Health Care Expenditure and Financing in Hong Kong

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CONTENTS

EXECUTIVE SUMMARY

1. The objective of this research is to analyze health care expenditure and resource allocation patterns within the health care system. The research also examines existing funding methods.

2. The government set its policy on subsidized health care services in the 1964 White Paper, "Development of Medical Services in Hong Kong". The government would carry out a comprehensive review of the health care system in 1998.

3. Total health care expenditure has increased five times to nearly $60 billion between 1986/87 and 1996/97. In comparison to the GDP of Hong Kong, total health care expenditure rose from 3.7% in 1986/87 to 4.8% in 1996/97. This signifies a relative growth of 30% in the community's expenditure on health care in the past 11 years. Private health care expenditure as a percentage to total health care expenditure has decreased from 64.2% in 1986/87 to 58% in 1996/97. Public health care expenditure as a percentage to total health care expenditure has risen from 35.8% to 42% during the same period.

Public health care expenditure

4. Public health care expenditure has increased nearly six times from $4,303 million in 1986/87 to $25,051 million in 1996/97. In comparison to the GDP of Hong Kong, public health care expenditure rose from 1.3% in 1986/87 to 2.0% in 1996/97. This signifies a relative growth of 53.8% in the past 11 years. It has grown three times as fast as private health care expenditure.

5. The Department of Health (DH) as the public primary health care provider has been getting a decreasing share of government resources. The proportion of the public health care expenditure on DH has decreased from 13.2% in 1989/90 to 10.2% in 1996/97. DH's total expenditure was $2.6 billion in 1996/97.

6. Staff cost accounted for 72% of DH's expenditure in 1989/90 and 75% in 1996/97. Expenditure on specialist supplies and equipment has been less than 8% during the same period. In terms of function, DH spent around 75% of its resources on primary health care and the rest on dental student training, provision of medical and dental services to civil servants and treatment of drug addicts.

7. Of the four types of primary health care, curative care as a percentage to the primary health care expenditure has decreased from 50.9% in 1992/93 to 44.8% in 1996/97. Expenditure on disease prevention has increased from 36.6% of the primary health care expenditure in 1992/93 to 42% in 1996/97. Resources on health promotion has risen from 2.9% of the primary health care expenditure to 3.4% in 1996/97 while that for rehabilitative care has been around 2%.

8. Government revenue has financed 93% of DH's expenditure between 1989/90 and 1996/97. Around 7% of DH's expenditure is recovered from fees and charges. More than 65% of the income has come from out-patient services and the rest from charges for hospital services, dental services, licensing and registration.

9. Estimated fees waived for CSSA recipients amounted to 3.8% of DH's fee income in 1993/94 and 9% in 1996/97. In providing free medical services to civil servants, potential revenue foregone amounted to 18.9% of DH's fee income in 1993/94 and 19.5% in 1996/97.

10. The Hospital Authority (HA), as the manager of all public hospitals in Hong Kong, has been allocated between 73% to 84% of the public health care expenditure since its establishment on 1 December 1991. In 1996/97, government grant to HA reached $21 billion.

11. Staff cost has accounted for around 80% of HA's expenditure. Expenditure on medical supplies and equipment has been around 9% of HA's expenditure.

12. About 75% of HA's expenditure has been spent on acute and extended care for in-patients between 1994/95 and 1996/97. Expenditure on ambulatory care has accounted for about 22% of HA's expenditure and community care about 2%.

13. Estimated fees waived for needy members of the public amounted to 22.7% of HA's income from medical fees and charges in 1992/93 and 35.5% in 1996/97. In providing medical services to civil servants, potential revenue foregone was 40.3% of HA's income from medical fees and charges in 1992/93 and 35.9% in 1996/97.

14. Government grant has been the major source of funding for HA and has accounted for around 96% of HA's total income between 1992/93 and 1996/97. Medical fees and charges has accounted for about 3% of HA's total income and non-medical charges about 1% during the same period.

Private health care expenditure

15. Private health care expenditure has increased more than four times from $7,703 million to $34,610 million between 1986/87 and 1996/97. In comparison to the GDP of Hong Kong, private health care expenditure has increased from 2.4% in 1986/87 to 2.8% in 1996/97. This signifies a relative growth of 16.7% in the past 11 years. It has grown at only one-third of that of public health care expenditure. In 1996/97, 75% of the expenditure was spent on medical treatment by western medicine and 25% on Chinese medicines, over-the-counter drugs and traditional Chinese medicine practitioners.

16. Children aged below 5 years and elderly persons aged 65 years or above were found to be the two groups which have a higher chance of going to hospitals and consulting doctors for out-patient services. Health care expenditure for the two age groups is likely to be higher than that for other age groups.

17. Primary curative care provided by private general practitioners (GPs) were found to be affordable to individuals with median monthly employment earnings. Private GPs and traditional Chinese medicine practitioners together provide about 77% of the out-patient care to Hong Kong people.

18. The median total charges for staying in private hospitals were found to be higher then the median monthly employment earnings. Those with median monthly employment earnings may not be able to afford private hospitals without using other means. About 10% of the in-patient care is delivered by private hospitals in Hong Kong.

19. People with medical insurance or company medical benefits were found to have a higher rate of going to private hospitals but some of them would still use public hospitals.

HEALTH CARE EXPENDITURE AND FINANCING IN HONG KONG

PART 1 - INTRODUCTION

1. Background

1.1 The Provisional Legislative Council (PLC) Panel on Health Services requested the Research and Library Services Division (RLS) to research on the existing health care system in Hong Kong. Research has been conducted on three aspects of the system. The first paper, "Long Term Health Care Policy" (RP01/PLC) outlined the health care system under the existing policy. The second paper, "Health Care for Elderly People" (RP02/PLC) reviewed government policy on health care services for the elderly. This paper is the third in the series and studies health care financing in Hong Kong.

2. Objective and Scope

2.1 The objective of the research is to analyze expenditure and resource allocation patterns within the health care system.

2.2 The scope of the research as agreed by the Panel is as follows:

(a) describe changes in public and private health care expenditure;

(b) review the current health care financing methods including user charges and medical insurance;

(c) compare different health care financing methods.

2.3 This paper concentrates on point (a) and (b) of the scope. Comparison on various health care financing methods adopted by overseas countries will be provided in research reports to follow.

3. Methodology

3.1 The study involves a combination of information collection, literature review, interviews, survey and analysis.

3.2 In addition to materials available in PLC library, books and articles were borrowed from academic libraries in Hong Kong and other researchers. Interviews were made with officials of the Health and Welfare Bureau (HWB), representatives of the Hospital Authority (HA), medical professionals and academics. Letters were sent to the Census and Statistics Department, the Hong Kong Medical Association, the Office of the Commissioner of Insurance and the Medical Insurance Association under the Hong Kong Federation of Insurers for information. RLS also conducted a survey by sending a questionnaire to 105 companies authorized to offer health insurance to gather information on premium and claim limits of medical insurance plans in Hong Kong. RLS held a meeting with the Medical Insurance Association on 7 November 1997 to explain the purpose of the survey and to clarify points concerning the questionnaire. After the meeting, the Medical Insurance Association issued a note to its members providing guidance on filling in the questionnaire. Only 18 medical insurance companies (17%) returned the questionnaire. The little response has made it difficult for RLS to draw up a representative picture on the insurance packages in Hong Kong, RLS has thus decided not to proceed with processing the survey result.

PART 2 - HEALTH CARE FINANCING POLICY

4. Development in Health Care Financing Policy

4.1 Health care services in Hong Kong in the early days were provided mainly by charitable organizations. In 1872, the first private charity hospital, Tung Wah Group Hospital, was built with funds raised by some Chinese community leaders.

4.2 The government announced its policy on health care services in its first White Paper, "Development of Medical Services in Hong Kong" in 1964. The policy objective was 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". The policy objective was modified in the 1974 White Paper, "Further Development of Medical and Health Services in Hong Kong", which outlined a ten-year health care policy for the territory. The policy objective was to "safeguard and promote the general 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". Since the government did not have a differential charging policy, public health care services in effect became accessible to all Hong Kong residents regardless of income. The provision of "low cost or free" health care services has entailed heavy government subsidy. The health care policy has not been changed since 1974.

4.3 In 1985, a government consultant, W.D. Scott, was commissioned to review the management of the existing hospital system. The consultant in its report, "The Delivery of Medical Services in Hospitals" recommended the establishment of an independently administered hospital system. He also made recommendations on cost reduction and cost recovery of hospital services and the introduction of higher class accommodation (B-class beds) in public hospitals. The government then proceeded with establishing the Hospital Authority (HA).

4.4 The Provisional Hospital Authority took up the recommendations of cost recovery in its report published in 1989. It believed that the eventual cost recovery for hospital services should be between 15% to 20%.

4.5 In 1990, the Working Party on Primary Health Care[1] which was set up to review the provision of primary health care services, recommended the government conduct a study which would lead to a policy statement on the future financing of health and medical services in Hong Kong. The report, "Health for All The Way Forward: Report of the Working Party on Primary Health Care" reiterated the government's policy that "no one should be prevented, through lack of means, from obtaining adequate medical treatment". The principle was incorporated in section 4(d) of the Hospital Authority Ordinance.

[1] Please refer to Appendix I for the terms of reference and membership of the Working Party.

4.6 In 1993, the government published a consultation document entitled "Towards Better Health" to collect views on options to raise additional revenue to finance hospital services. The five options were as follows:

- Percentage subsidy approach - the operating cost of each type of hospital services would be subsidized to the same percentage
- Target group approach - this involves the introduction of semi-private rooms and itemized charging with a target waiver system for patients who could not afford the charges
- Coordinated voluntary insurance approach - this approach consists of a framework whereby private insurance companies offer plans that meet approved criteria for adequacy of coverage and appropriateness of premium
- Compulsory comprehensive insurance approach - all households in Hong Kong would be required to contribute to a centrally administered medical insurance scheme
- Prioritization of treatment approach - this approach involves public health care providers to classify medical conditions and treatments in order of priority and fund them according to available resources

4.7 The government reported that it received 494 submissions - 294 from individuals, 45 from health care professionals, 83 from organizations, 19 from District Boards, 7 from political parties, 33 signature campaigns and 13 surveys. The majority of the submissions indicated support for the coordinated voluntary insurance approach, plus the semi-private room and target waiver components of the target group approach. However, the submissions did not support itemized charging component of the target group approach. Opposition was shown for the other three options.

4.8 In January 1994, the Governor-in-Council approved in principle the introduction of semi-private beds in public hospitals and a coordinated voluntary insurance scheme[2]. The government then set up an internal committee, the "Towards Better Health" Assessment Committee, to develop the two proposals. A pilot scheme on semi-private beds was launched in five hospitals, namely Ruttonjee Hospital, Tsan Yuk Hospital, Grantham Hospital, Pok Oi Hospital and Pamela Youde Nethersole Eastern Hospital, with a total of 81 beds. The Assessment Committee also discussed with the Medical Insurance Association in April 1995 on the implementation of the coordinated voluntary insurance scheme.

[2] p.72, HA Business Plan 1994/95.

4.9 The government has completed a review of the pilot scheme, covering the period July 1994 to September 1996. However, it would defer making any decision until a comprehensive review of the health care financing and delivery system is completed. The implementation of the coordinated voluntary insurance scheme would also await the decision concerning semi-private beds.

4.10 In October 1997, the Chief Executive of the Hong Kong Special Administrative Region, Mr. Tung Chee Hwa, announced in his maiden policy address that the government would carry out a comprehensive review of the existing health care system in 1998. In the review, the government will examine "how to achieve a better interface between primary health care, out-patient and hospital in-patient services". The government will also review "whether the existing split of workload between the public and private sectors is reasonable". It will also study "how patients and the community can best share the health care costs"[3].

[3] p.42-43, "Building Hong Kong For a New Era", Address by the Chief Executive The Honorable Tung Chee Hwa at the Provisional Legislative Council meeting on 8 October 1997.

PART 3 - TOTAL HEALTH CARE EXPENDITURE

5. Total Health Care Expenditure

5.1 Hong Kong's total expenditure on health care has increased five times from $12 billion in 1986/87 to nearly $60 billion in 1996/97 (Table 1) whereas in the same period GDP increased by only 3.8 times. Total health care expenditure accounted for a higher percentage to GDP at 4.8% in 1996/97 when compared to 3.7% in 1986/87, which signifies a relative growth of 30% in the period between 1986/87 and 1996/97.

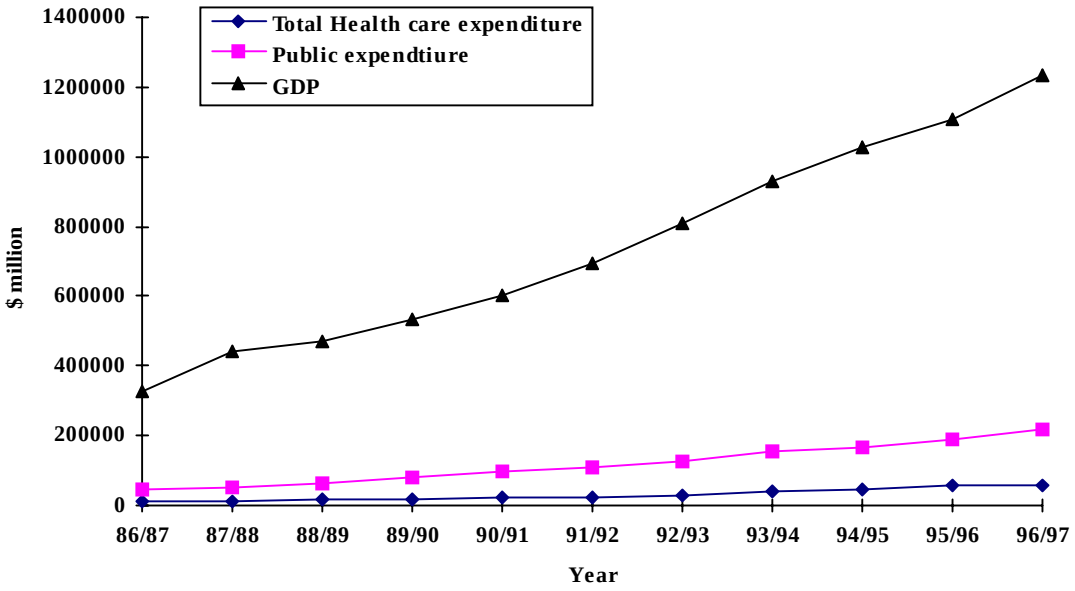
Table 1 - Total Health Care Expenditure ($M)

	1986/87	1987/88	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97*
Health care expenditure (a)	12,006	13,621	15,240	17,303	21,319	25,296	30,701	37,739	44,126	54,895	59,661
Public expenditure (b)	47,931	53,636	64,799	81,945	95,198	108,422	123,492	155,207	165,950	191,338	217,194
GDP (c)	327,710	400,323	472,813	536,263	599,671	695,525	807,353	927,290	1,028,618	1,107,024	1,234,964
(a)/(b) in %	25.0	25.4	23.5	21.1	22.4	23.3	24.9	24.3	26.6	28.7	27.5
(a)/(c) in %	3.7	3.4	3.2	3.2	3.6	3.6	3.8	4.1	4.3	5.0	4.8

Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

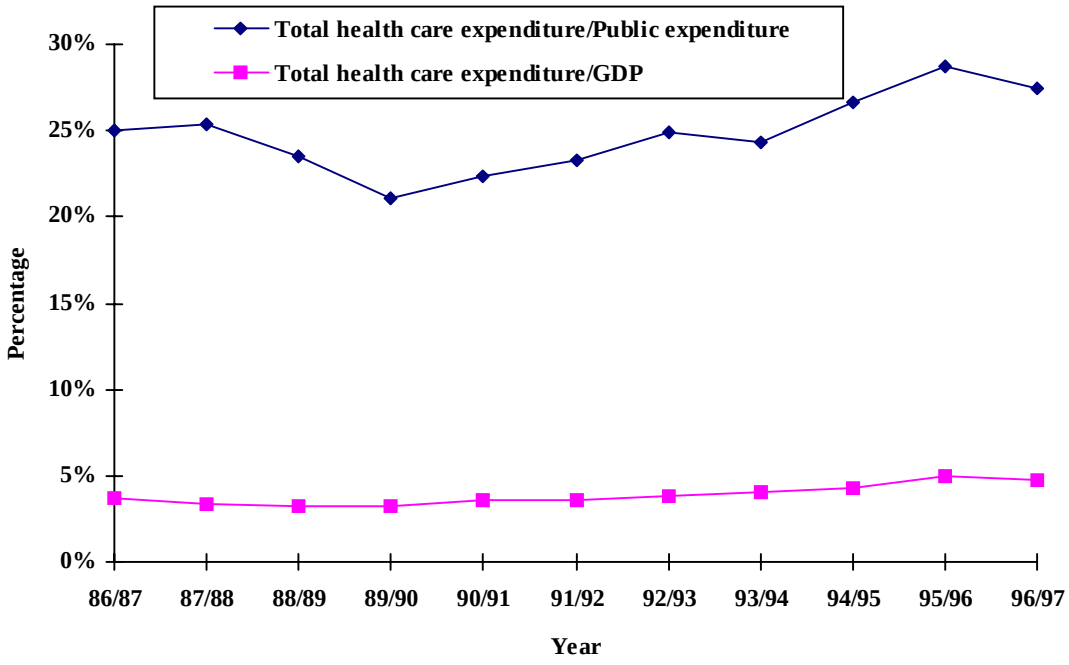
Remark: * Revised estimate

Figure 1 - Total Health Care Expenditure



Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

Figure 2 - Proportion of Health Care Expenditure



Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

6. Public and Private Health Care Expenditure

6.1 In the years between 1986/87 and 1996/97, private health care expenditure has accounted for a decreasing share of the total health care expenditure. The percentage decreased from 64.2% in 1986/87 to 58% in 1996/97. Public health care expenditure has accounted for an increasing share of the total health care expenditure. The percentage increased from 35.8% in 1986/87 to 42% in 1996/97.

6.2 Public health care expenditure comprises both capital and recurrent expenditure and includes mainly expenditure made by the Department of Health (DH) and HA. Private health care expenditure includes expenditure on medical treatment as well as that on medicines and drugs.

Table 2 - Public and Private Health Care Expenditure ($M)

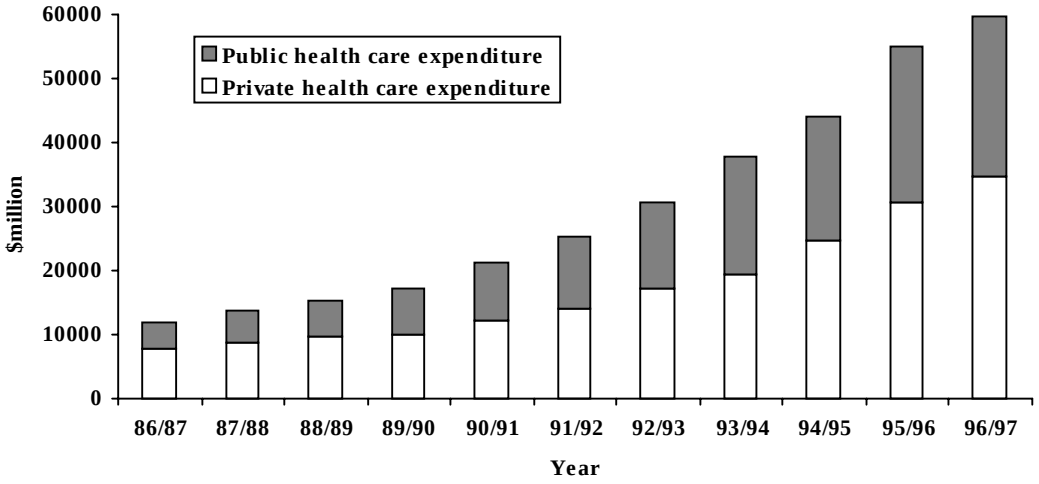
	1986/87	1987/88	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97*
Private health care expenditure (a)	7,703	8,700	9,567	9,996	12,032	14,132	17,065	19,282	24,804	30,610	34,610
Public health care expenditure (b) **	4,303	4 ,921	5,673	7,307	9,287	11,164	13,636	18,457	19,322	24,285	25,051
Total health care expenditure (c)	12,006	13,621	15,240	17,303	21,319	25,296	30,701	37,739	44,126	54,895	59,661
GDP (d)	327,710	400,323	472,813	536,263	599,671	695,525	807,353	927,290	1,028,618	1,107,024	1,234,964
(a)/(c) in %	64.2	63.9	62.8	57.8	56.4	55.9	55.6	51.1	56.2	55.8	58.0
(b)/(c) in %	35.8	36.1	37.2	42.2	43.6	44.1	44.4	48.9	43.8	44.2	42.0
(a)/(d) in %	2.4	2.2	2.0	1.9	2.0	2.0	2.1	2.1	2.4	2.8	2.8
(b)/(d) in %	1.3	1.2	1.2	1.4	1.5	1.6	1.7	2.0	1.9	2.2	2.0

Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

Remarks: * Revised estimate

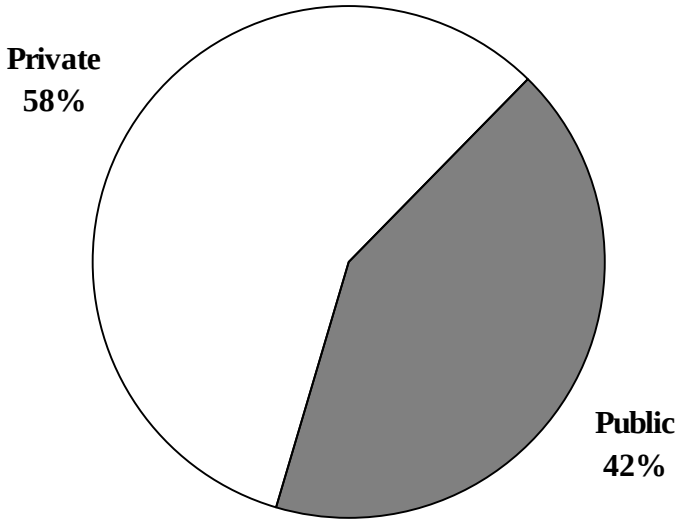
** Data on government consumption expenditure of health care are not available. RLS has used public expenditure on health care as a proxy. Government consumption expenditure is expenditure used in providing goods and services not recovered from fees and charges. Such expenditure includes compensation of employees and purchases of goods and services by non-trading government departments and quasi-government non-profit bodies.

Figure 3 - Public and Private Health Care Expenditure



Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

Chart 1 - Public and Private Health Care Expenditure in 1996/97



Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

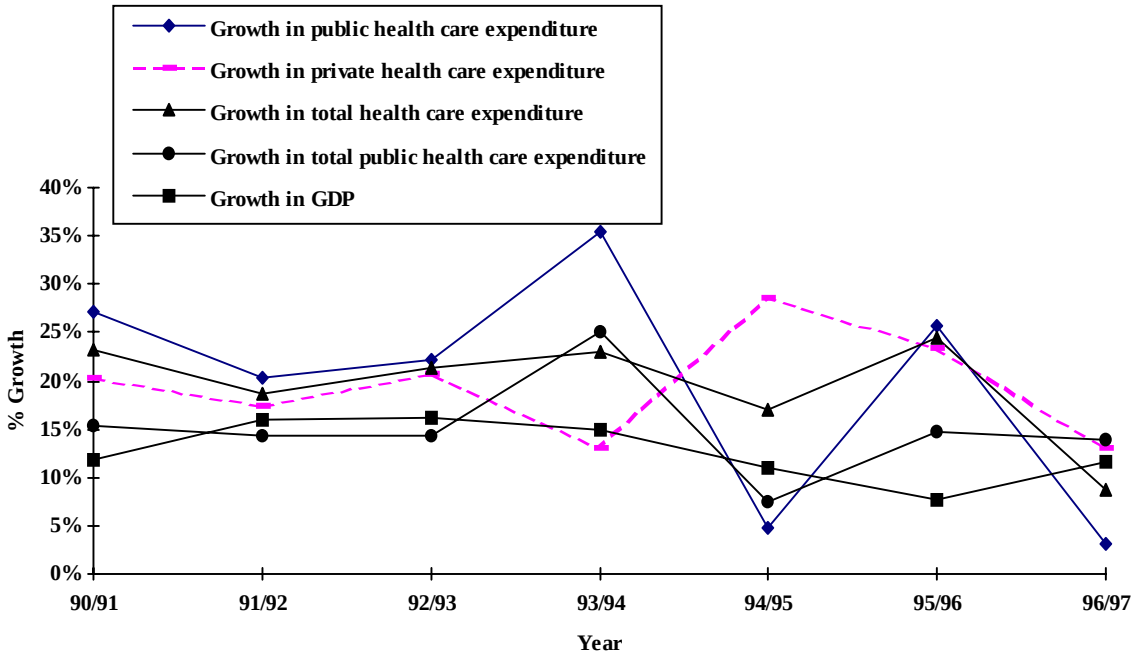
6.3 It is noted in Table 3 and Figure 4 that the growth in health care expenditure does not correlate with the growth in GDP. It implies that the public spend money on health care according to their needs rather than the general economic condition.

Table 3 - Growth Rate of Health Care Expenditure (%)

Year-on-Year Growth	**90/91**	**91/92**	**92/93**	**93/94**	**94/95**	**95/96**	**96/97**
Public health care expenditure	27.1	20.2	22.1	35.4	4.7	25.7	3.2
Private health care expenditure	20.4	17.5	20.8	13.0	28.6	23.4	13.1
Total health care expenditure	23.2	18.7	21.4	22.9	16.9	24.4	8.7
Total public expenditure	16.2	13.9	13.9	25.7	6.9	15.3	13.5
GDP	11.8	16.0	16.1	14.9	10.9	7.6	11.6

Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

Figure 4 - Growth Rate of Health Care Expenditure



Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

Discussion

6.4 Total health care expenditure has increased rapidly over the past 10 years and will further increase for the following reasons:

- increase in population
- increase in elderly population
- high consumer expectation
- increase in the use of hi-tech medical equipment, hi-tech medical procedures and expensive drugs

6.5 The burden of health care expenditure ultimately falls on the public since they have to pay tax to finance the public health care system and to pay user charges at the point of obtaining the services. The government may need to examine how resources should be allocated in the most cost-effective way in delivering the services to the public and how to broaden the sources of funding.

PART 4 - EXPENDITURE PATTERNS AND SOURCES OF FUNDING OF THE PUBLIC HEALTH CARE SYSTEM

7. Public Health Care Expenditure

7.1 The actual amount of public health care expenditure has increased nearly six times from $4,303 million in 1986/87 to $25,051 million in 1996/97. In relative terms, public health care expenditure as a proportion to GDP increased from 1.3% in 1986/87 to 2% in 1996/97.

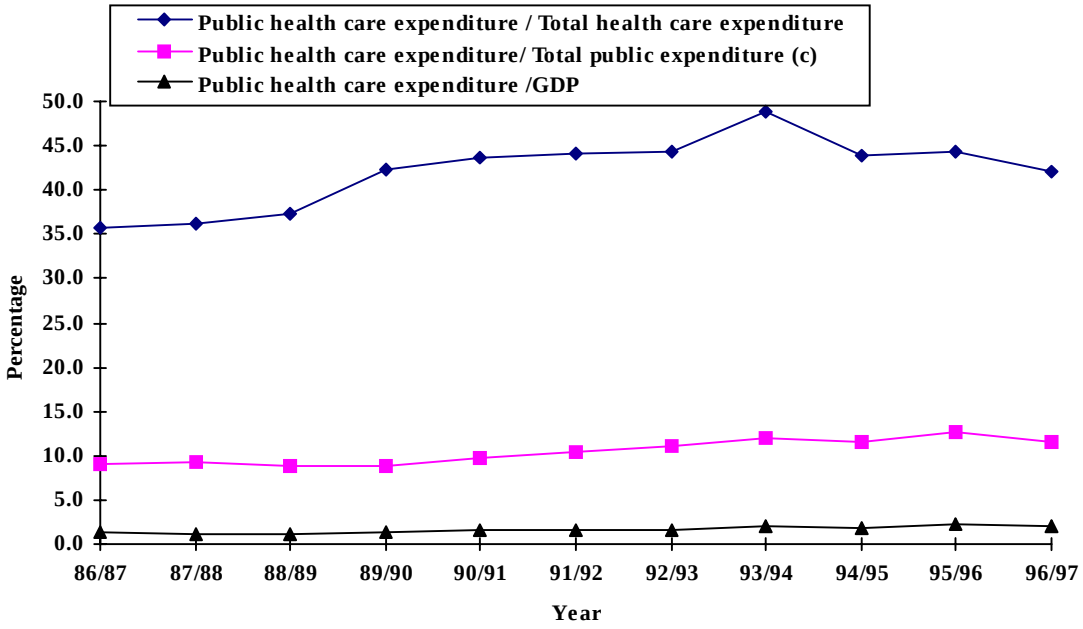
Table 4 - Health Care Expenditure in Public Expenditure ($M)

	1986/87	1987/88	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97
Public health care expenditure (a)	4,303	4,921	5,673	7,307	9,287	11,164	13,636	18,457	19,322	24,285	25,051*
Total health care expenditure (b)	12,006	13,621	15,240	17,303	21,319	25,296	30,701	37,739	44,126	54,895	59,661
Total public expenditure (c)	47,931	53,636	64,799	81,945	95,198	108,422	123,492	155,207	165,950	191,338	217,194
GDP (d)	327,710	400,323	472,813	536,263	599,671	695,525	807,353	927,290	1,028,618	1,107,024	1,234,964
(a)/(b) in %	35.8	36.1	37.2	42.2	43.6	44.1	44.4	48.9	43.8	44.2	42.0
(a)/(c) in %	9.0	9.2	8.8	8.9	9.8	10.3	11.0	11.9	11.6	12.7	11.5
(a)/(d) in %	1.3	1.2	1.2	1.4	1.5	1.6	1.7	2.0	1.9	2.2	2.0

Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

Remark: * Revised estimate

Figure 5 - Public Health Care Expenditure



Sources : Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

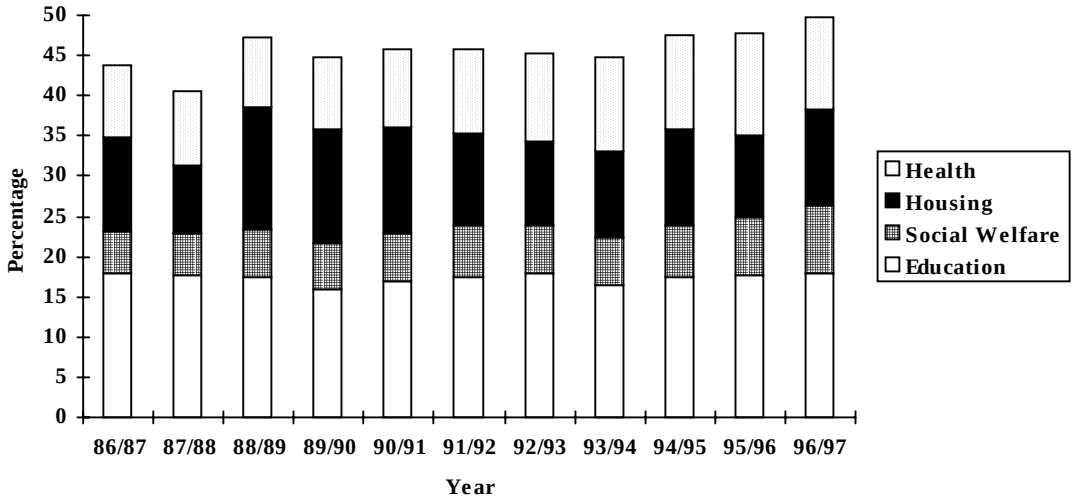
7.2 Health care expenditure as a percentage to total public expenditure has risen from 9% in 1986/87 to 11.5% in 1996/97. During the same period, education expenditure remained relatively stable at around 17% and housing expenditure around 11%. Expenditure on social welfare has increased from 5.3% in 1986/87 to 8.4% in 1996/97.

Table 5 - Proportion of Public Expenditure on Major Policy Areas (%)

	1986/87	1987/88	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97
Education	17.9	17.6	17.5	15.9	16.9	17.4	17.9	16.4	17.4	17.6	18.0
Social Welfare	5.3	5.3	5.9	5.8	6.1	6.4	5.9	5.9	6.6	7.4	8.4
Housing	11.6	8.5	15.1	14.1	13.0	11.6	10.5	10.7	11.9	10.0	11.9
Health	9.0	9.2	8.8	8.9	9.8	10.3	11.0	11.9	11.6	12.7	11.5

Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

Figure 6 - Proportion of Public Expenditure on Major Policy Areas



Sources: Hong Kong Annual Reports 1989 to 1997

7.3 The government reported that it had put emphasis on expansion of general public medical and health services, particularly hospital beds when there was a shortage of hospital beds in the 1960s and 1970s. Such historical development has resulted in a health care system which emphasizes more on curative than preventive care. The emphasis has not been changed over the years. In 1996/97, $21 billion or 84% of the public health care expenditure was allocated to HA for hospital services while about $2.6 billion or 10% of the public health care expenditure was allocated to DH (Table 6). HA expenditure has grown at an average of 17.3% per annum since its establishment. In contrast, DH expenditure has grown at an average of 13.1% per annum during the same period. Since HA and DH took up a total of 94% of the total public health care expenditure, this research will concentrate on analyzing the expenditure by these two providers of public health care.

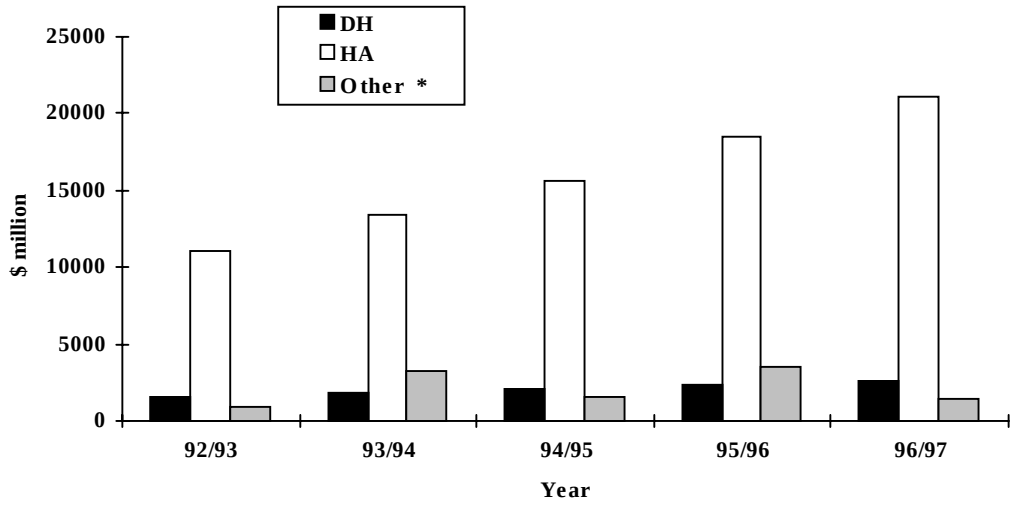
Table 6 - Major Components of Public Health Care Expenditure

Year	DH		HA		Others*	
	Amount ($M)	% to total	Amount ($M)	% to total	Amount ($M)	% to total
1992/93	1,573.4	11.5	11,131.1	81.6	931.5	6.8
1993/94	1,782.5	9.7	13,435.5	72.8	3,239.0	17.5
1994/95	2,031.0	10.5	15,664.0	81.1	1,627.0	8.4
1995/96	2,283.0	9.4	18,502.9	76.2	3,499.1	14.4
1996/97#	2,559.7	10.2	21,074.8	84.1	1,416.5	5.7

Sources: Estimates 1993/94 to 1997/98

Remarks: # Revised estimate
* Others include expenditure for relevant functions performed by the HWB, Hospital Services Department (HSD), Agriculture and Fisheries Department, Government Laboratory and subventions for Hong Kong Council on Smoking and Health.

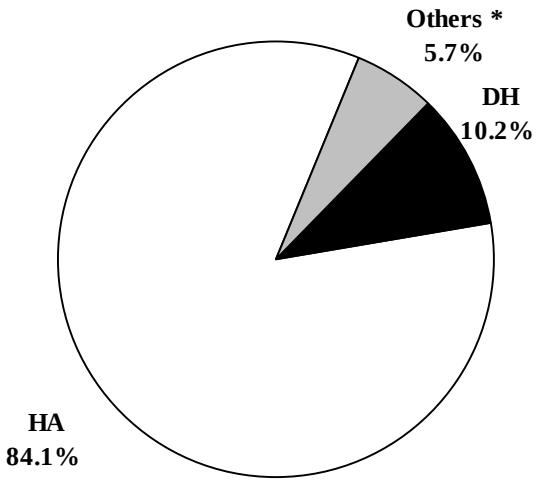
Figure 7 - Major Components of Public Health Care Expenditure



Sources: Estimates 1993/94 to 1997/98

Remarks: * Others include expenditure for relevant functions performed by the HWB, Hospital Services Department (HSD), Agriculture and Fisheries Department, Government Laboratory and subventions for Hong Kong Council on Smoking and Health.

Chart 2 - Distribution of Public Health Care Expenditure in 1996/97



Sources: Estimates 1993/94 to 1997/98

Remarks: * Others include expenditure for relevant functions performed by the HWB, Hospital Services Department (HSD), Agriculture and Fisheries Department, Government Laboratory and subventions for Hong Kong Council on Smoking and Health.

7.4 It should be noted that in 1992/93 to 1996/97, an average of 10% of the public health care expenditure (Table 6) has been taken up by functions which are not directly related to the provision of the public health care services. In 1996/97, this expenditure accounted for 5.7% of public health expenditure and was spent on the following departments, organizations and subventions[4]:

- Agriculture and Fisheries Department - to prevent the introduction and spread of animal and plant diseases
- Government Laboratory - to analyze food and pharmaceutical products and to test articles for possible safety and health hazards
- HWB - to formulate and oversee implementation of policies to safeguard and promote public health and to ensure no one is prevented, through lack of means, from obtaining adequate medical treatment
- HSD - to discharge the management responsibility for civil servants working in HA, to maintain their morale and efficiency to facilitate the smooth operation of all public hospitals in a mixed staff situation, and to look after the interests of these civil servants
- Subvention to Hong Kong Council on Smoking and Health - to provide a focal point for all initiatives against the health hazards of using tobacco products

8. Department of Health

8.1 DH became a separate department on 1 April 1989 upon the re-organization of the former Medical and Health Department[5]. DH is the government health advisor and agency to execute health care policy and statutory functions. It is responsible for the promotion of public health, disease prevention, and curative and rehabilitative services. It is the main public primary health care provider.

[4] Draft estimates for 1997/98 and DH Annual Report 1995/96

[5] On 1 April, 1989 the Medical and Health Department was re-organized into the DH and HSD. DH operated a wide range of services to promote health and prevent diseases. HSD was responsible for carrying out government policies on hospital services, specialist clinics and other facilities. On 1 December 1991, HSD transferred to HA the operational responsibilities, i.e. management and control, of all public hospitals.

Expenditure

8.2 In 1996/97, total expenditure for DH was $2,559.7 million which represented 10.2% of the public health care expenditure (Table 7). DH's expenditure was $967.8 million when it was established in 1989/90 and accounted for about 13% of the public health care expenditure. It is generally recognized that primary care could help to reduce the need for the more expensive secondary or tertiary care. However, DH as the main public provider of primary health care, has been receiving a decreasing share of the government's resources.

Table 7 - Total Expenditure for DH

Year	DH expenditure ($M)	Public health care expenditure ($M)	DH expenditure / public health care expenditure (%)
1989/90	967.8	7,307.0	13.2
1990/91	1,222.7	9,287.0	13.2
1991/92	1,405.3	11,164.0	12.6
1992/93	1,573.4	13,636.0	11.5
1993/94	1,782.5	18,457.0	9.7
1994/95	2,031.0	19,322.0	10.5
1995/96	2,283.0	24,285.0	9.4
1996/97*	2,559.7	25,051.0*	10.2

Sources: Estimates 1991/92 to 1997/98
Hong Kong Annual Reports 1989 to 1997

Remark: * Revised estimate

DH Expenditure by Major Items

8.3 Table 8 and Figure 8 show that staff cost has been the largest expenditure item for DH. Total staff cost was $1,919.6 million in 1996/97 and accounted for 75% of DH's total expenditure in that year. Expenditure on specialist supplies and equipment including drugs has been less than 8% of DH's expenditure between 1989/90 and 1996/97.

Table 8 - DH Expenditure by Major Items

Year	Total expenditure for DH ($M)	Staff cost		Expenditure on specialist supplies & equipment*		Other expenditure**	
		($M)	% of total expenditure	($M)	% of total expenditure	($M)	% of total expenditure
1989/90	967.8	695.7	71.9	75.7	7.8	196.4	20.3
1990/91	1,222.7	901.1	73.7	90.8	7.4	230.8	18.9
1991/92	1,405.3	1,026.7	73.1	102.5	7.3	276.1	19.6
1992/93	1,573.4	1,168.1	74.2	115.6	7.3	289.7	18.5
1993/94	1,782.5	1,325.7	74.4	128.6	7.2	328.2	18.4
1994/95	2,031.0	1,508.9	74.3	149.9	7.4	372.2	18.3
1995/96	2,283.0	1,712.0	75.0	164.9	7.2	406.1	17.8
1996/97#	2,559.7	1,919.6	75.0	187.6	7.3	452.5	17.7

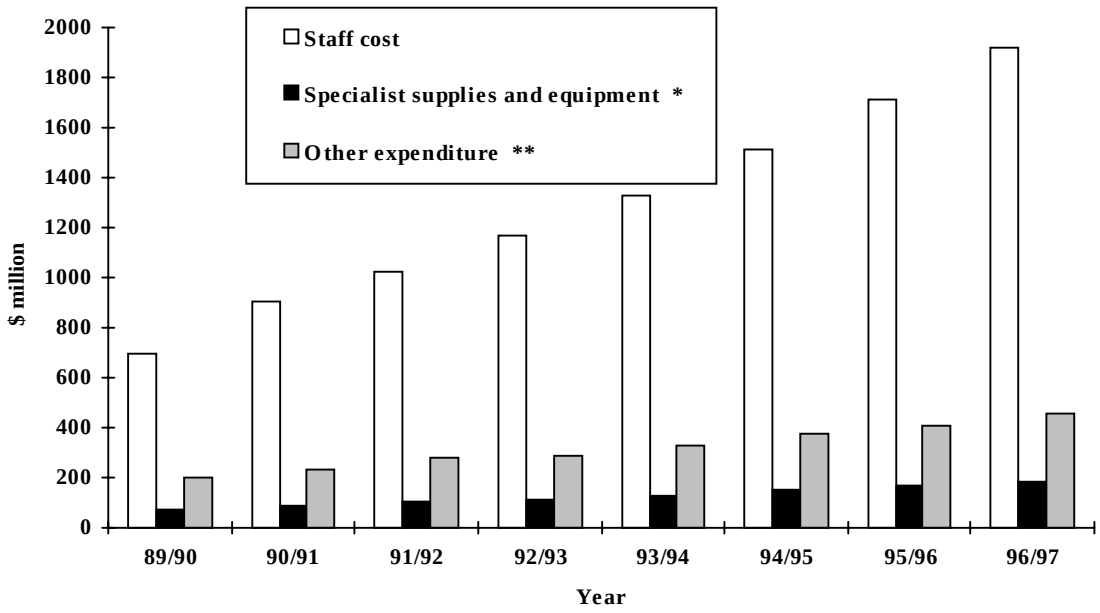
Sources: Estimates 1991/92 to 1997/98

Remarks: * Specialist supplies and equipment include medical drugs, chemicals, dressings, medical instruments, laboratory equipment, hospital bedding and medical supplies and consumables

** Other expenditure includes general departmental expenses, payment for temporary staff and contracting of dental prostheses, subventions and capital expenditure etc.

Revised estimate

Figure 8 - DH Expenditure by Major Items



Sources: Estimates 1991/92 to 1997/98

Remarks: * Specialist supplies and equipment include medical drugs, chemicals, dressings, medical instruments, laboratory equipment, hospital bedding and medical supplies and consumables

** Other expenditure includes general departmental expenses, payment for temporary staff and contracting of dental prostheses, subventions and capital expenditure etc.

DH Expenditure by Service Type

8.4 About three quarters of DH's expenditure has been spent on the provision of primary health care services to the public. In 1996/97, this amounted to $1,919.2 million (Table 9). Primary health care expenditure was $704.2 million in 1989/90 and represented 73% of DH's expenditure.

8.5 As shown in Tables 9 and 10, one quarter of DH's resources has been spent on activities not related to the provision of primary health care services to the public. In 1996/97,

- 16.8% of DH's expenditure or $430.1 million was used to provide medical and dental services for civil servants, retired civil servants and their dependents to fulfill government's contractual obligation to its employees. The proportion of DH's resources on this item has remained fairly constant since 1989/90.

- 4.4% of DH's expenditure or $112.9 million was used to provide training facilities for students of the Faculty of Dentistry of the University of Hong Kong and for dental ancillary personnel. This item followed the old item of "dental and first aid training" which consumed around 4.8% of DH's expenditure between 1989/90 and 1991/92.

- 3.8% of DH's expenditure or $97.5 million was used for treatment of drug addicts. This item has received a decreasing share of DH's expenditure, viz. 5.5% in 1989/90 to 3.8% in 1996/97.

Table 9 - DH Expenditure by Service Type ($M)

Year	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97
Primary health care	**704.2**	**903.8**	**1,037.1**	**1,178.4**	**1,335.4**	**1,518.3**	**1,707.2**	**1,919.2**
Treatment/curative care	472.3	617.4	722.5	599.8	668.7	757.2	807.3	860.6
Health education/ promotion	13.6	20.6	40.0	33.8	43.2	51.1	55.4	64.4
Disease prevention	-	-	-	431.4	496.8	569.3	669.3	795.8
Rehabilitative services	-	-	-	24.9	27.4	31.4	39.6	43.1
Family health services	183.8	223.0	235.8	-	-	-	-	-
Statutory functions[6]	-	-	-	88.5	99.3	109.3	135.6	155.3
School Medical Service Scheme	34.5	42.8	38.9	-	-	-	-	-
Non-primary health care	**263.6**	**318.9**	**368.1**	**395.0**	**447.1**	**512.7**	**575.8**	**640.5**
Medical and dental services for civil servants	162.9	203.3	238.9	261.8	299.4	349.4	391.5	430.1
Dental and first aid training	47.6	58.7	67.7	-	-	-	-	-
Prince Philip Dental Hospital	-	-	-	64.3	74.2	82.6	95.9	112.9
Treatment of drug abusers	53.1	56.9	61.5	68.9	73.5	80.7	88.4	97.5
Total	**967.8**	**1,222.7**	**1,405.2**	**1,573.4**	**1,782.5**	**2,031.0**	**2,283.0**	**2,559.7**

Sources: Estimates 1991/92 to 1997/98

Remarks: '-' means not applicable

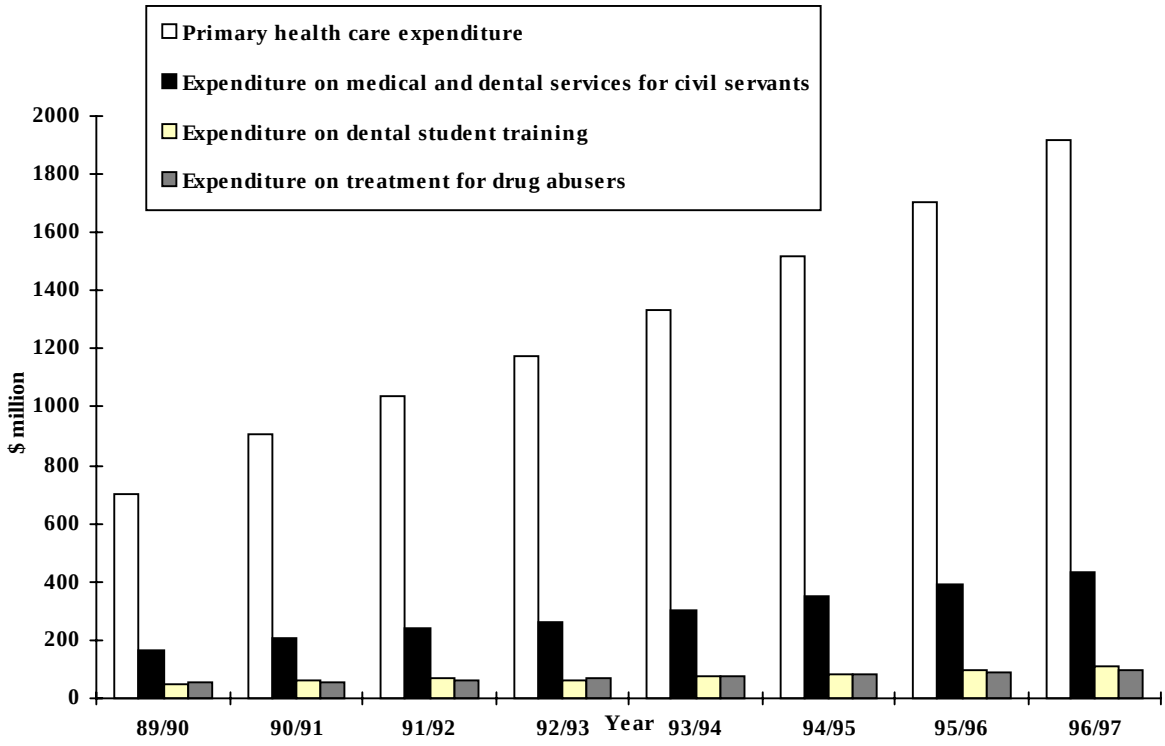
[6] Statutory functions include preventing the importation of quarantinable diseases and their spread in Hong Kong; ensuring that food available for human consumption is wholesome, hygienic, safe and properly labelled; ensuring the safety, quality and effectiveness of pharmaceutical products through product registration and licensing control; promoting/protecting the health of radiation workers and minimizing public exposure to radiation hazards; providing secretariat support to statutory bodies responsible for the registration and discipline control of health care professionals and the enforcement of legislation for the registration of health care institutions; and providing services in forensic medicine and operating public mortuaries.

Table 10 - Breakdown of DH Expenditure by Service Type (%)

	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97
Primary health care expenditure/ Total	72.8	73.9	73.8	74.9	74.9	74.8	74.8	75.0
Expenditure on medical and dental services for civil servants/Total	16.8	16.6	17.0	16.6	16.8	17.2	17.1	16.8
Expenditure on dental student training /Total	4.9	4.8	4.8	4.1	4.2	4.1	4.2	4.4
Expenditure on treatment for drug abusers/Total	5.5	4.7	4.4	4.4	4.1	4.0	3.9	3.8

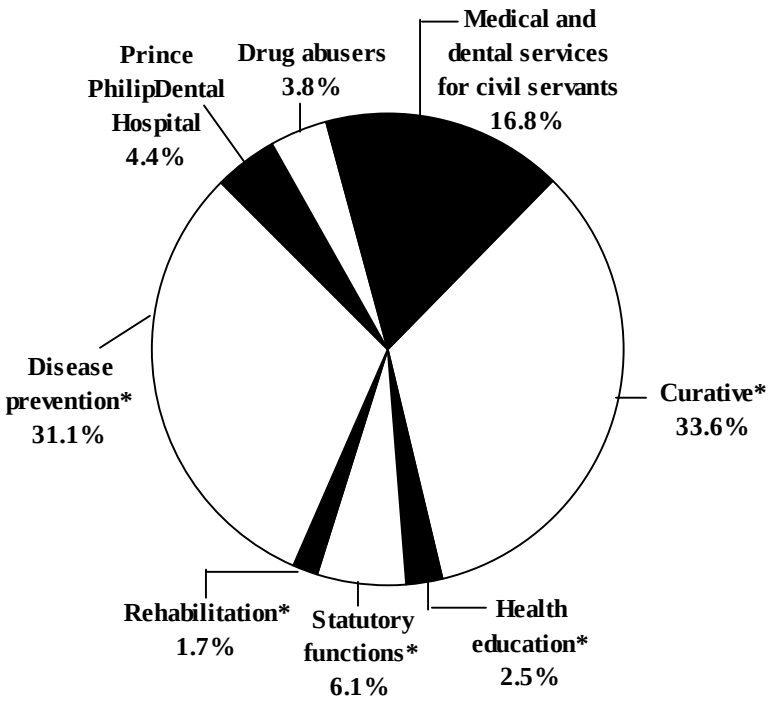
Sources: Estimates 1991/92 to 1997/98

Figure 9 - DH Expenditure by Service Type



Sources: Estimates 1991/92 to 1997/98

Chart 3 - DH Expenditure by Service Type in 1996/97



Sources: Estimates 1991/92 to 1997/98

Remark: * indicates primary health care services

Primary Health Care

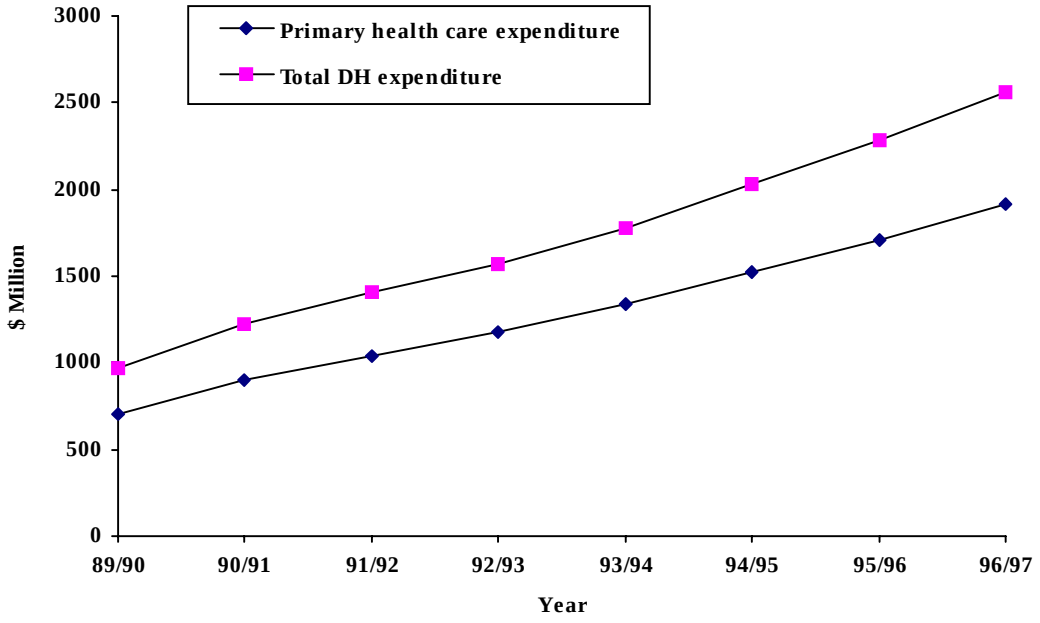
8.6 In 1996/97, primary health care expenditure amounted to $1,919.2 million, which was 7.7% of the public health care expenditure, or 3.2% of the total health care expenditure. From 1989/90 to 1996/97, primary health care expenditure has remained relatively stable at about 0.15% of GDP (Table 11). Nevertheless, within the public health care expenditure, primary health care expenditure in these past eight years (1989/90 to 1996/97) has received a decrease in allocation, viz. from 9.6% to 7.7% of the public health care expenditure and from 4.1% to 3.2% of the total health care expenditure.

Table 11 - DH Expenditure on Primary Health Care Expenditure

	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97
	$ Million							
Primary health care expenditure (a)	704.2	903.8	1,037.1	1,178.4	1,335.4	1,518.3	1,707.2	1,919.2
Total public health care expenditure (b)	7,307	9,287	11,164	13,636	18,457	19,322	24,285	25,051
Total health care expenditure (c)	17,303	21,319	25,296	30,701	37,739	44,126	54,895	59,661
GDP (d)	536,263	599,671	695,525	807,353	927,290	1,028,618	1,107,024	1,234,964
(a)/(b) in %	9.6	9.7	9.3	8.6	7.2	7.9	7.0	7.7
(a)/(c) in %	4.1	4.2	4.1	3.8	3.5	3.4	3.1	3.2
(a)/(d) in %	0.13	0.15	0.15	0.15	0.14	0.15	0.15	0.16

Sources: Census and Statistics Department
Estimates 1991/92 to 1997/98

Figure 10 - DH Expenditure on Primary Health Care



Sources: Estimates 1991/92 to 1997/98
Census and Statistics Department

Curative Care

8.7 DH provides general and specialized out-patient treatment for various illnesses. It provides primary curative care to the community through its network of GOP clinics. The SOP clinics provide curative services to patients with tuberculosis and chest diseases, skin diseases or HIV infection. Dental service is provided to hospital in-patients, emergency cases and groups with special oral health care needs. The department also subvents two herbalist clinics run by the Tung Wah Group of Hospitals with part of its budget for curative care. In 1996/97, DH spent $860.6 million on providing curative care, which represented 33.6% of its expenditure, or 44.8% of its allocation to provide primary health care services. This amounted to 3.4% of the public health care expenditure, or 1.4% of the total health care expenditure of the Hong Kong community.

8.8 Table 12 shows that DH has been spending a decreasing proportion of its resources on curative care. Resources allocated to curative care decreased from 50.9% of DH's total expenditure on primary health care in 1992/93 to about 44.8% in 1996/97. This means only 4.4% of the total public health care expenditure in 1992/93 and 3.4% in 1996/97 was for providing curative care at out-patient clinics operated by DH. DH had a bigger budget for treatment for the years between 1989/90 and 1991/92 since it also covered expenditure on surveillance, prevention and control of disease. Resources allocated to this programme area in 1989/90 amounted to 67% of DH's total expenditure.

8.9 The number of potential users of DH curative care is on the increase. In 1994/95, 337 000 students or 46% of the student population were looked after by private medical practitioners for curative service of episodic illnesses under the former School Medical Service Scheme[7] . Under the scheme, a student paid $20 (in 1994) for each consultation made to one of the 508 GPs who participated in the scheme. The abolition of the scheme in 1994 means that some of the students who were looked after by GPs under the scheme would depend on DH's out-patient clinics for curative services. On the other hand, as noted in RLS report, "Health Care for Elderly People", an increasing number of elderly people aged 65 years or above depend on DH's clinics for curative care at primary level[8] .

8.10 Faced with a smaller share of resources but an increasing demand for services, DH rationed services to patients through queuing. Waiting time for first attendance to SOP clinics increased from 8.1 weeks in 1992 to 10.9 weeks in 1996 and the number on the waiting list for SOP services increased significantly from 52 176 people to 111 933 people. Information on actual waiting time for GOP services is not available. The pledged waiting time is less than one hour for patients with episodic illness[9] .

7 DH Annual Report, 1993/94.
8 p.25, Health Care for Elderly People, RP02/PLC , 25 October, 1997.
9 p.25-28, Long Term Health Care Policy, RP01/PLC , 8 October, 1997.

8.11 It is clear from the point of view of resource allocation that the government did not expand primary curative care. However, the users, particularly the elderly patients and those with chronic illnesses would wait longer and longer unless the government improves the delivery of such services. According to DH, about one-third of the patients attending GOP clinics between 1994 and 1996 aged 65 years or above. The percentage of patients at GOP clinics with chronic illnesses in 1994, 1995 and 1996 was 41.1%, 44.4% and 43.7% respectively. While all Hong Kong residents are eligible to use GOP clinics, most of them (nearly 80%) would consult private medical practitioners or traditional Chinese medicine practitioners for out-patient services. The profile of users of GDP clinics in 1994-96 represents a disproportionate concentration of the elderly and patients with chronic illnesses. The government may need to re-examine the role played by GOP clinics so that resources would be allocated to meet the need of users such as the elderly and those with chronic illnesses more effectively.

Table 12 - Primary Curative Care Expenditure, 1989/90 to 1996/97

	1989/90*	1990/91*	1991/92*	1992/93	1993/94	1994/95	1995/96	1996/97
	$ Million							
Expenditure on treatment /curative care (a) *	472.3	617.4	722.5	599.8	668.7	757.2	807.3	860.6
Primary health care expenditure (b)	704.2	903.8	1,037.1	1,178.4	1,335.4	1,518.3	1,707.2	1,919.2
Public health care expenditure (c)	7,307	9,287	11,164	13,636	18,457	19,322	24,285	25,051
Total health care expenditure (d)	17,303	21,319	25,296	30,701	37,739	44,126	54,895	59,661
GDP (e)	536,263	599,671	695,525	807,353	927,290	1,028,618	1,107,024	1,234,964
(a)/(b) in%	67.1	68.3	69.7	50.9	50.1	49.9	47.3	44.8
(a)/(c) in%	6.5	6.7	6.5	4.4	3.6	3.9	3.3	3.4
(a)/(d) in%	2.7	2.9	2.9	2.0	1.8	1.7	1.5	1.4
(a)/(e) in%	0.088	0.103	0.104	0.074	0.072	0.074	0.073	0.070

Sources: Census and Statistics Department
Estimates 1991/92 to 1997/98

Remarks: * The programme area covered expenditure on surveillance, prevention and control of disease for the years between 1989/90 and 19991/92.

Health Education/ Promotion

8.12 DH promotes health and increases health awareness in the community through the District Health System, a wide range of health education activities including exhibitions, workshops, dissemination of materials, and the provision of training and support to various interested agencies. The work is discharged by the department's Central Health Education, Oral Health Education, AIDS and Hygiene Education Units and regional offices.

8.13 In 1996/97, health care promotion expenditure amounted to $64.4 million, which represented 3.4% of primary health care expenditure, or 2.5% of DH's total expenditure (Table 13). In other words, this item was 0.3% of the public health care expenditure, or represented 0.1% of the total health expenditure in Hong Kong. The expenditure translated into 294 000 attendance at health education activities and 930 000 calls made to pre-recorded health education telephone service. The number of people reached was 4% and 9% respectively when compared to the total population of over six million people in 1996/97.

8.14 Public expenditure on health care promotion has doubled in relative terms in the eight years between 1989/90 and 1996/97 as a proportion to GDP; but as a proportion to total health care expenditure, it has remained relatively stable at 0.11% in 1992/93 to 1996/97.

Table 13 - Health Education/Promotion Expenditure, 1989/90 to 1996/97

	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97
	$ Million							
Expenditure on health education/ promotion (a)	13.6	20.6	40.0	33.8	43.2	51.1	55.4	64.4
Primary health care expenditure (b)	704.2	903.8	1,037.1	1,178.4	1,335.4	1,518.3	1,707.2	1,919.2
Public health care expenditure (c)	7,307	9,287	11,164	13,636	18,457	19,322	24,285	25,051
Total health care expenditure (d)	17,303	21,319	25,296	30,701	37,739	44,126	54,895	59,661
GDP (e)	536,263	599,671	695,525	807,353	927,290	1,028,618	1,107,024	1,234,964
(a)/(b) in%	1.93	2.28	3.86	2.87	3.23	3.37	3.25	3.36
(a)/(c) in%	0.19	0.22	0.36	0.25	0.23	0.26	0.23	0.26
(a)/(d) in%	0.08	0.10	0.16	0.11	0.11	0.12	0.10	0.11
(a)/(e) in%	0.0025	0.034	0.0058	0.0042	0.0047	0.0050	0.0050	0.0052

Sources: Census and Statistics Department
Estimates 1991/92 to 1997/98

Disease Prevention

8.15 Disease prevention has become a programme area on DH's expenditure since 1992/93. These resources are spent to prevent and control endemic diseases and reduce avoidable disease and premature death. The work includes immunization against infectious diseases, counselling and health screening etc. In 1996/97, disease prevention expenditure amounted to $795.8 million, which represented 41.5% of primary health care expenditure, or 31.1% of DH's total expenditure. In other words, this item was 3.2% of the entire public health expenditure, or consumed 1.3% of the total health expenditure in Hong Kong.

8.16 DH has been spending an increasing amount of resources on disease prevention. In 1992/93, DH spent 36.6% of its primary health care expenditure on disease prevention, which increased to 41.5% in 1996/97.

Table 14 - Disease Prevention Expenditure

	1992/93	1993/94	1994/95	1995/96	1996/97
	$ Million				
Expenditure on disease prevention (a)	431.4	496.8	569.3	669.3	795.8
Primary health care expenditure (b)	1,178.4	1,335.4	1,518.3	1,707.2	1,919.2
Public health care expenditure (c)	13,636	18,457	19,322	24,285	25,051
Total health care expenditure (d)	30,701	37,739	44,126	54,895	59,661
GDP (e)	807,353	927,290	1,028,618	1,107,024	1,234,964
(a)/(b) in %	36.6	37.2	37.5	39.2	41.5
(a)/(c) in %	3.2	2.7	3.0	2.8	3.2
(a)/(d) in %	1.4	1.3	1.3	1.2	1.3
(a)/(e) in %	0.0534	0.0536	0.0553	0.0605	0.0644

Sources: Census and Statistics Department
Estimates 1991/92 to 1997/98

Rehabilitative Care

8.17 Rehabilitative care has become a programme area in DH since 1992/93 and provides assessment for children with developmental disabilities. In 1996/97, expenditure on rehabilitative care amounted to $43.1 million, which represented 2.3% of DH primary health care expenditure, or 1.7% of DH's total expenditure. In other words, this item was 0.2% of the public health care expenditure, or consumed 0.1% of the total health care expenditure in Hong Kong.

8.18 DH has increased its allocation of resources to rehabilitative care from 1.6% of its expenditure in 1992/93 to 1.7% in 1996/97. However, little rehabilitative services were provided to age groups other than children. The lack of sufficient rehabilitative services would pose difficulties in discharging patients especially elderly patients from hospitals and would increase the chance of re-admission.

Table 15 - Expenditure on Rehabilitative Services, 1992/93 to 1996/97

	1992/93	1993/94	1994/95	1995/96	1996/97
	$ Million				
Expenditure on Rehabilitative Services (a)	24.9	27.4	31.4	39.6	43.1
Primary health care expenditure (b)	1,178.4	1,335.4	1,518.3	1,707.2	1,919.2
Public health care expenditure (c)	13,636	18,457	19,322	24,285	25,051
Total health care expenditure (d)	30,701	37,739	44,126	54,895	59,661
GDP (e)	807,353	927,290	1,028,618	1,107,024	1,234,964
(a)/(b) in %	2.1	2.1	2.1	2.3	2.3
(a)/(c) in %	0.2	0.2	0.2	0.2	0.2
(a)/(d) in %	0.1	0.1	0.1	0.1	0.1
(a)/(e) in %	0.0031	0.0030	0.0031	0.0036	0.0035

Sources: Census and Statistics Department
Estimates 1993/94 to 1997/98

Sources of Funding

8.19 General revenue contributed to fund around 93% of DH's expenditure, as DH is a government department. DH recovers the remainder of its expenditure through fees and charges. Fees and charges collected by DH include out-patient charges, hospital charges, dental charges, charges for licensing drug manufacturers, wholesalers and retailers and charges for registration of medical and supplementary professions etc. As shown in Table 16, DH recovered $184 million or 7.7% of its expenditure through fees and charges in 1996/97. The amount was $76.3 million in 1989/90 and recovered 7.9% of DH's expenditure in that year.

8.20 Out-patient services have been the major source of income from fees and charges for DH. In 1996/97, income from out-patient charges was $121.3 million and accounted for nearly 66% of DH's total income in that year (Table 17). However, income from out-patient charges has decreased to 66% in 1996/97 from 72% in the early 1990's.

8.21 On the other hand, income from charges other than hospital charges, has increased to 34% in 1996/97 from 28% in the early 1990's. They include dental charges, charges for licensing drug manufactures, wholesalers and retailers and charges for registrations and certificates of medical and supplementary professions etc. They may represent an increasingly important source of income for DH.

8.22 It is notable to mention that income derived from hospital charges, namely charges against in-patients in six maternity homes which are mainly located on the outlying islands, have decreased to 0.1% in 1996/97 from 1.1% in 1989/90. This represents an insignificant source of income for DH.

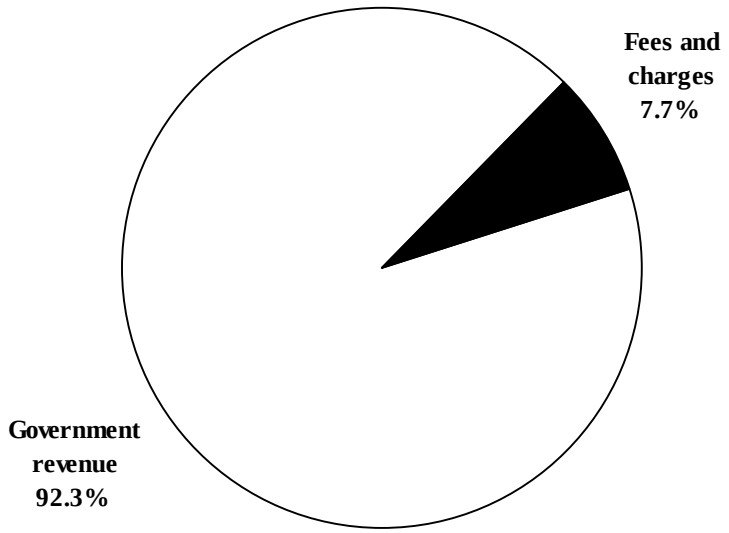
Table 16 - DH Income and Expenditure

Year	Income from fees and charges ($M)	Total expenditure ($M)	Income from fees and charges / Total expenditure (%)
1989/90	76.3	967.8	7.9
1990/91	84.3	1,222.7	6.9
1991/92	94.1	1,405.3	6.7
1992/93	104.2	1,573.4	6.6
1993/94	113.5	1,782.5	6.4
1994/95	147.0	2,031.0	7.2
1995/96	176.7	2,283.0	7.7
1996/97*	184.0	2,559.7	7.7

Sources: HWB
Estimates 1991/92 to 1997/98

Remarks: * Revised estimate

Chart 4 - Sources of Funding for DH in 1996/97



Sources: HWB
Estimates 1991/92 to 1997/98

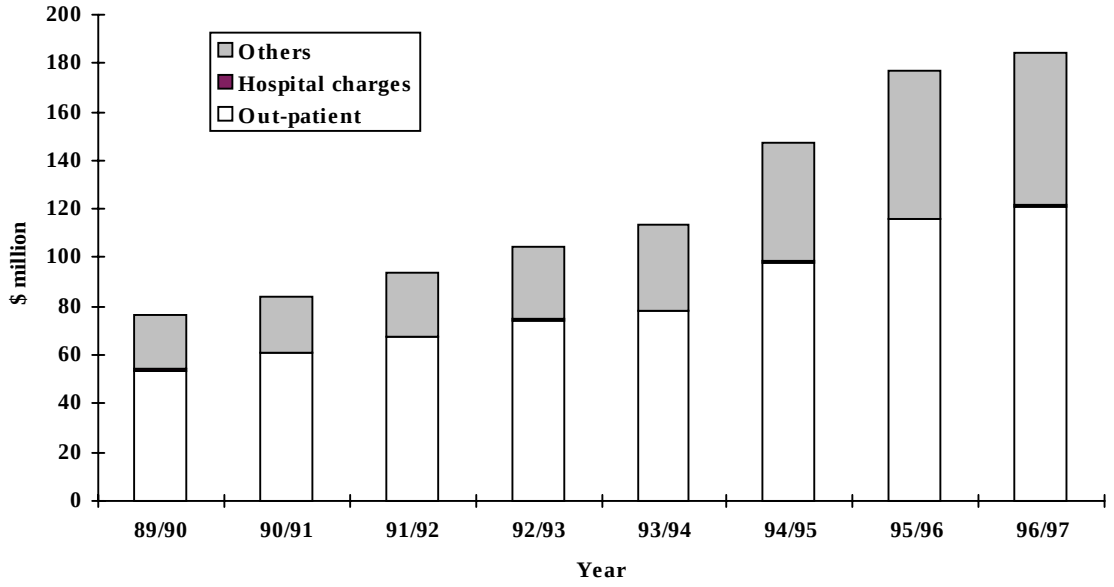
Table 17 - Breakdown of DH Income from Fees and Charges

Year	Total ($M)	Out-patient ($M)	Out-patient/ total (%)	Hospital* charges ($M)	Hospital charges/ total (%)	Others** ($M)	Others/ Total (%)
89/90	76.3	53.6	70.2	0.8	1.1	21.9	28.7
90/91	84.3	60.6	71.9	0.6	0.7	23.1	27.4
91/92	94.1	67.4	71.6	0.5	0.5	26.2	27.8
92/93	104.2	74.3	71.3	0.3	0.3	29.6	28.4
93/94	113.5	77.8	68.5	0.2	0.2	35.5	31.3
94/95	147.0	98.3	66.8	0.1	0.1	48.6	33.1
95/96	176.7	115.7	65.5	0.1	0.1	60.9	34.4
96/97	184.0	121.3	65.9	0.1	0.1	62.6	34.0

Sources: HWB
Estimates 1991/92 to 1997/98

Remarks: * Income from six maternity homes located in Tai Po, Sha Tau Kok and on outlying islands.
** Others include dental charges, charges for licensing drug manufactures, wholesalers and retailers and charges for registrations and certificates of medical and supplementary professions etc.

Figure 11 - DH Income from Fees and Charges



Sources: HWB
Estimates 1991/92 to 1997/98

8.23 Health care services provided by DH are heavily subsidized by the government. The public pay a flat rate for out-patient services and in-patient services. The current rate is $68 for in-patient services, $37 for GOP clinics and $44 for SOP clinics. The cost recovery rate for in-patient services has been around 4%. The cost recovered from GOP clinics has been around 19% of the cost and that for SOP clinics has been around 10%.

Table 18 - Cost Recovery Level for Services Provided by DH

	In-patients*			GOP			SOP		
Year	Fee ($)	Estimated Cost ($)	Recovery %	Fee ($)	Estimated Cost ($)	Recovery %	Fee ($)	Estimated Cost ($)	Recovery %
1.4.92/1.6.92 - 31.3.94	43	n.a.	n.a.	21	111	18.9	33	311	10.6
1.4.94-30.4.95	54	1,418	3.8	29	152	19.1	36	337	10.7
1.5.95-14.11.96	60	1,567	3.8	34	175	19.4	40	369	10.8
15.11.96 to present	68	1,758	3.9	37	191	19.4	44	453	9.7

Source: HWB

Remarks: * Maternity beds
n.a. means not available

Chart 5 - Cost Recovery Level for DH In-patient Services in 1996/97

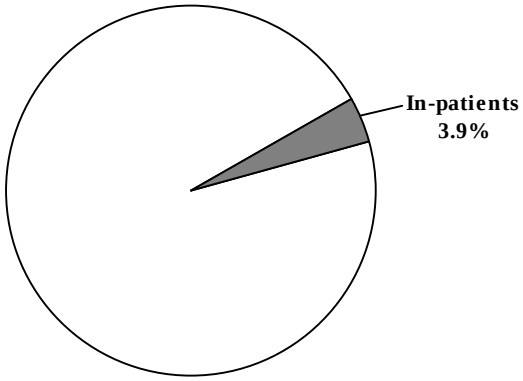


Chart 6 - Cost Recovery Level for DH GOP Services in 1996/97

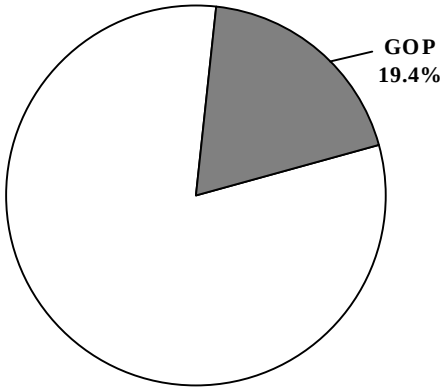
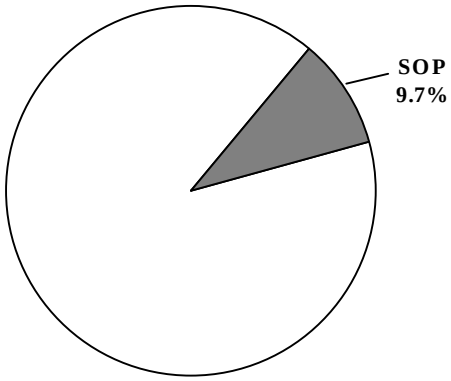


Chart 7 - Cost Recovery Level for DH SOP Services in 1996/97



Sources for Chart 5 to Chart 7: HWB

8.24 DH provides free services to CSSA recipients. According to DH, about 10.8% of the 4 130 000 patients attending GOP clinics in 1996 were CSSA recipients. The estimated amount of fees waived for CSSA recipients is given in Table 19. The estimated amount of fees waived has increased from $4.3 million in 1993/94 to $16.6 million in 1996/97. This trend implies a growing demand of GOP services by CSSA recipients.

Table 19 - Estimated Amount of Fees Waived by DH

	Total income from fees and charges ($M)	Estimated amount of fee waived by DH ($M)	% to total income from fees and charges
1993/94	113.5	4.3	3.8
1994/95	147.0	8.0	8.6
1995/96	176.7	12.6	7.1
1996/97	184.0	16.6	9.0

Source: DH

8.25 DH also provides free out-patient services to civil servants (and their dependents) and retired civil servants. The amount of revenue forgone has been relatively stable at around 19% of the total income from fees and charges for the years between 1993/94 and 1996/97 (Table 20).

Table 20 - Estimated Revenue Foregone in Providing Services to Civil Servants

	Total income from fees and charges ($M)	Estimated revenue foregone ($M)	% to total income from fees and charges
1993/94	113.5	21.4	18.9
1994/95	147.0	28.2	19.2
1995/96	176.7	34.5	19.5
1996/97	184.0	35.8	19.5

Source: DH

9. Hospital Authority

9.1 HA is a statutory body established on 1 December 1990 by the Hospital Authority Ordinance to manage all public hospitals in Hong Kong. It formally took over the management of public hospitals from HSD on 1 December 1991. While HA has launched many managerial and structural reform initiatives, it has not changed the funding arrangements. The bulk of its specialist and in-patient care is still financed by the government through revenue generated from taxation.

Expenditure

9.2 The government has been spending a large part of its health care expenditure on hospital services. In 1996/97, government's expenditure on HA reached $21 billion, representing 84% of the public health care expenditure (Table 21). Since the establishment of HA, 70% to 80% of the public health care expenditure was allocated to HA.

Table 21 - Public Expenditure on HA

Year	Government annual grant* to HA ($M)	Public health care expenditure ($M)	Government annual grant to HA / public health care expenditure (%)
1992/93	11,131.1	13,636.0	81.6
1993/94	13,435.5	18,457.0	72.8
1994/95	15,664.0	19,322.0	81.1
1995/96	18,502.9	24,285.0	76.2
1996/97**	21,074.8	25,051.0	84.1

Sources: Census and Statistics Department
Estimates 1993/94 to 1997/98

Remarks: * It should be noted that from 1994/95 onwards, government departments and agencies charge HA for providing services. In 1994/95, $34 million was earmarked for HA to take over the management of non-emergency patient transport of Hong Kong and Kowloon regions and for paying government services. In 1995/96, $49 million was earmarked for HA to take over the management of non-emergency patient transport of New Territories regions and for paying government services. In 1996/97, $41 million was earmarked for paying government services. In 1997/98, the amount for paying government services is $538 million.

** Revised estimate

HA Expenditure by Major Items

9.3 Table 22 shows that staff cost has been the largest expenditure item for HA. It has accounted for around 80% of HA's financial provision. "This reflects the labour intensive nature of the service, as well as the relatively high labour cost"[10]. Expenditure on medical supplies and equipment including drugs has been around 9% of HA's financial provision. Expensive drugs and equipment do not seem to have a great impact on HA's overall expenditure.

Table 22 - Expenditure by Major Items for HA

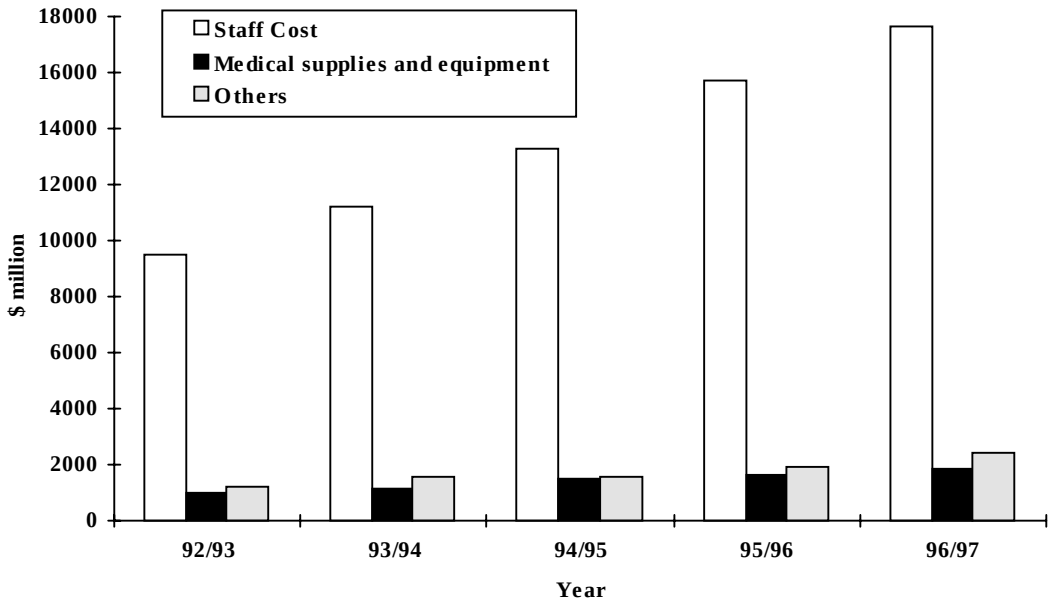
Year	Total financial provision	Staff cost		Medical supplies and equipment		Others*	
	($M)	($M)	% to total	($M)	% to total	($M)	% to total
92/93	11,662.8	9,471.3	81.2	997.1	8.6	1,194.4	10.2
93/94	14,012.2	11,236.7	80.2	1,170.6	8.4	1,604.9	11.5
94/95	16,329.9	13,255.6	81.2	1,472.0	9.0	1,602.3	9.8
95/96	19,256.9	15,710.6	81.6	1,632.6	8.5	1,913.7	9.9
96/97**	21,865.8	17,609.4	80.5	1,854.0	8.5	2,402.4	11.0

Sources: HA Annual Reports 1992/93 to 1995/96
HA Annual Plans 1996/97 to 1997/98

Remarks: * Others include other operating expenses, expenses on leases etc.
** Revised estimate

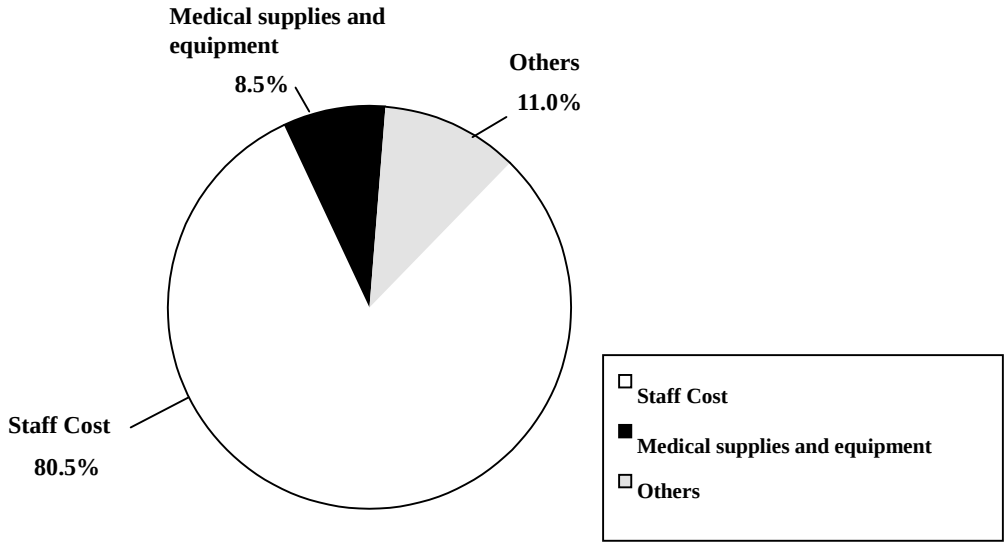
[10] p.16 HA Business Plan 1992/93.

Figure 12 - HA Expenditure by Major Items



Sources: HA Annual Reports 1992/93 to 1995/96
HA Annual Plans 1996/97 to 1997/98

Chart 8 - HA Expenditure by Major Items in 1996/97



Sources: HA Annual Reports 1992/93 to 1995/96
HA Annual Plans 1996/97 to 1997/98

HA Expenditure by Service Type

9.4 About 75% of HA's expenditure has been spent on acute and extended care for patients who stay in hospitals for treatment. This amounted to $16,346.5 million in 1996/97. The demand for public hospital services has been great. In 1986, the number of in-patient days in public hospitals was 6.5 million. The number rose to 7.4 million in 1996, representing an increase of nearly one million in-patient days or an increase of 14% in 10 years[11] .

9.5 About 22% of HA's expenditure was spent on ambulatory care in 1996/97. This amounted to $6,346.5 million. HA spent 2% of its expenditure on community care in 1996/97 which amounted to $430.7 million in that year.

Table 23 - Estimated HA Expenditure by Service Type ($M)

Service Type	Component	1994/1995	1995/1996	1996/1997*
Recurrent	**Total recurrent expenditure**	**15,995.9**	**18,906.9**	**21,536.9**
Acute & Extended care	***Total in-patient expenditure***	***12,332.8***	***14,444.9***	***16,346.5***
	Acute and General hospitals	11,405.0	13,405.0	15,162.0
	Psychiatric hospitals	927.8	1,039.9	1,184.5
Ambulatory care	***Total ambulatory care expenditure***	***3,391.1***	***4,102.8***	***4,759.7***
	A&E	847.8	1,002.0	1,120.0
	SOP	2,399.4	2,930.6	3,445.9
	GOP & staff clinics	143.9	170.2	193.8
Community care	***Total community care expenditure***	***272.0***	***359.2***	***430.7***
Capital	**Total capital expenditure**	**334.0**	**350.0**	**328.9**
TOTAL	**HA TOTAL**	**16,329.9**	**19,256.9**	**21,865.8**

Source: HA

Remarks: * Provisional
Data in the table was based on HA expenditure/budget (including HA headquarters, non-hospital institutions, and education service) but has excluded notional costs such as depreciation, and services provided by the government.

[11] For details, please refer to p.28-29, Long Term Health Care Policy, RP01/PLC, 8 October, 1997.

Table 24 - Proportion of HA Expenditure by Care Type (%)

	1994/95	1995/96	1996/97
Acute and extended care expenditure / total HA expenditure (%)	75.5	75.0	74.8
Ambulatory care expenditure / total HA expenditure (%)	20.8	21.3	21.8
Community care expenditure / total HA expenditure (%)	1.7	1.9	2.0
Capital expenditure / total HA expenditure (%)	2.0	1.8	1.5

Source: HA

Acute and Extended Care

9.6 Acute care refers to treatment provided to patients in the acute stage of illness to restore health. Such care is provided to patients requiring intensive medical, nursing and technological input. Extended care refers to services provided to patients requiring continuous medical and nursing care for an extended period and includes convalescent, rehabilitative and infirmary care. The largest amount of HA expenditure has been allocated to acute and general hospitals. These hospitals provide acute and/or extended care. In 1996/97, $15,162 million or 69.3% of HA's total resources was allocated to acute and general hospitals (Table 25). This means 60.5% of the public health care expenditure or 25.4% of the total health care expenditure was spent on acute and general hospitals. The percentage has been fairly constant at around 69% between 1994/95 and 1996/97.

Table 25 - HA Expenditure on Acute & General Hospitals ($M)

	1994/95	1995/96	1996/97
Acute & General hospitals (a)	11,405.0	13,405.0	15,162.0
HA Total (b)	16,329.9	19,256.9	21,865.8
Public health care expenditure (c)	19,322.0	24,285.0	25,051.0
Total health care expenditure (d)	44,126.0	54,895.0	59,661.0
GDP (e)	1,028,618.0	1,107,024.0	1,234,964.0
(a)/(b) in %	69.8	69.6	69.3
(a)/(c) in %	59.0	55.2	60.5
(a)/(d) in %	25.8	24.4	25.4
(a)/(e) in %	1.1088	1.2109	1.2277

Source: HA

9.7 Psychiatric care is also a type of extended care. It includes care for both the mentally ill and the mentally handicapped. HA spent $1,184.5 million or 5.4% of its resources on psychiatric hospitals in 1996/97 (Table 26). This means 4.7% of public health care expenditure or 2% of total health care expenditure was spent on psychiatric care in that year. The percentage of HA resources on psychiatric care has been fairly stable at around 5% in the three years between 1994/95 and 1996/97.

Table 26 - HA Expenditure on Psychiatric Hospitals ($M)

	1994/95	1995/96	1996/97
Psychiatric hospitals (a)	927.8	1,039.9	1,184.5
HA Total (b)	16,329.9	19,256.9	21,865.8
Public health care expenditure (c)	19,322.0	24,285.0	25,051.0
Total health care expenditure (d)	44,126.0	54,895.0	59,661.0
GDP (e)	1,028,618.0	1,107,024.0	1,234,964.0
(a)/(b) in %	5.7	5.4	5.4
(a)/(c) in %	4.8	4.3	4.7
(a)/(d) in %	2.1	1.9	2.0
(a)/(e) in %	0.0902	0.0939	0.0959

Source: HA

9.8 Table 27 shows that in 1996/97, there were a total of 25 947 public hospital beds in Hong Kong, comprising 70% (18 250) general acute beds, 22% (5 770) psychiatric beds, and the remaining 7% (1 927) infirmary beds.

9.9 In 1996/97, general acute beds each cost $3,370 per day, infirmary beds each cost $1,611 per day, and psychiatric beds each $765 per day.

9.10 HA has recognized an increasing shortfall in infirmary beds in both of its review on the demand and supply of hospitals in 1992 and 1995[12] . In 1996/97, the shortfall was 2 233 infirmary beds. (Please see Appendix II for details). If the shortfall continues, some of the expensive general acute beds may be taken up by patients who need extended care such as elderly patients and patients with chronic diseases.

9.11 The average bed occupancy rate for general in-patients has been increasing. The rate was 76.5% in 1992/93 and has increased to 82.8% in 1996/97. However, separate occupancy rate for general acute beds and infirmary beds is not available. It is not possible to know if patients requiring extended care have occupied the more expensive general acute beds due to the shortfall in supply of infirmary beds.

[12] HA Business Plan 1993/94 and HA Annual Plan 1995/96.

9.12 The average occupancy rate of beds for mentally ill patients has been higher than that for general acute beds during 1992/93 to 1996/97. However, the rate has decreased from 93.8% in 1993/94 to 89.5% in 1996/97.

9.13 The average occupancy rate of beds for mentally handicapped patients has been higher than that for general acute beds except in 1994/95. The occupancy rate has increased from 79.2% in 1993/94 to 85.5% in 1996/97. The hospital beds for both mentally ill patients and mentally handicapped patients are much cheaper than general acute beds.

Table 27 - Distribution, Cost and Occupancy Rate of Hospital Beds

Number of hospital beds	**92/93**	**93/94**	**94/95**	**95/96**	**96/97**
General	16 506	16 788	17 240	17 677	18 250
Infirmary	1 128	1 203	1 462	1 772	1 927
Mentally ill	4 471	4 471	4 639	4 843	4 945
Mentally handicapped	525	825	825	825	825
Total	22 630	23 287	24 166	25 117	25 947
Cost per bed per day ($)					
General acute	2 200	2 590	2 850	3 107	3 370
Infirmary	1 100	1 100	1 200	1 350	1 611
Psychiatric (mentally ill & mentally handicapped)	470	550	650	710	765
Average bed occupancy rate (%)					
General in-patient services	76.5	78.8	79.2	81.4	82.8
Mentally ill in-patient services	n.a.	93.8	94.6	90.5	89.5
Mentally handicapped in-patient services	n.a.	79.2	78.1	84.7	85.5

Sources: Estimate 1993/94 to 1997/98
Remark: n.a. means not available

Ambulatory Care

9.14 Ambulatory care refers to services delivered to patients on an out-patient or day only basis. It includes A&E services, SOP services and GOP services.

9.15 About 5% of HA's total expenditure or $1,120 million (Table 28) in 1996/97 was spent on A&E services. This means 4.5% of public health care expenditure or 1.9% of total health care expenditure was for A&E services. The amount of HA resources allocated to A&E services has been fairly stable at around 5% in the three years between 1994/95 and 1996/97. The demand for A&E attendance increased rapidly by 16.1% and 14.2% over the previous year in 1994/95 and 1995/96 respectively. The rate of increase slowed down to 5.1% in 1996/97 (Table 29).

Table 28 - HA Expenditure on A&E Services ($M)

	1994/95	1995/96	1996/97
A & E services (a)	847.8	1,002.0	1,120.0
HA Total (b)	16,329.9	19,256.9	21,865.8
Public health care expenditure (c)	19,322.0	24,285.0	25,051.0
Total health care expenditure (d)	44,126.0	54,895.0	59,661.0
GDP (e)	1,028,618	1,107,024	1,234,964
(a)/(b) in %	5.2	5.2	5.1
(a)/(c) in %	4.4	4.1	4.5
(a)/(d) in %	1.9	1.8	1.9
(a)/(e) in %	0.0824	0.0905	0.0907

Source: HA

Table 29 - Utilization of A&E Services

Year	A&E Attendance*	Year-on-year change (%)
1992/93	1 378 181	-
1993/94	1 492 637	8.3
1994/95	1 733 040	16.1
1995/96	1 979 212	14.2
1996/97	2 080 006	5.1

Source: HA

Remarks: * Figures in the table included A&E attendance for the Hong Kong Eye Hospital.
Except for 1992/93, figures in the table covered both first and follow up attendance.
'-' means not applicable

9.16 SOP services include specialist medical consultation, physiotherapy, occupational therapy and other rehabilitative services. A number of clinical specialties are also run mainly on an out-patient basis and are delivered through centres for ophthalmology, for ear, nose and throat services. HA spent $3,445.9 million or 15.8% of it resources on SOP services (Table 30) in 1996/97. It means 13.8% of the public health care expenditure or 5.8% of the total health care expenditure was for SOP services.

9.17 The demand for SOP services is increasing rapidly. Attendance to HA's SOP services rose quickly from about 2.5 million in 1986 to more than 4 million in 1995[13]. As the modern trend of health care provision has been a shift from in-patient based services to ambulatory care, the government may need to review allocation of resources between in-patient services and SOP services to ensure that the demands of patients could be satisfied in the most cost-effective way.

Table 30 - HA Expenditure on SOP ($M)

	1994/95	1995/96	1996/97
SOP (a)	2,399.4	2,930.6	3,445.9
HA Total (b)	16,329.9	19,256.9	21,865.8
Public health care expenditure (c)	19,322.0	24,285.0	25,051.0
Total health care expenditure (d)	44,126.0	54,895.0	59,661.0
GDP (e)	1,028,618.0	1,107,024.0	1,234,964.0
(a)/(b) in %	14.7	15.2	15.8
(a)/(c) in %	12.4	12.1	13.8
(a)/(d) in %	5.4	5.3	5.8
(a)/(e) in %	0.2333	0.2647	0.2790

Source: HA

[13] p.27, Long Term Health Care Policy, RP01/PLC , 8 October, 1997.

9.18 Expenditure on GOP services amounted to less than 1% of HA's expenditure. It has been a relatively minor function for HA.

Table 31 - HA Expenditure on GOP ($M)

	1994/95	1995/96	1996/97
GOP & Staff Clinic (a)	143.9	170.2	193.8
HA Total (b)	16,329.9	19,256.9	21,865.8
Public health care expenditure (c)	19,322.0	24,285.0	25,051.0
Total health care expenditure (d)	44,126.0	54,895.0	59,661.0
GDP (e)	1,028,618.0	1,107,024.0	1,234,964.0
(a)/(b) in %	0.9	0.9	0.9
(a)/(c) in %	0.7	0.7	0.8
(a)/(d) in %	0.3	0.3	0.3
(a)/(e) in %	0.0140	0.0154	0.0157

Community Care

9.19 Community care is an extension of hospital services into the community and home environment for the patients. Community care includes community nursing service, psychiatric day service and geriatric day service. HA spent 2% of its resources or $430.7 million on community care in 1996/97. It means 1.7% of the public health care expenditure or 0.7% of the total health care expenditure was for community care. The availability of community care would help to reduce pressure on hospital beds. There has also been a large demand for geriatric day hospital from elderly patients[14].

[14] p.35-36, Health Care for Elderly People, RP02/PLC, 25 October, 1997.

Table 32 - HA Expenditure on Community Care ($M)

	1994/95	1995/96	1996/97
Community Care (a)	272.0	359.2	430.7
HA Total (b)	16,329.9	19,256.9	21,865.8
Public health care expenditure (c)	19,322.0	24,285.0	25,051.0
Total health care expenditure (d)	44,126.0	54,895.0	59,661.0
GDP (e)	1,028,618.0	1,107,024.0	1,234,964.0
(a)/(b) in %	1.7	1.9	2.0
(a)/(c) in %	1.4	1.5	1.7
(a)/(d) in %	0.6	0.7	0.7
(a)/(e) in %	0.0264	0.0324	0.0349

Source: HA

Sources of Funding

9.20 HA had surplus during the initial years of its establishment when budgeted expenditure was lower than income. It began to have a small deficit in 1994/95 and 1995/96.

Table 33 - HA Income and Expenditure

Year	Surplus/(Deficit) ($)
1992/93	65,673,000
1993/94	134,671,000
1994/95	(51,909)
1995/96	(45,954)

Sources: HA Annual Reports, 1992/93 to 1995/96

Government Grant

9.21 Government grant is the major source of funding for HA. Table 34 and Figure 13 show that government grant for HA in 1996/97 was more than $21 billion and accounted for 96% of HA's total income. The amount was $11 billion in 1992/93 and amounted to 95.4% of HA's total income.

9.22 The government grant consists of three block grants, one for recurrent expenditure, another for capital accounts, and a third for information technology. The amount funded is subject to negotiation with the Government on a yearly basis, and subject to the approval of the legislature.

9.23 Within this framework, HA is permitted to generate alternative sources of revenue and seek donations. Income from these sources will not be taken into account by the Government when determining the annual grant. The Authority may also retain 50% of any real increases in fees and charges and savings up to 5% of the budgeted expenditure.

Table 34 - HA Income from Different Funding Sources ($M)

Year	Government annual grant	Medical fees and charges			Non-medical charges *	Total
		Inpatient	Outpatient	Others **		
1992/93	11,131.1	261.0	144.0	17.0	110.0	11,662.8
1993/94	13,435.5	285.0	147.0	23.0	121.0	14,012.2
1994/95	15,664.0	315.0	174.0	29.0	148.0	16,329.9
1995/96	18,502.9	322.0	218.0	32.0	182.0	19,256.9
1996/97 ***	21,074.8	361.0	231.0	37.0	162.0	21,865.8

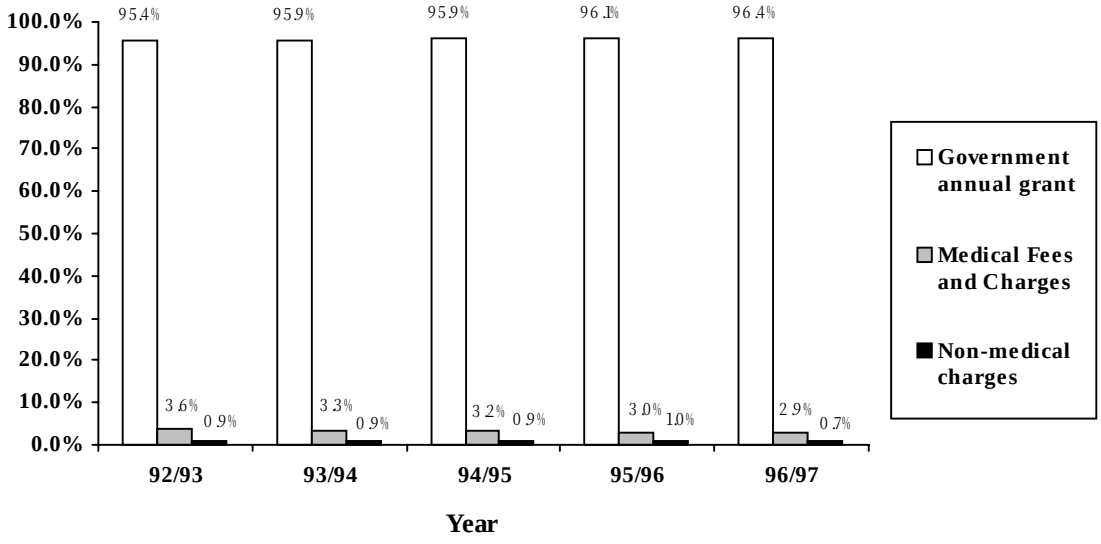
Sources: Estimates 1993/94 to 1997/98 and HA

Remarks: * Other medical fees and charges are derived from community nursing service, community psychiatric nursing service, geriatric day hospital, psychiatric day hospital and medical reports

** Non-medical charge includes investment income, rental income and other sources of income etc.

*** Revised estimate

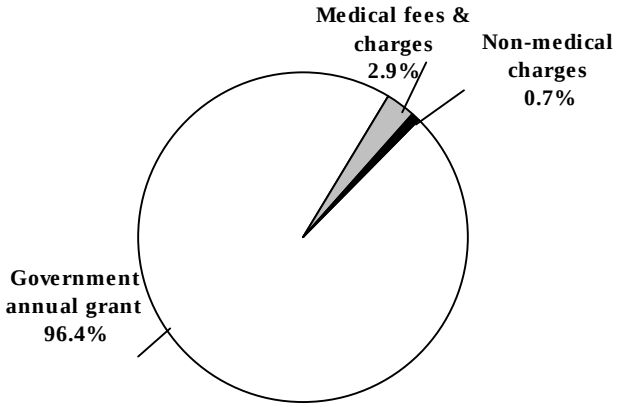
Figure 13 - Funding Sources for HA



Sources: Estimates 1990/91 to 1997/98 and HA

Remark: * Non-medical charge includes investment income, rental income and other sources of income etc.

Chart 9 - Funding Sources for HA in 1996/97



Sources: Estimates 1990/91 to 1997/98 and HA

Remark: * Non-medical charge includes investment income, rental income and other sources of income etc.

Medical Fees and Charges

9.24 Hospitals under HA provide a comprehensive range of secondary and tertiary care at a heavily subsidized rate. Patients pay a fixed, all-inclusive fee for hospital services and specialist services. The flat rate is based on the cost of providing meals only, but the payment covers the provision of treatment, and all X-ray and laboratory tests. In addition to the daily charges, patients need to pay the full cost of certain medical items (Appendix III). However, for those who cannot afford to pay for medical items, they can apply to the Samaritan Fund for financial assistance.

9.25 It is noted in Table 34 that medical fees and charges amounted to $629 million and accounted for 3% of HA's total income in 1996/97. This represented an increase of 49% from $422 million, or 3.6%, of HA's total income in 1992/93. The cost recovery rate for in-patient services varies from 2% for general acute beds to 4.2% for convalescent and infirmary beds and 8.9 % for psychiatric beds in 1996/97 (Table 35). Patients pay a flat rate at $68 in 1996/97 for hospital services.

9.26 Income generated from fees and charges remains low since only a small percentage of the cost of providing the services is recovered. To raise public awareness of the cost associated with the public hospital services provided, HA lists the cost of hospital treatment on patient bills. The average full cost of services listed is calculated based on the estimated average cost per bed-day for the respective type of hospitals.

Table 35 - Cost ($) and Cost Recovery Rate (%) for In-patient Services

	General acute			Infirmary			Psychiatric		
Year	Fees and Charges ($)	Cost ($)	Cost Recovery (%)	Fees and Charges ($)	Cost ($)	Cost Recovery (%)	Fees and Charges ($)	Cost ($)	Cost Recovery (%)
1992/93	43.0	2,200.0	2.0	43.0	1,000.0	4.3	43.0	470	9.1
1993/94	54.0	2,590.0	2.1	54.0	1,100.0	4.9	54.0	550	9.8
1994/95	54.0	2,850.0	1.9	54.0	1,200.0	4.5	54.0	650	8.3
1995/96*	60.0	3,107.0	1.9	60.0	1,350.0	4.4	60.0	710	8.5
1996/97*	68.0	3,370.0	2.0	68.0	1,611.0	4.2	68.0	765	8.9

Source: HA

Note: * Costs for these years are projected based on 1994/95 annual costing using inflation rates advised by Treasury

9.27 Cost recovery rate for SOP services decreased to 9.2% in 1996/97 from 12.5% in 1992/93 (Table 36). The cost recovery rate for GOP services also decreased to 21% in 1996/97 from 26% in 1994/95. A&E services which are provided free of charge cost $623 per attendance in 1996/97.

Table 36 - Cost ($) and Cost Recovery Rate (%) for Ambulatory Care

	SOP services			GOP services			A&E services		
Year	Fees and Charges Per Attendance ($)	Cost ($)	Cost Recovery (%)	Fees and Charges Per Attendance ($)	Cost ($)	Cost Recovery(%)	Fees and Charges Per Attendance ($)	Cost ($)	Cost Recovery (%)
1992/93	33.0	265.0	12.5	21.0	n.a.	-	Free	473.0	-
1993/94	33.0	340.0	9.7	21.0	n.a.	-	Free	522.0	-
1994/95	36.0	386.0	9.3	29.0	111.0	26.1	Free	541.0	-
1995/96	40.0	441.0	9.1	34.0	152.0	22.4	Free	574.0	-
1996/97*	44.0	478.0	9.2	37.0	175.0	21.1	Free	623.0	-

Source: HA

Remarks: n.a. means not available
- means not applicable

9.28 The cost recovery rate for community nursing service increased to 14% in 1996/97 from 9.9% in 1993/94 (Table 37). Geriatric day service has recovered around 5.6% of the cost through fees and charges. The cost recovery rate for psychiatric day service has been around 10%.

Table 37 - Cost Recovery Level for Community Services

	Community nursing service			Geriatric day service			Psychiatric day service		
Year	Fees and Charges ($)	Cost ($)	Cost Recovery (%)	Fees and Charges ($)	Cost ($)	Cost Recovery (%)	Fees and Charges ($)	Cost ($)	Cost Recovery (%)
1992/93	34.0	n.a.	n.a.	34.0	n.a.	n.a.	34.0	n.a.	n.a.
1993/94	34.0	345.0	9.9	34.0	n.a.	n.a.	34.0	n.a.	n.a.
1994/95	44.0	328.0	13.4	44.0	818.0	5.4	44.0	486.0	9.1
1995/96	48.0	361.0	13.3	48.0	909.0	5.3	48.0	503.0	9.5
1996/97*	55.0	393.0	14.0	55.0	987.0	5.6	55.0	547.0	10.1

Source: HA

Remark : n.a. means not available

9.29 HA provides free services to CSSA recipients. In 1996/97, there were an estimated number of 97 000 CSSA in-patient and 538 000 out-patient episodes in 1996/97. Those who did not have enough means to pay the charges could apply to have their fees and charges waived. The amount of fees waived in the past few years is given in Table 38. This signifies a growing proportion (from 22.7% of total income from medical fees and charges in 1992/93 to 35.5% in 1996/97) of payment which has been waived. Hence, this trend also implies a growing demand for public subsidy for medical treatment offered at HA hospitals.

Table 38 - Medical Fees and Charges Waived by HA

Year	Total income from medical fees and charges ($M)	Estimated amount of fee waived ($M)	% to total income from medical fees and charges
1992/93	422.0	96.0	22.7
1993/94	455.0	87.0	19.1
1994/95	518.0	132.0	25.5
1995/96	572.0	154.0	26.9
1996/97	629.0	223.0	35.5

Source: HA

9.30 HA also provides some services free of charge to civil servants (over 180,000). The existing arrangement between the government and HA in providing health care benefits for civil servants is as follows:

- pensioners and civil servants (and their eligible family members) are entitled to free medical services at all SOP clinics and at the GOP department of Fanling Hospital and St. John Hospital;

- HA staff on civil service terms and their eligible family members are eligible for free medical services at GOP departments of all HA hospitals, as well as HA's staff clinics

The estimated revenue forgone for health care services provided to civil servants is given in Table 39. This represented the loss of 35.9% of potential income from medical fees and charges. HA also provides free health care services to its staff (46 000) but there is no estimate on the amount of revenue foregone.

9.31 Since 71.4% of HA's income from medical fees and charges in 1996/97 was foregone or waived, it means that in effect, $449 million revenue could have contributed to decreasing 2.1% of the funding from the public purse.

Table 39 - Revenue Foregone for Services to Civil Servants

Year	Total income from medical fees and charges ($M)	Estimated revenue foregone ($M)	% to total income from medical fees and charges
1992/93	422.0	170.0	40.3
1993/94	455.0	174.0	38.2
1994/95	518.0	182.0	35.1
1995/96	572.0	240.0	42.0
1996/97	629.0	226.0	35.9

Source: HA

Private Patients

9.32 While Hong Kong residents receive heavily subsidized hospital services, non-Hong Kong residents pay the full average maintenance cost of all hospital beds and the full cost of professional services. In 1997, non-residents have to pay $3,130 per day for acute and infirmary bed and $865 per day for psychiatric bed. Revenue from private patients for 1996/97 was $70.9 million. This represented 11.3% of total income from medical fees and charges or 0.3% of HA's total expenditure in that year. HA in a reply to RLS said that there was currently no plan to increase revenue from the private ward.

Donations

9.33 HA is permitted to seek donations to fund its expenditure. One of the guiding principles for accepting donation is that it should predominantly be for or of benefit to patient care. Donations for specific use are accounted for in a designated fund under reserves account. Non-specified cash donations for general operating purposes are recorded as donations in the income and expenditure account in the year of receipt and grouped under income generated by non-medical charges. Non-medical charges accounted for 0.7% of HA's income in 1996/97.

Table 40 - Donations to HA ($M)

Year	Capital donations	Designated donations	Non-specified cash donations
1992/93	13.6	11.5	1.3
1993/94	97.0	38.5	28.2
1994/95	211.2	53.7	9.9
1995/96	382.6	42.6	8.1

Source: HA Annual Reports 1992/93 to 1995/96

Discussion

9.34 The government has put less than 8% of the public health care expenditure on primary health care in 1996/97. This compared to 84% of the public health care expenditure allocated to hospital services.

9.35 With such resource allocation, a large part of the potential users of public primary health care services have to seek treatment from medical practitioners in the private sector to satisfy their needs especially for out-patient services. The government may need to re-define the role of GOP clinics operated by DH so that services could be delivered more effectively to patients in need of care.

9.36 Apart from primary curative care, disease prevention received the largest share of resources when compared to the other two types of services under primary health care i.e. health education/promotion, and rehabilitative services. Expenditure on disease prevention would enable diseases to be detected and treated in an early stage and would help to reduce demand on the more expensive secondary and tertiary care. However, health education and rehabilitative care which are equally important have been allocated with little resources.

9.37 Expenditure on general acute beds is likely to be higher than that on other beds since 70% of beds under HA are acute beds and they are the most expensive. Only 7% of beds under HA have been provided for infirmary care. The supply of infirmary beds may not be sufficient to meet the increasing demand by elderly patients and may result in some of the general acute beds being occupied by elderly chronic patients. The government may need to examine the distribution of resources among the various types of beds. It may also need to examine the role of ambulatory care and community care in reducing the pressure on hospital services.

9.38 The existing government policy does not distinguish users in terms of their ability to pay. Everyone in the community has access to public hospital services and out-patient services at low charges. In 1996/97, DH received 93% of its expenditure from the public purse while HA received 96%. If the increase in demand for public health care services outpaces the increase in government funding, patients would face decrease in quality of services e.g. longer waiting time. The government may need to review its policy on charging and in rationing services through queuing to deliver health services in a cost-effective manner to those who need the care.

PART 5 - PRIVATE HEALTH CARE EXPENDITURE AND SOURCES OF FUNDING

10. Private Health Care Expenditure

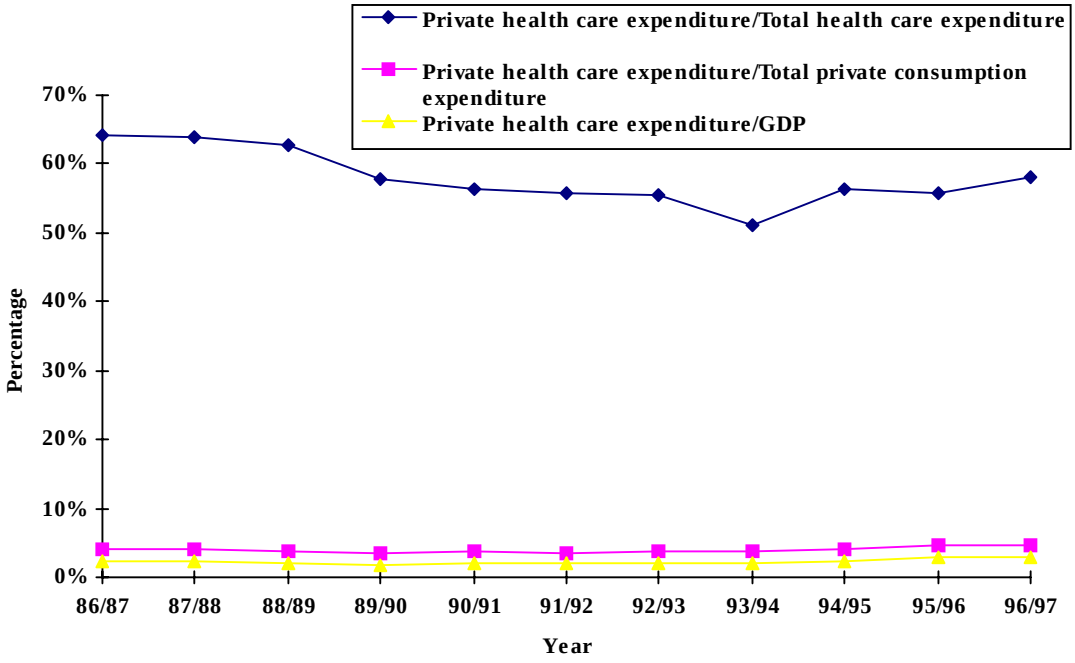
10.1 In 1996/7, private health care expenditure amounted to $34,610 million. Private health care expenditure has increased more than four times from $7,703 million to $34,610 million between 1986/87 and 1996/97. It accounted for 4.1% of total private consumption expenditure in 1986/87 and 4.8% in 1996/97 (Table 41).

Table 41 - Private Health Care Expenditure

	86/87	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97
Private health care expenditure (a)	7,703	8,700	9,567	9,996	12,032	14,132	17,065	19,282	24,804	30,610	34,610
Total health care expenditure (b)	12,006	13,621	15,240	17,303	21,319	25,296	30,701	37,739	44,126	54,895	59,661
Total private consumption expenditure (c)	189,159	219,315	254,682	287,677	330,459	391,098	451,670	514,239	592,665	661,254	728,092
GDP (d)	327,710	400,323	472,813	536,263	599,671	695,525	807,353	927,290	1,028,618	1,107,024	1,234,964
(a)/(b) in %	64.2	63.9	62.8	57.8	56.4	55.9	55.6	51.1	56.2	55.8	58.0
(a)/(c) in %	4.1	4.0	3.8	3.5	3.6	3.6	3.8	3.7	4.2	4.6	4.8
(a)/(d) in %	2.4	2.2	2.0	1.9	2.0	2.0	2.1	2.1	2.4	2.8	2.8

Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

Figure 14 - Private Health Care Expenditure



Sources: Census and Statistics Department
Hong Kong Annual Reports 1989 to 1997

10.2 Private health care has increased as a proportion to GDP, from 2.4% in 1986/87 to 2.8% in 1996/97. This signified a relative increase in private consumption on health care.

10.3 In 1996/97, $26,048 million or about 75% of the private health care expenditure was spent on medical treatment by western medicine such as doctor consultation and hospital services (Table 42). However, there is no information on the breakdown of the medical treatment expenses into the proportion spent on primary medical services and hospital services respectively. The proportion of health care expenditure on medical treatment as a whole has increased from 67.5% in 1986/87 to 75.3% in 1996/97.

10.4 In 1996/97, about $8,562 million or 25% of the private health care expenditure was spent on medicines and drugs. These include expenses on over-the-counter drugs, Chinese medicine and consultation with traditional Chinese medicine practitioners. The proportion of health care expenditure on medicines and drugs has decreased from 32.5% in 1986/87 to 24.7% in 1996/97.

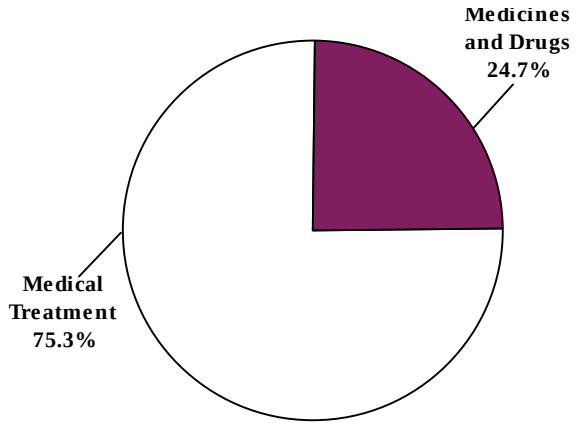
Table 42 - Breakdown of Private Health Care Expenditure

Year	Expenses on medical treatment ($M)	Expenses on medical treatment/ Total private health care expenditure (%)	Expenses on medicines and drugs ($M)	Expenses on medicine and drugs/Total Private Health expenditure (%)
1986/87	5,201	67.5	2,502	32.5
1987/88	5,675	65.2	3,025	34.8
1988/89	6,310	66.0	3,257	34.0
1989/90	7,153	71.6	2,843	28.4
1990/91	8,593	71.4	3,439	28.6
1991/92	9,872	69.9	4,260	30.1
1992/93	11,793	69.1	5,272	30.9
1993/94	14,087	73.1	5,195	26.9
1994/95	18,094	72.9	6,710	27.1
1995/96	22,024	72.0	8,586	28.0
1996/97	26,048	75.3	8,562	24.7

Source: Census and Statistics Department

Remarks: Expenses on medical treatment include consultation with both private and public doctors. The Census and Statistics Department estimated expenses on consultation with private GPs based on the results of a benchmark survey conducted once every five years.
Expenses on medicines and drugs include expenses on consultation with traditional Chinese medicines practitioners.

Chart 10 - Expenditure on Medical Treatment and Drugs in 1996/97



Source: Census and Statistics Department
Remark: Expenses on medicines and drugs include expenses on consultation with traditional Chinese medicine practitioners.

10.5 While on the whole, the public spent $26,048 million on medical treatment and $8,562 million on medicines and drugs in 1996/97, some age groups in fact consumed more health care services than other age groups. Table 43 shows that elderly persons aged 65 years or above had the highest chance of hospitalization according to a survey by the Census and Statistics Department in 1995[15]. The rate of hospitalization for children aged below 5 years ranked second among all age groups. For age groups between 15-24 years and 55-64 years, the chance of going to hospitals tended to increase with age.

Table 43 - Rate of Hospitalization by Age Groups

Age group (years)	In-patients*
	Rate per 1 000 persons
= 4	50.7
5 - 14	12.0
15 - 24	13.7
25 - 34	28.8
35 - 44	28.5
45 - 54	31.6
55 - 64	38.9
= 65	66.7
Overall	30.4
Median (years)	40.0

Source: Special Topics Report No. 13, Census and Statistics Department, 1996

Notes: * 1995 information

[15] Special Topics Report No.13, Census and Statistics Department, 1996.

10.6 Table 44 shows that children aged below 5 years had the highest chance of consulting doctors for out-patient services according to a survey by the Census and Statistics Department in 1996[16]. Elderly persons aged 65 years or above ranked second in the rate of doctor consultation. The rate of doctor consultation tended to increase with age for age groups between 15-24 years and 55-64 years. Based on the rates of hospitalization and doctor consultation, it is inferred that health care expenditure for those aged below 5 years and those aged 65 years or above is likely to be higher than that of other age groups.

Table 44 - Rate of Doctor Consultation by Age Groups

Age group	Doctor consultation for Out-patient services*
	Rate per 1 000 persons
= 4	298.0
5 - 14	148.0
15 - 24	99.0
25 - 34	110.0
35 - 44	122.0
45 - 54	154.0
55 - 64	181.0
= 65	233.0
Overall	149.0
Median (years)	37.0

Source: Special Topics Report No. 15, Census and Statistics Department, 1997

Notes: * 1996 information

[16] Special Topics Report No. 15, Census and Statistics Department, 1997.

10.7 In addition to expenses paid directly at the point of obtaining health care services, some individuals would purchase insurance to foot future bills on doctor consultation and hospitalization. Insurance payment is a kind of health care expenditure for the consumers. According to the Annual Report 1996 of the Office of the Commissioner of Insurance, gross premium for the class "accident and health" increased from $1,109 million in 1991 to $2,302.9 million in 1995 (Table 45). However, breakdown of premiums in terms of accident insurance and health insurance is not available.

Table 45 - Gross Premium for Accident and Health Insurance ($M)

Year	Total
1991	1,109.5
1992	1,316.7
1993	1,719.6
1994	2,078.5
1995	2,302.9

Source: Office of the Commissioner of Insurance Annual Report 1996

Sources of Funding for Individuals

10.8 In funding their health care needs, individuals either pay directly at the point of service delivery or indirectly through tax or insurance. Individual users in Hong Kong are using a combination of the three funding methods in varying degrees.

Taxation

10.9 It is noted in Part 4 that public health care services funded by taxation are not able to satisfy all the needs of individuals. This is particularly obvious in primary health care. Most people have to obtain primary curative care from private medical practitioners or traditional Chinese medicine practitioners who together provide about 77% of out-patient care to the public[17] . About 10% of the in-patients used private hospitals instead of the tax-financed public hospitals[18] .

[17] p.11 to p.12, Long Term Health Care Policy, RP01/PLC, 8 October 1997.
[18] p.13 and p.29, Long Term Health Care Policy, RP01/PLC, 8 October 1997.

User Charges

10.10 Monthly income is the major source for individuals in paying their health care needs. The median monthly employment earnings was between $2,800 to $3,000 in 1986 and $9,000 and $10,000 in 1996 (Table 46). Per capita health care expenditure was about $460 in 1996 and accounted for 4.6% to 5.3% of the median monthly employment earnings in that year. Such level of health care expenditure was sufficient to cover fees for consultations with private GPs and user charges for public out-patient clinics. According to the findings of a survey conducted by the Hong Kong Medical Association in 1996, the median fees charged by private GPs and specialists were $150 and $350 respectively[19] . Private GPs and traditional Chinese medicine practitioners together provide about 77% of the out-patient care to Hong Kong people. Outpatient care by public hospitals and clinics provide about 23% of the primary curative care[20] . Public GOP and SOP clinics charged $34 and $40 respectively in 1996.

Table 46 - Median Monthly Employment Earnings and Health Care Expenditure

Year	Median Monthly Employment Earnings ($)	Monthly Per Capita Health Care Expenditure ($)	% to Median Monthly Employment Earnings
1986	2,800 - 3,000	116.30	3.9 - 4.2
1987	3,200 - 3,400	130.00	3.8 - 4.1
1988	3,600 - 4,000	141.60	3.5 -3.9
1989	4,400 - 4,800	146.40	3.1 - 3.3
1990	5,100 - 5,500	175.90	3.2 - 3.4
1991	5,800 - 6,200	204.80	3.3 - 3.5
1992	6,600 - 6,900	244.80	3.5 - 3.7
1993	7,000 - 7,500	272.30	3.6 - 3.9
1994	8,000	342.80	4.2
1995	8,500 - 9,500	414.80	4.4 - 4.8
1996	9,000 - 10,000	457.10	4.6 - 5.3

Source: Census and Statistics Department

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

[20] p.11 to p.12, Long Term Health Care Policy, RP01/PLC, 8 October 1997.

10.11 In Hong Kong, about 90% of the in-patient care is delivered by public hospitals and about 10% by private hospitals[21]. According to the survey conducted by the Census and Statistics Department in 1995[22], the median total charges for staying in private hospitals for a median duration of three days were $10,000 (Table 47) for patients who did not have operation, and $18,000 for those who had operation. The level of either total median charges was found to be higher than the median monthly employment earnings in 1995. Median monthly employment earnings was between $8,500 and $9,000 in 1995.

Table 47 - Total Charges by Private Hospital in 1995

Total charges paid ($)	Whether had operation performed in operating theatre					
	Yes		No		Total	
	No. ('000)	%	No. ('000)	%	No. ('000)	%
Known	**27.5**	**99.4**	**21.0**	**98.4**	**48.5**	**98.9**
<5,000	0.9	3.2	4.6	21.7	5.4	11.2
5,000 - 9,999	3.2	11.5	5.8	27.5	8.9	18.4
10,000 - 14,999	5.6	20.4	5.3	25.0	10.9	22.4
15,000 - 19,999	4.6	16.6	1.8	8.3	6.3	13.0
20,000 - 29,999	6.1	22.3	1.4	6.7	7.5	15.5
30,000 - 39,999	3.2	11.5	1.4	6.7	4.6	9.4
= 40,000	4.0	14.7	0.9	4.2	4.9	10.1
Unknown	**0.2**	**0.6**	**0.4**	**1.6**	**0.5**	**1.1**
Total	***27.7***	***100.0***	***21.4***	***100.0***	***49.0***	***100.0***
Median* ($)	18,000		10,000		13,000	

Source: Table 3.3b, Special Topics Report No.13, Census and Statistics Department, 1996

[21] p.13 and p.29, Long Term Health Care Policy, RP01/PLC, 8 October 1997.
[22] Special Topics Report No.13, Census and Statistics Department, 1996.

Insurance

10.12 Individuals with medical insurance or company medical benefits were found to have a higher rate of using private hospitals (Table 48). In the survey conducted by the Census and Statistics Department in 1995[23] , it was found that among those in-patients who were covered by medical insurance or company medical benefits, 60.7% stayed in private hospitals (21 400 out of 35 200). Among those who did not have medical insurance or company medical benefits, 18.3% (27 100 out of 147 800) stayed in private hospitals.

Table 48 - Medical Insurance and Choice of Hospitals

Whether charges covered by medical insurance or subsidized by employers	Type of hospital of last admission					
	Hospital Authority		Private		Total	
	No. ('000)	%	No. ('000)	%	No. ('000)	%
Yes	**13.8**	**10.3**	**21.4**	**43.6**	**35.2**	**19.2**
Percentage of charges covered or subsidized						
25%	0.4	2.5	0.4	1.6	0.7	2.0
25% - 49%	2.1	15.2	1.1	4.9	3.2	9.0
50% - 74%	2.3	16.5	5.3	24.6	7.5	21.4
75% - 100%	7.9	57.0	13.7	63.9	21.5	61.2
Unknown	1.2	8.9	1.1	4.9	2.3	6.5
No	**120.6**	**89.6**	**27.1**	**55.4**	**147.8**	**80.8**
Don't know	**0.2**	**0.1**	**0.5**	**1.1**	**0.7**	**0.4**
Total	***134.6***	***100.0***	***49.0***	***100.0***	***183.7***	***100.0***

Source: Table 3.1g, Special Topics Report No.13, Census and Statistics Department, 1996

[23] Special Topics Report No.13, Census and Statistics Department, 1996.

10.13 Table 48 also showed that for those who stayed in private hospitals, 43.6% (21 400 out of 49 000) were covered by medical insurance or company medical benefits.

10.14 Among those who stayed in public hospitals, about 10% had some form of medical insurance or medical subsidy provided by employers (13 800 out of 134 600) (Table 48). If these patients stayed in private wards of the public hospitals, they would have paid the full cost for their services. If they stayed in semi-private wards or public wards, they would have enjoyed between 40% to 98% of government subsidy for the hospital services. One possible explanation for patients with medical benefits using subsidized public hospital services is that there are limits to the number of times and amount of expenses one can claim under an insurance package. Individuals may turn to public hospitals if they have used up their claims under the insurance package. In addition, without the certainty of the length of hospital stay and how much would be incurred, some people would choose to use public hospitals. Furthermore, since public hospital services are accessible to all Hong Kong residents, some other users may have used public hospitals due to easy accessibility and not have considered carefully the cost even though they could afford higher charges.

10.15 It should be noted that insurance companies would charge high-risk persons a higher premium since they are more likely to claim benefits than low-risk clients. For example, premium for elderly people would be higher than that for young people. People with chronic diseases are unlikely to receive underwriting from insurance companies. In the private insurance system, high-risk groups, the old and the chronically ill, and those who do not have insurance would fall back on the public system for treatment unless they have enough means to satisfy their health care needs including those on hospital services.

11. Discussion

11.1 Private health care expenditure has increased by four times in the past 10 years. Health care expenditure for pre-school children and elderly people is likely to be higher than that of other age groups since they are found to have a higher chance of using both out-patient and in-patient services.

11.2 Individuals need to use their income to pay user charges at the point of receiving health care services. They may also subscribe to insurance plans and claim compensation after they receive treatment. Fees charged by GPs have been generally affordable for people with median monthly employment earnings. However, the median total charges for private hospitals are found to be higher than median monthly employment earnings. Those with median monthly employment earnings may not be able to afford private hospitals without using other means. Those who have medical insurance or company medical benefits are found to have a higher rate in using private hospitals.

PART 6 - OVERALL DISCUSSION

12.1 The government maintains its policy that no one should be prevented, through lack of means, from obtaining adequate medical treatment. However, the policy does not give clear direction for resource allocation on different types of health care services.

12.2 The government has put emphasis on hospital services rather than on primary health care due to the more pressing need for hospital services during the 1950s and 1960s. However, the emphasis was perpetuated due to a lack of comprehensive review of health care policy since 1974. The overall expenditure for primary health care is relatively small and has accounted for a decreasing share of the public health care expenditure.

12.3 Primary health care, if well delivered, would reduce demand on hospital services and thus would reduce the overall expenditure on health care services. While DH has increased resources for disease prevention, the amount is small in terms of total public health care expenditure. For other aspects of primary health care services, little resources have been provided for health education and rehabilitative services. It is clear that decreasing share of resources has been allocated to primary curative care, probably reflecting that the out-patient services operated by DH were not a priority. However, the government has not set a policy on how to deliver the services effectively to those who depend on the services such as the elderly and patients with chronic illnesses.

12.4 Expenditure for general acute beds is likely to be higher than that for other types of beds. The supply of infirmary beds may not be able to meet the demand especially when there is an increasing number of elderly patients. The more expensive acute beds may be occupied by elderly patients with chronic diseases if the shortfall in supply of infirmary beds continues. While about 21% of HA's resources are allocated to ambulatory services, the supply of SOP services may not be able to satisfy the rapidly increasing demand.

12.5 The public's health care needs have not been fully satisfied in the public health care system which is financed by taxation. Most individuals have to consult GPs for primary curative care and have to pay out-of-pocket for the expenses. Out-patient services offered by private GPs are generally affordable for those who have median employment earnings. Private hospitals provide about 10% of the in-patient care in Hong Kong. The median total charges for private hospitals are found to be higher than median monthly employment earnings. Individuals with median employment earnings would not be able to afford private hospitals unless he has medical insurance or savings.

12.6 Tax is used for financing public health care services in Hong Kong. User charges have played a limited role in cost recovery. More and more people are having private insurance to meet their health care needs. There are also suggestions that earmarked tax and central insurance should be explored as options for financing the growing health care expenditure. The merits and disadvantages of individual financing system and their applicability to Hong Kong need detailed examination.

12.7 The government may need to review the resource allocation among the various types of services within the public health care system to ensure the quality and cost-effectiveness of services. The government may also need to identify services that require additional resources and draw up an overall strategy in financing the existing and new services.

Appendix I

WORKING PARTY ON PRIMARY HEALTH CARE

Terms of reference

(1) To review the present primary health care in Hong Kong with reference to the provision of -

a) the general out-patient service,

b) maternal and child health care including family planning,

c) the school medical service,

d) health education,

e) immunization against the major infectious diseases and prevention and control of communicable and non-communicable diseases;

and to review where there are adequate arrangements for coordinating the various parts of the service.

(2) Following from (1) above, to advise on measures and changes needed to improve the delivery of primary health care to the public.

(3) To suggest arrangements to strengthen the co-ordination between the out-patient clinics and the hospitals including the issues of keeping patients out of hospitals and encouraging ambulatory care.

(4) To consider whether general out-patient services and any other aspects of primary health care should be brought under the Hospital Authority.

(5) To examine the respective roles of the public and private sectors and the educational bodies with the aim of achieving better co-ordination and co-operation among those sectors in the overall development of primary health care in Hong Kong.

(6) To assess the resource implications required for implementing the recommendations.

Membership

Chairman	Professor Rosie T T YOUNG, OBE, JP	
Members	Professor S P B DONNAN	(until 12.05.1990)
	Professor P C LEUNG	(from 13.05.1990)
	(nominated by The Chinese University of Hong Kong)	
	Professor John C Y LEONG	
	(nominated by the University of Hong Kong)	
	Dr. Anthony NG	
	(nominated by the Hong Kong Medical Association)	
	Dr. Christopher D ADAMSON-LUNG	
	(nominated by the British Medical Association, Hong Kong Branch)	
	Dr. Peter C Y LEE, LLD, JP	
	(nominated by the Hong Kong College of General Practitioners)	
	Mr. Donald CHIA	
	Mrs. Alice CHONG	
	Miss Mona LO	
	Miss Moyna WONG	
	Mr. YEUNG Po-kwan, OBE, CPM, JP	
Ex Officio	Chairman, School Medical Service Board	
	Dr. Natalis C L YUEN, JP	
	Director of Health	
	Dr. S H LEE, ISO, JP	
	Deputy Director of Health	
	Dr. K H PANG, JP	
	A representative of the Hospital Services Department	
	Deputy Director of Hospital Services (Professional Services)	
	Dr. Lawrence F M LAI, JP	
	A representative of the Finance Branch	
	Assistant Financial Secretary	
	Mr. Brian BRESNIHAN	
	A representative of the Health and Welfare Branch	
	Principal Assistant Secretary for Health and Welfare	
	Mrs. Carrie LAM	
Secretary	Assistant Secretary for Health and Welfare	
	Mr. G F WOODHEAD	(until 31.05.1990)
	Ms Annie CHOI	(from 01.06.1990)

Appendix II

The Projected Demand for Public Hospital Beds for 1993 to 1997

Year	General beds	Special beds			
		Infirmary	Mentally-ill	Mentally-handicapped	Total
1993	16 720	3 730	5 800	1 270	27 520
1994	17 050	3 830	5 830	1 260	27 970
1995	17 450	3 940	5 870	1 250	28 510
1996	17 720	4 050	5 890	1 240	28 900
1997	18 050	4 160	5 920	1 220	29 350

Note : The planning basis of the special beds are as follows:

1. Infirmary
   - General 5 beds per 1 000 population aged 65 and over
   - Mental 1.5 beds per 10 000 population
2. Mentally-ill 1 bed per 1 000 population
3. Mentally-handicapped 1/3 of the estimated number of severely mentally handicapped, based on a prevalence rate of 0.1% for the 0-39 age group and 0.0004% for the above 39 age group.

Source: Hong Kong Hospital Authority Business Plan 1993 - 1994.

Appendix III

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

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