For discussion
on 25 April 2017

Legislative Council Panel on Health Services

Revision of Fees and Charges for Public Healthcare Services

Purpose

This paper sets out the views of the Food and Health Bureau ("FHB") on the findings of the review conducted by the Hospital Authority ("HA") on the level of fees and charges for public healthcare services in HA.

Background

2. Under Section 4(d) of the HA Ordinance (Cap. 113), HA shall "recommend to the Secretary for Food and Health ("SFH"), for the purposes of Section 18, appropriate policies on fees for the use of hospital services by the public, having regard to the principle that no person should be prevented, through lack of means, from obtaining adequate medical treatment".

3. Section 18 of the HA Ordinance stipulates that a Hospital Governing Committee may determine fees payable for hospital services provided by the public hospital for which it is established, subject to any directions that may be given by the HA, which in turn shall comply with the directions that may be given by SFH. The level of fees and charges determined under this section should be gazetted for public notice.

4. HA took over the management of all public and subvented hospitals in early 1990s and inherited their fees and charges framework. Under this framework, public services are charged by major service categories and on a per-diem basis, i.e. outpatient services are charged by encounter and inpatient services by day rates. Public services (other than those outside the scope of standard services[1]) are charged at highly subsidised rates to Eligible Persons ("EP")[2] and at a full cost recovery basis to Non-Eligible Persons ("NEP").

[1] Services outside the scope of HA standard services are charged separately on a cost recovery basis. These include, for example, Privately Purchased Medical Items and Self-Financed Items of drugs.

[2] Persons meeting the following criteria are eligible for the rates of charges applicable to EP as stipulated in the Gazette:
(i) holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance (Chapter 177), 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;
(ii) children who are Hong Kong residents and under 11 years of age; or
(iii) other persons approved by the Chief Executive of the HA.

Private services, on the other hand, are charged on itemised basis apart from those covered by the daily hospital maintenance fee; the itemised rates for private services are set at higher of cost or market price.

Guiding Principles for Public Hospital Fees and Charges Setting

5. In 2002, the Government commissioned a consultancy study on "restructuring of fees and charges for public healthcare services", and accepted its recommendations on fee revision. With reference to the consultancy study, the established guiding principles in setting and reviewing public hospital fees are:

(a) Cost sharing – while maintaining access, patients should share the cost of service, especially those who can afford to pay more.

(b) Affordability – to ensure that the fee structure is affordable to both the general public and to lower income groups, and help those who cannot afford with a fee waiver system.

(c) Appropriateness – fees and charges as a means to encourage appropriate use of services, such as fees for Accident & Emergency ("A&E") service.

(d) Resource prioritisation – by providing higher subsidies for services of greater needs and financial risks to patients.

(e) Facilitating access by vulnerable groups – through targeting public subsidies to low-income groups and chronic patients.

(f) Public acceptance – by ensuring that the fee structure can be clearly understood by patients and service providers, and that it is politically acceptable and administratively simple.

Previous Adjustments of Fees and Charges

6. The fees and charges for public services to EP have not been adjusted since 2003. The fees and charges for public services to NEP

(excluding the obstetric ("OBS") package[3]) and the fees and charges for private services were last revised on 1 April 2013.

The Review Conducted by HA

7. HA commenced its latest review exercise on fees and charges in 2015, having regard to the guiding principles for public healthcare fees and charges, the change in costs and other relevant factors. Based on the review results, the proposed level of fees and charges by major categories for private, NEP and EP services by HA are tabulated in **Annexes A, B and C** respectively. The rationale behind HA's recommendations is outlined in ensuing paragraphs.

8. Members have been briefed on HA's proposals at the meeting of 16 January 2017.

Revision of Fees and Charges for NEP and Private Services

9. In accordance with the principle that services to NEP and private patients should not be subsidized by public money, HA recommends revising private charges based on 2015/16 cost level and with reference to market information, and revising the fees and charges for NEP public services based on 2015/16 cost level. The proposed fees and charges for private and NEP services by HA are set out in **Annexes A and B** respectively.

Revision of A&E Charge for EP

10. HA recommends revising A&E charge for EP from $100 to $220 per attendance, taking reference to 2015/16 service cost level and using the 2002 subsidy level as a proxy, with the aim of encouraging appropriate use of the much overloaded A&E services so that priority can be given to urgent cases (i.e. Triage 1, 2 and 3). It should be noted that following the introduction of A&E charge in 2002, A&E attendances dropped from 2.5 million in 2001/02 to 2.1 million in 2004/05. A&E attendances of less urgent cases (triage 4 and 5) also dropped rapidly by 22% (as compared to 2001/02 and 2004/05). In recent years, A&E attendance has climbed back to around 2.2 million. The problem of A&E overcrowding and long waiting time is getting worse especially during the winter surge periods. It is envisaged that the proposed fee increase would

[3] The NEP OBS package was introduced in September 2005 at $20,000 and was revised to $39,000 for booked cases and $48,000 for non-booked cases in September 2007. As one of the measures to address the increasing NEP demand for obstetric services in HA, the package charge for non-booked cases was further increased from $48,000 to $90,000 with effect from 12 May 2012, which was benchmarked against private doctor/hospital charges. There was no fee change for OBS booked case (i.e. $39,000 since 2007) since then, with regard to the various administrative measures implemented (e.g. stop accepting booking from NEP for HA delivery services).

encourage patients of semi-urgent and non-urgent A&E cases (i.e. Triage 4 and 5) (which constituted around 65% of overall A&E attendance) to seek private healthcare services, thereby easing the A&E workload for benefiting the more needy patients.

Revision of Other Fees and Charges for EP Services (other than A&E)

11. The fees and charges for other EP services have not been adjusted since 2003, while their costs of services have been increased from 33% to 70% (as compared to 2003 level). Amongst the various guiding principles for review of public hospital fees, HA is of the view that revising the fees and charges for other EP services to help maintain a reasonable level of cost sharing with patients, especially those who can afford, would be one of the key considerations.

12. At the same time, having regard to the established guiding principle of using fees and charges as a means to encourage appropriate use of services, options to withhold or cut down the magnitude of fee revision for certain services with a view to rationalizing anomalies in the existing fees and charges schedule have been considered. On this basis, HA proposes maintaining the current fee of Community Nursing Services ("CNS") at $80 per visit (currently higher than the prevailing maintenance fee for rehabilitation bed at $68 per day which is recommended to be raised to $110 per day) notwithstanding the increase in cost, as an incentive to patients for early discharge from rehabilitation hospitals. The proposed fees and charges for EP services by HA are set out in **Annex C**.

Other Issues Related to Fees and Charges

13. Apart from the fee proposals, HA also takes the opportunity to recommend revisiting the service categories in the Gazette on HA fees and charges. Due to technology advancement, some procedures, in particular more advanced diagnostic and even therapeutic procedures, previously done in inpatient setting can now be performed in ambulatory setting. The setup, workflow and cost of these evolving ambulatory services differ significantly with that under traditional inpatient setting. The service categories in Gazette are lagging behind healthcare service development. In this regard, HA suggests exploring a new service category for the more complex procedures that are becoming suitable to be performed in ambulatory settings, but the addition of service category should be fee neutral to EP. Examples of items under this proposed new service category are set out in **Annex D**.

Food and Health Bureau's Views

14. We agree with the broad guiding principles in setting and reviewing public hospital fees, in particular the need to encourage appropriate use of public healthcare services.

15. Regarding the revision of fees and charges for NEP and private patients, we agree with HA's view that these services should not be subsidized by public money and NEP fees should observe the principle of cost recovery whilst the revision in private services fees should continuously take reference from cost and market prices.

16. For the revision of A&E charge for EP, we note that there are concerns that the proposed level of increase may deter the grass-root sector from seeking medical consultation, and some suggest that there should not be a substantial increase in A&E charge unless there is enhancement in the provision of primary care services.

17. As announced in the 2017 Policy Address, the Government will provide an additional $2 billion to the HA in total recurrent expenditure. The additional provision will enable the HA to meet service demand by increasing, among others, the quotas for general outpatient consultation. In 2016/17, there would be a further increase of around 27 000 consultation quota in General Outpatient Clinic ("GOPC"), including in evening clinics and public holiday clinics. In 2017/18 and 2018/19, where resources are available, HA would gradually attain an increase of over 44 000 consultation quota for GOPC. HA would continue to closely monitor the service demand and utilization, and plan for appropriate increase in consultation quota so as to enhance primary care services. Moreover, the Policy Address also announced to continue extending the coverage of the GOPC Public-Private Partnership Programme to more areas, with a view to covering all 18 districts of the territory in phases in the coming two years.

18. Meanwhile, we also note that there are public concerns that the drastic increase in A&E charge for EP to $220 as proposed by HA may increase the financial burden of the general public in using the A&E services and may possibly affect their accessibility to adequate medical care. On the other hand, community stakeholders engaged by HA during the public engagement process generally indicated broad understanding of the rationale and policy objectives of the fees and charges review and revisions, and recognized the need to encourage more appropriate use of A&E service and its potential benefit.

Taking into account the feedback received, **we consider that it would be more appropriate to increase A&E charge from $100 to $180**, instead of $220 recommended by HA. The Government's subsidy level after the proposed increase will be 85%, as compared with 82% when the A&E charge was first introduced in 2002. We consider that the proposal of setting A&E charge at $180 should be able to strike a balance between encouraging appropriate use of public healthcare services and addressing the concerns on increasing the financial burden of the general public in using the A&E services.

19. As for outpatient charges for EP, **we consider that GOPC charge should be moderately increased from $45 to $50 (by 11%)**, instead of $61 as recommended by HA to encourage diversion of less urgent A&E patients. In view of the growing demand for Specialist Outpatient Clinic ("SOPC") services due to ageing population and increasing prevalence of chronic diseases, **we consider that SOPC first attendance outpatient charges should be increased from $100 to $135 (+35%),** instead of $170; **subsequent attendance charges from $60 to $80 (+33%),** instead of $100; **and drug charge per item from $10 to $15 (+50%)**, instead of $17, to reduce the financial impact on patients.

20. Regarding the other charges for EP, **we consider that the fees for daily inpatient maintenance, community service and day hospital should be increased within the range from 9% to 47%**, as compared with HA's recommended increase from 33% to 62%. Minimizing the financial impact on these patients is also in line with the HA's objective of encouraging day care and community care services to facilitate patients' participation and re-integration into the community, which in turn reduces the need for hospital care. **We also consider that the maintenance fee of acute bed should be increased from $100 to $120 (+20%), instead of $150 recommended by HA**. **We agree to keep the charge for CNS at $80** as recommended by HA in order to provide incentive for patients to early discharge from rehabilitation hospital. **We also consider geriatric day hospital and psychiatric day hospital fees should be increased moderately from $55 to $60 (+9%)**, instead of $73 and $78 respectively as recommended by HA. **We also agree to keep the charge for rehabilitation day hospital at $55** as recommended by HA as the subsidy level remains unchanged (i.e. 96%). The recommended fees and charges by the FHB for EP are set out in **Annex E**.

21. Regarding HA's proposal to revisit the service categories in the Gazette, we agree to adopt HA's proposal in order to cater for services like

hemodialysis, day chemotherapy for oncology treatment which are to be performed in an ambulatory setting.

Future Review Mechanism

22. Under prevailing fee review mechanism, the fees and charges of HA will be reviewed biennially by the HA Board, by making reference to the latest service cost information and the established basis for calculating hospital fees and charges. The review mechanism keeps the government updated on cost information and consideration relevant for determining the appropriate policies on fees for the use of hospital services by the public.

Medical Fee Waiving Mechanism

Comprehensive Social Security Assistance ("CSSA") Waiver

23. The public healthcare services in Hong Kong are heavily subsidised by the Government and the fees are affordable by the general public. To ensure that no one will be denied adequate medical care due to lack of means, we have put in place a mechanism of medical fee waiver to provide assistance to needy patients. Recipients of CSSA are waived from payment of their public healthcare expenses.

The Non-CSSA Waiver

24. For Non-CSSA recipients who could not afford medical expense at the public sector, such as low-income group, chronically ill patients and elderly patients who have little income or assets, they can apply for medical fee waiver at the Medical Social Services Units of public hospitals and clinics or the Integrated Family Services Centres & the Family and Child Protective Services Units of the Social Welfare Department. The Medical Social Worker/ Social Worker ("MSW"/"SW") would assess the application in accordance with the prevailing financial eligibility criteria under waiver mechanism. Even if a patient fails to meet the financial criteria, MSW/SW will also exercise their discretion to grant waivers, where appropriate, to a patient with special difficulties on a case-by-case basis. A medical fee waiver granted by the MSW/ SW after assessment will either be one-off or valid for a period of time, which is applicable for inpatient services, ambulatory and community services such as A&E, SOPC, GOPC and Day Hospital.

25. During the public engagement process, there are concerns that the medical fee waiver mechanism should be enhanced in order to facilitate those needy patients to benefit from the mechanism, especially the elderly and A&E frequent users. Some patient groups further suggest that HA should seize the opportunity to review the waiver mechanism, such as extending the length of waiver period. To better address the healthcare service demand of the needy elderly, we will extend the medical fee waiver for public healthcare services to cover Old Age Living Allowance recipients aged 75 or above with assets not exceeding $144,000 (elderly singletons) or $218,000 (elderly couples). It is estimated that about 140,000 persons would benefit from this initiative. Meanwhile, HA will also proactively consider enhancing the user-friendliness of convenience of the waiver mechanism for elderly and A&E frequent users for continuous service improvements.

Way Forward

26. Subject to further deliberations within the Government, we aim to implement the new fees and charges in mid-2017.

Advice Sought

27. Members are invited to note the content of the paper.

Food and Health Bureau
April 2017

Annex A

Private Charges Proposed by HA

Charging basis: itemized, higher of cost or market price

Major Services	Current Charge (HK$)	Proposed Charge (HK$)	Percentage of Increase
Private Wards			
a. Acute Hospitals			
- 1st Class	5,640	6,650	18%
- 2nd Class	3,760	4,430	18%
b. Other Hospitals			
- 1st Class	5,610	6,120	9%
- 2nd Class	3,740	4,080	9%
Critical Care Units			
a. Intensive Care Unit	14,600	15,350	5%
b. High Dependency Unit	9,500	No change	–

Annex B

Public Charges for Non-Eligible Persons Proposed by HA

Charging basis: per-diem, full cost recovery

Major Services	Current Charge (HK$)	Proposed Charge (HK$)	Percentage of Increase
Daily Inpatient Maintenance			
a. General Ward	4,680	5,100	9%
b. Intensive Care Unit	23,000	24,400	6%
c. High Dependency Unit	12,000	13,650	14%
Outpatient Attendance			
a. Specialist Clinic	1,110	1,190	7%
b. General Clinic	385	445	16%
c. A&E	990	1,230	24%

Annex C

Public Charges for Eligible Persons Proposed by HA

Charging basis: per-diem, highly subsidized rates

Major Services	Current Charge (HK$)	Proposed Charge (HK$)
Daily Inpatient Maintenance		
a. Acute Bed - Admission Fee - Maintenance Fee	 50 100	 81 150
b. Convalescent / Rehabilitation / Infirmary / Psychiatric Bed Maintenance Fee	68	110
Outpatient Attendance		
a. Specialist Clinic - First Attendance - Subsequent Attendance - Drug Charge per Item	 100 60 10	 170 100 17
b. General Clinic	45	61
c. A&E	100	220
Community Service		
a. Community Nursing Service	80	80
b. Community Allied Health Service	64	100
Day Hospital		
a. Geriatric Day Hospital	55	73
b. Psychiatric Day Hospital	55	78
c. Rehabilitation Day Hospital	55	No change

Annex D

Examples of Items

under the Proposed New Service Category of Ambulatory Settings

(a) Day Chemotherapy

(b) Haemodialysis

(c) Cataract

(d) Colonoscopy with or without Polypectomy

(e) Oesophagogastroduodenoscopy

Annex E

The Government's Revised Proposal on

Public Charges for Eligible Persons

Charging basis: per-diem, highly subsidized rates. Last revised in April 2003.

Major Services	Current Charge (HK$)	Revised Charge (HK$)	Increase Rate	Subsidy Level (2016 Cost)	Subsidy Level (2003 Cost)
Outpatient Attendance					
a. A&E	100	180[220]	80%[120%]	85%[82%]	82%
b. General Clinic	45	50[61]	11%[36%]	89%[86%]	86%
c. Specialist Clinic					
- First Attendance	100	135[170]	35%[70%]	89%[86%]	86%
- Subsequent Attendance	60	80[100]	33%[67%]	93%[92%]	91%
- Drug Charge per Item	10	15[17]	50%[70%]	NA[4]	NA
Daily Inpatient Maintenance					
a. Acute Bed					
- Admission Fee	50	75[81]	50%[62%]	NA[5]	NA
- Maintenance Fee	100	120 [150]	20% [50%]	97%	97%

[4] A charge at $10 per item for medication was introduced in 2003 to discourage overuse of drugs and to reduce wastage. The proposed increase in drug charge by HA from $10 to $17 is calculated on the basis of service cost growth rate which reflects mainly the inflation rate and the annual paid adjustment of staff cost. Hence, the subsidy level is not available.

[5] Given the relatively higher cost of service provided during the first day of hospitalization, an additional $50 admission fee for the first day of hospitalization was introduced since 2003. The proposed increase in charge by HA from $50 to $81 is calculated on the basis of service cost growth rate which reflects mainly the inflation rate and the annual paid adjustment of staff cost. Hence, the subsidy level is not available.

Major Services	Current Charge (HK$)	Revised Charge (HK$)	Increase Rate	Subsidy Level (2016 Cost)	Subsidy Level (2003 Cost)
b. Convalescent/ Rehabilitation/ Infirmary/ Psychiatric Bed Maintenance Fee	68	100[110]	47%[62%]	96%[95%]	95%
Community Service					
a. Community Nursing Service	80	80	No change	85%	77%
b. Community Allied Health Service	64	80[100]	25%[56%]	95%[94%]	NA[6]
Day Hospital					
a. Geriatric Day Hospital	55	60[73]	9%[33%]	97%[95%]	96%
b. Psychiatric Day Hospital	55	60[78]	9%[42%]	96%[94%]	94%
c. Rehabilitation Day Hospital	55	No change	No change	96%	96%

Note: [ ] denotes the original increase proposed by HA

[6] 2003 cost for Community Allied Health Service is not readily available.