For discussion
on 21 December 2015

LEGISLATIVE COUNCIL PANEL ON HEALTH SERVICES

The Hospital Authority's Private Patient Services

Purpose

This paper provides an overview on the private patient services in the Hospital Authority (HA).

Background

2. The practice of providing private patient services at public hospitals for patients has a long history. It can be traced back to the time of the former Medical and Health Department and continues in HA after the latter's establishment in 1990. The main rationale for providing such services at public hospitals is that there are specialised expertise and facilities in the public medical sector, especially at the teaching hospitals, which are not generally available in the private sector. It is therefore considered appropriate to offer the public a way to access these specialised services by means of private patient services.

3. Given its primary role as a public healthcare service provider, HA is mindful of the importance of safeguarding public funds and public services in the provision of private patient services. To this end, HA is abided by the principle that public funds should not be used to subsidise private patients. The charges for private patient services in HA are hence set on the higher of cost or market price. To enhance transparency, HA publishes in the Gazette the charges of private patient services, which include inpatient maintenance fee, doctor fee, consultation fee, and itemized charges covering diagnostic and therapeutic/operative procedures. On top of the private service charges, medication and prostheses are separately charged at cost.

Scope of Private Patient Services

4. HA offers two main types of private services, namely private specialist outpatient (SOP) services and private inpatient services. HA restricts the time its staff can engage in private patient services to not more than one session per week. The total number of private beds in public hospitals is limited to not more than 379, representing 1.37% of HA's total number of beds.

5. The majority of the private patient services is provided at the two teaching hospitals, namely the Queen Mary Hospital (QMH) affiliated with the University of Hong Kong and the Prince of Wales Hospital (PWH) affiliated with the Chinese University of Hong Kong. Other hospitals, for example, the Queen Elizabeth Hospital (QEH), also provide private patient services but they do so on a much smaller scale.

6. The total number of private bed-days in 2013-14 and 2014-15 (details at **Annex**) account for less than 1% of the total number of bed days in HA in the respective year, while the number of private SOP attendance in 2013-14 and 2014-15 (details at **Annex**) accounts for less than 1% of the total SOP attendances in HA in the respective year.

7. HA pools the income generated from private patient services together with its general income to support its provision of public healthcare services. In 2013-14 and 2014-15, the income generated from private patient services [1] in HA is $349 million and $379 million respectively.

Roles and Responsibilities of HA and the Universities

8. HA and the two local universities with medical faculties i.e. the University of Hong Kong and the Chinese University of Hong Kong (the "Universities"), share the common mission of serving the community with a high standard of clinical service, and the vision that education and research enable the maintenance and advancement of such standard. Indeed, clinical service, teaching and research are essentially linked to one another and HA and Universities have all along been contributing resources to these activities in varying extents.

[1] Net of income on private services shared with the University of Hong Kong and the Chinese University of Hong Kong.

9. HA's private patient services are provided by HA staff and clinical professors from the two Universities. HA requires clinical professors from the two Universities to be appointed as HA's honorary staff before they can practise medicine on public patients in the teaching hospitals. The professors are allowed to provide private patient services in accordance with a set of formal governance and management procedures. In general, the Universities will make recommendation for the granting of rights to practise private services in HA based on objective criteria. HA will consider the Universities' recommendation having regard to HA's own clinical governance arrangement and the Universities' established mechanisms on private services.

10. Private patient services offered in HA hospitals are HA services with contribution from clinical professors of the two Universities. HA has set up a standardised system to process relevant clinical documentation, billing and revenue collection of private services, etc. pursuant to HA procedures and requirements.

11. To recognise the contribution of the two Universities in private patient services, a fee sharing arrangement between HA and the Universities is in place. In general, revenue generated from consultation and procedure is shared in the ratio of 75 (Universities): 25 (HA), whereas that from supporting services (like radiology investigation and laboratory tests) is shared in the ratio of 75 (HA): 25 (Universities) in view of the higher contribution from HA in the latter scenario. The way the two Universities handle their shares of revenue from private services is a matter of the Universities and is outside the jurisdiction of HA.

12. Both HA and the Universities have implemented internal control measures to govern the provision of HA private patient services by honorary staff from the Universities. For instance, HA requires these honorary staff to be formally approved by their Heads of Departments and Faculty Deans of the Universities, and then by the Hospital Chief Executive concerned before allowing them to participate in private services. HA also maintains a system to track and handle the billing and fee collection of private services. Moreover, HA Head Office has established a Teaching Hospital Committee with the Universities to discuss collaboration matters between HA and the Universities, including the arrangement regarding the provision of private services by clinical professors of the Universities.

Recent Review on Private Patient Services

13. With the long history in the provision of private services in HA, we reckon the need to ensure relevant practices commensurate with modern day's aspirations. To this end, HA and the two Universities set up a Private Service Review Working Group in September 2014 to identify priority areas for improvement in the administration of private services and the processing of related revenue in the teaching hospitals.

14. The Private Service Review Working Group has identified the following areas for improvement –

(a) Granting of rights to practice private services

Approval on the granting of rights should specify the scope of practice, conditions of approval and duration of rights granted, etc. The information should be properly documented in order to strengthen control. A register of approved doctors should be maintained and kept up-to-date.

(b) Determination of charges

Fees and charges for private services in HA hospitals are abided by the Gazette. For services where a range of charges is applicable (e.g. private consultation services), there should be explicit principles and/or criteria in place to guide the determination of charge, drawing reference to objective factors as far as possible.

(c) Billing, fee collection and revenue management issues

Billing and fee collection for private services is handled by HA using the same system for public services. Where system tracking is not available and manual records are necessary to keep track of the services rendered for billing purpose in private services, control should be in place (e.g. independent checking) to ensure the accuracy of the information.

(d) Income sharing between HA and Universities

There should be periodic review on income sharing arrangements between HA and the Universities.

(e) Use of income generated from private services

HA doctors do not receive additional pay from taking part in private services and the incomes received are to be used on hospital operation. HA should develop a common set of guidelines for all hospitals on the use of income generated.

15. To follow up with the areas of improvement identified, HA has developed a set of common guiding principles for administrative and financial arrangement of private services. HA will monitor the provision of private services and discuss with the Universities on further improvement as necessary.

Advice Sought

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

Food and Health Bureau
Hospital Authority
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Annex

The total number of private bed-days in 2013-14 and 2014-15

Hospital/Year	2013-14	2014-15
Total no. of private inpatient bed-days ('000)	45.3	48.0
• QMH and associated hospitals[2] ('000)	19.3	19.9
• PWH and associated hospitals ('000)	7.1	8.1
• QEH[3] ('000)	16.0	17.0
• Other HA hospitals ('000)	2.9	3.0
Total inpatient bed-days occupied in HA ('000)	7,479	7,585
% of private bed-days over total bed days in HA	0.6%	0.6%

Note: The above statistics represent bed-days of private wards

The total number of private SOP attendances in 2013-14 and 2014-15

Hospital/Year	2013-14	2014-15
Total no. of private SOP attendance ('000)	64.1	66.8
• QMH and associated hospitals ('000)	37.4	38.5
• PWH and associated hospitals ('000)	20.7	21.4
• QEH ('000)	0.5	0.4
• Other HA hospitals ('000)	5.5	6.5
Total SOP attendance in HA ('000)	7,041	7,192
% of private SOP attendance over total SOP attendance in HA	0.9%	0.9%

Data Source: HA patient billing and revenue collection system

[2] Associated hospitals means other HA hospitals in the same cluster, where the teaching staff from the university may provide private services.

[3] Over 90% of private inpatient bed-days occupied at QEH was provided to Civil Service Eligible Persons and HA staff at free/concessionary rate under respective staff medical benefit schemes.