health system could be released, which in turn could free up resources to improve the public healthcare safety net.

**Safety Net Design Considerations**

8.9 Other considerations in designing the future safety net include:-

(a) The level of medical care covered by the safety net has to be defined, specified and should not be without limit. The scope of coverage should be defined after taking into consideration of the treatment efficacy, safety, cost effectiveness and opportunity cost basing on scientific evidence.

(b) Similarly, the standard of living protected by the safety net has to be defined, specified and should not be without limit. This level will be a matter of value judgment that needs consensus building through community participation.

(c) The level of financial subsidy provided by the safety net to individual cases should be related to affordability. Apart from the very poor, a co-contribution mechanism should be introduced. This will ensure that the always limited financial resources can benefit more patients.

(d) The future safety net with good control and monitoring should also be applicable to publicly funded medical services, no matter whether they are provided in the public or other sectors.

(e) The system and the administration should be credible, transparent, simple and efficient. There may be a need to set up an independent mechanism to administer the system.

(f) The enhanced measures should align and synchronize with the existing public safety net mechanism (i.e. Samaritan Fund and the medical fee waiver mechanism) to ensure coherence.

8.10 Irrespective of the future design of the safety net, HA will continue to improve the standard of public services and shorten the waiting time as far as possible and as permitted by the resources available.

## IX. FINANCING REFORM AND SUPPLEMENTARY FINANCING OPTIONS

9.1 To recap the financing reform and supplementary financing options proposal, the Government puts forward that:-

(a) The Government will continue to be the major financing source for healthcare and is committed to increasing recurrent government expenditure for medical and health services from 15% to 17% of overall recurrent government expenditure by 2011/12; earmarked $50 billion from the fiscal reserves to assist the implementation of healthcare reform; and

(b) Introducing supplementary financing for healthcare with six options:-
   (i) Social health insurance
   (ii) Out-of-pocket payments (user fees)
   (iii) Medical savings accounts
   (iv) Voluntary private health insurance
   (v) Mandatory private health insurance
   (vi) Personal healthcare reserve, a combination of mandatory savings and insurance.

9.2 The objectives of the financing reform are to overcome the structural weaknesses in the current healthcare system, namely (a) insufficient emphasis on holistic primary care, (b) over-reliance on the public hospital system, (c) significant public-private imbalance and (d) limited continuity and integration of care. It is envisaged that additional funding source will be injected into the system to implement the service reform proposals, such as subsidy in form of health coupons, to promote preventive care, investment in technical infrastructure to enable information sharing between sectors for continuity of care, and provision of additional financial assistance to those with needs.

9.3 In the Consultation Document, details on how the pooled resources would be distributed to healthcare services providers (i.e. the service purchasing and payment-to-providers mechanisms) are not available. This may be the focus of the second stage consultation and largely dependent on the outcome of this consultation as well as which supplementary financing option(s) is/are favoured by the community. At this stage, it is difficult to assess the likely impact on public healthcare services and HA as the major public service provider when the “money-follow-patient” concept is implemented.

9.4 Despite all these uncertainties, HA’s view is that whatever outcome of the consultation, healthcare reform should build on existing strength of current system and develop strategies to address the weaknesses and associated issues. The current strength of our public healthcare system enables universal accessibility of all Hong Kong residents, protects the low

income and underprivileged, and insures against diseases with high financial risks. Being the ultimate safety net, HA has the responsibility to provide services that may not be viable in the private sector, whether because of lack of volume or lack of profitability because of the personal cost involved.

9.5 Under the proposed "money-follow-patient" concept and market reform as described in Page 42 of the Document (whence "*individuals to be in a position to choose private healthcare and promoting healthy competition in quality and cost-effectiveness"*), HA should not fall into the trap of competing revenues with the private sector for patients who otherwise should have the means to patronize the private sector for non-catastrophic or treatment of non-urgent conditions. Without a secure funding mechanism for public healthcare service, the existing strength of our current public system will be undermined.

**Public Funding & Target Subsidy**

9.6 The Government has given the undertaking that necessary healthcare services will remain accessible and affordable to the community. To deliver on this promise, the public healthcare system will continue to serve as a safety net for the low-income, under-privileged and those in needs. HA's low cost system not only provides a universal safety net, but also creates the financial incentive to attract all patients for all services. HA believes that public funding should be targeted to reflect HA's priority responsibilities, i.e. the target subsidy approach:-

(a) Services with the greatest health needs and high financial risks (e.g. organ transplants) should continue to be very highly subsidized – This will include acute and emergency treatment for conditions with life threatening disease and catastrophic illness, e.g. expensive transplants, heart /complex cancer surgery, infection disease and major trauma etc.

(b) Non-urgent and more discretionary services or those purely at patient choices (such as better amenities) should be subject to lower subsidy level to serve as price signals and provide incentives for patients to choose the most appropriate form of care – Examples of lower subsidy items are:-

(i) Services likely to be inappropriately utilized, such as A&E Department. Currently, around 60%-70% of A&E attendances are due to semi-urgent or non-urgent conditions. A large number of these patients can be safely treated by general practitioners at reasonable cost. It is costly to treat these minor ailments at A&E Departments.

(ii) Unnecessary dependence on public hospital services, such as SOPD follow-up of stable chronic illness or long-stays in acute hospitals for people suitable for long term care services outside the public sector.

(iii) Treatment for non-emergency and non-catastrophic conditions that are available in private sector (to encourage utilization by patients with the means to do so).

(c) In parallel with introducing the "target subsidy" approach for public health services, it is vital to ensure that enhancements to the current safety net mechanism are put in place to provide better protection. More details on development of the future enhanced safety net mechanism have been separately covered in Section VIII "Strengthen Public Healthcare Safety Net".

9.7 To cope with the rising demand for healthcare services as a result of ageing and the increasing expectations from the public, a lot of healthcare professionals well trained for the provision of quality care will be needed. The HA is the training ground for the majority of healthcare professionals. In this regard, the cost of providing training opportunities to the next generation and to uphold the practice of quality care shall be an important element of public funding.

**Supplementary Financing**

9.8 Supplementary financing not only helps to relieve our future tax payers' burden on footing the healthcare bills, it will also help to release pressure of the current public system. Supplementary financing will enable patients with the capacity to pay and provide them with the incentives to use services provided by the private sector through the "money-follow-patient" concept, and achieve the objective of offering more choices for individuals seeking healthcare services. This will also facilitate the delivery of more secondary care (especially those fall outside the four priority areas) by the private sector and help addressing the current public/private imbalance.

9.9 Supplementary financing should both assist in diverting demand to the private sector as well as providing additional funding for HA's future response to the ageing population and growth in costs of new technologies and modern services techniques. Although choice between supplementary financing options is a matter of the community's societal value, it should also note that different financing options will serve different purposes for different types of healthcare services, e.g.

(a) Insurance (mandatory or voluntary) will be an appropriate supplementary financing option for most incidental hospital services – the risk-pooling concept.

(b) Savings accounts on the other hand will be more suitable for coverage of general non-insurable services such as personal well-being primary /preventive care and episodic outpatient attendances – the self-responsibility concept.

## X. MOVING FORWARD- HOW CAN HA CONTRIBUTE TO THE REFORM?

10.1 In order to ensure effective allocation of resources injected into the system for the delivery of appropriate healthcare services by both public and private providers, the following are identified as the key attributes for HA (both as the "advisor" to the Government and as the major public healthcare service "provider") to move forward to contribute in achieving the desired outcome of a sustainable healthcare system:-

### As An "Advisor" To The Government On Needs And Resources Required For Healthcare Services

10.2 One of the statutory duties under the HA Ordinance is to advise the Government of the needs of the community and the resources required to meet those needs. HA has a role to play in forward planning for the future healthcare needs, based on the known cost and demand pressure, and advise the Government of the needs of public healthcare services. HA will also assist the Government in planning and coordination of future healthcare services capacity, e.g. infrastructure requirement, manpower needs and training, establishment of tertiary specialist services and centres of excellence.

### A sustainable public healthcare service funding arrangement

10.3 With the Government's pledge to continue to provide highly-subsidized public healthcare services to the population, HA as the key public provider will remain as the ultimate healthcare safety net for the community. While it is envisaged that the proposed reform will help to reduce pressure and over-reliance on the public hospital system, it will be equally important to ensure sufficient and stable funding be continued to provide to HA for delivery of the necessary public healthcare services in support of the Government's healthcare policy.

### A sustainable workforce of healthcare professional to meet rising service demand

10.4 An adequate supply of well-trained healthcare professional with the right skill mix is also critical to the delivery of quality healthcare services. To this end, HA has put in place a mechanism for systematic review and projection of workforce requirements taking into consideration of the rising healthcare needs as well as anticipated supply of healthcare professionals. Since training of healthcare professionals takes time, projection of long-term manpower needs by HA will serve to inform the Government the future supply requirements in order for the local tertiary institutions to take necessary actions well in advance.

**Review subsidy level for public healthcare service**

10.5 Following the target subsidy approach with different subsidy levels for priority and non-urgent services and with enhanced safety net mechanism in place, rationalization of the fee structure for public healthcare services should be considered. The guiding principles put forward in Chapter 5 of the Consultation Document may be applied as follows:-

(a) **Resource prioritization** - higher subsidy for services with greater needs and higher financial risks, e.g. emergency hospital treatment (emergency admission and intensive care) and catastrophic illness (elective admission for high-cost treatment e.g. expensive transplants, heart surgery, complex cancer surgery).

(b) **Affordable services** – two-level safety net each targeting to different community groups. In general, the focus should be on the catastrophic or chronic illnesses targeting to prevent the cost for reasonable treatment of medical illnesses from grossly affecting the standard of living of an individual or family. It is in the situation of the very poor that coverage should be extended to non-catastrophic or non-chronic episodes of illness to ensure the universal access to a reasonable level of medical care.

(c) **Judicious and appropriate use** – provide incentive for patients to choose the most appropriate form of care with different price signals (e.g. lower subsidy for services likely be abused such as A&E Department) and reduce unnecessary dependence on public hospital services (such as SOPD follow-up of uncomplicated chronic illness, convalescent / rehabilitation / infirmary / hospice where alternatives available in community care / institutions / home care).

(d) **Shared responsibility** – lower subsidy rates for discretionary services such as
   (i) Non-emergency, non-catastrophic conditions.
   (ii) Short episode, one off treatment.
   (iii) Treatment available in private sector (encourage utilization in private sector by affordable patients).

**Rationalize fees and charges for public healthcare services**

10.6 HA agrees that there is a need to review the public medical fees and charges, but disagrees that user fees will deal with the future funding shortfall from the ageing population and technology changes. User fees should be about price signals, and fee increases could be used to cover the cost of the enhanced safety net proposal discussed above and if there is any residual one-off revenue, to improve the existing quality of services. User fees through fees and charges or in the form of co-payment emphasize self-reliance and support freedom of choice. For the public healthcare services aiming to ensure universal accessibility, user charges at point of service would

serve as a demand management tool to reduce inappropriate healthcare demand and unnecessary use of services. A well designed and rational fees structure can enable targeting of the Government subsidy to specific patient groups more efficiently, encourage judicious use of services and effective allocation of subsidies for services that produce the best outcomes. An obvious example is the use of our Accident & Emergency Department (with an average cost of around $700 per attendance) to treat minor and incidental ailments that could have been handled comfortably by a general practitioner or a family doctor.

**Improve the safety net mechanism**

10.7 Another means of effective use of public resources is to provide financial assistance to those in need. Other than the low income and under-privileged groups, middle income families may also face financial difficulties in case of catastrophic medical illnesses. With the introduction of insurance or savings accounts, the chances of those unfortunate individuals or families facing financial catastrophes due to medical illnesses will be low. However in cases when excessive out-of-pocket payment is required, the safety net mechanism (such as capping the maximum annual public healthcare expenses to a level not to jeopardize the standard of living) shall kick in.

10.8 The existing safety net mechanisms should also be reviewed and streamlined. The various financial assistance schemes designed for different healthcare expenditure items, e.g. the Medical Fee Waiver Mechanism, Samaritan Fund application procedures, should be brought under one umbrella with one set of standard transparent means testing criteria.

**Enhance the purchasing function**

10.9 With the increasing roles of HA in establishing public-private partnership programmes, the functions of HA have been changing from a pure service provider to a purchaser, purchasing healthcare services on behalf of the Government. The Cataract Surgeries Programme is such an example. HA shall continue to strengthen its “purchasing function” for publicly funded healthcare services, including advising the Government on the effective allocation of public resources for the delivery of different services by different providers (both public and private) as well as monitoring the usage of public funding by providers to ensure best value for money.

**<u>As The Key Public Healthcare Services “Provider”</u>**

10.10 HA shall continue to build on its strength and to provide universally accessible quality and cost-effective patient care to the Hong Kong community.

10.11 HA shall also strive to improve healthcare quality across Hong Kong through training and innovative service models and quality systems. To assure and continuously improve the quality and safety of patient care, HA shall introduce internationally recognized accreditation system. Besides, HA shall also continue to prudently invest in information technology systems to support and ultimately improve the care process and augment the safety and incident reporting mechanisms.

10.12 In support of the Government's proposal to promote public-private partnership in healthcare, HA shall work closely with the private sector to enhance choices and quality through PPP. The development of the Primary and Community Health Centres (PCHCs) concept (a new service delivery model that provides holistic primary health services in an integrated manner) is an example of this. In addition to providing a coordinated platform for public and private providers, this PCHC concept will also add a strong pillar to the current healthcare system by offering support to general practitioners (in both public and private sectors) in the delivery of multi-disciplinary primary health services to patients.

10.13 HA shall continue to respond to the changing needs of patients and market place in the new environment, e.g. provide alternative choices of services. For instance, a patient with insurance coverage may call for more choices of inpatient services in terms of better amenities or shorter waiting time. Since it will take time for the private sector to build up its capacity and capability, HA may consider as an interim solution the provision of limited additional "private" services. Without compromising HA's function as the ultimate healthcare safety net for the community, such "limited additional private" services will be provided on full-cost recovery basis to serve as a benchmark for the private sector on cost-effectiveness.

**Continue To Improve Efficiency Of HA's Services**

10.14 As a responsible public organization, HA will continue its endeavors to improve productivity and efficiency in ensuring best use of public resources for the provision of publicly subsidized healthcare services. Consideration will be given to the introduction of more innovative care models, and deployment of advanced information technology, e.g. filmless radiology, to streamline the patient care process.

10.15 Continual efforts will be devoted to improving efficiency and cost effectiveness of its services by reducing avoidable hospitalization, reducing length of stay of hospital treatment in both acute and extended care as well as introducing evidence-based drug and technology assessment system. Besides, development of day and ambulatory surgery and various outreach and community initiatives for areas such as Geriatric and Psychiatric services to substitute inpatient treatment by ambulatory and community setting will also be continued. New internal resource allocation mechanism will also be introduced to provide incentives for hospitals to improve productivity and deliver services in a more efficient manner while at the same time safeguarding quality.

## XI. CONCLUSION AND KEY MESSAGES

11.1 In summary, while the Government's commitment to increase public expenditure on healthcare as the primary financing source is welcomed, a critical success factor to the proposed reform is to ensure funding injected into the system is best allocated to promote effective integration of public and private providers in the delivery of appropriate and efficient healthcare services to the community.

### Enhance Primary Care

11.2 In support of Government's vision of a robust primary care system, HA may position our primary care services in three areas, namely:-

(a) Serving as training platform for the development of both public and private primary care practitioners;
(b) Setting reference benchmarks through the development of primary care model/protocol; and
(c) Focusing our provision of primary medical care via the general outpatient clinics for low income /under-privileged groups.

In addition, HA will pilot the development of the Primary and Community Health Centre to deliver a more holistic, comprehensive and effective care based on a multi-disciplinary approach.

### Promote Public-Private Partnership (PPP) In Healthcare

11.3 Being a major healthcare provider in Hong Kong, HA has a well developed infrastructure which enables us to contribute positively in the development of PPP in healthcare. The development of the Primary and Community Health Centre concept (a new service delivery model that provides holistic primary health services) and the use of HA's clinical information system as a foundation for development of a territory-wide Electronic Health Record sharing between public and private healthcare providers are examples of PPP initiatives where HA can contribute. Other possible contributions of HA may include serving as the purchaser, allowing private sector to use HA's facilities, developing joint venture with private sector, diverting non-priority services to private sector, supporting the private sector with HA's community network, multi-disciplinary team structure, developed expertise and training capabilities.

### Develop Electronic Health Record (eHR) Sharing

11.4 HA's clinical information system platform will provide a foundation for development of a territory-wide Electronic Health Record (eHR) system for sharing with other healthcare sectors. Moving from eHR, HA further looks towards the development of personal health records which enables individuals to manage their own health and promotes self-care.

**Strengthen Public Healthcare Safety Net**

11.5 Following the Government's proposed reform direction, HA will remain as the ultimate safety net for the community, especially for those who lack the means to pay for their own healthcare. An enhanced two-level safety net each targeting at different community groups may be considered. While the "spending cap" concept may be explored to protect those suffering from catastrophic and chronic illnesses, subsidy for services with greater needs and higher financial risk may be increased.

**On Public Funding**

11.6 Following Government's pledge to continue to provide highly-subsidized public healthcare services to the population, it is envisaged that:-

(a) HA as the key public provider will remain as the ultimate safety net for the community and subvention from Government will continue to serve as our major source of funding. In this regard, a stable funding environment for the public healthcare system will be vital.

(b) Public funding should be targeted for priority areas of public healthcare services with different subsidy levels for higher priority and lesser-priority services. Meanwhile, enhancement of the safety net mechanism to provide better protection not only for the low income and underprivileged groups but also the middle income families in case of catastrophic medical illnesses should also be considered.

(c) In addition to provision of priority public health services, public funding should also be focused on:-
   (i) Provision of training to healthcare professionals to meet the increasing demand.
   (ii) Safeguarding the quality of care across public and private sectors.

**On Supplementary Financing**

11.7 With Government funding continues to serve as the primary source of financing for the healthcare system, supplementary financing will add value to the healthcare system by facilitating choices of services by patients (i.e. enable patients with the payment means and provide them with incentives for judicious use of healthcare services from both public and private sectors).

11.8 Though choice between supplementary financing options is a matter of the community's societal value, it is important that:-

(a) Strength of the existing public health system (i.e. universal access, low administrative overhead with adequate utilization and cost control) should be maintained.

(b) Different financing options should serve different purposes for different types of healthcare services. For example, insurance (mandatory or voluntary) will be more appropriate for incidental hospital services whereas savings accounts will better suit general non-insurable services like personal well-being primary/preventive care and episodic outpatient attendance.

**HA In Moving Forward To Support The Proposed Reform In Achieving A Sustainable Healthcare System**

11.9 The key attributes for HA to move forward have been identified at two levels:-

**As an "advisor" to the Government on the needs and resources required for public healthcare services**

(a) Assisting the Government in planning and coordination of future healthcare services delivery, e.g. workforce projection and assessment of appropriate supply of professionals to meet future service needs, training of specialists, and establishment of tertiary specialist services and centres of excellence.

(b) Ensuring a sustainable and stable funding arrangement is in place for the provision of necessary public healthcare services to the community.

(c) Reviewing the subsidy level of various public healthcare services to target public resources to the most needy and adjust user fees to serve as an effective means of encouraging responsibility by both the providers and users for judicious use of valuable healthcare resources.

(d) Enhancing the safety net mechanism to provide better protection not only for the low income and underprivileged groups but also the middle income families in case of catastrophic medical illnesses.

(e) Continuing to strengthen the "purchasing function" for publicly funded healthcare services, including advising the Government on the effective allocation of public resources for the delivery of different services by different providers (both public and private) and monitoring the usage of public funding by providers to ensure best value for money.

**As the key public healthcare service "provider"**

(f) Continue to build on our strength and to provide universally accessible quality and cost-effective patient care to the Hong Kong community.

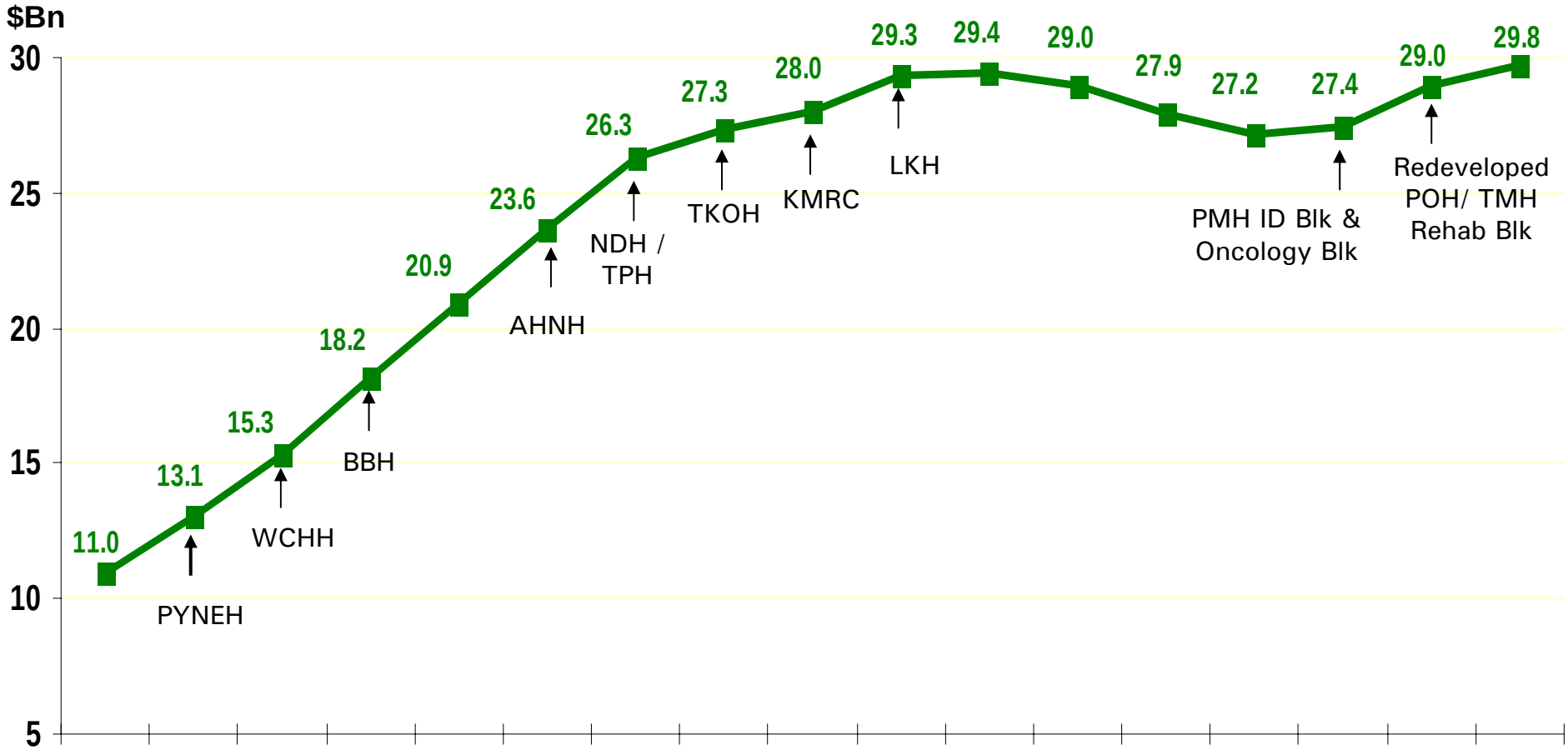
(g) Strive to improve quality across Hong Kong through training and innovative service models and quality systems, e.g. accreditation and information technology system.

(h) Support public-private partnership (PPP) in healthcare by working with private sector to enhance choices and quality through PPP.

(i) Continue to respond to the changing needs of patients and market place in the new environment, e.g. provide alternative choices of services.

(j) Continue to improve efficiency and cost effectiveness of HA's services in ensuring best use of public resources for the provision of publicly subsidized healthcare services, e.g. introducing cost-effective technology like filmless radiology.

# Trend of Recurrent Funding to HA from 1992/93 to 2008/09 (Para 3.5)



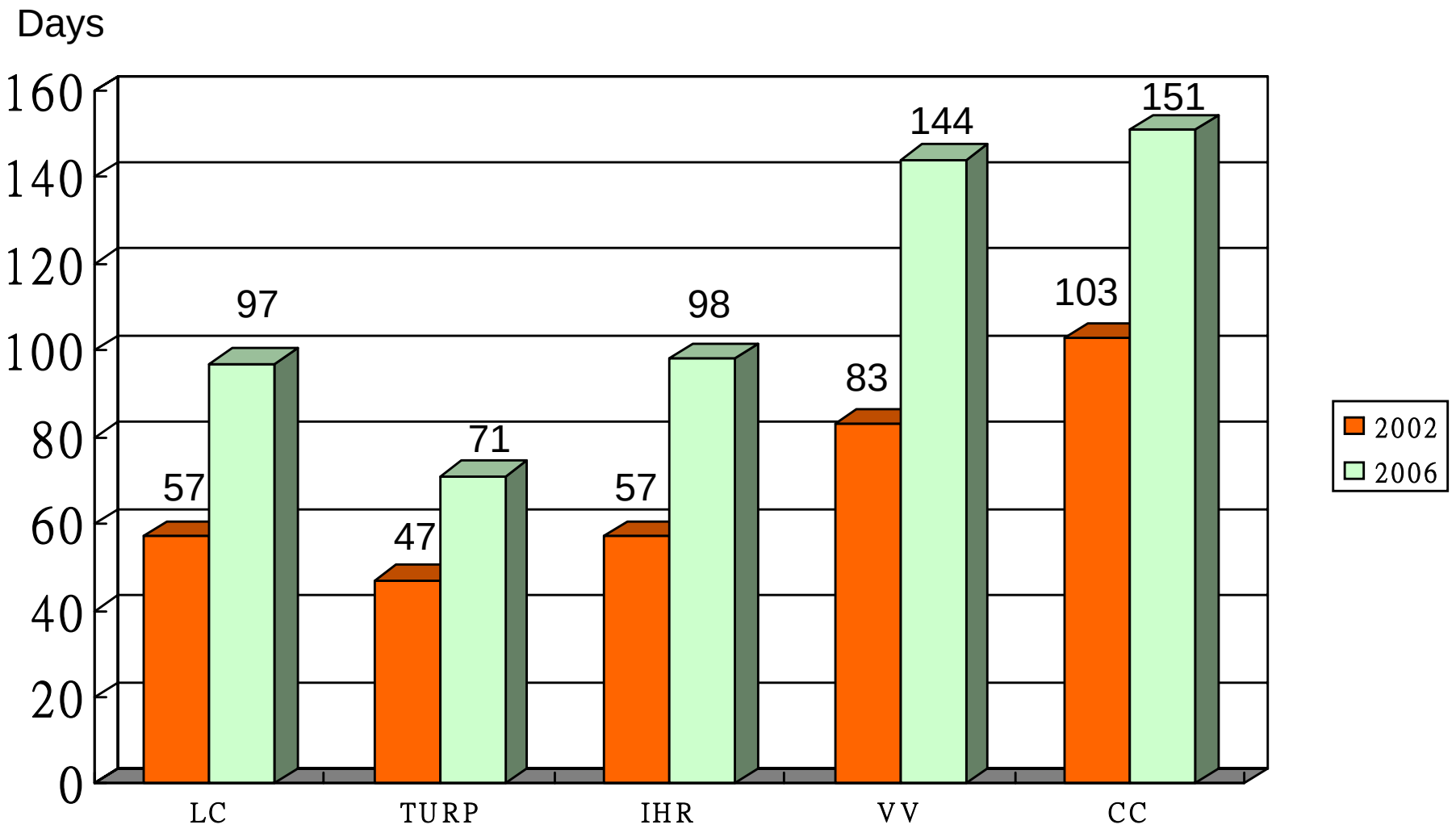

| 92/93 | 93/94 | 94/95 | 95/96 | 96/97 | 97/98 | 98/99 | 99/00 | 00/01 | 01/02 | 02/03 | 03/04 | 04/05 | 05/06 | 06/07 | 07/08 | 08/09 Estimate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13.5% | 14.0% | 14.5% | 15.1% | 15.5% | 15.8% | 16.0% | 15.7% | 15.2% | 15.0% | 14.9% | 14.7% | 14.5% | 14.5% | 14.5% | 14.4% | 13.9% |

**% HA Net Recurrent Subvention to Govt Recurrent Expenditure**

Remarks: Recurrent net subvention excludes Training & Development Fund and Samaritan Fund.

↑ denotes commencement in opening of new hospitals: 93/94 Pamela Youde Nethersole Eastern Hospital, 94/95 Wong Chuk Hang Hospital, 97/98 Alice Ho Miu Ling Nethersole Hospital, 98/99 North District Hospital/Tai Po Hospital, 99/00 Tseung Kwan O Hospital, 00/01 Kowloon Medical Rehab Centre, 01/02 Lai King Hospital. Bradbury Hospice joined HA in 95/96, 06/07 Princess Margaret Hospital Infection Disease Block & Oncology Block, 07/08 Redeveloped Pok Oi Hospital/Tuen Mun Hospital Rehabilitation Block.

# HA Median Waiting Time of 5 Selected Non-Priority Operations (Para 3.5)




LC - Laparoscopic Cholecystectomy

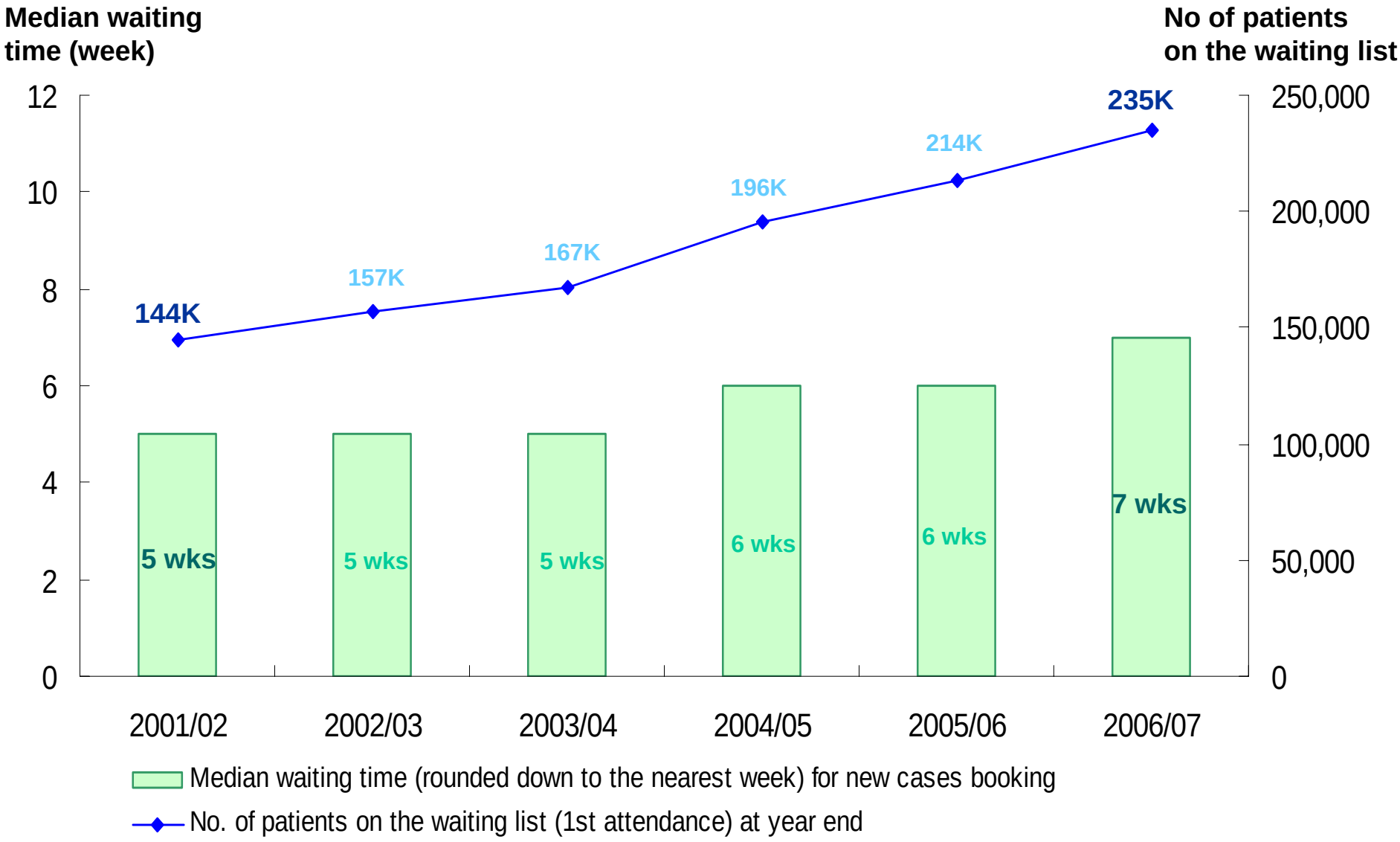
TURP – Transurethral Resection of Prostate

IHR - Inguinal Hernia Repair

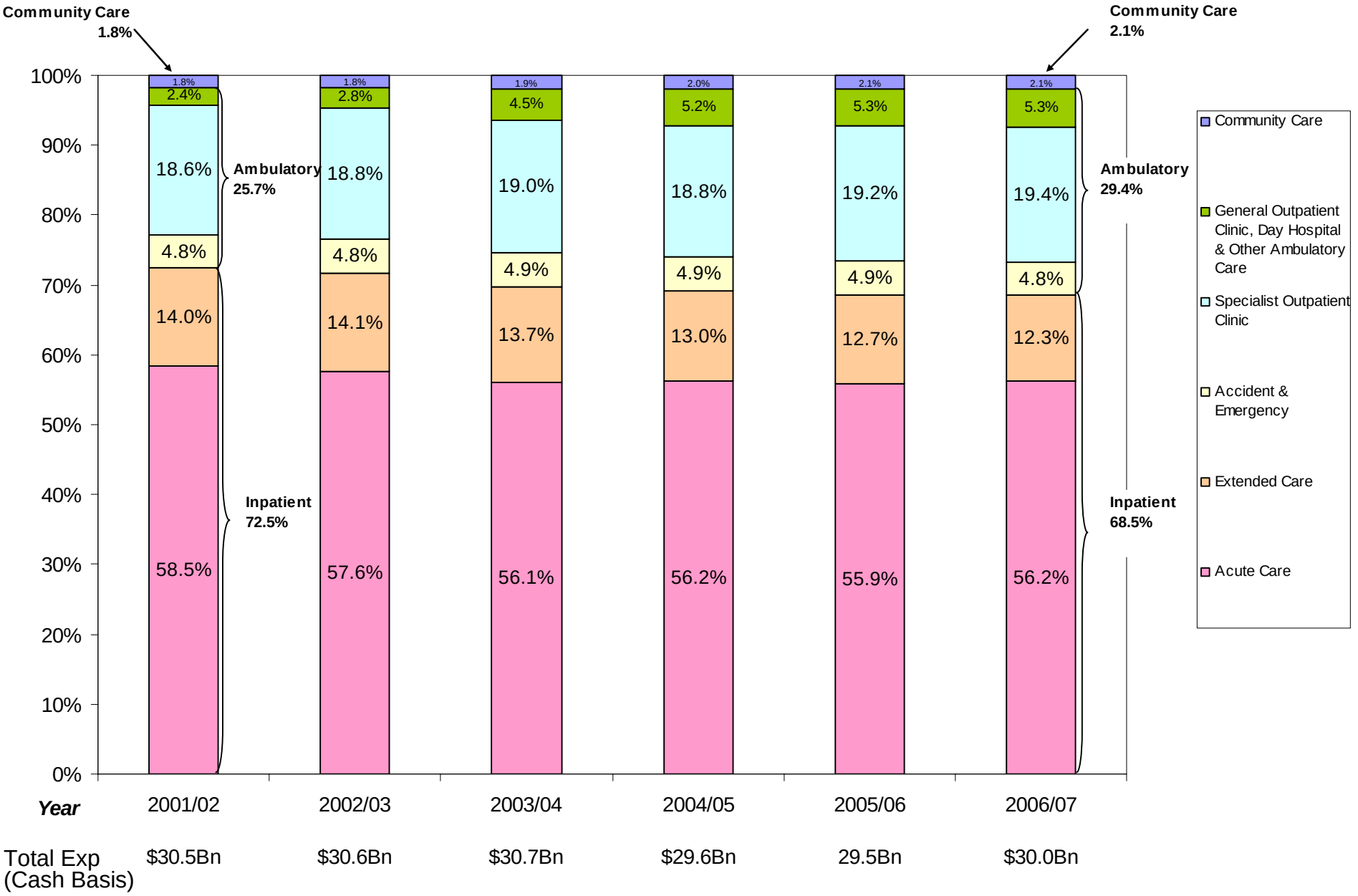
VV – Varicose Vein operation

CC - Circumcision

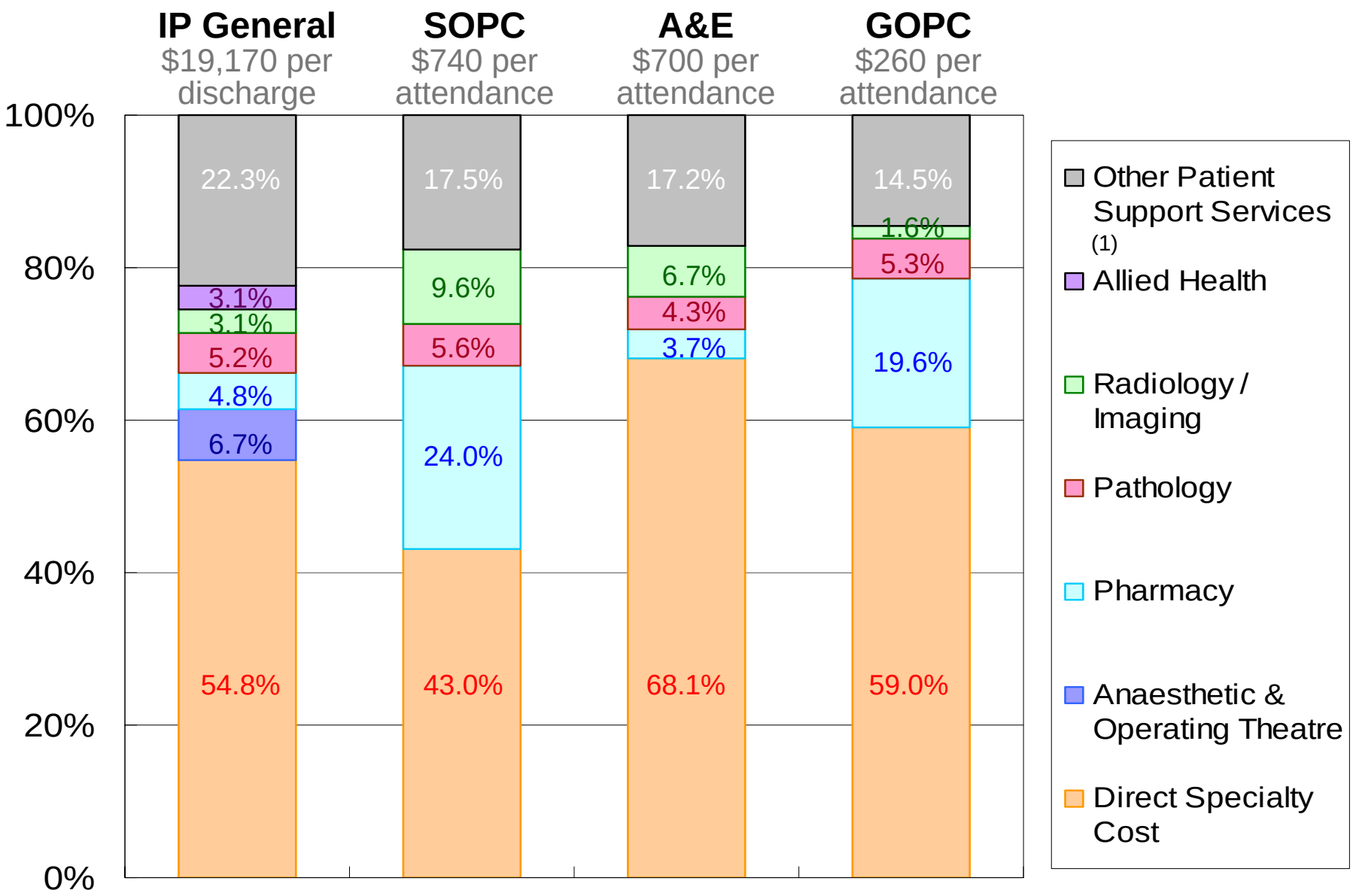
# SOP Waiting Time Analysis (Excl Family Medicine/Integrated Clinics) - Median Waiting Time for New Cases Booking (Para 3.5)



# HA Service Resource Utilization Profile from 2001/02 to 2006/07 (Para 4.5)



# Costing Profile of HA Services (2006/07) (Para 4.5)




Note (1): Examples are utilities, IT system maintenance & support, building & medial equipment maintenance, portering & domestic services, catering, laundry & linen and services from Central Sterile Supplies Department.

# Service & Resource Utilization Profile by 4 Target Areas (2006/07) (Para 4.6)

| Service | Examples | |
|---|---|---|
| **Expensive & Specialised Service (1)** | • Expensive transplants (e.g. heart/liver/bone marrow)<br>• Quaternary & tertiary services (e.g. burns, cardiac surgery, renal transplant)<br>• Multi-specialties services | [30.4%] |
| **Acute & Emergency (1)** | • Acute illness required emergency IP admission<br>• A&E services | [33.5%] |
| Non-expensive & Non-urgent | • IP & SOP (non-urgent)<br>• Integrated clinic<br>• Allied health<br>• Nurse clinic | [15.0%] |
| Other Non-dispensable Services | • Mental illness<br>• Infirmary<br>• IP Rehabilitation<br>• GOP<br>• Community care | [21.1%] |

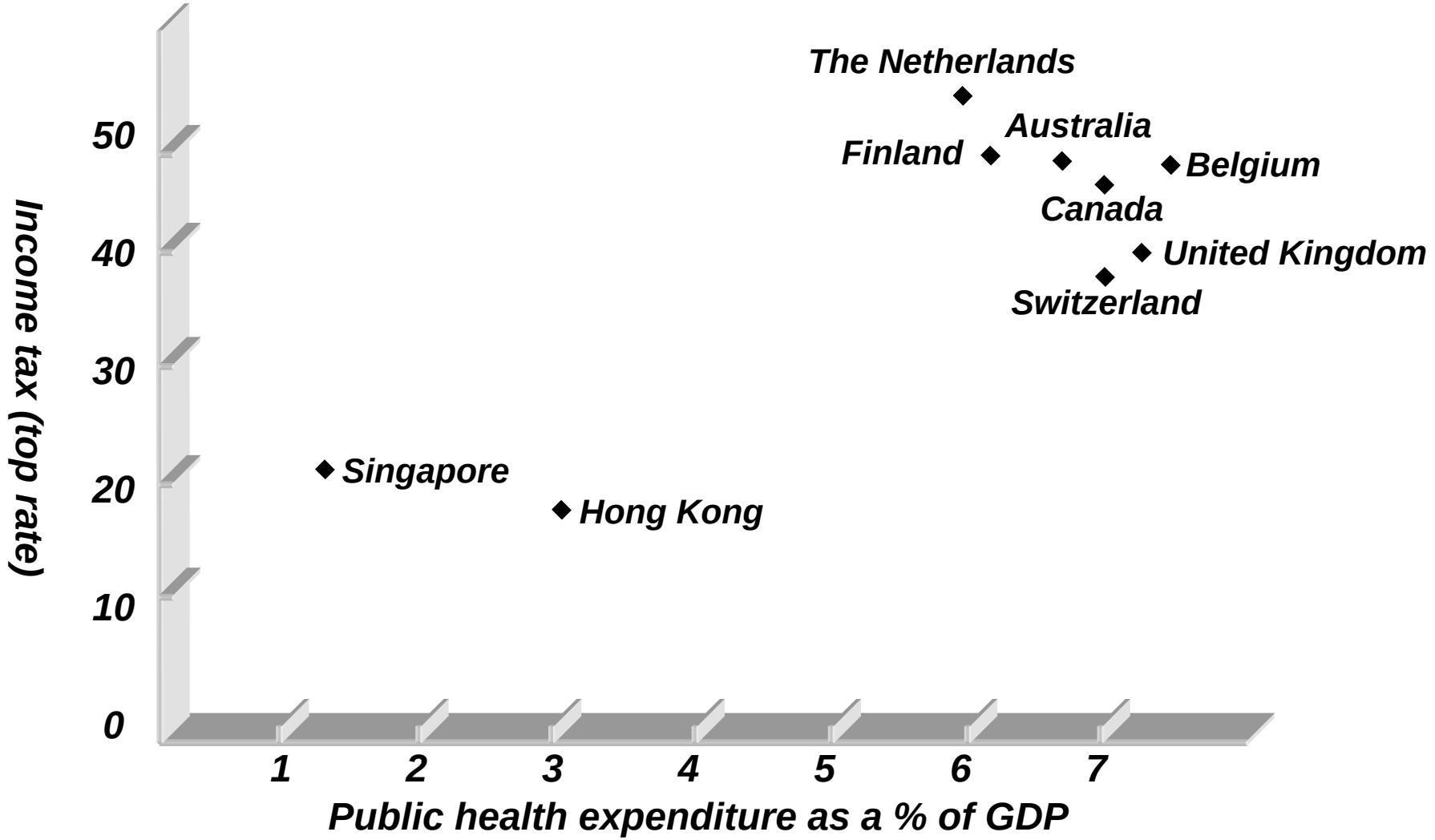
**Low income & under-privileged group** [32%]

Others [68%]

**Training** (~ 7%)

Note (1): Including IP treatment and subsequent SOP follow-up.

# Selected Economies with Universal Public Hospital Access (Para 4.7)



# HA Cost by Expenditure Category from 2001/02 to 2006/07 (Para 4.9)


Note: (1) "Others" costs consist mainly of Building, Medical and Office Equipment Maintenance.
(2) In 2006/07, the personal emolument includes compensation for doctors' claim regarding the performance of on-call duties during rest days, statutory and public holidays.

# Sample Analysis of Annual Spending on HA Fees & Charges by High-Frequent Users (2004/05) (Para 8.5b)

| | Patient A: High User | | Patient B: High User | | Patient C: Catastrophic User | |
|---|---|---|---|---|---|---|
| | Chronic renal failure requiring frequent attendances for dialysis | | Cancer with operation and outpatient/inpatient chemotherapy / radiotherapy | | Require PPMI items e.g. cardiac stents, internal defibrillator and cancer drugs for treatment | |
| **Utilization of HA Services** | Bedday /Attd | **Fee $** | Bedday /Attd | **Fee $** | Bedday /Attd | **Fee $** |
| **Inpatient** | | | | | | |
| Acute General (incl admission fee) | 36 | **$3,700** | 97 | **$9,850** | 74 | **$7,700** |
| Convalescent / Rehabilitation | - | **-** | 19 | **$1,292** | - | **-** |
| **Accident & Emergency** | | | | | | |
| Attendance | 3 | **$300** | 2 | **$200** | - | **-** |
| **Specialist Outpatient** | | | | | | |
| 1st Attendance | 1 | **$100** | - | **-** | - | **-** |
| Follow-up Attendance | 14 | **$840** | 19 | **$1,140** | 18 | **$1,080** |
| Day Procedure | - | **-** | 15 | **$1,200** | - | **-** |
| Renal Day Patient | 72 | **$7,200** | - | **-** | - | **-** |
| SOP Drug (16 weeks) | 36 | **$360** | 10 | **$100** | 38 | **$380** |
| **Allied Health (Outpatient)** | | | | | | |
| 1st Attendance | - | **-** | - | **-** | 1 | **$100** |
| Follow-up Attendance | - | **-** | - | **-** | 9 | **$540** |
| **Day Hospital** | - | **-** | 18 | **$990** | - | **-** |
| **Privately Purchased Medical Items (PPMI)** | - | **-** | - | **-** | - | **$180,000** |
| **Total Fees & Charges on HA Services** | | **$12,500** | | **$14,772** | | **$189,800** |