

For discussion on  
10 July 2006

## **LegCo Panel on Health Services Regulation of “Health Maintenance Organizations” (“HMOs”)**

### **Purpose**

This paper reports to Members the Administration’s views on the way forward in respect of the regulation of “Health Maintenance Organizations” (“HMOs”).

### **Background**

2. The Panel discussed the subject of regulation of “HMOs” at its meetings on 13 February 2006 and 30 March 2006. The Panel requested the Administration to meet stakeholders to seek their views and report to Members on the outcome of the consultation and the Administration’s proposed measures.

3. A Working Group was set up by the Department of Health to study the issue and collect views from stakeholders. In the past two months, the Working Group conducted documentary research and met the stakeholders, including users (consumers, patients’ groups, employees), doctors’ and dentists’ associations, medical service providers, private hospitals operators and administrators, purchasers (employers), scheme administrators, insurance companies and insurance brokers. The Working Group took the opportunity to attain a better understanding of the “HMOs” landscape in Hong Kong.

### **The “HMOs” landscape**

4. In the United States, HMO is generally defined as an organisation which directly or through contracts with providers furnishes comprehensive health care services on a prepaid basis to an enrolled population in a designated geographic area. Often HMOs emphasise

health maintenance and disease prevention and task primary care physicians as gatekeepers to oversee enrollees' health needs and make necessary referrals. This type of HMOs does not exist in Hong Kong.

5. The expression "HMO" in Hong Kong is frequently referred by concerned medical/dental professionals as groups related to the provision of primary healthcare services. They may mean -

- group medical practices; and
- scheme administrators.

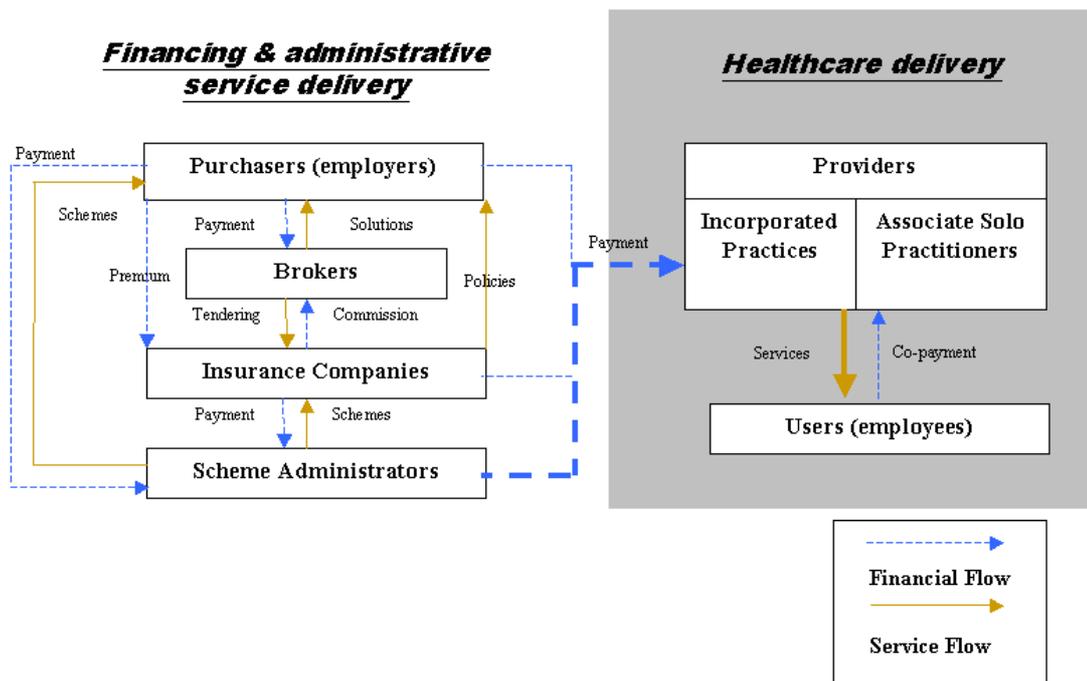
### *Group medical practices*

6. We understand that the late 1990s witnessed rapid development of many new group medical practices. Some of these practices are referred to as "HMOs" by the medical profession. They may carry one or more of the following characteristics: incorporated entities; may not be owned by doctors; doctors being employed to deliver service; existence of a distinct management layer; participating in contract medicine; operating for profit etc.

7. These group medical practices may not necessarily be owned by doctors, but most have doctors in their top management team. In some instances, management of medical affairs is retained in the hands of a doctor or a medical committee consisting of doctors. Many such groups take contracts offered by employers or insurers.

### *Scheme administrators*

8. From our discussion with stakeholders, we understand that employer-financed medical benefits has become increasingly prevalent in the private healthcare market in Hong Kong. While in some cases employees are reimbursed by employer/insurer for use of medical services, more often the service providers (doctors) deal with the employer or insurer in settling the medical charges (contract medical services arrangement). There is little monetary transaction between the patient and doctor direct. The healthcare delivery and financial arrangements are summarized in the following diagram:



Note: The arrangement embodies division of labour, with each party focusing on its core competency. For example, brokers provide consultative, search and tendering services to find most suitable insurance plans for purchasers. Insurers price and assume the risk of fluctuation of medical cost.

9. Scheme administrators are specialized organisations providing a bridge between the employers (or insurers) and the service providers (doctors). They liaise with medical service providers on behalf of purchasers or insurance companies to arrange healthcare plans that suit the needs of users and purchasers. They also provide administrative support to purchases/insurers/providers. In addition, they could have the added value of performing some form of quality control function by weeding out the service providers who, for example, have been the subject of complaints.

10. Some scheme administrators are from the medical profession and may also act as service providers themselves. Other administrators may employ medical service providers to deliver service, and such providers could be large incorporated practices or solo-practitioners. In fact, we understand that many solo-practitioners become affiliated to scheme administrators so that they could take on contract medical services business.

## **Stakeholders' views**

### *Users*

11. Users (consumers, patients, employees) in general feel that the evolution of the medical practices has positive impact on the primary healthcare market. The benefits identified by users include more affordable and convenient services, better accessibility because of the wider clinic networks, longer operating hours, enhanced service quality and professionalism. Employers (as third-party purchasers) reckon that the evolution of group medical practices affords more choices to both themselves and their employees, and that the expertise of scheme administrators provides for more efficient administration of medical benefits and quality assurance.

### *Group medical practices and scheme administrators*

12. Group medical practices add that their size and the pool of expertise and resources enable them to introduce internal medical and management education, set up clinical protocols, widen the scope of services, better coordinate the workload of doctors, introduce new apparatus which can be expensive, apply information technology extensively and enjoy economy of scale. Some providers and scheme administrators are of the view that containment of medical costs and reduction of administrative hassles have attracted more employers, notably smaller and medium enterprises, to start providing medical benefits to their employees. These organisations also emphasise that they help to raise the service standard of frontline doctors for the reputation of their groups.

### *Professional bodies*

13. Doctors' and dentists' associations are primarily concerned that the emergence of "HMOs" in the current context and their drive to contain cost and expand business might result in compromising patients' welfare and eroding practitioners' professional autonomy. Examples quoted include "HMOs" controlling the prescription in the use of certain drugs and investigations and setting target revisit rates and referral rates

for individual doctors. They are of the view that the low service fee paid to contracting doctors by "HMOs" would undermine the quality of medical service. Employee doctors might also be professionally implicated by promotional activities organised unilaterally by the management. Furthermore, there are concerns that "HMOs" may be enticed to be engaged in illegal or unethical activities, such as employing unregistered doctors and administering unregistered pharmaceutical products. Innocent frontline doctors might end up being held responsible for the unethical actions taken by the "HMOs".

### ***Regulatory options***

14. There are diverse views among the doctors/dentists' associations interviewed on how "HMOs" should be regulated. Some focus on restricting ownership of incorporated medical practices while others suggest introducing a registration regime for "HMOs", irrespective of their mode of existence. There is also a suggestion of introducing medical directors to be held accountable for the medical decisions in "HMOs".

15. Users in general understand that the professional standards of doctors are assured through the statutory regulatory regime with the Medical Council as the regulator. Users would welcome additional protection and assurance. Proposals floated by users include the introduction of a medical director in operation of these group medical practices or providers, issuing codes of practice for such entities and imposing mandatory indemnity insurance.

16. Large group practices and scheme administrators in general do not have strong views about the medical director concept, as many of them already have such a person in place to oversee medical affairs. Some stakeholders regard the suggestion of code of practice worth exploring, as it may facilitate the growth of primary healthcare industry but feel that assistance from the government would be needed in drawing up such a code.

## **The Administration's views**

17. The Administration's primary concern, as reflected in Legco papers no. CB(2)1026/05-06(05) and CB(2)1530/05-06(01), is to ensure the professional standards of medical services delivered. As reflected in the views expressed by users above, the evolution of group medical practices and scheme administrators has brought benefits to patients. Nonetheless, we note that there is scope for strengthening the present regime. This would facilitate the further development of the primary health care market and at the same time, provide better quality assurance to patients.

### ***Proposed measures***

18. We note the concerns expressed by some professional bodies that junior doctors might be misguided by their employers to act improperly. We see scope for enhancing, amongst medical students, education on medical ethics and medical legislation in Hong Kong. Newly qualified practitioners should also be reminded of the details of Medical Council's Professional Code and Conduct.

19. While it is perfectly legitimate to introduce measures such as case management arrangement, treatment protocol and monitoring revisit rates, and to instil some form of quality assurance in the provision of medical services, we see benefits in having a professionally qualified person to take responsibility for developing such measures which may interface with clinical judgment of frontline doctors. The suggestion of requiring the appointment of a medical director who would be held accountable for such matters should therefore be further pursued. A number of issues, including the detailed role of such medical directors, the need for registration, the appropriate regulator, and the delineation of responsibilities between medical directors, frontline doctors and owners of the medical practices also need to be studied.

20. Currently, with the exception of private hospitals and nursing homes, most private medical facilities (including medical clinics) are not subject to statutory regulation. The standard of medical services provided is however assured through regulation of medical practitioners.

In the longer term, we would need to consider whether such healthcare facilities should be subject to some form of statutory registration.

21. Members are invited to note and give their views on the Administration's proposed measures set out above.

Health, Welfare and Food Bureau  
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