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For Discussion
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Legislative Council Panel on Health Services

Private Patient Services at Public Hospitals and Fee Sharing Arrangements

Purpose

This paper briefs members on the private patient services provided at public hospitals and the fee sharing arrangements.

Background

Reasons for providing private services at public hospitals

2. The practice of providing private services at public hospitals can be traced back to the time of the former Medical and Health Department. The provision of such services was continued when the Hospital Authority (HA) was established in 1990. The main rationale for the provision of private services at public hospitals is due to the fact that there are levels of specialized expertise and facilities in the public medical sector (especially at the teaching hospitals), which are not generally available in the private sector. It is therefore considered appropriate to offer the public, some of whom might want to procure private services, a means for accessing these specialized services.

Private fees charging principles

3. The public healthcare and inpatient services in Hong Kong are provided to all eligible persons at a heavily subsidized rate of about 95% without any means testing. Because of the substantial amount of public funds used in maintaining the public healthcare service, we must ensure that the resources are being utilized in the most appropriate manner and are dedicated centrally to those in genuine need of such service. As such, our public healthcare sector should target its services at the following four areas –

(a) acute and emergency care;

(b) for low income and under-privileged groups;

(c) illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and

(d) training of health care professionals.

At the same time, public funds should not subsidize for those who wish to use private services at the public hospitals. It is therefore the policy that the HA should charge market rates for its private services, which should at least equal the full costs of providing such services. This charging policy ensures that the HA's private services would not interfere with the normal operation of the private market.

4. To instill flexibility and reflect more accurately variations in the complexity of the patients' clinical conditions and the special expertise that might be required in providing treatment, the fee charging rates were revised in 2005. Instead of a fixed rate charging mechanism, relevant HA hospitals and clinics are allowed to charge their private service consultations at appropriate levels within pre-set ranges as shown in the **Annex**, taking into account the complexity of the patient's case and the expertise required to provide the service.

Types of private services provided at public hospitals

5. There are two main types of private services at public hospitals: private specialist out-patient (SOP) services and private in-patient (IP) services.

6. In respect of HA's private SOP services, majority of the relevant activities are concentrated at the two teaching hospitals, namely the Queen Mary Hospital (QMH) and the Prince of Wales Hospital (PWH). Other non-teaching hospitals, for example the Queen Elizabeth Hospital (QEH), also provide some private SOP services, but on a much smaller scale. The number of private SOP attendance between 2003-04 and 2005-06 is set out in the table below.

Year / Hospital	2003-04	2004-05	2005-06
QMH and associated hospitals*	18 316	20 529	23 797
PWH and associated hospitals*	1 344	2 243	3 409
QEH	396	434	445
Other HA hospitals	-	269	623
Total (No. of private SOP attendance)	**20 056**	**23 475**	**28 274**

7. In 2005-06, there was a total of 6 018 338 SOP attendance at public hospitals, and private SOP attendance accounted for only 0.47% of that total. To ensure that public services would not be adversely affected by the provision of private SOP service, there are guidelines in place at public hospitals that restrict the time each doctor can devote to private services to one consultation session a week (i.e. 3 to 4 hours).

8. The majority of HA's private IP services are provided by the two teaching hospitals and the QEH, although private beds are available at 20 other public hospitals. The total number of private bed-days between 2003-04 and 2005-06 is set out in the table below.

Year / Hospital	2003-04	2004-05	2005-06
QMH and associated hospitals *	17 834	18 799	19 652
PWH and associated hospitals *	2 117	5 707	5 541
QEH	14 099	15 527	17 246
Other HA hospitals	1 265	1 825	2 620
Total (No. of private bed-days)	35 315	41 858	45 059

* Associated hospitals means other HA hospitals, where the teaching staff from the universities may provide private consultations.

9. In 2005-06, total bed-days utilized in public hospitals was 7 209 732 and private bed-days accounted for 0.62% of that total. To ensure that public services would not be adversely affected by private IP services, the

Government and the HA agreed that the total number of private beds in public hospitals should be limited to a maximum of 379 beds only.

Fee Sharing Arrangements

10. At the Panel meeting on 12 March 2007, Members requested the Administration to provide the following information regarding fee sharing arrangements –

(a) fee sharing arrangements between the HA and the two Universities with medical faculties for private patient services provided by the teaching staff from the two Universities concerned;

(b) fee sharing arrangements between the HA and the public hospitals for private patient services provided by non-teaching staff (i.e. HA staff performing private patient services); and

(c) income generated from private patient services in each public hospital providing such services for the past five years.

<u>Fee sharing arrangements between the HA and the two Universities with medical faculties for private patient services provided by the teaching staff from the two Universities concerned</u>

11. The HA and these two universities share the common mission to serve the community with a high standard of clinical service, and the vision that education and research enable the maintenance and advancement of such standard. Indeed, clinical services, teaching and research are in essence not separable and both institutions have been contributing resources in all three activities to varying extents.

12. Following the establishment of HA in 1990, financial arrangements of the HA and the universities were agreed, covering, amongst other things, private patient services. Accordingly, private patients are subject to different fees and charges for different services. These are published in the gazette and include –

(a) maintenance fee (for in-patient). The fee includes accommodation in private wards, general nursing services, catering, and domestic services;

(b) medication fee (for both in and out-patients);

(c) doctor fee (for in-patient);

(d) consultation fee (for out-patient); and

(e) itemized charges (for both in and out-patients, including diagnostic and therapeutic/operative procedures).

13. For maintenance and medication fees, because all the costs are borne by the HA, there is no refund to the universities after collection of the fees by HA. For income earned from doctor fee, consultation fee, and itemized charges, it is shared between the relevant clusters of the HA and the universities according to agreements as summarized in the table below.

Department	**University's share (%)**	
	Inpatient	**Outpatient**
Anaesthesia (Note 1)	75	75
Clinical Oncology (Note 2)	25/75	25/75
Diagnostic Radiology (Note 3)	25/75	25/75
Medicine	75	75
Obstetrics and Gynaecology	75	75
Ophthalmology	75	75
Orthopaedics and Traumatology	75	75
Paediatrics	75	75
Pathology	75	25
Psychiatry	75	75
Surgery	75	75

Notes

1. Includes Intensive Care Unit fees for CUHK.
2. 25% refund is applicable to Clinical Oncology services except for Chemotherapy services which is refunded at 75%.
3. The sharing percentage for services related to the CUHK's Ultrasound and MRI is at 75%.

Fee sharing arrangements between the HA and the public hospitals for private patient services provided by non-teaching staff (i.e. HA staff performing private patient services)

14. The HA's core business is to provide public hospital services for the general public, though very limited amount of private patient service are also provided (see percentage figures in paragraphs 7 and 9 above). Apart from the teaching staff from the two Universities with medical faculties who will be providing private patient services, some HA medical staff will also provide limited private service at patients' choice. There is no fee sharing arrangements between the HA and the public hospitals for private patient services provided by the non-teaching staff. The private fees income received is recorded together with public fee income and both types of fee income are counted towards income received by the HA.

Income generated from private patient services in public hospitals providing such services for the past five years

15. Income generated from private patient services in public hospitals providing such services for years 2002-03 to 2006-07 (first 11 months) is summarized in the table below.

Cluster / Year	Income received by HA (in $ million)				
	HKWC/ HKU@	**NTEC/ CUHK**	**KCC#**	**Others**	**Total**
2002/03	67.8	22.7	15.9	4.1	110.4
2003/04	80.2	4.5	8.4	1.4	94.5
2004/05	106.8	13.1	9.2	2.5	131.6
2005/06	116.2	20.3	16.8	2.0	155.3
2006/07 (11 months)	120.9	35.5	15.5	3.6	175.5
Total	**491.9**	**96.1**	**65.8**	**13.6**	**667.3**

@ Includes Ophthalmology services in Hong Kong West Cluster (HKWC) provided by CUHK professors.

Includes Ophthalmology services provided in Hong Kong Eye Hospital by CUHK professors under the same fee sharing arrangement.

Fee Collection and Monitoring Mechanism

16. While private patient fees received by the HA in 2005-06 represents only 9.9% of its total medical fee income, the amount of this income has increased over the past few years (paragraph 15 refers). Since private patient service involves at least three parties and that income to be receivable by the HA represents public money, we agree that it is important for the HA to have a system in place to ensure that all such fees are properly recorded, charged and audited.

17. At present, all patient fees are collected by the HA and are captured by its Patient Billing and Revenue Collection (PBRC) system which is capable of calculating, recording and managing the different fee levels in accordance with the published rates. For private patient billing charges, there is another feeder system which interfaces with the PBRC. Once a bill is issued, the PBRC system also tracks the settlement, which follows the standard overall financial regulations and operational guidelines of the HA. At the end of each month, a detailed "Refund Statement" for professorial fee refund is sent to each of the department heads of Faculties of Medicine of the universities concerned. The report provides details of each transaction by inpatient and outpatient services.

18. The PBRC system, which is the core billing system of the HA, forms part of the HA Financial and Accounting Regulatory Framework which provides the overarching governance and reporting hierarchy for all HA financial operations, including revenue recording, accounting and the control environment necessary to ensure completeness and timely recording of activities. The HA's financial system is subject to constant reviews and updating and is annually audited by the HA's External Auditors for the purpose of expressing opinion on the Annual Account of the HA.

Advice Sought

19. Members are invited to note the content of this paper.

Health, Welfare and Food Bureau
Hospital Authority
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Annex

Private Service Consultation
Gazetted Fees

	Charges ($)
Inpatient consultation per visit per specialty	550 – 2,250
Outpatient charges • First consultation per visit	550 – 1,750
• Subsequent follow up consultation	450 – 1,150

Note

In adopting the pre-set ranges for private service consultation fees, the HA divides the level of expertise required into two levels, namely the Associate Professor/Specialist level and the Professor/Consultant level, with each expertise level commanding a sub-range of fees. The actual amount of the consultation fee would make reference to the complexity of individual cases. Take the range of fees for SOP consultation as an example. The lower limit of the range at $550 would be for the treatment of a relatively simple case taking reference to the time cost of a 20-minute consultation by an Associate Professor/Specialist, whereas the upper limit of the range at $1,750 would be for the treatment of a complex case taking reference to the time cost of a 45-minute consultation by a Professor/Consultant. In this way, the fee structure is able to take much more appropriate account of the resources used (both in terms of expertise and clinical complexity) for the provision of private consultation service.