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Panel on Health Services

**Background paper prepared by the Legislative Council Secretariat
for the meeting on 19 July 2005**

Health Care Reform

Purpose

This paper gives an account of the past discussions by the Panel on Health Services (the Panel) on health care reform.

Background

“Towards Better Health”

2. In 1993, the document “Towards Better Health”, commonly known as the “Rainbow Document”, was published by the Government. The document highlighted the need to reform the health care system and identified five options as possible remedies, which included the percentage subsidy approach, target group approach, coordinated voluntary insurance, compulsory insurance, and prioritisation of treatment. As none of the options or a combination of them had the general support of the community, it was decided at the end of the consultation period that the status quo should be maintained.

“Improving Hong Kong’s Health Care System : Why and For Whom”

3. In November 1997, the Government commissioned a team of economists, physicians, epidemiologists, and public health specialists from Harvard University (the Harvard Team) to conduct a study of Hong Kong’s health care system and recommend reform options. The Harvard Team submitted their final Report to the Administration in March 1999. According to this Report, the present system suffered from three key weaknesses, i.e. compartmentalisation in the delivery of service; variable quality of care, particularly in the private sector; and questionable financial and organisational sustainability. The study included a comprehensive assessment of the current

system, and a proposal for alternative options to improve financing and delivery of health care. The report of the study was published in April 1999 and a four-month consultation exercise followed.

4. During the consultation period, the Administration received over 2 200 written submissions from all sectors of the community offering advice and suggestions on how to improve Hong Kong's care system. While opinions on different reform options varied, the public was generally supportive of the need for reform. There was a concern that unless some reform measures were carried out, the health care system might not be able to continue to offer the community the same quality of services in the future.

“Lifelong Investment in Health”

5. In December 2000, having regard to the outcome of the consultation exercise, the Government issued a Health Care Reform Consultation Document entitled “Lifelong Investment in Health” to seek public views on a package of reform proposals.

“Improving Hong Kong's Health Care System: Why and For Whom” (the Harvard Report)

6. At the meeting of the Panel on Health Services on 12 April 1999, Professor William HSIAO and Professor Winnie YIP of the Harvard Team briefed members on their assessment of Hong Kong's health care system.

Achievements of the system

7. The Harvard Team highlighted the following achievements of the Hong Kong health care system -

- (a) Hong Kong had a relatively equitable system, i.e. the majority of Hong Kong residents had equal access to health care services and similar utilisation rates regardless of financial means; and
- (b) the establishment of the Hospital Authority (HA) in 1990 had brought steady improvements to the quality and efficiency of public hospitals : Patients had become more satisfied with the technical quality of care as well as the attitudes of health care personnel. Efficiency gains had also been made in specific areas such as procurement of drugs.

Weaknesses of the system

8. The Harvard Team pointed out that Hong Kong's health care system had

the following weaknesses -

- (a) the long-term financial sustainability of the current health care system was highly questionable. Having regard to the factors for growth including the ageing population, increasing specialisation in medicine, rising public expectations for quality health care services, and increasing adoption of new technology, public health expenditure as a share of government expenditure, which was 14% in 1996-97, might rise to 20 to 23% in the next 18 years;
- (b) Hong Kong's health care system was highly compartmentalised. There were "thick walls" between the public and private sectors and between primary, secondary and tertiary care. The lack of coordination and cohesion between primary and inpatient care, acute and community medicine, and the private and public sectors often resulted in duplication of services and discontinuity of health care. In addition, Hong Kong's health care system, being a hospital dominated system with emphasis on medical specialisation, was outdated. Such a system did not suit the needs of the society, which experienced growing incidence of chronic diseases and growing socio-health problems, such as mental disease, substance abuse and violence; and
- (c) the quality of health care was highly variable. Patients were dissatisfied with poor communication between patients and providers, long waiting time and the limited time physicians spent with patients. Hong Kong also lacked ongoing training in family medicine. The highly variable quality of care was caused by several factors combined including physician dominance, the privilege enjoyed by the medical profession to self-regulate without strong check and balance measures put in place and the fact that patients did not have adequate information on how to make a rational decision in choosing a provider or the treatment option.

Guiding principle

9. The Harvard Team pointed out that the Government-appointed Steering Committee had consensus on the guiding principle for health care reform in Hong Kong, which was "Every resident should have access to reasonable quality and affordable health care. The Government assures this access through a system of shared responsibility between the Government and residents where those who can afford to pay for health care should pay."

Reform options

10. The Harvard Team put forward the following options for discussion -
- (a) status quo : the fundamental problems in the system would become more serious as time went by.
 - (b) cap the Government budget : quality of and access to public health care services would fall. Those who could afford would go to the private sector and the demand for private insurance would grow.
 - (c) raise user fees : user fees would lead to increase 17 to 23 times by 2016. Patients who paid \$68 in 1998 for hospital care would have to pay \$1,400 for each day of hospitalisation in 2016.
 - (d) Health Security Plan (HSP) and MEDISAGE : this option had two components in meeting the multiple needs of the population. A MEDISAGE programme was proposed to deal with the need for elderly care. Under MEDISAGE, employers and employees would contribute 1% of wages to individual savings accounts for long-term care insurance. Compulsory enrolment in an insurance (HSP) was proposed to cover large medical expenses of the population. Under HSP, employers and employees together would pay 2% of wages. The plan would cover large and unexpected medical expenses for inpatient care and outpatient specialist care for certain chronic diseases such as cancer and diabetic conditions.
 - (e) Competitive Integrated Health Care : the financing arrangements in this option would be similar to those of the previous option but the benefit package would be expanded to include preventive care, outpatient care, hospital care and rehabilitation. Under this option, HA would be re-organised into 12 to 18 regional health integrated systems that could contract with private general practitioners and specialists to provide a defined benefit package of total care. Private hospitals and physician groups could similarly organise themselves into integrated systems to provide “total care”.

Deliberations of the Panel

11. During the ensuing discussion at the meeting on 12 April 1999, members raised various questions about MEDISAGE and HSP. Members noted that MEDISAGE did not cover spouses because 70% of families had

both spouses working. The benefit package of MEDISAGE could be modified to cover spouses but the contribution rate would be higher. Some members expressed concern about the heavy burden on employees in having to contribute to health care on top of their contribution to the Mandatory Provident Fund (MPF).

12. The Secretary for Health and Welfare (SHW) responded that the Government was open about how to reform the health care system. She said that the Government needed time to consider what the future system should be. Even though HA was an important part of the health care system and took up a lot of resources, the Government did not want to resort to piece-meal solutions by considering how to reform HA only.

13. Following the initial discussion at the meeting on 12 April 1999, the Panel discussed Hong Kong's health care system, the direction of future reform, and health care financing at six subsequent meetings. Deputations from the health care professions and patient organisations were invited to present their views at five of the meetings.

14. At the meeting on 28 June 1999, the Medical Council of Hong Kong informed members that it had decided that all general practitioners would be required to undergo continuing medical education. It was also considering increasing the number of its lay members to enhance its transparency and accountability. The Hong Kong Academy of Medicine (HKAM) informed members that it would introduce a quality assurance system for medical service to help address the problem of variable quality of health care. As regards the problem of compartmentalisation of Hong Kong's health care system, HKAM was of the view that strengthening primary care and developing family medicine were effective ways to resolve the problem.

15. At the meeting on 12 July 1999, the Hong Kong Medical Association considered that the Government should define more clearly the role and scope of public health services. A patient organisation expressed concern about the effectiveness and transparency of the existing complaint mechanisms in respect of medical incidents and supported the establishment of an Ombudsman Office for handling health care complaints as recommended in the Harvard Report. There was also discussion on the "money follows the patients" concept and health care financing options.

16. At the meeting on 20 July 1999, the Consumer Council supported the establishment of an Institute for Health Policy and Economics as recommended in the Harvard Report to determine the best use of resources and the creation of an Ombudsman Office to provide assistance to consumers with complaints about health care. Representatives of the nursing profession pointed out that the Harvard Report had made little comment on the role of non-medical health care providers in health promotion and prevention and that expanding the role

of nurse to their full potential would contribute to a more cost-effective service and increased value for money.

17. Professor Richard Y C WONG, Director of the School of Business of The University of Hong Kong, considered that the problem with the current financing system of Hong Kong's health care was that it had allowed the public-funded HA to become too large. There was a need for it to be downsized and for its role to be restricted to allow room for development of other providers and models. Prof. WONG pointed out that health financing reform was inseparable from health care reform as the two were interrelated. He supported putting in place a subsidised voluntary insurance scheme for health care instead of a compulsory scheme as proposed by the Harvard Team. As health care reform required much data and information, Prof. WONG expressed support for the establishment of an Institute for Health Policy and Economics.

18. At the Panel meeting on 21 July 1999, Dr P L LAM of the Department of Business Studies of the Hong Kong Polytechnic University proposed that the Government should reduce its funding to HA and use the savings to subsidise privately purchased health insurance premiums. To make up for the reduction in Government funding, user fees in public hospitals and clinics should be raised to recover 30% of the costs in seven years' time, as opposed to the then existing level of 3%. Dr LAM was of the view that this should not pose a heavy burden on patients as the insurance coverage would subsidise part of the user fees. Dr LAM suggested that tax incentives should be provided to employers and employees to encourage them to purchase health insurance.

19. At the Panel meeting on 9 August 1999, members noted that the Administration would issue a consultation paper at the end of 1999 upon the completion of analysis of the views received during the consultation exercise. The paper would set out the direction the Administration proposed to pursue in respect of the development of Hong Kong's health care system. The Administration pointed out that apart from the Harvard proposal, at least two other major proposals had been put forward by the community, namely, a medical saving scheme and voluntary private medical insurance. The Administration would try to set out the merits and demerits of various options in the forthcoming consultation paper.

Consultation Document on Health Care Reform entitled "Lifelong Investment in Health"

20. At the Panel meeting on 12 December 2000, SHW briefed members on the above Consultation Document. The proposed strategic directions as set out in the Consultation Document are as follows -

- (a) strengthen preventive care;
- (b) re-organise primary medical care;
- (c) develop a community-focused, patient-centred and knowledge-based integrated health care service;
- (d) improve public/private interface;
- (e) facilitate dental care; and
- (f) promote Chinese medicine.

SHW pointed out that the proposals had been devised based on careful analysis of the feedback received on the Harvard Report and discussions on the subject with different stakeholders. There would be a 16-week public consultation period ending on 31 March 2001.

21. On improvements to the systems of quality assurance, the Administration proposed to enhance the quality assurance mechanisms through a combination of education and training, systems support and regulatory measures.

22. As regards options for financing health care, the Administration proposed to pursue the following strategic directions -

- (a) reduce costs and enhance productivity;
- (b) revamp public fees structure; and
- (c) establish Health Protection Accounts (HPA).

23. A summary of the key reform proposals is in **Annex A**.

Deliberations of the Panel

The HPA Scheme

24. The discussion at the meeting on 12 December 2000 was mainly focused on the HPA scheme which required every individual from the age of 40 to 64 to contribute 1 to 2% of his/her earnings to a personal account to cover the future medical needs of both the individual and the spouse when the individual reached the age of 65 or earlier in case of disability. Some members expressed objection to the HPA scheme as the working population was already required to contribute 5% of their salaries to the MPF Scheme.

They shared the view that the extra contribution would be a heavy burden on low income people, many of whom already had their salaries frozen or reduced following the economic downturn.

25. SHW agreed that it was not the right time to implement an HPA scheme, given that the economy had not yet fully recovered. Nevertheless, in view of the increasing demands which the ageing population, advances in medical technology and rising expectations for quality health services would put on the public health budget, the Administration considered it timely to seek public views on the scheme, which was aimed at reducing the burden on the next generation and strengthening the long-term financial sustainability of the public health care system.

26. SHW reassured members that the Administration would continue to finance the public health care system and would thoroughly consult the public before deciding whether and, if so, how to proceed with the implementation of the various proposals contained in the Consultation Document.

Reforms to the service delivery system

27. At the meeting of the Panel on 8 January 2001, members discussed the reforms to the service delivery system as set out in paragraphs 13 to 78 of the Consultation Document. Questions were raised on the proposed transfer of the Department of Health (DH)'s general outpatient service to HA and the development of ambulatory and community care. The Administration explained that the former was to facilitate continuity of care through the primary and secondary levels in the public sector while the latter was to ensure that resources would be deployed in the most cost-effective manner.

28. As regards the imbalance between the workload of the private and public sectors, the Administration pointed out that having regard to the huge price difference between the two sectors, there was no quick and easy solution to narrow down the uneven distribution of workload. The Administration did not wish to greatly increase the fees and charges of public hospitals or to interfere with the pricing of private hospital services to rectify the present lopsided situation. As there was a demand for private hospital services priced at an affordable level by the middle-class, HA would explore with the private sector the development of new health care products in which both the public and private sectors could participate, thereby expanding patients' choice.

29. A member expressed the view that the Consultation Document failed to facilitate discussion as the proposals did not contain any details. The Administration responded that it had only provided an outline of the proposals in the Consultation Document as it would like to know the views of the public before formulating detailed plans of implementation. The public would be consulted again after detailed plans had been formulated. The Administration

said that the Consultation Document had incorporated many proposals recommended by the Harvard consultants.

Reforms to the system of quality assurance

30. The Panel discussed the reforms to the system of quality assurance as set out in paragraph 79 to 104 of the Consultation Document at its meeting on 12 February 2001.

31. Some members expressed concern about the proposal to set up a Complaints Office in DH to assist patients in lodging complaints as they considered that the proposal was at variance with the public view that such an office should be an independent body. The Administration pointed out that with DH taking on the role as an advocate for health and a regulator to ensure quality in the health care sector, DH was well placed to take on the task of health care complaints. Members maintained the view that the credibility and impartiality of the Complaints Office could only be assured if it was independent of the Government and that its members were lay persons. As practised in some overseas countries, outside health care professionals could be invited to provide expert advice on a need basis.

32. As regards the proposal to require all health care professionals to undertake continuing education and development before their practising certificates would be renewed, the Administration considered it best for the respective regulatory bodies to determine the continuing education and development requirements which their members must satisfy before their practising certificates would be renewed, and the detailed implementation plan.

Report on the Public Consultation on the Health Care Reform

33. At the Panel meeting on 17 July 2001, the Administration briefed members on the outcome of the consultation exercise on the health care reform and the way forward proposed by the Administration.

Reform proposals that received general support

34. The Administration reported that based on the written submissions received, the feedback collected from District Councils and the briefing sessions the Administration attended during the consultation period, the following reform proposals had received wide support from different sectors of the community -

- (a) the revamped role of DH as health advocate and strengthening of prevention care;
- (b) development of family medicine and community-based integrated

services;

- (c) introduction of Chinese medicine into the public sector;
- (d) continuing medical education for all health care professionals;
- (e) cost-containing measures by HA; and
- (f) revamping of fees structure (subject to safety net being available for the poor and the needy).

Members noted that DH and HA had been asked to work out implementation plans for these proposals.

Reform proposals met with mixed views

35. The Administration reported that mixed views had been received on the following proposals -

- (a) transfer of general outpatient service to HA;
- (b) public/private interface;
- (c) dental care;
- (d) Complaints Office; and
- (e) HPA.

36. The Administration reported that the concept of medical savings received a fair amount of support and that its latest tracking survey conducted in May 2001 also revealed that more respondents preferred a compulsory medical savings scheme (44%) to a compulsory social insurance scheme (28%). The Administration also pointed out that it was planning to commission further in-depth studies to examine the feasibility of different structures for and the various operational aspects of HPA for the purpose of further consulting the public.

37. A summary table setting out the key public comments on individual reform proposals and the Administration's proposed way forward for each of them is in **Annex B**.

Other tasks in progress

38. The Administration informed the Panel that it had commissioned a consultancy study, headed by a health care economist from the University of

California, Berkeley, to assess the impact of fees restructuring on the utilisation of public and private health care services. The Administration was also considering appointing a panel of overseas experts to advise on health care reform matters and the related policy issues.

Discussion by the Panel

39. Noting that the Administration had set up a working group with insurance industry representatives to identify scope for closer collaboration and to devise new products and policies that would dovetail with the implementation of the HPA scheme, a member asked whether the Administration had come to a view that the HPA proposal should be implemented despite strong reservation expressed by the public. SHW explained that the reason for pursuing the HPA proposal was because the public health care system could not be sustainable in the long term through taxation alone. As HSP proposed by the Harvard Team had not been well received by the public, the HPA proposal was the best option which the Administration could think of to help finance the public health care services. The relevant studies referred to in paragraph 36 above would take about 18 months to complete. With more details in hand on completion of the studies, the Administration would be in a better position to address the public's common concerns, such as the rate of contribution, reimbursement arrangements and the implementation timetable.

40. As regards the review of fees structure, SHW clarified that the aim was to examine how to target Government subsidy to various services in the most appropriate manner, as it was believed that public funds should be channelled to assist lower income groups and to services of major financial risks to patients. SHW assured members that even with the implementation of the fees revision, the Administration would continue to uphold its long-held policy of ensuring that no one would be denied adequate medical care because of insufficient means. Public health care services would continue to be heavily subsidised. Patients having difficulty in paying for the heavily subsidised services because of serious or chronic illnesses would be protected with a second safety net modelled on the existing Samaritan Fund.

Other relevant discussions

41. At the Panel meeting on 5 November 2002, members were briefed on the restructuring of fees and charges for public health services, including the introduction of charges for attendance at accident and emergency departments of public hospitals. On 9 December 2002, the Administration briefed the Panel on the progress made by the two working groups on public/private interface as well as the ongoing and future initiatives undertaken by HA in enhancing the collaboration between the public and private sectors. The Administration also briefed members on the redefined roles of DH and on the

transfer of general outpatient clinics from DH to HA at the Panel meetings on 8 April 2002 and 8 July 2002 respectively.

42. At the Panel meeting on 14 June 2004, the Administration reported to members the key findings of an initial research on health care financing. The Administration pointed out that the research had demonstrated that it was feasible to introduce a medical savings scheme in Hong Kong. Given the complexity of the subject and the far-reaching implications of a new financial arrangement, further studies would be needed to develop new financing options that would be sustainable in the long term, and equitable and accessible to all members of the community. The Administration would take into account the views of the community and consult the Legislative Council, the major stakeholders and the general public again when more details about the new model were available.

Recent development

43. As proposed by the Administration, the Panel will discuss the subject of health care reform at its next meeting on 19 July 2005.

Relevant papers

44. Members are invited to access the LegCo website (<http://www.legco.gov.hk>) to view -

- (a) Legislative Council Brief on Public Consultation on Health Care Reform (File Ref : HW CR 8/2/3921/96(00) and the Administration's paper on "Consultation Document on Health Care Reform" issued by the Health and Welfare Bureau in December 2000);
- (b) the Administration's information paper on "Comparison of Harvard Report recommendations and Proposals in the Consultation Document on Health Care Reform" (LC Paper No. CB(2)1737/00-01(03));
- (c) the Administration's papers on the studies on health care financing and feasibility of a medical savings scheme in Hong Kong (LC Paper Nos. CB(2)2692/03-04(03) and CB(2)3138/03-04(01)); and
- (d) the minutes of the meetings of the Panel held on 12 April 1999, 14 and 28 June 1999, 12, 20 and 21 July 1999, 9 August 1999, 12 December 2000, 8 January 2001, 12 February 2001, 17 July

2001, 8 April 2002, 8 July 2002, 5 November 2002, and 14 June 2004.

Relevant question and motions

- (a) a written question on the transfer of provision of general outpatient service from DH to HA asked by Hon Michael MAK at the Council meeting on 25 April 2001; and
- (b) the following relevant motions moved by Members at Council meetings -
 - (i) “Expediting the incorporation of Chinese medicine into the public health care system” moved by Hon David CHU on 17 January 2001;
 - (ii) “Consultation Document on Health Care Reform” moved by Hon Mrs Selina CHOW on 14 March 2001;
 - (iii) “Better health care financial policy” moved by Hon Michael MAK on 14 January 2004; and
 - (iv) “Medical reform” moved by Dr Hon KWOK Ka-ki on 8 December 2004.

Council Business Division 2
Legislative Council Secretariat
13 July 2005

Annex A**“Lifelong Investment in Health” -
Consultation Document on Health Care Reform****Summary of Reform Proposals****Introduction**

The consultation document on health care reform, entitled “Lifelong Investment in Health”, was released for public consultation on 12 December 2000. It sets out 11 strategic reform proposals for the three main pillars of our health care system - the system of service delivery, quality assurance and the long-term financing arrangement.

Our Vision

2. Our vision is to re-create, through our proposed reforms, a health care system which will enhance the quality of life of the population and enable individuals to develop their full human potentials. To achieve this aim, the health care system must be able to protect and promote the health of the community, to provide comprehensive and lifelong holistic care to each individual, to offer accessible, equitable and quality services to each patient, and at the same time to remain cost effective, sustainable and affordable. We emphasise in the document that the pursuit for better health has to be a shared responsibility among the individual, the community and Government.

The proposals**(A) Reform to the Health Care Delivery System**

3. We aim to provide a comprehensive and seamless health care service to the population. We propose to:

- strengthen preventive care through inter-sectoral co-operation and enhanced public participation. The Director of Health will take the lead
- enhance primary medical care through promotion of family medicine and development of other primary care models

- develop nurses, pharmacists and other allied health professionals as primary care practitioners to cater for a community-focused health care system
- transfer Department of Health's general out-patient service to the Hospital Authority to achieve integration of primary and specialists care in the public sector
- expand ambulatory care and outreach programmes to enable patients to continue to live at home while receiving care and treatment. The service should be patient-centred and comprehensive
- encourage better collaboration between the public and private sectors to ensure continuity of care. The two sectors can join hands to develop new health care products, thereby providing patients with more choices
- develop an electronic Health Information Infrastructure to link up the public and private health sectors, and also with the welfare and community groups, for sharing of information and to build up an electronic lifelong health record for each individual
- enhance preventive and promotional efforts on oral health, and encourage the provision of affordable dental care services by non-governmental organisations
- provide Chinese medicine in the public sector, starting with out-patient service, extending to public hospitals, with a view to promoting collaboration between western and Chinese medicines

(B) Improvements to the System of Quality Assurance

4. We aim to enhance the quality of our health care service. We propose to:

- require all health care professionals to undertake continuing professional education and development to update their knowledge and skill
- work with health care professionals to incorporate appropriate knowledge base of environmental, social, behavioural, management

and communication sciences to their training to enable them to deliver holistic care to patients

- encourage all health care institutions to establish quality assurance mechanisms, such as clinical audit and risk management, to ensure consistency of standards
- encourage private medical practitioners to make their pricing transparent and to advise their patients of their liberty not to purchase drugs from their clinics to allow consumers more choice
- review statutory regulations related to health care, such as licensing of private hospitals, sale of drugs and operation of managed care, to identify areas that need to be strengthened to ensure patients safety
- set up a Complaint Office in the Department of Health to investigate and mediate patient complaints
- establish a Research Office in the Health and Welfare Bureau to support the formulation of health care policies

(C) Options for Financing Health Care Service

5. We aim to ensure the long term financial sustainability of our public health care system. We propose to:

- enforce vigorously the cost containment measures in the public sector to slow down the overall increase in costs
- review how to prioritise public subsidies to areas of most needs, i.e. the lower income groups and the expensive services
- review how to restructure public fees to reduce inappropriate and misuse of services, thus helping to manage costs
- maintain a safety net to enable the financial vulnerable to continue to have equal access to quality medical care
- encourage the purchase of voluntary insurance to support patients seeking services in the private health care sector
- set up individual Health Protection Accounts to assist patients to

pay for their own medical services after retirement

- study in detail the "Medisage" plan proposed by the Harvard consultants for financing long term care needs

6. We aim to ensure the long term financial sustainability of our public health care system through a mixed funding mode of risk pooling (allocation from public revenue), personal responsibility (payment of fees) and early planning for retirement health care needs (savings). In the process, the needs of the lower income groups are well protected as they will continue to have access to affordable and quality health care services, and no one will be denied adequate medical care because of insufficient means.

Health and Welfare Bureau
April 2001

Health Care Reform
Summary of public response and proposed way forward

| Proposals in the Consultation Document | General Public Comments | Proposed Way Forward |
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| | <p>Improve Service Delivery System</p> <p>To strengthen preventive care through an intersectoral infrastructure with an enhanced role of the Department of Health (DH) as the Health Advocate</p> <p>To enhance primary medical care through promotion of family medicine. General out-patient service of the DH will be transferred to the Hospital Authority (HA).</p> | <p>Wide support from the community.</p> <p>Wide support from the general public and political parties; but reservations from health care professionals who were skeptical of the effectiveness in achieving the desired result of a better integration of primary and secondary care.</p> |

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| Improve Service Delivery System | To develop a community-focused integrated health care service | Wide support from the community. | HA to take the lead in formulating the plan by end 2001. |
| | To improve public / private interface | Support from the community sustained but not from health care professionals who opined that the Government must delineate the scope of medical service provided by the public sector before the imbalance issue could be addressed. | Discussion with the private health care providers, including individual practitioners and hospitals, will commence to explore areas of possible collaboration. We expect proposals to be produced in six months' from the first meeting. |
| | To facilitate dental care programmes | Criticisms from the community on the lack of subsidised dental care service for the lower income group and the elders. | To encourage more non-governmental organisations (NGOs) to provide affordable dental care on a self-financing basis. |
| | To introduce Chinese medicine in the public health care system | Wide support from the community. | To examine how best out-patient Chinese medicine services may be provided in the public sector. |

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| Improve Quality Assurance | To introduce continuous medical education and development of health care professionals | Wide support from the community. | To commence dialogues with various professional groups to discuss the mode and system of accreditation of continuing medical education (CME) courses and credits. |
| | To encourage all health care institutions to establish quality assurance mechanisms to ensure consistency of standards | Proposal generally supported by the community, though not widely discussed. | To review and expand the mechanisms already in place in public hospitals such as clinical protocols, clinical audit and risk management; and to encourage voluntary adoption in private hospitals. |
| | To carry out a comprehensive review of the present statutory regulations in relation to the operation of clinics, use of medical facilities/equipment, and provision of medical services in general | Proposal generally supported by the community, though not widely discussed. | To draw up a list of possible areas for improvement; and to introduce legislative changes where necessary. |

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| Improve Quality Assurance | To set up a Complaint Office in the Department of Health to improve patient complaint mechanisms | <p>General consensus on the need for improvement but skeptical of the role, function and power of a Complaint Office under DH.</p> <p>Subsequent to the recent incident of the Hong Kong Medical Council, the community at large, and the LegCo in particular, was concerned with the existing patient complaint mechanism. A sub-committee was set up under the LegCo Health Service Panel to look into the matter. The Sub-committee urged for the setting up of an independent Complaint Office.</p> | <p>HWB is currently following up on the work of the LegCo Sub-committee, while awaiting the recommendations from the Working Group on Reform of the Medical Council.</p> |
| | To set up an in-house Research Office to enhance capability of quality policy making. | <p>Wide support from the community.</p> | <p>An in-house Research Office, staffed initially by two medical officers, has been set up to develop our policy research capacity and recommend a research agenda for the Bureau.</p> |

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| Financing Options | To reduce cost by continuing the effective cost-containment measures already in practice | Wide support from the community. | Review of the effectiveness of the cost-containment measures in HA underway. To consider further cost-containment measures in 2002. |
| | To review the public fees structure to better target and prioritise subsidy | General support from the community (subject to a safety net being available for the poor and the needy). | A consultancy study, headed by a health care economist from the University of California, Berkeley, commissioned to assess the impact of fees restructuring on the utilisation of public and private health care services. Study expected to complete by March 2002. |

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| | <p>To introduce the Health Protection Account as a supplementary source of funding for the health care system in the long term; and to study the Medisage scheme for long-term care needs</p> | <p>Strong reservation from various sectors of the community. Some however supported the concept of a medical savings account.</p> <p>Wide support for further study.</p> | <p>A working group has been set up with representatives from the insurance industry to identify scope for collaboration and to devise new products and policies that dovetail with the implementation of the HPA.</p> <p>Before commissioning further in-depth studies involving actuarial and health care financing experts, an internal working group will be formed to examine the scope and issues of studies in greater detail.</p> <p>To consult the public further upon production of more concrete findings from the studies in 18 months.</p> |
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