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Long Term Health Care Policy

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EXECUTIVE SUMMARY

1. The objective of this research is to outline the current health care policy, the policy formulation process and its implementation. The research aims at identifying factors which may affect the long-term development of health care services.

2. The Government published its first policy paper on medical services in 1964 and the second one in 1974. Since then, there has been no comprehensive review or update of the policy objective. The government is expected to complete its first comprehensive review on this subject in 1998.

3. The Government's health care objective is to safeguard and promote general public health and to ensure the provision of medical and health services for the people of Hong Kong such that no one should be prevented through lack of means from obtaining adequate medical treatment. The Government also provides a safety net for the needy who cannot afford even the subsidized rate.

4. The Health and Welfare Bureau (HWB) is responsible for formulating health care policy. The policy executors are Department of Health (DH) and Hospital Authority (HA). Other departments related to public health are Environmental Protection Department (EPD), Urban Services and Regional Services Departments. The supply of private health care services is determined by market forces.

5. Public expenditure on health care has increased by almost six times in the past 10 years to HK$25,051 million in 1996/97. HA has the larger share, amounting to over 90% of total recurrent expenditure of HA and DH.

6. A survey in 1996 showed that when Hong Kong people needed out-patient service, about 66% would consult private practitioners. The elderly and lower-income people (approx. 21% of total population) would consult public doctors. About 11% of population would seek treatment from traditional Chinese medicine practitioners (TCMPs).

7. About 90% of hospital care is delivered through public hospitals. Patients pay HK$68 for an acute bed in 1997 which covers less than 2% of the cost of services. However, fees and charges in private hospitals which look after the remaining 10% of the population are much higher.

8. Over one million of the population are covered by group or individual medical insurance.

9. The Government provides dental services to less than 10% of the population, most of whom are school children and civil servants.

10. The major factors which may affect the long-term development of the health care system are: a) a comprehensive review or update of the policy objective to catch up with the needs of a changing society, b) Lack of an integrated health care system to provide continual health care services, c) Increase in demand for health care services, d) Increasing expenses and cost on services, e) Shortage of medical staff to support health care services, f) Fragmented policy planning and implementation among government departments, medical insurers and other constituency groups.

LONG TERM HEALTH CARE POLICY

PART 1 - INTRODUCTION

1. Background

1.1 As the review on Health Care System conducted by the Government is expected to be completed by 1998, members of the Provisional Legislative Council (PLC) Panel on Health Services have requested the Research and Library Services Division (RLS) of the PLC Secretariat to conduct a research on the current health care system so as to facilitate their future discussions.

2. Objective and Scope

2.1 This report is the first in a series of RLS researches on the health care system. The objective of this research is to outline the policy, the policy formulation process and the implementation of the current health care policy. In particular, the study will try to identify any existing problems and factors which may affect further development of the provision of health care services in Hong Kong. Since the provision of health care services directly relates to demand and requires allocation of resources, this paper should be read in conjunction with two subsequent RLS reports on "Health Care Financing" and "Health Care Service for the Elderly" for a comprehensive review of the subject.

2.2 The scope of this study covers mainly the public health care provider, since it is the major provider of health care services. The time frame used for trend analysis is ten years. This also provides us with a base to scrutinize government proposals for development in the next ten years. We have chosen "ten years" as the measurement of "long-term" as Hong Kong is a rapidly changing society and is consistent with Hong Kong Government practice, viz. "Long Term Housing Strategy 1996-2006". Overseas comparisons will be made in our subsequent report on "Health Care Financing".

2.3 This paper is divided into six parts. Part 1 is the introduction. Part 2 describes the structure of the health care system in Hong Kong. Part 3 depicts the health care delivery process as a system, in terms of both input and output. Part 4 describes the provision of dental services. Part 5 analyses existing problems and other key factors which may affect the further development of the health care system. Part 6 is the concluding summary.

3. Methodology

3.1 To obtain information for analysis, the researchers studied relevant materials such as government information papers, research reports of various institutions, Hong Kong Hansard and Legislative Council (LegCo) Briefs. Briefing was provided to the RLS by Health and Welfare Bureau (HWB) and the Hospital Authority (HA). Related academics and medical professionals such as the chief executive and medical consultants of a few hospitals were interviewed. Letters and faxes were also sent to relevant groups such as The Hong Kong Federation of Insurers, Medical Council of Hong Kong, The Hong Kong Medical Association, The Estate Doctors Association, Census and Statistics Department (C&SD), Immigration Department, Security Bureau and follow up telephone calls were made to obtain the necessary information and statistics from all concerned parties.

3.2 This research paper is based on the information obtained from these sources.

PART 2 - HEALTH CARE POLICY IN HONG KONG

4. Development of the Health Care System

4.1 Government medical service was first introduced to Hong Kong in 1843 and the first Government Civil Hospital was established in 1850 but was destroyed in a typhoon in 1874. At that time, the service was mainly restricted to garrison and European residents whilst the majority of the local residents relied on medical services provided by traditional Chinese medicine practitioners (TCMPs). It was only in 1964 that the government published the first White Paper on medical services.

4.2 The second White Paper was published in 1974 which outlined a ten-year health care policy for the territory. The policy objective was, amongst others, "to ......ensure the provision of medical and personal health facilities for the people......including particularly that large section of the community which relies on subsidized medical attention." Since then, there has been no change in the policy objective, nor any fundamental review of this objective.

4.3 Rather, a series of separate reviews was conducted: first, the system of provision of hospital care was overhauled through the establishment of the Provisional Hospital Authority in 1988 and the incorporation of the HA in 1990. Secondly, a Working Party on Primary Health Care was set up in 1989 to review the provision of primary health care services, which resulted in the pilot launching of a district health system (DHS). Thirdly, a review which touched on health care financing was conducted in 1993 but it did not receive total support from the community. A point to note is that all these reviews upheld, and did not question or try to refine, the policy objective set in 1974, that "no one should be denied adequate medical treatment through lack of means."

4.4 In 1996 the government started to conduct a review of the health care system "to develop a health care policy and system that can cater for Hong Kong's needs in the coming decades". This exercise is expected to be completed by 1998. Appendix I summarizes the development of the health care system and the evolution of health care policy in Hong Kong.

5. Scope of Review of the Health Care System 1996

5.1 According to information provided by HWB, "the review is a macro-level examination of the Hong Kong health care financing and delivery system, which addresses issues such as the role of the public and private sectors, the interface between primary, secondary and tertiary care, existing sources of funding, the scope of public services, how services should best be financed and delivered in future, examination of systems in other countries and whether useful features from them could be applied to Hong Kong".

6. Principle of Health Care Policy

6.1 The Government's health care policy is **"to safeguard and promote the general public health of the community as a whole and to ensure the provision of medical and personal health services for the people of Hong Kong such that no one should be prevented through lack of means from obtaining adequate medical treatment".**

6.2 The Government also provides a safety net for the needy who cannot afford even the subsidized rate. For example, the Comprehensive Social Security Assistance (CSSA) recipients receive public medical treatment free of charge; and patients who cannot afford to purchase certain medical items[1] in public hospitals which are not included in the daily maintenance charge can also apply to the Samaritan Fund for financial assistance.

7. Policy Maker - Health and Welfare Bureau (HWB)

7.1 The HWB is responsible for formulating health care policy. It monitors the implementation of health care policy and delivery of services by the Department of Health (DH) and the HA. It coordinates the activities of these departments to ensure effective use of resources.

8. Policy Executors

Department of Health (DH)

8.1 DH is the government health advisor and agency to execute health care policy and statutory functions. It is responsible for public health, disease prevention, curative and rehabilitative services and health promotion. In short, DH is mainly responsible for providing primary health care services[2]. The range of services provided by DH is listed in Appendix IV.

8.2 In 1996, DH employed a total of 2,441 medical professional staff, including 519 doctors, 211 dentists and 1,043 registered nurses[3].

Hospital Authority (HA)

8.3 The HA is an independent statutory body which was established in 1990 to manage and control all public hospitals in Hong Kong. It is funded by Government and implements Government's hospital-based health care policy. HA is accountable to the Government and the public through its annual planning process and the publication of the Annual Plan for public scrutiny on the targets and achievements in the year. It also submits annual reports and financial statements to the Government via the Secretary for Health and Welfare (SHW).

1 Appendix II shows the categories of privately purchased medical items in public hospitals.
2 Appendix III lists the definitions of various health care services.
3 Hong Kong Annual Report 1997, p469.

8.4 HA currently manages 44 public hospitals/institutions, 48 specialist out-patient (SOP) centres, and employs 47,247 full-time staff. At the end of 1996, HA managed a total of 25,500 hospital beds which represented 4.05 public hospital beds per 1,000 population[4].

8.5 HA provides secondary and tertiary care which includes:

- General in-patient services
- Psychiatric (mentally ill and mentally handicapped) in-patient services
- SOP services
- Accident and emergency (A&E) services
- Community care services such as psychiatric and geriatric day hospitals, community nursing, and community psychiatric nursing services

Urban Services and Regional Services Departments

8.6 Working under the policy guidance of the two municipal councils, the Urban Services Department (USD) and the Regional Services Department (RSD) are responsible for environmental health and hygiene in the territory. These include cleaning streets and gullies; collection of night soil, refuse and junk; management of refuse collection points, public toilets and bathhouses; pest control; and services for the dead. Discharging these responsibilities involves the deployment of 7,274 people and a fleet of 598 specialized vehicles[5]. USD and RSD are also the executive arms for carrying out food hygiene policy, i.e. licensing of restaurants and meat inspection in slaughter houses. However, it should be noted that these departments are not responsible to HWB.

Environmental Protection Department (EPD)

8.7 The department is responsible for all pollution prevention and control measures, including the planning of the territory's sewage and wastes management programmes. However, it is accountable to Secretary for Planning, Environment and Lands (SPEL), not SHW.

Private Health Care Service Providers

8.8 The policy on private health care service providers is to ensure the co-existence of the public and private service providers. All registered medical practitioners and private clinics are regulated by the Medical Registration Ordinance administered by the Medical Council of Hong Kong and the Medical Clinics Ordinance administered by DH. Private hospitals must be registered with DH and are required to comply with the Guide to Hospital Standards issued by DH.

[4] Hospital Authority Annual Plan 1997-1998, p7.
[5] Hong Kong Annual Report 1997, p172.

8.9 In December 1996, there were 9,196 doctors registered with the Medical Council, of whom 3,090 were HA doctors whilst 519 were DH doctors[6].

9. Statutory and Advisory Bodies

Health and Medical Development Advisory Committee (HMDAC)

9.1 The HMDAC was established in 1992 as a non-statutory advisory body to advise the Government on the development of health care services and the interface between the health and hospital services. The membership list and terms of reference are listed in Appendix V.

Other Medical Professional Bodies

9.2 The Hong Kong Medical Council is responsible for the registration of medical practitioners and has disciplinary responsibilities under the Medical Registration Ordinance. Other medical professional bodies which register, regulate training, hold examinations leading to registration or enrolment and exercise disciplinary powers include the Dental Council, Pharmacy Board, Nursing Board and Midwives Board.

[6] Hong Kong Annual Report 1997, p469.

PART 3 - HEALTH CARE DELIVERY SYSTEM

10. Health Indices of Hong Kong Residents

10.1 The health of the Hong Kong population has improved gradually in the past ten years. Table 1 shows that the average life expectancy at birth has been rising steadily from 74.2 years in 1987 to 76.3 years in 1996 for male, and from 79.7 years to 81.8 years for female in the corresponding period. Infant mortality rate marked 4.1 per 1,000 live births whilst the maternal mortality rate was 3.1 per 100,000 total births in 1996.

Table 1 - Health Indices of Hong Kong Residents 1987-1996

Year	Life expectancy at birth (year)		Infant mortality rate (per 1,000 live births)	Maternal mortality rate (per 100,000 total births)
	Male	Female		
1987	74.2	79.7	7.4	4.3
1988	74.4	79.9	7.4	4.1
1989	74.2	80.0	7.4	5.5
1990	74.6	80.3	6.2	4.3
1991	75.2	80.7	6.4	5.7
1992	74.8	80.7	4.8	5.5
1993	75.3	80.9	4.8	4.2
1994	75.7	81.5	4.5	11.1
1995	76.0	81.5	4.6	7.3
1996	76.3	81.8	4.1	3.1*

Remark: * Provisional figure.
Source: Census and Statistics Department
Department of Health

11. Leading Causes of Death

11.1 Chronic degenerative diseases constitute the major causes of death in Hong Kong. It can be seen from Table 2 that the top three killers, namely malignant neoplasms, heart diseases and cerebrovascular diseases accounted for 10,031, 4,837 and 3,286 deaths respectively in 1996, representing 56.6% of all deaths. Corresponding crude death rates were 156.4, 76.9 and 52.2 per 100,000 population in that order.

Table 2 - Leading Causes of Death[1] in Hong Kong 1987-1996

Year	Malignant neoplasms	Heart diseases, including hypertensive heart disease	Cerebro-vascular disease	Pneumonia all forms	Injury & poisoning	Others[2]	Total
1987	8,258	4,515	3,136	1,681	1,584	7,785	26,959
1988	8,177	4,599	3,145	2,013	1,551	7,891	27,376
1989	8,585	4,836	2,915	2,029	1,653	8,467	28,485
1990	8,669	4,976	3,075	2,000	1,752	8,729	29,201
1991	8,832	4,858	3,009	1,819	1,810	8,354	28,682
1992	9,021	5,359	3,067	2,002	1,693	9,384	30,526
1993	9,311	4,707	3,247	2,209	1,694	9,054	30,222
1994	9,390	4,909	3,225	2,009	1,718	8,855	30,106
1995	9,680	4,886	3,310	3,266	1,590	8,162	30,894
1996*	10,031	4,837	3,286	3,725	1,699	8,471	32,049

Remarks:
1. Figures are based on registered deaths.
2. Including nephritis, nephrotic syndrome and nephrosis, septicaemia, chronic liver diseases and cirrhosis, diabetes mellitus, tuberculosis, chronic and unspecified brochitis, emphysema and asthma, certain conditions originating in the perinatal period, and other causes.

* Provisional figures.

Sources: Hong Kong Annual Report 1991 p437, 1993 p446, 1995 p505, 1997 p468

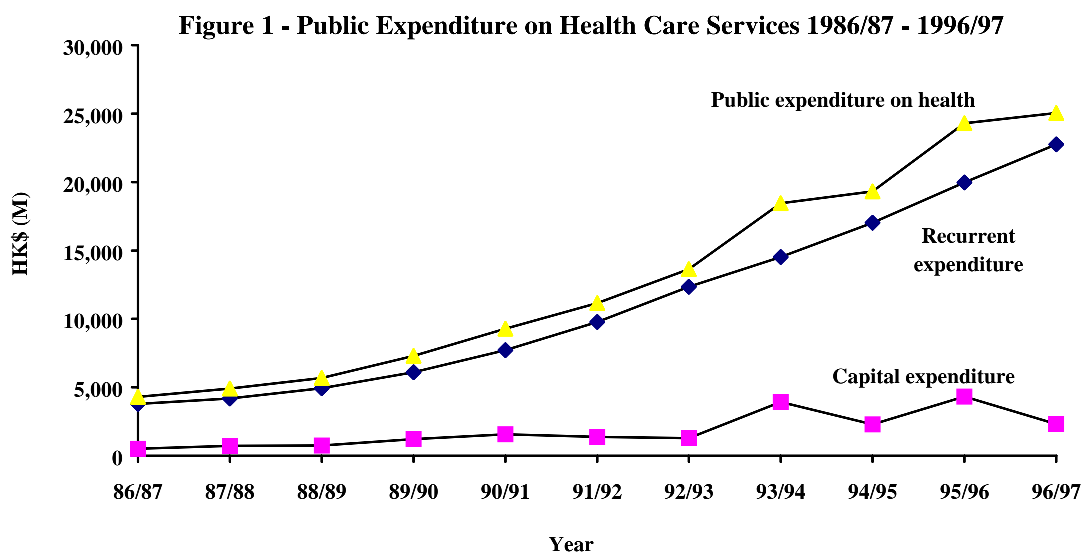
12. Public Expenditure on Health Care Services

12.1 Table 3 and Figure 1 show public expenditure on health care services in 1986/87 - 1996/97. It can be noted that public expenditure on health care services has risen drastically by almost six times in the past ten years reaching HK$25,051 million in 1996/97, accounting for 11.5% of total public expenditure and 2% of GDP.

Table 3 - Public Expenditure on Health Care Services 1986/87-1996/97 (HK$m)

Year	Recurrent expenditure on health care services	Capital expenditure on health care services	Public expenditure on health care services	% Change	% to total public expenditure	% to GDP
86/87	3,783.3	519.6	4,302.9	+14.2	9.0	1.3
87/88	4,192.4	729.0	4,921.4	+14.4	9.2	1.2
88/89	4,933.0	740.0	5,673.0	+15.3	8.8	1.2
89/90	6,093.0	1,214.0	7,307.0	+28.8	8.9	1.4
90/91	7,724.0	1,563.0	9,287.0	+27.1	9.8	1.5
91/92	9,785.0	1,379.0	11,164.0	+20.2	10.3	1.6
92/93	12,340.0	1,296.0	13,636.0	+22.1	11.0	1.7
93/94	14,520.0	3,937.0	18,457.0	+35.4	11.9	2.0
94/95	17,027.0	2,295.0	19,322.0	+4.7	11.6	1.9
95/96	19,963.0	4,322.0	24,285.0	+25.7	12.7	2.2
96/97	22,740.0	2,311.0	25,051.0*	+3.2	11.5	2.0

Remark: * Revised estimate.
Sources: Hong Kong Annual Report 1989 p366, 1991 p410, 1993 p417, 1995 p476, 1997 p441



Sources: Ibid.

12.2 Table 4 lists the recurrent expenditure of HA & DH in 1993/94 - 1997/98. HA explained that personal emoluments and staff on cost accounted for 80% of total expenses. Excluding the cost on plant, vehicles, equipment and information system, the actual expenditure on medication for patients was less than 18%. Detailed analysis on health care expenditure will be presented in the subsequent RLS research report on "Health Care Financing".

Table 4 - Recurrent Expenditure of HA & DH 1993/94-1997/98 (HK$m)

Year	HA		DH		Total
	HK$(m)	% Share	HK$(m)	% Share	HK$(m)
1993/94	13,052.6	90.8	1,327.0	9.2	14,379.6
1994/95	15,330.0	91.1	1,503.0	8.9	16,833.0
1995/96	18,152.9	91.5	1,685.0	8.5	19,837.9
1996/97 (revised)	20,745.9	91.6	1,898.0	8.4	22,643.9
1997/98 (estimate)	22,400.1	91.2	2,155.9	8.8	24,556.0

Remark: Excluding treatment of drug abusers, Prince Philip Dental Hospital, and medical and dental treatment for civil servants.
Source: Health and Welfare Bureau

13. Implementation of Health Care Policy : the Delivery System

13.1 Hong Kong has a simple health care delivery system. Primary care is mainly provided by private general practitioners (GPs) on a fee-for-service basis and by GOP clinics run by either DH or HA. Primary care is also provided by TCMPs. Secondary and tertiary care is provided by hospitals which are run by the HA or the private sector. In general, if primary care is well delivered, it will decrease the chance of patients using the more expensive secondary or tertiary care, especially in the case of chronic illnesses.

Out-patient Services

13.2 Table 5 shows the types of doctors consulted in a health status survey conducted by the C&SD in May-June 1996. It can be seen that over 66% of the respondents consulted private practitioners when they needed GOP service treatment whilst 12% and 9% visited DH and HA clinics respectively. The remaining 11% consulted TCMPs.

Table 5 - Types of Doctors Consulted for Out-Patient Service Treatment in 1996

Type of doctor consulted	No. ('000)	%
Private practitioners of western medicine*	920.2	66.3
Doctors in clinics under DH (other than those in A&E departments of clinics)	166.6	12.0
Herbalists/bone-setters/acupuncturists	145.4	10.5
Doctors in out-patient departments of hospitals under HA	125.3	9.0
Doctors in A&E department of clinics under DH and of hospitals under HA	30.5	2.2
Total	1,388.0	100.0

Remark:
* Including private practitioners of western medicine, whether registered or not, and doctors in out-patient departments of private hospitals, clinics of institutions, charitable organizations and exempted clinics.

Source: Special Topics Report No. 15, Census and Statistics Department, p73

Private Out-patient Services

13.3 The majority of the working population and their families receive primary care from private practitioners. According to the survey conducted by the Hong Kong Medical Association (HKMA) in mid-June 1996 on private doctors' fees, the median fees charged by private GPs and specialists were HK$150 and HK$350 respectively[7]. A similar survey conducted by the Medical Insurance Association in July 1996 showed the corresponding fees were HK$203 and HK$429 respectively[8].

13.4 According to information provided by the Estate Doctors Association (EDA) Ltd.[9], an EDA Medical Aid Scheme was established since December 1984. The participating member doctors will reduce their consultation fee for patients who are receiving CSSA and who are aged over 65 years. The amount of reduction in fees is determined entirely by the participating doctors.

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7 Hong Kong Medical Association releases, Survey Results on Private Doctors' Fees, 16 December 1996.

8 Report of Medical Insurance Association, The Prevailing Medical Fees Survey 1996, The Hong Kong Federation of Insurers, November 1996.

9 Estate Doctors Association Ltd. consists of 1,535 members, all of whom are registered medical practitioners. About 1,048 members are in private practice.

Public Out-patient Services

13.5 In 1996, public clinics made the following charges for Hong Kong residents: HK$37 for GOP service and HK$44 for SOP service. The fee included medication and covered roughly 19% and 10% of the actual average cost per consultation for GOP service and SOP service respectively.[10] The HA indicated that the clients were primarily the elderly and lower-income patients.

In-patient Services

Public Hospitals

13.6 The bulk of in-patient care is delivered through public hospitals. Table 6 shows that the HA provides 90% of all hospital beds whilst private hospitals provide only 10% of in-patient care services. The HA hospitals provide a comprehensive range of secondary and tertiary health care at a heavily subsidized rate. In 1997, patients who are Hong Kong residents only need to pay HK$68[11] for an acute bed per day[12] which covers less than 2% of the actual average cost[13].

Table 6 - Share of Public and Private Hospitals by Number of Beds 1986-1996

Year	HA/HSD * hospitals		Government maternity home		All public hospitals		Private hospitals		Total
	No.	%	No.	%	No.	%	No.	%	No.
1986	20,868	87.4	405	1.7	21,273	89.1	2,599	10.9	23,872
1987	21,175	87.4	379	1.6	21,554	89.0	2,660	11.0	24,214
1988	21,234	87.1	385	1.6	21,619	88.7	2,749	11.3	24,368
1989	21,216	87.2	363	1.5	21,579	88.7	2,763	11.4	24,342
1990	21,374	87.3	315	1.3	21,689	88.6	2,790	11.4	24,479
1991	21,684	87.6	173	0.7	21,857	88.3	2,907	11.7	24,764
1992	22,437	87.8	164	0.6	22,601	88.4	2,955	11.6	25,556
1993	23,271	88.4	131	0.5	23,402	88.9	2,933	11.1	26,335
1994	23,955	88.9	84	0.3	24,309	89.2	2,914	10.8	26,953
1995	25,020	89.3	85	0.3	25,105	89.6	2,926	10.4	28,031
1996	25,600	89.4	72	0.3	25,672	89.7	2,954	10.3	28,626

Remark: * HSD refers to Hospital Services Department which managed government hospitals prior to 1990.

Source: Hospital Authority

Private Hospitals

[10] According to information provided by the DH, estimated cost in 1996 for GOP service is HK$191 and for SOP service is HK$453.

[11] HK$68 covers the cost for food, accommodation, tests, medicine and surgery or other treatment.

[12] Charges for non-Hong Kong residents per day is: HK$3,130 for acute or convalescent and infirmary bed, HK$865 for psychiatric bed.

[13] According to information provided by the HA, cost for a HA acute bed (general ward) is HK$3,370, convalescent and infirmary bed is HK$1,611, psychiatric bed is HK$765 whereas in-patient services cost for DH is HK$1,758.

13.7 Private hospitals only admit patients on a fee-for-service basis. Charges can be paid after services are rendered. The patients may pay out of his own pocket or by private health care insurance.

13.8 Table 7 and Table 8 present the results of two surveys conducted by HKMA and The Hong Kong Federation of Insurers respectively on fees and charges in private hospitals.

Table 7 - Median Charges of GPs in Performing Various Types of Surgeries, Attendance and Bedside Procedures in Hospital by Class of Wards 1996 (HK$)

Type of services	1st class	2nd class	3rd class
Daily attendance	1,200	800	400
Bedside procedure	2,500	1,500	1,000
Ultra-major operation	70,000	30,000	20,000
Major operation	27,500	15,000	10,000
Intermediate operation	15,000	9,500	5,000
Minor operation	5,000	3,500	2,200

Source: Hong Kong Medical Association releases, Survey Results on Private Doctors' Fees, December 1996 16

Table 8 - Hospital and Surgical Fees of Private Hospitals

Services	Average Fee (HK$)
Room & Board	661/day
Hospital Expenses	6,900/disability
Surgeon's Fee (in hospital)	12,497/disability
(at clinic)	1,474/disability
Anaesthetist's Fee	4,170/disability
Operating Theatre	4,195/disability
In Hospital Physician Fee	807/day

Source: Report of Medical Insurance Association, The Prevailing Medical Fees Survey 1996, The Hong Kong Federation of Insurers, November 1996

Medical Insurance

13.9 In 1996, at least over one million people, or over 17% of the population, were covered by medical insurance (Table 9). Among them, 1,039,428 were covered by group insurance provided by employers. Another 1,038,732 bought their own medical insurance. However, it is unknown how many of those who were covered by group were also covered by individual insurance policies[14].

Table 9 - Medical Insurance Statistics 1993-1996

Year	Group		Individual		Total	
	No. of policies	No. of people covered	No. of policies	No. of people covered	No. of policies	No. of* people covered
1993	10,595	627,153	237,776	297,047	248,371	924,200
1994	11,573	693,824	273,287	386,376	284,860	1,080,200
1995	15,402	856,690	981,513	1,061,650	996,915	1,918,340
1996	16,350	1,039,428	1,094,646	1,038,732	1,110,996	2,078,160

Remarks: * means the total number may involve double-counting, hence, is indicative only.
Source: The Hong Kong Federation of Insurers

Complaints System

13.10 A feedback system is important to gauge the effectiveness and efficiency of the public health care service providers. Table 10 shows the complaints received by various organizations on health care services in 1993-1996.

[14] The statistics were provided by the 42 member companies of the Medical Insurance Association. These insurers amounted to 40% of the 105 companies authorized under the Insurance Companies Ordinance to carry out medical insurance business.

Table 10 - Complaints Received by Related Organizations on Health Care Services 1993-1996

Organizations	1993	1994	1995	1996
Department of Health	416	418	472	435
Hospital Authority	1,762	1,911	1,847	1,735
Medical Council of Hong Kong	134	170	177	168
HKMA Patients' Rights & Responsibilities Committee[1]	37	16	6	22
Ombudsman of Hong Kong[2]	10	76	89	132
Consumer Council	n.a.	n.a.	15	24
Legislative Council	5	6	4	9

Remarks:
1. 1993 covering 8/1992-1/1994, 1994 covering 8/1994-5/1995, 1995 covering 8/1995-3/1996
2. 1993 covering 1/7/93-30/6/94, 1994 covering 1/7/94-30/7/95, 1995 covering 27/5/95-25/5/96, 1996 covering 25/5/96-14/5/97

n.a. not available

Sources: Annual Report of The Ombudsman of Hong Kong, June 1994-1997
Department of Health
Hospital Authority
Medical Council of Hong Kong
Hong Kong Medical Association
Consumer Council
Provisional Legislative Council, Complaints Division

Department of Health

13.11 In 1996, DH received 435 complaints, among which 162 cases complained about staff performance, 120 about administration procedures and 105 about staff manner.

Hospital Authority

13.12 Among all the organizations which handle complaints on health care services, the HA received the most cases since it is the largest and the chief supplier of hospital services. In 1996, the HA received 1,735 complaints, of which 38% were about medical services and 31% were about staff attitude.

Medical Council of Hong Kong

13.13 The Medical Council of Hong Kong is empowered by law to deal with complaints against registered medical practitioners touching on a matter of professional misconduct. It has no jurisdiction whatsoever over claims for refund or compensation, which should be pursued through separate civil proceedings. In 1996, the Council handled 168 cases, of which 101 cases complained about the "unprofessional responsibility of doctors to patients".

HKMA Patients Rights and Responsibilities Committee

13.14 Complaints on health care services are also directed to the HKMA Patients' Rights & Responsibilities Committee which was set up in 1992. The association handles complaint cases by mediation. This involves all parties concerned in the complaints, i.e. patients, doctors, members of the HKMA Patients Rights and Responsibilities Committee and a representative from the Consumer Council. In 1996, a total of 22 cases were received, 18 of which were complaints about private practitioners.

Ombudsman of Hong Kong

13.15 In 1996/97, the Ombudsman received 24 complaints against DH and 108 complaints against HA. They mainly involved failure to provide proper medical treatment and to keep patients informed, negligence in caring and bad manner of hospital staff.

Consumer Council

13.16 The Consumer Council does not accept complaints against government departments; however, some citizens would send in letters complaining about medical treatment received in government hospitals or clinics. The Consumer Council would then refer these cases to the appropriate body for follow-up actions. In 1996, there were 5 and 19 complaints on hospitals and doctors respectively.

Legislative Council

13.17 The Complaints Division of the PLC handles various kinds of complaints. However, complaints on health and medical services were relatively few, amounting to less than ten cases in each of the past few years.

PART 4 - DENTAL SERVICES

14.1 The government provides very limited dental service to the public. It is the government's policy to provide:

- Oral health education and promotion to the public;
- School Dental Care Service to primary school children;
- Curative and emergency services to patients of public hospitals, prisoners and trainees of penal institutions, civil servants, pensioners and their dependents.

14.2 The latest available survey covering the whole community on dental consultation was conducted by the C&SD in October-December 1990. The result indicated that out of 1,000 persons, only 50 had their teeth examined or treated in the survey period. This reflects a low community awareness of the need for regular dental care.

14.3 The majority of the respondents in the 1990 survey who received dental treatment were aged 5-14, corresponding to a rate of 105.6 persons per 1,000 population. This was most probably due to the provision of the government school dental care service to primary school children. In 1995/96, a total of 385,580 or 82.4% of the primary school population received annual dental examinations and basic dental care[15].

14.4 Table 11 lists the attendance at dental service provided by DH. It should be noted that DH provided dental service to less than 10% of total population. It should also be noted that the general public only accounted for 12% of the attendance at this dental service while the rest were civil servants and their dependents and pensioners. Among the attendance at DH dental service, less than 30% were rendered dentally fit.

[15] Hong Kong Annual Report 1997, p164

Table 11 - Statistics on General Dental Service of DH 1986-95 (No. of Attendance)

Year	Civil Servants/ Pensioners/ Dependents	General public	Total	% of total attendance to total population	Attendance for persons rendered dentally fit	% of persons rendered dentally fit
1986	416,480	46,456	462,936	8.4	134,394	29.0
1987	455,963	49,261	505,224	9.1	150,173	29.7
1988	477,414	48,054	525,468	9.4	164,974	31.4
1989	465,444	46,740	512,184	9.1	159,709	31.2
1990	461,554	49,410	510,964	9.1	159,992	31.3
1991	465,607 *	50,150	515,757	9.1	161,874	31.4
1992	473,443 *	53,524	526,967	9.2	162,415	30.8
1993	470,296 *	56,367	526,663	9.0	167,870	31.9
1994	486,262 *	65,984	552,246	9.2	164,885	29.9
1995	513,240*#	75,375	588,615	9.6	173,883	29.5

Remarks: * Including Hospital Authority staff and their dependents.
Including estimate for Pamela Youde Nethersole Eastern Hospital.
Sources: Annual Report of Department of Health 1990/91-1991/92 Table 55, 1995/96 Table 57
Census and Statistics Department

14.5 The Governor committed in his Policy Address of 1993 to provide dental services to patients with special needs. They are:

- patients with serious and disabling oral diseases;
- patients who are severely handicapped mentally or physically; and
- individuals with specific medical diseases

It is estimated that about 11,000 patients would be covered in these three categories; 1,900 of them were covered already, and a total of 3,000 would be covered by 1996/97. However, the schedule to cover all patients in these categories is unknown[16]; neither is there a plan to extend this service to the needy and the elderly people.

14.6 In 1995, a report on oral health was published by the Dental Services Division of DH, which mainly focused on the prevention of caries and periodontal disease. As the government's policy on dental service was only confined to the provision of preventive and educational services[17], the 1996 government review on health care system would focus on health care financing, not dental service.

16 LegCo Panel on Health Services, Record of Meeting held on 14 October 1996.
17 Information Note to LegCo Panel on Health Services, Review of the Health Care System, January 1997.

PART 5 - FACTORS AFFECTING THE DEVELOPMENT OF THE HEALTH CARE SYSTEM

15. Lack of Comprehensive Health Care Policy Update Since 1974

15.1 Follow the publication of the 1974 White Paper which set the policy objective as "......to ensure the provision of medical and personal health facilities....for the people......including particularly that large section of the community which relies on subsidized medical attention", the government did not undertake a comprehensive review of the policy objective. Subsequent papers upheld the policy that "no one should be denied adequate medical treatment through lack of means".

15.2 However, there is no definition for "adequate medical treatment" and "lack of means". As diagnosis and medical treatment becomes sophisticated, it is difficult to define the "adequate" level of treatment provided to patients. On the other hand, due to the sophistication of diagnosis and medical treatment, the cost involved becomes increasingly higher due to high research and development cost. However, who should pay for what services is not specified and there is no test for "means".

15.3 It turns out that everyone becomes entitled to the government health care services regardless of his income. This has led to a wide range of heavily-subsidized services being provided by the government at a low charge for anyone who wants them. Demand becomes immeasurable whereas supply is constrained. This results in a distortion of the efficiency of the whole health care system as well as in the overall allocation of public resources. Given the tremendous socioeconomic changes that Hong Kong experienced in the past 20 years, a review of the health care policy objective is fundamental in planning for the further development of health care services.

15.4 On the implementation of health care policy, the government reviewed and overhauled the provision of hospital services through the establishment of the Provisional Hospital Authority in 1988 and the incorporation of HA in 1990. It also published a paper on primary health care services in 1990 and implemented a pilot scheme of DHS. It published a consultation paper in 1993 on health care financing but did not receive total support from the community. However, these were operational changes and can not allow us to measure whether or not they helped to achieve the policy objective when "adequate medical treatment" and "lack of means" are not clearly defined.

16. Fragmented Health Services Planning

16.1 Health is a physical, physiological, psychological and social state of well being. It can only be optimally maintained and improved by means of an integrated health care system which provides different levels and types of continual care. In the health care policy making process, there is no effective authority which can cut across levels, functions, institutions, and sectors to plan health services. The existing planning activities are organized along institutional lines, with the HA planning for public hospital services and the DH planning for public primary health care services. The environmental aspect , such as purification of water which is important to public health, is the responsibility of the Water Supplies Department which reports to the Secretary for Works. On the other hand, food hygiene and environmental health are within the domain of the USD, RSD and EPD. This fragmentation in health care policy making has resulted in uncoordinated government response to some unexpected public health crises. Planning for an integrated health care system becomes difficult when it is conducted in such a fragmented manner.

16.2 In the absence of integrated health care planning to guide the development of health care facilities, individual institutions may tend to expand beyond optimal levels. Consequently, resources may not be used in the most efficient way.

17. Barriers to an Integrated Health Care Services

17.1 There are significant barriers to the implementation of an integrated health care system, which are detailed in paragraphs 17.2-17.10.

Lack of Interface Between Public and Private Health Care Service Providers

17.2 As discussed in paragraph 13.1, the private sector provides most of the primary health care services whilst the public sector provides most of the hospital care services. Primary care and hospital care lie in a continuum. After a patient leaves the hospital, he would need follow-up primary care, which is sometimes obtained from the private sector. However, there is limited interface and coordination between these health care service providers. Many patients are not aware of or do not execute their rights to obtain their medical reports from public health care service providers; consequently, when they consult their GPs, there is no record to follow. This behaviour greatly affects the continuity and quality of patient care, and also the allocative efficiency of the whole system.

Lack of an Institution of Family Doctor

17.3 Most people in Hong Kong are not being taken care of by a particular doctor. For GOP service, a patient may shop around for the cheapest medical treatment. Similar to the situation mentioned in paragraph 17.2, the patient seldom requests his medical report to be passed from one GP to the next; consequently, this affects the continuity and quality of care.

17.4 Experience from overseas countries has shown that if a person has his own family doctor who knows his health history, it can ensure the continuity of health care and reduce the chance of duplication of medication. Besides, the family doctor can act as a gate-keeper to using the expensive secondary and tertiary care. Mutual understanding between the GP and patient gives the latter more confidence. If a patient falls ill, he may first seek advice and acquire more knowledge from his family doctor before using hospital services.

17.5 However, implementing this system of family doctor in Hong Kong is costly because there is a great price differential between the public and private health care service providers, and also among different private health care service providers. To reduce the public sector workload and to attract the patients to visit private sector family doctors, the government will need to subsidize all the patients or the family doctors such that the former can afford to pay the service at a reasonable price whilst the income for the latter can be guaranteed. Without sufficient market transparency on cost and supply, it becomes impossible to calculate the cost implications.

Lack of Interface Between GPs and TCMPs

17.6 Primary care is also supplemented by TCMPs in the private sector. However, the medical philosophy, treatment and medication of TCMPs are very different from those of GPs. Often there is little communication between these two groups of practitioners. Even when a patient passes the medical report from his TCMP to the GP, or vice versa, the receiving practitioner may not find the medical report useful. This affects the continuity of patient care.

Lack of Interface Between Primary/Secondary/Tertiary Health Care

17.7 According to information provided by HWB, Hong Kong's health care system is concentrated on curative rather than preventive care. This is due to the shortage of hospital beds in the 1960-70's. Thus, emphasis has been put on expansion of secondary health care but little attention has been paid to the coordination between hospital and primary health care. Such a separation of primary care and hospital-based secondary, tertiary and extended care creates problems in the coordination and continuity of care.

Lack of Interface Between Health Care Service Providers, Other Government Departments and Service Organizations

17.8 An integrated health care system emphasizes the continuum of health care provision. Thus, support and assistance from private GPs, other government departments and service organizations are important to enhance the identification of health needs and implementation of health programme in the community. For example, the Social Welfare Department (SWD) can provide information on the health needs of the poor and the elderly people. It can also assist in promoting public health care. In addition, health care promotion can also be supplemented by GPs and service organizations which have wide contacts with people from different walks of life. However, at present there is little collaboration between the public and private health care service providers, the concerned government departments and service organizations.

Non-availability of Integrated Information System

17.9 There is limited collaboration among health care providers to develop an integrated health care information system and communications network to facilitate information sharing and support effective business operation, service planning, utilization review and resource management.

17.10 Although a territory-wide public hospital patient database has been developed since 1992, it is only confined to HA outlets. It has not been extended to other health care providers (DH or GPs) in which patient referral, service networking or share-care programmes can be centralized.

18. Non-intervention Policy on Private Health Care Services

18.1 Although the private sector delivers almost 70% of out-patient care and 10% of in-patient care, it is not the government's policy to plan the development for the private sector. Private health care development is left to be determined by market forces.

18.2 It can be seen in Table 6 that there has been little growth in private hospital beds since the 1980s. During the past ten years, the number of private hospital beds has increased only by 355 (13.7%) from 2,599 in 1986 to 2,954 in 1996, whereas in public hospitals, the total number of beds increased by 4,732 (22.7%) in the corresponding period. The sluggish growth has been attributed to the following reasons:

- Private health insurance subscription covers only over 1/6 of the population; hence, more than 2/3 of the population have to pay their own hospital charges. If they visit private hospitals, they may have to pay charges which are significantly higher than public hospital charges;
- Increase in land and real estate prices that increases the operating cost of private hospitals, which receive no preferential treatment.

19. Slow Progress in the Registration of Traditional Chinese Medicine (TCM) Practice

19.1 TCMPs are not registered although there exists 4,000 to 10,000 TCMPs, over 1,600 retail herbal shops, and the fact that over 60% of the population have consulted TCMPs[18]. There is no accreditation for training programmes and no control over the manufacturing, sale, or dispensing of herbal and other proprietary Chinese medicine, including the highly toxic medicines.

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[18] Report of the Working Party on Chinese Medicine, October 1994, p5.

19.2 Attempts to rectify this situation are slow. A Working Party was appointed by SHW in 1989 which took five years to produce a report that recommended the setting up of another committee to look at the problem further. A Preparatory Committee on Chinese Medicine (PCCM) was then established in April 1995. In 1996, the Committee completed an enrolment exercise for TCMPs, revised the list of potent/toxic Chinese herbs and published an educational leaflet on the safe use of Chinese medicine.

19.3 In 1997, a report on the criteria and procedures for the legislative framework for the promotion , development and regulations of TCM in the territory was published. It recommended the establishment of a statutory body to co-ordinate TCMPs and to control the sale, processing and manufacturing of TCM; to develop a registration, examination, training and disciplinary system for TCMPs; to introduce a licensing system for proprietary Chinese medicines; to enforce the existing legislative controls governing the labelling, adulteration and advertising of Chinese medicinal materials and proprietary Chinese medicines.

19.4 The report also mentioned the research on the integration of TCM practice into the health care system. However, the scope of the research has not been defined; neither is there a time schedule planned for the research. Thus, the role of TCMP in the health care system is still unclear even after registration. For example, whether a TCMP can issue the sick leave notice for an employee or the death certificate for a patient remains questionable. Therefore, until further research is conducted, the government will not extend any TCM practice in the public sector.

20. Slow Progress in the Implementation of the Primary Health Care Report

20.1 The Working Party on Primary Health Care, whose report was endorsed by the government in 1991, made 102 recommendations to improve primary health care services. However, only a few recommendations are being implemented. Although RLS enquired about the action plan and progress on the implementation of the services, no response was received from the government.

20.2 Among all the recommendations, the implementation of DHS was reported to be effective. The concept was to divide the whole territory into districts, and all DH clinic facilities within each district to be organized into a network of services comprising a balance of preventive, promotive, curative and rehabilitative services. A pilot project was launched in Kwun Tong in 1992 and is now being implemented in two more districts. However, the schedule for territory-wide implementation is unknown.

21. Increase in Demand

Demand for GOP Services

Number of Attendance

21.1 DH provides primary medical care services through its GOP clinics. Patients with minor ailments or with stabilized chronic illnesses are treated or followed up at the GOP clinics. Patients with chronic illnesses requiring secondary or specialist care are referred to the specialist clinics of the HA for further investigation and management. As shown in Table 12, DH handled about 5,500,000 attendance in each of the past five years whereas the number of attendance for HA varied between 700,000 - 800,000 in the corresponding period.

Table 12 - GOP Services Attendance 1986-1995

Year	HSD/HA[1]	% Change	DH[2]	% Change
1986	769,115	+1.9	5,540,111	+1.8
1987	760,052	-1.2	5,735,828	+3.5
1988	753,790	-0.8	5,754,968	+0.3
1989	724,248	-3.9	5,570,340	-3.2
1990	721,770	-0.3	5,629,549	+1.0
1991	730,150	+1.2	5,477,144	-2.7
1992	808,440	+10.7	5,439,329	-0.7
1993	765,095	-5.4	5,461,647	+0.4
1994	737,691	-3.6	5,424,957	-0.7
1995	751,807	+1.9	5,580,609	+2.9

Remarks:
1. General out-patient attendance for HSD/HA refers to cases seen by doctors.
2. General out-patient attendance for DH refers to doctor consultations, dressings, injections, and accident and emergency attendance.

Sources: Hong Kong Annual Digest of Statistics 1994 p240, 1996 p239

Waiting Time

21.2 According to information provided by DH on GOP services, the pledged waiting time for patients with episodic illness is less than one hour while that for patients with chronic illness with advance appointment is half an hour. RLS asked for data on actual waiting time for all services, but received no information from SHW.

21.3 For GOP departments operated by HA, the average queuing time for medical consultation is less than 90 minutes[19]. RLS asked for data on actual waiting time for all services, but received no information from HA.

21.4 The lack of information on actual waiting time for DH disables RLS from performing an analysis on the opportunity cost of time of patients in the allocation of resources within the public health care system. Since the capacity of public hospitals and clinics is limited, and the price i.e. charge or fee, supply of health care services is fixed, demand for health care services is met by the opportunity cost of time. Time spent on waiting could have been economically productive. Patients with the most leisure time or the least money will queue for hours since public health service is cheap and accessible by everyone.

Demand for SOP Services

Number of Attendance

21.5 As regards the SOP services listed in Table 13, attendance at HA continued to grow significantly since 1992 (6.3% over 1991). It further grew by 7.8% in 1993 and rose to 10.5% in 1995. On the other hand, attendance at DH declined steadily from over 6 million in the late 1980's to 5.3 million in 1995. This can be attributed to the greater variety of services and medication which HA institutions were able to provide.

[19] Hong Kong Hansard 3 April 1996.

Table 13 - SOP Services Attendance 1986-1995

Year	HSD/HA[1]	% Change	DH[2]	% Change
1986	2,591,172	+3.9	5,997,993	+3.5
1987	2,720,905	+5.0	6,257,570	+4.3
1988	2,815,102	+3.5	5,840,387	-6.7
1989	2,762,529	-1.9	5,518,937	-5.5
1990	2,831,423	+2.5	5,686,338	+3.0
1991	2,909,665	+2.8	5,495,257	-3.4
1992	3,092,628	+6.3	5,334,151	-2.9
1993	3,335,293	+7.8	4,971,197	-6.8
1994	3,652,411	+9.5	5,026,136	+1.1
1995	4,037,396	+10.5	5,266,059	+4.8

Remarks:
1. Specialist out-patient attendance for HSD/HA refers to medicine, surgery, orthopaedics & traumatology, obstetrics & gynaecology, paediatrics, eye, ear-nose-throat, psychiatric, geriatrics, radiotherapy and oncology, tuberculosis & chest, dental and dermatology services.
2. Specialist out-patient attendance for DH refers to child health, ante-natal, post-natal, family planning, methadone, tuberculosis & chest, leprosy, social hygiene and dermatology.

Sources: Hong Kong Annual Digest of Statistics 1994 p240, 1996 p239

Waiting Time

21.6 Table 14 lists the waiting time and the number of patients awaiting first attendance from 1992 to 1996. It can be seen that the waiting list has been increasing and so has been the waiting time. As at the end of 1996, there were 111,933 people awaiting SOP services, and a patient had to wait on average almost 11 weeks before he could consult a doctor.

Table 14 - Waiting Time and Waiting List of SOP Services of DH (1st attendance) 1992-1996

Year	Average waiting time (weeks)	Waiting list (No. of persons awaiting 1st attendance)
1992	8.1	52,176
1993	8.2	62,805
1994	7.9	68,898
1995	9.1	93,722
1996	10.9	111,933

Source: Health and Welfare Bureau

21.7 For HA services, the longest and the average waiting time for the first appointment for some SOP services in 1995 are listed in Table 15 below. The long waiting time for these services can be attributed to the growing demand for specialist medical treatment which was not met by the private sector health care providers. In general, the average waiting time in 1996 for 90% of the specialist clinical services for the first appointment was less than three months[20].

Table 15 - Waiting Time for Some SOP Services of HA in 1995 (Weeks)

Type of Services	Longest waiting time for first appointment	Average waiting time for first appointment
Ear-nose-throat clinics	12	4
Eye clinics	24	14.5
Dermatological clinics	12	8

Source: Hong Kong Hansard 12 July 1995

Demand for In-patient Services

21.8 Since the establishment of the HA in 1988, one could observe a switch in patients from using private hospital services to using public hospital services. Table 16 demonstrates the change in the percentage share between public and private hospitals by number of patient days. The proportion of stay in public hospitals gradually increased from 90.1% in 1988 to 92.9% in 1996. One reason could be an improvement in both the quality and quantity of health care services provided by public hospitals. Another reason could be the low charge (HK$68 per day, all charges inclusive) at HA hospitals.

[20] Hong Kong Hansard 3 April 1996.

Table 16 - Share of Public and Private Hospitals by Number of In-Patient Days 1986-1996

Year	Public hospitals		Private hospitals		Total
	No.	**% share**	**No.**	**% share**	**No.**
1986	6,507,586	91.2*	630,532	8.8	7,138,118
1987	6,579,589	90.7*	671,934	9.3	7,251,523
1988	6,657,854	90.1*	735,941	10.0	7,393,795
1989	6,494,299	90.2*	707,029	9.8	7,201,328
1990	6,459,089	90.3*	697,881	9.8	7,156,970
1991	6,402,777	90.5*	673,027	9.5	7,075,804
1992	6,526,006	90.6*[#]	679,516	9.4	7,205,522
1993	6,666,278	91.4[#]	630,296	8.6	7,296,574
1994	6,877,648	92.3[#]	576,268	7.7	7,453,916
1995	7,121,507	92.9[#]	544,616	7.1	7,666,123
1996	7,422,904	92.9[#]	564,365	7.1	7,987,269

Remarks:
* Excluding day patient discharges and deaths.
# Including day patient discharges and deaths for HA or HSD hospitals.
Source: Hospital Authority

21.9 Table 17 presents the result of a survey conducted by C&SD on hospitalization in April - August 1995. It can be seen that people from almost all walks of life sought public hospital services regardless of their income. Even for people with monthly household income of between HK$30,000 - HK$39,999, 18 out of 1,000 persons used public hospital services whilst only 11 out of 1,000 persons used private hospital services. For those earning HK$40,000 and above, the rate of choosing public and private hospital services were the same, i.e. 15 out of every 1,000 persons.

Table 17 - Percentage Distribution of In-patient in HA and Private Hospitals by Monthly Household Income 1995

	HA hospital		Private hospital	
Monthly household income (HK$)	**%**	**Rate per 1,000 persons**	**%**	**Rate per 1,000 persons**
<5,000	6.8	43.1	2.1	5.0
5,000-9,999	19.8	27.5	8.6	4.3
10,000-14,999	23.0	25.4	11.8	4.7
15,000-19,999	16.0	22.7	11.8	6.1
20,000-24,999	9.6	17.5	12.9	8.5
25,000-29,999	7.9	19.8	13.6	12.4
30,000-39,999	8.2	18.0	14.3	11.4
>40,000	8.7	14.7	25.0	15.3
Median monthly household income	*HK$15,000*		*HK$25,000*	

Source: Hong Kong Monthly Digest of Statistics May 1996, Table 4

21.10 Some private hospitals have already expressed the view that they are facing financial difficulties due to inadequate utilization of their services. If such situation persists, shrinkage of the private sector will continue. This would add greater pressure on public hospital services.

Demand for A&E Services

Number of Attendance

21.11 Table 18 shows the attendance for A&E services. It can be seen that the attendance increased over the previous year was 14.4% in 1994 and 15.7% in 1995. Previous research by RLS showed that in a 2-week sample (over a public holiday) conducted in 1996, attendance broken down by triage category was as follows: less than 2% were emergencies, 20% were urgent cases, and over 70% were semi-urgent or non-urgent cases. (For details, please read IN1/96-97 “Information Note: Demand for Accident and Emergency Services During Public Holidays”, Legislative Council Secretariat, November 1996). Although this sample covered public holidays, RLS interviews with relevant professionals have confirmed that misuse of A&E services is serious on non-public holidays. Such misuse of A&E services has been attributed to:

- Convenience, easy and reliable access, availability of services even during typhoons, rainstorms and after office hours;
- Availability of advanced medical facilities and one-stop service in public hospitals;
- High standard of medical, nursing and supporting staff;
- Patient-centred customer services; and
- No financial charge

Table 18 - A&E Services Attendance* 1986-1995

Year	HSD/HA	% Change
1986	1,166,931	-2.2
1987	1,246,133	+6.8
1988	1,264,874	+1.5
1989	1,232,740	-2.5
1990	1,237,995	+0.4
1991	1,288,995	+4.1
1992	1,372,055	+6.4
1993	1,453,126	+5.9
1994	1,661,694	+14.4
1995	1,923,073	+15.7

Remark: * Including first and follow-up attendance.
Sources: Hong Kong Annual Digest of Statistics 1994 p240, 1996 p239

21.12 Table 19 shows the cost of A&E services per attendance. In 1997/98, the estimated cost per attendance is HK$676, or a total of about HK$1,300 million [1,923,073 (taking 1995 attendance as reference) x HK$676], amounting to about 5.8% of HA's recurrent expenditure (estimate) for the year.

Table 19 - Cost[1] of A&E Services Per Attendance 1992/93 - 1997/98 (HK$)

Year	Cost per attendance (HK$)	% Change
1992/93	473	n.a.
1993/94	522	+10.4
1994/95	541	+3.6
1995/96	574	+6.1
1996/97*	623	+8.5
1997/98*	676	+8.5

Remark:
* Cost for these years is projected using inflation rates advised by the Treasury.
1. Cost of services includes staff cost, drugs and consumables, depreciation, services provided by Government departments, and administration overheads.

n.a. not available.
Source: Hospital Authority

Waiting Time

21.13 A&E services treat patients on a first-come-first-served basis and the patient receives initial assessment immediately. The target average waiting time for patients to be seen by a doctor is 30 minutes[21].

Population Growth

21.14 According to the population growth projected by the C&SD in 1997, Hong Kong's population will reach 6,860,000 by the year 2000, an increase of 9% as compared to 1996. It is projected that by 2006, total population will be increased to 7,382,600 and will reach 8,205,900 by 2016. This represents an increase of 1,913,900 people within 20 years. The additional 1.9 million people will naturally generate a demand for health care services.

[21] Policy on Patients' Waiting Time, Information Paper for LegCo Panel on Health Services, February 1996.

Mismatch Between Distribution of Population and Hospitals

21.15 Public hospitals are organized by clusters on a regional basis, with most resources concentrated in a few major regional hospitals. The distribution of hospitals may not be able to meet the changes in demand which arise from the shift in population and demographic changes. It can be seen from Table 20 that the number of beds of all hospital categories per 1,000 population in Hong Kong West is higher than that in other regions. The situation in NT North is the worst with only 1.1 acute bed and 0.4 extended care bed per 1,000 population. Detailed geographic distribution of hospital beds by categories by hospitals is listed in Appendix VI.

Table 20 - Geographical Distribution of Hospital Beds by Categories Per 1,000 Population as at 31st March 1996*

District	General acute (Group 1A)	General acute (Group 1B)	Extended care (Group 2)	Extended care (Group 3)	Psychiatric (Group 4)
HK West	6.1	-	3.6	1.6	-
HK East	1.2	0.5	0.4	0.1	-
Kln Central	2.9	-	2.1	-	-
Kln West	-	2.2	-	1.3	-
Kln East	-	1.5	0.4	0.1	-
NT South	1.7	1.9	0.8	-	2.8
NT East	1.8	-	-	1.1	-
NT North	1.1	-	0.4	-	1.3
All regions	1.4	0.7	0.7	0.4	0.6

Remark: * Excluding Hong Kong Eye Hospital, Nam Long Hospital, Grantham Hospital, Hong Kong Red Cross Blood Transfusion Service and Rehabaid Centre which do not belong to any of the clusters.

Sources: Hong Kong Hansard, 10 July 1996
1996 Population By-Census

Ageing Population

21.16 Due to the decreasing birth rate and increasing life expectancy, Hong Kong's population is getting older and older as shown in Table 21. The median age in 1996 was 34 years, with 10% of total population aged 65 and above. It is projected that by 2006, the elderly population will be increased to 11.3%, the median age will be 39 years; and by 2016, it will further increase to 13.3% (1,091,700 elderly people) and the median age will be 41 years.

Table 21 - Proportion of Elderly Aged 65 and Above to Total Population 1996-2016

Year	No.	% to total population
1996	631,300	10.0
1997	655,400	10.1
1998	679,200	10.2
1999	703,200	10.4
2000	725,800	10.6
2001	750,000	10.8
2002	772,600	11.0
2003	789,800	11.1
2004	805,700	11.2
2005	819,100	11.2
2006	830,200	11.3
2007	838,500	11.2
2008	845,500	11.2
2009	854,500	11.2
2010	868,300	11.3
2011	890,800	11.4
2012	920,900	11.7
2013	958,100	12.0
2014	1,000,000	12.4
2015	1,044,600	12.9
2016	1,091,700	13.3

Source: Hong Kong Population Projections 1997-2016

21.17 According to information provided by the HA, elderly persons consume more health care services than younger persons. It is estimated that about 50% of the old age may have some form of chronic disease and 20% are disabled. About 15% of elderly persons suffer from diabetes mellitus, 1/3 from hypertension and 1/4 from osteoporosis. Cancer is also most prevalent in the elderly age group. In 1996, 1/5 of the people aged 65 and above have been admitted into HA hospitals. Their hospitalization constitutes about 42% of HA's in-patient bed days. The average length of hospital stay is 21.9 days which is more than 50% higher than that of general patients. Detailed analysis on medical needs of the elderly people will be presented in the subsequent RLS research report on "Health Care Policy on the Elderly".

21.18 In the past few years, the elderly people are becoming more institutionalized because of the changing social environment, the break down of the traditional family structure and the lack of family support. More and more elderly people live on their own and need substantial health and medical care. RLS has tried to obtain relevant data from government sources but received no information as of to-date.

Cross-border Patients

21.19 The number of visitors from the Mainland increased significantly in the past few years. It can be seen in Table 22 that there were 294,389 Two-Way Permit Holders visiting Hong Kong in 1996. According to information provided by the HA, there has been an increase in the number of deliveries by mothers entering Hong Kong from the Mainland. In 1995 and 1996, there were 6,892 and 6,230 babies delivered in public hospitals by mothers from the Mainland entering Hong Kong[22]. This represented a respective 10.0% and 9.7% of total live births in Hong Kong in the corresponding period. If this trend continues, greater demand on health care services is unavoidable.

Table 22 - Arrivals by 2-Way Permit Holders 1987 - 1996

Year	Number of arrivals	% Change
1987	85,673	+30.7
1988	120,089	+40.2
1989	131,603	+9.6
1990	133,021	+1.1
1991	140,378	+5.5
1992	160,415	+14.3
1993	209,400	+30.5
1994	245,927	+17.4
1995	260,313	+5.8
1996	294,389	+13.1

Source: Immigration Department

21.20 Table 23 lists the arrivals by One-Way Permit Holders by age and sex. It should be noted that the proportion of children arrivals increased substantially in 1996, reaching 29,084, accounting for almost half of the One-Way Permit arrivals. Currently, out of the 150 daily quota, 45 are specifically reserved for children who, according to the Basic Law 24(2)(3) have the right of abode in Hong Kong. It is estimated that there are 66,000 children[23] awaiting to come to the territory under the One-Way Permit System. They may impose great demand for health care services in Hong Kong in the short-, medium-, and long-term.

22 Referring to the deliveries by the Chinese tourists/double entry visa holders, illegal immigrants or over-stayers from the Mainland.

23 Provisional Legislative Council Brief, Immigration (Amendment) (No.5) Bill 1997, Security Bureau, 8 July 1997.

Table 23 - Arrivals by One-Way Permit Holders by Age 1987-1996

Year	0-18 yrs		19-64 yrs		65 yrs & above		Unknown		Total
	No.	%	No.	%	No.	%	No.	%	No.
1987	10,030	36.9	16,292	60.0	765	2.8	87	0.3	27,174
1988	10,111	36.1	17,166	61.2	721	2.6	48	0.2	28,046
1989	10,280	37.7	16,199	59.4	761	2.8	15	0.1	27,255
1990	10,529	37.6	16,841	60.2	585	2.1	21	0.1	27,976
1991	9,430	35.2	16,768	62.6	563	2.1	21	0.1	26,782
1992	9,511	33.5	18,291	64.5	562	2.0	2	*	28,366
1993	10,298	31.3	21,977	66.8	615	1.9	19	0.1	32,909
1994	13,284	34.8	24,376	63.8	558	1.5	0	0	38,218
1995	19,332	42.0	26,042	56.6	612	1.3	0	0	45,986
1996	29,084	47.5	31,489	51.5	606	1.0	0	0	61,179

Remark: * implies less than 0.5%
Source: Security Bureau

Increasing Consumer Aspirations

21.21 Higher consumer aspirations and new technology have increased the demand for health care services. What was considered acceptable in the past might now be regarded as inadequate. The traditional paternalistic approach of providers making decisions on behalf of patients is no longer tenable for an informed public in a changing socio-economic environment.

21.22 Better education and improvement in communication network have also enhanced both the patient or his family to participate in the decision making process of how and what health care should be provided. Patients are becoming less tolerant of long waiting times and poor environments. Yet, the current system may not be able to meet further cost pressures arising from this demand.

22. Increasing Public Expenditure

Low Charges Attracts Demand

22.1 Charges at public hospitals are very low because they are heavily subsidized by the government. At present, the fees on average cover less than 2% of total cost. Due to the improved standards and low charges at public hospitals, patients have been attracted to the public sector from the private sector. At present, demand and supply are only regulated by waiting time. Given the opportunity cost of time, patient resentment could lead to social discontent or it could lead to an unsustainable growth in public health care expenditure.

Increasing Cost of Health Care Products

22.2 The trend of increasing sophistication in the diagnosis and treatment of medical conditions is unlikely to be reversed. The proliferation of hi-tech medical equipment and expensive drugs will further push up health care costs further in the coming years.

Possible Changes in Economic Growth

22.3 In the past few years, positive economic growth enabled the HA and DH to meet the increase in the demand for health care services. However, since the global economy is cyclical, any possible economic downturn may affect the funding for health care services. This may be because those who have become unemployed would no longer afford private health care services or private health insurance; instead, they would use the public health care services. In addition, lower employment would lead to lower government revenue due to less income tax.

Demand from Economically Inactive Population

22.4 As mentioned in Section 21, a large portion of the increase in demand for health care services is due to an increase in elderly people and children who are not considered economically active and who do not pay much income tax. Whether or not the economically active can provide an adequate tax base to fund the increasing cost of health care services is uncertain.

23. Increasing Health Care Cost

Inflation in Health Care Products

23.1 In many developed countries, the inflation rate of hospital products often exceeds consumer price index. Each year, the government uses the consumer price index to budget for health care expenditures; however, if inflation rate of health care products is higher than consumer price index, the amount of health care products purchased will reduce. If this trend is to continue, it can affect the quality and quantity of health care services provided by the public sector, as well as access to these services.

Increasing Cost on Research and Development

23.2 Scientific breakthroughs and technological advances have made new diagnostic and treatment methods available for innumerable diseases and states of ill health. However, the cost on research, development and marketing of medical technologies and development is substantial. This cost is inevitably borne by the consumer at the end, in the form of high cost of equipment or drugs.

23.3 The choice of new drugs has been a contentious issue. Newly developed drugs are usually expensive because they profit under a patent. But this does not mean that new drugs are better than old drugs. However, patients can have the wrong impression that the latest development is the best and ask for the newest drugs. If a hospital dispenses new drugs and discards the old ones, it will lead to wasting of resources.

Supply Driven Demand

23.4 Although most patients are better educated, they are not medical professionals and do not possess professional knowledge to judge what optimal health care is required. If one is covered by health insurance, one may consult the doctor more frequently because one wants to know more about one's illness and get more medication.

24. Maintaining the Right Staff Mix

Supply of Medical Officers in HA

24.1 It can be seen from Table 24 that the total number of medical officers (all grades) in HA had the biggest growth in 1994/1995 at 9.2% increase over the previous year. It has slowed down to 4.8% in 1996/1997.

Table 24 - Strength of Medical Officers in various ranks in HA 1991/92-1996/97

Year	Consultant		Senior Medical Officer		Medical Officer		Total	
	No.	% share	No.	% share	No.	% share	No.	% change
1991/92	236	10.4	489	21.5	1,554	68.2	2,279	n.a.
1992/93	247	10.4	531	22.4	1,591	67.2	2,369	+3.9
1993/94	291	11.4	548	21.6	1,703	67.0	2,542	+7.3
1994/95	366	13.2	611	22.0	1,798	64.8	2,775	+9.2
1995/96	416	14.0	705	23.7	1,848	62.2	2,969	+7.0
1996/97	435	14.0	764	24.6	1,913	61.5	3,112	+4.8

Source: Hospital Authority

24.2 The proportion of consultants and senior medical officers (SMOs) have increased from 10.4% to 14.0% and 21.5% to 24.6% respectively in the past five years. This was due to the decentralization of authority from HA Head Office which led to a transfer of managerial staff originally stationed at HA Head Office to hospitals. Consultant positions were created to meet the medical needs of the patients and to improve the quality of services. In most cases, patients are treated by medical officers (MOs) under the supervision of SMOs and consultants.

24.3 According to information provided by HA, the working hours of the health care professionals is about 44 hours per week. Doctors are required to be on call on rotational basis; the frequency of on call duties depend on the nature of services/specialties provided in various hospitals. The target for Chiefs of Service and Ward Managers to spend not less than 75% and Consultants and Nursing Officers not less than 90% of their time in clinical duties and patient service are achievable[24].

Supply of Nursing Staff in HA

24.4 Table 25 and Figure 2 show the steady growth of nursing staff in HA. Except for 1995/96, the growth reached 6.7% over the previous year, the increase remained at 2-3% throughout the past five years.

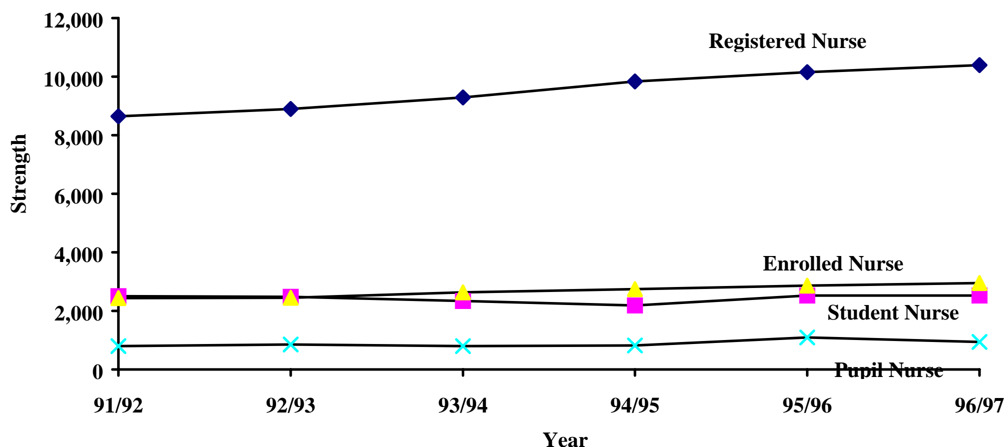
Table 25 - Strength of Nursing Staff in HA 1991/92-1996/97

Staff	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97
General						
Registered nurse	*8,650*	*8,891*	*9,289*	*9,831*	*10,150*	*10,396*
Student nurse	*2,506*	*2,485*	*2,337*	*2,184*	*2,528*	*2,529*
Enrolled nurse	*2,438*	*2,449*	*2,629*	*2,741*	*2,866*	*2,949*
Pupil nurse	*802*	*848*	*799*	*824*	*1,096*	*940*
Psychiatric						
Registered nurse	*864*	*900*	*976*	*981*	*968*	*974*
Student nurse	*164*	*146*	*99*	*110*	*204*	*301*
Enrolled nurse	*496*	*529*	*524*	*553*	*617*	*636*
Pupil nurse	*142*	*119*	*116*	*113*	*77*	*70*
Midwife	**141**	**129**	**116**	**100**	**96**	**86**
Others	**83**	**77**	**50**	**37**	**36**	**38**
Total	**16,286**	**16,573**	**16,935**	**17,474**	**18,638**	**18,919**
% Change	**n.a.**	**+1.8**	**+2.2**	**+3.2**	**+6.7**	**+1.5**

Remark: Staff strength includes all full-time/part-time staff on permanent or contract terms. Temporary staff and staff on honorary appointment are excluded.
n.a. not available
Source: Hospital Authority

[24] Hospital Authority, Press Release, September 20, 1997.

Figure 2 - Strength of General Nursing Staff in HA 1991/92-1996/97



Source: Hospital Authority

24.5 In an opinion survey conducted by the Social Sciences Research Centre, University of Hong Kong, in early 1996, almost all surveyed doctors and nurses (97% of respondents) think that there were insufficient nurses in the ward to provide adequate services. The shortage of nursing staff was mainly due to the harsh working conditions, irregular working hours, unpleasant job nature and increasing diversification of nursing care. They envisaged that if the shortage of nursing staff continues, there may be a decrease in staff morale and quality of service. With the increase of workload, it might further induce nurses to drop out.

24.6 In the 1996 HA Nursing Manpower review, there was a shortage of 580 nurses for clinical specialties, and the distribution is shown in Table 26 below. According to information from HA, "intensive efforts will be made in parallel to recruit and retain nurses in HA."

Table 26 - Shortage of Nurses in HA 1996

Specialty	Medical*	Surgical	Psychiatric	Critical Care#	Total
Additional Nurses	300	86	89	105	580

Remarks:
* Including geriatric.
# Including intensive care and neonatal intensive care units.
Source: Information Note to LegCo Panel on Health Services, 13 January 1997

Turnover of Medical Staff in HA

24.7 Table 27 shows the turnover of medical staff for HA in the past five years. In general, the turnover for doctors was less than that of nurses and allied health staff, maintaining at about 7%. For nurses, the turnover reached 13.3% in 1994/95 but decreased gradually thereafter. Last year, the turnover for nurses was 8.7%.

Table 27 - Turnover of Medical Staff in HA 1992/93-1997/98 (%) [1,2]

Year	Doctors	Nurses	Allied health staff[3]	Interns/Externs/ Dental officers
92/93	8.7	10.0	8.3	11.9
93/94	7.2	10.3	7.7	28.4
94/95	6.8	13.3	10.0	23.0
95/96	6.7	9.8	8.9	13.3
96/97	7.0	8.7	6.0	20.9
97/98 [4]	5.6	7.5	5.2	2.4

Remarks:
1. Turnover includes all types of cessation from HA. Promotions and transfers across hospitals are excluded. Staff leaving HA under the phasing-out programme are not included as turnover.
2. The turnover rate above is based on the total staff leaving during the financial year over the average strength during the same period.
3. Including physiotherapists, occupational therapists, dietitians, clinical psychologists, radiographers, medical laboratory technicians, medical social workers, pharmacists, dispensers and other health care professionals such as audiology technicians, mould laboratory technicians, optometrists, orthoptists, podiatrists, prosthetists and orthotists, scientific officers (medical), and speech therapists.
4. Annualized rate based on turnover data for the period Apr 97 to Jun 97.

Source: Hospital Authority

Manpower:Bed Ratio Analysis

24.8 HA has adopted a macro and a micro approach to manpower planning. HA has been using general manpower indicators for the macro projection of requirements for future manpower, particularly for the new hospital projects. The indicators provide a useful reference for evaluating manpower provision against the staffing range of the specialty. Since every hospital has its own specific roles and characteristics and different patient mix, the indicators only provide guidelines for staffing and do not indicate absolute staffing requirements.

24.9 The general manpower indicators for HA established in 1993 is listed in Appendix VII. RLS asked for similar manpower indicators for 1996, but no information is provided by HA.

24.10 Table 28 and 29 summarize the manpower: bed ratio deduced by RLS based on the number of beds, doctors and nurses of different hospitals as at 31st March 1996. RLS singles out the minimum and maximum manpower: bed ratio for each hospital category (Appendix VIII) and compares them to the 1993 indicators as shown in Appendix VII. It can be seen that except for general acute hospital (Group 1A), where the maximum and minimum manpower: bed ratios were higher than the 1993 HA indicators, the corresponding manpower:bed ratios of other hospital categories were lower than the 1993 HA indicators.

Table 28 - Comparison of 1996 Doctor:Bed Ratio to 1993 HA's Manpower Indicators* by Hospital Categories

Hospital	Minimum	Maximum
General acute (Group 1A)	**3.4**	**5.6**
Queen Elizabeth Hospital	4.4	
Pamela Youde Nethersole Eastern Hospital		5.9
General acute (Group 1B)	**6.4**	**17.0**
United Christian Hospital	4.8	
Ruttonjee Hospital		10.3
Extended care (Group 2)	**9.4**	**33.1**
Tang Shiu Kin Hospital	4.9	
Kowloon Hospital		34.9
Extended care (Group 3)	**29.4**	**158.5**
Shatin Hospital	22.5	
Cheshire Home (Chung Hom Kok)		no doctor
Group 4	**47.2**	**150.0**
Kwai Chung Hospital	31.8	
Lai Chi Kok Hospital		141.3

Remark: * 1993 HA Manpower indicators in bold print.
Source: Hong Kong Hansard, 10 July 1996

Table 29 - Comparison of 1996 Nurse:Bed Ratio to 1993 HA Manpower Indicators* by Hospital Categories

Hospital	Minimum	Maximum
General acute (Group 1A)	**0.9**	**1.4**
Prince of Wales Hospital	0.8	
Pamela Youde Nethersole Eastern Hospital		1.6
General acute (Group 1B)	**0.9**	**3.5**
Our Lady of Maryknoll Hospital	0.7	
Ruttonjee Hospital		1.8
Extended care (Group 2)	**0.8**	**5.1**
Tang Shiu Kin Hospital	0.8	
Pok Oi Hospital		2.3
Extended care (Group 3)	**4.0**	**22.5**
Shatin Hospital	1.8	
Cheshire Home (Chung Hom Kok)		6.9
Group 4	**3.5**	**11.7**
Kwai Chung Hospital	2.4	
Lai Chi Kok Hospital		6.1

Remark: * 1993 HA Manpower indicators in bold print.
Source: Hong Kong Hansard, 10 July 1996

24.11 Although most of the 1996 manpower: bed ratios conformed with the 1993 HA indicators, there was still shortage of nursing staff in HA as discussed in paragraph 24.6. This is because manpower situation varied from specialty to specialty, and from time to time. Some wards might have to face greater demand for services. Sometimes, given the same occupancy rate, a higher turnover of patients in a specific ward would also imply a greater demand for services. This would lead to a higher demand for doctors and nurses.

24.12 An activity profile study which reflected the current pattern of manpower utilization as well as the output and content of clinical activities in representative/selected areas was conducted in 1996. It revealed that about 20% of the existing duties of nurses were non-nursing tasks or simple nursing tasks such as personal care that could be delegated to other supporting staff such as Health Care Assistants. This shows that **having the right staff mix and manpower level at different wards** are important.

24.13 Meanwhile, HA has developed another set of manpower indicators which include the element of staff mix and occupancy (Appendix IX). However, since information is not available on the number of patients discharged per doctor by specialty by hospitals, RLS cannot proceed with further analysis of the manpower situation.

<u>Staffing Situation in DH</u>

24.14 Table 30 shows the strength of doctors of DH. In the past five years, the total number of doctors in DH increased by 16%.

Table 30 - Strength of Doctors in DH 1992-1997

Year	No.	% Change
1992	447	-2.0
1993	478	+6.9
1994	492	+2.9
1995	501	+1.8
1996	519	+3.6

Sources: Hong Kong Annual Report 1993-1997

24.15 According to information provided by DH, each doctor in out-patient services usually sees 90-95 patients per day while each doctor in specialized service sees less depending on individual specialty.

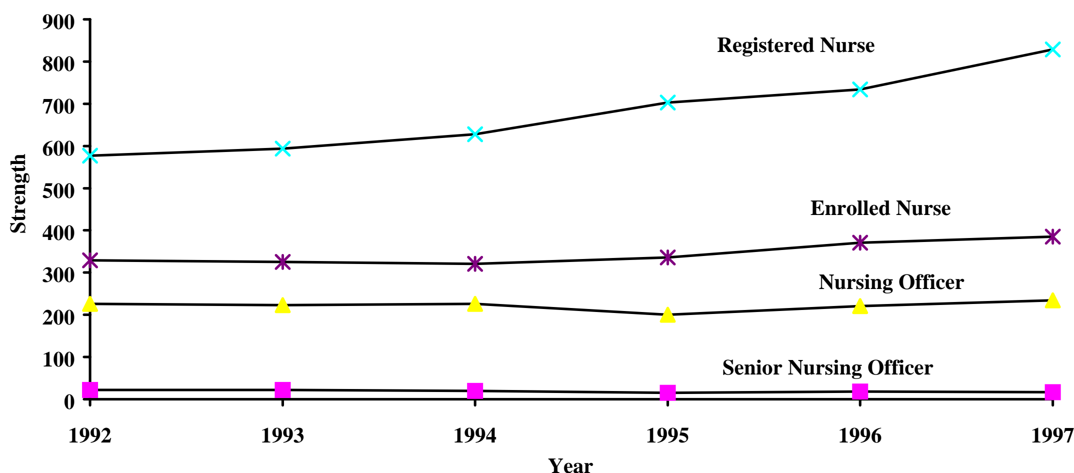
24.16 Table 31 and Figure 3 show the changes in nursing staff in DH. It can be seen that during the past five years, total nursing staff in DH has increased by 247 from 1,343 in 1992 to 1,590 in 1997. Registered nurses accounted for almost 50% of DH's total nursing staff.

Table 31 - Strength of Nursing Staff in DH 1992-1997

Year	Chief nursing officer	Senior nursing officer	Nursing officer	Registered nurse	Enrolled nurse	Senior inoculator/ inoculator	Midwife	Total
1992	1	22	226	577	329	82	106	1,343
1993	1	22	223	594	325	79	98	1,342
1994	2	20	226	628	321	76	92	1,365
1995	2	15	200	703	336	69	90	1,415
1996	1	18	221	734	371	72	83	1,500
1997	2	17	234	829	385	57	66	1,590

Source: Health and Welfare Bureau

Figure 3 - Strength of Nursing Staff in DH 1992-1997



Source: Health and Welfare Bureau

24.17 A comprehensive survey on manpower situation in respect of doctors, nurses, dental and allied health in both public and private sector will be conducted by DH and a preliminary result is expected to be available in 1997[25].

25. Role of DH

25.1 Since it is a global trend to strengthen primary health care services, and since DH is currently the largest public primary health care provider, it can further expand its services. This includes the establishment of a closer, interactive relationship with a more effective two-way flow of information between the public and private primary health care and secondary health care providers. DH can also create opportunities for the community to participate in the identification of health needs and to mobilize the community resources in the implementation of health care programmes, and to integrate the community health service provided by services organizations with that provided by the health care providers.

25.2 The 1996 review did not emphasize DH's role in developing primary health care. The review was only aimed at reducing the financial expenses of the public sector in curative care and to mobilize the private sector to play a greater role in preventive care.

25 LegCo Panel on Health Services, Record of Meeting 13 January 1997.

26. Role of HMDAC

26.1 HMDAC is the only statutory body that should provide some direction for the development of the health care system. However, with the modification of its terms of reference to focus on primary health care, it is doubtful whether HMDAC could address the overall development of the entire health care system.

27. Role of Statutory and Ad Hoc Committees

27.1 Most of the recommendations that came from the statutory and ad hoc committees such as the Medical Council, the Nursing Board, the working parties on Primary Health Care; TCM; Rehabilitation Policies and Services, and the Medicine Insurance Study Group were separate and not linked to a key health care policy. They usually deal with acute problems that attract public attention, and often only advocate greater government spending on particular areas.

PART 6 - CONCLUDING SUMMARY

28.1 The health care policy in Hong Kong guarantees universal access of health care to the whole population. Although the health care system has been popularly used by Hong Kong residents, there are phenomena which manifest an inadequate policy and planning machinery that can lead to increasing health care expenditure and a financing problem. If these issues are not strategically tackled, they can become out of control and will affect the quality and quantity of the provision of public health care services, which, in turn, will affect the general public's well being. The major factors affecting the development of the current health care system are summarized in Table 32.

Table 32 - Factors Affecting the Development of the Current Health Care System

	Factors	Problems
1	• Lack of comprehensive review or update of health care policy objective since 1974 • No definition of "adequate medical treatment" and "lack of means"	• Cannot catch up with the needs of a changing society • High public expenditure due to the availability of a wide range of heavily-subsidized public health care services
2	• Fragmented health services planning • Fragmented input from statutory and ad hoc committees and other constituency groups	Inefficient allocation of resources
3	• Lack of interface between public & private health care service providers; primary/secondary/ tertiary health care service providers; health care services providers & service organizations; GPs & TCMPs • Lack of an institution of family doctor • Non-availability of integrated information system • Slow progress in implementing TCMP registration	• Difficulty in implementing an integrated health care system • Inefficient allocation of resources • Role of TCMP not clear
4	• Supply and demand for health care services in private sector is determined by market forces	• Competition from the public sector might impede the growth of a pluralist system of health care providers
5	• Slow progress in the follow up on the Primary Health Care Report	Impeded the territory-wide provision of primary health care
6	• Improvement in service quality & quantity in HA hospitals • Low fees and charges of public health care services • Growth in population, elderly people, mothers and children from the Mainland • Mismatch between distribution of population & hospitals • Increasing consumer aspirations	Increase in demand which could lead to increased social discontent or unforeseeable increase in public expenditure
7	• Increasing cost of health care products • Possible downturn in economic growth • Increasing demand from economically inactive population	Unplanned or unforeseeable increase in public expenditure
8	• Inflation in health care products • Increasing cost on research and development	Unforeseeable increase in health care cost
9	• Shortage of medical staff	Lack of professional expertise to support the implementation of health care system
10	• Change in terms of reference of HMDAC	Priority focus on primary health care, not the whole health care system

Appendix I

Development of Health Care System in Hong Kong

1843

Government medical service was first introduced to the colony in 1843 and the first hospital erected was the Seamen's Hospital opened by the Medical Missionary Society of Canton and Macau whereas the first Government Civil Hospital was established in 1850 but was destroyed in a typhoon in 1874. Both were served by colonial surgeons and the patients were mainly garrison and European residents living in the territory. For almost all local residents, they were being taking care of by private practitioners who usually used traditional herbal medicine, bone-setting and acupuncture skills to cure the illness. In 1872, the first private charity hospital -- the Tung Wah Hospital was built by some Chinese community leaders. It was staffed by both traditional Chinese practitioners and Western medical practitioners.

The First White Paper in 1964

In the immediate postwar period, the government concentrated on developing preventive health care services, particularly on communicable disease control. In the 1960s, the government started to develop medical services. A White Paper on "Development of Medical Services in Hong Kong" was drafted in 1964 setting the standards of provision of medical and health services for 1963-1972. By 1970, there were a total of 16,471 beds with a ratio of 4.03 beds per 1,000 population[26]. All public hospitals were funded from general taxation and all Hong Kong residents were entitled to the services regardless of their income.

The Second White Paper in 1974

In the 1970s, medical services further expanded under the administration of the Governor Sir Murray McLehose. In 1974, a White Paper on "Further Development of Medical and Health Services in Hong Kong" was drafted, setting an objective of 5.5 beds per 1,000 population. A regional approach on the planning and administration of health care services was adopted. In each region, the government was required to provide a regional hospital to patients requiring acute care, one or more district hospitals to deliver the basic hospital services, one or more specialist clinics, and a number of general clinics which provide primary health care services to the majority of the population.

[26] Hong Kong Annual Report 1970 (Chinese Version), p95

Establishing Provisional Hospital Authority in 1988

Due to the rapid growth of government hospitals in the 1980s and the increasing amount of health care expenditure, a study on the delivery of medical services in hospitals was conducted aiming at privatizing some of the health care services. A Provisional Hospital Authority was established in 1988, and the Hospital Authority was formally incorporated in July 1990.

Health Care System Review in 1996

In 1993, a consultative document on health care financing was published. However, it did not receive total support from the public. In 1996, the government started to review the health care system and the study is expected to be completed by 1998.

The chronological development in health care policy is listed in the following table.

Development of Health Care Policy

Year	Event/Document	Details	Policy Objectives
1964	"Development of Medical Services in Hong Kong" (White Paper)	Outlined Hong Kong's immediate requirements in medical and health services and set standards of provision of medical and health services for the period 1963-1972.	"To provide, directly or indirectly, low cost or free medical and personal health services to that large section of the community which is unable to seek medical attention from other sources."
Jul 1974	"The Further Development of Medical and Health Services in Hong Kong" (White Paper)	Set out Government proposals to maintain and expand the general public health services and develop additional facilities and services for in-patients and out-patients for the next ten years.	"To safeguard and promote the general public health of the community as a whole and the need to ensure the provision of medical and personal health facilities for the people of Hong Kong, including particularly that large section of the community which relies on subsidized medical attention."

Year	Event/Document	Details	Policy Objectives
Dec 1985	"The Delivery of Medical Services in Hospitals" (Consultancy Report)	• Confined to reviewing the management and administration of hospitals. • Recommended proposals to improve the quality and distribution of medical services in hospitals in the short to medium term (e.g. establishment of HA)	"To ensure the provision of medical and personal health facilities for the people of Hong Kong, including particularly that large section of the community which relies on subsidized medical attention."
Dec 1990	"Health for All the Way Ahead" - Report of the Working Party on Primary Health Care	• Put forward a set of proposals mainly on primary care. • Also recommended Government to conduct a study leading to a policy statement on future financing of health and medical services.	"No one should be prevented, through lack of means, from obtaining adequate medical treatment."
Jul 1993	"Towards Better Health" Consultation Document	Almost 500 submissions received. The public indicated overall support for the coordinated voluntary insurance approach, plus the semi-private room and target waiver group components of the target group approach (but did not support itemized charging).	To uphold the policy that "no one should be denied adequate medical treatment through lack of means."
1996	Review of the Health Care System	Working Group on the Review of the Health Care System (with regular members from HWB, DH and HA) set up to recommend detailed long-term strategies on review of the system.	"To conduct a comprehensive review of the health care system to enable HWB to develop a health care policy and system that can cater for Hong Kong's needs in the coming decades."

Source: Health and Welfare Bureau

Appendix II

Categories of Privately Purchased Medical Items in Public Hospitals

1. Percutaneous Transluminal Coronary Angioplasty (PTCA) and other consumables for interventional cardiology

2. Cardiac pacemakers

3. Intraocular lens

4. Myoelectric prosthesis

5. Custom-made prosthesis

6. Implants for purely cosmetic surgery

7. Appliances for prosthetic and orthotic services, physiotherapy and occupational therapy services

8. Growth hormone and interferon

9. Home use equipment, appliances and consumables

Source: LegCo Panel on Health Services, Information Paper on Privately Purchased Medical Items for Public Patients, July 1996

Appendix III

Definition of Health Care Services

Health care services are classified into primary, secondary and tertiary level, with acute, extended[27], ambulatory and community care components.

Primary Care

Primary care is the patient's first point of contact of the health care system and most illnesses can be treated at this level.

Secondary Care

Secondary care refers to more specialized and complex medical care usually provided in a hospital. Patients are normally referred by primary care practitioners.

Tertiary Care

Tertiary care caters for a small proportion of patients who require highly complex and specialized care in a hospital setting. It often requires costly technological support for diagnosis and treatment.

Acute Care

Acute care provides care for patients with emergencies or non-emergencies requiring intensive medical, nursing, rehabilitation and technological input to restore health and minimize illness and disability. Treatment can be delivered at all three levels of medical care.

Extended Care

Extended care provides medical rehabilitation to the disabled, chronically ill and elderly, in either institutional or community setting.

Ambulatory Care

These are services or facilities providing care for patients on an out-patient or day only basis.

Community Care

Services, facilities or programmes supporting patients and their care-givers at home or in the community.

Source: Hospital Authority Annual Plan 1996-97, p28

[27] Including long-stay and rehabilitation services

Appendix IV

Services provided by Department of Health

In 1996, DH operated 60 GOP clinics, 48 mother and child health centres, 13 student health centres, 16 tuberculosis and chest clinics, 13 social hygiene clinics, five dermatology clinics, five clinical genetic clinics, four child assessment centres and other clinic services[28]. It also provided mobile dispensaries, floating clinics and a flying doctor service catering for residents living in remote areas and outlying islands. The range of services provided by DH is as follows:

- Personal Health Services

  Including GOP service, surveillance and control of communicable diseases, family health and family planning, health education, woman health and elderly health services.

- Non-regionalized Services

  These cover tuberculosis and chest service, social hygiene and special skin service, child assessment service, clinical genetic service, public health laboratory service, forensic pathology service, occupational health service, student health service and special preventive programme on AIDS and hepatitis B.

- Special Health Services

  These cover radiation health, port health, narcotics and drug administration, pharmaceutical service.

- Hygiene Services

  These cover food and environmental hygiene monitoring, pest control and health education.

- Dental Service

  This provides general dental service, school dental service and oral health education.

Source: Department of Health, Annual Report, 1995/96, p17

[28] Hong Kong Annual Report 1997, p163.

Appendix V

Health and Medical Development Advisory Committee (HMDAC)

Membership

Dr. David FANG Jin-sheng, J.P. (Chairman)
Director of Health (Vice-Chairman ex officio)
Dr. LEE Kin-hung, M.B.E.
Mrs. Alice PONG TSO Shing-yuk
Dr. Homer TSO Wei-kwok
Professor Peter YUEN Pok-man
Professor NG Mun-hon
Dr. John H. BOEY
Mrs. Alice CHEONG YUK Tak-fun
Ms. Nancy KIT-Kwong-chi
Mrs. Cecilia LEE IP Wai-kay, M.B.E.
Mrs. Alice TSANG LAU Kit-ping
Chief Executive Officer/Hospital Authority (ex officio)

Terms of Reference

- Bearing in mind the objectives of Government in the development of primary health care, to keep under review the general level of health in the community; and

- Having regard to the needs of the community and the availability of manpower and financial resources, to advise Government, through the Secretary for Health and Welfare, on the development of health care services and the interface between health and hospital services.

Source: Civil and Miscellaneous List, 1 July 1996

Appendix VI

Geographic Distribution of Hospital Beds by Categories by Hospitals * as at 31st March 1996

	General acute (Group 1A)	**General acute (Group 1B)**	**Extended care (Group 2)**	**Extended care (Group 3)**	**Psychiatric (Group 4)**	**Unknown**
Hong Kong West						
Queen Mary Hospital	1,390					
Tsan Yuk Hospital	195					
Tung Wah Hospital			787			
Fung Yiu King Hospital				296		
Duchess of Kent Children's Hospital			150			
MacLehose Medical Rehabilitation Centre				130		
Total beds	***1,585***		***937***	***426***		
Population[1]	***259,224***					
Beds/'000 pop'n	***6.1***		***3.6***	***1.6***		
Hong Kong East						
Pamela Youde Nethersole Eastern Hospital	1,363					
Tang Shiu Kin Hospital			88			
Ruttonjee Hospital		597				
Tung Wah Eastern Hospital			303			
St. John Hospital			83			
Cheshire Home (Chung Hom Kok)				90		
Wong Chuk Hang Hospital						200
Total beds	***1,363***	***597***	***474***	***90***		***200***
Population[2]	***1,116,470***					
Beds/'000 pop'n	***1.2***	***0.5***	***0.4***	***0.1***		***0.2***
Kowloon Central						
Queen Elizabeth Hospital	1,846					
Kowloon Hospital			977			
Hong Kong Buddhist Hospital			353			
Total beds	***1,846***		***1,330***			
Population[3]	***638,778***					
Beds/'000 pop'n	***2.9***		***2.1***			

	General acute (Group 1A)	**General acute (Group 1B)**	**Extended care (Group 2)**	**Extended care (Group 3)**	**Psychiatric (Group 4)**	**Unknown**
Kowloon West						
Kwong Wah Hospital		1,417				
Wong Tai Sin Hospital				1,003		
Our Lady of Maryknoll Hospital		252				
Total beds		***1,669***		***1,003***		
Population[4]	***762,147***					
Beds/'000 pop'n		***2.2***		***1.3***		
Kowloon East						
United Christian Hospital		878				
Haven of Hope Hospital			257			
Margaret Trench Medical Rehabilitation Centre				80		
Total beds		***878***	***257***	***80***		
Population[5]	***587,071***					
Beds/'000 pop'n		***1.5***	***0.4***	***0.1***		
NT South						
Princess Margaret Hospital	1,245					
Kwai Chung Hospital					1,622	
Caritas Medical Centre		1,386				
Lai Chi Kok Hospital					424	
Yan Chai Hospital			608			
Total beds	***1,245***	***1,386***	***608***		***2,046***	
Population[6]	***741,527***					
Beds/'000 pop'n	***1.7***	***1.9***	***0.8***		***2.8***	
NT East						
Prince of Wales Hospital	1,384					
Shatin Hospital				540		
Cheshire Home (Sha Tin)				296		
Bradbury Hospice						26
Total beds	***1,384***			***836***		***26***
Population[7]	***780,869***					
Beds/'000 pop'n	***1.8***			***1.1***		***0.03***

	General acute (Group 1A)	General acute (Group 1B)	Extended care (Group 2)	Extended care (Group 3)	Psychiatric (Group 4)	Unknown
NT North						
Tuen Mun Hospital	1,417					
Pok Oi Hospital			470			
Fanling Hospital			100			
Castle Peak Hospital					1,741	
Siu Lam Hospital						300
Total beds	***1,417***		***570***		***1,741***	***300***
Population[8]	***1,321,280***					
Beds/'000 pop'n	***1.1***		***0.4***		***1.3***	***0.2***
Total beds in all regions	**8,840**	**4,530**	**4,176**	**2,435**	**3,787**	**526**
Total population	**6,207,366**					
Beds/'000 pop'n	**1.4**	**0.7**	**0.7**	**0.4**	**0.6**	**0.1**

Remarks:

* Excluding Hong Kong Eye Hospital, Nam Long Hospital, Grantham Hospital, Hong Kong Red Cross Blood Transfusion Service and Rehabaid Centre which do not belong to any cluster.

1. Covering population in Central and Western District.
2. Covering population of 171,656 in Wanchai, 594,087 in Eastern Hong Kong Island, 287,670 in Southern Hong Kong Island and 63,057 on Islands.
3. Covering population of 260,573 in Yau Tsim Mong and 378,205 in Kowloon City.
4. Covering population of 365,927 in Sham Shui Po and 396,220 in Wong Tai Sin.
5. Covering population in Kwun Tong District.
6. Covering population of 470,726 in Kwai Tsing and 270,801 in Tsuen Wan.
7. Covering population of 582,993 in Shatin and 197,876 in Sai Kung.
8. Covering population of 463,703 in Tuen Mun, 341,030 in Yuen Long, 231,907 in NT North and 284,640 in Tai Po.

Sources: Hong Kong Hansard, 10 July 1996, and 1996 Population By-Census

Appendix VII

Average Number of Bed Per Medical Staff by Type of Hospitals 1993

	Group 1	**Group 1A**	**Group 1B**	**Group 2**	**Group 3**	**Group 4**
Doctor						
Minimum	3.4	3.4	6.4	9.4	29.4	47.2
Median	6.0	4.4	7.4	19.1	98.7	98.5
Maximum	17.0	5.6	17.0	33.1	158.5	150.0
RN/SN						
Minimum	0.9	0.9	0.9	0.8	4.0	3.5
Median	1.3	1.1	2.1	3.1	8.9	8.7
Maximum	3.5	1.4	3.5	5.1	22.5	11.7
EN/PN						
Minimum	1.4	4.9	1.4	1.9	4.2	7.0
Median	8.2	8.7	6.4	4.7	8.2	8.1
Maximum	17.7	12.9	17.7	6.2	13.8	11.8

Remarks:
Group 1 are acute general hospitals including PMH, PWH, QEH, QMH, TYH, TMH, PYNEH, CMC, GH, KWH, OLMH, RH, UCH
Group 1A are acute general hospitals including PMH, PWH, QEH, QMH, TYH, TMH, PYNEH
Group 1B are acute general hospitals including CMC, GH, KWH, OLMH, RH, UCH
Group 2 are extended care hospitals including DKCH, HHH, TWEH, YCH, FH, HKBH, KH, POH, SJH, TWH, TSKH.
Group 3 are extended care hospitals including CH(S), MMRC, MTMRC, NLH, SH, FYKCH, WTSH, CH (CHK).
Group 4 are psychiatric hospitals including CPH, KCH, LCKH
Including teaching staff for QMH & PWH
Activities of CMC include those for acute beds only
Source: Information Paper for LegCo, Panel on Health Services, Nursing Manpower, 8 January 1996

Appendix VIII

Manpower:Bed Ratio by Categories by Hospitals as at 31st March 1996

	General acute (Group 1A)	General acute (Group 1B)	Extended care (Group 2)	Extended care (Group 3)	Psychiatric (Group 4)	Unknown	No. of Doctors	*No. of beds per doctor*	No. of Nurses	*No. of beds per nurse*
Hong Kong West										
Queen Mary Hospital	1,390						278	*5.0*	1,565	*0.9*
Tsan Yuk Hospital	195						18	*10.8*	159	*1.2*
Tung Wah Hospital			787				34	*23.1*	393	*2.0*
Fung Yiu King Hospital				296			5	*59.2*	75	*3.9*
Duchess of Kent Children's Hospital			150				n.a.	n.a.	n.a.	n.a.
MacLehose Medical Rehabilitation Centre				130			1	*130.0*	34	*3.8*
Hong Kong East										
Pamela Youde Nethersole Eastern Hospital	1,363						232	*5.9*	854	*1.6*
Tang Shiu Kin Hospital			88				18	*4.9*	109	*0.8*
Ruttonjee Hospital		597					58	*10.3*	330	*1.8*
Tung Wah Eastern Hospital			303				41	*7.4*	279	*1.1*
St. John Hospital			83				6	*13.8*	38	*2.2*
Cheshire Home (Chung Hom Kok)				90			-	-	13	*6.9*
Wong Chuk Hang Hospital						200	4	*50.0*	44	*4.5*

	General acute (Group 1A)	General acute (Group 1B)	Extended care (Group 2)	Extended care (Group 3)	Psychiatric (Group 4)	Unknown	No. of Doctors	*No. of beds per doctor*	No. of Nurses	*No. of beds per nurse*
Kowloon Central										
Queen Elizabeth Hospital	1,846						421	*4.4*	1,928	*1.0*
Kowloon Hospital			977				28	*34.9*	724	*1.3*
Hong Kong Buddhist Hospital			353				15	*23.5*	152	*2.3*
Kowloon West										
Kwong Wah Hospital		1,417					210	*6.7*	1,205	*1.2*
Wong Tai Sin Hospital				1,003			24	*41.8*	244	*4.1*
Our Lady of Maryknoll Hospital		252					35	*7.2*	340	*0.7*
Kowloon East										
United Christian Hospital		878					184	*4.8*	1,136	*0.8*
Haven of Hope Hospital			257				12	*21.4*	239	*1.1*
Margaret Trench Medical Rehabilitation Centre				80			1	*80.0*	15	*5.3*
NT South										
Princess Margaret Hospital	1,245						265	*4.7*	1,400	*0.9*
Kwai Chung Hospital					1,622		51	*31.8*	680	*2.4*
Caritas Medical Centre		1,386					158	*8.8*	888	*1.6*
Lai Chi Kok Hospital					424		3	*141.3*	69	*6.1*
Yan Chai Hospital			608				109	*5.6*	661	*0.9*

	General acute (Group 1A)	General acute (Group 1B)	Extended care (Group 2)	Extended care (Group 3)	Psychiatric (Group 4)	Unknown	No. of Doctors	*No. of beds per doctor*	No. of Nurses	*No. of beds per nurse*
NT East										
Prince of Wales Hospital	1,384						300	*4.6*	1,632	*0.8*
Shatin Hospital				540			24	*22.5*	295	*1.8*
Cheshire Home (Sha Tin)				296			3	*98.7*	88	*3.4*
Bradbury Hospice						26	2	*13.0*	30	*0.9*
NT North										
Tuen Mun Hospital	1,417						250	*5.7*	1,303	*1.1*
Pok Oi Hospital			470				32	*14.7*	201	*2.3*
Fanling Hospital			100				11	*9.1*	77	*1.3*
Castle Peak Hospital					1,741		40	*43.5*	586	*3.0*
Siu Lam Hospital						300	2	*150.0*	68	*4.4*
Others										
Hong Kong Eye Hospital						14	30	*0.5*	50	*0.3*
Nam Long Hospital				180			7	*25.7*	70	*2.6*
Grantham Hospital		579					41	*14.1*	468	*1.2*
Hong Kong Red Cross Blood Transfusion Service							2	*n/a*	90	*n/a*
Rehabaid Centre							n/a	*n/a*	n/a	*n/a*

Remarks:
n.a. not available
n/a not applicable
Source: Hong Kong Hansard, 10 July 1996.

Appendix IX

HA Manpower Indicators 1996 : Number of Patient Discharged Per Doctor Per Annum

Specialty	Acute Care Hospitals
Medicine	350-600
Surgery	400-650
Paediatrics	350-550
Gynaecology/Obstetrics	600-800
Orthopaedics & Traumatology	250-400
A&E*	6,000-7,500

Remark: * Number of patients attended the first appointment in that year.
Source: Hong Kong Hansard, 10 July 1996

HA Nursing Manpower Indicators 1996*

Specialty	Acute Care Hospitals	Extended Care Hospitals
Medicine	16-21	10-13
Surgery	15-20	10-13
Paediatrics	15-19	13-14
Obstetrics	14-18	13-14
Gynaecology	14-17	n/a
Orthopaedics	14-17	10-13
Geriatrics	13-17	10-13

Remarks:
* Number of nurses for a standard ward of 34 beds at 85% occupancy (excluding ward managers) and a staff mix ratio of 68% qualified nurses and 32% nurse learners.

n/a not applicable

Source: LegCo Panel on Health Services, Information Note on Nursing Manpower Indicators, 11 March 1996

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