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Panel on Health Services

Background brief prepared by the Legislative Council Secretariat for the meeting on 16 January 2017

Fees and charges for public hospital services

Purpose

This paper provides background information and summarizes the concerns of the members of the Panel on Health Services ("the Panel") on the review of fees and charges for public hospital services.

Background

2. The public healthcare system is the cornerstone of the twin track healthcare system, acting as the safety net for all such that no one will be denied adequate medical care due to lack of means. It has long been the Government's policy to provide public healthcare services at highly subsidized rates to local residents. At present, highly subsidized public hospital services are provided to Eligible Persons ("EP") in the context of fee-charging by the Hospital Authority ("HA"). EP is defined as patients who fall into the categories of being (a) holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance (Cap. 177);[1] (b) children who are Hong Kong resident and under 11 years of age; and (c) other persons approved by the Chief Executive of HA. Recipients of Comprehensive Social Security Assistance ("CSSA") are waived from payment of the fees and charges of HA. Other vulnerable groups other than CSSA recipients can apply for a medical fee waiver.

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[1] Except those who obtained their Hong Kong Identity Card by virtue of a previous permission to land or remain in Hong Kong granted to them and such permission has expired or ceased to be valid.

3. The fees and charges for EP were last revised on 1 April 2003[2] based on the general support received for the proposal of revamping the fee structure of the public healthcare sector (including both HA and the Department of Health) as put forth in the Health Care Reform Consultation Document published by the Government in December 2000.[3] The purpose of revamping the fee structure was to ensure that public subsidies could be targeted to areas of most needs and inappropriate use and misuse of services could be reduced.

4. While the priority for public healthcare services is for EP, HA provides healthcare services to Non-eligible Persons ("NEP")[4] under a life or limb threatening situation or when capacity permits. NEP are charged on a cost-recovery basis. In addition, HA has been providing private services[5] for both EP and NEP. The fees for private services are set on the higher of cost or market price for the respective services. The last major revision on fees and charges for NEP and private patients were made on 1 April 2013.

Deliberations of the Panel

5. The Panel held five meetings between 2001 and 2003 to discuss the restructuring of fees and charges for EP services and received the views of deputations at one meeting. The deliberations and concerns of members are summarized in the following paragraphs.

Principles guiding the review

6. Members noted that following a comprehensive review of the fee structure of the public healthcare sector, the Government would, among others, introduce a new charge of $100 per attendance for the A&E services of HA on 29 November 2002. In addition, the fees for general inpatient beds, specialist outpatient ("SOP") services and general outpatient ("GOP") services of HA would respectively be increased from $68 to $100 (with a $50 admission fee) per day, from $44 to $60 (with a higher charge of $100 for the first attendance

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[2] Except for the new charge of the Accident and Emergency ("A&E") services which took effect on 29 November 2002.

[3] A three-pronged approach on healthcare financing, which included (a) reducing cost and enhancing productivity; (b) introducing medical savings through a scheme of Health Protection Accounts; and (c) revamping the fee structure of the public healthcare sector, was proposed in the Consultation Document with a view to ensuring the long-term sustainability of the public healthcare system.

[4] Persons who are not EP are classified as NEP.

[5] Private services are provided as a means for the public to access specialized expertise and facilities in the public medical sector, notably in the two teaching hospitals of Queen Mary Hospital and Prince of Wales Hospital, which are not generally available in the private sector.

and a separate charge of $10 per drug item which would cover a duration of up to 16 weeks) per attendance, and from $37 to $45 per attendance with effective from 1 April 2003. The revised fee level for the above services represented a subsidy level ranging from 80% to 96%. While some members supported the revision in order to target finite public resources to patients most in need, most members were concerned that the new and revised fees and charges for public hospital services might deter patients, particularly those who had limited means, from seeking medical care.

7. According to the Administration, the principles guiding the review of the fee structure included (a) cost sharing by patients, particularly those who could afford to pay more; (b) affordability of the general public and the lower income group; (c) minimizing unnecessary use of services by increasing the service charges; (d) resource prioritization by providing higher subsidies for services of greater needs and financial risks to patients; and (e) facilitating access by vulnerable groups through targeting public subsidies to low income groups and chronic patients; and (f) public acceptance. Following the restructuring, the fees would on the one hand continue to be generally affordable, and on the other hand be able to influence patient behaviour. CSSA recipients would continue to be exempted from the medical fees and charges at public hospitals and clinics. In addition, a medical fee waiving mechanism was in place to provide protection to those vulnerable people not on CSSA.

8. The Administration stressed that it was necessary to revamp the fee structure, as the public healthcare system was facing great financial pressure and the problem of inappropriate use and misuse. It would conduct regular review in this regard in the light of the Government's global budget and its policy on public healthcare services; the cost of HA in providing the services; the ability of users in paying for public healthcare services; the service demand and role of the private sector in the provision of healthcare services; and the size of population who had difficulty to pay for their public healthcare expenditure.

Introduction of a user charge for A&E services of HA

9. Many members expressed reservation about the introduction of a user charge of $100 for A&E services as a way to minimize unnecessary use of the services for primary or non-emergency medical care. Some members considered that the Administration should instead step up public education on the proper use of A&E services; increase the service quotas of public GOP clinics; extend the service hours of the public GOP clinics; and explore ways to attract patients who could afford to pay for private healthcare services to use such services.

10. The Administration advised that most developed economies had imposed a user charge for A&E services and international experiences revealed that imposing a user charge for A&E services could discourage unnecessary use. In 2001-2002, about 75% of the attendances at the A&E Departments of public hospitals were semi-urgent or non-urgent cases. It was expected that the introduction of a user charge for the A&E services would result in an 11% decrease in service utilization. It should be noted that the $100 fee level still represented a subsidy level of 82%, which was considered reasonable by international standard and was in line with the findings of the three tracking surveys conducted by the Administration in May 2000, January 2001 and May 2001 respectively.

11. Members were subsequently advised that there was a 11.3% decrease in the average daily attendance at the A&E Departments of public hospitals in the first three months after the introduction of the charge (i.e. December 2002 to February 2003) as compared with the corresponding period of the previous year. In terms of triage categories, the proportion of semi-urgent and non-urgent cases had decreased to about 70.5% in the period of December 2002 to January 2003, with a respective decrease of 10.7% and 35.5% in the number of semi-urgent cases and non-urgent cases. In the Administration's view, this showed that the introduction of the new charge for A&E services was effective in diverting patients not in critical and life-threatening conditions to use alternative modes of medical services that best suited their needs, thereby shortening the waiting time for urgent cases. To ensure proper use of A&E services of public hospitals, more work would be undertaken by HA to educate the public in this regard.

12. On the question of whether the income generated from the new service charge would be used on improving the A&E services of public hospitals, HA advised that similar to the use of income from other types of service, income generated from A&E services would be used on areas most in need.

Medical fee waiving mechanism for public hospital services

13. Members called on the Administration to enhance HA's medical fee waiver mechanism by, say, relaxing the assessment criteria and raising the asset limit for families with elderly members, in parallel with the introduction of the revised fee structure for public hospital services. There was a suggestion that patients aged 60 or 65 and above should be partially or fully exempted from paying the fees, as many elders were reluctant to undergo a means test in order to be eligible for a medical fee waiver.

14. The Administration advised that the suggestion went against the principle that assistance should only be targeted at those in need and not those who could

afford the fees. Members were assured that HA would step up its efforts to apprise elderly patients not on CSSA of the medical fee waiver mechanism. To ensure that the fee revision would not impact disproportionately on the low income, chronically ill and elderly patients with little income and asset, the medical fee waiver mechanism would be enhanced from April 2003 to improve its transparency and objectivity. Medical Social Workers of public hospitals and clinics would assess the waiver applications with due consideration given to the patient's financial condition and non-financial factors which included but not limited to (a) the patient's frequency of use of the different public medical services and severity of the illness; (b) whether the patient was a disabled person, single parent with dependent children, or from other vulnerable groups; (c) whether a fee waiver could provide incentive and support to solve the patient's family problems; (d) whether a patient had any special expenses that made it difficult to pay for the medical fees; and (e) other justifiable social factors. Depending on patients' actual needs, full or partial waivers would be granted on a one-off basis or valid for a number of months.

15. Some members considered that the eligibility and assessment criteria under the enhanced medical fee waiver mechanism were far from clear and transparent, as much was left to the discretion of Medical Social Workers.

Latest developments

16. According to HA, fees and charges for EP, NEP and private services will be reviewed biennially under the prevailing fee review mechanism. On 15 December 2016, the HA Board endorsed the latest Fees and Charges Review Report ("the Report") and the recommendations. It was recommended, among others, that the fees and charges for EP services should be adjusted. The proposed adjustments included an increase in the fee for A&E services from $100 to $220 having regard to the increased cost and the fee gap between the existing A&E fee and the median charge of private doctors which stood at around $300, so as to encourage appropriate use of public hospital services by shaping health taking behaviour as well as resources prioritization. The press release issued by HA in this regard is in **Appendix I**.

17. According to HA, it will engage the community to collect their views on the Report. The Report and the views so collected will be submitted for consideration of the Food and Health Bureau in due course. The Administration will brief the Panel on the review of the fees and charges for public hospital services on 16 January 2017.

Relevant papers

18. A list of the relevant papers on the Legislative Council website is in **Appendix II**.

Council Business Division 2
Legislative Council Secretariat
10 January 2017

Appendix I

醫院管理局 HOSPITAL AUTHORITY 新聞稿 PRESS RELEASE

Tuesday, 15 December 2016

HA Board Endorsed Fees and Charges Review Report

The Hospital Authority (HA) Board today (15 December) discussed and endorsed the Fees and Charges Review Report (The Report) and the proposed recommendations. The Report and the proposed recommendations will shortly be submitted to the Food and Health Bureau (FHB) for consideration. In the next few months, HA will engage the community to collect their views on the review report including Legislative Council members, District Council members and patient groups, which will be reflected to FHB for reference.

The HA spokesperson said under prevailing fee review mechanism, the fees and charges will be reviewed biennially, covering Eligible Persons (EP), Non-eligible Persons (NEP) and private services. Fees and charges for NEP and private services were last reviewed in April 2013. According to the latest review result, riding on the current principle of cost recovery for NEP services, the magnitude of increase in NEP fees would range from $60 to $1,650, whilst the magnitude of increase in private services fees will continuously take reference with cost and market price.

The spokesperson also pointed out, fees and charges for EP services have not been adjusted since the year 2003, whilst the service cost has increased considerably. In reviewing the fees and charges for EP services, the factor of co-payment and cost sharing would be taken into account, as people should be responsible for their own health, in particular those who could afford to pay more when using public medical services.

"For factors which have also been considered in the review include the affordability, encouraging appropriate use of services and easy-to-understand as well as comprehend. HA would make resources prioritisation based on medical needs and financial situation of people. A waiver system for patients with financial difficulties would also be set up."

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Media Enquiries: News Duty Officer Pager: 7328 3855 Fax: 2504 0018 Hospital Authority Building, 147B Argyle Street, Kowloon

"The Report also recommends adjusting the fees and charges for EP services. On Accident and Emergency (A&E) Service, the objective of adjusting the fees aims to encourage appropriate use of public hospital services by shaping health seeking behaviour as well as resources prioritization. The total number of A&E attendance at present is round 2.2 million per year, in which around 65 % are semi-urgent and non-urgent cases. It is expected that fee adjustment would make part of semi-urgent and non-urgent cases to change to other more appropriate medical service instead of A&E service to alleviate the work pressure of A&E as well as to allow critical and urgent cases to be treated by healthcare staff more quickly and properly."

"According to a survey conducted by HA earlier, the median charge of private doctors is around $300 which is much higher than the existing A&E fee of $100. It is expected that the fee gap between A&E and private doctors would be narrowed if the adjustment is implemented. Furthermore, the A&E fee still maintains at $100 despite the cost has increased from $570 to $1,230 since 2003 and the Report proposes to adjust the fee to $220 based on the cost increase," the spokesperson added.

The Report also proposes to maintain the fee for Community Nursing Service at $80 in order to encourage more people who have recovered to discharge. For other services of EP, the magnitude of fee increase ranges from $7 to $70. Patient with Comprehensive Social Security Assistance are not affected as their medical fees would be waived under prevailing mechanism.

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Table of the proposed fees is attached.

傳媒查詢：當值新聞主任傳呼機號碼：7328 3855 傳真：2504 0018 九龍亞皆老街147B醫院管理局大樓
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Hospital Authority
Fees and Charges Review Result

a. Private Charges

Charging basis: itemized, higher of cost or market price

Major Services	2013 Cost (HK$)	2016 Cost (HK$)	Current Charge (HK$)	Proposed Charge (HK$)
Private Wards				
a. Acute Hospitals	3,762	4,430		
- 1st Class			5,640	6,650
- 2nd Class			3,760	4,430
b. Other Hospitals	3,742	4,080		
- 1st Class			5,610	6,120
- 2nd Class			3,740	4,080
Critical Care Units				
a. Intensive Care Unit	14,615	15,370	14,600	15,350

b. Public Charge for Non-Eligible Person

Charging basis: per-diem, full cost recovery

Major Services	2013 Cost (HK$)	2016 Cost (HK$)	Current Charge (HK$)	Proposed Charge (HK$)
Daily Inpatient Maintenance				
a. General Ward	4,682	5,100	4,680	5,100
b. Intensive Care Unit	23,006	24,410	23,000	24,400
c. High Dependency Unit	11,983	13,660	12,000	13,650
Outpatient Attendance				
a. Specialist Clinic	1,106	1,190	1,110	1,190
b. General Clinic	383	445	385	445
c. A&E	991	1,230	990	1,230

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c. Public Charges for Eligible Person

Charging basis: per-diem, highly subsidized rates

Major Services	2003 Cost (HK$)	2016 Cost (HK$)	Current Charge (HK$)	Proposed Charge (HK$)
Daily Inpatient Maintenance				
a. Acute Bed	3,630	5,490	100	150
b. Convalescent / Rehabilitation / Infirmary / Psychiatric Bed Maintenance Fee	1,450	2,390	68	110
Outpatient Attendance				
a. Specialist Clinic - First Attendance - Subsequent Attendance - Drug charge per item	701	1,190	 100 60 10	 170 100 17
b. General Clinic	329	445	45	61
c. A&E	570	1,230	100	220
d. Community Nursing Service	341	535	80	80

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Appendix II

Relevant papers on the fees and charges for public hospital services

Committee	Date of meeting	Paper
Panel on Health Services	12.11.2001 (Item IV)	Agenda Minutes
	5.11.2002 (Item I)	Agenda Minutes CB(2)338/02-03(01)
	11.11.2002 (Item III)	Agenda Minutes CB(2)2682/02-03(01)
	24.2.2003 (Item I)	Agenda Minutes
	10.3.2003 (Item III)	Agenda Minutes CB(2)2682/02-03(01)

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