Long Term Health Care Policy

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Prepared by

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EXECUTIVE SUMMARY

1. The objective of this research is to outline the current health care policy, the policy formulation process and its implementation. The research aims at identifying factors which may affect the long-term development of health care services.

2. The Government published its first policy paper on medical services in 1964 and the second one in 1974. Since then, there has been no comprehensive review or update of the policy objective. The government is expected to complete its first comprehensive review on this subject in 1998.

3. The Government’s health care objective is to safeguard and promote general public health and to ensure the provision of medical and health services for the people of Hong Kong such that no one should be prevented through lack of means from obtaining adequate medical treatment. The Government also provides a safety net for the needy who cannot afford even the subsidized rate.

4. The Health and Welfare Bureau (HWB) is responsible for formulating health care policy. The policy executors are Department of Health (DH) and Hospital Authority (HA). Other departments related to public health are Environmental Protection Department (EPD), Urban Services and Regional Services Departments. The supply of private health care services is determined by market forces.

5. Public expenditure on health care has increased by almost six times in the past 10 years to HK$25,051 million in 1996/97. HA has the larger share, amounting to over 90% of total recurrent expenditure of HA and DH.

6. A survey in 1996 showed that when Hong Kong people needed out-patient service, about 66% would consult private practitioners. The elderly and lower-income people (approx. 21% of total population) would consult public doctors. About 11% of population would seek treatment from traditional Chinese medicine practitioners (TCMPs).

7. About 90% of hospital care is delivered through public hospitals. Patients pay HK$68 for an acute bed in 1997 which covers less than 2% of the cost of services. However, fees and charges in private hospitals which look after the remaining 10% of the population are much higher.

8. Over one million of the population are covered by group or individual medical insurance.

9. The Government provides dental services to less than 10% of the population, most of whom are school children and civil servants.

10. The major factors which may affect the long-term development of the health care system are: a) a comprehensive review or update of the policy objective to catch up with the needs of a changing society, b) Lack of an integrated health care system to provide continual health care services, c) Increase in demand for health care services, d) Increasing expenses and cost on services, e) Shortage of medical staff to support health care services, f) Fragmented policy planning and implementation among government departments, medical insurers and other constituency groups.
PART 1 - INTRODUCTION

1. Background

1.1 As the review on Health Care System conducted by the Government is expected to be completed by 1998, members of the Provisional Legislative Council (PLC) Panel on Health Services have requested the Research and Library Services Division (RLS) of the PLC Secretariat to conduct a research on the current health care system so as to facilitate their future discussions.

2. Objective and Scope

2.1 This report is the first in a series of RLS researches on the health care system. The objective of this research is to outline the policy, the policy formulation process and the implementation of the current health care policy. In particular, the study will try to identify any existing problems and factors which may affect further development of the provision of health care services in Hong Kong. Since the provision of health care services directly relates to demand and requires allocation of resources, this paper should be read in conjunction with two subsequent RLS reports on “Health Care Financing” and “Health Care Service for the Elderly” for a comprehensive review of the subject.

2.2 The scope of this study covers mainly the public health care provider, since it is the major provider of health care services. The time frame used for trend analysis is ten years. This also provides us with a base to scrutinize government proposals for development in the next ten years. We have chosen “ten years” as the measurement of “long-term” as Hong Kong is a rapidly changing society and is consistent with Hong Kong Government practice, viz. “Long Term Housing Strategy 1996-2006”. Overseas comparisons will be made in our subsequent report on “Health Care Financing”.

2.3 This paper is divided into six parts. Part 1 is the introduction. Part 2 describes the structure of the health care system in Hong Kong. Part 3 depicts the health care delivery process as a system, in terms of both input and output. Part 4 describes the provision of dental services. Part 5 analyses existing problems and other key factors which may affect the further development of the health care system. Part 6 is the concluding summary.
3. **Methodology**

3.1 To obtain information for analysis, the researchers studied relevant materials such as government information papers, research reports of various institutions, Hong Kong Hansard and Legislative Council (LegCo) Briefs. Briefing was provided to the RLS by Health and Welfare Bureau (HWB) and the Hospital Authority (HA). Related academics and medical professionals such as the chief executive and medical consultants of a few hospitals were interviewed. Letters and faxes were also sent to relevant groups such as The Hong Kong Federation of Insurers, Medical Council of Hong Kong, The Hong Kong Medical Association, The Estate Doctors Association, Census and Statistics Department (C&SD), Immigration Department, Security Bureau and follow up telephone calls were made to obtain the necessary information and statistics from all concerned parties.

3.2 This research paper is based on the information obtained from these sources.
PART 2 - HEALTH CARE POLICY IN HONG KONG

4. Development of the Health Care System

4.1 Government medical service was first introduced to Hong Kong in 1843 and the first Government Civil Hospital was established in 1850 but was destroyed in a typhoon in 1874. At that time, the service was mainly restricted to garrison and European residents whilst the majority of the local residents relied on medical services provided by traditional Chinese medicine practitioners (TCMPs). It was only in 1964 that the government published the first White Paper on medical services.

4.2 The second White Paper was published in 1974 which outlined a ten-year health care policy for the territory. The policy objective was, amongst others, “to ......ensure the provision of medical and personal health facilities for the people......including particularly that large section of the community which relies on subsidized medical attention.” Since then, there has been no change in the policy objective, nor any fundamental review of this objective.

4.3 Rather, a series of separate reviews was conducted: first, the system of provision of hospital care was overhauled through the establishment of the Provisional Hospital Authority in 1988 and the incorporation of the HA in 1990. Secondly, a Working Party on Primary Health Care was set up in 1989 to review the provision of primary health care services, which resulted in the pilot launching of a district health system (DHS). Thirdly, a review which touched on health care financing was conducted in 1993 but it did not receive total support from the community. A point to note is that all these reviews upheld, and did not question or try to refine, the policy objective set in 1974, that “no one should be denied adequate medical treatment through lack of means.”

4.4 In 1996 the government started to conduct a review of the health care system “to develop a health care policy and system that can cater for Hong Kong’s needs in the coming decades”. This exercise is expected to be completed by 1998. Appendix I summarizes the development of the health care system and the evolution of health care policy in Hong Kong.

5. Scope of Review of the Health Care System 1996

5.1 According to information provided by HWB, “the review is a macro-level examination of the Hong Kong health care financing and delivery system, which addresses issues such as the role of the public and private sectors, the interface between primary, secondary and tertiary care, existing sources of funding, the scope of public services, how services should best be financed and delivered in future, examination of systems in other countries and whether useful features from them could be applied to Hong Kong”.

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6. Principle of Health Care Policy

6.1 The Government’s health care policy is “to safeguard and promote the general public health of the community as a whole and to ensure the provision of medical and personal health services for the people of Hong Kong such that no one should be prevented through lack of means from obtaining adequate medical treatment”.

6.2 The Government also provides a safety net for the needy who cannot afford even the subsidized rate. For example, the Comprehensive Social Security Assistance (CSSA) recipients receive public medical treatment free of charge; and patients who cannot afford to purchase certain medical items in public hospitals which are not included in the daily maintenance charge can also apply to the Samaritan Fund for financial assistance.

7. Policy Maker - Health and Welfare Bureau (HWB)

7.1 The HWB is responsible for formulating health care policy. It monitors the implementation of health care policy and delivery of services by the Department of Health (DH) and the HA. It coordinates the activities of these departments to ensure effective use of resources.

8. Policy Executors

Department of Health (DH)

8.1 DH is the government health advisor and agency to execute health care policy and statutory functions. It is responsible for public health, disease prevention, curative and rehabilitative services and health promotion. In short, DH is mainly responsible for providing primary health care services. The range of services provided by DH is listed in Appendix IV.

8.2 In 1996, DH employed a total of 2,441 medical professional staff, including 519 doctors, 211 dentists and 1,043 registered nurses.

Hospital Authority (HA)

8.3 The HA is an independent statutory body which was established in 1990 to manage and control all public hospitals in Hong Kong. It is funded by Government and implements Government’s hospital-based health care policy. HA is accountable to the Government and the public through its annual planning process and the publication of the Annual Plan for public scrutiny on the targets and achievements in the year. It also submits annual reports and financial statements to the Government via the Secretary for Health and Welfare (SHW).

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1 Appendix II shows the categories of privately purchased medical items in public hospitals.
2 Appendix III lists the definitions of various health care services.
3 Hong Kong Annual Report 1997, p469.
8.4 HA currently manages 44 public hospitals/institutions, 48 specialist outpatient (SOP) centres, and employs 47,247 full-time staff. At the end of 1996, HA managed a total of 25,500 hospital beds which represented 4.05 public hospital beds per 1,000 population\(^4\).

8.5 HA provides secondary and tertiary care which includes:

- General in-patient services
- Psychiatric (mentally ill and mentally handicapped) in-patient services
- SOP services
- Accident and emergency (A&E) services
- Community care services such as psychiatric and geriatric day hospitals, community nursing, and community psychiatric nursing services

**Urban Services and Regional Services Departments**

8.6 Working under the policy guidance of the two municipal councils, the Urban Services Department (USD) and the Regional Services Department (RSD) are responsible for environmental health and hygiene in the territory. These include cleaning streets and gullies; collection of night soil, refuse and junk; management of refuse collection points, public toilets and bathhouses; pest control; and services for the dead. Discharging these responsibilities involves the deployment of 7,274 people and a fleet of 598 specialized vehicles\(^5\). USD and RSD are also the executive arms for carrying out food hygiene policy, i.e. licensing of restaurants and meat inspection in slaughter houses. However, it should be noted that these departments are not responsible to HWB.

**Environmental Protection Department (EPD)**

8.7 The department is responsible for all pollution prevention and control measures, including the planning of the territory’s sewage and wastes management programmes. However, it is accountable to Secretary for Planning, Environment and Lands (SPEL), not SHW.

**Private Health Care Service Providers**

8.8 The policy on private health care service providers is to ensure the coexistence of the public and private service providers. All registered medical practitioners and private clinics are regulated by the Medical Registration Ordinance administered by the Medical Council of Hong Kong and the Medical Clinics Ordinance administered by DH. Private hospitals must be registered with DH and are required to comply with the Guide to Hospital Standards issued by DH.

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\(^5\) Hong Kong Annual Report 1997, p172.
8.9 In December 1996, there were 9,196 doctors registered with the Medical Council, of whom 3,090 were HA doctors whilst 519 were DH doctors.

9. Statutory and Advisory Bodies

Health and Medical Development Advisory Committee (HMDAC)

9.1 The HMDAC was established in 1992 as a non-statutory advisory body to advise the Government on the development of health care services and the interface between the health and hospital services. The membership list and terms of reference are listed in Appendix V.

Other Medical Professional Bodies

9.2 The Hong Kong Medical Council is responsible for the registration of medical practitioners and has disciplinary responsibilities under the Medical Registration Ordinance. Other medical professional bodies which register, regulate training, hold examinations leading to registration or enrolment and exercise disciplinary powers include the Dental Council, Pharmacy Board, Nursing Board and Midwives Board.

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6 Hong Kong Annual Report 1997, p469.
PART 3 - HEALTH CARE DELIVERY SYSTEM

10. Health Indices of Hong Kong Residents

10.1 The health of the Hong Kong population has improved gradually in the past ten years. Table 1 shows that the average life expectancy at birth has been rising steadily from 74.2 years in 1987 to 76.3 years in 1996 for male, and from 79.7 years to 81.8 years for female in the corresponding period. Infant mortality rate marked 4.1 per 1,000 live births whilst the maternal mortality rate was 3.1 per 100,000 total births in 1996.

Table 1 - Health Indices of Hong Kong Residents 1987-1996

<table>
<thead>
<tr>
<th>Year</th>
<th>Life expectancy at birth (year)</th>
<th>Infant mortality rate (per 1,000 live births)</th>
<th>Maternal mortality rate (per 100,000 total births)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>1987</td>
<td>74.2</td>
<td>79.7</td>
<td>7.4</td>
</tr>
<tr>
<td>1988</td>
<td>74.4</td>
<td>79.9</td>
<td>7.4</td>
</tr>
<tr>
<td>1989</td>
<td>74.2</td>
<td>80.0</td>
<td>7.4</td>
</tr>
<tr>
<td>1990</td>
<td>74.6</td>
<td>80.3</td>
<td>6.2</td>
</tr>
<tr>
<td>1991</td>
<td>75.2</td>
<td>80.7</td>
<td>6.4</td>
</tr>
<tr>
<td>1992</td>
<td>74.8</td>
<td>80.7</td>
<td>4.8</td>
</tr>
<tr>
<td>1993</td>
<td>75.3</td>
<td>80.9</td>
<td>4.8</td>
</tr>
<tr>
<td>1994</td>
<td>75.7</td>
<td>81.5</td>
<td>4.5</td>
</tr>
<tr>
<td>1995</td>
<td>76.0</td>
<td>81.5</td>
<td>4.6</td>
</tr>
<tr>
<td>1996</td>
<td>76.3</td>
<td>81.8</td>
<td>4.1</td>
</tr>
</tbody>
</table>

Remark: * Provisional figure.
Source: Census and Statistics Department
Department of Health

11. Leading Causes of Death

11.1 Chronic degenerative diseases constitute the major causes of death in Hong Kong. It can be seen from Table 2 that the top three killers, namely malignant neoplasms, heart diseases and cerebrovascular diseases accounted for 10,031, 4,837 and 3,286 deaths respectively in 1996, representing 56.6% of all deaths. Corresponding crude death rates were 156.4, 76.9 and 52.2 per 100,000 population in that order.
## Table 2 - Leading Causes of Death\(^1\) in Hong Kong 1987-1996

<table>
<thead>
<tr>
<th>Year</th>
<th>Malignant neoplasms</th>
<th>Heart diseases, including hypertensive heart disease</th>
<th>Cerebrovascular disease</th>
<th>Pneumonia all forms</th>
<th>Injury &amp; poisoning</th>
<th>Others(^2)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>8,258</td>
<td>4,515</td>
<td>3,136</td>
<td>1,681</td>
<td>1,584</td>
<td>7,785</td>
<td>26,959</td>
</tr>
<tr>
<td>1988</td>
<td>8,177</td>
<td>4,599</td>
<td>3,145</td>
<td>2,013</td>
<td>1,551</td>
<td>7,891</td>
<td>27,376</td>
</tr>
<tr>
<td>1989</td>
<td>8,585</td>
<td>4,836</td>
<td>2,915</td>
<td>2,029</td>
<td>1,653</td>
<td>8,467</td>
<td>28,485</td>
</tr>
<tr>
<td>1990</td>
<td>8,669</td>
<td>4,976</td>
<td>3,075</td>
<td>2,000</td>
<td>1,752</td>
<td>8,729</td>
<td>29,201</td>
</tr>
<tr>
<td>1991</td>
<td>8,832</td>
<td>4,858</td>
<td>3,009</td>
<td>1,819</td>
<td>1,810</td>
<td>8,354</td>
<td>28,682</td>
</tr>
<tr>
<td>1992</td>
<td>9,021</td>
<td>5,359</td>
<td>3,067</td>
<td>2,002</td>
<td>1,693</td>
<td>9,384</td>
<td>30,526</td>
</tr>
<tr>
<td>1993</td>
<td>9,311</td>
<td>4,707</td>
<td>3,247</td>
<td>2,209</td>
<td>1,694</td>
<td>9,054</td>
<td>30,222</td>
</tr>
<tr>
<td>1994</td>
<td>9,390</td>
<td>4,909</td>
<td>3,225</td>
<td>2,009</td>
<td>1,718</td>
<td>8,855</td>
<td>30,106</td>
</tr>
<tr>
<td>1995</td>
<td>9,680</td>
<td>4,886</td>
<td>3,310</td>
<td>3,266</td>
<td>1,590</td>
<td>8,162</td>
<td>30,894</td>
</tr>
<tr>
<td>1996*</td>
<td>10,031</td>
<td>4,837</td>
<td>3,286</td>
<td>3,725</td>
<td>1,699</td>
<td>8,471</td>
<td>32,049</td>
</tr>
</tbody>
</table>

Remarks:
1. Figures are based on registered deaths.
2. Including nephritis, nephrotic syndrome and nephrosis, septicemia, chronic liver diseases and cirrhosis, diabetes mellitus, tuberculosis, chronic and unspecified bronchitis, emphysema and asthma, certain conditions originating in the perinatal period, and other causes.
* Provisional figures.

### 12. Public Expenditure on Health Care Services

12.1 Table 3 and Figure 1 show public expenditure on health care services in 1986/87 - 1996/97. It can be noted that public expenditure on health care services has risen drastically by almost six times in the past ten years reaching HK$25,051 million in 1996/97, accounting for 11.5% of total public expenditure and 2% of GDP.
Table 3 - Public Expenditure on Health Care Services 1986/87-1996/97 (HK$m)

<table>
<thead>
<tr>
<th>Year</th>
<th>Recurrent expenditure on health care services</th>
<th>Capital expenditure on health care services</th>
<th>Public expenditure on health care services</th>
<th>% Change</th>
<th>% to total public expenditure</th>
<th>% to GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>86/87</td>
<td>3,783.3</td>
<td>519.6</td>
<td>4,302.9</td>
<td>+14.2</td>
<td>9.0</td>
<td>1.3</td>
</tr>
<tr>
<td>87/88</td>
<td>4,192.4</td>
<td>729.0</td>
<td>4,921.4</td>
<td>+14.4</td>
<td>9.2</td>
<td>1.2</td>
</tr>
<tr>
<td>88/89</td>
<td>4,933.0</td>
<td>740.0</td>
<td>5,673.0</td>
<td>+15.3</td>
<td>8.8</td>
<td>1.2</td>
</tr>
<tr>
<td>89/90</td>
<td>6,093.0</td>
<td>1,214.0</td>
<td>7,307.0</td>
<td>+28.8</td>
<td>8.9</td>
<td>1.4</td>
</tr>
<tr>
<td>90/91</td>
<td>7,724.0</td>
<td>1,563.0</td>
<td>9,287.0</td>
<td>+27.1</td>
<td>9.8</td>
<td>1.5</td>
</tr>
<tr>
<td>91/92</td>
<td>9,785.0</td>
<td>1,379.0</td>
<td>11,164.0</td>
<td>+20.2</td>
<td>10.3</td>
<td>1.6</td>
</tr>
<tr>
<td>92/93</td>
<td>12,340.0</td>
<td>1,296.0</td>
<td>13,636.0</td>
<td>+22.1</td>
<td>11.0</td>
<td>1.7</td>
</tr>
<tr>
<td>93/94</td>
<td>14,520.0</td>
<td>3,937.0</td>
<td>18,457.0</td>
<td>+35.4</td>
<td>11.9</td>
<td>2.0</td>
</tr>
<tr>
<td>94/95</td>
<td>17,027.0</td>
<td>2,295.0</td>
<td>19,322.0</td>
<td>+47.0</td>
<td>11.6</td>
<td>1.9</td>
</tr>
<tr>
<td>95/96</td>
<td>19,963.0</td>
<td>4,322.0</td>
<td>24,285.0</td>
<td>+25.7</td>
<td>12.7</td>
<td>2.2</td>
</tr>
<tr>
<td>96/97</td>
<td>22,740.0</td>
<td>2,311.0</td>
<td>25,051.0*</td>
<td>+3.2</td>
<td>11.5</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Remark: * Revised estimate.
12.2 Table 4 lists the recurrent expenditure of HA & DH in 1993/94 - 1997/98. HA explained that personal emoluments and staff on cost accounted for 80% of total expenses. Excluding the cost on plant, vehicles, equipment and information system, the actual expenditure on medication for patients was less than 18%. Detailed analysis on health care expenditure will be presented in the subsequent RLS research report on “Health Care Financing”.

Table 4 - Recurrent Expenditure of HA & DH 1993/94-1997/98 (HK$m)

<table>
<thead>
<tr>
<th>Year</th>
<th>HA</th>
<th></th>
<th>DH</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HK$(m)</td>
<td>% Share</td>
<td>HK$(m)</td>
<td>% Share</td>
<td>HK$(m)</td>
</tr>
<tr>
<td>1993/94</td>
<td>13,052.6</td>
<td>90.8</td>
<td>1,327.0</td>
<td>9.2</td>
<td>14,379.6</td>
</tr>
<tr>
<td>1994/95</td>
<td>15,330.0</td>
<td>91.1</td>
<td>1,503.0</td>
<td>8.9</td>
<td>16,833.0</td>
</tr>
<tr>
<td>1995/96</td>
<td>18,152.9</td>
<td>91.5</td>
<td>1,685.0</td>
<td>8.5</td>
<td>19,837.9</td>
</tr>
<tr>
<td>1996/97 (revised)</td>
<td>20,745.9</td>
<td>91.6</td>
<td>1,898.0</td>
<td>8.4</td>
<td>22,643.9</td>
</tr>
<tr>
<td>1997/98 (estimate)</td>
<td>22,400.1</td>
<td>91.2</td>
<td>2,155.9</td>
<td>8.8</td>
<td>24,556.0</td>
</tr>
</tbody>
</table>

Remark: Excluding treatment of drug abusers, Prince Philip Dental Hospital, and medical and dental treatment for civil servants.

Source: Health and Welfare Bureau


13.1 Hong Kong has a simple health care delivery system. Primary care is mainly provided by private general practitioners (GPs) on a fee-for-service basis and by GOP clinics run by either DH or HA. Primary care is also provided by TCMPs. Secondary and tertiary care is provided by hospitals which are run by the HA or the private sector. In general, if primary care is well delivered, it will decrease the chance of patients using the more expensive secondary or tertiary care, especially in the case of chronic illnesses.

Out-patient Services

13.2 Table 5 shows the types of doctors consulted in a health status survey conducted by the C&SD in May-June 1996. It can be seen that over 66% of the respondents consulted private practitioners when they needed GOP service treatment whilst 12% and 9% visited DH and HA clinics respectively. The remaining 11% consulted TCMPs.
Table 5 - Types of Doctors Consulted for Out-Patient Service Treatment in 1996

<table>
<thead>
<tr>
<th>Type of doctor consulted</th>
<th>No. (‘000)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practitioners of western medicine*</td>
<td>920.2</td>
<td>66.3</td>
</tr>
<tr>
<td>Doctors in clinics under DH (other than those in A&amp;E departments of clinics)</td>
<td>166.6</td>
<td>12.0</td>
</tr>
<tr>
<td>Herbalists/bone-setters/acupuncturists</td>
<td>145.4</td>
<td>10.5</td>
</tr>
<tr>
<td>Doctors in out-patient departments of hospitals under HA</td>
<td>125.3</td>
<td>9.0</td>
</tr>
<tr>
<td>Doctors in A&amp;E department of clinics under DH and of hospitals under HA</td>
<td>30.5</td>
<td>2.2</td>
</tr>
<tr>
<td>Total</td>
<td>1,388.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Remark:
* Including private practitioners of western medicine, whether registered or not, and doctors in out-patient departments of private hospitals, clinics of institutions, charitable organizations and exempted clinics.

Source: Special Topics Report No. 15, Census and Statistics Department, p73

Private Out-patient Services

13.3 The majority of the working population and their families receive primary care from private practitioners. According to the survey conducted by the Hong Kong Medical Association (HKMA) in mid-June 1996 on private doctors’ fees, the median fees charged by private GPs and specialists were HK$150 and HK$350 respectively. A similar survey conducted by the Medical Insurance Association in July 1996 showed the corresponding fees were HK$203 and HK$429 respectively.

13.4 According to information provided by the Estate Doctors Association (EDA) Ltd., an EDA Medical Aid Scheme was established since December 1984. The participating member doctors will reduce their consultation fee for patients who are receiving CSSA and who are aged over 65 years. The amount of reduction in fees is determined entirely by the participating doctors.
Public Out-patient Services

13.5 In 1996, public clinics made the following charges for Hong Kong residents: HK$37 for GOP service and HK$44 for SOP service. The fee included medication and covered roughly 19% and 10% of the actual average cost per consultation for GOP service and SOP service respectively. The HA indicated that the clients were primarily the elderly and lower-income patients.

In-patient Services

Public Hospitals

13.6 The bulk of in-patient care is delivered through public hospitals. Table 6 shows that the HA provides 90% of all hospital beds whilst private hospitals provide only 10% of in-patient care services. The HA hospitals provide a comprehensive range of secondary and tertiary health care at a heavily subsidized rate. In 1997, patients who are Hong Kong residents only need to pay HK$68 for an acute bed per day which covers less than 2% of the actual average cost.

Table 6 - Share of Public and Private Hospitals by Number of Beds 1986-1996

<table>
<thead>
<tr>
<th>Year</th>
<th>HA/HSD * hospitals</th>
<th>Government maternity home</th>
<th>All public hospitals</th>
<th>Private hospitals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>1986</td>
<td>20,868</td>
<td>87.4</td>
<td>405</td>
<td>1.7</td>
<td>21,273</td>
</tr>
<tr>
<td>1987</td>
<td>21,175</td>
<td>87.4</td>
<td>379</td>
<td>1.6</td>
<td>21,554</td>
</tr>
<tr>
<td>1988</td>
<td>21,234</td>
<td>87.1</td>
<td>385</td>
<td>1.6</td>
<td>21,619</td>
</tr>
<tr>
<td>1989</td>
<td>21,216</td>
<td>87.2</td>
<td>363</td>
<td>1.5</td>
<td>21,579</td>
</tr>
<tr>
<td>1990</td>
<td>21,374</td>
<td>87.3</td>
<td>315</td>
<td>1.3</td>
<td>21,689</td>
</tr>
<tr>
<td>1991</td>
<td>21,684</td>
<td>87.6</td>
<td>173</td>
<td>0.7</td>
<td>21,857</td>
</tr>
<tr>
<td>1992</td>
<td>22,437</td>
<td>87.8</td>
<td>164</td>
<td>0.6</td>
<td>22,601</td>
</tr>
<tr>
<td>1993</td>
<td>23,271</td>
<td>88.4</td>
<td>131</td>
<td>0.5</td>
<td>23,402</td>
</tr>
<tr>
<td>1994</td>
<td>23,955</td>
<td>88.9</td>
<td>84</td>
<td>0.3</td>
<td>24,309</td>
</tr>
<tr>
<td>1995</td>
<td>25,020</td>
<td>89.3</td>
<td>85</td>
<td>0.3</td>
<td>25,105</td>
</tr>
<tr>
<td>1996</td>
<td>25,600</td>
<td>89.4</td>
<td>72</td>
<td>0.3</td>
<td>25,672</td>
</tr>
</tbody>
</table>

Remark: * HSD refers to Hospital Services Department which managed government hospitals prior to 1990.

Source: Hospital Authority

Private Hospitals

10 According to information provided by the DH, estimated cost in 1996 for GOP service is HK$191 and for SOP service is HK$453.
11 HK$68 covers the cost for food, accommodation, tests, medicine and surgery or other treatment.
12 Charges for non-Hong Kong residents per day is: HK$3,130 for acute or convalescent and infirmary bed, HK$865 for psychiatric bed.
13 According to information provided by the HA, cost for a HA acute bed (general ward) is HK$3,370, convalescent and infirmary bed is HK$1,611, psychiatric bed is HK$765 whereas in-patient services cost for DH is HK$1,758.
13.7 Private hospitals only admit patients on a fee-for-service basis. Charges can be paid after services are rendered. The patients may pay out of his own pocket or by private health care insurance.

13.8 Table 7 and Table 8 present the results of two surveys conducted by HKMA and The Hong Kong Federation of Insurers respectively on fees and charges in private hospitals.

**Table 7 - Median Charges of GPs in Performing Various Types of Surgeries, Attendance and Bedside Procedures in Hospital by Class of Wards 1996 (HK$)**

<table>
<thead>
<tr>
<th>Type of services</th>
<th>1st class</th>
<th>2nd class</th>
<th>3rd class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily attendance</td>
<td>1,200</td>
<td>800</td>
<td>400</td>
</tr>
<tr>
<td>Bedside procedure</td>
<td>2,500</td>
<td>1,500</td>
<td>1,000</td>
</tr>
<tr>
<td>Ultra-major operation</td>
<td>70,000</td>
<td>30,000</td>
<td>20,000</td>
</tr>
<tr>
<td>Major operation</td>
<td>27,500</td>
<td>15,000</td>
<td>10,000</td>
</tr>
<tr>
<td>Intermediate operation</td>
<td>15,000</td>
<td>9,500</td>
<td>5,000</td>
</tr>
<tr>
<td>Minor operation</td>
<td>5,000</td>
<td>3,500</td>
<td>2,200</td>
</tr>
</tbody>
</table>

Source: Hong Kong Medical Association releases, Survey Results on Private Doctors' Fees, December 1996

**Table 8 - Hospital and Surgical Fees of Private Hospitals**

<table>
<thead>
<tr>
<th>Services</th>
<th>Average Fee (HK$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board</td>
<td>661/day</td>
</tr>
<tr>
<td>Hospital Expenses</td>
<td>6,900/disability</td>
</tr>
<tr>
<td>Surgeon's Fee (in hospital)</td>
<td>12,497/disability</td>
</tr>
<tr>
<td></td>
<td>(at clinic)</td>
</tr>
<tr>
<td>Anaesthetist's Fee</td>
<td>4,170/disability</td>
</tr>
<tr>
<td>Operating Theatre</td>
<td>4,195/disability</td>
</tr>
<tr>
<td>In Hospital Physician Fee</td>
<td>807/day</td>
</tr>
</tbody>
</table>

Medical Insurance

13.9 In 1996, at least over one million people, or over 17% of the population, were covered by medical insurance (Table 9). Among them, 1,039,428 were covered by group insurance provided by employers. Another 1,038,732 bought their own medical insurance. However, it is unknown how many of those who were covered by group were also covered by individual insurance policies\textsuperscript{14}.

Table 9 - Medical Insurance Statistics 1993-1996

| Year | Group | | | Individual | | | Total | | |
|------|-------|--------|--------|--------|--------|--------|--------|--------|
|      | No. of policies | No. of people covered | No. of policies | No. of people covered | No. of policies | No. of people covered |
| 1993 | 10,595 | 627,153 | 237,776 | 297,047 | 248,371 | 924,200 |
| 1994 | 11,573 | 693,824 | 273,287 | 386,376 | 284,860 | 1,080,200 |
| 1995 | 15,402 | 856,690 | 981,513 | 1,061,650 | 996,915 | 1,918,340 |
| 1996 | 16,350 | 1,039,428 | 1,094,646 | 1,038,732 | 1,110,996 | 2,078,160 |

Remarks: * means the total number may involve double-counting, hence, is indicative only.
Source: The Hong Kong Federation of Insurers

Complaints System

13.10 A feedback system is important to gauge the effectiveness and efficiency of the public health care service providers. Table 10 shows the complaints received by various organizations on health care services in 1993-1996.

\textsuperscript{14} The statistics were provided by the 42 member companies of the Medical Insurance Association. These insurers amounted to 40% of the 105 companies authorized under the Insurance Companies Ordinance to carry out medical insurance business.
### Table 10 - Complaints Received by Related Organizations on Health Care Services 1993-1996

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health</td>
<td>416</td>
<td>418</td>
<td>472</td>
<td>435</td>
</tr>
<tr>
<td>Hospital Authority</td>
<td>1,762</td>
<td>1,911</td>
<td>1,847</td>
<td>1,735</td>
</tr>
<tr>
<td>Medical Council of Hong Kong</td>
<td>134</td>
<td>170</td>
<td>177</td>
<td>168</td>
</tr>
<tr>
<td>HKMA Patients’ Rights &amp; Responsibilities Committee¹</td>
<td>37</td>
<td>16</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Ombudsman of Hong Kong²</td>
<td>10</td>
<td>76</td>
<td>89</td>
<td>132</td>
</tr>
<tr>
<td>Consumer Council</td>
<td>n.a.</td>
<td>n.a.</td>
<td>15</td>
<td>24</td>
</tr>
<tr>
<td>Legislative Council</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

**Remarks:**
n.a. not available

**Sources:**
- Annual Report of The Ombudsman of Hong Kong, June 1994-1997
- Department of Health
- Hospital Authority
- Medical Council of Hong Kong
- Hong Kong Medical Association
- Consumer Council
- Provisional Legislative Council, Complaints Division

**Department of Health**

13.11 In 1996, DH received 435 complaints, among which 162 cases complained about staff performance, 120 about administration procedures and 105 about staff manner.

**Hospital Authority**

13.12 Among all the organizations which handle complaints on health care services, the HA received the most cases since it is the largest and the chief supplier of hospital services. In 1996, the HA received 1,735 complaints, of which 38% were about medical services and 31% were about staff attitude.
Medical Council of Hong Kong

13.13 The Medical Council of Hong Kong is empowered by law to deal with complaints against registered medical practitioners touching on a matter of professional misconduct. It has no jurisdiction whatsoever over claims for refund or compensation, which should be pursued through separate civil proceedings. In 1996, the Council handled 168 cases, of which 101 cases complained about the “unprofessional responsibility of doctors to patients”.

HKMA Patients Rights and Responsibilities Committee

13.14 Complaints on health care services are also directed to the HKMA Patients’ Rights & Responsibilities Committee which was set up in 1992. The association handles complaint cases by mediation. This involves all parties concerned in the complaints, i.e. patients, doctors, members of the HKMA Patients Rights and Responsibilities Committee and a representative from the Consumer Council. In 1996, a total of 22 cases were received, 18 of which were complaints about private practitioners.

Ombudsman of Hong Kong

13.15 In 1996/97, the Ombudsman received 24 complaints against DH and 108 complaints against HA. They mainly involved failure to provide proper medical treatment and to keep patients informed, negligence in caring and bad manner of hospital staff.

Consumer Council

13.16 The Consumer Council does not accept complaints against government departments; however, some citizens would send in letters complaining about medical treatment received in government hospitals or clinics. The Consumer Council would then refer these cases to the appropriate body for follow-up actions. In 1996, there were 5 and 19 complaints on hospitals and doctors respectively.

Legislative Council

13.17 The Complaints Division of the PLC handles various kinds of complaints. However, complaints on health and medical services were relatively few, amounting to less than ten cases in each of the past few years.
PART 4 - DENTAL SERVICES

14.1 The government provides very limited dental service to the public. It is the government’s policy to provide:

- Oral health education and promotion to the public;
- School Dental Care Service to primary school children;
- Curative and emergency services to patients of public hospitals, prisoners and trainees of penal institutions, civil servants, pensioners and their dependents.

14.2 The latest available survey covering the whole community on dental consultation was conducted by the C&SD in October-December 1990. The result indicated that out of 1,000 persons, only 50 had their teeth examined or treated in the survey period. This reflects a low community awareness of the need for regular dental care.

14.3 The majority of the respondents in the 1990 survey who received dental treatment were aged 5-14, corresponding to a rate of 105.6 persons per 1,000 population. This was most probably due to the provision of the government school dental care service to primary school children. In 1995/96, a total of 385,580 or 82.4% of the primary school population received annual dental examinations and basic dental care\textsuperscript{15}.

14.4 Table 11 lists the attendance at dental service provided by DH. It should be noted that DH provided dental service to less than 10% of total population. It should also be noted that the general public only accounted for 12% of the attendance at this dental service while the rest were civil servants and their dependents and pensioners. Among the attendance at DH dental service, less than 30% were rendered dentally fit.

\textsuperscript{15} Hong Kong Annual Report 1997, p164
Table 11 - Statistics on General Dental Service of DH 1986-95 (No. of Attendance)

<table>
<thead>
<tr>
<th>Year</th>
<th>Civil Servants/Pensioners/Dependents</th>
<th>General public</th>
<th>Total</th>
<th>% of total attendance to total population</th>
<th>Attendance for persons rendered dentally fit</th>
<th>% of persons rendered dentally fit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>416,480</td>
<td>46,456</td>
<td>462,936</td>
<td>8.4</td>
<td>134,394</td>
<td>29.0</td>
</tr>
<tr>
<td>1987</td>
<td>455,963</td>
<td>49,261</td>
<td>505,224</td>
<td>9.1</td>
<td>150,173</td>
<td>29.7</td>
</tr>
<tr>
<td>1988</td>
<td>477,414</td>
<td>48,054</td>
<td>525,468</td>
<td>9.4</td>
<td>164,974</td>
<td>31.4</td>
</tr>
<tr>
<td>1989</td>
<td>465,444</td>
<td>46,740</td>
<td>512,184</td>
<td>9.1</td>
<td>159,709</td>
<td>31.2</td>
</tr>
<tr>
<td>1990</td>
<td>461,554</td>
<td>49,410</td>
<td>510,964</td>
<td>9.1</td>
<td>159,992</td>
<td>31.3</td>
</tr>
<tr>
<td>1991</td>
<td>465,607*</td>
<td>50,150</td>
<td>515,757</td>
<td>9.1</td>
<td>161,874</td>
<td>31.4</td>
</tr>
<tr>
<td>1992</td>
<td>473,443*</td>
<td>53,524</td>
<td>526,967</td>
<td>9.2</td>
<td>162,415</td>
<td>30.8</td>
</tr>
<tr>
<td>1993</td>
<td>470,296*</td>
<td>56,367</td>
<td>526,663</td>
<td>9.0</td>
<td>167,870</td>
<td>31.9</td>
</tr>
<tr>
<td>1994</td>
<td>486,262*</td>
<td>65,984</td>
<td>552,246</td>
<td>9.2</td>
<td>164,885</td>
<td>29.9</td>
</tr>
<tr>
<td>1995</td>
<td>513,240*#</td>
<td>75,375</td>
<td>588,615</td>
<td>9.6</td>
<td>173,883</td>
<td>29.5</td>
</tr>
</tbody>
</table>

Remarks: * Including Hospital Authority staff and their dependents.
# Including estimate for Pamela Youde Nethersole Eastern Hospital.
Sources: Annual Report of Department of Health 1990/91-1991/92 Table 55, 1995/96 Table 57
Census and Statistics Department

14.5 The Governor committed in his Policy Address of 1993 to provide dental services to patients with special needs. They are:

- patients with serious and disabling oral diseases;
- patients who are severely handicapped mentally or physically; and
- individuals with specific medical diseases

It is estimated that about 11,000 patients would be covered in these three categories; 1,900 of them were covered already, and a total of 3,000 would be covered by 1996/97. However, the schedule to cover all patients in these categories is unknown; neither is there a plan to extend this service to the needy and the elderly people.

14.6 In 1995, a report on oral health was published by the Dental Services Division of DH, which mainly focused on the prevention of caries and periodontal disease. As the government’s policy on dental service was only confined to the provision of preventive and educational services, the 1996 government review on health care system would focus on health care financing, not dental service.

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16 LegCo Panel on Health Services, Record of Meeting held on 14 October 1996.
PART 5 - FACTORS AFFECTING THE DEVELOPMENT OF THE HEALTH CARE SYSTEM

15. Lack of Comprehensive Health Care Policy Update Since 1974

15.1 Follow the publication of the 1974 White Paper which set the policy objective as “......to ensure the provision of medical and personal health facilities....for the people.....including particularly that large section of the community which relies on subsidized medical attention”, the government did not undertake a comprehensive review of the policy objective. Subsequent papers upheld the policy that “no one should be denied adequate medical treatment through lack of means”.

15.2 However, there is no definition for “adequate medical treatment” and “lack of means”. As diagnosis and medical treatment becomes sophisticated, it is difficult to define the “adequate” level of treatment provided to patients. On the other hand, due to the sophistication of diagnosis and medical treatment, the cost involved becomes increasingly higher due to high research and development cost. However, who should pay for what services is not specified and there is no test for “means”.

15.3 It turns out that everyone becomes entitled to the government health care services regardless of his income. This has led to a wide range of heavily-subsidized services being provided by the government at a low charge for anyone who wants them. Demand becomes immeasurable whereas supply is constrained. This results in a distortion of the efficiency of the whole health care system as well as in the overall allocation of public resources. Given the tremendous socioeconomic changes that Hong Kong experienced in the past 20 years, a review of the health care policy objective is fundamental in planning for the further development of health care services.

15.4 On the implementation of health care policy, the government reviewed and overhauled the provision of hospital services through the establishment of the Provisional Hospital Authority in 1988 and the incorporation of HA in 1990. It also published a paper on primary health care services in 1990 and implemented a pilot scheme of DHS. It published a consultation paper in 1993 on health care financing but did not receive total support from the community. However, these were operational changes and can not allow us to measure whether or not they helped to achieve the policy objective when “adequate medical treatment” and “lack of means” are not clearly defined.
16. **Fragmented Health Services Planning**

16.1 Health is a physical, physiological, psychological and social state of well being. It can only be optimally maintained and improved by means of an integrated health care system which provides different levels and types of continual care. In the health care policy making process, there is no effective authority which can cut across levels, functions, institutions, and sectors to plan health services. The existing planning activities are organized along institutional lines, with the HA planning for public hospital services and the DH planning for public primary health care services. The environmental aspect, such as purification of water which is important to public health, is the responsibility of the Water Supplies Department which reports to the Secretary for Works. On the other hand, food hygiene and environmental health are within the domain of the USD, RSD and EPD. This fragmentation in health care policy making has resulted in uncoordinated government response to some unexpected public health crises. Planning for an integrated health care system becomes difficult when it is conducted in such a fragmented manner.

16.2 In the absence of integrated health care planning to guide the development of health care facilities, individual institutions may tend to expand beyond optimal levels. Consequently, resources may not be used in the most efficient way.

17. **Barriers to an Integrated Health Care Services**

17.1 There are significant barriers to the implementation of an integrated health care system, which are detailed in paragraphs 17.2-17.10.

**Lack of Interface Between Public and Private Health Care Service Providers**

17.2 As discussed in paragraph 13.1, the private sector provides most of the primary health care services whilst the public sector provides most of the hospital care services. Primary care and hospital care lie in a continuum. After a patient leaves the hospital, he would need follow-up primary care, which is sometimes obtained from the private sector. However, there is limited interface and coordination between these health care service providers. Many patients are not aware of or do not execute their rights to obtain their medical reports from public health care service providers; consequently, when they consult their GPs, there is no record to follow. This behaviour greatly affects the continuity and quality of patient care, and also the allocative efficiency of the whole system.

**Lack of an Institution of Family Doctor**

17.3 Most people in Hong Kong are not being taken care of by a particular doctor. For GOP service, a patient may shop around for the cheapest medical treatment. Similar to the situation mentioned in paragraph 17.2, the patient seldom requests his medical report to be passed from one GP to the next; consequently, this affects the continuity and quality of care.
17.4 Experience from overseas countries has shown that if a person has his own family doctor who knows his health history, it can ensure the continuity of health care and reduce the chance of duplication of medication. Besides, the family doctor can act as a gate-keeper to using the expensive secondary and tertiary care. Mutual understanding between the GP and patient gives the latter more confidence. If a patient falls ill, he may first seek advice and acquire more knowledge from his family doctor before using hospital services.

17.5 However, implementing this system of family doctor in Hong Kong is costly because there is a great price differential between the public and private health care service providers, and also among different private health care service providers. To reduce the public sector workload and to attract the patients to visit private sector family doctors, the government will need to subsidize all the patients or the family doctors such that the former can afford to pay the service at a reasonable price whilst the income for the latter can be guaranteed. Without sufficient market transparency on cost and supply, it becomes impossible to calculate the cost implications.

**Lack of Interface Between GPs and TCMPs**

17.6 Primary care is also supplemented by TCMPs in the private sector. However, the medical philosophy, treatment and medication of TCMPs are very different from those of GPs. Often there is little communication between these two groups of practitioners. Even when a patient passes the medical report from his TCMP to the GP, or vice versa, the receiving practitioner may not find the medical report useful. This affects the continuity of patient care.

**Lack of Interface Between Primary/Secondary/Tertiary Health Care**

17.7 According to information provided by HWB, Hong Kong’s health care system is concentrated on curative rather than preventive care. This is due to the shortage of hospital beds in the 1960-70’s. Thus, emphasis has been put on expansion of secondary health care but little attention has been paid to the coordination between hospital and primary health care. Such a separation of primary care and hospital-based secondary, tertiary and extended care creates problems in the coordination and continuity of care.

**Lack of Interface Between Health Care Service Providers, Other Government Departments and Service Organizations**

17.8 An integrated health care system emphasizes the continuum of health care provision. Thus, support and assistance from private GPs, other government departments and service organizations are important to enhance the identification of health needs and implementation of health programme in the community. For example, the Social Welfare Department (SWD) can provide information on the health needs of the poor and the elderly people. It can also assist in promoting public health care. In addition, health care promotion can also be supplemented by GPs and service organizations which have wide contacts with people from different walks of life. However, at present there is little collaboration between the public and private health care service providers, the concerned government departments and service organizations.

**Non-availability of Integrated Information System**
17.9 There is limited collaboration among health care providers to develop an integrated health care information system and communications network to facilitate information sharing and support effective business operation, service planning, utilization review and resource management.

17.10 Although a territory-wide public hospital patient database has been developed since 1992, it is only confined to HA outlets. It has not been extended to other health care providers (DH or GPs) in which patient referral, service networking or share-care programmes can be centralized.

18. Non-intervention Policy on Private Health Care Services

18.1 Although the private sector delivers almost 70% of out-patient care and 10% of in-patient care, it is not the government’s policy to plan the development for the private sector. Private health care development is left to be determined by market forces.

18.2 It can be seen in Table 6 that there has been little growth in private hospital beds since the 1980s. During the past ten years, the number of private hospital beds has increased only by 355 (13.7%) from 2,599 in 1986 to 2,954 in 1996, whereas in public hospitals, the total number of beds increased by 4,732 (22.7%) in the corresponding period. The sluggish growth has been attributed to the following reasons:

- Private health insurance subscription covers only over 1/6 of the population; hence, more than 2/3 of the population have to pay their own hospital charges. If they visit private hospitals, they may have to pay charges which are significantly higher than public hospital charges;
- Increase in land and real estate prices that increases the operating cost of private hospitals, which receive no preferential treatment.

19. Slow Progress in the Registration of Traditional Chinese Medicine (TCM) Practice

19.1 TCMPs are not registered although there exists 4,000 to 10,000 TCMPs, over 1,600 retail herbal shops, and the fact that over 60% of the population have consulted TCMPs\(^\text{18}\). There is no accreditation for training programmes and no control over the manufacturing, sale, or dispensing of herbal and other proprietary Chinese medicine, including the highly toxic medicines.

19.2 Attempts to rectify this situation are slow. A Working Party was appointed by SHW in 1989 which took five years to produce a report that recommended the setting up of another committee to look at the problem further. A Preparatory Committee on Chinese Medicine (PCCM) was then established in April 1995. In 1996, the Committee completed an enrolment exercise for TCMPs, revised the list of potent/toxic Chinese herbs and published an educational leaflet on the safe use of Chinese medicine.

19.3 In 1997, a report on the criteria and procedures for the legislative framework for the promotion, development and regulations of TCM in the territory was published. It recommended the establishment of a statutory body to co-ordinate TCMPs and to control the sale, processing and manufacturing of TCM; to develop a registration, examination, training and disciplinary system for TCMPs; to introduce a licensing system for proprietary Chinese medicines; to enforce the existing legislative controls governing the labelling, adulteration and advertising of Chinese medicinal materials and proprietary Chinese medicines.

19.4 The report also mentioned the research on the integration of TCM practice into the health care system. However, the scope of the research has not been defined; neither is there a time schedule planned for the research. Thus, the role of TCMP in the health care system is still unclear even after registration. For example, whether a TCMP can issue the sick leave notice for an employee or the death certificate for a patient remains questionable. Therefore, until further research is conducted, the government will not extend any TCM practice in the public sector.

20. Slow Progress in the Implementation of the Primary Health Care Report

20.1 The Working Party on Primary Health Care, whose report was endorsed by the government in 1991, made 102 recommendations to improve primary health care services. However, only a few recommendations are being implemented. Although RLS enquired about the action plan and progress on the implementation of the services, no response was received from the government.

20.2 Among all the recommendations, the implementation of DHS was reported to be effective. The concept was to divide the whole territory into districts, and all DH clinic facilities within each district to be organized into a network of services comprising a balance of preventive, promotive, curative and rehabilitative services. A pilot project was launched in Kwun Tong in 1992 and is now being implemented in two more districts. However, the schedule for territory-wide implementation is unknown.
21. Increase in Demand

Demand for GOP Services

Number of Attendance

21.1 DH provides primary medical care services through its GOP clinics. Patients with minor ailments or with stabilized chronic illnesses are treated or followed up at the GOP clinics. Patients with chronic illnesses requiring secondary or specialist care are referred to the specialist clinics of the HA for further investigation and management. As shown in Table 12, DH handled about 5,500,000 attendance in each of the past five years whereas the number of attendance for HA varied between 700,000 - 800,000 in the corresponding period.

Table 12 - GOP Services Attendance 1986-1995

<table>
<thead>
<tr>
<th>Year</th>
<th>HSD/HA¹</th>
<th>% Change</th>
<th>DH²</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>769,115</td>
<td>+1.9</td>
<td>5,540,111</td>
<td>+1.8</td>
</tr>
<tr>
<td>1987</td>
<td>760,052</td>
<td>-1.2</td>
<td>5,735,828</td>
<td>+3.5</td>
</tr>
<tr>
<td>1988</td>
<td>753,790</td>
<td>-0.8</td>
<td>5,754,968</td>
<td>+0.3</td>
</tr>
<tr>
<td>1989</td>
<td>724,248</td>
<td>-3.9</td>
<td>5,570,340</td>
<td>-3.2</td>
</tr>
<tr>
<td>1990</td>
<td>721,770</td>
<td>-0.3</td>
<td>5,629,549</td>
<td>+1.0</td>
</tr>
<tr>
<td>1991</td>
<td>730,150</td>
<td>+1.2</td>
<td>5,477,144</td>
<td>-2.7</td>
</tr>
<tr>
<td>1992</td>
<td>808,440</td>
<td>+10.7</td>
<td>5,439,329</td>
<td>-0.7</td>
</tr>
<tr>
<td>1993</td>
<td>765,095</td>
<td>-5.4</td>
<td>5,461,647</td>
<td>+0.4</td>
</tr>
<tr>
<td>1994</td>
<td>737,691</td>
<td>-3.6</td>
<td>5,424,957</td>
<td>-0.7</td>
</tr>
<tr>
<td>1995</td>
<td>751,807</td>
<td>+1.9</td>
<td>5,580,609</td>
<td>+2.9</td>
</tr>
</tbody>
</table>

Remarks:
1. General out-patient attendance for HSD/HA refers to cases seen by doctors.
2. General out-patient attendance for DH refers to doctor consultations, dressings, injections, and accident and emergency attendance.

Sources: Hong Kong Annual Digest of Statistics 1994 p240, 1996 p239
Waiting Time

21.2 According to information provided by DH on GOP services, the pledged waiting time for patients with episodic illness is less than one hour while that for patients with chronic illness with advance appointment is half an hour. RLS asked for data on actual waiting time for all services, but received no information from SHW.

21.3 For GOP departments operated by HA, the average queuing time for medical consultation is less than 90 minutes\(^{19}\). RLS asked for data on actual waiting time for all services, but received no information from HA.

21.4 The lack of information on actual waiting time for DH disables RLS from performing an analysis on the opportunity cost of time of patients in the allocation of resources within the public health care system. Since the capacity of public hospitals and clinics is limited, and the price i.e. charge or fee, supply of health care services is fixed, demand for health care services is met by the opportunity cost of time. Time spent on waiting could have been economically productive. Patients with the most leisure time or the least money will queue for hours since public health service is cheap and accessible by everyone.

Demand for SOP Services

Number of Attendance

21.5 As regards the SOP services listed in Table 13, attendance at HA continued to grow significantly since 1992 (6.3% over 1991). It further grew by 7.8% in 1993 and rose to 10.5% in 1995. On the other hand, attendance at DH declined steadily from over 6 million in the late 1980’s to 5.3 million in 1995. This can be attributed to the greater variety of services and medication which HA institutions were able to provide.

---

\(^{19}\) Hong Kong Hansard 3 April 1996.
Table 13 - SOP Services Attendance 1986-1995

<table>
<thead>
<tr>
<th>Year</th>
<th>HSD/HA(^1)</th>
<th>% Change</th>
<th>DH(^2)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>2,591,172</td>
<td>+3.9</td>
<td>5,997,993</td>
<td>+3.5</td>
</tr>
<tr>
<td>1987</td>
<td>2,720,905</td>
<td>+5.0</td>
<td>6,257,570</td>
<td>+4.3</td>
</tr>
<tr>
<td>1988</td>
<td>2,815,102</td>
<td>+3.5</td>
<td>5,840,387</td>
<td>-6.7</td>
</tr>
<tr>
<td>1989</td>
<td>2,762,529</td>
<td>-1.9</td>
<td>5,518,937</td>
<td>-5.5</td>
</tr>
<tr>
<td>1990</td>
<td>2,831,423</td>
<td>+2.5</td>
<td>5,686,338</td>
<td>+3.0</td>
</tr>
<tr>
<td>1991</td>
<td>2,909,665</td>
<td>+2.8</td>
<td>5,495,257</td>
<td>-3.4</td>
</tr>
<tr>
<td>1992</td>
<td>3,092,628</td>
<td>+6.3</td>
<td>5,334,151</td>
<td>-2.9</td>
</tr>
<tr>
<td>1993</td>
<td>3,335,293</td>
<td>+7.8</td>
<td>4,971,197</td>
<td>-6.8</td>
</tr>
<tr>
<td>1994</td>
<td>3,652,411</td>
<td>+9.5</td>
<td>5,026,136</td>
<td>+1.1</td>
</tr>
<tr>
<td>1995</td>
<td>4,037,396</td>
<td>+10.5</td>
<td>5,266,059</td>
<td>+4.8</td>
</tr>
</tbody>
</table>

Remarks:
1. Specialist out-patient attendance for HSD/HA refers to medicine, surgery, orthopaedics & traumatology, obstetrics & gynaecology, paediatrics, eye, ear-nose-throat, psychiatric, geriatrics, radiotherapy and oncology, tuberculosis & chest, dental and dermatology services.
2. Specialist out-patient attendance for DH refers to child health, ante-natal, post-natal, family planning, methadone, tuberculosis & chest, leprosy, social hygiene and dermatology.
Sources: Hong Kong Annual Digest of Statistics 1994 p240, 1996 p239

Waiting Time

21.6 Table 14 lists the waiting time and the number of patients awaiting first attendance from 1992 to 1996. It can be seen that the waiting list has been increasing and so has been the waiting time. As at the end of 1996, there were 111,933 people awaiting SOP services, and a patient had to wait on average almost 11 weeks before he could consult a doctor.

Table 14 - Waiting Time and Waiting List of SOP Services of DH (1st attendance) 1992-1996

<table>
<thead>
<tr>
<th>Year</th>
<th>Average waiting time (weeks)</th>
<th>Waiting list (No. of persons awaiting 1st attendance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>8.1</td>
<td>52,176</td>
</tr>
<tr>
<td>1993</td>
<td>8.2</td>
<td>62,805</td>
</tr>
<tr>
<td>1994</td>
<td>7.9</td>
<td>68,898</td>
</tr>
<tr>
<td>1995</td>
<td>9.1</td>
<td>93,722</td>
</tr>
<tr>
<td>1996</td>
<td>10.9</td>
<td>111,933</td>
</tr>
</tbody>
</table>

Source: Health and Welfare Bureau
21.7 For HA services, the longest and the average waiting time for the first appointment for some SOP services in 1995 are listed in Table 15 below. The long waiting time for these services can be attributed to the growing demand for specialist medical treatment which was not met by the private sector health care providers. In general, the average waiting time in 1996 for 90% of the specialist clinical services for the first appointment was less than three months\(^{20}\).

**Table 15 - Waiting Time for Some SOP Services of HA in 1995 (Weeks)**

<table>
<thead>
<tr>
<th>Type of Services</th>
<th>Longest waiting time for first appointment</th>
<th>Average waiting time for first appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear-nose-throat clinics</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Eye clinics</td>
<td>24</td>
<td>14.5</td>
</tr>
<tr>
<td>Dermatological clinics</td>
<td>12</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Hong Kong Hansard 12 July 1995

**Demand for In-patient Services**

21.8 Since the establishment of the HA in 1988, one could observe a switch in patients from using private hospital services to using public hospital services. Table 16 demonstrates the change in the percentage share between public and private hospitals by number of patient days. The proportion of stay in public hospitals gradually increased from 90.1% in 1988 to 92.9% in 1996. One reason could be an improvement in both the quality and quantity of health care services provided by public hospitals. Another reason could be the low charge (HK$68 per day, all charges inclusive) at HA hospitals.

\(^{20}\) Hong Kong Hansard 3 April 1996.
Table 16 - Share of Public and Private Hospitals by Number of In-Patient Days 1986-1996

| Year | Public hospitals | | Private hospitals | | Total |
|------|------------------|------------------|------------------|------------------|
|      | No. | % share | No. | % share | No. |
| 1986 | 6,507,586 | 91.2* | 630,532 | 8.8 | 7,138,118 |
| 1987 | 6,579,589 | 90.7* | 671,934 | 9.3 | 7,251,523 |
| 1988 | 6,657,854 | 90.1* | 735,941 | 10.0 | 7,393,795 |
| 1989 | 6,494,299 | 90.2* | 707,029 | 9.8 | 7,201,328 |
| 1990 | 6,459,089 | 90.3* | 697,881 | 9.7 | 7,156,970 |
| 1991 | 6,402,777 | 90.5* | 673,027 | 9.5 | 7,075,804 |
| 1992 | 6,526,006 | 90.6* | 679,516 | 9.4 | 7,205,522 |
| 1993 | 6,666,278 | 91.4* | 630,296 | 8.6 | 7,296,574 |
| 1994 | 6,877,648 | 92.3* | 576,268 | 7.7 | 7,453,916 |
| 1995 | 7,121,507 | 92.9* | 544,616 | 7.1 | 7,666,123 |
| 1996 | 7,422,904 | 92.9* | 564,365 | 7.1 | 7,987,269 |

Remarks:
* Excluding day patient discharges and deaths.
# Including day patient discharges and deaths for HA or HSD hospitals.
Source: Hospital Authority

21.9 Table 17 presents the result of a survey conducted by C&SD on hospitalization in April - August 1995. It can be seen that people from almost all walks of life sought public hospital services regardless of their income. Even for people with monthly household income of between HK$30,000 - HK$39,999, 18 out of 1,000 persons used public hospital services whilst only 11 out of 1,000 persons used private hospital services. For those earning HK$40,000 and above, the rate of choosing public and private hospital services were the same, i.e. 15 out of every 1,000 persons.

Table 17 - Percentage Distribution of In-patient in HA and Private Hospitals by Monthly Household Income 1995

<table>
<thead>
<tr>
<th>Monthly household income (HK$)</th>
<th>HA hospital</th>
<th>Private hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Rate per 1,000 persons</td>
</tr>
<tr>
<td>&lt;5,000</td>
<td>6.8</td>
<td>43.1</td>
</tr>
<tr>
<td>5,000-9,999</td>
<td>19.8</td>
<td>27.5</td>
</tr>
<tr>
<td>10,000-14,999</td>
<td>23.0</td>
<td>25.4</td>
</tr>
<tr>
<td>15,000-19,999</td>
<td>16.0</td>
<td>22.7</td>
</tr>
<tr>
<td>20,000-24,999</td>
<td>9.6</td>
<td>17.5</td>
</tr>
<tr>
<td>25,000-29,999</td>
<td>7.9</td>
<td>19.8</td>
</tr>
<tr>
<td>30,000-39,999</td>
<td>8.2</td>
<td>18.0</td>
</tr>
<tr>
<td>&gt;40,000</td>
<td>8.7</td>
<td>14.7</td>
</tr>
</tbody>
</table>

Median monthly household income

HK$15,000 | HK$25,000

Source: Hong Kong Monthly Digest of Statistics May 1996, Table 4
21.10 Some private hospitals have already expressed the view that they are facing financial difficulties due to inadequate utilization of their services. If such situation persists, shrinkage of the private sector will continue. This would add greater pressure on public hospital services.

**Demand for A&E Services**

**Number of Attendance**

21.11 Table 18 shows the attendance for A&E services. It can be seen that the attendance increased over the previous year was 14.4% in 1994 and 15.7% in 1995. Previous research by RLS showed that in a 2-week sample (over a public holiday) conducted in 1996, attendance broken down by triage category was as follows: less than 2% were emergencies, 20% were urgent cases, and over 70% were semi-urgent or non-urgent cases. (For details, please read IN1/96-97 “Information Note: Demand for Accident and Emergency Services During Public Holidays”, Legislative Council Secretariat, November 1996). Although this sample covered public holidays, RLS interviews with relevant professionals have confirmed that misuse of A&E services is serious on non-public holidays. Such misuse of A&E services has been attributed to:

- Convenience, easy and reliable access, availability of services even during typhoons, rainstorms and after office hours;
- Availability of advanced medical facilities and one-stop service in public hospitals;
- High standard of medical, nursing and supporting staff;
- Patient-centred customer services; and
- No financial charge

<table>
<thead>
<tr>
<th>Year</th>
<th>HSD/HA</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>1,166,931</td>
<td>-2.2</td>
</tr>
<tr>
<td>1987</td>
<td>1,246,133</td>
<td>+6.8</td>
</tr>
<tr>
<td>1988</td>
<td>1,264,874</td>
<td>+1.5</td>
</tr>
<tr>
<td>1989</td>
<td>1,232,740</td>
<td>-2.5</td>
</tr>
<tr>
<td>1990</td>
<td>1,237,995</td>
<td>+0.4</td>
</tr>
<tr>
<td>1991</td>
<td>1,288,995</td>
<td>+4.1</td>
</tr>
<tr>
<td>1992</td>
<td>1,372,055</td>
<td>+6.4</td>
</tr>
<tr>
<td>1993</td>
<td>1,453,126</td>
<td>+5.9</td>
</tr>
<tr>
<td>1994</td>
<td>1,661,694</td>
<td>+14.4</td>
</tr>
<tr>
<td>1995</td>
<td>1,923,073</td>
<td>+15.7</td>
</tr>
</tbody>
</table>

Remark: * Including first and follow-up attendance.
Sources: Hong Kong Annual Digest of Statistics 1994 p240, 1996 p239
21.12 Table 19 shows the cost of A&E services per attendance. In 1997/98, the estimated cost per attendance is HK$676, or a total of about HK$1,300 million [1,923,073 (taking 1995 attendance as reference) x HK$676], amounting to about 5.8% of HA’s recurrent expenditure (estimate) for the year.

### Table 19 - Cost of A&E Services Per Attendance 1992/93 - 1997/98 (HK$)

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost per attendance (HK$)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992/93</td>
<td>473</td>
<td>n.a.</td>
</tr>
<tr>
<td>1993/94</td>
<td>522</td>
<td>+10.4</td>
</tr>
<tr>
<td>1994/95</td>
<td>541</td>
<td>+3.6</td>
</tr>
<tr>
<td>1995/96</td>
<td>574</td>
<td>+6.1</td>
</tr>
<tr>
<td>1996/97*</td>
<td>623</td>
<td>+8.5</td>
</tr>
<tr>
<td>1997/98*</td>
<td>676</td>
<td>+8.5</td>
</tr>
</tbody>
</table>

Remark:
* Cost for these years is projected using inflation rates advised by the Treasury.
1. Cost of services includes staff cost, drugs and consumables, depreciation, services provided by Government departments, and administration overheads.

n.a. not available.

Source: Hospital Authority

Waiting Time

21.13 A&E services treat patients on a first-come-first-served basis and the patient receives initial assessment immediately. The target average waiting time for patients to be seen by a doctor is 30 minutes.

Population Growth

21.14 According to the population growth projected by the C&SD in 1997, Hong Kong’s population will reach 6,860,000 by the year 2000, an increase of 9% as compared to 1996. It is projected that by 2006, total population will be increased to 7,382,600 and will reach 8,205,900 by 2016. This represents an increase of 1,913,900 people within 20 years. The additional 1.9 million people will naturally generate a demand for health care services.

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Mismatch Between Distribution of Population and Hospitals

21.15 Public hospitals are organized by clusters on a regional basis, with most resources concentrated in a few major regional hospitals. The distribution of hospitals may not be able to meet the changes in demand which arise from the shift in population and demographic changes. It can be seen from Table 20 that the number of beds of all hospital categories per 1,000 population in Hong Kong West is higher than that in other regions. The situation in NT North is the worst with only 1.1 acute bed and 0.4 extended care bed per 1,000 population. Detailed geographic distribution of hospital beds by categories by hospitals is listed in Appendix VI.

Table 20 - Geographical Distribution of Hospital Beds by Categories Per 1,000 Population as at 31st March 1996*

<table>
<thead>
<tr>
<th>District</th>
<th>General acute (Group 1A)</th>
<th>General acute (Group 1B)</th>
<th>Extended care (Group 2)</th>
<th>Extended care (Group 3)</th>
<th>Psychiatric (Group 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HK West</td>
<td>6.1</td>
<td>-</td>
<td>3.6</td>
<td>1.6</td>
<td>-</td>
</tr>
<tr>
<td>HK East</td>
<td>1.2</td>
<td>0.5</td>
<td>0.4</td>
<td>0.1</td>
<td>-</td>
</tr>
<tr>
<td>Kln Central</td>
<td>2.9</td>
<td>-</td>
<td>2.1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kln West</td>
<td>-</td>
<td>2.2</td>
<td>-</td>
<td>1.3</td>
<td>-</td>
</tr>
<tr>
<td>Kln East</td>
<td>-</td>
<td>1.5</td>
<td>0.4</td>
<td>0.1</td>
<td>-</td>
</tr>
<tr>
<td>NT South</td>
<td>1.7</td>
<td>1.9</td>
<td>0.8</td>
<td>-</td>
<td>2.8</td>
</tr>
<tr>
<td>NT East</td>
<td>1.8</td>
<td>-</td>
<td>-</td>
<td>1.1</td>
<td>-</td>
</tr>
<tr>
<td>NT North</td>
<td>1.1</td>
<td>-</td>
<td>0.4</td>
<td>-</td>
<td>1.3</td>
</tr>
<tr>
<td>All regions</td>
<td>1.4</td>
<td>0.7</td>
<td>0.7</td>
<td>0.4</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Remark: * Excluding Hong Kong Eye Hospital, Nam Long Hospital, Grantham Hospital, Hong Kong Red Cross Blood Transfusion Service and Rehabaid Centre which do not belong to any of the clusters.

Sources: Hong Kong Hansard, 10 July 1996
1996 Population By-Census

Ageing Population

21.16 Due to the decreasing birth rate and increasing life expectancy, Hong Kong’s population is getting older and older as shown in Table 21. The median age in 1996 was 34 years, with 10% of total population aged 65 and above. It is projected that by 2006, the elderly population will be increased to 11.3%, the median age will be 39 years; and by 2016, it will further increase to 13.3% (1,091,700 elderly people) and the median age will be 41 years.
Table 21 - Proportion of Elderly Aged 65 and Above to Total Population 1996-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>No.</th>
<th>% to total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>631,300</td>
<td>10.0</td>
</tr>
<tr>
<td>1997</td>
<td>655,400</td>
<td>10.1</td>
</tr>
<tr>
<td>1998</td>
<td>679,200</td>
<td>10.2</td>
</tr>
<tr>
<td>1999</td>
<td>703,200</td>
<td>10.4</td>
</tr>
<tr>
<td>2000</td>
<td>725,800</td>
<td>10.6</td>
</tr>
<tr>
<td>2001</td>
<td>750,000</td>
<td>10.8</td>
</tr>
<tr>
<td>2002</td>
<td>772,600</td>
<td>11.0</td>
</tr>
<tr>
<td>2003</td>
<td>789,800</td>
<td>11.1</td>
</tr>
<tr>
<td>2004</td>
<td>805,700</td>
<td>11.2</td>
</tr>
<tr>
<td>2005</td>
<td>819,100</td>
<td>11.2</td>
</tr>
<tr>
<td>2006</td>
<td>830,200</td>
<td>11.3</td>
</tr>
<tr>
<td>2007</td>
<td>838,500</td>
<td>11.2</td>
</tr>
<tr>
<td>2008</td>
<td>845,500</td>
<td>11.2</td>
</tr>
<tr>
<td>2009</td>
<td>854,500</td>
<td>11.2</td>
</tr>
<tr>
<td>2010</td>
<td>868,300</td>
<td>11.3</td>
</tr>
<tr>
<td>2011</td>
<td>890,800</td>
<td>11.4</td>
</tr>
<tr>
<td>2012</td>
<td>920,900</td>
<td>11.7</td>
</tr>
<tr>
<td>2013</td>
<td>958,100</td>
<td>12.0</td>
</tr>
<tr>
<td>2014</td>
<td>1,000,000</td>
<td>12.4</td>
</tr>
<tr>
<td>2015</td>
<td>1,044,600</td>
<td>12.9</td>
</tr>
<tr>
<td>2016</td>
<td>1,091,700</td>
<td>13.3</td>
</tr>
</tbody>
</table>

Source: Hong Kong Population Projections 1997-2016

21.17 According to information provided by the HA, elderly persons consume more health care services than younger persons. It is estimated that about 50% of the old age may have some form of chronic disease and 20% are disabled. About 15% of elderly persons suffer from diabetes mellitus, 1/3 from hypertension and 1/4 from osteoporosis. Cancer is also most prevalent in the elderly age group. In 1996, 1/5 of the people aged 65 and above have been admitted into HA hospitals. Their hospitalization constitutes about 42% of HA’s in-patient bed days. The average length of hospital stay is 21.9 days which is more than 50% higher than that of general patients. Detailed analysis on medical needs of the elderly people will be presented in the subsequent RLS research report on “Health Care Policy on the Elderly”.

21.18 In the past few years, the elderly people are becoming more institutionalized because of the changing social environment, the break down of the traditional family structure and the lack of family support. More and more elderly people live on their own and need substantial health and medical care. RLS has tried to obtain relevant data from government sources but received no information as of to-date.
Cross-border Patients

21.19 The number of visitors from the Mainland increased significantly in the past few years. It can be seen in Table 22 that there were 294,389 Two-Way Permit Holders visiting Hong Kong in 1996. According to information provided by the HA, there has been an increase in the number of deliveries by mothers entering Hong Kong from the Mainland. In 1995 and 1996, there were 6,892 and 6,230 babies delivered in public hospitals by mothers from the Mainland entering Hong Kong. This represented a respective 10.0% and 9.7% of total live births in Hong Kong in the corresponding period. If this trend continues, greater demand on health care services is unavoidable.

Table 22 - Arrivals by 2-Way Permit Holders 1987 - 1996

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of arrivals</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>85,673</td>
<td>+30.7</td>
</tr>
<tr>
<td>1988</td>
<td>120,089</td>
<td>+40.2</td>
</tr>
<tr>
<td>1989</td>
<td>131,603</td>
<td>+9.6</td>
</tr>
<tr>
<td>1990</td>
<td>133,021</td>
<td>+1.1</td>
</tr>
<tr>
<td>1991</td>
<td>140,378</td>
<td>+5.5</td>
</tr>
<tr>
<td>1992</td>
<td>160,415</td>
<td>+14.3</td>
</tr>
<tr>
<td>1993</td>
<td>209,400</td>
<td>+30.5</td>
</tr>
<tr>
<td>1994</td>
<td>245,927</td>
<td>+17.4</td>
</tr>
<tr>
<td>1995</td>
<td>260,313</td>
<td>+5.8</td>
</tr>
<tr>
<td>1996</td>
<td>294,389</td>
<td>+13.1</td>
</tr>
</tbody>
</table>

Source: Immigration Department

21.20 Table 23 lists the arrivals by One-Way Permit Holders by age and sex. It should be noted that the proportion of children arrivals increased substantially in 1996, reaching 29,084, accounting for almost half of the One-Way Permit arrivals. Currently, out of the 150 daily quota, 45 are specifically reserved for children who, according to the Basic Law 24(2)(3) have the right of abode in Hong Kong. It is estimated that there are 66,000 children awaiting to come to the territory under the One-Way Permit System. They may impose great demand for health care services in Hong Kong in the short-, medium-, and long-term.

22 Referring to the deliveries by the Chinese tourists/double entry visa holders, illegal immigrants or over-stayers from the Mainland.

23 Provisional Legislative Council Brief, Immigration (Amendment) (No.5) Bill 1997, Security Bureau, 8 July 1997.
### Table 23 - Arrivals by One-Way Permit Holders by Age 1987-1996

<table>
<thead>
<tr>
<th>Year</th>
<th>0-18 yrs</th>
<th>19-64 yrs</th>
<th>65 yrs &amp; above</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>1987</td>
<td>10,030</td>
<td>36.9</td>
<td>16,292</td>
<td>60.0</td>
<td>765</td>
</tr>
<tr>
<td>1988</td>
<td>10,111</td>
<td>36.1</td>
<td>17,166</td>
<td>61.2</td>
<td>721</td>
</tr>
<tr>
<td>1989</td>
<td>10,280</td>
<td>37.7</td>
<td>16,199</td>
<td>59.4</td>
<td>761</td>
</tr>
<tr>
<td>1990</td>
<td>10,529</td>
<td>37.6</td>
<td>16,841</td>
<td>60.2</td>
<td>585</td>
</tr>
<tr>
<td>1991</td>
<td>9,430</td>
<td>35.2</td>
<td>16,768</td>
<td>62.6</td>
<td>563</td>
</tr>
<tr>
<td>1992</td>
<td>9,511</td>
<td>33.5</td>
<td>18,291</td>
<td>64.5</td>
<td>562</td>
</tr>
<tr>
<td>1993</td>
<td>10,298</td>
<td>31.3</td>
<td>21,977</td>
<td>66.8</td>
<td>615</td>
</tr>
<tr>
<td>1994</td>
<td>13,284</td>
<td>34.8</td>
<td>24,376</td>
<td>63.8</td>
<td>558</td>
</tr>
<tr>
<td>1995</td>
<td>19,332</td>
<td>42.0</td>
<td>26,042</td>
<td>56.6</td>
<td>612</td>
</tr>
<tr>
<td>1996</td>
<td>29,084</td>
<td>47.5</td>
<td>31,489</td>
<td>51.5</td>
<td>606</td>
</tr>
</tbody>
</table>

Remark: * implies less than 0.5%  
Source: Security Bureau

### Increasing Consumer Aspirations

21.21 Higher consumer aspirations and new technology have increased the demand for health care services. What was considered acceptable in the past might now be regarded as inadequate. The traditional paternalistic approach of providers making decisions on behalf of patients is no longer tenable for an informed public in a changing socio-economic environment.

21.22 Better education and improvement in communication network have also enhanced both the patient or his family to participate in the decision making process of how and what health care should be provided. Patients are becoming less tolerant of long waiting times and poor environments. Yet, the current system may not be able to meet further cost pressures arising from this demand.

### 22. Increasing Public Expenditure

#### Low Charges Attracts Demand

22.1 Charges at public hospitals are very low because they are heavily subsidized by the government. At present, the fees on average cover less than 2% of total cost. Due to the improved standards and low charges at public hospitals, patients have been attracted to the public sector from the private sector. At present, demand and supply are only regulated by waiting time. Given the opportunity cost of time, patient resentment could lead to social discontent or it could lead to an unsustainable growth in public health care expenditure.
Increasing Cost of Health Care Products

22.2 The trend of increasing sophistication in the diagnosis and treatment of medical conditions is unlikely to be reversed. The proliferation of hi-tech medical equipment and expensive drugs will further push up health care costs further in the coming years.

Possible Changes in Economic Growth

22.3 In the past few years, positive economic growth enabled the HA and DH to meet the increase in the demand for health care services. However, since the global economy is cyclical, any possible economic downturn may affect the funding for health care services. This may be because those who have become unemployed would no longer afford private health care services or private health insurance; instead, they would use the public health care services. In addition, lower employment would lead to lower government revenue due to less income tax.

Demand from Economically Inactive Population

22.4 As mentioned in Section 21, a large portion of the increase in demand for health care services is due to an increase in elderly people and children who are not considered economically active and who do not pay much income tax. Whether or not the economically active can provide an adequate tax base to fund the increasing cost of health care services is uncertain.

23. Increasing Health Care Cost

Inflation in Health Care Products

23.1 In many developed countries, the inflation rate of hospital products often exceeds consumer price index. Each year, the government uses the consumer price index to budget for health care expenditures; however, if inflation rate of health care products is higher than consumer price index, the amount of health care products purchased will reduce. If this trend is to continue, it can affect the quality and quantity of health care services provided by the public sector, as well as access to these services.

Increasing Cost on Research and Development

23.2 Scientific breakthroughs and technological advances have made new diagnostic and treatment methods available for innumerable diseases and states of ill health. However, the cost on research, development and marketing of medical technologies and development is substantial. This cost is inevitably borne by the consumer at the end, in the form of high cost of equipment or drugs.
23.3 The choice of new drugs has been a contentious issue. Newly developed drugs are usually expensive because they profit under a patent. But this does not mean that new drugs are better than old drugs. However, patients can have the wrong impression that the latest development is the best and ask for the newest drugs. If a hospital dispenses new drugs and discards the old ones, it will lead to wasting of resources.

Supply Driven Demand

23.4 Although most patients are better educated, they are not medical professionals and do not possess professional knowledge to judge what optimal health care is required. If one is covered by health insurance, one may consult the doctor more frequently because one wants to know more about one’s illness and get more medication.

24. Maintaining the Right Staff Mix

Supply of Medical Officers in HA

24.1 It can be seen from Table 24 that the total number of medical officers (all grades) in HA had the biggest growth in 1994/1995 at 9.2% increase over the previous year. It has slowed down to 4.8% in 1996/1997.

Table 24 - Strength of Medical Officers in various ranks in HA 1991/92-1996/97

<table>
<thead>
<tr>
<th>Year</th>
<th>Consultant No.</th>
<th>% share</th>
<th>Senior Medical Officer No.</th>
<th>% share</th>
<th>Medical Officer No.</th>
<th>% share</th>
<th>Total No.</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991/92</td>
<td>236</td>
<td>10.4</td>
<td>489</td>
<td>21.5</td>
<td>1,554</td>
<td>68.2</td>
<td>2,279</td>
<td>n.a.</td>
</tr>
<tr>
<td>1992/93</td>
<td>247</td>
<td>10.4</td>
<td>531</td>
<td>22.4</td>
<td>1,591</td>
<td>67.2</td>
<td>2,369</td>
<td>+3.9</td>
</tr>
<tr>
<td>1993/94</td>
<td>291</td>
<td>11.4</td>
<td>548</td>
<td>21.6</td>
<td>1,703</td>
<td>67.0</td>
<td>2,542</td>
<td>+7.3</td>
</tr>
<tr>
<td>1994/95</td>
<td>366</td>
<td>13.2</td>
<td>611</td>
<td>22.0</td>
<td>1,798</td>
<td>64.8</td>
<td>2,775</td>
<td>+9.2</td>
</tr>
<tr>
<td>1995/96</td>
<td>416</td>
<td>14.0</td>
<td>705</td>
<td>23.7</td>
<td>1,848</td>
<td>62.2</td>
<td>2,969</td>
<td>+7.0</td>
</tr>
<tr>
<td>1996/97</td>
<td>435</td>
<td>14.0</td>
<td>764</td>
<td>24.6</td>
<td>1,913</td>
<td>61.5</td>
<td>3,112</td>
<td>+4.8</td>
</tr>
</tbody>
</table>

Source: Hospital Authority

24.2 The proportion of consultants and senior medical officers (SMOs) have increased from 10.4% to 14.0% and 21.5% to 24.6% respectively in the past five years. This was due to the decentralization of authority from HA Head Office which led to a transfer of managerial staff originally stationed at HA Head Office to hospitals. Consultant positions were created to meet the medical needs of the patients and to improve the quality of services. In most cases, patients are treated by medical officers (MOs) under the supervision of SMOs and consultants.
24.3 According to information provided by HA, the working hours of the health care professionals is about 44 hours per week. Doctors are required to be on call on rotational basis; the frequency of on call duties depend on the nature of services/specialties provided in various hospitals. The target for Chiefs of Service and Ward Managers to spend not less than 75% and Consultants and Nursing Officers not less than 90% of their time in clinical duties and patient service are achievable\(^ {24} \).

Supply of Nursing Staff in HA

24.4 Table 25 and Figure 2 show the steady growth of nursing staff in HA. Except for 1995/96, the growth reached 6.7% over the previous year, the increase remained at 2-3% throughout the past five years.

Table 25 - Strength of Nursing Staff in HA 1991/92-1996/97

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered nurse</td>
<td>8,650</td>
<td>8,891</td>
<td>9,289</td>
<td>9,831</td>
<td>10,150</td>
<td>10,396</td>
</tr>
<tr>
<td>Student nurse</td>
<td>2,506</td>
<td>2,485</td>
<td>2,337</td>
<td>2,184</td>
<td>2,528</td>
<td>2,529</td>
</tr>
<tr>
<td>Enrolled nurse</td>
<td>2,438</td>
<td>2,449</td>
<td>2,629</td>
<td>2,741</td>
<td>2,866</td>
<td>2,949</td>
</tr>
<tr>
<td>Pupil nurse</td>
<td>802</td>
<td>848</td>
<td>799</td>
<td>824</td>
<td>1,096</td>
<td>940</td>
</tr>
<tr>
<td><strong>Psychiatric</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered nurse</td>
<td>864</td>
<td>900</td>
<td>976</td>
<td>981</td>
<td>968</td>
<td>974</td>
</tr>
<tr>
<td>Student nurse</td>
<td>164</td>
<td>146</td>
<td>99</td>
<td>110</td>
<td>204</td>
<td>301</td>
</tr>
<tr>
<td>Enrolled nurse</td>
<td>496</td>
<td>529</td>
<td>524</td>
<td>553</td>
<td>617</td>
<td>636</td>
</tr>
<tr>
<td>Pupil nurse</td>
<td>142</td>
<td>119</td>
<td>116</td>
<td>113</td>
<td>77</td>
<td>70</td>
</tr>
<tr>
<td><strong>Midwife</strong></td>
<td>141</td>
<td>129</td>
<td>116</td>
<td>100</td>
<td>96</td>
<td>86</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td>83</td>
<td>77</td>
<td>50</td>
<td>37</td>
<td>36</td>
<td>38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>16,286</td>
<td>16,573</td>
<td>16,935</td>
<td>17,474</td>
<td>18,638</td>
<td>18,919</td>
</tr>
<tr>
<td>% Change</td>
<td>n.a.</td>
<td>+1.8</td>
<td>+2.2</td>
<td>+3.2</td>
<td>+6.7</td>
<td>+1.5</td>
</tr>
</tbody>
</table>

Remark: Staff strength includes all full-time/part-time staff on permanent or contract terms. Temporary staff and staff on honorary appointment are excluded.

n.a. not available

Source: Hospital Authority

\(^ {24} \) Hospital Authority, Press Release, September 20, 1997.
24.5 In an opinion survey conducted by the Social Sciences Research Centre, University of Hong Kong, in early 1996, almost all surveyed doctors and nurses (97% of respondents) think that there were insufficient nurses in the ward to provide adequate services. The shortage of nursing staff was mainly due to the harsh working conditions, irregular working hours, unpleasant job nature and increasing diversification of nursing care. They envisaged that if the shortage of nursing staff continues, there may be a decrease in staff morale and quality of service. With the increase of workload, it might further induce nurses to drop out.

24.6 In the 1996 HA Nursing Manpower review, there was a shortage of 580 nurses for clinical specialties, and the distribution is shown in Table 26 below. According to information from HA, “intensive efforts will be made in parallel to recruit and retain nurses in HA.”

### Table 26 - Shortage of Nurses in HA 1996

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Medical*</th>
<th>Surgical</th>
<th>Psychiatric</th>
<th>Critical Care#</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Nurses</td>
<td>300</td>
<td>86</td>
<td>89</td>
<td>105</td>
<td>580</td>
</tr>
</tbody>
</table>

Remarks:
* Including geriatric.
# Including intensive care and neonatal intensive care units.
Source: Information Note to LegCo Panel on Health Services, 13 January 1997
Turnover of Medical Staff in HA

24.7 Table 27 shows the turnover of medical staff for HA in the past five years. In general, the turnover for doctors was less than that of nurses and allied health staff, maintaining at about 7%. For nurses, the turnover reached 13.3% in 1994/95 but decreased gradually thereafter. Last year, the turnover for nurses was 8.7%.

Table 27 - Turnover of Medical Staff in HA 1992/93-1997/98 (%) ¹,²

<table>
<thead>
<tr>
<th>Year</th>
<th>Doctors</th>
<th>Nurses</th>
<th>Allied health staff³</th>
<th>Interns/Externs/Dental officers</th>
</tr>
</thead>
<tbody>
<tr>
<td>92/93</td>
<td>8.7</td>
<td>10.0</td>
<td>8.3</td>
<td>11.9</td>
</tr>
<tr>
<td>93/94</td>
<td>7.2</td>
<td>10.3</td>
<td>7.7</td>
<td>28.4</td>
</tr>
<tr>
<td>94/95</td>
<td>6.8</td>
<td>13.3</td>
<td>10.0</td>
<td>23.0</td>
</tr>
<tr>
<td>95/96</td>
<td>6.7</td>
<td>9.8</td>
<td>8.9</td>
<td>13.3</td>
</tr>
<tr>
<td>96/97</td>
<td>7.0</td>
<td>8.7</td>
<td>6.0</td>
<td>20.9</td>
</tr>
<tr>
<td>97/98</td>
<td>5.6</td>
<td>7.5</td>
<td>5.2</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Remarks:
1. Turnover includes all types of cessation from HA. Promotions and transfers across hospitals are excluded. Staff leaving HA under the phasing-out programme are not included as turnover.
2. The turnover rate above is based on the total staff leaving during the financial year over the average strength during the same period.
3. Including physiotherapists, occupational therapists, dietitians, clinical psychologists, radiographers, medical laboratory technicians, medical social workers, pharmacists, dispensers and other health care professionals such as audiology technicians, mould laboratory technicians, optometrists, orthoptists, podiatrists, prosthetists and orthotists, scientific officers (medical), and speech therapists.
4. Annualized rate based on turnover data for the period Apr 97 to Jun 97.
Source: Hospital Authority

Manpower: Bed Ratio Analysis

24.8 HA has adopted a macro and a micro approach to manpower planning. HA has been using general manpower indicators for the macro projection of requirements for future manpower, particularly for the new hospital projects. The indicators provide a useful reference for evaluating manpower provision against the staffing range of the specialty. Since every hospital has its own specific roles and characteristics and different patient mix, the indicators only provide guidelines for staffing and do not indicate absolute staffing requirements.

24.9 The general manpower indicators for HA established in 1993 is listed in Appendix VII. RLS asked for similar manpower indicators for 1996, but no information is provided by HA.
Table 28 and 29 summarize the manpower: bed ratio deduced by RLS based on the number of beds, doctors and nurses of different hospitals as at 31st March 1996. RLS singles out the minimum and maximum manpower: bed ratio for each hospital category (Appendix VIII) and compares them to the 1993 indicators as shown in Appendix VII. It can be seen that except for general acute hospital (Group 1A), where the maximum and minimum manpower: bed ratios were higher than the 1993 HA indicators, the corresponding manpower:bed ratios of other hospital categories were lower than the 1993 HA indicators.

Table 28 - Comparison of 1996 Doctor:Bed Ratio to 1993 HA’s Manpower Indicators* by Hospital Categories

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>General acute (Group 1A)</td>
<td>3.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td>Pamela Youde Nethersole Eastern Hospital</td>
<td></td>
<td>5.9</td>
</tr>
<tr>
<td>General acute (Group 1B)</td>
<td>6.4</td>
<td>17.0</td>
</tr>
<tr>
<td>United Christian Hospital</td>
<td>4.8</td>
<td></td>
</tr>
<tr>
<td>Ruttonjee Hospital</td>
<td></td>
<td>10.3</td>
</tr>
<tr>
<td>Extended care (Group 2)</td>
<td>9.4</td>
<td>33.1</td>
</tr>
<tr>
<td>Tang Shiu Kin Hospital</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Kowloon Hospital</td>
<td></td>
<td>34.9</td>
</tr>
<tr>
<td>Extended care (Group 3)</td>
<td>29.4</td>
<td>158.5</td>
</tr>
<tr>
<td>Shatin Hospital</td>
<td>22.5</td>
<td></td>
</tr>
<tr>
<td>Cheshire Home (Chung Hom Kok)</td>
<td>no doctor</td>
<td></td>
</tr>
<tr>
<td>Group 4</td>
<td>47.2</td>
<td>150.0</td>
</tr>
<tr>
<td>Kwai Chung Hospital</td>
<td>31.8</td>
<td></td>
</tr>
<tr>
<td>Lai Chi Kok Hospital</td>
<td></td>
<td>141.3</td>
</tr>
</tbody>
</table>

Remark: * 1993 HA Manpower indicators in bold print.
Source: Hong Kong Hansard, 10 July 1996
### Table 29 - Comparison of 1996 Nurse:Bed Ratio to 1993 HA Manpower Indicators* by Hospital Categories

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>General acute (Group 1A)</td>
<td>0.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Prince of Wales Hospital</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Pamela Youde Nethersole Eastern Hospital</td>
<td></td>
<td>1.6</td>
</tr>
<tr>
<td>General acute (Group 1B)</td>
<td>0.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Our Lady of Maryknoll Hospital</td>
<td>0.7</td>
<td>1.8</td>
</tr>
<tr>
<td>Ruttonjee Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended care (Group 2)</td>
<td>0.8</td>
<td>5.1</td>
</tr>
<tr>
<td>Tang Shiu Kin Hospital</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Pok Oi Hospital</td>
<td></td>
<td>2.3</td>
</tr>
<tr>
<td>Extended care (Group 3)</td>
<td>4.0</td>
<td>22.5</td>
</tr>
<tr>
<td>Shatin Hospital</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>Cheshire Home (Chung Hom Kok)</td>
<td></td>
<td>6.9</td>
</tr>
<tr>
<td>Group 4</td>
<td>3.5</td>
<td>11.7</td>
</tr>
<tr>
<td>Kwai Chung Hospital</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Lai Chi Kok Hospital</td>
<td></td>
<td>6.1</td>
</tr>
</tbody>
</table>

Remark: * 1993 HA Manpower indicators in bold print.

Source: Hong Kong Hansard, 10 July 1996

24.11 Although most of the 1996 manpower: bed ratios conformed with the 1993 HA indicators, there was still shortage of nursing staff in HA as discussed in paragraph 24.6. This is because manpower situation varied from specialty to specialty, and from time to time. Some wards might have to face greater demand for services. Sometimes, given the same occupancy rate, a higher turnover of patients in a specific ward would also imply a greater demand for services. This would lead to a higher demand for doctors and nurses.

24.12 An activity profile study which reflected the current pattern of manpower utilization as well as the output and content of clinical activities in representative/selected areas was conducted in 1996. It revealed that about 20% of the existing duties of nurses were non-nursing tasks or simple nursing tasks such as personal care that could be delegated to other supporting staff such as Health Care Assistants. This shows that having the right staff mix and manpower level at different wards are important.

24.13 Meanwhile, HA has developed another set of manpower indicators which include the element of staff mix and occupancy (Appendix IX). However, since information is not available on the number of patients discharged per doctor by specialty by hospitals, RLS cannot proceed with further analysis of the manpower situation.
Staffing Situation in DH

24.14 Table 30 shows the strength of doctors of DH. In the past five years, the total number of doctors in DH increased by 16%.

Table 30 - Strength of Doctors in DH 1992-1997

<table>
<thead>
<tr>
<th>Year</th>
<th>No.</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>447</td>
<td>-2.0</td>
</tr>
<tr>
<td>1993</td>
<td>478</td>
<td>+6.9</td>
</tr>
<tr>
<td>1994</td>
<td>492</td>
<td>+2.9</td>
</tr>
<tr>
<td>1995</td>
<td>501</td>
<td>+1.8</td>
</tr>
<tr>
<td>1996</td>
<td>519</td>
<td>+3.6</td>
</tr>
</tbody>
</table>

Sources: Hong Kong Annual Report 1993-1997

24.15 According to information provided by DH, each doctor in out-patient services usually sees 90-95 patients per day while each doctor in specialized service sees less depending on individual specialty.

24.16 Table 31 and Figure 3 show the changes in nursing staff in DH. It can be seen that during the past five years, total nursing staff in DH has increased by 247 from 1,343 in 1992 to 1,590 in 1997. Registered nurses accounted for almost 50% of DH’s total nursing staff.

Table 31 - Strength of Nursing Staff in DH 1992-1997

<table>
<thead>
<tr>
<th>Year</th>
<th>Chief nursing officer</th>
<th>Senior nursing officer</th>
<th>Nursing officer</th>
<th>Registered nurse</th>
<th>Enrolled nurse</th>
<th>Senior inoculator/inoculator</th>
<th>Midwife</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>1</td>
<td>22</td>
<td>226</td>
<td>577</td>
<td>329</td>
<td>82</td>
<td>106</td>
<td>1,343</td>
</tr>
<tr>
<td>1993</td>
<td>1</td>
<td>22</td>
<td>223</td>
<td>594</td>
<td>325</td>
<td>79</td>
<td>98</td>
<td>1,342</td>
</tr>
<tr>
<td>1994</td>
<td>2</td>
<td>20</td>
<td>226</td>
<td>628</td>
<td>321</td>
<td>76</td>
<td>92</td>
<td>1,365</td>
</tr>
<tr>
<td>1995</td>
<td>2</td>
<td>15</td>
<td>200</td>
<td>703</td>
<td>336</td>
<td>69</td>
<td>90</td>
<td>1,415</td>
</tr>
<tr>
<td>1996</td>
<td>1</td>
<td>18</td>
<td>221</td>
<td>734</td>
<td>371</td>
<td>72</td>
<td>83</td>
<td>1,500</td>
</tr>
<tr>
<td>1997</td>
<td>2</td>
<td>17</td>
<td>234</td>
<td>829</td>
<td>385</td>
<td>57</td>
<td>66</td>
<td>1,590</td>
</tr>
</tbody>
</table>

Source: Health and Welfare Bureau
24.17 A comprehensive survey on manpower situation in respect of doctors, nurses, dental and allied health in both public and private sector will be conducted by DH and a preliminary result is expected to be available in 1997\(^\text{25}\).

25. Role of DH

25.1 Since it is a global trend to strengthen primary health care services, and since DH is currently the largest public primary health care provider, it can further expand its services. This includes the establishment of a closer, interactive relationship with a more effective two-way flow of information between the public and private primary health care and secondary health care providers. DH can also create opportunities for the community to participate in the identification of health needs and to mobilize the community resources in the implementation of health care programmes, and to integrate the community health service provided by services organizations with that provided by the health care providers.

25.2 The 1996 review did not emphasize DH’s role in developing primary health care. The review was only aimed at reducing the financial expenses of the public sector in curative care and to mobilize the private sector to play a greater role in preventive care.

\(^{25}\) LegCo Panel on Health Services, Record of Meeting 13 January 1997.
26. Role of HMDAC

26.1 HMDAC is the only statutory body that should provide some direction for the development of the health care system. However, with the modification of its terms of reference to focus on primary health care, it is doubtful whether HMDAC could address the overall development of the entire health care system.

27. Role of Statutory and Ad Hoc Committees

27.1 Most of the recommendations that came from the statutory and ad hoc committees such as the Medical Council, the Nursing Board, the working parties on Primary Health Care; TCM; Rehabilitation Policies and Services, and the Medicine Insurance Study Group were separate and not linked to a key health care policy. They usually deal with acute problems that attract public attention, and often only advocate greater government spending on particular areas.
PART 6 - CONCLUDING SUMMARY

28.1 The health care policy in Hong Kong guarantees universal access of health care to the whole population. Although the health care system has been popularly used by Hong Kong residents, there are phenomena which manifest an inadequate policy and planning machinery that can lead to increasing health care expenditure and a financing problem. If these issues are not strategically tackled, they can become out of control and will affect the quality and quantity of the provision of public health care services, which, in turn, will affect the general public’s well being. The major factors affecting the development of the current health care system are summarized in Table 32.
### Table 32 - Factors Affecting the Development of the Current Health Care System

<table>
<thead>
<tr>
<th></th>
<th>Factors</th>
<th>Problems</th>
</tr>
</thead>
</table>
| 1 | • Lack of comprehensive review or update of health care policy objective since 1974  
• No definition of “adequate medical treatment” and “lack of means” | • Cannot catch up with the needs of a changing society  
• High public expenditure due to the availability of a wide range of heavily-subsidized public health care services |
| 2 | • Fragmented health services planning  
• Fragmented input from statutory and ad hoc committees and other constituency groups | Inefficient allocation of resources |
| 3 | • Lack of interface between public & private health care service providers; primary/secondary/ tertiary health care service providers; health care services providers & service organizations; GPs & TCMPs  
• Lack of an institution of family doctor  
• Non-availability of integrated information system  
• Slow progress in implementing TCMP registration | • Difficulty in implementing an integrated health care system  
• Inefficient allocation of resources  
• Role of TCMP not clear |
| 4 | • Supply and demand for health care services in private sector is determined by market forces | • Competition from the public sector might impede the growth of a pluralist system of health care providers |
| 5 | • Slow progress in the follow up on the Primary Health Care Report | Impeded the territory-wide provision of primary health care |
| 6 | • Improvement in service quality & quantity in HA hospitals  
• Low fees and charges of public health care services  
• Growth in population, elderly people, mothers and children from the Mainland  
• Mismatch between distribution of population & hospitals  
• Increasing consumer aspirations | Increase in demand which could lead to increased social discontent or unforeseeable increase in public expenditure |
| 7 | • Increasing cost of health care products  
• Possible downturn in economic growth  
• Increasing demand from economically inactive population | Unplanned or unforeseeable increase in public expenditure |
| 8 | • Inflation in health care products  
• Increasing cost on research and development | Unforeseeable increase in health care cost |
| 9 | • Shortage of medical staff | Lack of professional expertise to support the implementation of health care system |
| 10 | • Change in terms of reference of HMDAC | Priority focus on primary health care, not the whole health care system |
Appendix I

Development of Health Care System in Hong Kong

1843

Government medical service was first introduced to the colony in 1843 and the first hospital erected was the Seamen’s Hospital opened by the Medical Missionary Society of Canton and Macau whereas the first Government Civil Hospital was established in 1850 but was destroyed in a typhoon in 1874. Both were served by colonial surgeons and the patients were mainly garrison and European residents living in the territory. For almost all local residents, they were being taking care of by private practitioners who usually used traditional herbal medicine, bone-setting and acupuncture skills to cure the illness. In 1872, the first private charity hospital -- the Tung Wah Hospital was built by some Chinese community leaders. It was staffed by both traditional Chinese practitioners and Western medical practitioners.

The First White Paper in 1964

In the immediate postwar period, the government concentrated on developing preventive health care services, particularly on communicable disease control. In the 1960s, the government started to develop medical services. A White Paper on “Development of Medical Services in Hong Kong” was drafted in 1964 setting the standards of provision of medical and health services for 1963-1972. By 1970, there were a total of 16,471 beds with a ratio of 4.03 beds per 1,000 population. All public hospitals were funded from general taxation and all Hong Kong residents were entitled to the services regardless of their income.

The Second White Paper in 1974

In the 1970s, medical services further expanded under the administration of the Governor Sir Murray McLehose. In 1974, a White Paper on “Further Development of Medical and Health Services in Hong Kong” was drafted, setting an objective of 5.5 beds per 1,000 population. A regional approach on the planning and administration of health care services was adopted. In each region, the government was required to provide a regional hospital to patients requiring acute care, one or more district hospitals to deliver the basic hospital services, one or more specialist clinics, and a number of general clinics which provide primary health care services to the majority of the population.

26 Hong Kong Annual Report 1970 (Chinese Version), p95
Establishing Provisional Hospital Authority in 1988

Due to the rapid growth of government hospitals in the 1980s and the increasing amount of health care expenditure, a study on the delivery of medical services in hospitals was conducted aiming at privatizing some of the health care services. A Provisional Hospital Authority was established in 1988, and the Hospital Authority was formally incorporated in July 1990.

Health Care System Review in 1996

In 1993, a consultative document on health care financing was published. However, it did not receive total support from the public. In 1996, the government started to review the health care system and the study is expected to be completed by 1998.

The chronological development in health care policy is listed in the following table.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event/Document</th>
<th>Details</th>
<th>Policy Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1964</td>
<td>“Development of Medical Services in Hong Kong” (White Paper)</td>
<td>Outlined Hong Kong’s immediate requirements in medical and health services and set standards of provision of medical and health services for the period 1963-1972.</td>
<td>“To provide, directly or indirectly, low cost or free medical and personal health services to that large section of the community which is unable to seek medical attention from other sources.”</td>
</tr>
<tr>
<td>Jul 1974</td>
<td>“The Further Development of Medical and Health Services in Hong Kong” (White Paper)</td>
<td>Set out Government proposals to maintain and expand the general public health services and develop additional facilities and services for in-patients and out-patients for the next ten years.</td>
<td>“To safeguard and promote the general public health of the community as a whole and the need to ensure the provision of medical and personal health facilities for the people of Hong Kong, including particularly that large section of the community which relies on subsidized medical attention.”</td>
</tr>
<tr>
<td>Year</td>
<td>Event/Document</td>
<td>Details</td>
<td>Policy Objectives</td>
</tr>
<tr>
<td>------</td>
<td>----------------</td>
<td>---------</td>
<td>------------------</td>
</tr>
<tr>
<td>Dec 1985</td>
<td>“The Delivery of Medical Services in Hospitals” (Consultancy Report)</td>
<td>Confined to reviewing the management and administration of hospitals. Recommended proposals to improve the quality and distribution of medical services in hospitals in the short to medium term (e.g. establishment of HA)</td>
<td>“To ensure the provision of medical and personal health facilities for the people of Hong Kong, including particularly that large section of the community which relies on subsidized medical attention.”</td>
</tr>
<tr>
<td>Dec 1990</td>
<td>“Health for All the Way Ahead” - Report of the Working Party on Primary Health Care</td>
<td>Put forward a set of proposals mainly on primary care. Also recommended Government to conduct a study leading to a policy statement on future financing of health and medical services.</td>
<td>“No one should be prevented, through lack of means, from obtaining adequate medical treatment.”</td>
</tr>
<tr>
<td>Jul 1993</td>
<td>“Towards Better Health” Consultation Document</td>
<td>Almost 500 submissions received. The public indicated overall support for the coordinated voluntary insurance approach, plus the semi-private room and target waiver group components of the target group approach (but did not support itemized charging).</td>
<td>To uphold the policy that “no one should be denied adequate medical treatment through lack of means.”</td>
</tr>
<tr>
<td>1996</td>
<td>Review of the Health Care System</td>
<td>Working Group on the Review of the Health Care System (with regular members from HWB, DH and HA) set up to recommend detailed long-term strategies on review of the system.</td>
<td>“To conduct a comprehensive review of the health care system to enable HWB to develop a health care policy and system that can cater for Hong Kong’s needs in the coming decades.”</td>
</tr>
</tbody>
</table>

Source: Health and Welfare Bureau
Appendix II

Categories of Privately Purchased Medical Items in Public Hospitals

1. Percutaneous Transluminal Coronary Angioplasty (PTCA) and other consumables for interventional cardiology

2. Cardiac pacemakers

3. Intraocular lens

4. Myoelectric prosthesis

5. Custom-made prosthesis

6. Implants for purely cosmetic surgery

7. Appliances for prosthetic and orthotic services, physiotherapy and occupational therapy services

8. Growth hormone and interferon

9. Home use equipment, appliances and consumables

Source: LegCo Panel on Health Services, Information Paper on Privately Purchased Medical Items for Public Patients, July 1996
Appendix III

Definition of Health Care Services

Health care services are classified into primary, secondary and tertiary level, with acute, extended\textsuperscript{27}, ambulatory and community care components.

**Primary Care**

Primary care is the patient’s first point of contact of the health care system and most illnesses can be treated at this level.

**Secondary Care**

Secondary care refers to more specialized and complex medical care usually provided in a hospital. Patients are normally referred by primary care practitioners.

**Tertiary Care**

Tertiary care caters for a small proportion of patients who require highly complex and specialized care in a hospital setting. It often requires costly technological support for diagnosis and treatment.

**Acute Care**

Acute care provides care for patients with emergencies or non-emergencies requiring intensive medical, nursing, rehabilitation and technological input to restore health and minimize illness and disability. Treatment can be delivered at all three levels of medical care.

**Extended Care**

Extended care provides medical rehabilitation to the disabled, chronically ill and elderly, in either institutional or community setting.

**Ambulatory Care**

These are services or facilities providing care for patients on an outpatient or day only basis.

**Community Care**

Services, facilities or programmes supporting patients and their caregivers at home or in the community.

Source: Hospital Authority Annual Plan 1996-97, p28

\textsuperscript{27} Including long-stay and rehabilitation services
Appendix IV

Services provided by Department of Health

In 1996, DH operated 60 GOP clinics, 48 mother and child health centres, 13 student health centres, 16 tuberculosis and chest clinics, 13 social hygiene clinics, five dermatology clinics, five clinical genetic clinics, four child assessment centres and other clinic services. It also provided mobile dispensaries, floating clinics and a flying doctor service catering for residents living in remote areas and outlying islands. The range of services provided by DH is as follows:

- **Personal Health Services**
  
  Including GOP service, surveillance and control of communicable diseases, family health and family planning, health education, woman health and elderly health services.

- **Non-regionalized Services**
  
  These cover tuberculosis and chest service, social hygiene and special skin service, child assessment service, clinical genetic service, public health laboratory service, forensic pathology service, occupational health service, student health service and special preventive programme on AIDS and hepatitis B.

- **Special Health Services**
  
  These cover radiation health, port health, narcotics and drug administration, pharmaceutical service.

- **Hygiene Services**
  
  These cover food and environmental hygiene monitoring, pest control and health education.

- **Dental Service**
  
  This provides general dental service, school dental service and oral health education.

Source: Department of Health, Annual Report, 1995/96, p17

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28 Hong Kong Annual Report 1997, p163.
Appendix V

Health and Medical Development Advisory Committee (HMDAC)

Membership

Dr. David FANG Jin-sheng, J.P. (Chairman)  Dr. John H. BOEY
Director of Health (Vice-Chairman ex officio)  Mrs. Alice CHEONG YUK Tak-fun
Dr. LEE Kin-hung, M.B.E.  Ms. Nancy KIT-Kwong-chi
Mrs. Alice PONG TSO Shing-yuk  Mrs. Cecilia LEE IP Wai-kay, M.B.E.
Dr. Homer TSO Wei-kwok  Mrs. Alice TSANG LAU Kit-ping
Professor Peter YUEN Pok-man  Chief Executive Officer/Hospital
Professor NG Mun-hon  Authority (ex officio)

Terms of Reference

- Bearing in mind the objectives of Government in the development of primary health care, to keep under review the general level of health in the community; and

- Having regard to the needs of the community and the availability of manpower and financial resources, to advise Government, through the Secretary for Health and Welfare, on the development of health care services and the interface between health and hospital services.

Source: Civil and Miscellaneous List, 1 July 1996
### Appendix VI

**Geographic Distribution of Hospital Beds by Categories by Hospitals**

*as at 31st March 1996*

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>General acute (Group 1A)</th>
<th>General acute (Group 1B)</th>
<th>Extended care (Group 2)</th>
<th>Extended care (Group 3)</th>
<th>Psychiatric (Group 4)</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hong Kong West</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Mary Hospital</td>
<td>1,390</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tsan Yuk Hospital</td>
<td></td>
<td></td>
<td></td>
<td>787</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tung Wah Hospital</td>
<td></td>
<td></td>
<td>296</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fung Yiu King Hospital</td>
<td></td>
<td></td>
<td>150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duchess of Kent Children’s Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>130</td>
<td></td>
</tr>
<tr>
<td>MacLehose Medical Rehabilitation Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td>1,585</td>
<td>937</td>
<td>426</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>259,224</td>
</tr>
<tr>
<td><strong>Beds ⁄ 000 pop’u</strong></td>
<td>6.1</td>
<td>3.6</td>
<td>1.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hong Kong East</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pamela Youde Nethersole Eastern Hospital</td>
<td>1,363</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tang Shiu Kin Hospital</td>
<td></td>
<td></td>
<td>88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruttonjee Hospital</td>
<td></td>
<td></td>
<td>597</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tung Wah Eastern Hospital</td>
<td></td>
<td></td>
<td>303</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. John Hospital</td>
<td></td>
<td></td>
<td>83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheshire Home (Chung Hom Kok)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Wong Chuk Hang Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>200</td>
<td></td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td>1,363</td>
<td>597</td>
<td>474</td>
<td>90</td>
<td></td>
<td>200</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,116,470</td>
</tr>
<tr>
<td><strong>Beds ⁄ 000 pop’u</strong></td>
<td>1.2</td>
<td>0.5</td>
<td>0.4</td>
<td>0.1</td>
<td></td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Kowloon Central</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>1,846</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kowloon Hospital</td>
<td></td>
<td></td>
<td>977</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hong Kong Buddhist Hospital</td>
<td></td>
<td></td>
<td>353</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td>1,846</td>
<td></td>
<td>1,330</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>638,778</td>
</tr>
<tr>
<td><strong>Beds ⁄ 000 pop’u</strong></td>
<td>2.9</td>
<td>2.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>General acute (Group 1A)</td>
<td>General acute (Group 1B)</td>
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### Provisional Legislative Council Secretariat
#### Long Term Health Care Policy

**General acute (Group 1A)**  
- Tuen Mun Hospital: 1,417  
- Pok Oi Hospital  
- Fanling Hospital  
- Castle Peak Hospital  
- Siu Lam Hospital: 300  

**General acute (Group 1B)**  
- Total beds: 570  

**Extended care (Group 2)**  
- Total beds: 1,741  

**Extended care (Group 3)**  
- Total beds: 300  

**Psychiatric (Group 4)**  
- Total beds: 1,321,280  

**Unknown**

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<th>Extended care (Group 3)</th>
<th>Psychiatric (Group 4)</th>
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**Remarks:**

* Excluding Hong Kong Eye Hospital, Nam Long Hospital, Grantham Hospital, Hong Kong Red Cross Blood Transfusion Service and Rehabaid Centre which do not belong to any cluster.

1. Covering population in Central and Western District.
2. Covering population of 171,656 in Wanchai, 594,087 in Eastern Hong Kong Island, 287,670 in Southern Hong Kong Island and 63,057 on Islands.
3. Covering population of 260,573 in Yau Tsim Mong and 378,205 in Kowloon City.
5. Covering population in Kwun Tong District.
7. Covering population of 582,993 in Shatin and 197,876 in Sai Kung.

**Sources:** Hong Kong Hansard, 10 July 1996, and 1996 Population By-Census
## Appendix VII

### Average Number of Bed Per Medical Staff by Type of Hospitals 1993

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<tr>
<th></th>
<th>Group 1</th>
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<th>Group 1B</th>
<th>Group 2</th>
<th>Group 3</th>
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**Remarks:**

Group 1 are acute general hospitals including PMH, PWH, QEH, QMH, TYH, TMH, PYNEH, CMC, GH, KWH, OLMH, RH, UCH
Group 1A are acute general hospitals including PMH, PWH, QEH, QMH, TYH, TMH, PYNEH
Group 1B are acute general hospitals including CMC, GH, KWH, OLMH, RH, UCH
Group 2 are extended care hospitals including DKCH, HHH, TWEH, YCH, FH, HKBH, KH, POH, SJH, TWH, TSKH.
Group 3 are extended care hospitals including CH(S), MMRC, MTMRC, NLH, SH, FYKCH, WTSH, CH (CHK).
Group 4 are psychiatric hospitals including CPH, KCH, LCKH
Including teaching staff for QMH & PWH
Activities of CMC include those for acute beds only
Source: Information Paper for LegCo, Panel on Health Services, Nursing Manpower, 8 January 1996
## Appendix VIII

### Manpower: Bed Ratio by Categories by Hospitals as at 31st March 1996

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<th>No. of beds per doctor</th>
<th>No. of Nurses</th>
<th>No. of beds per nurse</th>
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Remarks:
n.a. not available
n/a not applicable

Source: Hong Kong Hansard, 10 July 1996.
### Appendix IX

**HA Manpower Indicators 1996: Number of Patient Discharged Per Doctor Per Annum**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Acute Care Hospitals</th>
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<tbody>
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<td>Medicine</td>
<td>350-600</td>
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<tr>
<td>Surgery</td>
<td>400-650</td>
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<tr>
<td>Paediatrics</td>
<td>350-550</td>
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<tr>
<td>Gynaecology/Obstetrics</td>
<td>600-800</td>
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<td>Orthopaedics &amp; Traumatology</td>
<td>250-400</td>
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<td>A&amp;E*</td>
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</table>

Remark: * Number of patients attended the first appointment in that year.
Source: Hong Kong Hansard, 10 July 1996

**HA Nursing Manpower Indicators 1996**

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<th>Acute Care Hospitals</th>
<th>Extended Care Hospitals</th>
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<td>Geriatrics</td>
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</table>

Remarks:
* Number of nurses for a standard ward of 34 beds at 85% occupancy (excluding ward managers) and a staff mix ratio of 68% qualified nurses and 32% nurse learners.
n/a not applicable
Source: LegCo Panel on Health Services, Information Note on Nursing Manpower Indicators, 11 March 1996
References

1. Hong Kong Annual Digest of Statistics 1984-1996
2. Hong Kong Monthly Digest of Statistics, May 1996
6. Asia Healthcare Focus
8. Dr. Gerald H. Choa, A History of Medicine in Hong Kong
15. Peter P. Yuen, “Medical and Health”, The Other Hong Kong Report 1992
16. Peter P. Yuen, “Medical and Health Issues”, The Other Hong Kong Report 1997
18. Special Topics Report No. VIII, Social Data Collected by the General Household Survey, Census and Statistics Department, Hong Kong
19. Special Topics Report No. 13, Census and Statistics Department, Hong Kong
20. Special Topics Report No. 15, Census and Statistics Department, Hong Kong
21. Survey on Medical and Nursing Staff’s Opinion on Nursing Manpower in Public Hospitals, Social Sciences Research Center, The University of Hong Kong Summary Report, February 1996
22. Chris Ham, Health Policy in Britain (2nd edition, 1985), Basingstoke: Macmillan
25. McKeown, T. (1976), The Role of Medicine, London, Nuffield Provincial Hospitals Trust
28. Environment Hong Kong 1996
30. Hong Kong Hansard 12 July 1995, 3 April 1996
32. Hong Kong Population Projections 1997-2016, Census and Statistics Department
33. Provisional Legislative Council Brief, Immigration (Amendment) (No.5) Bill 1997, Security Bureau, 8 July 1997
34. Information Note to LegCo Panel on Health Services, 13 January 1997
35. LegCo Panel on Health Services, Record of Meeting 13 January 1997
36. Hong Kong Medical Association releases, Survey Results on Private Doctors' Fees, 16 December 1996
37. Attitudes towards Dental Health Policy and Dental Care among Hong Kong Policy-makers, Community Health Project, Department of Periodontology and Public Health, University of Hong Kong, 1995
40. Information Paper to LegCo Panel on Health Services, Accident and Emergency (A&E) Services in Public Hospitals, Hospital Authority, October 1996
41. Information Paper to LegCo Panel on Health Services, 20 May 1996
42. Information Note to LegCo Panel on Health Services, Primary Health Care Services, Department of Health, April 1997
43. Information Paper to LegCo Panel on Health Services, District Health System, Department of Health, September 1996
44. Information Paper for LegCo, Panel on Health Services, Nursing Manpower, 8 January 1996
45. Information Note to LegCo Panel on Health Services, Review of the Health Care System, January 1997
46. LegCo Panel on Health Services, Information Paper on Privately Purchased Medical Items for Public Patients, July 1996
47. LegCo Panel on Health Services, Information Paper on the Basis for the Creation of Consultant Positions in Public Hospitals of HA, 11 March 1996
48. LegCo Panel on Health Services, Record of Meeting held on 8 January 1996
49. LegCo Panel on Health Services, Record of Meeting held on 20 May 1996
50. LegCo Panel on Health Services, Record of Meeting held on 8 July 1996
51. LegCo Panel on Health Services, Record of Meeting held on 14 October 1996
52. Civil and Miscellaneous List, 1 July 1993
53. 香港中醫藥發展籌備委員會報告書，1997年3月