For discussion **FCR(2015-16)39**
on 4 December 2015

ITEM FOR FINANCE COMMITTEE

HEAD 140 – GOVERNMENT SECRETARIAT :
FOOD AND HEALTH BUREAU (HEALTH BRANCH)
Subhead 700 – General non-recurrent
New Item "$10 Billion Endowment Fund to the Hospital Authority for Public-Private Partnership Initiatives"

Members are invited to approve a new commitment of $10 billion for the Hospital Authority to establish an endowment fund for Public-Private Partnership Initiatives.

PROBLEM

As announced in the 2015-16 Budget, we see the need for the Hospital Authority (HA) to set up an endowment fund and make use of its investment returns for public-private partnership (PPP) initiatives so as to alleviate pressure on the public healthcare system.

PROPOSAL

2. The Secretary for Food and Health proposes to allocate to HA $10 billion for setting up an endowment fund (the HA PPP Fund) to generate investment returns for regularising and enhancing clinical PPP programmes being undertaken on a pilot basis, as well as developing new clinical PPP initiatives in future.

JUSTIFICATION

3. Promotion of PPP is one of the proposals put forward in the Healthcare Reform Consultation Document "Your Health, Your Life" conducted

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in 2008. It offers greater choice of clinical services; provides more convenience to the ageing patient population so that they can have access to medical care within their neighbourhood without having to travel long distance to hospitals or consultation; promotes continuity of care so that the patient can be followed up by the same doctor as far as possible; facilitates collaboration among healthcare providers; makes better use of resources in both the public and private healthcare sectors and facilitates cross-fertilization of expertise and experience. More importantly, pursuance of PPP can help build a common platform between the public and private healthcare sectors involving medical specialists, general practitioners and other disciplines of healthcare professionals, thereby facilitating the provision of integrated medical care for patients in a comprehensive and holistic manner. Furthermore, the platform could also network with social welfare, education and other non-medical sectors for enhancing support to patients. Through the PPP programmes, relevant infrastructure will be built to ensure functioning and continual development of the platform.

4. Another direction in the healthcare reforms is to enhance primary care. Primary care is the first contact point in the healthcare system. It provides not only episodic illness care, but also comprehensive, continuing, co-ordinated and person-centred healthcare in the context of family and community. Whilst facing an uprising prevalence of chronic diseases, patients with chronic diseases are now heavily relying on public healthcare services under the current system. On the other hand, about 70% of the outpatient consultations are provided by the private sector and the remaining some 30% by the public sector. Through PPP, there is a high potential to tap on the available capacity and capability of the private sector in managing more patients with chronic diseases. This will facilitate better disease prevention, early detection of health issues, timely intervention and personalized care, which would lead to better health maintenance and thus ultimately help achieve healthy ageing in the community.

5. Primary care stresses the establishment of long-term continuous relationship between a patient and his/her family doctor. The family doctor concept allows a much more direct and continuous relationship with individual patients, as family doctors may provide better continued, integrated and holistic care through the access of lifelong health records of individual patients thereby facilitating referral and follow-up of cases between different levels of care. Family doctors are also better positioned to carry out preventive care through enhanced public health education, promotion and protection of well-being as well as to improve patients' quality of life through holistic care. Currently, "doctor-shopping" is a fairly common practice whereby patients tend to seek medical care on the same health problem from multiple doctors in parallel. A lot of patients are also simultaneously consulting both the private and public sectors. Such behaviors are not conducive to

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the continuity of patient care. PPP can encourage patients to build a long-term patient-doctor relationship with one family doctor taking care of the patient's chronic, acute and other health problems, hence actualising the family doctor concept.

6. Currently, there is a significant public-private imbalance in our healthcare system. With very limited choice for patients and inadequate collaboration among healthcare providers in the public and private sectors, service utilisation for secondary and tertiary healthcare services is heavily skewed towards the highly subsidised public sector. This renders the current healthcare system unhealthy and unlikely to be sustainable in the long run. PPP seeks to enable a portion of patients, currently relying mainly on the public sector, to have better means to access private healthcare services and choose between public and private healthcare services. This will help reduce the over-reliance on public healthcare services and redress the current significant public-private imbalance. In addition, by channeling some prevailing patient load and pressing service demand to the private sector, it allows the public sector to free up certain capacity of secondary and tertiary healthcare services so that they will be more focused on priority areas. These include acute and emergency care, services for those with a greater need for public healthcare services particularly the low income group and the underprivileged, illnesses that entail high costs, advanced technology and multidisciplinary professional teamwork in their treatment; as well as training of healthcare professionals.

7. A large proportion of chronic disease patients, especially the elderly, are currently under the care of the public healthcare system. The General Outpatient Clinic Public-Private Partnership Programme (GOPC PPP), which was launched on a pilot basis in mid-2014, helps promote further exchange of clinical knowledge and experience between the public and private sectors in chronic disease management. It also helps promote the family doctor concept and continuity of care in the community.

8. In line with the Government's healthcare reform proposals, HA has launched a variety of clinical PPP initiatives on a pilot basis since 2008 with designated one-off funding from Government, including the Cataract Surgeries Programme (CSP) (2008), Tin Shui Wai Primary Care Partnership Project (TSW PPP) (2008), Haemodialysis Public Private Partnership Programme (HD PPP) (2010), Patient Empowerment Programme (PEP) (2010), Pilot Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector (Radi Collaboration) (2012), and GOPC PPP (2014). Given the

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demand and positive feedback for the HD PPP and PEP, the two programmes have become recurrent programmes since 2012-13 and have since been funded by HA's recurrent funding. In 2015-16, the estimated expenditure of the above mentioned programmes is around $140 million.

9. Implementation of such clinical pilot PPP programmes has generally been smooth. A brief introduction and a snapshot of the current scope of individual programmes are at Enclosure 1. The implementation progress as at March 2015 of these programmes is at Enclosure 2.

Encl. 1
Encl. 2

INITIAL PROPOSAL ON THE USE OF HA PPP FUND

10. Having regard to responses from the community, patients and healthcare professionals with these piloting clinical PPP programmes, HA has drawn up initial plans to make use of the investment returns from the HA PPP Fund for regularising and enhancing PPP initiatives undertaken on a pilot basis, as well as developing new clinical PPP initiatives in future. Details are set out in the ensuing paragraphs.

Existing Programmes and Expansion

(a) Expansion of GOPC PPP

11. The GOPC PPP was launched by HA in mid-2014 in three pilot districts namely Kwun Tong, Wong Tai Sin and Tuen Mun, targeting at patients with hypertension (HT) with or without hyperlipidaemia, and later diabetes mellitus (DM). The initial support and response from private doctors has been positive. As at end October 2015, 91 private doctors have enrolled in the GOPC PPP. The enrolment process is on-going and interested private doctors in these three districts are welcomed to join at any time. The number of participating private doctors which are broken down by districts is detailed at Enclosure 3.

Encl. 3

12. The first batch of patient invitations was issued in July 2014, with subsequent batches sent out every three to six weeks. To facilitate patients' understanding of the Programme details and boost enrolment, district patient fora are arranged following the issuance of each batch of patient invitations. The initial response is positive. As at end-October 2015, 6 028 patients have been successfully enrolled under the Programme. More details are set out at Enclosure 3**.**

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13. Apart from providing some relief to HA's general outpatient services by sharing the heavy service burden and tapping resources in the private sector, the GOPC PPP is considered a significant tool to help build a robust primary care system, drive the practice of family doctor concept and promote chronic disease management in the community with greater participation from private doctors.

14. HA will continue to monitor closely the implementation of the GOPC PPP. It is also undertaking an interim review to look into the key implementation issues and operating experiences, focusing on the Programme's scope, operations, and support. With the investment returns from the HA PPP Fund, HA intends to regularise and extend the Programme to the remaining 15 districts of Hong Kong in three years, starting from 2016-17. As a start, the target number of patients for each district will be maintained at around 2 000. Having regard to the responses from private doctors and patients as well as results from the interim review, HA may consider expanding the scope of chronic diseases and number of patients benefitting under the Programme where appropriate. After the Programme is extended to all districts, HA will explore room for further collaboration with private doctors in chronic disease management and those primary care initiatives now under Department of Health (e.g. the primary care reference framework promulgated by the Primary Care Office and promoting wider use of the Primary Care Directory).

(b) Other Existing Programmes

15. With the investment income from the HA PPP Fund, HA will continue to implement and enhance the other current clinical PPP programmes to meet increasing demand. With ageing population, it is anticipated that the Radi Collaboration Programme will have an annual 2.5% growth in the number of radiological scans per year while the HD PPP Programme will be providing additional dialysis of 16 patients in 2016-17 and 21 patients per year from 2017-18 onwards. For both programmes, there is a need to strengthen the internal service capacity of HA, so as to meet the service demand for patients who are not suitable for joining PPP programmes or opt not to join such programmes.

New Initiatives and Development

(c) Provision of infirmary service through PPP

16. In line with the Government's policy direction and the benefits of developing a social infirmary service in the longer term, HA has been exploring collaboration with non-governmental organisations (NGOs) to enhance the choices

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of infirmary care services for patients on the Central Infirmary Waiting List managed by HA. An Infirmary Service PPP Programme is about to be implemented on a pilot basis, through contracting with an NGO to operate infirmary services at the Wong Chuk Hang Hospital with a maximum capacity of 64 beds for three years and possible extension by two years subject to evaluation. The service is expected to commence in the second half of 2016.

(d) Colonoscopy PPP Programme

17. Dovetailing with the Government's Colorectal Cancer Screening Pilot Programme, a Colonoscopy PPP Programme will be launched by HA whereby patients are referred to the private sector for additional services not covered by the Pilot Programme including colonoscopy assessment and corresponding clinical management. Histopathology and CT colonography service for such referred patients will also be procured when needed.

18. The investment income from the HA PPP Fund will enable HA to continue to explore new PPP initiatives to meet the emerging healthcare needs of the public and redress the imbalance between public and private healthcare services. For instance, in response to the rising occurrence and popularity of certain chronic diseases such as common mental disorder and dementia, HA is exploring the possibility of referring suitable and stable patients to the private sector for continual medical follow-ups to help reduce waiting time for HA's Special Outpatient Departments.

19. Continual engagement of all relevant stakeholders is a key building block for a successful and sustainable clinical PPP programme. While exploring and developing new clinical PPP initiatives, there will be extensive consultations with all relevant stakeholders including the Legislative Council (LegCo) and District Councils, patients and patient groups, community partners and healthcare providers in both private and public sectors. These would help obtain valuable feedback and promote public acceptance of such clinical PPP initiatives.

(e) Risk Assessment and Management

20. In light of the anticipated increase in scale, scope and complexity of both the existing and developing clinical PPP programmes, as well as the escalating public and patient expectations, we consider it necessary to establish a proper framework to manage and control the associated risks arising from these clinical

PPP programmes. Such framework will help address the potential risks in clinical service quality, service operations, information technology, data privacy, etc. To safeguard the use of public money against these risks while ensuring the smooth operation of the PPP programmes, HA is planning to conduct a risk assessment consultancy study to develop a structured PPP risk management framework with necessary internal controls to facilitate the identification and prioritization of potential risks as well as formulation of necessary risk mitigation strategy and measures.

(f) Technology and IT Infrastructure for PPP

21. Since the first roll-out of clinical PPP programmes in 2008, private sector healthcare providers in these programmes have used, and modified where necessary, the Public-Private Interface – Electronic Patient Record Sharing Pilot Project (PPI-ePR) platform to access as well as to share key clinical data of patients across sectors. The technical systems of PPI-ePR and existing clinical PPP programmes were migrated to the eHR Sharing System (eHRSS) platform in November 2014. This new eHRSS platform now serves as the common infrastructure for the PPI-ePR, clinical PPP programmes as well as the future eHRSS, to be launched in the first quarter of 2016. This will facilitate more efficient integration of PPP data with the eHRSS and the eHRSS platform will provide easy access to eHRSS and different clinical PPP programmes in a secure manner. This will be a powerful motivating force for private medical professionals to participate in the future eHRSS.

(g) Governance

22. In line with the governance framework of the Samaritan Fund, an HA PPP Fund Management Committee (the Committee) co-chaired by the Chief Executive/HA and Food and Health Bureau (FHB)'s representative will be set up to oversee the use of investment returns for the HA PPP Fund to fund PPP initiatives under HA. HA will provide regular reports on the use of the PPP Fund and outcome of the PPP initiatives for monitoring by FHB. We will also brief the Panel on Health Services regularly on the progress of these PPP initiatives, including development of new initiatives to meet community demands. Annual audited financial statements on the PPP Fund will be prepared and tabled, together with the auditor's report, to the LegCo annually.

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FINANCIAL IMPLICATIONS

Projected Expenditure of PPP Initiatives

23. With reference to HA's PPP programmes at Enclosure 2**,** the estimated expenditure for 2015-16 is $140 million. With the continual and expanding operation of these existing PPP initiatives as well as development of new initiatives, the annual total expenditure is estimated to reach around $240 million in 2016-17 and $420 million by 2020-21. For reference, a preliminary breakdown of the estimated expenditure is as follows –

	2015-16 Estimated Annual Expenditure (in $ million)	2016-17 Estimated Annual Expenditure[Note] (in $ million)	2020-21 Estimated Annual Expenditure[Note] (in $ million)
GOPC PPP and its expansion	28	58	186
Other Existing PPP Programmes and enhancements	109	123	166
New Initiatives and Development	-	43	53
Technology and Administration	3	15	13
Total:	140	239	418

Proposed Financial Arrangement

24. To support the development of different pilot clinical PPP initiatives, Government has been allocating to HA various one-off designated funding during the past few years. Out of the estimated expenditure of $140 million for PPP programmes in 2015-16, $47.8 million comes from HA's recurrent funding (for two of the prevailing initiatives, namely the PEP and HD PPP programmes), while the rest is from Government's one-off designated funding to HA in earlier years. The remaining balance of the designated funding by the end of 2015-16 is estimated at around $400 million.

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[Note] The estimated annual expenditure is based on projected activity and cost estimates derived from assumptions on patient participation rates, contractual price changes and inflation rates. The actual expenditure may fluctuate subject to variations in market conditions and other relevant factors different to the assumptions used in the above estimates.

25. To finance the continued operation of existing PPP proprammes as well as the development of new initiatives, a steady stream of recurrent funding would be required. With the HA PPP Fund of $10 billion, HA could make use of the investment returns together with the remaining balance of the one-off designated funding to support the on-going operation of these PPP programmes commencing from 2016-17. As no investment income is expected to be available from the HA PPP Fund for use in 2016-17, HA would continue to make use of the remaining one-off designated funding for PPP programmes as a bridging measure. Any residual balance of this designated funding will subsequently be subsumed into the investment returns of the Fund to be overseen by the Committee (see paragraph 22) upon its establishment.

Proposed Placement of the HA PPP Fund with the Exchange Fund

26. With reference to the existing placements with the Exchange Fund for the Samaritan Fund and the one-off grant for the HA's minor works projects, the $10 billion endowment fund (the Placement) would be placed with the Exchange Fund. The actual investment return on the Placement each year will be tied to the average performance of the Investment Portfolio of the Exchange Fund over the past six years and can fluctuate from year to year depending on the investment environment and other relevant factors. For the purpose of financial planning, it is assumed that the annual rate of return on the Placement is 4.3% (with reference to the estimated investment return for fiscal reserves on the placement with the Exchange Fund as adopted in the Medium Range Forecast of the 2015-16 Budget). Based on this assumption, the funding available from the Placement to support the PPP programmes is estimated to be around $430 million per annum.

27. Subject to the approval of FC on the non-recurrent commitment of $10 billion for the HA PPP Fund, HA will finalise the Placement arrangement with the Hong Kong Monetary Authority accordingly. The Committee (mentioned in paragraph 22) will review the financial position of the HA PPP Fund periodically. Although the general principle is that the operation of the HA PPP Fund will be funded by investment returns, the seed capital may also be used in response to special needs that may arise, taking into account the cash flow requirements of the PPP initiatives, the overall financial situation of the HA PPP Fund and the need to ensure prudent management of public funds.

Re-deployment of Recurrent Resources

28. As HA has been facing pressing demand in many clinical service areas, PPP has helped ease out such service demand by tapping into the expertise and capacity of service providers outside of HA. At the same time, the continuous build-up of HA's internal capacity remains necessary for enhancing

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service accessibility for patients. Amongst the PPP initiatives mentioned in paragraphs 11 to 18, the PEP and HD PPP programmes are particularly targeted to support patients with chronic illnesses such as DM, HT and renal disease, while the Radi Collaboration Programme helps with addressing demand on radiological investigations. Like other PPP initiatives, these three programmes bolster public-private sector provision of services whilst providing more choice for HA patients. They clearly come within the intended remit of the HA PPP Fund.

29. To spare resources for HA to build up its internal capacity, we intend to include the PEP and HD PPP programmes currently funded mainly by HA's recurrent resources of $47.8 million (mentioned in paragraph 24) into the scope of $10 billion endowment fund. Following this consolidation of PPP programmes within the HA's PPP Fund, HA plans to re-deploy these baseline resources so released to further build up its recurrent service capacity of the same high-demand service areas relating to these two Programmes as well as the Radi Collaboration Programme. Specifically, HA plans to deploy $18.3 million in 2016-17 to enhancing the capacity of haemodialysis and peritoneal dialysis units of HA in treating additional number of patients to cope with the increasing demand of end-stage renal disease. HA is also planning to re-deploy $28.9 million to increase the patient quota on primary care services in General Outpatient Department and Family Medicine Services. The remaining amount will be re-deployed to contribute towards increasing the number of radiology scans provided to patients at HA. Such reinforcement of HA's recurrent internal capacity dovetails with the original service focus of the said three PPPs, and will continue to complement them in enhancing the overall service access and provision for chronic and primary care patients.

PUBLIC CONSULTATION

30. On 16 November 2015, we consulted the LegCo Panel on Health Services on the subject and Members supported the submission of the proposal to the Finance Committee of the LegCo for approval.

BACKGROUND

31. Over the years, Hong Kong has developed a high-quality and highly efficient healthcare system for the public with impressive health standards achieved. Yet, with an ageing population, epidemiological shift to chronic diseases and the need to keep pace with medical technology advancement, Hong Kong's healthcare system is facing pressing challenges, calling for development of new concepts and new service delivery models to ensure its long-term sustainability.

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32. In 2008, in the Consultation Document on Healthcare Reform "Your Health, Your Life", we took a critical look at how to channel the available resources into the system to achieve the best results for all and to enable the healthcare system to continue to meet the healthcare needs of the community. Taking into consideration the service structure, the following healthcare reform proposals were put forth, including –

(a) Enhance primary care;

(b) Promote public-private partnership in healthcare;

(c) Develop electronic health record sharing;

(d) Strengthen public healthcare safety net; and

(e) Reform healthcare financing arrangements.

33. With broad support received from the community, we have been taking active steps since then to actualise the proposed changes for addressing the foreseen challenges and achieving a more sustainable healthcare system that makes our community healthier.

34. In his 2015 Policy Address, the Chief Executive pledged to extend the GOPC PPP to 18 districts in phases. The Financial Secretary then pledged in the 2015-16 Budget to set up a fund ($10 billion) for the HA to make use of investment return for the HA's PPP initiatives including the GOPC PPP with an aim to alleviate pressure on the public healthcare system due to manpower shortages and surge in demand and provide better quality of care for the patients.

Food and Health Bureau
Hospital Authority
November 2015

Programme Brief on Public-Private Partnership Programmes

Cataract Surgeries Programme (CSP)

Commenced in February 2008, the Programme aimed to address the service demand and improve access of HA patients to cataract surgeries through a PPP delivery model. Patients on the HA clusters' routine cataract surgery waiting lists for a specified period are invited to undertake surgeries in the private sector on a voluntary basis with a fixed government subsidy of $5,000 subject to a co-payment of no more than $8,000 for each cataract surgery. Charity quotas are offered to those patients with limited economic means such as recipients of Comprehensive Social Security Assistance (CSSA) and patients granted with medical fee waiver.

Tin Shui Wai Primary Care Partnership Project (TSW PPP)

2. The Programme is a pilot PPP model for the delivery of primary care service and promoting the family doctor concept in the community. First piloted in Tin Shui Wai (TSW) North as the Tin Shui Wai Primary Care Partnership Project (TSW PPP) in June 2008, the Programme purchased primary care service from private medical practitioners and was extended to the whole TSW district since June 2010. The TSW PPP primarily targets at clinically stable patients suffering from specific chronic diseases such as diabetes and/ or hypertension who need long-term follow up management at the General Outpatient Clinics (GOPC). The patients are invited to join the TSW PPP voluntarily, paying the same fee as for the HA GOPC service.

Haemodialysis Public-Private Partnership Programme (HD PPP)

3. Clinically suitable end stage renal disease patients, as assessed by Nephrologists of the HA, are invited to join the Programme voluntarily. Recruited patients may receive HD treatment in one of the partner community HD centres of their choice. The HD services are procured from six qualified community HD centres. HA renal units continue to provide regular clinic follow-up, drug prescriptions and investigations. A two-way communication system was developed such that community HD providers could access the clinical information of participants while the community HD treatment records were made available to clinicians of HA taking care of the patients.

/***Patient*** *…..*

Patient Empowerment Programme (PEP)

4. A chronic disease patient empowerment course is consisted of two components, namely a disease-specific knowledge enhancement part and a generic self-enablement part. The former was designed by the HA specialists while the latter was designed by the selected non-governmental organisations (NGOs) partner of the Programme. Suitable primary care chronic disease patients, mainly suffering from diabetes and hypertension, are referred by the HA to attend empowerment sessions in the community. The empowerment sessions are procured from three NGOs in the community covering all seven clusters. A two-way communication system was developed such that partner NGOs could access the clinical information of participants as needed while the progress and outcomes of the empowerment course were made available to HA clinicians taking care of the patients.

Pilot Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector (Radi Collaboration)

5. This Pilot Project aims at exploring a new operation model to cope with the increasing demand for cancer radiological investigation services through purchase of Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) services from the private sector. Subject to clinical eligibility screening, patients from selected cancer groups that are in need of CT/MRI examinations for sequential clinical management can be invited to join the Pilot Project. The Pilot Project, initially providing services to selected patients with colorectal cancer, breast cancer, nasopharyngeal cancer and lymphoma and, was extended from May 2014 onwards to cover selected patients suffering from prostate cancer, stomach cancer, cervix cancer, corpus uteri cancer, head and neck cancer, sarcoma and germ cell tumor.

6. Invited patients can take part in the Pilot Project on a voluntary basis under full subsidy and can choose their own service provider from HA's panel of contractors engaged through open tender. Patients' health information under the HA is, with consent, shared with private service providers through the Public Private Interface-Electronic Patient Record Sharing System (PPI-ePR) and investigation results are returned to the HA through the Radiological Image Sharing System.

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7. The Pilot Project was launched in May 2012 covering the Hong Kong East Cluster, Kowloon East Cluster, Kowloon West Cluster and New Territories West Cluster and was extended to the Hong Kong West Cluster, Kowloon Central Cluster and New Territories East Cluster from September 2012 onwards. Generally speaking, the results of investigations are returned to HA in electronic form within five working days after the day of service booking.

General Outpatient Clinic Public-Private Partnership Programme (GOPC PPP)

8. The Programme aims to help HA manage demand for general outpatient service, enhance patient access to primary care services, provide choice to patients for receiving primary care services from the private sector, promote family doctor concept, and foster the development of the territory-wide electronic health record.

9. The Programme was launched in Kwun Tong, Wong Tai Sin and Tuen Mun districts in mid-2014 on a pilot basis targeted to enroll about 6 000 patients initially. Clinically stable patients having hypertension with or without hyperlipidemia, and later diabetes mellitus patients, currently taken care of by HA GOPC were invited for voluntary participation. All private doctors practising in these three districts were welcomed to participate in this Programme.

10. Each participating patient will receive up to ten subsidised visits per year, including medical consultations covering both chronic and acute care; drugs for treating their chronic conditions and episodic illnesses to be received directly from private doctors at their clinics; and investigation services provided by HA as specified through private doctors' referral.

11. Under the Programme, participating patients only need to pay the HA GOPC fee of $45 (as per Gazette) for each consultation. Those who are recipients of CSSA or holders of valid full or partial medical fee waiver certificates will enjoy the same fee waiver arrangements as for HA's services. Under mutual agreement, individual patients may receive further services and treatment at their own expenses. Those who are aged 70 or above and have participated in the Elderly Health Care Voucher Scheme can meet such additional charges from their Health Care Voucher accounts.

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12. For service provision, participating private doctors may receive a maximum total payment of $2,872 per year (on a reimbursement basis), covering a maximum of ten consultations, including the HA GOPC fee of $45 to be paid by the patients to the private doctors direct after each consultation. For CSSA recipients and waiver patients, HA will bear the GOPC fee.

13. HA has commenced an interim review to look into the key implementation issues and operating experiences, focusing on the Programme's scope, operations, and support. It is anticipated that, by end-2015, HA will map out an initial roll-out plan for extending the GOPC PPP Programme, including the scope of chronic diseases, number of patients, and implementation timeframe for individual districts.

Enclosure 2 to FCR(2015-16)39

Cumulative Progress of HA Clinical PPP Programmes since Launch

Programmes	Provisions up to 2014-15	Progress as of 31 March 2015	Projected Progress in 2016-17	Projected Progress in 2020-21
General Outpatient Clinic Public-Private Partnership Programme* (N1)	3 000 #@	3 647 @	10 000	35 000
Other Existing Programmes				
Tin Shui Wai Primary Care Partnership Project (N1)	1 500	1 618	1 618	*Expected to be migrated to GOPC PPP as part of its programme extension to other districts*
Haemodialysis Public-Private Partnership Programme (N2)	188	188 ^	204	288
Cataract Surgeries Programme (N3)	15 400	15 599	17 699	20 099
Patient Empowerment Programme (N1)	64 200	84 031	112 031	168 031
Pilot Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector (N4)	15 500	19 541	40 721	100 210

* Patient invitation starting July 2014
# Full year provisions
@ Programme implemented in Wong Tai Sin, Kwun Tong and Tuen Mun Districts only
^ Cumulatively benefiting 292 patients
N1: Cumulative number of patients
N2: Cumulative capacity
N3: Cumulative number of surgeries
N4: Cumulative number of scans

Enclosure 3 to FCR(2015-16)39

Progress of the
General Outpatient Clinic Public-Private Partnership Programme
(as at end-October 2015)

1. Private Doctor Enrolment

	Participating Doctors
Kwun Tong	37
Wong Tai Sin	20
Tuen Mun	34
Total:	91

2. Patient Enrolment

	Ever Enrolled Patients since Programme Launch	Participating Patients
Kwun Tong	2 367	2 149
Wong Tai Sin	1 514	1 435
Tuen Mun	2 147	2 029
Total:	6 028	5 613
