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Panel on Health Services

Updated background brief prepared by the Legislative Council Secretariat for the meeting on 25 April 2017

Fees and charges for public hospital services

Purpose

This paper provides background information and summarizes the concerns of members of the Panel on Health Services ("the Panel") on the 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 local residents, or Eligible Persons ("EP") in the context of fee-charging by the Hospital Authority ("HA").[1] 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);[2] (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.

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[1] Except those public services outside the scope of HA's standard services which are charged separately on a cost recovery basis.

[2] 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.

Other vulnerable groups other than CSSA recipients can apply for a medical fee waiver.

3. The fees and charges for EP were last revised on 1 April 2003[3] 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.[4] 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")[5] 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[6] 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 the fees and charges for NEP (excluding the obstetric package) and the fees and charges for private patients were made on 1 April 2013.

5. Under the prevailing fee review mechanism, HA reviews its fees and charges for public services to EP and NEP, and private services biennially. HA commenced its latest review exercise in this regard in 2015 ("the 2015 review"). On 15 December 2016, the HA Board endorsed the latest Fees and Charges Review Report and the recommendations. The revised level of fees and charges of the major services for EP, NEP and private services as proposed by HA are in **Appendices I, II and III** respectively. HA also takes the opportunity to recommend revisiting the service categories in the Gazette on HA fees and charges to cater for the procedures that are becoming suitable to be performed in ambulatory settings, such as day chemotherapy, haemodialysis, cataract, colonoscopy with or without polypectomy, and oesophagogastroduodenoscopy.

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

[4] 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.

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

[6] 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.

Deliberations of the Panel

6. The Panel discussed the fees and charges for public hospital services at a number of meetings held between 2001 and 2017, and received the views of deputations at one meeting. The deliberations and concerns of members are summarized in the following paragraphs.

Principles guiding the fee review

7. 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 also be increased 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.

8. 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) fee and charges as a means to encourage appropriate use of services; (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.

9. Members noted that based on the results of the 2015 review, HA proposed to increase the A&E charge for EP from $100 to $220 per attendance, and increase the charges for SOP services and GOP services respectively from $60 to $100 per attendance (with the first attendance charge be increased from $100 to $170 and the drug charge per item be increased from $10 to $17), and from $45 to $61 per attendance. As regards inpatient maintenance, the admission fee and daily maintenance fee of acute bed was proposed to be increased from $50 to $81, and from $100 to $150 respectively. Noting the above guiding

principles in setting or reviewing public hospital fees, members were concerned about the factors that had been taken into account in the 2015 review.

10. According to the Administration and HA, as stipulated under the Hospital Authority Ordinance (Cap. 113), HA should recommend to the Secretary for Food and Health ("SFH") 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. HA would review its level of fees and charges for public hospital services on a biennial basis and submit its recommendations to SFH for consideration. The guiding principles of cost sharing, appropriateness and facilitating access by vulnerable groups were based on the overarching principle that the public healthcare system would serve as a safety net for the provision of highly subsidized public healthcare services to local residents. The 2015 review had taken into account, among others, the increased cost and the fee gap between the existing A&E charge and the median charge of private doctors.

11. On members' question about the additional income to be generated from the proposed fee revision and its use, HA advised that the annual medical fee income and the overall operating expenditure of HA currently stood at around $2 billion and $58 billion respectively. It was estimated that the medical fee income of HA would be increased by $0.9 billion (i.e. less than 2%) if the fees and charges for services of HA were to be adjusted as proposed. The additional medical fee income would be counted towards the total income of HA for the provision of public healthcare services.

Charge for A&E services of HA

12. Many members expressed reservation about the introduction of a user charge of $100 for A&E services in 2002 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.

13. Members were subsequently advised that with the introduction of the A&E charge, A&E attendances had dropped from 2.5 million in 2001-2002 to 2.1 million in 2004-2005. While the A&E attendances had reverted to around 2.2 million in recent years, the A&E attendances of semi-urgent and non-urgent cases had dropped by around 20% as compared with the figure in 2001-2002 when about 75% of the A&E attendances were semi-urgent 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.

14. Members generally had strong views against the proposal of HA to drastically increase the A&E charge from $100 to $220 per attendance under the 2015 review. They considered that the provision of public GOP services were still far from inadequate to meet the service needs, and hence vulnerable patients with episodic diseases might choose to seek the affordable A&E services. The proposed increase in the A&E charge might deter the low-income group from seeking timely medical care, especially at times when no public GOP services were available. They urged HA to strengthen its GOP services during evenings and on Sundays and public holidays, and provide round-the-clock GOP services at selected districts. This apart, the Administration and HA should be prudent in considering whether the proposed revision should be applied to elderly patients seeking A&E services.

15. According to HA, patients of semi-urgent and non-urgent A&E cases currently constituted around 65% of overall A&E attendance. The proposed revision of the A&E charge aimed at encouraging appropriate use of the much overloaded the A&E services so that priority could be given to urgent cases. HA would increase the consultation quota for GOP clinics in 2018-2019. It also planned to strengthen the GOP services in evenings and on public holidays in the coming years if manpower and financial resources allowed. Separately, elderly patients could make use of vouchers under the Elderly Health Care Voucher Scheme to receive primary care services in the private sector.

16. There was a concern that the proposed revision of the A&E charge would induce an increase in the consultation fee of private doctors providing primary care services. This might defeat the purpose of encouraging patients not in urgent conditions to seek private healthcare services through narrowing the fee gap between the A&E departments of HA and private doctors. There was a view that HA should consider charging a lower fee for A&E services provided during daytime to guard against the possibility that the proposal would induce those private clinics currently charged a fee lower than $220 to increase their charges. Another view was that only the daytime A&E charge for semi-urgent and non-urgent cases should be increased so as to encourage these patients to use private primary care services. The Administration advised that HA was conducting various activities to engage community stakeholders on the revision proposals. The Administration would decide on the way forward having regard to the views received by HA during the public engagement exercise.

17. At the meeting on 16 January 2017, the Panel passed a motion urging the Administration to, apart from increasing the fees for A&E services, add quota for the public of the grass-root level under the General Outpatient Clinic Public-Private Partnership Programme so as to provide the low-income group with affordable healthcare services and relieve the long waiting time problem of A&E services. The Panel also passed another motion expressing the view that it was inappropriate for HA to substantially increase the fees for A&E services before improvement was made to its outpatient services, including the services in the evenings and on Sundays and during public holidays.

Fees and charges for NEP and private patients

18. The last major revision on fees and charges for NEP and private patients were made on 1 April 2013. Members noted that the fees and charges for NEP inpatient and outpatient services would be increased to the cost level of 2013-2014 at an average rate of 44.5% in order to achieve an overall recovery of costs, whereas the fees and charges for private patients would be increased at an average rate of 45.0% to bring the private charges up to the higher of cost or market price for the respective services. Some members were concerned that the increase in the fees and charges for NEP might aggregate the problem of default payments from NEP.

19. The Administration advised that measures had been put in place to minimize payment in default. These measures included requiring NEP in public wards to pay a deposit of $33,000 upon admission; issuing interim bills to NEP patients on a weekly basis during their hospitalization and final bills upon their discharge; and reminding patients or their family members to settle the fees timely. In addition, HA could suspend the provision of non-emergency medical services to NEP with outstanding fees and impose administrative charges on outstanding fees overdue. Where appropriate, legal actions would be taken to recover the default payments.

20. Given the prevalence of marriages between residents of Hong Kong and the Mainland, some members considered that non-local spouses of Hong Kong permanent residents should be allowed to access public healthcare services at subsidized rates. There was a view that HA should create an extra tier in its fee-charging category for those NEP whose spouses were Hong Kong residents. The Panel passed a motion at its meeting on 17 December 2012 urging the Administration to accord Mainland spouses of Hong Kong residents equal status with Hong Kong residents and abolish all discriminatory charging policies.

21. According to the Administration, to ensure that the public healthcare services could meet public demand and sustain in the long-term within the

limited financial resources, there was a genuine need to draw up eligibility criteria for receiving the heavily subsidized public healthcare services and accord priority to taking care of the needs of local residents. The eligibility criteria were applied throughout with regard to the status of the patient directly receiving the services (i.e. depending on whether the patient was EP or not), rather than the status of the family members of the patient concerned. The Administration had no plan to change this policy.

22. On the question about the basis for setting the revised fees and charges for private patients, the Administration advised that the charge for first class bed would be 150% of the charge for second class bed. This apart, the fees for most private services were in general set according to their cost, as well as the market price of the services if readily available so as to avoid attracting patients who were willing and able to afford private healthcare services to opt for private services at HA.

Medical fee waiving mechanism for public hospital services

23. 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.

24. 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. The medical fee waiver mechanism had been enhanced since 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.

25. 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. Members were advised that for inpatient cases granted with medical fee waivers in 2015-2016, 291 488 cases, 30 675 cases and 2 577 cases were respectively CSSA recipients, EP who were not on CSSA and NEP. As regards outpatient attendances granted with medical fee waivers in 2015-2016, around 3.2 million cases were CSSA recipients, 182 140 cases were EP who were not on CSSA and 20 853 cases were NEP.

Latest development

26. The Administration will brief the Panel on 25 April 2017 on its views on the revised level of fees and charges as proposed by HA according to the results of the 2015 review. The plan of the Administration is to implement the new fees and charges in mid-2017.

Relevant papers

27. A list of the relevant papers on the Legislative Council website is in **Appendix IV**.

Council Business Division 2
Legislative Council Secretariat
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Appendix I

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

Source: Extract from the Administration's paper entitled "Review of the fees and charges for public hospital services" (LC Paper No. CB(2)1224/16-17(01))

Appendix II

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%

Source: Extract from the Administration's paper entitled "Review of the fees and charges for public hospital services" (LC Paper No. CB(2)1224/16-17(01))

Appendix III

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	–

Source: Extract from the Administration's paper entitled "Review of the fees and charges for public hospital services" (LC Paper No. CB(2)1224/16-17(01))

Appendix IV

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)
	10.3.2003 (Item III)	Agenda Minutes CB(2)2682/02-03(01)
	17.5.2005 (Item VI)	Agenda Minutes
	13.6.2005 (Item IV)	Agenda Minutes
	17.12.2012 (Item VI)	Agenda Minutes CB(2)899/12-13(01)
	16.1.2017 (Item V)	Agenda CB(2)1157/16-17(01)

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