Medical Stakeholders' Opinion Research on Health Protection Scheme - Focus Group Study

Final Report

Prepared for

Food and Health Bureau

The Government of the Hong Kong Special Administrative Region

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Executive Summary

1. The Government of the Hong Kong Special Administrative Region (the Government) proposed a government-regulated, voluntary Health Protection Scheme (HPS) in the second stage public consultation document on healthcare reform. To collect and analyze the views of stakeholders from the medical sector on the proposed HPS, the Food and Health Bureau (FHB) has commissioned the School of Public Health and Primary Care, the Chinese University of Hong Kong (SPHPC, CUHK), to conduct a study. The aim of this study is to generate both quantitative and qualitative analyses regarding their comments, concerns and suggestions about the HPS from the stakeholder angle. This report will present the qualitative section of this study.

2. We conducted seven focus group discussions and 3 in-depth telephone interviews from February to March 2011 with a total of 42 doctors and 6 hospital administrators who were working in public hospitals, academic institutions, private hospitals, private general practices, private specialist practices and private hospital administration. The modulator led the focus group discussions and telephone interviews based on a semi-structured discussion guide which consisted of open ended questions emphasizing issues related to the (1) Medical pricing based on Diagnosis-Related Groups (DRG), (2) Claims Arbitration Mechanism (CAM) and quality assurance, (3) manpower and, (4) other alternative measures and opinions that could better enable the HPS to function effectively and promote a healthy development of the healthcare system and medical sector. In the analysis, a five-stage qualitative analysis framework approach was followed.

Main Findings

Medical Pricing based on Diagnosis-Related Groups (DRG)

3. Most of the participants considered that the objective of the Health Protection Scheme (HPS) to increase price transparency on the private healthcare market was important. However, views were divided regarding whether and how far the promotion of DRG-based medical pricing method was the suitable means to achieve the desired end.

4. As far as desirability was concerned, some participants thought that the current healthcare market still had room to improve in terms of price transparency and self-adjustment forces to control cost. They opined that greater use of DRG-based pricing method could potentially strengthen price benchmarking to the benefit of patient confidence and medical cost containment. On the other hand, some participants disagreed and thought that despite predominance of itemized pricing method nowadays, there was no lack of price transparency in the private healthcare market. It was also pointed out that a shift from itemized to packaged pricing model could not guarantee better clarity and certainty in medical cost to patients. Furthermore, the promotion of DRG-based pricing was regarded as a de facto government intervention into price setting in a free market, which was deemed unjustified.

5. As regards feasibility, there was a consensus that it would be technically challenging to practice DRG-based pricing method in certain clinical problems, such as chronic medical conditions and complicated cases which needed multiple assessments and procedures for diagnosis. Moreover, many concerns were shared by those who tended to be positive, indifferent or negative towards the method.

6. Participants contributed useful ideas that enriched understanding of the technical challenges on assignment of DRG codes, coding of complicated cases, and difficulties due to patient heterogeneity and different choices of treatments. Possible changes in market ecology, including doctors' choices of cases, quality of healthcare and gaming on the charging system induced by the new pricing model, were also discussed.

7. Participants generally agreed that DRG-based pricing method was considerable to the healthcare system but had concerns and worries on its feasibility. Their overall attitude towards the DRG-based pricing method depends on the combined influence of the concerns in these two angles.

Claims Arbitration Mechanism (CAM) and Quality Assurance

8. Participants in general opined that the role of CAM should be clearly defined and well differentiated from the existing regulatory bodies. It was a consensus that the new CAM should deal with disputes related to insurance claims only, and that any issues embodied in the disputes that were related to professional conduct of the medical practitioners should be referred back to the Medical Council of Hong Kong (MCHK). Some participants thought that the role of CAM might be extended to all health insurance disputes rather than only those under the aegis of HPS, and coordination with MCHK on all matters related to professional conduct in all health insurance disputes.

9. Participants pointed out that CAM could be an expensive system because it might be very costly to obtain the expert opinions necessary to examine the health insurance claim disputes. Moreover, the presence of

an additional dispute settlement channel would probably induce a higher number of complaints or disputes, valid or invalid, thereby further increasing the resources needed to operate the mechanism.

10. Some participants were concerned about the composition of key personnel in the CAM, which would affect its credibility and quality of its work. They opined that the CAM could involve relevant representatives in medical profession, and also representatives with other backgrounds who were familiar with the operation of the healthcare market and medical payment system.

11. Participants generally opined that the existing quality assurance framework encompassing the regulatory and professional accreditation requirements implemented by the MCHK and the Hong Kong Academy of Medicine were adequate.

12. Participants were cautious on the effectiveness of certain novel ideas to enhance quality assurance in the private healthcare market. Taking doctor service as an example, some participants questioned the effectiveness of a proposal to introduce indicators for quality assurance, and cautioned the possible downside risks.

13. Some participants opined that it would be more effective to enhance patient education so that patients could make informed choice which in effect helped keeping the quality of care in check.

Manpower

14. The participants from the public and academic sectors had no particular view on the private market reaction and were rather concerned

that the brain drain in the public healthcare sector would be aggravated. Most of the participants from the private sector did not think that the implementation of HPS would lead to shortage of private doctor services as market supply was adequate and flexible.

15. It was a consensus that adequate long-term manpower supply was fundamental to the healthy development of the healthcare system in Hong Kong, including both the public and private sectors. Some participants argued that increasing medical student training quota could not solve the manpower problem immediately. Besides, the participants generally agreed on the need to conduct a comprehensive and objective assessment of the future healthcare manpower need, with the assessment taking a global view and not being confined to considerations surrounding the HPS only. Apart from medical practitioners, nurses and allied health professionals should also be covered. The projection results should also be considered in conjunction with the planning for private hospital beds and facilities.

16. Participants had divided views on increasing the intake of non-local doctors to practice in Hong Kong. Some participants thought that this would be useful to avoid manpower shortage provided that the qualification of the doctors admitted was up to standard. They also thought that the intake program could be tailored to fit the needs and shortages in different specialty fields. On the other hand, some participants from the private sector had great reservation about this idea with the worry that it would be difficult to ensure that the professional standard of the non-local doctors was on par with the local doctors. They suggested promoting existing local doctors in the public sector and improving the employment benefits rather than inviting non-local doctors.

17. To ease the shortage of doctors in the public sector, those participants who considered the private market had spare capacity suggested that the public sector could hire services from the private doctors on a temporary basis.

18. Participants raised the concern of the inadequate nursing and allied health manpower supply in the existing healthcare system which might hinder the provision of some of the health services in both public and private sectors.

Other alternative measures and opinions that could better enable the HPS to function effectively and promote a healthy development of the healthcare system and medical sector

19. Most participants agreed to make use of the $50 billion set aside from the fiscal reserve to support healthcare reform to embark the HPS. However, participants were concerned about the details of the scheme and the means of using the money effectively and efficiently so that patients who were in need would get the most benefit. They also raised the concern of sustainability of the system when the designated money was used up. Other alternatives in spending the money effectively to improve the healthcare system were also discussed.

20. Some participants suggested that the core coverage of the HPS could include primary healthcare and preventive care as they were effective in saving medical cost. A more comprehensive standard plan with general outpatient services and consultations of private doctors, Chinese medicine practitioners and chiropractors incorporated, was also suggested.

21. As regards the future development of the Hong Kong healthcare system, participants suggested that the government should introduce private hospital services which were affordable by middle class. Besides, the public healthcare system should introduce a co-payment policy for those who could afford to pay more, and the government should consider subsidizing elderly patients to buy private health insurance.

22**.** Participants joining the focus group discussions were likely to be more interested and familiar with the HPS or healthcare reform. There could be a possibility that the views identified in this study might not fully represent the views of all medical stakeholders in Hong Kong. There could be also a potential that the views of the participants might not be fully interpreted and a few participants might dominate in some of the discussion groups. We tried to minimize these by having more than one investigator to perform the data analysis and interpretation in each focus group discussion, and the moderator had tried to encourage each participant to talk freely in each discussion topic.

報告摘要

1. 在醫療改革第二階段公眾諮詢文件中，香港特別行政區政府（政府）建議推行一個由政府監管和市民自願參與的醫療保障計劃（醫保計劃）。食物及衞生局委托了香港中文大學公共衞生及基層醫療學院進行是次研究，以收集及分析醫療界持份者對醫保計劃之意見。研究目的旨在透過定量及定質方法搜集和分析有關持份者對醫保計劃的評論、關注及建議。本報告集中提供上述研究中關於定質分析的內容。

2. 在二零一一年二月至三月期間，我們進行了七次聚焦小組討論及三次深入的電話訪問，共訪問了四十二位醫生及六位醫院行政人員，他們分別任職於公立醫院、學術機構、私家醫院、私家普通科執業、私家專科執業及私家醫院行政管理。主持人根據半結構性討論指引來帶領各聚焦小組討論及進行電話訪問，以開放式問題探討下列題目：（1）根據症候族群分類釐定醫療收費，（2）索償仲裁機制及質素保證，（3）人力資源，以及（4）其他有助醫保計劃有效運作及推動醫療系統和醫療行業健康發展的相關措施及意見。結果分析採用了五個階段的定質分析框架方法。

主要研究結果

根據症候族群分類釐定醫療收費

3. 大部份參加者認爲，藉醫保計劃提高私營醫療市場收費透明度的政策目標是重要的。至於以按症候族群分類訂定醫療收費方式去達到上述目標及此做法有多大程度合適，參加者的意見分歧，未有一致的看法。

4. 從可取性的角度來看，部份參加者認爲，現時私營醫療市場在價格透明度及通過自行調節處理成本壓力方面，仍有改善空間。他們認爲更廣泛地使用按症候族群分類訂定收費，有望能加強醫療服務價格的基準參考，對增加病人信心及控制醫療成本兩方面均有幫助。然而，部份參加者反對以上說法，認爲儘管現時私營醫療市場以逐項收費模式爲主，但當中並不存在價格透明度不足的問題。他們又指出，即使把逐項收費模式改爲套餐式收費模式，也不一定能保證醫療費用會變得更清晰和明確。有參加者更認爲政府提倡按症候族群分類訂定收費，實際上是對自由市場價格制定進行干預，做法並不恰當。

5. 在可行性方面，參加者則存有共識，普遍認爲在某些臨床治療上，例如處理慢性疾病，和牽涉多重檢驗和診斷程序的複雜病症，要實行按症候族群分類的收費方式，技術上存在挑戰。各參加者中，不論對此收費方式的看法傾向正面、中立或負面的，均表達了上述類似的關注。

6. 參加者亦提供了一些有用的見解，有助明白按症候族群分類收費涉及的一些技術性挑戰，包括爲病人分配症候族群的編碼，爲複雜病症的編碼，以及因應病人狀況不一及選擇不同治療而帶來的編碼困難。參加者同時討論了市場生態方面可能發生的轉變，包括醫生對病症的選擇、醫療服務的質素和新收費模式可能出現的漏洞而被利用的情況。

7. 參加者普遍認同，在醫療系統中引入按症候族群分類收費方式的構想是值得考慮的，不過，他們對其可行性表示關注以至憂慮。因此，他們對按症候族群分類收費方式整體上的取態，大致上是取決於以上

兩種角度合併考慮的結果。

索償仲裁機制及質素保證

8. 參加者普遍認爲索償仲裁機制的角色必須清楚界定，並需與現存的監管機構有明顯區分。此外，參加者有共識認爲新的索償仲裁機制應該只處理與保險索償有關的糾紛，而有關糾紛如涉及醫生專業操守的事宜，則應交由香港醫務委員會處理。部份參加者並且認爲，索償仲裁機制的角色，除專責處理與醫保計劃有關的糾紛外，或可延伸至所有醫療保險糾紛，並可與香港醫務委員會協調，以處理所有醫療保險糾紛中涉及專業操守的事宜。

9. 有參加者指出，索償仲裁機制或會是一個相當昂貴的制度，因爲要取得調查醫療保險索償糾紛所須的專業意見，所須支出可能不菲。再者，若設立一個新的處理糾紛渠道，或會引發更多的投訴或糾紛個案，不論投訴是否成立，均意味着需要投放更多的資源以確保機制的正常運作。

10. 部份參加者對索償仲裁機制的主要成員組合表示關注，因他們認爲成員組合會影響機制的信譽及其工作質素。他們認爲，索償仲裁機制的成員可包含各醫療專業的相關代表，以及來自其他不同背景，而又熟悉醫療市場和醫療付款系統運作的代表。

11. 參加者普遍認爲，現行的質素保證框架已經足夠，因已包含了由香港醫務委員會及香港醫學專科學院進行的監管及專業資格考核制度。

12. 就關於一些加強私營醫療市場質素保證的創新建議，有參加者對其成效持謹慎態度。以醫生服務爲例，部份參加者質疑建議引入的質素指標是否可靠，並警告有關做法可能帶來一些潛在風險。

13. 部份參加者認爲，加強病人教育的成效會更大。加強教育可讓病人在更了解病情的情況下作出適當的決定，從而有助監察醫療服務的質素。

人力資源

14. 來自公營及學術界別的參加者相當關注到公營醫療系統內人才流失的情況，會因醫保計劃的推行而加劇，但對私營市場的影響則没有特別的意見。至於來自私營界別的參加者，大部分認爲現時私家醫生服務的市場供應充足並具有彈性，預期推行醫保計劃並不會導致私家醫生服務出現短缺。

15. 參加者一致認爲，不論在公營和私營界別，確保醫療人手的供應充裕，對香港醫療系統的穩健發展至爲重要。部份參加者指出，增加醫科生學額並不能即時解決人手短缺的問題。此外，參加者普遍認同，有需要就未來的醫療人力需要進行一個全面和客觀的評估。該評估應具宏觀的視野，而不應只局限於與醫保計劃相關的考慮。除執業醫生外，評估應同時涵蓋護士及專職醫療人員。在研究評估結果時，亦應與私家醫院床位及設施的規劃一併考慮。

16. 參加者對於應否加強吸納非本地醫生來港執業持不同意見。部份參加者認爲，若聘請的醫生資格達標，吸納非本地醫生的做法有助避免醫療人手出現短缺，而吸納的醫生數目可按不同專科的需要和人手

短缺的情況而定。不過，部份私營界別的參加者對此建議表示很大程度的保留。他們擔心，要確保非本地執業醫生的專業水平能夠與本地醫生看齊，會有困難。他們建議，與其聘請非本地醫生，不如擢升目前公營界別的本地醫生，並改善僱員待遇。

17. 就紓緩公營界別醫生人手短缺的問題，一些認爲私營市場仍有剩餘人手的參加者提議，公營界別可以短期形式聘用私家醫生。

18. 有參加者關注到目前醫療系統內，護士及專職醫療人員供應不足的情況，他們認爲部份醫護服務，無論是公營及私營界別提供的，均會受到窒礙。

<u>其他有助醫保計劃有效運作及推動醫療系統和醫療行業健康發展的相關措施及意見</u>

19. 大部份參加者同意動用政府財政儲備中預留以支持醫療改革的五佰億元，推動醫保計劃。然而，參加者亦關注到計劃的詳情，以及如何有效善用該筆預留撥款，以確保有需要的病人能夠最爲受益。他們同時關注到一旦撥款用畢，醫保計劃能否持續地運行。此外，參加者亦討論了除醫保計劃外，使用該筆款項改善醫療系統的其他可能做法。

20. 部份參加者提議，醫保計劃的主要覆蓋範圍可包括基層醫療及疾病預防，因爲兩者都能有效減低醫療開支。他們同時建議制定一個更全面的標準醫保計劃，保障範圍可伸延至普通科門診服務，以及私家醫生、中醫及脊醫的一般診治服務。

21. 就香港醫療系統的未來發展而言，有參加者建議政府應引入中產階層能夠負擔得起的私家醫院服務。另外，他們認爲公營醫療系統應引入共同負擔費用的政策，讓有能力的人士自行負擔更多醫療費用，而政府也應該考慮資助年長的病人購買私人醫療保險。

22. 聚焦小組討論的參加者有較大機會是屬於對醫保計劃及醫療改革比較關心和熟悉的一群。因此，本研究所得的觀點，未必能完全代表香港醫療界所有持份者的意見。此外，本文對參加者的觀點有可能未能作出全面的詮釋。在某些討論小組中，亦可能出現了個別參加者較爲主導了討論的情況。爲儘量減少上述情況的發生和影響，我們有多於一位調查員爲各聚焦小組討論進行資料分析及解讀，及在小組討論中，主持人已嘗試鼓勵各參與者就所有討論題目隨意發言。

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Chapter 1 Introduction

1.1 Background

The Government proposed a government-regulated, voluntary Health Protection Scheme (HPS) in the second stage public consultation document on healthcare reform. The HPS aims to enhance the long-term sustainability of the healthcare system by better ensuring the quality and value-for-money of private health insurance and private healthcare services. It also aims to ease the pressure on the public healthcare system, thereby benefitting those who depend on the public system for their healthcare. The Government will consider making use of the $50 billion set aside from the fiscal reserve to support healthcare reform to encourage the public to participate in the HPS.

To collect and analyze the views of stakeholders from the medical sector on the proposed HPS, the Food and Health Bureau (FHB) has commissioned the School of Public Health and Primary Care, the Chinese University of Hong Kong (SPHPC, CUHK), to conduct a study. The aim of this study is to generate both quantitative and qualitative analyses regarding their comments, concerns and suggestions about the HPS from the stakeholder angle. The findings are expected to provide useful reference to the Government in further deliberating the HPS.

This report will present the qualitative section of this study.

1.2 Objectives

The objectives of this study are to qualitatively collect and analyze the views of medical stakeholders on:

- The healthcare reform direction proposed in the second stage public consultation and the HPS in general, including its underlying concepts, principles, stated objectives and basic structure, etc.
- The introduction of a benefit structure based on Diagnosis-Related Groups (DRG) to promote packaged charging for most medical conditions and hence increase medical price transparency
- The introduction of the health insurance claims arbitration mechanism and the appropriate regulatory measures that can better enable the HPS to function effectively and promote the healthy development of the healthcare system and medical sector
- The appropriate strategy and planning in healthcare, manpower and other resources that can better enable the HPS to function effectively and promote the healthy development of the medical sector
- Other possible measures that can better enable the HPS to function effectively and promote the healthy development of the healthcare system and medical sector

1.3 Methodology

1.3.1 Study design

Seven homogenous focus groups with nine Hospital Authority residents (1 group), eight academics/college fellows (1 group), six private hospital residents (1 group), six private general practitioners (1 group), ten private specialists (2 groups), and six private hospital administrators (1 group) were formed. Participants were recruited by the snowball sampling method and also identified from the medical stakeholder survey of this study. Some of the doctors who had completed and returned the survey indicated that they were interested to participate in the focus group discussion. They were approached by research helpers by telephone and

a brief introduction of the purpose of the focus group study was explained to them. As we could not recruit enough participants from the postal survey respondents alone, we therefore also invited potential participants through professional network using the snowball sampling method. This sampling method is particularly important for the hospital administrators' group as eligible participants would also involve individuals who are not covered by the postal survey.

A stimulus with background information on the HPS, DRG, Claims Arbitration Mechanism (CAM) and a semi-structured discussion guide were prepared to facilitate the focus group discussions. The stimulus and discussion guide were tested at a pilot focus group involving four doctors and refined before conducting the main focus groups. A few days before each focus group, the stimulus was provided to the participants to facilitate the discussion. At the beginning of each focus group discussion, the purpose and procedures of the focus group were explained again and written informed consent was obtained from each of the participants. The moderator led the discussion based on the semi-structured discussion guide. The participants were encouraged to express their views freely. Each focus group discussion lasted for approximately 90-120 minutes and proceedings were audio-recorded and transcribed verbatim. A token of HK$300 was given to each participant as an appreciation.

In addition, three in-depth telephone interviews with private specialists were conducted because some participants were unable to attend the private specialist focus groups. The purpose and procedures of the telephone interview were explained and verbal informed consent was obtained from each of the interviewees. The moderator led the

interview based on the same semi-structured discussion guide. The interviewees were encouraged to express their views freely. Each telephone interview lasted for approximately 30-45 minutes and proceedings were audio-recorded and transcribed verbatim. A token of HK$300 was sent to each participant in person as an appreciation.

1.3.2 Subjects

A total of 42 medical doctors and six hospital administrators participated in the study. The medical doctors were all registered under the Medical Council of Hong Kong (MCHK) and the six hospital administrators were from six different private hospitals in Hong Kong. The demographic characteristics of the participants were shown in Table 1.

1.3.3 Instruments

A stimulus with background information on the HPS, DRG and CAM was provided to facilitate the discussions. The moderator led the focus group discussions and telephone interviews based on a semi-structured discussion guide. It consisted of open ended questions focusing on issues related to (1) DRG, (2) the CAM and quality assurance, (3) manpower, and (4) other alternatives measures and opinions that can better enable the HPS to function effectively and promote the healthy development of the healthcare system and medical sector.

1.3.4 Data analysis

A five-stage data analysis in framework approach was used in the analysis: Familiarization, Identifying a thematic Framework, Indexing, Charting, and Mapping and interpretation.[1] The transcripts were analyzed

[1] Pope C, Ziebland S, Mays N. Qualitative research in health care: Analysing qualitative data. *BMJ* 2000, 320:114-116.

independently by two investigators using the NVivo 7 software (QSR International Pty. Ltd. ©1999-2006). Broad themes were first identified. Emergent themes which occurred repeatedly across and within focus groups were noted as recurrent themes. Each theme was assigned to a topic category based on its content. Categories were further divided into sub-categories where appropriate, creating a tree-diagram. The two investigators discussed and examined the transcripts for connections among these themes until consensus was reached. The master framework was applied to all the transcripts. Interpretations of the themes were illustrated by extracts from the transcripts.

1.4 Study Limitation

As participants were recruited by the snowball sampling method and identified from the medical stakeholder survey of this study, these participants were likely to be more interested and familiar with the HPS or healthcare reform. There could be a possibility that the views identified in this study might not fully represent the views of all medical stakeholders in Hong Kong. The analyses were based on the best understanding of the views collected, but there could be a chance that the views of the participants were not accurately interpreted. We had tried to minimize this by having more than one investigator to perform the data analysis and interpretation for each focus group discussion. Although the moderator had tried his best to encourage each participant to talk freely in each discussion topic, there could be a few dominant participants in some of the discussion groups. The results of this study were not for statistical inferences by virtue of its qualitative nature and inadequate sampling if used for quantitative analysis.

Chapter 2 Results

2.1 Medical pricing based on Diagnosis-Related Groups (DRG)

2.1.1 Overview

One major feature proposed for the HPS is to promote packaged pricing for common treatments or procedures categorized by "Diagnosis-Related Groups" (DRGs). DRG is a way of classifying medical conditions requiring treatments or procedures by diagnosis or complexity in both hospital admissions or ambulatory procedures. DRG-based pricing has been a common practice in charging for medical services provided by hospitals and doctors in many countries for many years.

Most of the participants considered that the objective of the HPS to increase price transparency on the private healthcare market was important. However, views were divided regarding whether and how far the promotion of DRG-based medical pricing method was the suitable means to achieve the desired end. Broadly speaking, the discussion can be analyzed by the desirability and feasibility perspectives.

As far as desirability was concerned, some participants thought that the current private healthcare market still had room to improve in terms of price transparency and self-adjustment forces to control cost. They opined that greater use of DRG-based pricing method could potentially strengthen price benchmarking to the benefit of patient confidence and medical cost containment. On the other hand, some participants disagreed and thought that despite predominance of itemized pricing methods nowadays, there was no lack of price transparency in the private

healthcare market. It was also pointed out that a shift from itemized to packaged pricing model could not guarantee better clarity and certainty in medical cost to patients. Furthermore, the promotion of DRG-based pricing was regarded as a de facto government intervention into price setting in a free market, which was deemed unjustified.

As regards feasibility, there was a consensus that it would be technically challenging to practice DRG-based pricing method in certain clinical problems, such as chronic medical conditions and complicated cases which needed multiple assessments and procedures for diagnosis. Moreover, quite many concerns were shared by those who tended to be positive, indifferent or negative towards the method. Based on their own experiences and knowledge, the participants contributed many useful ideas that enriched understanding of the technical challenges and market implications associated with DRG-based packaged pricing, such as the practical issues for DRG classification, possible changes in market ecology induced by a new pricing model.

Participants generally agreed that DRG-based pricing method is considerable to the healthcare system but had concerns and worries on its feasibility. Their overall attitude towards the DRG-based pricing method depends on the combined influence of the concerns in these two angles.

2.1.2 Desirability

Some participants thought that the adoption of DRG as the basis to charge patients for hospitalization and ambulatory procedures was in the right direction to increase price transparency and contain medical cost increase

in the private healthcare market. They expected that DRG-based pricing method would enable the patients to have a better prediction of the expenditure amount needed (and the amount of reimbursement and co-payment if they were insured).

"If a price is set by the government, patients can estimate the hospital charges. I think this is favourable for patients as (price) transparency will be increased. Right now there are many criticisms on the lack of a ceiling price for medical fee. It is all up to the doctors to charge, so the final bill amount may exceed the patient's budget." (Academics)

"I think this (DRG-based packaged charging) can increase price transparency. For instance, for the same procedure, comparative information about the average cost in the public hospitals and charges in the private sector will be made known…." (Private GP)

"HA (Hospital Authority) has been adopting DRG all along. If DRG is to be applied to support packaged pricing, I think it will have a positive effect on (price) transparency." (Private specialist)

"There is no problem with packaged pricing. Currently the United States also uses this method, which helps enhance price transparency! …The packaged price level should not deviate from reality. If a hernia surgery costs $30,000, it will be impossible to have a packaged charge $300,000." (Private specialist (phone))

"DRG sounds good. If the charge is fixed and all-inclusive, the patient can be better prepared in advance about the budget while hospital billing also becomes easier." (Hospital administrator)

There was also an expectation that packaged pricing would encourage price competitions among service providers in the private healthcare market. This could help keeping medical inflation in better check, and foster competitiveness of the private healthcare market in the long run.

"DRG allows patients to know how much they can claim from insurance, and the market players would tend to align their charges with the DRG-based charges as far as possible in order to stay competitive. This phenomenon would in theory indirectly rationalize the private healthcare charges and pull down the charges a bit…" (Public hospital resident)

"DRG is a benchmark. It serves as a reference which can exert indirect impact on the charges in the private market." (Public hospital resident)

"Currently the private doctor charges are often said to be lack of control and ceiling as it is totally up to the doctors to charge and so the final bill may end up exceeding the patients' budget substantially. I thus think that those patients with health insurance will be concerned about the adequacy of insurance compensation to cover the charges, and that doctors who can offer greater assurance in this respect are more likely to attract patients." (Academics)

"DRG helps to control costs… The insurance benefit limit is fixed, and insured patients have to pay the excess of the charges over the limit." (Private specialist (phone))

However, some participants objected to the promotion of DRG-based

pricing method in the private healthcare market because it was based on misperception that the market was lack of transparency. They were content with the degree of price transparency of the itemizing pricing mechanism and they believed that itemizing pricing could have similar effect as DRG-based pricing method in terms of transparency. They also pointed out that the private healthcare providers were generally ready to answer enquiries from the patients about the details of charges. Patients would ask and compare charges of different healthcare providers before receiving treatments. Moreover, they observed that the private hospital bills set out the charges by service items clearly. As such, they considered private healthcare charges reasonably transparent nowadays. They also believed that price transparency could not lead to better medical cost containment. There was no point to shift to a new pricing system.

"I definitely do not accept packaged pricing... The current charging practice is extremely transparent… When we ask the private hospitals about their charges, they can provide detailed breakdown by service item as fine as the charges for each meal, each injection, each medication, etc. The charge for each item is listed clearly on the bill, so there is no problem with price transparency." (Private GP)

"Nowadays patients would ask about the medical fees when they consult a doctor, and the doctors are obliged to answer. Patients know how to compare, and may choose the one who charges more. If DRG is used, patients would perceive that all doctors should charge the same price regardless of their reputation and qualifications." (Private hospital specialist)

"DRG can't save cost. It should be cost neutral instead. As far as transparency and competitiveness are concerned, DRG does not necessarily fare better than itemized charging if the latter is done properly." (Private specialist)

Some participants opined that the promotion of DRG-based healthcare pricing by the Government would become a de facto intervention into price setting in the private healthcare market which they considered should not be regulated. They thought that price setting should be left to free market to determine as in the case of other commercial activities, and queried why private healthcare was singled out for price control.

"Private healthcare sector is a free market. I wonder if it is necessary to standardize the costs and prices of private healthcare services. If a patient can afford a higher price, he can choose a famous doctor whom he is more confident in. Otherwise, he can choose a less famous doctor. This manifests operation of a free market with free choice." (Public hospital resident)

"The government proposes DRG because it wants to regulate private healthcare charges, but I don't understand why this should be the case… Different patients have different needs… The question is whether the regulation is intended to set a price ceiling or a price floor… both are important. Problems might also arise if the charges are too low… The service providers can recoup the price difference through other channels." (Private specialist)

"The government should not get itself involved in a private market." (Private hospital resident)

"The purpose of using DRG is to control the insurance premium and also the private hospital charges. However, these two items are not controllable." (Private specialist)

2.1.3 Feasibility

The participants commonly agreed that implementation of DRG-based pricing method would be technically challenging in practice and might involve complex issues to resolve, including assignment of DRG codes, applicability to complicated and uncertain cases and price setting mechanism. There was also a considerable degree of commonality in the technical issues identified to resolve necessarily, and the possible implications to market ecology which might translate into downside risks if not properly managed.

Assignment of DRG codes

It was common that a patient presented with symptoms rather than a diagnosis before hospital admissions or ambulatory procedures. A single symptom might be the manifestation from an ailment disease to a serious condition. It would also be a challenge to use DRG codes on cases with multiple complications or comorbid conditions. Most of the time, these patients might require a series of investigations before the diagnosis could be ascertained. Under these circumstances, the DRG code and hence the corresponding packaged charges might not be made known to the patients upfront or in the early instance, or only a rough estimation of medical charges could be provided to patients.

"Some diseases may first appear as just a symptom. The patients won't

know what's wrong until they consult a doctor. A case with glaucoma may turn out to have macular degeneration as well, and thus requires more treatments and procedures. Some cases are not that straight forward." (Private hospital specialist)

"…There are many undifferentiated problems in family practice, such as tiredness which requires numerous investigations…" (Academics)

"…A patient may be admitted due to high blood glucose level. How can a case of controlling the blood glucose level be defined as a DRG? I think it is difficult." (Public hospital resident)

"It would be problematic to charge medical fees based on diagnosis. For example, stomachache can be purely stomachache, or it can be due to pneumonia or other problems… Medical fees in most countries are on procedure basis… There is no regulation of doctor's fees, though a reference price may be provided. Under the HPS, the insurance companies are in effect setting the medical fees, which certainly would not be high." (Private specialist)

Coding of complicated and clinical uncertain cases

It was commonly agreed that DRG-based pricing was more readily applicable to simple, straight-forward and one-off treatment procedures. For application to diagnoses with various degree of complication, it would be more challenging to practice as the resources for and cost of treatment could vary widely from one case to another. Taking psychiatric diseases or chronic medical problems as example, even for the same diagnosis, the duration of hospital stay and procedures used might differ substantially for different patients. Besides, the cost of treatment

would heighten significantly if there were more than one diagnosis to handle. Therefore, the DRG coding system had to be very refined so as to benchmark the charges for complicated and co-morbid cases appropriately.

Besides, a relatively simple diagnosis might evolve into one with greater complication and co-morbidity during the course of hospitalization. The final packaged charge might be out of patient's expectation in the first place and led to frustration and disputes.

"Packaged pricing is already observed for maternity services in private hospitals. Patients can find out what service items are included in the package, and pay a lump sum if they accept. . . This is what packages are about." (Private specialist)

"…For a straight forward operation, charging the same price for all cases is not an issue as long as the cost varies within a certain range. This spirit is acceptable under such a condition… that's how it's done in Australia." (Private specialist (phone))

"Nowadays most of the cases pertain to chronic diseases, some of which are quite often psychiatric diseases. The treatment process involves ambulatory cases and recurrent episodes instead of single episodes." (Public hospital resident)

"For certain complicated diseases, chronic illnesses or cases with evolving complications, DRG is not feasible unless we adopt a complex set of DRG coding. It was once used in the United States, but it was infeasible for mental illness." (Private specialist)

"It is difficult to provide an advance estimate of hospital charges upon admission. For example, a patient who is admitted for a simple appendicitis may need to pay $20,000, but if there are major complications, the charge may increase to $100,000. How can a patient know in advance whether the final bill will be $20,000 or $100,000? ...If the bill turns out to be $100,000 and the patient expected a bill of $20,000, the patient may file a complaint." (Public hospital resident)

Patient heterogeneity

Even for a well-defined procedure, the difference in age and health status could require different workloads in clinical management and hence substantial difference in the cost of care.

"Take OT (operation theatre case) as an example, there are many variations which (DRG coding) cannot factor in well. Do you think that the cost of colonic surgery is the same between a person aged 30 and a person aged 80 with chronic heart disease and heart failure? …The variation can be enormous." (Private specialist)

Different choices of treatment

Along with technological advancement, more choices of treatment at different cost levels were available to match with different patients' health condition and budget. Choice of treatment would be restricted if the DRG coding system could not allow for such variation or could not be updated quickly enough to take increased choices of advanced treatment into consideration.

"There are many new technologies, and different choices of surgery and

medication. For example, two different methods can be used to treat a same case, with one being more effective but more expensive. Under DRG, I cannot use the more expensive method if it is not included in the coding. This indirectly affects (the choice of treatment). " (Public hospital resident)

"Patients always want an estimation (of medical fees) before admission. To reply on that, I need to know which doctor is in-charge plus many other details before I can provide an estimated amount. Still I have to tell the patient that this is not the actual fee as it depends on the exact procedure to be done. The more advanced are the (medical) technologies, the more difficult it is to price in packages." (Hospital administrator)

Administration cost

The complexities inherent to the DRG coding system and its application in a private market setting implied that in order to ensure its validity and reliability, a lot of administrative resources would have to be deployed to establish a robust DRG-based coding system with reasonable classification and price benchmarks, and keep the system up-to-date to reflect latest market and technological changes in a timely manner. Whether these administration cost provided value-for-money might be judgmental.

"We also have to take administration cost into consideration… We have to pay salaries for staffing, including the accountants. You have to count administration cost to arrive at the total (cost of adopting DRG-based charging)." (Private specialist)

"Many administrative resources are required, for example, computer

system. Large hospitals have the resources to do this, while it is not certain if small hospitals are capable of doing the same thing." (Hospital administrator)

"I believe it would be best if the government could subsidize the related administration cost. This is very important. A computer system is also needed…" (Hospital administrator)

Price setting mechanism

Participants were concerned about the criteria and mechanism used in determining the price of each DRG codes. Patient heterogeneity including differences in age and pre-morbid conditions; and different choice of assessments and procedures due to varied degree of disease complexity could affect the actual medical cost. That the price benchmark of each DRG code could fairly reflect the actual medical cost was important to the private healthcare market.

"(Assuming that) for an 80-year-old female patient who undergoes a surgery to remove tonsils, we have a DRG code for her. Even if she has ischemic heart disease, diabetes, hypertension and cancer, there are related codes for use. The code entails a bill of $100,000 for 3 days of hospitalization. Does it mean that the money received would be shared by only one doctor with the hospital? What if the patient has complication after the surgery and needs an endocrinologist for treating diabetes and a cardiologist for ischemic heart disease? Is the charge still $100,000? And how could the cost be shared by the hospital and the doctors involved?" (Private specialist)

"I have several concerns. First of all, how will the packaged price be

set? On what criteria will that be based? Will it be set on a cost basis? I really don't know if private hospitals have the resources to ascertain the required cost level. If it is based on the cost data of Hospital Authority, it is not fair (to private hospitals). It's not easy to set an appropriate (DRG-based) pricing mechanism." (Hospital administrator)

"First of all, how would you calculate the cost (for each DRG)? Who will do the calculation? …There are already many variations in the ICD code. A slight difference in the description of the diagnoses can result in totally different corresponding amount of resources. Secondly, the resources, facilities and costing methods are different for each of the 12 private hospitals. How can a standard cost be calculated?" (Hospital administrator)

Views on possible implications to market ecology

There could be possible implications to market ecology of which doctors might refuse cases with complexities, and therefore, patients' choice of doctors would be reduced. The quality of healthcare could also be affected as there might be lesser volume of services, medications and assessments within the DRG-based package. Besides, gaming on the charging system could further defeat the purpose of cost containment.

(i)Doctors' choices of cases

Most of the private doctors were self-employed and had limited turnover of the same diagnosis that could allow effective risk pooling, which should be conducted by insurance companies rather than healthcare providers.

If the DRG coding system could not adequately allow for reasonable

variation in cost associated with complexities, patients' health condition and other factors, it might present a degree of financial risk that a private doctor was unable to bear. In response, some doctors might refuse to offer DRG-based pricing and decline those patients who insisted on that, while some others might only be willing to offer DRG-based pricing selectively to the cases that appeared to be simpler and straight forward. As a result, the patients' choice of doctors would be reduced.

"Insurance is about risk pooling. We buy insurance to protect ourselves from unpredictable events. Theoretically, insurance function should be performed by insurance companies, rather than doctors. As such, the medical community should not be involved in insurance. I agree with the Hong Kong Medical Association that the medical community should not take up any role to provide insurance protection. We have no problem if the government wants to take up… but being a part of the medical community, I personally would not accept DRG." (Private GP)

"The Hong Kong Medical Association obviously objects to packaged pricing as it once stated that packaged pricing was immoral and it violated the code of professional conduct." (Private GP)

"Suppose this scheme is compulsory,… (then doctors) will refuse to handle complicated cases." (Private specialist)

"…only uncomplicated surgeries will be performed. This may result in some cases declined by (private) doctors… No (private) hospitals will admit them… Doctors may take up cases selectively." (Public hospital resident)

"I worry that (DRG) would be disadvantageous to patients with relatively more comorbidities. Private doctors may only choose to treat simpler cases and those with relatively less comorbidities. Their revenue can increase if they have a larger number of these cases to handle." (Academics)

(ii)Quality of healthcare

Although the DRG-based packaged price levels were not the statutory ceilings, the private healthcare providers (including hospitals and doctors) might strive to compete in price and compromise on the quality of healthcare. For instance, there might be lesser volume of services and lower quality of medication and assessment within the package for the sake of cost saving. Then the market might become more competitive only in terms of price, but not in terms of service quality.

"Right now many GPs seem to have fixed a price… but when competition drags down the price level, the quality of medicines prescribed will naturally be compromised. For example, a GP can prescribe Ampicillin or another better yet more expensive medicine to a patient, but if the price is low, he is bound to prescribe a cheaper medicine. Actually the quality of private healthcare services may diminish in the future while the patients may not be aware of this." (Public hospital resident)

"Suppose (the DRG for) a PTCA (percutaneous transluminal coronary angioplasty) is set at $90,000, which is actually not enough, still the hospitals compromise to offer PTCA at $90,000, then service of what quality will be offered? …Resident doctors will be the first ones adversely affected. If medical fees are regulated, what (services) can we provide

to the patients? …The prime cost of chemotherapy is probably at least $10,000. Private hospitals must strive to make profit. While patients go to private hospitals for the sake of treatments and services of better quality, (with DRG) they may end up receiving public-sector-type of service." (Private hospital resident)

"…involves problems of containing cost by compromising on quality. If I only receive a certain fixed charge, I am bound to minimize the prescription… so this may not help to increase competition, improve service quality or divert public patients to the private healthcare market." (Private GP)

"The problem with using packaged pricing is that the doctors may cut down on the investigation procedures. Take appendix (appendicitis) as an example, not every patient needs an MRI, but if (the fee is limited to) $12,000, the doctor may tend not to do MRI (because of the limited fee)." (Private specialist)

(iii) Gaming on the charging system

The effectiveness of DRG-based pricing to contain medical cost rise would be undermined if it induced certain behavioral changes that could defeat the purpose of cost containment.

A case in point was the inducement for the private healthcare providers to charge up to the benchmarked price level even if the normal charge for a case was less than the benchmark. Another possible reaction was the tendency to up-code, for example, choosing DRG code which reflects higher level of complexity when the dividing line was blurred. A further possibility was to discharge a patient from hospital prematurely

and re-admit him/her shortly afterwards to justify a new episode and hence a new count of package. These phenomena were envisaged to be more likely when the patients were insured and the insurance benefits were likewise DRG-based, though they also existed under the itemized charging mechanism nowadays.

"If a doctor thinks that the cost of the case has exceeded the package charge, what will happen? The doctor could discharge the patient and then re-admit him/her, and the case would become a new admission with a new DRG. Will this happen?" (Private GP)

"In particular, for some cases like colectomy, the average hospital stay is 5 days. However, the patient has complication, such as pancreatitis, after the procedure. The doctor may be bound to discharge the patient on the fifth day and re-admit him/her in order to get more payment (to compensate for the cost)." (Private GP)

"…It is like the case of free-of-charge tours, somehow charges through other channels would exist to allow the low price. In the Mainland market, many doctors charge a low consultation fee but make up for the revenue by prescribing more intravenous injections and investigations …" (Private specialist)

"If you know the rules of this game, you will know which code comes with a higher price and change the diagnosis accordingly." (Private hospital specialist)

"All insurance systems are being abused, so you have to design some measures to prevent the scheme from being abused too much…"

(Academics)

2.1.4 Other relevant and note-worthy views

The participants also expressed their suggestions including, engaging medical stakeholders in developing the DRG-based pricing system, separation of packaged price for hospital and doctor services, and subsidizing patients who had higher medical service utilization.

(i) Stakeholder involvement

Medical stakeholders should be considerably engaged in the process of designing the DRG-based pricing system and its implementation details, in order that their concerns and insights could be properly incorporated.

"I think that the group most vulnerable to the impact of DRG was not consulted…No doctors have been involved in doing this piece (public consultation document). This is just like the situation of structural reform in HA some years ago…Doctors have contributed only medical inputs…" (Private specialist)

(ii) Separation of packaged price for hospital and doctor services

For the sake of clarity, there should be separate DRG-based pricing system for hospital service and doctor service. The doctor charges should be further fragmented by doctor in-charge, anesthetists and other attending doctors if applicable. This arrangement could allow greater flexibility for the doctors in deciding whether to partner with the private hospitals in offering packaged pricing.

"I strongly think that hospital charge and doctor's fee should be separated in a package. If the two prices are bundled in a package,

doctor's fee will be set by the private hospital. There are two advantages of separating the two charges, first, the fees are clear, and second, doctors can freely decide whether to participate in the scheme on a case by case basis." (Private specialist)

"How are doctor charges calculated? We (private doctors) are independent from the private hospitals. So, the arrangement between the scheme and private hospitals and that between the scheme and private doctors should be handled separately. An arrangement bundling the two with a fixed overall price to cover both hospital and doctor's fees may not be feasible." (Private specialist (Phone))

(iii) Subsidizing patients with higher medical service utilization

As packaged price entailed implicit cross subsidy from the patients with lower service utilization to those with higher service utilization, the former group of patients might find it unfair to them and this might dampen the relationship between the doctors and the patients.

"*Some people have the wishful thinking that everyone's premiums could be increased a bit to cover…meaning that the same packaged price will be charged for both relatively more complicated and relatively less complicated cases. But the question is whether this is fair to the payee? If everyone has to pay a higher premium because of packaged pricing to share out the cost, it is probably not that fair to those patients with less complicated problems." (Private GP)*

2.2 Government-regulated Health Insurance Claims Arbitration Mechanism and Quality Assurance

2.2.1 Overview of Government-regulated Health Insurance Claims Arbitration Mechanism

The proposed HPS will implement the Health Insurance Claims Arbitration Mechanism (CAM) which aims to handle disputes over health insurance claims and arbitrate disagreements between patients, private health insurers and/or private healthcare providers over such claims. The CAM will be regulated by the Government with a view to maintaining impartiality and ensuring protection of the consumers in the private health insurance and private healthcare services markets.

Most of the participants welcomed or were open to the idea of setting up a CAM. They considered this an opportunity to have the patients' interest better represented in the event of claim disputes with the health insurers. Yet there were considerable concerns over the delineation of its role in relation to the existing regulatory and supervisory bodies, and also the administration cost and other practical issues. It was also pointed out that the power of the CAM should not extend to cover matters related to professional conduct of medical practitioners, which should continue to fall under the existing regulatory bodies.

2.2.2 Role of CAM

Participants supported that the establishment of CAM can provide a designated regulatory body for patients to handle their insurance claims. Participants in general opined that the role of CAM should be clearly defined and well differentiated from the existing regulatory bodies,

especially the MCHK. It was a consensus that the new CAM should deal with disputes related to insurance claims only, and that any issues embodied in the disputes that were related to professional conduct of the medical practitioners should be referred back to MCHK.

"How can the numerous disputes and complaints arising from the existing variable market practices be resolved? Patients can only negotiate with their insurance companies at the moment… and neither of these two parties can have a neutral position and provide opinions without bias. Even when a doctor is involved… we need a central mechanism to handle the disputes and complaints… especially if this scheme is to be implemented." (Academics)

"It (the proposed Claims Arbitration Mechanism) can serve an intermediary role. It should refer cases to the Medical Council if they are relevant. Any money issues should be referred to the lawyers. If it (Claims Arbitration Mechanism) can handle the case on its own, it should handle it; otherwise a case should be referred to an appropriate body.… I think what is needed is a coordinating body rather than a powerful authority to take care of everything on its own." (Academics)

"…It's good to have an arbitrator, and other (complaint) channels can be reduced or removed. The consumers then won't have to go through the current dispersed mechanism(s), which often involve going to courts after going to the Consumer Council." (Hospital administrator)

"…First of all, (its role) should not overlap with those of existing bodies… it will be strange if they overlap…" (Academics)

"I think it will largely handle claim disputes, rather than professional conduct and practice." (Academics)

"…professional misconduct should be handled by the Medical Council… professional issues should be handled by professional bodies." (Private specialist)

Some participants thought that the role of CAM might be extended to all health insurance disputes rather than limited to those under the aegis of HPS only, and coordination with MCHK on all matters related to professional conduct in all health insurance disputes. Also, there was an opinion that CAM might monitor the performance of health insurers on all aspects and also handled disputes with customers not only in claims settlement but also with other matters.

"A regulatory body which handles not only claims but also all other issues related to medical insurance should be considered…" (Private GP)

"It is useful from the patient's point of view. When patients want to file complaints, whether they are about claims or surgeries, the patients often have no idea about where to go. They don't have a channel where they can get more information. It would be nice if there is a place or an organization to handle patients' complaints." (Private GP)

Some participants were cautious about the necessity to set up a new regulatory body and instead thought that enhancement of patient interest could also be achieved through the existing framework. For example, it was suggested that a designated team could be set up within the MCHK

or the existing Insurance Claims Complaints Bureau (ICCB) to deal with HPS-related insurance disputes in the future.

"We already have Medical Council and Consumer Council. Is it necessary to set up another department to specialize in handling these matters?" (Private hospital resident)

"…I refrain from agreeing or not at this point, but the idea of claims arbitration is worth to consider. I think the existing mechanism can be further improved." (Private GP)

"Currently patients file complaints related to over-charging with the Medical Council as these issues also relate to (professional) conduct… I think it is better for the Medical Council to handle these issues instead of creating a new body; another option is to let the board of the Medical Council decide whether they could handle the particular complaint in question." (Private hospital resident)

"We have the Insurance Claims Complaints Bureau (ICCB), which is a public organization that arbitrates claim disputes… Since we have this mechanism already, we can enhance it instead of creating a new body if one thinks that ICCB's current authority, monetary limit of arbitration or member representations are not sufficient or ideal." (Private GP)

Practical issues about CAM

The participants were concerned about the high administration cost and composition of the board in CAM.

(a) Administration cost

It was pointed out that CAM could be an expensive system because it might be very costly to obtain the expert opinions necessary to examine the health insurance claim disputes. Moreover, the presence of an additional dispute settlement channel would probably induce a higher number of complaints or disputes, valid or invalid, thereby further increasing the resources needed to operate the mechanism. It was worried that if administration cost was prohibitive, the mechanism might not be financially sustainable.

"This mechanism will induce more claims, just like the situation in the United States…" (Private specialist)

"As the system design now stands, the public money of 50 billion dollars devoted to it would be eaten up by high administrative cost for various investigations and other elements built into it." (Public hospital specialist)

(b) Composition of the board in CAM

Some participants were concerned about the composition of key personnel in the CAM, which would affect its credibility and the quality of its works. They opined that the CAM should involve relevant representatives in medical profession (e.g. experts / specialists from the stream relevant to each individual case) and also representatives with other background who were familiar with the operation of the healthcare market and medical payment system. However, the insurance industry stakeholders should not be involved to avoid conflict of interest.

"(The effectiveness of the claims arbitration mechanism) will depend on the composition of key personnel involved." (Private GP)

"The selection of arbitration members is very important. It is necessary to have more than a few members and they must be very familiar with (healthcare) operation and charging mechanism for specific types of treatments in order to judge whether the charges are reasonable. It is impossible for members who are orthopedics to handle obstetrics & gynaecology cases." (Private hospital resident)

"I am not sure about whether insurance companies should be involved in the (claims arbitration) board. General public could be involved, but having representatives from insurance companies may lead to conflict of interest. Having too many doctors could create their own circle which may be accused of protecting their peers. The representation of the general public should be large enough." (Private specialist (phone))

"I think insurance companies should not be involved… but doctors must be involved or else it would be impossible for the board to understand what the complaint is about. There should be some representation from the general public too. They would be more representative if voted by citizens, for example, district council members. They can perform a monitoring role in the board." (Private specialist (phone))

2.2.3 **Overview of Quality Assurance**

It was a consensus that medical professional conduct is crucial to the success of healthcare system in Hong Kong and that quality assurance for healthcare services is of utmost importance. As far as doctor services is concerned, participants generally opined that the existing quality assurance framework encompassing the regulatory and professional

accreditation requirements implemented by the MCHK and Hong Kong Academy of Medicine were adequate. As regards private hospitals, the regulatory framework and the supervision by the Department of Health, together with the initiatives of private hospitals to participate in hospital accreditation, were also regarded as adequate to ensure high quality of services.

The participants mostly agreed that the existing quality assurance mechanism was effective. Participants were cautious on the effectiveness of certain novel ideas to enhance quality assurance in the private healthcare market. Taking doctor service as an example, some participants questioned the effectiveness of a proposal to introduce indicators for quality assurance, and cautioned the possible downside risks. Some of them opined that it would be more effective to enhance patient education so that they could make informed choice which in effect helped keeping the quality of care in check.

2.2.4 Assessment of the status quo

The assessment of the status quo was primarily based on the existing system used in quality control of private doctors and hospitals; internal control of private hospitals, such as hospital accreditation; and reputation with patients.

(i) Existing system on quality control

Participants generally thought that the professional requirements for doctors implemented by MCHK and the colleges under the Hong Kong Academy of Medicine largely served the purpose of assuring quality of care by doctors. As regards private hospitals, many participants opined that the code of practice for private hospitals as promulgated by the

Department of Health and the regular investigations provided effective means to uphold quality of private hospital services.

"CME (continuing medical education) is already working on quality assurance. Although participation is voluntary, doctors who do not attend it cannot keep apace with the latest medical advancements and would fall behind and lose out in competition." (Private specialist (phone))

"Colleges are working on this… there is rigorous assessment on whether a specialist is qualified and whether he/she has fulfilled continued learning requirements, such as continuing professional development (CPD) or CME…" (Private specialist)

"…Our current credential is already enough." (Hospital administrator)

(ii) Internal control of private hospitals

Hospital accreditation was also playing an important role to ensure that private hospitals were up to the standard. Participants from the private hospital management group pointed out that many private hospitals had been taking their own initiatives to participate in hospital accreditation in recent years as they were very concerned about the goodwill and branding of the hospitals. They opined that private doctors and hospitals placed importance on their reputations and quality of treatments and services provided.

"I think the quality of private hospital services is definitely promising. First of all, there are hospital regulations. The Department of Health closely monitors hospital operation by performing at least three to four

inspections a year, and would withhold license if the quality standards are not met. Also, we frequently initiate assessment of service quality for accreditation purpose; we have completed six times already…" (Hospital administrator)

"While working in a private hospital, I met many patients coming from the advanced countries. There was once a female tourist who had abdominal pain at midnight. She was diagnosed with acute cholecystitis the next day and we immediately performed an endoscopic surgery for her. Two days later, she was discharged. She had not thought that healthcare in Southeast Asia could be so much better than that in the United States. She said she had had that pain for ten years without the chance yet to see a doctor on it… Many foreigners using the services by private doctors in Hong Kong were surprised by our system's efficiency, affordability and quality." (Private specialist)

"I think the service quality of private hospitals is definitely assuring. First of all, there are regulations… Why would a patient prefer to pay $10,000 instead of $100? It is definitely because the (service and quality) are worth the money paid. If there is no added value, why is there a waiting list in the private hospitals? Why is the supply of private hospital beds tight? Why are there so many doctors leaving the public hospitals for the private ones? All these must result from substantial market demand…" (Hospital administrator)

In order to maintain high quality health services, private hospitals had conducted internal clinical audits to ensure quality of services provided. Besides, the hospital management also closely monitored the quality of care provided by the resident / visiting doctors and other healthcare

professionals. Peer supervision also had an impact on the performance of private doctors.

"There are many unofficial channels for private hospitals to assess the quality of care by a private doctor. For example, if it is known to a hospital that a surgeon has had several medical accidents before, he/she will be debarred from having affiliation with the hospital." (Public hospital resident)

"We are usually less certain about the quality of care by those (doctors) from abroad initially. So, we need to monitor their performance with the help of our nurses. This can only be done after the doctors start serving in the hospital…" (Hospital administrator)

(iii) Reputation with patients

Some participants opined that both private doctors and hospitals highly valued their reputations as the market was open and patients had free choice of service providers. As such, the attention should be placed more on the awareness and ability of the patients to choose wisely, which would laterally generate market forces to keep the quality of care in check.

"A doctor providing care of poor quality naturally lose clients and therefore slim business provides a signal that casts doubt on the doctors' performance. So the market serves as an audit of the doctors' care quality." (Private specialist (phone))

"Patients always have the final right to choose doctors. The choice could be based on the charges, location of clinic, and the attention that a doctor

pays to patients. The patient choice helps upkeep the quality of care." (Private GP)

"When we talk about quality assurance, we have to understand that private market is self-regulated and self-assured. If a doctor performs well, patients naturally approach you. The government often mis-perceives that the private healthcare market is chaotic, which hurts the image of many private doctors." (Private GP)

"If our service were of poor quality, our clients would have left long ago. The fact that many doctors have a sizeable clientele despite higher charges speaks for itself." (Private specialist)

"If the quality of care is poor, a doctor won't be able to stay in business. Evaluation of doctor performance is meaningless. If a doctor has no patient, it means that the quality of his/her care is not up to standard. A doctor providing care of poor quality can't attract clients." (Private specialist (phone))

2.2.5 Other views on quality assurance

The participants also had some views on improving the quality assurance of the healthcare system. They believed that quality assurance should be applied to both public and private sectors. They also opined that it was necessary to enhance patients' awareness of quality of health services through education and patient empowerment. However, they had reservations on the effectiveness of some of the health services performance indicators including the publication of league tables and performance scores. They were concerned that doctors might choose

simple and less complicated cases in order to obtain higher scores.

Implementation of quality assurance measures to both public and private sectors

The participants generally agreed that the health services quality in the private sector was up to the standard. However, some of them had made suggestions to further enhance the quality assurance measures, such as enhancing the role of colleges under the Hong Kong Academy of Medicine. Some participants also opined that if quality assurance was to be enhanced, such measure should be implemented in both private and public healthcare sectors, and should not be restricted to the private sector alone or further restricted to services related to HPS only.

"If we are talking about quality, then all doctors, private or public, should be monitored." (Private hospital specialist)

"… about the whole claim arbitration, I personally prefer keeping the present mechanism and seeking improvement on this basis." (Private GP)

"I think this is in effect disapproving the present mechanism, such as the colleges' assessment and specialty examinations, whereby passing of the assessment and examination is necessary to obtain the specialty qualification… If it is aimed to enhance quality control, I would suggest empowering the colleges to strengthen quality assurance measures rather than creating a new system." (Private hospital specialist)

Enhancing patients' awareness

Some participants considered that a more informed environment for the patients to choose healthcare services could naturally lead to greater

consciousness of the healthcare providers to compete and maintain a high standard of services. Enhancement of patient education and empowering patients to actively involve in the disease manage process and make informed choices would be desirable. The efforts in this direction could improve the relationship between private doctors/hospitals and patients as very often disputes were due to miscommunications rather than professional misconducts.

"The communication with patients was very poor, and sometimes the notes are (unclear). It is doubtful how the doctors communicate with patients and seek patients' consent prior to clinical decision. There are always arguments about these. Does quality assurance really help? It is hard to say." (Private specialist (phone))

"Healthcare is inherently so sophisticated. The general public as laymen may not be able to distinguish between good and bad about the related matters. Public education is thus important. Only when a certain level of knowledge is established can a patient be positioned to judge on whether something under healthcare is good or bad. " (Private specialist)

"…government needs to educate the public well. For example, instead of being just informed that the charge for a given case is $90,000, the patients should be let aware that this amount may not cover everything and is not necessarily all-inclusive." (Private hospital specialist)

Effectiveness of performance indicators

Participants also discussed about the use of league table to compare and publish the performance indicators. Participants generally did not support this idea, as they considered such measures were misleading and

unfair. Some used the example that doctors might have poor performance in the charting because their patients had long duration of stay or poor recovery from surgery; but that might be due to that doctor's willingness to treat patient with severe or complicated conditions, rather than poor quality of service provided. Besides, some healthcare providers might be induced to make use of imperfection of the system to increase their scores without commensurate improvement in performance of care. A downside risk cited was that a doctor might refrain from treating those patients with relatively serious and uncertain conditions so as to maintain a good score if the indicator was based on the length of hospitalization before discharge.

"At this point it is meaningless as performance ranking can be made up. … If you know how it works, you can cheat the system and attain a higher score." (Private GP)

"I don't think there should be an official ranking chart. There are already many rankings provided by unofficial channels." (Academics)

"…(speaking of current practices), there are private doctors who refuse to handle cases with complications. There have been incidents that some patients initially admitted to private hospitals were subsequently transferred to public hospitals because the patients' condition is complicated or has deteriorated. Or in some cases, the patients might call the doctors all night long, so the doctors refused to take up these cases. This situation will worsen if complication rate is published online in the future. It will be very difficult for patients with severe or complicated conditions to find a doctor." (Private GP)

“If doctors tend to not admit patients over 65 and to perform only uncomplicated surgeries, there will be some cases that no doctor takes up. If ranking is published, the situation will become worse as both hospitals and doctors will become more selective (to avoid adverse impact on ranking).” (Public hospital resident)

2.3 Manpower issues

2.3.1 Overview

Most of the participants from the private sector did not think that the implementation of HPS would lead to shortage of private doctor services as market supply was adequate and flexible. The participants from the public and academic sectors had no particular view on the private market reaction and were rather concerned that the brain drain in the public healthcare sector would be aggravated. This worry was also shared by participants in private sector.

It was a consensus that adequate long-term manpower supply was fundamental to the healthy development of the healthcare system in Hong Kong, including both the public and private sectors. The participants generally agreed on the need to conduct a comprehensive and objective assessment of the future healthcare manpower need, with the assessment taking a global view and not being confined to considerations surrounding the HPS only. Apart from medical practitioners, nurses and allied health professionals should also be covered. The projection results should also be considered in conjunction with the planning for private hospital beds and facilities.

Participants also discussed different measures that might be adopted to increase the capacity of the healthcare system to cater for long-term changes in demand, including training quota of healthcare professionals, acceptance of qualified healthcare professionals to practice in Hong Kong, and public-private collaboration.

2.3.2 The current supply of doctors in public and private sectors

Participants from the academic group believed that the overall supply of doctors was inadequate in Hong Kong, particularly in the public sector. On the other hand, participants from the public and private sectors largely thought that supply of doctors in private sector was currently adequate although they agreed that the supply of doctors in the public sector was relative tighter. Some of them pointed out that the number of doctors per total population in Hong Kong was not low when compared to many other countries. Some even opined that there was spare capacity among private doctors to take up more patients. They perceived that the current problem was actually the imbalance of doctors between public and private sectors, with insufficiency lying with the public side. Some thought that more and more public doctors would continue to move to the private sector if the working environment and remuneration in the public hospitals continued to lack attraction.

Views on the supply of private doctors

"There will still be enough private doctors if some patients shift to the private sector. Doctors are flexible and can accept working longer, unlike nurses who tend to work for a regular number of hours a day…" (Private GP)

"Speaking of the workload and capacity of private doctors who are actively practising, you can see that no matter how many patients shift to private, they can still take care of them…" (Private specialist)

"I think the private doctor supply is very sufficient. Even if (the private

share of patient load) is to increase by several percentage points, there should not be any problem…" (Private specialist (phone))

"The working environment in the private sector is freer and can attract HA doctors to join when they see the demand shift from public to private." (Hospital administrator)

"I have been a doctor for a long time and there have never been enough doctors. If HPS is that good and patients do shift from public to private, there may not be enough private doctors in the private market… but from what we heard from the private doctors, the current supply of private doctors is adequate." (Academics)

"There are over 10,000 doctors in Hong Kong. If you divide the population of 7 million by the number of doctors, there is a doctor per 500-600 people. The ratio is not low." (Private GP)

Views on the supply of public doctors

"The shortage falls in HA and other parts of the public sector… because doctors are leaving and no doctors are promoted. Over the years, the public sector is lack of a remunerative environment attractive enough to hire doctors from outside. It is not the case that doctors from outside do not want to join the public sector." (Private specialist)

"I think the shortage is in HA. The private market is saturated; there are more than enough doctors but not enough patients. If more public doctors shift to private, how can they survive? The penetration of the private healthcare market is really small at just 7%, while the government is taking up 93%." (Private specialist (phone))

"Even if you increase the number of public doctors, after working for a certain period of time, they will go to private. So in the end, the doctors in the public sector are always relatively green. Their lives are not easy. The biggest problem is the reliance of a majority of the population on the public healthcare system… there is a problem with the balance…" (Hospital administrator)

Participants from all groups shared the view that the resource shortage in both the public and private sectors pertained to nurses and allied health workers. Other facilities like hospital beds, as well as operation theatres, should be considered in parallel.

"There are not enough nurses in both public and private sectors at present. The nursing requirement in the private sector is much higher than the public sector. In the public sector, there are only one scrub nurse and one runner in an operation theatre, but in Union Hospital for example, they have two scrub nurses on table and many runners… (The patient shift if occurs) might draw a lot of nurses from the public sector." (Public hospital resident)

"This scheme focuses on inpatient care particularly in relation to procedures. (This would cause a strain as) the capacity of operation theatres in the private hospitals is insufficient. In the private hospitals, many operation theatres are now heavily used for the labour of mainland pregnant women. It is very difficult even for surgeons to find a theatre to operate on their patients…So, it has to be carefully considered on whether there are enough private hospitals and inpatient beds (to support the scheme)…" (Public hospital resident)

"I think it is a long-term problem… It is very difficult to book a bed in private hospitals now. To build a new hospital, we need doctors, nurses and paramedics. It is more difficult to hire nurses than doctors. We can't run a new hospital with doctors but without nurses. Even if we have doctors and nurses, but nothing else, we still can't run it. This is a big problem." (Academics)

"There are not enough radiographers… Actually the nursing shortage may be relieved in a few years time. What we notice now is that there is not enough manpower in allied health professionals…" (Hospital administrator)

"We don't see any expansion in training for pharmacists, lab technicians or radiographers…" (Hospital administrator)

2.3.3 Measures to solve the manpower problem

Participants also discussed measures to solve the manpower problem in the Hong Kong healthcare system which included appropriate review of manpower and facilities, training quotas of medical students and specialist, intake of non-local doctors and public-private collaboration. They generally believed that estimation of manpower should be based on the growth of population and healthcare needs of Hong Kong. Participants largely agreed that increasing quota of medical students could not solve the manpower issues in short term, particular in the public sector. As regards quota of specialists, availability of trainers and training cases should be considered. Participants had divided opinions on the intake of non-local doctors. Some suggested promoting existing

local doctors in public hospitals and improving the working environment and employment benefits rather than increasing intake of non-local doctors. Even some participants agreed to invite non-local doctors to Hong Kong, they emphasized the importance of their trainings and qualifications. Moreover, some participants suggested hiring doctors and specialists from the private sector on a temporary basis to relieve the manpower pressure in the public sector.

Manpower and facilities reviews

In general, participants considered that a comprehensive manpower review should be an appropriate starting point to solve the manpower problem. Such review should take a global perspective and not restricted to the impact of HPS alone. Also, the review should also consider the need of doctors with respect to the Hong Kong population as a whole, and should not be confined to public or private sector alone.

"We need a comprehensive review… our population is aging, there are more and more aging related diseases." (Public hospital resident)

"As the population grows, we have to assess the corresponding (change in healthcare) manpower need carefully. The government can roughly estimate the demand, taking into consideration the growth in population and the doctor to patient ratio, to find out how many more doctors will be needed. It can be a rough estimation. But the most important thing is to avoid an imbalance." (Private GP)

"…there are seven million people in Hong Kong. Except for the influx of non-local pregnant women, there would be no other factors which lead to a drastic change in disease pattern and a surge in demand for

healthcare services all of a sudden." (Private specialist)

Training quotas of medical students and specialists

While some participants were receptive to this idea, some did not think that increasing training quota of medical student could provide timely solution to the manpower problem especially in the public sector for two major reasons. Firstly, the time needed to train up a medical student to become a doctor and then a specialist was too long to cope with manpower shortage in a couple of years. Secondly, it was uncertain how many of the new doctors would continue to serve in the public sector after training.

Besides, participants generally raised a feasibility concern about the availability of more trainers and clinical cases (for training purposes) to match with the increase in training quota. Some participants opined that the increase in training quota for specialist training should be more targeted towards specialties where shortage was more serious.

"The training quota of medical students should be increased with the growth of the population." (Private specialist)

"The training quota cannot be increased without criteria. Some considerations such as the proper ratio of trainer to trainee being one to one or one to two and, annual throughput of hospitals, should be taken into account. While the supply of trainers are always in excess, the problem is how much GA (general anesthesia) time is available, which will determine how many major operations could be conducted (by a trainer), and in turn how may trainees could be assigned to a trainer. The training quota cannot be increased all of a sudden. There are not enough

resources to train too many students." (Public hospital resident)

"Increasing the training quota of medical students may bring about shocks to the healthcare sector in a decade's time….increased quota cannot solve the current problem because it takes six years to train up a doctor. By the time they graduate, the manpower shortage may not exist anymore.' (Private specialist)

"For certain specialties such as psychiatry, the increase in the supply of doctors has been relatively small. So, even if the number is doubled, the effect is limited because of a low base …" (Private specialist)

"You can't solve the problem in Obstetrics… It takes 10 years to train Obstetricians. Who knows what will happen in 10 years? I think Obstetrics is particularly the case…" (Public hospital resident)

Intake of non-local doctors

Participants had rather divided views on increasing the intake of non-local doctors to practice in Hong Kong. There were participants from either sector who welcomed or had reservation about this idea. Some participants thought that this would be a useful means to solve manpower shortage provided that the qualification of the doctors admitted was up to standard. They also thought that the intake program could be tailored to fit the needs and shortages in different specialty fields.

On the other hand, some participants from the private sector had great reservation about this idea with the worry that it would be difficult to ensure that the professional standard of the non-local doctors was on par with the local doctors. They suggested promoting existing local doctors

in the public sectors and improving the working environment and employment benefits rather than inviting non-local doctors. Some participants also worried that non-local doctors might not be willing to make a long-term commitment to work in Hong Kong and some of them might return to their home countries after a certain period of time.

"There can be more intakes for specialties which are more short of manpower, but the intake should be stopped as soon as the manpower becomes sufficient…" (Private specialist)

"…what we should do now is to allow non-local doctors to work in Hong Kong… Increasing the training quota cannot solve the current problem. It takes six years to train a doctor, and the need may not exist anymore in six years' time.' (Private specialist)

"…Long-term planning that gives regard to the population profile is needed. At the moment, the elderly has the most pressing need. After a certain point of time, however, the elderly population will decrease. For the short-term need, we can take in non-local doctors." (Private specialist)

"…there should be quality assurance for non-local doctors to ensure that they provide care of good quality. They should be required to meet some criteria, for instance, proficiency in Cantonese or Mandarin." (Academics)

"There is a very sufficient supply of doctors in the private sector. We should think about how to retain our manpower (in the public sector). Increasing training quota or taking in doctors from the Commonwealth of

Nations are not workable solutions." (Private GP)

"If we have money to hire non-local specialists, why can't we use the budget to promote HA doctors? If the (non-local) doctors are recruited to work in the frontline, would anyone want to be a junior MO (medical officer)? He won't do it." (Private specialist)

Public-private collaboration

To ease the shortage of doctors in the public sector, those considered the private market had spare capacity suggested that the public sector could hire the services from the private doctors on a seasonal or temporary basis to relieve the pressure in public sector.

"So if there is more money to spend… we should use it on HA. For example, for where there is manpower shortage, we can outsource the services to non-HA doctors or hire private doctors to serve in HA (on a temporary or part-time basis) provided that all these doctors must pass certain assessments to ensure that they are up to standard." (Private specialist)

2.4 Other alternative measures and opinions that can better enable the HPS to function and the Hong Kong healthcare system to develop healthily

2.4.1 Overview

Participants commented on the use of public funding and coverage of the HPS and gave their views on the future development of the Hong Kong healthcare system.

Most participants agreed to make use of the $50 billion set aside from the fiscal reserve to support healthcare reform to embark the HPS. However, participants were concerned about the details of the scheme and the means of using the money effectively and efficiently so that patients who were in need would get the most benefit. They also raised the concern of sustainability of the system when the fiscal reserve was used up. Other alternatives in spending the money effectively to improve the healthcare system were also discussed.

In addition, some participants suggested that the core coverage of the HPS could include primary healthcare and preventive care as they were effective in saving medical cost. A more comprehensive standard plan with general outpatient services and consultations of private doctors, Chinese medicine practitioners and chiropractors incorporated, was also suggested.

As regards their views on the future development of the Hong Kong healthcare system, participants suggested that the government should introduce hospitals which were affordable by middle class. Besides, the public healthcare system should introduce a co-payment policy for those

who could afford to pay more, and the government should consider subsidizing elderly patients to buy private health insurance.

2.4.2 **Use of public funding**

Incentives

Most of the participants agreed in using $50 billion set aside from the fiscal reserve to support healthcare reform for the purpose of embarking the HPS. They believed that if there was no incentive at the beginning, it would be difficult to attract the general public to join the scheme. Even if government reserve was not used in the HPS, most of the patients would eventually go back to the public sector for services and treatments.

"(The Scheme) is only feasible when there is public funding support. Insurance companies are 'for-profit'… they will not insure a person if the case is not profitable. People who are normally rejected by insurance companies can be allowed by the Scheme to access health insurance, but this can only happen with public funding support." (Public hospital resident)

"I think (the Scheme) is acceptable. If you don't subsidize these people (with higher health risks) to buy health insurance through public funding, they still consume government resources through public healthcare. The gist is rather how best to attract them to join the Scheme. Will there be tax refund or other incentives?" (Private GP)

"There must be incentives initially if you want to induce people to join the Scheme, especially the first batch of participants. They have to pay for the Scheme every year, but you may only help them at the beginning…"

(Private specialist (phone))

"I think it's ok. The purpose (of the Scheme) is to divert some of the HA patients to the private sector. There must be some incentives. The details like the mode of incentives/subsidies are what matter. For those already with heath insurance, will there be any incentives to attract them to migrate to the Scheme? For people who are not insured yet, it is important to attract them to join." (Hospital administrator)

Details on the scheme

However, participants were concerned about the means of using the money effectively and efficiently. They were worried about the high administrative cost and insurance companies would get the most benefits from the healthcare reform, not the patients who were in need. They also had queries about the details of the scheme, like subsidizing of the poor, incentives for those who were currently insured and strategies to sustain the scheme when the fiscal reserve was used up and ensuring people joining the scheme continuously.

"It is alright to implement this Scheme. Aside from considerations on how to generate revenue and how to attract buyers, there should also be careful planning. At the end, is $50 billion really enough?" (Public hospital resident)

"In principle, I don't object using public funding to subsidize people to take out health insurance in order for the Scheme to take off. However, as the Hong Kong Medical Association has pointed out, the support of $50 billion can allow the Scheme to start off with guaranteed acceptance of enrolments and the premium kept at an affordable level, but would these

scenarios sustain after the money is used up?" (Private GP)

"We must be careful if using the whole sum of $50 billion as subsidies. There is a chance that eventually all the benefits go to the insurers while the patients' access to doctors' or private doctors services does not improve." (Private specialist)

"Many people will buy health insurance if subsidized, but may drop out once the subsidy ceases. Then the money used as subsidy will be wasted." (Private specialist (phone))

Alternatives in using the $50 billion set aside from the fiscal reserve to support healthcare reform

Some participants suggested other alternatives in spending the money. They believed that primary care, health promotion and preventive care were also important in the healthcare system. The $50 billion could be considered in further developing services in these areas as primary and preventive care had been supported to lower healthcare cost in the long run. Some participants recommended spending the money on staff training, hiring staff in the public sector, improving technologies and systems in hospitals and developing public-private collaboration.

"When deliberating on how to use the $50 billion, which is not a small sum, one should also think about the important issues of the whole healthcare system in Hong Kong in 5, 10 or 15 years' time. The money can support a variety of needs related to aging population, chronic diseases, and primary care models, etc." (Public hospital resident)

"Primary care plays an important role. It could be included in another

scheme… We can make use of some of the money to enhance primary care such as disease prevention care instead of focusing on hospitalization only." (Private GP)

"How about using the $50 billion to build a government-run private hospital, train more doctors, retain talents, or develop new technologies?" (Private specialist)

"If we have the money, we should use it to increase the capacity of HA by, say, expanding the manpower, outsourcing more services, or even hiring some private doctors..." (Private specialist)

"If primary care performs well, patients can be admitted to hospital at an earlier stage and the length of hospital stay can be shortened. At the moment, patients are forced to stay in hospitals because of the lack of community care. If community care is enhanced, the patients won't have to stay in the hospital all the time and in turn the government expenditure can be reduced …" (Hospital administrator)

2.4.3 **Coverage of HPS**

Some participants opined that the core coverage of HPS could be made more flexible by allowing consumers to opt to include primary healthcare, preventive care and general outpatient services in the standard plan. As mentioned previously, primary care and preventive care was effective in saving medical cost at the end, it was worth to include these coverage in the standard plan. They also believed that the coverage of HPS should be more comprehensive rather than hospital care and procedures alone. Other expenses like consultation of private doctors, Chinese medicine

practitioners and chiropractors could also be considered.

"HPS only talks about surgeries but not all illnesses need surgical procedures. In the event of chronic disease like depression, diabetes mellitus or hypertension, the patients cannot benefit from HPS because non-surgical cases are not claimable, including the private doctor fees involved." (Private GP)

"The (Scheme's) coverage is not comprehensive enough. For example, income protection (for the sickness period) and upon occurrence of critical illness are not included. When a patient is suffering from a serious illness like cancer, what they need is not only coverage for medical expenses related to hospitalization but also recovery of income loss from not being able to work. In fact, patients have to pay for a lot of expenses out of their own pockets, like purchase of wheelchairs for a patient with stroke …" (Private GP)

"Why does HPS only cover ambulatory care and inpatient services? Why not making it more comprehensive to cover all medical expenses? People are expecting that doctors' consultation fees should be covered, but now they have to pay extra money for outpatient services. They may think that it is necessary to buy top-up insurance." (Private specialist)

"I think more financial resources should be invested in primary care. Moreover, patients should be provided more autonomy on the choice of subsidized care, such as services of Chinese traditional practitioners and chiropractors, which are not allowed currently… I think it should be more diversified." (Private specialist (phone))

"Inclusion of preventive care seems to make HPS more costly, but actually, at the end, money can be saved by doing that…" (Hospital administrator)

"The direction of health care management should not be disease based anymore. It should focus more on primary care or preventive care, yet none of these is covered by HPS…" (Hospital administrator)

2.4.4 Other suggestions on the Hong Kong healthcare system

More affordable private hospital services

Hong Kong should consider enhancing private hospital services in the public sector which were affordable by middle class. Participants opined that the existing private hospital services and treatments were too expensive for most of the middle class people. In fact, the middle class was willing to pay more rather than queuing for services in public hospitals. If second class or more affordable private hospital services were available for this group of people, the demand of services in public sector could be relieved.

"Public hospitals can reserve some beds to target at middle-class patients and charge them at a higher rate. For example, if the average cost of public inpatient services per day is $3,300, hospitalization of 5 to 7 days only costs around $20,000 and it's all inclusive already. To be more precise, as the cost is already capped, it is equivalent to charging based on DRG (diagnosis-related groups). As for cases with complications, the charge can be capped at a higher amount, for example $33,000. This arrangement benefits the patients who cannot afford private services but do not want to wait for a long time for the public services." (Private

specialist)

"At least one or two public hospitals in the urban area should be transformed into private hospitals, but they must offer packaged charges with transparency and are subject to government control. Then the idea will become feasible. This will create more beds and benefit our citizens as they can opt using these more affordable private services apart from public services." (Private specialist (phone))

Copayment of medical cost

One of the advantages of copayment was to inhibit unnecessary or ineffective assessments and treatments provided to patients. In turn, resources and medical costs could be saved to those who were really in need. The most disadvantaged group could be totally subsidized by the government while the percentage of copayment of other citizens could be determined by their financial status.

"Co-payment can prevent patients from abusing insurance protection and making unreasonable request for services in order to maximize their claims at no cost. They (the unreasonable patients) will expect the Scheme should cover all the inpatient cost and will blame the doctors if not all hospitalization expenses are covered by the Scheme." (Private specialist)

"The biggest problem now is that many patients who can afford private services still go to HA… Everyone tries to take the most advantage from the public healthcare system. Actually, one possible solution is for HA to charge patients according to their income. The recipients of Comprehensive Social Security Assistance may be treated for free while

people with relatively higher income may be charged at a higher rate with the subsidy ratio lowered to 30-70%." (Private specialist)

"Co-payment if used can control the increase in medical cost. People are inherently greedy. If they are offered a package covering everything, they will utilize it to the limit. But if there is a co-payment arrangement such that the insurer only reimburses 25% of the cost while the insured patient bears 75%, he/she will think twice about its necessity and make appropriate use of the insurance protection." (Hospital administrator)

Subsidizing elderly to subscribe private insurance

For those who were currently insured, some participants suggested using fiscal reserve to subsidize them, especially when they turned 65 or were retired. Many of these elderly were insured when they were employed but they might not be able to afford private insurance when they were retired.

"…I think it is necessary to look after the population who are about to retire. Many of them used to buy health insurance with their own money, but the insurance protection will lapse when they turn 65. We need to make sure that they can remain insured." (Private specialist)

Table 1 Demographics of participants

Doctor Code	Specialty	Working unit	Gender	Number of years of practice	Medical degree obtained in
Group 1 Public hospital residents					
a	Medicine (Geriatrics)	Hospital Authority	F	11-15	HK
b	Surgery	Hospital Authority	F	16-20	HK
c	Family medicine	Hospital Authority	F	11-15	HK
d	Accident and emergency	Hospital Authority	F	6-10	HK
e	Medicine	Hospital Authority	M	6-10	HK
f	Surgery (Neurosurgery)	Hospital Authority	M	16-20	HK
g	Medicine	Hospital Authority	F	16-20	HK
h	Medicine	Hospital Authority	M	≥21	HK
i	Psychiatry	Hospital Authority	M	16-20	HK
Group 2 Academics					
a	Surgery	HA/ Private clinics under private healthcare org/ University	M	16-20	HK
b	Family medicine	University	M	11-15	HK
c	General practitioner	University	F	6-10	Overseas
d	Medicine (Gastroenterology & hepatology)	University	M	16-20	HK
e	Community medicine	Others statutory board and	F	≥21	HK

		physical committee			
f	Medicine (Nephrology)	HA / University	M	≥21	HK
g	General practitioner	University	M	11-15	Overseas
h	Pediatrics	University	M	≥21	Overseas
Group 3 Private hospital specialists					
b	Obstetrics and gynecology	Private hospital	F	11-15	HK
c	Pediatrics	Private hospital	F	16-20	HK
d	Orthopedics	Private hospital	M	Missing / Unwilling to disclose	Missing / Unwilling to disclose
e	Obstetrics and gynecology	Private hospital	M	16-20	Overseas
h	Ophthalmology	Private hospital	M	≥21	HK
i	General practitioner	Private hospital	M	≥21	HK
Group 4 Private general practitioners					
a	General practitioner	Insurance company/ Private clinic	M	≥21	HK
b	General practitioner	Private clinic under private healthcare organization	M	16-20	Overseas
e	General practitioner	Private clinic under private healthcare organization	M	≥21	HK

f	General practitioner	Private clinic under private healthcare organization	M	11-15	HK
g	General practitioner	Private clinic	M	6-10	HK
h	General practitioner	Private clinic	M	11-15	HK
Group 5 Private specialists					
a	Surgery (Plastic)	Private clinic	M	≥21	HK
b	Surgery (Ear, nose and throat)	Private clinics under private healthcare organization	M	1-5	Overseas
c	Anesthesiology	Private hospital	F	11-15	HK
d	Surgery (Ear, nose and throat)	Private hospital	M	Missing / Unwilling to disclose	HK
e	Obstetrics and gynecology	Private clinic	F	≥21	HK
f	Medicine (Internal)	Private clinic under private healthcare organization	M	16-20	HK
g	Surgery	Private clinic	M	≥21	HK
					HK
Group 6 Private specialists					HK
b	Psychiatry	Private clinic	M	≥21	HK
f	Obstetrics and gynecology	University/ Private hospital/ Private clinic	M	≥21	HK
g	Medicine (Dermatology)	Private clinic	M	≥21	HK

Telephone interviews					
a	Surgery	Private clinic	M	≥21	Overseas
b	Medicine (Cardiology)	Private clinic	M	≥21	Hong Kong
c	Oncology	Private clinic	M	≥21	Overseas
Group 7 Private hospital administrators					
a	Hospital administrator	Private hospital	M	≥21	Not applicable
b	Hospital administrator	Private hospital	F	≥21	Not applicable
c	Hospital administrator	Private hospital	M	11-15	Not applicable
d	Hospital administrator	Private hospital	M	≥21	Not applicable
e	Doctor	Private hospital	M	16-20	Not applicable
f	Hospital administrator	Private hospital	F	≥21	Not applicable

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