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LEGISLATIVE COUNCIL BRIEF

RESTRUCTURING OF FEES AND CHARGES FOR PUBLIC HEALTH CARE SERVICES

INTRODUCTION

At the meeting of the Executive Council on 5 November 2002, the Council ADVISED and the Chief Executive ORDERED that: -

(a) the proposed new charge for Accident & Emergency (A&E) service at public hospitals under the Hospital Authority (HA) should be implemented from 29 November 2002, as set out in **Annex A**;

(b) the fees and charges for hospital services other than A&E service at public hospitals under HA should be revised on 1 April 2003, after the current moratorium on public fees is lifted, as set out in **Annex B**; and

(c) the fees and charges for Government clinics on General Out-patient (GOP) Service and Specialist Out-patient (SOP) Service under the Department of Health (DH) should be revised on 1 April 2003, after the current moratorium on public fees is lifted, as set out in **Annex C**.

JUSTIFICATIONS

2. The fundamental objective of Government financing in health care services is to improve health and to provide protection for the citizens

from potentially high financial risks arising from catastrophic or prolonged illnesses. To fulfil this role, the public health care system must remain accessible to all, affordable by individuals, and of a high standard. Given the finite resources, public funds should be channelled to assist lower income groups and to services which carry major financial risks to patients. These principles formed the cornerstone in the financing proposals set out in the Health Care Reform Consultation Document published in December 2000. In the Consultation Document, we reaffirmed the Government's commitment to continue to invest in public health care services but in the light of rapidly rising costs, we also recognised the need to identify supplementary sources of funding to ensure the system's long-term financial sustainability. We proposed to adopt a three-pronged approach in ensuring the long-term financial sustainability of our public health care system:

(a) reduce cost and enhance productivity;

(b) introduce medical savings through a scheme of Health Protection Accounts (HPA); and

(c) revamp public fee structure.

3. On the revamping of public fee structure, we propose to carry out a full-scale review of the existing fee structure so that our subsidy can be targetted at various services in the most appropriate manner to ensure that public health services remain accessible and affordable to all individuals. The review also examines how the relative priorities of services provided may be reflected in the subsidy level and how inappropriate use and misuse of services can be minimised. Following the review and subsequent revisions of the fee structure, charges would continue to be affordable but should also be effective in influencing patient behaviour. Any fee revision must also build on a fee waiver system which can assist those who have insufficient income or who have difficulty to pay for even the heavily subsidised services because of serious or chronic illnesses. This proposal has received general support from the community. In July 2001, we reported to this Council that we would conduct a comprehensive review of our current fee structure. The study has

now been completed and the findings provide useful reference in our deliberation and determination of a new fee structure.

4. In reviewing the fee structure, we have taken into account the following guiding principles: -

(a) Cost sharing – while maintaining access, patients should share the cost of service, especially those who can afford to pay more.

(b) Affordability – to ensure that the fee structure is affordable to both the general public and to lower income groups, and help those who cannot afford with a fee waiver system.

(c) Minimising unnecessary use – by increasing the charge to reduce unnecessary use of services, such as fees for A&E service.

(d) Resource prioritisation – by providing higher subsidies for services of greater needs and financial risks to patients.

(e) Facilitating access by vulnerable groups – through targeting public subsidies to low-income groups and chronic patients.

(f) Public acceptance – by ensuring that the fee structure can be clearly understood by patients and providers, and that it is politically acceptable and administratively simple.

We believe the above principles, which should be acceptable to the community, would help addressing our identified problems.

5. In determining the most appropriate level of public subsidy to financing health care services, we have to give regard to a host of factors as follows: -

(a) the Government's global budget and its ability and policy to fund health services vis-à-vis other social programmes;

(b) the costing of HA providing the services, which is affected by factors such as inflation and the pace of technology advancement,

etc;

(c) the ability of users in paying for public health care services;

(d) demand and growth in demand over time for public health care services and the role of private sector in provision of health care services; and

(e) size of population who have difficulty to pay for their health care expenditure and are eligible for the financial assistance provided by the Government.

OTHER OPTIONS

6. If we do not revamp the fee structure as soon as possible, our public health care system will continue to face great financial pressure and suffer from undesirable utilisation pattern due to inappropriate use and misuse. Moreover, the system's long-term financial sustainability will be highly questionable.

THE REVISED FEE STRUCTURE

7. The new fees and charges for public health care services are set out in **Annex A** (for HA's A&E service), **Annex B** (for HA's other services) and **Annex C** (for DH's services). Except for the charge of A&E service (which will be effective on 29 November 2002), all new fees and charges will be effective from 1 April 2003, i.e., after the current moratorium on public fees is lifted.

8. We will provide medical fee assistance to protect the poor and the needy. Recipients of Comprehensive Social Security Assistance (CSSA) will continue to be exempted from the charge. Lower-income group, chronic patients or the elderly who are **not** CSSA recipients but have difficulty to pay for their medical fees may apply for assistance under the enhanced fee waiver

mechanism, which will evolve into a medical fee assistance scheme (please refer to paragraphs 32 to 34).

9. The justifications for the revised fee levels for various services are set out from paragraphs 10 to 29.

A&E Service

10. With effect from 29 November 2002, a charge of $100 per attendance will be imposed for A&E service for all persons who are eligible for the subsidised rates (the present definition includes all HKID Card holders, their spouses, and their children under the age of 11). Patients who are subsequently referred to in-patient service will have their admission fee for in-patient service exempted (please refer to paragraph 16).

11. As its name suggests, A&E service is designed for patients with emergency and life-threatening conditions, and is therefore very different from other outpatient services by nature. However, since A&E service is free of charge in Hong Kong, there are patients who perceive A&E service as a form of free primary medical care and use it for non-emergency treatments. As a result, in 2001/02, there were about 2.5 million attendances in the A&E Departments of public hospitals, of which some 75% were classified as semi-urgent or non-urgent attendances.

12. Our international studies revealed that most developed economies have imposed a user charge for A&E service, and Hong Kong is a very rare exception to this practice. International experiences also support that imposing a user charge for A&E service can discourage unnecessary use and reduce the total usage by about 15 to 25%. However, there is no evidence that such a user charge would lead to delayed health seeking by patients or higher eventual costs as illnesses have became more serious.

13. Furthermore, from a cost-efficiency point of view, the unit cost of providing A&E service ($570 per attendance in 2001/02) is more than twice the unit cost of our GOP service ($226 per attendance in 2001/02). Hence

charging a higher fee for A&E service than GOP service would encourage patients who are not in emergency conditions to use GOP service rather than A&E service.

14. Given that the average unit cost of A&E service is $570, a $100 fee level for A&E service would still represent an 82% subsidy by the Government, which is a reasonable subsidy level by international standard. Moreover, this level is also in line with the results of the three tracking surveys we have conducted during the course of the Health Care Reform's public consultation, in which over half of the respondents had accepted a charge of $100 per attendance (please refer to paragraph 37 and **Annex D** for more details about the three tracking surveys).

15. We estimate that the proposed fee structure could result in an 11% decrease in terms of overall utilisation and an additional revenue of about $116 million.

In-patient Service

16. The fee level for general beds in public hospital in-patient service will be set at $100 per day with effect from 1 April 2003. Given the relatively higher cost of service provided during the first day of hospitalisation, an additional $50 admission fee for the first day of hospitalisation will be introduced. This admission fee will be exempted if the patient is referred from A&E departments.

17. Since 1996, a flat fee of $68 per day has been applied to all eligible persons receiving public ward in-patient service in HA's hospitals. Given that the average unit cost of providing such service is $2,490 per day (at 2001/02 price level), this represents a 97% subsidy level which is very high when compared to many other developed economies. This high subsidy level has led to unnecessary use, and there are concerns that we are over-subsidising patients of the middle and high-income groups.

18. For patients using convalescent, rehabilitation, infirmary and

psychiatric beds, in view of their generally longer hospitalisation period and hence higher financial burden, the existing fee level ($68 per day) for these beds will remain unchanged.

19. The revised fee level still represents a high subsidy level of 96%. We estimate that the proposed fee structure for in-patient services would result in an additional revenue of $68 million.

SOP Service

20. With effect from 1 April 2003, the fee level for SOP service will be revised from the existing $44 to $60 per attendance. In addition, a separate charge of $10 per drug item for medication prescribed at the SOP clinics will be charged. A higher charge of $100 will also be charged for first attendance at a SOP clinic.

21. The present fee level for SOP service is $44 per attendance. Given that the average unit cost of providing the service is $660 (much higher than that of GOP service, which is $226), the subsidy level is about 93%. This subsidy level is rather high when compared to other developed economies, and that the present fee structure over-subsidises the middle and higher income groups. The insignificant price difference between SOP and GOP services ($7) has also provided little incentive for the patients to select the most appropriate level of medical care for their particular kind of illnesses. To achieve efficiency, the fee for SOP service should therefore be set at a level higher than GOP service with a view to encouraging the patients to make better use of the GOP service. In view of the more comprehensive service (e.g., testings and investigations) provided during the patient's first attendance at a SOP clinic (hence the higher cost), and to discourage patients from making unnecessary SOP appointments, a higher charge will be levied when a patient visits a SOP clinic for the first time.

22. At present, there is no separate charge for medications in the public health care system. As there is no opportunity cost for patients, wastage due to unnecessary requests for medication and poor compliance of

medication use is not uncommon. In fact, almost all developed economies have some cost sharing mechanism on medications, and such a fee could discourage overuse and reduce wastage.

23. The revised fee level still represents a subsidy level of 88%. We estimate that the proposed fee structure would result in an additional revenue of $110 million ($102 million from SOP clinics under HA and $8 million from SOP clinics under DH).

GOP Service

24. The fee level of GOP service will be increased from $37 to $45 per attendance with effect from 1 April 2003. The same will also be applied to consultation services at Elderly Health Centres under DH, of which the charge is pegged to the GOP rate.

25. The present fee level of GOP service is $37 per attendance, representing a subsidy level of 84%. To encourage patients to first approach GOP service rather than the more specialised and costly A&E or SOP services, we do not propose any plan to introduce major change to the existing GOP fee structure, or to impose a separate medication fee for drugs prescribed in the GOP clinics which are usually cheaper than those used in the SOP service. However, since the average unit cost for GOP service has increased from $191 to $226 per attendance from 1996 to 2002, the fee level of the GOP service should be slightly increased to reflect this rise in cost.

26. The revised fee level still represents a subsidy level of 80%. We estimate that the fee revision would provide an additional revenue of $25 million ($4 million from GOP clinics under HA, and $21 million from GOP clinics and Elderly Health Centres under DH).

Other Services

27. For geriatric and psychiatric day hospital services provided by HA, the existing fee level of $55 per attendance will remain unchanged to

encourage continuation of rehabilitation care in an out-patient setting, hence reducing the demand on in-patient service.

28. For other public services provided by HA and/or DH, their fee levels will be revised in line with the past practice (i.e., base on the actual rate of cost increase since the last fee revision in 1996, or continue to be pegged to the charge of a certain service). For example, the fee level of dressings and injections provided by HA and DH in out-patient services will be increased from $15 to $17 per attendance. The revised fee level will be effective from 1 April 2003.

29. For private services provided by HA and services provided to non-eligible persons, with effect from 1 April 2003, HA will charge market rates for these services, which should at least equal to the full costs of providing the services. We are working with HA on the appropriate fee levels for these services. We roughly estimate that the fee revision of the above services would provide an additional revenue of $30 million.

30. Concurrently, we are reviewing the system of Privately Purchased Medical Items and also the eligibility of non local residents to our highly subsidized health care services. These two issues are part and parcel of our overall review and revision of fees in the public sector.

Future Revisions

31. The current proposed fee revision will yield a total additional revenue of about $350 million. In future, we shall conduct regular review of a basket of factors as per paragraph 5 in determining whether further revision to the existing fee levels is necessary. In particular the affordability of the general public will be assessed to ascertain their ability to pay for health care services and the consequences on the economic well-being of the household.

The Non-CSSA Waiver Mechanism

32. At present, there is a mechanism for patients who are not CSSA

recipients but have insufficient earnings or have difficulty to pay for even the highly subsidized services because of serious or chronic illnesses to seek financial assistance from Medical Social Workers stationed in the public hospitals. The existing criteria, which take into account both non-financial and financial factors of an applicant when assessing his/her eligibility for assistance, have been in use since July 1994.

33. To ensure our fundamental philosophy that no one will be denied adequate medical care due to lack of means will be upheld after the revamp of the fee structure, and to ensure that the fee revision does not impact disproportionately on low income groups, the existing non-CSSA mechanism must be maintained and further enhanced into a medical fee assistance scheme. Under this enhanced scheme, we shall develop a set of objective and transparent criteria to assess a patient's eligibility for partial or full fee exemption for public medical fees. In determining a patient's eligibility for exemptions, we shall consider factors such as the patient's financial condition in relation to the Monthly Median Domestic Household Income, clinical condition in terms of frequency of use of the services and age. We will also consider other factors such as possible relationship problems between the patient and his/her relatives, or other special expenses specific to the patient's family situation which may render it difficult for the patient to pay for the medical expenses.

34. It should be emphasized that the enhancement of the fee waiver system is crucial to a successful fee restructuring exercise. Without this enhanced system, we would not be able to achieve our policy objective of better targeting our subsidies to assist the lower income groups. The new criteria will be introduced in parallel with the implementation of the new fees and charges of most health care services on 1 April 2003 (except A&E service).

IMPLICATIONS OF THE FEE REVISION

35. The revised fee structure for public health care services has

economic, financial, staffing and sustainability implications as set out in **Annex E**.

36. The revised fee structure for public health care services is in conformity with the Basic Law, including the provisions concerning human rights. It has no productivity or environmental implications.

PUBLIC CONSULTATION

37. To assess the degree of public acceptance towards fee increase, we have commissioned three tracking surveys in May 2000, January 2001 and May 2001 respectively. In gist, a majority of the respondents opined that those who could afford to pay should pay more for public health care services, and a majority of the respondents agreed that the current level of government subsidy in health care services is too much in areas of GOP, SOP as well as in-patient services. Nevertheless, many members of the public had considered that the fee increase should be accompanied by a mechanism to protect the poor and the needy. The key results of these surveys are summarised in **Annex D**.

38. We reported the outcome of the public consultation on Health Care Reform to the LegCo Panel on Health Services in July 2001. At the meeting, we briefed Members on the findings of the three tracking surveys, which indicated majority support for the new A&E charge. Since then, we have maintained ongoing dialogue with political parties, medical professionals, patient groups and mass media on the subject of fee restructuring that the main objective of the exercise is for improving efficiency and equity of the public health care system. In addition, it is an important means to ensure the long-term financial sustainability of the system.

BACKGROUND

39. The Hospital Authority Ordinance (Cap.113) stipulates that the

Secretary for Health, Welfare & Food may give directions to HA to determine the fees payable for hospital services provided by the public hospital and specify the circumstances in which such fees may be reduced or waived. The decisions made under this section should be gazetted for public notice.

40. The last fee revision exercise for public health care services was conducted in July 1996. Before that, fees and charges for services at public hospitals and clinics were reviewed on an annual basis to keep them in line with the cost increase and inflation rates, so that the Government subsidy level to various services could be maintained at a constant level.

41. In December 2000, the Government has published the Health Care Reform Consultation Document, in which one of the strategic directions was to revamp the fee structure of our public health care sector, so that the public subsidies could be targeted to areas of most needs and inappropriate use and misuse of services could be reduced. The two other strategic directions on health care financing are to reduce cost and enhance productivity, and to introduce medical savings through an HPA scheme.

42. On reducing cost and enhancing productivity, prior to the introduction of the Enhanced Productivity Programme (EPP), HA has already achieved 11% saving through HA's own productivity enhancement initiatives. In addition to this, HA has achieved another 3% savings in 2000/01 and 2001/02 and is expected to achieve a further 2% in 2002/03. HA will continue to implement its EPP initiatives and develop new strategies to generate further productivity savings, such as:

(a) centralisation and networking of hospital services among hospitals or clusters to achieve economies of scale, and, in line with this cluster-based management, administrative downsizing HA Head Office and hospitals;

(b) re-engineering work processes and reorganisation of services such as providing catering services for hospitals/institutions through central production units;

(c) implementing "invest-to-save" projects such as energy conservation and automation projects; and

(d) human resource measures such as voluntary retirement scheme, restructuring of pay scales, delayering of grade structures and multi-skilling initiatives.

The foregoing initiatives will gradually accrue long-term savings in HA, and ensure that public medical services are provided in a cost-effective manner.

43. On introducing an HPA scheme, we propose to introduce medical savings through the establishment of this scheme. A mandatory contributory scheme by nature, the HPA is designed to assist individuals to continue to pay for heavily subsidized medical services after their retirement, and not to shift the burden to the next generations. The HPA scheme is a long term measure to introduce a steady stream of supplementary funding source to complement financing from the Government. It would also encourage and facilitate insurance industry to play a more active role in health care financing by devising innovative products to dovetail with the proposed HPA scheme, hence giving the public more choices of care and gradually reducing their reliance on public health care services. At present, we are conducting detailed studies on the various operational aspects of the HPA, and intend to complete them by the end of 2003 for further consultation with the public.

SUBJECT OFFICER

Mr Eddie Poon
Principal Assistant Secretary
Health, Welfare & Food Bureau
Tel: 2973 8107

Health, Welfare & Food Bureau
5 November 2002

RESTRUCTURING OF FEES AND CHARGES FOR PUBLIC HEALTH CARE SERVICES

ANNEXES

Annex A - Hospital Authority, Fees for Accident & Emergency Service (to be Implemented from 29 November 2002)

Annex B - Hospital Authority, Fees for Other Services (to be Implemented from 1 April 2003)

Annex C - Department of Health, Fees for Maternity Wards Service, General Out-patient Service and Specialist Out-patient Service (to be Implemented from 1 April 2003)

Annex D - Summary of the Three Tracking Surveys

Annex E - Economic, Financial, Staffing and Sustainability Implications

Annex A

Hospital Authority,
Fees for Accident & Emergency Service
(to be Implemented from 29 November 2002)

For Eligible Persons	$100 per attendance
For Non-Eligible Persons	$570 per attendance

Annex B

Hospital Authority,
Fees for Services other than A&E
(to be Implemented from 1 April 2003)

For Eligible Persons

(a)	In-patient (per day)	
(i)	General Bed (Note 1)	$100
(ii)	Convalescent, Rehabilitation, Infirmary and Psychiatric Bed (Note 2)	$68
(b)	Out-patient (per attendance)	
(i)	General Out-patient Department	$45
(ii)	Specialist Out-patient Department (Note 3)	$60
(iii)	Dressing & Injection	$17
(iv)	Geriatric Day Hospital (Note 2)	$55
(v)	Psychiatric Day Hospital (Note 2)	$55

Note 1 : An additional admission fee of $50 will be charged for the 1st day of hospitalisation. This admission fee will be waived if the patient is referred by A&E Departments.

Note 2 : To remain unchanged at existing fee level.

Note 3 : The charge for a patient's first attendance to a SOP clinic is $100. An additional medication fee of $10 per drug item will be charged for all SOP attendances.

Annex C

Department of Health,
Fees for Maternity Wards Service,
General Out-patient Service and Specialist Out-patient Service
(to be Implemented from 1 April 2003)

For Eligible Persons

(a) In-patient (per day)	
(i) Clinics with Maternity Wards (Note 1)	Free
(b) Out-patient (per attendance)	
(i) General Out-patient Department	$45
(ii) Specialist Out-patient Department (Note 2)	$60
(iii) Dressing & Injection	$17

Note 1: There are only three Maternity Wards under DH, which are located in Tai O Clinic, North Lamma Clinic and Peng Chau Clinic. It is gazetted that no charge should be made for eligible persons admitted as in-patients in these wards.

Note 2: The charge for a patient's first attendance to a SOP clinic is $100. An addition medication fee of $10 per drug item will be charged will be charged for all SOP attendances.

Annex D

Comparison between the Main Results of the Three Tracking Surveys on Health Financing

Methodology

The survey target of the three Tracking Surveys on health financing was persons aged 18 to 65 living in Hong Kong. A random sample, proportionally from all the 18 districts, of about 1,000 persons representing the target population were interviewed by telephone.

Sample size and response rate

	1st survey	**2nd survey**	**3rd survey**
Date of survey	2 to 12 May 2000	12 to 18 Jan 2001	24 April to 4 May 2001
Sample size	1 012	1 013	1 019
Response rate	75%	75%	75%

Results

General Out-patient Clinic

% of respondents who agreed to increase the fee to:

	1st survey	**2nd survey**	**3rd survey**
	(%)	(%)	(%)
$50	77.3	88.7	85.4
$70	31.9	57.9	53.4
$100	14.2	26.4	25.5

Specialist Out-patient Clinics

% of respondents who agreed to increase the fee to:

	1st survey	**2nd survey**	**3rd survey**
	(%)	(%)	(%)
$50	61.8	85.5	79.7
$70	38.3	63.0	60.1
$100	17.1	33.1	32.5

In-patient Service

% of respondents who agreed to increase the fee to:

1st survey		**2nd survey**		**3rd survey**	
	(%)		(%)		(%)
$100	70.7	$100	86.4	$100	84.5
$150	33.8				
$200	25.8	$200	49.7	$200	46.9
$500	7.0	$400	13.6	$400	13.1

Opinions on introducing new fees and charges

A&E Service

Charging	**1st survey (% agree)**	**2nd survey (% agree)**	**3rd survey (% agree)**
$100	56.8	58.5	56.5
$150	32.9	29.3	30.1

Medications

Charging	**1st survey (% agree)**	**2nd survey (% agree)**	**3rd survey (% agree)**
$30	82.1	86.2	83.9
$50	57.4	67.7	64.5
$70	34.8	45.1	40.3

Annex E

Economic, Financial, Staffing and Sustainability Implications

Economic Implications

The effect of the fee revision for public health care services on the composite Consumer Price Index in overall terms should be very small. Yet the impact on different consumer groups or income groups will differ. CSSA recipients will nevertheless be fully insulated, while other households of lesser means will benefit from the enhanced fee waiver system.

2. The fee increase will help improve efficiency and equity in provision of the public health care services. As some patients who can afford to pay more may shift to use private health care services after the fee revision, the market share of the private sector may increase somewhat as a result. This should also be conducive to competition in provision of the services in general. However, as public subsidy will still be a very substantial part in the provision of public health care services, the impact on competition on the private health care services is likely to be limited.

Financial Implications

3. Additional revenue generated from the revised fees and charges is estimated to be about $350 million per annum.

4. HA has estimated that the introduction of the new charge for A&E service will incur an one-off set up cost of $8 million (including necessary renovative works and installation of required computer systems) and a recurrent operating cost of $18 million per year (including system maintenance cost and additional administrative staff required to implement the A&E charge).

Staffing Implications

5. The fee revision will not apply to civil service eligible persons (civil servants and their eligible dependants, as well as retired civil servants and their eligible dependants). This is because as part of the conditions of service of civil servants, civil service eligible persons are eligible to free medical advice and treatment and medicines provided by the Government and HA, except for the specified Hospital Maintenance Fee (HMF) in respect of in-patient which are set out in the relevant Civil Service Regulations and which are at a rate lower than the in-patient charge for the public. We will separately examine with HA how the level of HMF should be adjusted in the light of the proposed increase in the fee level for our public ward in-patient service.

6. The enhanced non-CSSA waiver mechanism will be built on existing staffing structure. The number of additional clerical support required, if any, will be small. There will be no civil service implications.

Sustainability Implications

7. In addition to improving the long-term financial sustainability of the public health care system, the fee revision also accords with the sustainability principle of protecting public health in an efficient and equitable manner.

Health, Welfare and Food Bureau
November 2002